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APPROVAL

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Thesis Title: ACUTE STRESS AND COPING IN NORTHWESTERN BRITISH COLUMBIA NURSES IN RELATION TO THE TRANSFER OF TRAUMA PATIENTS

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Abstract

Nursing is recognized as a stressful profession. While a number of stressful situations are commonly encountered by all nurses, rural nurses in northwest British Columbia face stressors unique to their practice. This study examined a specific situation (transfer of trauma patients) in which northern rural nurses encountered stress, and the coping resources applied in managing that stress. A qualitative research design was used. Data were collected through four focus groups comprised of emergency nurses, operating room nurses, and critical care nurses. Four types of situations in which nurses felt stressed were identified and included system problems, lack of communication and support, visual impact, and professional discord and friction. Inter-rater reliability was established in the analysis phase of categorizing the stressful situations. Nurses described using both problem-focused coping and emotion-focused coping strategies when managing stress. Nurses placed more emphasis on using forms of emotion-focused coping, in particular, co-worker social support. Lazarus and Folkman’s transactional model of stress was also presented as an approach in examining the individual nature of stress, appraisal of stress, and coping.
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CHAPTER ONE

Introduction

Nursing has been recognized as a stressful profession. Parasuraman and Hansen (1987) state that among those persons employed in human service organizations, nursing professionals suffer particularly severe stress. Hingley (1984) describes nursing as a very stressful profession by nature:

Everyday the nurse confronts stark suffering, grief and death as few other people do. Many nursing tasks are mundane and unrewarding. Many are, by normal standards, distasteful and disgusting. Others are often degrading; some are simply frightening (p.19).

Working in the aforementioned environment would certainly be demanding. To some, this may seem to be an overstated view of nursing as not all nurses experience these situations in their daily work. However, various demands have been identified that nurses typically face and view as stressful, regardless of rewarding experiences. These demands, or major job stressors include exposure to death and dying; dealing with emotional demands of patients and their families; inadequate staffing and work overload; and conflicts with fellow health-care workers (Constable & Russell, 1986; Dewe, 1987; Gray-Toft & Anderson, 1981).

"Stress is a particular relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being" (Lazarus & Folkman, 1984, p.19). This definition of stress focuses on the relationship between the person and environment and the evaluative process used in assessing this relationship. Stress is a part of our everyday life--even minor hassles can contribute to stress. How we interpret this stress defines how we cope with it and, in turn, influences the outcome of the interaction (Dewe, 1993; Numerof & Abrams, 1984; Tyler & Cushway, 1995). For purposes of this study, acute stress will be defined as an intense,
time-limited situation that exceeds one’s resources, whereas chronic stress is a persistent and lingering state (Lazarus & Folkman, 1984).

A segment of the nursing stress literature examines levels of stress in different work areas in an attempt to identify those nurses who may experience higher levels of stress than others. Nurses working in specialized care units have been compared with nurses working in general care units. By administering Nursing Stress Inventory measures, Numerof and Abrams (1984) and Dewe (1988) found that nurses in specialized care units do not necessarily experience higher levels of stress than their counterparts. They pointed out that critical care nurses have been identified as possibly experiencing more stress due to the nature of their work, but it is inaccurate to assume they are the most stressed nurses. Reflecting on past experience, I am of the opinion that in addition to general stressors common to all nurses, unit-specific stressors exist, and depending on how they are personally interpreted, can result in greater stress for individual nurses. Stress stems from the nurse’s relationship or interaction with her environment. In describing their transactional model of stress, Lazarus and Folkman (1984) state that “...stress is neither in the environment nor in the person but a product of their interplay” (p.354). This model is elaborated on later.

There is scant literature regarding nursing and stress among nurses employed in rural or isolated regions (Birkland, 1994; Hamer, 1997; Scott, 1991; Sibbald, 1998). The absence of literature is of particular interest to me since I have worked for many years in the Northern region of British Columbia which is vastly rural. Much of the literature that discusses nursing stress focuses on nurses employed in urban or metropolitan hospitals (Dewe, 1987; Gray-Toft & Anderson, 1981; Hawley, 1992; McCranie, Lambert & Lambert, 1987; Parasuraman & Hansen, 1987; Parkes, 1986). I believe that the stressors described by these authors are chronic stressors that are ever present and perhaps inherent to the profession of nursing. For example, criticism from physicians, conflict with
co-workers, performing non-nursing tasks, or having inadequate time to care for patients are general, ongoing and persistent situations that arise in any nursing environment (Dewe, 1988; Gray-Toft & Anderson, 1981; McGrath, Reid, & Boore, 1989). A common expression often used by nurses is "if no one else will do it, it must be a nurse's job". Time constraints are ever present no matter how well organized a nurse is. Patient care is administered according to a schedule with little regard for the patient's preference. Health-care requires an interdisciplinary approach; and consequently it is not unusual for conflicts to arise between professionals when discussing and implementing patient care.

In addition to experiencing chronic stressors, I believe rural nurses deal with acute stressors in their daily work that are unique to them. Lack of human and or technological resources is a reality in the rural or isolated region (Birkland, 1994). The absence of a resource can at times be seen as a stressor. For example, it can be very frustrating for nurses to know that certain products are readily available in urban regions, but not in rural areas. If the product is required, it must be requested and flown in. At the very least, this can take several hours. Weather-induced delays in transfer of trauma patients also pose a challenge. Poor weather, combined with lack of Instrument Landing Systems or radar guidance at most northern airports due to mountainous terrain can result in lengthy waits for an air ambulance flight. The severity of injuries is compounded by any delay in advanced treatment, thus escalating tension in an already stressful situation. Physical transport of patients within urban regions, however, is straightforward and weather is of little concern. Oftentimes, physicians are unavailable in the rural hospital setting and the nurse must make a decision concerning patients. This can be a stressful situation as nurses may be fearful of making a mistake or lack confidence in their decision. It is not unusual for a rural emergency department to be unstaffed after midnight. A night shift charge nurse is responsible for attending to patients who present to the emergency department in addition to performing other assigned duties. At the same time, the physician is not
physically present, but ‘on-call’. There are no residents or interns in rural hospitals. It can be argued that these stressors are chronic in nature rather than acute, but they do not routinely and constantly challenge nurses. However, there are instances when these situational, environmental, and personal factors interact to create an acute stress situation.

Health-care

The emergence of acute stressors may be linked to our present system of health-care delivery, or our health-care environment. Governments, regional health boards, and community health councils are constantly reforming the context of health-care delivery. Comprehensiveness of health services (all insured health services provided by hospitals or additional health services rendered by other health care practitioners) has become an issue and “...communities must now ask themselves if they can tolerate the lack of certain services that may be needed and effective, but costly and beneficial to relatively few” (Vail, 1995, p.59). Also, one must recognize that including a service as part of the publicly funded package does not mean it is accessible (Morton & Loos, 1995) -- accessibility and comprehensiveness being only two of five conditions in the Canada Health Act that must be adhered to for federal cash transfer for health. This relationship between comprehensiveness and accessibility means that health-care providers and communities are now having to make decisions about acceptable travel distances to receive services, acceptable waiting periods, and how often services should be used (Vail, 1995). These decisions may result in more patients being transferred for care which may be stressful for northern nurses. The continuum of care is disrupted with transfer of patients to other facilities, and the nurse may feel her work is incomplete.

Southard and Trunkey (1990) stated that “The availability of necessary resources decreases proportionally when population density diminishes” (p. 321). Federal transfer payments in Canada for provincial health-care have been decreased over the years. The impact of fiscal restraint has slowly filtered down to where it is felt most—the public
domain. Hospitals throughout the Province of British Columbia are faced with difficult decisions in regard to providing basic and specialized services. Despite budgetary restrictions, metropolitan regions have been, and continue to be, a mecca for health-care delivery support, while northern and isolated regions struggle to deliver basic health services with limited resources. Rural hospitals have experienced bed closures, increased workload, decrease in staff numbers, and quite possibly, an increase in stress among nurses.

**Trauma**

In addition to providing basic health-care, rural nurses often minister to the needs of accident or trauma patients. Due to the limited availability of advanced medical care, specialized equipment, and other resources for post-critical care, many trauma or accident patients are transferred to urban hospitals for treatment. While many of these patients are cared for efficiently and successfully in the rural hospital (Rinker & Sabo, 1989), it is the patients who require complicated surgical procedures, intensive follow-up by specialized personnel, extensive rehabilitation therapy, or the needs of a service not provided by the community hospital who are routinely transferred to a larger hospital. It is most often an emergency (ER) nurse, operating room (OR) nurse, or an intensive care unit (ICU) nurse who is involved in providing the initial care and resuscitation of the trauma patient. Once the victim has been stabilized and transferred to another facility, the nurse's contact with the patient ends. The opportunity to finish the task of caring does not exist in this instance. During these situations nurses are faced with acute stress, that is, an intense, brief or time-limited situation that taxes or exceeds the nurse's resources. As nurses, we are accustomed to providing continuous uninterrupted care for patients, having daily contact with patients, and seeing patients through their hospitalization. Nurses feel that they have 'nursed' the patient and seen the results of their care. However, there is no opportunity to 'completely nurse' the transferred trauma patient, and the business of
nursing remains incomplete. The work that was commenced by nurses in one facility will be completed by others in a distant location. The actions and results of nursing care at that facility are rarely communicated back to the northern rural nurses. Nurses typically impose high standards of care upon themselves, some of which are unrealistic. While it is obvious that a trauma patient requires a higher level of care, we may feel we are not meeting our personal goals when care is transferred, and this too can be stressful.

Baum (1987) identifies the intensity of the event, scope of the event, and the familiarity with the type of event as contributing to the stress experienced in a trauma situation. While we are usually able to deal with the tasks required in nursing a trauma patient, we are generally unprepared for the emotional impact the event can have on us. Holaday, Warren-Miller, Smith, and Yost (1995) found that social and peer support, and humour when carrying out work, are important aspects of coping with trauma. Lazarus and Folkman (1984) believe that individual appraisal of an event precedes coping activities, and that coping changes as the person-environment relationship is re-evaluated.

The focus of this research was to investigate acute stress and coping among northern nurses in relation to dealing with transfer of trauma or accident patients.

Coping with Stress

Coping with stressors, acute or chronic, requires an availability of resources. Lazarus and Folkman (1984) define coping as “...constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person” (p.141). Coping either manages or alters the situation, or checks the emotional response. Lazarus and Folkman (1984) refer to these types of coping as problem-focused, usually applied when the condition is appraised as amenable to change, and emotion-focused coping, usually applied when the individual feels nothing can be done to modify challenging environmental conditions. There are limited resources available in rural regions, and often access to skilled
professionals is circumscribed for a variety of reasons—confidentiality issues or location of professional help for example. Information about how northern nurses cope with stress needs to be examined further.

In addition to relying on social support from others as an aid in coping, I have also witnessed and personally experienced the reliance on one’s own reserve as a method of coping during acute stress. Many professionals do not acknowledge their colleagues’ distress as legitimate, and as a result, professionals look to themselves to resolve stress. Figley (1995) states that there is much attention directed to people in harm’s way, but little attention has been devoted to caregivers. This parallels the experience of rural nurses facing acute stress in the aftermath of caring for a trauma patient who has been transferred. There are no formally established debriefing programs in northern British Columbia hospitals to provide psychological or emotional support for nurses and others. The debriefings I have attended were, in fact, case-reviews of events with attention focused on the treatment of the patient. Attempts to discuss personal issues were met with resistance and a change of topic. Ellis and Miller (1994) feel their communication research has clearly demonstrated that social support from co-workers can be a potent antidote to stress in the nursing occupation. They further consider supportive co-worker communication to be a form of social support, which is beneficial in reducing nursing stress by acknowledging the nurse’s experience.

Social Support

Social support for nurses may take shape in a variety of ways, for example, talking with colleagues, sharing experiences, receiving advice and information, or venting with a colleague. Sarason, Levine, Basham, and Sarason (1983) view social support as having two components: the perception that there are others one can turn to in times of need, and, a degree of satisfaction with the available support. Taylor (1986) states that sometimes social support is not forthcoming to those under stress, and sometimes efforts
to provide social support fail to generate the intended effect of stress alleviation. Lack of appropriate critical incident stress debriefing compounds the situation—there is no avenue for emotional release available.

What I have attempted to convey thus far is the diverse work of nursing and some stressors experienced by nurses in rural areas. Coping with these stressors is of importance, as options are limited (for example, limited professional support, relying on one’s own resources, or applying for medical leave). There is little hope of the stressors being eliminated since they are specific to the style of health-care delivery within the northern region of British Columbia. Social support appears to be of benefit to nurses, but can be lacking in certain elements. There seem to be few attempts by administrative personnel to follow-up stressful incidents with staff. It seems that stress experienced by nurses after patient transfer is not universally acknowledged as an authentic concept.

**Background to the Question**

My interest in this issue emerged while working as an operating room nurse in northern British Columbia and experiencing acute stress after caring for trauma patients who have been transferred. The demanding care required, and the urgency, can be overwhelming. Regardless of the limited patient contact, nurses are still drawn into the intensity of medical situations.

The event is appraised differently by individuals which also determines whether the potential stressor is viewed as a threat or a challenge. In addition, people differ in how they appraise their own resources and capabilities (Singer & Davidson, 1986) which determines if they will apply an emotion-focused strategy or problem-focused coping strategy. Stress is not a fixed person-environment relationship, but an evolving process, involving multiple appraisals and reappraisals (Roskies, 1987). I have seen colleagues temporarily incapacitated because they have been denied validation or legitimization of a stressful event by colleagues, nurses and physicians. Lazarus and Folkman (1984) state
that people will have better adaptational outcomes if they receive or believe that they will receive social support when needed.

Ellis and Miller (1994) believe that nurses need to know that individuals are available to listen and understand. Receiving tangible support is essential in order for people to feel good about themselves. The psychological paradox surrounding the crisis event can often lead to lack of closure for the nurse. The nurse may feel it necessary to restrain whatever feelings she is harbouring surrounding the event in order to gain and retain professional approval from her colleagues. Yet, at the same time, she is knowingly denying herself the opportunity to actively cope with the event. Pennebaker and Susman (1988) refer to this restraint as inhibition, which in itself is a stressor, and which can also significantly prolong the coping process. This restraint, or avoidance coping, can be viewed as emotion-focused coping.

According to Lazarus and Folkman (1984), denial or denial-like behaviours may be adaptive at certain stages of an encounter, but it is important to consider what is being denied. Past trauma events may resurface when nurses are faced with a new trauma situation. Some colleagues can vividly describe the minutest details of an event that occurred several years ago, and compare that event to an event they have just faced. Burns and Harm (1993) discuss the ways succeeding events can arouse emotions from the original critical event, and also emphasize the importance of debriefing interventions in helping nurses to cope with the stress of serious clinical events. This is of significance for nurses in small northern communities which tend to be close-knit. It is not unusual to recognize patients wherever one goes. The likelihood of personally knowing the trauma victim, recognizing the victim, or knowing someone else who is related to the victim does exist. This situation can also contribute to acute stress.

Do nurses in other northern rural hospitals experience similar episodes of acute stress in relation to treatment and transfer of trauma patients? Hospitals in the northern
British Columbia region range in size from 18 beds to 48 beds, excluding extended care (Guide to Canadian Healthcare Facilities, 1997). In addition to hospitals, there are a number of nursing stations or health centres located in the region’s sparsely populated areas. These stations typically have one or two holding beds or emergency beds. In the hospital where I work, it is not uncommon to receive trauma or accident patients from a health centre, or another hospital in the region, for life-sustaining treatment prior to the patient’s transfer to an urban centre. Often, patients are discharged from the urban hospital directly to the community in which they reside. At this time, there is no mechanism in place for the receiving hospital to report back to the referring hospital in relation to the patient’s immediate or future progress. Rather, it is up to the individual physicians and nurses involved in each facility to communicate with each other. This can be very frustrating as the lines of communication are not always available or accessible. Finally, there is little opportunity for delayed patient-nurse contact when the patient bypasses the hospital system and recuperates at home. When a patient is transferred back to a rural facility for continuing care, nurses have an opportunity to re-establish the therapeutic relationship that was commenced prior to patient transfer. This can provide the much needed closure to the nurse’s coping efforts.

**Research Question**

Nurses in northern rural British Columbia hospitals can experience acute stress related to caring for and transferring of trauma or accident patients. This study investigates the phenomenon of acute stress and various ways of coping among northern nurses in relation to transfer of trauma patients. It is believed that northern rural nurses rely on social support as a form of coping in situations appraised as stressful. Data were collected by using focus groups comprised of nurses from various northern British Columbia hospitals.
CHAPTER TWO

Literature Review

Stress is a part of our everyday existence. Many people try to avoid stress while others seem to thrive on it. Traditionally, stress has been defined in terms of stimulus or response. According to Lazarus and Folkman (1984), these views have limited utility, because a stimulus gets defined as stressful only in terms of a stress response. Individual differences in evaluating the events are not taken into account.

The practice of nursing is diverse and replete with a never ending variety of patient care situations. Just as a specific situation is individually assessed and attended to by nurses, so is the perception and meaning of the event. That is, each nurse will assess the nature of the event and assign her own personal meaning to it. What may be stressful for one nurse may not be for another. For example, treatment of a trauma patient with subsequent transfer to an urban facility may be viewed as a threat by one nurse, yet another will appraise the event as a positive or irrelevant challenge. That nurse will then cope in a manner different from the nurse who judged the event to be threatening.

Lazarus and Folkman (1984) focus on the individual nature of the stress experience. For this reason, their transactional model of stress will be utilized in examining northern nurses dealing with trauma patients.

Transactional Model of Stress

The transactional model of stress advocated by Lazarus and Folkman (1984) views the person and the environment in a "...dynamic, mutually reciprocal, bidirectional relationship" (p. 293). In other words, individuals do not respond to the environment in a fixed, predetermined manner. There is an ongoing, 'sliding scale' of interplay between the person and the environment which changes in relation to personal meaning. Unlike traditional models of stress, the transactional model joins together person and environment elements to form new meaning through appraisal (Lazarus & Folkman, 1984).
Cognitive Appraisal

Individuals go through a mental process of evaluation in deciding whether a transaction with the environment is relevant to their well-being; the significance of the event is evaluated in terms of personal interest or risk. Lazarus and Folkman (1984) discuss two aspects of appraisal—primary and secondary appraisal. Primary appraisal is an assessment of what an individual judges to be at stake in the transaction, and the magnitude of its potential costs and or benefits. During primary appraisal, the individual asks the question “what does this encounter mean to me?”. Three types of primary appraisal are identified by Lazarus and Folkman—irrelevant, benign-positive, and stressful. An encounter can be classed as irrelevant if individuals do not gain or lose anything in the transaction; the event is not perceived to be personally intimidating. Encounters viewed as favourable or potentially positive with enhanced well-being are classed as benign-positive appraisals (Lazarus & Folkman, 1984). Stressful appraisals are those in which the individual anticipates challenge, threat, and harm or loss as the outcome of the encounter. Challenge and threat are closely related concepts that are not necessarily mutually exclusive (Lazarus & Folkman, 1984), or clear (Lazarus & Launier, 1978). Threat is associated with negative emotions and relates to anticipated harm and or loss, which allows for anticipatory coping; challenge also calls for coping, but the focus is on the potential for gain in the encounter and is characterized by pleasurable emotions (Lazarus & Folkman, 1984). In harm and or loss appraisals, some damage has already occurred. The determining factor relates to the event being viewed in a positive or negative manner, that is “…whether one emphasizes in the appraisal the potential harm in a transaction (threat), or the difficult-to-attain, possibly risky, but positive mastery or gain (challenge)” (Lazarus & Launier, 1978, p. 304). Lazarus and Launier also state the difference in appraisal is dependent on the nature of the particular environmental events.

In secondary appraisal, individuals are concerned with ‘how and what’ can be done
to manage the situation. Secondary appraisal is seen as a critical feature of every stressful encounter because the outcome depends on what, if anything, can be done, as well as what is at stake for the individual (Lazarus & Folkman, 1984). Management of the encounter is referred to as coping, and the coping method used is influenced by secondary appraisal. Secondary appraisal is a methodical evaluation of the coping options available to individuals, the effectiveness of the chosen coping option, and the ability to use the chosen coping method (Lazarus & Folkman, 1984). For example, a nurse may review her options in debriefing a critical event. She could discuss the scenario with staff involved, close friends only, a professional counsellor, keep it to herself, or make a journal entry. The choice depends on what the nurse feels would be most effective and why. Also, the nurse must feel able to follow through with the coping option—she may be able to record her thoughts, but be unable to speak to a counsellor about the incident.

Secondary appraisal and primary appraisal naturally interact with each other. This interaction results in the degree of stress experienced and the emotional characteristics attached to the stress. Primary and secondary appraisals are a key aspect of Lazarus and Folkman's (1984) concept of coping. Secondary appraisal gives shape to an individual’s coping method, and at the same time, influences the process of primary appraisal. If an individual deals with a potential threat easily, it is appraised as having little threat, and vice versa. An individual’s interpretation of the event determines the nature of the challenge, which influences their appraisal of potential coping resources and responses.

**Coping**

Lazarus and Folkman (1984) view coping as a process-oriented effort. Unlike traditional views of coping that are trait or style oriented, the process-oriented approach is relatively young and offers much to us in terms of examining individuality and the coping experience. Coping has been defined earlier in this paper as “...constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that
There are three elements to this definition. It is process oriented, focusing on what individuals do in a specific encounter, and the changes that occur throughout the encounter. The emphasis is on change rather than stability. Coping is also viewed in a contextual manner. A person’s appraisal of the situational demands and resources for managing them influence coping efforts (Lazarus, 1993). Finally, no assumptions are made about effective or ineffective coping. Coping is the effort of managing a situational demand, regardless of outcome (Folkman, Lazarus, Dunkel-Schetter, DeLongis, & Rand, 1986).

Coping can be seen to have two important functions—regulating emotional response to the problem (emotion-focused coping), and managing the problem causing the distress (problem-focused coping) (Folkman et al., 1986; Lazarus & Folkman, 1984). Emotion-focused coping is more likely to be used when, based on appraisal, the individual feels nothing can be done to modify the situation. In this instance, changing the relational meaning of the situation is very effective in controlling stress and emotion. Avoidance, denial, distancing, and selective attention are some examples of emotion-focused coping (Lazarus & Folkman, 1984). Pennebaker, Hughes, and O’Heeron (1987) found that the need to discuss an important event or feeling, but not being able to do so, is a particularly relevant form of inhibition. They felt that if the event could eventually be disclosed, the work involved in maintaining the silence would be reduced, resulting in decreased personal stress. I believe inhibition fits into the category of emotion-focused coping.

Problem-focused coping is directed at defining the problem, generating alternative solutions, examining the alternatives, making a choice, and acting upon that choice (Lazarus & Folkman, 1984). Strategies used to manage work problems could be seen as problem-focused coping, for example, rehearsal of a specific scenario to ensure a smooth
flow of events when required. Problem-focused coping can be further divided into two forms. One is a confrontive, interpersonal manner, for example, trying to get someone to change his or her mind, or standing your own ground. The other form follows planned problem-solving techniques. For example, making a specific plan and implementing it, or, trying a list of different possible solutions. While problem-focused coping influences the environment one works in, it does not guarantee a satisfactory solution to a problem, nor does it guarantee that a problem will not recur.

While one form of coping may appear more prominent than the other in a given situation, it is important to recognize that each form is influenced by the other. At times it may be difficult to differentiate between problem-focused coping and emotion-focused coping because both can occur simultaneously. Lazarus (1993) notes that there is a strong tendency in western values to venerate problem-focused coping, while emotion-focused coping is regarded somewhat dubiously.

In general, coping process emphasizes temporal and contextual influences on coping, and any associated changes, whereas coping style emphasizes personality characteristics or traits without regard for particular stressful encounters (Folkman & Lazarus, 1990; Lazarus, 1993). It is acknowledged, however, that some strategies of coping are more stable or consistent across stressful encounters than others (Lazarus, 1993), and that more research is needed to determine the degree to which coping strategies are influenced by social context, personality variables, or both.

Coping Outcome

Coping has traditionally been likened to success or mastery over a particular stressful situation, for example, ‘She coped very well last week’ or ‘She is not coping well in her new job’. Implicit in these general statements is a sense of adequacy and or competence, or lack thereof. Lazarus and Folkman (1984) caution against confounding coping processes with coping outcomes, as coping is defined by the behaviours or efforts
directed at managing stressful situations, and not the success of those efforts. Emphasis on successful mastery of a situation ignores the effort and functions of coping itself, which at times are more important than the outcome.

While Lazarus and Folkman (1984) consider it desirable to view coping processes and coping outcomes as two separate components, in actuality, it is difficult to do so. For example, Parasuraman and Hansen (1987) describe coping in terms of adaptive or maladaptive coping and outcomes when describing coping with work stressors in nursing. Heim (1991) advocates a transactional model of coping in his work on job stressors and coping in health professions; however, he discusses this in terms of good or bad coping in conjunction with good or bad outcomes. As a society, it is far easier to define coping processes in terms of outcomes, rather than viewing coping as a discrete process.

**Coping and Emotion**

There is often more than one emotion to consider in any encounter. As the person-environment relationship changes, the emotions associated with the meaning of the encounter change also. Coping can then be viewed as a mediator of emotional response by changing the emotional state throughout the encounter (Folkman & Lazarus, 1990; Lazarus, 1993). Folkman and Lazarus (1990) consider three ways in which coping can be a mediator: (a) by diverting attention from the source of distress, (b) by changing the subjective meaning of the person-environment transaction, and (c) by changing the actual terms of the person-environment relationship, for example, using problem-focused coping (p. 214).

**Social Support**

Lazarus and Folkman (1984) state that while the awareness of people gaining growth and support from social relationships has been established, it is not readily apparent how the process actually works. A reason for this confusion may be that social support has been described and measured in different ways. While it is now
acknowledged that there is a difference between the number and types of relationships a person has (social networks), and the perception of the value of social interactions (social support), inconsistencies can still be found. For example, Tyler and Cushway (1994) suggested that nurses in hospitals had an adequate level of social support because they were involved in large social networks, but the two were not examined separately in their study. Social support is often viewed as a part of our social environment, but Lazarus and Folkman prefer to treat it as a "...resource, available in the social environment, which the person must cultivate and use" (p. 250).

Coping Efforts

Lazarus and Folkman (1984) hold that discussions of coping must include those efforts used to manage stressful situations, regardless of the outcome. One particular coping strategy should not be viewed as better or worse than any other, and a contextual assessment is required.

There may be many strategies or ways of coping that fall under the umbrella of emotion-focused coping. One strategy that stands out for me in particular is denial or any denial-like forms of coping. This is of interest because I have witnessed such coping in colleagues when they have been processing the events of a stressful situation. For example, because involvement in critical incidents is part of the job, a colleague may feel that he or she should just 'handle it or not do it at all'. In this instance normalization of the event is denied. Lazarus and Folkman (1984) present some support for coping by denial "...when there is no direct action that is relevant, denial and denial-like processes contain the potential for alleviating distress..." (p. 137). It must be noted, that while denial is suitable for certain elements of a situation, it is not suitable for the entire scenario of events because denial can potentially mask further threats. Also, a temporal aspect must be considered when evaluating the effectiveness of a denial-like strategy. Initially denial can limit the emotional distress of the situation, but denial over time may prevent
individuals from objectively addressing the issue with an effective coping strategy.

The nature of nurses' work requires an ongoing interaction with the environment where care is delivered. It is commonplace to see or hear nurses discussing events that were personally troublesome or rewarding. There seems to exist, however, an invisible cut-off point regarding the depth to which troublesome events are discussed or even acknowledged. This may be tied into the fact that everybody experiences an event individually, and the impact of that event will differ from its impact upon the next person.

Research on Traumatic Events

Traumatic experiences affect people physically and psychologically. How people experience or interpret an event can be more significant than the event itself. Attempting to understand the personal meaning of an event requires a close examination and perhaps a discussion of the event with others. However, a perceived negative reaction, personal embarrassment, or fear, may inhibit an individual from confronting and assimilating the experience. Pennebaker, Hughes, and O'Heeron (1987) attempted to evaluate psychological and physiological parameters of confessing traumatic experiences among college students. Measures of skin-conductance levels (SCL), blood pressure, heart rate, and muscle activity were obtained before, during, and after each interview. In general, they found that when high-disclosers discussed traumatic events, their SCLs were lower than when discussing trivial events, and the opposite was true for students classed as low-disclosers. Pennebaker et al. (1987) defined degree of disclosure as "...the proclivity to talk about extremely personal and stressful information in the laboratory settings" (p. 783). A shortcoming of this study was that there was no direct evidence that the subjects were previously inhibiting the information they divulged (Pennebaker et al., 1987). The authors could not evaluate the degree to which specific events had previously been inhibited, nor could they determine the degree to which the students wanted to tell others about their traumatic event but had actively not done so. Despite this, they held that their
findings reflected those of previous studies, and supported the concept of inhibition as valid. In a related study, Pennebaker and Hoover (1985) found that sometimes individuals were unable to discuss personally traumatic events for fear of embarrassment. In those instances, the confiding process is actively inhibited, which in itself, is stressful. The combination of the offending event, and inhibition, can then work against the individual and produce long-term stress and deleterious health effects. In a survey of 75 medical psychology students, Pennebaker and Hoover (1985) found a distinguishing characteristic of their study to be that, regardless of the kind of traumatic experience, not confiding in others about the event was associated with a difference in health status among the students. ‘Non-confiders’ had more health problems than ‘confiders’. Interestingly, there were no differences between the groups in terms of the number of close friends they had. This begs us to take a closer look at the effects social support has on stress reduction. What particular aspect of social support must be available in order for individuals to confide in one another?

Pennebaker and Susman (1988) found that disclosure of important personal events had psychological and physical benefits, and that not discussing a traumatic event with others is a significant long-term stressor. In one study, 46 psychology students were asked to write about a traumatic event each day for 4 days. Students were instructed to write either about the facts of the event only, or to include their emotions, feelings, and thoughts in relation to the event. Questionnaires were completed by the students during the study, and also 4 months post-study. At 6 months post-study, information was obtained regarding the students illness related visits to the health centre. It was found that the number of students illness visits to health clinics dropped significantly when they were allowed to include their emotions and feelings in their writings, and students were generally happier than before the study.

Pennebaker, Colder, and Sharp (1990) studied 130 college freshmen to determine
whether the students’ coping abilities could be enhanced by confrontational writing. The
students were instructed to write about their deepest thoughts and feelings related to
attending college, or superficial topics without mention of emotion and feelings.
Pennebaker et al. (1990) saw the transition to college as an ideal phase for studying the
coping process because the students were in a new psychological, academic, social, and
physical environment. Based on the reduced number of health-centre illness visits
measured, Pennebaker et al. (1990) concluded that writing about upsetting events had
physical and long-term psychological benefits. While Pennebaker (e.g., 1985, 1987, 1988,
1990) focused on college students in his studies, I feel the general concept of inhibition as
described by the author deserves close attention in relation to nurses. In particular, the
idea that inhibition forces individuals to actively avoid thinking about that event is
especially revealing. This process (which is seen to be taxing in the long-run) requires
energy that may be put to better use in resolving stressful situations through ways other
than inhibition or denial.

Lazarus and Folkman’s (1984) transactional model of stress has been introduced as
a favourable approach in examining and understanding the concept of stress. The
interplay between the individual and the environment, and the appraisal and coping
processes used are of key importance in how individuals manage stressful situations.
Examining stress and coping as a process enables us to better understand the nature of
stress as being an individual experience; that is, a person’s transaction with the
environment and his or her appraisal of that transaction somehow gives shape to the
personal meaning attached with that event. The personal meaning of the event is then
translated into a coping process as required by individuals. Lazarus and Folkman (1984)
call attention to the fact that “...many sources of stress cannot be mastered, and effective
coping under these conditions is that which allows the person to tolerate, minimize,
accept, or ignore what cannot be mastered” (p. 140).
Pennebaker’s studies of college students showed that emotion-focused coping (inhibition) was used to manage a particular problem causing the distress. The association between emotion-focused coping and problem-focused coping must not be overlooked, as they can occur simultaneously. For example, a student who is inhibiting thoughts may at the same time be applying a problem-focused strategy by making a plan and sticking to it.


**Stress Related Nursing Research**

The majority of nursing stress literature reviewed relates to nurses in urban or metropolitan institutions. It was difficult to find studies pertaining to rural nursing, especially Canadian nurses. Despite this limitation, the research clearly demonstrates that stress in nursing is a universal issue. Researchers have examined different aspects of nursing stress in order to understand it better. Parkes (1986) studied coping among student nurses. Tyler and Cushway (1995) looked at the effects of social support on coping among nurses, and Ellis and Miller (1994) examined supportive communication and stress among nurses. Regardless of the approach used, one common theme is evident — stress in nursing is an individual experience based on the nurse’s interaction with the environment.

Numerof and Abrams (1984) studied nurses in a medium-sized Midwestern,
American hospital to identify sources of experienced stress, and to determine if personal variables were predictive of such experienced stress. Demographic data were obtained, and the Nursing Stress Inventory was administered, which included items relating to organizational environment, work demands, emotional aspects of patient care, death-related issues, lack of administrative support, and supervisor's role (Numerof & Abrams, 1984). One hypothesis of interest was that stress would be experienced differently as a function of a clinical area. Numerof and Abrams thought that paediatric and obstetric nurses would have lower levels of stress than emergency, intensive care, or surgery nurses. The authors found that while some units were more stressful than others, they were not the ones assumed and predicted to be more stressful. This is significant and indicates that the nature of the particular environment and nurse's interaction with that environment forms reported stress. The authors concluded that what an individual brings to the job situation in terms of personality and experience are related to experienced stress. They also felt that stress could not be regarded as a single phenomenon, but better understood in terms of a discrete dimension in which the potential stressor and degree of stress associated with that event is taken into account (Numerof & Abrams, 1984). In other words, stress is not composed of only one, solitary item; rather, distinct human and environmental elements join together which result in experienced stress.

I found this article relevant to situations I have encountered. For example, experienced nurses are likely to handle stressful situations differently than novice nurses. The coping process allows the experienced nurse to filter out the irrelevant material, whereas the novice nurse is often overwhelmed and has difficulty in separating the relevant from irrelevant components. An important concept here is that of automatized adaptive behaviour. Lazarus and Folkman (1984) state the distinction between automatized responses and coping is not always clear, "...that most people deal with the demands of daily living in ways that do not exceed their resources is evidence that many coping
processes become automatized. [H]owever at one point most such demands exceed available resources and require coping” (p. 131).

Gray-Toft and Anderson (1981) developed the Nursing Stress Scale which measures the frequency and major sources of stress experienced by nurses on hospital units. Seven major sources of stress were identified: death and dying, conflict with physicians, lack of support, inadequate preparation, conflict with other nurses, workload, and uncertainty regarding treatment. These sources of stress fall into three domains—physical, social, and psychological environments. As a measurement tool, the Nursing Stress Scale is of relevance (Eastburg, Williamson, Gorsuch, & Ridley, 1994; McCranie, Lambert, & Lambert, 1987; Tyler & Cushway, 1995). Not only does it acknowledge and identify different domains of stress, it can also specify a source of nursing stress. The ability of the scale to identify nurses who are under excessive stress further attests to the concept of stress as an individual experience. The Nursing Stress Scale was developed based on information obtained from nurses in a large, private hospital. In view of this, it would be interesting to see how nurses from rural areas respond to the items on the Nursing Stress Scale. Perhaps some differences in sources of stress exist.

Using a large nation-wide sample of 2,500 New Zealand nurses, Dewe (1987) examined situations which they reported as stressful. By using such a large sample, Dewe thought problems of previous studies could be addressed. A large-scale sample had previously not been used, and Dewe felt smaller sample sizes may limit the generalizability of results. Dewe’s other concern was the sources of stress examined—in previous studies, the sources were selected by the researchers and the nurses had little opportunity to personally identify other sources of stress.

Dewe (1987) gathered information via interviews on specific situations the nurses reported as stressful. Based on this information, a questionnaire was then developed that examined factors contributing to nurses’ stress and their coping strategies. This
questionnaire was then distributed nation-wide to nurses working in general hospitals and obstetric hospitals. The sources of identified stress fell into five groups: work overload, staff difficulties, dealing with critically ill patients, dealing with difficult patients, and concern over patient care (Dewe, 1987). These stressors can also be categorized as physical, social, or psychological stressors. Dewe points out that while the stated sources of stress can be individually examined statistically, in reality they are not independent of each other. In focusing on each individual stressor alone, we may fail to see the relationships between the stressors and the environment.

Dewe (1988) thought that while it was tempting to focus on a specific nursing specialty when discussing stress, it was essential to examine the kinds of stressors encountered in all nursing wards. He found past research in comparing nursing stressors across wards to be limited because of sample size, the lack of variety in settings, and limited number of wards chosen for comparison. By using the identified sources of stress from his 1987 research, Dewe (1988) examined the frequency of nursing stressors in the same nation-wide sample of nurses. Nurses were asked to think about the occurrence of each stressful event over the past 3 months, and indicate the frequency of the event, how tense they felt, and how tired they felt. This study highlights three areas. First, specific groups of nurses experience particular stressors more frequently than others (Dewe, 1988). Second, different wards may experience different stressors more frequently, and finally, the ward environment may contribute to reduction in frequency of stressors. For example, Dewe (1988) found the operating room (OR) to differ from the intensive-care unit (ICU) in stress frequency based on the routines and schedules imposed in the operating room. Certain stressors appear to be commonly encountered by all nurses, but some nurses encountered different stressors more frequently (or not). Therefore, all nurses do not experience the same stressors, or to the same degree or frequency. These findings draw attention to the notion of the individual nurse transacting with her given
environment in experiencing stress, which leads us back to the transactional model of stress.

While Dewe's 1987 and 1988 studies utilized a nation-wide sample of general and obstetric nurses, which would enhance generalizability of results, there are limitations. Dewe looked only at full-time and part-time nurses, with the majority of respondents from hospitals ranging in size from 101-500 or more beds. In addressing only full-time and part-time nurses, Dewe omits a significant portion of the nursing workforce. At times, rural hospitals rely heavily on casual employees to meet staffing needs. In addition to casual nurses, float nurses (those who assist wherever needed during the course of their shift) also were not included in the research. Float nurses may not feel the same allegiance to a particular nursing ward as a nurse who works on the same ward all the time. Perhaps these two groups of nurses would experience different stressors from those of the nurses studied. The segregation of nursing wards in rural hospitals is not always as distinct as in large hospitals. For example, medical, surgical, paediatric, and maternity patients may all be on the same ward, the only distinction being room assignment. In these instances, nurses care for a diverse group of patients and may encounter numerous and conflicting stressors. Dewe compared distinct nursing wards in his research, and did not examine stressors in a mixed patient care environment. Despite these criticisms, I think Dewe's 1987 and 1988 studies show stress to be an individual experience, and that one must consider the role of the nurse in examining stress. It is important to note again that the studies reviewed, including Dewe's, relate to metropolitan or non-rural hospitals, and that there are relatively few works that are rural-focused.

Personality characteristics as moderators of stress, or promoters of stress resistance, have previously been examined by some researchers. Hardiness, in particular, has been identified as an individual personality characteristic that may affect the impact of a stressful event (Kobassa, 1979). Individuals who remained healthy after experiencing
high degrees of stress were labelled hardy. It was felt that their beliefs, attitudes, and behaviour contributed to their hardiness, and this distinguished them from individuals who became ill after experiencing stress. McCranie, Lambert, and Lambert (1987) examined work stress, hardiness and burnout among 107 nurses from 18 different clinical units in a large, urban hospital. Hardiness, which in their study is comprised of control, commitment, and challenge, had previously been identified by Suzanne Kobassa as a personality characteristic that may promote stress resistance (Lambert & Lambert, 1987). Control refers to believing and acting as if one can influence the course of events; commitment refers to a sense of purpose and meaningfulness to various areas of life; and challenge refers to viewing change in life as normal and a growth catalyst (McCranie et al., 1987). Instruments used in the McCranie et al. study were a Measure of Hardiness (Kobassa, Maddi, Donner, Merrick, & White, 1984), a Tedium scale to measure burnout (Pines & Aronson, 1981), and the Nursing Stress Scale (Gray-Toft & Anderson, 1981a, 1981b). The questionnaires were all self-administered. The authors found that nurses who scored low in hardiness reported more burnout than nurses who were considered hardy. Also, nurses who encountered more frequent work related stressors experienced greater burnout. McCranie et al. found that hardiness appeared to have beneficial main effects in reducing burnout, but did not seem to prevent high levels of job stress from leading to high levels of burnout. The authors did not find hardiness to have a moderating effect on stress, perhaps because the one-time data collection in this study has made it difficult to identify a relationship between personality hardiness, job stressors, and burnout. It was suggested that occupational stressors are more impersonal and less controllable than other stressors. The authors also stated that hardiness alone was not sufficient in preventing burnout, and that a person-environment focused strategy was required.

Parkes (1986) studied 135 student nurses in an attempt to determine how
individual differences, environmental factors, and situational characteristics influenced coping in stressful situations. She referred to the transactional model advocated by Lazarus and Folkman (1984) and the structural model, in which relations between measures of life stress and outcomes are seen as moderated by stable personality characteristics. In this study, Parkes referred to her model as an extension of Lazarus and Cohen's (1977) work, which stressed studying the interactions between person and environmental variables in predicting coping behaviour. Parkes considered situational, environmental, and person factors. Situational factors referred to the nature of the stressful event the student nurse was coping with. Environmental factors referred to the characteristics of the work environment where the event took place. Person factors were represented by personality characteristics which were assessed prior to the stressful event (Parkes, 1986). Parkes hypothesized that variables from situational, environmental, and person factors would influence coping in particular situations.

Students were interviewed about a recent stressful episode and completed the Ways of Coping Questionnaire that rated the importance of the event, and indicated which coping strategies were used. Other measures used were the Eysenck Personality Questionnaire (Eysenck & Eysenck, 1975) and the Work Relationships Index (Moos, 1981). Parkes found that the coping responses were significantly related to individual differences, characteristics of the environment, and the specific nature of the event. Parkes' findings suggest that different appraisals of interactions between person and environment variables may form the basis for the different types of coping methods used by student nurses. For example, Parkes found that stable individual characteristics (extraversion or neuroticism for example) and the nature of the environment could be predictors of coping behaviour, but one must recognize that it is difficult to control for the emotional nature of stressful events. Parkes stated that her research does not fall entirely within the realm of Lazarus' transactional model. She was concerned with examining
situational, environmental, and person variables as direct predictors of coping rather than their combined effect. Parkes also stated that while traditional models of stress and coping are suitable for research, they do not take into account the complex processes of coping during a stressful encounter.

It is curious that Parkes (1986) used first year nursing students for her study. Student nurses are already stressed in their role of learner; their unfamiliarity with the nursing profession as it really is may have influenced their responses. Experienced nurses, or student nurses closer to graduation could also be studied. Seasoned nurses may have added a different dimension to this study as their stress experiences certainly would be different from those of student nurses.

This study is interesting in that Parkes applied the transactional model of stress in examining very specific nursing stressors amongst student nurses from different hospital wards. This offers support for the concept of the individual nature of stress and coping. That is, coping depends on the characterization of the event, environmental and personal resources, and personal meaning of the event. Future researchers need to study the nature of rural nursing stress and coping by examining the work of experienced rural nurses--this will help define and develop rural nursing as a distinct type of nursing with distinct stressors.

**Nursing Social Support**

Social support refers to interactions occurring in social relationships, and the evaluation of their supportiveness (Sarason, Levine, Basham, & Sarason, 1983). Lazarus and Folkman (1984) regard social support as a resource available in the social environment, which falls under the rubric of coping. Based on individual and situational differences, social support can be an emotion-focused strategy, or a problem-focused coping strategy. Tyler and Cushway (1995) examined the buffering effects of coping and social support on stress in 245 nurses, employed in two hospitals in the English Midlands.
A self-administered questionnaire packet consisted of background information, the Nursing Stress Scale (Gray-Toft & Anderson, 1981), a Job Satisfaction Scale (Harris, Hingley, & Cooper, 1988), a General Health Questionnaire (Goldberg & Hillier, 1979), and a Coping Questionnaire (Moos, Cronkite, Billings, & Finney, 1984). A specific social support tool was not used to measure this item; rather, background information included a component about availability of social support, the Nursing Stress Scale had a 'lack of social support' item, and the Job Satisfaction Scale had a component about involvement and staff support.

Of the seven sources of stress identified by the Nursing Stress Scale, "lack of social support" was found to be an unimportant overall source of stress for these nurses (Tyler & Cushway, 1995). The concept of social support is not specifically defined in this study, and a standardized measure was not used. It appears that certain people (partners or spouses, other family members, and friends) were identified as sources of support from the questionnaires. There was a strong direct effect on psychological distress as measured by the General Health Questionnaire—the more social support nurses had within the organization, the better they felt. There was also no evidence in the study to suggest that those without social support were more susceptible to stress than those who had more social support, and there was no evidence to suggest that social support interacted with any other sources of stress. Tyler and Cushway offer two explanations for these results. First, by the nature of their profession nurses always have a certain level of social support available, so a small decrease in availability is negligible. Second, the specific occupational stressor which affects psychological well-being is not influenced by social support. It is of interest that Tyler and Cushway thought that nurses always have a certain level of social support available. Without a specific definition of social support to refer to in their study, it is possible that the authors were referring to the social network of nurses, and thereby, implying that having these social relationships is equivalent to receiving social support.
The ages of nurses in the study ranged from 19-60 years. Depending on one’s particular life stage, stress and social support will have different meanings. Access to and utilization of social support can differ for persons of different generations. The authors also point out that the direct effect of social support on well being as measured by the General Health Questionnaire (nurses felt better if they had more social support within the organization), does not support their first explanation, which was that a decrease in the availability of social support was negligible.

Despite the mixed results of this study, nurses felt better if they had social support within the organization. This may be because our colleagues are often the only people who really understand the stress we experience. It is extremely difficult to convey the essence of our distress to persons not familiar with the nature of nurses’ work. Since we work closely with other nurses in our daily work, it is reasonable to suppose that the more support we receive from our colleagues in our work environment, the ‘better’ we will feel. The overall concept of social support may appear clear, but it actually is quite complicated. What does social support offer to one person that it doesn’t offer another? Why is social support helpful at one moment, but not another? Do different people require different types of social support? It seems important to determine that social support is available, but just as important, it is necessary to examine what type of social support is most beneficial for an individual.

Tyler and Cushway (1995) and Constable and Russell (1986) emphasize the inconsistencies in previous research findings concerning the buffering effects of social support on stress in the work environment. Some studies have found no interaction effects, while other studies found that stress and social support interact in predicting mental health outcome.

Constable and Russell (1986) studied the effects of various aspects of the hospital work environment on burnout among nurses, and also the effects of social support in
reducing burnout. They hypothesized that negative aspects of the work environment would have a direct effect on the extent of burnout, that social support had a direct effect on burnout, and that social support from job related sources were the only significant factors in reducing work stress in nurses.

Data were obtained from 310 nurses who worked at a large United States military medical centre. Instruments which were used included the Maslach Burnout Inventory (Maslach & Jackson, 1981), the Work Environment Scale (Moos & Insel, 1974), and a Social Support Measure (House & Wells, 1978). The Social Support Measure looked at supervisor, co-worker, spouse, and friend/relative sources of support. As they had expected, Constable and Russell (1986) found that nurses who reported working in a negative work setting experienced greater emotional exhaustion. Negative effects of the work environment were buffered by high levels of supervisor support, thereby reducing emotional exhaustion; however, a significant relationship between co-worker support and burnout was not present.

Unlike Tyler and Cushway (1995), Constable and Russell administered a Social Support Measure that specifically investigated four dimensions of social support. Specific questions from this instrument were used to gain insight into aspects of social support, for example, "How much is each of the following people willing to listen to your work-related problems?" and "How much is each of the following people helpful to you in getting the job done?" (p. 22). This last question may explain why Constable and Russell found a significant relationship between supervisor support and reduced emotional exhaustion. It could be that only supervisors had the authority to address negative aspects of the work setting, and were thereby seen as more supportive than a co-worker.

Contrary to Constable and Russell’s findings of ‘no relationship between co-worker support and burnout’, I have personally found that it was my co-workers, and not my supervisors, who were consistently supportive of me. This support did not
necessarily lower my stress, but it did help my coping process. I also recognize that the study focused on burn-out, but if left unchecked, stress can lead to burnout.

In a study by Eastburg, Williamson, Gorsuch, and Ridley (1994), the relationship between work-related support, personality variables, and burnout among nurses was examined. Participants consisted of 76 emergency, intensive care, and medical-surgical nurses in a 150-bed private medical hospital. Instruments used in this study were subscales of the Work Environment Scale (Moos, 1986), the 16 Personality Factor Questionnaire (Cattell, Eber, & Tatsuoka, 1970), PROSCAN, a personality inventory, (Houston & Solomon, 1977), the Maslach Burnout Inventory (Maslach & Jackson, 1981), and a modified version of the Nurse Stress Scale (Gray-Toft & Anderson, 1981). Information on personal demographics was also obtained.

In general, the findings were as follows: a strong relationship between work-related social support and burnout was found—as supervisor and peer support increased, burnout levels decreased significantly (Eastburg et al., 1994). Support for a relationship between personality variances and burnout in nurses was also found, thus suggesting that traits other than hardiness could account for an increased resistance to burnout in some work areas. Eastburg et al. also found that extraverted nurses may need more social support than introverted nurses to avoid emotional exhaustion, and that extraverted nurses were more sensitive to changes in peer support than introverted nurses. The authors did not elaborate on this finding.

It is interesting that nurses are perceived as ‘hardy people’. Many people think that there is a particular quality required in order to be a nurse, especially an emergency, surgical, or intensive care nurse. This quality is often referred to as hardiness, but I feel it is not the same as Kobassa’s concept of hardiness, which is comprised of control, commitment, and challenge. People living in isolated or rural regions are also referred to as ‘hardy types’. I have heard northern rural nurses described as ‘a hardy bunch’ or
‘strong’ in various conversations, and am intrigued that hardiness, over compassion or empathy for example, comes to mind when personality factors are discussed.

Eastburg et al. also found that burnout levels decreased significantly as peer cohesion and high levels of supervisor support increased. This is relevant when looking at particularly stressful incidents in isolated regions. For nurses to cope with these incidents, peer cohesion is important. A common bond is shared if everyone supports each other and works together. High levels of supervisor support can benefit nurses through acknowledgement of the stressful event, acknowledgement of a nurse’s stress, and a desire to assist nurses in coping. Supervisor support and peer cohesion are also particularly important avenues of support in rural areas since other sources of support are limited.

The effects of supportive communication on burnout among nurses was examined by Ellis and Miller (1994). Data were gathered from 490 nurses in a large Midwestern, United States, hospital. Instruments used were the Maslach Burnout Inventory (Maslach & Jackson, 1981), the Organizational Commitment Questionnaire (Mowday, Steers, & Porter, 1979), and a Role Ambiguity Measure (Rizzo, House & Lirtzman, 1970).

Supportive communication in Ellis and Miller’s (1994) study consists of three dimensions—informational support, instrumental support, and emotional support. Study results indicated that emotional support had broader effects in reducing burnout than did informational or instrumental support. Emotional support was found to be a critical type of communication as the beneficial effects were also carried outside of the workplace; informational and instrumental support also decreased emotional exhaustion, but only within the organization (Ellis & Miller, 1994). It was believed that supportive co-worker communication, as a form of social support, was beneficial in reducing the stress inherent in the nursing field. Ellis and Miller thought that supportive communication also enhanced personal control.

Perceived inability to manage specific responses, or understand them, can
contribute to increased stress and a sense of loss of control for some individuals. Supportive communication can lessen the personal and emotional exhaustion experienced when dealing with stressful events. Acknowledging an individual nurse’s stress via supportive communication allows a nurse to come to terms with the situation, feel acceptance from peers, and ultimately, move on. In essence, it allows the nurse to cope.

Another realm of the social support construct demanding attention is that of critical incident stress debriefing (CISD). Critical incidents are extraordinary clinical events that have the potential to cause unusually strong emotional reactions (e.g., anger, depression, fear, frustration, flashbacks) which can later interfere with an individual’s ability to function (Burns & Harm, 1993; Hollister, 1996). CISD is a group process designed to alleviate posttraumatic stress symptoms via psychological and emotional support. Supportive communication is an integral part of the group process.

In a study of 692 emergency nurses, Burns and Harm (1993) discovered that only 32% of the survey population had ever participated in a debriefing session, but that the majority of those nurses who did participate found the debriefing helpful. Burns and Harm found that visible images had the most stressful impact on nurses, and that the same event would not necessarily be classified as stressful or critical by all nurses. It was also discovered that succeeding critical events aroused emotions from an original event; nurses frequently described critical events by noting their similarities (Burns & Harm, 1993). The acute stress felt is a normal response to an atypical event, and a supportive group process is essential in alleviating this particular stress. Burns and Harm are careful to note that “CISD is not group therapy and should not be presented as such” (p. 435). Hollister (1996) states the objectives of CISD are to lessen the impact of stressful events, to accelerate recovery from those events, and to facilitate the return of employees to their jobs. It is generally thought that if debriefing processes are initiated within twenty-four to seventy-two hours after the event, stress is alleviated sooner, and the full impact of events
can be dealt with while events are still being processed by an individual. Lack of social support and debriefing were cited by Holaday, Warren-Miller, Smith, and Yost (1995) as reasons why nurses and other health-care workers experience vicarious traumatization or compassion stress.

Figley (1995) reports that those who have enormous capacity for expressing feeling and empathy tend to be at risk of compassion stress. Compassion fatigue is felt by Figley to be an occupational hazard of caring service providers. Figley (1995) differentiates between compassion stress and burnout: compassion stress can emerge suddenly, has a rapid onset of symptoms (sleep difficulties or reliving the event for example), causes a sense of helplessness and confusion and has a faster recovery rate than burnout, which is a state of mental, physical, and emotional exhaustion. Burnout is a process that becomes worse and compassion stress is an acute state. In preventing this compassion fatigue, Figley advocates the recognition of upsetting clinical events, confidential discussion of these events, and the processing of clinical events that are upsetting to the individual. This is reflective of the CISD concept.

Nurses in rural regions are not immune to the stressful effects of dealing with trauma. Due to small community populations, the likelihood of personally knowing the trauma patient exists. Despite the literature that supports CISD as alleviating stress symptoms, I find it interesting that formal hospital-based CISD programs do not exist in the northern British Columbia region. Peer interactions in critical incident debriefing provide an opportunity for caregivers to express feelings to each other, verbalize congruent reactions, and help activate individual and collective coping skills (Garnett, 1989; Spitzer & Burke, 1993). Social support is important in the process of coping, and CISD is one avenue of providing this support. However, Pennebaker (as cited in Benner & Wrubel, 1989) found individuals can not receive social support if thoughts and feelings about stressful events are not expressed. CISD provides a neutral environment that
encourages supportive interactions among individuals, and also helps in normalizing the situation.

The perception of social support as being available when needed is important for individuals, and one way of receiving social support is through CISD. Social support can be, for example, of an informational or emotional form. Depending on the circumstances of the particular event, it may be difficult for nurses to access certain aspects of social support that are personally meaningful. Sometimes, social support is not available. In these instances, CISD is invaluable in acknowledging individual distress and in providing an avenue to begin or enhance the individual coping process. These programs deserve a second look, as the psychological and emotional benefits for both nurses and communities cannot be ignored.

Rural Nursing

Rural nursing can be considered as a specific type of nursing. Bigbee (1993) defines rural nursing as the practice of professional nursing within the physical and sociocultural context of sparsely populated communities. British Columbia has a very uneven population distribution. Fifty-seven percent of the total population is concentrated in the Vancouver and Victoria regions; the remainder of the province is sparsely populated with the majority of the remaining population close to the United States border (Foster & Edgell, 1992). Based on this description, nurses in northern British Columbia can be viewed as practicing within a rural context of sparse population.

Bigbee (1993) identifies five areas in which rural nursing generally differs from urban nursing. First, close community ties and relations can result in rural nurses feeling that they can never escape from work. Second, rural nurses are required to be specialists as well as generalists in their practice due to the limited number of personnel available. Third, while there may be an increased independence associated with a broader scope of practice, professional isolation and lack of backup are pitfalls. Fourth, the social
organization of the community and work environment promote professional unity, and finally, rural nurses have a high degree of positive visibility in the community. Erkel, Nivens, and Kennedy (1995) found that by living and practicing in a rural community, nursing students recognized that unique rural challenges existed, especially in dealing with culturally and geographically diverse groups. Erkel et al. (1995) also noted that students had “...an awakening to differences in access to rural and urban healthcare” (p. 362).

While nurses can experience similar chronic stressors, rural nurses are uniquely challenged by acute stressors in their work. Bigbee’s (1993) dimensions of rural nursing solidified my perceptions, and also helped me understand some sources of stress that I have experienced. For example, accidents in the small community catch everyone’s attention. It is not unusual for an accident or trauma to be the primary topic of discussion following the event. On numerous occasions, friends and acquaintances have approached me wishing to discuss a particular event. As a nurse in a rural community, I often feel I can not completely leave my work at the hospital. The ability for someone to identify me as ‘someone in-the-know’ does not allow me time to focus on other aspects of my life. It also does not respect my privacy for personal coping.

Often times, the type of accident or trauma is specific to the geographical region. For example, forestry is a main industry in the Northwest region of British Columbia. Many people work in the bush as loggers or heavy equipment operators. The area being logged is often distant from the community. When word comes that an accident victim is expected, preparations are made for specific types of injury, for example, amputations, crush injuries, or massive internal injuries. Traumas of this nature are not usually seen in an urban centre as a primary admission. The nature of a trauma presented in the rural region often has a deep visual impact on nurses and other care providers. While health-care workers are prepared to manage a patient’s injuries, I doubt that they can always be mentally prepared to accept the visual presentation. Traumatic injuries
compromise the patient’s physical and emotional integrity. They also disrupt a nurse’s concept of the ‘whole’ patient. Often the visual impact can be the most stressful part of the event. It is only natural to try to imagine the events leading up to, during, and after the accident, and the pain and suffering endured by the patient during the event. Based on the personal meaning to the individual health-care worker, these types of visual experiences may take longer than non-visual experiences to resolve. Many people employed in physically demanding work are young. Nursing patients who are similar in age to oneself adds another dimension to the stress experienced. Nurses may examine their own life events, and picture themselves in a patient’s situation. This may haunt nurses for some time after the event.

Nurses choose rural nursing for a variety of reasons. They may have previous close ties to the community; their partner may have been transferred to the community; they may be seeking a specific work environment; or they want to be away from a metropolitan lifestyle and enjoy rural living. Despite the unique stressors experienced in rural nursing, many nurses I know find their work gratifying and would not give up their work for a different locale or profession.

Issues of rural nursing have been examined in various ways. Bushy (1991) examines issues relevant to rural nursing, including alternate practitioners, program planning, contraceptive use among adolescents, and risk factors of cardiovascular disease. These issues are examined in the context of rural America, where the health-care system is vastly different than that of rural Canada. There is a lack of studies that focus on northern rural nursing, especially those that examine specific stressors of northern nurses. A review of rural related literature shows that much of the information is based on anecdotal evidence or verbal description of events rather than research evidence. Despite the lack of specific measures, issues of rural nurses are evident through the rich descriptions offered. Sibbald (1998) recounts how years of trauma experience became invaluable to nurses in a
Manitoba nursing station as they coped with a plane crash. Evidence of emotion-focused- and problem-focused coping is plentiful and obvious in the article. Examples of emotion-focused coping include thinking critically despite the emotional burden, keeping a positive outlook, and providing emotional warmth and support to victims and volunteers. Problem-focused coping included constant patient assessment, delegating duties, teaching volunteers, and working together. In this situation, problem- and emotion-focused coping facilitated each other as nurses managed a most stressful situation. Despite the fact that these coping strategies were not examined in depth, nor categorically organized, the nature of the stressful situation and coping efforts is conveyed to the reader.

In a similar, but quite detailed manner, Hamer (1997) describes the response to a ski lift disaster by rural nurses in a British Columbia diagnostic and treatment centre. Briefly mentioned is the fact that counsellors were called upon to assist patients and their families. Also noted, in retrospect, was the belief that despite the next day being Christmas Eve and staff members not wanting to further compromise their personal plans, a staff session immediately would have been beneficial in understanding the situation better. Two debriefing sessions along with a technical critique were held, however the time-frame in which this occurred remains unclear. While not specifically labelled or referred to, forms of emotion- and problem-focused coping are evident in this literature, and include mentally and physically preparing for a multi-trauma situation; implementing a specific disaster plan, and modifying it as required; teaching volunteers; and offering emotional support and companionship to patients, families, and rescue personnel.

Birkland (1994) discusses stressors of outpost nursing by recounting a rural trauma scenario. While not specifically identified in the article, the lack of social support is quite apparent, which can increase stress. Scott (1991) described the stressors of professional and social isolation of nurses in small remote Northwest Territory communities, and the impact of workstyle on the nurse. Emotional and moral support
from a counselling team and occupational health nurse were identified as specific, effective interventions in helping a nurse to cope: "...transitions were startling and consistent" (p. 20). Signs of returning health in nurses on stress leave were usually evident within 7 to 10 days. Physical absence from the community, in conjunction with supportive counselling and uninterrupted sleep, hastened the nurses' return to work. Nurses who previously felt they were losing control of their self and their work environment were now eager to return to work with a new outlook. The particular Employee Assistance Program (EAP) utilized was thought to be a proven model in maintaining occupational health among nurses in remote communities. However, when health services were transferred from federal jurisdiction to territorial jurisdiction in 1988, occupational health services (being federally mandated) were not transferred. As a result, the EAP as it was known ceased to exist. Despite a lack of critically written studies addressing rural nursing stressors, the literature reviewed identifies distinctive characteristics and issues of rural nursing. Greater attention is required in defining the nature of rural nursing as one branch of the nursing profession that has distinct strengths, challenges, and needs.

Support for rural nursing as a specific dimension of nursing is of great importance. If we acknowledge that differences in the environments of health-care delivery present unique challenges, we must acknowledge that individuals will have different experiences and interpretations within these environments. This brings us back to the transactional perspective of Lazarus and Folkman (1984) in which the individual and environment are in a bidirectional relationship: "the person and environment elements join together to form new meaning" (p. 326).

Overall, the nursing literature focuses on urban nurses coping with stress across a number of different situations and settings. While the nursing stress is seen to be a universal issue, the stressors of nursing and associated coping methods cannot be, and should not be, regarded as universally similar. Differences in area of practice constitute
differences in experiencing and coping with stress. Lazarus and Folkman’s (1984) transactional model of stress has been presented for this reason. Stress is present in everyone’s life regardless of geographic location; however, it is the relationship between the person and environment which is of importance in defining the stress experience. Applying this model can assist in explaining stressors of rural nursing, rather than just describing them: that is, moving from a descriptive to an explanatory position. An understanding of stressors can facilitate the development of strategies, specific or generic, to assist rural nurses to cope with traumatic stress episodes.

This study focused on northern rural nurses in a specific situation—nursing stress and coping in caring for and transfer of the trauma patient. Nurses from different facilities, who work in emergency, intensive-care, or operating room departments, were interviewed in a focus group setting with the view of eliciting descriptions of personal experiences in caring for trauma patients who were transferred to an urban facility for further health-care. A key question was posed to focus the group discussion on the topic of interest. This was followed by probing or supporting questions to further clarify the participants’ reflections when required. For example, the key question was: “Think back to a situation in which you cared for a trauma or accident patient who was subsequently transferred to another facility for further care. Take your time in recalling the event, and try to focus on how you felt when the patient was transferred from your facility. I will ask you to share this with the group.” An example of a probing question was: “What does it mean to you when you do not feel supported by colleagues or others?” The focus group interviews were approximately 60-90 minutes in length. Following the group interview, a social support measure was completed and demographic data were collected.
CHAPTER THREE

Method

A qualitative approach using focus groups was used for this study. A focus group is a planned group discussion, repeated several times with different groups of people, to obtain an individual perspective relating to a specific topic (Krueger, 1994; Palys, 1992). Ethical approval to conduct this study was obtained from the University of Northern British Columbia.

Focus Groups

The focus group method is appropriate for this research for several reasons. Krueger (1994) states that smaller groups are preferable when dealing with specialized participants and the researcher’s intent is to obtain an in-depth view of the issue at hand. Krueger supports small groups when participants have had intense experience with the topic, or may have a great deal to discuss about the topic. He states that small groups “are helpful when insights, perceptions, and explanations are more important than actual numbers” (p. 30). In addition, a focus group allows researchers or moderators of groups to probe responses for deeper insight which is not possible with other structured questioning methods.

A group setting can offer support or even encourage openness in individual responses. Participants also have the opportunity to further clarify and provide examples of their experiences. Another reason that focus groups are an appropriate method is that the data obtained during focus groups may be more detailed than that from individual interviews, which do not offer group dynamics or interactions.

Focus groups offer a different dimension in data gathering. Participants can respond to and add to the responses of other individuals. Data can be obtained more rapidly with groups, whereas individual interviews would be slower, and may yield less data. Another consideration in choosing a focus group design was the elimination of
repeated long distance travel to interview nurses on an individual basis.

Krueger refers to focus groups as a "...socially oriented research method capturing real-life data in a social environment..." (p. 37). Participants are able to share and describe their feelings, reactions, and thoughts with each other and the researcher in relation to a particular experience. This fits well with Lazarus and Folkman's theoretical framework in which the person and environment transact to form new meaning through appraisal. The emphasis is on the individual nature of the experience, and it was felt that a focus group would best capture that individual experience. Focus group questions centered on nurses' experiences with trauma patients who have been transferred for further care, and individual nurses' responses to their situations. Through the use of key questions (Appendix A) to guide the focus group, participants were encouraged to speak freely and openly. Questions were purposely open-ended to encourage explanation and elaboration in relation to the topic of interest. A detailed response to a question can also indicate the importance of a particular event to the participant. A number of studies (Constable & Russell, 1986; Dewe, 1993; Numerof & Abrams, 1984; Parkes, 1986) have described nursing stressors and coping in regard to urban nurses, but there is a lack of information regarding stressors and coping among northern rural nurses.

Participants

Eighteen female and one male nurse were interviewed in four separate focus groups. Participants were emergency room, operating room, and intensive-care nurses who were employed in a rural hospital in northwestern British Columbia. Nurses from three hospitals that serve as air-ambulance medivac sites in the region were invited to participate in a focus group in their community. A contact person, who distributed an information letter to all eligible nurses, was established at each location. Nurses who were interested in participating in the study notified the contact person, or myself directly. Due to a large response at one facility, focus group participants were chosen at random. A
lesser response occurred at the other two facilities. Interested participants were invited to join in a focus group discussion on a specific date. In this case, chance was still a determinant of participation based on the individual’s ability to participate on a given date.

**Demographics**

Participants’ ages ranged from 34 to 53 years of age, with a mean age of 43.3 years. Of the 19 participants, two were single, three were living with a partner, twelve were married, one was divorced, and one did not indicate marital status. There was one Asian participant, and the remainder were Caucasian. Educational background was as follows: 12 nurses had a registered nurse diploma, seven had a bachelor’s degree in nursing, and one had a master’s degree. Four nurses also had a post-graduate diploma in nursing, and two had non-nursing diplomas. The participants had between 10 and 30 years of total nursing experience, with a mean of 15.5 years. The years of experience in their present clinical area ranged from three to 20 years, with a mean of 11.6 years. Five nurses worked in emergency, six worked in a critical care area, seven worked in the operating room or post-anaesthetic care unit, and one was primarily an education co-ordinator. Seven nurses worked full-time, five worked part-time, and seven worked on a casual basis with an average of 10.2 shifts per month. Variation in the demographic variables was approximately equal in each focus group. Appendix E has complete demographic details.

**Procedure**

Participation in the focus group was presented as an opportunity to assist with research on acute stress and coping among northern rural nurses in relation to the transfer of trauma or accident patients. An information letter (Appendix B) described the nature of the research and invited participation in the study. Rural nursing was presented to the participants as a distinct type of nursing. The importance of increasing knowledge within the nursing profession in relation to acute stress and coping among rural nurses was
emphasized. It was also stressed that the focus group was not intended to be a debriefing or therapy session. A list of counselling resources was distributed prior to commencement of each focus group should the participants have required personal assistance afterwards.

There was one focus group conducted in each of two communities, and two focus groups in one community, for a total of four focus groups. Each focus group consisted of approximately three to seven people. Nurses participated in one focus group only, and were randomly assigned. However, nurses from one facility did not participate in a focus group with nurses from a different facility. The names of nurses from the facility with a large response were printed on slips of paper and put into a paper bag. The bag was shaken and names were individually drawn out by the researcher. As each name was chosen, it was alternately assigned to a group. For example, name one was assigned to Group A, name two was assigned to Group B, name three was assigned to Group A, name four was assigned to Group B, and so on, until all the names in the bag were drawn. The researcher then contacted the nurse who was selected and asked him or her to confirm his or her participation in a focus group. Inability to participate in their assigned group resulted in elimination from the study. The following method was applied for the other two facilities: three alternate dates for a focus group were printed on slips of paper and placed in a paper bag. The bag was shaken and one date drawn by the researcher. This was the date chosen for the focus group. The nurses were contacted by the researcher and asked to participate in a focus group on a specific date. Chance was still a determining factor in this instance, based on a randomly chosen date by the researcher, and the individual’s ability to participate in the focus group on that particular date. Informed consent (Appendix C) was obtained prior to commencement of each focus group. Participants were informed that the session would be tape-recorded and strict anonymity and confidentiality would be maintained. A second tape-recorder was used to ensure complete gathering of data.
An assistant, with a non-nursing background who was a master’s student in counselling, was present during each focus group. In addition to discretely operating the tape-recorders (e.g., positioning microphones, changing cassettes), and handling environmental factors (e.g., lighting, excess noise, seating, refreshments), the assistant monitored the researcher’s role for potential threats to quality. For example, the assistant informed the researcher if participants were being inadvertently cued for their responses by asking leading questions, made the researcher aware that she needed to take a more neutral stance in the discussion, or let the researcher know she was talking and leading too much. The assistant was also to monitor individual responses, and identify anybody who appeared to feel threatened or vulnerable due to the nature of the discussion. Identified individuals could be discreetly approached by the researcher during a break and be encouraged to access a community resource. At the conclusion of the focus group, the researcher and assistant privately discussed the flow of the group interview. The assistant identified areas for improvement or strategies that worked well, for example, being alert to stating a question clearly, or the effective use of silence after a particular comment.

Each focus group lasted approximately 60-90 minutes in duration. Through the use of key questions to guide the focus group, participants were encouraged to speak freely and openly. At the beginning of each group, participants were asked to reflect upon a particular situation in which they cared for a patient who was subsequently transferred to another facility, and how they coped with this situation. Going around the table, each nurse in turn spoke for approximately five minutes. This provided each participant an opportunity to share their experience on an individual basis. A group discussion followed, giving everyone the opportunity to speak to each other, reflect on comments, interact, and further expand on thoughts and reflections. By creating a framework for spontaneous discussion, the key questions were answered without the researcher pointedly asking questions. In some groups, supporting questions were introduced at appropriate intervals.
during the discussion based on the content and direction of that discussion. Supporting questions were used to clarify or encourage further discussion among participants. A summary of pivotal issues with participant validation finalized the focus group discussion. Any other thoughts were added at that time. A demographic questionnaire (Appendix D) and a social support measure (Appendix F) were completed by participants after the focus group interview.

Measures

A social support measure and a demographic measure were used in this study. The demographic measure described participant age, ethnicity, work experience, education, and marital status. The social support measure elicited information about nurses' social supports and their satisfaction with the support available. As indicated in the literature review section, social support is beneficial to persons experiencing stress. A perception of support availability and satisfaction with the available support needed to be present for the support to be regarded as meaningful in some way to the individual. The Social Support Questionnaire (SSQ) developed by Sarason, Levine, Basham, and Sarason (1983) was selected to assess the extent of participants perceived social supports and their satisfaction with these supports.

The SSQ is a 27-item questionnaire which requires a two-part answer for each question. The participants are asked to (a) list the people to whom they can turn to and whom they rely on in a given situation, and (b) how satisfied they are with the social support. The number score (N) for each item is the number of perceived support persons identified. The satisfaction with support is rated on a scale ranging from very satisfied to very dissatisfied. This gives a satisfaction (S) score for each item that ranges from one to six. The overall SSQ-N and SSQ-S scores are obtained by dividing the total N and S scores for all items by 27.

The SSQ was shown to have high reliability and good test-retest reliability.
alpha coefficient of internal reliability for SSQ-N scores was .97; for the SSQ-S scores the alpha coefficient was .94. The test-retest correlations (4 week interval) for SSQ-N and SSQ-S were .90 and .83 (Sarason, Levine, Basham, & Sarason, 1983). The correlation between the SSQ-N and SSQ-S scores was modest at .34. According to the authors, this provides justification for examining social support in two dimensions. In other words, for social support to be considered a solitary concept, the correlation scores would have to be higher. Finally, the SSQ is not affected by the social desirability response set. Due to the limited number of participants in my study, the SSQ was used in a descriptive manner. The purpose of the research was not to focus specifically on quantifying the social support construct, but to understand if nurses valued social support as a coping strategy.

**Approach to Data Analysis**

Audio-tapes and notes were transcribed verbatim by the researcher as soon as possible following each session. Data from all four focus groups were considered together. During transcription, participants were identified by pseudonyms which were later used in the results and discussion chapter. The audio-tapes were then reviewed together with the transcriptions to check for accuracy and to gain a better feel for the information. Once this process was completed, the audio-tapes were locked away for security.

A theme analysis of the data was conducted, and four categories of acute stress emerged. Krueger's (1994) seven factors of analysis were embodied during the data analysis. They include: (a) Consider the words. The words and phrases from the transcripts were analyzed in terms of perceived meanings, (b) Consider the context. All data were kept in original transcript form during analysis to gain an understanding of comments made, (c) Consider the internal consistency. The data were reviewed to determine if participants shifted their opinion after interacting with others, or if they remained unchanged. In most instances, participants did not alter their position, and
seemed able to understand the differing opinion, (d) Consider the frequency or extensiveness of comments. Topics which were discussed by more participants and comments that were made more than others were noted. Topics which were discussed by more participants helped to form themes in the data analysis, (e) Consider the intensity of the comments. The audio-tapes recorded changes in individual speech patterns which were interpreted as a display of an individual's depth of feeling about a topic. Volume of speech, rate of speech, and emphasis on words were considered with the given response, (f) Consider the specificity of the responses. Comments that were based on actual experience were given more weight than general, non-specific comments, and (g) Find the big ideas. While individual comments were acknowledged as valuable, the analysis focused on ideas that emerged from the accumulated data across all groups. In order to manage the data, stressors specific to northern rural nurses were dealt with separately from ways of coping. The specific process of data analysis is outlined in greater detail below.

**Step One**

Immersion in the data as a whole was achieved by reviewing the transcripts on their own, and then with the audio-tapes. The transcripts were again reviewed, and relevant pieces of data were underlined and identified in the margins as relating to a particular topic or category. The data consisted of nurses' quotations that related to experiences of acute stress. Data that was similar in concept was assigned the same colour code throughout all the transcripts. Once the concepts were grouped together by their similarity in content, they were cross-referenced across the categories, and commonalities between the categories were identified. When more than one concept was expressed or discussed by a participant in a segment of text, the text was coded under the first theme expressed, and then cross-referenced across the other themes.
The data were collapsed into four broad categories with 10 sub-categories. These were:

1. System problems: (a) lack of resources [human, medical, or technological], (b) time factor in receiving and or transporting the patient, (c) close community ties and relations.

2. Lack of communication and support: (a) lack of follow-up regarding patient status, (b) lack of support from administration, co-workers, colleagues, (c) lack of debriefing.

3. Visual impact: (a) age of patient, (b) nature of injury exceeding nurse’s preparedness.

4. Professional discord and friction: (a) transport team issues, (b) competence issues.

A master’s student in counselling, who was not a nurse, was provided with a description of the categories, and was asked to sort identified data pieces from each focus group into one of the categories. This was then compared to the classification of the data done by the researcher. Inter-rater agreement for each of the four focus groups was: group A - 81%, group B - 91%, group C - 93%, and group D - 90%. The two coders discussed their differences and agreed on how to classify the data, resulting in 100% inter-rater agreement.

Step Two

The transcripts from each focus group were reviewed again for examples of coping or coping gestures. All data were reviewed in their original context, and specific words or phrases that were indicative of coping were highlighted, and then grouped with other similar pieces of data. Coping options were coded as either problem-focused coping, emotion-focused coping, or automatized responses. The completed social support measures were also reviewed.
CHAPTER FOUR

Results

Situations that northern nurses have identified as being stressful are described in this section. Direct quotations from focus group participants are used to recount their experiences.

Situations of Acute Stress

The data from the tape-recorded interviews were distributed into four types of categories in which nurses felt acute stress. While these categories are described and discussed individually, an interaction exists between them. Organizing the data into distinct categories allows for meaningful comprehension of the nurses’ experiences. The four situations of acute stress were:

1) System problems. This includes organizational, institutional, and regional issues.

2) Lack of communication and support. These situations include lack of concern for the care-giver and the patient being lost to follow-up.

3) Visual impact. This relates to the nature of the injury and the age of the patient.

4) Professional discord and friction. These situations are characterized by differences of opinion and professional conflict.

Common to all of the participants was their commitment and concern for the patient, not only during the described encounter, but also after the patient was transferred to another facility for further care.

System Problems

Many of the situations identified by the participants related to the allocation of resources, and the availability of resources within their hospital. These experiences can be understood in terms of three sub-categories of situations: (a) lack of resources, (b) time factor, and (c) close community ties and relations.
Lack of resources. Nurses described a lack of resources in terms of human, medical, or technological resources. There seemed to be a general sense of frustration and angst when faced with these situations. One nurse felt she devoted precious time on administrative type duties instead of nursing care. Sylvia stated:

And then it took so long to get him down there, and it took a lot of phone calls - myself and another nurse and Doctor X spending quite a bit of time....I found myself spending a lot of time phoning hospitals, when I could really be looking after my other patients, and getting really wrapped up in the emotional, uh, it just created so much tension.

A number of nurses felt a lack of manpower intensified situations they were involved in. Lorraine offered, “We don’t have a social worker attached to our hospital or anybody to help us with patients....so not only are we dealing with the trauma patient, we’re having to deal with the family.” She added, “and trying to look after the patient, you want to inform the family, but if you’re talking to the family, it’s taking away from the care that you can give to their loved one. And then you’re answering the phone in the mean time...”

Irene explained:

She [the nurse] has guilt about the other patients that aren’t having their needs met while she’s attending to the acute trauma. I always feel like there’s somebody missing on the team, like I need someone who will go and be with the family....I don’t have time for it, you know, I’m involved with the patient, but I feel them out there, out by the elevator, wringing their hands, not knowing what’s going on.

Donna describes caring for a trauma patient while working with a nurse who was unfamiliar with ICU duties:

Also at the same time I was taking care of that patient, there were three other patients in the ICU, and the nurse taking care of those patients was not an ICU nurse....I also have to look over other medications that the nurse is giving and also
the drips, and also that she was regulating those medications that the three
other patients were having accordingly....so that is really stressful when you don’t
have a partner who is trained to work in the unit.

Dianne shared her experience in the following way, “I was the only RN on....and found
myself almost a jack-of-all-trades.” Working with medical personnel not familiar with
resource availability in the north also creates tension. Lorraine explained:

I notice also that we have a lot of locums that come up, and often they’re used to
working down south, and so they think that by snapping their fingers to get the
blood, or other [supplies] you know, get the lab in, this and that done just like that,
or ‘where’s the CT scan’, well, we don’t have it here, and they’re like ‘what?’, and
like ‘get the respirologist’, well, we don’t have that either, it’s just ‘us’, it’s just
you and me doc, we’re it...

The limited availability or quantities of medical supplies and lack of technological
resources can be distressing at times. This, combined with trying to locate a hospital to
accept the patient for further care, creates a stressful situation. Vicky described caring for
a critically wounded gunshot patient who had been stabilized for transport “and then
nobody wanted to take him in XXXX, they said a couple of places that he wasn’t probably
going to make it, so they didn’t want to take him.” Patty also described caring for a child
requiring urgent transfer but “the people in XXXX didn’t really want her to come down,
just kind of telling us to keep her here, and she would die here.” The nurses added that
these patients were eventually transferred out, and both returned to their communities as
survivors. Other participants commented on the present state of health-care as eroding,
and the resultant problems and strains of working within this environment. Susan
explained:

This is a situation that’s going to be coming about and what can we do?? Now,
our hospital’s ICU is full, we have our own patient that needs to go to ICU, we’ve
got a patient in ICU that’s waiting for 4 days to get transferred out, now what do we do?? We’ve got a patient that needs to go, we can’t transfer him anywhere cause nobody will accept anybody, what do we do with these people? So politically, we’re going to have a big problem here...I was arguing on the phone with this other nurse in emergency, which is causing hard feelings between other workers...and I had to make a decision with nobody, really, to back me up. I tried to phone X and X wouldn’t answer the phone, so I just made a decision and went ahead and did it [ordered the patient transfer].

Sarah recalled an incident in which a lack of supplies was a key factor:

They just couldn’t stop the bleeding, we didn’t have any platelets and whatever else we needed to help him out, and he was just haemorrhaging and haemorrhaging....I think I felt inadequate as the surgery was going on, knowing that we should be doing more and I wished we had a better facility and a few more resources to pull on, so I think that carried on afterwards for a while in my mind.

Ellen recalled “you had to be inventive with the equipment, whereas some places you have all the equipment you need.” And Angela offered, “up here, you’re the only one, or your team is the only team—you have to rely on each other.”

Resuming other job duties for the remainder of the shift after a patient transfer was overwhelming for some nurses. Inadequate staffing patterns often meant that nurses had an unreasonable workload. Lorraine recalled her situation, “You have to go back and work your regular load, and it’s quite stressful ....to go back and have to function normally on the ward as if nothing happened is pretty hard, and we were really, really busy and short staffed that day too.” Vicky described caring for her trauma patient in the ER and also a woman in the ICU simultaneously.

Departmental staffing patterns can also add to the frustration. These staffing practices appear to be similar in the various hospitals and well-established. Angela
explained, "they finally go, [the patient] and you’re again the only ICU nurse or the only emergency nurse, so you go back and do your stuff....we work in isolation, in that there’s one ICU nurse and one emergency nurse, you don’t even have the opportunity to get together and debrief."

Several nurses made reference to the fact they had to contend with housekeeping duties after their patient was transferred. Most northern hospitals have limited ancillary staff working around the clock, resulting in nurses assuming non-nursing duties. These housekeeping duties can be emotionally taxing in themselves; it is as if the nurse is required to remove any evidence of the preceding event. Dianne recounted, "I found it very difficult getting this man stabilized and going and giving the blood, and getting everything that needed to be done in the room...and then having to deal with the family. And having to do the clean up....to this day I still get worked up about it." Ellen joined in by saying "the clean-up after is almost emotionally too much."

Judy described an OR scenario, "We’re on a call-back, and it’s midnight, and you know you’ve got to be there once the patient leaves the door, [because] then you have to be there another hour at least to clean up before you can leave..." Donna related her ICU experience, "we have acutely ill patients, you know, they [employer] demand that we still perform the same things, still empty the wastebasket, clean your [work area] housekeeping, etc. etc."

Time factor. Waiting for patients to arrive at the hospital or waiting for them to be transferred to another facility was at times stressful for the nurses. Many nurses expressed their frustration at having to wait hours before a patient transport team arrived, and then with having to wait several hours before the team left with the patient. Local geographical terrain and weather play a role in the patient’s arrival and departure also. Irene explained, “The team arrives finally--you could wait all night as you know, you could wait a day, you could wait just a matter of hours depending on weather and stuff like this.” Leah recalled
caring for a critically burned child, “We kept him down in emerg until, oh God, it was hours...and the team finally got there.” Susan described her frustration in trying to transfer a patient who was already prepared for transfer:

Then the ambulance arrives, I get the phone call from XXXX, well, they don’t want to take this lady now...but in the meantime, all this has been arranged. The ambulance is already here, they had a hard time coming in because of avalanches and stuff like that, it doesn’t make any sense to me.

Lorraine described her frustration in anticipating the transport team’s arrival, only to hear of ongoing delays:

I’ll be phoning, and the EHS is on other calls and they can’t come up right away, sometimes they have four calls ahead of us, and they triage them, but it takes a long time for the medivacs to come up sometimes. The wait seems to be a long time, sometimes it’s days and sometimes hours....the infant transport team couldn’t make it up because they were out on another call and they would be a few hours, and that was about 7 o’clock, and then by 10 o’clock they phoned and said there was another delay, they finally didn’t come up till about 2 or 4 in the morning.

Angela described her experience in terms of her previous work in an urban centre:

I’ve worked in the north, and then I’ve gone down and worked in XXXX, and then I’ve come back to the north, and really notice the time frame....the team comes in, and you’re not halfway to getting them on that plane yet, it’s not a matter of ‘show up, we’re done’, up here, it’s show up, and now jump into a bunch more [work] and you are looking at an extended period of time, and your adrenaline level continues to be at that high for a really long time...up here it’s a 4 to 6 hour minimum that you’re dealing with the trauma, and then the team arrives and you’ve got 2 hours more after that when they’re there with you.

Shelly very quietly described the arduous nature of her experience in anticipating the
arrival of a patient who had been mauled by a grizzly bear:

I think the worst experience with that one was waiting for him to get here, because they called me very early in the day, a phone call from his buddies saying that it had happened...I lost contact with them, and then it was hours before he came in and that was really hard...the next thing that I heard about him was, oh, probably about 4 or 5 hours later, but by the time I heard again, actually, I was beginning to wonder if it was a hoax...it was a really tough one because you’ve got yourself keyed up for it and nothing happens, and then you have to rebuild it again, and it was hard to do the second time, to get ready.

The geographical location of the trauma contributed to the patient’s lengthy delay in arriving at the hospital. Shelly explained, “There’s no road or anything, you have to fly to it—and he apparently was up river, and they had to float him down the river on a makeshift raft to where a helicopter could land.”

In almost all instances, the first few hours of patient care dictates the final outcome in a trauma situation. The first hour of care, commonly referred to as the ‘golden hour’ is placed in a different context in the north. Charlotte described her experience in a frustrated and exasperated manner, “[T]he biggest frustration being, you’re here in the north and the expert care the child needs isn’t here--and that long golden hour that they talk about in trauma doesn’t exist for our patients.” Charlotte further added, “You’re frustrated as hell because you know you’ve done trauma nursing for years and you know what time means in that perspective, and here they are [transport team] putzing around...” Ellen felt that the receiving hospital often did not acknowledge the excellent care provided in the north, “the first hour thing--the golden hour--they don’t think about it”, because the patient is arriving at their hospital under different circumstances.

In discussing the length of time involved in transferring a patient, Dianne stated, “it produces a lot of anxiety, the amount of time they [transport team] take, it’s a long time”
and Sylvia had a similar sentiment, "that was a real situation where they [transport team] have to get to XXXX as soon as possible, and you're worried about the time, and how long it takes for them [transport team] to get a person ready and out of here."

Close community ties and relations. Close community ties and relations were categorized under system problems because the hospitals function within the global community system. The community also depends on the hospital for the well-being of citizens. The ties that exist at a seemingly superficial level are actually much deeper. Donna described how the ties that bind can also be taxing:

I looked at the patient and I knew him...and that's something we deal with in the north, particularly in small communities, is that these patients aren't just patients, they are friends, they are neighbours, they are people at your rotary club, on and on, and I think that there's a lot of emotions we deal with because of that, that makes nursing in the north particularly difficult, because at that point you have to separate yourself—am I going to be the relative here, or am I going to be the nurse, and it really takes some backbone to separate the two.

Ellen described the impact of caring for a young community member, "Every time you hear the name, everybody responds, because we're still remembering." Donna recounted an experience in which she knew the transfer patient's partner and mother. She described the following encounter at a social gathering, "...and then the mother told me 'were you there Donna?' [caring for the patient], and I said 'yes'--and you cannot let go of it, it's a small community, it goes on and on--and she [the mother] said 'so, what happened', and I said 'oh my gosh, am I going to tell her about this?' and we are at a social gathering..."

Several nurses explained why they felt stressed in caring for community members. Lorraine offered:

Also in the north, because it's a smaller community, you have to remember that a lot of our patients are friends of ours, family members, so and so goes to school
with little Annie, so it’s not impersonal, almost always you know at least somebody who’s around that patient, or the patient themselves.

Vicky shared her experience in caring for a young gunshot victim whose three friends had been murdered during the same assault. References to community ties were many, for example, “...X had to go out to the houses of the other boys that were killed, to tell, to be with the parents...” and “he [the doctor] goes sheet white because his son had been planning on going with some of these boys...” Charlotte expanded and offered how community ties can be stress provoking for her and fellow co-workers:

You probably knew a lot of those families of those boys that came in....you see little things from families--their kids play hockey with my son, you know some of the patients that come in regularly....and there’s a community thing, or some intimate circumstance that you’re now involved in. Here, well, my husband was the policeman that brought the patient in that night, so there’s this instant, your husband might even have been working that night.

While it is desirable to have a close relationship with one’s community, there are instances in which this relationship can impede upon the nurse as she tries to function within the community system.

Lack of Communication and Support

In many instances, lack of communication and support heightened the stress the nurse was already experiencing. Nurses described feeling empty when the perceived support they sought was non-existent. There were three types of situations which were stressful for the nurses: (a) lack of follow-up communication regarding patient status, (b) lack of support from administration, co-workers, and colleagues, and (c) lack of debriefing opportunities.

Lack of follow-up communication regarding patient status. Several nurses felt that they did not have a sense of closure when their patients were transferred out and there was
very little or no follow-up communication. Speaking very quietly, Shelly explained:

Sometimes it’s hard because you send people out and you don’t hear anymore and you don’t know what happened to them—so you can’t really close it—this one I was involved in, when he was sent out, a few weeks later, the first thing I heard, the first report I heard, was the fact that he was really unhappy that we had saved him—so that doesn’t really make you feel very good.

Charlotte spoke in a pensive manner regarding her experience:

We followed up, what little we could....I worked in another area [where] you can follow them through their hospital stay, even if you’re in ICU you pop out onto the ward to see them, you can see their progress. Here, it’s different, totally different...it’s a frustration that you can’t see them through or you can’t look after them in your own ICU - you can’t be there to see their progress, be it good or bad.

Judy spoke in a deliberate tone, “And frequently we never know what happened--I think that’s one of the most frustrating things--you might have come in and done your darndest on a patient and there’s never anything that comes back....so it’s not very satisfying, it’s unsatisfying.” Angela added, “you know, that would be more satisfying to us if we knew....up here, I spend more time with the person. So I like to know, and it’s not more of a curiosity, it’s my way of dealing with ‘did we give good care’...” Ellen stated that not having the ability to communicate with the in-flight team was stressful, “[W]ho do you talk to and say ‘I didn’t do that, I forgot to do it’--who do you call and say that to if they’re in flight?” Patty discussed her experience with an intensity:

And the one thing that really [occurs] in these quite intense experiences, people go off, and you don’t hear anything....it’s sort of like they go into a black hole or something, and they’re gone...there’s not any means or systems to access that [follow up] information, like when you’re phoning [to the referral hospital] you feel like you’re bothering people, and there’s not a real receptiveness to getting
that information...and I need it, I had this intense experience with this person, that’s a pretty normal thing to need to know what happened to them. Like, we’re in the caring profession, right?

Other nurses also pointed out that there was no system in place allowing for consistent and continuing feedback on their patient. Some spoke of learning about their patient via the community grapevine. Irene said, “[I] don’t like it though when you run into somebody somewhere like Safeway or somewhere and they give you an update on the patient you should have known what was going on with.” Almost all of the patients transferred from the north return directly to their community once they are discharged from the urban hospital. The community hospital is bypassed, resulting in lack of patient contact even at a delayed time.

**Lack of support from administration, co-workers, and colleagues.** Many nurses described feeling unsupported at times during their experiences. Many of the accounts were told in a manner of disbelief, anger, or sheer frustration. During these descriptions, there was much group interaction as other participants related to the speaker. Patty recalled her experience when she cared for a child involved in a motor vehicle accident, “I remember being so affected by it and trying to talk with people after, and talking with a couple nurses and wanting to have a debriefing, and I got told ‘no, they don’t work’.” Leah described feeling unsupported after she actively sought assistance from a hospital manager, “I talked to the education co-ordinator, thinking it was fairly traumatic...I sort of thought, maybe this does deserve a debriefing, you know so we could all just sit about talking...and she said ‘Well, it really didn’t bother me that much’.” Ellen angrily described the lack of support from her co-workers during one event. She had cared for a patient all night, at which point he was transferred:

He finally left and I got the room cleaned up enough so that we could do another arrest in there...one of the suctions needed another thing in it, nobody could get it
for me...I went back up to the unit, and only max an hour after I had left, I brought that thing down, [at change of shift] and, well, I got blasted [by the on-coming shift] when I got down there because the room hadn’t been absolutely clean....I was really angry, and that’s non-support...that made me upset, made me feel like I hadn’t done what I should do and when in fact I did the best and it wasn’t acknowledged.

Angela felt, that at times, nurses didn’t have “the luxury” of co-worker support due to staffing patterns. She concluded by saying, “If you’re going to have your 10 minute cry, it’s going to be in front of your ICU monitor with two patients...and I think that’s a big stress up here that we often brush off because we’re isolated...”

Two nurses told of their experiences in which attention to administrative functions superseded any thought of care for the care-giver. Bonnie shared her experience:

She was in very bad shape when we got in, and I can just remember feeling so helpless, and I don’t remember us ever having a debriefing. I remember sitting down with the circulating nurse the next day because there was conflicts in time on our operative record, and what the surgeon had said, the different times.

Dianne described her experience:

I was approached by administration actually, the very next morning, before this fellow was actually transferred out, and told to go back and make sure my charting was up [accurate] because they thought there’d be a law suit over this--I remember that...they never offered me any type of professional support or personal support or anything, but they wanted to make sure that my documentation was right, so that there wouldn’t be a law suit.

Patty felt that she wasn’t heard by her co-workers:

I would talk to other people, and it’s not that people weren’t necessarily kind, but I found that I would start to talk about this [situation] and then I was getting very
quickly, a worse story...what I needed at that particular time was to be able to tell my story, you know, can I have this little space...I just found I wasn’t given that opportunity.

It is important to note that although several nurses experienced a lack of support from various people in the hospital system, they also gave numerous accounts of being supported by their co-workers.

Lack of debriefing. Lack of debriefing opportunities or gestures were closely linked with nurses feeling unsupported by administrative personnel. Many participants felt their efforts went unacknowledged, and that hospital management was not acutely aware of how the nurse actually functioned within the hospital. Charlotte explained:

And then you come back to work, and you find out the firemen have debriefings with professionals, the police have debriefings with professionals, you know the ambulance attendants were invited to the firemen’s debriefings with the professionals, but we’re all sitting there, going ‘yeah, but we’re O.K. because we’re all supposed to deal with this because it’s our job and we’re supposed to be fine’....I guess we have to sort of take care of ourselves and to make ourselves arrange these sorts of debriefings, because obviously no one in our real work environment is thinking about how we feel.

Vicky related, “Or somebody will say to you, do you think you need a debriefing, and you say, ‘no, I’m fine, I’m cool’ because you get this look--they’re looking at you as if ‘Oh please don’t tell me you need debriefing--I’ll have to arrange that for you now...” Patty described her experience when she requested a debriefing. She had been told “they don’t work” and further shared her story:

There’s not always an openness to debriefing, it’s not normalized [referring to critical event] and we want to do that kind of stuff. It stuck with me for a while, I was always running into these walls about why we shouldn’t do a debriefing, or
nobody's interested, or they're such a waste of time, or they're a pain in the ass to organize.

Bonnie reminisced about her experience, indicating a debriefing may have been beneficial for her, "maybe if there had been [debriefing], I think even up to now, I haven't really fully dealt with that case." Susan commented on her experience, "...it was an awful situation with no debriefing, and the only thing that saved me was that I was booked for holidays a week later."

Several nurses commented on the impromptu types of debriefings they had. These were more of a technical examination of events rather than a venue for expressing feelings and receiving support. Other nurses noted that when a debriefing was finally arranged, the structure of the debriefing was not what they hoped for. Patty explained:

So we did have one [a debriefing] which once the hospital got hold of the idea to have one, cause it started off as an idea for us to have one, so they brought in these mental health workers...we're all sitting around there and there's these mental health workers ...we're getting, like this lecture on post-traumatic stress syndrome, and we're all going like???[what are they talking about] Nobody's saying anything--that's not what we wanted, that wasn't the intention...now you're being treated like in a psychiatric way with this thing...there wasn't any management representative there to say 'oh, I think you've done whatever', it was just the health-care people and these beamed in mental health workers.

Another nurse commented that her debriefing also took place on the psychiatric ward and it was led by a social worker. Several participants thought that management personnel were unclear as to what was being asked for in a debriefing, which caused an obstruction in receiving this type of support. Also, when a debriefing was finally organized, it was an institutionalized, formal process, with no account given to the actual needs of the individual participants.
Visual Impact

At certain times, the visual nature of the trauma was stressful for many nurses. Age of the patient and the extent of the injury exceeding mental preparedness were identified as problematic issues.

Age. When speaking about their experiences, participants described scenarios involving children, or patients similar in age to themselves. Charlotte explained:

A young boy came in burned. He came in conscious...and immediately you know this child was in a lot of trouble and things were going to get a lot worse before they got better....when it’s a child for some reason, it’s closer to home maybe, it just seems to be more of an emergency.

Patty shared, “There was one a few years ago now that was one of those situations that had such a profound effect on me that I don’t know how I ever lived through it— but a little child was run over...” Leah told of a young child who was severely burned after playing with matches and fuel:

He was brought in wrapped in a sleeping bag in the back of a pick-up truck, and carried into emerg, smelling like the accelerant, you know, hair all burned off, ...and I thought at first the sleeping bag had burned and stuck to him, but it was actually pieces of burned skin kind of hanging off his body...and I remember the anaesthetist saying [to him] ‘I’m afraid I’m going to have to put a really big one [intravenous needle] in’ and he said ‘but I’m only eight!’--I’ll never forget that-- but I’m only eight!

Nature of injury exceeding preparedness. At times, the nature of the injury far exceeded what the nurse had mentally prepared for, and this was disturbing. Patient awareness was also unnerving for the nurses. In describing her experience, Diane stated:

It’s one that I’ll remember probably the rest of my career...they threw open the back doors [of the ambulance], there was no warning, and they pulled the gurney
off, and there was blood everywhere, the back of the ambulance was covered in blood, the members [RCMP] were saturated [with blood].

Vicky told of her experience:

Well it was just the worst thing you could imagine when he came in, because when they wheeled him through the door--I thought he was dead--and then you see all these holes over the body, and I said something to him, and he was speaking, and I couldn’t believe it.

Shelly recalls feeling unprepared in her instance:

When he got there he was really bad off...you look at him and you think he’s dead because he has slashes and gashes everywhere...and then he starts talking to you, and I’m like, ‘where’s that coming from?

Lorraine was shaken by her experience:

It was a gunshot wound to the face, half the face had been blown off....when I went to catheterize him, that’s when he moved, and the doctors realized that he was actually with us and he kind of made a noise...it was just horrible.

Shelly captured the essence of this type of experience:

You imagine the worst, and usually what you imagine is way worse than what you get, but it wasn’t--that’s frightening too, because you always imagine way worse than what you’re gonna get, and when it actually exceeds what you imagine, it’s a little bit hard to deal with.

Professional Discord and Friction

Differences of opinion and professional conflict were evident in many of the nurses’ accounts. These stressors were separated into two categories: (a) transport team issues, and (b) competence issues.

Transport team issues. Nurses felt that the patient transport team was critical of care rendered, and that repeated procedures prior to departing were unnecessary when
time was critical. Vicky cited an example:

For me, the care of that person becomes very personal...and then they [transport team] come to pick up the patient, and they say ‘we need this type of tape’—well, you know, you’re here with this poor young boy or child for how many hours, thinking he’s going to die, and they’re annoyed because you have half inch tape...like, this person is living because of the care he’s got to this point—don’t go there with the tape!

Charlotte shared her experience:

I am often left feeling angry when those guys come and scoop your patients up and spend an hour criticizing your care...they have a job to do and they have a very narrow perspective in what they need to do...nonetheless, it is very, very frustrating...you’re not even thinking about the patient anymore, you’re so damn mad because bloody goof thought you should have put normal saline in the endotracheal tube instead of air, or, why didn’t you use plastic tape.

Donna recalled her experience in dealing with the routine of the transport team:

They [transport team] want to quote-unquote stabilize the patient...our specialist said renal perfusion is zero, he [the patient] needs hemodialysis badly, but they [transport team] have to stabilize him...I said what is there to stabilize? It’s shot, you know?? [referring to renal function] I felt so bad, because of the routine.

Many nurses felt that while the transport team was extremely competent, they were very impersonal in their manner. Some nurses struggled with ownership of patient issues and were reluctant to hand over responsibility of the patient to the team. Charlotte felt “it’s kind of a weird feeling to let go”. Angela stated, “They’re scooped out of our control, and we had them for this extended period.” In describing her interaction with the transport team, Leah emphasized:

[the team was]...very business-like in taking over, taking him off our machine and
putting him on their machine, and they sort of don’t look at this little guy like he has a name or a family, or he’s somebody from somewhere, he’s just, he’s just their transport item, and that’s what they’re there for, and you sort of feel, you know, hoping they’re going to look after him, because you’ve put so much effort into it, so much heart into it, and away they go.

Patty recalled, “he [the patient] was so ready for transport, [I] had him ready to go and was thinking, ‘what are they going to ask, or what are they going to need’, and it doesn’t matter, they still, you get pushed aside and [the transport team] do their thing, come and reapply their expertise on [the patient] which kind of negates your [efforts].”

Competence issues. Many nurses felt they were required to defend the patient care they had given when dealing with the transport team or their counterparts in an urban hospital. Participants said they were also made to feel as if the level of care was lesser in the north than in an urban centre. Ellen shared her experience, “they give you such a hard [time]—down there, they more or less call you incompetent. Do you know what I mean, they’re really bad at that.” Dianne offered her perspective:

They make you feel like an idiot. ‘Well, you didn’t do this, why didn’t you do this?’...And they made you feel you were second class ‘oh well, you know, you work up north—we don’t expect that of you’—the transfer teams are particularly bad at that, when I think we have done a particularly good job with our limited resources.

These accounts suggest that nurses in the north have to deal with a ‘frontier mentality’ from their southern counterparts. Many participants felt their counterparts had no knowledge of basic living amenities in the north, or that viable communities existed in the northern region of the province, let alone competent delivery of health-care.

Charlotte described a conversation she had with a doctor who accepted her patient, and then criticized the patient’s condition upon arrival at his hospital. This patient
did not have the benefit of undergoing a CT scan prior to transfer, which would have been beneficial in making a further diagnosis. Charlotte offered:

I said [to the doctor] you’re missing a small point here—we don’t have one of those [CT scanner]...so you’re mad again—you’re defending what you did—you know you did your best, you gave more than 120%...and then you have this turkey on the other end of the phone who’s got all the resources at hand saying ‘well you missed this’ or ‘you should have done...’ and that’s very, very frustrating.

Irene offered her experience:

You always think in the back of your mind, when they [patient] leave, is, ‘will those receiving him down south, respect your efforts, acknowledge your efforts, see you as professionally competent, or as having provided good professional care, etc. etc.’, you know, certainly the reputation of the north is there too.

When asked to expand further about the reputation of the north, Irene explained:

Well, I used to work XXXX emergency, and I can remember when the planes would bring in patients from outside, and I can remember the sarcasm starting before the patient even landed,...I’ve always felt like the north had to answer for its skills, it’s like women have to be twice as good as men, you know, to get half as much praise, well, it was the nurses in the north had to be twice as good as nurses in the south...I guess it’s just some sort of geographic insecurity.

Charlotte felt that a competitive nature existed between hospitals everywhere, but that it was especially frustrating for northern nurses, “that’s very frustrating--I’m sure between XXXX and XXXX they have that same sort of competitive upmanship or whatever, so us peons up in the north--we have to expect it to.”

Stress relating to competence issues also surfaced when nurses were required to execute an unfamiliar procedure, a rarely performed procedure, or use equipment that was seldom required. Judy explained, “We’re doing something that we haven’t [done before
or recently] or using a piece of equipment, that, when we bought it we knew how to put it together, but now we can’t remember...so that adds to the stress, makes the whole thing stressful.” Lorraine added, “Or the equipment hasn’t been used for months and months, maybe a year, and then you go to put it together and it falls apart or something.”

The circumstances in which participants experienced acute stress are described in four separate, but connected categories: system problems, lack of communication and support, visual impact, and professional discord and friction. These categories existed across all four groups, yet not all participants experienced exactly the same stressors. The difference may lie in the interpretation of the event to the nurse involved, and the meaning of that event to the nurse. As Angela so simply stated, “It depends on the incident...I’ve been at this for many, many moons ...and then one of them will just do it to me “

Coping Strategies

While the previous section dealt with difficulties that resulted in a stressful situation, this section will describe what helped a nurse to understand and manage her experience. Nurses’ coping responses were categorized as: (a) problem-focused, (b) emotion-focused, or (c) automatized response. Most of the coping responses discussed were noted to be emotion-focused coping. While each category is described separately, it is important to understand that nurses used both problem- and emotion-focused coping to manage the internal and external demands of their stress-producing situations.

Problem-focused Coping

This coping response was used when nurses felt they could change their environment to better manage their stress. Some of these strategies can alter or change the problem, but they are dependent on the problem being dealt with. Planful problem-solving and confrontive coping were two types of problem-focused coping described by participants.

Planful problem-solving. Shelly described how her personal life was affected after
caring for her patient, and how she attempted to manage her stress, “I’ve always been aware of bears, and, living in the north, you always have this plan in your head what you’ll do if you ever run into one, and after that I was really nervous walking.” Angela described how nurses and doctors coped together in some instances, “You have to rely on each other...that’s the time we all pull together as a team and we’re using each other’s resources to problem-solve until the almighty team can come up.” Lorraine offered, “Up here, you have to depend on each other to hopefully keep educating ourselves, because down south, they have all the specialists...here, you’re only by yourself.” Several nurses described a strategy they felt would be of benefit to them. Judy said, “I would feel more comfortable now, saying, hey, I think we need something [debriefing, for example] some of us are having a bit of trouble with this.”

**Confrontive coping.** These responses describe nurses’ assertive efforts to alter their situation. There can be an angry or belligerent attitude expressed. Charlotte responded, “I am often left feeling angry when those guys come....so often by the time the patient leaves, they’ve [transport team] really debriefed you because you’ve gotten all the anger out now.” In remembering the difficulties encountered in persevering and trying to organize a debriefing, the nurses’ voices took on a hostile tone:

- Patty: That somehow gets wrapped up to be like, you’re somehow failing [in requesting a debriefing] you’re not being like the hard-nosed nurse, I don’t know what that’s about...
- Sylvia: And the thing is, we all have different needs, it’s like we know now ‘like you’re OK, but don’t I count?’ [in reference to person who felt a debriefing was not necessary] Just because one person doesn’t need a debriefing doesn’t mean everybody’s the same.

These participants felt they had to stand their ground to fight for what they wanted.
Confrontive coping and planful-problem solving were often described together by the participants when they discussed their coping measures.

**Emotion-focused Coping**

Examples of emotion-focused coping strategies were plentiful as the nurses recounted their experiences. Many nurses felt there was nothing they could do to substantially alter the conditions of their environment. In these instances, three forms of emotion-focused coping were evident: (a) positive re-appraisal, (b) avoidance and self-control, and (c) seeking social support.

**Positive re-appraisal.** This strategy relates to efforts that created positive meaning. The nurses' descriptions included personal growth and enlightened thinking; some even had a spiritual tone to them. Karen described, “I think these trauma experiences, over time, made me realize that we are a team, and we all learn from that experience.” Dianne recounted her experience and the impact she felt, “It was quite big in my early career as a nurse. I’ll always remember it, and it’s good for reflection for me to look back and look at the organization and how it all did come together, and I did manage it.” Donna shared, “in many ways you question your skills--I’m a pretty spiritual person, so I think I was there for a reason, there was a purpose why I am there, so I accept that...it made me a better person...” Other nurses described being a better person by going through their experience, or using the experience to grow as a person. Participants also validated themselves and their nursing care through positive re-appraisal. Angela explained, “I like to know [the patient outcome] and it’s not more of a curiosity--it’s my way of dealing with ‘did we give good care...could we have done something better’, you always question that in yourself.” Lorraine felt that “experience helps you be a better nurse--you learn by experience.” Charlotte stated, “…surviving these horrible incidents, I think, in some bizarre way, makes you stronger...makes you more certain that if it happens again, I coped a few times, I’ll be OK, and I’ll get through it.” Vicky felt that, for herself, “a lot of the
time things happen, and you have to learn from everything whether it be clinically, 
spiritually...”

In discussing the negative aspect of not having a debriefing, Irene felt “it’s a lost 
opportunity for learning, so not just to satisfy a curiosity, but did we do the right thing, 
were we on the right track.” Lorraine also tried to rationalize in a positive manner:
Yeah, because some of the trauma patients that we sent [transferred] if we had the 
cat scan, then you would see they weren’t salvageable, so let them spend the last 
few hours with their family, instead of taking them away and having them code on 
the plane or as soon as they get into the emergency, because we’ve had that 
happen.

Avoidance and self-control. These coping gestures relate to wishful thinking and 
trying to manage one’s feelings and actions. Angela described, “Sometimes after 
something traumatic, I’m quite quiet at home, and it really bugs me if my other half wants 
to know what’s wrong, and I just need that 12 hours to be OK, and that’s my quiet time.” 
Patty described an ‘expectation turned reality’ of nurse’s self control, “Because I think 
there is a lot of expected [behaviour] you know, ‘we’re such hotshots, we can just deal 
with this, we deal with it all the time’, you know?” Dianne recalled the effort involved in 
regulating her feelings:
I can remember how huge that [critical event] was in my life, that’s all that I 
thought about—it consumed my thoughts, all day, every day, for a long time. And 
of course you can’t talk about confidential matters...and it was very difficult to 
express your feelings because you’re limited by what you can say, it was a very 
tough time.

A few participants described keeping their professional and personal lives separate 
as a way of controlling their experience. Susan said, “We work very closely together, 
support each other, but when it comes to personal things outside of the hospital, [we are]
very separated ...we don’t really talk much about things.” Karen clarified by adding, “They want to keep work on a professional basis, because it is true, that when you get emotionally involved with someone, a crisis comes up, sometimes it’s more difficult to deal with.”

Charlotte described caring for a child and the self-control efforts she noticed:

There was myself, and another nurse...a female paediatrician, there happened to be a female surgeon locum, and a female anaesthetist, and all of us were moms, and it was a really, a really interesting situation--nobody looked at anybody.

Vicky divulged that she could not give herself permission to display emotion and felt she had to maintain self-control, “I started to cry, and it was like, OK Vicky, you CAN’T cry--I can’t cry because I gotta go look after this woman, and I can’t do this now, I can’t lose it here.” Shelly quietly spoke of containing her emotions, “I think sometimes it gets to where everyone goes to their own little corner--I know that’s happened to me before, and I think, wow, I’m all by myself, you know, like nobody wants to talk about it, so I guess I don’t either then.”

Seeking social support. Participants offered numerous accounts of seeking social support as a means of coping. Social support was obtained through a combination of supportive communication, emotional support, and perceived support. The participants spoke of their co-workers as being especially vital to them a support resource.

Charlotte explained:

We all talked about what we did and that sort of thing. It wasn’t a planned thing--I think sometimes for women it’s easier, I know as nurses, you’re always, at 2 o’clock in the morning you start talking about these most incredible things, that I think are a really good way of dealing with it.

Sarah offered:

I feel I get the support, that I’ve always [had support] when I’m in a stressful
situation, I need to talk to somebody, it’s my only way of coping and getting through it, and I always can find somebody that I can seek out that I can talk to and I do, I actively do that.

Several nurses felt that their co-workers were always available for support. Angela offered, “they’ve always been there for me...I think because we’re such a small knit group, there isn’t one person I can recall that I wouldn’t feel comfortable sharing a cry with.” Judy explained, “I’ve always been supported too, and supporting too, if it didn’t bother me, I still recognize it might bother the other person.” Lorraine also perceived support from her co-workers:

I think you look to your colleagues for their support and their help because we will all help each other. I think especially being up in the north that we’ve really only got each other, and that we’re a small hospital and you need to help each other out.

Several nurses felt that their co-workers were the only ones who could truly understand and support them during their stressful time. Sylvia emphasized:

I think just to talk to someone about the situation, I mean, to talk to someone that can totally identify what you’re going through, I’m not talking about a significant other, that’s totally different, but talking to your colleagues, and just to say ‘oh, I felt like this’, and to feel like you’re not alone, and that other people can identify with your feelings, and be validated, really, not to have some psychiatrist come along like we’re a bunch of nut cases, can’t handle our job--you know, just to chat.

Irene stated, “I think nurses get rid of that kind of sadness of stress by talking to each other--we need to do that.” Linda described the support her colleagues give each other in her department, “The next morning we talk about it, if people have something to share...you know, little things, just talking a bit, it doesn’t necessarily have to be a long
time." Judy offered her experience, "I think that's why when you look at another nurse, often, we are most comfortable with other nurses, probably because they really know, what, where it's at, and they only can understand."

For some participants, family and friends were not their primary support choice when it came to managing work-related stress due to confidentiality issues and a lack of understanding. Lorraine explained, "They [family and friends] don't understand, I don't think, because they don't really know what goes on in a hospital, they don't know that one minute you're resuscitating somebody and another time you're picking bits of a skull out..." Shelly noted, "I think a lot of times, you need to talk to somebody who's in the know, by in the know I mean somebody who can understand the situations...if I go home and try to debrief with my husband, it's usually not very effective—he just doesn't understand." Charlotte stated, "the confidentiality issue makes it tough" and Dianne agreed, "the confidentiality part is a big deal, how much can you tell them—'well, I had this patient, things didn't go well'—end of story." Several participants pointed out that although family and friends could not fully appreciate their experiences, support was available for physical and emotional needs, and that different forms of support were received from these people.

Several nurses recounted their experiences of supportive communication and the value they felt. Linda stated, "You go through that high and you come to a low, so you have to spend that time to talk about it, and you don't realize that. You don't realize how you are like this." Sylvia explained her need for supportive communication when she cared for a child:

Children show such raw emotion—and it's all that intense emotion, and when you feel like you are connecting with that little human, and you're feeling that emotional pain, that's where I feel a debriefing is very important, because otherwise you carry that with you.
Irene described a situation where a patient had just been transferred and the next shift was coming on, "The transfer had just happened, it was a total mess, they weren't cleaning up, what they needed was to sit down and talk and talk and talk, and they went through the situation with us, the next shift coming on."

Ellen described receiving social support from another professional:

I got stopped by the RCMP...and then he identified who I was, and then I said "I just had one hell of a day and I guess I'm still going". He said, "tell me about it"-- and that was at the side of the road--and that's what you get from the community.

Two other nurses felt they received absolute support from their pets. Susan explained, "Some people don't want to be there when you're angry--your dog is calming, that's the funniest thing about pets, is that they have unconditional love." In referring to her pet, Dianne stated, "I find her so therapeutic--what I like is I come home at the end of the day, and she comes up, and just looks at me [as if to say] 'I've waited all day for you'--it makes you feel like a million bucks."

The importance and value of social support to the nurses as a coping strategy was evident in the rich descriptions offered by the participants. Many of the nurses felt that co-worker social support was available to them when they most needed it. They also believed it was important to pull together during times of stress, even if in reality this did not always occur.

Social support questionnaire (SSQ). The social support questionnaire was administered to all participants. Three questionnaires were eliminated due to incomplete responses. The SSQ yielded scores regarding the perceived number of supports a participant had, and his or her satisfaction with the support available. The number scores (N), or the number of perceived supports, ranged from 1.2 to 7.18 across the groups, with a mean of 3.4 persons listed as supports. The satisfaction with support score (S), ranged
from 6 (very satisfied) to 3.8 (a little satisfied) across the groups, with a mean of 5.5.

A few participants indicated 'no one' as a support when answering questions related to emotional aspects of their relationship. Two of these questions, for example, were “Who can you really count on to help you feel more relaxed when you are under pressure or tense?” and “Whom can you count on to help you feel better when you are very irritable, ready to get angry at almost anything?” However, the participants were generally satisfied with no support in these instances, as evidenced by their S scores. They ranged from 5 to 4.3 for these participants. Some nurses listed “God” or “the church” as being support providers, and a few participants made reference to their pets as being support resources.

Overall, across the groups, the participants indicated they were satisfied with the perceived social support available to them. The fact that some nurses had fewer supports than others suggests that it is not the number of perceived supports available that is fulfilling, but rather it is the quality of those supports that is satisfying and beneficial.

Automatized Response

Several nurses described the initial response to their situation as occurring in an automatic fashion, almost without effort. Charlotte recounted, “We were all upset, and you can tell that you put that auto pilot thing on that you do when you’re in a crisis to get through it.” Vicky recalled her experience where a surgeon instructed her to perform a procedure she hadn’t done in months, “You just go into this robot mode....he looked at me and said ‘Vicky, just do it--and it was just all of a sudden everything comes back--bang--do it.” Shelly offered her experience, “Then you just go into the mode and you just look after it and you do one thing at a time and you get through it.” Judy explained how an automatized response is helpful, “Part of that stress of a whole case like that comes from that [unfamiliarity]--if you’re doing it all the time, that would not be stressful at all to you, it would be just a walk in the park, another day.”
Emotion-focused coping surfaced as the preferred coping strategy used by the participants in managing their stress. Multiple references were made in regard to the value and the need for social support as a coping strategy. Few issues, if any, were perceived by the nurses to be amenable to change. As a result, problem-focused coping was not significantly appreciated to be a favourable coping option.
CHAPTER FIVE

Discussion

In this section, the meaning of the results will be discussed, linking this research with the existent literature. The purpose of this study was to explore acute stress and coping among northern nurses in relation to the transfer of trauma patients. The discussion will be organized in terms of nurses’ stressors and coping options. It is hoped that the findings will make the work complexities of northern rural nursing more visible and understandable to both those working in the north and to those who are unfamiliar with the unique practice of their northern colleagues.

Review of Categories of Acute Stress

There is a limited amount of literature specific to northern nurses. There were some similarities between this study and the available literature, and these will be discussed.

System problems have been cited as being stressful in several studies (Bigbee, 1993; Birkland, 1994; Hawley, 1992; MacLeod, Browne, & Leipert, 1998; Morton & Loos, 1995; Scott, 1991). MacLeod et al. (1998) found that working without back-up was demanding and challenging for the nurses. Birkland (1994) identified the lack of human and technological resources as a reality in the north. This author also noted that waiting for a transport plane indefinitely was “confirming your worst fears.” While not specifically addressing nursing stress, Morton and Loos (1995) emphasized the fact that there is a lack of health-care workers in the north, and in some communities, emergency departments are closed during the evening because of the man-power shortage. In a study pertaining to emergency nurse stress, Hawley (1992) identified the organizational structure, departmental staffing patterns, and working with inexperienced medical and nursing staff as stressors. The data obtained in my study are similar to the findings of the literature.

Nurses in my study spoke of wanting to provide an excellent standard of care, but
felt that they were unable to do so because of human and technological limitations. Several nurses made reference to the fact that “having all of the resources available at your fingertips” would result in a better level of care and decrease personal stress. The participants often felt at a disadvantage when it came to providing what they perceived to be, an acceptable standard of care. For these nurses, a discrepancy existed between their perceived ideals of nursing and the actualities of their daily work. In all probability, the ideal image of nursing will remain just that—an ideal. Although the Canadian health-care system boasts of its universal coverage, accessibility to health-care is not clearly universal. One barrier that prevents equal access to health-care is geographic location (Morton & Loos, 1995). Another more immediate barrier to universal access relates to the hospital’s financial affairs. When deficits arise, as they often do, hospital boards are faced with deciding which services to eliminate or ration. This, in turn, contributes to physicians relocating because they cannot economically justify staying in a region where (a) there is no work for them, and (b) they cannot give patients the care they are entitled to because of imposed fiscal restrictions. A domino effect—the exodus of health workers—can then result in the availability and provision of even fewer health services.

Nurses also felt torn between providing immediate patient care and maintaining patient contact with the family members, especially if the family was personally known. Birkland (1994) identified the familiarity between nurses and patients as a stressor in providing care. Bigbee (1993) also identified the difficult position that rural nurses may find themselves in because of patient familiarity and that caring for friends and relatives can be alarming. Many participants spoke of the difficulty in actively performing the nurse-role instead of the friend-role when nursing a patient familiar to them. One nurse described relocating to a different rural community, and not experiencing stress related to community ties. She stated, “That attachment hadn’t been formed yet, so that way made it easier on you personally.” The interconnectedness of the community also makes it
difficult for the nurse to truly escape work. The nurses in my study stated that community ties were problematic at times, and that it was difficult to keep their professional life from encroaching on their personal life. One nurse gave a detailed description of being approached at a social function, with the expectation that she would divulge private information.

In the literature relating to the general nursing population, inadequate staffing and work overload issues were identified as nursing stressors, but viewed in the context of working in metropolitan hospitals (Constable & Russell, 1986; Dewe, 1987, Gray-Toft & Anderson, 1981). Other system stressors described by nurses in my study included working in isolation in departments, waiting for the patient or transport team to arrive and leave, or trying to apply the golden-hour rule. These were not addressed in the literature. This may reflect the nature of rural nursing as being distinct from urban nursing and the unique issues that rural nurses cope with.

Lack of communication and support was identified by the participants as stressful. Little or no patient follow-up communication was a stressor for participants; however, this experience was not evident in the nursing literature. Southard and Trunkey (1990) draw attention to the fact that trauma co-ordinators routinely contacted the transferring hospital to give updated patient information. They discussed how this type of communication resulted in both rural and urban centres having a greater understanding of each other’s problems. The nurses in my study noted that there seemed to be no apparent system in place for obtaining accurate, updated patient information, and that often many people were attempting to obtain information at the same time. The nurses described feeling dissatisfied because patient outcome was unknown, explaining that they needed this information to achieve a sense of closure and validate their nursing care. The nurses also commented that they did not like learning about their patient from the community grapevine. They felt that they should have had access to this information first in order to
normalize and achieve a sense of closure in their experience.

Lack of support from administration and co-workers was identified as stressful for the nurses. Similar findings were noted by Burns and Harm (1993). They found that many emergency nurses were reluctant to participate in debriefings, but did not identify specific reasons. Support from nurse managers and charge nurses was seen as crucial in order for nurses to be willing to participate in debriefings. Hawley (1992) noted that support from co-workers and supervisors needed to be encouraged in order to reduce nurses’ stress.

Findings from a study by Constable and Russell (1986) suggest that high levels of support from supervisors can decrease nurses’ stress, but the authors did not confirm the value of co-worker support. This is in direct conflict with the data obtained from participants in my study, which suggested that co-worker support was very important.

Nurses in my study also cited the lack of debriefing gestures as a source of stress. Participants gave many examples of other professionals being supported through debriefing, and wondered why they were not included in these sessions. The nurses were often angry when describing how they felt ignored by others when it came to a debriefing. Hollister (1996) noted that prior to implementation of a debriefing program in one American hospital, nurses suffered from decreased job performance, satisfaction, and morale. Hamer (1997) alluded to the fact that debriefing for nurses was awkward following a ski resort disaster because of the impending holiday celebrations. In retrospect, those nurses felt that even a brief session that evening would have been beneficial for them. Burns and Harm (1993) found that debriefings were not helpful when the facilitator did not have any relevant or similar experience. This is consistent with information obtained from nurses in my study, indicating the need for participants and the facilitator to identify with each other at some level to ensure a valuable debriefing experience occurs. The nurses felt that the mental health workers in charge of their debriefing did not appreciate the nature of the nurses’ stress, and as a result, the debriefing
was of little value to the nurses.

Visual aspects of the trauma were identified as sources of stress for the participants. In a study about critical incident stress, Werner, Bates, Bell, Murdoch, and Robinson (1992) found that experiences with children or young people, the goriness or enormity of the incident, and being unprepared for the incident, were stressful factors for emergency response workers. This was congruent with what nurses shared in the focus groups. There were several accounts of trauma involving children or young adults, and these accidents were viewed as senseless and tragic not only for the families and the community, but also personally for the nurse. Burns and Harm (1993) found that providing care to a trauma patient who resembled self or family members in age or appearance was stressful for emergency nurses. When participants in my study shared their experiences, they often talked about children or people similar in age to themselves. Perhaps these experiences were shared because the nurses somehow identified with their patients on a personal level. Participants also spoke of being overwhelmed when they were mentally unprepared for their experience, or when the trauma exceeded their expectation. This is consistent with findings in studies by Burns and Harm (1993) and Werner et al. (1992).

Many nurses described feeling criticized by the transport team, and undermined in their efforts to provide care and prepare their patient for transfer. They often felt that their care or procedures were dismissed as inadequate and not acceptable. Experiences of professional discord and friction in relation to dealing with transport team issues were not evident in studies of rural nursing or the general nursing population. This can be explained in a few ways. My study specifically focused on nursing stress in relation to the transfer of trauma patients; other studies focused on issues of rural nursing in a general manner. Data collection in various studies was often by use of questionnaires, while I used focus groups which generated different types of information. “Under serviced area”
is a term currently employed in British Columbia to identify remote communities with limited health-care resources and/or practitioners. While the term is technically correct, it may unfortunately tempt some individuals to equate an under-serviced area with less than adequate delivery of health-care. Several nurses described how they were made to feel "incompetent" or "less skilled" when dealing with their southern counterparts. One nurse described her past experience in perpetuating the perceptions that still exist about northern nursing and health-care, that is, nursing skills and the delivery of health-care in the north are, at best, second rate. It is possible, based on the individual nature of event appraisal, that other nurses did not encounter stress-producing situations when they interacted with the transport team. It was unsettling to hear the nurses describe their accounts of professional discord. While not everybody can always work together harmoniously, it is expected that professionals respect each others’ practice and conduct themselves in a similar manner. The primary concern is the patient and allowances have to be made for differences in patient care. Some nurses also commented that they were reluctant to transfer patient care over to the transport team because of the differences in professional opinion.

Nurses also described the stress encountered when required to perform unfamiliar procedures or participate in rarely performed procedures. They explained that they felt as if their professional competency was in question, which left many of them feeling quite frustrated and questioning the excellent skills they had. Birkland (1994) described a rarely performed procedure as stressful for the nurse. Hawley (1992) identified the under-utilization of skills as stressful for emergency nurses.

The findings in this study indicate that, similar to other research, a variety of circumstances were seen as stressful by the nurses. What is highlighted, however, is that northern nurses encountered unique stressors in their practice when caring for and transferring trauma patients to an urban facility.
Review of Nurses' Coping Strategies

Problem-focused coping and emotion-focused coping strategies were used by the participants in managing their stress. Automatized responses, which according to Lazarus and Folkman (1984) are adaptive behaviours and not coping responses, were also noted to be used by some nurses. The appraisal of the event not only classifies it as stressful or irrelevant, it also directs the choice of coping strategies available to the nurse.

Problem-focused coping was used to an extent by some participants in an attempt to change their person-environment relationship, thereby reducing or regulating the stress they felt in that encounter. Lazarus and Folkman (1984) note that problem-focused coping is used when people feel they can change the conditions of their environment. Planful problem-solving and confrontive coping were two strategies used by the nurses. Dewe (1993) found that nurses in his study used problem-oriented behaviours to cope with stress. He also found that all but one of the coping strategies used by the nurses were emotion-focused. This is congruent with my findings, in that the participants generally relied on emotion-focused coping as a stress management strategy. This may reflect the fact that nurses really cannot control their work environment and that many stressors are not amenable to change because they are actually controlled by the system. Hospitals are designated as care-providing facilities, and it is normal for nurses to routinely care for people who are suffering, and sometimes die. Since one role of the hospital is to provide this ‘caring’ service, the environment itself is not amenable to change. Nurses also want to give excellent care, but the resources are not always available for them. This is also something that is not easily changed. Considering the present state of the health-care system in the Province of British Columbia, it may continue to be an obstacle that nurses cannot overcome.

Lazarus and Folkman (1984) noted that emotion-focused coping was dominant when high levels of stress were encountered. They also draw attention to the fact that
problem-focused coping is not an option in some situations.

Social support as a form of emotion-focused coping was highly regarded and often used by the participants in managing their stress. Nurses referred to their co-workers as people who could be instrumental in this process. Supportive communication was found to be an important component of social support by the participants. This type of support allowed the nurses to express their feelings with each other, and receive messages of acceptance and validation from each other. Ellis and Miller’s (1994) study supports the value of co-worker communication. They also found that informational communication, which some of my participants engaged in, was beneficial in improving role definition and increasing skill level. Participants emphasized the importance and value of supportive communication because they felt they were allowed to express their emotions and be accepted for who they were.

Nurses in my study often spoke of knowing or feeling that their co-workers were available to rely on for support. The belief that there are others available to care for the individual, is referred to as perceived support by Sarason, Pierce, and Sarason (1994). Associated with this is the level of satisfaction that one has with the support available. Participants described supporting each other by listening and offering encouragement during stressful times. They often referred to their co-worker as being someone who could “totally identify” what they were experiencing. They also noted they were most comfortable sharing their experience with another nurse, because only they could truly understand. Lazarus and Folkman (1984) noted that when social support was offered freely and voluntarily, this sent a signal to the individual indicating that the person was cared for and valued by others. This behaviour was evident in the participants’ descriptions of their accounts. One nurse stated, “I’ve always been supported, and supporting too—if it didn’t bother me, I recognize it might bother the other person.” Another nurse described the effect of spontaneously offered support, “I say to them ‘I
think you did that really well', or anything, because if it was me, it sure makes you feel a whole lot more worthy.”

Participants also noted that they received different types of support from their family and friends, even though these people could not fully understand the nurses’ experience. At times, the nurses found it beneficial to seek support from a non-medical person because the nature of the interaction dictated that the nurse stop thinking about nursing. One nurse described feeling “refreshed and totally uplifted” after being supported by her friends. Depending on the situation, it appears that nurses sought out specific people who could provide them with what was needed at that particular time as a means of managing their stress.

Several participants commented that “God” and “their church” were sources of social support. This was not addressed in the literature reviewed; however, Lazarus and Folkman (1984) listed “I prayed” as a coping response in their Ways of Coping checklist. Having a strong religious faith may provide the participants with a belief system which helps them to find personal meaning in their stressful situation. Also, participating in church activities involves social interactions, which can provide other aspects of social support. Lazarus and Folkman (1984) also commented that specific beliefs can serve as a basis for hope, which can bolster coping efforts.

A few nurses indicated that their pets were support resources. Again, this was not addressed in the nursing literature, yet the beneficial effects of pet therapy are supported in literature (see Cusack, 1988; also Jenkins, 1986) and the media (Big dogs/Little dogs, n.d.). While animals cannot verbally respond to the nurses’ stress, they may sense when their master is emotionally distressed. It was during these moments that participants felt that their pets “tuned” into them, made physical contact, and somehow regulated their emotions. They spoke of their pets as being “therapeutic” and “calming”. One possible explanation is that perhaps, the pets, being social creatures themselves, also craved
attention from their masters, resulting in a reciprocal relationship.

Participants also spoke of debriefing as a means of support and coping. There are several accounts that emphasize critical incident stress debriefing (CISD) to be a valuable method of stress management for nurses and others (Burns & Harm, 1993; Holaday, Warren-Miller, Smith, and Yost, 1995; Hollister, 1996; Lane, 1994; Spitzer & Burke, 1993). Critical incident stress debriefing provides a supportive environment where nurses can express their thoughts and emotions in relation to the event, and discuss how they are presently dealing with their feelings. Hollister (1996) described CISD as a group process where participants share their feelings, examine and understand personal responses to the event, and establish personal goals as part of a re-entry phase. Based on the supportive qualities and functions of CISD, it can be seen as yet another form of emotion-focused coping.

Although the majority of nurses in my study did not participate in a CISD, they thought this was an activity that would be beneficial for them despite the fact that their managers were resistant to organizing them. Some nurses shared instances in which CISD was finally organized, yet the focus of the debriefing was not congruent with the nurses’ needs, which created more stress for the participants. One nurse stated, “We didn’t really have a facilitator so we’re having to facilitate ourselves, which is not a good idea, you should have somebody outside the whole thing.” Hollister (1996) pointed out that the facilitator should not be involved with the traumatic event, while Spitzer and Burke (1993) noted that having a background similar to those involved can be helpful in establishing a sense of identity between the participants and the facilitator. One explanation for the observed resistance to organizing debriefings may be that the purpose of a debriefing is poorly understood, or not understood at all, by administrative personnel and those in a position to arrange these sessions. Because they are not directly involved in the front-line care of patients, these people’s perceptions and interpretations of events can differ greatly.
from those of the nurse.

One nurse also explained that neither she, nor her colleagues were consulted regarding the content or direction of the debriefing prior to it eventually being organized. The debriefing process seemed to be based on what administrative personnel thought would be beneficial to nurses. This is not unusual, or surprising and is seen elsewhere. In discussing education for poor, prenatal women, Morton and Loos (1995) noted that the programmes were based on the values and beliefs of the middle-class professionals who designed them and that the participants were not consulted regarding their own needs, values, or beliefs. One nurse emphasized that the goals of the debriefing be compatible with those of the nurse. Nurses also commented that they needed to know in advance what the actual goals of the session were; they did not want to be met with discussions about changing or designing administrative policy when they were instead expecting psychological and emotional support. This type of hidden agenda can be destructive to the nurse’s coping process because he or she may feel as if he or she now has to also fix the problem, when what actually is needed is an understanding of the issue. There are obviously different approaches to the process of debriefing, and the focus of a debriefing may differ between institutions. To avoid mixed messages and ineffective debriefing situations, the hospital, with input from the staff, needs to adopt a specific framework for debriefing and let this be known prior to the occurrence of critical incidents. If the focus of the debriefing is known in advance, it can become part of the hospital’s culture, and personnel would not be engaged in a debriefing process that has a different agenda and unclear expectations each time. Another explanation for the seemingly impotent behaviour of administrative personnel relates to the form of coping itself. Lazarus (1993) noted that, in our society, taking action against problems in the form of problem-focused coping is more desirable than emotion-focused coping. This may be because some people are uncomfortable with the notion of having to deal with ‘emotions’ and ‘feelings’, and
view problem-focused coping as giving instant, tangible, results.

The fact that problem-focused coping and emotion-focused coping were addressed separately in this section is not meant to imply that an interaction between the two does not exist. There is a relationship between them, and often they are simultaneously applied to manage the stressful event. In discussing their coping strategies, nurses in my study described using both problem- and emotion-focused coping; however, much more recognition and value was given to emotion-focused coping. It would seem that emotion-focused coping is applied first when coping with health-related critical incidents. This allows the individual to look after the 'self' first in managing his or her stress; then if possible, the individual could apply a problem-focused coping strategy. Emotion-focused coping is not a weaker way of coping; it is a method that is available to the individual at that particular time. Lazarus and Folkman (1984) noted that both problem- and emotion-focused coping were used by everybody in almost every stressful encounter.

Nurses in this study experienced acute stress when caring for and transferring trauma patients. While many nurses experienced similar stressors, others experienced different ones. Likewise, coping strategies were not employed by all of the nurses in a similar fashion, nor were they all used by all of the participants. Also, a coping strategy that was used at one time by a nurse, may not have been used at another time by the same nurse. This indicates that the nurses interpreted the meaning of the event, and acted upon that meaning, in an individual fashion. This is consistent with Lazarus and Folkman’s (1984) work, in which they emphasize the transactional model—person and environment elements join together to form new meaning through individual appraisal. Because individuals do not respond to their environment in a pre-determined manner, there can be no standard interpretation or response to the events. The appraisal of the event can then influence one’s choice of coping strategies. In many instances, nurses in my study used emotion-focused coping, and while it did not change the actual terms of the
person–environment relationship, the meaning of that relationship was changed through regulating the nurses’ emotional response. The situations that northern nurses face and work in vary from day to day. It would seem plausible that the stressors experienced by these nurses are unparalleled.

**Automatized Adaptive Behaviour**

While Lazarus and Folkman (1984) do not view automatized adaptive behaviour as coping efforts, it needs to be addressed in this section. Lazarus and Folkman explain that when a situation is repeatedly encountered, it is probable that the responses to that situation will become increasingly automatized or automatic. Initially, the distinction between coping and automatized behaviour can be muddy, and it is only when the individual gains experience with the situation that coping efforts are no longer needed. Sometimes, situational demands will exceed one’s available resources, and coping is again required.

Automatized adaptive behaviours were described as being used by several participants. They spoke of “going into a robot mode” or “putting that autopilot on when you’re in a crisis to get through it.” This would suggest that the routine performance of necessary tasks and procedures were executed by the nurses without mental effort; it was when the demands of the event became non-routine, or taxed available personal resources, that nurses then interpreted the event as stressful and coping measures were required.

**Limitations and Strengths**

A concern relates to the sample size (N=19) which may have limited the range of experiences described; however, existing literature supports my sample size as being adequate for focus group research (Krueger, 1994).

Another limitation was my personal closeness to the issue being examined. As Krueger (1993) commented, quality can be threatened when the moderator is too close to the topic. The participants may recognize this and offer similar views to those of the
As described earlier, I involved a graduate student, who was not a nurse, to participate in the focus group process. Her role was to monitor my actions and communications for signs of leading behaviour or responses. At the end of each focus group, we discussed with each other any possibility or suggestion of bias being present in my behaviour and communication. It was concluded that an impartial atmosphere had been maintained.

One of the strengths of this study was the desire of the participants to share their stories, in detail, regardless of the sensitive nature of their experience. They willingly answered questions without hesitation, and were very open to participating in a group discussion with other nurses. This may indicate that the nurses want, and need, the opportunity to discuss their situations informally. An informed facilitator could bring the nurses together as a group in their discussion, as opposed to someone telling and instructing them about their situation, which was the past experience for some nurses in this study.

An unexpected finding emerged in relation to the patient population. Many nurses commented that not only do they experience the described stressors and coping when managing a trauma patient and the associated transfer, but also when managing a medical patient and transferring them for further care. This observation may suggest that the patient transfer process in general, is stressful for these nurses.

**Implications for Nursing**

Nurses are responsible for providing a substantial amount of complex care to their patients. In the rural north, this is often accomplished in the face of professional isolation and limited technological resources from which to draw. It is important for others to understand how these situations can affect the nurse and result in stress. Future researchers may want to use the identified categories of stress from this study as a basis for developing a needs assessment questionnaire for northern nurses. They may also want
to continue to explore methods of delivering more support for northern nurses, for example, crisis intervention.

Greater attention needs to be directed to not only acknowledging nurses’ stress but also to provide a mechanism that promotes coping. The implementation of a hospital-based CISD program in the northern region would be of immense value to the nurses. Many programs already exist, so there is no need to develop another one. These programs, however, need to be recognized as beneficial and implemented in the workplace. Nurses need the opportunity to debrief; they want to talk about their situation in a neutral setting where they feel they have some control over the process. They do not need someone telling them, or instructing them, about their experience. They need someone to listen to them and help them to understand their experience. It is not necessary for each hospital to have its own debriefing team. A regional effort in establishing an informed, travelling hospital debriefing team would benefit all of the communities.

An awareness of northern nurses’ issues could be included in the basic curriculum of student nurses. This would promote the fact that urban and rural nurses do differ in their practice, yet it would also emphasize that the focus of each type of nursing practice is to ultimately deliver an excellent standard of patient care, regardless of the geographic location of that care. Mutual respect amongst nurses could also be fostered, and questions about professional competency would be diminished. As Erkel, Nivens, and Kennedy (1995) observed, nursing students, who were actually immersed in a rural community as a part of their education, gained first-hand knowledge of the unique nature of rural nursing and the demands involved in the delivery of health-care in a geographically diverse location.

Professional differences between the transport teams and nurses need to be addressed. The expectations that each profession has of each other need to be made
known so that people can then practice within these guidelines, while at the same time, meeting the specifics of their own role. There will always be differences of opinion, but the working relationship can be made more harmonious.

Given the present state of health-care, and the method in delivering that health-care in this province, it is highly unlikely that the way in which nurses practice in the north will be altered. This begs for nurses’ stress to be acknowledged and understood, so that the management of that stress does not, in fact, create additional distress for the nurse.

Summary

This study extends the research findings pertaining to northern nursing and reinforces the notion that nursing stressors are unique in the north. Existing literature was validated, with a new perspective offered in viewing northern nurses’ stress and coping. In this study, four categories or situations characterized as being stressful for northern nurses were identified. These were: (a) system problems, (b) lack of communication and support, (c) visual impact, and (d) professional discord and friction. These categories are not mutually exclusive, and at times more than one category was identified during a nurse’s detailed account of her stress experience.

Coping strategies consisted of problem- and emotion-focused coping, with social support emerging as a type of emotion-focused coping that was highly regarded and often used by the nurses. Most participants perceived social support to be available for them, and the majority of participants were fairly satisfied with their support. Evidence of automatized adaptive behaviour was also apparent.

The fact that nurses described different stressors and different coping strategies in their accounts draws attention to the notion that event experience is an individual experience. The event is appraised in terms of meaning for that particular individual, which then influences coping strategies selected. Unfortunately, a great deal of a nurse’s
energy is spent in trying to convince others that his or her concerns and stressors are legitimate. Nurses are valuable members of their northern communities. They, too, are entitled to being supported in their times of need. Care for the care-giver cannot be ignored.
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House, J. S., & Wells, J. A. (1978). Occupational stress, social support, and


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Appendix A

Key Interview Questions

1. Think back to a situation in which you cared for a trauma and or accident patient(s) who was subsequently transferred to another facility for further care. Take your time in recalling the event, and try to focus on how you felt when the patient was transferred out of your facility. Tell me about the situation, your colleagues’ response, your feelings surrounding the event, things you did to cope, or how your nursing practice was affected by this experience. I will ask you to share this with the group.

Supporting questions

2. What type of social support is important in helping you to cope with these stressful situations?

3. What does it mean to you when you do not feel supported by colleagues or others?

4. Think about your life away from work in relation to the event. In what ways was your personal life affected? How did you cope?

5. When did this particular event occur?

6. Is there anything else you would like to discuss?
Appendix B

Information letter

Dear Nursing Colleague,

I am a registered nurse who is currently completing a Master’s degree in Community Health at the University of Northern British Columbia. I have been employed as a registered nurse in a rural hospital in northwestern British Columbia for the past fifteen years.

My thesis topic is about acute stress and coping in rural nurses in relation to transfer of trauma or accident patients. I believe that rural nursing is a type of nursing practice that has distinct issues, strengths, and needs, which are individually interpreted and experienced. I am asking you to voluntarily participate in my research as a way of expanding nursing’s present knowledge of acute stress and coping among rural nurses.

I invite you to participate in a focus group comprised of emergency, intensive care, and or operating room nurses from your facility. The focus group discussion will centre on your individual experiences in relation to stress and coping when dealing with transfer of patients to a different facility for further care. It is expected that the focus group would be at least one hour in length, and not longer than two hours. The discussion will be tape-recorded for research purposes, however all information and responses will remain strictly confidential and anonymous, and secured under lock and key. It is asked that participants also maintain group confidentiality by not discussing events outside of the focus group. Each focus group will consist of approximately 3 to 8 nurses, and it is important that you realise you may not be in the same focus group as your friend or colleague. At the end of the discussion, you will be asked to complete two questionnaires which will take approximately 15 minutes.

Informed and signed consent will be obtained prior to your participation in a focus group. As your participation is entirely voluntary, you may choose to withdraw at any point.

Please submit the next page, in the envelope provided, to the contact person named at your facility, or to me directly. Thank you for taking time to read this letter and considering to participate in my research.

Alice Moszczynski, RN, BSN, CPN(C)
Community Health Master’s Candidate
Terrace, B.C.
250-635-4752

Faculty Supervisor: Dr. Colleen Haney
Education Program, UNBC, Prince George, B.C.
250-960-5639
I would like to participate in a focus group discussion about acute stress and coping experiences of northwestern British Columbia nurses in relation to transfer of trauma or accident patients. I understand that I am expressing my desire to participate in a focus group, and that this is not a consent form.

__________________________
Name (please print)

__________________________
Facility

__________________________
Usual work department
Title of study: An examination of acute stress and coping in northwestern British Columbia rural nurses in relation to transfer of trauma or accident patients.

Purpose of the study: To explore acute stress and coping mechanisms in northwestern British Columbia rural nurses.

This is certify, that I, ______________________________, agree to voluntarily participate in this study. I have been informed that this study is being conducted by Alice Moszczynski as part of her thesis requirements for the degree of Master in Community Health Science at the University of Northern British Columbia. This study is supervised by Dr. Colleen Haney in the Education Program, Faculty of Health and Human Sciences, University of Northern British Columbia.

I agree to participate in a focus group with three to eight other emergency room, intensive care, and or operating room nurses who work in the same hospital as I do. I agree to allow the interviews to be audiotaped, and for the researcher to take notes during the interviews. I agree to allow the tapes and notes to be transcribed for the purposes of data analysis. I am aware that the information I provide will be analysed for the purpose of identifying acute stress and coping. I am aware that I may be quoted directly in the write-up of this study, but that my anonymity will be ensured. I understand that all data collected will remain confidential with regard to my identity. Participants will be identified by code on the transcription. I understand that only the investigator, her supervisor, and a transcription clerk will have access to the tapes and notes. The tapes and notes will be securely stored under lock.

I understand that my participation in this study is completely voluntary and that I may choose to withdraw at any point without negative consequences. I understand that should I withdraw before the completion of this research, I may also request that the researcher withdraw any data I have offered to the date of my withdrawal. I may ask any questions I want about this research project. Questions I ask will be answered to my satisfaction. I will receive a copy of this consent form.

Date: ____________________________

Participant Signature

Faculty Supervisor: 
Dr. Colleen Haney 
Education Program, UNBC 
250-960-5639 // haney@unbc.ca

Investigator’s Signature: 
Alice Moszczynski, RN, BSN, CPN(C) 
Community Health Master’s Candidate 
250-635-4752 // alicem@kermode.net
Appendix D

Personal Demographics

For the purpose of describing participant characteristics, please answer the following questions about yourself. Answers will remain strictly confidential and anonymous. Choose (X) the most applicable response(s) unless otherwise indicated.

1. Please indicate your education. Choose (X) any categories that apply.
   RN diploma ( )
   Post-graduate diploma in nursing ( ) specify __________________________
   Bachelor's degree in nursing ( )
   Post-graduate degree in nursing ( ) specify ___________________________
   Non-nursing diploma ( ) specify ____________________________
   Non-nursing degree ( ) specify ____________________________

2. Which category best describes your job status.
   Full-time ( )
   Part-time ( )
   Casual ( ) approximate number of shifts per month______________
   Temporary full-time ( )
   Temporary part-time ( )
   Other ( ) specify ____________________________

3. At present, which clinical area do you usually work in.
   Emergency ( )
   Critical care [ICU, CCU, MICU, etc.] ( )
   OR/PACU ( )
   Other ( ) specify ____________________________

4. If you work in more than one clinical area, indicate the approximate time worked in each area for the past year. Example: Emergency 40%; Critical care 60%.
   Emergency ______ Critical Care ______ OR/PACU ______
   Other (specify) ________________________________

5. a) How many years have you practised nursing? ____________________________
b) Overall, how many years experience do you have in your present clinical area?

6. What is your age?

7. Please indicate your marital status.
   - Single ( )
   - Living with partner ( )
   - Married ( )
   - Separated/divorced ( )
   - Widowed ( )

8. Please indicate your ethnicity.
   - First Nations ( )
   - Caucasian ( )
   - East Indian ( )
   - Asian ( )
   - Hispanic ( )
   - Middle Eastern ( )
   - African ( )
   - Other ( ) specify ________________________________

9. Please describe the reasons you chose your particular clinical area of nursing to practice in.
Appendix E

Demographic Details

Education
12 RN diploma
7 RN Bachelor’s degree
in addition:
1 Master’s degree
4 Post-graduate diploma in nursing
2 Non-nursing diplomas

Employment status
7 Full-time
5 Part-time
7 Casual

Clinical work area
5 Emergency
6 Critical care
7 Operating room/Recovery room
1 Education

Years experience overall (years)
5 Ten to fifteen
6 Sixteen to twenty
6 Twenty-one to twenty-five
2 Twenty-six or more

Age (years)
34 - 53

Marital status
2 Single
3 Living with partner
12 Married
1 Divorced
1 No answer

Ethnicity
18 Caucasian
1 Asian
Appendix F

Social Support Questionnaire (SSQ)

Note. From “Assessing Social Support: The Social Support Questionnaire,”
Reprinted with permission.
INSTRUCTIONS:

The following questions ask about people in your environment who provide you with help or support. Each question has two parts. For the first part, list all the people you know, excluding yourself, whom you can count on for help or support in the manner described. Give the person's initials and their relationship to you (see example). Do not list more than one person next to each of the letters beneath the question.

For the second part, circle how satisfied you are with the overall support you have.

If you have no support for a question, check the words 'No one.' but still rate your level of satisfaction. Do not list more than nine persons per question.

Please answer all questions as best you can. All your responses will be kept confidential.

EXAMPLE:

Who do you know whom you can trust with information that could get you in trouble?

No one 1) T.N. (brother) 4) T.N. (father) 7)
2) L.M. (friend) 5) L.M. (employer) 8)
3) R.S. (friend) 6) 9)

How satisfied?

6 - very satisfied 5 - fairly satisfied 4 - a little satisfied 3 - a little dissatisfied 2 - fairly dissatisfied 1 - very dissatisfied
1. Whom can you really count on to listen to you when you need to talk?

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2. Whom could you really count on to help you if a person whom you thought was a good friend insulted you and told you that he/she didn't want to see you again?

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3. Whose lives do you feel that you are an important part of?

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4. Whom do you feel would help you if you were married and had just separated from your spouse?

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5. Whom could you really count on to help you out in a crisis situation, even though they would have to go out of their way to do so?

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6. Whom can you talk with frankly, without having to watch what you say?

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7. Who helps you feel that you truly have something positive to contribute to others?

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8. Whom can you really count on to distract you from your worries when you feel under stress?

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9. Whom can you really count on to be dependable when you need help?

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10. Whom could you really count on to help you out if you had just been fired from your job or expelled from school?

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12. Whom do you feel really appreciates you as a person?

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How satisfied?

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<th>6 - very</th>
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</tr>
</tbody>
</table>
13. Whom can you really count on to give you useful suggestions that help you to avoid making mistakes?

No one 1) 2) 3) 4) 5) 6) 7) 8) 9)

How satisfied?

6 - very satisfied 5 - fairly satisfied 4 - a little satisfied 3 - a little satisfied 2 - fairly satisfied 1 - very satisfied

14. Whom can you count on to listen openly and uncritically to your innermost feelings?

No one 1) 2) 3) 4) 5) 6) 7) 8) 9)

How satisfied?

6 - very satisfied 5 - fairly satisfied 4 - a little satisfied 3 - a little satisfied 2 - fairly satisfied 1 - very satisfied

15. Who'll comfort you when you need it by holding you in their arms?

No one 1) 2) 3) 4) 5) 6) 7) 8) 9)

How satisfied?

6 - very satisfied 5 - fairly satisfied 4 - a little satisfied 3 - a little satisfied 2 - fairly satisfied 1 - very satisfied

16. Whom do you feel would help if a good friend of yours had been in a car accident and was hospitalized in serious condition?

No one 1) 2) 3) 4) 5) 6) 7) 8) 9)

How satisfied?

6 - very satisfied 5 - fairly satisfied 4 - a little satisfied 3 - a little satisfied 2 - fairly satisfied 1 - very satisfied

17. Whom can you really count on to help you feel more relaxed when you are under pressure or tense?

No one 1) 2) 3) 4) 5) 6) 7) 8) 9)

How satisfied?

6 - very satisfied 5 - fairly satisfied 4 - a little satisfied 3 - a little satisfied 2 - fairly satisfied 1 - very satisfied

18. Whom do you feel would help if a family member very close to you died?

No one 1) 2) 3) 4) 5) 6) 7) 8) 9)

How satisfied?

6 - very satisfied 5 - fairly satisfied 4 - a little satisfied 3 - a little satisfied 2 - fairly satisfied 1 - very satisfied
19. Who accepts you totally, including both your worst and your best points?
No one  1)  4)  7)  
2)  5)  8)  
3)  6)  9)  

How satisfied?
6 - very satisfied  5 - fairly satisfied  4 - a little satisfied  3 - a little dissatisfied  2 - fairly dissatisfied  1 - very dissatisfied

20. Whom can you really count on to care about you, regardless of what is happening to you?
No one  1)  4)  7)  
2)  5)  8)  
3)  6)  9)  

How satisfied?
6 - very satisfied  5 - fairly satisfied  4 - a little satisfied  3 - a little dissatisfied  2 - fairly dissatisfied  1 - very dissatisfied

21. Whom can you really count on to listen to you when you are very angry at someone else?
No one  1)  4)  7)  
2)  5)  8)  
3)  6)  9)  

How satisfied?
6 - very satisfied  5 - fairly satisfied  4 - a little satisfied  3 - a little dissatisfied  2 - fairly dissatisfied  1 - very dissatisfied

22. Whom can you really count on to tell you, in a thoughtful manner, when you need to improve in some way?
No one  1)  4)  7)  
2)  5)  8)  
3)  6)  9)  

How satisfied?
6 - very satisfied  5 - fairly satisfied  4 - a little satisfied  3 - a little dissatisfied  2 - fairly dissatisfied  1 - very dissatisfied

23. Whom can you really count on to help you feel better when you are feeling generally down-in-the-dumps?
No one  1)  4)  7)  
2)  5)  8)  
3)  6)  9)  

How satisfied?
6 - very satisfied  5 - fairly satisfied  4 - a little satisfied  3 - a little dissatisfied  2 - fairly dissatisfied  1 - very dissatisfied

24. Whom do you feel truly loves you deeply?
No one  1)  4)  7)  
2)  5)  8)  
3)  6)  9)  

How satisfied?
6 - very satisfied  5 - fairly satisfied  4 - a little satisfied  3 - a little dissatisfied  2 - fairly dissatisfied  1 - very dissatisfied
25. Whom can you count on to console you when you are very upset?

No one  1)  4)  7)  
  2)  5)  8)  
  3)  6)  9)  

How satisfied?

   6 - very satisfied  5 - fairly satisfied  4 - a little satisfied  3 - a little dissatisfied  2 - fairly dissatisfied  1 - very dissatisfied

26. Whom can you really count on to support you in major decisions you make?

No one  1)  4)  7)  
  2)  5)  8)  
  3)  6)  9)  

How satisfied?

   6 - very satisfied  5 - fairly satisfied  4 - a little satisfied  3 - a little dissatisfied  2 - fairly dissatisfied  1 - very dissatisfied

27. Whom can you really count on to help you feel better when you are very irritable, ready to get angry at almost anything?

No one  1)  4)  7)  
  2)  5)  8)  
  3)  6)  9)  

How satisfied?

   6 - very satisfied  5 - fairly satisfied  4 - a little satisfied  3 - a little dissatisfied  2 - fairly dissatisfied  1 - very dissatisfied