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The Lived Experience of K-12 Educators Who Practice Within An Acute Care Inpatient Psychiatric Hospital

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THE LIVED EXPERIENCE OF K-12 EDUCATORS WHO PRACTICE WITHIN AN

ACUTE CARE INPATIENT PSYCHIATRIC HOSPITAL

A Dissertation

Submitted to the School of Education

Duquesne University

In partial fulfillment of the requirements for

the degree of Doctor of Education

By

William C. Davies

August 2011

DUQUESNE UNIVERSITY
SCHOOL OF EDUCATION
INTERDISCIPLINARY DOCTORAL PROGRAM FOR EDUCATIONAL LEADERS

Dissertation
Submitted in Partial Fulfillment of the Requirements
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ACUTE CARE INPATIENT PSYCHIATRIC HOSPITAL

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ABSTRACT

THE LIVED EXPERIENCE OF K-12 EDUCATORS WHO PRACTICE WITHIN AN

ACUTE CARE INPATIENT PSYCHIATRIC HOSPITAL

By

William C. Davies

Dissertation supervised by Dr. James E. Henderson

Human service professionals serve roles in society in which they are responsible for the well-being of countless numbers of people. These professionals span important fields including nursing, social work, law enforcement, medicine, and education. This study focused on a specific subgroup of human service professionals: special education teachers who practice within an acute care inpatient psychiatric facility. The purpose of this qualitative study was to investigate the lived experiences of educators in order to identify emergent themes that best describe their experiences.

The psychiatric hospital in this study is a large hospital located within an urban area of the Northeastern United States. The hospital is part of a large, not-for-profit medical system that serves both clients with private health insurance as well as clients on a variety of government sponsored health plans. Within this setting, the turnover rate for

the special education teachers was approximately 72% between 2005-2010. Using a sample of 6 volunteer teachers, qualitative data related to their lived experiences were collected through the use of semi-structured interviews. The hermeneutic phenomenological approach was utilized to explore emergent themes in the lived human world, as we may find it at any particular moment.

Within the literature review, five themes were formulated from the experience of personal narratives and from research findings related to this topic in regards to other mental health professionals. The five themes were utilized as a guide and a lens with the understanding that there were going to be more existing themes within the setting that become exposed during the investigation. The five themes were: effort/reward imbalance, workplace bullying/horizontal violence, sleep disturbance, burnout and efficacy.

The results of this study led to 4 global emergent themes and 17 emergent subthemes. The four global themes that describe the lived experience of educators are relationships, safety, whole body reactions, and system reactions. The findings lend important data to the relative dearth of information related to the lived experiences of professional educators who practice within large acute care inpatient psychiatric facilities.

DEDICATION

To my family

ACKNOWLEDGEMENTS

I would like to acknowledge and express my heartfelt gratitude to the following:

Most importantly, I thank God who provides me with strength, passion, and courage.

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TABLE OF CONTENTS

The Lived Experience of K-12 Educators in an Acute Care Inpatient Psychiatric Hospital

Chapter I

Introduction

Introduction to the Study

This study investigated the lived experience of educators within an acute care inpatient psychiatric facility. Within this context, these educators were special education teachers who specialized in the continuing education of children and adolescents with emotional disturbance, behavioral issues and psychiatric diagnoses.

"Special education teachers are more likely to leave teaching than are other groups of teachers and the shortages in this field are greater than in any other area of certification" (Prather-Jones, 2010, p. 1). In the setting for this research, the turnover rate over the time span between 2005-2010 was approximately 72%. Therefore, within the past five years, nearly three-quarters of the teachers have either left the site for another position or have left the field entirely. The turnover at the site for this research has resulted in a perceived lack of veteran, master and mentor educators, which could have an impact upon the quality of education provided. Such high turnover rates could lead to a discontinuity of instruction and a loss of teaching expertise therefore, leading to lost time and resources as a significant amount of time is spent hiring and training a constant stream of new hires (Loeb, & Darling-Hammond, 2005). This study attempted to take the first step in identifying and correcting the issues that cause such turnover by understanding the lived experience of educators within this setting. The following story illustrates the intensity of one teacher's experience. The story, as with the other vignettes

and stories throughout the dissertation, actually happened though details and identifiers were changed.

Sally's story. Sally, an educator within an acute care inpatient psychiatric facility, arrived an hour late for work one day. She had been late for the last three days and had been taking extended lunches, disappearing for two or three hours at a time. On this day, Sally walked into the school and into another educator's room, slammed her bag on the table and said, "let's get this dumb shit over with. Yes, another day in paradise." Since Sally did not actually have a classroom, her materials were stored on a cart that she would wheel into the kitchen area of the Child and Adolescent Unit. Sally had eight patients today. Three of the patients were in fifth grade, one was in seventh grade, three were in ninth grade and one was in eleventh grade. Most of her patients had a diagnosis of conduct disorder, which is defined as a persistent pattern of behavior that violates the rights of others through aggression to people and animals, destruction of property, deceitfulness or theft and serious violations of rules (American Psychiatric Association, 2000). Her patient who was in the eleventh grade was particularly aggressive as he had deliberately destroyed property, hurt people and animals, and used his own feces as a tool in acts of aggression.

As Sally attempted to engage the patients in a lesson about the rainforest, the eleventh grade patient decided to flip a table, run over to Sally's cart, steel a small stapler and insert it into his anus. Sally then hurried the other patients out of the room and proceeded to reprimand the staff person who brought this particular patient to the kitchen classroom. Sally reprimanded the staff person in front of the other patients and the Charge Nurse who immediately called Sally's supervisor. After school ended for the

morning, Sally's supervisor called Sally into her office and attempted to have a discussion about the incident. At that point, Sally became belligerent and referred to the Charge Nurse as "that bitch" and stated "If she has a fucking problem with the way I do things, then let that bitch tell me." Sally also shouted at her supervisor by saying "I don't give a shit about this anymore," stormed out of the room, slammed her supervisor's door and screamed "Fuck her!" Within thirty minutes, Sally, a twenty-three year special education teacher veteran and former special education supervisor at a public school, who had been working in the psychiatric hospital for five months, was terminated for her behavior.

Sally's is one example of a well-trained and veteran special education teacher who, after a series of events and circumstances within the environment of a psychiatric hospital, exposed her raw emotions in a fit of uncontrollable and unprofessional rage that was so overwhelming, shocking, and unprofessional that Sally lost her job.

Human service professionals. Human service professionals serve roles in society in which they may be responsible for the well-being of countless people. These individuals span important fields such as nursing, social work, law enforcement, medicine, and education. For example, a social worker may help an individual who has been sexually abused, and a nurse may assist an individual who is dying of brain cancer. When one is engaged in a field which serves humanity, such as education, the constant immersion in the lives and situations of others can be stressful and may lead to burnout and possible job resignation. This notion is supported by research as Byrne (1999) reviewed literature regarding teacher burnout and made the argument that "teachers

exhibit signs of emotional exhaustion when they feel that they can no longer give of themselves to students as they did earlier in their careers"(Byrne, 1999, p. 15).

Educators in K-12 settings are human service professionals that facilitate learning experiences for children. Educating within an acute care inpatient psychiatric hospital "requires emotional involvement that puts stress on service providers, it is not uncommon to have emotionally drained and chronically frustrated workers" (Acker, 1999, p. 113).

In situations where a child cannot adequately function within a typical classroom environment, he/she may be placed in an outside educational setting. These settings range from approved private schools to juvenile detention centers and residential treatment facilities. When a child is unable to function in alternative placements to a typical school setting, he/she may be temporarily placed into an acute care inpatient psychiatric facility. Within the psychiatric facility, the child is provided care by a team of health service professionals who include psychiatrists, psychologists, residents, medical students, social workers, educational staff, nurses, nutritionists, and milieu therapists. Within the various interactions between the child and these professionals, there is one interaction that permits the child to connect to his/her school that is outside of the hospital environment. That interaction is with the child's educator within the acute care inpatient psychiatric hospital.

Prior research. Through an exhaustive literature review, there are no studies related to educating within an acute care inpatient psychiatric hospital. Therefore, other research findings from the fields of social work and nursing are utilized to help explain and relate to concepts that are similar with regards to educators in this setting.

The setting. The psychiatric hospital in this study can be described as a large urban psychiatric hospital in the Northeastern United States. The hospital is part of a large, not-for-profit medical system that serves both clients with private pay insurance as well as clients on a variety of government sponsored health plans. The hospital is considered a teaching hospital and is immersed in an academic medical center. The hospital has multiple inpatient units for individuals younger than 21 years of age. Several of these inpatient units provide a state licensed inpatient school with state certified special educators.

The educator's experience. There are six full time educators located within this setting. Educators within this specific psychiatric hospital have to facilitate the education of at least ten patients, who vary in age from three to 21 years. While the average length of stay is approximately seven to ten days, some children, depending on which unit they receive care, may stay in the hospital for upwards of a year. Therefore, these educators have the additional duties of facilitating the education for a population of children who may span several grade levels as well as having to adjust each lesson to individual patients, given the variety of diagnoses and developmental levels. Lastly, the educators interact among themselves, with the patients, with the patients' schools from outside of the hospital, with the parents of the patients, and with other mental health professionals.

The Purpose

The purpose of this qualitative study was to investigate the lived experience of educators within an acute care inpatient psychiatric facility in order to identify emergent themes that best describe their experience. These themes can then be used as tools to understand why events such as "Sally's Story" occur. Through a better comprehension of

the educator's lived experience, administrators and principals within such facilities can formulate strategies to proactively change the experience so that the negative aspects of the experience could be limited and ultimately exterminated. In other words, an understanding of the experience of educators in a large psychiatric hospital may allow leaders to obtain a better understanding of not only their experience but what factors may lead to certain events that tend to occur within the setting.

Ultimate goals. This study can lend important data that contribute to the ultimate goals of decreasing educator turnover rate in psychiatric facilities, increasing the quality of education within acute care inpatient psychiatric facilities, and transforming educational positions within psychiatric facilities from short term jobs to long term careers.

Research Questions

1. What themes emerge related to the lived experience of educators within an acute care inpatient psychiatric facility?

2. Does teaching within an acute care psychiatric setting have an impact on an educator's ability to feel healthy?

3. Do the residual feelings of working within this environment have an impact upon the professional self-efficacy of the educators?

4. Do the educators experience a lack of autonomy within the workplace?

5. Do the educators feel that individuals within this setting engage in horizontal violence or workplace bullying?

Potential Limitations of the Study

Bias and Coercion. The PI had a bias regarding this study as the PI was the supervisor of the potential subjects as well as an educator within the setting. Also, there may have been a possibility that the educator participants may have felt the need to participate in this study and provide socially desirable content because of their relationship with the PI. Recognizing potential limitations, the PI developed a methodology that included an outside interviewer, research specialist and two coders. Also, the PI included procedures such as having no contact with participants and the removal of all identifiers to protect participants' confidentiality and limit subjectivity. Though identifiers were removed, participants had knowledge that this was the PI's study after they received the recruitment letter. The consent form was formulated to expose the possibility of a breach of confidentiality.

Recruitment letter. A recruitment letter for this study is included in Appendix A.

Consent form. A consent form for this study is included in Appendix B.

Generalizability. This study was conducted in a large, acute care inpatient psychiatric facility located within an urban area. Therefore, the lived experience of the educators in the study may not represent those of educators in other parts of the country, such as those in smaller or longer term facilities or those working in facilities located in rural communities. Also, the findings may be more difficult to generalize to hospital settings that are not considered a teaching hospital that is not immersed in an academic setting.

Definition of Terms

Bully- displaying behavior that is part of a deliberate and ongoing scheme of harmful actions that may cause physical and psychological harm to another (Simon & Simon, 2006).

Burnout - a phenomenon that is described as having three components: emotional exhaustion, depersonalization, and a lack of personal accomplishment (Corrigan, Holmes, Luchins, Buican, Basit, & Parks, 1994).

Collective efficacy- "the performance capability of a social system as a whole" (Bandura, 1997, p. 469).

Emotional exhaustion- feeling overextended and depleted of one's emotional resources (Janssen, Schaufeli, & Houkes, 1999).

Depersonalization- a negative, callous or excessively detached response to other people (Janssen, Schaufeli, & Houkes, 1999).

Reduced personal accomplishment- a decline in one's feeling of competence and successful achievement in one's work (Janssen, Schaufeli, & Houkes, 1999).

Self-efficacy- beliefs about an individual's capabilities to produce designated levels of performance that exercise influence over events that affect their lives (Bandura, 1994).

Servant leader- an educational leader who is guided by "a delicate balance between love for oneself and for others" (Hoyle, 2002, p.24).

Vicarious traumatization (VT)- the impact of repeated empathic engagement with trauma survivors and associated cognitive, schematic, and other psychological effects (Sprang, Clark, & Whitt-Woosley, 2007).

Chapter II

Literature Review

Introduction to the Literature Review

The following literature review describes themes and experiences in the field of education as well as in a healthcare system, specifically a healthcare system with a mental health component such as an acute care inpatient psychiatric hospital. The themes described in the literature review may contribute to the perceptions or experience of a workplace environment. A perception of the workplace environment or workplace experience is essentially the lived experience.

Five literature review themes. Five literature review themes were formed from two influences. The first influence was from my personal narrative as I was employed within a acute inpatient psychiatric facility at the time of the study. The second influence came from an extensive literature review. Five themes tended to reoccur in the literature. The five themes were not only about other professionals who work within an acute care inpatient psychiatric facility such as social workers and nurses, but from regular and special educators in other school environments.

Having the five themes in mind during the research process assisted in establishing a path of exploration into the experience of being an educator within an acute care inpatient psychiatric facility. I used the following five themes as a guide and a lens with the understanding that there may be more existing themes within the setting that may became exposed during the investigation:

1. Effort/Reward Imbalance

2. Workplace bullying and horizontal violence

3. Sleep Disturbance

4. Burnout

    a. Overtime and burnout

    b. Social support and burnout

    c. Role ambiguity, role conflict, and burnout

5. Efficacy and social cognitive theory

    a. Professional self-efficacy

    b. Collective efficacy

Effort/reward imbalance.

Too many workplaces are almost devoid of meaning and purpose. They are ruled by technology, efficiency, and the bottom line, with little regard for what human beings need in order to experience personal fulfillment and success (Bolman and Deal, 2001, p.6).

Feelings of pay inequity may exist within the educators in the acute care inpatient psychiatric facility. Inequity occurs when there is an imbalance of effort and reward (Taris, Van Horn, Schaufeli, & Schreurs, 2004). Specifically, the imbalance between effort and reward is referred to as equity theory, as individuals try to achieve reciprocity in relationships. One may internally strive for a balance between work provided and pay acquired. When reciprocity is not achieved, individuals may feel as though the relationship is inequitable (Bakker, Schaufeli, Demerouti, Janssen, Van Der Hulst, & Brouwer, 2000). When the relationship is inequitable and in order to achieve reciprocity, employees may try to reduce the inequity.

As Shaw and Gupta (2001) state, "pay is arguably one of the most critical, if not the most critical, outcome of organizational membership for employees" (p. 299).

Therefore, "pay satisfaction has a direct influence on job satisfaction and organizational commitment" (Summers & Hendrix, 1991, p. 156). An example of pay inequity related to the lived experience of one educator within an acute care inpatient psychiatric hospital demonstrates this issue. Before the individual became the school's principal, she was a teacher within the psychiatric hospital for eight years. She had always had a suspicion that she was not paid as well as her newly hired colleagues. Not only had the newly hired colleagues had less education and experience, she suspected they were hired because of their personal relationships with the formal principal. Also, she believed that her pay raises were diminished to allow the former principal to give inflated pay increases to the educators that he hired based on these personal relationships. This suspicion was only-further supported as the former principal became enraged when the educator carefully attempted to privately discuss the topic. For at least a year, this teacher felt an imbalance between the services she provided and her pay. She felt somewhat demoralized, and at times, neglected her duties as she felt she was not receiving fair compensation in comparison to her colleagues.

In the example stated above, the educator, at times neglected her duties as she felt as if she was experiencing pay inequity. In fact, Taris, Van Horn, Schaufeli, and Schreurs (2004) argue that there is a psychological contract concerning expectations about the exchange relationship between an employee and the organization. When this contract is not honored by the organization, a result of negative work outcomes may appear. By making the environment equitable, educators may want to stay longer, thereby gaining more experience and becoming more proficient in the field of educating in a psychiatric

hospital environment while demonstrating a positive impact upon student achievement (Skrla, McKenzie, & Scheurich, 2009).

A possible solution that some employees may find as a way to reduce inequity is through leaving a position (Griffeth, & Gaertner, 2001). In fact, in the study by Bakker et al., (2000), the authors assessed 154 teachers in regards to burnout and depression related to the imbalance of effort and reward by using the Maslach Burnout Inventory (MBI) (Maslach, Jackson, & Leiter, 1996). The authors were able to separate burnout and depression and discovered that the lack of reciprocity with regard to student relationships can predict burnout. Bakker et al., (2000) came to the conclusion that aligns with Brock and Grady's (2000) argument that when individuals "are not rewarded or recognized for their extraordinary effort, disillusionment can lead to burnout" (p. 9).

In a study by Geurts, Schaufeli and Christel (1999), the authors tested a social exchange model in relation with equity theory, which compared the perceived inequity of employees with rates of turnover and absenteeism rates. The study found that poor organizational commitment was a direct response to employees' perceived notions of inequity. In other words, if scrutinized through the lens of equity theory, an employee reduces his/her organizational commitment as a method of restoring an equitable exchange relationship (Geurts, Schaufeli and Christel, 1999). An example of a possible restoration of an equitable exchange relationship within the lived experience of educators in an acute care inpatient psychiatric facility may be to interpret a lack of commitment to the organization as a symptom of a perceived inequitable relationship.

Within an acute care inpatient psychiatric facility, educators may experience an imbalance between effort and reward as such an imbalance may eventually lead to

12

turnover problems. For most patients, the average length of stay is generally five to ten days. Therefore, different patients continuously enter and leave the educator's classroom. Subsequently, a teacher may not be able to build meaningful relationships with the patients. This could potentially lead to a situation in which the teacher continually experiences an imbalance between effort and reward. Also, young patients are hospitalized during their most acute psychiatric state. When they show enough improvement within the facility, they are discharged and replaced with new patients experiencing a highly acute state of mental health concerns. Because educators in acute care psychiatric facilities rarely witness long-term progress in the patients' mental health status, it may be difficult for them to see much improvement as discharge from the facility is eminent when the patient begins to stabilize, thereby causing an imbalance of effort and reward. Figure 1 presents a pictogram to assist in presenting this phenomenon.
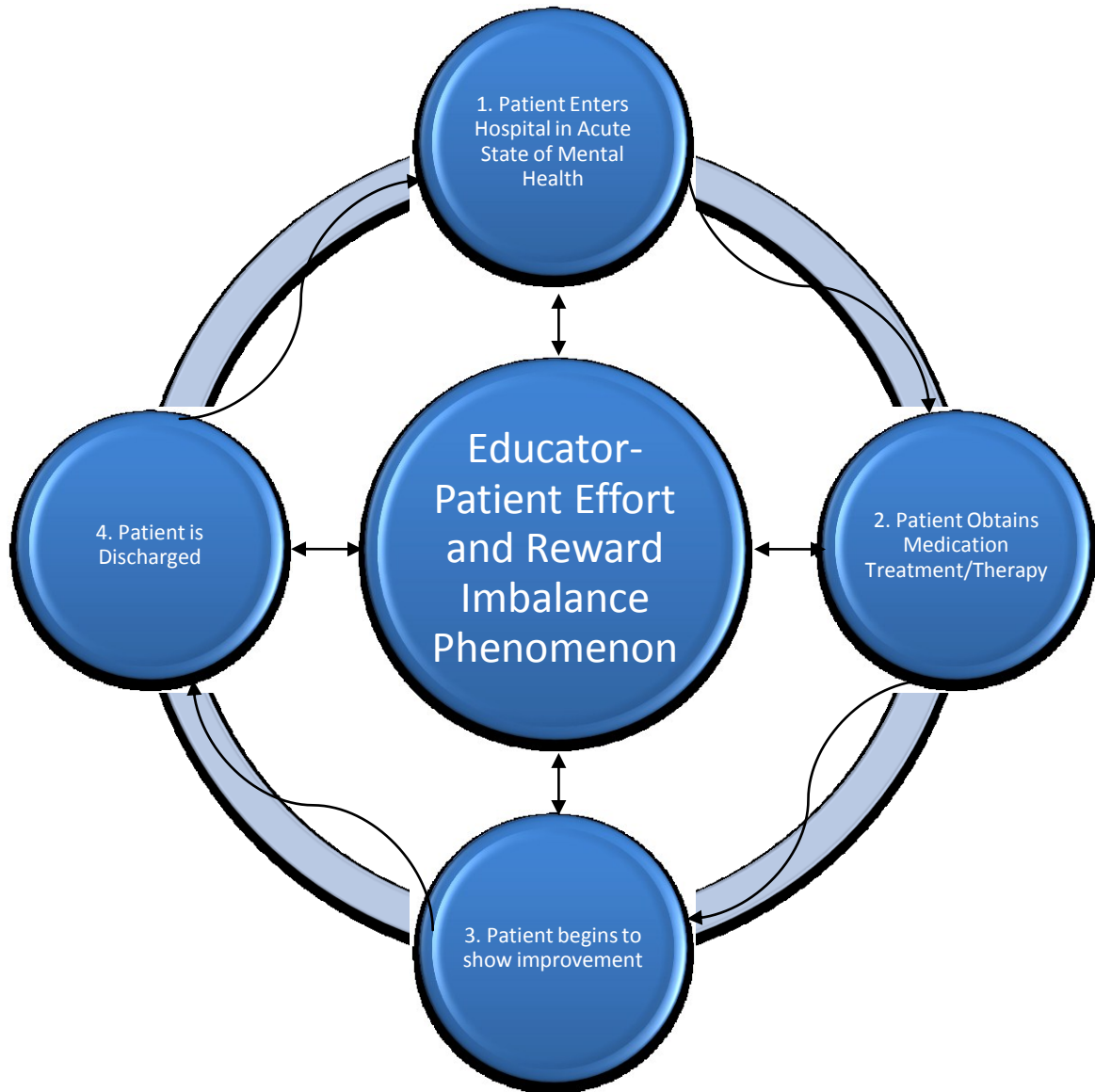
Figure 1. Educator-Patient Effort and Reward Imbalance Phenomenon

An imbalance of effort and reward may also occur as the teacher provides the basic job duties as well as the daily routines within a hospital. These basic duties include and are not limited to providing information to the treatment team about the patients' academic and behavioral status, writing a psychodevelopmental behavioral therapy note for each patient every day, calling the patients' schools, providing a stimulating work environment and inputting the hours spent with each patient for billing purposes. Providing these basic duties and routines within the setting can create an overwhelming amount of hours spent on paper work, leading to higher levels of burnout (Siebert, 2005). Siebert (2005) conducted a study of 751 social workers and discovered that 75% of the sample experienced burnout at some point within their careers and 36% scored as currently burned out. "Respondents scoring higher on the burnout measure felt less successful and were more likely to agree that they have difficult clients, face ethical compromises, and have a stressful workplace" (Siebert, 2005, p. 37).

A lack of autonomy within the professional roles of educators in the organizational climate of this acute care inpatient psychiatric hospital also relates to the imbalance of effort versus reward. Without autonomy, in regards to meeting the demands of one's employment, a diminishment in self-esteem and confidence may occur (Siegrist, 1996). Siegrist (1996) argues for the existence of an exchange process in which society contributes towards rewards for individuals who work. The rewards are administered through three avenues that consist of status control, money, and esteem. When an individual deems that there is an imbalance within the three avenues, a state of distress and strain will occur. Siegrist (1996) titles this imbalance, the effort-reward imbalance.

When effort and reward are equalized, it may be argued that an organization will display what Schwahn and Spady, (1998), describe as employees finding meaning in their work as well as behaving responsibly with high levels of achievement. Within an organization of perceived effort and reward balance, a culture of innovation, cooperation and success become prevalent (Schwahn & Spady, 1998). In other words, momentum in regards to "the feeling among a group of people that their lives and work are intertwined and moving toward a recognizable and legitimate goal"(DePree, 2004, p. 17) is actualized.

Workplace bullying and horizontal violence.

As was eloquently written by Sutton (2007): "A few demeaning creeps can overwhelm the warm feeling generated by hordes of civilized people" (p. 180). Sutton (2007) was referring to individuals who act as bullies in the workplace. A bully may often be thought of as a role occupied by children in a school setting where one child targets another peer. Typically a more vulnerable child is targeted. Yet, in recent years the term bully has been used to describe specific individuals in the workplace. These individuals, as in the school yard, target victims who "are more likely to be submissive, low in independence, introverted and highly conscientious, anxious and neurotic" (Smith, Singer, Hoel, & Cooper, 2003, p. 175). Roscigno, Lopez, and Hodson, (2009) discuss how these individuals target not only those who seem to be vulnerable but also those who may be seen as a threat to the bully's sense of power and superiority, leading to nearly 20% of workers getting subjected to workplace bullying during any given year. Behaviors associated with bullying in the workplace can range from subtle psychological attacks to different forms of physical violence. These actions can occur laterally, from the

16

top-down or bottom-up, and horizontally between colleagues of equal rank (Roscigno, Lopez, & Hodson, 2009). For those who are bullied, 40% will quit their jobs, 24% will get fired, and 13% will transfer. In 23% of the cases, the bully will receive some sort of punishment from the organization (Namie & Namie, 2009). In some extreme cases the victim of bullying turns to violence as was described in this paraphrased vignette from (Namie & Namie, 2009, p.17). Of particular interest in this vignette is the reaction of the co-workers who also had to endure abuse by the bully.

> One man killed himself and his branch manager on the day of his return from heart attack induced by the manager. Before entering the office, the manager provoked him in the parking lot. The employee, described as very gentile and caring, returned to his car and drove away, only to return with a loaded gun. His coworkers considered the killings a tragedy only because of the suicide.

A bully is more than someone who is occasionally rude or uncivil. A bully can be described as displaying behavior that is part of a deliberate and ongoing scheme of harmful actions that may cause physical and psychological harm (Simon & Simon, 2006). For example, a workplace bully may target a subordinate who he/she feels is threatening the false stability the bully has created through intimidation, fear, and apathy. The bully may constantly speak sarcastically to the victim as well as speak poorly of the victim to colleagues and possibly try to terminate the victim on technicalities within the workplace laws and norms. The victim may dread coming to work, have difficulty sleeping, have elevations in blood pressure due to increased stress, and may have relationship difficulties.

In severe cases, a workplace bully may be an individual with sociopathic tendencies. This individual is typically void of a consciousness. In other words, this individual is not internally restrained from desires of morality. The idea of not having a

consciousness is bizarre to most people as total guiltlessness can be beyond

comprehension. Unfortunately, a poor understanding of what it means to have a total lack

of guilt leads many of these bullies to escape consequences as most people cannot

comprehend actions not based upon common conceptions of consciousness. Stout

(2005), in addressing a sociopath directly describes such as person as the following:

> You manipulate and bully the people who are under your thumb, as often and as outrageously as you can without getting fired or held accountable. You do this for its own sake, even when it serves no purpose except to give you a thrill. Making people jump means you have power—or this is the way you see it—and bullying provides you with an adrenaline rush. It is fun (p.4).

Since many workplaces typically support an environment saturated with power

structures and relations, bullies may have an ideal arena to cause great damage (Roscigno

et al., 2009). In other words, "many people who have strong power needs are attracted to

hierarchical organizations that can provide them with opportunities to exert power and

influence" (Simon & Simon, 2006, p. 154). Unfortunately, since many hospitals are

organized within an hierarchical medical model this structure could allow such bullies to

thrive.

Hutchinson, Vickers, Jackson, & Wilkes (2005), completed a literature review

and discussed how individuals who engage in bullying behaviors over time and through

persistence, diminish the workplace environment and harm others. Those who are the

victims of bullying in the workplace may experience anxiety, depression, lowered self-

esteem and self-efficacy, and post-traumatic stress disorder. Ultimately, bullying can lead

to reduced productivity and loyalty, lowered morale, and increased staff turnover

(Hutchinson, et al., 2005).

Not only do bullies diminish the workplace environment, it may also be argued that they create a false sense of discipline. A false sense of discipline is created as employees engage in disciplined work but only from extrinsic forces, not intrinsic motivations. Heavy emphasis on extrinsic discipline may provide positive results but, if the bully is removed from the situation, the discipline is removed and results quickly diminish leading to organizational decline (Collins, 2001).

Furthermore, the bullying experienced by victims can result in psychological despair as 20% percent of all workers have reported being bullied within a given year, which is related to turnover and financial harm for employers (Roscigno et al., 2009). In fact, "workplace bullying can be a major occupational stressor creating enormous legal and financial problems for organizations" (Smith et al., 2003, p. 176). In 2003, aggression in the workplace "caused some 500,000 employees to miss 1,751,100 days of work, or 3.5 days per incident. The missed work equated to approximately $55 million in lost wages" (Simon & Simon, 2006, p. 48). In short, bullies can contribute to a destruction of the workplace culture, considerable damage to revenues, and health difficulties for employees.

The notion of bullying in the workplace enhanced and provided a narrative to engage during the process of comprehending the data provided by the participants in this study. This being said, we may be closer to answering the question posed by Rath and Harter (2010), "Is a good boss as important as a good doctor?" (p. 25).

A psychologist's case. The following story illustrates a male psychologist's experiences in an acute care inpatient psychiatric facility. He was a victim of both direct

verbal bullying and subtle psychological bullying by an individual with possible

sociopathic tendencies.

During a meeting with the heads of the other disciplines within the hospital, a

discussion ensued about how to better serve the patients. After much discussion it

was clear that most of the unit staff supported a suggestion by the psychologist to

ensure a higher quality of patient care; all accepted the idea except for the nurse

manager. After the meeting was over, the nurse manager cornered the

psychologist and the clinical administrator and told them that they need to "get

with the fucking program and stop being stupid dickheads." The psychologist was

so appalled by the confrontation that he reported the incident to his supervisor,

who contacted human resources. The human resources consultant told the

psychologist to write a statement. After the statement was written, the nurse

manager received a minor warning about appropriate workplace behavior.

Afterwards, when the nurse manager and the psychologist had to work

together, the psychologist tried to conduct himself professionally and cordially

toward the nurse manager. However, the nurse manager, for the majority of the

time, acted as though the psychologist was invisible. The nurse manager did not

respond when the psychologist greeted her and looked past him when having a

conversation. The psychologist experienced these behaviors as subtle forms of

bullying. These subtle forms were difficult to document, and the psychologist

knew if he allowed these actions to bother him, this would lead to further

psychological distress.

Sleep disturbance. Working within an acute care inpatient psychiatric hospital can be stressful, not only from serving the inpatient population but from working within the boundaries of the organizational culture. On a given day, an educator may experience physical aggression by the students, horizontal violence by colleagues, and harassment and intimidation by persons in higher organizational positions. These experiences can lead to a stress reaction, contributing to disturbed sleep patterns and possibly a loss of sleep. A lack of sleep can have an effect on the body both physically and mentally as well as an effect on one's quality of work. Kecklund and Akerstedt, (2003) assessed 37 subjects, screening them for habitual sleep quality. The subjects were asked to follow their normal habits during the evening hours and sleep quality was recorded. The researchers found that workplace stressors are related to sleep as stress has been correlated with short-term insomnia and subjective sleep quality (Kecklund & Akerstedt, 2003). In fact, occupational stress, particularly the inability to stop worrying about work during non-work hours, has been found to be a significant predictor of disturbed sleep (Kecklund & Akerstedt, 2003).

When sleep is disturbed or one does not sleep, which can be related to burnout and stress from one's occupation, "tasks relying on high level cognitive skills have been found to deteriorate" (Harrison & Horne, 1999, p. 129). In one research study, ten participants underwent trials of comprehension with sleep versus no sleep. Specifically, Harrison and Horne (1999) found that deterioration of mental capabilities is particularly profound beyond 32 to 36 hours of sleep loss. Educating within a psychiatric facility can be viewed as a position that requires a higher level of cognitive skills as one must

constantly address the individual needs of each patient and must remain alert as a crisis situation could develop at any moment.

Stress, and particularly stressful events, may also be correlated with one's dreams, thereby potentially impacting the quality of sleep (Levin & Nielson, 2009). In a study by Shirom, Oliver and Stein (2010), work related stress was argued to have a specific path to psychological strain. In particular and in relation to sleep disturbance, the researchers hypothesized that "Stressors are unidirectional predictors of somatic complaints" (Shirom, Oliver & Stein, 2010, p. 315). In a sample of 1,048 participants the data strongly supported their hypothesis. Therefore, interventions could be put into place to improve the well being of educators by decreasing the frequency of sleep disturbance.

Educators within an acute care inpatient psychiatric hospital engage in periodic stressful event management as the population of children they serve can be physically aggressive and violent. The brief story provided at the beginning of chapter one is an example of a stressful event. Below is another example of a stressful event that occurred to a colleague within the acute care inpatient psychiatric hospital environment:

A patient with a history of severe aggression became agitated and started a physical altercation with a peer. A staff member tried to intervene and she was promptly thrown to the floor by one of the patients involved in the physical altercation. The patient then rapidly banged the staff person's head off of and onto the floor. The initial result was unconsciousness. Upon awaking, the staff member had a severe concussion and an almost total elimination of short term memory functioning for over a year.

Not only was this a stressful event for my colleague, but several others who witnessed the event expressed a stress reaction that resulted in sleep disturbance. Levin and Nielson (2009), found that "there is a strong link between trauma exposure and subsequent disturbed dreaming" (p. 85). If disturbed dreaming or nightmares become chronic, Krakow and Zadra (2006) found that an insomnia-like pattern of sleep disturbance has a high probability of occurring. This study utilized a lens that recognizes sleep disturbance as a possible experience within the sample as the participants engage in stressful environmental events.

Burnout.

"What does it profit us if we gain the world but lose our souls?" (Bolman & Deal, 2001, p. 5).

Throughout the literature, there seems to be general agreement that burnout can be described by one feeling emotionally exhausted, depersonalized, and displaying a lack of personal accomplishment (Maslach, 1982). Many of the educators within the setting of this research seem to experience symptoms of burnout. In fact, "fifty-seven percent of psychiatric and 71% of family/children workers identified themselves as being moderately or severely burned out"(Lloyd, King, & Chenoweth, 2002, p. 260).

Burnout is a phenomenon that is described as having three components: emotional exhaustion, depersonalization, and a lack of personal accomplishment (Corrigan et al., 1994). Emotional exhaustion is described as feeling overextended and depleted of one's emotional resources. Depersonalization refers to a negative, callous or excessively detached response to other people. Reduced personal accomplishment refers to a decline

in one's feeling of competence and successful achievement in one's work. (Janssen, Schaufeli, & Houkes, 1999, p. 75).

Of relevance to this study is data that indicates "the prevalence of teacher burnout may be as high as 40% of teachers suffering some degree of burnout during their career, and possibly as high as 50%" (Brock & Grady, 2000, p. 9). This percentage of educators described in the previous quote are professionals within a regular and typical educational environment. If the rate of burnout is this high in a typical environment or school, I would argue that one would obtain dramatic results regarding the percentage of burnout within specialty schools such as a school within an acute care inpatient psychiatric facility or another type of school that is geared towards serving children with acute psychiatric diagnoses.

Overtime and burnout. The experience of educating in an acute care inpatient psychiatric hospital can lead to an environment that may require overtime work hours. Since the educators within this environment are salaried employees, overtime work is not rewarded with extra pay. These educators may have to work overtime to finish a plethora of paperwork, assist with behavioral difficulties on the unit, attend a mandatory meeting, or plan for the academic activities of the next day. Beckers, Van Der Linden, Smulders, Kompier, Taris, and Geurts (2008) discuss how burnout, caused by voluntary versus involuntary overtime, may have a profound impact on one's health and in particular, fatigue. Data were collected on 2,415 subjects via a questionnaire that focused on the work situation and well-being of employees. Overtime was classified as either voluntary or involuntary. Of the sample, 69.8% reported that they worked overtime. Using ANOVA's, the results yielded that the combination of involuntary overtime without

sufficient rewards for such work is associated with high levels of fatigue and decreased satisfaction with work. (p <.01; Beckers, et al., 2008).

Performing overtime work can come from a feeling of compassion toward clients, thereby requiring more overtime work. When one is engaged with helping individuals who have been through traumatic events, vicarious traumatization (VT) may occur. VT "describes the impact of repeated empathic engagement with trauma survivors and associated cognitive, schematic, and other psychological effects" (Sprang, Clark, & Whitt-Woosley, 2007, p. 260). On a daily basis, educators within an acute care inpatient psychiatric hospital are engaged with the most actually ill psychiatric population. Many children with whom these educators interact have experienced devastating and traumatic events such as being raped, watching a murder, committing murder themselves, killing animals, or being severely abused including verbal, physical, and sexual abuse. Being exposed to children who have experienced such situations can be associated with vicarious traumatization but can also lead to secondary traumatic stress or compassion fatigue (Sprang, Clark & Whitt-Woosley, 2007). In fact, Sprang et al. (2007) not only discovered that 13% of their population sample of 6,720 certified behavior health providers suffered from compassion fatigue but that being female increased the risk of compassion fatigue. In the sample for this study, five out of six educators were female. Compassion fatigue is a concept that was kept in mind when the data from the sample of this study were analyzed.

In conclusion, having autonomy and flexibility over one's work schedule may reverse the negative effects that working overtime may have on family life (Fenwick & Tausig, 2001; Golden & Wiens-Tuers, 2006). Since longer hours can cause a work-

family imbalance (Golden & Wiens-Tuers, 2006), having flexibility in one's work schedule will assist in "enabling workers to achieve control of demands and responsibilities in both their work and non-work life" (Fenwick & Tausig, 2001, p. 1193).

Social support and burnout.

> "If I can get an idea past my boss and his boss and the financial vice president and the general counsel, it's probably too feeble an idea to change anything" (Gardner in Wren, 1990, p. 299).

During the experience of educating within an acute care inpatient psychiatric hospital, an educator may feel a lack of social support, from his/her peers, other mental health professionals and from supervisors. One group of professionals who work with the educators in this setting are social workers and studies indicate that social support, particularly in the form of supervision can help social workers combat feelings of burnout. Lloyd, King, and Chenoweth, (2002) conducted a literature review and found that social support from peers and supervisors lowered levels of burnout and that a lack of support was a correlate of burnout. Creating a positive social support system may help reduce the negative effects of an unhealthy work environment. In one study, Siebert (2005) found that many of the study participants left their prior place of employment because of a stressful workplace environment. Also, not being valued by other mental health professionals may have a negative effect on social workers' self-efficacy, leading to a diminishment of personal accomplishment and an increased chance for burnout. In other words, when self-efficacy is negatively impacted, the professional is at higher risk for burnout (Grayson & Alvarez, 2008). It is possible that the educators within the facility may feel devalued by other mental health professionals as well as, at times, lack social support, leading to resentment and feelings of professional and emotional isolation.

As discussed previously, social workers who work in an acute care psychiatric hospital may experience similar lived experiences as educators. Within this setting, psychiatric nurses may also have similar experiences, as they interact with the same patients and staff members as the educator. In regards to psychiatric nursing and social support, Jenkins and Elliot (2003), utilized a sample of 93 nursing staff from 11 acute mental health wards. The nurses completed the Mental Health Professionals Stress Scale, The Maslach Burnout Inventory, and the House and Wells Social Support Scale. Almost half of the psychiatric nurses in this study displayed high levels of emotional exhaustion. Notably, those with higher levels of social support, whether from administration or from colleagues, had lower levels of emotional exhaustion.

In a study that compared forensic nurses and mainstream mental health nurses, Happell, Martin and Pinkahana (2003) discovered a similar phenomenon of high levels of emotional exhaustion with psychiatric nurses as well as significant levels of depersonalization. The results of these studies of nursing professionals informed this study of educators in an acute care psychiatric hospital. These studies magnify the importance of social support as it may reduce levels of emotional exhaustion, therefore possibly lowering the risk of burnout.

Role ambiguity, role conflict and burnout.

"Do not try to teach a pig to sing—it wastes your time and annoys the pig"(Clifton and Nelson, 1992, p. 17).

Educators in an acute care inpatient psychiatric facility may experience both role ambiguity and conflict. Role conflict has negative effects on both the organization and the individual, and minimizing role conflict negates feelings of burnout (Acker, 1999; Siegrist, 1996).

27

As presented earlier, there are no studies of educators who work within acute care psychiatric facilities. However, other mental health professionals' experiences have been investigated. Specifically, the experience of social workers within similar facilities has been investigated, and was used as a lens in this study to assist in the interpretation of the experience of educators within the acute care inpatient psychiatric facility. In social work, "role conflict intensifies the amount of burnout and job dissatisfaction experienced by social workers" (Lloyd, King, & Chenoweth, 2002, p. 257). Lloyd, et al., (2002) argued that role conflict exists between client advocacy or professional philosophy and meeting agency needs. This conflict between client advocacy and professional philosophy may also relate with role conflict within the lives of educators within an acute care inpatient psychiatric facility. For instance, it is possible for an educator to believe that each patient's school should be provided with educational recommendations in order to sustain the patient in his/her regular school environment. The facility policy may cause conflict with such a stance, as the policy might state that educators are not to give such recommendations. Such a lens of role conflict was utilized during the interpretation of the data.

Burnout may have a profound impact upon one's career. With regards to the experience of educators within an acute care inpatient psychiatric facility, educators, particularly newer employees, may become overly emotionally involved with a patient's case. Educators may put countless extra hours into developing personalized education plans for a particular patient and may become inappropriately involved in other aspects of a patient's case, such as issues of placement, therapy and medication. Acker (1999) administered a questionnaire that utilized scales in order to investigate job involvement

28

satisfaction as the Maslach Burnout Inventory (Maslach et. al., 1996). Acker (1999) found that the more the subjects were emotionally involved with clients, the more likely the subjects were to be emotionally exhausted ($p < .01$). Also, a higher level of job involvement was correlated with depersonalization ($p < .05$).

With regards to a hospital setting, burnout may have a profound impact upon the quality of patient care. As Acker (1999) states in her research about social worker burnout and job satisfaction, "social workers who are burned out and do not derive gratification from their jobs and are more likely to provide poor quality service" (p. 116). This could also be seen in educators within a facility. An educator may feel burned out and become apathetic towards providing a quality educational experience for the patients.

In Lloyd, King and Chenoweth (2002), a review of the literature found that 73% of social workers have considered leaving their jobs due to the effects of such feelings as emotional exhaustion, lack of professional self-efficacy, and depersonalization. In fact "clinical staff who are overwhelmed or emotionally exhausted with their jobs are less likely to provide optimal patient care" (Corrigan et al., 1994, p. 65).

When one feels rejecting and unhelpful toward patients, due to burnout, the quality of the care provided may suffer. Holmqvist & Jeanneau (2006), investigated the relationship between burnout and the psychiatric staff's feelings towards patients. The study consisted of 510 participants who were employed across 28 treatment units. The Burnout Measure and the Maslach Burnout Inventory (Maslach et al, 1996) were utilized to document levels of burnout among the participants. A feeling checklist was utilized to measure how staff felt toward patients. Psychiatric staff who felt tedium, emotional

exhaustion, and depersonalization had an increased risk of also experiencing rejecting

and unhelpful feelings (Holmqvist & Jeanneau, 2006).

Within an organization such as a hospital, many factors, such as unpaid overtime,

lack of autonomy or an unhealthy work environment, can contribute to burnout. Burnout

reduces the quality of patient care and hospital climate and could endanger the safety of

patients (Sparks, Cooper, Yitzhak, & Shirom, 1997). The diminishment of patient care

and patient safety, due to such factors as lack of adequate pay, is an injustice to the

patients who should consistently be provided a high quality of care. There is also an

injustice to the educators who may be negatively impacted in their professional as well as

personal lives. When situations such as unfair pay practices become a reality, hospitals

can decrease the risk of staff burnout by promoting pay equity studies. Hospitals can also

reduce the levels of burnout or elements of burnout by promoting staff autonomy,

decreasing role ambiguity and conflict, and increasing social support within the context

of the workplace environment (Lloyd, King, & Chenoweth, 2002). Therefore, as

Kilfedder, Power and Wells (2000) recommended in regards to burnout in psychiatric

nursing, a multi-faceted and comprehensive approach to alleviating burnout and elements

of burnout may be needed and addressed through organizational and individual

interventions.

Efficacy and Social Cognitive Theory.

"According to social cognitive theory, the control individuals and collectives

exert over their lives is influenced by their perceptions of efficacy" (Goddard, 2001, p.

467). In other words, if people do not believe that they can influence outcomes, they

would have minimal confidence with regards to overcoming difficulties or achieving tasks.

As Bandura (2000) writes:

> Efficacy beliefs influence whether people think erratically or strategically, optimistically or pessimistically; what courses of action they choose to pursue; the goals they set for themselves and their commitment to them; how much effort they put forth in given endeavors; the outcomes they expect their efforts to produce; how long they preserve in the face of obstacles; their resilience to adversity; how much stress and depression they experience in coping with taxing environmental demands; and the accomplishments they realize. (p.75)

In the setting of an acute care inpatient psychiatric hospital, educators make decisions that ultimately lead to the lived experience of such educators. These decisions are made within the context of not only one's sense of self-efficacy but also through the lens of the sense of collective efficacy, or the efficacy of a collective group.

Professional self-efficacy. According to Bandura (1994, p.4) "Self-efficacy is defined as peoples' beliefs about their capabilities to produce designated levels of performance that exercise influence over events that affect their lives. Self efficacy beliefs determine how people feel, think, motivate themselves and behave." Professional self-efficacy as it relates to one's perceived professional capacities is an important element that needs to be explored in the quest to understand the lived experience of an educator within an acute care inpatient psychiatric facility. An educator with high professional self-efficacy may have a much different perceived experience than an educator with low professional self-efficacy. According to Bandura (1997), low self-efficacy can be linked with helplessness and depression, and high self-efficacy can lead individuals to engage in tasks that are deemed more difficult. Individuals with higher levels of self-efficacy also tend to have a higher resilience to stressful events and those

31

with lower levels of self-efficacy may be at risk for higher anxiety as well as diminishing their accomplishments.

Skaalvik (2007) conducted a study of 246 teachers from 12 elementary and middle schools in Norway. The study revealed and supported teacher self-efficacy as a multidimensional construct with six correlated dimensions. These dimensions were:

1. Adapting education to individual students' needs

2. Motivating students

3. Instruction

4. Cooperating with colleagues and parents

5. Keeping discipline

6. Coping with changes and challenges

The dimensions listed as part of the multidimensional construct regarding the conceptualization of teacher self-efficacy were an important reference tool as the data were analyzed within this study of the lived experience of educators within an acute care patient psychiatric hospital.

Another important finding in Skaalvik (2007), was that a strong correlation between teacher burnout and teacher self-efficacy was established. In other words, individuals with low self-efficacy had a tendency to construct situations as a threatening force to their perceived deficiencies. At this point, anxiety increases and defense mechanisms may become heightened creating a possibility of emotional exhaustion and depersonalization, both of which are dimensions of burnout.

The next vignettes present examples of professional self-efficacy in teachers within two separate settings:

Ann's classroom. Ann is an educator in an elementary school. Ann has twenty-four students and one student has an individualized education plan (IEP) that allows for modifications to be made for math, as the student has a learning disability that makes it difficult for him to retain mathematical knowledge. The adaptation is to allow the student to have a small sheet of paper with the equations or other mathematical information written down as the student cannot retain such information. Other than the one student with the IEP, Ann experiences minor behavior difficulties such as verbal arguments. However, when Ann experiences verbal arguments, she becomes incredibly agitated and starts to yell at the children. Ann's blood pressure goes up and she feels like she is failing the other children when this happens. After Ann redirects the students, Ann starts to calm down, feels emotionally withdrawn, and slumps in her desk chair. Ann sometimes questions her abilities as a teacher and always asks herself, "why do these arguments keep happening in my class?"

Tim's classroom. Tim is a special educator within a private school for students with a wide range of mental health concerns. Tim teaches ten children. Each child has an IEP and not only do most of the children need academic modifications but most of his students are on behavior plans as well. Students regularly physically attack each other as well as Tim and his classroom aide. In fact, just yesterday Tim's only classroom computer was thrown across the room by a student and it hit the head of another student. The aggressive student had to be physically restrained as the other student was lying on the ground, unconscious with blood pouring from his nose. The classroom had to be cleared of the other students as the aggressive student was taken to the "calm down room" and the student with the head trauma was taken to the emergency room. After

class, Tim discussed the event with his supervisor, and they processed through the events that led up to the chaotic scene. Tim understood the nature of the job and that the student who threw the computer was experiencing psychosis in which voices told him to throw the computer at the other child who he thought was staring at him.

The differences between the reactions of Ann and Tim to events in the classroom are staggering. Though Ann's setting can be safely described as a less stressful situation, she had lower professional self-efficacy than Tim who worked in a classroom that was much more stressful than Ann's classroom.

The preceding stories, particularly Tim's story, illustrate that, depending on the student population, educators may have different reactions that lead to different experiences as well as differences in coping styles depending on their level of professional self-efficacy. Experiences such as Tim's could be characterized as extreme, though one could argue that educators within an acute care psychiatric facility may experience similar circumstances as the population being served has acute mental health concerns, prompting a particular group of individuals to be locked within a building with constant observation because they cannot be trusted to keep themselves or others safe on the outside of the facility.

Although student behavior can be associated with burnout, it is likely that the interaction of student behavior, along with a host of other factors including the level of professional self-efficacy determines the level of burnout that and educator may experience. In a study by Hastings and Bhaum (2003), 100 regular classroom teachers completed a questionnaire with three sections that focused student behavior in regards to three levels: disrespect, attentiveness and sociability. The researchers used The Maslach

Burnout Inventory (Maslach et al., 1996) to measure teacher distress. As previously stated, burnout is a phenomenon that is described as having three components: emotional exhaustion, depersonalization, and a lack of personal accomplishment (Corrigan et al., 1994). Through a regression analysis conducted in the study by Hastings & Bham (2003), educator emotional exhaustion was predicted by student disrespect (p= 0.037). Educator depersonalization was predicted by a lack of student's sociable behavior (p= 0.031) and disrespect (p= 0.009). Finally, a lack of educator personal accomplishment was predicted by a lack of the students' sociable behavior (p= 0.005).

In a study by Schwarzer and Hallum (2008), the researchers studied how perceived teacher self-efficacy may predict burnout and job stress. Four-hundred and fifty-eight teachers participated in a longitudinal questionnaire study, and the researchers found that latent self-efficacy predicted job burnout and stress. This study is relevant to the current study as the lived experience of educators within an acute care inpatient psychiatric facility could potentially be impacted by a mixture of student behavior difficulties and low professional self-efficacy which in turn could be related to job stress and burnout.

In an attempt to understand what attributes are present with regards to educators who have stayed in the field of teaching students with emotional and behavioral disorders, Prather-Jones (2010) utilized open-ended interviews with educators to explore personal factors and perspectives. The 13 educators who were interviewed had to be in the field for at least 6 years. The researchers found that administrative and collegial support, particularly during the initial years of teaching, combined with the personal characteristics of being intrinsically motivated, aware of and accepting of limitations,

flexible and enjoying of variety, able to not take anything personally, and having a sincere interest in children with emotional behavior disorders were common elements among the experienced participants. This study did not specifically state participants understanding or perception of their professional self-efficacy; however if one references the previously stated theory of self-efficacy in which, self efficacy beliefs determine how people feel, think, motivate themselves and behave, one may be able to make connections from the results of this study to self efficacy beliefs. In Prather-Jones (2010) one may argue that the personal characteristics, particularly being intrinsically motivated, have a relation to self-efficacy. Therefore a connection may be made that the educators who were interviewed had a healthy level of perceived self-efficacy.

Collective efficacy. An important element of the overall efficacy paradigm as well as an informative piece in this literature review and study is the notion of collective efficacy. Collective efficacy is "associated with the tasks, level of effort, persistence, thoughts, stress levels and achievement of groups" (Goddard, 2001, p. 467). Bandura (1997, p. 469) described collective efficacy in the following manner, "collective efficacy is concerned with the performance capability of a social system as a whole." Caprara, Barbaranelli, Borgogni, and Steca (2003) discuss overall efficacy as not only an individual's perceived self-efficacy but as a combination of an individual's perceived self-efficacy and collective efficacy or the ability of individuals to operate in concert with others. In other words, "Both perceived self- and collective-efficacy beliefs correspond to cognitive structures, likely chronic appraisals people make about their capacity and the capacity of a social system as a whole to master specific domains of actions" (Caprara, Barbaranelli, Borgogni, and Steca, 2003, p. 821).

Collective efficacy is an important construct that was taken into consideration during this study. Questions during the interview process for this study were constructed to explore the concept of collective efficacy as a theme, as this concept relates to the lived experience of educators within an acute care inpatient psychiatric hospital as "high levels of distress may debilitate group performance by diminishing member confidence in group capability (Goddard, 2001, p. 469). Also, the beliefs of any member about the behaviors of other members is critical in determining the understandings and beliefs of individuals about the entire group or organization, (Caprara, Barbaranelli, Borgogni, & Steca 2003).

In a study by Caprara, Barbaranelli, Borgogni, & Steca (2003), an examination of how educators perceived self- and collective-efficacy as an interaction to determine levels of job satisfaction and how teachers' perceptions of colleagues within the school constitute a link between perceived self-efficacy and collective efficacy was explored. The sample consisted of 2,688 teachers from 103 schools. The researchers found that the perceived self-efficacy of teachers significantly influenced their perceptions of their job satisfaction and their colleagues perceptions. There was a moderate link between perceived collective efficacy and job satisfaction through the effects of the perceived perception of colleague behavior.

A study by Goddard (2001), attempted to determine if mastery experience is different in relation to schools in their senses of collective efficacy, if there is a relationship between student achievement and collective efficacy, and if student achievement has any relation to the group perception of collective efficacy. The researchers found that collective efficacy and mastery experience are strongly related.

37

The researchers also found that collective efficacy was related positively to student achievement. Finally the researchers found that group consensus of collective efficacy was not strongly related to student achievement.

Summary model. Figure 2 pulls together the information from this literature review into a pictogram of the lived experience of educators. This information informed the research questions for this study. As indicated, organizational culture and efficacy (Level 1) lay the foundation for effort/reward imbalance and workplace climate (Level 2), which in turn, influences symptoms of burnout and sleep disturbance (Level 3). Eventually, these three levels influence turnover rates, morale problems, the number of mentor educators and the quality of education provided to patients.

Conclusion

This literature review indicated that five themes might arise from the qualitative interviews in the present study: sleep disturbance, pay inequity, workplace bullying and horizontal violence, burnout, and professional self-efficacy. This literature review and supporting anecdotal evidence provided only a basic guide to my path of exploration into the experience of being an educator within an acute care inpatient psychiatric facility as other themes emerged during this qualitative study.

Level 1
- Organizational Culture
  - Policies
  - Practices
- Efficacy
  - Professional Self
  - Collective

Level 2
- Effort-Reward Imbalance
  - Overtime
  - Role Ambiguity/Conflict
- Workplace Climate
  - Social Support
  - Workplace Bullying
  - Horizontal Violence
  - Social Support

Level 3
- Burnout
  - Emotional
  - Physical
  - Mental
  - Spiritual
- Sleep Disturbance

Level 4
- Turnover
- Quality of Education provided to Patients
- Morale
- Lack of Mentor Educators

Figure 2. Literature Review Summary Model

<div align="center">**Chapter III**</div>

"The human being is a person who signifies—gives and derives meaning to and from the 'things' of the world" (Van Manen, 1990, p. 14).

<div align="center">**Methodology**</div>

Introduction to the Methodology

This chapter will address participants, design and the data collection procedure. This study investigated the lived experience of educators within an acute care inpatient psychiatric facility. The study was driven by questions formed from a thorough review of the literature. The questions that drove the study are as follows:

1. What themes emerge related to the lived experience of educators within an acute care inpatient psychiatric facility?

2. Does teaching within an acute care psychiatric setting have an impact on the mental health of the educators?

3. Do the residual feelings of working within this environment have an impact on an educators' ability to feel healthy?

4. Do the educators experience a lack of autonomy within the workplace?

5. Do the educators feel that individuals engage in horizontal violence or workplace bullying?

This study utilized a qualitative approach because it enables us to discover and document aspects of reality that we "cannot necessarily anticipate, and thus to transcend the limitations of our own perspective" (Beeson, 1997, p. 2). Therefore, the qualitative approach is useful in providing a holistic interpretive illustration using strategies such as inductive reasoning (Creswell, 2003; Nusbaum et al., 2008).

Within the qualitative approach, a phenomenological lens was utilized as a path that "describes the meaning for several individuals of their lived experiences of a concept or a phenomenon" (Creswell, 2007, p. 57). It is important to note that the methods of phenomenological study may have a path, though the path is constructed during the process rather than by predetermined suppositions (Van Manen, 1990).

The hermeneutic lens was also utilized as it may illuminate the lived human world, as we may find it at any particular moment (Van Manen, 1990). In other words "hermeneutic science involves the art of reading a text so that the intention and meaning behind appearances are fully understood" (Moustakas, 1994, p. 9). To further this notion, a hermeneutic lens was employed as one brings forstructures or transference to an event (Henry, 2002). In this study, the researcher brought transference to understanding what it means to educate within an acute care psychiatric hospital. This being said, the "preconceived notions are not necessarily obstacles that have to be circumvented; they are, rather, the most basic and necessary conditions that initially guide us to the phenomenon in question" (Henry, 2002, p. 6). This study utilized the lenses of hermeneutics and phenomenology to help understand the phenomenon. Yet, during the coding phase, the lens of grounded theory was employed as data began to form into discrete categories allowing the theory or themes to emerge (Cluss et al., 2006). In summary, this study utilized a mixture of lenses that began with phenomenology and hermeneutics and then shifts into grounded theory.

This particular researcher was interested in the lived human world of educators within an acute care inpatient psychiatric hospital. Furthermore, it was critical to identify and bear in mind that one interpretation of an experience is just that, a single

interpretation; in any situation, fuller and richer interpretations of the lived experience could potentially exist (Van Manen, 1990).

Research sample. The research sample included six special educators who facilitated education within an acute care inpatient psychiatric facility. The educators ranged in experience, education, gender and racial identity. Five of the educators were of European background and one was of Hispanic background. Five of the educators were female and one was male. Within this context, these educators specialized in the continuing education of children and adolescents with emotional disturbance, behavioral issues and psychiatric diagnoses.

After institutional review board approval of this study, the six educators received a recruitment letter informing them that the study was part of the principal investigator's dissertation (see Appendix A for the recruitment letter). The informed consent specifically stated that there may be a risk of a breach of confidentially as the educators were colleagues and supervisee's of the principal investigator, though specific steps were implemented to protect the confidentiality of the educators. These steps included the utilization of an outside research team for interviewing, transcription, analyzing, and coding; all identifying material of the educators or anyone else was eliminated by the transcriber; all data was stored and all data will be destroyed by the qualitative research center. The subjects voluntarily participated. See Appendix B for the consent form.

The sample subjects were employed as educators in a large urban psychiatric hospital in the Northeastern United States. The hospital is part of a large, not-for-profit medical system that serves both clients with health care insurance as well as clients on a variety of government sponsored health plans. The hospital has multiple inpatient units

for individuals younger than 21 years of age. Several of these inpatient units provide a state licensed inpatient school with state certified special educators.

Research design overview. This research was viewed through the lens of a qualitative hermeneutic phenomenological approach and with regards to the design, utilized grounded theory to assist in crafting a codebook. The grounded theory approach was used as data began to form into discrete categories allowing the theory or themes to emerge (Cluss et al., 2006).

Data collection methods. Research professionals from a Qualitative Data Analysis Program at a local university were utilized. The research professionals included an interviewer who was chosen for her background in qualitative research and familiarity with the setting, a research analyst, a transcriber, and 2 coders ATLAS.ti 6.0 was utilized to assist in this process.

Procedures. The following outlines the process that was undertaken by the individuals at the Qualitative Data Analysis Program:

1. The interviewer met with the principal investigator (PI) to discuss the project goals, the interview protocol and the interview guide.

2. Using the interview guide, the interviewer conducted and recorded the six interviews. At the end of each interview, the interviewer recorded field notes of her observations. Each audio recording was assigned a number to protect subject identity and enhance anonymity.

3. The interviewer transferred the audio recordings to a research specialist at the center.

4. The research specialist assigned the audio files to a transcriber at the center for transcription.

5. The transcriber, who was a different individual from the research specialist, transcribed the recordings verbatim.

6. The research specialist proofread/edited the transcripts and emailed them to the PI.

7. One of the research specialists and two coders met with the PI and discussed the project goals and anything changed during or after the data collection period. They then read a sub-set of the transcripts and drafted a codebook using a grounded theory approach.

8. The coding team worked with the PI to revise the proposed codebook.

9. Two of the coders each coded one of the transcripts independently using ATLAS.ti 6.0.

10. The research specialist conducted a kappa report that measured inter-rater agreement between the coders.

11. The coding team worked with the PI and identified discrepancies in coding and revised the codebook as necessary.

12. The coders each coded a second transcript independently using ATLAS.ti 6.0.

13. The research specialist ran a kappa report to measure inter-rater agreement between the coders.

14. The coding team worked with the PI and identified discrepancies in coding and revised the codebook as necessary.

15. The coders coded the remaining four transcripts.

16. The research specialist ran a kappa report and measured inter-rater agreement between the coders.

17. Discrepancies in coding were identified by the research specialist, who worked with the PI to clarify code applications for the coders.

18. The coders used the final version of the codebook and edited the first two transcripts.

19. The research specialist adjudicated mismatches in all of the transcripts.

20. The research specialist worked with the PI to generate output reports by codes and frequencies of codes.

Materials. An interview guide was developed based upon influences of the phenomenological approach which include viewing the path of exploration as constructed during the data collection process rather than prior. Semi-structured interviews were employed and the interviews were administered by an interviewer from a qualitative research center at a local university.

Interview guide. An interview guide for this study is included as Appendix A.

Chapter IV

Results

Introduction to Results

  This chapter presents results of six interviews of six educators within an acute care psychiatric facility. The results include a description of the target sample, the results of progressive Kappa reports, and four emergent themes with supporting textual evidence.

  Target sample. The target sample consisted of six educators who work full time within an acute care psychiatric facility. After receiving the recruitment letter, all six educators agreed to participate in this study and signed the consent form. The sample was predominantly female (five females and one male), and ranged in age from 29 years to 55 years. Five educators were of European descent and one was of Hispanic decent. Four educators were at the masters level of education and two were at the bachelors level of education. Their length of employment ranged from eight months to nine years, with five out of six being employed in this setting for less than three years.

  Kappa Reports. Coders at a local university's qualitative data analysis center conducted several Kappa reports throughout the progression of this research project. The first Kappa report measured the inter-rater reliability between two coders as they coded the first interview text utilizing a coding scheme that was formulated by the research specialist. The outcome score was 0.30. As 0.30 is a less than desired outcome, the PI, research specialist and staff met to clarify misconceptions and questions about the codes. After the meeting, a second participant text was coded. The results of a second Kappa report indicated an inter-rater reliability score of 0.57. After the second Kappa report was

conducted, the PI and staff met again to clarify any misconceptions or questions. A final

Kappa report was conducted with the remaining four interview texts as well as the

previous two texts.   The final Kappa report indicated an inter-rater reliability score of

0.61. The value of 0.61 is considered substantial with regards to Kappa magnitude

(Landis & Koch, 1977). For the complete final Kappa report, refer to Appendix C.

Significant Kappa scores. Out of 25 codes, 12 of the codes generated an inter-

rater reliability score of .60 or higher and were accepted as reliable. The following codes

are listed in order of strength of Kappa Score.

1. Feelings at the end of the work week: 1.23

2. Adverse events: 1.03

3. Feelings at the beginning of the work day: 1.00

4. Expectations at hire: 0.85

5. Relationship with medical staff: 0.81

6. Desired changes: 0.79

7. Negative feelings: 0.78

8. Positive feelings: 0.78

9. Conflict between educational and medical model: 0.73

10. Relationships with patients: 0.66

11. Available resources: 0.65

12. Relationship with milieu therapists: 0.61

Code frequencies. From the interview texts, a code frequency table was

constructed (see Appendix D). The frequencies ranged from 2 to 199. The most

frequently emergent code was the negative aspects or perceptions and appeared at the

47

frequency count of 199. The least frequently emergent code was sleep disturbance as it appeared at the frequency count of two.

    Global and subthemes. From the codes, four global themes emerged. From the four global themes, 17 subthemes were constructed. The four global themes and 17 subthemes are:

1. Relationships

    a. Relationships with patients

    b. Relationships with educators

    c. Relationships with nurses

    d. Relationships with doctors

    e. Relationships with social workers

    f. Relationships with milieu therapists

    g. Relationships in staff in general

2. Safety

    a. Anticipating violence between patients

    b. Anticipating violence from patients

    c. Coping with violence

3. Whole body reactions

    a. Emotional stress

    b. Hypervigilance

    c. Physically draining

4. System Issues

    a. Lack of materials/funding

b. Frustration with hospital policy and regulations

c. Lack of adequate space

d. Compensation and time off

Theme 1: Relationships. For theme 1 the following six subthemes emerged:

Relationships with patients (Subtheme 1a), Relationships with educators (Subtheme 1b),

Relationships with nurses (Subtheme 1c), Relationships with doctors (Subtheme 1d),

Relationships with social workers (Subtheme 1e), Relationships with milieu therapists

(Subtheme 1f), and Relationships with staff in general (Subtheme 1g).

Subtheme 1a: Relationships with patients. Relationships with patients were

described as mostly positive by the educators, though there were a few instances of

negative experiences.

Educator 1 stated:

"The best part of my day is working with the patients."

Educator 2 stated:

[With regards to the best part of the day] "when everything just seems to jive together is wonderful to see," and "I do like the kids even though sometimes it's a little bit difficult. And it's wonderful when a concept finally sinks into them and you see that light, like 'P'choong!' that's wonderful."

Educator 3 stated:

"I really like what I do," and "if I could be in the classroom all day, I'd be much happier."

Educator 4 stated:

"If a patient writes, you know, 'you listen to me,' it's that kind of interaction that you get day to day that you know what you're doing is right. So I think that is the best part of my day," and "it's amazing that just a few words, you know, can change the patient. So that's why I come to work every day. That's why I like what I do."

Educator 5 stated:

"The best part of a typical day is when we complete something that was difficult," and "oh, we did a lab today. Believe it or not, the young man was blind, so to do the lab was difficult for him, but together we were able to work it out. It was pretty amazing what he could accomplish."

Educator 6 stated:

"I really feel like all, all of the student that we have have wonderful qualities in them. I enjoy having the opportunity to get to know them on a personal level."

With regards to the negative comments, the educators expressed stress as an outcome of having patients of various ages, diagnoses and academic levels within one classroom.

Educator 1 stated:

"We have such a diversity of students. We have from probably the valedictorian of some school to way below basic special ed student."

Educator 2 stated:

"When I first started, it was very uncomfortable just because there isn't a regular day and there's no regular schoolwork and there's no regular concepts you can teach because you have such a varying degree of students in your class."

Educator 3 stated:

"I have kids with autism and mental retardation and developmental delays, plus psychiatric conditions as well. So they're 6 through 22. So it's kind of hard to get them all to be doing the same thing," and "kids were all hitting each other and some have MR and other are like doing Sudoku, so it's a hard balance with just one other adult."

Educator 4 stated:

"Cause I might have a 15-year old that might be on a third grade level, then again, I might have a 17-year old on college level, and so I try to individualize instruction, but you can't always do that because, you know, the minute you're spending 10 minutes with this person, something might happen over here."

50

Educator 6 stated:

"It's never the same group, so the next day you might have two different kids which make the group…you know the whole dynamic of the, of the group is different."

Subtheme 1b: Relationships with other educators. Relationships with the other educators were described as positive.

Educator 1 stated:

"I like the other teachers I work with." "It's kind of like a brotherhood, where you have everyone's back, and you look out and protect each other"and "we use humor, and support to help each other out" and "we kind of joke around and might not always be appropriate, but you know, when you have a chair thrown at your head, you know, kinda gotta cut the ice somehow."

Educator 2 stated:

"Our own little club back there, and within that hallways where we are is fine. We all seem to get along and we joke around," and "it's like our own little world, our own little bubble back there, "and "when we are together, like in teacher meetings, we actually laugh and have a good time."

Educator 5 stated:

"They're very nice," and "so I just feel like they're great colleagues to have and I enjoy being friends with them, also."

Educator 6 stated:

"I really enjoy the other teachers I work with. It's a great group. We joke around a lot, um, you now everybody seems to have a really good sense of humor."

Subtheme 1c: Relationships with nurses. Relationships with nurses were only discussed on two instances. From these two instances, educator 1seemed to be view the relationship negatively while educator 5 seemed to view the relationship positively.

Educator 1 stated:

"Sometimes we feel that there's a lack of respect there for the teachers," and "they use us to get a break from the kids, and they sometimes force patients down that really aren't safe to be in the classroom."

Educator 5 stated:

"We had a nurse manager—it seems like people who are unpleasant on the floor don't stay long. We had a nurse manager a while back, she was a little difficult. But she didn't last. The other nurse manager came back, and then it's like the atmosphere on the unit just changed."

Subtheme 1d: Relationships with doctors. Relationships with doctors seemed to be viewed positively.

Educator 1 stated:

"The doctors are always nice, ask for our input and things like that."

Educator 4 stated:

"Doctors—doctors are pretty good. They're pretty good because they know that we're dealing with the patients that we have."

Subtheme 1e: Relationships with social workers. Relationships with social workers seemed to be viewed negatively.

Educator 1 stated:

[With regards to the teachers]"Sometimes the social workers are just like, 'eh, whatever'."

Educator 2 stated:

"As far as social workers, well…I…[laughing]. Let's just say they're not my favorite group in the whole hospital, and I think part of that has to do with one of them in particular who's, I think, not the nicest of people. And I think she carries

that around with her, you know, like a cloak or something. I mean, you can see her coming, you think, 'ohh. Here we go.'

Educator 4 stated:

"Social workers—you know, they come by, they're lookin in our room, and, you know, and they're taking notes or giving us the evil eye."

Subtheme 1f: Relationships with milieu therapists (MTs). The relationships described between the educators and the milieu therapists was described in mostly negative terms.

Educator 2 stated:

"There's a few of them that I don't particularly care for in my classroom. I think they're not very nice to the kids at all," and "I've heard kids say, you know, comments that the MT's have made that were not very respectful towards us."

Educator 3 stated:

"Making the other staff members (MT's) smile once in a while. And I try, [laughing] believe me."

Educator 4 stated:

"I feel that they're not our always best of friends. They're the ones who are supposed to be there to help us with the patients, and sometimes I feel like they're there for more social reasons, for themselves," and "we've tried to—you know, open up, but it's been pretty much shut down."

Subtheme 1g: Relationships with staff in general. While not specifically naming the profession or staff subgroup, four educators had negative feelings about relationships in general.

Educator 1 stated:

"Sometimes we feel that there's a lack of respect there for the teachers. We're kind of viewed as babysitters."

Educator 2 stated:

"Once you step out on that unit, I always feel like we're being judged and assessed for some reason," and "I always feel like we are being watched, waiting for, to screw it up somehow. So that's really difficult, for me, to work like that," and [in reference to treatment team meeting] "I'm not sure how much our opinions are worth, to tell you the truth, or how much they are taken into account," and "It just doesn't seem like anyone is happy there. Do you know what I mean? It's like you go into the office and nobody smiles."

Educator 4 stated:

"I feel like we are always being scrutinized. You know, like someone is watching us constantly when they should be doing their own job," and "I feel like nobody respects the education portion of the hospital," and [in reference to the treatment team meeting] "they're very impersonal," and "some people will come in and sit in a certain chair at, you know, a certain place in the room, and God forbid you sit in that chair," and "so it's some old folks there with some old thinking, and it'd be nice to have that change a little bit."

Educator 6 stated:

"Sometimes when staff, um…doesn't…you know like honor your requests or like if you say you know a particular student really shouldn't be in the classroom that day, um, they might ignore your request and bring him or her into the classroom and which is usually not asked."

Educator 5 has a positive comment about relationship with staff in general

Educator 5 stated:

"The staff is really supportive of each other. I love the people I work with. They're incredible with each other."

Theme 2: Safety. Five educators discussed issues related to safety during their work experiences. The second global theme of safety was constructed with the three sub-themes: Anticipating violence between patients (Subtheme 2a), Anticipating violence from patients (Subtheme 2b), Coping with violence (Subtheme 2c)

Subtheme 2a: Anticipating violence between patients. The educators discussed

anticipating violence between patients.

Educator 2 stated:

"He just exploded and just started punching the other kid. So it's—you know, you always have to be aware that there's that potential for violence. And I think that's what O has a hard time with especially."

Educator 4 stated:

"A patient can flip out at any point in time," and "but what could be the worst part is if one patient is after another patient. And it's very close quarters so anything can happen, and when it happens, it happens very quickly."

Educator 6 stated:

"We had to separate a lot of people and they had a lot of problems with aggression and fighting and sexually acting out."

Subtheme 2b: Anticipating violence from patients

Educator 1 stated:

"It could be a day where you have fights, people cutting themselves, anything could happen," and "one minute they're fine, the next minute they completely turn on you," and "you have conduct disorder kids that threaten to hit you, or will hit you."

Educator 3 stated:

"We have a lot of very violent kids. So a lot of kids are ending up, you know, safety officers come in and take them to seclusion, and there's a lot of bruises," and "a lot of violent activities, fights between kids," and "I ended up, you know, getting x-rays a couple of weeks ago."

Subtheme 2c: Coping with violence

Educator 1 stated:

"If the patient gets to the point where they're too much and they can't handle it

in the classroom, they give them a time out, basically, ask them to go back to their room. And that's for the safety of everyone. That doesn't always work, though, too. Sometimes the patient will go off and you have to go with your instinct, and that does occur. But overall, you know, my theory is if you keep the patients engaged, just like students in school, and you keep one-on-one with each one of them, then things are down to a minimum, and it's not so bad."

 Educator 2 stated:

 "With that population you kind of-it's your fault, usually. You know, you didn't understand something, you didn't know what they wanted. And it's not the kid's fault. So it's kind of frustrating, like, "What could I have done to help that situation better?"

Educator 3 stated;

"It's kind of hard to keep track of all the other kids and making sure that this child is not gonna explode or do something that's gonna throw off the whole class. So that's kind of difficult sometimes."

Educator 4 stated:

"That's why I always try to read the logs. You know, you see those-you can see signs forming, but you always-when they're happening, you don't relate them to the pattern. You know, you can see patterns, but it's always afterthought, be like "Oh, I saw this coming." But you don't see it right away".

Educator 6 stated:

 "And I think that it can be stressful with the kids, just being oppositional sometimes. You'll spend a lot of time planning an activity and it doesn't, it's, it usually doesn't go as you planned and it's not going to and I think that if you're not able to accept that and just go with the flow and then you're going to have a really hard time. You might have planned something to be like a 5 minute icebreaker activity and you might do it the whole time, the whole hour and a half and then you might have something planned for the whole time and they lost interest after about two minutes, so you kind of have to be really flexible"

Theme 3: Whole body reactions. The third global theme of whole body reactions emerged and was constructed upon the following three sub-themes: Emotional Distress (Subtheme 3a), Hypervigilance (Subtheme 3b), and Physically Draining (Subtheme 3c).

Subtheme 3a: Emotional Distress. Emotional distress was found to be a common

theme as five educators described their reactions to the environment.

Educator 1 stated:

"If you take this job home with you, it just wears at you, and you're stressed out all of the time. And you can only take so much," and "five teachers have come and gone. And some of them just got better positions, but other ones were just so fed up with the everyday actions of working in—with the acute mental health, that they just grew tired, grew—become—I don't know, grumpy, worn out, stressed, and have to leave to save themselves, basically."

Educator 2 stated:

"I'm not gonna lie. It is emotionally draining to work there. I mean, there is no way around it," and "there were times when I thought, there is no way I can stay here another day," and "if you're looking for a cushy 9-to-5 job with no stress, that's not the place for you. Don't go there," and "by the end of the week, you're just so drained that you're like, you know what? I don't need this."

Educator 3 stated:

"People want to do stuff on Fridays and I'm like, don't you want to watch a movies in our pajamas?"

Educator 4 stated:

"Considering that I used to teach five or six classes a day of 25+ kids, this is more overwhelming than that."

Educator 6 stated:

"Sometimes you, you, you take it home with you," and "it can be very emotional for me at times."

Notably, educator 5 was an exception to this theme and expressed positive, emotional

feelings.

Educator 5 stated:

"Happy" and "satisfied."

Subtheme 3b: Hypervigilance. Hypervigilance was described as a reaction to the

environment that the educators experienced.

Educator 2 stated:

"You have to be on all the time," and "and it's especially those times where you have kids that are swallowing things and trying to hide things to hurt themselves with."

Educator 3 stated:

"Anticipating all day is exhausting, so I kind of want to just get home and watch mindless TV."

Educator 4 stated:

"You have to improvise where needed. I'm always thinking. I'm always trying to be one step ahead of everybody. And even though I have ten patients, I feel like I have thirty."

Subtheme 3c: Physically draining. The experience led the educators to discuss how

they felt physically drained.

Educator 1 stated:

"It's just physically draining."

Educator 3 stated:

"People want to do stuff on Fridays and I'm like, "don't you want to watch a movies in our pajamas?"

Educator 6 stated:

"By the end of the work week, I'm tired," and "Like before this job Friday nights I would go out and do things and typically Friday night I look forward to coming home and relaxing."

Theme 4: System Issues. The fourth global theme of system issues emerged and

was constructed upon the following four sub-themes: Lack of materials/funding

(Subtheme 4a), Frustration with hospital policies and regulations (Subtheme 4b), Lack of

adequate space (Subtheme 4c), and Compensation and time off (Subtheme 4d).

Subtheme 4a: Lack of materials/funding. A common theme throughout the

interviews was a perception that there is an inadequate supply of teaching materials, for

the classrooms.

Educator 1 stated:

"We don't always have the materials we need" and "we ask for things and I guess
it goes through—a screening process, I guess, I'm not even sure how it works. Or
we want books, and they're—'oh, we don't want to spend this much money on
paperback books,' so we make copies, then they also using the copier too much,"
and "why would [the organization] have problems getting materials or providing
for these kids, and it was—it was kind of disappointing when you see what little
the school there gets."

Educator 3 stated:

"The room is really bad. There's not a lot of supplies like—my kids need sensory
toys and they don't really have anything for them."

Educator 4 stated:

"And the equipment—we have nothing for the patients, really. I have a VCR that
doesn't work, you know. Just little things like that, you kow—it would be nice to
have, you know public school things and not the inpatient unit, hospitalization
equipment."

Educator 6 stated:

"I know everything is about money but it just seems like maybe they could give a
little more for the kids to do different things. Just even various art projects and
supplies."

Again, educator 5 was an exception and comments on an obvious difference

between amount and quality of supplies.

Educator 5 stated:

"I have beautiful maps, " and "if I ask for toys if I have a little kid, I get brand new toys, I don't have a lot of used stuff," and "it's just very different in terms of what the other floors are like."

Subtheme 4b: Frustration with hospital policies and regulations. A common theme emerged that related to educators' frustration with certain policies and regulations, which they viewed as contrary to the educational needs of the students as well as contrary to the professional needs of the education staff.

Educator 1 stated:

"To dealing with the hospital policies and not education policy, that's frustrating. Like the things we try to do, or have tried that hasn't gotten approval for us to do, which would benefit educational-wise, but you know, we're always told it's a hospital, it's not a school," and "I'm a teacher, I'm supposed to do this, and you're told, No. It's a hospital first."

Educator 2 stated:

"You're not allowed to use big pencils and not allowed to use pens and not allowed to use staplers and you're not—so that's hard."
Educator 3 stated:

"They have a sensory room there, but there's nothing in it that a sensory room should have, like vibrating things, and lights, and everything that they need, and its hard too because a lot of that stuff is seen as a restraint in the hospital," and "so there are weird regulations in the hospital that are different and hard to get used to," and "like my role, I feel like—this is going to sound bad, but its almost to like piss the kid off so that we can see what behaviors are going to come out when they're—when demands are placed on them in the real world, so that they can medicate appropriately."

Educator 6 stated:

"We'll have bendy pens as opposed to regular pens…people have actually swallowed pencils and pens and things like that in the past."

Subtheme 4c: Lack of adequate space. The theme of inadequate and dilapidated space was prevalent, with the exception of subject 5, in the interview texts.

Educator 2 stated:

"I would really love a classroom. That's very hard to be in a kitchen trying to teach a class and you have a dryer going and people coming in and out," and "what kind of school is this if we are in the kitchen?" and "The space is just horrible up there, just horrible," and "there's not a single room we can use because they're all being used."

Educator 4 stated:

"It's so isolative—no windows. You know, the rooms are tiny. The cubicles are to the wall—it sometimes feels like a prison. So when I enter, I mean, I try not to think that way, but it does."

Educator 5 stated:

"Our floor is much nicer. It's like a hotel compared, in terms of the attractiveness of the rooms, my classroom is very attractive."

Educator 6 stated:

"There is not enough room and some of us have to teach in the kitchen."

Subtheme 4d: Compensation and time off. A common theme was that the

educators expressed frustration with their level of pay and time off compared to their

counter-parts in the public school system.

Educator 1 stated:

"Money, pay. It's you know, it's decent, but you don't move up as quickly as you do in a public school" and "able to take time off—we don't get the summers off like other schools do, and sometimes it seems like people have a problem if we take a day off, " and "we can't call a substitute, but—you know, and I think sometimes they forget where if a nurse calls off, or an MT calls off, they can pull people from other floors."

Educator 4 stated:

"I wish I made a lot more money," and "they say it's an approved private school, but they don't follow any approved private school rules, like you know, we don't have summers off, we don't get holidays off, we have to take pto," and we don't make public—or even private school salaries," and "when I see everyone else is off, that my friends are—a lot of teachers, and they all have off, and they're all making 15,000 more than me you know," and "like you get all these PTO hours, but everyone gets mad if you take them, so it's—you know, its kind of dumb. You

don't really—you don't get any time off for the holidays. Teachers get two weeks off for Christams and New Years."

Educator 6 stated:

"I would like to see as far as teaching, them to be a little more competitive with public school salaries."

Conclusion

The results of this study included six transcripts that were coded and were checked for inter-rater reliability. The final Kappa report led to a rating of 0.61, which is considered substantial. Four global themes emerged and were subdivided into 17 emergent sub-themes that described the lived experience of educators within an acute care inpatient psychiatric facility.

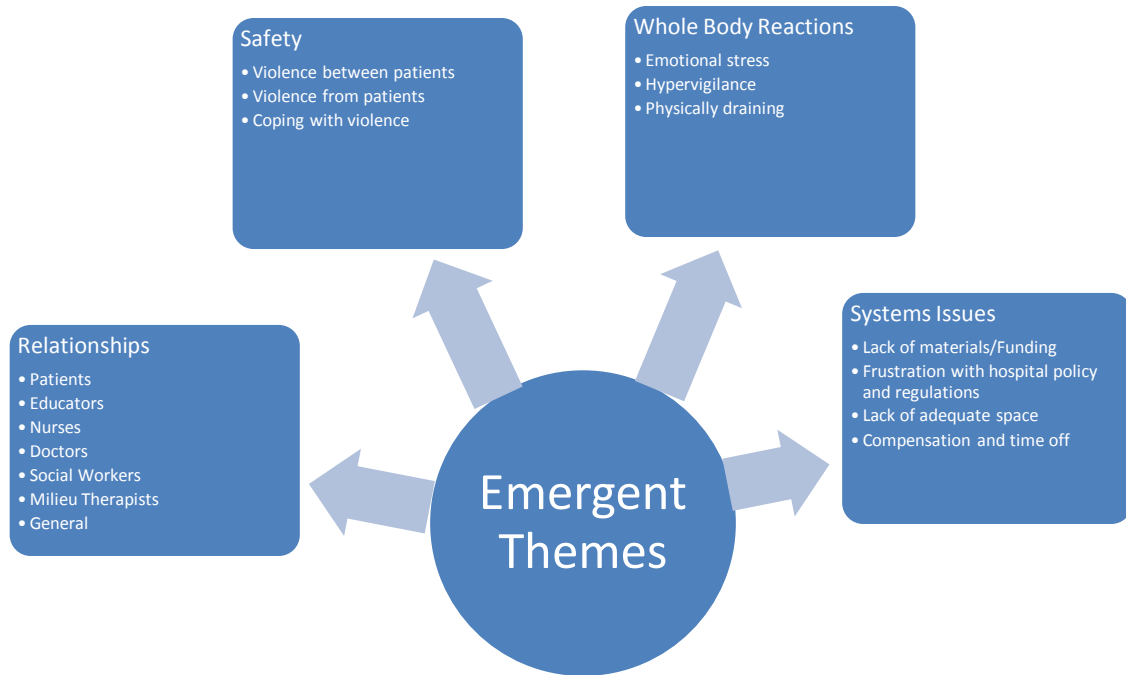Figure 3 represents a pictogram of the global and subthemes.

Figure 3. Emergent Themes and Sub-themes

Chapter V

"Leaders who know the force of love go the extra mile to help individuals who have stumbled" (Hoyle, 2002, p.7).

Discussion

Introduction to Discussion

Teaching within an acute care psychiatric facility lends to experiences that have, until this study, yet to be analyzed for emergent themes that best describe the lived experience. Through the methodological lenses of phenomenology, hermeneutics and finally grounded theory, this study identified 4 emergent global themes and 17 sub-themes that describe the experiences of educators within an acute care psychiatric facility. This chapter discusses the emergent themes and subthemes in relation to existing literature and presents the limitations of this study. Finally, this chapter concludes with a discussion of implications for further research and implications for practice.

Discussion. The findings of this study lend considerable insights into the experiences of educators within an acute care psychiatric facility. Some of these experiences are similar to those of other professionals who work within an acute care psychiatric facility, but some of the findings from this study underscore the unique needs and experiences of educators as they teach patients, process interpersonal relationships with patients and other professionals, and try to manage environmental factors that have an impact on their job and personal well being.

Relationships. Educators within an acute care psychiatric facility have to interact with and form relationships with patients, other educators, physicians, social workers, nurses, psychologists, and milieu therapists. As all human relationships involve the social/psychological dimension of trust which includes commitment, influence and

64

communication (Lowe & Schellenberg, 2001), the relationships that the educators

cultivate and respond to within this environment are essential to understanding their lived

experience. In other words, the teachers facilitate education in an environment that

requires interaction with others. The interactions with others are key to their lived

experience.

Relationships with patients. Educators described relationships with patients as

both positively and negatively internally motivating. Without exception, all educators

expressed some positive feelings for their patients and they seemed to be internally

motivated by the sincere desire to provide a quality educational experience. The

educators attempted to fully understand the actions of their patients which included an

attempt to accept the psychological limitations of the patients who have acute mental

health concerns.

Positive and longer term implications can be actualized as an understanding and

accepting view of the limitations of youth who have acute mental health concerns have

been found by Prather-Jones (2010) as common elements of educators' of children with

emotional behavior disorders who were able to stay in the field for longer than six years.

In other words, strength of this selective sample is that they seem truly invested in

understanding their patients and their patients' mental health concerns. The educators'

feelings towards their patients reflect their sincere interest and their attempts to

understanding their patients. For example, educators remarked that:

"The best part of my day is working with the patients."

"If a patient writes, you know, 'you listen to me,' it's that kind of interaction that
you get day to day that you know what you're doing is right. So I think that is the
best part of my day," and "it's amazing that just a few words, you know, can

change the patient. So that's why I come to work every day. That's why I like what I do."

"I really feel like all, all of the student that we have, have wonderful qualities in them. I enjoy having the opportunity to get to know them on a personal level.

However, educators who are emotionally invested in the care and well being of youth who have acute mental health concerns need to be aware of not becoming emotionally exhausted. Acker (1999) found that the more social workers were emotionally involved with clients, the more likely the social workers were to be emotionally exhausted ($p < .01$). Also, a higher level of job involvement was correlated with depersonalization ($p < .05$).

Educators in an acute psychiatric hospital may experience an overexposure to traumatic events that patients have experienced. This could cause vicarious traumatization (VT) which "describes the impact of repeated empathic engagement with trauma survivors and associated cognitive, schematic, and other psychological effects" (Sprang, Clark, & Whitt-Woosley, 2007, p. 260). Being exposed to children who have experienced traumatic situations can lead to secondary traumatic stress or compassion fatigue (Sprang, Clark & Whitt-Woosley, 2007). In fact, Sprang et al. (2007) not only discovered that 13% of their population sample of 6,720 certified behavior health providers suffered from compassion fatigue but that being female increased the risk of compassion fatigue. In this study, five out of six educators were female.

In this study, comments from Educator 6 illustrate this educator's high level of emotional involvement and the potential for compassion fatigue:

"the majority of kids that come in I you know can relate to in a lot of ways, um, empathize with you know in some cases really bad, you know, if I've gone through that I'd be suicidal too. I think you know if I saw my mom fall off a horse—this is one, one kid that sticks out in my mind—and dies in front of me,

66

I'd I don't even know if I would have made it to the point of being in the hospital."

One negative aspect of the educators' relationships with their patients involved the discomfort of managing patients in acute phases of varying psychiatric diagnoses. Child and adolescent psychiatric diagnoses within this acute psychiatric facility vary from behavioral disorders (i.e., Conduct Disorders) to psychotic disorders (i.e., Schizophrenia).

One educator discussed her discomfort:

"When I first started, it was very uncomfortable just because there isn't a regular day and there's no regular schoolwork and there's no regular concepts you can teach because you have such a varying degree of students in your class."

Another negative experience involved the length of patient stay. In the acute care psychiatric facility for this study, the length of stay varied from a few days to several months. Therefore, the classroom census was constantly changing as patients entered and exited the student group. This continual fluctuation of group membership lend to instability.

One educator discussed instability and stated:

"It's never the same group, so the next day you might have two different kids which make the group…you know the whole dynamic of the group is different."

Relationships with other educators. The educators in this study expressed a positive and healthy relationship with their education colleagues. One educator stated:

"Our own little club back there, and within that hallways where we are is fine. We all seem to get along and we joke around," and "it's like our own little world, our own little bubble back there,"and "when we are together, like in teacher meetings, we actually laugh and have a good time."

Having positive and healthy relationships with coworkers has been found to lower levels of burnout. In their literature review, Lloyd, King, and Chenoweth, (2002) found

that social support from peers and supervisors lowered levels of burnout and a lack of support was a correlate of burnout. Jenkins & Elliot (2003) studied psychiatric nurses and found that lower levels of emotional exhaustion can be achieved with higher levels of social support.

Additionally, the educators in this study seemed to use humor as a coping mechanism. This is illustrated in a statement made by one educator:

> "we use humor, and support to help each other out" and "we kind of joke around and might not always be appropriate, but you know, when you have a chair thrown at your head, you know, kinda gotta cut the ice somehow."

Promoting humor in the workplace is a useful coping strategy that can make employees more productive, improve working relationships, forces thinking skills, increases job satisfaction and enhances teaching effectiveness (Wazner, Booth-Butterfield & Booth-Butterfield, 2005).

Relationships with other professionals. Throughout the workday, educators in this study interacted with physicians, nurses, social workers and milieu therapists. Results from this study found that the educators seemed to have positive relationships with the physicians, but most expressed negative comments about their relationships with the other professional groups (i.e., social workers, nurses and milieu therapists).

Having positive relationships with other professionals can lead to a greater sense of positive and healthy collective self-efficacy. Bandura (1997, p. 469) described collective efficacy in the following manner, "collective efficacy is concerned with the performance capability of a social system as a whole." Job satisfaction is related to perceptions of collective efficacy and having positive and healthy relationships with other professionals expands one's perception of healthy collective efficacy (Caprara,

Barbaranelli, Borgogni, and Steca 2003). Collective efficacy is "associated with the tasks,

level of effort, persistence, thoughts, stress levels and achievement of groups" (Goddard,

2001, p. 467).

Regarding physicians, one educator stated:

"The doctors are always nice, ask for our input and things like that."

In contrast, one educator stated:

"As far as social workers, well…I…[laughing]. Let's just say they're not my favorite group in the whole hospital, and I think part of that has to do with one of them in particular who's, I think, not the nicest of people. And I think she carries that around with her, you know, like a cloak or something. I mean, you can see her coming, you think, 'ohh. Here we go.'

Regarding nurses, one educator stated:

"Sometimes we feel that there's a lack of respect there for the teachers," and "they use us to get a break from the kids, and they sometimes force patients down that really aren't safe to be in the classroom."

Regarding milieu therapists, one educator stated:

"I feel that they're not our always best of friends. They're the ones who are supposed to be there to help us with the patients, and sometimes I feel like they're there for more social reasons, for themselves," and "we've tried to—you know, open up, but it's been pretty much shut down."

Having negative or unhealthy relationships within the work environment may lead

to a decreased sense of efficacy. When self-efficacy is negatively impacted, the

professional is at higher risk for burnout (Grayson & Alvarez, 2008). Not only is self-

efficacy impacted but so is the efficacy of the collective work group. In other words,

"high levels of distress may debilitate group performance by diminishing member

confidence in group capability (Goddard, 2001, p. 469). Also, Siebert (2005) found that

individuals are more willing to leave their place of employment because of a stressful

workplace environment.

Horizontal violence/Workplace Bullying. Horizontal violence or workplace

bullying can exist in an environment of negative relationships. Behaviors associated with

bullying in the workplace can range from subtle psychological attacks to different forms

of physical violence. These actions can occur laterally, from the top-down or bottom-up,

and horizontally between colleagues of equal rank (Roscigno, Lopez, & Hodson, 2009).

An example of a subtle psychological attack was voiced by several educators:

> "Social workers—you know, they come by, they're lookin in our room, and, you
> know, and they're taking notes or giving us the evil eye," and "I feel like we are
> always being scrutinized. You know, like someone is watching us constantly
> when they should be doing their own job," and "I feel like nobody respects the
> education portion of the hospital."

Safety. The second emergent theme involved safety, especially as it related to

anticipating violent behaviors between patients or fear of violent behaviors from patients.

Violence from or between patients can have long term effects on mental health

professionals. These effects include loss of confidence, burnout and change of profession

(Fernandes, Bouthillette, Raboud, Bullock, Moore, Christenson, Grafstein, Rae, Ouellet,

Gillrie & Way, 1999). In fact, violent behavior exhibited by a patient can be a predictor

of emotional exhaustion, depersonalization and a lack of personal accomplishment

(Hastings & Bhum 2003). One educator described violence in this setting by stating:

> "A patient can flip out at any point in time," and "but what could be the worst part
> is if one patient is after another patient. And it's very close quarters so anything
> can happen, and when it happens, it happens very quickly."

Another educator stated:

"It could be a day where you have fights, people cutting themselves, anything could happen," and "one minute they're fine, the next minute they completely turn on you," and "you have conduct disorder kids that threaten to hit you, or will hit you."

Violence from patients can have an impact upon the professional and personal feelings of the educator. As Kleespies and Dettmer (2000) discuss, mental health professionals may have reactions towards their patients because the knowledge of the patients' conditions may be intensely emotional. From the professional standpoint, educators may have conflicts with their personal feelings with regards to intervention as well as how other colleagues may view their reactions. This struggle between personal feelings and professional obligations could result in, isolation from support sources, such as supervisors and colleagues (Kleespies & Dettmer, 2000).

Whole body reactions. Many of the educators in this study expressed symptoms of burnout. Burnout is a phenomenon that is described as having three components: emotional exhaustion, depersonalization, and a lack of personal accomplishment (Corrigan et al., 1994; Maslach, 1982). The results of this study are consistent with one study that found "57% of psychiatric and 71% of family/children workers identified themselves as being moderately or severely burned out" (Lloyd, King, & Chenoweth, 2002, p. 260).

Emotional exhaustion. Educators within this study displayed signs of emotional exhaustion. This is evident in the following statement:

"I'm not gonna lie. It is emotionally draining to work there. I mean, there is no way around it, " and "there were times when I thought, 'there is no way I can stay here another day," and "if you're looking for a cushy 9-to-5 job with no stress, that's not the place for you. Don't go there," and "by the end of the week, you're just so drained that you're like, 'you know what? I don't need this."

Emotional exhaustion is described as feeling overextended and depleted of one's emotional resources (Janssen, Schaufeli, & Houkes, 1999). In fact "clinical staff who are overwhelmed or emotionally exhausted with their jobs are less likely to provide optimal patient care" (Corrigan et al., 1994, p. 65). When teachers experience emotional exhaustion they could provide a lesser quality of education to their students.

Depersonalization. Depersonalization refers to a negative, callous or excessively detached response to other people (Janssen, Schaufeli, & Houkes, 1999). Interestingly, while the educators did not describe themselves as depersonalized, they made several comments regarding depersonalizing type behaviors that were exhibited by other professionals. For example, one educator stated:

> "they're very impersonal," and "some people will come in and sit in a certain chair at, you know, a certain place in the room, and God forbid you sit in that chair," and "so it's some old folks there with some old thinking, and it'd be nice to have that change a little bit."

In their review of the literature, Lloyd, King and Chenoweth (2002), found that 73% of social workers have considered leaving their jobs due to the effects of feelings which included emotional exhaustion, lack of professional self-efficacy, and depersonalization. As Acker (1999) states in her research about social worker burnout and job satisfaction "social workers who are burned out and do not derive gratification from their jobs and are more likely to provide poor quality service" (p. 116). Therefore, it is important that educational leaders address issues of burnout.

Reduced personal accomplishment. Reduced personal accomplishment refers to a decline in one's feeling of competence and successful achievement in one's work (Janssen, Schaufeli, & Houkes, 1999). Reduced personal accomplishment did not emerge as a theme in this study.

System Issues. The educators in this study viewed the employer to employee

exchange process as inequitable as demonstrated by expressions of a perceived lack of

materials and funding, inadequate space, frustration with hospital policies and

regulations, and poor compensation and time off. In other words, Inequity occurs when

there is an imbalance of effort and reward (Taris, Van Horn, Schaufeli, & Schreurs,

2004).

Lack of materials and inadequate space. Regarding equipment, one educator

stated:

> "And the equipment—we have nothing for the patients, really. I have a VCR that
> doesn't work, you know. Just little things like that, you know—it would be nice to
> have, you know public school things and not the inpatient unit, hospitalization
> equipment."

Regarding the physical space one educator stated:

> "I would really love a classroom. That's very hard to be in a kitchen trying to
> teach a class and you have a dryer going and people coming in and out," and
> "what kind of school is this if we are in the kitchen?" and "The space is just
> horrible up there, just horrible," and "there's not a single room we can use
> because they're all being used."

According to Siegrist (1996) the existence of an exchange process administers

rewards through three avenues that consist of status control, money, and esteem. For

employees, pay tends to be the most important aspect of organizational membership

(Shaw & Gupta 2001) particularly as it relates to organizational commitment (Summers

& Hendrix, 1991.)   The educators in this study deemed that there was an imbalance of

financial compensation. One educator stated:

> "I wish I made a lot more money," and "they say it's an approved private school,
> but they don't follow any approved private school rules, like you know, we don't
> have summers off, we don't get holidays off, we have to take pto," and we don't
> make public—or even private school salaries," and "when I see everyone else is
> off, that my friends are—a lot of teachers, and they all have off, and they're all

making 15,000 more than me you know," and "like you get all these PTO hours, but everyone gets mad if you take them, so it's—you know, its kind of dumb. You don't really—you don't get any time off for the holidays. Teachers get two weeks off for Christams and New Years."

Taris, Van Horn, Schaufeli, and Schreurs (2004) argued that there is a psychological contract concerning expectations about the exchange relationship between an employee and the organization. When this contract is not honored by the organization, a result of negative work outcomes may appear. Negative work outcomes could be passive aggression, lower quality of work output and even leaving the organization completely (Griffeth, R.W., & Gaertner, S., 2001). Brock and Grady's (2000) note that when individuals "are not rewarded or recognized for their extraordinary effort, disillusionment can lead to burnout" (p. 9). Not only could burnout and disillusionment occur, but poor organizational commitment could occur (Geurts, Schaufeli & Christel 1999).

Restoring the effort and reward imbalance through adequate compensation for the educational needs of the patients, thereby reducing role conflict, and through fair educator compensation may lead employees to find meaning in their work. Also, educators could behave responsibly with high levels of achievement (Schwahn & Spady, 1998).

Policies and Regulations. The educators displayed frustration with some hospital policies and regulations. Many educators viewed the hospital regulations to be in direct contradiction of their educational principles. When there is a contradiction between the policies of the organization and the professional or personal principles of group or individual, role conflict can occur. Lloyd, King, and Chenoweth (2002) argue that role conflict exists between client advocacy or professional philosophy and meeting agency

74

needs. Role conflict has negative effects on both the organization and the individual, and minimizing role conflict negates feelings of burnout (Acker, 1999; Siegrist, 1996). One educator expressed an example of role conflict:

> "To dealing with the hospital policies and not education policy, that's frustrating. Like the things we try to do, or have tried that hasn't gotten approval for us to do, which would benefit educational-wise, but you know, we're always told it's a hospital, it's not a school," and "I'm a teacher, I'm supposed to do this, and you're told, 'No. It's a hospital first."

Professional and personal conflict with the organizational regulations and priorities could have an impact upon the professional self-efficacy of the educators. According to Bandura (1994, p. 4) "Self-efficacy is defined as peoples' beliefs about their capabilities to produce designated levels of performance that exercise influence over events that affect their lives. Self-efficacy beliefs determine how people feel, think, motivate themselves and behave." Skaalvik (2007) revealed that teacher self-efficacy is a multidimensional construct with six correlated dimensions. These dimensions include: 1) adapting education to individual students' needs, 2) motivating students, 3) instruction, 4) cooperating with colleagues and parents, 5) keeping discipline and 6) coping with changes and challenges. Results from this study indicate that at least three of the six dimensions of teacher self-efficacy (Skaalvik 2007) were violated: 1) adapting education to individual students' needs as updated and adequate materials are difficult to acquire; 2) instruction, as proper materials are difficult to acquire therefore disrupting instruction; and 3) cooperating with colleagues, as educators perceived that certain professionals, particularly social workers, made it difficult for genuine cooperation to occur. As more dimensions are violated, a change toward lowered educator self-efficacy may occur. Low self-efficacy can be linked with helplessness, depression and may present a risk for

overwhelming anxiety (Bandura 1997). Skaalvik (2007) furthers this notion as individuals with low self-efficacy have a tendency to construct situations as a threatening force to their perceived deficiencies. At that point, anxiety increases and defense mechanisms may become heightened creating a possibility of emotional exhaustion and depersonalization, both of which are dimensions of burnout.

Limitations

This study had limitations that included researcher bias/influence and a lack of generalizability.

Researcher bias and influence. The principal investigator (PI) of this study is a principal and educator within an acute care inpatient psychiatric facility. Therefore, the PI has preconceived notions and assumptions of the lived experiences of an educator within an acute care inpatient psychiatric facility, which may have influenced the methodology of this study. The PI contracted with a local university's qualitative data analysis center to have a research specialist conduct all of the interviews off-site and to keep all recorded and non-recorded data off-site. Also, the educators who participated in the study are professional colleagues of the PI. The PI adjusted and formulated the methodology to address this bias. The educators were sent a letter that described the voluntary nature of the study as well as clearly identifying the PI. The letter had a contact person, who was not the PI, to arrange the interview. The research specialist, along with a team of coders, developed codes from the transcripts. The research team coded the transcripts and ran a succession of Kappa reports to measure inter-rater reliability. These precautions assisted in countering the PI's bias and influence

Although the aforementioned measures were utilized to minimize the PI's

76

bias during data collection and analysis, researcher bias may have been introduced when the PI synthesized relevant data and literature for a discussion of the lived experiences of subjects in this study (Chapter 5).

Finally, though steps were implemented to limit the influence of the PI's bias and influence, participants could have felt the need to participate because of the professional relationship with the PI. Also, there is a possibility that the content of educators' responses could have been influenced by what the educators thought the PI wanted to obtain. Though these are possibilities, the PI implemented a procedure that ethically and genuinely addressed these potential limitations.

Lack of generalizability. The facility that employed the educators within this study is rather large and located within an urban area of a northeastern city of the United States; therefore, this setting has commonalities with other, similar facilities. However, the entire emergent experience of these educators may be limited in the ability to generalize to other settings, such as those located in Western, Southern, rural, or suburban areas of the United States. Additionally, as this setting is considered a teaching hospital and is located within a university setting, there may also be a limit to the ability to generalize to a non-teaching, non-university settings.

Implications for Future Research

This study identified four emergent themes that describe the lived experience of educators within a particular acute care psychiatric facility. Future research could consist of replicating this study in similar settings in different areas of the country as specific symptomatic elements, such as levels of stress and burnout, could be explored. Not only

will this address issues of generalizability, but it could test the validity of the findings from this study. It would also be of interest to conduct a similar study in other countries to determine whether similar or dissimilar themes can be extracted from the data.

This study is cross-sectional in design and does not capture a longitudinal perspective of the lived experiences. It would be of interest to conduct interviews with educators over time to determine whether experiences change or remain static over time. Also, descriptive studies with larger samples of educators could examine specific predictors of educator distress and/or burnout.

Notably, educator 5 in this study had a different lived experience than other educators in this study. Educator 5 provided information that was mostly contrary in all areas with regards to the responses of all the other educators. For example, regarding staff relationships, materials and space educator 5 made the following statements:

> "The staff is really supportive of each other. I love the people I work with. They're incredible with each other," and "our floor is much nicer. It's like a hotel compared, in terms of the attractiveness of the rooms, my classroom is very attractive," and "I have beautiful maps," and "if I ask for toys if I have a little kid, I get brand new toys, I don't have a lot of used stuff," and "it's just very different in terms of what the other floors are like."

In response to a question about how one feels at the end of the week ,

Educator 5 responded: "Happy" and "satisfied."

Future research would enlighten the field as to whether this subject is an outlier or represents a smaller subgroup of more satisfied, supported educators. In other words, one could conduct a study that compares teachers with more positive experiences with those with more negative experiences to determine factors influencing these outcomes.

Implications for Practice

This study is an important first step in understanding the lived experience of educators within acute care psychiatric facilities, which to date, is understudied. Now that emergent themes have been discovered and explored, a better global understanding of the experience is available. Results from this study have important implications for practice.

The charge of the leader. An educational leader within an acute care psychiatric setting can use the data from this study to acknowledge the experience of educators and to address specific elements within the experience. Prominent areas to emphasize include managing relationships with other mental health professionals, anticipating and coping with violence between patients and from patients, and managing system issues.

Interdisciplinary relationships. With regards to difficult and challenging interdisciplinary relationships, educational leaders can conduct educational sessions to discuss and espouse healthy coping skills. An example of a healthy coping skill is espoused by Houston and Sokolow (2006) who state "if you train yourself to pause and step-back as a challenge confronts you, you'll have a chance to look at the bigger picture and get a full appreciation of what you are up against" (p. 79). Once one pauses to take appreciation of the situation and not engage in a toxic reaction the educator could experience "an awareness that all problems have opportunities and possibilities embedded within them" (Houston & Sokolow, 2006, p. 82).

With the assistance of other disciplinary leaders, the educational leader should establish interdisciplinary workshops or training sessions for effective communication and collaboration skill building. The workshop or training session could be developed around four objectives: 1) Identify effective communication styles/techniques, 2)

Develop conflict engagement and resolution strategies, 3) Improve the art of listening and 4) Enhance verbal and written communication. Espousing healthy coping skills and establishing workshops or training sessions that develop communication and collaboration skills allow the educators to focus more on teaching. Sutton noted that when "people are emotionally depleted they stop focusing on their jobs and instead work on improving their moods" (Sutton, 2010, p.120). As Pfeffer and Sutton (2006) discussed, one should focus the energy of threats into a change agent for the organization. In other words, leaders should not only reduce feelings of uncertainty, but should also accept it and embrace it (Pfeffer & Sutton, 2006).

Anticipating and managing violent behaviors. Violent patient behaviors occurred within the educational setting of this study. Therefore, the educational leader may want to introduce staff training in management of aggression and other patient population traits. Such trainings have proven to be useful in the reduction of negative behaviors of patients (Needham, Abderhalden, Meer, Dassen, Haug, Halfens, & Fischer, 2004). For example, Daffern, Thomas, Ferguson, Podubinski, Hollander, Kulkhani, deCastella and Foley (2010) describe some patients as having a hostile-dominant interpersonal style. In training sessions, the leader may facilitate discussions that allow the educators the opportunity to explore behavioral and pedagogical methods that reduce the violence from patients who are described as having a hostile-dominant interpersonal style.

Emotional Support. Educational leaders within similar settings can assist educators to process and use problem solving skills. Processing and problem solving may be utilized immediately, although this approach has been deemed most useful during supervisory sessions, especially when the supervisor is adept at providing emotional

80

support (Kleespies & Dettmer, 2000). If a supervisor is not available for an emotionally supportive and processing supervision, Kleespies and Dettmer (2000) suggest that a trusted colleague be utilized for processing and debriefing. In their study of health care professionals' experience of violence in an emergency room, Fernandes and associates (1999) discovered that the most widely utilized coping mechanism and avenue of tension relief was seeking collegial support. Within the sample for this study, the collegial support among the educators was strong. This support could be utilized by the educational leader to enhance coping with violence between and from patients.

System issues. Educational leaders need to address system issues regarding inadequate materials, inadequate space and poor compensation. Educational leaders may advocate for and address the differences with regards to compensation, materials and physical space between the reality of the psychiatric hospital and the public schools. This means being proactive and minimizing reactive situations. When a leader is in a reactive mode, "you are essentially giving your energy over to the priorities of other people and other situations, as opposed to staying focused in proactive mode where you are taking your energy and aiming it toward what you want to see happen" (Houston & Sokolow, 2006, p. 18). This also means that the educational leader is attuned to the holistic needs of the educators. In other words, the educational leader should aspire to be a servant leader by being guided by "a delicate balance between love for oneself and for others" (Hoyle, 2002, p. 24).

Workplace climate. The educational leader must be on the forefront of developing site specific strategies that improve workplace climate. The creation and/or the maintenance of a healthy workplace environment will not only make a happier workplace

but it will assist in retaining employees (Lavoie-Temblay, Paquet, Duchesne, Santo, Gavrancic, Courcy, & Gagon, 2010). Developing and/or maintaining a healthy workplace environment is a collaborative process as educators exist in a collaborative environment. Therefore, addressing horizontal violence by addressing organizational antecedents as well as through staff and manager educational efforts will serve as useful tools (Katrinli, Atabay, Gunay, & Cangarli, 2010).

Finally, the educational leader should advocate for the needs of everyone within the work community and attend to their whole wellbeing. In other words, "the combination of our love for what we do each day, the quality of our relationships, the security of our finances, the vibrancy of our physical health, and the pride we take in what we have contributed to our communities" (Rath & Harter, 2010, p. 4).

Build on areas of strength. As an educational leader, it is important to build on areas of strength, particularly when the professional sense of collective efficacy of the group is at stake. Within this study, two strengths were clear: the educators' internal motivation/desire to educate and emotionally connect with their students and the reflective ability of the educator group. The motivation and desire to provide a quality education to their students is a very important aspect of job satisfaction as was seen across cultures in a study by Kwong, Wang, & Clifton (2010). Additionally, this study recognized the ability of the educators to reflect upon their experiences and ask themselves what they could have done differently for the next incident. As one educator stated:

> "With that population you kind of-it's your fault, usually. You know, you didn't understand something, you didn't know what they wanted. And it's not the kid's fault. So it's kind of frustrating, like, "What could I have done to help that situation better?"

82

Meetings within the educator group should focus on reflective discussions as an opportunity to improve the professional sense of collective efficacy, which may decrease the level of stress that is caused from other environmental elements (Klassen, 2010).

Revisiting Sally's Story

In chapter one, the story of Sally was presented. To briefly recap, Sally was an educator within an acute care psychiatric facility. Sally lost control of her emotions after being approached and questioned about a series of incidents within her classroom. Sally, a veteran public school special educator, verbally assaulted her supervisor and was terminated from her position. Revisiting and analyzing Sally's story through the lens of the results and implications of this study can lend valuable insight into what happened and why it happened.

> Sally, an educator within an acute care inpatient psychiatric facility, arrived an hour late for work one day. She had been late for the last three days and had been taking extended lunches, disappearing for two or three hours at a time. On this day, Sally walked into the school and into another educator's room, slammed her bag on the table and said, "let's get this dumb shit over with. Yes, another day in paradise."

The first paragraph of the story lends important insight into the emotional state of Sally as she entered the workplace on that particular day. An interpretation can be made through the lens of the third global theme of *whole body reactions* and in particular the subtheme 3a) *emotional stress*. Sally was clearly emotionally stressed as she slammed her bag on the table and used derogatory language. At this point the educational leader may want to consider processing the emotions with Sally as a way to relieve stress and tension.

> Since Sally does not actually have a classroom, her materials are stored on a cart that she wheels into the kitchen area of the Child and Adolescent Unit.

One could interpret the previous text as a reaction to the fourth global theme, *system issues*. Particularly subtheme 4a) *lack of materials/funding and subtheme* 4c) *lack of adequate space*, as Sally only had materials stored on a cart and she taught in a kitchen, not a classroom. This was also a point of issue with one educator in this study who stated:

> "I would really love a classroom. That's very hard to be in a kitchen trying to teach a class and you have a dryer going and people coming in and out," and "what kind of school is this if we are in the kitchen?" and "The space is just horrible up there, just horrible," and "there's not a single room we can use because they're all being used."

> Sally's story then continued with:

> Sally has eight patients today. Three of the patients are in fifth grade, one is in seventh grade, three are in ninth grade and one is in eleventh grade. Most of her patients have a diagnosis of conduct disorder, which is defined as a persistent pattern of behavior that violates the rights of others through aggression to people and animals, destruction of property, deceitfulness or theft and serious violations of rules (American Psychiatric Association, 2000). Her patient who is in the eleventh grade is particularly aggressive as he had deliberately destroyed property, hurt people and animals, and used his own feces as a tool in acts of aggression.

One could interpret the previous text through the lens of global theme one, *relationships*, and in specifically, sub-theme 1a) *relationships with patients*. The relationship in this story is similar to the negative feelings that the subjects in this study expressed towards their patients, who were at a wide arrange of ages, abilities, and diagnosis within one classroom. Having a wide range of patients in one room was a source of stress for the subjects in this study and could have been a source of stress for Sally. One educator recalled a similar situation:

> "Cause I might have a 15-year old that might be on a third grade level, then again, I might have a 17-year old on college level, and so I try to individualize

instruction, but you can't always do that because, you know, the minute you're spending 10 minutes with this person, something might happen over here."

Sally's story then continued with:

As Sally attempted to engage the patients in a lesson about the rainforest, the eleventh grade patient decided to flip a table, ran over to Sally's cart, stole a small stapler and inserted it into his anus. Sally then hurried the other patients out of the room and proceeded to reprimand the staff person who brought this particular patient to the kitchen classroom. Sally reprimanded the staff person in front of the other patients and the Charge Nurse who immediately called Sally's supervisor.

Sally had a reaction to the behavior of her patients as well to the milieu therapist who brought the patient into the room. Sally encountered patient violence which is consistent with the participants in this study and can be viewed through global theme two, *safety*, and particularly subtheme 2b) *anticipating violence from patients*. The previous text could also be viewed through the lens of global theme one, *relationships* and in particular, subtheme 1f) *relationships with milieu therapists*. Sally became upset with the milieu therapist who brought the patient into the room. There is consistent and similar frustration from the subjects in this study towards the milieu therapists as illustrated by one educator who stated:

"I feel that they're not our always best of friends. They're the ones who are supposed to be there to help us with the patients, and sometimes I feel like they're there for more social reasons, for themselves."

Sally's story then continued with:

After school ended for the morning, Sally's supervisor called Sally into her office and attempted to have a discussion about the incident. At this point, Sally became belligerent and referred to the Charge Nurse as "that bitch" and stated "If she has a fucking problem with the way I do things, then let that bitch tell me." Sally also shouted at her supervisor by saying "I don't give a shit about this anymore," stormed out of the room, slammed her supervisor's door and screamed "Fuck her!" Within thirty minutes, Sally, a twenty-three year special education teacher veteran and former special education supervisor at a public school, who had been working in the psychiatric hospital for five months, was terminated for her behavior.

Within the previous text, Sally's supervisor attempted to address the event with Sally. Addressing the event through processing and problem solving would have allowed Sally to cope with and get a better understanding of the situation, thereby minimizing stress and emotional exhaustion (Kleespies & Dettmer, 2000). Unfortunately, Sally was unable to process and problem solve as her actions led to her termination.

Conclusion

Reflecting upon Sally's story and the lived experience of educators in this study lend to the conclusion that educating within an acute care psychiatric facility can be a stressful and highly emotional experience. The four emergent themes from this study and their 17 subthemes provide guidance and insight for an educational leader. The themes suggest that an educational leader within an acute care inpatient psychiatric facility focus on processing events and expectations with educators, advocate for their needs, maintain and develop a healthy workplace environment and build from areas of strength, such as a strong sense of collective professional efficacy. The educational leader should build upon these themes through systematic, cultural and climate changing actions that address and serve the holistic needs of educators within an acute care inpatient psychiatric facility while never forgetting the primary goal: providing the highest quality of education to patients.

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Appendix A

Recruitment Letter

William Davies
Doctoral Student and Principal Investigator
Duquesne University
412.246.5173

To Whom it May Concern:

We are conducting a research study that looks at experiences of special educators who teach within an acute care psychiatric facility. Since you are currently teaching within Western Psychiatric Institute and Clinic, you are eligible for this study. For the interview, you will be asked questions such as, "describe your typical day," "what do you like about your job" and "how do you feel at the end of the workday?"

The study involves an interview with a Research Specialist who will ask you questions related to your work experience. The interview will last approximately 45 minutes to an hour. If you are interested in participating, please contact Laurel Person Mecca at The University of Pittsburgh's Qualitative Data Analysis Center at 412.624.1613. You may also contact me with any additional questions at 412.246.5173.

Sincerely,

William Davies

Appendix B

Consent Form

DUQUESNE
UNIVERSITY

INTERDISCIPLINARY DOCTORAL PROGRAM FOR EDUCATIONAL LEADERS
CANEVIN HALL

600 FORBES AVENUE
PITTSBURGH, PA 15282
TEL 412.396.4038
FAX 412.396.6100
idpel@duq.edu
www.education.duq.edu/idpel

CONSENT TO PARTICIPATE IN A RESEARCH STUDY

TITLE: The Lived Experience of Educators within
an Acute Care Inpatient Psychiatric Hospital

INVESTIGATOR: William Davies

ADVISOR: The advisor for this research is Dr. James Henderson in the
School of Education at Duquesne University. This research
fulfills
the dissertation requirement for the degree of Doctorate of
Education in the Interdisciplinary Doctorate of Education for
Educational Leaders program at Duquesne University.

SOURCE OF SUPPORT: This study does not have a funding source.

PURPOSE: You are being asked to participate in a research study that
seeks to
understand the experience of educators within an acute care
inpatient psychiatric hospital.

YOUR PARTICIPATON: You will be asked to participate in the following procedure:
-One audio taped interview that will take approximately 45
minutes to an hour.
This is the only request that will be made of you.

101

RISKS AND BENEFITS: Your participation will expand the understanding of what it means to educate children and adolescents within an acute care inpatient psychiatric hospital. While there is a potential risk of a breach of confidentiality, as you are a colleague and supervisee of the student investigator, the following steps were implemented to protect your confidentiality:

1. A research team from the University of Pittsburgh's Qualitative Data Analysis Center is being utilized to conduct the interviews.

2. Identifying material of you or anyone you speak about will be deleted by the transcriber and will not be available to the student investigator.

3. All data will be stored and therefore destroyed by the Qualitative Data Analysis Center.

There are no known risks beyond those of everyday life.

COMPENSATION: Participants will not be compensated. Also, this study will not be of monetary cost to you.

CONFIDENTIALITY: Any identifying material of you or anyone you speak about will be deleted from the transcripts. Subjects will be identified by a number to keep identities confidential. All consent forms, written materials and audio recordings will be stored in a locked space within the research specialist's center and will be destroyed two years post completion of the data gathering. Identifiers will be removed during transcription by a transcriber but de-identified transcripts may be quoted in the dissertation.

In addition to the investigators listed on the first page of this authorization (consent) form and their research staff the following individuals will or may have access to identifiable information related to your participation in this research study:

102

Authorized representatives of the University of Pittsburgh Research

Conduct and Compliance Office may review your identifiable research information for the purpose of monitoring the appropriate

conduct of this research study.

RIGHT TO WITHDRAW: You may withdraw from the study and you may choose to withdraw your data at anytime.

SUMMARY OF RESULTS: If requested, a summary of the results of this study will be provided to you at no cost. The results will be provided to you by the University of Pittsburgh's Qualitative Data Analysis Center.

VOLUNTARY CONSENT: I have read the above statements and understand what is being requested of me. I also understand that my participation is voluntary and that I am free to withdraw my consent at any time, for any reason. On these terms, I certify that I am willing to participate in this research project. I understand that should I have any further questions about my participation in this study, I may call the student investigator, William Davies (412-246-5173), Dr. James Henderson, Advisor and Chair for this Study (412-396-4880), or Dr. Paul Richer, Chair of the Duquesne University Institutional Review Board (412-396-6326).

_____   _____

Participant's Signature   Date

_____   _____

Researcher's Signature   Date

Appendix C

Interview Questions for Participants

Interview Guide

Participant Research Number: _____   Date: _____
Interview Location: _____   Interviewer Initials: _____
Start: _____ End: _____

Thank you for participating in this interview. We are trying to understand what it is like for you to work in this setting….*Please feel comfortable to stop me at any time if you need a break.*

 Background Questions
       1.   What is your educational background?
       2.   How long have you been in the field of education?
       3.   How long have you worked in this setting?
Open-ended Questions: (follow leads and ask for examples when possible)

1. Describe your experiences during a "typical" work day….. start at the beginning of your work day…(include examples)

If Not described:
       1a. How do you usually feel at the beginning of a work day?
          1b. What events/experiences happen as the day goes on?
       1c. How do you usually feel at the end of a work day?

2. How do you usually feel at the end of a work <u>week</u>?

3. Can you describe the best part of your job?

4. Can you describe the worst part of your job?

5. Tell me about your work group_____

6. Looking back, how would you describe about your whole work experience here?

       6a. Is it what you expected when you were hired?

7. Are there any changes that would you like to see here in the future to make it a better place to work?

  Thank you for your participation and for your time.

Appendix D

List of Codes and Code Definitions

DAVIES *INPATIENT PSYCHIATRIC EDUCATORS* CODES

1. <u>Acute Care Education~Description of the Field</u> – Any references to the educator's understanding of the general field of working as an educator in an acute care inpatient psychiatric hospital, including thoughts on trends, staff turnover, direction of the field, culture of/attitudes within the field, etc. Can also include references to the differences between the WPIC school system and either the patients' regular school system or outside school systems at large. Consider applying this code when there is discussion of the changing dynamics inherent in the WPIC system (patients entering/leaving treatment, irregular schedules, etc.).

2. <u>Adverse Events</u> – References to those instances when the educator must deal with a patient who is acting out, having difficulty following directions, in a state of distress, etc. These instances either can be personally experienced or typical within the setting, and the effects can be isolated to the patient or be extended to the classroom setting at large or staff at large. Can also be applied to discussions of how volatile situations are defused. Look for specific examples when applying this code.

3. <u>Available Resources</u> – References to the tools the educator has at his/her disposal. This can include meetings spaces, sufficient supply of materials/lack thereof (amount, quality, appropriateness), types of materials (e.g., "safe" items vs. those that could be used as weapons), as well as substitutions and those ways by which the educator learns to improvise.

4. <u>Background~Professional, Pre-WPIC</u> – Any references to the educator's professional experiences before working at WPIC; e.g., working in the public school system or working in a hospital setting.

5. <u>Burnout</u> – References to the educator exhausting his/her energy and resolve in the course of working in the acute care inpatient psychiatric hospital setting. Examples can include burnout as related to putting in overtime, as related to any ambiguity the educator feels regarding his/her role and/or degree of autonomy (including conflicts that arise as a result), as well as how burnout might be related to the educator's social support network.

6. <u>Conflict between Educational and Medical Model</u> – References to the struggle of accomplishing educational goals within what is essentially a non-educational setting, and the overarching reality that the work occurs in a hospital setting and not a school setting, and the consequences that result.

7. <u>Coping Mechanisms</u> – References to anything the educator does in order to successfully work in the chosen setting, with regards to energy, peace of mind, burn out, "sense of balance," stress, etc. This can include those done at work as well as those done outside of work.

8. <u>Corporate Atmosphere</u> – References to the idea of WPIC as a faceless entity (the "system"), and the "corporate culture" that seems to influence decisions. Can apply when discussion conveys a sense of maintaining "the bottom (financial) line."

9. <u>Desired Changes</u> – Any references to those aspects of the work that the educator would like to see changed. This can be for any number of reasons (good of the program, good of the patients, good of the team, good of the general environment, personal benefit). Look for specific examples when applying this code.

10. <u>Efficacy</u> – Any references to the educator's sense of "making a difference" through the work he/she does. This can be both personal and professional in nature, and also can be related to either a single student or the collective at large (hospital, program, floor, etc.).

11. <u>Effort Reward Imbalance</u> – Any references to inequalities the educator experiences in terms of a cost/benefit-type ratio. Likely examples include pay, the amount of time and effort the educator puts into working with patients vs. the actual outcome of that effort, and any other inequities where the educator "gives" more than is "received."

12. <u>Expectations at Hire</u> – Any references to what the educator might have expected from the job prior to being hired, and how these expectations might or might not have been met (this can include unforeseen positives as well as unforeseen challenges).

13. <u>Feelings~Beginning of Work Day</u> – References to thoughts and feelings the educator typically experiences at the beginning of an average work day.

14. <u>Feelings~End of Work Day</u> – References to thoughts and feelings the educator typically experiences at the end of an average work day.

15. <u>Feelings~End of Work Week</u> – References to thoughts and feelings the educator typically experiences at the beginning of an average work week.

16. <u>Hypervigilance</u> – References to any feelings of always having to be "on" while at work, and never turning one's back or letting down one's guard. Can also be applied to discussion of a heightened sense of awareness or alertness to avoid students self-injuring or injuring others (including the teachers themselves).

17. <u>Motivations for Teaching</u> – References to the educator's passion for choosing this type of work, and what intrinsically drives him/her in working with the patients. Note: do not apply this code when instructors simply discuss the aspects of their job that they find enjoyable.

18. Other – Any substantive comments which do not easily fit into any of the other code definitions. Always be sure to add a comment when applying this code. Any references to the educator's relationship with the outside school system could be captured here.

19. Negative – References to anything the educator identifies as a negative aspect or a challenge of his/her current position. This can include day-to-day frustrations (failing equipment, classroom interruptions, insufficient teaching space), strains on energy/resolve (both personal and in others), conflict (between educator & patients or educator & various staff, either day-to-day or isolated extreme examples), etc. This code also can be applied to discussion of "the worst part" of the teaching day. NOTE: This code will tend to co-occur with other codes that address more specific aspects of the educator's experience, such as Available Resources, Daily Routine, Relationships codes, etc.

20. Positive – References to anything the educator identifies as a positive aspect or highlight of his/her current position. This can include anecdotes, reasons for continuing to work in the field, take-away lessons and insights, pleasant surprises, motivators, camaraderie with patients and/or other staff/team members, etc. This code also can be applied to discussion of "the best part" of the teaching day. NOTE: This code will tend to co-occur with other codes that address more specific aspects of the educator's experience, such as Available Resources, Daily Routine, Relationships codes, etc.

21. Relationships~Administrators – Any references to how the educator views his/her relationship with administrators (e.g., program directors or other hospital administrators) in the acute care inpatient psychiatric hospital setting.

22. Relationships~Fellow Teachers – Any references to how the educator views his/her relationship with fellow teachers in the acute care inpatient psychiatric hospital setting.

23. Relationships~Medical Staff – Any references to how the educator views his/her relationship with medical staff (doctors, nurses, psychiatrists/psychologists) in the acute care inpatient psychiatric hospital setting. Medical staff are considered members of the treatment team.

24. Relationships~MT's – Any references to how the educator views his/her relationship with Milieu Therapists in the acute care inpatient psychiatric hospital setting. This code is relevant whenever there is discussion of patients being moved from/returned to the classroom, or being moved around the facility, as well as to their general observation ("watching over the patients"). Note that there is always an MT in the classroom.

25. Relationships~Patients – Any references to how the educator views his/her relationship with his patients, in terms of care, guidance, expectations, and any

theories, beliefs, or philosophies to which the educator subscribes regarding how the patients should be approached and handled. Allusions to the quality of the relationship is a key component of this code.

26. Relationships~Social Workers – Any references to how the educator views his/her relationship with social workers in the acute care inpatient psychiatric hospital setting. Social workers are considered members of the treatment team.

27. Sleep Disturbance – References to how the educator's sleep/restfulness is impacted negatively by the work environment; e.g., nightmares and difficulty sleeping.

28. Stress – References to the stress and the emotional/mental toll that the educator experiences in the course of working both with patients and with "the system" (can be specific team members or simply the larger culture). Commonly associated words/phrases include (but are not limited to): tension, burnout, exhaustion, anxiety, worry, strain, fatigue, pressure.

29. Target Population – Any descriptions of the patients. This can include patient ages, grade levels, and diagnoses/disabilities. If the educator is relaying a story about a particular patient and uses specific descriptive information, be sure also to apply this code. Consider applying this code when there is discussion of the changing dynamics inherent in the WPIC system (patients entering/leaving treatment, irregular schedules, etc.).

30. Workplace Bullying/Horizontal Violence – References to conflict that occurs among various team members in the workplace setting, often with the educator feeling underappreciated, disrespected, overly scrutinized, and undermined with regards to authority. Conflict can occur either hierarchically (administrators to educators) or laterally (team members across different departments). Conflict can be either subtle or overt.

Appendix E

Full and Final Kappa Report

Code	Coder 1	Coder 2	Exact Match	Overlap	Kappa	Kappa (inc. Overlap)
Adverse Events	29	42	6	28	0.09	1.03
Available Resources	36	35	11	20	0.18	0.65
Background~Professional, Pre-WPIC	6	13	1	4	0.06	0.33
Burnout	25	38	4	17	0.07	0.47
Conflict Ed.and Med	79	69	20	47	0.16	0.73
Coping Mechanisms	12	18	3	7	0.11	0.37
Desired Changes	20	16	7	9	0.24	0.79
Efficacy	22	17	5	7	0.15	0.35
Effort Reward Imbalance	7	6	1	4	0.08	0.42
Expectations at Hire	7	9	3	6	0.23	0.85
Feelings~Beginning of Work Day	5	8	3	4	0.30	1.00
Feelings~End of Work Day	6	7	3	2	0.30	0.50
Feelings~End of Work Week	7	9	3	6	0.23	1.23
Hypervigilance	12	16	2	6	0.08	0.31
Motivations for Teaching	3	19	1	2	0.05	0.19
Negative	97	102	29	63	0.17	0.78
Positive	75	83	32	43	0.25	0.78
Relationships~Fellow Teachers	21	21	8	8	0.24	0.53
Relationships~Medical Staff	41	36	10	27	0.15	0.81
Relationships~MTs	31	20	5	14	0.11	0.61
Relationships~Patients	31	50	8	23	0.11	0.66
Relationships~SWs	20	16	4	10	0.13	0.50
Sleep Disturbance	1	1	0	1	0.00	0.50
Target Population	50	42	7	24	0.08	0.40
Workplace	14	15	2	7	0.07	0.41

Bullying/Horizontal Violence						
Totals	**657**	**708**	**178**	**388**	**0.15**	**0.61**

Appendix F

Frequency Chart

Acute Care Education~Description of the Field	Adverse Events	Available Resources	Background~Professional, Pre-WPIC	Burnout
Interview 1- 9	3	16	4	0
Interview 2- 11	10	7	6	7
Interview 3- 14	3	11	3	6
Interview 4- 10	16	17	2	4
Interview 5- 21	4	5	1	1
Interview 6- 21	35	15	3	0
TOTALS: 86	71	71	19	18

Conflict between Educational and Medical Model	Coping Mechanisms	Corporate Atmosphere	Desired Changes	Efficacy	Effort Reward Imbalance	Expectations at Hire	Feelings~Beginning of Work Day
9	4	3	8	3	0	3	2
13	3	2	5	3	6	2	2
6	11	2	7	8	0	2	2
7	7	8	5	10	4	2	2
9	0	1	4	8	0	4	1
7	5	2	7	7	3	3	4
51	30	18	36	39	13	16	13

Feelings~End of Work Day	Feelings~End of Work Week	Hypervigilance	Motivations for Teaching	Negative	Other	Positive	Relationships~Administrators
2	1	7	3	27	4	13	1
2	2	6	2	29	3	15	2
2	3	8	3	40	4	20	2
2	3	3	1	48	7	18	5
1	2	0	3	21	14	41	1
4	5	4	10	34	21	51	2
13	16	28	22	199	53	158	13

Relationships~Fellow Teachers	Relationships~Medical Staff	Relationships~MT's	Relationships~Patients	Relationships~Social Workers	Sleep Disturbance	Stress
3	12	9	12	11	0	4
0	6	3	8	1	2	11
9	9	10	13	8	0	13
11	14	11	12	6	0	14
6	18	9	14	9	0	0
13	18	9	22	1	0	6
42	77	51	81	36	2	48

Target Population	Workplace Bullying/Horizontal Violence	TOTALS:
11	5	189
24	2	195
11	6	236
11	9	269
14	0	212
21	7	340
92	29	1441