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Boredom in the workplace: A qualitative study of psychiatric nurses in Greece

by

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ABSTRACT

Boredom has been a concept rather neglected by organizational psychology. For some scholars boredom is an emotion limited to jobs that entail repetitiveness, monotony and standard procedures or more simply to blue-collar work. Therefore, boredom is not a feeling but a characteristic of particular jobs. However, disciplines in psychology (personality and individual differences psychology and cognitive psychology) as well as sociology have proved that boredom may inflict anyone who has certain predispositions/ personality or works in a setting that "promotes" such emotions.

The purpose of this thesis is to identify and investigate whether and how boredom is expressed among professionals and in a work-setting that may be characterised as challenging. The sample consisted of psychiatric nurses of a Greek mental hospital.

The use of qualitative methodology helped not only in the identification of boredom, but in providing a holistic account of this suppressed emotion. Field-work was carried out within a six-month period, in which 20 psychiatric nurses were interviewed (both formally and informally) and observed while working. The prolonged time spend in the field provided the opportunity to learn about the rituals, procedures, language, behaviours, emotions and beliefs about the life in the psychiatric hospital as described or exemplified by nurses.

The results of the study indicate that boredom is not a private emotion, but an emotional construct that is developed gradually over time and through various intermingling factors (personal-group-organizational). The findings support the notion that work-boredom is not confined into the strict boundaries of task attributes or personality characteristics and is not a straightforward emotion like dissatisfaction. Rather, it is an emotion that may be expressed in diverse and even contradictory forms (apathy or hostility), as a short-term emotional reaction against specific job features or as prevalent mental state attributed to the broader work environment.

Boredom proves to be an "interesting" subject for inquiry because of the contradictions, the variability and the complex mechanisms that underlie it.

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1.1. Presenting Boredom & Research questions

"All human action stems from the need

not to feel bored" Pascal

"All paid jobs absorb and degrade

the mind" Aristotle

The above quotations show explicitly the ambivalent feelings that are stirred by work. Western civilization has set up a *modus vivendi* characterised by a continuous striving for progress and affluence, both results of hard work. Apart from the tangible gains (survival, economic and scientific growth) work has also been attributed with psychological as well as ethical benefits. Psychologists have often discussed the significance of work as a means toward self-fulfilment (Maslow 1970) or as a factor for developing a stable and healthy personality (Erikson 1959). Self-actualization (Rogers 1967), self-efficacy (Bandura 1997) and finding a meaning in one's life (Frankl 1984) are some of the positive outcomes deriving from work. Those notions were further enhanced by religious principles regarding work as a basic human virtue contrasted to sloth and apathy which are seen as sins (Dante, Genesis 440bc).

But do all kinds of work lead to self-actualization, do all people find their jobs meaningful and lastly, are the above sufficient preconditions for a motivating and enjoyable working life? Moreover, if we accept the philosophical statements quoted at the beginning then work is not an ideal in its own right but rather a necessary fact of life which can induce negative emotions and degradation.

The argument that will be presented here should not be regarded as an attack against work, since its necessity and utility are indisputable. Rather it will be an attempt to provide a further insight into the reality of working life. The starting point of the research was a previous project conducted for my MA dissertation (Loukidou 2003). During field work, that took place in a psychiatric hospital in Greece, a first observation was that the target group (nurses) did not carry out any more work than what was absolutely necessary and spent most of the working time socializing with each other. The additional negative comments concerning the work itself and the hospital as an institution, evoked questions about the aetiology of nurses' negative affect and lack of organizational citizenship behaviour.

Such behaviour could be easily identified as job-dissatisfaction, lack of involvement and motivation, a stress coping strategy or a passive way to express resentment against the work, the management or the hospital as a whole. However what was recognised as the prevalent feeling was boredom that was manifesting itself in the way nurses "dragged" themselves to perform their routine tasks and in the disproportionate allocation of time between work and breaks. From those impressions the present research questions were formed: are people simply bored in their jobs and if yes why and what aspects of work induce such a feeling?

Past research and literature in human resources management and occupational psychology have tackled similar issues and this comprises the problem for this project. Is boredom an autonomous, separate emotion that needs to be studied on its own or does it share too many similarities with other already investigated feelings (such as lack of motivation, involvement, satisfaction etc.)? Is boredom an emotion irrelevant to work? Are the two terms (boredom-work) contradictory and one cannot exist in the presence of the other? Can boredom at work be merely considered an outcome of the absence of the previously mentioned factors? In order to answer these questions we need to review the literature and investigate what boredom is, how is it expressed in organizational settings and why it occurs.

Unfortunately there is no single definition of boredom. Not only is there incongruence between different theoretical perspectives (psychology, sociology, organizational psychology) but there is also little agreement within these perspectives (Fisher 1993, Damrad-Frye & Laird 1989). In work settings, boredom is viewed in cognitive terms such as lack of sustained attention on a task, excessive or little stimulation (Leong & Schneller 1993, Klapp 1986) and lack of interest (Sansone, Weir, Harpster & Morgan 1992). Sociological theories use more abstract terminology such as sense of futility (Brissett & Snow 1993), of absence of goals or meaningless goals and of inability to perform according to one's own personal and professional standards (Darden & Marks 1999).

The absence of a concrete definition may, at least partially, be due to lack of empirical data. Most studies on boredom were conducted in the shopfloor, with blue-collar workers as participants (Smith 1981). There are few projects involving professionals but they are of little magnitude and coherence and do not encounter the setting or the organization as a relevant variable. Can we assume that non-

manual work can offer individuals enough intellectual stimulation so as not to experience boredom?

Having this in mind, the selection of the setting and of the professional group is grounded on the following conditions:

- A setting that is tolerant of the free expression of employees' emotions.
- A type of work that requires advanced qualifications and skills and that involves variety.

The public sector services provide a good framework for the study of boredom because of two basic characteristics: the first one concerns the contrast between formal and informal behaviour that is often observed in bureaucratic structures. Many studies have demonstrated that work behaviour (especially in the service sector) does not always coincide with the rigid rules of the organization (Heffron 1989). Apart from this general concept that applies to most public sector organizations, public hospitals acquire another distinct characteristic. This regards their categorization as professional bureaucracies (Heffron 1989, Germov 2005), which signify that the structural and normative features of the organization co-exist with the norms and standards of particular professions (eg. medical, psychiatric, nursing etc.). Therefore, the contrast between the formal and informal behaviour, may be enhanced by possible clashes between the organization and the hosted professions (Mintzberg 1979, Heffron 1989, Brazier 2005). This can result in power struggles with various emotional manifestations.

The second feature of public sector organizations concerns the work conditions they foster. They provide relatively secure employment that could be accountable for any misbehaviour and underperformance (Vigoda 2000), the opportunities they offer for career- advancement are limited that can hinder motivation and the extracted effort (Nabi 2000) and lastly, they do not adopt a client-based orientation (Zammuto & Krakower 1991, Want 2003) that could motivate employees. Since employees are not at risk of being redundant, are aware of their restricted career-promotion opportunities and their performance is not assessed by client-criteria, they can easily under-perform without any costs. Such features have resulted in common assumptions about public sector employees being "lazy" and doing nothing more than the absolutely necessary (Pipan 2000). In a climate with some degree of latitude for personal expression, it would be interesting to find out if the use of that freedom was such that it provided boredom.

Since Greece is a country whose economy relies still and to a great extent on public sector (Sotirakou & Zeppou 2005), it is justifiable to select it as the broad context for gathering data. Most importantly there is a "public sector culture" which manifests itself in many forms: quality of services, long work breaks, failure to hold on to work hours etc. Furthermore the public sector is considered a setting that demands little from employees, offers security (Sotirakou & Zeppou 2005) but on the other hand it is not suitable for people with high career aspirations since promotion takes time and does not always depend on personal accomplishments (Sotiropoulos 2004). Although this is a common knowledge in Greece, it is an informal reality that has to be experienced in order to be recognised. The possibility for a cross-cultural study (for example G.Britain-Greece) was abolished due to basic structural differences in the organization and management of public sector in the two countries and the researcher's unfamiliarity with the British culture.

Psychiatric nursing was selected as the context of this thesis. This was based on two criteria: first, having met the primary condition of including professionals, psychiatric nursing also includes the element of "variety". As we will discuss later on, psychiatric nurses engage in a variety of tasks ranging from offering medical and psychological support to patients to the organization and management of a specific ward.

A second determinant for selecting psychiatric nursing as the basic unit for investigating boredom, was the contradiction between the "public sector culture" and the "caring ethos" that this profession advocates. Can nurses, as public employees, afford to feel bored with their work? What are the reasons that might lead them to feel bored since there is "variety" in their job? How does this comply with the moral standards that their professional status would suggest?

Given the lack of a consistent definition of boredom, the absence of empirical data deriving from research on professionals and the negative connotations that the word boredom inflicts on people, the selection of qualitative methodology seemed inevitable. Observations and un-structured interviews constitute the methods for acquiring data. It was expected, that there would be a certain difficulty in making employees reveal their feelings about the job and the setting, but hopefully this would be overcome by the long presence of the researcher in the field.

To summarize, the aims and aspirations of this thesis are to:

- explore boredom in a occupational setting other than a factory
- investigate the factors that might evoke feelings of boredom
- investigate how boredom manifests itself

More specifically, the intention is to find out how the setting (public psychiatric hospital), the job (nursing) and the interaction of the two might induce feelings of boredom in employees.

1.2 Outline of the thesis

The outline of the thesis will follow as such: in the second chapter it is presented a review of the existing literature on boredom. Focus has been placed upon theories of organizational psychology, as they are directly associated with the project. In order to obtain a more holistic understanding of the phenomenon the review also encompasses the views of personality and individual differences psychology, cognitive psychology and sociology.

The third chapter provides a basic description of the psychiatric nursing profession. Due to space limitations, the depiction of psychiatric nursing is general including only the basic facets, which are: status, ideology, emotional labour, duties-practice and the hurdles that it faces.

Chapter 4 reviews the broad work context that is public mental hospitals. It draws upon literature on public organizations and on the impact of their characteristics on employees.

In the fifth chapter, an analysis is presented of the Greek public sector and of the mental health care context.

Chapter 6 outlines the methodological approach adopted in this study.

Chapters 7 through 12 are the analysis chapters.

In chapter 13, the thesis is discussed.

Chapter 2: Boredom

2.1. Introduction

Boredom has been the subject of inquiry for diverse theoretical disciplines. From philosophy (Durkheim 1972[1893], Sartre 1947) to psychology (Vodanovich & Kass 1990) and from sociology (Marx 1967[1844], Barbalet 1999) to management (Hackman & Oldham 1976), boredom is accounted for deficiencies and detriments of individuals, societies and organizations. Depending on the theoretical assumptions and principles of each discipline (and many times within the same discipline) the causes, manifestations and results of boredom differ immensely, thus creating a blurred picture of what exactly is boredom (Balzer, Smith & Burnfield 2004).

As it is seen though boredom was not entirely neglected, it has not been given the appropriate attention and interest (Smith 1981, Fisher 1998). Various reasons account for this lack of data. The first and most prominent one is the absence of a robust and coherent definition. Theories regarding the nature of boredom have dealt with it as an emotion, as a mental state and as a drive. Furthermore, depending on these initial categorizations, boredom may be viewed as an inherent individual characteristic, as a transient or more pervasive feeling or as a motive. The immediate implication of this confusion is a divergence in the search for causes and outcomes. Hence, psychoanalysis may be looking for childhood traumas (Wangh 1975, Fenichel 1957) whereas personality and individual psychology may be attributing boredom to specific characteristics such as extraversion (Hill 1975, Mackworth 1969), while organizational theories will be examining job features (O'Hanlon 1981).

Why, however, is so hard to define boredom? Why there is such contradiction within and among theories? Is boredom a consequence, a defence mechanism to stress or is it an antecedent to it? The difficulty in answering these questions lies in the complexity of observing and measuring boredom. The identification of boredom lies either mostly in verbal expressions (Hill 1975, Darden & Marks 1999) or in indirect measurements of its outcomes, such as lapses of attention (Dyer-Smith & Wesson 1995, Damrad-Frye & Laird 1989). Moreover, the similarities of boredom with other emotions and mental states such as fatigue, sleepiness and depression make boredom rather difficult to recognise.

An additional obstacle to the investigation of boredom is the negative connotations that are associated with it. Somehow boredom has come to be regarded as a

personal failure or deficiency (Darden & Marks 1999). The origins of such belief will be briefly presented here as it is not among the purposes of this paper. Religion (especially Christianity, in particular Protestantism) has placed extreme importance to the advantages of work, hence making idleness and boredom sinful attributions (Gemmill & Oakley 1992). The industrial revolution has further "substituted" religious beliefs, in placing work and progress as society's objectives and individuals who failed to follow were condemned. In recent times, the affluence of stimuli that can be easily reached and that match every taste and interest, boredom cannot be easily admitted or even more does not fit in. The investigation of boredom has been also limited due to the culture or image that organizations attempt to present. As Garsten (2005) identified in her study in Apple computers, boredom was not supposed to be felt, let alone shown, in a company that promoted a creative, dynamic and challenging profile. In other words boredom may be seen as an "insult" (Garsten 2005, p.11) to the organization and therefore not eligible to be experienced. According to Mann (2007) boredom is the second most commonly suppressed emotion at work.

Why should we then investigate a phenomenon that has inherent difficulties? Various studies have shown the significance of boredom, through its relations with undesirable behaviours, like alcohol and drug abuse (Samuels & Samuels 1974, Johnstone & O'Malley 1986, Greene, Kremar, Walters, Rubin & Hale 2000), eating disorders (Abramson & Stinson 1977, Leon & Chamberlain 1973, Ganley 1989), juvenile delinquency (Brisset & Snow 1993), poor school performance (Maroldo 1986, Robinson 1975). In the domain of work boredom has been associated with low satisfaction (Gardell 1971, O'Hanlon 1981, Kass, Vodanovich & Callender 2001) and performance (Wyatt et al.1929, O'Hanlon 1981), increased accident rates (Branton 1970, Drory 1982), absenteeism (Saito, Kishida, Endo & Saito 1972). However, research on work boredom has generally failed to include professionals and was mostly preoccupied with shop-floor workers. Two recent publications in the mass media have redirected the interest on boredom from the factory to the management "suites". The first one is by Amy Joyce and was published in the Washington Post (August 2005) under the title "Boredom numbs the work world" and the second one is by David Bolchover "The living dead: Switched off, zoned out: the shocking truth about office life" (2005). Both writers refer to employees who use a vast range of methods in order to cope with boredom (from surfing the web or reading books to actually leave the workplace while on duty). The staggering fact of both reports is that they encounter jobs which otherwise are thought as well paid and socially valued.

2.2. Organizational Psychology

Following the long tradition of objectification and measurement in psychological research, studies in organizational psychology were based on quantitative methodologies and on strict conceptualizations of boredom (Guest, Williams & Dewe 1978). The focus was placed on measurements of output, errors, attentional failures and accidents as they occurred within specific timings and in relation to repetitive or monotonous tasks (Smith 1981). Feelings of boredom were usually identified by statements regarding the interest of the activity or by one point scales (Guest, Williams & Dewe 1978). Another characteristic of those studies were the samples used. Mostly factory workers, employees in repetitive jobs and students constituted the research subjects. Within this methodological framework boredom has been identified as "a psycho-physiological state that is produced by prolonged exposure to monotonous stimulation" (O'Hanlon 1981, p.54). According to this definition the main cause of boredom is external to the individual and attributed to task or job characteristics. The physical dimension of boredom is comprised of two interrelated mechanisms: "the inhibiting cortical arousal (habituation) and the compensatory process elicited to restore arousal to an optimal level for task performance (effort)" (O'Hanlon 1981, p.76). The emotional component of boredom includes disinterest and dissatisfaction with the monotonous elements of the situation that are identified by the individual as the source of the feeling (O'Hanlon 1981). From this definition four basic features of boredom can be deduced: repetition, habituation, dissatisfaction and effort. Despite the significance of those constituents, future research has shown that the presence of those variables does not necessarily result in boredom and furthermore they oversimplify an emotion and its causes (Guest, Williams & Dewe 1978, Perkins & Hill 1985).

Focus of early studies on boredom was exclusively placed on monotonous tasks in industrial settings. According to O'Hanlon's (1981) categorization those tasks involved mechanical assembly, inspection and monitoring and continuous manual control. To a large extent researchers were preoccupied with measurements of output and errors as they occurred in specific and predetermined times. Findings of those primary studies could be summarized in the negative relationships between boredom and: work output (Wyatt 1929, Wyatt, Fraser & Stock 1927), fault detection (Wyatt & Landon 1932) and deterioration in coordination (Bartlett 1943). Observations regarding individuals' reactions to the boring or monotonous task were also made, although they were contradictory. For example Langdon and Stock (1937) found that workers tended to talk more and became restless toward the end of

their work day, whereas Barmack (1937, 1938) found that boredom was accompanying a tendency to revert to sleep or a sleep-like state.

The causes of boredom were attributed to measurable factors such as repetitiveness and monotony (Davies 1926, Bartlett 1943) and restriction of attention to un-motivating tasks (Barmack 1937). In congruence with the broader context of psychological research of the time, that demanded objective measurements of emotions and behaviours in order to be considered "scientific" (Smith 1981), those initial studies offered a basis for understanding work boredom, despite their limitations.

From the mid 1940s till 1950s research on boredom seemed to have been halted. However between 1950 and 1960 interest in boredom started to revive again and a few studies were conducted. The novelty of those studies lied in the inclusion of subjective factors rather than task related ones.

Smith (1953, 1955) replicated early research regarding industrial monotony and output, but failed to find a connection. Basing her study on the subjective reports of workers in highly repetitive jobs, she found that lower output was not attributed to boredom. Additionally and in confirmation of an earlier study conducted by Evans and Laseau (1950), she found that many workers enjoyed the repetitiveness of their work and did not feel bored. In contradiction to Smith's findings, Wendt (1955) found a negative correlation between boredom and performance, when high school students were required to perform an arithmetic task. Though both studies used subjective reports for identifying boredom, there were significant differences in the chosen samples, settings and tasks that restrict any comparison.

The link between boredom and absenteeism was introduced by Walker and Guest in 1952. The study, conducted in an automobile factory, identified workers' absenteeism as a result of boredom. However, much controversy was created in the two following decades regarding that relation. In opposition to the 1952 study, Kilbridge (1961) and MacKinny, Wernimont and Galitz (1962) found no relation between boredom and absenteeism, while the studies of Turner and Lawrence (1965) and Hackman and Lawler (1971) had contradictory findings. Nonetheless, the issue was revised by Saito and colleagues in subsequent studies (1972, 1973 and 1977) and the relation was confirmed.

During that time research on boredom proliferated and earlier findings regarding performance were confirmed and enriched (Mackworth 1969, Tickner & Poulton 1973, Thackray, Bailey & Touchstone 1977). A study that stands out from the bulk of research that was mainly preoccupied with monotonous jobs and tasks was conducted by Locke and Bryan in 1967. The researchers induced another variable in the study of boredom, that of performance goals. Although previous studies (Mathewson 1931, Smith 1953, Whyte 1955) have mentioned the relationship between workers' production and type of performance goal (whether it is just to end the shift or units accomplished within specific time) this research comprises a complete account on the influence of goals on the levels of performance and on boredom. It was identified that abstract goals decrease the level of interest in an activity whereas the contrary occurred with specific goals.

Identifying goals and absenteeism, respectively, as a cause and effect of boredom, research has broadened its scope. Boredom was now viewed as an emotion with a variety of possible sources and with more extended consequences (O'Hanlon 1981). The underlying question was whether the aversive feelings toward a monotonous task could be generalised to the entire work environment (O'Hanlon 1981). In order to explore the generalised effects and causes of boredom, researchers set out to determine the relationship between boredom and job satisfaction. Several studies have shown the relationship between boredom and job dissatisfaction. Gardell (1971) reported that workers who perceived their tasks monotonous were significantly less satisfied with life in general. The findings of a survey conducted with employees from various occupations (Caplan, Cobb, French, van Harrison & Pinneau 1975) also related boredom to overall job dissatisfaction. In more recent studies (Lee 1986, MacDonald & MacIntyre 1997, Kass, Vodanovich & Callender 2001) it was found a significant negative association between boredom and job satisfaction, with high bored workers being dissatisfied with various aspects of their job, such as nature of work, pay, promotion opportunities, supervision and co-workers (Lee 1986).

The major contribution of research during the 1970s and 1980s was the association of work boredom to health. Positive correlations between boredom induced by monotonous work and diseases or health-risk behaviours were identified in two studies. In the first one (Samilova 1971) it was reported that women who were doing repetitive jobs were at risk of suffering from cardiovascular disease, gastritis, diseases affecting the muscles and joints, more than women who were employed in less repetitive jobs. In the second study, Ferguson (1973) found that Australian

telegraphists, who perceived great monotony in their job, suffered from asthma, hand tremor, regular drinking and excessive smoking. In respect to mental health, studies have shown remarkable associations. Bored workers tended to score high in scales of neuroticism (Kornhauser 1965, Gardell 1971, Hill 1975, Nachreiner & Ernst 1978), experienced feelings of hostility (Kornhauser 1965, Broadbend 1979), depression (Caplan, Cobb, French, van Harrison & Pinneau 1975) and anxiety (Gardell 1971). In respect to anxiety and stress as causes of or related to boredom, theorists have not reached a definite conclusion. In his review of past studies, Thackray (1981) states that there is no support for such assumption. The reviewed literature consisted of laboratory and (a few) field studies on sensory deprivation, vigilance and industrial work. Measurements of stress were based on physiological indexes (heart rate, blood pressure etc.) in the laboratory studies and on behavioural indices (smoking, coffee-consumption, obesity) or on medical records of participants in the case of field studies. According to Thackray, limitations of past research were critical enough to question the association between boredom and stress. It is not clear whether boredom causes stress, however, one of the results of a relatively recent study on the influence of occupational prestige and work strain on mood (Matthews, Raikkonen, Everson, Flory, Marco, Owens & Lloyd 2000), was the relation between boredom and stress. The authors recruited 100 healthy men and women in job positions that varied, from professional and managerial (considered as high in occupational prestige) to technical and clerical (low in occupational status). Measurements involved diary entries of mood at specific intervals during work, at home and at the end of each day, interviews as well as cardiovascular measures. Boredom was reported when individuals experienced high work strain during the day and at their total evaluation of the whole day. According to the statistical analyses, boredom was caused due to work overload. An interesting finding of the study was that the negative mood and boredom generated from strain at work had a spill-over effect to non-work settings. It was not the purpose of the study to identify whether boredom was caused by stress, however, the findings suggest that there is a relation between the two.

Related to health damages associated with boredom, was Branton's (1970) study regarding accidents in the work setting. He found that tasks requiring repetitive motor activity led to timing errors which were causing accidents. In his two- year study, he reported 427 injuries. The importance of such findings is found on a re-conceptualization of work boredom. The former perception of boredom as a transient or superficial emotion was proven to be limited. Acknowledging the health variable,

the necessity for a more thorough investigation of boredom, its causes and its outcomes was brought forward.

The studies that followed were more sophisticated in respect to the variables included. Attempts to integrate job/task, environmental and individual characteristics were made that led to significant advances not only to the understanding of work boredom but to relative subjects such as work design, personnel selection and occupational guidance. Moreover, research was diverted from the industrial settings and started encompassing other occupations. This change was not straightforward, as theorists either studied boredom in artificial environments or in monotonous jobs (call centres). This was perhaps necessary in order to identify new factors before testing them in real settings. Despite this, the realization that boredom may be induced in different kinds of work was an important step ahead.

Environmental factors that were studied within the work domain were people and the type of organization. It was initially proposed that presence of other people while performing a boring task may alleviate boredom (Bond & Titus 1983). The classical study of Roy (1959-1960) and the "banana game" that workers played is a good example of how co-workers can help reduce the boredom inflicted by an un-stimulating work environment. More than reducing boredom, other people can function as a source of interest in an activity. In the study of Isaac, Sansone and Smith (1999) it was found that people with higher interpersonal orientation perceived a task as more interesting when in the presence of another person. This finding was also applied to people with lower interpersonal orientation, though to a significant lesser degree. However, the issue of social context and boredom cannot be regarded as a simple one. The theory of emotional contagion and research on emotions at work supports a more complicated view. Lee (1986) in developing a questionnaire to evaluate job boredom, found a negative correlation among boredom and co-workers, suggesting that other people can be a source of boredom instead of alleviating it. Moreover, research on interpersonal encounters (Leary, Rogers, Canfield & Coe 1986) concluded that other people can induce boredom due to their content (banal topics, egocentrism) and style (tediousness, passivity) of speech. Fisher (1987) as well found that a cause of boredom was "uninteresting, unfriendly or uncommunicative co-workers" (Fisher 1993, p.399). Co-workers may inflict feelings of boredom due to their negative views, opinions and attitudes towards the job/task (Weiss & Shaw 1979, Griffin 1983, Thomas & Griffin 1983, Zalensky & Ford 1990). The theory of emotional contagion supports the view that emotions may be spread

due to the human ability to mimic, to show empathy and to tune in with other peoples' emotional states (Kelly & Barsade 2001).

It is evident from the conflicting findings on the presence of others, that various moderators such as personality, discourse between workers, and group norms may play a vital role in determining co-workers' influence on boredom.

However, people do not act solely on their personal inhibitions, perceptions and emotions. Their environment affects both emotions and behaviour. Since work does not occur in a vacuum, but in a specific setting which has its own characteristics and fosters its own rules, procedures and norms, it is therefore necessary to draw upon organizational research in order to see the relationship between boredom and the work setting. According to Fisher (1993) organizations may provoke boredom in two ways: directly through their rules (limited talking, specific procedures to be followed and small breaks) that reduce the amount and variety of stimulation and indirectly by posing limitations in respect to activities and behaviour that are accepted. Garsten (2005) similarly suggests that boredom is cultivated in organizations due to inherent characteristics, such as rules, routines and repetition. Forbidden activities may become more desirable (Brehm & Brehm 1981) while the prescribed ones may be more difficult to attend to and hence more boring (Fisher 1993). This notion is in congruence with Fenichel's (1957) theory which suggests that boredom occurs when there are constraints on behaviour. In relation to the constraint of behaviour is the issue of autonomy. It is reported (Hackman & Oldham 1980, Naughton 1988) that jobs that are characterised by low autonomy may contribute to feelings of boredom. In the same vain, organizations that obtain very fixed procedures (e.g. bureaucracies) and do not allow for creativity, the opposite of compliance (Schubert 1978), have greater probabilities to impose boredom on their employees (Gemmill & Oakley 1992). However, there is also evidence for the opposite. Boredom may occur in jobs and organizations that permit autonomy and creativity, as in the case of mental health occupations. In a review regarding the psychiatric profession (Morrant 1984) it was proposed that psychiatrists may suffer of boredom, due to patients' behavioural characteristics (inability to give and receive love, show appreciation) or due to patients' slow progress. Moreover, Fisher (1993) contends that executives and professionals may also feel bored in their job despite the great levels of autonomy that may acquire. Equally people in repetitive jobs that do not possess any autonomy, may not experience boredom but satisfaction and content (Csikszentmihalyi 1975).

Studies in organizational psychology have provided significant information regarding the phenomenon of work boredom. Starting from industrial settings, researchers have identified three basic causes of boredom basically related to task and situational characteristics: monotony, repetitiveness and constraint. Later research has elaborated more sophisticated factors, such as goals, autonomy, co-workers, which could be easily applied to various occupations. In respect to the consequences of boredom, interest shifted gradually from performance levels to person related attitudes and behaviours. Lower output, performance declines, errors, accidents were some of the primary identified effects of work boredom. It was further recognised that boredom had a more pervasive impact on employees as it was express in increased absenteeism, lower satisfaction and physical and mental health problems.

The contribution of those studies is indisputable; however there are certain drawbacks that need to be further elaborated. A first opposition regards the attribution of boredom to situational factors. The exclusion of individual characteristics and perceptions, leads to oversimplification and more importantly it fails to offer an explanation of why boredom is experienced in the absence of those factors or why it does not always occur under their presence (Csikszentmihalyi 1975, Guest, Williams & Dewe 1978). A second argument concerns the methodological approaches of those studies. Boredom was measured by single-statement items or indirectly by measurements of attentional lapses, errors or interest in the activity (Balzer, Smith & Burnfield 2004). Sampling was another factor limiting the generalization of the findings. In its majority research was based on assembly-line workers and students, providing no empirical data for other occupations. The few surveys that included various professional categories failed to give deep and more detailed descriptions of the phenomenon.

Those limitations were partially corrected by personality and individual differences psychology which have provided additional information on how individual attributes and dispositions may affect perceptions of the job and consequently experiences of boredom.

2.3. Personality and Individual differences psychology

It is unanimously accepted that between the external environment/situation and the experience of certain emotions, individuals play the mediating but vital role. Though, as it is seen in the above review, it is more probable for specific situational

characteristics (monotony, repetitiveness) to induce boredom, personality and other individual characteristics will determine whether boredom will be experienced. In order to identify the individual factors that influence perception of a task and consequently emotions, research of that discipline was based on psychological tests and on experimental methodologies (Vodanovich & Kass 1990, Vodanovich, Weddle & Piotrowski 1997, Sansone, Wiebe & Morgan 1999). Most of those studies took place in universities with students as samples, while the few of them that occurred in work settings used solely blue-collar workers (Kass, Vodanovich & Callender 2001).

Theorists have attempted to identify personality traits that would make individuals more susceptible to boredom under specific work conditions. One of the most studied dimensions is extroversion-introversion. Theory suggests that extraverts are more likely to feel bored when engaged in simple, repetitive (Wyatt & Langdon 1937, Smith 1955, Hill 1975, Guest, Williams & Dewe 1978, Gardner & Cummings 1988) and in vigilance tasks (Davies & Hockey 1966, Mackworth 1969). These studies were based on the assumption that extraverts acquire lower levels of arousal and in order to maintain an optimum they need increased and varied stimulation (Eysenck 1967, Sharpless & Jasper 1956). Moreover it was also supported that when the task situation was enriched by other stimuli (noise) extraverts performed much better than introverts (Damrad-Frye & Laird 1989).

A first attempt to directly measure boredom susceptibility was made by Zuckerman (1979). He asserts that there is an optimal level of arousal which the individual wishes to maintain and which acts as a motivator (Zuckerman 1969). Based on that premise he developed the Sensation Seeking Scale in order to identify individuals with high optimal levels of arousal. He suggested that those people are more prone to boredom and he included a subscale named "boredom susceptibility". However, a more analytical and complete measurement of boredom as a personality trait was created by Farmer and Sundberg in 1986 (Vodanovich & Kass 1990). Their Boredom Proneness Scale is a 28-item self-report instrument that gives a single score based on true-false answers to the 28 statements. Vodanovich and Kass (1990) found that the scale is not unidimensional (as the single score suggests) but could be analysed in five factors: external stimulation- need for excitement, change and challenge, internal stimulation-ability to keep oneself interested and entertained, affective responses-emotional reactions to boredom, perception of time-use of time and constraint-reactions to waiting. Though Fisher (1993) argues that the correlation between the two measures (Zuckerman's and Farmer and Sundberg's) is not

significant, Vodanovich and Kass (1990) found content similarity among the external stimulation factor and Zuckerman's sensation seeking scale.

As Vodanovich and Kass (1990) suggest, the application of the Boredom Proneness (BP) scale in the work domain would provide useful information regarding personnel selection, occupational guidance, career planning etc. Subsequent research has focused on the relationship between BP scores and work variables.

A first study was conducted by Farmer and Sundberg (1986) in order to define the relationship between the BP scale and the Lee's Job Boredom scale (1986). The authors found a significant positive relationship among the two measures.

Boredom proneness was studied in relation to work values (Vodanovich, Weddle & Piotrowski 1997) which are categorised into extrinsic (attitudes to earnings, social status of the job, upward striving) and intrinsic (pride in work, job involvement, activity preference). The researchers found that individuals who scored high in the boredom proneness scale acquired higher external work value scores and the opposite (low boredom prone subjects had higher internal work value scores). The importance of that study lies in the implications to personnel selection and to the satisfaction and motivations used by organizations. Boredom prone people would be best suitable for jobs that provide external, tangible rewards and would be more affected by strategies that focus on external compensations rather than job enrichment programs. The predicting potential of the BP scale was also tested in a project at a manufacturing plant (Kass, Vodanovich & Callender 2001). The investigators distinguished boredom into state (a transient condition) and trait (a disposition) and studied their relationship to satisfaction, absenteeism and tenure. As it was expected workers who scored higher in both types of boredom, expressed more dissatisfaction with the work itself, pay, promotion, supervision and co-workers. Such finding is also supported by previous research on teachers and restaurant workers (Gould & Seib 1997), clerical workers (Lee 1986), workers in monotonous jobs (Gardell 1971) and other job categories (MacDonald & MacIntyre 1997). The study had an interesting finding in regard to the relationship between job-state boredom and tenure and absenteeism. It was indicated that high levels of job boredom were associated with longer organizational tenure and greater absenteeism. Drory (1982) also found in his study on truck drivers a positive relation among boredom and job tenure. This was explained by the opponent process theory (Landy 1978, Munchinsky 1987) which

states that prolonged exposure to the same stimuli leads to lower levels of arousal which further results to less satisfaction and boredom.

Other personality traits that have been investigated as related to boredom were: need of achievement (Wendt 1955) which was reported as reducing boredom when at high levels and dogmatism and low sociability (Leong & Schneller 1993) which were identified as factors contributing to boredom. Regarding dogmatism, a related study by Stagner (1975) concluded that workers with authoritarian traits may tolerate repetitive tasks better than others. Other personality characteristics that were studied in terms of their mediating role between boredom and performance were conscientiousness and hardiness (Sansone, Wiebe & Morgan 1999). The main finding of the above study was that conscientious people tend to be less bored and perform better in a monotonous task due to their high sense of duty and self-discipline. Csikszentihalyi (1975) introduced another personality dimension, in the theory of boredom. According to his beliefs, people with autotelic personalities, who are intrinsically motivated, are able to fully enjoy the activities in which they are engaged, even if those activities are considered mundane and tedious.

Individual differences were also incorporated in the study of boredom. Intelligence age, education, expertise and gender were recognised as the variables accountable for differences in the experience of boredom. Theorists (Wyatt & Langdon 1937, London, Schubert & Washburn 1972, Drory 1982) have identified a positive relationship between boredom and intellectual capacity, meaning that more intelligent people will tend to be more bored when engaged in simple, un-challenging and easy tasks. However, this correlation was doubted by research that has shown that when individuals perform a task that exceeds their abilities they also tend to feel bored (Fisher 1993).

Age displayed a negative correlation with boredom, with younger people tending to be more bored than older ones in monotonous jobs (Smith 1955, Stagner 1975, Hill 1975, Drory 1982). Expertise is another characteristic that enhances the probabilities of boredom. Mastering a task to a level that it no longer demands conscious effort may lead to boredom (Fisher 1993). A study by Dyer-Smith and Wesson (1995) has shown that experts tend to feel more bored, present more lapses of attention, need more time to correct errors and have more accidents.

As Perkins and Hill (1985) noted "boredom is in the eye of the beholder" and that was the major contribution of personality and individual differences psychology. Limitations of this strand of research regard basically methodological issues. A primary concern is the use of very specific (students) and homogenous (age, gender) populations (Vodanovich & Kass 1990, Vodanovich, Weddle & Piotrowski 1997, Kass, Vodanovich & Callender 2001). The need for transference and testing of findings in real-life situations is an imperative for future research. A second argument relates to the use of psychological and boredom measures. Issues of reliability and validity are brought forward especially in respect to boredom scales (Kass, Vodanovich & Callender 2001). According to Balzer et al. (2004, p.291) "..there is no single source reference that provides descriptions and psychometric evaluations (e.g. does the instrument measure boredom at work in a consistent and conceptually appropriate manner?) of available measures".

2.4. Cognitive psychology

The contribution of cognitive psychology to the study of boredom has been double: it helped in defining the concept and recognising its behavioural aspects and secondly in offering empirical data regarding the variations of the phenomenon among individuals. Though conducted in laboratory settings with non-representative samples (mostly students) its major advantage is that it integrates several theories such as: sensory deprivation (Suedfeld 1975), attention (Gardner, Dunham, Cummings & Pierce 1989) and arousal. O'Hanlon (1981) and Smith (1981) in their reviews refer extensively to the conceptualization of boredom as a cognitive/perceptual condition which people experience when the amount, quality and occurrence of stimulation offered by the environment are not appropriate. Research on the causes and effects of boredom at work has elaborated five basic constructs as relevant to boredom: arousal, sensory deprivation and cognitive alterations, difficulty in sustaining attention and consequent attentional deficiencies.

There are two contradicting theories regarding the role of arousal in boredom. In the first approach it is argued that low external stimulation causes low internal arousal (Barmark 1937, Fiske & Maddi 1961, Hebb 1955, Geiwitz 1966) which is expressed as inattention, daydreaming, sleepiness and performance detriments (Damrad- Frye & Laird 1989). The second theory asserts that low external stimulation has the exact opposite outcome that is high levels of internal arousal (Berlyne 1960). Boredom, in this case is seen as a drive which causes restlessness and struggle to maintain action in order for the individual to compensate for the poorness of the environment

(Thackray, Bailey & Touchstone 1977, Stave 1977, Perkins & Hill 1985). Both theories acquire empirical support from various settings. For example McBain (1970) explored long distance driving and found that monotonous environments may lead to low arousal, lack of alertness and more accidents. In opposition, London, Shubert and Washburn (1972) in a study regarding monitoring, concluded that boredom leads to an increase of arousal. Whether boredom is state of low or high internal arousal is yet unconfirmed. However, the central point of those studies is that boredom is related to attention- either when the bored individual struggles to sustain it or when there is a complete abandonment of the effort (inattention).

Attention has been given great significance in the study of boredom. It has been included as a sub-category in the Boredom Proneness Scale (BPS) and research has supported the notion that boredom consists of attentional shortcomings (Kass, Wallace & Vodanovich 2003). Theory assumes that when there is a necessity to perform a task that is boring or uninteresting, attention will deteriorate and this will be expressed as lower performance (accidents, errors, false detection etc). Attention difficulties have also been reported in vigilance tasks (Fisher 1998), where there is a need to sustain attention in the absence of relevant to task information. Boredom, if defined as the inability to sustain attention, is not only a matter of low task demands but also of infrequent task requirements (Weinger 1999). Research concerned with vigilance and boredom has been mainly conducted in experimental settings or in jobs such as traffic air control (Thackray 1981). Weinger (1999) has expanded past research by studying an occupational category that is not traditionally defined as vigilance work. In his review on anaesthesiologists, found that 90% of anaesthesia providers experience at least occasionally boredom because of low workload and infrequent task demands. The effect of low workload and vigilance has also been explored in a study on security specialists (Charlton & Hertz 1989) whose main and single responsibility was to guard nuclear weapons in the US Air Force. The central outcome of the study, was that individuals experienced great levels of boredom due to the long periods of inactivity combined with the need to be alert in case something occurred. In a more recent study on military personnel, Wallace, Vodanovich and Restino (2003) found that greater boredom proneness scores were predictors of cognitive failures, such as reduced attention and vigilance.

Other studies have explored relative to attention behaviours, such as distractibility (Thackray, Jones & Touchstone 1973, Damrad-Frye & Laird 1989), daydreaming (Davies 1926, Antrobus, Coleman & Singer 1967) and preoccupation with un-related

to the task thoughts (McBain 1970, Gardner, Dunham, Cummings & Pierce 1989, Fisher 1998). The similarity of these studies is found on the assumption that such behaviours function as antidotes to boredom.

A third approach to the study of boredom was concerned with the relation between the individual's cognitive abilities and the demands of the environment. An initial proposition was that boredom occurs when the capabilities of the individual exceed the requirements of the task/situation (London, Shubert & Washburn 1972). The validity of this assumption was questioned by further research regarding expertise and schema complexity. While Dyer-Smith and Wesson (1995) contend that experts may be more susceptible to boredom and conduct more errors or have more lapses of attention, Fisher (1993) takes the opposite view. Drawing upon the "schema" cognitive theory, she believes that people who acquire more complicated schemas regarding a task or a situation will be less bored because they will look at "extra" information that a person with relatively simpler "schemas" cannot identify or recognise. A previous similar study (Perkins & Hill 1985) that used as a theoretical framework Kelly's (1955) personal construct theory identified that bored individuals made fewer distinctions among stimuli whereas subjects interested in the task made more. The contradiction between these views lies in methodological differences and in theoretical premises used. In the study of Dyer-Smith and Wesson (1995) subjects were tested in continuous vigilance task and the effect of habituation was also included, while Perkins and Hill (1985) used totally different methodology and assessment procedures.

In relation to the level of stimulation, two theories will be discussed. The first one emerges of the studies on sensory and deprivation and it is mainly concerned with the consequences of boredom, whereas the theory of optimal levels of arousal discusses its causes. Suedfeld (1975) in his review notes that all types of sensory and perceptual deprivation as well as social isolation, confinement and restriction of movement may lead to changes in perception and to increased levels of anxiety and stress. While those findings emerged from laboratory settings and under totally controlled situations, alterations in perception and in particular perception of time was also studied in real situations within the field of organizational psychology. Suedfeld (1975) reports experiments that related the loss of sense of time to social isolation and confinement. Applying this finding to work settings, Grubb (1975) found that the nature of task affected the way assembly workers perceived the passage of time. Other studies (London & Monello 1974, Drory 1982) have also supported the

distortion in the perception of time (time dragging, slow passage of time) when engaged in monotonous or repetitive tasks. In a recent study, conducted by Danckert & Allman (2005), it was asserted that it is not only the nature of task per se that may inflict feelings of boredom, but also the estimations that individuals make in relation to the time needed to complete an activity. The researchers manipulated the participants' perception of the passage of time while completing a task. It was identified that when individuals felt that the task took longer than it actually did, the reported levels of boredom increased. These studies have shown that boredom inflicted by monotonous tasks results in distorted perception of the passage of time, which in turn increases the experience of boredom.

Following the studies of sensory deprivation, Zuckerman (1979) developed the Sensation Seeking Scale in order to explain the differences found among individuals in respect to optimal levels of arousal. According to his view individuals differ in the amount of stimuli required to maintain an optimal level of arousal and that sensation seekers have a high need "for varied, novel and complex sensations and experiences and the willingness to take physical and social risks for the sake of such experiences" (Zuckerman 1979, p.10). The basic assumption of this theory is that such people are more easily bored when faced with un-interesting, repetitive and monotonous stimuli/tasks/situations.

2.5. Sociology

The incorporation of sociology in the study of work boredom is a necessity deriving from two facts: the first one concerns the central position that work acquires in Western societies and the second one is related to the assumption that organizations constitute small social contexts possessing their own rules, norms and structures (Selznick 1957, Perrow 1986). As such, sociological ideas connecting broader contexts and boredom may be transplanted in specific organizational settings. Marx (1967[1844]) was among the first sociologists who made a clear association between boredom and work in capitalistic societies. The extensive division of labour and the inability of the worker to see the final product of his effort, result in alienation, a concept that is closely related to boredom (Tolor 1989). Durkheim (1972[1893]) proposed the concept of anomie-normlessness and many sociologists after him argued that it is indistinguishable from boredom (Darden & Marks 1999). The absence of norms in society creates an environment of excessive stimulation in which the individual experiences a sense of loss of purpose, which in turn leads to boredom (Barbalet 1999). In the same realm but configured in contemporary

societies Orrin Klapp (1986) has argued that Western civilization has induced boredom due to the overload of stimuli that it offers. Two sociological theories- symbolic interactionism and existentialism- will be elaborated here due to their close relation with the previously presented studies.

The basic premise of symbolic interactionism is that boredom occurs in a social context and is an interactional rather than an individual or actional phenomenon (Brissett & Snow 1993). It is already seen that some studies in organizational psychology have stressed the issue of subjectivity in the experience of boredom (Csikszentimihalyi 1975, Perkins & Hill 1985, Fisher 1993) however they have limited their investigation in the relation between individuals and monotonous tasks. Symbolic interactionism reframes boredom in the cultural context and conceptualises it as a social construct, an interpretation of an experience (Conrad 1997). The term "social construct" signifies that boredom is the result of an experience to which various social attributions are attached. The underlying assumption is that those attributions and interpretations are socially and culturally embedded and developed through interaction. As it will be explained later on, transferring this perspective in the work domain, it can be argued that boredom is the result of both the general social beliefs regarding a particular job and the more specific perceptions, appraisals and feelings circulating in a specific work setting.

The two major themes that symbolic interactionists point out as associated with boredom are: expectations and roles. Conrad (1997) has identified boredom as a part of social expectations, meaning that unless individuals anticipate the possibility of something else boredom will not be experienced. Referring to socially derived expectations about general interactions or specific situations and contexts, Conrad suggests that boredom occurs when those expectations are not met. In other words, when people anticipate a change or more from a situation it is meant that the current one is not satisfying at all or at least there is nothing to do but wait a transformation then boredom is the likely outcome. In contrast to this perspective, other theorists (Brissett & Snow 1993, Darden & Marks 1999, Bargdill 2000) argued that boredom stems from having no expectations because of a very assured and specific future. According to this view, individuals may be engaged in various situations but their behaviour has no implications or control over the future. It is the sense that events have their own inevitable succession, with no personal implications for the future of the person who is engaged in them.

An important contribution of both views is that they place the time dimension in the study of boredom. Expectations are not only related to the future but they also signify certain perceptions of the present. Whether anticipating change or sameness, the present situation becomes endless, as if time has stuck (Darden & Marks 1999). Past research on monotonous and repetitive tasks has identified that prolonged involvement in boring tasks enhances boredom and deteriorates performance. However, the sociological perspective broadens the issue by including the subjective experience of the passage of time while in an uninteresting situation. As Darden and Marks (1999, p.27) note "..the present does not reach out to embrace the future" meaning that for the bored person the current condition seems eternal. Perception of time is an important aspect of boredom, hence making theorists such as Wangh (1975) suggest that it is the sense of time that makes humans predisposed to boredom.

A second cause of boredom has been identified in the theory of roles. In symbolic interaction terminology roles refer to formal positions that people occupy or categories in which they belong to (doctor, parent, obese etc). Darden and Marks (1999) have identified from their telephone survey, two cases which roles can become antecedents of boredom: when the selected role does not measure up to the individual's standards and when for any reason the person is distanced from the role he/she is performing. In an ethnographic study on security specialists of the US Air Force (Charlton & Hertz 1989) it was identified that among the factors that affected employees' boredom was the inconsistency between the formal characteristics of their role and the actual performance of that role. The conflict, created by the contradiction between the advanced skills, value and prestige and the long periods of inactivity, resulted in experiences of boredom. The issue of roles is of extreme significance as it associates boredom with occupational roles and with the settings in which those roles are performed. Moreover, it highlights the importance of expectations regarding a certain profession or a work setting in subsequent feelings while actually in the field.

An additional issue that both symbolic interactionism and existentialism have elaborated is the concept of meaning (Barbalet 1999, Bargdill 2000). Both theories argue that the absence of meaning in a situation or activity results in boredom. Perkins and Hill (1985) have also pointed out the importance of meaning, however their attempts to measure it by relating it to the subjects' ability to create constructs regarding a specific stimulus, dissociate their perception from the sociological one.

Sociological views of boredom refer to meaning as one's general purpose in life, an experience of "flow" in actions and a feeling of complete involvement (Csikszentimihalyi 1990) and a reason for existence (Frankl 1984). Further reinforcing an overlap with some psychological approaches, Isaksen (2000), using the Humanistic Psychology framework, has transferred these concepts into the work environment and proposed the basic elements of meaning at work: the reasons one has for working, what he/she seeks to accomplish by working and the continuity experienced in work (Isaksen 2000, p.87).

Despite the basic assumption about boredom resulting from a meaningless (work) life, existentialists, such as Sartre (1947), O'Connor (1967), Straus (1980) and Knowles (1986), believe that it is the individual who is responsible for creating a meaning. In contrast, symbolic interactionists argue that the interaction between person and situation will determine whether there is meaning or not. Adopting a similar view, Isaksen (2000) found that meaning can be found even in repetitive jobs. Interviews with 30 workers who were performing tasks, such as preparing cold meals, dishwashing, packing trolleys have shown that in their majority they were able to construct a meaning in their work environment. Another difference between the two theories is found in symbolic interactionists' argument that boredom may occur even when there is meaning but it is totally shared (Stone 1962, Darden & Marks 1999). According to this perspective boredom may be seen as the outcome of a situation in which there is no ambiguity, negotiation or conflicting views and in which everything is agreed and predictable. It should be noted at this point that meaning cannot be imposed by external factors, such as managerial strategies to increase employee involvement, but is a construct dependable on the individual and his/her perception of the environment (Isaksen 2000).

Though there is no abundance of sociological studies on the topic of boredom and the existing ones take a broader perspective, investigating general samples and situations, they have offered a useful insight regarding the causes of boredom. Moreover the concepts that have been elaborated can be easily applied in the work domain and more importantly to all occupational categories, unlike studies that have focused on industrial settings or monotonous jobs.

2.6. Summary
The above review shows that boredom is a concept that theorists have largely neglected, as it is seen from the relative small amount of studies conducted, or

partially touched upon. The difficulties in defining it, observe its behavioural aspects, as well as the derogative connotations associated may have discouraged researchers from investigating it systematically.

Boredom has been conceptualised in narrow terms, such as an emotion deriving from monotony, repetitiveness and prolonged exposure to uninteresting stimuli or as a cognitive state characterised by lapses of attention and errors and affecting arousal levels. Such studies aimed at identifying causal relationships between boredom and performance and have been conducted either in industrial settings or artificial environments, with blue-collar workers or students constituting the sample respectively. However, those initial studies have provided the basis for future research and perhaps helped improve work conditions in such settings.

A second theoretical approach to boredom, has taken an opposing view. While the first one was concerned with the identification of external variables that may affect boredom, this one stressed the importance of individual factors. Personality and individual differences psychology argued that boredom does not depend on task characteristics, but factors such as boredom proneness, extroversion, conscientiousness, hardiness, dogmatism, age, education, intelligence are the ultimate determinants of experiencing boredom. The emphasis on the individual and his/her predispositions proved to be quite helpful in recruitment and selection procedures as well as in occupational guidance and career planning (Vodanovich & Kass 1990). Again the drawback of these studies is the restricted range of samples and settings in which they were conducted.

Lastly, the sociological view of boredom, though not placing it in specific settings or situations, has offered a deeper and more thorough understanding of it. The few studies that have been conducted were based on qualitative methodological principles (unlike psychological studies that have used solely quantitative methods) which allow for more and richer data to be extracted. Secondly, by framing boredom as a social construct, sociology has managed to simultaneously relate boredom to both situational and individual variables. The exploration of roles, meanings and expectations as they emerge from the interaction between the individual and the social environment has identified new elements in the experience of boredom. A further step would be the examination of those findings in specific work settings and with more homogenous populations.

The following table (table 1) summarizes the five different theoretical approaches to boredom.

Table 1: Theoretical Approaches of Boredom

Perspective	Methodology	Definition	Findings	Limitations
Organizational psychology	Quantitative	Psycho-physiological state	Task characteristics, such as monotony and repetitiveness along with work variables, such as autonomy, quality of goals may impose boredom	No variety in occupations studied
Personality & Individual Differences Psychology	Quantitative		Individual characteristics that influence experience boredom	
Cognitive Psychology	Quantitative /experimental		Attention, levels of arousal, complexity of schemas and ability to allocate mental resources to novel tasks are affected by boredom	Quantification of boredom
Sociology	Qualitative	Boredom as a social construct	Subjective expectations and perceptions of roles and meaning affect boredom	No large scale studies, variety of samples.

Chapter 3: Nursing

3.1. Introduction

In the previous chapter the existing literature on boredom was investigated. The lack of evidence regarding specific contexts and professions questions the generalisability of the findings. Can we accept routine or repetitiveness as antecedents of boredom outside factory jobs? Does boredom always lead to impaired productivity or errors in performance in tasks that do not involve vigilance or machine work? And finally can we assume that boredom is manifested in the same ways in all professions?

It is the aim of this study to examine how professions as whole entities with distinct characteristics might evoke feelings of boredom. In order to accomplish that, it is necessary to acquire a thorough description of the profession in question and of the way it is practiced in specific settings.

The following analysis is based on concepts that have been identified in the literature on boredom. The incorporation of the first three characteristics of nursing- status, caring and emotional labour- are based on sociological theories about the significance of role perception (Darden & Marks 1999) and meaning deriving from an activity (Barbalet 1999) in the experience of boredom. In specific terms:

- Does the status of a profession affect employees' perceptions about the meaning of their job?
- Does the caring ideology, traditionally associated to nursing, provide a meaningful role for nurses?
- What are the effects of the stereotype of the "good, sympathetic nurse" on nurses?

The last two sections- duties and actual practice- provide a description of what constitutes psychiatric nursing in theory and in actual practice. Task and work variables have been identified by organizational psychology theories, as the primary determinants of boredom and therefore their analysis is central to this project.

3.2. Status

Unlike other health care professions, such as medicine, psychiatry, psychology etc. that are highly valued, nursing not only remains under-recognized (Meerabeau 2004) but in addition it is associated with negative stereotypes, such as handmaidens or even sexual objects (Jinks & Bradley 2004). There are several reasons that account for the position of nursing in the professional hierarchy.

For decades nurses were trained in hospitals and obtained mostly practical skills. Only recently has nursing been affiliated in universities curriculum. In the late 1990s the application of Project 2000 in the UK constituted nursing as an academic course, while in Greece this shift came about in the 1980s (Academic Guide of National and Kapodiastriako Univeristy, 2000). However, in both countries there are still programmes of practical training on nursing. The fact that nursing could be exercised without acquiring university education was a factor that might explain its status in relation to other medical professions.

Additionally nursing receives derogative characterizations partly because of the nature of work that involves. As one of the basic duties of nurses is taking care of patients' personal hygiene, "dirt" becomes closely associated with nursing. There are strict social norms and taboos about cleanliness and the products of the human body that constitute such work being perceived as low in status and repulsive (Meerabeau 2004). Hughes (1951) defines dirty work as the tasks and occupations that are likely to be perceived as disgusting or degrading. People that perform these tasks are stigmatised by society though they act as its agents taking up the work that others would not. Following Ashforth and Kreiner's (1999) criteria about what can be categorised as dirty work, it becomes explicit that dirty work does not only involve physical taint but social taint as well. Occupations that involve contact with stigmatised groups such as psychiatric patients and AIDS victims also fall under the dirty work classification. In a study regarding public perceptions of the psychiatric nursing role, it was found that despite the general positive perception of the role, yet the stigma of mental illness permeated and influenced the perception of the psychiatric nursing role (Walker, Jackson & Barker 1998). Therefore certain nursing specialties cannot be disassociated from this category even if the aspect of dealing with physical taint is removed.

A third reason that accounts for the low status of nursing concerns its association to femininity. Nursing has always been depicted as a profession most appropriate for women (Miers 2000, Jinks & Bradley 2004) and even nowadays the vast majority of nurses are females. As Hallam (2002) showed in a review of the ways that nurses were presented in the media, nursing was considered to be an occupation that did not distract women from what was supposed to be their female identity. According to the article the kind, helpful, servile nurse was a role model for many young women in the past decades. Until recently there was a clear sexist distinction in the medical

hierarchy, with doctors being male and nurses being female. Meerabeau (2004) indicates that the gendered nature of nursing is closely related to dealing with the hygiene of the human body and to the special relationship that evolves between carers and cared-for. She claims that work that entails body care is low in status and usually taken up by women.

In conclusion nursing receives its occupational status from three strongly connected factors, namely the level and quality of education, the main tasks and activities that nurses perform and the gendered nature of the occupation.

3.3. Caring

A popular assumption regarding nursing is that it is founded on a "caring ideology" (Mackintosh 2000). Caring has been identified as the core of nursing, an ethical element that not only directs and governs its practice (Leininger 1981, 1984) but separates nursing from other disciplines (Kurtz & Wang 1991).

In a definition given by Cortis and Kendrick (2003) care has been described as an "attitude that leads to the beneficial attending, through acts and omissions of one person toward another. When a person engages in caring practices affirms to the other a sense of mattering that they are valued and worthy of loving attention" (p.78). A number of themes stem out from this conceptualization of care:

a. Care as a moral concept
Many scholars (Kyle 1995, Warelow 1996, Bradshow 1996, Woodward 1997) share the view of caring as an altruistic, ethical and fundamental nursing value. According to this view care develops only within a relationship and involves respect for the individual's identity and personal needs. In this context care is described as the actions nurses do in order to provide help, support and that are based on the unconditional acceptance of and sensitivity to the other person's being.
b. Care as an affect
According to Kirby and Slevin (1992) the basic elements of care are feelings of compassion and empathy toward the recipient. Moreover in Watson's (1989) "carative factors" which compose the essence of care, there is included the "promotion and acceptance of the expression of feelings". Considering these descriptions, care is not only an affect but a motivating factor for the nurse to attend to the patient (Cortis & Kendrick 2003).

The emphasis on care as a central feature of nursing was further developed to a "science of care" (Dunlop 1986, Barker, Reynolds & Ward 1995) or to the "professionalisation" of caring (Hallam 2002). Advocates of the caring movement, as it is characterised, attempted to establish a global construct that would unify nursing as a discipline (Barker, Reynolds & Ward 1995). An additional aim was to move away from the medical paradigm that was considered to dominate health care (Kirby & Slevin 1992). What these theorists believed was that nursing was exercised in a mechanical way by focusing on practical skills and instead of the nurse-patient relationship. The emphasis on care was said to be a more humanistic approach to nursing contrasted to the "techno-care" introduced by positivism and behaviourism (Barker, Reynolds & Ward 1995).

The caring discourse was received by the field with great uncertainty. Peplau (1987), a pioneer nursing theorist, stated that is actually the focus on the caring-ethos that has prohibited nursing from acquiring a scientific role and be regarded as a profession with solid and distinct boundaries. The emphasis on caring as a unique attribute of nursing cannot be accepted since other professions, such as social and psychotherapeutic work, entail the caring element as well (Barker, Reynolds & Ward 1995, Brown, Crawford & Darongamas 2003). And lastly, research has shown that the actual behaviour of nurses is incongruent with the caring ideology (Playle 1995, Barker et.al 1995, Mackintosh 2000) and therefore the latter cannot acquire a central position in the description of the profession.

Certainly, these arguments do not intend to totally dismiss caring out of nursing. Their purpose is to comprise the two poles and offer a new focus to the discipline.

3.4. Emotional labour

The centrality and significance of dealing with and managing emotions is most explicit in nursing. As many theorists of organizational behaviour (Warr 2002, Fineman 2000) have pointed, emotions play a vital role in the domain of work and especially in service occupations (Ashforth & Humphreys 1993). Emotions at work have been explored in two ways: either as the individual's personal response to environmental stimuli or as responses that are directed by the organization and the role that one is performing. While the first concerns the inner emotional experiences that the work environment provokes, the latter refers to the public expression of certain feelings as part of enacting a specific work role. Emotional labour (Hochschild 1979, 1983) or face-work (Goffman 1967) are the terms used to describe the act of

displaying socially desired emotions during work encounters. The emphasis here is placed on the overt behaviour of the role occupant regardless of his/her true feelings (Grandey, Fisk, Mattila, Jansen & Sideman 2005). These control or display rules (Ekman 1973) refer to the social, organizational and occupational expectations or norms about what constitutes appropriate performance of a work role (Rafaeli & Sutton 1989). It should be noticed here that display rules vary not only among but also within occupations according to the organizational setting and the culture in which they are situated (Ashforth & Humphreys 1993). Furthermore, it is argued in relation to the emergence of display rules out of social expectations that these two often clash or are not in absolute congruence. An example given by Lief and Fox (1963) demonstrated how social display norms regarding doctors' behaviour (e.g. expression of personal concern) were not met by doctors' occupational norms (e.g. being more detached). The degree of compliance to social display expectations is determined by the status and power of the occupation or the organization in question (Ashforth & Humphreys 1993).

In conclusion, the social stereotypes regarding certain professions, the management and suppression of authentic feelings and the expression of acceptable emotions at a cultural and occupational level, intermingle and define emotional labour. These three elements are apparent in nursing thus making it one of the 48 occupational categories that are high in emotional labour (Hochschild 1983, Bolton 2001).

Public views as well as theoretical principles coincide on what constitutes the nursing role. Images of nurses as caring, sympathetic, loving and involved with patients have been identified by a number of theorists (Leidner 1991/1993, O'Brien 1994, James 1989/1992). The discipline itself has conformed to these public representations of nurses and has even moved further on to characterise them as the essence of nursing (Mackintosh 2000). Brodish (1982) has defined nursing as the therapeutic use of the self for the benefits of others, while Biley (1992) proposed concepts such as "presencing" and "being with" as the right focus for the discipline. Nurses, according to theorists such as Kitson (1985) and Shannon (1991) are expected to show commitment, support patients practically and emotionally, sympathise and cope with their pain. In a study conducted by Wolf (1986) nurses complied with expectations regarding their emotional display by placing comforting, patience and sensitivity among the emotions that are highly important in their relationship with patients. The whole caring discourse represents clearly shared beliefs and expectations about the appropriate role performance of nurses.

The management of disgust has been referred to as one of the "emotional tasks" that nurses have to accomplish (Meerabeau 2004). Dealing with the human body, being responsible for its cleanliness are basic nursing duties and compose what Ashforth and Kreiner (1999) have labelled dirty work. Feelings of repulsion and disgust that evolve naturally must be suppressed or hidden in order for the actor to be able not only to carry out such tasks but to present at the same time a caring "face".

Dissonance between inner and publicly appropriate emotions is also apparent in another nursing role, that of alleviating psychologically the human suffering. Peplau (1962), Watson (1989), Shannon (1991) suggested that nursing entails some sort of counselling work, meaning the provision of emotional support in order to help patients deal with their disabilities. Delivering efficiently that kind of help requires the carer to have already resolved his/her own fears and uneasiness concerning human pain. Yet, coming face to face with terminal diseases and intolerable pain necessitates vast emotional resources and multiple defence mechanisms on the part of nurses in order to lead to beneficial attending of patients.

3.5. Formal duties

Moving from these general views regarding nursing I will now describe the practice of psychiatric nursing which will be the focus of this project. The history of psychiatric nursing has been quite turbulent, thus the discipline seems to be in a constant flux. Being at the crossroads where many related disciplines (psychiatry, nursing, psychology, psychobiology etc.) meet (McCabe 2000), along with its short-term history are some of the factors that have not allowed the development of a unique and distinct theoretical model that would be identified only with psychiatric nursing. Although it stands out as a distinct specialty and is assimilated in all nursing courses, its identity and practice fluctuate according to two basic factors (Butterworth 1995, Stuart & Laraia 1998):

1. the setting
2. the theoretical model that prevails in a specific setting.

Psychiatric nurses' activities are separated into three main categories according to the level at which they intervene. In general they function at primary, secondary and tertiary prevention, though their involvement is most explicit at the last two.

Primary prevention regards any attempts to diminish the possibility of illness by changing the factors that might cause it. It mostly involves work in the community, therefore it will not be analysed here.

Detecting and dealing with a problem at an early stage (secondary prevention) presupposes that nurses take the following actions (Stuart & Laraia 1998, Ragia 1999):

1. intake screening and evaluation,
2. treatment services,
3. creation of a therapeutic milieu,
4. supervision of patients receiving medication,
5. suicide prevention,
6. crisis intervention.

Tertiary prevention involves reducing the disability that an illness has already caused. At this level nurses (Stuart & Laraia 1998, Ragia 1999):

1. promote vocational training and rehabilitation,
2. ease the transition from psychiatric facilities to the community,
3. provide partial hospitalization options for patients.

It is evident from the above that psychiatric nurses' role encompasses both the organisation and implementation of action. More specifically the nursing process involves six sequential stages (Stuart & Laraia 1998): 1.assessment, 2.diagnosis, 3. identification of goals, 4. planning, 5. implementation and 6.evaluation.

The first stage concerns the collection of data about the patients' condition. Nurses are responsible for gathering objective information using observation, interviews (with the patient and/or family) and professional assessment tools. The analysis and synthesis of the data will enable nurses to compare patients' mental state with norms as described in established diagnostic tools, such as the DSM-4 (Diagnostic and Statistical Manual for mental disorders). After the problem has been diagnosed, nurses' next duty is to identify the goals of treatment. These goals should be accepted by the patient, attainable and address patients' overt behaviour. Once aims have been identified, nurses develop a plan about which goals should be primarily pursued and what activities should be included. At the fifth phase (implementation) nursing interventions vary and reflect a holistic approach to patient care. Among their responsibilities is to create a therapeutic environment, help with self-care activities,

provide medication and counselling. In collaboration with other health care professionals they work for the promotion and maintenance of patients' mental health. Evaluation of the outcomes, though it is mentioned as the last step of the nursing plan, it is a continuous process that informs nurses about the appropriateness and effectiveness of their goals and actions.

Nurses' work in psychiatric hospitals is separated into two basic categories:
a. direct care activities, which involve continuous assessment of patients' mental and physical condition, guarding against patients' violent behaviour, administration of medication, feeding and cleaning, provision of a safe therapeutic environment, formal and informal interaction with patients (Tummers, Janssen, Landeweerd & Houkes 2001, Stuart, Worley, Morris & Bevilacqua 2000).
b. documentation about patients' progress, needs of the unit, delegation of duties, staff scheduling and generally reporting to superiors about issues of the ward.

The range of duties that nurses can be engaged in renders the transition among work-roles as a typical phenomenon in psychiatric nursing. The acquisition and performance of a specific role are determined not only by the type of setting but also by the needs of any particular patient (Morrison, Shealy, Kowalski, LaMont & Range 1994). Moreover, nursing roles also fluctuate according to factors such as the organizational characteristics of the setting (structure, values, goals, number of staff etc) and the theoretical models about mental health/illness that underpin practice (Stuart & Laraia 1998).

Psychiatric nursing practice is characterised by great variability and complexity. Certainly nursing educational texts attempt to clarify and describe formal roles and activities, however it is argued that actual practice differs from what is formally defined as psychiatric nursing.

3.6. Actual behaviour
There is a considerable amount of research which addresses psychiatric nurses' behaviour, actions and problems. Psychiatric nurses not only constitute the majority of health care professionals within a psychiatric care environment, but they also provide 24-hour care. It is therefore necessary to identify their activities, measure their effectiveness and know about the problems that might interfere in their work.

As it was shown in the previous section, theoretically nurses' activities cover a big range in which the interaction with the recipients of care is emphasised. In academic nursing texts, practice is described as heterogeneous and demanding and generally the presentation of nursing as the most vital profession in the mental health system is quite explicit. However, studies on psychiatric nurses' duties convey a different reality. The majority of nurses' time is spent on documentation/paperwork or on interaction with other staff members. In 1995 research conducted in the USA displayed that psychiatric nurses spent 15.5% of their time on paperwork (Hagerty, Bissonnette, Bostrom, Lovell & Sieloff 1995) which formed the majority of their total working time. In another study, again in the USA (Stuart, Worley, Morris & Bevilacqua 2000), nurses reported dissatisfaction with spending most of their time on paperwork. Martin's study (1992) of UK psychiatric nurses conveyed that although nurses spent so little time with patients, they "failed to offer much detail about what they were doing" (p.35).

In respect to nurses' interaction with patients the length of service, the educational level and the type of ward influence their quantity and quality. In a study conducted by Tyson, Lambert and Beattie (1995) in Australia, it was observed that psychiatric nurses with lower educational qualifications and who worked in long-term or psycho-geriatric wards spent more time with patients than those who obtained advanced skills and were in acute wards. However as the study showed most of nurses' time was spent on other activities which were not specified.

Another study (Thomas, Beaven, Blacksmith, Ekland, Hein, Osborne & Reno 1999) provided further evidence that psychiatric nurses' interactions with patients were limited because of three main factors: the large number of patients in a ward that prevented quality interactions, the amount of paperwork and the fact that nurses had to "fill in" for other staff. These observed behaviours appear to somewhat contradict Peplau's (1987) definition of nursing as an interpersonal process.

It should be taken into consideration that such studies are based on nurses' self-reports, therefore a certain degree of bias is expected. The possibility that nurses "use" the way that mental health services function for stating that it is what deprives them from proper professional action can be a valid alternative. Two older studies (Sanson-Fisher, Poole & Thompson 1978, Fairbanks, McGuire, Cole, Sbordone, Silvers, Richards & Akers 1977) have elaborated this issue of nurses' behaviour in mental hospitals and have come up with the following results: nurses not only spent

the minimum time with patients but they also physically segregated themselves from them by gathering in "nursing stations". Moreover, it was identified that nurses evaluated their effectiveness not on the basis of patients' progress but by using self or peer assessment. Such behaviour might suggest that the ultimate goal for nursing staff is to carry out daily tasks and not get deeply involved in patients' treatment. A second suggestion deriving from these studies is that the bureaucratic demands placed upon nurses' time might offer an "escape" from potentially unpleasant contacts with patients. This possibility is further supported by Leighton (1982) in his description of barriers for effective mental health care. As he contends "there is something particular in these disorders that evokes human beings existential apprehension that is akin to the fear of the dead, ghosts….That something is incomprehensible behaviour. Madmen and madwomen are perceived as unpredictable and therefore as uncanny and dire" (p.8).

There is substantial literature that has elaborated psychiatric nurses' behaviour in relation to the problems they face in their work. The blurring of roles, little autonomy, limited career prospects, increased demands are some of the identified hurdles that nurses have to deal with and that result in low involvement, dissatisfaction, burnout and high rates of turnover. Such outcomes further deteriorate performance as this is described in several studies (Cigantesco, Picardi, Chiaia, Balbi & Morosini 2003).

Past research (Cameron, Horsburgh & Armstrong-Stassen 1994, Depp, Arnold, Dawkins & Selzer 1983) has identified psychiatric nurses as the least satisfied professional group among other mental health care providers. This is particularly observed in public psychiatric hospitals. Most researchers agree on the reasons for the high rates of nurses' dissatisfaction with their work. These include:
1. lack of autonomy to utilise knowledge and skills (Stuart, Worley, Morris & Bevilacqua 2000)
2. workload which stems from crowded units and staff shortages (Alexander, Lichnstein, Joo Oh & Ullman 1998, Guppy & Gutteridge 1991)
3. role clarity- the degree to which information about tasks associated with the job is conveyed by the organization to its members (Alexander, Lichnstein, Joo Oh & Ullman 1998)
4. role conflict that is created "between personal beliefs during training and role definitions in work settings" (Decker 1985)
5. little opportunities for promotion (Knoop 1995, Pierce, Hazel & Mion 1996)

6. little recognition for their work (Dallender, Nolan, Soares, Thomsen & Arnetz 1999).

The above aspects are mostly related with the organization of work and work relations among professionals in mental health services. There are however factors inherent to the job of psychiatric nurses that also have a negative impact on nurses' affective reactions and performance. Violent incidents in psychiatric wards have been recognised as a continuously increasing problem (Noble & Rodger 1989). As research has shown even minor assaults that do not result in injury can be detrimental to nurses' well-being (Whitfield & Shelly 1991, Whittington & Wykes 1992, Dunn & Ritter 1995, Carson, Fagin & Ritter 1995). Certainly a major stressor in psychiatric nursing is coming face to face with severe mental illnesses and death (Dallender, Nolan, Soares, Thompsen & Arnetz 1999). The emotions stirred by working with mental patients as well as the fact that such patients can be extremely demanding and relatively slow in progress require from nurses vast emotional resources and might ultimately result in exhaustion and burnout for nurses.

The degree to which the above mentioned factors intervene in psychiatric nurses' work will actually determine the quality of the delivered care. It is however difficult to maintain professional standards when working in such stressful conditions. Therefore any discrepancies between theoretical descriptions of psychiatric nursing and actual practice are expected up to a degree.

3.7. Summary
The purpose of this chapter was to provide a thorough description of the psychiatric nursing profession. Starting from a generalized view, nursing constitutes a profession low in status, associated with altruistic concepts of care and sympathy and requiring the continuous and successful management of emotions. The prevalence of these features has been identified to various extents across types of nursing and health care settings. While academic nursing texts provide a clear and straightforward description of the roles, duties and activities entailed in psychiatric nursing, in an effort to detach the profession from those unfavourable features and create a more "professional" image, the actual practice suggests the contrary. According to the literature, psychiatric nurses are the least satisfied group among other health care providers due to: the absence of autonomy and recognition, the stress caused by dealing with mental disorders and the blurring of roles and duties.

Chapter 4: Public Organizations

4.1. Introduction

One of the main aims of this thesis is to provide an account of boredom that will incorporate work context variables apart from factors such as task or job factors. Organizational studies have stressed the importance of the structural and cultural features of work contexts in influencing work behaviour as well as emotions. The following analysis is also associated with nursing, since as it was described in the previous chapter, nursing work varies in relation to the context in which it takes place. The chapter begins with basic concepts of organization theory (structure and culture) and their effects on employees' behaviour. The analysis regards public organizations and in specific bureaucracies and it moves on to public hospitals which are the focus of this research.

4.2. Structure

Organization theory has a long tradition in identifying the characteristics that make organizations distinct entities and lead them to success or extinction. From Frederick Taylor (1987[1911]) to more recent theories of human resources management, organization studies have encountered various issues in their attempt to determine and provide a model for performance excellence and effectiveness.

In order to define the factors affecting success, a primary concern was to identify categories of organizations based on universally applied criteria. One of these criteria is organizational structure (Heffron 1989). As Osborn, Hunt and Jauch (1980) noted, structure is the "anatomy of an organization" and they have defined it as an attempt to arrange roles and relationships so that the work of an organization is directed toward accomplishing the goals and mission of the organization. Though organizational theorists have not been interested enough in defining structure, they have been largely preoccupied with dimensions that may characterise it (Allinson 1984). Each classification used different concepts, however scholars have commonly referred to three basic features: formalization, centralization and complexity (Heffron 1989, Payne & Pugh 1976). Formalization means the extent to which jobs, activities and behaviour are standardised and the means by which this standardization is accomplished (Heffron 1989). Centralization refers to the degree to which authority and control are delegated and complexity to the number of different professions employed in the organization, the number of its hierarchical levels and to the extent of its geographical dispersion (Heffron 1989). In other words organizations are

categorised according to the division of labour, the mechanisms for control and coordination.

Based upon these dimensions, organizations may be classified into various categories. Nonetheless, a gross distinction could be made between bureaucratic and other types of organizational structure. Despite the exceptions, bureaucracies have long been identified with the public sector, therefore the following analysis will consider public sector organizations.

Since Weber (1947) and his conceptualization of bureaucracy as the ideal way of organizing work, theorists have been quite sceptical regarding the effectiveness of bureaucratic organizations. What are, however, the specific characteristics of the bureaucratic structure that once made it ideal and seem to have condemned it in current times?

It should be clarified here that bureaucratic organizations have not always been perceived as uni-dimensional. According to Hall (1963) and Pugh, Hickson, Hinings and Turner (1968) there are multiple dimensions in respect to which an organization may be classified as bureaucratic. This debate, however, goes beyond the purpose of this analysis, which is the identification of the basic characteristics of the bureaucratic structure.

It has been broadly accepted that bureaucracies represent prototypes of extensive division of labour. Though many companies and institutions may display such a feature without being bureaucratic, the distinction lies in the extent and implications that bureaucracies make use of it. Dividing work into segments signifies a detailed description of positions, procedures and activities. This fragmentation of work implies the employment of standardised procedures of evaluation, since work output is specific and of limited range, as well as standardised coordination mechanisms between the various work units. Moreover, work formalization leads to the standardization of employees' behaviour. The specific guidelines for executing a job, the formal procedures of reporting and assessing and the regulated channels of communication, form the basis for action. Despite the predictability, the stability and order that those prescribed processes may bring into the organization, they also refrain employees from any form of creativity, constitute them as dispensable and dehumanise them (Heffron 1989).

Most public sector organizations tend to be centralised, meaning that decision-making and power are located in upper hierarchical levels. Control over routine administrative functions such as budgeting, purchasing and personnel is usually left to the discretion of upper-level management (Heffron 1989). What is distinct in bureaucracies is that authority is not given to a person but to a position. Though Weber (1947) recognised the possibility of authority stemming from charisma, it is most likely that powerful positions are offered to people with the suitable qualifications. The issue of centralization becomes complicated in highly professional organizations. Authority may be given to certain positions, however, specialists, because of their knowledge, will determine what will be actually done and in what way (Heffron 1989). Despite the variations, power tends to be concentrated in bureaucracies. According to the supporters of centralization, its basic advantage is the facilitation of leadership, direction and supervision (Heffron 1989). However, the benefits of centralization do not compensate for its drawbacks. Resistance to change (a feature of bureaucracy), inflexibility, prohibition of plurality in decision making and slowness in communication (Heffron 1989) are some of the disadvantages of centralising power. In relation to employees, various studies have shown the importance of autonomy and participation in decision making in employee motivation (Frey 1997), satisfaction (Frenkel, Tam, Korczynski & Shine 1998), general well-being (Hackman & Oldham 1975, Karasek & Theorell 1990) and ultimately performance (Karasek & Theorell 1990).

The last dimension, complexity, refers to the number of specializations existing in an organization and their coordination, to the depth of its hierarchy (tall or flat) and to the physical division of the organization into separate units. It is obvious that the more occupational categories an organization employs, the more difficult it would be to control and coordinate them (Heffron 1989). It is imperative for the organization to clearly define the function of its different sections and make them co-operate smoothly and effectively, in order to avoid conflict in respect to goals and orientation (Heffron 1989).

This is particularly true for professional bureaucracies. According to Heffron (1989, p.42) in this type of organization, "the operative functions are performed by professionals, specialists who have received their training and indoctrination outside the organization". This insinuates that professionals are primarily identified with the values, norms and codes of ethics of their profession and later with those of the organization in which they work. Furthermore, expertise provides those who acquire

it with power and control over their work. Therefore, hierarchical control and formalization-at least that deriving from within the organization- are diminished. The situation becomes even more problematic when those specialists compete for more power and status. Hospitals, which will provide the context of this thesis, are considered typical examples of professional bureaucracy and of power struggles. The accumulation of diverse disciplines such as medicine, psychology, nursing and medical technicians, often results in conflict for status. According to Mosher (1982) the health system is dominated by doctors, this however does not imply that other disciplines accept unconditionally their authority. For example, many nursing theorists condemned stereotypes about nurses being doctor's handmaidens (Jinks & Bradley 2004) and have attempted to re-establish the status of nursing as a profession (Peplau 1987). Conflicts for power also emerge within the same discipline, among various categories of doctors (surgeons, anesthesiologists etc) and among nurses (registered, practical and aides). Moreover with the application of the new public management, hospital administrators form a separate profession that is gradually involved in the incessant struggle for power (Heffron 1989).

4.3. Implications of bureaucratic structure

From this description, it is seen that certain characteristics, like formality, concentration of authority and complexity, are attributed to bureaucracies. It is in our interest to identify the possible implications of these features on employees. Some first implications have already been stressed, however a more thorough analysis in respect to attitudes and behaviour will be presented.

An initial consideration regards the enforcement of formal rules upon employees' behaviour. Bureaucracies tend to rely to a great extent on prescribed actions and procedures that are followed by compulsory recording of all decisions and administrative acts (Allinson 1984). Obedience to those rules is considered necessary for the effective function of the organization, basically because those prescriptions are based on rationality (for example law) or have been established through the course of time (Allinson 1984). The role of the employee is, therefore, the unquestionable fulfilment of those written rules in respect to work performance and general behaviour. Little autonomy, constant supervision and recording of actions, specific rules for addressing superiors, co-workers and clients, all lead to a mechanistic way of work. This is additionally enhanced by the fact that work is segmented to small parts, thus making employees easily dispensable (Heffron 1989). Employees become simple cogs in the organization trained to perform specific, un-

meaningful tasks (Weber 1947). According to Blau and Scott (1962) this inhibits freedom and in Marx's (1967 [1844]) terms, it constitutes alienation from one's own work and self. Employees are not seen as human beings but as positions or roles assigned with specific tasks and basing their behaviour on strict rules (Kallinikos 2004). Whether it is in assembly lines where organizations seek to regulate even bodily movements (Braverman 1974, Noble 1984) or in service organizations where the verbal conduct with clients is specific and predetermined (Frenkel, Tam, Korczynski & Shine 1998) employees are deprived of their freedom and human dignity (Marcuse 1955, Castoriades 1985, Hayek 1960).

Whether as means for employees' depersonalization or directly through the imposition of rules and rigid procedures, formalization has been linked to low involvement and commitment (Walton 1985). When rules determine behaviour, personal involvement is lost because of the total dependency of employees on them and those who represent them, i.e. superiors (Crozier 1964). Similarly, Hartline Maxham and McKee (2000) found that bureaucracies with their insistence on rigid rules and regulations tend to have less committed employees. Being subjected to rules and processes hinders creativity (Macher 1988, Adler & Borys 1996) and restricts experimentation (Drucker 1980), both negatively associated with involvement and commitment (Macher 1988).

An issue of extreme significance, related to the imposition of rules, is that of responsibility. Though rules may provide a safe basis for behaviour and action (Kallinikos 2004), they can be detrimental in cases of novice or un-predicted situations. Learning to rely on orders, results not only in rigidity (Merton 1940) but it also limits personal responsibility (Allinson 1984). The famous experiment of Milgram in the 1960s on obedience to authority, identified that individuals were able to give high voltage shocks and justified their actions by referring to the orders they had received from an authority figure (Milgram 1974). Similarly, employees in bureaucratic organizations may displace failures, mistakes, lapses either to the system for not providing specific guidance or to the incompetence of co-workers or whole departments (Pierce 1981, Rigg 1992). Fear of responsibility may be exemplified in several other aspects of organizational life, as for example, admitting faults and inadequacies while not taking any action to change them and expecting others to initiate a reform (Caiden 1991). It is rather interesting, as Rigg (1992, p.13) argues that "people like control, but relinquish it quickly".

It should be noted that lack of responsibility and involvement do not stem solely from the existence of strict rules and regulations. Formalization coupled with restriction of autonomy and preservation of authority increases the possibilities of those attitudes. It has been argued that among the variables that enhance employee involvement is participation in decision making (Shadur, Kienzle & Rodwell 1999, Packard 1989). Moreover, autonomy and control over one's work allows for more job satisfaction (Breaugh 1985, Greenberg 1980, Snizek, Bullard & Hayes 1983, Packard 1989, Rigg 1992), increases motivation (Adler 1996, 1999) and are associated with lower levels of stress (Cherniss 1980, Karasek & Theorell 1990, Hendrix, Steel, Leap & Summers 1991, Leiter 1991, Guterman & Jayaranthe 1994).

In respect to the last characteristic of bureaucracies, complexity, the basic issue that scholars as well as managers have pointed out is that of intra-organizational conflict. Size, variety of specializations employed and type of hierarchical structure of the organization present causal relationships with intra-organizational conflict (Heffron 1989). It should be clarified that it is not complexity per se that creates conflict in organizations, but the discrepancies between organizational and professional rules or norms (DeCotiis & Gryski 1981). Conflict has been found to result from the absence of depth in communication and from the infrequency of contact between the subunits of an organization (Carroad & Carroad 1982, Gupta, Raj & Wilemon 1986). Coupling the extensive deprtamentalization or specialization in large scale organizations with centralized control, not only leads to inappropriateness of interaction but it creates a "we vs. them" situation among employees (Child 1973, Corwin 1969, Allinson 1984). As communication is hindered by the large number of diverse departments and by the standardised procedures on which interaction is based, the main effects are seen in lower levels of product or service quality (Menon, Jaworski & Kohli 1997). From a psychological point of view however, the significance of conflict lies in its adverse effects on employees' morale and general well-being. Various studies within the organizational psychology discipline, with most prominent the models of Cohen and Wills (1985), Karasek and Theorell (1990) and Warr (1999) have shown that social support is a major determinant of work-related stress and satisfaction. Employees' social relations are among the major determinants of job satisfaction (Sargent & Terry 2000) and work-related stress (Kinman & Jones 2005).

Conflict however is not only developed through bad communication practices, but is also related to a specific type of bureaucracy, the professional (Heffron 1989). As described earlier, professional bureaucracies base their function on professionals,

specialists who have received their training outside the organization. In professional bureaucracies, conflict may derive from the incongruence between the organization's norms and the norms that are attached to a certain occupation. When the organization requires particular behaviours or sets strict guidelines about the completion of certain jobs and those clash with the principles of specific occupations, then conflict is likely to arise (Lait & Wallace 2002). The outcomes of this incompatibility are ambiguity about one's occupational role and identity and finally stress (Lait & Wallace 2002, Kahn & Quinn 1970, Cherniss 1980, Leiter 1991).

The above brief analysis shows the adverse effects of bureaucratic structures upon employees. Role conflict, stress, dissatisfaction are, among others, the results of the imposition of strict rules, standard procedures and centralised power.

4.4. Culture

The incorporation of culture in organization theory and practice has been increasingly popular during the last two decades (Halley 1998). The basic conceptualization behind this integration of theories is that organizations represent social entities (Selznick 1957, Perrow 1986) and as such they develop or have specific cultural characteristics that may affect behaviour (Schein 1992), perceptions (Mintzberg 1990, Schein 2004), emotions and finally productivity or success (Kotter & Heskett 1992).

Before proceeding into a definition of organizational culture, it should be noted that cultural variations exist among as well as within organizations. Nationality, sector, company and department are the factors that influence and determine organization cultures (Alvesson & Berg 1992, Hofstede 1980). For example Hofstede (1980) identified a distinction between Latin/Mediterranean and Anglo/Scandinavian/Dutch organizational cultures based on national criteria. Alvesson and Berg (1992) contended that there are differences among organizational cultures according to types of industries (automobile, consultancy, universities etc) while Foster-Fishman and Keys (1997) and Schultz (1994) argued that there are multiple cultures within the same organization, according to profession and functional position.

The vagueness of the term "culture" has created great theoretical debate and inconsistency regarding its definition and its study (Barley 1983, Halley 2004). According to Schultz (1994) there are three major perspectives in the study of organizational culture:

1. Rationalism, which regards culture as a tool for achievement of organizational goals. The basic assumption of this perspective is that culture is something that can be managed in order for the organization to reach success. It is regarded as a variable among others that affects organizational performance and efficiency (Peters & Waterman 1982, Deal & Kennedy 1982).

2. Functionalism, which sees culture as a pattern of shared values and assumptions that perform functions which in turn aim at external adaptation and internal integration. Edgar Schein (2004) has defined organizational culture as a pattern of shared basic assumptions that was learned by a group because it solved its problems of external adaptation and internal integration and as such it was considered valid to be taught to new members as the correct way to perceive, think and feel in respect to those problems.

3. Symbolism that perceives culture as a pattern of socially constructed meanings and symbols. In this view, actions, language, beliefs, behavioural patterns are assigned with meanings by the members of the organization and that constitutes organizational culture (Schultz 1994, Ashkanasy, Wilderom & Peterson 2000). Culture, therefore, is not something that there is in an organization but the organization is conceptualized as a cultural, symbolic unit (Alvesson & Berg 1992).

Despite the differences between the three perspectives, they all agree upon the constituents of culture, which may be summarised using Schein's (2004) classification of levels of culture: at the upper level, there are artefacts which are the visible signs of culture, such as structures, dress codes, ceremonies, technology, products, myths, stories and language. The medial level is composed of the espoused beliefs, values that are exhibited as strategies and goals. And at the deeper level there are the underlying assumptions, the taken-for-granted expectations, thoughts and feelings (Schein 1992).

Depending on the criteria used there have been various typologies of organizational culture, for example:
 -Harrison and Stokes's (1992) who asserted that there are four types of culture: power, role, task and person/support.
 -Want's (2003) who identified six types using as a criterion the organization's orientation to success and change: predatory, frozen, chaotic, political, bureaucratic and service cultures.
-Wallach (1983) who has identified three separate organizational cultures: bureaucratic, innovative and supportive.

-Etzioni (1975) who distinguished three cultural types according to relationship between the individual and the organization: coercive, utilitarian and normative.

Irrespective of the theoretical view of each theory, the definitions and typologies presented above set a number of questions: first, do organizations represent or have one culture or different cultures exist and intermingle in the same organization? A second concern is whether there is congruence between the culture that the organization asserts it acquires and the actual cultural manifestations. In other words, is there always congruence between what people think of culture and how they actually behave?

The answer to the first problem derives from the work of Martin (1992) who criticised the common conceptualization of organizational culture as a cohesive phenomenon which is shared by all members of the organization. In contrast she claimed that there are three perspectives of culture:

    a) integration, that emphasises the consensus among organizational members

    b) differentiation, that asserts that there are different sub-cultures developed according to professional background, position in the organization etc. These sub-cultures exhibit distinctive behavioural and cognitive patterns (Schultz 1994) and may be in conflict with each other (Martin & Siehl 1983).

    c) fragmentation or ambiguity, refers to organizational cultures that present uncertainty, lack of clarity and confusion. The shared understandings or meanings that are the cornerstone of culture do not exist in this perspective or they are limited to specific organizational circumstances (Schultz 1994).

In relation to the second matter, Siehl & Martin (1990) argue that there is a distinction between what members of a culture say they think, believe and do and how they actually behave. According to these theorists, the focus and interest should be placed upon the exhibited behavioural patterns and attitudes.

4.5. Bureaucratic cultures

It is rather unlikely to encounter an analysis of bureaucratic organizations when the concept of culture is discussed (Schultz 1994, Parker & Bradley 2000). The benefits of including culture theory in the study of public organizations can be separated into two broad categories: first, the culture concept may provide explanations and a deeper understanding of the attitudes, beliefs and behaviours expressed by public sector employees and secondly it may become a useful "tool" for organizational

change, especially in the light of the "new public management" (Bluedorn & Ludgren 1993, Harrow & Wilcocks 1990).

Based on the model of Zammuto and Krakower (1991) organizational culture can be assessed using two dimensions: interaction with the internal and external environment and flexibility and control. According to Parker and Bradley (2000) the cultural characteristics of bureaucratic organizations are: focus on internal processes, such as integration, information management and communication (Parker & Bradley 2000, p.128) and focus on control which implies emphasis on stability, rules, procedures, conformity and technical matters (Parker & Bradley 2000, p.129).

A basic element of bureaucratic cultures, as the model of Zammuto and Krakower (1991) suggests, is the absence of customer orientation and product or service quality. According to Want (2003) bureaucratic cultures place the need of customers below the needs of the bureaucracy/organization. Several implications of this feature are of particular significance for public service organizations. Pipan (2000) in a study regarding Italian public services, identified that customers are largely dissatisfied, present hostile feelings towards public service employees and depend on favours, friendships and on their acquaintances in the organization in order to "get their job done" (Pipan 2000, p.405).

Another characteristic of bureaucratic cultures is the emphasis on authority and control. According to Peters (1989) the definition and obedience to authority is a cultural function. In bureaucracies authority is determined by rules and laws and is characterised by impersonality (Peters 1989). Though this may be seen as a feature that provides clarity and ensures good practice, in "Weberian" terms (Weber 1947) it becomes complicated when encountering the various parties (politicians, policy makers, non-profit organizations, other interest groups) that interfere in the function of public organizations (Hughes 1994). The outcome of this interference is double: first organizational goals become blurred and therefore performance is hindered (Parker & Bradley 2000) and secondly employees lose their trust in the organization and perceive unfairness and lack of support (Iverson, McLeod & Erwin 1996). A good example of this was the problems that the Greek National Health System was facing in relation to doctors' shifts, hospitals' debts to suppliers and to the inability of the system to absorb the new appointed managers (Pipili 17/01/99).

In such environments, employees' commitment to the organization is minimized (Mathieu & Zajac 1990, Iverson et al 1996) and behaviour is likely to be directed to the maximization of self-interests (Ferris, Russ & Fandt 1989). This was also supported by the work of MacIntyre (1981) and Jackall (1988) in which it was found that managers in bureaucratic organizations tend to pursue personal or group goals that may or not be consistent with those of the employing organization. The promotion of private goals insinuates not only employees' neglect of organizational aims as a whole (Vigoda 2000) but a conflicting nature of relationships among organizational members. Stupak (1992) argues that "the culture of bureaucracy honours the act of blaming" and that bureaucrats define themselves through their enemies and opponents. Further support of this argument derives from the study of Pipan (2000) in which it was identified that employees of Italian public services categorised their co-workers as "enemies and foes".

4.6. Impact of bureaucratic culture on employees

The vagueness of the term, the variety of the theoretical perspectives and the various types of bureaucracies do not allow for generalizations on the topic of the effect of organizational culture on employees. However, a brief reference to some of the relative studies will be presented irrespective of their theoretical background.

From the above description it is evident that the cultural characteristics of bureaucracies such as the focus on internal processes instead of customer satisfaction and the confusion regarding organizational goals may lead to employees' lack of motivation. According to Franco, Bennett, and Kanfer (2002) cultures that foster a strong organizational mission, delegate authority and have effective communication and information channels have increased levels of employee motivation.

Though employees in the public sector have largely been characterised as idle and un-motivated (Pipan 2000, Vigoda 2000) there are studies that have shown that certain characteristics of bureaucracies impose feelings of dissatisfaction and stress. For example in a survey conducted amongst psychiatric hospital employees, it was found that the most prominent factor for job satisfaction was employees' perception of management's integrity and fairness (Aronson, Sieveking, Laurenceau & Bellet 2003). Moreover, as Koberg and Chusmir (1987) argued, supportive cultures are positively related to job satisfaction.

From another perspective, employees' perceptions concerning the existence of unfairness, blame and subtle or overt conflict in the organization may result in negative emotional states, such as anger (Hine 2004, Gayle & Preiss 1998, Rhoades, Arnold & Jay 2001) or in counter-productive work behaviours, such as sabotage, conflict and withdrawal (Fox, Spector & Miles 2001, Spector, Fox, Penney, Bruursema, Goh & Kessler 2006). In a study conducted by Parker and DeCotiis (1983) it was found that among the organizational variables determining job stress were trust, fairness and support.

Another important effect of bureaucratic culture is on propensity to leave. Generally culture is among the variables affecting employees' withdrawal intentions (Carmeli 2005). Innovative and supportive cultures are found to be negatively related to propensity to leave the organization (Koberg & Chusmir 1987).

4.7. Public hospitals

According to Schultz (1994) organizations that resemble mostly central bureaucracies are, among others, hospitals. Due to their large size and the existence of various specializations within them, they function on the basis of formalization and central co-ordination (Mahmoudi & Miller 1985) both core characteristics of bureaucracy.

However, the categorization of hospitals as bureaucratic organizations should not be considered as straightforward and simple. This is mainly because the two sets of principles according to which hospitals operate: first the bureaucratic ideals that emphasize obedience to rules and procedures, fairness, dedication to the common good (Balle 1999) and secondly the professional and scientific values that concern caring (Kahn 1993), ethical codes (Llewellyn, Eden & Lay 1999) and advances of science (Arndt & Bigelow 2000).

What characterises hospitals is the amalgamation of professionalism and bureaucracy (Heffron 1989). They have been conceptualised as "negotiated order" (Strauss 1963) that involves dual power structures: that of bureaucratic rules and that of professionalism (Germov 2005). Due to the proliferation of the medical sciences hospital design has been specialty/discipline-based (Lega & DePietro 2005). In such a system the demand for integration and co-ordination becomes greater along with the development and implementation of national regulations and policies (Kinston 1983).

Public hospitals operate in the broader context of health care services: they are organized by the state/government, operate according to its regulations and policies and are dependent on its financing (Schofield 2001). In many European countries, like France, Italy and Greece the health system operates in "sectors" which are geographically defined areas with a number of community health services provided to the population of that area (WHR 2001). In that way the overcrowding of big health institutions is avoided and community health centres take the primary role in the provision of health services. The organization of such a system forms a pyramid at the head of which is the Ministry of Health. The following diagram is an example taken from Greece (www.ypyp.gr, 2004):

Diagram 1: Organization of health services

MINISTRY OF HEALTH

↓

GENERAL DISTRICT HOSPITALS

↑↓

PREFECTURE HOSPITALS

↓↑

COMMUNITY HEALTH CENTRES
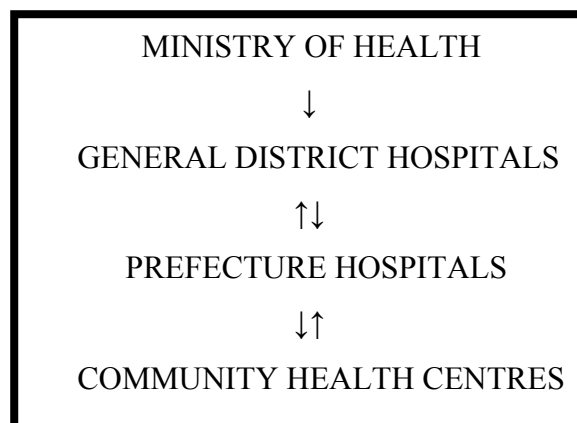
The difference between district and prefecture hospitals lies in the number of specialties they cover and the technical equipment they acquire. The above diagram illustrates the bureaucratic structure of health services and the mediating role of public hospitals as implementing agents of governmental policies and co-ordinators of action between the various services.

A basic characteristic of public hospitals, as in most public institutions, is the disvalue of profits (Duggan 2000). Considering the fact that hospitals have traditionally provided medical care to the indigent the imbalance between the payments received by the hospital and the costs to treat these people becomes greater (Duggan 2000). This is of major importance because the absence of market criteria (profit or share price) makes difficult the evaluation of success or efficiency. Meeting the objectives of governmental policies (Schofield 2001) and/or maximising the well-being of the people served by the hospital (Duggan 2000) are the indicators of "success". An

additional problem in establishing performance assessments in public services is the difficulty in defining and measuring service quality (Pipan 2000, Gowan, Seymour, Ibarreche & Lackey 2001). The delivery of services upon demand and in the presence of the customer/patient makes such processes complex, unpredictable and difficult to standardize and therefore evaluate them (Gowan, Seymour, Ibarreche & Lackey 2001). In a study (Harrison & Dowswell 2002) conducted in the UK regarding the attitudes of general practitioners towards formal recording of clinical activity and decisions, it was found that their clinical actions could always be described in a formal written way.

The function of public hospitals may be conceptualized as a two-level process: at the administrative level preoccupations with budgeting, management of resources, implementation of policies and at an operational level delivering humane health care services (Kinston 1983). These two levels may be incompatible as practice has shown. Problems such as staff shortages and budgetary constraints (Brazier 2005) may inhibit the service quality provided by hospitals (Lega & DePietro 2005).

Though hospital organization and management depends on nation-specific regimes and characteristics the issue of intra-organizational conflict is a common ground for different health systems (Lega & DePietro 2005, Sotiropoulos 2004). Hospitals consist of professionals who require high levels of autonomy because of the specialist and indeterminate nature of their work (Germov 2005). On the other hand, hospitals as organizations need to fulfil their overall goals with their given capabilities and certain constraints (Kornhauser 1962). It has been suggested (Hall 1982) that professionalization is incompatible with formalization-a basic characteristic of bureaucracy. The problem of professional-organizational conflict starts before individuals enter the organization, during their training as they become aware of the norms and values of their profession (Wilensky 1964, Mintzberg 1979, Heffron 1989). However in a study (Mahmudi & Miller 1985) conducted in 10 hospitals in the USA, it was found that specialization and formalization do not clash with professionalism. This is mainly because bureaucratic control is reinforced by employees' professional standards.

This is however an idealistic view of the medical profession and how it can function in a bureaucratic system. The power struggles in the health and more specifically in the hospital system are a shared assumption (Kinston 1983, Brazier 2005).Whether or not doctors acquire managerial positions, their power in the hospital system is

indisputable (Kinston 1983, Polder & Jochemsen 2000). Clinicians are those who decide about the admissions and discharges of patients, the diagnosis and choice of treatment all processes which have major implications on resources and budgeting (Llewellyn, Eden & Lay 1999). This often triggers conflicts between doctors and managers (Brazier 2005) or between doctors and other health care professionals (Kinston 1983). Additionally, it has been argued that what drives the allocation of resources in health care settings are the priorities and self-interests of the professionals rather than patients' needs (Culyer 1996, Lega & DePietro 2005). From the culture perspective of organizations, it has also been suggested that employees commit primarily and stronger to the sub-culture to which they belong (nursing, medicine etc) than to the overall culture of the employing organization (Lok & Crawford 2001). This implies that professionals will tend to promote the interests of their professional group instead of giving priority to the organizational goals. As Raelin (1989) described it, when professionals enter into bureaucratic organizations the "clash of cultures" is a great possibility.

4.8. Summary

The purpose of this section is to provide a basic description and understanding of the organizational variables of public hospitals and how these impact on employees.

General descriptions of bureaucracy and organizational culture were incorporated as a theoretical framework. Concepts such as centralization, formalization and complexity have provided a basic understanding of how public institutions are organized and operate. The impact of these attributes on employees was also discussed in broad terms and it was identified that certain features of bureaucracy may result in various emotional, perceptual and behavioural reactions such as stress, low involvement etc.

By incorporating in the analysis the organizational culture variable a more thorough understanding was obtained about public organizations and employees. The important issue of different sub-cultures existing in the same organization was identified and how these may form diverse value and goal systems. Cultural theory also provided some justification regarding public employees' commitment and job satisfaction, withdrawal intentions and motivation.

Finally a more focused and complex description was obtained regarding bureaucracy and bureaucratic culture with reference to public hospitals.

5.1. Introduction

The purpose of this chapter is to provide a view of the Greek public health and mental health sector. Apart from differences in the organization and management of the Greek public sector with the Western organizational models, Greek public organizations have distinct characteristics that derive from cultural and political norms. Some historical data regarding the health and mental health organizations have also been incorporated in order to provide a better understanding and because some traces have remained until now.

5.2. Public sector

It has been argued that organizational structure and governance depend primarily on the national institutional contexts and national cultures (DiMaggio & Powell 1983, Hofstede 2002). Despite the similarities encountered world-wide in public sector organizations, there are important differences that should be addressed. A first distinction has been made by Hofstede (1980, 1991) between the Latin/Mediterranean and the Anglo/Scandinavian/Dutch national cultures. Sotiropoulos (2004) has also made a similar categorization between the South European and Anglo-Saxon model of organization.

The Greek public sector is a large, complex system consisting of various types and sizes of public organizations-health, education, military etc (Sotirakou & Zeppou 2005). Public ownership and tall hierarchical structures are the basic characteristics of the system. Public organizations, in their majority, represent typical bureaucracies: highly centralized, with decisions and control exerted by top hierarchical levels and actions assigned to lower ranks (Sotirakou & Zeppou 2005).

Despite the fact that public sector employees are paid worse than their private counterparts (Bourantas & Papalexandris 1999, Sotirakou & Zeppou 2005) they obtain better social insurance, health and pension schemes (Sotiropoulos 2004). Employment is characterised by security and a stable and rising salary, which makes the public sector extremely popular for the state's work-force (Sotirakou & Zeppou 2005).

The issue of organizational politics prevailing in the public sector has been common knowledge in Greece, though rarely touched upon by academics. Public institutions function upon personal relationships and political clientelism (Makridimitris 1993,

Sotiropoulos 2004, Dent 2005). After each government turnover, top administrative positions are filled by appointees of the "government elite" (Sotiropoulos 2004) and the usual practice of political parties to offer or promise their voters jobs in the public sector, are indisputable facts in the Greek reality (Spanou 2000). Weber's (1947) idealistic conception of recruiting upon meritocracy is not applied even for the lower hierarchical ranks. Again, the criteria used for employing new staff are kinship and locality-who you know and where you come from (Papalexandris 1992, Tsivacou 1996).

In such a system of organization and functioning, concepts such as efficiency, effectiveness and performance evaluation are far from being properly applied (Tsoukas 1994). Instead, political criteria and protectionism prevail and substitute rational, objective evaluation mechanisms (Sotiropoulos 2004, Ballas & Tsoukas 2004).

Various implications stem from the dominance of the political culture in public sector organizations such as goal-setting and achievement as well as employee organizational behaviour. Public sector operates according to demands of multiple sources, such as governmental policies, non-profit organizations and professional or worker unions. The compilation of all these controlling social bodies results in goal disorientation, inability to create and pursue clear missions and ultimately absence of performance measures. Policies and legislation change with every government or minister turnover (Ballas & Tsoukas 2004), laws that have been appointed remain inactive and unions sabotage governmental decisions according to their interests. It is logical to assume that in such an environment employees will become indifferent to their work and to organizational goals and finally lose their faith and trust in the organization (Balle 1999, Ballas & Tsoukas 2004). In a study (Sotirakou & Zeppou 2005) conducted in a public educational institution in Athens, managers rated "goal accomplishment" as the least important dimension for performance. The researchers concluded that "clarifying, measuring and achieving long-term goals remain a difficult process for Greek public administration" (Sotirakou & Zeppou 2005, p73).

5.3. Health sector

The Greek National Health System (Greek abbreviation E.S.Y) was established in 1983 under the governance of the socialist party (PASOK), which held the vision of state-provided health, not subjected to profit making (Ballas & Tsoukas 2004). The ESY provides universal coverage to the population and at its launch the

establishment of private hospitals and clinics was prohibited (www.who.int 2004). Medical staff were exclusively employed by the system and paid by salary (Ballas & Tsoukas 2004, www.who.int 1996). Patients were assigned to doctors chosen by the ESY bureaucracy (Ballas & Tsoukas 2004). Medical insurance is separated into compulsory and voluntary, with the latter being additional and implemented by private companies that have permission from the government (Exadaktylos 2005). The main social insurance organizations (compulsory insurance) are under the jurisdiction of the Ministry of Labour and Social Insurance and play a significant role in the provision and financing of ambulatory services (www.who.int 1996).

The Ministry of Health and Social Cohesion (previously named ministry of health and welfare) constitutes the head of the organizational pyramid (www.who.int 2004). Its responsibilities include: planning and implementing health policies, definition of the extent of funding and allocation of resources (www.who.int 2004). In 2001 the system was reformed and much authority was delegated to17 regional health divisions (Greek abbreviation PESYPs) responsible for: implementation of national policies at a regional level, supervision and co-ordination of regional health services and allocation of funding (Tountas, Karnaki & Pavi 2001, Ballas & Tsoukas 2004). Each PESYP has under its jurisdiction hospitals of a specific region and a number of associated rural area health centres (Ballas & Tsoukas 2004). Government representation is minor in the PESYPs and the Health Ministry deals only with validating financial transactions of the PESYPs and with health issues and services throughout the country (Ballas & Tsoukas 2004, www.who.int 2004).

Medical care operates at three levels:
1. Primary care: is provided by approximately 180 health centres belonging to ESY and involve preventive, curative and rehabilitation services. Other providers are the out-patient units of hospitals, health centres and clinics of the Social Insurance Foundation (Greek abbreviation IKA) and private hospitals and doctors. What has been problematic with primary care, is the absence of a referral system appointing patients to the appropriate service. Patients are free to choose the service they want and this often leads to the over-crowding of the out-patient departments of hospitals (Kontodimopoulos, Nanos & Niakas 2005).
2. Secondary care: is provided by out-patient of public district and private hospitals. As seen there is no clear boundary between primary and secondary care as both categories use almost the same services (Kontodimopoulos, Nanos & Niakas 2005).

3. Tertiary care: refers to patient hospitalization and concerns complicated or specialized health problems (Exadaktylos 2005). Secondary and tertiary care is provided by a total of 139 hospitals, 114 general and 25 specialized, with the latter serving more regions (Exadaktylos 2005).

5.4. Mental health care

Mental health services in Greece have undergone profound transformations accounted to: the establishment of the National Health System (ESY) in 1983, the broader changes occurred in the European mental health context and the negative publicity that Greece received in relation to the psychiatric hospital of Leros. The introduction of ESY provided a more organized and co-ordinated context for the development of mental health services. During the same period Europe was moving away from the model of institutional psychiatry to community mental health care (Madianos, Tsiantis & Zacharakis 1999) and Greece had to follow its example. However, what seemed to have necessitated the transformation of Greek mental health services was the world-wide revulsion at patients' condition in the Mental hospital of Leros Island. Patients were pictured naked, in animal-like state, with no coverage of their basic needs, while incidents of abuse were also reported. The case was brought to the attention of the Commission of European Communities, which demanded immediate action to be taken (Madianos, Tsiantis & Zacharakis 1999).

Changes concerned the overall organization and function of mental health care: reduction of the number of beds in mental hospitals, development of psychiatric units in general hospitals, establishment of community and rehabilitation centres and improvements in the building infrastructure of the existing mental hospitals (Karastergiou, Mastrogianni, Georgiadou, Kotrotsios & Mauratziotou 2005).

The organization and operation of mental health services is the same as for the broader public health sector. Each hospital, centre, day-clinic belongs to the relevant regional health authority (PESYP) which refers to the administration of mental health of the Ministry of Health and Social Cohesion. The administration of mental health is divided into three sections:
1. department of hospital care
2. department of out-hospital care
3. department for dealing against the use of addictive substances (www.ypyp.gr).

Despite the laborious and extensive changes in mental health services, the system still faces significant problems. Among the primary concerns is the issue of funding. According to a report of the World Health Organization published in 2003 (www.who.int) 28% of the countries do not have a separate budget for mental health. Additionally the general financial problems of the Greek public sector do not allow for major or radical transformations. Recently the minister of health announced an extension of the de-institutionalization programme and the development of more out-hospital residential units, however the National Accounting Council has not yet approved the funding (Kouklaki 1/06/05).

A second problem concerns the number and distribution of staff in mental health services. The ongoing efforts to increase the personnel in public health services have resulted in significant improvements, however the staff-patient ratio in mental health still remains low. Moreover, according to the findings of a study regarding the delivery of health care in Greece (Madianos, Zacharakis, Tsitsa & Stefanis 1999), there is an uneven geographical distribution of mental health services, with most services and staff (psychiatrists, neuro-psychologists, nurses) gathered in the major urban areas (specifically Athens and Thessaloniki). For example the psychiatric hospital of Athens covers the needs of five regions of Greece, namely: south Attica, Cyclades, South Aegean, Peloponnisos and Sterea Ellada (www.ypyp.gr).

The aims of de-institutionalization and de-centralization of mental health services have been partially achieved, however as many Greek psychiatrists point out there are still issues that need further elaboration. One of which is the vocational and complete re-induction of discharged patients into the community (Mpouganis & Petropoulou 13/02/05).The system has not been able to fully integrate discharged patients into society and this is attributed to both public attitudes against mental illness and the absence of relevant and co-ordinated services (Mpouganis & Petropoulou 13/02/05). The numbers of patients in out-hospital residential units (guest-houses etc) are quite high and the possibility of turning into small asylums is quite strong (Mpouganis & Petropoulou 13/02/05). Furthermore, the selection criterion used for discharging patients distinguishes them into "good and bad", hence making the psychiatric hospitals a necessity for "bad" patients and the reform still incomplete.

An additional problem that exemplifies the inadequacies of the system is the low number of mental health centres of primary care (Elafros 19/12/04). Their estimated

number is 37 throughout the country instead of, at least, 82 (Elafros 19/12/04). These numbers show that there is no emphasis in preventive mental health care or avoidance of further admissions in the psychiatric hospitals. In contrast, there seems to be a mechanism that first accepts more patients in the big institutions and then attempts to de-institutionalise them.

5.5. Hospital structure & organization

Hospital care in Greece is provided by different types of hospitals, which are distinguished in respect to various criteria.

The first gross categorization of hospitals concerns the type of service offered. General hospitals have departments of more than one specialty, while specialised ones have one specialization, such as psychiatric, anti-cancer etc (Exadaktylos 2005).

The geographical area and the population served, provide two additional measures for classification. Hospitals are separated into three categories:
   a. local, with area of responsibility up to 50.000 residents
   b. prefectural, which serve up to 200.000 residents. They function in every prefecture and have departments, at least, in basic specializations
   c. regional, which cover the needs of the region and have departments of almost all specialties.

Local and prefectural hospitals provide secondary level care, while regional hospitals are considered units of tertiary medical care (Exadaktylos 2005).
Another distinction is made in respect to the provision of training. Hospitals might offer full training (university hospitals), limited (usually university clinics within general or specialised hospitals) or no training at all (Exadaktylos 2005).

The 2001 health reform brought changes in all levels of health services. A major one was the introduction of management in hospitals, an issue often discussed since the mid 1990s (Venieris 2003). However the government had to deal with several problems and till now the picture of hospital management is rather blurred (Venieris 2003). As reported in the press, managers who were appointed to positions in various hospitals, were never employed (Pipili 17/01/99). Objection to the introduction of management in health services was also encountered by university

hospital doctors. Consequent strikes aimed at the abolition of the plan and at doctors keeping control over hospital management (Venieris 2003).

Public hospitals are organized into clinics, each dedicated to a different specialty (Vassalou 2001). Responsible for the overall functioning of the clinic, the patients' treatment and perhaps the provision of training to medical students, is the director. Despite his/her high position, the director cannot decide on significant organizational changes in the clinic (Vassalou 2001).

Clinics constitute the medical service of the hospital, which is monitored by the director and the scientific committee (Vassalou 2001). The rest of the hospital's departments (nursing, financial, technical etc) operate under the supervision of directors. These directors compose the council/board that assists the governor of the hospital in the administration and management of the hospital (Tountas, Karnaki & Pavi 2001). The governor is responsible for managing "closed" prospective budgets which have to be approved by the relevant PESYP (Tountas, Karnaki & Pavi 2001).

A graphic example of hospital organization is taken from the psychiatric hospital of Thessaloniki (diagram 2).

Diagram 2: Hospital Organization
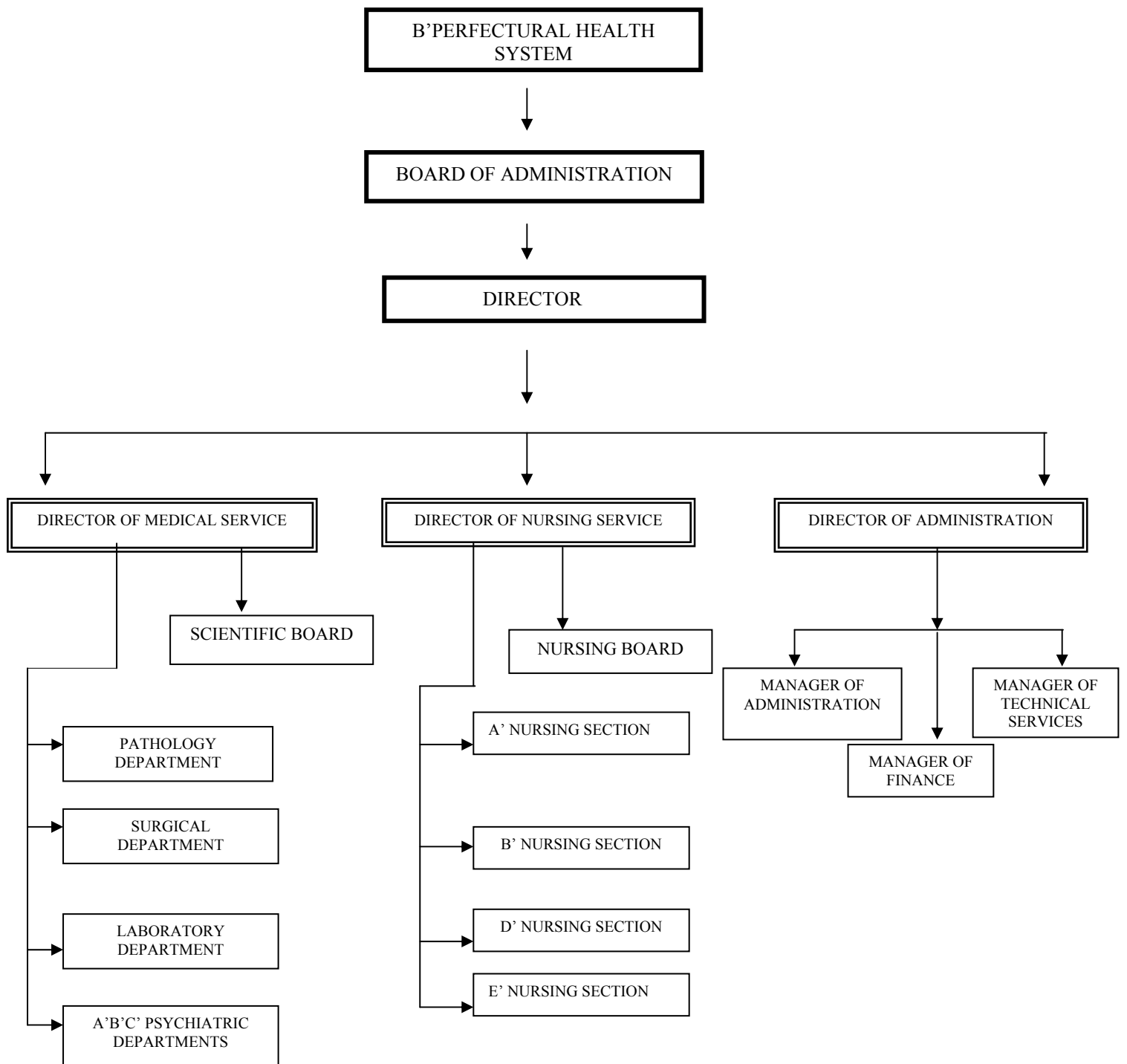
Several problems have been encountered in the management of public hospitals. Many scholars as well as the press have stressed the bad financial condition of public hospitals (Giokas 2001, Polyzos 2002, Pipili 17/01/99). Having as a major

source of funding (74%) the state budget (Giokas 2001) the economic problems that hospitals face include: high running costs (Giokas 2001, Polyzos 2002) and huge debts to suppliers (Pipili 17/01/99).

Additional problems stem from the absence of central planning (Giokas 2001), lack of objective criteria for the allocation of resources (Giokas 2001) and inability to specify needs and imperatives locally instead of nationally (Vassalou 2001). Such inefficiencies have led to: unsatisfactory levels of equipment and high-tech appliances (Giokas 2001), inadequate proportions of patient-staff ratios, especially in respect to nursing (Giokas 2001), limited use of information systems (Theodorakioglou & Tsiotras 2000), atrophy of accounting systems (Ballas & Tsoukas 2004), inappropriateness of building infrastructure (Angelopoulou, Kangis & Babis 1998, Giokas 2001) and low service quality (Giokas 2001).

It seems that the major problem that hospitals have to deal with is the absence of clear goals, performance or efficiency measures (Vassalou 2001, Giokas 2001). Apart from the vague mission to treat patients, there is no strategy or even short-term aims determined by the hospitals' governors or boards (Vassalou 2001). In a study (Theodorakioglou & Tsiotras 2000) regarding quality management in Greek public hospitals, it was found that managers, in the majority, were unaware of basic quality terms and did not apply a quality management programme. Moreover, only a small percentage of the sample used "key quality indicators to assess organizational performance" (Theodorakioglou & Tsiotras 2000, p.1157). The absence of goals, strategies and quality measurements often leads to confusion among staff and is often used as an excuse to avoid work-absenteeism rates in 1998 reached 75% (Theodorakioglou & Tsiotras 2000).

Such inadequacies have given rise to the phenomenon of "black market" in public hospitals (Tountas, Karnaki & Pavi 2001, Ballas & Tsoukas 2004). From its inception the ESY and its constituents (hospitals, health centres etc) have suffered from considerable abuse. In the study of Ballas and Tsoukas (2004) the chairman of one PESYP revealed that the consumption of medicines could not be explained by the number of patients treated in the hospitals of his jurisdiction, implying that the system was being abused. Reports about corruption in hospitals, such as funds being used by specific interest groups have been well known and published in press (Pipili 17/01/99). Moreover, the issue of patients bribing doctors and nurses in order to

receive better treatment and to bypass long queues constitutes a common practice in Greek public hospitals (Tountas, Karnaki & Pavi 2001, Ballas & Tsoukas 2004).

Nonetheless, these negative attributes of public hospitals were not reflected in a comparative study of patients' perceptions of public and private hospitals. According to the researchers (Angelopoulou, Kangis & Babis 1998) patients were more satisfied with the cost of medical care, the nurses' abilities and the doctors' qualifications and less with the building infrastructure and timings (long waiting lists) of public hospitals. However, as the authors noted, the positive evaluation of public hospital services may be attributed to patients' inhibition of revealing their real feelings or to their lack of specialised knowledge (Angelopoulou, Kangis & Babis 1998).

5.6. Policy for hiring new staff

Public organizations in Greece are under state control and management. Until 1994 personnel recruitment and selection was based on nepotism and on the political connections the applicant might have had.

In 1994 the Supreme Board of Personnel Selection (Greek abbreviation A.S.E.P) was established, in order to recruit and select staff for public sector organizations. A.S.E.P is an independent construct that is assessing the candidates' knowledge for the applied position (www.asep.gr). Assessment may take the form of written exams or simply by evaluating the applicants' academic performance and work experience (www.asep.gr, www.ekep.gr). The announcements for regular public employee vacancies are published in the Government Gazette (ASEP Issue) which is available free of charge by the National Printing House, the seats of Prefectures, Provinces and the Citizens' Service Centres (www.ekep.gr).

The Organization of Employment of Work Force (O.A.E.D) is another independent institution that informs and provides staff to public and private sector organizations. Basic aim of this institution is to inform unemployed people about placements that are relevant to their skills. O.A.E.D also holds sponsored programmes that take place in various organizations and companies that aim at the advancement of skills and acquisition of vocational experience (www.oaed.gr).

The same procedures are followed by hospitals. Depending on its needs, each hospital announces through A.S.E.P new positions that address to several educational levels. Staff selection may be carried out by the hospital, without the interference of A.S.E.P. Recently the psychiatric hospital of Attica announced

vacancies for various positions (medicine, nursing, psychology, administration). The process, which only included group interviews, was completed entirely by the hospital.

As it may be observed, recruitment and selection techniques in Greek public sector organizations are far behind in comparison to other European countries (http://europa.eu.int/index_en.htm). The absence of any psychometric tools or other sophisticated assessment techniques makes personnel selection a process that is based only on the relevant knowledge of applicants. Factors such as skills, preferences, personality are not measured at all. Selection and allocation of new employees in each job is done randomly, with only criterion the needs of each department.

5.7. Nursing education

Nursing education in Greece is divided in three categories that vary according to the years of training, the academic curriculum, the emphasis given on practical or theoretical skills and the qualifications obtained. There is no unified picture of nursing education nor of the roles and responsibilities assigned to each training category (Mpouloutza 16/05/04). Over the years various transformations have taken place in the nursing education. From the first nursing schools which were linked to the church and had a religious character (Dent 2003) to the current establishment of advanced degrees (masters and PhD) in university nursing faculties (Mpouloutza 16/05/04).

Nursing education is composed of three distinct categories:

a) Intermediate Technical Nursing Schools

This is a two year programme with a practical orientation and is provided by hospitals. Applicants must be over 15 years old and must have graduated from junior high school. Graduates are assistant nurses who work under the direction and supervision of certified nurses.

b) Departments of Nursing in Technical Educational Institutions.

The Greek University system is divided into two levels:

-the Advanced Educational Institutions-Universities (Greek abbreviation A.E.I) which hold 4 or 5 year academic programmes depending on the faculty.

-the Technical Educational Institutions (Greek abbreviation T.E.I) which provide 3 year programmes with a more practical orientation.

Subscription in these institutions depends on the candidate's scores in the National Examination, which is held in the end of the academic year and in his/her academic record during the last two years in High School. Candidates provide a list with the faculties of their preference and are examined in general subjects (math, physics, literature etc). In the last two years of High School they select their academic orientation and accordingly the additional subjects they are going to take. For example there is the theoretical orientation for which students have to take up subjects such as Ancient Greek, Latin etc. Therefore entrance in each faculty depends on:

1. the candidate's academic scores

2. the number of candidates for each faculty.

It is a system that depends in a great extent on luck since candidates may be accepted in faculties which are last in their list of preferences. According to the president of the National Organization of Nurses only 10% of the people who enter the nursing faculties have a clear professional orientation towards nursing (Mpouloutza 16/05/04).

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In 1980 in the Medical School of the University of Athens, was founded the department of Nursing. This a 4 year academic programme and applicants may be certificated nurses. Aim of the programme is to provide the necessary skills for the organization and administration of health services, to contribute to the nursing research and to supply students with the scientific knowledge for the organization, provision, supervision and evaluation of nursing care.

In 1985 a law was introduced which acknowledged as certificated nurses graduates from the Advanced and Technical Educational Institutions. The same law recognised 4 nursing specialties: pathology, children, psychiatric and surgery. This law although it contributed to the enhancement of nursing in Greece, has not incorporated the exact nursing duties and activities.

Nurses who have graduated from the advanced educational institutions (A.E.I and T.E.I) may apply for one of the four specializations. These training programmes are organized independently from universities and are provided by hospitals. Their duration is 1 year and they are composed of 40% theory and 60% practice (Klimis 2000). It should be noted that it is not necessary for nurses to attend these programmes in order to apply for a job in a specialised unit/department.

5.8. Summary

Following a long tradition of bad management and political interference of public sector organizations, public hospitals in Greece suffer from a variety of problems. Financial problems, absence of central planning, objective criteria for allocation of resources, staff shortages, inappropriateness of building infrastructure, service quality are among the problematic areas of public hospitals. In such work environment where goals are unclear or even absent and performance measures do not take place at all or rely on personal relationships, staff has become indifferent, confused and usually finds solutions in absenteeism and/or counter-productive behaviours.

Chapter 6: Qualitative Methods

6.1. Introduction

A common view among researchers from diverse disciplines is that the methodology employed for a research project should be inexorably connected with the topic and the aims of the study (Denzin & Lincoln 1998, Silverman 2000, Miles & Huberman 2002). The selection of specific methods for investigating a phenomenon is determined by a variety of issues such as the researcher's broad area of interest (psychology, sociology, management etc.) the particular discipline with which she/he is identified (clinical psychology, human resources management) the number and variety of previous studies on a certain topic and his/her own theoretical position about what constitutes reality and how this should be investigated.

Selecting between the duality of qualitative-quantitative methodologies reflects the ways in which a researcher thinks about and studies social realities (Strauss & Corbin 1998). These ways of "thinking" have ontological and epistemological underpinnings that have influenced particular disciplines. Thus psychological research has favoured objectification and accurate measurement while sociology has more frequently been associated with qualitative methodologies. However, as various academic texts on methodology point out, the ultimate decision residues around the aim of a specific project and certain combinations or 'deviations' from traditional approaches are expected.

Following this brief presentation of what constitutes an "appropriate" approach to research, I will exemplify how the aims and aspirations of the present research have determined the selection of a qualitative methodology.

Despite placing my research within the broader field of occupational psychology which is dominated by quantitative studies, the very nature of the research problem demanded a different methodology.

Boredom in work settings has been addressed as the outcome of certain job/work variables and as the mediating factor for lower performance, attentional failures and errors. Those studies were conducted in laboratory or industrial environments with very specific samples such as students or blue-collar workers (O'Hanlon 1980, Smith 1981, Fisher 1998). A broader and more subjective approach to boredom was attempted by sociology, however, it did not conclude with any concrete or sufficient data (Darden & Marks 1999). Considering that occupational boredom is not

sufficiently studied in organizations and particularly among professionals, the basic aim of the study was to identify whether it exists in such social contexts and if so, why. Exploring areas about which little is known or gaining further insight about a phenomenon is common basis for conducting a qualitative research (Maxwell 1996, Strauss & Corbin 1998).

Connected to the above rationale, previous research has been preoccupied with the identification of specific variables that influence experiences of boredom, without taking a more holistic approach. While task and job characteristics have been investigated to an extent, broader contextual factors such as organizational structure, culture, norms and processes have not been incorporated. Such concepts are difficult to be extracted from quantitative research methods and have traditionally been addressed by qualitative methodologies (Maxwell 1996, Strauss & Corbin 1998, Descombe 2003).

Providing an understanding of the natural context in which emotions are experienced leads to the concepts of subjectivity and meaning. How people view their work environment and their professional roles and how these perceptions influence emotions is an aim that the present research will attempt to answer. Despite the basic premise of cognitive psychology that emotions are the outcomes of cognitive appraisals, beliefs and perceptions of a given situation, literature so far has not investigated in depth the subjective experience of boredom. In contrast, it has elaborated the phenomenon either through closed questions (were you bored?) or through assumptions that derived from physiological measures or performance outcomes. What best characterizes qualitative research is its commitment to viewing and describing events, behaviour etc. from the perspective of the people who are being studied (Bryman 1988). The meanings that people attribute to their social environment and to the processes that take place in it, the feelings that accompany those meanings are all subject to analysis and interpretation. Because qualitative researchers rely on people's accounts of the phenomenon under study there is no prior decision about what should be studied and how it should be done. This gives qualitative research the opportunity to incorporate issues that may be of high relevance and interest. It should be noted here that the emphasis of qualitative research on the interpretations of meanings and of the processes that underlie them signifies also an emphasis on the context. The context, as it is viewed by the subjects of the study, provides the necessary framework for understanding and analysing

behaviours that occur in it. As Bryman (1988) argues, behaviour, events and meanings are inseparable from their context.

Lastly, qualitative methodology seemed most appropriate because of the sensitive nature of the topic. Boredom, despite its prevalence, is associated with negative connotations many of which imply personal failures, inadequacies or inabilities (Gemmill & Oakley 1992, Darden & Marks 1999). As sociologists Darden and Marks (1999) have argued "boredom is a socially disvalued emotion". The above quotation is particularly true for the work domain and in specific for health care professions, which are the focus of this study. Health care professions entail a moral/ethical aspect (caring for those in need) and are based on principles such as empathy, genuine interest etc. Direct and straightforward methodologies would put the healthcare professionals in defence, because of the inconsistency between boredom and the ethical standards of their profession. On the contrary, qualitative methods allow for a more flexible and implicit approach to the phenomenon and permit individuals to open-up and discuss their experiences of it (Descombe 2003).

6.2. Ontology-Epistemology: Constructivism/Interpretivist

Selecting a particular methodology presupposes certain ontological and epistemological premises (Lincoln & Guba 2000). In the previous section it was argued that one of the aims of the study was to understand the subjective experience of boredom as it occurs within and is influenced by a specific context. This simple statement, however, is underlined by assumptions regarding what constitutes reality and how this reality can become known. These assumptions, also referred to as 'paradigms' or 'interpretive framework' (Denzin & Lincoln 1998, p.26) will guide research to its final completion and presentation.

Constructivism is among the four major paradigms that Lincoln and Guba (2000) have identified and has its foundations in ontological relativity (Patton 2002). Relativism asserts that there is no single worldview and that no worldview is determined solely by the empirical data about the world. Reality, in this sense is subjective, different from the physical world and constructed through culture and language and within specific contexts (Patton 2002). Comprehending reality as constructed leads to the acknowledgement of the existence of multiple realities expressed in a variety of symbols and language systems (Denzin & Lincoln 1998). Therefore constructionists have a double aim to achieve: first, to identify those realities and their implications in the lives and interactions of the people who

construct them (Patton 2002) and secondly, to identify how these realities fit 'purposeful acts of intentional human beings' (Denzin & Lincoln 1998, p. 235).

It should be noted at this point that reality is not only constructed by the unique experiences of individual cases, but by collective processes such as culture. There is a twofold procedure of making sense of the world, individual and social, which is reflected in the distinction made by Grotty (1998) between constructivism and constructionism or social constructionism.

Summarizing the above, truth about a phenomenon, an action or even an emotion (Grotty 1998) is not single or objective but is multiple, constructed in specific time and context.

The axiomatic belief that reality is subjective and plural raises the question of how can we know it or even if it is possible to study it (Potter 1996). If reality is constructed within specific contextual and time frameworks can it be valid and/or generalized (Patton 2002)? And lastly, how do the researcher's subjective reality and presuppositions influence a certain study (Denzin & Lincoln 1998)?

Constructivists argue that knowledge about a phenomenon is embedded in the context researchers use in order to interpret it (Potter 1996) and is created through the interaction between the investigator and the object of inquiry (Denzin & Lincoln 1998). Constructions of knowledge therefore "do not exist outside of the persons who create and hold them" (Guba & Lincoln 1989, p.143) and are "relative to time and space" (Patton 2002) hence the rejection of the concept of generalization. Likewise issues of internal and external validity are replaced by the terms trustworthiness and authenticity (Guba & Lincoln 1994). However I will return to those terms in the following section.

6.3. Evaluation criteria for qualitative research

Qualitative research is a vast domain which draws upon different paradigms, perspectives, theories and methodologies. Such diversity has created considerable confusion about what should be regarded 'good' qualitative research (Symon & Cassell 2004). Typical concerns involve: the appropriateness of applying positivist criteria, namely reliability, validity and generalizability to qualitative studies and secondly the formulation of new assessment approaches suitable for different epistemological positions (Symon & Cassell 2004). While the first proposition seems

inappropriate for studies which rely on constructivist assumptions, the second bears the possibility for an over-production of assessment lists and consequently further confusion (Symon & Cassell 2004). For example Potter (1996) presents eight different approaches to evaluation criteria in which labels and terms are interchanged, signifying the same or diverse concepts.

Placing my research within the broader context of the constructivist paradigm suggests the use of 'alternative' assessment criteria than those determined by positivistic inquiry. There seems to be a consensus among theorists about the credibility (it parallels internal validity) of the findings/analysis (Potter 1996, Bryman 2004) upon which I will draw.

6.3.1. Internal validity

Validity in qualitative research refers to the question of whether interpretations of a phenomenon fit its description or are the explanations provided credible. Two issues are raised from this conceptualization: the first one relates to the suitability and trustworthiness of the methods employed in order to arrive at those interpretations (internal validity) and the second is concerned with the generalizability of the findings (external validity). It is the former one that will follow my discussion.

By arguing about the internal validity of a research project, theorists refer both to the process of gathering data and to the verification of the data interpretation by those involved in the project (Hammersley & Atkinson 1983, Bryman 2004). The first concept reflects the "canons of good practice" (Bryman 2004, p.275) which entail practical considerations regarding the selection and use of methods for inquiry and the researcher's position in the whole process (Hammersley & Atkinson 1983, Miles & Huberman 1984, Lincoln & Guba 2000).

I have already discussed the grounds upon which the specific qualitative methods were selected. I shall now refer to the process in more detail, following Wolcott's (1990) notion about the necessity of presenting accurately the nature and extent of data. Data gathering lasted 6 months which is considered enough time, in the course of a PhD thesis, in order to gain insight into the particular context and the people in it. According to ethnographic and case study research principles, it is important for the researcher to clarify his/her position in the field. I assigned to myself the role of observer-as- participant, according to Gold's (1958) classification, which allows interaction with the studied group but no involvement in its activities. The possibility

of being recognised by the sample solely as an 'outsider' or 'intruder' was acknowledged from the beginning of fieldwork. Implications resulting from such potential included the psychological withdrawal of the sample and unwillingness to disclose personal information. I eschewed this possibility by engaging myself in nurses' conversations and small-talks, by using their linguistic style and by expressing my student status. The significance of the latter reflects Greek cultural norms and general beliefs regarding authority and knowledge, especially for a sample consisting mostly of nursing staff who were not fully qualified.

A second point being made by Miles and Huberman (1984) concerns the risks against validity that derive from the researchers' bias. The authors argue that a typical source of error stems from the investigators' misuse of data in order to fit a certain pattern or theory. Lincoln and Guba (2000) refer to the issue as the "fairness" with which different viewpoints of respondents are represented in the analysis. Some of the tactics that are suggested in order to avoid such biases were employed in the study. Two of these were specificaly included in the process: making comparisons and triangulation (Miles & Huberman 1984). Making comparisons and contrasts was an ongoing process necessitated by the selection of two long-stay psychiatric wards, one with male, and the other female patients, and by the heterogeneity of the sample. Variations included age, educational background and years of work experience all of which were taken into account in the analysis.

Triangulation refers to the use of more than one method or source of data in order to augment objectivity and as such it was much associated with quantitative research (Bryman 2004). Though Potter (1996) and Bryman (2004) make references to qualitative research that has benefited from it, the concept of 'objectivity' contrasts with the basic premise of constructionism about the existence of multiple subjective realities, upon which my project is based. The two methods employed in this project, semi-structured interviews and observations, should be viewed not as an attempt to provide evidence about a definite or 'objective' interpretation but a strategy for gaining a deeper insight about the subjective experiences of the participants.

Lastly, internal validity may be hindered by another bias concerning the researchers' subjectivity. Lincoln and Guba (1985) talked about the critical subjectivity with which an investigator should be equipped. It regards the self-awareness about one's own emotional states, positions, past experiences, prejudices and orientations that are likely to shape the interpretation and the approach to the study (Greswell 1998).

Especially in the context of constructionism which assumes that reality is constructed through the participant-researcher interaction (Denzin & Lincoln 1998), it is of extreme importance to acknowledge personal bias. My personal beliefs and theoretical background about occupational boredom and what should constitute 'good' nursing work were not set aside, but were challenged throughout the whole research process. As Denzin and Lincoln (2000) argued knowledge is constructed through a dialectic in which participants learn and challenge each other. Moreover, I thought it useful to keep a very basic record about my own experiences in the field, in order to describe the general feeling that an 'outsider' got from the wards.

Apart from the selection and 'appropriate' use of data collection methods, internal validity is also enhanced by the verification of the findings by participants. Respondent or member validation refers to the presentation of the findings or interpretations to the people under study in order to gain their confirmation (Bryman 2004). While Lincoln and Guba (1985) argue that participants should be provided with an account of the researcher's conclusions so they can judge its accuracy, this is not always feasible. Providing an account of the findings suggests that certain connections with theories and concepts would be made, thus making understanding difficult (Bryman 2004). This applied in my case, as the majority of the sample had only a basic educational background and certain concepts that were addressed during interviews had to be paraphrased in order to get the ideas across to interviewees.

Alternatively, as Bryman (2004) suggests, respondent validation can be obtained by providing each participant with a summary of what he/she has said during an interview, a conversation or of what he/she has been observed doing. This tactic was employed during the whole data collection process. Interviews were characterised by 'active listening', a term used in psychotherapeutic interviewing to describe repetition of interviewee's words, summaries of basic issues or themes that promote understanding and offer the opportunity for clarifications to be made (Rogers 1969). Aside from the psychotherapeutic field, qualitative theorists have pointed, as important characteristics of the investigator his/her responsiveness, having professional immediacy and ability for clarification and summarization (Morse, Barrett, Mayan, Olson & Spiers 2002). Moreover, being in the field and observing nurses engaged in various activities and situations offered the chance not only to ask immediate 'on the spot' questions but to create a basis for further questioning during interviews.

6.3.2. External Validity

The term external validity has been equated with a variety of alternatives such as transferability (Guba & Lincoln 1985), generalizability (Anderson 1987) and applicability (Marshall & Rossman 1989) which all refer to the basic question of whether the findings can be generalized to another setting/population. However, this seems to clash with the basic aim of qualitative research which is the understanding of the subjective meanings, perceptions and experiences of a particular group or culture within specific contexts. Contextualization is regarded a basic characteristic of qualitative research (Bryman 1988), meaning that findings are always inexorably connected with particular cases. Some scholars (Anderson 1987, Mitchell 1983, Hartley 1994) argue that generalization is about theoretical propositions, identification of processes and patterns of action and not about populations or representativeness of the case. In a similar vein, Lincoln and Guba (1985) proposed the solution of 'thick description' which entails the detailed account of the participants and the setting under study that would allow others to judge whether findings can be transferred because of common characteristics.

Others, like Yin (1989) and Silverman (2000) suggest the selection of the case or sample in terms of its typicality or extreme deviance of the phenomenon under study. Those theorists contend that generalizability can be obtained by selecting a sample where the process/emotion/behaviour under investigation is most likely to occur or where it is totally absent. The definition of a case as 'typical' or 'deviant' rests upon theory and existing literature (Silverman 2000) however it is not always a straightforward decision. In the present research the categorization of typical and non-typical cases of boredom is not very clear because of the limited literature. If it is considered that a typical case of boredom at work is represented by manual, repetitive labour (Smith 1981, O'Hanlon 1981) then all other professions (nursing, teaching etc) should be regarded as deviant cases, which is a very pre-mature assumption. The present case encompasses two features: the first one is the bureaucratic form of the organization (public hospital) and the second is the health person-centred nature of the particular occupation (nursing). Literature on public sector organizations in general and in Greece (Pipan 2000, Vigoda 2000, Ballas & Tsoukas 2004) suggests that certain bureaucratic features may impose or enhance work boredom, hence their classification as prototypical examples of boredom. On the other hand, there is a vast literature on stress in health care occupations which clearly places the case of boredom among psychiatric nurses as an extreme

exemplar. Consequently it is unclear whether public mental hospitals represent a deviant or typical case of boredom. In order to solve this I used Stake's (2000) categorization of case studies into three types:

-Intrinsic, where the aim is to gain understanding about the particular case.

-Instrumental, where the particular case is examined in order to gain understanding about another phenomenon. As the author suggests, case studies of this type are more likely to facilitate generalizations.

-Collective, where multiple cases are studied in order to examine another phenomenon.

Since the basic aim of my project is to explore boredom at work, I have identified with the second type of Stake's (2000) classification. Thus the case (the psychiatric hospital) becomes of secondary interest and plays a supportive role in the understanding of boredom. The case is still explored in depth however the basic concern is to identify processes and conditions that may influence a phenomenon and can be identified in other contexts as well (Stake 2000, Hartley 2004). As Bromley (1986) argued, the outcomes of a case study do not apply only to a particular case but represent a model or typical pattern of facts and relationships that can be applied to a set of cases.

In order to strengthen the potential for generalization comparisons and contrasts within the single case may also be employed (Hartley 2004). For this purpose I have included in my project two long-stay psychiatric wards, within the same psychiatric hospital, one occupied by female patients and the other by male. Comparisons and contrasts were made, however, specific attention was given to draw inferences about the whole organization (hospital).

6.3.3. Reliability

The concept of reliability, as used in quantitative research, clashes strongly with the premises of qualitative approaches. Reliability refers to the consistency of the findings and entails stability of results over time, consistency between different investigators (inter-observer reliability) and consistency between results (internal reliability). It is difficult and even of no use to apply such criteria in a study based on semi-structured interviews and on un-structured observations of a particular context, which assumes that reality is subjective and constructed constantly. As Janesick (2000, p. 394) points out "the value of the case study is its uniqueness, consequently reliability in the traditional sense is pointless". However, advocates of qualitative

methods have not abandoned the concept of reliability, but have altered its meaning (Bryman 2004).

LeCompte and Goetz (1982) perceived external reliability as the extent to which a project can be replicated. Though they recognised the difficulty of freezing a social environment, they went on to suggest that in order to replicate a study a researcher should adopt a similar position to the original researcher. This is connected with what Bogdan and Taylor (1975) and Wolcott (1990) have suggested about providing a detailed account of the research process and techniques in order to increase the credibility of the findings. However, even by assuming the same role and the same processes, what these authors fail to recognise is the influence of personality and emotional factors and their interaction in a specific context.

Though the application of the external reliability criterion is dubious, the notion of internal reliability or inter-observer consistency (LeCompte & Goetz 1982) or dependability (Guba & Lincoln 1985, 1994) is much more adaptable to qualitative research. LeCompte and Goetz (1982) proposed the solution of multiple observers in order to reach consistency of what is heard or seen. In the course of a PhD thesis, this is evidently not applicable. Other researchers have suggested the use of auditors (Guba & Lincoln 1985, 1994, Greswell 1998) who should be provided with the full records of the research process and then examine whether or not the findings are supported by data. For this study, I have shared a number of interview transcripts and field notes with my supervisors and discussed my interpretations. The provision of full records of fieldwork was particularly difficult in my case, as the study was conducted in Greece and communication with my supervisors was conducted via e-mails.

6.4. Research Methods/Process
6.4.1. Criteria for selecting the participant organization
The selection of the participant organization was decided upon practical as well as theoretical grounds.

A primary practical reason for studying boredom in a psychiatric hospital, was the identification of the phenomenon in a similar setting while conducting my Masters dissertation. The project took place in a state mental hospital of North Greece and had disclosed that the sample, constituted of nurses, expressed behaviours associated to boredom (lack of interest, deteriorated performance, disengagement

from roles). It was, therefore, decided to investigate boredom in the setting that was initially observed.

Studying the existing literature on boredom, further reasons supported the selection of psychiatric hospital and psychiatric nurses as the participant organization and sample, respectively. First, it provided a contrast to the already studied organizational settings. The majority of psychological research on boredom was conducted in factory settings or artificial environments-laboratory (Smith 1981, Fisher 1998). The few studies concerned with other occupational settings have been limited in scope, as they have elaborated on issues that had been identified in those early investigations (repetitiveness).

A second reason regards the type of the organization. Choosing a public organization coincided with organization studies literature that regards most such institutions as under-performing and ineffective. While research of this type has explored variables (organizational and work design, incentives, rewards etc) that influence employees' performance and motivation, however, it has either neglected boredom or assumed it as granted without further investigating it.

In connection with the above, the selection of state mental hospital as the case study was considered appropriate in order to explore boredom in a non-typical public organization. As stated previously, boredom in public organizations is a common assumption, based, however, on research in administrative and governmental bodies. Public mental hospitals, on the other hand, constitute not only institutions run by the state but therapeutic environments where patients form the clientele and performance concerns health matters.

A last reason for the chosen organization regards my own predispositions. Previous work as a psychologist in similar settings has equipped me with a basic knowledge of work in such institutions. Moreover, the familiarity gained from these experiences as well as from field work for my Masters dissertation, was important for getting access to the specific organization.

6.4.2. Criteria for selecting a Greek psychiatric hospital

After several discussions with my supervisors, Greece was considered to be the most appropriate location for carrying out the study.

Among the most prominent reasons was my familiarity with the Greek public sector in general and the lack of any experiences with the British one. Cultural differences between the two countries, in respect to general perceptions of work and expression of emotions, were considered to be important. Including a British organization in the project, would require additional time in order to familiarise myself with structural and cultural attributes, something that was not feasible for a PhD thesis.

A second consideration regarded language issues. Because of the sensitive nature of the subject, it was necessary to acquire flexible communication skills in order to extract information regarding boredom without being straightforward. I considered my command of the English language not sufficient for this purpose. Furthermore, the possibility of loosing data because of misunderstandings or misinterpretations of language was a significant consideration to be made.

A last reason concerned the proliferation of both academic studies and media publications on the ineffectiveness of the Greek public sector. In association with the limited research on occupational boredom, it was considered best to carry out the study in Greece, where the likelihood of identifying the specific emotion was greater. The holistic approach that my thesis attempted to take, by including variables either neglected (organizational structure and culture) or under-studied (roles, meaning), necessitated the use of an environment that boredom would be easy to recognise and studied to a deeper and more thorough level. Studying relevant literature of British psychiatric hospitals, it was suspected that such a precondition would remain unmet or would complicate the project.

6.4.3. Contacting the organization/Access

The process of identifying the participant organizations started in March of 2004. Two psychiatric and one general hospital (with psychiatric department) were contacted. The procedure followed in all of them was identical. The initial stage was to present to the director of the Scientific Board of hospitals the research aims, procedure and timings and submit a formal request for access. Having informed my supervisors about a general trend in Greek public sector, especially in the higher hierarchical levels, not to openly discuss negative perceptions, emotions despite common awareness, it was decided not to reveal the real research aim. This, coupled with the negative connotations that are associated with boredom (Gemmill & Oakley 1992, Darden & Marks 1999, Mann 2007) were the basic reasons for referring to the broader concept of "emotions" instead of specializing our aim to "boredom".

Following that, I was told to wait for a reply. In May 2004, one of the psychiatric hospitals contacted me, accepting my proposal, while contact with the other two was completely lost. In October 2004 I returned to Greece in order to commence my field work. In my first visit to the hospital, I was informed that the documents that I had submitted (letter about the research' purposes signed by my supervisors and the research office along with the formal request form) had been lost and that the whole procedure should be repeated.

The necessary action was taken again and the final call from the hospital was received in late November. In my third visit in the hospital, I was informed that although the director of the Scientific Board was in accordance, I should address the issue to the Administration Board as well. Despite several calls to the hospital, the decision to permit access was only made in December. Despite the fact that all details had been arranged with the nursing director and the head nurses, I was informed by the secretary of the Scientific Board that I should present the project to the Board again. The reason for this second presentation was the Director's objection to observations. The Board expressed fears of including in my thesis behaviours that might be un-acceptable to outsiders. Following that and despite my affirmations of confidentiality and anonymity, the Board rejected completely observations in the ward.

A personal meeting was proposed by the neurologist for the following day. The recommendation I received was to follow my initial plan (including observations) as nobody would be aware of how long I would remain in the ward each day.

Eventually, field work commenced in the mid of January after Christmas vacation. It should be noticed at this point, that my I remained in the wards throughout the field-work. The head nurses, with whom I had discussed the aim and methodology of my research, were in accordance and had informed all staff about my presence in the wards.

6.4.4. Recruiting participants

The process of recruitment has not been formal. Staff of the participant wards had been informed about the research and the procedure by their head nurses. Participation in the project was dependent solely on individuals' interest and willingness. As the Scientific Board had stressed repeatedly, there should not be any

kind of pressure, nor from my part or officially (from head nurse or administration), on staff in engaging in the research.

Throughout field work, interviews were arranged and conducted on the spot. The whole process relied on nurses' good will and mood at a given time.

a. Description of sample

In this section, a brief description of the sample is presented. Apart from nurses who actively took part in the study, through interviews, the table below includes nurses who were not formally interviewed but who have been observed and have disclosed personal feelings and opinions, either to the researcher or to their co-employees, in the form of spontaneous conversations. All staff were aware of the research procedure, including observations.

The tables (2 & 3) below describe the sample in the two wards (female and male).

Table 2: Female Ward

	Name	Age	Title	Years of employment	Special Features	Marital Status
1	Roula	30-35	Head nurse	15	Hard-working, expected transfer to a new unit	Single
2	Panos (male)	30	Responsible		Active, engaged in a nursing organization	Single
3	Toula	23	Practical nurse	1		Single
4	Maria	23	Practical nurse	1	Under psychiatric medication	Single
5	Vaso	45-50	Practical nurse	21		Married
6	Soula	40-45	Practical nurse	23	Timid, fearful of developing health problems by being in this environment. Under psychiatric medication	Married

	Name	Age	Title	Years of employment	Special Features	Marital Status
7	Matzi	45-50	Graduate of old nursing school	22	Under psychiatric medication	Single
8	Thomas (male)	30	Trained nurse	3 months	Timid, employed with the law regarding people with disabilities	Single
9	Voula	45	Practical nurse	18	Talkative, out-going	Married
10	Theodora	50-55	Practical nurse	22	Expected transfer to another unit, very strict	Married
11	Elisavet	28	Trained nurse	5		Single
12	Christina	40	Trained nurse (probably)		Focused on her job, active, replaced the responsible and the head nurse in case of their absence	Married
13	Xenia	40	Practical nurse	17		Married

Table 3: Male Ward

	Name	Age	Title	Years of employment	Special features	Marital status
1	Rena	35	Head nurse	16		Married
2	Marina	29	Trained nurse	7	Active	Single
3	Katerina	31	Trained nurse	9		Single
4	Sofia	33	Trained nurse	10		Single
5	Dina	40	Trained nurse	15		Single
6	Efi	45	Practical nurse	18		Married
7	Kostas (male)	45	Practical nurse	18	Detached from the group, concealing feelings	Single

b. Titles

In this section, the titles of staff in the wards are explained. It should be noticed that these descriptions stemmed from observations and from respondents. As the sample disclosed, there were no formal duties attached to each position. Furthermore, the categorization of staff as "trained" or "practical" nurse should not be regarded in absolute terms because nursing education in Greece is quite complicated, due to the variety of courses offered and the absence of any formal classification of these schools.

Head nurse: typically, a graduate of a University course in Nursing holds this position. Such courses vary in the number years that are necessary for completion (there are 3-year and 4-year courses). The duties of the head nurse regard the general management of the ward, as for example allocation of staff in different shifts, supervision of subordinates and in some cases duties also include the undertaking of clear nursing activities.

Responsible of the ward: typically, a graduate of a University course in Nursing. However, the position may also be appointed to people without such advanced education but with many years of experience in the field. The responsible shares the same duties with the head nurse and usually acts as an assistant. Additional duties

involve allocating medication, informing the patients' book and undertaking nursing tasks.

Trained nurse: nurses who have graduated from University or from a 2-year nursing course.

Practical nurse: nurses who have no nursing education or those who have graduated from the old nursing schools that emphasised the ethical/moral aspect of nursing.

6.5. Data Collection
6.5.1. Interviews
As Paul ten Have (1999) has argued, the most popular style of conducting qualitative social research is to interview a number of individuals. However, not all social research is based on interviews nor all interviews are conducted in the same way (Kvale 1996). Ontological, epistemological assumptions as well as research aims determine the use of interviewing as a method for gathering data (Kvale 1996, Descombe 2003).

In the present research two significant factors have determined the employment of interviews as the particular tool for data accumulation: the first concerned the aim of the project, which was to explore boredom in a natural work setting. Prior research has identified boredom in specific settings (laboratories or factories) and with particular samples (students or blue-collar workers). The lack of detailed information regarding professionals required a research tool that would extract information from such novel samples.

Moreover, the investigation of boredom so far has been limited to objectified/measurable factors, such as work or personality and/or individual variables. As Kvale (1996) argues, scientific psychology has neglected the knowledge produced by human conversation and relied heavily on the principles of natural sciences. In contrast, the aim of this project was to identify the subjective perceptions and meanings of work boredom. Qualitative interviews allow the individual to express his/her opinions/thought/emotions and provide an insight into what the interviewee perceives as relevant or important (Bryman 2004).

The second factor determining the use of interviews, regarded the nature of the phenomenon under study. Boredom, falls into two of the categories described by

Descombe (2003) as necessitating the use of interviewing: it is an emotion and therefore can only be identified by asking people and secondly it is considered a sensitive issue. The latter may be justified both by the amount of literature which has elaborated the phenomenon and by a general tendency to view boredom as a personal failure. Sociologists Darden and Marks (1999) have argued that boredom constitutes a "socially disvalued emotion", largely neglected by researchers despite its prevalence and its frequent occurrence. Furthermore, the eligibility of boredom may be acknowledged for certain occupations, which entail considerable amount of repetition and sustained attention. In opposition, for health care professions, boredom is a condition both morally and professionally unacceptable. Since the selected sample was constituted of psychiatric nurses, the need for a flexible and open approach to investigate boredom could not be surmounted.

6.5.2. Semi-structured interviews

Qualitative interviewing is categorised into two broad types: the totally un-structured and the semi-structured interview (Bryman 2004). While the first allows maximum freedom of the interviewees and control over the interview process, it does not ensure that certain issues will be covered or that the interviewee will be inclined into talking, as they may limit their responses to the simple facts (Corbin & Morse 2003).

Semi-structured interviews offer the opportunity to the researcher to investigate issues relevant to the research topic and simultaneously provide interviewees with considerable autonomy to reply in their own way (Bryman 2004).

The development of the interview guide was based on three basic sources: literature, past research and existing questionnaires. Three main areas have been identified as important for the investigation of occupational boredom: job characteristics, organizational features and personal perceptions of the nursing role.

At the initial stage interviews were quite focused on these subjects, allowing however the interviewees to talk about issues in which they had a personal interest. There were several alterations in the interview guide during field work. As observations of the wards had disclosed themes that their occurrence seemed significant to the sample, questions regarding those themes were also included. For example a theme that was identified even from the first days in the first ward was quarrels between nurses. Since the sample was preoccupied with those incidents, it seemed useful to inquire it further.

Moreover, some of the themes which had been initially incorporated into the interview guide had to be abolished as they had no actual application to reality. For example the issue of performance measures was identified to be irrelevant to the particular context, as the initial interviews had revealed. Most of the changes in the interview guide were made on the spot, depending on the personality, educational background and the communication style of interviewees. This is aligned with Kvale's (1996) argument about qualitative interviews being a craft and depending largely on decisions made during the process. Some of the interviewees expected specific questions and replied in a conservative and restricted manner. In such cases all questions from the guide were asked and no alteration was made. When an interviewee was perceived to be more relaxed and willing to actively participate in the process, interviews were taking the form of a "professional conversation" as Kvale (1996, p.5) argued. Questions from the guide, served only for re-establishing the focus on the research topic in cases where interviewees were overwhelmed by their own issues.

Another alteration in the interview guide concerned the language used. Because questions derived from theoretical concepts their perception by some interviewees seemed difficult, as the initial interviews indicated. Some of the concepts were more abstract (for example roles, meaning, goals) and needed to be altered or paraphrased in more conceivable terms. Attention was given to limit any discrepancies between the primary theoretical concept and the subsequent question. This was achieved by combining questions and going back and forth to issues that had been already discussed. For example, many nurses had a difficulty to conceptualize the term 'role'. In order to solve this, I relied on nurses' answers regarding views of patients, of the hospital and rephrase them into a new context in order to extract their perception of their role. The question "what is your role?" was altered into "you say that patients are incurable and the hospital is just a shelter, then what do you do in here?". Such adjustments in the order and wording of questions are eligible in the frame of qualitative interviews, as the aim is to gain insights into the subjects' personal views (Bryman 2004).

6.5.3. Audio-taping

The usefulness of tape-recording interviews consists of two basic advantages: first it allows the interview to proceed normally by giving the opportunity to the researcher to fully engage in what is being said without being distracted by note-taking (Bryman

2004). Secondly, it provides a vast amount of data regarding the dynamics of the interview (Kvale 1996). As Bryman (2004) notes, it is of particular interest not only what the interviewee says but also the way that says it. Pauses, tone and the like may offer valuable information that can be also assessed, as they might reflect emotional states or discrepancies between what is said and what is felt. Moreover, tape-recording can be extremely useful for particularly lengthy interviews.

Unfortunately the majority of the sample refused to be tape-recorded. Despite affirmations regarding confidentiality, the sample was uncomfortable with recording. Efforts to introduce a tape-recorder were also made during the interview and after the interviewees were more relaxed and accustomed with the situation, but the sample was persistent to the initial refusal. Only 4 interviewees allowed the tape-recorder, while for the rest note-taking was the only alternative.

With the consent of the interviewees notes were taken during the interview process. Despite the arguments against this, as it interrupts the procedure (Bryman 2004), it was considered most appropriate in order not to lose any information. The option to write down the interviews after being conducted was abolished, as there would be several restrictions. As Kvale (1996) points out, not only there is a limited amount of information that can be sustained for a long period, especially in case of long interviews, but also memory can be selective influenced by biases.

Note-keeping included not only the content of speech but also behavioural cues, such as facial expressions, gestures, tone of voice in order to have a fuller account of the interviewees' perceptions. Additional information regarding the interview process as well as further remarks on the respondents was written after the interview.

6.5.4. Interview context/Relationship with sample

All interviews were conducted in private, in a specific room used as a storage area for drugs. The room was clean and comfortable enough, equipped with all the necessities for an interview to take place: two desks, chairs and a small sofa. The room could be locked, as it did, in order to avoid patients' intrusion. Furthermore it was located at a distance from the nursing station and the head nurse's office, which ensured that no overhearing could be attempted. However, there were instances that the interview process was interrupted, either because a drug was in demand or, more rarely, the interviewee was needed. Overall, the location of interviews met the requirements suggested by Descombe (2003).

The establishment of a good rapport between the researcher and the informants is a prerequisite for a successful interview to take place (Kvale 1996). Disciplines such as clinical psychology and psychotherapy, which rely on interviewing, have placed the development of a trusting and empathetic relationship among the primary concerns that a therapist should have (Kvale 1996). Similarly, in a research project that aims at identifying the emotions, experiences and inner thoughts of the subjects' work life, the priority should be given to the creation of an atmosphere in which interviewees will feel free to open up. Affirmations about confidentiality and anonymity, though a basic and necessary first step (Kvale 1996), do not always presuppose that the interviewee will be willing to disclose personal experiences. Additional preconditions need to be covered, in order to allow more free expressions. According to Kvale (1996) giving time to interviewees to familiarise themselves both with the concept of being interviewed and with the interviewer, is a helpful and valuable first approach. In the framework of the micro-ethnographic research, it is expected that considerable time would be spent in the field (Bryman 2004). This has enabled the sample and me to familiarise with each other before being engaged in the interview process. At the beginning of field work, my concerns involved: provide information about the project, confirming my status as a student (and not as a 'scholar' or a representative of administration) and motivate nurses to participate in the interviews. Within limits, I tried to imitate the sample's linguistic style and get involved in the occurring small-talks.

A second issue stressed by Kvale (1996) regards the researcher's behaviour during the interview. Qualities such as being clear, gentle and an active listener are valuable in order to make respondents to open up (Kvale 1996). My educational background and work experience as a psychologist have proved to be extremely helpful in this. All interviews started by confirming anonymity and by asking easy questions, regarding the work history of the interviewees. Re-briefing answers, providing empathy and understanding and employing a naïve curiosity were some of the strategies applied in order to achieve the double aim of extracting information and yet sustain a relaxed atmosphere.

Despite the strategies and approaches employed, there were individuals who strongly refused to be interviewed and others whose initial consent was followed by typical or socially desired replies. The overall feeling that I got from the sample was that of "cannot be bothered".

6.5.5. Observations

Observations in qualitative research have been closely associated with ethnographic studies, suggesting that the researcher participates in a particular social group or organization, in order to understand the culture, processes and meanings of events that occur in a specific setting (Patterson, Bottorff & Hewat 2003, Bryman 2004). There is a considerable confusion regarding the terms participant observation and ethnography, as the two are often used interchangeably or signify different meanings (Bryman 2004). In a very simplistic approach, the researcher's participation has been perceived in two distinct ways, having further methodological implications. Disciplines such as sociology and anthropology have stressed the importance of the complete integration of the researcher in the context under investigation. In this framework, participant observation implies that the researcher actually becomes a member of a group, concealing his/her real identity and "living" the life of that group (Paterson, Bottorff & Hewat 2003, ten Have 2004). The methodological implications of such principles regard: the type of data that will be gathered, usually a detailed description of the specific culture (ten Have 2004), the data sources that will be used, will the researcher provide a subjective and personal account or will he/she manage to objectify reality (Bell 1999) and lastly the long time spent in the field (Bryman 2004, Hammersley 2004).

Departing from this perspective, observations vary across disciplines and methodological principles. For example, Paul ten Have (2004) talks about "facet-ethnographies" where observations are focused on specific aspects of the life studied. Similarly Bryman (2004) described "micro-ethnographies" as research that places attention to a tightly-defined topic, is conducted during a short period of time (from a couple of weeks to a few months) and in a full- or part-time basis. In sociological ethnography, observational data are gathered by "hanging out" with a group or a subculture and not actively participating in its activities (Silverman 2000, Descombe 2003).

In the present research observations were included with a broader conceptualization, as a means for gathering and triangulating data. The value of observations lies in the fact that they enable the researcher to "draw inferences about someone's meaning and perspective that couldn't be obtained relying exclusively on interview data" (Maxwell 1996, p.75). Even in this perspective, the role of the researcher remains an important aspect of observations. A first decision to be made concerns whether the

identity of the researcher will remain disclosed or revealed. In my case, the issue was resolved very early on by the selection of the setting. Choosing a psychiatric hospital as the case study, inevitably led to assuming an overt role in order to gain access. The alternative of working in the hospital was not feasible, since there are certain procedures for hiring new staff and secondly I had no qualifications as a nurse. Despite the fact that my identity was "open" to the sample, however it remained disclosed to patients. In both wards nurses introduced me to patients as a "psychologist", a new employee of the hospital.

The second issue stressed by Gold (1958) was the degree of participation. Gold (1958) has classified participant-observer roles into a continuum ranging from involvement of the complete participant to detachment of the complete observer. In between variations regard the role of participant-as-observer that is the researcher actively participates in the activities of the group but his/her identity remains open and the observer-as-participant which entails no participation but allows interaction with the group under study, in contrast to the complete observer. Being an observer-as-participant was selected upon the same grounds as with assuming an overt role. Though no participation in the activities of nurses was a straightforward matter, however being completely detached from any interaction with sample and with patients was not possible. The decision to combine interviews and observations as data gathering tools predetermined a kind of rapport with the sample which would not be accomplished by retaining an isolated stance. As Bryman (2004) argues the kind of role the researcher adopts has significant implications for field relationships.

It is however important to note that some trivial form of participation existed. Bryman (2004) sites ethnographies where the distinction between being an active or passive participant is not clear. Considering the type of patients and the physical environment of the wards, interaction with patients seemed inevitable. As field work progressed and patients had become accustomed to my presence there were instances where I acted as an employee of the hospital. For example patients' usual request for cigarettes was directed to me several times. Another example is that many of the patients would start a conversation with me. It felt ethically correct to engage in these small-talks though in all instances I kept them short. In other cases, though more rarely, I acted as an informant between patients and nurses. Patients would talk about health problems or general worries and I was found to inform nurses about them. Attention was given not to make the sample feel "inadequate" or "indifferent" so I supplied any information in the form of questions or as naïve curiosity. Luckily, no

serious problems were reported to me and I didn't have to 'abandon' my research identity.

6.5.6. What was observed/ Field notes

Being in the field as an observer yields the important question of what is going to be observed, which further extends to issues of validity and reliability. Observations as a method for collecting data, acquire inherent problems because they tend to be inconsistent between researchers and because they provide data that are influenced by the personal circumstances of each researcher (Descombe 2003). It is highly unlikely that two researchers will produce the same accounts of the things that they jointly observe. Issues of competence, familiarity, past experiences and psychological state may affect the selection of stimuli that will be observed (Descombe 2003). Producing a list with activities and behaviours that should be seek out and note down their frequencies, a method referred as 'systematic observation', would be a solution to the problem of variance between researchers (Descombe 2003).

However, the aim of the present project as well as theoretical limitations justified the selection of a more open approach. Many theorists (Van Maanen 1988, Silverman 2000, Descombe 2004) point out that observations should follow a continuum, starting as non-selective and gradually becoming more focused and specific. It is of particular importance to try and gain an overall feel for the situation and write down whatever impressions occur because, as Van Maanen (1988) contends, it will be difficult to know in advance what will or will not be useful in the future. This strategy is preferable when the research questions are not strictly pre-defined or even totally absent (Bryman 2004). Considering the absence of any concrete data on the behavioural manifestations of boredom, I could only use the relevant theories as suggestions and not as definite cues to look for. For example, it has been proposed that boredom resembles a sleep-like state (McBain 1970, Damrad- Frye & Laird 1989) but such condition may also imply tiredness. Similarly, perception of the passage of time, which is considered a dimension of boredom, cannot be inferred exclusively by behaviours such as watching the clock. It was therefore necessary to double-check such behaviours with questions, before note them down as observable signs of boredom.

Aside from these theoretical considerations, the aim of the study was to provide an inter-disciplinary approach to boredom. In consequence, observations had to include

concepts deriving from diverse disciplines, such occupational psychology, cognitive psychology and sociology. Each of these theoretical frameworks indicates the search of different aspects of boredom which had to be captured by observations. I started my observations bearing this in mind and trying to be open about the things that were going to be noted down. At the initial stage, attention was given to duties, activities and rituals that took place in the wards. As time progressed and the same actions were repeated, observations became more focused to issues such as time distribution among tasks and breaks, nurses' expressions or attitudes while performing a task and body postures and general conduct while at a break.

Because of the relatively fast saturation of these categories and the information obtained from interviews, the focus of observations shifted to more complex themes, such as staff' relationships, attitudes towards patients, inconsistencies between what the sample revealed in interviews and what was actually doing and the role of particular people that expressed 'deviant' behaviours.

Because of the low-level of activity that occurred in the wards, field notes included a great amount of conversations among staff. As it is suggested by Silverman (2000) it is extremely important to note down "what you can see as well as hear" (p.126). Listening to what people discussed during their work time provided double information: first, according to cognitive studies, irrelevant-to-work talk may be a sign of boredom or of low interest in the job (McBain 1970, Gardner, Dunham, Cummings & Pierce 1989, Fisher 1998) and secondly the conversational content and the language used may offer valuable insights about individuals' perceptions of their work reality.

A crucial issue about observations regards note-taking. How, where and when the researcher should write down what is observed. All theorists (Silverman 2000, Descombe 2003, Bryman 2004) stress the importance of private note-taking in order not to disrupt the naturalness of the setting and not to make the sample under study self-conscious of the research process. As those authors dictate the best way to take notes is to privately jot down "little phrases, quotes, key words and the like" (Lofland & Lofland 1995, p.90) in order to help memory and at the end of each field session write down full accounts of those "scratched notes". It was difficult to make notes while in the field as most of the time nurses were gathered in the nursing station. Wandering around the wards and keeping my notes in private (for example in the patients' dorms) was not an option, first because it would be considered by the staff

as 'invasion' or 'checking out' and secondly because it would upset patients' lives. I tried to keep notes whenever staff where out of the nursing station, performing their duties. In order not to lose any observational data, I divided time between observing and going back in the station to note down my impressions. Because my role was overt and nurses acclaimed to have been used to students coming in the ward for research, some brief notes were also kept in the presence of the sample, but that was after a long period of being in the field. Detailed notes were written down on my way home.

6.6. Data Analysis

6.6.1. Introduction

It is commonly acknowledged that qualitative research, in its whole, fails to provide readers with detailed and structured accounts of the ways in which data are analysed and how certain interpretations or conclusions are reached (Burgess 1982). To an extent, this is explained by the processes of creativity, intuition and imagination that are involved when analysing qualitative data and which are often difficult to be made explicit (Jones 1985, Coffey & Atkinson 1996).

There are various approaches of data analysis that could be clustered in three sets, according to Tesch (1990):

1. language oriented, which are interested in the use of language and the meaning of words
2. descriptive/interpretive oriented, which include detailed descriptions and interpretations of phenomena as well as their meaning to those who experience it
3. theory-building oriented, that attempt to identify connections between social phenomena.

Though each of these approaches has its own rationale and seeks different information, they all share some common features. Miles and Huberman (1994) and Dey (1993) suggest similar processes that could be summarized as: breaking down and identifying data, classifying data into relevant themes and identifying the ways in which those themes are connected.

I have placed my data analysis in the second set of Tesch's (1990) classification, since my aim was first to provide an interdisciplinary account of occupational

boredom and therefore not to suggest a new theory and secondly to describe boredom and its meaning in a novel context.

6.6.2. Thematic analysis

According to Boyatzis (1998) thematic analysis is a way of seeing, a process that involves both logical and intuitive thinking (Ritchie & Spencer 1994) by which the researcher makes judgements about meaning, identifies important issues and connects ideas. As such thematic analysis can be applied to research data of various disciplines, regardless of their specific epistemological and ontological orientation (Boyatzis 1998). The rationale for choosing thematic analysis rests in two factors: first, my research draws from diverse disciplines, such as occupational psychology and sociology and secondly it involves data from multiple sources (interviews and observations).

For some theorists the term 'theme' refers to a specific category or topic that is identified in the data (Patton 2002) while for others it is closely connected with the frequency of occurrence of specific incidents, words or phrases (Bryman & Burgess 1994). A more inclusive conceptualization derives from Boyatzis (1998) who asserts that "a theme is a pattern found in the information that at minimum describes and organizes the possible observations and at maximum interprets aspects of the phenomenon" (Boyatzis 1998, p.4). The generation of themes can be done either inductively (themes deriving from raw data) or deductively (themes developed according to prior theory or research). For theory-driven codes, the researcher begins with the existing theories of what occurs and then decides upon the signals that support this theory. Pre-determined codes may not be useful for all projects. As Strauss and Corbin (1990) pointed out, when describing methods and techniques of grounded theory, codes should be developed directly from close examination of data. However, Miles and Huberman (1994) suggest as the preferred method to create a 'provisional start list of codes prior fieldwork' (Miles & Huberman 1994, p.58) because, as these authors contend, it helps connecting research questions directly to the data. Nevertheless, having a pre-determined list of themes does not mean that these themes are definite. On the contrary, it's the data that will ultimately suggest what is useful or applicable and it should be expected that redefining or discarding certain codes will be part of the process (Miles & Huberman 1994). The process that is followed is comprised of three stages: in the first stage, a list of themes is developed often by using the interview topic guide or theoretical concepts. These themes may encompass sub-themes that are related to a broader concept.

Depending on the extent to which the interview guide is structured, the number of pre-determined themes and sub-themes varies. It is crucial, at this stage, to keep a balance between not considering data by using an extensive list of themes and having no direction by having a sparse set of pre-determined themes.

At the second stage, data is viewed thoroughly in order to identify sections, phrases or even words that are relevant to the previously produced themes. It is at this phase that new codes may emerge and previous ones need to be abolished or that a code classified as a sub-theme of a broader category fits better under another category. One of the strengths of thematic analysis, that is being made obvious at this phase, is that it allows for same segments of data to be classified under more than one code/theme.

After all data is read through and classified, the process of interpretation takes place, in the form of commentary on theory.

6.6.3. Process of theme/code development

A recent tendency among qualitative researchers regards the use computer programmes for the categorization and management of data. The aid offered by such programmes is enormous, especially when data is voluminous, and it basically involves segmenting, sorting out, re-organizing and finding commonalities, differences, patterns and structures (Basit 2003). Carrying out all these actions manually, not only can be a very tedious and slow process but it also restricts detailed analysis. As Seale and Silverman (1997) suggested the rigour of qualitative research is enhanced by the use of computer programmes for data analysis.

Despite the advantages of using computers, I have preferred to carry out the process manually. A primary factor for this decision was my desire to get a thorough grasp of the data, which was achieved through multiple revisions of the interviews and field notes. It has been suggested that computer programmes distance researchers from their data (Seidel 1991). The work of computer programmes is to search for relevant segments of data retrieve them and categorise them under the label that the researcher has assigned. Whilst this is a valuable assistance, it conceals two problems: the first concerns that data are de-contextualised and therefore their completeness might be lost and the second regards the inability of computers to search not for actual content of segments but for their meaning (Catterall & Maclaran 1996).

In this study, I have used prior theories on boredom in order to create a list of the themes that were relevant. Those themes derived from four sets of literature: psychological theories (cognitive and occupational psychology), sociological theories (symbolic interaction and existentialism), nursing and public organization studies. Each of the first three theoretical strands entails a different conceptualization of boredom and consequently proposes diverse indicators to be looked for. For example cognitive psychology seeks attentional failures, errors in performance that result from boredom. Occupational psychology stresses the importance of task repetitiveness and absence of clear work goals in the development of boring experiences. Sociological theories include contextual factors, such as norms or socially constructed meanings as well as subjective perceptions of work roles and work environment. Nursing literature has provided the framework for understanding what psychiatric nursing entails and for identifying contrasts between theory and practice. Lastly, literature on public organizations and in specific bureaucracies, has been the basis for understanding the function of the psychiatric hospital and for identifying any contextual factors that may interfere in the experience of boredom.

Data comprised of interview and informal conversation transcripts and field notes and was coded according to those initial categories. All words, sentences, phrases and paragraphs that were connected to the pre-identified categories and sub-categories were underlined and the name of the appropriate category was inserted in the margins of the text. In order to facilitate the coding procedure, all texts had dates and names of interviewees. All codes were written down on a separate paper and the names and dates that were associated to a particular code were inserted next to it.

The initial themes extracted from these theories involved: the nursing job in terms of duties, exercise of skills and knowledge, level of difficulty and goal-setting (Chapter 3, section 3.5).

A second theme concerned work features in terms of organization design, culture, structure and processes. The initial sub-themes regarded issues of performance measurements, rewards, level of autonomy, career prospects, co-operation with other professionals and staff relations (Chapter 2, section 2.2).

Taken from sociological literature, the third theme addressed the issue of roles. According to sociological theories, role-perception is associated with a number of

concepts: professional training, work context, duties and activities and perception of the recipients and/or results of work (Chapter 2, section 2.5).

At the initial stage of coding, the four broad themes that were developed, each of which containing a number of sub-categories, were, as shown in the table (table 4) below:

Table 4: Thematic Categories

Nursing job	Job features	Roles	Behaviour
Duties and tasks performed in the wards	Existence of performance measures and rewards	Emotional labour and caring	Attention given to tasks
Difficulty of tasks	Level of autonomy	Perception of patients	Absenteeism
Goal setting	Staff relations	Factors affecting the occupational decision (e.g. preference)	Amount and type of interaction with patients
Pleasure/Interest in the job	Career prospects	Meaning deriving from the job	Activities in the nursing station
Exercise of skills	Co-operation with other professionals	Exercise of skills	Levels of arousal or sluggishness, expression of sleep-like states
		Social status	Staff relations
Perception of passage of time			

As it is seen some of the sub-categories were classified under more than one of the broader themes. This was because of the researcher's double intention: first to get a description of the nursing job and the hosting organization and secondly to extract subjects' personal meanings of those attributes. Moreover, the double use of the same sub-category was regarded appropriate due its theoretical association with the broader themes. For example, "exercise of skills and knowledge" was placed under the "nursing job" in order to identify what skills have been acquired and actually practiced in the particular context and also in the "roles" category due to the assumption that roles are defined, partially, by the skills and qualifications obtained.

Reading through the data, the above sub-categories were expanded and re-organized, a number of themes have emerged, of which some related to the pre-existing categories and some comprised new concepts. For example it was revealed

that the combination of two sub-categories 'co-operation with other professionals' and 'level of autonomy' was related to nurses' perception about their position in the hierarchy and their social status, so it was decided that the theme 'social status' should remain encompassing the concept of co-operation. Additionally, the 'level of difficulty' had to be divided into two sub-categories: task difficulty and difficulty of the job, which was related to the type of patients. While nurses perceived their actual tasks as easy, the difficulty of their profession was conceptualized in terms of patient type and in consequence the type of interactions with them. In respect to the sub-theme "perception of time passage", it was decided to be classified under the "behaviour" category because it was associated closer to nurses' actual behaviour and not to the exercise of nursing, as it was assumed initially.

The new thematic sub-categories that were developed were: in the "roles" category, interviews conveyed that an important aspect of the perception of the nursing role was staff's prior expectations about the hospital and the job, as well as their first impressions. The introduction of the "negligent behaviour/misconduct" was based upon observations and interviews and comprised of all data (stories, incidents and observed behaviours) that signified inattention, mistakes, neglect of duties. The revelation of such incidents was followed by justifications that nurses made in order to excuse themselves. These attributions were of three types:

        a. type of patients (blame patients)

        b. group and organizational norms (blame other staff, hospital)

        c. personal characteristics (education, emotional fatigue).

Due to their interrelation with the pre-existing categories they were categorised as such, presented in Table 5:

Table 5: New Themes

Nursing job	Job features	Roles	Behaviour	Emotions
Difficulty of tasks	Responsibility	Prior expectations	Incidents of negligence and misconduct	Fear of mental illness
Difficulty of job	Group norms	First impressions	Perception of passage of time	Freeze response
	Organizational norms			Depression

As it is seen from the table, new themes and codes were developed. At a deeper level of analysis, the excuses nurses provided for their negligence (blaming patients or the hospital), raised two issues: their sense of responsibility and of control. All data were revised in order to search for cues that were revealing the absence of control and the low sense of responsibility and coded as such. As expected, some of the text segments had two or more codes inserted next to them. Specifically, the "responsibility" code was inserted in every segment that revealed nurses' attributions about the outcomes of their behaviour and the code "freeze response" was added in data concerning nurses' low sense of control and inability to change or improve their situation.

From psychological theories about the association of the "freeze response" condition with depression (Seligman 1974, Martinko & Gardner 1982, Hill & Larson 1992), a new theme emerged, which was named "emotions". Theory suggests that among the basic constituents of depression are: having no future expectations, the perceived locus of control is outside the individual or there is no sense of control, loss of interest, sense of futility, loss of hope (Bardgill 2000, Vodanovich & Kass 1990, Vodanovich & Mikulas 1993). Data were reviewed again and all segments that signified the above were copied and pasted in another paper and coded as "depression".

Analysing the data in the view of nurses' emotional condition, a new sub-theme was identified, which was named fear of madness. This label encompassed all discussions that referred to nurses' health problems developed over the years of working in the hospital, their out-of-work behaviour (e.g. not tolerating any noise), their perceptions of their work behaviour (e.g. shouting or losing their temper) and of the unlimited possibilities for anyone to suffer from a mental illness.

In conclusion, the process of code development was characterised by several revisions of the accumulated data. I have started analysis using a provisional list of themes, suggested by the literature, which provided a thick description of the life in the two wards and of nurses' general behaviour. At a second level, the existing themes were re-organized and new associations were found. Data were reviewed in the light of these new connections and new codes emerged. Writing up began very early on, something that helped me both to organize better and analyse more in depth my data. It was a process that relied in intuition, in the sense that while I was

writing, new ideas were coming up and they were then verified by searching in the data for relevant quotes or notes.

Chapter 7: Job Features

7.1. Performance measures-Rewards

It has been argued that jobs that are not intrinsically interesting or enjoyable require extrinsic motivations (pay, prestige, promotion opportunities) in order to decrease the boredom that is imposed (Hamilton, Haier & Buchsbaum 1984). In a similar vein, research on boredom proneness and work values (Vodanovich, Weddle & Piotrowski 1997) has identified that, high boredom-prone individuals had higher external work value scores (earnings, social status, upward striving) than those lower in boredom proneness. Since performance measures have been traditionally regarded as methods for setting targets for employees (Deci & Ryan 1985, Coates 1996), they have been included in the present study as external motivators that may decrease boredom. Nurses were explicitly asked about whether and how their work was evaluated and whether these performance measures have been affecting the outcomes of their job and their general attitude.

Like all public organizations in Greece, the psychiatric hospital did not utilize performance measures (Tsoukas 1994), hence the absence of rewards and penalties for good performance and for misconduct respectively. Nurses' work was evaluated only by the head nurse and only informally. This evaluation usually took place during work and involved only possible mistakes and corrections as well as positive comments when a difficult situation was solved. Nursing work in the long-stay ward consisted only of basic duties and was aimed at the mere survival of patients. However nurses felt that being with those patients and taking care of them 24 hours a day was something that merited recognition and reward. This demand stemmed from beliefs regarding patients and their job (being with the recluses of society, being at risk, doing an unhealthy profession) and involved both tangible as well as intangible rewards. The disrespect with which the nursing profession was regarded reflected the hospital's management and governmental policies. Nurses talked about a general indifference on the part of doctors and management for what they offer to patients. They expected from their co-employees to understand them and recognise their work. Although they failed to be more specific about what their reward should be, their demands concerned mostly appreciation and respect for them. Many nurses said about not hearing even a "thank you" from their superiors and they mentioned that their only reward was patients' expressions of love and gratitude. Apart those vague demands, nurses also referred to governmental policies regarding their profession. They thought that it was unacceptable not to receive special packages for their work, such as supplements for doing a dangerous and unhealthy profession.

Another request was related to the vacations to which they were entitled. Like all employees in Greece they could receive only one month vacation leave. They argued this was too little due to the nature of their occupation. According to them psychiatric nursing was very demanding and psychologically exhausting. Anna argued "We need at least two months in order to relax and to forget patients' screams", Theodora commented "They (government) do not even do the least for us. And not only they give us nothing for salary, they have completely forgotten us", while Fotini and Vaso added, respectively "They don't know what it's like to work in here. Alright we have poor wages but at least give us more vacation time. Not for anything else but in order to come back with our batteries full" and "We do all the work and doctors get the money".

7.2. Career prospects

Promotion opportunities have been identified as a work factor determining not only employee involvement and motivation (Nabi 2000) but occupational boredom as well (Lee 1986). According to a study conducted by Vodanovich, Kass and Callender (2001) it was identified that, individuals who were less satisfied with their career prospects experienced increased levels of job boredom.

Nurses' career prospects were not discussed in detail. According to the head nurse and a couple of trained nurses, career advancement was a matter not based on meritocracy but on good and valuable acquaintances in the hospital. Typically, nurses who had received the psychiatric specialty, who had attended seminars and who had given lectures were preferred for advanced positions (mainly administrative). However, there were cases where individuals with no such qualifications held very demanding job positions only because of their political preferences or of their friends who were high in the hierarchy. There were also reports about head nurses, in other wards, who "had no clue about nursing and generally about the job". Nurses didn't have high expectations for themselves. They were totally aware of their skills and capabilities and whether they could require career advancement. Nonetheless, it was odd the fact that they didn't care to develop their knowledge and improve their position in the hospital, since they didn't like the current one. This was explained by two factors: the first of which related to age. Most of the staff were middle-age married women, with many years of experience in the hospital and who soon would be retired. They considered it futile expanding their training since in a few years they would leave the hospital permanently and they also had personal activities to be occupied with. As some of them said, like Efi "I have

three kids waiting for me at home, I can't start going to seminars", Theodora "why should I do it? I work here 25 years and I know all there is to know" and Voula "I just wait to get retired. I can't wait for the day that I will never have to come here again". The second factor was nurses' awareness that nothing would change in their work life by attending seminars. Most of the sample didn't belong to a union or to a political party and didn't have powerful friends in the hospital, factors that are of extreme importance in all Greek public organizations. With the change of the government in 2004, a new general director was appointed in the hospital. Nurses talked with severe realism and cynicism about their career prospects. Sarcasm was a common approach to the term "career" since their beliefs about nursing were totally negative. In their minds they were contemned to do a dirty, demanding and un-rewarding job.

7.3. Level of autonomy

Organizational psychology studies (Turner & Lawrence 1965, Hackman & Oldham 1975, Breaugh 1985) have stressed the significance of work autonomy levels being related to the occurrence of boredom. Research in industrial settings has identified that even the mere change from machine- to individual-paced work may reduced workers' boredom (Thackray 1981). Moreover, literature on public organizations (Heffron 1989) refers to the low levels of employee autonomy (due to strict hierarchies and standard procedures) as one of the factors contributing to expressed idleness, low motivation and boredom.

In the case of nursing, studies (Durand-Thomas, Beaven, Blacksmith, Ekland, Hein, Osborne & Reno 1999, Stuart, Worley, Morris & Bevilacqua 2000) have shown that the lack of autonomy and participation in decision-making are some of the problems that nurses commonly encounter.

The findings indicated that the majority of nurses, with the exception of the head nurses and the responsibles of the wards, felt that they were deprived from taking any initiative and that they possessed little autonomy. Nurses' replies could be distinguished into two categories: the first comprised of answers that revealed no autonomy due to fear, lack of education and group/hospital norms. Matzi, a practical nurse with many years of experience, argued "I don't take any initiatives because I am scared" and Elisavet "no, I follow doctor's orders and nothing more, what if something happens?". When the researcher became more specific about the concept of autonomy and asked about "why, for example, not forming discussion groups with patients?" nurses initial reaction was that of surprise, as Matzi expressed "I have

never thought about it" and it was followed by justifications regarding either the lack of skills, as Vaso argued "I don't have the necessary knowledge" or the existence of norms that kept work to its minimum, as Sofia commented "just one bird does not bring spring" (meaning that one person alone cannot take such initiatives that require co-operation and organization). It was identified that nurses' answers resulted in the same issues that were mentioned when asked about the inactivity presented in the wards. It should be noticed here, that the concept of autonomy entails decisions about the organization and design of work as well as practising new ideas (Hackman & Oldham 1975, Breaugh 1985, Morgeson, Johnson, Campion, Medsker & Mumford 2006). However, nursing as exercised in the two wards, did not allow for any variations due to the amount and simplicity of tasks. An example was given by Toula, a young nurse who said "At school we learnt how to make the beds in a certain way. We don't do them like that here. It's much easier in practice". Maria, another young nurse revealed "Doctors don't want us to tie patients. But they are not here, they don't know what is like. Once a doctor who was against that (restraining patients) came and saw how a patient acted and ordered us to tie her". Vaso also supported this "We have to get the head nurse's permission to tie a patient. But when she is not here, we do it anyhow". Such claims were not perceived by nurses as evidence for autonomy, but as established ways of carrying out tasks.

The second set of answers consisted of nurses who confused autonomy or initiative with the inherent duties of nursing. Some nurses like Soula and Elisavet replied respectively: "yes, I do take initiatives. When I see that a patient is not well I will call the doctor" or "small things. When something happens we report it". However, a case reported by Sofia, a nurse in the male ward, signified that even that kind of autonomy or initiative was received negatively by doctors. As Sofia said "There was a patient here who I could tell that wasn't all right. It was not anything specific, but just for a few days he was not acting in the usual way. I told the doctor who said not to worry. I came one day at work and found out that he had been transferred to the pathology unit urgently because of heart problems. They (doctors) don't take us seriously, they don't care about anything".

As many nurses reported, the absence of doctors did not make their job easier because they had to search for them in cases of emergency, get orders over the telephone or refer patients to doctors of other units who had no previous contact with patients of the specific wards. As previously mentioned, this only imposed fear on nurses, as in the case of Matzi who argued "I don't take any initiatives because I am

scared" and was considered by others, like Anna, an additional burden on their work "we have to look for them, they tell us what to do without actually seeing patients just from our reports".

From such statements it was deduced that there was a lack of understanding of the concept of autonomy or initiative and consequently the total absence of it. Even the slightest initiative, as perceived by nurses, for example, the reports to doctors, was loosing its meaning by doctors' attitude (indifference).

Autonomy was concentrated in the head nurses and the responsibles of the wards. As the head nurse of the female unit revealed "you can do things. If you ask for something you generally get it, at least I did. When I was first assigned to another unit, I said that I would choose the staff (nurses) and organize it as I wanted and they (administration) let me on my own. That ward had become a model of good work for the whole hospital. Everybody wanted to work there". However, as she mentioned it was because of her strong will and her attitude "I never worked for the money and I did over-hours thousands of times. They know me in the hospital, I have a good reputation. If you are interested in the job, you can do a lot of things". The responsible of the ward described his job as "you have the freedom to 'move', to take initiatives. You are closer to the management, your contact with them is more direct. However, this is only fictional power not real. Nurses have the real power. If they are against something (from the shift you are placing them into to imposing extra work) they have ways to react. And with the doctors being absent, I do their job, like writing reports, signing for things that they should".

The low level of autonomy was not perceived by nurses as a negative aspect of their job. Even when nurses had the freedom to modify their work, a freedom given by the absence of doctors and by the laxity of the administration, they perceived it as lack of interest and organization from the part of their superiors and preferred to stick to the predominant ways of work. According to the head nurse of the female ward, there was no standard way of organizing work in each ward, instead "each ward has its own ways..it depends on the head nurse, the staff". Norms about work, as they have been established over the years and staff's willingness or discretion were the factors influencing the ways by which this freedom would be used.

7.4. Staff relations

The importance of employees' relations has been recognised by occupational psychology very early on (Conger 1994, Mitroff & Denton 1999, Chalofsky 2003). Though literature, at its bulk, has referred to it as a contributing factor to employees' satisfaction, in the present research it has been addressed from a different perspective. Previous studies concerning the effect of other people on one's interest in a task (Bond & Titus 1983, Isaac, Sansone & Smith 1999) and co-employees functioning as a source of relieving boredom (Thomas & Griffin 1983, Lee 1986, Fisher 1987, Zalensky & Ford 1990) provided the theoretical base for incorporating the issue in the present study.

Regarding the first theme, how others can enhance one's interest in the task/activity, there was not any evidence either from interviews or from observations. Quite the contrary, group norms regarding the amount of effort or interest in the job and in patients, seemed to act in a negative way. Few nurses in both wards argued about the negative influence of norms on their work. Elisavet said "others won't let you do more" and "I went to check on patients and a co-employee reproached me, he said 'what are you trying to prove'". Matzi also claimed that other employees deprive them from being more attentive or from bringing changes in the wards. Sofia, a young nurse in the male ward rationalised "When I first came here, I tried to develop a kind of relationship with patients. Nothing important or specific, but the others either they would try to restrain me with things like 'what are you doing come sit with us' or they would just leave you alone. After a point you just have to decide where you want to be". It should be noted, that the majority of nurses considered their tasks as trivial and not demanding as revealed in statements such as those made by Anna "the work is not difficult" and Toula "it is not a difficult job, just cleaning, feeding and giving medications" and their patients as "finished". Therefore, interest in the task or in the job could not be increased by "others" because it was generally absent.

In respect to the second issue, other people alleviating one's boredom, field work has identified two possible ways. Co-employees can diminish feelings of boredom, either by becoming "friends" or "foes".

In congruence with Roy's (1959-1960) study, where co-workers had created a "fun" and game-like atmosphere in their work setting in order to cope with boredom, nurses as well had formed groups of friends who expressed similar attitudes. It was observed, in both wards, that certain people had developed closer relationships and

those were exemplified by longer stay in the station, more intimate discussions, more freedom in speech and generally by a more relaxed attitude. In the female ward when morning shifts were carried out by a specific group of four nurses, Voula, Toula, Matina and Christina, the atmosphere was more relaxed and there was a freedom of expression. Sexual comments, making fun of each other or of patients and verbalization of emotions were regular. As Toula, a newly employed nurse said "I only do the morning shifts-we have a very good team (she laughs).We are having a good time. Time passes pleasantly. There are quite a few jobs and you don't have time to get bored. We just sat down. We finished our jobs/ tasks and we are sitting now". It was this group that had thrown the lunch party (accompanied by alcohol) in the station during a morning shift and this group that was scolded by the head nurse because of a patient's dehydration. Voula, a gregarious practical nurse with many years of experience in the hospital, was the one who revealed more often and more explicitly her feelings while the others either silently expressed agreement (through facial gestures) or verbally sympathised with her. Though Voula very often expressed feelings of boredom "I am bored. I leave you for 5-6 months and I will only come to visit you. What's the point of being here anyway?" or "feeding them again...why are we coming here? Tomorrow will be the same" however she did not let such feelings overwhelm her. She would say a joke, make fun of a patient or jump into another subject right away. Her emotional manifestations had a formed a cycle, moving from boredom to "pleasure" and boredom again.

The climate in the male's ward was not as "open" as in the female one. Because field work in this ward took place in late spring most nurses preferred to spend time outside the unit. Therefore, such fun-like attitude as in the female ward was not observed. What was more evident was the formation of dyads. This does not suggest that there wasn't any "friendly" interaction between all staff, but it was more likely to observe nurses in smaller groups (2 or 3 people) talking about more personal issues.

A theme that emerged from all interviews was the importance of doing a shift with a friend or as Vaso put it "the most important thing is to be in the shift with someone who you can communicate with". The significance of this lay in, as Xenia a practical nurse said "when a co-employee is not good you are going to have to work more" and she continued "you have to step back a little bit in order to co-operate. When the other is not like that, then there is a problem". Maria, a newly employed nurse remembered "I had done a shift with a nurse who was really bossy. She used to tell me 'do this, do that because I am bored'. She wasn't helping me at all. And I was

thinking 'why?' You end up being a sucker". Performing a shift with 'friends', was a precondition not only for the even distribution of duties and for efficient co-ordination but also for more satisfaction. However, the allocation of nurses in each shift was random and hence it was not always possible to be with 'friends'. It was observed that whenever this occurred nurses' behaviour was altered.

The following example will illustrate this. During a morning shift, in the female ward, staff was constituted by 5 nurses of similar educational and work backgrounds. Nonetheless, they were not identified as a coherent group, due to their different attitudes to work. Voula, the out-going, extravert practical nurse, was eager to finish her tasks and "have fun" with her co-employees, "I don't like sitting here doing nothing, I like to have a bit of fun while I am here". Theodora, a practical nurse as well, was stricter and behaved rather bossily to patients and staff. While in the station, she would often discuss the problems of the ward or of the hospital in general "let's see what they are going to do with these people after the funding is finished. They will all end up here again or in the streets" (talk about de-institutionalization programme funded both by the state and the European Union). Or she would complain about her co-employees "the young nurses don't have any respect for us, they come here and say 'I won't do this or that because it's not my responsibility'. And who is going to do it? I am old, I don't have the strength to do heavy jobs". When both nurses were present the atmosphere in the ward was tense. Voula would restrain herself from telling jokes, being sarcastic about her job and from revealing her feelings of boredom, while Theodora would remain silent or walk out of the station in order to check on patients (something not necessary since other nurses were already there). Whenever Voula was out of the station, Theodora would start her usual comments about nurses' behaviour "they don't work, they just think how to spend time, have fun" clearly referring to Voula.

From the above example two conclusions can be made in respect of the issue of other people alleviating boredom: the first is the direct impact of working with friends and hence being able to engage in a variety of conversations, have fun or simply being free to express opinions and feelings. The second conclusion derives from the distinction of co-employees to "friends and foes". As it was observed, when nurses worked with "foes" or without their close group, they refrained from overt claims of boredom and spent less time (though not much) in the station. Whether boredom was experienced during those instances was not questioned.

Though such a clash of personalities was not identified among other nurses, however conflicts regarding job issues occurred were quite often. The basic characteristics of those conflicts were: the triviality or easy resolution of the referred subjects and their persistence even after the actual problems had been solved. The meaning of those arguments was not a mere disagreement between nurses, but a mechanism for coping with a boring work life. The first incident occurred during the initial phase of field work and went on for a couple of weeks. Nurses were arguing about what shift should carry the dirty laundry out of the ward. As there was no rotation among shifts (usually specific people worked in the morning ones) and the distribution of nurses in each shift was uneven (4-6 nurses in the morning shift and 2 in the evening and night ones) the task was performed by specific nurses. It was expected, therefore, for these people to perceive unfairness by the current distribution of duties. It was suspected that nurses argued over the issue for weeks before the launch of field work. By the time the researcher was in the ward, a solution to the matter had already been found. Nonetheless, even after that, nurses were still discussing and argued over it. As the head nurse of the ward said "I had arranged a meeting for all staff of the ward to discuss it and solve it. Nobody came. After that I said to them 'since nobody showed up I suppose there is no problem, so I will take care of the matter'. So I did". Nurses also verified the head nurse's words, but additional comments showing their opposition were also made by Theodora "there was no point. You think now things are better? Only the morning shift should carry out the laundry because they are more" and Anna "they should have workers to do this". When the head nurse was asked about the reason for the conflict she replied, with a puzzled look on her face "that's what I have been asking myself. I haven't figured that out yet". The responsible of the ward also commented "the hardest thing in here is to manage these people (nurses), to keep balances". Toula, a young nurse said "Well this is a usual problem…and always there would be something….always there is going to be a "problem. But I don't occupy myself with this kind of stuff that is why they don't say something about me. But when they accuse us generally as a shift (means morning shift), I just don't pay much attention to the specific people who say these things. If they want they may as well do our shift and see if it easy. They should do it first and then let's see if they would talk". Maria, another young nurse also supported such a perception "It all happens so they have something to occupy themselves. Well…because apart from work we have so many things to consider (sarcastic). Even when a problem is solved they always find something to nag about. What do they want? They asked for a meeting so we can agree on some issues. Nobody came, even the people who proposed the meeting, because if they had

come there wouldn't be any problems. Everything would have been solved. But then what would they do? So we argue about who didn't gather the dirty clothes, who did this and who did that (she laughs). Now the problem with the clothes has been solved in a way so they start arguing about why we don't do cyclical shifts. As you have noticed there are certain people who do the morning shifts. Now they ask to change this and everybody do all the shifts. There is always something".

In the male ward a similar attitude prevailed, though not to this extent. Marina, a relatively new nurse had been given the keys of the ward and this was considered by the rest of the staff as something not appropriate. As she recounted "I am here with a short-term contract but I work really hard. The head nurse trusts me so she has given me the keys. The others did not welcome this, I don't know why. Maybe it's because I am new here and I won't be staying for long. Nobody has ever told me anything, but I know there is talk behind my back".

Arguments regarding who is going to perform the "extra" tasks, as for example take a patient to the doctor in another unit or take documents to the administration building, were usual but solved right away. However, such conflicts expanded to other issues as well. The rivalry between trained and practical nurses, which came up whenever an extra task should be carried out, has already been noted. With practical nurses being older and more experienced, their usual arguments involved age, as Anna stated "being too old for that", health problems, as Theodora and Matzi argued respectively "I have waist problems, I cannot carry the dirty laundry" and "my legs are hurting, I need time to rest" and educational purposes, mentioned by Theodora "I have done all that. They are young they have to learn". The same arguments were used against young nurses as well, with the latter feeling exploited or as they said "suckers". During a morning shift in the female ward, it was observed that most of the extra work was carried out by two young nurses, while the others were in the station. When Maria (one of the young nurses) complained about running up and down all day and was too tired to take a patient to the doctor, the others started arguing about who is going to do it. The matter was solved with the interference of the head nurse, who ordered two other nurses to perform the task. However, the incident did not end. Towards the end of the shift and while everybody was in the station, the two nurses (with the support of the rest of the staff) scolded Maria for reporting the incident to the head nurse. A new round of conflict had emerged about the necessity not to reveal everything to the head nurse.

From the above, it might be concluded that co-employees may relieve boredom in various ways. Either by becoming a source of fun, as in the case of nurses who had developed closer relationships between them and engaged in personal conversations and in fun activities (lunch party) or by becoming "foes" and thus providing subjects for arguments, other people may contribute to the alleviation of boredom in positive as well as in negative ways.

7.5. Social status

Research on occupational boredom has been largely occupied with low status jobs (such as factory work), suggesting that boredom may be imposed by core characteristics of such occupations (repetitiveness, absence of meaning etc). Csikszentmihalyi (1992) was among the few theorists who suggested that boredom may be found in prestigious professions or be absent in occupations that are generally considered trivial. Additionally, two media publications (Bolchover 2005, Joyce 2005) suggested that even high status jobs may also be regarded as boring. Indirectly, the social significance of a profession may facilitate those who practice it in attaching a deeper meaning to it and thus perceive it as something purposeful, valued and consequently not boring (Heinsler, Kleinman & Stenross 1990, Fine 1996).

In the present research, the interviewees provided data concerning the social status of psychiatric nursing as it is perceived by their acquaintances. Feelings associated with those perceptions were examined as well. In this chapter, only a thick description is going to be presented, while a deeper analysis will be presented in following chapters (roles, meaning).

The majority of nurses perceived a negative public attitude towards their job. Either in the form of absolute disgust or as milder comments regarding the difficulty of the work environment, nurses revealed that their acquaintances expressed a general tendency to disvalue the nursing role. Added to these perceptions, the media has depicted psychiatric nurses, of public mental hospitals, as idle, un-skilled and neglecting their job. Reports regarding employees' misbehaviour towards patients (Konstans 23/9/04), absence of moral and ethical standards and under-performance have been presented in the press and television quite often, thus enhancing nurses' rage and sense of unfair treatment.

An incident that occurred in the female ward, best describes nurses' mixed feelings regarding their public image. During a morning shift, a team of journalists came in the ward in order to make a report on patients of the psychiatric hospital. Nurses were not aware of the fact, as the psychiatrist who had arranged the meeting did not inform them. In the mere presence of the un-identified guests, nurses literally jumped out of the station, where they were gathered and rushed to the door in order to identify the people who had showed up. After the initial fear, imposed by the intrusion of someone into their environment (at first nurses thought that the journalists were hospital employees and had come to check the ward), comments regarding the trustworthiness of the future report started off. Christina, a trained nurse who for the whole field work seemed composed, active and avoided any disclosure of feelings, for the first time expressed annoyance "they (reporters) should do an article about nurses not only for patients. They should ask us what it is like to work here" and she continued "if they hear any patient asking for food they will think that we don't feed them. They are psychiatric patients, you might give them food and they will keep asking why you didn't give it to them". There was a general uneasiness in the ward, with nurses talking about false reports that had appeared in the press in the past. Voula, a practical out-going nurse finally stated "let them say whatever they want. Like it is our fault!" and another one supported her "we are the easy target. They don't say anything about doctors, administration". Nurses' emotions fluctuated from fear of what the reporters might publish, to rage about their opinions being neglected and finally submission to the power of media.

Nurses revealed similar emotions when faced with the perceptions of their acquaintances regarding their job. As they said most people from their close environment thought negatively of their job "you can see the aversion in their faces. They ask me if I am not afraid. They have no idea. I have been all these years in the hospital and no patient has ever touched me. I take offence, because I don't want it. It pisses me off" Matzi said, while Efi recalled "When I was first employed here, I was ashamed to say where I work. People thought of the hospital differently back then. Now I just say it because I am able to work here". Two rather interesting comments derived from two young nurses, Sofia and Marina: "There is prejudice against psychiatric nurses. People think that you are one and the same with patients" and "They tell me that they feel sorry for me. One of the reasons I broke up with my fiancé was because I was working here. He never accepted it. It's a stigma working in here. I feel really bad because people think this way but because I found some truths in these beliefs. I also feel bad because it doesn't represent me, it's not who I

am". Other nurses had to deal with less aggressive or even humorous comments, like those reported by Dina "They ask me how I can stand all this. If I didn't know I would say the same", Sofia "They usually say to me 'bless your patience'. You feel that every job has its difficulties, its dangers", Katerina "They (people) just don't understand, they say 'God! What you must go through!' I can't describe what it means to be in a psychiatric hospital" and Toula "Everybody tells me that in a short time they will also come (as patients). They ask me how I cope in there. I don't have a problem with what they tell me, I won't get upset…it is just that they don't know. If they come and work they might even like it". Nurses' attempts to defend their job became even more explicit. Maria said "People say to me 'what you must have seen'. It is totally different to be here and see what is going on than see it in television. Whatever they say on television is lies". Marina, a nurse from the male ward also expressed a defensive stance "people generally do not value our profession. They should understand that we are necessary to the patients. Some might recognise that we work under such conditions but generally there is no respect". Similarly, Katerina and Dina replied "they think I am a hero for being able to manage all this" and "they admire me for my patience, others just don't care".

From the above quotes, it is clear that nurses had mixed emotions about their profession. Anger for not being understood by others, shame for working in a psychiatric hospital and for the unfavourable image of their profession and finally some pride for being able to do a job that others wouldn't be able to do. It was quite intriguing to listen to nurses talking about their job impromptu. A couple of comments were made, outside the interview context, while nurses were in the station. Voula in a general mood of questioning her role said "Why do we come here? Tomorrow will be the same again. If we say that we work in this whore house people will make fun of us". Xenia in another instance said "I am ashamed for wearing this uniform. Is this a hospital? They have thrown them (patients) in here and wait for them to die". Such statements express that a certain identification with public opinions existed. This was also supported by the absence of any verbal declaration of pride, when nurses listened to other people's amazement or curiosity. In contrast, pride was made obvious by nurses' smiles when recounting their experiences. By reflecting on their position and other's perception of it, nurses felt strong for doing something that would create uneasiness to other people. However, this self-assuring perception was accompanied by a slight bitterness for having to do what others disvalue and they themselves thought of in negative terms.

7.6. Summary

This chapter was focused on organizational and work features that have been identified by the literature as significant factors for the experience of boredom.

At the beginning it was explored the effect of broader organizational mechanisms, such as the performance measures and the rewards on nurses work behaviour. It was identified that the absence of evaluation criteria for effectiveness resulted in nurses' relaxed attitude and avoidance of effort, since there was no one checking on them.

In accordance to previous nursing studies, the absence of rewards was perceived in terms of the lack of recognition or value of their work and their role and did not concern tangible assets. The absence of these features delivered the message to nurses that the system was indifferent to their performance or general conduct since they could behave according to their own discretion without expecting any rewards or penalties.

The subject of career prospects revealed two other dimensions to what has been investigated so far in the organizational psychology field. The first one was related to individuals' aspirations for career advancement. Practical nurses, being aware of their limited skills and qualifications, had no career goals. It is therefore crucial to include the individual factor in the relationship between boredom and career prospects. The second aspect concerned perceptions about meritocracy. All nurses, with trained ones being stricter, agreed that opportunities for career promotion were based on powerful acquaintances in the hospital or on political orientation. This perception resulted in nurses' beliefs that even if they attempted to acquire formal skills nothing would change. The issue of meritocracy has further connections with employees' perceptions about the fairness and justice of the organization, which have been identified by organizational studies literature as vital for employees' attitudes.

Work autonomy has been identified as a basic determinant of boredom. The basic principle of relevant studies asserts that low autonomy levels lead to boredom. In the present study, while nurses enjoyed the maximum freedom due to the absence of superiors checking on or constraining them, however this freedom was not utilized. Justifications regarded mostly the lack of knowledge, fear of causing a negative outcome or reluctance of co-employees to work more. Nurses did not report any

complaints about not being able to take initiatives but considered the absence of doctors (that resulted in their freedom) as a positive aspect of their job.

Relationships among staff members were investigated in two ways. The first was connected to the assertion of organizational psychology studies about other people inflicting interest in an activity. The findings suggested the contrary. The prevailing norms in the wards were based on the belief that less work is better. Any nurse who attempted to work more with patients was reproached. The second dimension concerned the assumption about others being sources for alleviating boredom. Nurses categorised their co-employees as friends and foes. Both categories provided coping mechanisms against boredom: the first by creating an atmosphere of fun and the latter by causing arguments that were carried on for days even after they had been discussed and solved.

The social status of psychiatric nursing was investigated in order to identify whether it constituted a form of intangible reward or a contributing factor to the expressed boredom. Nurses were extremely aware of the negative public image of their profession. Their emotions were mixed, anger and bitterness for being accused of indifference and neglect, shame for being identified with patients and some pride for being able to do what others could not.

Overall, nurses were employed in an institution that was not providing incentives, was not functioning upon merit and was indifferent to the well-being of both its employees and its clients (patients). In addition to such negative organizational attributes, the low status of psychiatric nursing was another contributing factor to nurses' negative perceptions and emotions about their job.

8.1. Duties-Routine

Task variety has constituted a baseline for psychological research of boredom (O'Hanlon 1981). Cognitive and organizational psychology studies (Smith 1981, Damrad-Frye & Laird 1989) have found a negative association between task variety and repetition and boredom, with the latter resulting from monotonous and repetitive activities. Moreover, organizational design theorists (Hackman & Oldham 1976, 1980) have stressed the importance of job rotation and task multiplicity in order to keep employees satisfied and prevent boredom from occurring.

Psychiatric nursing has been described, in much detail, in academic texts as a profession which requires engagement in various tasks that range from ensuring patients hygiene (cleaning) to purely nursing duties and to offering psychological support (Stuart & Laraia 1998). Theoretically, at least, nursing is considered a profession un-related to task monotony and repetitiveness.

Field work in the long-term psychiatric wards, however, contrasted greatly the theoretical assumptions and practical activity. There was a standard routine of activities carried out on a daily basis.

The morning shift begun at 7 o'clock. Usually nurses had to wait for all patients to wake up in order to start their duties. Nurses delivered breakfast and morning medication to patients and afterwards all patients were lined up in the common area of the ward in order to get showered. After helping patients to get dressed nurses gathered the dirty laundry to specific rooms of the ward in order to be collected. The time spent in performing the morning duties was approximately 2 or 3 hours. Usually by 11 o'clock all morning tasks had been carried out and nurses were gathered in the station for a break. At around 12 o' clock, two nurses (usually the responsible of the ward and another nurse) allocated medications into specific boxes (one for each patient) that would be delivered through the rest of the day. The head nurse did not participate in any of those activities and was usually found in her office (a separate room in the ward) taking care of paperwork, or outside of the ward. Lunch was delivered between 1 and 2 in the afternoon. However, this was not fixed as it was dependent on both the catering service that the hospital employed and the cooks that delivered it and helping nurses to distribute it to patients. Sometimes food was not brought into the ward until 2.30. After lunch was served and medication dispensed to

inmates, nurses returned to the station where they spent time until the end of their shift which was at 3 o' clock.

Afternoon shifts lasted until 11 o' clock at night. The only fixed duty was serving dinner and dispensing medications to patients around 8 o' clock. It should be noticed, that staffing levels were considerably lower than in the morning shifts (only two nurses). As the responsible of the ward revealed "we usually assign 2 nurses in the afternoon shifts. There is a kind of co-operation among wards. When a ward is in shortage of staff, it asks for extra help from other wards. So even if I assign 3 people in the afternoon shift, one will surely end up in another ward, so there is no point, no extra hands in my ward".

Nurses in the afternoon shift, usually began work by reading the patients' book (a book informed daily by the head nurse or the responsible of the ward regarding patients' condition) in order to get notice of any additional requirements or specific actions that needed to be taken. It should be noticed that this was not a ritual performed by all staff. Usually it would be one person only who would read the book and tell the others about any alterations or notifications concerning patients. Depending on the tasks ordered in the patients' book, nurses took the appropriate action, otherwise they spent time in the nursing station or in the hall that divided the station from the rest of the ward and offered better visual access. Randomly and usually after spending much time in the station, nurses would go in the dorms to check on patients.

8.2. Pleasure/Interest

Csikszentmihalyi (1975) argued that taking pleasure in an activity is a basic factor against experiences of boredom. According to his view, even mundane or seemingly uninteresting tasks might be considered as pleasurable if the individual who performs them finds them as such. Others like Geiwitz (1966), Vodanovich & Mikulas (1993) noted that one of the variables that may provoke boredom is unpleasantness with what one is doing. Similar assumptions regard the interest in an activity as a factor influencing feelings of boredom (Perkins & Hill 1985). Though both assumptions rely heavily on personal predispositions and preferences, there are also studies reporting that other people can act as a source of interest in an activity and thus limit boredom (Bond & Titus 1983, Isaac, Sansone & Smith 1999, Thomas & Griffin 1983, Zalensky & Ford 1990).

The studied sample has confirmed the above mentioned theories. The majority of nurses could not find any pleasure in their job, which mainly consisted of cleaning patients. A first observation was nurses' reaction to the question "is there any pleasurable aspect in your job?". All nurses, like Theodora and Anna, repeated the question "pleasure?" in a way that disclosed surprise for being asked such a thing and took a few minutes to think about it. Usually answers to the researcher's questions were spontaneous and immediate, however this particular question was received as awkward and incomprehensible "what pleasure?". Some of the staff were unable to find any pleasure in the job and "there isn't any" was a common reply, given by Vaso, Efi and Dina. Thomas, a male nurse, justified the absence of any pleasurable aspect of the job by "it's just a routine, there is nothing pleasurable about it". Vaso and Theodora, however, were more direct and abrupt and pointed out the dirty aspect of their job as the basic reason for not being able to find pleasure: "every day, for years now I am cleaning patients and you are saying about pleasure" or "I am tired of cleaning patients, nothing is pleasurable about it".

Other nurses such as Xenia referred to the "small parties that we are having..the fun between us, not with patients". Voula rationalised her fun-like attitude in the ward "I like having a bit of fun at work. Otherwise its boring..I don't like just sitting or knitting like others".

Getting morally rewarded from patients was another pleasurable aspect of the job. Matzi thought of as pleasurable saving patients' lives "I have saved many patients from choking" and Soula "when they call you mum or when they look at you as if they are saying thank you". Even when this was not happening nurses felt well from knowing that they had done something "extra" for patients. Efi, a practical nurse said "we used to take them for a walk, it was nice" or as another nurse recalled "there was this patient whose mother was in another ward. I used to take her regularly to see her mother. I did something for her and when her mum died I felt sorry for her for stopping these visits".

There was a marked distinction between young and old nurses regarding the interest in their job, with the former clearly expressing more interest. Toula, a newly employed nurse said "I am here to learn, I try to learn about everything, from drugs to how to behave to patients" and another one "it is interesting because you get to see what depression or schizophrenia is like". Young nurses in the male ward, which was occupied by patients in a relatively better condition than in the female one, contended

that "sometimes it is interesting to listen to their stories, they have got a lot to tell you", like Marina did or as Sofia added "the way they ask you about things, which are totally un-dated is sometimes funny, it makes you laugh a bit". However, trained nurses with longer years of employment in the specific wards had begun to lose their initial enthusiasm "nothing is going on here" Elisavet argued, while the head nurse noted "I ended up getting thrilled when a purely nursing duty comes up, which it does very rarely in here". Practical nurses in contrast refused to find any interest in their job. Justifications for the disinterest shown varied. Xenia for example included attributions to patients "they don't understand, you can't communicate with them", Matzi stressed the lack of skills that would enable them to find an interesting activity "I don't have the education to do more with patients" and Anna talked about the psychological fatigue from years of work "what interest? I have been in here for 20 years, I have given them (patients) my life, I am too tired for anything more".

A cynical and un-expected reply derived from two nurses, Elisavet and Vaso, in the female ward, regarding the issue. Though the interviewer had moved on to other themes, both nurses replied, in a sarcastic and perhaps sadistic (?) tone, that the only source of satisfaction was found in tying patients "A! You don't know what it feels like. It's like an orgasm" and the other "after they (patients) have taken the Mickey out of you, it is the most pleasurable thing to tie them".

It was made obvious that pleasure or interest was limited to the newly employed staff and to trained nurses but only for a short period. The psychiatric nursing job, as practised in the two long term wards, was considered dirty (nurses' emphasis on cleaning patients) and standard (daily routine). If any pleasure existed, it was to be found not in the actual job but in the social context (nurses' gatherings and efforts to have fun while at work). This totally negative perception of the nursing profession minimised the significance of the psychological/moral rewards nurses received from patients and made them even more cynical and thus more dissatisfied.

8.3. Difficulty/Challenge

Many theorists (Zucherman 1979, Vodanovich & Mikulas 1993, Locke & Bryan 1967, Hebb 1966, Berlyne 1960, Klapp 1986) believe that there is an optimal level of arousal in which the individual performs better than in cases of either low or excessive stimulation. Such theories argue that when a task or a goal is challenging enough and the person thinks that he/she can carry it out by putting in some effort then boredom cannot be experienced. In a similar vein, many scholars (Hackman &

Oldham 1980, Fisher 1998, Balzer, Smith & Burnfield 2004) have referred to jobs that are characterised by 'qualitative under-load' and that induce feelings of boredom, due to their simple, unchallenging nature or because they do not require the full use of the individual's skills.

Difficulty and challenge in the studied wards, however, were perceived in diverse terms. No nurse reported that there was a challenge in her job. Duties were fixed and there were no specific goals to attain apart from vague claims of Anna "be good at my job" or Matzi "not get called by a superior" or simply "finish my shift" as Vaso added. Justifications for the absence of any challenge were related with the type of patients occupying the two long-stay wards. Patients were perceived as "finished", "you can't do anything with them" and comparisons to other types of patients were often made. Many nurses referred to the distinction between patients in general and short and long-term psychiatric hospitals: Marina stated "here it is only give medication, make the beds. It is totally different in other hospitals, people leave, do not get stuck there for ever", while Maria added "I wish I was in the addictions unit. They do more things there, they talk, organize games, here…you try and talk to Eleni (a patient)" and Sofia commented "things are much looser here, I have been in a general hospital and there wasn't time not even to go to the toilette". The psychiatrist of one ward sympathised with the nurses "this ward is worse than the short-term ones. There is a progress, something is happening there".

Difficulty, in nurses' view was not related to the theoretical conceptualization that assumes that there is allocation of mental or somatic resources, a certain amount of effort and a goal to be reached. In contrast it reflected the psychological burden or fatigue that was accumulated over the years. All nurses who had worked in the hospital for more than 10 years complained about the difficulty of being in a stressful, unpleasant and un-rewarding environment. Even nurses who seemed more in control, like Christina, who was an active middle-age woman who clearly stood out from her peers, referred to the difficulties of the profession "why do they (the media) never say anything about nurses? Write down about what it is like working in a psychiatric environment, all they do is make stories about patients and blame us". Other nurses were more exact about the difficulties facing in the wards, like Anna who said "I am tired of all the yelling, shouting, screaming. I don't mind anything else but the shouting…At home I can't even stand the radio or the television", Xenia "all these voices affect you, you get headaches" and Soula "all this noise, that patients come and ask for things incessantly, they are difficult patients". The problems that

older nurses were facing were not related to nursing tasks, but as Soula and Xenia said "it is not the somatic fatigue but the psychological", "our nerves are damaged, we yell in our homes". Though such complaints were not expressed by newly employed staff, however the issue of cleaning patients was common to everybody. Despite nurses' claims of being used to it, they all referred to the dirty work they had to carry out as a factor that enhanced their feelings of tiredness and psychological burden: Theodora, "I am tired of cleaning", Efi, "I wish I was in a cleaner environment" and Vaso, "it's disgusting but all jobs have their pros and cons". Dirty work was a difficult work aspect that had affected all nurses at their first days of employment. As Matzi, Soula and Efi recalled those days, their reactions were powerful and this could be observed even at the time of the interviews from the way they delivered their answers: "I couldn't eat meat", "I thought that I was going to die" and "I didn't think that I would be able to do it". According to their statements "getting used to it" was the only solution possible in order to continue working.

For newly employed nurses difficulty was also experienced in relation to patients. The issue of what constitutes appropriate behaviour was brought up, however it was resolved by stating that it is either a learning process, as Toula argued: "I learn from everything" or in Maria's view that it is a matter of vicarious learning and that other provide the appropriate behavioural models: "at first I didn't know how to behave, I was watching the others. But with such patients you have to shout and be strict". Nurses in the male ward experienced similar difficulties. Despite their claims that male patients were better than the female ones because of two reasons, as the head nurse claimed: "they recognise that they have to deal with women" and their general condition in terms of social abilities was considered relatively good "they may say things that are out of date, however some of them are quite able to communicate", difficulties existed nonetheless. As nurses argued some of the patients were flirtatious and this constituted both a pleasant attribute and a source of stress: Sofia, "you have to keep a balance. You can't be abrupt and scold them but you have to show to them what your role in here is" and Dina, "I laugh but you have to show them that there are limits". Nurses, in the male ward, pointed out as another difficulty of their job, calming down or restraining agitated patients. Patients' build and strength were causing nurses a sense of fear, as Marina said "I am kind of afraid of patients' reactions, it's not easy to restrain them, it needs two or more of us" and Sofia "though I have never encountered any difficulties, it is different from working with female patients. It is not that they are going to hurt you but when they get restless it is harder

to control them" and Dina "the trick is not to show fear, make them understand who is the boss in here".

Difficulties associated with patients, were identified as the cause for a subtle rivalry that existed among the two wards. Staff of each unit tried to justify the difficulties encountered in their work as more serious in comparison to the ones in the other ward. Nurses in the female unit argued that problems in their job derived from various factors: the responsible of the ward stressed the fact that his ward was occupied by a mixture of disorders not clustered under one type "it is not a purely psychiatric unit. There is a great variety of cases, from psychiatric to mental impairments", while for nurses like Soula and Voula patients' condition was the problematic factor: "there are a lot of patients who are not able to get up. This means extra work for us" and "female patients are more restless, they might attack you at any time". The last quote was a belief shared by staff in both wards. However, even though nurses in the male unit recognised that male patients were more "quiet", they still considered working with men more difficult because they were harder to control in case of an emergency. Moreover, work in a male ward, required a certain attitude by nurses, as Dina said "you have to be careful in how to behave to them". For nurses in the male ward being on constant guard and trying to behave in a certain manner (hiding feelings and expressing calmness and control) constituted a major difficulty of their work. This is in congruence with literature on emotional labour (Hochschild 1986) which has pointed out the negative psychological effects of being in a profession that requires the display of specific emotions regardless of the true emotional condition of the individual. Observations justified nurses' claims, as there was a marked difference in staff' behaviour towards patients between the two wards. Nurses in the female ward were more abrupt both verbally and behaviourally and expressed their feelings more, things that were not observed in the male ward.

As can be seen, nurses' perception of difficulty did not reflect the theories that state that the levels of task difficulty influence feelings of boredom. As most of the staff argued, the actual job was not difficult but encompassed a standard routine which was easy to carry out. This, evidently, confirms past research conclusions about low task demands inflicting feelings of boredom. Moreover, from nurses' descriptions it was considered that none of the perceived difficulties could be altered as they constituted inherent characteristics of the job and of patients. Cleaning and working with psychiatric patients who expressed irrational or annoying behaviours (e.g. shouting) were, obviously, the very essence of psychiatric nursing. Though nurses

recognised that this was the nature of the job and nothing else could be done but to "get used to it" (as they said), they were still affected psychologically and kept on complaining. Perhaps their complaints, apart from being neglected and reinforcing their negative feelings, functioned as a mechanism for passively reacting to an unfavourable condition.

8.4. Goals

From early on, theorists have identified the importance of goal setting in the experience of boredom (Mathewson 1931, Smith 1953, Whyte 1955, Locke & Bryan 1967). Studies have also shown that boredom and interest in an activity are not only affected by the mere existence of goals but by their specificity as well (Lock & Bryan 1967). Outside the field of organizational psychology, the significance of clear goals has been also noted by Humanistic Psychology and Sociology. Individuals who set or who are given clear objectives to accomplish are able to find meaning in their work and therefore eliminate boredom (Frankl 1984, Bargdill 2000, Isaksen 2000).

Despite the fact that the broader context of mental health had gone under major changes during the last decade, the absence of clear objectives remains a weakness of the Greek health sector (Theodorakioglou & Tsiotras 2000, Vassalou 2001, Giokas 2001). It was identified that there were no specific goals regarding patients of long-stay wards. Formally, the ultimate goal was to readjust these patients to go back into the community. However, there was no specific orientation for the patients who remained in the hospital.

Nurses spoke in general terms of their goals in the ward. The fact that each one of them had a personal perception of what constitutes "a goal" signifies the absence of any formal goals. Some of their replies were: Soula "my goal is to finish my shift without anything bad happening", Vaso "I don't have any goals", Matzi "my goal is just to do my job right", Toula "I try to be nice to patients, not to shout at them" and Efi "I try to be a good nurse in order to satisfy my head nurse".

The responsible of the ward connected the lack of goals with the absence of doctors "there are no goals. The new general director wanted to change some things around here, but doctors like things as they are..And why shouldn't they like them? You saw that doctors never come here, so how can we develop a plan for these patients?" Goal-setting was a personal matter for the staff and concerned only the execution of specific tasks, the avoidance of any problems and the satisfaction of superiors.

Nurses' goals could be characterised as short-term, dissociated from patients and negative in nature. Considering the broader context of mental health, that is in a process of de-institutionalization, this finding certainly does not coincide. Informal interviews with people in the field (a psychiatrist and a neurologist) revealed that a basic role of the hospital should be the preparation of patients for the out-hospital units. Despite the fact that many of the patients of the specific wards had already been transferred and there were others that were going to be, there weren't any guidelines or goals for staff to attend to. In some cases, patients weren't even informed about the change they were going to experience.

According to nurses' statements there was no formal direction given from superiors. Long-term wards were considered "human bins" and meeting patients' basic needs was already a "big deal". It should be stated at this point that the general aim of de-institutionalization did not affect nurses. The hospital had not provided staff with any guidelines concerning the preparation of patients for their adjustment in the out-hospital units. Even when nurses were asked about the reasons for not trying to work with patients in order to make their job easier (for example teach them basic rules of personal hygiene) they were hesitant. Nurses felt that they were in a situation with no way out. On one hand the lack of goals prevented them from having a sense of trying and achieving and consequently resulted in feelings of futility, indifference and irritation. And on the other hand setting and trying to achieve their own goals exceeded their abilities. According to theories of organizational psychology, both situations may lead to feelings of boredom, because individuals are confined into apathy or inactivity. It was obvious that the hospital had cultivated and maintained since its establishment an un-motivating culture. The lack of organizational goals not only coincided but described the hospital's function and role that was a "warehouse for the unwanted" (Matsa & Michalakeas 1998).

8.5. Summary

In this chapter the basic characteristics of psychiatric nursing, as exercised in the two long-term wards, were investigated.

One of the primary findings regarded the contradiction between nursing texts and actual practice in respect to descriptions of the profession. Unlike academic books, which depict the richness and variety of psychiatric nursing, the main duties of the present sample consisted of only three activities: cleaning, feeding and dispensing medication. Differentiation existed among the two wards and concerned the equality

of distribution of extra tasks (document delivery, taking patients to other units etc.). In the female ward, extra tasks were carried out by young, newly employed nurses, while in the male one, where age differences were not great, extra tasks were evenly allocated. All nurses perceived monotony and routine in their job and preferred to spend most of their time in the nursing station, physically separated from patients.

This was in accordance to nursing studies which have argued about the physical segregation between staff and patients. However, while in those studies other activities, such as paperwork, provided a valid excuse, in this study nurses simply socialized with each other. Time distribution between tasks and breaks was disproportionate, with breaks constituting the main activity and duties being an interruption.

Duties were not only seen by staff as monotonous, but they were also perceived as unpleasant and uninteresting. Taking pleasure in an activity is considered to be by the relevant literature, a basic antidote to boredom. Tasks were repeated, involved dirty work and dealing with serious mental illnesses, all attributes that were stopped nurses from finding any interest in them. If any pleasure was to be found, this concerned nurses' social gatherings and to a much smaller frequency, the moral rewards they received from patients. There was a marked distinction among old and newly employed staff. New employees found interest in their job because they were under a learning phase which consisted of: learning about the actual job (patients, duties) and learning about the social aspect of work (norms, attitudes etc).

Investigating the levels of task difficulty, as organizational and cognitive psychology studies have stressed as important determinant of boredom, nurses responded in absolute terms. There was no inherent difficulty in tasks. Difficulty for this sample, was conceptualised in respect to: being with patients whose condition was though as incurable, dealing with their irrational and annoying behaviours (e.g. shouting), management of disgust, working in an un-pleasant environment and in specific for nurses in the male ward, difficulty was related to balancing their expressed and real emotions. It was identified, that such perceptions of difficulty did not involve any action or effort, but required just vast emotional resources from nurses. In the case of nurses in the male ward, trying to keep a balance between who is the boss and yet being kind to patients was the difficulty faced. This resembled literature on emotional labour, however, the sample's motives originated from fear of patients and not from presenting a certain attitude to clients.

A last important finding concerned the absence of work goals. Nurses had no specific targets to meet imposed by the hospital. The long-term wards were perceived by nurses and their superiors as the last resort for patients with severe mental disorders. Even the concept of de-institutionalization did not result in any changes in the hospital work. Patients were released from the long-term wards without any preparatory process taking place. Psychiatrists, either through their absence or by admitting that the hospital is not an appropriate environment for patients' rehabilitation, did not set any goals for staff or were delivering the message that setting goals would be a futile process. At individual level, nurses revealed only avoidance goals, such as ending the shift without problems.

In general, the inherent disadvantages of psychiatric nursing (dealing with dirt and with mental illness) along with the organization of work (disproportionate distribution of time between tasks and breaks) and the absence of goals, contributed to nurses' boredom.

Chapter 9: Roles

9.1. Decision to enter the profession/the hospital

Theorists (Perkins & Hill 1985, Lee 1986, Fisher 1993, Isaac, Sansone & Smith 1999) of various psychological paradigms have stressed the importance of preferences and interests as factors determining experiences of boredom. However, the focus of those studies has been placed on the causal relationship that is developed after one is already engaged in a task/job. Holland (1997) suggested that desire to enter a specific profession will affect subsequent feelings of interest, satisfaction and performance (Gottfredson 2002, Arnold 2004).

Concerning the decision to get involved in the nursing profession, it was striking that the sample, in the main, based it on reasons that were dissociated with former wishes or desires. Their engagement to nursing was not a result of a specific occupational orientation. Apart from two nurses who wanted to work in the health care domain, the rest had no desire to enter the field. Nursing, for that sample constituted a profession which met immediate needs, "I needed to work" was the direct answer of all nurses. The majority of nurses had no education and were coming from a low socio-economic environment. Many of them had additional problems, like Matzi "I was an orphan and I had to find a job to support myself" and Voula "My husband died after 2 years of marriage and I had to support my two baby girls" were some of their replies.

Considering the time when they got the job in the hospital (most of the nurses in the female ward had worked in the hospital for 20 years), it can be assumed that nursing was an occupation which required no specific training and offered direct and secure employment. For younger nurses (the majority of which worked in the male ward) the selection of the specific profession was based on financial reasons: training was obtained as part of the basic high school education that requires no additional expenses, unlike attending a university course. Moreover, the public awareness about staff shortages in hospitals, makes nursing a non-saturated work domain hence enhancing probabilities of employment.

Their decision to work in X hospital was also enhanced by the fact that many of them either lived near the hospital or they had some acquaintances who already worked there. It was implied that these were the determinant factors for applying to the mental hospital. Being in everyday contact with the hospital "even as an image" as Toula, a young nurse, graduate of the two year nursing programme, said, helped

neutralize the negative beliefs that existed generally. "Though I had never visited the hospital before, I could watch patients, I watched the ambulance bringing them here, it wasn't something just in my mind" Toula explained. Some others claimed that if it hadn't been for their acquaintances, they wouldn't work in X hospital. A deeper inquiry revealed that this had a double meaning: first that people who already had a job in the hospital recommended it as a good opportunity and boosted their applications. Theodora, a practical nurse said "I had a neighbour who worked here and told me that it is quite nice". Secondly, that they provided psychological support in terms of informing them (about the hospital, the management, the co-employees) and familiarizing them with the environment. "When I first got here I wanted to die. Thank God I had relatives who already worked here and helped me. Almost everybody in the hospital knew who I was (because of my relatives) and helped me take things looser" Soula, another practical nurse argued. Most of nurses' statements were that they got involved in this job "by chance". Efi said: "I never thought that I could work here. I was a sewer and somebody told me that the hospital wanted new staff. I wanted to start working outside the house and I thought it would be a good idea". Sofia who worked in the male ward and who had received a university degree in nursing said "I wanted to be a doctor. Unfortunately I didn't enter the medical school. My grades were low and the only school that I could attend was nursing". Even nurses, like Maria and Toula, who had attended the 2 years training programme admitted that this was an "easy solution" for their work future.

Regarding their decision to work in the mental hospital, it is clear that it was taken by chance as well. Practical nurses applied to X hospital due to circumstances (acquaintances, job vacancies at the time), while registered nurses were found there by chance. As many nurses explained, they had applied to many hospitals both mental and general ones and they were accepted in X. Some of their comments were "I was registered in OAED[1] and I had filled in a document with my preferences. The psychiatric hospital was my last one but I was accepted here" Thomas recalled, while Dina explained "I had applied to several hospitals but X was the first one in which I was accepted. These procedures take a long time and I needed a job right away". It was surprising the fact that the head nurse didn't start working right after she was informed that she had got the job "They contacted me in August and told me that I had been accepted. I postponed as much as I could. I wasn't ready to go there. I finally went in January". The dislike for psychiatric nursing was admitted by Elisavet

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[1] OAED= Organization for Employment of Human Resources

who revealed "I was still at nursing school and had to do my practice in the mental hospital. I didn't go. I only went once and the head nurse saw my reaction and told me that I was too sensitive for that job and not to go again".

According to these statements, it is obvious that there was no specific orientation towards nursing or psychiatric nursing. A set of factors, such as the informal processes for job acquisition, the absence of any criteria on the hospital's part for hiring new staff and the sample's low educational and socio-economic status are the determinants for selecting psychiatric nursing. It was revealed that there wasn't just lack of desire or specific career aspirations, but un-awareness of what constitutes nursing and in some cases an aversion to it.

9.2. Prior expectations/First impressions

While psychological research has limited its scope in measurable variables (task/job attributes, personality factors), sociology has broaden our understanding of boredom by elaborating on other issues, such as expectations. According to Conrad (1997) when prior expectations regarding a situation remain unmet, boredom is the probable outcome. Furthermore and in respect to role theory, Darden and Marks (1999) have argued that when expectations regarding a professional role do not coincide with its actual performance, boredom is likely to occur.

The majority of the sample had no previous knowledge of what nursing entailed. Expectations regarded only the setting and what was publicly known about it. The specific hospital has a long history and has become a synonym for madness. Over the years the media has reported many problematic areas in the hospital's function. While various improvements had taken place, the X is still referred to in derogative terms. Such expectations may have a certain negative psychological effect, however they cannot account for feelings of boredom if not met. As a couple of informants revealed, those public assumptions about the hospital's inefficiency impose onto prospective employees specific expectations about work, "people when they first come here expect not to work much" and "it is not like before, when you had 100 patients to deal with and you were running up and down trying to take care of everything. Young nurses know that things have changed. They know what to expect". As will be analysed later on, prior expectations concerned either little work (for new staff) or difficult work conditions (for older employees).

9.2.1. First impressions- Older staff

Nurses' perceptions of their role were formed while at work. Nurses said that the nursing job includes certain duties: cleaning, feeding and giving medications to patients. Even nurses who had attended nursing schools, like Toula, said that what they had learned was to "take care of patients". For practical nurses the absence of any education had created a limited perception of the nursing role: Theodora argued that "I learned everything at work. What else there is to do?", Matzi explained "If I knew more I would do more, but now?" and Anna revealed "We are so tired from all that work that we cannot do anything more than the basics".

While the absence of prior expectations concerning the nursing job had not affected nurses' current perceptions, their first impressions had a significant impact on their work.

Many nurses referred to the bad conditions that existed when they were first employed in the hospital. Those initial impressions seem to have determined nurses' perceptions of their work. Their descriptions of the situation in X 20 years ago were very vivid. Theodora recalled "do you know what it's like being for the first time in a ward with 120 naked patients and having to wash them?", Efi confirmed "at that time we did a lot of hard work because we were responsible for too many patients" and Soula added "we didn't even have syringes at the time, we didn't have anything. We were everything, we used to clean the wards as well as the patients and we cooked for 80 people".

The psychological effect of such experiences was enormous for Matzi "I couldn't eat meat for 6 months. Maybe it was because of watching all those patients and cleaning them", "at first I wanted to die, I couldn't stand it" Theodora "I was crying for a whole week. I was returning home and I was crying and my kids were telling me to stop doing it" and Soula "at the beginning I was scared and disgusted by the patients". It seems that nurses felt that because of the hard work under bad conditions in the past, it was justified to do just the necessary now. Furthermore, those initial impressions have formed a solid basis for the perception of psychiatric nursing. For this group of staff the nursing role was assimilated to that of a cleaner, a guard or supervisor and protector of patients. Older nurses have no previous knowledge or perspective of the nursing role and they have accepted as their only reality those initial experiences.

This group was characterised by fatigue both emotional and somatic, as Soula and Efi replied in a tone of bitterness "We gave them (patients) our lives, our selves, what else to give them?" The improvements of the hospital environment had not altered their perceptions of what work should be comprised of, but have provided them the opportunity to perform the same duties with less stress.

9.2.2. First impressions-Trained and younger nurses

The second group consisted of younger and trained staff. It should be noted that variations existed in the level of education and in the years of experience and secondly across the two wards. It has already been mentioned that in the male ward, staff were more coherent in terms of age, comprising primarily younger nurses, in comparison to the female ward, which consisted of older staff. The composition of staff played a significant role in the formation of nurses' first impressions.

For this group prior expectations about the nursing job had, at large, remained unmet. Young nurses, of all educational backgrounds, unanimously pointed out the incongruence between what they had learned at nursing schools and the actual practice. Some talked about the skills they had acquired and never exercised: Maria "We learned at school how to give injections. They told us how to find a vein. I can't remember anything now. I haven't done it since school". Others talked about the quality of service they provide: Toula "at school we learned how to make the beds in a certain way, here such details don't matter", while others rationalized: Marina "in such units the only thing needed is working hands. You don't have to have special knowledge. Anybody can clean or feed a patient". Some nurses, with advanced education, confessed prior aspirations about delivering good performance in the hospital: Dina "I had dreams about organizing the ward", Katerina "I wanted to offer" and Sofia "I believed that I could make the best out of it. But after a while you are devoured by the routine". Despite this discrepancy, this group had a more definite perception of their work role. For them psychiatric nursing embraced a whole set of duties, activities and responsibilities regardless of what was actually exercised. Unlike the un-educated staff who degraded their role into "cleaners and guards", being a graduate from a contemporary nursing school was providing this group with a more favourable conceptualization of their role.

This discrepancy between training and the way that nursing was exercised, was contradicted, partially, by nurses' prior expectations regarding their workload. All respondents argued that work in a psychiatric hospital was thought to be of less

intensity in comparison to work required in general hospitals. For some nurses, this constituted a defining reason for choosing their current work environment. Katerina argued "I wouldn't want to work in a general hospital. It's tough there. You run all day" and Marina "I wanted to work here. I knew that work in other hospitals I wouldn't have to deal with such disorders and that people come and go but still it is more demanding there". It seems that expectations regarding the job and the hospital clashed. On one hand, nurses did not expect that their duties would consist of only basic and trivial activities and on the other, they anticipated that work in the specific setting would not be demanding. Such anticipation provided the rationale for the diversity between training and practice. Trained nurses contended that the hospital's bureaucratic organization and the mentality prevailed were the causes of the way their role was performed.

This was more evident in the female ward, where older nurses formed the majority and the distribution of duties was uneven. Young nurses in this ward were more active and spent less time in the station. In addition to the everyday duties (cleaning, feeding, dispensing medication) they also took part in other tasks: taking patients to doctors outside the ward, filling in documents about patients' progress, did administrative tasks and carried out various nursing duties (taking blood pressure, temperature etc). It should be clarified that these "extra" tasks were allocated among nurses not from the head nurse or the responsible of the ward. The head nurse announced to the whole group what needed to be done and nurses consented on who was going to do what. It could be observed during those arrangements that younger nurses were more willing to carry out these tasks and usually they did. Though this attitude was explained by willingness to learn more and obtain experience"I am here to learn and I want to learn more.." as Toula, a recently hired nurse confessed, it was not always deliberate but forced by other factors, such as the indifference of older nurses "they (older staff) are bored and we have to do everything..They use us.." Maria, a 24 year old nurse revealed or the avoidance of arguments as a young nurse reasoned "I prefer doing something myself than having to listen to arguments about who is going to take a patient to the doctor". Such complaints stemmed both from feelings of being exploited and from prior perceptions about workload in the psychiatric hospital. Prior expectations about the limited work conducted in public mental hospitals regarded only senior staff and not young or new employees. Young nurses found themselves working more while their older co-employees were having long-lasting breaks.

Trained and young nurses did not confirm theoretical propositions about prior expectations affecting boredom. While there was discrepancy between the actual nursing role and the theoretical descriptions of it, it was not powerful enough to cause feelings of boredom. For this group, it seemed more important to confirm prior expectations regarding the relaxed and un-demanding work environment of the hospital.

9.3. Male nurses

Male nurses represented only a small percentage of the total nursing staff but there were within variations in respect to educational background, years of experience, attitudes and behaviour. Only three male nurses were interviewed and all information regarding the total group was obtained from them. The following section provides detailed evidence regarding each of the three interviewees work history and attitude at work and role perception. There were two basic sub-categories: older men who were first employed by the hospital as carriers of patients or guards and then they were advanced to nurses and a second group comprised of men who failed to enter in medical schools and ended up in nursing faculties. A third category though smaller than the first two, was represented by people for whom nursing was the first occupational choice and had attended a 2 year nursing course or seminars. The latter category tended to identify with the first group (unskilled, old nurses).

The organizational history of the hospital (Filandrianos 1977) demonstrates that men were employed to carry out the heavy jobs and keep order in an environment that was not purely therapeutic. The mixing of mentally disturbed, outcasts and criminals during the hospital's initial years of function, required a work force that would be willing to work in such environment and would also be able to control the inmates. It took decades to alter that situation but the role of men in this institution had been already defined. Though men are now hired as nurses, and participate to all other duties, their basic contribution (or at least what they try to present as basic) is protecting patients and female staff. An incident that occurred during field work exemplifies the role of "protector" that men have acquired. It required a male nurse to disarm an excited patient who was in possession of a knife with which was threatening to hurt himself. And generally whenever a patient needed to be tied down, it was usually men who would do it. Although routine activities were carried out by all staff, the impression given was that men were additional hands, an extra help to the "main" female staff. For example, men usually took care of difficult patients or patients who happened to be over-stimulated a particular day. What was, therefore,

the meaning that male nurses were extracting from a job that mostly required physical strength and emotional detachment?

Variations regarding age, years of experience and level of education influenced clearly role perception. The first interviewee was the responsible of the ward. A young man, who had attended the university nursing course, had worked in a general hospital abroad, acquired a high position in nurses' union and was currently involved in the organization of a nursing conference. Panos, had failed to enter the medical school, however he conceived nursing as a challenge and attended the course. He was extremely aware of what to expect working in a public hospital, but he was constantly setting new goals in order to find an interest in a job that was not his first choice. He attended the 1-year psychiatric specialty and following that he was constantly updating his knowledge on the field by attending seminars, conferences, subscribing to journals etc. His job was mainly administrative, although "I do everything, despite the fact that I don't have to. I want to stay in touch with what's going on in here, with patients and staff. I could just stay in the office tell everybody that I am busy and that would be it. But I am out there, I constantly observe what is happening". He talked of his job with exceptional realism, referring to norms, relations and duties. Panos could not be characterised as cynical and his whole attitude suggested strong belief and tenure to personal goals. He had no delusions about his job position "I may be closer to the management but this is only fake power, however, there are certain things under my jurisdiction", he was realistic about the essence of it "I am just managing people (staff), try to keep everybody happy and at the same time meet the needs of the ward". He disregarded the whole caring paradigm and viewed only the scientific aspect of nursing. He rationalised that by telling that it was not helpful for patients "it just keeps them dependent" and nor to him "I sometimes feel sorry for them but I try not to let it out". Obviously Panos was an exception in the ward or was trying to make more explicit to the researcher his difference from the rest of the staff. He regarded nursing as "just a job" and perhaps this superficial similarity with the rest of the group, helped him become accepted by them.

The contrast between Panos and Kostas demonstrated how personal characteristics affect ones' beliefs, behaviour and meanings that will derive from the environment. Kostas, a middle-aged, unskilled nurse represented the typical male attitude in the hospital. In congruence with the "macho" image, he would act as if nothing affected him, without expressing any emotion, trying to keep a light atmosphere in spite of what was going on, would make a string of sexual comments and would keep an

image of coolness and indifference. During breaks, he would often leave the ward because he could not keep up with women's talk. His long experience in the hospital gave him a superiority which was manifested in the way he commented about young educated staff "what do they know, how much can a book tell?" His whole energy was invested in trying to find ways to amuse himself and pass the time as pleasantly as it was possible. Seeing others work with patients was a "waste of time" and all activities were perceived as boring. Being non-involved was obvious from simple things that occurred in the ward. He would not follow discussions regarding the hospital or the management, unless he was personally associated. For example nurses used to make comments about their whole work setting (its disadvantages, inefficiencies etc) but Kostas would remain detached if there was not a personal loss or benefit. Patients provided another topic for conversation among nurses. Either it concerned telling amusing incidents in which patients were involved or exchanging general information about them, nurses were accepting them as part of their work life. On the contrary, Kostas would never initiate or participate in such discussions and would limit his input by simply report on patients' medical/psychiatric condition. By ignoring patients Kostas was ignoring or disregarded his professional role. Role theory (Biddle & Thomas 1966) contends that roles are comprised by dualities "you cannot have a doctor unless you have got a patient".

Thomas was the last male interviewee. He was a newcomer in the ward and was hired under the law for people with disabilities (his left hand had a problem and probably his mental abilities were below the average). He was extremely reserved and cautious during the interview and even during informal chit-chat in the nursing station. In his first day in the ward seemed quite overwhelmed, despite that he had already worked in other hospitals before. Though other nurses tried to include him in their conversations, he was quite reluctant to respond. One of his first comments was "it's the people in here" but unfortunately he did not want to expand later on. In fact he changed his whole view and tried to conceal things during the interview, which occurred after 2 months of his arrival. It was also suspected that perhaps he might have lied during the interview in order to present a more favourable image of himself.

Thomas had attended a 2-year nursing course after parental advice "it would be easier to get a job as a nurse". His rejection of the nursing profession was grounded on the emotional aspect of nursing "it's not the best thing it can happen. Seeing a young one suffering from cancer, it is too distressful" and on the actual practice "what's there? General nursing is about giving medication and make the beds" His

view regarding the function of the psychiatric hospital was contradictory to the ward he was in and to other staff's comments "I like it here because there are patients who are released. You've got hopes for them". Thomas' perception of his role was quite limited "I am just trying to help and do my duties as good as I can. I am still learning". Perhaps, as the responsible of the ward had suggested, being aware of his disability made him very conscious about his performance in comparison to other nurses and defined his role as a helper-not a nurse. There was nothing to disturb or please him in his job "It is just a routine, there is nothing satisfying about it". He had no career aspirations, although he was contradictory about it "I don't like changes, you never know whether they are for better or for worse" and later on "who wouldn't improve his position if he was given the chance?" The impression given was that Thomas was trying to fit in the hospital, in his reference group (other nurses in the ward) and keep up with them in terms of work output. However, being aware of his limitations withheld him from being one of the group. This led to spending more time alone and not participating in conversations unless he was asked to. Of-course this had as a consequence for Thomas to set as a goal the termination of the shift "just to pass the 8 hours, that's my goal". Since his first day he was constantly looking at the wall clock, while others would tell jokes, talk etc.

In general Thomas presented quite inconsistent feelings about his work. There were conflicting areas which he had to resolve before saying that he has formed a coherent work identity.

9.4. Perception of patients & Behaviour towards them

A theme that came out of the interviews and observations is that of patients' diagnosis and its implications on nurses' attitudes and behaviour.

Access was denied to the full records of patients, hence all descriptions are based on: a previous study conducted in the mental hospital, direct observation of patients and on nurses' accounts on some of the patients.

A broad description of patients admitted to the psychiatric hospital derives from a survey conducted in 1998 (Varouchakis, Michalakeas, Matsa & Michalareas 1999) regarding patients' demographic characteristics, diagnosis and length of stay in the hospital. It was found that the majority of the patients were of middle age, unemployed, un-educated, single and suffered from schizophrenia and/or mental

impairment. The average length of stay in the hospital was between 10 and 20 years and only 2 out of 10 patients have the possibility of being released.

The female ward was created in 1999, after two previous wards were destroyed and patients were transferred. Thirty female patients lived in the ward. The youngest was 32 and the oldest was 85. There was a mixture of illnesses, varying from schizophrenia to mental impairment. Most of the patients suffered from various organic diseases due to their age.

The male ward was an old one that accommodated thirty-five male patients. Their age range was between 29 and 73. Again there was variation of disorders but there were fewer physical illnesses. The general level of patients' function and general ability was considered good in contrast to patients of the female ward.

The general perception held by the majority of nurses, was that those cases were "in-curable" or that they "were finished". Though the age of the patients could constitute a factor affecting nurses' conceptualization, it did not play a major part. Nurses based their beliefs solely on patients' behaviour and psychiatric record. There was no distinction between young or old patients, but they all fell under the same category "crazy". An informal discussion with one of the nurses, clarified this perception: The discussion occurred as some of the patients in the lounge of the ward were shouting. Voula (N): "You hear them? What can you expect? They are all crazy…Something must have happened and if one starts shouting the others will follow.."

Researcher (R): "Are they all like that? I saw a couple of them who seem quiet. For example Katerina, I have never seen her arguing or even talk (a young female patient)."
N: "Her? She is the worst. You know how stubborn she is? It takes ages to shower her."
R: "She is young, can't she bathe herself?"
N: "I don't know but we wash them all together. In this way they have a routine and we finish faster."

Vaso, a practical nurse when asked about her feelings towards younger patients replied "I don't see them differently. However, when I see young people, especially in the acute wards I feel scared about my children, that something might happen to them and they will end up here".

The only categorical distinction that nurses used for patients, was between "bad and good" according to patients' behaviour. Age or any other formal psychiatric description was not relevant to them. Voula, a practical nurse with many years of experience, said "some young nurses when they first come here they ask for the patients' records. What is the point? I never read them. What would be the use if you know that one is schizophrenic or depressive? You live with them and you learn about them. I know how to talk to Matoula (a patient) and how to behave to Niki (a patient)". Other nurses also reported that they rarely read the psychiatric records of patients. Usually, as they said, when a new patient arrived in the ward they were informed by the head nurse or by the psychiatrist. It was a common practice to rely on informal communication in order to acquire information regarding patients. By informal it is meant, that there was not any kind of organized or formal meeting that would prepare nurses for a new admission. Initial information was obtained by nurses who were bringing the new patient into the ward. Nurses who were going to accommodate the patient usually had a brief discussion with the head nurse and then it was expected that the "word would spread out" to the rest of the staff. It was observed that a huge amount of information was exchanged among nurses in the form of small talks during work or breaks. Despite the fact that those conversations were short, however they offered nurses the necessary knowledge. What usually interested them was "whether the patient was able to eat on her own" and "whether she was an easy and quiet patient".

The absence of any formal preparatory process for receiving a new patient was not inquired after. Nonetheless it was identified that nurses based their behaviour towards new patients upon the "trial and error" concept. As the majority of nurses were not educated, perhaps the provision of psychiatric information seemed futile. However, this is only a hypothesis. All behaviour was based on past experience, as Theodora said "when I first came in the hospital I was watching the others in order to learn how to react to specific patients", Vaso explained "you see them and when you have that many years of experience you learn what signs to notice even in new patients" and Efi argued "it's not that you think in advance how should I behave. You say something and then you check patients' reactions".

These two facts, the uni-dimensional classification of patients and the indifference shown regarding formal information seemed to have created a vicious cycle. Patients were all perceived as crazy, with limited abilities and with annoying behaviour. Such

a conceptualization refrained nurses from considering each patient separately, as a unique individual. This further led to patients' atrophy of even their slightest abilities and therefore nurses' initial perception was confirmed. Vaso confirmed this regarding a patient "we cannot control her. You never know what she is going to do. She jumps out of the window, she steals things from us or from the other patients. She was not always like that. Before she was brought here, she would help nurses to make the beds, she was willing to do errands, like take the dirty clothes to the laundry..Now she just doesn't listen".

A basic belief that was held by nurses, especially the ones who had several years of experience, was that the long-stay wards were the final resort for patients who either could not be cured or who had no family that would take care of them. Their perception of the hospital was still that of "an asylum" a "bin for the un-wanted". All behaviour presented was based on nurses' mood at a specific time. It was observed that the same patient might have been treated with kindness and patience at one time and with indifference or strictness at another. Generally when the climate in the nursing station was good nurses were more "open" to interact with patients. Nurses for example would make fun of, talk to or willingly give cigarettes to patients when the atmosphere in the station was calm. However, indifference and scolding of patients were the most frequent behaviours. These two patterns of behaviour could be said to be on a continuum, with the first happening when things run considerably smooth and nurses just could not be bothered. This was made obvious several times, especially when patients were asking for cigarettes. Nurses usually responded with a stance that represented *cannot be bothered now,* like Voula who replied to a patient "Oh! You have to wait" and *why do you ruin my peace of mind*, like Fotini who just made an expression without even saying anything. This was verbally stated many times with exclamations such as "what do you want now?" and "what is it again?" and was further supported by the apathy of nurses to patients' requests. At the other extreme were nurses' harsh reactions to the exact same demands. While the same words might be used nurses' tone of voice was stricter and louder, signifying that there was no room for negotiations or insistence. Such behaviour had usually its onset on various factors: whether the head nurse was present, whether there were problems during the shift and whether the group of staff was getting along well.

It was observed that whenever the head nurse was in the station nurses changed their behaviour towards patients as well as between themselves. They became calmer, more receptive and the content and tone of their speech was altered to a

kinder level. There was a marked difference in the way nurses talked when in the presence of the head nurse, suggesting that a kind of self-monitoring and adaptation was used. Nurses' verbal behaviour would follow the same patterns as other authority figures, such as the psychiatrists of the ward. An incident exemplifying this, was when Maria, a young nurse, not quite familiar with the norms, was shouting at patients and the psychiatrist who was there at the time stopped her from showing such behaviour. Despite the official justification (shouting at patients makes them more irritated) other nurses told her "try to keep it (voice) down, at least when they (psychiatrists) are here".

An incident that occurred in the first ward suggested that nurses' behaviour towards patients partially depended on the difficulties encountered during the shift. The episode of a dehydrated patient, who almost passed away, had created an intense atmosphere in the ward, affecting all staff. After the incident, nurses seemed troubled, not willing to talk much and rather uneasy. Though patients expressed the same behavioural patterns, which in any other case would be received with indifference, humour or strictness, nurses exhibited different reactions that resembled mostly anger. The after-the incident conversations provided an explanation for the hostile feelings towards patients. Nurses felt that patients should be blamed for the incident (and for several others that nurses were listing to the researcher) because of their reluctance to obey their instructions or rules. Nurses' stories revealed emotions such as anger for not being able to control patients "they don't listen!" and being fed up with having to deal with the aftermaths of patients' behaviour "to hell with all this".

Other evidence regarding the factors affecting nurses' behaviour to patients was related to group coherence. Nurses reported several times that they preferred to execute their shift with their friends or at least "with people that I can have a good communication" as one nurse put it. Otherwise, tension was likely to be occur regarding issues such as "who's done what" or simply because of personality clashes. In respect of the latter it was observed that when two specific nurses, Theodora, a strict and religious practical nurse and Voula a gregarious and fun-like practical nurse, were in the same shift, there was a general discomfort in the station. Neither of them could behave in her usual way while in the presence of the other and this often led to abrupt behaviour towards patients. Both of them implicitly revealed their feelings, either by talking negatively about "people in here who just want to pass time having fun" as in the case of Theodora or by expressing disapproval with facial gestures when the other was not in the station, as in the case of Voula. In such

instances, nurses were more controlling and demanding over patients, as if they were trying to establish a balance between the restriction of their behaviour in the station and their relative power over the patients. The responsible of the ward supported this hypothesis, when reflecting upon nurses' relationships and their effects on their general behaviour "they are ready to bite each other when they are given the chance and if they don't they just take it out on patients, but it happens to everyone doesn't it?". This was more explicit when a quarrel between nurses was set off regarding the laundry. The quarrel went on for days, as it brought up other issues, and was consuming nurses' time. During those days, nurses were stricter with patients, shouted more and tried to carry out their duties as fast as possible. Such behaviour contrasts formal reports regarding the interference of personal feelings in the work. Most nurses, like Toula and Dina, reported that they try to leave all personal matters out of the work domain because "patients understand when you are upset and this makes them edgy as well".

Nonetheless, all behaviour cannot be attributed to those infrequent events. Nurses usually avoided contact with patients even when the latter made efforts to interact. The following dialogue between a patient and nurse illustrates this:

Patient: "sister, when are we going to eat?"
Nurse: "in a while.."
Patient: "what's for lunch?"
Nurse: "ha! Come on now, you want to know the menu!"

Sarcasm was a common reaction to patients, even when those presented "normal" behaviours. Further more, such brief encounters were used by nurses as onsets for having a laugh between them. The same inquiries were responded by nurses with teasing such as "there'll be no food today". Again the tone would be playful and dependent on nurses' personality and affect.

The above descriptions reveal a significant fact: that all out-of-task interaction between patients and nurses was initiated by the former. Even then however, nurses were trying to avoid it either by trying to make fun of patients, by taking a harried look and giving simple answers or by not replying at all. Various times nurses justified their behaviour as an outcome of patients' inability to communicate. Elisavet, a trained nurse verbalised those beliefs "there is nothing to be done with them. They take their medicines and that's all. Nothing else can be done. You know, at first you

try to talk to them but when you get replies that have nothing to do with what you have asked or when they are constantly in their own worlds, you stop trying. Add to that the everyday burdens of the job…it is logical. Everybody says that they have got used to cleaning them but you never get used to it really".

In their talk about patients, all nurses compared the long to the short-stay wards. They all had a preference towards the latter as they were occupied by a variety of challenging cases, with which important work could be done and progress was visible and relatively fast. Patients in short-stay wards despite expressing more aggressive or un-controllable behaviour were able to communicate and above all, work was limited to cleaning and feeding them. Nonetheless, such preferences were contradicted by further elaboration of the matter. Nurses, after claiming that short-stay wards provided a better work environment, in terms of duties, nature of work and types of patients, added that they would not change their current work setting. The explanation given was that things were more relaxed in long-stay wards and that they did not have anyone "above my head", meaning that there was no one to check on their work, in contrast to short-stay wards where psychiatrists were always present. As one nurse put it "every ward has its pros and cons".

There was a marked difference in the second ward occupied by male patients. Though the same basic pattern of avoiding contact with patients was also observed, nurses kept a different stance. Again patients were the initiators of any voluntary interaction with nurses, but the latter seemed more willing to chat and considerably less abrupt when there were time limitations. It should be noted however that the general condition of patients in that ward was better, hence allowing nurses to leave open doors and permit patients to go out in the hospital's yard. Patients that remained in the ward were the less interactive. In this way a double gain was obtained: nurses could avoid interaction with the inmates by allowing them activities out-of the ward and patients could pass time easily and interact with other people in the hospital. This was implied by Marina, a young nurse when questioned about the "open door policy" of this ward as contrasted to the "closed door" in the female ward "it is not easy to keep them in, they are men, they want to go to the coffee shop, they want to go out. It makes them good, they can talk there, see others, instead of sitting here doing nothing".

This quote, supported by others as well, reveals an important contrast between nurses' perceptions of patients in the two wards. While in the female ward, patients

were referred to in neutral ways as "patients" or pejoratively as "crazy", in the male ward patients had maintained their masculine identity. Derogative terms were not used in the second ward. Instead nurses' descriptions frequently contained words such as "men" or simply "patients". Several reasons account for this diversity. The first one was related to patients' ability to communicate on a basic level, to carry out simple tasks and to maintain a basic connection with reality. Conversations among patients, as well as with nurses, covered a broad range of social or everyday matters, such as politics and sports or personal histories and inquiries regarding food, going out, celebrating etc. As Katerina and Dina said "we are ok here. They can even do some errands for us, most of them can eat on their own. They generally understand when told something". The head nurse of the ward added (while laughing) "you have seen them. Though what they say is usually out of date, they still have a vague understanding of reality". However, it was observed that whenever nurses talked of the "good condition" of the patients, they were eager to add that they "had other things making their work difficult". This was more evident whenever the researcher was commenting about patients in the opposite ward, as if there was a subtle rivalry between wards in respect to which one requires the most out of staff. According to nurses in the male ward, the difficulty of their work reflected the fact that they had to deal with men, Sofia "they are physically stronger and whenever there is a need to tie somebody down, it's not easy at all" and Dina "you have to be careful about how you talk to them. We try to be calm and yet show who is in charge around here". However, this contradicts the comments of the head nurse who said that "male patients are easier to handle, compared to women. They (women) might attack you at any time. Men, at least in here, understand that they are dealing with women and they have some respect for us". The two different views might be explained from the different positions held by nurses, Sofia was a young practical nurse in contrast to Rena who was the head nurse and constituted an authoritarian figure for both patients and staff. Another comment received was that male patients needed to be shown no fear or inhibition, as Katerina said "you have to act as if every patient is the same, whether a man or a woman, you have to do your job".

A theme that was brought up by a personal experience of the researcher was the flirting between nurses and patients. Nurses laughed about the issue in a tone that revealed familiarity. Sofia revealed that she had encountered a situation when a patient was trying to flirt with her "I didn't know how to handle it. He was giving me looks, he was always willing to help me with the making of beds and kept asking me whether I had a boyfriend, what's my star sign, you know things like that. He has

never gone beyond that point though". Various opinions were accumulated. The head nurse felt that it was "in their nature, some of them are quite young", others, like Dina, argued that patients might attempt to alter the patient-nurse relationship only with newly hired nurses "after a while they know where we stand and what our role here is". Nurses contemplated on the ways employed to discourage patients' flirty moods. Their manoeuvres consisted either of cutting patients short by telling them that they did not have time or by trying to divert the conversation. Remarks were also made concerning the necessity of not being abrupt or totally dismissive, as "you never know how they are going to react and of course you don't want them to become obsessive with you". Observing nurses' brief encounters with patients, they seemed friendly and yet detached, supporting their previous arguments.

The type of interaction observed in the second ward was noticeably better than in the first one in terms of duration and nature. Nurses were kinder, more available and more considerate towards patients. The major contributing factor for this stance was the preservation of the humane nature of patients, contrasted to the de-humanized processes that female patients were constantly undergoing in the first ward. Though patients' basic social abilities played a significant role to this, they had an additional effect: limit the interaction with nurses. For example, although both wards were equipped with television only in the second ward did patients watch it at various times. Being occupied with something (television) or being able to spend time out of the ward, patients were less demanding and did not seek interaction with nurses as much as in the female ward. This enabled nurses to be more relaxed and limit their work to the basic duties (cleaning, feeding and any other nursing duty). Two incidents verify the aloofness and perhaps irresponsibility which characterised nurses in the male ward. The first one concerned nurses' reluctance to accompany patients out of the ward. After patients were given permission to leave the ward, sometimes this was happening without nurses' awareness, no one was in position to locate the patient. Despite the limited possibility of escaping the hospital due to the presence of security, the vast area that the hospital covered was a sufficient factor for patients to get lost. Katerina and Marina replied with certainty that "patients always come back. They know that this is their home, where else can they go?" and "there would always be someone to notify us if an inmate has gone to another unit". Furthermore, as they added, no patient of their ward had ever attempted or managed to escape from the hospital.

The second incident occurred during an evening shift. Usually during those shifts staff numbers were lower but there is the possibility of requiring extra help from other wards/units. Two young nurses were allocated in the evening shift and although there was no necessity for additional help, as things were running smoothly, they asked and got another nurse from another ward. After her arrival, the two nurses left the hospital leaving the third one alone having to deal with 30 unknown patients. The episode was recounted by the third nurse to the researcher and no explanation was given about nurses' behaviour. Further inquiries about this incident were not made, as the researcher felt that it might have hindered nurses' willingness to talk to her. As the nurse added the incident had no implications for the two nurses, "what could I have done? I wouldn't tell anybody unless a problem had occurred in the ward. Then of course I was going to tell". It seemed that there was an unwritten rule between nurses of both wards that they should cover for each other and resolve matters such as this one between them without the interference of third parties, such as the head nurse or administrative staff. Though such severe misconduct had never happened during the field period, however, nurses did take turns for long breaks outside the ward. When the weather became warmer and whenever the head nurse was absent, both patients and part of the staff were found out of the ward. Sometimes nurses used as an excuse the out-ward duties, such as document delivery or bringing back the laundry, however the time spent was disproportional to the actual time needed for such errands.

A group discussion among nurses threw insight into the mixed feelings nurses had for patients. The conversation had as its onset an incident broadcast on the television news regarding the content of food in another psychiatric hospital. Investigations showed that there were traces of mice in patients' food and that none of the basic hygienic rules were applied in that hospital. Nurses' initial disgust and repulsion gave way to fury and pity expressed as "no, not at this point!" or "they (patients) are humans as well" and condemnation of the whole issue. Such statements suggested that bad living conditions or de-humanizing patients were acceptable, in their own ward, but there was a boundary separating these from the atrocity conducted in the other hospital. As the talk kept going in this way and comparisons between the two hospitals were made, nurses found some kind of amusement in the episode and started making sarcastic, humorous comments "lets gather all the insects and feed them, why wait for food to arrive?" or "every summer the same story..they don't know what to show in the news so they start looking at patients' living conditions as if these things didn't exist before". In the presence of the researcher nurses felt that they had

to eliminate any speculation about same practices occurring in this hospital "we have catering services here" or "yesterday I tried out the food and it was actually quite good". Overall, the impression made was that nurses were reluctant to let feelings of sympathy overwhelm them and tried, without much effort, to diminish them by allowing sarcasm and rationalizations.

9.5. Caring

From the section above, it has been made explicit that nurses' behaviour towards patients could not be regarded as supportive or affectionate, both constituents of caring. While the repeated admissions of patients or their lengthy stay in long-term wards, the everyday physical contact and the satisfaction of basic needs could be considered as elements upon which a caring rapport between inmates and nurses could be developed, observations confirmed the opposite. In some cases, as some old nurses revealed, nurses and patients have known each other since their first contact with the hospital. This, however, did not restrain nurses from the expression of inappropriate behaviour.

A primary evidence of the absence of caring, in the particular long-term wards was nurses' avoidance of contact with patients. The caring paradigm seemed to have failed in the particular settings. Nurses had various mechanisms to limit their contact with patients. The most evident one was their physical separation from them. After finishing their main duties, nurses were gathered in the nursing station that was out of patients' easy reach. Outside of the station was a narrow hall with a wooden barrier separating it from the rest of the ward. The hall had an additional door which remained locked. A couple of patients, in their attempts to get cigarettes or candies, would jump of the barrier and access the station. The hall offered nurses visual contact with the sitting area of the ward but not with the dorms or showers. Nurses' insistence on spending most of their time in the station not only obstructed relating to patients but it also diminished supervision. Furthermore, patients' quests for interaction were met by nurses with indifference or strictness. Depending on their mood, nurses would have a laugh with or at patients but this was not common.

Other evidence for the absence of caring was the procedure followed for cleaning patients. During the morning showers, patients were lined up and nurses, who wore special uniforms, used hoses to clean them. Physical contact was limited to the necessary and the whole process lacked of personal involvement. Such tasks were performed remarkably fast and in a completely impersonal way, that signifies both

nurses' uneasiness with dirt and exposure to human body and the dehumanization of patients.

Caring in terms of expressing kindness or friendliness was only presented towards favourite patients in the female ward. Almost every nurse, excluding male nurses, had a preference for a specific patient, a special connection that seemed not to be based on reason. Soula talked of her preference "I just can't shout at Matoula. When she puts on that silly smile on her face I immediately forget what she has done" and Efi "I know Maria for over 15 years now. She was brought when I first got here. I used to take her for walk almost every day. Now I am too tired for that" By this selective approach to patients, nurses ditched caring as an inherent characteristic of nursing. In addition, selective caring was not sufficient to provide meaning to nurses for two reasons: first, external circumstances may halt the relationship (death or transfer of a patient) and secondly, having such negative feelings towards patients in their totality may have outweighed the positive feelings for the chosen patient.

Nurses' behaviour in the male ward, was seemingly friendlier, however, it could not be categorised under the concept of caring. According to staff's reports male patients required certain attitude, keep a balance between being firm and yet expressing friendliness. Though this could be considered a manifestation of emotional labour, however its origins were identified to be: fear of male patients, as Sofia and Katerina said "they are physically stronger and whenever there is a need to tie somebody down, it's not easy at all" and the preservation of patients' male identity. By conceptualizing inmates as "men" and by acknowledging some of their basic needs (e.g. going out of the ward) and abilities (e.g. follow a simple conversation), nurses could not apply the same processes of de-humanizing patients, as did nurses in the female ward.

All nurses tried to explain the coldness and firmness of their behaviour by referring to the disadvantages of getting close to a patient. They argued that by showing affection they would promote dependence and clinging behaviours of patients. Anna said "We love them but it won't be good for them to show our affection" and Fotini commented "You can't help to feel sorry for them but it's not pity that they need, they need to become self-sufficient". The correctness of such statements clashes with the absence of any other method to enhance patients' social skills and positive behaviours. What nurses tried to accomplish by remaining detached from patients was: coming too close to madness, protect themselves from being disappointed and

discouraged from patients whose condition was not going to improve no matter how much effort they put. Nurses were very absolute in their arguments "it's not helpful to come too attached to patients" and they wouldn't provide any other information regarding the reasons for this behaviour. Caring was seen as a weakness, opposed to the image of strong, capable women that nurses liked to present. In order to achieve and support that image they had to totally dismiss the caring ideal. Moreover, developing closer relationships with patients would mean that they would have to abolish the image of difficult, demanding patients which was basic for their own self-presentation. Caring would require another way of working that was not supported neither from nurses' skills nor from the hospital.

9.6. Summary

In this section there was an analysis of how nurses have developed their perceptions of their role. The nursing role, as exercised in the particular wards, was generally considered in negative terms due to a cluster of factors: the lack of any prior desire to enter the profession, the negative psychological effect of the first impressions, the diversity between practice and training, former expectations regarding the setting and lastly the derogative perceptions of patients.

Apart from a few cases of a clear intention to work in the health care domain, the majority of nurses worked in the hospital because of the immediate absorption that the profession offered or because of acquaintances that helped in the application processes. Nurses decided to enter the profession because of chance or coincidence, without exhibiting any specific interest or desire.

For older practical nurses, the lack of an explicit orientation towards nursing along with the absence of knowledge regarding its practice had augmented the impact of their first impressions in the job. Those nurses were not prepared for the bad conditions existing in the hospital at the time, expectations concerned only vague and general aspects as depicted in the media, hence their initial reactions were psychologically detrimental and had affected their overall attitude to the job.

Improvements in the organization and infrastructure of X had clearly a different effect on younger nurses. The diversity between nursing training and practice was mentioned, however what this group of interviewees contended as most important was the undemanding nature of their work.

Despite the fact that these two groups had different experiences from their work in the psychiatric hospital, their current perception of their work was that it had no difficulties and it was relatively loose.

Such perceptions were formed from the type of patients that nurses attended to. The conceptualization of patients as finished and of the hospital as a "warehouse for the unwanted" had a major impact not only in the effort placed in the job but also in the behaviour towards patients. Even male patients who exhibited some basic social abilities were still considered as "not having any future".

The combination of those factors for the most part, made nurses disregard their traditional caring role and limit it to very basic duties.

Chapter 10: Behaviour

10.1. Attention in tasks

Attention has been considered by researchers as a major determinant of boredom. Lapses of attention are thought to be direct outcomes of boredom, especially in professions that require prolonged concentration such as driving, air control etc. The studies that have been conducted so far, measured cognitive procedures such as failures to perceive a stimulus, speed of recognising or reacting to stimulus, ability to follow instructions etc. Moreover, individuals who perform a task that is considered to be boring, pay less attention to the task (Damrad- Frye& Laird 1989, Dyer-Smith & Wesson 1997), have lower performance (Dyer-Smith & Wesson 1995, Drory 1982) and usually have more irrelevant thoughts while doing the task (Gardner, Dunham, Cummings & Pierce 1989). Some of the basic nursing tasks do not involve any complicated mental activity and therefore the type of attention that literature suggests could be dismissed. However there are similarities that will be discussed further.

Tasks in the long-stay wards were very specific and involved: cleaning, feeding and dispensing medications to patients. Other nursing activities, such as measuring temperature, blood pressure were also performed, but only to specific patients who had additional health problems, apart from the psychiatric ones. Execution of those tasks did not require special skills or concentration. As nurses said most of their daily duties were trivial and easy to carry out and only some tasks like feeding required additional attention. As the responsible of the female ward and Vaso said respectively "when we cut their nails we have to be careful not to do a mistake because you never know how they are going to react. They are not like other patients" and "feeding them might take some time because you have to be careful of choking". Observations confirmed nurses' arguments. During most of the tasks, nurses were totally concentrated and devoted to what they were doing. Even nurses who generally expressed a more indifferent stance, their attitude was altered when they cleaned for example a patient. Moreover, the majority of the staff claimed not having any irrelevant-to- task thoughts while performing one. Nurses argued that despite the triviality of their job, they couldn't afford to think of personal matters, because any mistake could upset patients. Some of them, like Toula, went further and confessed that if they started thinking of their problems they would get nervous and this could have a bad influence on patients' psychological condition. Contrary to the studies that argue that task triviality affects feelings of boredom and leads to defected attention, the present research has shown that nurses' perception about their job did not cause either feelings of boredom or attention failures. Possibly this

could be explained by the fear of causing undesired outcomes or simply because those tasks involved dealing with humans, rather than materials.

10.2. Attention as supervision

Nurses described their work as a constant supervision of patients. Additionally the absence of doctors and the inability of most patients to describe their condition or possible health problems required nurses to be even more vigilant to any changes in patients' behaviour. This could constitute a similarity with the attention required in other professions because of the alertness and readiness that was required in order to recognise and react to the signals that patients were giving.

However nurses' work was facilitated by a number of factors: first the fact that they worked as a group. Any behavioural and emotional changes that patients expressed were easier to notice since there were 5-6 nurses working in the ward. Secondly, the majority of nurses had many years of experience with psychiatric cases and they already knew very well the specific patients. As they argued, their expertise and knowledge of those patients helped them distinguish even the smallest change in patients' voices, way of walking, body posture etc. The third factor concerned the type of patients. Though most patients were diagnosed as schizophrenics, their prolonged stay in the hospital along with the medication that they were receiving had made them quiet or as the psychiatrist of the ward said "institutionalised". Additional measures had been taken by nurses themselves, in order to limit the range of their activities/attention. These *measures* varied across the two wards. For example the main door of the female ward remained closed all the time despite the fact that there were patients who were able to go out in the yard of the hospital. Nurses also used physical restraints whenever patients were upset or excited. Tying up patients was a common practice that nurses justified by arguing that it was for patients' own good. However, observations disclosed that nurses were taking that *measure* not only for patients' protection but for their own benefit as well. An agitated patient would require nurses' attention, something that nurses wanted to avoid. It was observed that whenever a patient was not obeying to nurses' orders about being quiet or not 'bothering' other patients, the usual tactic followed was physically restraining that patient. Additional evidence was given during an afternoon shift: the nurse had just come in the ward and started her job by tying up a patient who was known for her usual screaming. The act however in that case, was proactive since the patient was tied up on the grounds of her previous general conduct. Though institutionalization concerned male patients as well, their general condition was considered more

functional. The door of the male ward remained open at all times (except at nights) so patients could walk out in the yard of the hospital and physical restraints were not used as often as in the female ward. Working with patients who had sustained an average level of social abilities, signified that supervision did not need to be close or continuous. Male patients usually occupied themselves by watching television in the main area of the ward, by keeping company with each other or by going to the coffee shop that was situated in the yard of the hospital.

Although work in both wards was arranged in the most favourable way, there were incidents that demonstrated that nurses' attention was in decline. As *supervisors* nurses were not as watchful as they claimed to be. Different incidents in the two wards justify this. In the female ward, patients had showers without someone to watch them, others jumped out of the window to get out of the ward, admissions to the pathology department were usual because of dehydration and intoxication, thefts among patients were frequent occurrences which then led to arguments and one incident of fire because of smoking lead to the conclusion that nurses were quite inattentive. Nurses refused to take the blame for those incidents and accused patients for not listening to their orders and the hospital for not hiring more staff. However being in the ward disclosed that nurses work stopped when the routine tasks were carried out. After that nurses used to gather in the nursing station and left it only in infrequent periods. Supervising the patients seemed to be a boring activity for nurses, especially during the morning shifts when more staff were in the ward. Two facts led to this conclusion: the first one is related to the number of nurses who worked in each shift. Evening and night shifts were carried out by 1 or 2 nurses who were in full responsibility for the 30 patients that were in the ward. That responsibility was not spread out to a lot of people and may have made nurses more anxious and ultimately more attentive. During those shifts nurses made more visits to the patients' dorms and they were usually sitting in the hall outside the nursing station in order to have better visual contact with patients. The second fact was related to the composition of the group during morning shifts. Usually the same nurses worked in the morning with some exceptions who also worked in other shifts as well. Those 3-4 people had formed a close group which was composed of older and younger nurses. This group had developed its own codes of communication and working. Younger nurses used to perform more tasks while the older ones remained for longer periods in the station. The group had cultivated a general climate of "fun" that was characterised by sexual comments and teasing, chatting and joking. It was difficult for nurses to leave this "light-hearted" atmosphere and start walking up and down the

ward to check on patients. Possible explanations for this behaviour might be either that "supervising" was not considered by nurses as one of their basic duties or that someone else from the broader group (there were 5-7 nurses in the morning shift) would do it. It was not clear which of the two occurred, however nurses who didn't belong to the group were the ones who willingly left the station and wandered in the ward. This act had a double meaning for the "outsiders": first it was a coping strategy against boredom and secondly it was an act of rejection by the group. Nurses who had a more strict and religious perception of their job were usually the ones who left the station to check on patients.

In the male ward, incidents of this gravity were not observed. However, nurses presented a similar stance in regard to supervision. Relying on the "better condition" of patients had a negative impact on their perception of how watchful or attentive they should be. The few patients who were in-bed should not be a "worry", while the others were usually gathered in the main area in front of the nursing station hence they could be observed all the time. Such justifications were contradicted by the fact that the physical arrangement of the nursing station could not offer a sufficient view of the whole ward or of its main area. Secondly, despite nurses' claims about supervising patients on a continuous basis, as Katerina argued "it is our job to watch for them", observations disclosed that nurses were not always aware of patients' whereabouts. A couple of incidents when nurses were looking for patients, along with the fact that nobody accompanied patients outside the ward, suggested that nurses had a very abstract perception of what supervision is. When asked about whether they feared something happening to patients who were going out of the ward, their replies confirmed the irresponsible stance observed in the ward. Excuses were given by Katerina, Sofia and Marina and regarded patients' awareness of the ward being their "home" so their return to it was considered certain, out-of-ward employees providing information about a lost patient and the fact that no patient had ever tried to escape the hospital. However, nurses' rationalizations of their inattentiveness were based on factors that were not reliable or out of nurses' control.

Overall, in both wards supervising patients was not considered a permanent duty but an activity which either broke boredom or caused it. Depending on the situation and on the individual, checking on patients was used as an excuse to leave a boring gathering in the nursing station, or when it was compulsory, imposed feelings of boredom. A clear example of the latter was when the head nurse of the female ward demanded that nurses regularly check on patients and give them water after an

incident with a dehydrated patient. For a couple of days afterwards nurses followed the order, but they soon returned to their old habit. Besides that nurses expressed unwillingness and negativism for the new order and they dragged themselves to execute it. It was odd that nurses, like Theodora and Dina recognised supervision as part of their role "We are guards here nothing more than that" and yet they refused to act it out. In the male ward, supervision was abolished as an unnecessary act due to basic beliefs about patients' abilities (ability to return to the ward) and habits (watching television).

This might be because guarding, unlike other tasks, did not include any specific action but alertness and readiness to act. Previous studies regarding boredom and vigilance were confirmed but only in the case of morning shifts when staffing was higher and responsibility was dispensed.

10.3. Passage of time

The inactivity that was manifested in both wards could be attributed to various reasons, which are discussed in another chapter. It is important, however, to explore the effects it had on nurses' perception of time, a critical factor for assessing boredom. According to theorists (Brissett & Snow 1993, Barbalet 1999, Darden & Marks 1999, Danckert & Allman 2005) the way individuals perceive time is an element for deducing boredom. When one is bored, time seems to pass slowly, there is a feeling of an "endless present" and that time has stopped. Theory describes several situations in which people may feel they are "stuck in the present", such as being engaged in a boring activity, having nothing to do or being unable to foresee a different future.

Despite the fact that nurses generally despised their job, they did not complain while they were performing their duties. It was actually the contrary, they had an anticipation to start feeding or cleaning the patients. Nurses were looking forward to executing their main duties and very often when they had to wait they became anxious and restless. Some of the comments that signified this were made by Christina "why don't they bring the food?" Vaso "what are they waiting for?" and Voula "if we had to wait for doctors to come, all patients would have been dead by now". It seemed that those activities, independently of how trivial they were perceived, acted as breaks from boredom. Two opposed sentiments regarding duties were apparent: boredom for having to perform the same things everyday and a kind of relief for having something to do. Although nurses complained about the

repetitiveness of the tasks, they performed them with eagerness. This finding contradicts Ornstein (1970) who contends that the nature of task influences the perceived passage of time.

After the main duties had been carried out nurses were gathered in the station, practically doing nothing. Time seemed to be passing slowly, although they tried to occupy themselves. Xenia, a practical nurse who used to knit during her shift said "how else am I going to pass the time in here? It keeps me busy and it helps me clear my mind of their voices". Nurses were constantly looking at the clock, they were making comments related to time such as "we finished showers early today", "it's still 12 o'clock", "in two hours we are leaving". A dialogue between a Fotini, a practical and Christina, a trained nurse who had just come in the station is indicative of nurses' perception of time:

Christina: is it 1?
Fotini: yes, you are writing up the records that's why you didn't realize that time has passed. If you have to do something, it is easy.
Christina: I guess I got really busy today.

Although nurses disliked their inactivity, when something extra came up they were reluctant to do it. Usually newly hired nurses took up the "extra" tasks, while the older ones were in the station. Many times younger nurses complained about being tired or fed up of being taken advantage of by the rest of the staff. Learning new things and not having to be in the station all the time were the thoughts that compensated for those feelings. On the other hand, older nurses felt they deserved their longer breaks which resulted, as the literature suggests, in difficulty in starting an activity after a long period of "nothing to do" (Dyer-Smith & Wesson 1995, Fisher 1993).

Time passed even more slowly in the evening and night shifts, when personnel were much fewer and there wasn't so much to do. The researcher found it extremely difficult remaining in the ward during those shifts because what nurses did mostly was watch television. All nurses reported the same thing regarding the passage of time in the ward: there were days when they had many things to do and did not have time "not even for a cigarette" and days when they didn't know what to do. Although nurses reported that the first was more frequent, in reality most of the time nurses were trying to cope with boredom and smoking was one of their "strategies". Smoking in the ward had a special meaning for nurses: it signified how time was

spent in the ward. Many of them referred to it in order to describe a work day: Toula claimed "I started smoking when I first came here", Voula added "there are days that I smoke two packs", Thomas explained "I had quit smoking for 3 months and I started it again, how else am I going to get through the day?" and Fotini argued "if you are not a smoker, time doesn't pass easily". The resemblance between nurses and patients regarding smoking was remote but it was there. Smoking constituted the only activity patients had and an excuse for interacting with staff. Cigarettes had become the most valuable thing in the ward and the cause for many fights. Stealing cigarettes from each other was a usual phenomenon among patients, which resulted in fights and arguments. In the absence of any other activity, time passed with patients wandering around the ward looking for a cigarette or smoking. Nurses presented a similar picture, sat in the station smoking and chatting. This was a similarity that proved and exemplified the belief that institutionalization concerned both patients and staff.

10.4. Absenteeism

The above constitute only certain aspects of how boredom was manifested in the psychiatric wards. Nurses presented other behaviours that, according to the literature, were closely associated with boredom. Organizational theories contend that boredom may be expressed through absenteeism and organizational misbehaviour (Fisher 1993, Drory 1982) or as Barbalet (1999) noted "negative involvement".

Absenteeism in the wards was a multi-dimensional concept. It concerned the duration of each shift, the quality of work time and certainly the days off work. Nurses, like most public employees in Greece, had special cards on which the launch and end of each work day was written by special machines. Although validation of the card needed to be done by its holder, most employees (and nurses as well) arranged this between them and it was usual for one person to validate the cards of co-employees. In that way, employees may show up at work later while their cards were validated at the supposed launch time of their shift. Nurses used that method quite often for both the beginning and the end of their shifts. However, excessive misuse of this was not observed. Morning shifts begun at the proper time because, as nurses said, they felt for their co-employees who were doing the night shifts and wanted to leave. Nurses usually had a good excuse for being late at work and that concerned family or health problems. All nurses reported that being late for the morning shift was a rare phenomenon not only because they sympathised with

nurses of the night shift but also because of "fear" of the head nurse, who was always on time. Those rare delays to work could not be attributed to laziness or boredom. Being on time for work had a special significance for nurses. Despite the fact that many of them conveyed negative feelings before coming to the ward, they also expressed a substantial sense of responsibility and commitment towards their co-employees and their patients: Matzi "What will I gain if I am late? Since I have to work it's best to be right otherwise I will have problems with the head nurse", Vaso "These people are waiting for us to clean them, give them food, so why be late?" and Soula "It is really bad to have people waiting for you to change shifts. They are tired, they want to go home and have rest. I know it because I have been there". Yet, things were altered at the end of the morning shift. Nurses used to become inpatient and some of them left the ward earlier than they should. This only happened in the absence of the head nurse and only with a short time gap from the end of the shift.

While fear and sympathy for their co-employees withheld nurses from being late or leaving early, the head nurses had the freedom to escape the wards whenever they liked to. The phenomenon was observed in both wards and with high frequency. Justification of these informal hours off work varied.

Nurses in the male ward provided the same excuse whenever the researcher observed the head nurse's absence. This was always related to administrative work that had to be taken care of and demanded communication with staff situated in other buildings. The reliability of this justification was questioned first by the prolonged absence and secondly when the researcher ran into the head nurse having coffee with employees in one of the administration buildings.

For the head nurse of the female ward absenteeism was formally justified. She was responsible for the opening of a new unit in the hospital, so she had to leave nearly every day in order to supervise the process. She would run this unit and her mind was set on that project. She confessed that it was an opportunity to leave a ward that everyday became "a heavier burden". The case of the head nurse confirmed the literature on boredom. The new unit was almost ready, apart from some administrative details that needed to be taken care of. Its opening was expected week after week and that had caused a lot of stress and anticipation for the head nurse. She felt that she was neither in the new unit nor in her ward. Her anticipation was enhanced by her negative feelings regarding her current position.

According to the literature (Darden & Marks 1999), feelings of boredom may be provoked by situations in which the individual waits for something (e.g. waiting in a doctor's office) and during that time there is no specific role for him/her. Moreover future expectations define feelings and attitudes regarding one's present situation. There is a clear contradiction between the head nurse and the rest of the staff concerning expectations and their behavioural outcomes. The expected transfer made the head nurse stressed, uneasy with the environment and restless. Instead of being in the ward for her 8-hour work, she was escaping with the excuse of the preparation of the new unit. On the other hand the situation for nurses did not include any prospects for change and hence their more apathetic stance. The difference between the head nurse and the rest of nurses was found in the form of absenteeism: the first was physically absent, even for a few hours, while the latter only mentally, whilst physically present in the ward. Nurses spent most of their working time in the station, where they engaged into activities such as watching television, chatting, knitting or just relaxing. Despite the noise that patients were making and their constant requests for cigarettes, nurses seemed to have blocked out such stimuli.

Nonetheless, nurses' physical absenteeism was at significant rates. Apart from the standard days off that nurses were eligible to each week, they were asking for additional leaves. It was quite usual for nurses to call the head nurse and ask for a day off due to illness. It was common for the head nurse to change the week's schedule 2-3 times each day. According to the head nurses, absenteeism was a mechanism for declaring opposition to the schedule and for doing favourable shifts. Although theoretically there was a system of rotating shifts, specific people stayed on specific shifts. The problem was more evident in the female ward because the staff did not compose a coherent group. The female ward comprised nurses from two different units, who had been accustomed to certain ways of work into and who had developed their own communication codes. Mixing those people meant that new habits and rules had to be established, something that nurses were reluctant to accept.

The head nurse was constantly trying to make her staff work across all shifts but there were nurses who resisted doing it. Their most effective strategy was to claim illness and not to show up for work. Incidents like that occurred frequently and resulted in nurses having their way. Although disagreement with the shift schedule was the major reason for absenteeism, it was not the only one. There was also the

case that nurses were asking for a day off because they weren't given the same shift with friends. This, however, concerned the afternoon and night shifts that were carried out by two people only.

Whenever the week's schedule was out, nurses commented on two things: their shifts and who their co-employee was going to be. It was more likely for nurses to pay more attention to this than to the time they were going to work. As Theodora and Maria said respectively "it is very important to work with people you get along with. If you don't have good communication then the shift will be bad", "there was an afternoon shift that I was working with another nurse. It was the worst, she didn't do anything but giving me orders..I couldn't say 'no' cause she was older than me, but from that time I pray not to be with her". This was particularly true for the female ward, however all interviewees confirmed its significance.

Apart from the communication issue that is of extreme importance in dyadic relationships, it might be the case that not working with a friend could make the shift duller. Although nurses never admitted out-loud such thinking, observations during afternoon shifts revealed that being with a friend made time pass easier and more pleasantly. Conversations varied, the atmosphere was lighter and work seemed to be flowing more. In contrast two non-friendly co-employees would keep discussions work-related, they would perform different activities while at a break and generally would acquire more tight behaviours. The fact that during afternoon shifts there weren't as many duties as in the morning ones emphasised the importance of the quality of staff's relationships. Hence the levels of absenteeism increased during those shifts. Although literature suggests that performing a task in the presence of another person reduces boredom and increases the interest in the activity, it was contradicted by many nurses. It might seemed at a primary level, that nurses showed more interest in the job while working with non-friends, but a more thorough investigation concluded that this interest was superficial and derived from boredom or reluctance to get intimate with certain co-employees.

Absenteeism (if measured by days off work) did not result directly from boredom, but it was mostly the outcome of a cluster of reasons: type of shift (morning-afternoon-night) and type of nurses' relations during each shift. It was only in the second variable that boredom was an influential factor for absenteeism. Nonetheless, "mental absenteeism" was an everyday phenomenon.

10.5. Irresponsible/Negligent behaviour

Nurses' behaviour as it was observed directly and, discussed through formal interviews and casual conversations, has had a distinct feature: the absence of an underlying feeling of what constitutes organizational citizenship behaviour or misconduct. Defining organizational citizenship behaviour as a desirable work attitude that includes helping others, staying late, tolerating impositions or inconveniences and being actively involved in organizational life, all actions that have beneficial implications for both the organization and its employees (Bolino, Turnley & Niehoff 2004) the lack of such attributes became explicit from the beginning of field work. Nurses' behaviour clashed with both the "ideals" of the nursing profession and the overall aims of the hosting organization.

Literature on negligent behaviour in medical professions has defined it as "the adverse outcomes of medical treatment alleged to result from a lack of skill or attention by doctors involved" (Dingwall, Fenn & Quam 1991). From another perspective, negligent behaviour is seen as an outcome of the existence of organizational politics and consists of destructive-passive reactions that are aimed at harming the organization and its goals (Vigoda 2000, Spector, Fox, Penney, Bruursema, Goh & Kessler 2006). Furthermore, counter-productive work behaviour has been portrayed in the literature (Fox, Spector & Miles 2001) either as an emotion-based response to stressful organizational stimuli or as a cognition-based reaction to organizational injustice that both lead to aggression, delinquency, withdrawal and resistance.

What has been identified as negligent behaviour in the two wards ranged from everyday minor misconducts, such as long-lasting breaks and absenteeism (already discussed in the previous section) or telephone conversations, to the more severe misbehaviours, such as stealing or getting drunk during the shift. The latter were described by nurses in a very informal way, as gossip and not directly to the researcher, hence she (researcher) was hesitant of being more assertive by asking for further details as it might have hindered nurses' willingness to disclose more. Some of the cases were reported by a key informant that could not give names or details of the incidents. Depending on the gravity of the misbehaviour, nurses displayed various emotions, from the slight sense of achievement and contentment to fury and complete disapproval.

Episodes of patients starting a fire, being intoxicated because of excessive coffee drinking or being dehydrated were some of the most discussed examples that nurses referred to in order to show the researcher how un-controllable patients were. When they were confronted with their own responsibilities, nurses excused themselves by blaming the system for not hiring more staff or by attributing problems to patients' qualities, such as wit and fastness, which they had not mentioned before. A discussion between the researcher and Vaso, a practical nurse regarding the incident of a patient starting a fire in the ward some years ago, exemplifies nurses' stance:

Researcher (R): "How can they set a fire, since as I have seen, you give them cigarettes, lighters?"

Vaso (V): "You don't know them well (in a tone that suggested that things weren't what they seemed). They hide stuff in their wardrobes, under their beds..don't be fooled by their condition. When they want something they find their way…"

R: "Really? But how can they find lighters and I guess you have access to their personal belongings."

V: "I don't know, they steal from us or they are given things from their relatives, when they show up. And we don't always know what each one of them has..It's not like we search everyday for what they might possess."

R: "I have been told from another nurse that while she was working in another unit, a patient was found to have hidden a knife. Isn't this dangerous for both you and themselves?"

V: "They might have got it from the dining room. You can't keep an eye on them all the time. We have all these other things to do. We do it to the extent that time permits but not all the time. It can't be done."

Other nurses held the same views on the subject. It was not obvious whether nurses recognised their responsibility or they simply presented things in such a way so not to be blamed by an outsider (researcher). Certain contradictions suggest the latter. For example the inconsistency between nurses' assertions of guarding patients and the actual time spent in the nursing station, imply that patients had opportunities for misbehaving. Moreover, nurses' beliefs regarding patients' abilities fluctuated according to the situation or event which was being discussed. Depending on the situation, patients were considered able to build a plot in order to mischief nurses (as in the case of stealing a knife or effectively hide lighters) or totally disabled/ crazy. Irrespective of the basic beliefs that nurses acquired regarding patients and their own control upon them, such incidents imply that nurses failed to guard patients with

results that have been detrimental for patients' health (dehydration, intoxication) and almost fatal for the whole ward (fire). Spending most of the time in the nursing station nurses were reacting to events and not preventing them from happening. This is in contrast to what most nurses believed to be their principal role in the ward, that of guard. Discussions with two nurses, Fotini and Vaso, regarding the episodes of patient's intoxication and fire respectively, suggested that nurses took pride in reacting effectively during those incidents as their comments revealed "I grabbed her immediately and tried to make her vomit, while I was shouting to others to send someone to take her to the emergency unit" and "we managed to take them all out". However, it still remains the fact that none of those nurses considered that the occurrence of those incidents was a direct outcome of their neglect or insufficient attention.

Despite nurses' claims that they were always on guard, observations disclosed quite the contrary. Nurses' work time was spent mostly in the nursing station, either by watching television, talking on the phone about personal matters or engaging in group conversations. The relaxed atmosphere that prevailed in the station and nurses' un-awareness of what was going on in the rest of the ward was interrupted in three cases that confirmed the above.

The first one was when a patient rushed into the station and took a cup of coffee. Everybody in the station was taken aback and no reaction was attempted. By the time nurses realized what had happened the patient was already out of the station. A second incident occurred when a patient managed to escape the ward. Despite the closed-door policy in the female ward, a nurse had left it un-locked because she intended to go out. A short time afterwards a patient was seen out, running towards the male ward that was across. A fight between two male patients was the third episode that implied nurses' neglect of supervising patients. Nurses only learned about the fight because a third patient notified them. After breaking them up, one of the involved patients was crying about being almost strangled.

Such events illustrate the overall attitude that nurses expressed in the wards. Apart from the negligence or aloofness with which nurses approached their duties, there were also reports of misconduct. Some of the stories had happened before field work took place and were told without specific names or dates. All the comments and explanations that were given regarding the events constituted personal opinions of

the informants and it could not be identified whether those opinions constituted actual facts.

Staff relations in the wards were noticed to be a delicate matter as rivalries between nurses existed in various forms (from personal to work-related matters) with the most eminent the distribution of duties and the allocation of staff to the three shifts. Nurses reported inequalities in the amount of work they carried out and in the total of night shifts they were performing. Though most of the quarrels between nurses were somehow resolved either by the intervention of the head nurse or simply by the course of time, an incident was described that expressed nurses' potential for more destructive behaviour. The quarrel between some nurses and the responsible of the ward had its onset in unfavourable allocation of shifts that the latter had decided. As the informant suggested the underlying cause was a power game between nurses and the responsible. Nurses wanted to keep the old patterns of work while the responsible had set new guidelines and demands upon staff. As the distribution of medication is a main duty of the responsible, when the wrong medication was given to the wrong patients and one of the patients presented adverse symptoms the whole issue was brought to the attention of the administration that accused the responsible for not meeting effectively the demands of the job. The episode ended with the responsible being removed to another ward. As the informant contended, the accusations were totally false and accountable for the incident were the nurses who had mixed the medications. Although the competencies of the responsible were well known and there was not any other reason for conducting such a "mistake", no proofs could be given regarding these who were guilty. The absence of any fatal outcomes certainly does not minimise the significance of the event and exemplifies the extent to which nurses were willing to go in order to maintain their way of working. As the informant suggested "they (nurses) are in absolute power in here. They can do whatever the like if they want to. Not because of anything else but because they are the majority, and it is upon their work that the whole system of the hospital operates. The hospital would cover anything, as it did in this case. Do you think they (administration) don't know what is going on?"

Providing cover for misbehaviour was a common practice in the hospital, at all levels of the hierarchy and in respect to a variety of issues. Everyday minor misconducts, such leaving the wards earlier than the supposed time, taking single days off work without the knowledge of the head nurse, claiming to have performed duties that they had not, such as the case of nurse who in the presence of her co-employees, filled in a patient's record with faulty blood pressure levels, were all covered and more than

that, they acquired no specific significance for nurses. However, providing cover for an almost alcoholic co-employee created uneasiness, discomfort and a feeling of being fed up with the situation. The issue was brought up while nurses recalled festivities that have been taken place in the ward in the previous years:

Voula (to the researcher): "We have had quite a few good times here, you know a bit of drinking, having something to eat, having fun.. that sort of stuff."

Vaso (to Voula): "Do you remember Manos? I wonder what happened to him…"

Voula (again to the researcher): "He was something else! He was a good guy but had a thing for alcohol. He used to leave the ward and go to the nearby coffee shop, had a couple of drinks and then he would return to finish off the shift. He would be a bit tipsy, made jokes but of course we had to do his own job as well. Not that he couldn't, I guessed he used it more as an excuse to avoid work, but we had no hard feelings for him. Sometimes we would send him off and cover up for him. He used to call us "my girls"..Well it got tiring after one point. You know you are always in the mood for fun or doing extra work. When the head nurse realised what was going on, it wasn't hard after all because whenever he was out we had to make excuses for him, once he was delivering documents to the doctors, the other for a break, the next he went to bring the laundry, so she reported to the administration and he got sacked. She knew all along what the problem was and covered him as much as she could. But as things didn't change, she started thinking of possible consequences, her job would be at stake as well."

Vaso: "He was a nice man, but this thing went on for a year…We have devised everything, it was easy with the doctors because they didn't even realise who was missing, but with the head nurse it was another story. It had become a burden, trying to figure out how to cover him. If it had happened once in a while it would be ok, but this was an ongoing situation."

The underlying assumption of nurses' attitudes towards their former co-employee, was that misconduct could be ignored on the grounds of its rare occurrence, its gravity and the effort needed to conceal it. The above dialogue suggests that the actual behaviour of the male nurse was not considered in absolute terms but in relation to the effects it had on the rest of the staff.

A personal acquaintance of the researcher, who had worked in the hospital for a period and left for her own reasons, acted as an additional source and revealed an offence conducted by employees on a continuous basis. She became familiar with

the incident as she was present at a meeting held by the head nurse and the rest of the staff, excluding the psychiatrists. The subject of the meeting was the mysterious over-consumption of medication and had a warning character. The head nurse reported that she had to order for specific drugs more often than the usual. The fast consumption of drugs could not be justified by alterations in patients' doses, as she herself was well-aware of them. As the source suggested, the medication must have been stolen by members of the staff but it was difficult to make specific accusations.

Nurses' negligent behaviour could be categorised into two very broad sets: the first one concerned minor, everyday lapses of attention and ineffective control of patients. The basic characteristics of this type were: its continuous occurrence, even after more serious effects had taken place (fire) and the insignificance attached to it by nurses. Even the verbal context, in which incidents with patients were told, was in relation to the "craziness" or abnormal behaviour of patients.

The second set of misconduct entailed more serious "offences" that were characterised by individuality and active engagement in destructive behaviour. Though the first type of negligence could be attributed to group norms regarding work and absence and to the hospital's system that facilitated such behaviour, the second set should be better explained by individual characteristics of the persons involved. Because of the indirect way that the researcher familiarised herself with those stories no further insight was thrown into the matter. However, the significant issue implied by the key informants, was again the system's acceptance and reinforcement of misbehaviour by concealing it. Moreover, the first two incidents- the drunken employee and the mixing of patients' medication- described as serious "offences" insinuate two critical assumptions, at least for the persons involved: first, the total indifference about patients' health. Even if it is assumed that nurses knew what drugs to alter in order not to create serious side-effects to patients, the act by itself shows explicitly the lack of fundamental concern and respect towards another human-being. The second assumption that may be triggered by nurses' behaviour is related to perceptions of the job. The case of the alcoholic employee may be attributed to personal problems or may be considered an illness. However, from the given descriptions it was implied that the level of drinking, despite being a habitual act, was moderate ("not that he couldn't work. I guess he used it more as an excuse to avoid work"). Nurses expressed considerable acceptance of his behaviour, thinking only about the effects it had on their work-load. Being in a caring profession, as nursing is usually classified, was not of importance. By bringing their co-employees' drinking

habit to a personal level ("it had become a burden to figure out how to cover him") they disregarded their job, their work context and the recipients of their actions (patients).

In conclusion, negligent behaviour could be attributed to concepts regarding the job and the work setting. Though nurses never explicitly related these two, the carefree style with which nurses behaved insinuates that there weren't any "second thoughts" regarding the correctness of their actions. Nurses had become accustomed to negligence to the extent that it had no significant meaning. The tolerant environment of the hospital was another factor facilitating such behaviour. The absence of stricter measures regarding absence and general conduct in the wards, in addition to the norm of concealing things, allowed nurses to maintain the established approach to work.

10.6. Summary
The behavioural manifestations of boredom, as were observed in the present study, have expanded and partially contradicted previous findings.

A primary finding regarded attention both as a mental activity while performing a task and as a basic nursing duty. The sample expressed mixed behaviours. Attention to tasks was not hindered at any time. Contrary to past research that asserted that attention is limited when one is engaged in boring and un-challenging activities, nurses performed their main duties with concentration, accuracy and promptness. Despite the fact that their perceptions and emotions about their tasks were negative (performing the same trivial tasks every day, dealing with dirt etc) their performance was not impeded. The basic explanation offered regarded the nature of tasks, which were inexorably connected with patients. Dealing with the human body and more importantly with people with severe mental disorders had made nurses extremely cautious of their actions. Any inattention would lead to unfavourable outcomes, such as getting a patient upset, something that nurses wanted to avoid by any means.

Unlike the attention given when executing a task, nurses' behaviour was altered when attention became a duty, in the form of supervising patients. Despite claims about being guards of patients, supervision was not efficient. This contradiction was evident not only through several adverse outcomes that have been caused but through the norms that prevailed regarding supervision. Supervision was not seen as a formal duty and the prevailing belief was that by simply being in the ward was more

than enough to secure patients' well-being. In contrast, supervising patients was an activity based on the number of people occupied in each shift and on the composition of staff. Although morning shifts had more nurses, supervision was less frequent due to the basic norm that someone else would check on patients. On the contrary nurses in afternoon and night shifts, usually just two, were more aware of their responsibility and consciously visited to patients' dorms more often. The second factor that determined supervision was evident only during morning shift. When nurses worked with friends were usually more reluctant to leave the light atmosphere of the station and start checking on patients. However, supervision offered an escape and a valid excuse for nurses who wanted to leave the group in which they did not belong to.

Nurses had excluded supervision from their core duties hence most of their work time was spent in the nursing station. Various activities were taking place in the station in order to pass time, from chatting to knitting and from telling jokes to arguing over petty matters. All nurses reported that time passed slowly, adding however that this was not on a regular basis. Nonetheless, throughout field work it was observed that the busy days were much less frequent than the inactive ones. The slow passage of time was evident in behaviours such as the constant looking at clocks and the excessive smoking, while nurses verbally referred to it clearly and often. This is line with literature about the association of time with boredom as well as with studies that have connected boredom with health-risk behaviours, such as smoking.

Another element of nurses' behaviour at work was related to time taken off work. Literature has referred to a great part only to the physical escape from the work environment as a direct outcome of boredom. In the present study, absenteeism concerned basically hours off work, as for example early end of shift. Last minute notifications about single day-off were often but this was a reaction against unfavourable shifts and not of boredom. Absenteeism, in the studied wards, was mostly related to the quality of working time. As it was seen in the above sections, the distribution of time between task execution and breaks was unequal, with the latter clearly being longer than the first. As nurses segregated themselves from patients by spending most of the time in the stations, the un-related to work activities in there had become a source that relieved them from boredom and helped them mentally and psychologically escape from patients' shouts and *crazy* behaviours.

Limiting down the work time to only the basics and keeping a distance from patients, both mental and physical, nurses could not act in advance and stop patients' harmful behaviours. This irresponsibility was at large the basic reason for the reactive character of nurses' conduct in the wards. Incidents related to patients' worsening and to nurses' misconduct varied to the extent of their outcome, however they all disclose that staff were not aware of the gravity and significance of their role or position. Evidently, nurses attributed any false performance to the system that did not support them or even to patients for being un-controllable or simply crazy.

Chapter 11: Meaning

11.1. Negative meaning

The term "meaning" has a long tradition within existentialism (sociology) and existential psychology (Frankl 1984), however scholars have not concluded into an agreed definition of meaning in the workplace (Cartwright & Holmes 2006). In order to understand the concept, as it has been used in occupational psychology, there are three key questions that an employee asks in his/her search of meaning (Cartwright & Holmes 2006, p.202):

1. Where do I belong?

2. How do I connect and

3. What is my value contribution to others?

As it has been proposed by Baumeister (1991) "meaning" refers to the sense of purpose, to the values that provide a sense of justification and goodness and to the sense of self-worth. It is important, therefore, to keep in mind that meaning goes beyond purposes and goals, as it characterizes one's whole existence. An additional remark concerns the personal character of meaning. By this, it is meant that meaning cannot be imposed externally (Isaksen 2000) and can be found even in mundane tasks (Csikszentimihalyi 1975) and in low-status occupations (Heinsler, Kleinman & Stenross 1990).

This difficulty of defining "meaning" affected the research process. The sample could not conceptualize the term even though the initial question was altered and explained repeatedly. There were also interviews were the question was completely omitted because of the interviewee's limitations, as for example inability to understand the question or reluctance to reveal information about such a personal issue. After the first explorative interviews where direct questions about meaning were asked, the process took another form in order to make it more comprehensible. First nurses were asked about their perceptions and feelings regarding the negative aspects of their job (dealing with dirt, death and illness) and then they were asked whether they have gained anything from it, as individuals. That was a relatively easier way to make nurses think about the inherent qualities of their job, instead of asking them directly and it provided additional information concerning the validity of the assumptions made by organizational psychology.

The majority of nurses argued that there was no meaning in their job. Nursing constituted just means for living, "just a job" as they said that they had to do because

they were in need. Observations in the ward disclosed that nurses behaved in a mechanistic way, detached from any enthusiasm or satisfaction. They came in the ward, performed their routine tasks and left. At the end of their shift they felt that "another day has passed by" or glad that they were leaving.

At a first level, negative perceptions of their job prevailed. Nurses were giving accounts about how bad their work conditions were: "what's good about it? Nothing. The pay? Having your nerves wrecked everyday?", the unchallenging nature of their job, the difficulty of being with such patients and about the emotional and physical fatigue they were feeling after years of work "don't you see how things are in here? I am ashamed for wearing this uniform; I am ashamed to say where I work". It was rather difficult for them to perceive any meaning or any kind of benefit after listing the negative traits of their job. Actually nursing as a profession had nothing but negative connotations to the sample. Some of them, like Toula and Voula, were quite cynical when asked about whether there was anything positive in the nature of their job: "what? Do you mean if I feel that I contribute to society by taking care of these people?" (laughs).

However this obvious dislike was altered when nurses were confronted with the public perceptions of nursing. Especially psychiatric nursing has undergone through severe criticism after the media (Konstans 23/9/04, Mpouganis & Petropoulou 13/2/05) have exposed unfavourable images of patients' living conditions in state mental hospitals. Although nurses accounted for only part of the problem, they took on most of the criticism. By defending themselves and their profession, nurses disclosed a different perspective concerning their job and their role. It was revealed that their self-image and esteem was based on the hurdles of their work in the ward. Work in a mental hospital entails some sort of danger explained by the unpredictable, impulsive and sometimes harmful behaviour of patients. In a society that still perceives schizophrenics as dangerous (Economou, Gramandani, Richardson & Stefanis 2005) those nurses displayed courage and strong will by working in a relevant setting. Dealing with such patients presupposes that the carer is endowed with emotional strength, readiness to act and alerted. Though such elements were not clearly observed but were contradicted by nurses' indifferent behaviour, they existed in nurses' minds. With variations in the extent, all nurses perceived themselves as "strong women who could deal with anything". Though not overtly acclaimed, nurses talked with pride about their ability to act effectively in situations that demanded decisiveness and courage, as in the case of the earthquake

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described by Vaso: "We took them all out of the wards. We had no fear for ourselves, we saved them", preventing a patient from choking recalled by Elisavet: "I have saved many patients from choking", or by acting quickly in the case of an intoxicated patient "When I saw him drinking all that coffee I grabbed him immediately and made him vomit". Even nurses who had not encountered such difficulties, the simple act of being in an environment with constant noise was a confirmation for their patience and emotional strength "for twenty years I have been listening to their screams and shouts".

For Matzi, Soula and Theodora, old nurses who have experienced the shocking conditions of the hospital, their anger towards the public was transformed to a positive self-image that was endowed with patience: "they only say bad things about us. Have they ever tried to come and stay here for more than 5 minutes?" tolerance: "It is easy to say anything when you haven't got the faintest idea. They don't know what it's like to be hit by patients and taking care of them afterwards" ability to face difficulties or emergencies "You never know how they are going to react. You just have to be ready for everything" and emotional strength: "I was a young girl when I first worked here and in my first day I had to wash 60 men who were lined up naked in front of me". Nurses' tone of voice was harsh, revealing mixed feelings of pride for being able to do this job, anger for the underestimation of their profession and resentment for having to put up with all these difficulties.

Such reactions revealed that there was a hidden meaning in "suffering" and "sacrificing", as one practical nurse said "We have given them (patients) everything, our lives, everything". However, this was only brought in awareness in cases of being treated unfairly by the public. Only by talking and confronting peoples' perceptions of psychiatric nurses, they found that what they were doing was valuable and meaningful.

The notion of being sacrificed regarded not only patients but nurses' families as well. The majority of nurses came from poor socio-economical background and had to work in order to support their families. This by itself may increase one's sense of self-worth but nurses, by telling their personal stories, showed that it did more than that. Soula, an old nurse confessed "I educated my kids through this job. My daughter is now doing her master and I pay for it. It isn't that bad after all" and Voula revealed "My husband died only few years after our marriage. I had two baby girls to support. And I did. And now they are grown into wonderful girls. It was tough working here but

it certainly worth it". There was a particular nurse in the ward, Matzi, who didn't disclose any hard feelings about her job. On the contrary she reported being content for coming to work and help others. It was revealed later that she had serious family problems (abusive husband) and working in a mental hospital helped regain her self-esteem or just deal with her personal issues by seeing a worst aspect of life (illness). Apart from the fact that nurses provided for their families, the demanding nature of their job doubled their sense of self-efficacy.

This group of old and un-educated nurses had found meaning in an otherwise low-status job. According to the head nurse and the responsible of the ward, this was not a random fact. Their belief was that personal inefficiencies (education, self-esteem etc), family problems and poor economic status have made this group seek for a job in the particular hospital. As the head nurse questioned "Do you think it is a random fact that most of them have personal problems, no education and work here?" As the head nurse insinuated having an alternative perspective of life, acquiring a power position in respect to patients, being able to take care of and deal with the mentally ill provided an improved self-image. Two nurses of that group were working elsewhere prior to the hospital. This exemplifies that although there were occupations which could absorb a work force with limited vocational abilities, nursing was preferred. Nurses' reasoning for choosing nursing because of necessity to work was partly abolished. Vaso was a tailor and Efi was working in a supermarket. The reasons they gave for leaving those jobs were: the opportunity to work without anyone "above your head" (that means with no one to check on you), the chance to socialize and fit into a "group" and the security of employment.

11.2. Young female nurses and meaning

However, the difficulty and the "suffering" that nursing entailed was not perceived as meaningful by all nurses. Such perception was characteristic among older female nurses while younger and male nurses did not share it to the same extent. Milder but similar emotions were expressed by younger nurses as well. The awareness of being necessary for patients' survival was not obvious to the public, hence leading Katerina to protest "I feel that I am necessary, without me they wouldn't be able to do even simple things. Others don't know this, or they think of it indifferently" and Sofia to assert in a tone of self-pity "We offer patients the basics, their personal hygiene nothing more than that. But just by being here others see you as one of the patients. They are prejudiced against psychiatric nurses".

Nurses, who had just a few years in the field, were unable to find a meaning in their job as it was performed in the specific wards. Their skills and abilities remained under-exercised while their main duty was to clean patients. It was difficult for them to perceive a meaning in "suffering" because of two reasons: the first was related to their age and marital status. Their age varied from 22 to 32-35, most of them lived with their parents or alone and had no other obligations to attend. The notion of doing such a difficult and disvalued profession for a higher purpose, e.g. providing for their families, could not be applied as in the case of older nurses.

The second reason concerns the type of training that younger nurses had received. Nursing training in the past decades was greatly affected by Orthodox values and principles. With the introduction of nursing in Universities and other vocational schools, Christian values were diminished and significance was given to the scientific/medical models. Young nurses were deprived from the Orthodox ethos that its basic statement is "help others even if that entails one's own suffering". To them nursing was another occupation, with its own scientific basis which had to be learnt. Meaning for those nurses was found in learning the practicalities of the job and the manifestations of the various disorders and in acquiring of a proper behaviour in relation to patients and co-staff. Nurses who were just a few months in the ward confessed that it was intriguing to see what they had just studied about and practicing it. In an informal discussion with two newly hired nurses it was revealed that learning to deal with co-employees was an important matter:

Toula: "Maria doesn't know how to say no. When they tell her to do something she does it even if she has been running up and down all day. You have to learn how to say no to some things but in a way so not to create a problem"
Maria: "I know that but I try to think of it as a chance to learn more. It is tiring however and sometimes it gets on my nerves..I think what am I? A sucker?"
Those nurses were dealing with new experiences and this was meaningful by itself.

Moreover during the interviews they both revealed more personal meanings that derived from nursing. One said that being in a psychiatric ward helped her control her temper. She confessed that she was an ill-tempered person and working with this kind of patients was teaching her to be calmer and more tolerant. In her words "ever since I started working here I've changed. Things that used to upset me do not anymore..well at least not to the point they used to. It has helped me forget my personal problems. When I come in the ward I am a totally different person. And this

has affected me..my whole life". For Maria, nursing provided a different meaning that was the opportunity to gain some control over illness. As she said "I wanted to become a nurse because I want to learn how to take care of my mother if she ever becomes ill". Other nurses have informed the researcher about Maria and from their accounts it was suggested that Maria had a troubled family-life and was on anti-depression treatment. Possibly, helping others or having others to depend on her was a crucial element for developing a sense of self-worth.

However, this "learning and adjustment" phase did not last long. Nurses who worked for over a year in the hospital started to find the job in the specific wards trivial, uninteresting and boring. Elisavet, a 28-year old nurse who had worked in various units of the hospital within 4 years said "I do like exploring mental illness. It's fascinating! Before working here I thought that I could never do it..I wanted to work in a general hospital. But after the first months here I like it…But not in here…not in this shit-hole. Nothing is happening here. They are all catatonic, there's not much you can do but clean them. I was in a short-term ward and I was excited about it. Things were happening there.." It was obvious from her facial expressions (eyes wide open, smile) that work in the short-stay ward was quite fulfilling in contrast to the feelings that the current environment was evoking. Although she was just transferred in the ward negative expectations and anger for the unjustified transfer overwhelmed her. She described patients and staff in the ward as animals and that there was nothing to do to change either of them. Her despise stem from the contrast between the way she wanted to work and the established way and from the thought that her skills would remain under-exercised. She had attended a 2 year training programme and a 3-month seminar in Holland for mentally impaired children. She thought high of her skills in comparison to the rest of the staff. Her orientation was towards the provision of psychological help and the modification of patients' behaviour. Despite the clarity of her goals and the confidence in her abilities, she believed that there was nothing she could offer to those patients because of the severity of their condition. When she was confronted with the fact that mental health work includes all types of patients and not just the "good" ones, she altered her argument by projecting against her "lazy" co-employees.

Similar attitudes were expressed by other nurses in the same position with Sofia. Their perception of nursing as "just a job" was very explicitly stated. Even though they were working with humans, their actions had no deeper meaning or effect on them. Dina, a 36 year-old nurse clarified this "I take care of them but- I know it will

sound hard- they have lost their human substance". It was difficult for them to identify a meaning in a profession that was perceived as "someone has got to do it".

11.3. Head nurse and responsible

A marked difference was identified between nurses and their direct superiors in respect to obtaining a meaning from their job. The distinction could be attributed to a variety of reasons, such as: the specific career orientation in the health care domain, the level of education acquired and the autonomy that characterized the positions held.

Both the head nurse and the responsible of the ward had an active interest in health care and their primary desire was to enter the medical profession. That not accomplished, they have re-directed their preferences and priorities towards nursing. This was exemplified by the training they have received after University. Both have attended the one-year specialty course in psychiatric nursing and various seminars.

For the head nurse, the acquisition of this position gave her the autonomy to organize her work according to her training and deliver the maximum results. Her work history, in previous units as well as in the current one, was full of examples of alterations in wards which were previously considered "dumps" or of patients who had made astonishing improvements "I had even made patients with severe mental impairment to be able to eat on their own, without help". As she recalled "I have worked too hard, I have confronted directors and other staff, I have even sacrificed my personal life for the hospital and yet if you ask me I would do exactly the same again". Her past behaviour exemplifies deep involvement and meaning found in achieving her aspirations and goals "I have given my life for the hospital. I wanted to organize each ward I am in, to see how it can be improved". Her explanation for her attitude was "I have never considered myself a public employee, I have never worked for the money, I never stick to work-times".

However, this past over-productivity was not sustained. Her current ward was not satisfying her needs and tiredness was openly stated "I am tired of the psychiatric units. I am going to be transferred to the new pathology unit and that's where I have given all my attention". The prospect of being transferred, her one-year educational leave as well as the difficulties in the ward (mostly related with the staff and the fact that it was not chosen by her) had disengaged her from her current position and had become impediments for sustaining a meaning which was otherwise found in

visualizing and achieving a proper therapeutic environment for her subordinates and patients.

For Panos, the responsible of the ward, nursing constituted a challenge after his failure to enter the medical school. This challenge was actually a bet with himself to make the best out of a situation that was not among his priorities. Despite his prior expectations about working in a public psychiatric hospital "I knew that things here are more relaxed" he pursued his own goals by receiving the certificate in psychiatric nursing specialty, becoming an active member of a nursing union, organizing and taking part in nursing conferences and yet attending his duties in the ward with similar eagerness.

He was observed helping nurses in all their activities (cleaning, feeding) apart from carrying out administrative tasks. As he described performing all kinds of tasks, even those which he was not obliged to do, was necessary in order to remain involved and informed about his ward "I could just stay in the office and pretend that I have other things to do. Many people in my position do this". This behaviour, apart from exemplifying conscientiousness, was part of a general attitude towards enriching his knowledge and expanding his skills. These had become his personal targets and consequently the meaning of his work "If you observe every patient in here and wander and try to find why is she doing this or that, then you will get something in the end… It is a very complex environment; there is no routine, at least for me".

This constant pursue of knowledge was meaningful in its own right, but has also helped Panos in discovering and understanding better himself "I re-consider my values, my way of thinking". Gaining a deeper insight of his self had become a necessity developed through the hurdles of his position "..the most difficult aspect of the job is the management of people, sometimes you feel trapped. You are rejected by your co-employees if you try to change their ways of working and at the same time you are discarded by your superiors. You have to know yourself very well in order not to get affected by this".

The acquisition of meaning through learning both scientific and personal, however, was not sufficient. Panos intended to leave his job when "the right opportunity comes along". His goals regarding other professional alternatives were vague, however, he was clear about "I don't work my whole life as a psychiatric nurse. I want to remain in the mental health field but as something else".

There were noticeable similarities between these two people. Despite being aware of and having experienced the slowness and inefficiency of the hospital, they have managed to find a meaning in their job, instead of considering simply futile.

A number of reasons explain this: first their position provided them with the autonomy to act and pursue their personal and work goals. The autonomy processed however, was seen as an important but not sufficient factor. Both the head nurse and the responsible of the ward referred to other people in the same position who did not express similar attitudes or to the fact that they had to stand up to superiors and subordinates in order to achieve their targets. In their case, the advantage of having some authority and power was taken to its full.

This fact leads to the second contributing factor, which incorporated personality characteristics, educational level and career aspirations. From their accounts it was evident a high need of achievement and determination to reach their goals. Though their prior career aspiration of becoming doctors were not accomplished, they have set new goals and to a great extend they have accomplished them. Roula talked about her "good name" (meaning good reputation) in the hospital, while Panos referred to his activities in the nursing organization. In contrast to the fact that climbing up the hierarchical ladder in the hospital required "knowing people" in Roula's words or "being in a political party" as Panos commented, they still pursued academic qualifications. Knowledge acquisition was perceived by both as meaningful in its own right, but also supported their future career goals.

The last similarity connects their career orientation with their propensity to leave the ward. Implicitly, both interviewees have reached a point where they have given everything they could to their job and have also taken as much as possible. In Roula's case, this was more evident as she was already appointed to the new pathology unit. Any meaning found in the past had been saturated and the need for a change was at high levels. Panos, on the other hand, being employed in the ward fewer years than Roula and having not yet identified his next career steps, was still capable of leading a meaningful work life.

11.4. Summary

The exploration of meaning was proved to be a complicated matter for a number of reasons. The most prominent one regarded its communication. As interviews have

shown, meaning, if present, is not always experienced through consciousness or even if it does it cannot be easily explained and become a matter of discussion.

Furthermore, meaning as a personal matter was not a topic that could be extracted in the interview context and with an outsider. Time limitations and personal inhibitions accounted for the lack of data on the specific subject. For example, interviews with nurses from the male ward were not as fruitful or enlightening in comparison to those with staff from the female ward. Reluctance to disclose personal information could provide an explanation for the findings presented.

Bearing these in mind, it could be argued that only some of the older nurses-most of whom worked in the female ward- have found a meaning in "sacrificing" and "suffering" for the benefit of others (patients and families).

For the rest of the staff, nursing was not providing any kind of meaning. It was perceived as "just a job" that offered nothing but the means to survival.

The head nurse and the responsible of the female ward were noticeable exceptions. Perhaps their advanced education and/or their interest in psychiatry have provided the basis for this ongoing search of self-awareness. Additionally, their career aspirations constituted a meaningful aspect of their current work life, since they enabled them to learn, be involved and finally to be willing to try.

Chapter 12: Emotions

12.1. Depression

It has been argued that low mood and depression-like states reflect boredom (Vodanovich & Mikulas 1993). Similarities between boredom and depression are found in: loss of interest, sense of futility, loss of hope, low levels of arousal (Bardgill 2000, Vodanovich & Kass 1990, Vodanovich & Mikulas 1993). The important distinction between the two states relates to attributions that individuals make regarding their condition. Boredom and its accompanying emotions are considered to be imposed by the environment or the situation, while depression is attributed to deficiencies that the person believes he/she has.

The following analysis involves data from the female ward. A marked distinction between the two wards was observed, with the female ward presenting more signs of depression-like states. The differentiation was attributed to three basic factors: average age and years of employment of staff and to the type of patients and general condition in the wards. The male ward was occupied by younger staff and with fewer years of employment in the hospital. These features not only suggest that emotions such as the sense of futility or loss of hope are difficult to develop in a relatively novel work environment, but they also signify different perceptions regarding work that have been formed by different experiences. Having worked in the hospital for an average of 5-6 years, nurses in the male ward had not experienced the bad conditions that existed in the hospital 10 or 20 years ago. Moreover, their conceptualization of their work in neutral terms as "just a job" possibly provided a defence against the formulation of depressive feelings. Lastly, working with patients whose social abilities were not totally impaired created a work environment which was much easier to control in sharp contrast to the one existing in the female ward.

As it has been said previously, nurses preferred to stay in the station instead of being occupied with patients. The maximum time that it took them to perform all their duties might be 3-4 hours. Their daily ritual was: have coffee while waiting for all patients to wake up, give them breakfast and medicines, wash them and then get into the station for a break. Around 2 in the afternoon, lunch was served and at 3 o' clock the shift was ended. Analogous was the routine in the afternoon and night shifts eliminated the showers. Although tasks were executed quite fast, it seemed rather difficult for nurses to start an activity. This was made obvious by the time it took to start working and their mode of walking: slow pace and dragging of feet. Depending on the day the mood in the station was differentiated from very light-hearted to very low. Usually

nurses were sat in very relaxed positions- arms on the table holding the head, legs on the sofas- watching television or chatting. Their discussions were very vivid when they talked of personal matters or when they accused patients and co-employees. There were also days, however, when nurses were occupied with other activities, such as knitting, reading papers and were exchanging only a few phrases in a tired or bored way. Many theorists (Smith 1981, Antrobus, Coleman & Singer 1967) have discussed about the resemblance of boredom to sleep-like states and day-dreaming.

This psychological environment was changing in the presence of a particular nurse, Voula, who was acting out the emotions and thoughts of the majority of the staff. Very often she expressed feelings of boredom, annoyance, disinterest, futility and dislike for her job. Her role was not only to articulate the general perceptions of the job, but to reverse them as well. She was telling jokes, teased her co-employees, made sexual comments and organised spontaneous small "lunch parties". While the rest of the staff could be characterised as a passive recipient of a boring and undesired situation, she was the active agent who tried to cope with the condition. Nonetheless, this effort did not include working as she had clearly stated her dislike of her job. It could be said that there were two groups in the ward: the first one composed of the majority of nurses and the second one consisting of one individual. These two groups represented two different theories regarding the expression of boredom. It is not clear from the literature on this issue whether boredom is manifested as frustration and restlessness or apathy and passivity. Scholars like Perkins & Hill (1985), Barbalet (1999) and Fisher (1993) believe that boredom is associated with emotional upset, hostility, irritation and restlessness. Those theories regard boredom as a state where there is a mismatch between external stimuli and level of arousal that leads to a search for action. That particular nurse clearly belonged to this category. Through the role of "entertainer" she had managed to mentally alter a situation which was perceived as boring and meaningless.

In contrast to this set of literature, other theorists like Bardgill (2000), Vodanovich and Mikulas (1993), Gemmil and Oakley (1992) and Conrad (1997) contend that boredom resembles depression and sleep-like states and entails the "freeze response", a sense of hopelessness and passivity. It could be said that the rest of the staff was characterised by this emotional condition. Nurses had accepted the negatives of their job, did not expect any changes and most importantly did not believe that they could alter anything. Interviews with one of the psychiatrists of the ward, the head nurse and the responsible of the ward revealed that a few nurses were also under anti-

depressive treatment. The majority of the nurses presented symptoms similar to those described in the literature. This was particularly evident in older nurses with many years of experience in the hospital. Indifference for the job, refraining from any kind of effort and acceptance of a situation that would never change were the main characteristics of nurses' attitude. I will analyse this in more detail in the following section.

However, the diversity that is presented in the literature could not be regarded as definite. The distinction that has been made among nurses can only describe a general tendency. Factors such as personality, past experiences, specific situation influenced the way that individuals in the ward expressed and coped with boredom. To sum it up, nurses' behaviour in the ward could be portrayed as of low intensity, sluggish and un-enthusiastic with exceptions based on circumstances.

12.2. Freeze response

Psychological experiments have shown that in the face of stressful stimuli and with no possibility of escaping or altering the situation, subjects "freeze" -accept the situation as it is- and express depressive symptoms (Hill & Larson 1992). If subjects are exposed to such conditions for a prolonged period, then even in situations from which they can escape they tend to maintain the "freeze" response, a condition named by Seligman (1974) "learned helplessness" (Martinko & Gardner 1982). It is a reaction characterised by submission to the external stressful situation and by perceived inability to exercise any form of control over it.

It was identified that the expressed boredom symbolized a freeze response to the stressful work environment and was related to nurses' perception of control. The association was made because of two concepts used in the theoretical model of learned helplessness: the first one concerns, the role of the person's past history of stressful experiences in a specific environment/situation in retaining the passive reaction even after environmental changes have taken place (Martinko & Gardner 1982). It will be explained in the following pages, how the stressful first experiences of nurses in the hospital have determined their subsequent behaviour. The second concept regards the emotions that accompany the learned helplessness condition and their similarity with boredom. Actually learned helplessness was introduced as a model for depression (Hill & Larson 1992), a condition closely associated with boredom (Vodanovich & Kass 1990, Vodanovich & Mikulas 1993). Moreover, apathy and resignation are some of the related emotions to learned helplessness (Martinko

& Gardner 1982) that are also used for defining boredom. However, it should be noticed that this was an issue that affected mostly un-educated older nurses. Therefore, the following analysis concerns them.

It was clarified from the beginning of field work that the majority of nurses did not actively pursue working as nurses or in the psychiatric hospital. Two factors, the necessity to work and acquaintances in the hospital, played the decisive role for getting involved in the psychiatric nursing profession. It was a forced decision that nurses had to make in order to support their families and themselves. Interviewees revealed negative first impressions of their job and the setting which had several effects on their life: "couldn't eat meat for a month", "I was crying every day after work", "I wanted to die". Furthermore, those extreme passive reactions faded away as time was passed by and as nurses got used to what they had to deal with. Questioning them about their coping mechanisms, all nurses replied "we got used to it" and "what else can you do? You just deal with it". Any active efforts of altering the situation or leaving the organization were not mentioned. Psychological support was provided by peers, while the hospital administration was accused of being indifferent to their problems "they don't care, as simple as that" and "we have to deal with all of this and nobody ever thanks us. On top we are blamed for anything that might go wrong".

According to nurses' stories, the bad work conditions that they encountered when first employed, were improved and facilitated their job (additional staff were hired, better equipment was obtained, new buildings were constructed, a policy of fewer patients in each ward was established). Those improvements were mentioned by nurses as an explanation for remaining in the job. Soula (a practical middle-age nurse) said "only we know how we managed to cope with that. And many things have gradually changed since then, so that made it easier. The hospital isn't what it used to be". It was obvious that nurses expected from external sources the advancement of their working conditions and as long as this was not happening, they simply coped.

The above constitute the primary preconditions for nurses to develop the perception of helplessness and inability to control the external environment. The forced decision of entering a profession and a work environment which were generally attributed with negative characteristics, the unsupportive role of nurses' superiors and the difficulties of the job comprised the factors for establishing the notion of being in a situation with

no choices available and no control over it. As nurses put it, it was "either you get used to it or you leave".

The notion of control was elaborated as nurses were describing their roles in the hospital and their relations to the immediate superiors (doctors and head nurses). Considering their basic role as the "guards" or "carers" of patients they totally dismissed the primary role of "nurse". Even the term "carer" had a derogative association, as Theodora said "what role? We clean them, we feed them, that's all". Other nurses, like Efi and Xenia, felt that their job was equal to that of the cleaner and resulted in claims such as "we are the last cog in here". By undermining their position they minimised their responsibilities and consequently their sense of control.

Moreover, as nurses touched upon the differentiations among them regarding the level of education their main conclusion was that "we are all in the same boat". In their view that was what they were assigned with and any suggestions about altering it were thought of as unattainable, for example Matzi stated "I don't have the knowledge to do anything else", Anna reflected "you cannot do anything with those patients" and Elisavet "even if you want to do something more, you can't do it here. The others will mock you". Duties were fixed, either from the head nurse or the norms that prevailed in the hospital, qualifications were limited or totally absent, hence the feeling of not being able to change the current way of working.

Statements regarding nurses' relationship with doctors were not consistent. Others, like Matina and Fotini felt content that doctors were absent, because that gave them relative freedom "it's better here because there is nobody checking on you all the time", while others, like Matzi and Christina, were perceiving that as more stressful because "they are not here and we have to be responsible for everything" or "they don't care about their patients, they don't come to see them, check their condition…they haven't changed their medication for ages. We have to deal with that, look for them and ask them". Despite the freedom that nurses claimed to enjoy by the doctors' absence, it didn't provide them with opportunities to take initiatives with patients "I never do anything without the doctors' consent. I am afraid" and "we follow their orders and that's it. We will inform them if something is changed and we will wait for their decision". It was a freedom that nurses could not use. When nurses were asked whether doctors would object to them taking initiatives with patients (like forming discussion groups, teach them basic skills etc) they could not answer "I don't know, we have never tried", "these are matters for the head nurse and the doctors,

not ours" and "well, it depends on who you are dealing with. There are doctors who don't allow anything unless they have demanded it. It's just a feeling that you get from a person, for example Dr. X is not approachable, we barely ask him for the basics". Power was clearly concentrated in doctors and nurses succumbed to their demands. Even medical students were exercising the power attributed to the profession as the following dialogue between two nurses suggests:

Christina: "Even the students won't come here to see the patients. I asked for somebody to come and check Maria and they told me to bring her to them. She is old for Christ sake!"
Theodora: "The other day one of the young ones told me to fill in the records and take them to him. I won't do it, it's his job not mine."

It seemed that nurses accepted the power of the authority figures, such as doctors and head nurses, but were reluctant to be controlled by younger medical staff. Any reform was expected by the superiors, even in simple matters. As the head nurse noted "they won't do anything on their own. When I was assigned to this ward and saw where these people worked, I couldn't believe it. There was garbage everywhere, insects, it was a terrible thing. So I gathered them and just asked them how they could work in such an environment. I set out a programme of cleaning the ward and demanded everyone's participation". Another head nurse also supported the lack of nurses' initiative "it is Christmas, so I told them to bring from their homes any extra decorative stuff and decorate the ward. There were also some old ones here in the hospital so one day we just did it. It's not that they were bored to do it. They just don't think that it is not just for the patients but for themselves as well. They work here, they spend time in here".

Two basic speculations could be given for nurses' indifference even for their own benefits: the first one regards the belief that everything should be assigned from "above", while the second one relates to the notion that "if nothing is good in here, why bother for minor things such as cleaning or decorating?". A partial justification regarding the issue of orders deriving from the top was given by nurses' comments as well as by literature on bureaucratic organizations, which states that delegation of authority is limited and all power and control are concentrated in the upper levels of the hierarchy. However, this explanation may be applicable to specific job-related issues but cannot justify why nurses tolerated an environment that was non-hygienic or were unwilling to improve their work setting especially during religious holidays.

The apathetic attitude of nurses signified a learned tolerance to inadequacies of the work setting as well as a feeling of futility for such matters. A couple of nurses were asked about the absence of Christmas decorations, especially as the ward across constituted a noticeable contrast. Their replies were an amalgam of personal indifference and disregard of patients: "like they understand Christmas or anything apart from getting cigarettes" and "I don't know (why we haven't decorated the ward)….oh now….." or "would anything change if we had a Christmas tree? Like it's the only thing missing". Perhaps the indifference shown on matters of personal decency (as the acceptance of working in a dirty environment suggests) and of trying to boost morale (even through minor things such as the decorations) was stemming from a de-humanizing process that those nurses had undergone during their first period of employment in the hospital. Even things which nurses could control and affect were regarded as un-important in relation to the broader negative perception they had for their work. As the psychiatrist of the ward noted "they (nurses) are as institutionalised as the patients".

Despite the common assumption that nurses constitute authority figures for patients and therefore their role is inherently endowed with control, nurses' comments on the subject were conflicting and ambiguous. Talking about what they believed regarding how patients viewed them, all nurses replied that "they know we are the ones who take care of them" and "sometimes they might think that we are relatives, but they know that it is us to whom they are going to turn for everything, from cigarettes to anything". This awareness, however, was not actually justified as nurses at various times complained about patients' unwillingness to listen to their commands. A particularly interesting observation was the attribution that nurses made in the male ward about patients' behaviour. They believed that male patients were "better" than the females because they viewed them as "women" and behaved accordingly. From such justification, two important assumptions may be derived: the first concerns the control that nurses endowed with patients by considering them the ones who define the relationship between them. It was patients' awareness that they were dealing with women that made them conform to nurses' demands, at least to a better degree than female patients. Another issue, related to the previous one, is nurses' disregard of their role in the ward. According to their comments the primary factor that affected male patients' behaviour was not the power that signified the role "nurse" but an inherent characteristic of nurses, that was "femininity". Considering the nurse role as a secondary factor, they disvalued the knowledge, skills, experience associated with it and ultimately the control that stems from such attributes.

A similar attitude pervaded the female ward. Patients were accused for not conforming to orders "they don't drink water, we have to force them" or "did you jump of the window again? She always does that..if she breaks anything we will be accounted for..and we have told her a thousand times" and "we tell visitors not to bring any food for patients, because they might choke. We have all food mashed. They don't listen, the other time one almost choked". As in the male ward, patients were considered responsible for their actions, while nurses were unable or unwilling to control or supervise them more closely. As orders were not followed by patients a usual way for nurses to assume control was by tying them down. Most nurses reported that they found some kind of pleasure when tying a patient who had been agitated or disturbing other patients. From their comments on the subject, it was implied that a mixture of emotions accompanied this action: relief, pleasure and a sense of showing to patients who has the power in the ward- "it's like an orgasm", "you asked for it" and "I will tie you and then let's see if you keep on". Other incidents, such as that of fire in the ward, signified that control was associated with reactive behaviour and was comprised of corrective actions. A diversity that was observed in both wards was patients' reactions to the researcher contrasted to nurses. After the first visits in the wards patients expressed friendly attitudes to the researcher, such as talking, trying to hug her, offering personal belongings. Throughout the field work, no such behaviour was observed towards nurses. One of the nurses recommended to the researcher "don't encourage them, they will become pests". As the quote suggested, holding a distance from patients, was an implicit way in which nurses controlled patients' behaviour. By detaching themselves from patients, nurses were able to create an image of authority and be recognised by patients as those who may "punish" them in case of misconduct.

Either as employees in the hospital or in relation to patients, nurses did not consider themselves in a power position. Being the last cog in the hierarchy, following orders without taking any initiative and obtaining control through activities that were "negative" and un-related to their profession, such as being "women" or inflicting fear of punishment to patients, clearly did not give to nurses any sense of control or power. Nonetheless, a relative balance was reached, as nurses were trying to exercise control between them and in relation to daily matters.

Fights over petty issues were quite usual and nurses consumed a considerable amount of time and energy on them. The basic characteristics of those quarrels were

their triviality and easy resolution and the over-reaction of nurses. For example the issue of what shift should carry the laundry out of the ward was dominating nurses' discussions for a long period, with no result. Even when a meeting had been arranged, after nurses' request, no one showed up. Each nurse was trying to defend her position and used various arguments, such as age (being old to carry heavy loads), health problems and task overload. Most of the quarrels were related to "who is going to do what" with nurses trying to avoid extra tasks. Sofia, a young nurse revealed another incident which had become the subject for further but more subtle power struggles. She had been given the keys of the ward, although she was employed with a definite-term contract and she had been working for only a few months. As she conveyed, this was not welcomed by older nurses as it was an action that bypassed the existent norm of "seniority enjoying more privileges". As she revealed, the fuss created over the matter was not directly addressed to her, but "I know there has been talk behind my back, but I don't care". Power was the underlying issue in rivalries between trained and practical nurses. A young educated nurse revealed "you tell them that you have gone to university and they just look down on you. They say 'what can books tell you?'". From the practical nurses' perspective however it was a matter of how much work educated staff were carrying out "they tell you that they won't clean because it is not their responsibility. Just because they went to university doesn't mean that they should be exempted from duties". Feeling unable to control or affect broader issues such as conditions of work and the behaviour of their patients, nurses had thrown themselves into a power battle between them. As many nurses confessed, a basic problem regarding their relationships was the absence of a sense of unity and brotherhood "one is looking to harm the other, it wasn't like that before". The responsible of the ward considered as the most difficult aspect of the job "managing the staff, trying to keep everyone pleased and run the ward at the same time. Haven't you noticed that they are always edgy and ready to fight?"

Nurses had learned to conform to the negative aspects of their job, accept them as definite and tolerate them because they had no other options. Their limited qualifications confined their behavioural patterns towards patients into detachment and induction of fear. Their sense of self-efficacy was related to negative events, such as being able to tolerate an environment such was that of the psychiatric hospital. This had further led to an increased degree of apathy even for issues that were in their span of control and directly affecting them. Fights and rivalries between

nurses were the means for having a sense of control, an antidote to the general feeling of helplessness.

12.3. Fear of going mad

An intriguing characteristic of the sample was a distorted perception of mental illness. Despite their everyday contact with patients, nurses have maintained their prior expectations and stereotypical thinking. The simple characterization "crazy" or "psychopaths" used by nurses when referring to patients, was in sharp contrast with the scientific and moral principles of their profession. By using such language, nurses were able to detach themselves more easily from patients and additionally to sustain their identification with the public. The distinction between 'mad' and 'sane' and the need to be included in the latter, even by using the language that the sane-public use, were of extreme significance for the sample.

Prior images of mental illness and of the hospital were in agreement with the general fear and aversion of the public for the mentally ill. Research (Madianos, Economou, Hatjiandreou, Papageorgiou & Rogakou 1999, Angermeyer, Beck & Matschinger 2003, Economou, Gramandani, Richardson & Stefanis 2005) on public's beliefs regarding schizophrenics suggests that their most salient characteristic is dangerousness. "I had no idea about psychiatric patients. I thought what most people think of them" said Maria, "I didn't even know where the hospital was. Their appearance, the dirtiness..I was afraid of them" Vaso, a practical nurse, recalled. Soula and Efi stressed out the importance of having some relatives in the hospital in their adjustment "My husband some other relatives worked here before I came. So it was easier for me. I was scared at the beginning, but my husband was telling me to sit and talk to patients" and "I never thought I could make it in here. But I wanted to work and a friend who worked here suggested it and persuaded me. But if someone else had told me years ago that I was going to work in X I would laugh at him…"

This stereotypical conceptualization was more evident in older and practical nurses and was reinforced by two factors: the lack of education and the first impressions of patients and the hospital. It has been repeatedly stated that the sample was, to a great extent un-skilled or acquired general knowledge on nursing.

Coming from poor socio-economic backgrounds, with limited resources and intensified needs for immediate and secure employment, nursing was seen as the best occupational solution they could pursue. Anna, an old practical nurse, claimed

that "in my time there wasn't this thing..going to university, study..If I had known better…" while Soula described best the connection between poor financial resources and academic performance "I was an average student and my parents couldn't afford extra schooling, so I knew I could never make it to university". It was clear that deprivation from knowledge had not only maximized nurses' fears about mental illness but has affected their initial impressions.

Prior expectations, stereotypes and fears permeated even after nurses had begun working in the hospital. It has been already reported elsewhere that the adjustment period was described as tough and overwhelming by the majority of nurses. Especially for those who entered the job over a decade ago, when the work conditions in the hospital were totally inappropriate, the initial impressions were appalling. Nurses talked about strong emotional outbursts even though some of them had previous experience-theoretical or practical- in nursing. "I was crying for a week when I first started working. My kids were telling me to stop it if it makes me that sad" Theodora said, "I wanted to die. I didn't like at all" Soula revealed. For others like Matzi the initial shock was transformed into inability to eat or more specifically to eat meat during the first month of work. The more distant and unaware of mental disorders, institutions etc were nurses before working in the hospital, the more emotionally violent was their reaction after entering the field.

First impressions of the hospital, the patients and the job clearly had a major effect on nurses' sentiment and behaviour. It must be noted that the condition of the hospital about 20 years ago was unsuitable for both patients and staff. The overcrowding and mixing of patients, the shortages in staff, the lack of essential equipment (a nurse revealed that they didn't have many syringes so they had to use the same one for many patients) created an environment that was far from being characterised as therapeutic. The additional deficiencies or inefficiencies of the drugs of that time, probably made patients perceived like beasts and nurses as their tamers. Such condition made the prior stereotypical fear of mental patients to be transformed into fear/anxiety for "survival". How one can put up with such environment and not go crazy? As nurses reported they "have given everything to the hospital", they had struggled with patients, they had to tolerate patients' screams and noise and they had to provide for them.

All nurses agreed upon the necessity of being harsh to patients. Efi "you have to shout as well, they won't listen otherwise", Anna supported her co-nurse "you will go

mad if you try to talk to them. You cannot a have dialogue with them" and Vaso (laughing) "a patient hit me so I hit her too, I grabbed her from the hair..what did you think that I would let her go?" Such practices might have been proven helpful for nurses, if not for any other reason but to let go some of the stress. However, in the long run, it becomes vague who is the patient and who is the nurse. If one, who claims to be sane, expresses behaviours similar to those of one that is labelled "crazy", then the first might be induced with the fear of "going mad" as well. The incongruence between occupational role (nurse), self-image (sane, logical) and the expression of behaviours that are based completely on sentiment (anger, stress) may lead into questioning the healthiness of one's psychological condition. The fear of insanity was evident in the verbal conducts of nurses: explicit identification with patients-though humorous, continuous references to former employees who were under psychiatric medication, reports on behaviour out of the hospital that was considered abnormal and general questioning about the vulnerability of human mind. Nurses usually claimed to be as "crazy" as their patients and even the head nurse used the same language in referring to her "crazy" attempts to organise units that she used to work in. "We are all mad in here, there is no difference between us and them", "I am going to see the patients, I am more sane with them rather than with you" Voula told her co-employees in a humorous vain, "all this noise affects you, you get headaches, in the end I will go crazy myself…and if you consider that I tell you these, that I am supposed to be the calmer one in here..just imagine the others" Efi claimed. Soula pointed out the prevalence of this fear despite the changes that the hospital has undergone to the better "You can't just say that now things are better so I am ok. I still have nightmares about the hospital. It doesn't pass a night without dreaming the patients, the hospital" The psychiatrist of the ward provided a useful insight that supports this identification of staff with patients "the staff is not well. They are all much stressed. Many develop psychosomatic and physical problems. If the work environment is not good, if they don't take any satisfaction, it doesn't work. They might say that they have used to it but something remains…"

Health status, both mental and physical, was an important issue for nurses. Examples of former employees, who presented serious health problems after leaving the hospital or reference to their own problems, were common discussions among nurses:

Voula: *"I have to go to the cardiologist. My waist is totally damaged. Over the years we all become like this"*

Efi: "I have many health problems. I have developed them here"

Matzi: "most of the staff is on medication after leaving the hospital. We take up everything.. I am taking drugs-seroxat, zanax".

Nurses' personal lives were also affected negatively by their job. Anna a 60-year old nurse "I don't mind the job, though I have gained serious problems from it, but it's the voices….At home I can't stand either television or radio…I need quietness", Matina "I take it out on my children…I cannot bear the tiniest sound…and they are kids…they can't help it" and Vaso "I need at least two hours after work to get myself together..you can't stand it" As they said they have become quite edgy and demanding at home, expecting too much from their families.

When asked about the history of patients, nurses talked with disappointment and resentment, especially when referring to relatively young patients. They usually ended their stories with phrases such as "what can you say?" or "it doesn't take much to lose it" As they recounted the way that each patient was brought to the hospital, feelings of empathy, vulnerability, sadness could be traced for the first time. Efi verbalised these emotions by projecting them as a worry for the well-being of her children "when I see young people coming to the hospital, I am just scared for my own children…I am thinking why is a 25-year old brought in here and whether I am doing something wrong as a parent that might harm my kids. Before I start working I was like all mothers, anxious about the school marks, about their future..now I just want them to be healthy" and another nurse "being in here taught me not to take things so seriously, to loosen up, not to worry so much…whenever this is possible".

It is seen how first impressions and emotions were transformed into a general worry for mental and physical health. The initial emotional outbursts submerged as nurses learnt the job, yet the negative experiences have persisted accumulated with subsequent stress and difficulties. Combining nurses' inability to find more functional or mature ways for dealing with their emotions during their adjustment period in the hospital, with the on-going stress that they claimed to undergo, it is easy to understand their fear of going mad. Nurses have created a no-way out situation, where they just mounded up tension. Their reactions were limited to here-and-now situations with patients (tie them, fight with them etc) which further added to experiencing negative themselves while the overall outcome remained the same. The fear of going mad, acted as an alarm for nurses. By expressing it, though not consciously aware of its significance, they expressed a potential danger that

necessitated for some form of action against it. That "action" would be the inactivity, the detachment and consequently boredom. Being bored was a protective measure against the fear of insanity. It is already described how nurses avoided patients by physically segregating themselves in the nursing station, how they mentally escaped the environment by focusing on other activities and how they limited their work into the very basics. Having no other way to deal with patients but to convey behaviours that resemble those of patients, they preferred to bound their contact with them and end up being bored. Such hypothesis is in line with the psychoanalytic literature on boredom that postulates that boredom is a defence mechanism that protects the individual from unconscious fears or wishes. However, boredom may be a direct result of the previous emotional exhaustion that nurses have undergone. Emotional and physical fatigue experienced in the past could now be balanced by inactivity and mental absence. The improved work conditions (less patients, improved physical environment, more staff and better delegation of duties etc) allowed for the present apathy. Although a daring hypothesis, boredom may constitute an out-of-date balancing reaction to former stress.

12.4. Summary

Findings of past studies regarding the association of boredom with depression have been validated in this research as well. This validation, however, concerned mostly older nurses and it involved specific aspects of depression, such as the passive acceptance of working conditions, the sense of futility and the lack of future expectations.

It was identified that the development of such emotions had its onset in the initial encounters with the psychiatric environment and it progressed over time through the hospital's practices and the beliefs and assumptions that nurses maintain for both their patients and their role. In specific, old nurses had been found in a work setting that was psychologically demanding and that was characterised by serious weaknesses. Considering this group's lack of academic knowledge, along with the absence of an organized socialization process and of social support, the condition that nurses were faced with must have been shocking.

Accepting the negatives of their job and of the environment was the only coping mechanism. Being given no autonomy by doctors or administration, perceiving themselves as the last cog in the hospital and having limited control over patients, they were conditioned into passivity. Even the slightest change in the wards had to

be ordered, something that signified nurses' submission to externally controlled factors.

The perception of having no control over patients was another element that enhanced nurses' passivity in both wards. In the female ward this was identified by the confusion with which patients were confronted by nurses: either as "crazy" which resulted in the use of harsh language and in abrupt behaviour (tying patients, shouting at them) or as "normal" which resulted in having unrealistic expectations by patients obeying nurses' demands and orders or behaving normally). In the male ward, a basic the perceived lack of control was signified by the attribution nurses made about patients' good behaviour. This did not regard their nursing role but their femininity. In other words, male patients behaved better because they recognised nurses as women and not as professionals.

Nurses' passive behaviour did not only represent their sense of helplessness but facilitated their physical and emotional dissociation from mental illness. Having negative stereotypes about the mentally ill, dealing with demanding patients and having developed themselves psychological and physical health problems, were all factors that contributed to this behaviour.

Boredom, expressed as passivity, resulted from past negative experiences in the hospital, perceptions of inability to react or to control and from the inner fear of madness.

Chapter 13: Discussion

13.1. Presentation of the thesis

The aim of this thesis was to provide a new approach to work boredom. It was a challenging subject for a variety of reasons. The lack of a robust definition of the emotion, the obscurity in distinguishing it from other relevant feelings along with the complexity of integrating different theoretical disciplines formed some of the research's difficulties.

In this attempt, the definition used derived from the work of Darden and Marks (1999) and Brissett and Snow (1993), who describe boredom as an emotion/state that is pervasive, is reflected in the absence of meaning and regards one's whole existence in a given situation (as for example, being at work). Contrary to organizational psychology definitions (Fisher 1993, O'Hanlon 1981), which refer to specific affective (unpleasantness) and cognitive (disinterest, inattention) components of boredom, it was believed that this definition captured the essence of the experience.

Occupational boredom was studied in a new field, namely the public professional bureaucracy- the public mental hospital- and in an occupation seen as enjoying professional status (Stuart & Laraia 1998, McCabe 2000)-psychiatric nursing- that was novel in two ways: first, because of the limited number of studies investigating boredom among professionals and secondly, because the majority of studies concerning health care occupations have neglected boredom as if it cannot or does not occur in such settings. This basic aim was accompanied by two additional research questions: why people are bored in this particular profession and in what ways boredom may be manifested in the chosen setting.

The research findings were provided through qualitative methodology. The selected method could be considered as another novelty in the study of work boredom. The existing knowledge derives from quantitative studies, in which boredom was viewed as equivalent to its constituents (disinterest, habituation, lapses of attention, errors [chapter 2, section 2]) and was studied in relation to diverse variables. The contribution of such studies is immense, however, there is a gap regarding the nature of the experience as a whole. Qualitative methodology was chosen because it could fill in this gap. This, however, does not mean that past findings were not used. Contrary, they have formed the basis and a valuable guide for observations and interviews.

In the following paragraphs, the research findings are briefly presented and discussed.

13.2. Behavioural manifestations of boredom

One of the basic findings that were revealed concerned the incongruence between the academic descriptions of psychiatric nursing and its actual performance in the two wards. Organizational design theorists (Hackman & Oldham 1976) have stressed the importance of task variety as a key factor in the prevention of boredom. Furthermore, numerous studies in nursing (Guppy & Gutteridge 1991, Alexander, Lichnstein et al. 1998) and occupational psychology (Kinman & Jones 2005) have been devoted to the issue of task overload as a determinant of job stress. In contrast, boredom is thought, by some, to be related to task underload (O'Hanlon 1981, Smith 1981, Charlton & Hertz 1989, Weinger 1999).

According to the sample and to observations their basic duties composed of cleaning, feeding and giving medications to patients. Unlike nursing texts (Stuart & Laraia 1998) that depict psychiatric nursing as a profession endowed with variety and complexity, findings of the present study suggested the contrary. Behaviourally, this was expressed as long-breaks and physical segregation of nurses in the nursing station where time was spent in out-of-work activities. Nurses' verbal manifestations coincided with that behaviour, as they all perceived the monotonous and trivial nature of their job.

A major theme in the literature on boredom has been the attention given to a boring and un-challenging task. Attention, as a sign of boredom, has been measured either as errors in performance (Damrad- Frye& Laird 1989, Dyer-Smith & Wesson 1997, Drory 1982) or as irrelevant to task thoughts, daydreaming etc (Damrad- Frye & Laird 1989, Dyer-Smith & Wesson 1997).

In psychiatric nursing, attention regarded both the mental activity while performing a task and a basic duty (supervision). In contrast to studies that have concluded that attention is impeded when one is performing a trivial, un-challenging task/job, the present study did not support such assertion. Nurses were concentrated, accurate and fast when carrying out their duties. Despite the common belief about the simple and easy nature of tasks, their focus of attention remained intact, no irrelevant-to-task thoughts were revealed and there were no errors.

In respect to supervision, nurses obtained a confused perception, which, as a result, has affected their performance. When describing their duties they failed to include supervision as one of the basic activities, while at the same time they considered it among the vital components of their role. There was a contradiction between the belief that being in the ward was sufficient to ensure patients' well-being and the assertion that they were guards of patients. The outcomes of such confusion varied: unawareness about fights among patients and about patients' whereabouts, incident of fire set up by a patient, dehydrated patients etc.

The lack of supervision was associated to other behaviours that were identified as signs of boredom. The combination of the limited tasks that nurses had to carry out along with the absence of efficient and close supervision, signified that distribution of time between work and breaks was uneven. As said earlier, nurses did not spent time with patients and preferred to physically separate themselves from them. The additional unwillingness to guard patients in a regular and systematic way portrayed a picture where staff spent most of its working time in the nursing station.

Psychological as well as sociological theories (Brissett & Snow 1993, Wilson 1972, Barbalet 1999, Darden & Marks 1999) have referred to the perception of the passage of time as a sign of boredom and have discussed the possible behavioural outcomes. The sample presented behaviours similar to what the literature has suggested in order to pass the time in the station: smoking, which in some cases was excessive or was taken up after the employment in the wards, knitting, engagement in quarrels that would last unjustifiably for long periods or in *fun-like* activities. Nurses have clearly stated the reason for those behaviours: they were attempts to pass time in the wards.

Getting involved in out-of-work activities, may have relieved nurses' boredom while in the station, however, it has not reduced the overall boredom that was associated with the job. Those short-term attempts to pass time could not prevent nurses from complaining about the futile and un-interesting nature of their job, hence, the physical and mental absenteeism that characterised their behaviour.

The relation between boredom and absenteeism rates has been investigated in many studies (Walker & Guest 1952, Turner & Lawrence 1965, Hackman & Lawler 1971, Saito et al. 1972). The basic premise is that when individuals feel bored the levels of absenteeism increase. In the present study, escape from the boring work

environment was observed mostly with hours of work, towards the end of shifts. Single-days off work, without or with last-minute notification, were also reported but this was attributed to other reasons and not boredom.

Nonetheless, mental absenteeism was at significant rates. The disproportionate distribution of time between work and off-work activities and the insufficient supervision were among the obvious signs of this behaviour. Moreover, even when patients were shouting or making various requests to staff, nurses could block out these stimuli as if they were not happening. The advise given to the researcher was characteristic of this behaviour "don't pay attention to them (patients), they will bug you". Relevant to the issue of mental absenteeism are studies that have associated boredom with states such as day-dreaming (Davies 1926, Antrobus, Coleman & Singer 1967), distractibility (Thackray, Jones & Touchstone 1973, Damrad-Frye & Laird 1989) and preoccupation with un-related to the task thoughts (McBain 1970, Gardner et al. 1989). The difference between the present research and the above mentioned studies is found in the nature of task that provoked such behaviours. Individuals in those studies had to perform industrial or laboratory tasks none of which encompassed interaction with humans as work in the psychiatric wards did. Furthermore, mental absenteeism, expressed as distraction or day-dreaming, did not just occurred in the wards as it did in the previous listed studies. In a way it was the outcome of conditioned learning, as the advice of the nurse (don't pay attention to them, they will bug you) suggested.

The extent and nature of mental absenteeism varied across individuals. From the inattentiveness that characterized the majority of staff to incidents that crossed the boundaries of psychological withdrawal and could be categorised as negligence. Consuming alcohol during shifts, changing patients' drug dosages in order to harm a superior and stealing medication were some of the behaviours reported. Such episodes signified that the sample was *forgetting* its role and its position and was behaving on the grounds of personal moods, preferences and emotions, without reflecting on the outcomes of those behaviours.

The passivity and indifference that characterised nurses' behaviour towards the job and the patients, was also reflected in their emotional condition. The sample did not only neglect patients but themselves as well. Minor things, from decorating the wards during Christmas to creating a cleaner and aesthetically improved work environment and the underlying belief that such initiative would not make any difference suggest a

sense of futility and submissiveness to the status quo. Moreover, the notion that some psychiatrists and nurses had developed about staff being as institutionalised as patients provided additional evidence about the negative affect that was experienced. The identification of such emotions is in line with theories about the resemblance of boredom with depressive states (Caplan et al. 1975, Vodanovich & Mikulas 1993), which are characterised (among other things) by individuals' sense of futility and inability to find and sustain a meaning in their actions and activities.

In conclusion, boredom in the two wards was manifested as a general reluctance to perform extra tasks, unresponsiveness to patients' needs, engagement in irrelevant-to-job activities and conversations, perception of slow passage of time and physical and mental escape from the work environment. The emotional apathy which accompanied those behaviours was only randomly interrupted by incidents of unjustified hostility and of incompatible -with the context- amusement.

13.3. Findings discussed
In this section findings of past studies and theoretical assumptions are investigated and discussed in the psychiatric hospital context.

13.3.1. Time and boredom
One of the most obvious facts that indicated that boredom was present in the two long-stay wards, was the time distribution between tasks and breaks. As noted earlier in this chapter, it was observed that nurses' time was spent more in the nursing station than with patients. The station provided physical segregation from the rest of the ward and in there no work-related activity was taking place. The impression given was that these prolonged breaks were the actual reason for being in the ward, while tasks constituted an "interruption" of this continuity.

Organization psychology research has not elaborated the issue of time distribution. Perhaps because in industrial settings, where boredom was mainly studied, rules about work-time and breaks are very strict. The only clear assertion about the use of work time and its relation to boredom has been made by Joyce (2005) and Bolchover (2005). In their media publications, with small samples of professionals, it is explicitly stated that when individuals are bored in their jobs, the time dedicated to them is far less, while the non-work activities take place on a regular basis.

Some studies in the nursing field (Martin, 1992, Stuart et al. 2000) have also elaborated the matter, however, they have not made any linkages to boredom. What these studies have concluded, was that nurses tend to separate themselves from patients without always having a reason to do so, as for example carry out paperwork. The sample of this research expressed similar behaviours. Paperwork was carried out by specific people in the wards, usually the head nurse or the responsible, while the rest of the staff was found to perform nothing but the main tasks.

What people actually do in their work-time and the discretion they have over the ways they structure their time should be, therefore, among the primary concerns when investigating boredom among professionals.

The issue of time encompasses two additional aspects. The first one, early identified by cognitive psychology and sociology, relates to its perception. Studies in sensory deprivation (London & Manolo 1974, Suedfeld 1975, Drory 1982) concluded that a major effect of an un-stimulating environment is the distortion of time perception. Sociology (Darden & Marks 1999, Barbalet 1999) has expanded this finding by incorporating factors such as dissatisfaction with one's job, role and the absence of anticipations regarding future changes. What these theories have in common is the association of boredom with the perception of slow passage of time. Likewise, nurses referred to the slow passage of time several times during their shift and were observed constantly looking at the clock. They related it to the absence of tasks to perform as well as to their actions in the station. For example smoking had become a way of passing the time, something that supports psychology theories (Johnstone & O'Malley 1986, Samuels & Samuels 1974, Ferguson 1973) that have associated boredom with health-risk behaviours. The interesting fact regards nurses' claims about having nothing to do and that time did not pass easily. Observations disclosed a controversy between those statements and nurses' reluctance and sluggishness to carry out an extra task. Fights among staff regarding "who is going to do what" were quite common and contradicted the above complaints. It could be argued that boredom and its following perception of slow passage of time could not be diminished by performing a task that had come up unexpectedly or randomly. Random tasks, such as delivering some documents to another unit, just interrupted the relaxed state in which nurses were engaged. This is in congruence with a part of cognitive theories that contend that low external stimulation leads to low internal

levels of arousal. In other words, boredom brings more boredom that cannot be alleviated by the imposition of small, random tasks.

The second aspect of time was related to absenteeism. The time taken off work is also considered by organizational psychology theorists as an outcome and a possible sign of boredom (Walker & Guest 1952, Saito et al. 1972, Fisher 1993). Absenteeism is said to increase when people are engaged in boring or un-motivating tasks. The levels of absenteeism in the two wards were quite high. However, this was not related to boredom. Taking days off work was a method for protesting against un-favourable shifts and it was mainly observed during afternoon and evening shifts. To a lesser degree absenteeism reflected not working contracted hours, and especially towards the end of the morning shift. This however was not very common and usually nurses provided valid reasons.

These findings question the association of absenteeism rates with boredom (Saito et al. 1972) and are in line with studies in public organizations that include absenteeism in the general theme of anti-citizenship behaviour (Spector et al. 2006).

Though physical absence is considered as an outcome of boredom, mental absenteeism is a direct manifestation of boredom. Nurses' ability to escape mentally, while remaining physically in their environment was remarkable. Being in the station and occupied with their own activities offered them a shield from any external stimulation. Body-postures resembled sleep-like states, conversations and other activities offered nurses the chance to dissociate themselves from their work environment. Actually they were engaged in these in order to escape and not feel bored. It has been already stated in the previous section how it was identified the absent-mindedness that characterised the sample.

Mental absenteeism has been investigated in organizational psychology only indirectly, as fault detection or lower output. Cognitive psychology has expanded the issue of performance detriments as an outcome of boredom by including other variables such as day-dreaming (Davies 1926, Antrobus, Coleman & Singer 1967), distractability (Thackray, Jones & Touchstone 1973, Damrad-Frye & Laird 1989) and irrelevant-to-task thoughts (McBain 1970, Gardner et al. 1989). The incorporation of these factors is particularly helpful for detecting boredom in professions where the outcome of work is not easily measurable, such as in services. Furthermore, within the realm of arousal theories, mental absenteeism is connected to the readiness with

which employees start an activity. Distraction, day-dreaming may inhibit employees from immediately taking action. However, the validity of this proposition was confirmed only for random, extra tasks and not for the basic ones. Although nurses expressed behaviours were categorised as mental absenteeism, they reported no problems in carrying out their routine tasks directly after these had been ordered. By order it is meant the time schedule, since tasks were either associated with the work of other hospital units (such as feeding patients) or had to do with health matters (cleaning and dispensing medication). Literature on bureaucratic organizations has stressed the importance of formalization and standardization of procedures in employees' behaviour (Shadur, Kienzle & Rodwell 1999, Packard 1989, Heffron 1989). It was observed that nurses were extremely eager to start their duties (cleaning, feeding, distributing medication) not only because they had to deal with patients but also because they wanted to "get over with" these boring duties. Perhaps boredom was also manifested as impatience to start and finish a standard and trivial task as soon as possible, instead of taking the time and getting involved in it. As the present study has shown people may be physically present in their jobs but mentally absent.

To summarize, service professions require different measures for boredom than the traditionally studied industrial jobs. Time distribution is among the primary factors that need to be investigated, especially when employees have the discretion to structure their work-time. A second indicator has been already suggested by numerous studies (London & Manolo 1974, Suedfeld 1975, Drory 1982, Darden & Marks 1999, Barbalet 1999) and relates to the perception of the passage of time and the strategies used for altering this perception. Behaviours such as smoking and drinking are linked with boredom as mechanisms for reducing it (Samuels & Samuels 1974, Johnstone & O'Malley 1986, Greene, Kremar, Walters, Rubin & Hale 2000). A last variable, associated with the above, concerns mental absenteeism. Organizational and cognitive psychology studies have only investigated the issue as fault detection or lower output (Wyatt & Landon 1932, Gardner et al. 1989, Damrad- Frye & Laird 1989). In service sector professions, such as nursing, other factors interfere and determine behaviour. Among the primary ones, is that tasks are inexorably connected with human beings. Mental absenteeism characterises mostly individuals' work behaviour in its total and it is related to the ability or effort to block out external stimuli.

13.3.2. Tasks, duties and boredom

To a great extent organizational psychology has investigated boredom as an outcome of un-interesting, monotonous tasks or jobs. In the earlier studies of occupational boredom the attention has been placed almost exclusively on task characteristics (O'Hanlon 1981), while later on the discussion was flourished by broader features of work design (Locke & Bryan 1967, Hackman & Oldham 1980, Fisher 1993). A basic principle deriving from this kind of research was that lapses of attention, errors or accidents occur when one is engaged in a monotonous and uninteresting task and this reflects boredom. Cognitive psychology provided the theoretical framework, though many studies in organizational psychology, as well, have investigated attention as an aspect of boredom (Barmack 1937, O'Hanlon's 1981, Smith 1981).

The present study however suggests that boredom cannot be identified on the basis of those behaviours. Despite the fact that nurses perceived their duties as boring and un-challenging, their performance was characterised by concentration, accuracy and speed. This suggests that boredom does not always lead to failures of attention or inefficiencies. Other factors intervene and determine performance or behaviour. In the case of nurses, this factor was the recipient of the services. Unlike many other occupational and professional groups, nurses' tasks were inexorably connected with patients and in specific psychiatric patients. According to the sample's reports the nature of patients' disorder called for extreme attention as these patients were usually unable to give feedback about the service provided. Moreover, any lapses of attention would possibly cause patients' negative reaction that would further upset the whole ward, something that nurses wanted to avoid.

However, it should be noticed here that past studies e.g. (Branton 1970) referred to accidents or errors in performance when attention needed to be sustained for a prolonged period. Clearly this was not applicable in nursing tasks. What distinguishes nurses' tasks from those in past studies is that there was not a standard period for the completion of their duties. This sample had the autonomy to perform the required tasks in its own time or in relation to patients' behaviours/needs. Normally, that is when patients were cooperative, nurses tried to accomplish their routine duties as quickly as possible in order to gain more 'social' time. Ultimately, their attentiveness was directed by two interconnected factors: first, by the desire to preserve patients' calmness and secondly by the motive to achieve more non-work time.

A theme that was identified to be closely related to theoretical assumptions about attention was supervising patients. Supervision, as it was reported, was not a task formally ordered, did not involve any specific action and its termination was indefinite. The two latter characteristics exemplify the similarity of supervision with vigilance tasks. In respect to the first feature, although nurses identified as their basic role "being patients' guards", several times they had to be specifically ordered or reminded to perform that role more efficiently. Supervision, according to nurses' behaviour, constituted a secondary duty that was thought to be executed by their sole presence in the wards. Incidents that suggested the contrary were numerous. The primary one was the physical segregation from patients and the reactive nature of nurses' behaviour in cases of emergencies. Events about how nurses have effectively saved a patient were reported, however it was not in nurses' awareness that it was the ineffective supervision that has caused them in the first place.

Apart from the boring nature of supervision, a general belief regarding responsibility that was held by all staff was an additional factor for the ailments presented. Responsibility concerned a variety of issues and its avoidance was a prevalent attitude in the whole hospital. In respect to supervision, the common assumption that "someone else will check on patients" was evident, especially in the morning shifts. Justification for this assumption provided the number of nurses working during mornings which was usually 5-7 people. In this way responsibility was dispersed and eventually lost. In contrast, during afternoon and evening shifts which were performed by only two nurses, the boring aspect of supervision was diminished as staff were obliged to assume full responsibility of the whole ward. The fear of a possible emergency and the disproportionate ratio between nurses and patients (2/35) was making staff more responsible and consequently supervision more effective.

Drawing on organizational theories, employees' responsibility is considerably minimized in bureaucratic structures due to the extensive division of labour and to the reliance on fixed rules and procedures (Allinson 1984). This concept is more applicable in nurses' case than assertions of cognitive and organizational psychology about vigilance tasks. While there are similarities between supervising and vigilance, however, the work contexts in which they take place are totally different. Moreover, vigilance tasks may be the core characteristic of certain occupations, in contrast supervision is only an aspect of nursing. Therefore, inefficient supervision could not be attributed only to boredom but to the lack of sense of responsibility.

An overview about nurses' tasks has already been given in the previous sections. As organizational and cognitive psychology suggest respectively, the nature of tasks and employees' perceptions about them determine whether boredom is going to be experienced (O' Hanlon 1981, Perkins & Hill 1985). It was therefore a primary objective in this study, to investigate these assertions. A typical day in the wards involved cleaning, feeding and distributing medications to patients. Paperwork was usually carried out by the head nurses or the responsible of each ward, however there were a few cases when experienced nurses participated as for example by filling in a patient' s record. In the female ward other nursing tasks or errands were usually performed by two young and newly employed nurses. In the male ward task allocation was more balanced with all nurses participating equally, however additional help was given from patients for simple tasks such as delivering a document to another unit. There was a standard routine which dominated over other nursing activities. Even though the wards were occupied by old patients, which means that apart from the psychiatric problems there were also other problems of a medical nature, nurses perceived as their core duties cleaning, feeding and providing medicines. Repetitiveness and monotony were at high levels and formed the major complaint of nurses. This finding confirms organizational psychology studies (O' Hanlon 1981) that have proposed that monotonous and repetitive tasks inflict boredom in workers, as well as the cognitive views which have included the individual's perception about these two characteristics (Perkins & Hill 1985).

However, there are some inconsistencies between the present research and the literature. The first one concerns the difference between the contexts in which monotony has been investigated. What may be the similarities between a factory unit and a hospital ward that will lead to the same conclusions about monotony? Why are nursing duties, as described in academic texts, characterized by variability and richness while in actual practice they are seen as monotonous?

The similarities of the wards with the industrial settings in which monotony and repetitiveness have been explored were two: the first one regards the lack of task variability, while the second reflects the inability to strive for a specific goal.

In relation to task variability, the same movements, actions in fixed times occurred every day in the two wards. Variability reflected only unexpected events or emergencies. The few purely nursing tasks were not required on a daily basis, but

only in cases where a patient presented some physical illness. Some people from the sample had been performing the same duties for over 15 years, while the newcomers were already aware of their work future in the hospital. The impression given, which was also supported by nurses' statements was that the sample behaved in a mechanical way "come here, do my job and leave".

In connection with this was the second similarity. As in industrial jobs where the division of labour restrains workers from seeing the final outcome of their work and effort, similarly in the two wards there was no final outcome. Long-stay wards were considered as the last resort for patients. Only patients whose condition was extremely serious or had limited financial resources or no support from their families were admitted to these wards. Registering a patient in the long-term ward signified the failure of past therapeutic attempts and the categorization of the case as "in-curable". Therefore, the final product, which in the case of the hospital was patients' cure or improvement, could not even be visualized. It could be said that nurses resembled workers in that their only goal was to maintain the function of the unit/ward.

At a first level of analysis the similarities between psychiatric nursing and shop-floor jobs may be obvious and valid. However, it should be noticed that these concerned only nursing as performed in the particular long-term wards and they do not suggest any generalization to other nursing specialties or hospital units. Furthermore, the observed monotony and the subsequent mechanistic way of work were not part of a particular job design that was imposed by management, as it is in the case of factory work. In contrast, monotony was the chosen perception or a perceptual norm which was cultivated progressively from the beginning of one's employment in the long-stay wards. This was more explicit among qualified nurses who had acquired during their training a more complex view about psychiatric nursing. Gradually, those nurses had come to believe that work in the particular wards was nothing more than three basic duties and therefore monotonous. Unlike assertions of organizational and cognitive psychology studies (O' Hanlon 1981, Smith 1981, Hackman & Oldham 1980, Naughton 1988, Fisher 1993) about environmental or task influences on the experience of boredom, the present research proposes that boredom might be the product of socio-cognitive processes.

In conclusion, those exterior similarities of psychiatric nursing with factory jobs could not be attributed to the same organizational design reasons. More likely, it coincides

with what Perkins and Hill (1985) called 'perceived monotony', which signifies the role of individual perception of a job/task and with sociologists (e.g. Conrad 1997) who view boredom as social construct.

13.4. Development of boredom & task-monotony perceptions

Monotony in the studied wards was the salient characteristic of nursing job. As it was argued in the previous section, this monotony derived from the standardization of tasks and from the absence goals or the inability to visualise patients' improvement. This external similarity of nursing with industrial work, however, is contradicted by two basic observations: first, by superiors' assertions about patients' progress once they were released from the long-stay wards and admitted to out-hospital units. This signifies that the linkage between long-term wards and incurable patients was developed in the hospital context and was not valid in other therapeutic environments. A second observation regards the absence of clear duties or activities imposed by the hospital management. As informants revealed, each ward had developed its own routine according to the beliefs or aspirations of the head-nurse without any interference of management or superiors. Monotony, therefore, was constructed and not imposed by higher hierarchical levels.

The above insinuate that monotony was not a predetermined outcome of unchallenging tasks, but a socially constructed effect of perceptions and norms. As such, it resembles cognitive approaches which assert that individuals' perceptions interfere and determine the relationship between monotony-boredom. Nevertheless, cognitive psychology studies have placed their focus on showing this relationship, but they have neglected two aspects: the ways that such perceptions are developed and the importance of collective mechanisms in the formation of individual perceptions.

It was identified in the course of field work that the development of such beliefs not only would help the understanding of monotony, but would throw new insight on boredom as an emotion developed through individual and social mechanisms.

The formation of monotony perceptions should be addressed at multiple levels, starting from individual characteristics, group beliefs and leading to organizational norms and rules. In the following discussion other instances of boredom manifestations will be presented as well as their explanations. The reason for exploring collective mechanisms lies in the generalization of these perceptions.

At individual level, theories of personality have provided explanations regarding the association between task/job and performance and have further talked about how individual characteristics may affect perceptions about a task. Though in the present study personality factors were not assessed, however differences in age and educational level were observed and included.

13.4.1. Individual differences

A simple categorization of the sample was between trained and practical nurses. The latter group consisted of older people (40-64 years old) either with no training or acquiring a certificate in nursing obtained at the "old nursing schools". This type of training placed great emphasis in religious principles and in the moral/ethical values found in nursing. Trained nurses comprised a group with great variance. Age ranged approximately from 23 to 36 years and academic qualifications were of all levels, from the two year vocational training to university degrees. Age and educational level were related, with the majority of older nurses being practical and the young ones trained. The young nurses who had just attended the two year course were classified as trained due to the alterations in nursing education that had occurred.

According to studies in personality and individual differences psychology, age and intellectual capabilities tend to play a significant role in the experience of boredom. Studies have shown that younger people tend to be more easily bored in monotonous tasks (Smith 1955, Stagner 1975, Hill 1975, Drory 1982), while the same outcome derives when intelligent or educated people are occupied with tasks that do not require the maximum of their mental abilities (Wyatt & Langdon 1937, London, Schubert, Washburn 1972, Drory 1982). In a similar vain, the study of Dyer-Smith and Wesson (1995), included the issue of expertise, as a variable that determined boredom. Boredom, in that study was measured as errors and accidents when engaged in monotonous tasks, and experts' performance was found to be lower than what their expertise suggested. The above theoretical assumptions have created great debate and some of this incongruence is reflected in the present study.

a. Age
In respect to the age factor, it could not be said that there was a clear distinction in the experience of boredom among younger and older nurses. What seemed to be the salient 'variable' was the time of employment. For newly hired staff boredom was a fluctuating emotion dependent upon the day and the workload. Nurses who were in the wards for just a few months were in the process of learning about the

practicalities of the profession, gaining experience, fitting into the group and acquiring a general knowledge of the hospital's services and work procedures. Boredom was only felt during days when "there was not much to do". In contrast, for nurses with more years of employment, boredom represented the prevalent state interrupted by emergencies or by days when wards have been upset by something. It seemed that the socialization period was followed by an increasingly boring work reality.

Unlike theories that have only tried to establish a relationship between boredom and age, in the present study it was identified that age was related not to the experience of boredom but to its expression. Excluding the newly employed staff, for the rest of the sample, irrespective of their education, boredom was a pervasive feeling. For younger nurses, boredom was seen as an aspect of their job, which in a way was expected before entering the hospital. The attitude "it is just a job" helped nurses not to place much importance on it and to accept it with indifference and perhaps even prefer it in comparison to other work settings where the workload was greater. In contrast, older nurses were the ones who complained more frequently about being bored or for repeating the same duties every day. Furthermore, older nurses engaged more often in fights, something not observed among younger staff. This is in accordance with organizational psychology literature which states that boredom may increase employees' hostility and aggression levels (Kornhauser 1965, Broadbend 1979).

Such differences contradict the general belief about younger people being less tolerant to boredom. Two possible explanations may be offered: in respect of the increased aggression presented among older nurses, group cohesiveness clarified the matter. The female ward comprised mainly older staff and was recently formed by mixing staff from two other wards. As it was revealed by the head nurse, the composition of the group was not adequate, as nurses had learned different ways of work and had to be accustomed to new co-employees. Therefore, the complaints about being bored and the fights taking place among older nurses could be explained by the new environment in which nurses were working. The intriguing fact was that nurses perceived their ward as "new" despite the fact that it was established in 1999. Preserving this attitude was a way to pass the time or as some of the interviewees claimed "they have nothing else to do".

A second justification for younger nurses' calm acceptance of boredom derives from their expectations prior to employment. Expectations have been considered by

sociologists (Brissett & Snow 1993, Conrad 1997, Darden & Marks 1999, Bargdill 2000) as a contributing factor to subsequent experiences of boredom. Two theoretical perspectives have elaborated the issue. One asserts that the absence of any expectations for future changes influences boredom, while the second one takes the opposite view and argues that when expectations remain unmet, boredom is the likely outcome. In the present study, individuals' anticipations did not coincide with either of the two perspectives. While nurses reported a clash between training and practice, that did not seem to affect them much. In contrast, expectations about the hospital were the significant factor for their current behaviour. A general belief held by young nurses regarded the non-demanding nature of work in the psychiatric hospital. Furthermore, the hospital had a negative reputation about its efficiency and about the conscientiousness of its employees. It was expected, therefore, that things would be 'loose' and this constituted a decisive reason for seeking employment there for many of the group of young nurses. In a way boredom was anticipated to a degree and that made young nurses accept it more easily than older staff who did not have similar expectations.

In contrast to the assumptions of individual differences psychology, the sample's age did not have any effect on the experience of boredom. It was identified that all staff (excluding the new employees), regardless of age, felt boredom. An important variation, which has not been elaborated by personality and individual differences psychology, regarded the way that boredom was manifested. Studies in this field have only been interested in establishing relationships between factors, such as age or extraversion-introversion and boredom (Wyatt & Langdon 1937, Smith 1955, Hill 1975, Guest, Williams, Dewe 1978, Gurdner & Cummings 1988) and have neglected how boredom may be expressed in each of these groups. This study revealed that boredom may be present across all ages and signified the importance of the ways that is conveyed in each age-group. Younger staff accepted boredom as something 'granted' or 'expected' while older nurses presented a more aggressive and less tolerant stance.

b. Education/Expertise

In respect to individual differences, such as education, there is not a coherent theory. Education per se has not been elaborated by theorists, but two interrelated issues, mental abilities and expertise have been investigated by personality and individual differences psychology and cognitive psychology as well.

The role of intelligence in the experience of boredom was not investigated in the present study. Two basic reasons justify this elimination: first, the nature of this research was purely qualitative and did not encompass the use of quantitative measurements, such as IQ tests. Most importantly, however, was that by including such variable the purpose of the study would be redirected. My aim and focus was to provide an interdisciplinary approach of work boredom and not replicate past research findings.

In relation to expertise, the difficulty that was faced concerned its insufficient definition. The existing studies (Fisher 1993, Dyer-Smith & Wesson 1995) have not clarified whether expertise is a matter of education or of experience. There is only an insinuation that expertise is synonymous to academic qualifications and not to years of practice. This has led to inability to create fixed categories of the sample. For example there were trained nurses with few years of experience and non-qualified nurses who, however, have worked in the hospital for over 20 years and were in position to understand and take care of patients.

For simplification purposes, expertise was related to the formal qualifications obtained and not to years of employment. Therefore, experts in the present study were considered trained nurses.

A major view in cognitive studies (Dyer-Smith & Wesson 1995) contends that expertise leads to boredom when one is engaged in monotonous tasks and this is usually manifested as accidents or errors. Similarly, when mental abilities exceed task requirements, boredom is the likely outcome (London, Schubert & Washburn 1972). However, Fisher (1993) argued about the opposite, using the schema theory. Experts acquire more complex schemas, hence interest can be found in deriving extra stimuli from a situation. Findings of the present study support the first view, as trained nurses were the only ones who explicitly argued about the under-utilization of their skills and the inconsistency between training and practice. While most staff argued about the repetitiveness and simple nature of tasks, considering that trained nurses generally worked in the ward for less time than un-educated staff, it was derived that the limited task-demands were seen as a derogative only for a part of the first group. In respect to this, trained staff did not comprise a solid group, but two distinct categories had been formed: in the first one were individuals who complained about this incongruence and in the second those who had accepted it as it was. A primary supposition for this distinction regards personality traits and work

experiences of people in the 'complaining group'. It was observed that this group had worked in other hospital units and therefore could make comparisons and secondly they were energetic and quite assertive personalities.

This assumption was also enhanced by the fact that only trained nurses made this an issue, while non-trained nurses referred to it after being asked and without any sign of wanting more variance or complexity in their job. Perhaps boredom becomes more salient or negative for experts. The second supposition regards the rationale behind trained-nurses claims. Perhaps, by arguing about the incongruence between their qualifications and the demands of their job, they were attempting to defend their role as trained nurses. Distinguishing between educated and non-educated nurses was a major issue in the wards, and each group claimed about its significance, knowledge or expertise by contrasting the other.

A last remark should be made in respect to the outcome of boredom. Theory suggests that experts conduct more mistakes or have more accidents than non-experts (London, Shubert & Washburn 1972, Dyer-Smith & Wesson 1995). Such criteria for measuring or identifying boredom were not adaptable to the present study. It was observed that all nurses performed their tasks without any problems. Boredom was a condition that occurred before starting an activity or a belief about the job in general and not a state that affected task-execution. Performance detriments were detected only in relation to supervision, concerned all staff and derived from different reasons than expertise.

The second view which claims about the experts having more detailed schemas and therefore being able to search for and obtain additional information from a task (Fisher 1993) was not validated. Trained nurses did not express or argued about approaching patients or carrying out their tasks differently than non-trained nurses. The monotony of tasks was not eliminated by an effort to observe or interact more thoroughly with patients. This is also supported by some nursing studies (Tyson, Lambert, Beattie 1995) that assert that nurses with lower qualifications spend more time with patients. In a way trained nurses only claimed about their superiority and did not actively showed it. The rationalizations offered concerned the group-norms about workload and the lack of a systematic and organized attempt to improve patients' condition. It was intriguing that trained interviewees tried to de-personalize a matter that was, at least partially, in their own discretion.

In conclusion, there was not great variance in the experience of boredom between trained and non-qualified nurses. However, since most trained nurses had fewer years of employment it could be argued that boredom occurred much sooner compared to the non-trained older staff. While all trained nurses were aware of the under-utilization of their skills or as they had put it "anyone can do our job", it was observed that two intra-groups had been formed: the first composed of those who complained about the limited nature of the job and the second consisted of those who accepted or even preferred it. Another finding that does not support theory concerns the boredom-outcomes. Unlike past studies, the present sample exemplified that boredom does not always lead to negative states or to lower performance outcomes. The main tasks that nurses had to perform were executed perfectly without any problem or mistake being reported or observed.

c. Interest in the job

Interest in an activity is considered a crucial determinant of boredom. Organizational psychology has investigated variables that may increase the interest in a monotonous job, such as performance goals (Mathewson 1931, Smith 1953, Whyte 1955, Locke & Bryan 1967), autonomy (Hackman & Oldham 1980, Naughton 1988), co-employees (Lee 1986, Fisher 1987, Zalensky & Ford 1990), while some psychologists take a more abstract perspective by considering interest as a matter of preferences (Holland 1997, Gottfredson 2002, Arnold 2004) or even a personality characteristic-autotelic personalities- (Csikszentmihalyi 1975) that enables some people to find interest even in mundane tasks.

The importance of personal interests and inclinations is decisive for future work behaviour and attitudes and is closely connected to employee selection and involvement however it has not been elaborated by organizational psychology theorists. Only sociological theories have touched upon the matter by talking about the effect that the desirability of a professional role has upon future attitudes and performance (Darden & Marks 1999). In addition, occupational preferences may become of extreme importance for jobs that do not provide high external values, like pay or status. Nursing in many ways is considered a low status profession (Meerabeau 2004), as it involves "dirty work", dealing with stigmatized groups, such as psychiatric patients, is usually under-paid and is not valued by the public. It is, therefore, logical to assume that strong motivation for entering a profession that comprises such characteristics is of high importance in order for one to be able to overcome and deal effectively with these shortcomings.

Being interested in a task/job may be a straightforward matter for occupations that are not based on human interaction. In health care professions, however, "interest" has another aspect which includes the recipients of services. In such professions the task cannot be separated from the individual who is directly affected by it. The statement "I am doing something" transforms to "I am doing something for someone else". As it has been previously stated, the relationship between carers and cared for is highlighted in nursing (Peplau 1962, Barker, Reynolds & Ward 1995, Mackintosh 2000). According to theoretical and public views, nursing is characterized by caring relations that are (or should be) developed between nurses and patients. The very definition of caring includes acts such as expressing interest, attending and supporting (Kyle 1995, Warelow 1996, Bradshow 1996, Woodward 1997, Watson 1992). Moreover, the Greek old schools of nursing training have incorporated to a great extent the ethical and moral values of nursing practice. In sharp contrast, boredom has been conceptualized, by all theoretical perspectives, as the lack of interest originating basically from engaging in un-motivating, un-challenging or monotonous/repetitive tasks. Expanding on this assertion, boredom may be also manifested as a lack of interest towards the recipients of services. It is therefore necessary for all professions that entail extensive human interaction to identify the ways in which the disinterest may be expressed and the origins of this.

Following the discussion about individual differences and how these may affect work boredom, interest in this section regards two aspects. It represents both personal inclinations and as such it was investigated in respect to career orientation prior to employment and it also reflects concern about patients' needs.

It was intriguing that no interviewee had decided to enter the nursing profession on the grounds of preference. Only a small percentage of the sample which were trained nurses reported an interest in health care professions, but nursing constituted the last preference. Other reasons, for choosing nursing, were implicated, with the most vital one being the need for immediate employment. Even nurses who had some secondary benefits for selecting this profession, as some had stated "learn how to take care of my parents when they will be in need", they were faced with the negative practicalities of the job and in a way they had lost their initial interest or enthusiasm. Nurses' reports about being "cleaners", stigmatized by their job and additionally not receiving any recognition were very common and could not be neutralized or balanced by a former desire to be involved in the profession.

In relation to the second aspect of interest, it has been repeatedly stated, that nurses' disinterest towards patients was evident in many cases of explicit neglect, such as insufficient supervision that led to serious accidents (cases of dehydrated and intoxicated patients, fire in one of the wards etc) and in the limited time nurses spent with patients. Indifference to patients was also expressed through the language used when referring to them. Totally negative characterizations, such as "crazy" or "psychopath", were commonly used, especially in the female ward. Analogous to nurses' language was their behaviour, which ranged from complete indifference to shouting, pushing over or restraining patients. There was no individualistic approach towards patients, all tasks were carried out collectively in an attempt to make them easier and less time-consuming. The newly admitted patients received no support to adjust to their new environment, while those who were released were not even informed about their transfer. To a smaller or larger extent, patients in both wards were deprived of their human substance and consequently deprived of any expressions of interest or caring. Nurses' perceptions about patients resulted in the latter's de-humanization and this to the eligibility of showing no interest.

Moreover, drawing upon the theory of emotional labour (Hochschild 1979, 1983) that classifies nursing among the professions that entail to a great extent emotional labour, the expression of certain emotions is expected even if those do not represent reality. This however became problematic in the case of this sample. Evidently, nurses did not even attempt to keep a balance between what is felt (boredom, indifference) and what was supposed to be expressed (some kind of sympathy).

Nonetheless, there was an inconsistency between nurses' behaviour and their interviews. Some interviewees, particularly older staff, claimed during interviewing, that they had feelings for patients, they "cared for them" or "had given their lives to them". Rationalising this, it seemed that nurses had distinguished between their feelings and their behaviour because it was more "appropriate" for patients. As they argued, not developing relations with patients or expressing their sympathy provided them with the necessary, in mental health professions, boundaries that safeguarded patients' improvement and increased their independence. Perhaps such assertions were based on interviewees' effort to present a favourable image, by claiming the existence of inner feelings that had to be concealed for patients' benefit. From another perspective, however, there is a great distance between the psychological

principal of 'not closely relating to patients' and the abrupt behaviour expressed in the wards.

Some of the questions that were formed were: Could this behaviour be the outcome of the strong negative perceptions about patients or the outcome of the disinterest for the job? What kind of beliefs, rules or norms had such power to overrule the norms or behavioural rules of the nursing profession? If sympathetic feelings for patients did exist, were there any processes that not only prohibited their expression but suppressed them totally?

13.4.2. Group norms

So far, it is seen that vital antecedents of nurses' boredom were: their educational background, which was non-existent and limited the options that non-qualified nurses had in their job, the expectations prior to employment that young, trained nurses held, about the restricted task variety and complexity and lastly the criteria for selecting the profession, which were based on reasons other than desirability or preference. Such attributions may be valid for individual behaviours but do not provide a complete explanation about the disregard of the 'caring ethos', the total indifference towards patients or even the absence of any effort to succumb to public images about the nursing role. The question that was formed was: how people with differences in age, academic qualifications, personal interests and work experiences behave in such similar ways or express similar beliefs?

It was interesting the fact that nurses' perceptions about patients were expressed mainly during observations. When the sample was asked to provide the basic rationale for not working more with patients, the majority referred to the unwillingness of their co-employees. By claiming that "one bird does not bring spring" nurses were justifying the indifference shown towards patients. While practical nurses referred to their inability to provide additional services to patients due to their lack of skills, trained nurses' rationalizations expressed their main impediment as the groups' attitudes. The association of this belief with group norms is evident. Indifference was the only stance accepted and trying to express the opposite led to either overt hostility expressed in statements such as "what are you trying to prove?" or efforts to include the anti-conformist into the group "come here with us". After a period of time one would have to choose between the group (patients or co-workers) with which he/she desired to be identified. Nurses unanimously preferred to fit into the group of their co-workers.

Though there is a variety of reasons justifying the development of such norms, here only those related to individuals are presented. A primary one regarded the composition of staff. The majority of nurses, especially in the female ward, consisted of un-educated staff. This had a double effect: first, individuals were not familiar with the nursing professional norms, such as the expression of certain emotions towards patients. The second effect was related to the terms under which those people were hired in the hospital. As stated previously, practical nurses were employed either by chance or through acquaintances who already worked in the hospital. The work carried out in their initial stage of employment composed only of basic- for patients' survival- tasks. Those people had not learned or were not shown other nursing duties.

Furthermore, according to role theory (Darden & Marks 1999) and to nursing studies (Morrison, Shealy, Kowalski, LaMont & Range 1994, Stuart & Laraia 1998), the performance of a role is dependent not only on the professional norms but also on those which permeate the hosting organization. In the psychiatric hospital the absence of "face-work", a term used by Goffman (1967) for emotional labour, was obvious throughout the whole hierarchy. The rates of doctors' absenteeism were extremely high in both wards, no other health care professional had ever visited the patients and administration had never inspected the work conducted in the wards. In nurses' minds this was perceived as a clear expression of indifference and was permitting them to imitate it in their own ways.

Group norms as well as superiors' stance were providing nurses guidance for what was considered appropriate work behaviour. This partially resembles organizational psychology theory about co-employees influence on the interest expressed on a task (Weiss & Shaw 1979, Griffin 1983, Thomas & Griffin 1983, Lee 1986, Zalensky & Ford 1990). In the case of the two wards, co-employees were not just setting an example about behaviour towards patients, but they had set the rules and demanded obedience to them. Indifference, disregard of professional norms and boredom were in part the outcomes of powerful group norms that prevailed in the wards.

13.4.3. Organizational norms

At a deeper level, the existence and power of such group norms, presupposes a work environment that is tolerant or even reinforces employees' negative attitudes. It is therefore needed to have an insight about the hospital as an organization, in order

to understand the existence and prevalence of the group's "boredom norms". Literature on public organizations and bureaucracies has provided the theoretical framework for this discussion.

As a public organization the psychiatric hospital acquires the same structural and cultural features as most public sector institutions in Greece. Some of these characteristics provide a robust explanation for the indifference observed in the two wards as well as for the substitution of the professional norms by the ones developed by nurses' group.

To begin with, hospitals represent professional bureaucracies because of their hierarchical structure, the standardization of procedures and the employment of various professional categories (Mahmoudi & Miller 1984, Heffron 1989, Schultz 1994). Literature suggests that this "double identity" results in power conflicts both among professionals and among professionals and the organization (Germov 2005, Lega & DePietro 2005). A second defining feature concerned the history of the hospital and the way that this had affected its function and most importantly its reputation.

In respect to the power conflicts among professional groups in the hospital, nurses were the most disadvantaged group. The awareness of having no power in the hospital system and the perception that they were the only group that was actually working or had to deal with the most negative aspect of hospital work had a great impact on nurses' behaviour. Claims about "nobody is interested" or about being "forgotten" were quite usual. Such beliefs revealed not only a fact about the work-life in the wards, but also the identification of nurses with patients. Staff, especially in the female ward, explicitly argued about being in the same "boat" with patients, while one of the ward-psychiatrists suggested that institutionalization regarded both staff and patients. In many ways this was obvious through the similarities in behaviour that the two groups (patients and nurses) expressed: sitting, talking, smoking and wondering in the wards without a clear objective.

Having no power and identifying themselves with the mentally ill, boredom, for nurses in the female ward, was a method to preserve their identity. By claiming boredom they differentiated themselves from patients, since "crazy" people do not acquire the mental abilities to experience such emotions. A more straightforward explanation may be that boredom was the direct outcome of nurses' institutionalization.

Additionally, the absence of psychiatrists in the wards and the reluctance of hospital doctors to attend their duties were imposing extra problems on nurses. The perception of "having to do their job" was causing nurses feelings of anger or as they put it "being the suckers". Filling in for other staff, has also been included among the problems that nurses face in their job, according to nursing studies (Thomas, Beaven, Blacksmith, Ekland, Hein, Osborne & Reno 1999). Disinterest for patients, therefore, could be an attempt on the part of nurses to obtain some sense of "false power" over doctors and over the hospital system. Consequently, boredom may have been the outcome not only of mere imitation "if they are not bothered, why should we?" but a counter-attack to a system in which nurses had no power at all.

From another perspective, the general perceptions about bureaucracies promoting impersonality and low involvement through the formalization of duties may also provide a valid explanation for the indifference expressed. Studies have shown (Vigoda 2000, Pipan 2000) that public organization employees are generally idle, un-motivated and indifferent. It has been already argued that young nurses expected work to be non-demanding in the psychiatric hospital. Apart from the expectations formed because of the bureaucratic nature of the hospital, the additional beliefs and perceptions about its history had also contributed to the establishment of such expectations. Starting as an institution for the unwanted (Matsa & Michalakeas 1998), whether this signified mental disorders or delinquent behaviours, employing people with no education or as the literature suggests (Filandrianos 1977), outcasts and functioning only as a shelter with no therapeutic role, it resembled an infamous paradigm of psychiatric services. Despite the transformations and the verified progress, the long-term wards still suffered from this notoriety. In the Greek reality the hospital X is still a synonymous to madness (Matsa & Michalakeas 1998, Kokkinakos 2000). These expectations had prepared the sample for the work behaviour that should be expressed and were reinforced by reality.

Overall, nurses' perceptions about patients along with the organizational features of the hospital have contributed to the free expression of emotions experienced and the total disregard of the concept of presenting a certain attitude at work. In other words, nurses were not interested in their job or in their patients and were not obliged to express the contrary. Boredom was the outcome of three main psychological procedures: the perceived identification with patients, the reaction to the low-status

role that nurses had been given and the expectations that the hospital had imposed through its history and through its bureaucratic nature.

13.4.4. Organizational structure/procedures

It is already seen that beside the individual differences that may affect boredom, there are also collective mechanisms outside the individual or the actual job. Group norms and organizational culture features had contributed to the prevalence of boredom in the two long-stay wards. Using the sociological terminology (Darden & Marks 1999), boredom becomes a "social construct" that acquires certain meanings within a specific setting.

In the following pages, the hospital's organization and function will be presented as these are perceived by the sample. Some of the factors that are going to be discussed are directly connected to the boredom-behaviours that have been elaborated in the previous section, while others provide more complex explanations.

a. Absence of Performance Measures

Expanding on the assumptions of organizational psychology studies about the influence of performance goals on the experience of boredom, it was identified that performance measures may also have similar outcomes. Clear and specific goals do not only minimize boredom but also provide a tool for assessing performance and increasing employees' motivation through the provision of rewards, bonuses etc. As personality and individual differences psychology has shown these additional features (measuring performance and providing rewards) may be extremely important for people who have external work values (Vodanovich, Weddle & Piotrowski 1997).

However, despite their significance it is difficult to apply such mechanisms in services and especially in those provided by public sector institutions. Literature on professional bureaucracies, as hospitals are categorised (Heffron 1989), argues about their tendency for disvaluing profits (Duggan 2000) and the difficulty of evaluating success or efficiency (Pipan 2000, Gowan, Seymour, Ibarreche & Lackey 2001). However, having difficulty in assessing performance should not necessarily lead to the total neglect of the concept, as was the case in the two wards. As staff revealed there was no one checking on them. Typically the head nurses constituted the authority figures who would inspect nurses' work but not in a formal way. Furthermore, head nurses themselves were quite tolerant in respect of the ways their

staff were choosing to spend work time. The informality of inspections and the tolerance expressed by superiors were the factors that allowed nurses not to show any effort in their work. Even when they were told off for neglect, things were only altered for the following couple of days and after that the habitual ways of work returned. Assessing employees' performance includes reporting cases of neglect or misconduct, something that would at least provide some limitations to the over-freedom that nurses enjoyed. Having no mechanism for evaluating the conditions in the wards, staff's attendance to duties and general behaviour, the hospital did not impose any restrictions and possibly it was this that, in part, led to boredom.

b. Low Autonomy

The absence of organizational rules and performance measures may insinuate that the relative freedom that nurses had represented a certain degree of job autonomy. Restrictions on behaviour were not even imposed by the mere presence of authority figures, since psychiatrists were never seen in either of the two wards. Nursing studies have addressed the issue of nurses being the handmaidens of doctors (Hallam 2002) and of the dissatisfaction that derives from the low autonomy this implies (Stuart, Worley, Morris & Bevilacqua 2000).

At a first glance this study contradicts such assertions. As was previously presented, nurses were free to use their work time according to their moods and desires. However, this over-freedom did not signify autonomy and was not perceived as such by the sample. Although nurses believed that "having no one above your head" was an important and positive aspect of their job, they also perceived it as a difficulty in cases of emergency. In such incidents nurses would either have to locate the psychiatrist of the ward or contact one from other units, both time-consuming and stressful procedures, as nurses reported. What was more important was the fact that in the absence of psychiatrists, nurses became accountable for anything happening in the wards. Since psychiatrists represented the absolute power in the hospital, they would not be accused of anything, instead all responsibility would fall on nurses.

Despite their absence doctors had not delegated their power, since their absence was not formal but an act of neglect. This was made evident when nurses, in an attempt to take initiative, were forming opinions about patients' conditions. Although they were the ones having daily contact with patients, their reports were neglected by doctors either in the form of simply altering the dose of a drug (without even checking the patient) or by assessing them as non-important. Additionally, using their freedom

constructively was considered either as an attempt that would exceed their skills and knowledge and which was connected to fear of causing a negative outcome or as something that was beyond their duties or that could not be applied unless all staff was in agreement.

The majority of nurses claimed that reporting was the only initiative taken. Their autonomy was either perceived as non-existent or regarded informing superiors about anything unusual in patients' behaviour. Reporting, however, could not be categorised as an aspect of autonomy because firstly, it was a direct outcome of somebody else's behaviour (psychiatrists' absence) and secondly it was an act for minimizing responsibility. As some nurses argued, they kept a full record of all reports made to superiors out of fear of being fully accountable for patients. Furthermore, reporting of actions is a basic mechanism in bureaucratic structures. From the organization studies perspective, reporting is an obligatory action that results from characteristics such as centralization of authority and control, a concept antithetical to autonomy. As studies (Allinson 1984) have shown, reporting not only limits autonomy but it also transfers responsibility from the lower to the top hierarchical levels.

The lack of autonomy was not seen by nurses as problematic in terms of the inability to bring changes or be creative in their job. Even when interviewees were asked about alterations they would make if they had the power to do so, in the vast majority of replies concerned the building infrastructure and not any other aspect of their job. The freedom that the staff enjoyed due to the absence of superiors was seen both as a positive aspect since no one checked on them and as a stressful condition when unexpected, urgent incidents occurred.

In contrast to organizational psychology that has argued about the lack of autonomy imposing feelings of boredom (Hackman & Oldham 1976), in the present study such a connection was not identified. Low levels of autonomy signify that there are important constraints on general behaviour and on the potential for employees to experiment in their job, both factors that increase boredom. In this case, however, the low autonomy that nurses possessed was not inhibiting creativity or initiative, simply because the sample did not have such aspirations/needs or because their qualifications could not support such behaviours. It is important therefore to examine individual's characteristics before assuming that low levels of autonomy lead to boredom.

Nonetheless, as the organizational studies literature (Macher 1988, Hartline et.al 2000) has stressed, the issue of work autonomy has further implications that maybe associated with boredom, particularly with the concepts of employee responsibility and involvement. The meaning of autonomy is that the individual becomes an active agent of his/her decisions and actions and does not just follow orders. Decision making requires engagement in the task/job and leads to a sense of responsibility. As the sample showed, the opposite outcomes are brought in when autonomy is lacking. The perception of nurses in respect of responsibility was that it resulted in stress and worry, both dynamic states and opposed to their habitual sluggishness and indifference. It should be noted, however, that responsibility was not the outcome of autonomy or power, both positive concepts, but a result of others' negligent behaviour. It is logical to assume that boredom was the preferable state when compared to responsibility taken by force and concerned only negative aspects of the job.

c. Disinterest in Career Advancement/Absence of Career Opportunities

An issue much discussed in the organizational psychology literature (Nabi 2000, Vodanovich, Kass & Callender 2001) for its importance to employees' emotions, concerns the career opportunities offered in the work context. Specifically, studies have shown a connection between career prospects and boredom and Lee (1986) has included it in the Job Boredom Scale as a contributing factor to boredom experiences. However, it is not clear whether the association is direct or indirect. A proposition could be formed through nursing studies that assert that nurses' dissatisfaction is attributed partially to their limited career opportunities. Perhaps job dissatisfaction interferes in the relationship between promotion prospects and boredom.

In the present study, it was identified that in order to assess the influence of career opportunities on employees' work attitudes and emotions, it was necessary to establish whether or not individuals had and were capable of pursuing relevant aspirations. For instance, practical nurses had no interest in moving up the hierarchical ladder. This was partially due to their age the majority of them were middle-age women some of whom were just a few years away from getting their pension. The second reason was related to the lack of formal qualifications. The validity of those explanations was questioned because of their disinterest to gain more skills and hence improve their chances of being promoted. A variety of reasons

contributed to this attitude: the absence of a clear orientation towards nursing, the limited resources and the perception of the nursing job just as a means to survival. Among the rationalizations made by the head nurse was that practical nurses did not believe that acquiring advanced knowledge would make any difference to their job, they would still have to "clean patients". In any case, career opportunities were not influencing practical nurses' boredom because there were not any prior aspirations that had been frustrated. They were extremely aware of the reasons that led them to this profession and had accepted their position as the *status quo.*

Apart from these beliefs about their personal deficiencies not allowing career advancement, an assumption shared by all nurses (practical and trained) regarded the role of the hospital system. Skills, knowledge or even willingness to offer were not considered as sufficient preconditions for promotion because of the absence of meritocracy. Examples were given by head nurses, who claimed with pride that they strived and sacrificed their personal lives for their position without the "support of powerful acquaintances" in the hospital and by nurses who believed that even a simple transfer to a "better unit" required knowing the "right people". In addition to nurses' claims, the fact that the hospital's general director was appointed to his position right after the election of the new Greek government supports the assertion that friendships as well as political beliefs were the most significant factors for career promotion. Literature on Greek public organizations (Papalexandris 1992, Tsivacou 1996, Sotiropoulos 2004), though not proliferate, has touched upon the issue and exemplified that the absence of meritocracy is present in all facets of organizational life, from employee selection to career opportunities. In fact, many of the practical nurses got their job because they had some friends or relatives in the hospital.

It is difficult to come to a definite conclusion about trained nurses' perceptions of career issues. With the exception of the responsible of the wards and the head nurses, no other nurse revealed any career goals. It was not identified whether this was due to personal preferences or due to the awareness of the difficulty to achieve career promotion. Perhaps, there was a low motivation for career advancement that was reinforced and maintained by the limited and unequal opportunities that the hospital provided.

In that case the expressed apathy should be attributed to factors other than career prospects. Personality and individual differences psychology asserts that individuals with high need of achievement are not easily bored (Wendt 1955). Assuming that

desires for career advancement represent such need, then nurses boredom may be the outcome of a personality characteristic (low need of achievement).

The opposite view stems from the public organization literature and in specific the theory about organizational citizenship behaviour (Vigoda 2000). The basic assumption is that perceptions about the clarity and fairness of organizational procedures affect employees' behaviour. When employees believe that the organization lacks those features, it is likely that they will present negative attitudes ranging from indifference to active attempts to harm the organization. In the case of nurses, career opportunities represented an example of unfairness and of the existence of politics in the hospital. Consequently, boredom could be nurses' reaction to the prevalent inequality of the system and not the direct result of limited career opportunities.

By perceiving attempts for promotion as futile, the expressed boredom takes another meaning. Even if nurses' indifference to their job is considered as a passive mechanism for balancing the injustice with which they have attributed the hospital system this could not be regarded as a stance that surpassed the prevalent norms. Indifference and neglect of duties were not the exceptions but the rule in the wards. Moreover, being indifferent to the job is an attitude based on different mechanisms than being indifferent to one's own future, as this was expressed through the lack of career goals.

d. Socialization Practices

It was identified that a primary reason for the development of nurses' sense of futility, the mechanistic way in which they performed their daily duties, the passive acceptance of negative aspects of their job and their indifference for developing an improved work environment and promoting their career, was the initial encounter with the psychiatric hospital. It should be noticed that this feature regarded mostly old nurses however similarities existed with younger and newly employed staff.

Nurses' reports about the un-hygienic conditions in the wards, the disproportionate ratios between patients and staff and the lack of support were not just perceptions of some un-educated people but have been verified by voluminous amount of media publications of that time. Certainly, personality traits and individual characteristics, such as educational level, play a significant role in peoples' reactions to stressful and unfamiliar situations. However, nurses' descriptions about the hospital were so

powerful and vivid that have diminished the involvement of those factors. From their accounts, the proposition that was formed regarded the socialization process in the hospital and its effect on future behaviour. Apart from sociology that has referred to first impressions as formative for the subsequent emotions and attitudes, in terms of the expectations they create, no other theoretical perspective has reported a connection between socialization and boredom.

Nurses' stories about their initial contact with the hospital were quite shocking. As new employees they were literally thrown into wards occupied by 120 patients and told nothing but to "do as I do" from the more experienced staff. Duties were not fixed and nurses had to perform anything that was necessary, from taking care of patients to cleaning the wards. Emotions during that stage were overwhelming and persisted till the present. Being in need of work, 'escape' from an environment that was causing them strong negative reactions was not an option. Hence, their only solution was to learn to accept the situation. As nurses commonly argued "getting used to it" was the only coping mechanism they could apply, one however that did not entail any form of action. The phrase "got used to it" insinuates that the basic underlying assumption is that nothing can be done to alter the situation, not only that there is no anticipation for future change but that the individual is incapable of trying to bring a change. The first part clearly resembles the sociological theory about the connection between boredom and having no expectation for future change. However, the emphasis given to the passive acceptance of the situation, suggests the psychological theory of "learned helplessness" provides a more probable explanation. The differences between the two perspectives lie in the role of the individual and in the categorization of the situation. The sociological theory (Bargdill 2000) states that people who are in situations that do not have any prospects of changing are likely to feel bored. It is not clear whether individuals are or feel able to alter the unfavourable condition. Moreover, the situations that are described within this theoretical view were not characterised as extremely stressful but as un-motivating or un-interesting.

The theory of learned helplessness asserts that when people are faced with difficult and tense situations, with no possibility to change or escape them (the flight or fight reaction to stress and danger) they tend to freeze and tolerate them (Seligman 1974, Martinko & Gardner 1982). Old nurses expressed no attempts or interest to improve their work conditions, neither in the past nor during the time of field work. Overwhelmed by their initial impressions of the job with no other occupational

alternatives and having no power in an institution that was characterised by serious deficiencies, they had learned to just "get used" to everything. The expressed indifference to themselves, as shown by minor things such as not attempting to create a better work environment, was in fact an attitude that originated form the first period of employment. As one of them argued "that's the least to think about". Perhaps by expressing boredom or apathy they were balancing all the negative emotions they had experienced previously. Being bored was eligible in a way because of all the hard work they undertook in the past. Alternatively, boredom could be the superficial emotion that concealed a more basic attitude characterised as freeze response to stressful or unfavourable situations.

While the new generation of nurses had found the hospital improved in all aspects, again their socialization phase had many similarities with that of older staff. As their old co-employees, young nurses had been assigned to a ward randomly, with no selection criteria and had received no support or formal information about the job, their role or what was expected of them. The norm "do as others do" was applied in their case as well, despite the years that had passed by and the accompanying progress of the hospital. This had a double effect. First, it made wards the point of reference for new employees and consequently any group norms prevailing in them overruled against any other formal or professional principles. As has been stated in a previous section, the basic attitude in the wards was 'the less work the better', boredom was what young nurses were expected to show. The second implication concerned the message that the hospital delivered to its new staff. The impersonality with which the management treated new employees, though a widespread feature of bureaucracies, had a negative influence on employees' perceptions not only about their job but about their personal value as well. How can a new employee become interested or motivated if the employing organization neglects him/her even from the beginning of the work contract? Indifference, therefore, permeated the hospital through linear associations: started from the top hierarchical levels towards employees and from employees towards the job and ultimately the patients.

13.4.5. Summary
In the previous paragraphs, the present research was discussed in relation to existing theories of occupational psychology, nursing and organization studies. Some of these theories were confirmed, while others were contradicted or expanded by the findings of this research.

Table 6 summarizes the findings along with the existing theories of occupational boredom to which the findings relate.

Table 6: Findings and Theories

Boredom	Theories
Nursing in long-stay psychiatric wards can be a boring job	No similar suggestion in nursing studies, texts
Time distribution between tasks-breaks uneven, especially when employees have the discretion to structure their work-time	Only in media publications (Bolchover, Joyce)
Irrelevant-to-work activities	Only in media publications (Bolchover, Joyce)
Health-risk behaviour (smoking, drinking) and hostility during work-time	Psychology studies and Organizational psychology
Perceived monotony, no task-variety, unchallenging tasks	Organizational and Cognitive Psychology
Perception of slow passage of time	Sociological and Cognitive psychology
Mental absenteeism as an effort to block out extra stimuli, 'being elsewhere' and not just lapses of attention or performance detriments	Cognitive psychology investigated it as lower output, errors and inattention. Only a strand of research has focused on 'daydreaming'
Physical absenteeism not present at great levels and related to power issues, not boredom	Organizational psychology contended the contrary. Literature on Bureaucratic organizations insinuated a similar assertion
Attention to tasks remained intact	Cognitive psychology asserts the contrary
Supervision hindered but not as a direct outcome of boredom. Lack of a sense of responsibility mediated the relation	Organizational psychology and Cognitive psychology (vigilance tasks) contended that boredom results to lapses in attention
Readiness to start an activity was only hindered for random, extra tasks. For main tasks, the contrary was observed	Cognitive psychology asserts that it regards all tasks
Disinterest for the job and the recipients of services, because of no particular desire for the profession and of the negative perception of patients	Organizational and cognitive psychology claimed about the close relation between boredom and interest but consider the latter as an outcome of task attributes

A primary differentiation of this thesis, concerns the conceptualization of psychiatric nursing and its relation to boredom. While nursing studies assert that it is profession with variety and challenge, mostly associated with burnout, in the present study it could only be compared to vigilance jobs.

A second, but vital characteristic of work boredom, regards attention to task. Cognitive as well as organizational psychology theories have associated boredom with lapses of attention and performance detriments. However, the present research suggested that task execution remained intact, and problems arose only when attention took the form of supervising patients. Studies about vigilance jobs have proposed that performance may be hindered by boredom, due to the infrequency and low number of stimuli (Thackray 1981, Charlton & Hertz 1989, Weinger 1999). In the particular setting, however, it was identified that supervising patients was problematic because of the ability of nurses to block out stimuli and because of their lack of sense of responsibility.

A third differentiation of the findings of this thesis regards the relationship between boredom and interest. In the present research, this relationship was confirmed but it was based on a different rationale. While organizational and cognitive psychology assert that boredom results from disinterest in a task or activity, they contend that task attributes create this lack of interest and consequently induce boredom. Nurses' disinterest, however, resulted from a general despise for the job and from their perceptions of what constitutes psychiatric nursing. Additionally, when we investigate 'interest' in a service profession, such as psychiatric nursing, there is another meaning that we have to look into, that of 'interest for' the recipients of services. Again, the sample displayed a disinterest for the patients' well-being and improvement, due to a variety of reasons, such as negative perceptions of patients and fear of them.

Another suggestion about the occurrence of occupational boredom, neglected by organizational psychology theories, concerned the factors affecting perceptions of work monotony. While it has been argued that boredom results from individual perceptions of what constitutes task or job monotony (Perkins & Hill 1985), it has not been investigated what factors contribute to the formation of such perceptions. Apart from task or individual characteristics, that have been investigated by organizational, cognitive and personality and individual differences psychology respectively, the present findings add other variables, such as organizational structures and procedures as well as organizational and group norms. It should be noted that these factors function as determinants of boredom both directly and indirectly. As organizational theories contend, the limited delegation of authority, the absence of performance measures and the limited career opportunities may induce feelings of

boredom because individuals have nothing to strive for (Hackman & Oldham 1980, Lee 1986). In the case of the psychiatric hospital, these aspects of organizational function conveyed other practices or norms. For example while nurses had not been given any formal control, they had all the responsibility of the wards due to absence of doctors. Another example relates to the opportunities for career advancement, which in the hospital were absent because of the powerful role of organizational politics. This resulted not only in nurses' limited efforts but in the development of perceptions of unfairness. Boredom in this sense was the direct outcome of the existing organizational practices and a counter-attack to a system that supported injustice.

13.5. Limitations

At the beginning of this research, the aim was to examine if boredom may be present among professionals. This aim was only partially achieved due to the composition of the studied group. The majority of nurses who were interviewed were not qualified or had attended one-two year practical courses. The small number of qualified staff in the studied wards, along with the unwillingness of many potential interviewees to participate in the study were the decisive factors for not limiting down the sample to qualified nurses. Despite these difficulties the incorporation of non-qualified staff proved valuable because it allowed for comparisons to be made between trained and non-trained nurses. Furthermore, all staff were practicing a profession characterised by variety and challenge (Stuart & Laraia 1998). As it was observed there were no marked differences in the tasks performed by the two groups. It was therefore decided that including non-qualified nurses would not alter the outcomes of the research.

An opposing argument may be that qualitative research can be valid and reliable (the use of these terms is for communication purposes only) even with a small number of participants, presuming that interviews are thorough and extensive. In support to this, the research findings were based on observations as well as on interviews. As Hammersley (1990, p.597) suggests, "to rely on what people say about what they believe and do, without also observing what they do, is to neglect the complex relationship between attitudes and behaviour". Nearly six months were spent in the hospital, observing the sample's behaviour, listening to informal conversations and taking field notes. In this way, interviews and observations were giving feedback to each other, thus providing me with a more complete view of life in the wards.

However, two additional difficulties aroused during fieldwork. The first one related to the unwillingness of interviewees to be tape-recorded. The majority of participants were interviewed without the use of a recorder, despite the researcher's attempts to introduce the recorder in the course of the interviews. Although notes were kept as extensively as possible, it is acknowledged that some information may have been lost. The problem of not accumulating enough data by selecting only nurses with specific educational background and by not having the appropriate instruments for data-recording was identified early. The decision to allow more people to participate than to base the research only on a very small number of recorded interviews seemed preferable. It was believed that in that way a fuller description of the phenomenon of boredom and its related variables would be accomplished.

The second problem, regarded the individual characteristics of qualified staff. Registered nurses were younger and with much less years of experience (some were only employed in the hospital for a few months) in the particular hospital in comparison to their non-qualified co-employees.

This, of course, is not a drawback on its own. Nonetheless, among the aims of the study was to examine how broader factors may influence work- boredom. Literature on bureaucracies, health sector and on nursing has suggested that there are contextual variables that may affect employees' behaviour and emotions. It was, therefore, an imperative to incorporate such factors in the present study. Since access to formal documents was denied, information about the specific hospital and its organization, function and norms, was gathered through the older non-qualified staff. It was these employees, who because of their long-term experience in the hospital provided the deeper understanding and insight about the context.

Another limitation concerns the methodology employed. By choosing qualitative methodology the first implication regards the generalization of the findings. Consequently, the question why not using a methodology that would allow bigger samples and therefore increase the likelihood of generalizability of the findings comes up. This argument becomes stronger if one considers other possibilities for exploring occupational boredom, such as the use of questionnaires- Lee's (1986) occupational boredom questionnaire is a good example- that allow larger scale studies.

It is unanimously accepted that the aim of a research project, the researcher's theoretical stance and the methodology employed are inexorably connected and determine one another (Pope & Mays 2006). In this case as well, the use of qualitative methodology was decided upon the following reasons: first, the nature of the phenomenon under investigation. Unfortunately, our knowledge about occupational boredom is mainly limited to industrial settings where individuals are "authorised" to experience such emotions. Investigating boredom in a different setting, where different social expectations and codes of behaviour exist, it requires a diverse and a more sensitive approach. Qualitative techniques, such as un-structured interviews, informal chatting and observation, provide the researcher with the necessary flexibility to learn about topics that may not be "legitimate" in certain contexts. A second consideration, regarded a secondary aim of the research, which was to provide an interdisciplinary approach to boredom. In the reviewed literature, which encompassed organizational and cognitive psychology, personality and individual difference psychology and sociology, it was identified that there was a lack of concrete data about social contexts and processes and how these may affect the experience of boredom. As many scholars argue (Pope & Mays 2006, Kidd 2002) qualitative research is most useful for uncovering such information. Lastly, my own perception about boredom has influenced the use of the particular methodology. Reviewing the literature, the sense that boredom is a matter of individual predispositions or of specific organizational procedures seemed not convincing. Searching this "something else" that could explain boredom differently, necessitated the employment of qualitative methodology.

In respect to the issue of generalization of the findings, there are certain drawbacks, as in any qualitative research. As some research theorists (Firestone 1993, Malterud 2001) assert, generalizability of results is always problematic. The selected work-setting and the participants acquired very specific characteristics that make findings difficult to be transferred in other work environments. Clearly, it is not in my intention to argue that all psychiatric nurses or in all long-stay psychiatric wards employees suffer from boredom. The usefulness of qualitative studies lies in the fact that they provide thick descriptions about social life, processes and patterns of behaviour, which can be applied in similar forms in different settings (Payne & Williams 2005). When, for example, it is argued that the hospital inflicts feelings of boredom to employees, through its practices and through its culture, two things are suggested: first, that boredom is determined by such factors and therefore it is worth investigate

or test them in other settings and secondly, that occupational environments with similar characteristics may also inflict boredom to their employees.

Another methodological consideration is reflected in the role of the researcher in the field. Being a non-participant observer holds as many disadvantages as advantages. The basic opposition against this tactic concerns the effect of the researcher's mere presence on the behaviour of the group under study (Vinten 1994). An outsider (in contrast to the participant-observant) enhances the sample's awareness of the research process, makes individuals conscious about their overt behaviour and consequently creates biases in the data collected. At the initial stages in the field, this was particularly true. Nurses had all sorts of reactions to my presence: from being detached or ignoring me to making comments about what I should note down or openly asking me about the confidentiality of their conversations and behaviour (even though these were among the primary things ensured). Two things helped to overcome this problem: the first was the prolonged time spent in the field. Fieldwork was conducted in the period of approximately six months. This helped both the researcher and the sample to familiarise themselves with the new condition. A second factor concerned the researcher's stance in the field. Keeping notes secretly, attempting to join in the informal chatting of the group, keeping a low-profile, trying not to provoke with difficult questions (at least at the beginning of fieldwork) and generally giving the impression of being "on their side" were some of the characteristics of my behaviour. It should be noted, however, that such behaviour may not be appropriate in other settings and most importantly in other cultures. One has to get a sense of what is most likely to be accepted by the particular group under investigation.

13.6. Practical implications

In a recent survey, conducted by a private British human resources agency called Office Angels (www.office-angels.co.uk, 2006), about the cost of employees' boredom, it was identified that companies lose almost 6.85 billion pounds per year. This is only an indication of the direct and tangible affect of occupational boredom. Apart from the hours lost off work, bored employees may add extra costs to the hosting organization by consuming its resources for personal purposes, such as telephone use, internet surfing etc. A frequently observed phenomenon in the studied wards was nurses' abuse of the telephone for personal matters.

Boredom, as it was shown in the present study, was an indicator of hidden feelings, beliefs and practices. Nurses exhibited an unacceptable work and professional attitude by not carrying out their duties, being mentally or physically absent, expressing hostile or (at best) indifference to patients, occupying themselves with irrelevant-to-work activities etc. At a primary level, the conveyed boredom reflected only nurses' unwillingness to work properly.

However, at a deeper level of analysis, it was revealed that boredom was a phenomenon used to communicate deficiencies of the broader system. The importance of not attributing boredom only to the individual or to the inadequate fit between task and actor (as previous studies assert), lays in the realization that it may works as a sign of the insufficiencies of the organizational context. This is an aspect, extremely useful for managers because of its relation with broader organizational facets, such as structure, culture and practices.

The hospital administration expressed the same indifference towards both the staff and the patients. Nurses were accountable for the running of the wards, for the well-being of patients but without been given the full autonomy. A straightforward explanation, which has been supported by theories of organizational design, would attribute boredom to the lack of autonomy. Nurses were left alone to run the wards, but were given neither the guidance nor the power to make decisions. As it was revealed, this "false power" was exploited by nurses in the form of boredom, in order to attack a system that was not adequate either as a work environment neither as a therapeutic one. In a way, the responsibility assigned to nurses, without the merits of decision-making, was not wanted and it was expressed as boredom.

This issue applies in other contexts as well. Public sector organizations and in more general terms bureaucracies, share this feature with the studied hospital. Organizational structures that gather power at the top hierarchical levels and rely on strict procedures and extensive paperwork, create an environment where responsibility is diffused and its adverse effects, such as decreased job-interest and minimised effort, come along. Nurses' denial of responsibility for their behaviour was attributed and explained by three basic rationalizations: to the inherent deficiencies of the system, to the patients' nature of illness and lastly to the belief that someone else was more responsible or would simply do their job. Similarly, in bureaucracies the extensive distribution of work and the concentration of authority to top managerial positions may provide valid justifications for employees' unwillingness to provide

quality services. Certainly, such rationale is valid, as many studies have shown. However, when individuals fail to recognise their own share of accountability for their actions or apathy, then such claims become only excuses, which the system allows and provides.

Boredom was not a matter of inattention to task, as most theories agree upon, but a symptom which signifies that one does not care for the job. Tasks in the wards were carried out extremely fast and accurately and not at all inattentively, however, nurses' general stance betrayed indifference for the physical and mental well-being of the patients. In section chapter 10 the various ways of nurses' indifference were exemplified (accidents, use of derogative adjectives towards patients, limited interaction with patients).

This is of particular significance for the broader health sector. If boredom can occur in an occupation for which much is said about emotional labour, then the root of the problem is not only in the inadequate organizational design or practices, but in much deeper levels, as perhaps the education, training and the professional codes of ethics. In section chapter 3, section 3.3 it was presented the debate between nursing theorists about whether the "caring ethos" should be a vital part of nursing education or not. The problem is much complicated, however, by limiting the importance of "caring" in an occupation that has blurred boundaries, can lead, as the present study shown, to uninterested and bored nurses.

Although "caring" is an aspect of health professions, it entails the element of personal involvement and the lack of impersonality, a concept that can be applied in many types of service-work. This problem is most likely to occur in public services, where the competition is limited (or in some cases totally absent) and there is no need for organizations to acquire a competitive advantage because clients are obliged to use their services. Consequently, service organizations may suffer from boredom because of not adopting a client-oriented strategy. The application of such strategies not only ensures the provision of service-quality but also limits the impersonality with which clients may be dealt and in consequence may enhance employees' engagement and thus limit boredom.

Apart from the strategies employed by organizations in order to increase employees' interest towards the recipients of services, organizations affect employees' behaviour through more subtle means that are not always structured or controlled, such as their

norms and culture. Such facets are made known, at least to a small degree, at the initial phase of entering the organization. This research has made explicit that the socialization processes followed by the hospital were a determining factor for the occurrence of boredom. Actually, it was exactly the absence of any formal procedure for the assimilation of new employees and what this was communicating to the newcomers. Obtaining knowledge of the ways work was conducted and of the hospital' general function was a personal issue or, as the sample revealed, a matter of imitating older staff. The implicit message communicated by the administration, was that these newcomers were unimportant, just extra hands, without professional identity or significance. Consequently, registered nurses learned to forget their professionalism, while the non-educated ones learned to regard themselves as the management had predetermined. The indifference shown by the administration was reproduced by employees towards patients. Therefore, boredom, manifested as the absence of interest, was an emotion cultivated even from the early stages of employment. For that reason, it is extremely significant for organizations to develop socialization schemes that will engage new employees and will prevent feelings of indifference and boredom.

13.7. Next Stages

A primary and vital step in order to increase our understanding of occupational boredom would be to explore it in different settings and professions. It is already stated several times that the study of work boredom concerned mostly industrial jobs, conducted with students as samples or was of limited magnitude when it involved professionals. As the present research has demonstrated, boredom can occur in occupations, such as psychiatric nursing, that are described as challenging, which involve task variety and which obtain inherent meaning. While it was among the basic aspirations of this study to provide an account of boredom among professional, it was not fully succeed. By studying other professional settings and samples that have specific professional qualifications, we could specify the factors that affect boredom and thus be able to alter them and offer better work environments.

The incorporation of sociological and organizational culture studies proved to be a new basis for investigating work boredom. Past research has touched upon the issue of organizational design however it has neglected abstract concepts such as culture. Orrin Klapp (1986) in her book "Overload and boredom" asserts that western cultures impose boredom because they provide an excessive amount of stimuli without offering the time to individuals to get involved with them. A great example of this

proposition can be found in studies about boredom and leisure. Applying this concept to organizational settings provides us with a new field to explore. One of the findings of this research was that the hospital's culture inflicted feelings of boredom to employees. In fact, the reputation it had developed was such that employees preferred it because of the limited work that was taking place. Therefore, a next step in boredom research should be the thorough investigation of the ways that cultural factors impose boredom to employees.

The difficulty of studying boredom is comprised in its identification. Apart from the manifestations, such as inattention, day-dreaming, irrelevant-to-task thoughts, slow passage of time there are no other suggestions about how boredom may be expressed in a work environment. In this research, some additional signs were revealed, such as hostility among staff, low-sense of responsibility, low quality of interaction with recipients of services and mental absenteeism. It should be an imperative to study in a more organized and systematic fashion the relationship between these factors and boredom.

13.8. Conclusion

The following diagram (diagram 3) and text below summarises of the forgoing discussion of the results and indicates the development of boredom through the interaction of organizational, individual and job features.

Diagram 3: Boredom at Work
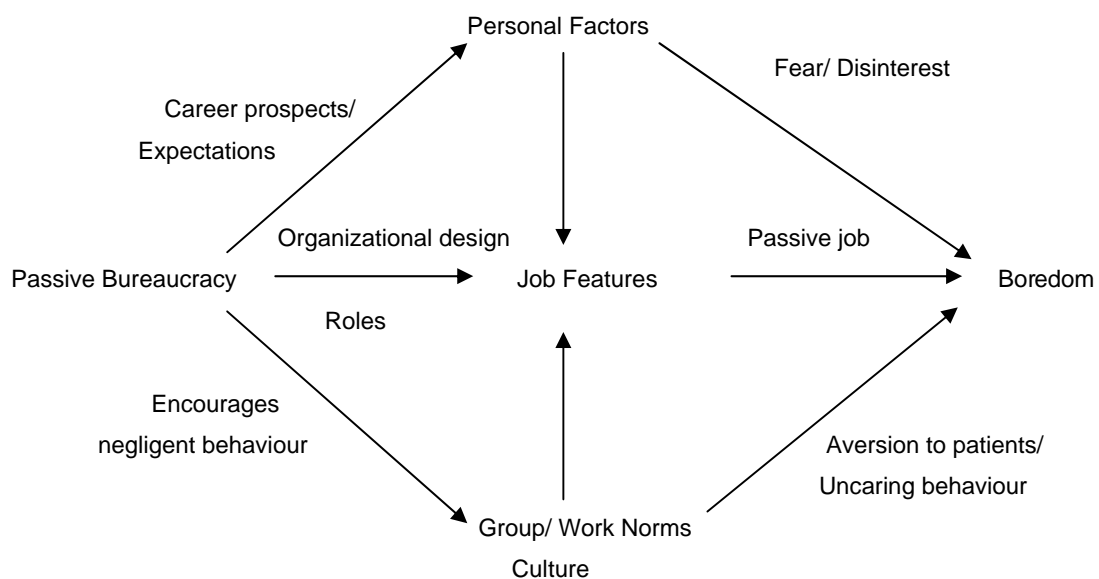
In this research boredom was studied in a new context (public psychiatric hospital) and in an occupation (psychiatric nursing) which is traditionally described as stressful and demanding. The basic aims of the study were:

- To investigate whether boredom existed in such setting.
- To identify the factors that influence boredom.
- To explore the manifestations of boredom.

In order to accomplish these objectives, literature from four major disciplines was recruited, namely: organizational psychology, cognitive psychology, personality and individual psychology and sociology. The employment of qualitative methodology (interviews and observations) was decided as the most appropriate for the aims of the research.

A major step in the study of occupational boredom, proved to be the incorporation of contextual factors and of sociological concepts. Whilst occupational contexts have been investigated by organizational psychology, this has only been conducted in terms of work design or by reference to factors existing across all types of companies and organizations (rules, procedures etc). The contribution of this research concerns the identification of cultural features of the hosting organization as determinants of work- boredom. A variety of intermingling factors were recognised as possible sources of nurses' apathy, indifference and boredom. Such these factors were: the hospital's history and reputation as an undemanding and "loose" work environment, the absence of systematic and organized socialization practices which transmitted the message of indifference towards new employees, the norms about the amount of effort extracted and work carried out, that prevailed throughout the whole hierarchy, the established negative attitude towards nurses as the "last cog" on part of doctors and management. It was seen that the hospital had developed over the years a culture of boredom, conveyed as indifference to staff and patients.

The influence of the above cultural features was reinforced or supported by specific attributes of organizational design. The low autonomy coupled with a forced responsibility, given to nurses due to the absence of doctors or other staff in the wards, created a blurred picture for nurses in respect to what they can and cannot do. Their chosen behaviour was to do nothing more than the absolute necessary. Performance measures and rewards, setting clear goals, supporting career advancement were not included as management strategies. Apart from the explicit

effects (e.g. on motivation) of such ill-defined design, there was also the problem of role-ambiguity. The application of such practices presupposes the existence of clear descriptions of jobs and roles, something that the hospital was lacking in. Nurses of all educational backgrounds had the same duties which were confined into the mere biological survival of patients. Having no therapeutic goals or plan and focusing on the basic needs of patients, not only affected nurses' role-perception but it also influenced their perception about patients. If doctors and administration did not care for patients' progress, it meant that it was not important or that those patients were "closed cases". The outcome was the detached and dehumanized way with which nurses behaved towards their patients and the limited effort extracted for patients' benefit.

Suggesting cultural features as influential factors of boredom, the logical assumption would be that individuals may play a vital role in the formation of such culture, since they are part of it. Personality and individual characteristics of the sample were found to contribute in the maintenance of these practices and ways of work. First, the majority of the sample was constituted of unskilled nurses, whose lack of qualifications constrict them from searching or knowing alternative modes of work and which further enhanced their pre-existing negative perceptions of mental illness. Trained staff had to succumb to the norms of this powerful group of practical nurses for two basic reasons: first, because they had fewer years of employment in the hospital and therefore they were not considered by older nurses as connoisseurs of the hospital practices or of the patients' condition/ needs. It was obvious that seniority determined authority and the power conflicts between the two groups resulted in the less amount of work conducted in the wards. The second reason was related to the unwillingness of newly-hired nurses to resist and propose novel ways of work. Most of them had chosen the particular hospital as their employer, on the basis of the limited work that was carried out in it.

The only point of convergence between the two groups was having no prior desire to enter the profession or the psychiatric hospital. And this was another factor that determined their subsequent behaviour.

In the studied wards, boredom was the outcome of many interrelated factors that were reinforcing each other. For example, the hospital did not have any specific recruiting and selection strategies and nurses had no prior preference to enter neither in the profession nor in the particular hospital. Boredom was constructed and

prevailed due to the association of multiple negative variables. As for the reasons of why sustaining a condition that leads to bored staff and ineffective practices, it was concluded that boredom had multiple functions: it provided nurses with a sense of "false power" or of "deceiving the system", it offered nurses a theme to occupy themselves instead of dealing with stronger emotions, such as the fear of mental illness and the aversion for patients, it functioned as a group/organizational norm that was justifying negligence and inappropriate behaviours.

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