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## Coping Styles Of Nurse Practitioners And The Effectiveness Of These Styles In Managing Stress

Carol J. Kolarik Smith

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COPING STYLES OF NURSE PRACTITIONERS  
AND THE EFFECTIVENESS OF THESE  
STYLES IN MANAGING STRESS

by

CAROL J. KOLARIK SMITH

A Thesis

Submitted in partial fulfillment of the requirements  
for the Degree of Master of Science in Nursing  
in the Division of Nursing  
Mississippi University for Women

COLUMBUS, MISSISSIPPI

AUGUST, 1991

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Coping Styles of Nurse Practitioners  
and the Effectiveness of These  
Styles in Managing Stress

by

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## Dedication

### To My Family

To my wonderful husband Jerry who has willingly and unselfishly endured and supported my commitment to complete this sometimes overwhelming project.

To my children, Michael and his wife Maria, Mimi and her husband David, and Tommy; you have been so patient and understanding through all of this.

To Jennifer, a grandmother's joy.

To my parents, Tony and Evelyn Kolarik, who have always been there for me.

I have truly missed all of you this past year.

To Nurses everywhere  
who cope effectively

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And last, but certainly not least, my heartfelt thanks to Lynn Smith, my special friend, classmate, mentor, confidante, counselor, and collaborator who was with me every step of the way and then some. No one will ever completely know what we have endured together. I will be forever grateful.

## Abstract

The purpose of this descriptive correlational study was to identify the coping styles used by nurse practitioners and determine the effectiveness of these styles in managing stress. The Roy Adaptation Model for Nursing was the theoretical framework used for this study. The research question which guided the data collection was what are the coping styles of nurse practitioners and how effective are these styles in managing the stress relative to functioning in the expanded role of nurse practitioner? The sample of convenience consisted of 72 nurse practitioners from Mississippi (30) and Tennessee (42) who completed and returned the survey questionnaire. Data were collected using the Jalowiec Coping Scale (JCS). A demographic questionnaire was used to identify variables such as age, sex, years of employment, and level of education. Major causes of work-related stress and other life stressors were determined by content analysis of two qualitative questions. Statistical analysis of the JCS included descriptive methods of quantitative responses. The most frequently used coping styles utilized by nurse practitioners were confrontive, optimistic, self-reliant, supportant, and emotive. The least used were evasive, fatalistic, and palliative. The

most effective coping styles were confrontive, evasive, supportant, and palliative. The least effective were optimistic, fatalistic, self-reliant, and emotive. Additional findings revealed there was no significant correlation between the demographic variables, coping styles, and coping effectiveness. However, there was significant correlations between the coping use and the coping effectiveness scores of the nurse practitioners.



## Table of Contents

	Page
Dedication.....	iii
Acknowledgements.....	iv
Abstract.....	v
List of Tables.....	ix
List of Figure.....	x
 Chapter	
I. The Research Problem.....	1
Introduction to the Problem.....	4
Theoretical Framework.....	7
Significance to Nursing.....	9
Assumptions.....	10
Statement of the Problem.....	10
Research Question.....	10
Definition of Terms.....	10
II. Review of the Literature.....	12
Overview of Coping.....	12
Nurses' Response to Stress.....	16
Nurses' Response to Stress and Coping.....	27
Conclusion.....	41
III. The Method.....	44
Variables.....	44
Research Question.....	45
Limitations.....	45
Setting, Population, and Sample.....	45
Instrumentation.....	46
Data Collection.....	49
Data Analysis.....	50

IV. The Findings.....	52
Results of Data Analysis.....	54
Additional Findings.....	66
Summary.....	68
V. The Outcomes.....	70
Summary of the Findings.....	70
Discussion.....	72
Conclusions.....	75
Implications for Nursing.....	76
Recommendations for Further Study.....	77
Research.....	77
Nursing.....	77
References.....	78
Appendices	
A. Demographic Survey.....	83
B. Jalowiec Coping Scale.....	85
C. Permission to Use Tool.....	90
D. Approval of Committee on Use of Human Subjects in Experimentation.....	92
E. Cover Letter to Participants.....	94

## List of Tables

Table	Page
1. Mean Coping Use and Effectiveness Scores.....	55
2. Mean Use Scores of Demographic Variables.....	58
3. Mean Effectiveness Scores of Various Demographic Variables.....	60
4. Work Stress Identified by Nurse Practitioners.....	65
5. Life Stress Identified by Nurse Practitioners.....	66
6. A Correlation of Coping Use and Effectiveness in Nurse Practitioners Using Pearson Product Moment Correlation Coefficient.....	68

List of Figure

Figure	<u>Page</u>
1. Coping use and effectiveness mean scores (range 0-3).....	56

## Chapter I

### The Research Problem

The term stress has often been linked with health related and helping professions. Nurses, teachers, physicians, social workers, and counselors are just a few of the professionals who fall into this category. Selye (1976) identifies stress as a threefold process. First, stress is an excessive rate of wear and tear on the body and occurs whenever the rate of the breakdown exceeds the rate of repair. Second, it is a nonspecific response of the body to any demand interpreted as a threat to physical or emotional homeostasis and third, a specific syndrome.

Nursing has been identified as an extremely stressful profession (Jacobson, 1983; Langemo, 1990). Over the past 20 years the literature which relates to stress in nursing has primarily focused on the various specialty roles in the nursing profession. Some of these specialties have included intensive care, hospice, and operating room nurses (Chiriboga, Jenkins, & Bailey, 1983; Larson, 1987). All of these studies concluded that the nurses employed in these specialty areas did experience stress; however, this stress appeared to be related to role expectations and role transition rather than the demands of the specialty itself.

The studies further concluded that this stress decreased as familiarity with the role occurred. Other factors, such as staffing problems, unexpected crisis, family demands, and a perceived lack of control, also contributed to the nurses stress.

In recent years, however, several studies have suggested that additional roles in nursing outside the specialty areas are also highly stressful. Ceslowitz (1989) examined the stress levels of staff nurses. The study found that staff nurses also experienced increased stress associated with role expectations. Stress for the staff nurse was affected by extraneous factors, such as staffing, patient and family demands, and lack of autonomy much like those employed in the specialty areas.

Much of the research done related to stress and the nurse indicate that regardless of the role of the professional nurse stress occurs. For example, caring for 45 acute medical-surgical patients with only one aide and one practical nurse, or being the only registered nurse on a 60-bed unit in a nursing home, can definitely qualify as conditions that are stressful (Jacobson, 1983). Nurse practitioners, functioning in the expanded role, also have increased demands which are stressful, such as managing the care of 15-20 ambulatory clients a day in a primary health care setting, professional isolation for those in freestanding clinics, and a lack of financial resources.

The stress that nurses experience is a significant factor in job satisfaction and performance (Jacobson, 1983). The stress experienced by nurse practitioners is usually the direct result of the expanded role expectations (Lukacs, 1982). More so than other nurses, nurse practitioners are expected to be active health care providers (Lukacs, 1982). By nature of the expanded role, nurse practitioners are explicitly accountable to clients for decisions and actions in health management (Baker, 1978; Moniz, 1978). Attributes, such as assertiveness, independence, and decisiveness, are essential for successful implementation of the nurse practitioner role.

Conflict occurs in the expanded role of the nurse practitioner because nurses have been traditionally socialized as helpers, not decision makers. Inconsistencies in role expectations for nurse practitioners occur among nursing educators, students, physicians, and patients. These inconsistencies can then result in stress related role conflict, uncertainty, and decreasing job satisfaction and performance (Edmunds, 1979; Mauksch, 1975). The identification of the stressful event and the causative stressor does little to resolve the stressful situation.

Jacobson (1983) identified that coping is the natural counterpart of stress. Coping is the person's effort to respond to and alleviate stress. The use of adaptive coping strategies by the nurse practitioner will effectively

relieve stress and facilitate a healthy lifestyle. Maladaptive coping strategies will be ineffective in alleviating stress and may be a catalyst for further stress (Jacobson, 1983).

### Introduction to the Problem

Selye (1974) defines stress as the response of a human being to the demands placed upon the individual, whether pleasant or unpleasant. As a member of a helping profession, nurse practitioners are exposed to a multitude of physical, psychological, and emotional stressors each day. Stressors are "agents or factors that challenge the adaptive capacities, thereby placing a strain upon that person which may result in stress and disease" (Luckman & Sorensen, 1987, p. 31).

Many of the stressors unique to nurse practitioners are rooted in the conflicts related to the changing role of women, the pressures of cost effectiveness in health care, and role confusion as to what a nurse practitioner does. Nurse practitioners must also deal with the role conflicts created by the expectations of others, since there is a wide diversity of opinion as to what the nurse practitioner should do (Lackman, 1983). Nurse practitioners who cannot cope effectively with the stressors associated with professional responsibilities cease to perform effectively, argue with colleagues, and are often ineffective with clients (Gillespie, 1986).



Lazarus (1966) refers to coping as problem-solving activities initiated by individuals when the demands tax individual adaptive resources and are relevant to the individual's welfare. This definition emphasizes the emotional element in coping and includes both the stressful and the gratifying aspects of that emotion (Jacobson, 1983).

Lazarus, Averill, and Opton (1974) define coping as a process characterized by "the continuous use of goal-directed strategies that are initiated and maintained over time and across encounters by means of cognitive appraisal and regulation of emotion" (p. 16). This definition identifies coping as an ongoing, cumulative activity that represents a gradual movement towards goals and is a necessary mechanism of growth (Jacobson, 1983).

Coping with stressful situations can therefore be seen as a process that involves four major tasks: (a) tolerating or relieving some or all of accompanying distress, (b) maintaining a sense of personal worth despite defeats, (c) maintaining positive interpersonal relationships, and (d) meeting the specific requirements of the stressful tasks (Lazarus, 1966).

Keeping in mind these general tasks, coping effectiveness can be thought of as a continuum from adaptive to maladaptive coping. Adaptive coping is resourceful in expending resources, meeting the demands of the stress, meeting the need of the individual, and is compatible with

group welfare. Adaptive coping also generates learning which can then be generalized to new situations (Jacobson, 1983).

Maladaptive coping strategies are detrimental to the individual's well-being. These maladaptive responses interfere with new learning, may generate additional and excessive stress, and may increase vulnerability to subsequent stress. Maladaptive coping responses may also consist of behavior that is too passive to generate the optimum level of involvement with stress that fosters learning and growth (Ziemer, 1982).

Ineffective maladaptive coping strategies may have a direct effect on patient care and job satisfaction of the nurse practitioner. These behaviors may include withdrawing from or avoiding the client; fostering client dependence, focusing on equipment rather than patients; denying, displacing, or suppressing feelings; and acting out negative feelings through absenteeism, tardiness, or failing to carry out assignments (Belodeau, 1973).

In order to function at an optimum level in the expanded role of nurse practitioner, it is imperative that nurse practitioners utilize effective adaptive coping strategies in the management of stress. For this reason, it is important to identify those methods of coping that are most frequently utilized and assess their effectiveness so that adaptive stress management can be initiated.

## Theoretical Framework

The Roy Adaptation Model for Nursing was selected as the theoretical framework for this study. Roy describes man as a biopsychosocial being who is in constant interaction with the changing environment (Roy, 1970). This interaction subjects the individual to a constant barrage of stressors with which one must cope in order to maintain homeostasis (Roy, 1980). Roy views coping as the behavioral control process initiated by the individual in an effort to respond to a stressor or to meet a need state (Rambo, 1984). These coping behaviors can be classified into four different adaptive modes and methods of responding: physiological, self-concept, role function, and interdependence (Marriner-Tomey, 1989).

The physiological mode is concerned with the structure of the body and the way it works. This mode involves the actions of cells, muscles, and hormones and the functions of all systems as they respond to stressors. The self-concept mode is concerned with meeting the psychological needs of integrity, self-image, and expression of feelings. This mode is the composite of beliefs and feelings that one holds about oneself at a given time. Role performance mode is the performance of duties based on various positions in society. Finally, the interdependence mode involves one's relations with significant others as well as support systems (Roy, 1980).

The multiple stressors with which nurse practitioners are faced demand adaptation in the physiological, self-concept, role function, and interdependence modes. Physiological adaptation is met by meeting the body's basic needs of nutrition, exercise, rest, fluid, and electrolytes. The self-concept mode of the nurse practitioner is often challenged through questioning of one's own knowledge level and identification of personal beliefs and values (Rambo, 1984).

The nurse practitioner faces many role functions and expectations as defined by society, peers, family, physicians, and self. This may result in many conflicting messages which can increase stress. Finally, the interdependence mode of the nurse practitioner involves maintenance of psychological integrity by meeting the needs of nurturance and affection.

Roy's model of adaptation can be operationalized by identifying the nurse practitioner as an adaptive person, using a variety of coping styles to alleviate stress in one or more of the four adaptive modes. The application of Roy's model of adaptation to nursing encourages and allows examination of the dynamic interface between person and environment (Scott & Howard, 1970), without which quality nursing care would be unattainable. Thus, coping and adaptation seem to offer a useful conceptual basis for clinical practice.

### Significance to Nursing

For the nurse practitioner who may be subject to stress each day, the need to identify effective means of coping with stressful situations is essential. The act of coping includes forms of problem solving as well as highly involved physical, psychological, and emotional efforts. The particular behaviors utilized to cope with a situation are called coping strategies. These responses are influenced by personality traits, developmental level, values, past experiences, coping strategies, and available resources. The person identifies the situation, comes to a decision as to what may be done, examines what has worked in the past and what is available now, and then responds.

Unique educational and self-evaluative opportunities exist when nurse practitioners can identify the practical significance of inappropriate coping and its subsequent impact on professional practice and health. With information gained from this study, nursing interventions to promote more effective coping can be tailored to meet individual nurse practitioner needs. As a result of continued accrual of data on coping behavior, contributions can be made to the conceptual bases for nursing practice (Jalowiec, Murphy, & Powers, 1984). By identifying various coping strategies, nurse practitioners will have a knowledge base to improve personal coping styles and assist others to cope more effectively.

### Assumptions

The assumptions of this study are:

1. Nurse practitioners experience stress.
2. Nurse practitioners use a variety of coping styles to alleviate stress.

### Statement of the Problem

It is impossible to completely remove the stress inherent in the expanded role of the nurse practitioner. However, many stressful situations can be minimized and alleviated with the use of effective coping strategies. This study identified the coping styles used by nurse practitioners and the effectiveness of these styles in managing stress.

### Research Question

What are the coping styles used by nurse practitioners and how effective are these styles managing stress?

### Definition of Terms

Coping styles: The eight conceptual coping styles identified by A. Jalowiec (personal communication, March 1991): confrontive, evasive, optimistic, fatalistic, emotive, palliative, supportant, and self-reliant. For the purpose of this study, the coping styles initiated by nurse practitioners will be operationalized by the Jalowiec Coping Scale.

Stress: The nonspecific response of the body to any demand made by internal or external stimuli as stated by the nurse practitioner and operationalized by the Jalowiec Coping Scale.

Effective: The extent to which the initiated coping style alleviates stress as indicated by the effectiveness score operationalized by the Jalowiec Coping Scale.

Nurse practitioner: A registered nurse, performing in the expanded role, and prepared through a formal educational program, obtaining either a Master of Science in Nursing or certificate.

## Chapter II

### Review of Literature

There is an abundance of literature related to coping and stress; however, little research has been done which examines the relationship of coping mechanisms and stress in nurses. This review of literature will first discuss the broad concept of coping. This will be followed by a general overview of literature related to nurses' response to stress. Finally, an examination of literature specific to the use of coping strategies by nurses who experience stress will be presented.

#### Overview of Coping

Throughout the past two decades there has been an escalating interest in research dealing with stress, coping, and coping strategies. To better understand the concept of coping, it is important to consider the models of coping that provide the framework for this concept and subsequent research.

Lazarus originally introduced a model of coping in 1966, and since that time this work has been expanded. Essentially, Lazarus considers coping to be a cognitive and transactional process whereby transactions are made between



the person and the environment: Coping mediates the relationship between the person and the environment (Lazarus, 1966).

Coping strategies are defined as behaviors that are directed toward modifying the stressors, redefining the situation, or alleviating stress (Dean & Lin, 1977; Lazarus & Launier, 1978; Pearlin & Schooler, 1978). People use different coping strategies that are relative to the particular stress situation encountered. When the individual discovers that some important motive or value is being threatened, coping activity is initiated as a result of this threat and by acknowledging that some aspect of personal being is in jeopardy (Lazarus, 1966).

Selye (1974) has contributed a great deal to the field of stress and coping with the development of his General Adaptation Syndrome (GAS). The GAS is a biological model which evolves through three stages: (a) the alarm reaction stage, (b) the stage of resistance, and (c) the stage of exhaustion. Selye (1976) believes that no one can live without experiencing some degree of stress all of the time. Not only can serious disease or intense physical and mental injury cause stress, but basic activities of daily living can also activate the body's stress response. It is the unique coping responses to these individual stressors that can make one person sick as a response to stress and yet invigorate and motivate another.

Pearlin and Schooler (1978) identified three major types of coping: (a) responses that change the situation that cause the strainful experience, (b) responses that control the meaning of the strainful experience after it occurs but before actual stress occurs, and (c) responses that function more for the control of stress itself after it has emerged.

In an effort to measure coping, Jalowiec and Powers (1981) developed a rating scale to assess coping responses to stress in their study with hypertensive and emergency room patients. This study compared the number and types of stressful life events (SLE) reported by persons with acute illness and by persons with chronic illness for a one-year period prior to illness onset. This study also identified methods used by the two groups in coping with stress, and explored the relationship between selected coping styles, levels of stress, and health status.

Fifty patients between 20 and 60 years of age volunteered to be interviewed. Twenty-five patients were newly diagnosed hypertensives referred for care at a university medical clinic, and 25 patients were seeking care at a university emergency room for non-serious acute illness. A convenience sample was used because of the limited number of hypertensive patients and the busy emergency room environment.

Stress was evaluated with a modified Rahe's stressful life event questionnaire. Coping was measured by a rating scale developed by the primary investigator. Results revealed that emergency room patients reported significantly more ( $p < .05$ ) SLEs for the one year preceding the onset of illness, although more hypertensive subjects rated their stress level as high. Emergency room patients experienced more SLEs in personal and social, home and family, and financial categories, while hypertensives experienced significantly more health related SLEs.

In order to measure coping behavior, a rating scale to assess individual coping responses to stress was developed by Jalowiec and Powers (1981). The literature on coping and adaptation was surveyed, and each coping strategy was listed on an index card. Following an extensive review of the literature, all coping mechanisms noted were collated, and based upon descriptive commonalities 40 coping strategies emerged. A Likert-type format with a five-point scale was used so subjects could rate each coping method according to degree of use.

This study found that the four methods most commonly utilized by both groups were identified as hope, control, objectivity, and abstract problem solving. Two methods were ranked as fifth and were identified as information seeking to enhance problem solving (emergency room subjects) and prayer and trust in God (hypertensive subjects). The least

used coping methods were characterized as negative ways of handling stress: blaming, resignation, alcohol, and ignoring. It is significant to note that the coping styles identified in this study were either adaptive (positive behaviors) or maladaptive (negative behaviors).

In summary, coping is the individual behavioral response that a person initiates enabling adaptation to stressful situations. These stressful situations may be in the form of extreme and unusual life change events or simply the persistent everyday life stressors that are encountered during the activities of daily living. Literature abounds with information and research that defines and discusses stress, coping, and coping strategies. Jalowiec and Powers (1981) developed a tool to identify coping behaviors and the effectiveness on stress. Since its development, this tool has been used extensively to identify coping behaviors in a wide variety of professions, illness states, and occupations.

#### Nurses' Response to Stress

Larson (1987) reports an investigation of internal stressors experienced by nurses which he describes as "helper secrets." The subjects consisted of 495 nurses participating in professional conferences and educational programs (seven in Northern California and one in Chicago). The nurses were asked anonymously to share "secret" behaviors, thoughts, and feelings related to their work by

writing them on uniform sheets of paper. The participants were asked to describe "difficult thoughts and feelings involving your work that you would definitely not feel comfortable openly telling to this group" (p. 20). Ninety-nine percent of the nurses were female and represented diverse clinical specialties. The 495 responses were analyzed using a content analysis procedure. A set of eight coding categories plus an "other" category was developed through examination of the responses. The author and a research assistant independently assigned each of the 495 responses to one of the nine categories; 87% agreement was obtained for all scoring.

Each of the categories reflected a different facet of the inner struggles of the nurses as they strove to be competent and caring health care professionals. The eight themes identified by this study were (a) Emotion and physical distancing, (b) "I feel inadequate," (c) "I'm angry," (d) "I'm in over my head," (e) "Too many demands," (f) Wishing for a patient's death, (g) One-way giving: "What about me," (h) "I want out," and (i) Other.

One of the most frequently occurring themes discovered in this study was the feeling of incompetence and inadequacy. Twenty percent of the "secrets" were assigned to this category. Larson (1987) believes these feelings to be understandable, considering the many challenges facing today's nurse, which include staying current with rapidly

changing medical technologies and negotiating complex psychosocial tasks. Feelings of inadequacies can also lead to an intense fear of error. Errors inevitably occur and the emotional consequences for the care-giver can be powerful and persistent.

A small group of secrets (3%) contained direct expressions of a desire to receive as well as to give. These secrets usually included a voice from within asking "what about me?" Conflicts occurred when the nurses felt they had no control over a situation and passively submitted to external demands rather than set limits in relation to their individual capacity to give. Nurses have a need for nurturance and self-care as a balance to giving and helping.

"Too many demands" was found in 5% of the disclosures. Being overburdened with multiple roles at work and at home created an inner turmoil that is kept concealed from others. Feelings of hating to fail, feeling manipulated and drained, and resentment were the hidden feelings and stressors.

Unspoken anger, frustration, and impatience--with patients, family members, co-workers, physician, and hospital administrators--accounted for another 20% of the inner secrets. These feelings can result in long-term feelings of guilt and depression.

"I'm in over my head" was expressed by 11% of the participants in the survey. Nurses are constantly moving back and forth on a continuum of emotional involvement, from

highly involved to less involved stances. Larson (1987) believed that every nurse must find a way to be emotionally involved with patients and families that is helpful, congruent with one's unique helping style, and not overwhelming.

Twenty-two percent of the participants reported descriptions of having actually emotionally or physically distanced themselves from patients, families, staff, or personal family, usually accompanied by explicit expressions of guilt. The paradoxical reality for the nurse in this situation is that these attempts to distance often raise, not lower, stress levels.

Five percent of the nurses confided they wished for their patients' death. When patients are enduring agonizing suffering, with no hope for recovery, or when the prognosis for a reasonable quality of life is poor, continuing lifesaving interventions can become a highly conflicted arena for the nurse. The frequency of such thoughts and feelings suggests that efforts to discuss staff feelings surrounding care of terminally ill patients are greatly needed.

A definite desire to leave the nursing field or to leave their current position was expressed by 3% of the participants. The other category accounted for 11% of the responses and included such items as multiple secret responses, philosophical comments, personal secrets,

unrelated work situation, and other responses not meeting the criteria.

Larson (1987) further demonstrated that individual differences in the tendency to conceal distressing experiences predict scores on indices of bodily and psychological health. The internal stressors of nurses can increase the likelihood of long-term stress related illnesses and burnout. In order to design appropriate interventions to prevent these health consequences, a better understanding of the origin of the helper secrets must be understood.

The origins of helper secrets are defined by Larson as tendency toward self-blame, unrealistic expectations, and discrepancies between real and ideal images of self as helper. What is so intriguing about many of these helper secrets is the fact that they are kept secret. The irony is that some, maybe all, of the nurse's co-workers are feeling the same way but most likely no one talks about it. When helpers do talk about their stress and learn to see it as an inevitable part of the work, constructive action can take place. When kept concealed, helper secrets can corrode from within; when revealed to empathic listeners, they can promote personal and professional growth and aid the nurse in meeting the challenge of caring.

As members of the helping profession, nurse practitioners are vulnerable to the internal stressors



described by Larson (1987). Emotional and physical distancing may be demonstrated by a lack of empathy and concern for clients and decreased time spent with clients during clinic visits. Feelings of inadequacy may occur in the novice practitioner and in difficult diagnostic situations. Anger with clients and family members occurs over lack of compliance, too many demands as a result of a busy clinic, and too many patients. Larson (1987) identified the importance of a strong support system for the nurse practitioner to promote the expression of external stressors and identify appropriate coping strategies.

The degree of burnout in both intensive care and nonintensive care nurses and factors associated with burnout in both groups were studied by Keane, Ducette, and Adler in 1985. The sample for this study consisted of all nurses on both the surgical intensive care unit (SICU) and the medical intensive care unit (MICU) of a large urban, university hospital. Two groups were also selected for comparison. The first consisted of all nurses on the medical and surgical intermediate care units. These units were chosen since they had some similarity to the intensive care units (ICU) with some variation in the level of stress. The second type of comparison group consisted of all the nurses on two general medical and surgical units in the hospital.

All of the nurses in the six units who had completed their 3- to 6-month orientation period were sent a letter

asking if they would participate in a study concerning stress in nursing. The letter explained that their supervisor would be asked to rate them on several factors but that all data would be anonymous and would not be individually identified. Only those nurses who agreed to participate were included in the study. The overall response rate was 54%.

The Staff Burnout Scale for Health Professionals (SBS-HP) was used to measure burnout. The SBS-HP assesses four aspects of burnout: cognitive, behavioral, affective, and psychophysiological. Dimensions of control and dimensions of challenge were assessed by Rotter's Locus of Control Scale and the Security Scale of California Life Goals Evaluation Schedule. To obtain an assessment of how the nurses felt about their job in a less structured fashion, each nurse was asked a series of open-ended questions that related to job performance and job satisfaction.

Keane et al. (1985) analyzed the data through a series of planned contrasts. The study concluded that nurses in ICUs do not experience more burnout than nurses in non-ICUs.

The Pearson correlations between the SBS-HP, the hardiness measures, biographical data, and supervisory ratings revealed that older nurses had slightly lower burnout scores, and nurses with baccalaureate degrees had somewhat higher levels of burnout than those with diplomas.

As expected, nurses who have greater degrees of alienation from work and self and feel more powerless experience higher levels of burnout as revealed by measures of the Security Scale. The total hardiness scores also correlated significantly with burnout.

To further describe the relationship between hardiness and burnout, a stepwise multiple regression was computed. The analysis indicated that alienation from work and locus of control (in that order) were the only variables to enter significantly into the prediction equation ( $p < .001$  for both). Powerlessness was the third variable to be entered, although it did not reach a conventional level of significance for inclusion ( $p < .08$ ).

The answers to the five open-ended questions were analyzed to ascertain if there were differences between the ICUs and the comparison groups. The nurses' responses to the questions concerning problems on their jobs were similar. For example, heavy patient load, inflexible work hours, and interference from physicians were the most common answers to what the nurses liked least about their jobs. The most common answer to what they liked best was the opportunity to work with and help people.

The data from this study indicated that nurses in the two ICUs did not differ in average burnout scores from nurses in other units. Also, there was no indication in the open-ended questions that ICU nurses were more negative,

felt more stress, or felt that success or failure on the job were caused by factors outside of their control. Overall, there was no indication in the data that ICU nurses could be differentiated from non-ICU nurses on any of the variables assessed.

This article is of significant importance to the nurse practitioner as it supports this researcher's assumption that nurse practitioners do experience stress and are vulnerable to episodes of burnout. Identification and development of effective coping strategies is of utmost importance for the nurse practitioner wishing to avoid the extreme consequences of stress burnout.

Olsen (1977) conducted a descriptive survey of 104 operating room (OR) nurses to determine what OR nurses perceived as stressful elements of their environment. The study included six hospitals; two that were state-funded and affiliated with a medical school, two privately funded hospitals, and two hospitals administered by a religious order. The number of procedures performed and the size of the OR nursing staff ranged from 10 to 45 nurses assisting in 15 to 70 procedures a day.

The nurses in the study were asked to respond to 68 items pertaining to potential OR stressful situations. A four-point Likert scale from 1 (no stress) to 4 (high stress) was used to determine those factors that the nurses perceived as stressful in the operating room environment. A

mean score was computed for each item. A score of 2.5 or greater was considered an indication of perceived stress. The group perceived the following categories as stressful: (a) physician attitudes, (b) equipment failure, (c) poor communication, (d) crisis situation, (e) policy changes, and (f) personnel shortages. When considering years of nursing experience and perceived stress, the researcher found no relationship between these two variables. However, when the participants were grouped by length of OR experience it was determined that as the length of experience in the OR increased, the stress perceived decreased. Olsen also found that position responsibility also affected stress. As the nurse moves up the hierarchy, stress increased when the surgeon arrived late, and when presented with the statements "Registered nurses should be phased out of the OR" and "There is no need for nursing in the OR." As the level of responsibility decreases, the level of stress increases with more task-associated situations as equipment failure and patient-associated situations as cardiac arrest. The stress scores revealed a curvilinear relationship between stress and position of responsibility. The study also revealed that there was no strong relation between the level of stress and educational preparation of the nurses included in the study.

As a result of these studies, Olsen (1977) concluded that OR nurses perceive stress in their work environment;

however, as the nurse becomes more familiar with role performance expectations less stress is experienced. The primary causes of OR stress are related to continual change which requires constant adaptation. The OR nurse must also cope with a variety of stresses derived from elements of human behavior that are peculiar to the OR situation as well as hospital policy, which is an element of the environment that can produce stress for each individual nurse.

Olsen (1977) discussed the stress experienced by OR nurses; however, this information can be easily applied to the stress experienced by the nurse practitioner. Nurse practitioners, like OR nurses, perceive stress in the work environment and familiarity with the work environment may decrease the amount of stress experienced. Just as continual change is a primary cause of stress in the OR nurse, nurse practitioners also experience continual change in the expanded nursing role. Changes in technology require constant adaptation and a variety of effective coping strategies used by the nurse practitioner. Identification of coping styles and the effectiveness of these styles used by nurse practitioners will provide a knowledge base for health professionals in stress management and stimulate interest for future research.

### Nurses' Response to Stress and Coping

Chiriboga, Jenkins, and Bailey (1983) conducted a study of stress and coping on hospice nurses in order to test and refine an analytic model of stress based on their previous research. The model builds on Lazarus' (1966) psychological framework of stress in which stress is defined as any event in which external or internal demands (or both) affect the adaptive resources of an individual.

The study sample consisted of 100 nurses employed full-time or part-time in hospice organizations. Supervisors of 27 hospice organizations provided their staff with the questionnaires. The resulting sample consisted of 80% of the RN staff of 20 hospices from nine states. The average number of registered nurses (RNs) employed in these hospice organizations was five, and each hospice organization served an average of 100 patients and their families. Fifty percent (50%) of the participants were aged 20 to 34, another 40% were 35-49; 57% were married; and 26% had experience at the graduate level.

The five factors in the psychological model of stress served to categorize the data obtained from open-ended and structured questions. The variables analyzed were age, marital status, and education for social conditioning; experience with death of close other (0 to 4+), motivation to join hospice, prior hospice experience, source of organizational pressure, initial work satisfaction, initial

work stress, and financial pressures for stress appraisal work; spouse, friend, and staff support for social resources. A modified version of the Lazarus Ways of Coping Scale was used to measure coping strategies. Nine factors were obtained from an oblique rotation factor analysis of the 75-item coping instrument. The sample on which the factor analysis was based included the 100 respondents plus an additional 89 respondents sampled in the same manner but with limited data. The associated internal reliabilities of the Cronbach scales all fall above the .50 lower level as appropriate to exploratory research. The nine strategies utilized by nurses in this study were defined as concerned behavior, anticipatory coping, professionalism, emotional avoidance, fantasized action, emotional response, meditation, conflicted behavior, and rationale action.

The results of the study revealed that hospice nurses who reported fewer experiences with death prior to entry, higher initial work stresses, and with secure financial status seemed to do better at coping with stress. Among the coping and resource variables, there was evidence that adaptive status could be predicted. Nurses who had a most favorable outcome to handling stress utilized professional orientation as a coping style, expressed their emotional responses to job-related stress, and used more cognitive coping strategies. Also, nurses who found their spouses and



the staff to be supportive seemed to have the most favorable outcome.

Social factors, such as marital status, age, and education, did not affect the overall outcome. Predisposing factors such as motivation for joining hospice, prior experience with hospice, and exposure to deaths of close others also did not affect overall outcome. However, exposure to deaths of close others predicted less favorable outcome at the trend level ( $p = .01$ ). Appraisal of work-related stress was the only variable to contribute significantly as a group. Nurses who felt most comfortable about their financial status had the most favorable outcomes. Surprisingly, nurses who reported less work stress during the period when they first entered the hospice organization did worse. The researchers found that nurses who had the most favorable outcome to stressful situations employed a professional orientation as a coping style, expressed their emotional responses to job-related stresses, and resorted to more cognitive or rational coping strategies. The findings from this study validate the importance of nurse practitioners to develop active, adaptive coping behaviors in order to effectively manage stress.

Ceslowitz (1989) examined the relationship between the use of coping strategies and burnout among 150 randomly selected staff nurses from four hospitals. The instruments

used were the frequency dimensions of the Maslach Burnout Inventory and Lazarus Ways of Coping Scale. In the canonical correlation analysis, two significant canonical variate sets classified nurses on the dimension of burnout. Nurses who experienced increased levels of burnout used the coping strategies of escape/avoidance, self-control, and confrontation ( $p < .001$ ). Nurses who experienced decreased levels of burnout used the coping strategies of planned problem solving, positive reappraisal, seeking social support, and self-control ( $p < .003$ ). Self-control coping, although present in both variate sets, was used to a lesser extent by nurses with decreased burnout levels. The positive relationship between planned problem solving and reduced burnout levels supports the theoretical framework of Lazarus and Roy's adaptation model. The Lazarus framework asserts that during the appraisal process, persons evaluate the effect of an event and available coping resources. Use of the available coping resources requires adaptation to the identified event. Persons with lower levels of burnout may perceive the event as amenable to change or they may perceive their coping resources as adequate. Either perception may promote the view that the situation is amenable to problem solving. The use of planned problem solving and seeking social support and positive reappraisal have been reported to result in the offering of greater

social support than when confronting and self-controlling coping were used.

The use of effective coping strategies can reduce stress and prevent burnout in the nurse practitioner. Maladaptive coping strategies are ineffective in alleviating stress and will only create further stress with which the nurse practitioner must cope.

In 1979 Oskins identified the situational stressors and coping methods used by intensive care nurse specialists. The three objectives of this study were (a) to identify the situational stressors perceived by the ICU nurse as present in the ICU environment, (b) to identify the coping methods used by the ICU nurse to manage stress, and (c) to measure the amount of life change stress in the ICU nurse by means of the Rahe Life-Change Event Scale.

The instrument used in this study was a questionnaire developed specifically to meet the objectives of the study. Based on previous ICU experience, literature review, and interviews with other ICU nurses, the researcher identified 12 potentially stressful case studies which were used for the questionnaire in the study.

The sample consisted of 79 intensive care registered nurses who had consented to participate. The sample represented 38% of the total population of ICU nurses employed in the adult intensive care units of the five participating hospitals. There were one male and 78 female

participants. The sample ranged from 20 to 50 years of age. Seventy-eight percent of the sample were from 20 to 30 years of age. The remainder of the sample was older than 30 years. A total of 44.3% of the sample had nursing experience exceeding 5 years. Those with 3 to 5 years of experience constituted only 19%, and those with 1 to 3 years of experience were the second largest group at 36.7%. This revealed a dropout area after 3 years of experience. A total of 75.9% of the nurses were staff nurses, and the remaining sample was supervisory personnel. The majority of the participants were diploma nurses (60.8%) and nurses with a Bachelor of Science in Nursing (BSN) at 26.6%. Interesting to note were certain deficiencies about the participants regarding stress management. A total of 60.5% had never participated in a course dealing with stress, and 64.6% had never been involved in a course dealing with crisis interventions. This deficiency indicated a definite need for continuing education in stress management for these nurses.

The data were analyzed by the use of descriptive statistics. The results of the study relative to the objectives revealed that (a) 75% of the sample agreed that five of the 12 situations were stressful. The stressful situations identified were poor staffing patterns, working with inexperienced float staff, families threatening to sue the hospital and staff, need for family counseling, and

personal crises of ICU nurse. The second objective which identified the coping methods used by the nurses revealed four coping strategies used 50% of the time. These coping strategies represented the following behaviors: to talk it out with others, to take definite actions on the basis of present understanding, to draw upon past experiences in similar situations, and to become anxious.

In analyzing the coping behaviors used by the ICU nurses, Oskins (1979) identified that many of the coping mechanisms seemed to be indicative of direct action. A stressful situation was perceived as threatening or challenging with increased anxiety levels causing the subjects to strike out at the problem angrily or to prepare to meet the worse situation. To relieve the increased anxiety level in order to function and solve the problem, the ICU nurses then used palliative modes, such as humor, rationalization, denial, projection, and crying to release tension and make themselves feel better.

The third objective was measurement of life stress by the Rahe Life-Change Event Scale. The Rahe scale indicates the amount of risk or tendency that an individual will have in developing illness from a particular stress level. Forty-three percent were in a no-risk category, while 57% were at risk in regard to health as indicated by the life-change score. Of this 57%, 20% were in the low-risk group, 21.5% were in the medium-risk group, and 15.2% were in the

high-risk group. The results of this data revealed that a significant number of participants showed some level of risk to their health from the stress levels that they were enduring.

Just as the nurse working in a critical care unit is faced with tremendous pressures, responsibilities, and emotional stresses, the nurse practitioner working in primary health care encounters pressures, responsibilities, and emotional stresses unique to the expanded role. The nurse practitioner is expected to be knowledgeable, resourceful, decisive, warm, friendly, supportive, and kind but is also expected to be objective. The client under stress is permitted to show anger, denial, hostility, negativism, or withdrawal; however, this behavior is inappropriate for the nurse practitioner experiencing stress. The nurse practitioner is often forced into a role in which stimuli are taken in but does not allow stimuli to be released. To avoid the loss of nurses in the practitioner role and diminished quality of client care, nurse practitioners must be aware of the situational stressors, the coping methods used, and the effectiveness of these strategies in alleviating stress.

Lukacs (1982) conducted a study which identified the frequency and length of adjustment periods among nurse practitioners, as well as feelings experienced by nurse practitioners as they adjusted to their new roles. An 84-

item questionnaire was distributed to 250 participants attending a 2 1/2-day continuing education conference on women's health in Seattle, Washington, in March 1980. Participation in the survey was voluntary, and respondents remained anonymous. In addition to the questionnaire, the participants also rated four sets of questions that addressed factors in the decision to seek nurse practitioner training: expectations of nurse practitioner training, feelings and experiences in the first 6 months of practice, and judgment regarding importance of selected factors in their present jobs.

The results of the study revealed that 86.7% of the participants experienced a period of adjustment for an average length of 5.9 months. It is interesting to note that the adjustment period of nurse practitioners who were the first in the clinical setting was significantly greater than the adjustment period for nurse practitioners who had been preceded by another. Fear of missing something and uncertainty regarding diagnosis and treatment were reported by participants as most descriptive of feeling during the first 6 months of practice. Consulting more often than necessary also received a high rating.

The nurse practitioners in this study identified that autonomy in work was the most important factor in their decision to seek nurse practitioner training, while taking action on feminist belief was the least important factor in

making the decision. This was followed closely by better working hours. Increased knowledge and skill was rated as the most realistic expectation for others considering nurse practitioner specialty, but higher pay was rated as the least realistic expectation.

The participants also rated pay as the poorest factor in their present position, along with opportunity to participate in clinic political decisions. Acceptance by clients received the highest rating in factors relating to present job, as well as acceptance by other nurse practitioners, and acceptance by other nurses.

This study documents the occurrence of a distinct adjustment period for nurse practitioners. It provides evidence that adjustment periods are a common phase of professional development for which nurse practitioner students can be prepared during the course of their training.

For the nurse practitioner in independent practice there are additional responsibilities which include political, economic, and social concerns. Nurse practitioners are often thrust into debates involving legal aspects of nursing practice, third-party payment, and cost-effectiveness of health services. It is essential to address such issues during the course of nurse practitioner training, preparing students to accurately appreciate



external influences that have great impact on their practice.

Results of Lukacs' (1982) study revealed that new nurse practitioners (< 6 months in role) experience uncertainty about their clinical abilities. Some practitioners recalled early frustration and uncertainty stemming from unclear job descriptions and little administrative support in their clinical setting.

Nurse practitioner program faculty can use the results of this survey to design "role adjustment" seminars and prepare preceptors who supervise clinical experiences for students.

This survey confirms a distinct "adjustment period" experienced by nurse practitioners in the first 6 months of practice. Factors identified by respondents and discussed in this paper can be used by faculty and preceptors to positively influence this adjustment. In addition, this survey supports the need for identification of coping strategies for effective stress management, especially during the role adjustment period.

In a study of nurse practitioners, Thibodeau and Hawkins (1989) sought to determine the level of confidence nurse practitioners have in their skills, their attitudes/values concerning the roles, and to discover the presence of any relationship between these two variables.

Examinations of the attitudes and values held by nurse practitioners concerning role components, model for practice, self-assessment of skills and knowledge can provide valuable information to enhance effectiveness of nurse practitioner performance. A descriptive, correlational design using the survey approach was done. A random sample of 135 subjects was selected from the NPACE (Nurse Practitioner Associates of Continuing Education) directory and its supplement of nurse practitioners which represented many specialty areas. The participants were mailed a brief explanatory cover letter, a consent form, a demographic survey, the self-assessment scale, and the attitudes/values scale which they were asked to complete and return in the stamped envelope within 2 weeks of receipt.

The self-assessment scale, developed by the researcher, consisted of 65 items that represented essential skills or knowledge related to the nurse practitioner role. The subjects were instructed to rate on a scale of 1 to 6 their levels of confidence regarding their ability to perform the skill or employ the knowledge listed in each item. The attitudes and values scale, also researcher-designed, consisted of 37 items related to nurse practitioner role functions. The participants were asked to indicate their levels of agreement with each statement on a scale of 1 to 6. Each item on the scale, as well as the total score, reflected the participants' orientation toward a medical or

a nursing model of practice. The tools were piloted for face and content validity and for reliability ( $r = +0.868$ ) using the test-retest method.

Seventy persons completed the survey, a return rate of 52%. The years employed in nursing ranged from less than one year to 40 years, with a mean of 17.61. The number of years employed in the nurse practitioner role ranged from less than one year to 16 years, with a mean of 7.20. All of the specialty areas were represented. The items in which the nurse practitioners had the least confidence were the ability to apply a conceptual model of nursing to practice, incorporating research into the nurse practitioner role, and the ability to perform a developmental assessment. The two items in which the nurse practitioners had the most confidence included knowing the component parts of the health history and knowing the difference between subjective and objective data. The nurse practitioners in this study appeared to have high confidence levels in their overall abilities to perform skills related to the nurse practitioner role.

The areas of least confidence were related to ability to apply conceptual models of nursing to practice and the ability to incorporate research into the practitioner role. The data revealed that nurse practitioners have a strong orientation toward a nursing model for practice, lending further support to the fact that nurse practitioners are not

junior doctors or physician assistants. Nurse practitioners in the sample had a clearly defined nursing identity and held attitudes and values that differentiated their functions from those of medical providers. Information about the relationship between attitudes and values and the self-assessments of nurse practitioners is useful since it helps to explain and understand role performance.

Dissonance between perceptions of one's ability to perform an activity and one's belief in the value of that activity can lead to role dissatisfaction and stress (Thibodeau & Hawkins, 1989). This lack of congruence might indicate a need for interventions to assist nurse practitioners in developing more positive self-perceptions. Conversely, agreement between self-assessment and values and attitudes can strengthen role perception and implementation. Congruence between attitudes and values and self-assessment could be interpreted as an indication of positive self-image in the role of nurse practitioner.

If nurse practitioners are to seriously promote their special expertise and identity as nurses, it seems critical to examine the models and values upon which their practices are based. This article further supports the assumption that nurse practitioners experience stress in the expanded role and strengthens the importance of developing effective coping strategies in an effort to alleviate stress.

## Conclusion

Stress is any event in which external or internal demands (or both) affect the adaptive resources of an individual (Lazarus & Launier, 1978). Coping strategies are defined as behaviors directed at modifying the stressors, redefining the situation, or reducing distress (Dean & Lin, 1977; Lazarus & Launier, 1978; Pearlin & Schooler, 1978). Various models to define coping and coping strategies have been defined by Lazarus, Selye, Pearlin, Schooler, and Jalowiec and Powers.

An investigation by Larson (1987) revealed that nurses experienced internal stressors which are not often shared with colleagues. The eight most common internal stressors are emotional and physical distancing, feelings of inadequacy, anger, lack of confidence, role strain, terminal patients, lack of self-nurturance, and wanting to leave the profession. The importance of a strong support system for nurse practitioners to express internal stressors was identified by this study.

Contrary to popular belief, Keane et al. (1985) found that nurses in ICUs do not differ in stress scores from nurses in other units. Also, there was no indication from the open-ended questions that ICU nurses were more negative about their jobs, felt more stress on their jobs, or felt that success or failure on the job was caused by factors outside of their control.

Olsen's (1977) descriptive survey with operating room nurses revealed that operating room nurses perceive stress in their work environment but experience less stress as the nurse becomes more familiar with the work environment. Also identified in this study was the necessity for a variety of effective coping strategies to alleviate the encountered stressors.

In 1983, Chiriboga et al. conducted a study of stress and coping on hospice nurses which revealed that hospice nurses who report fewer experiences with death prior to entry, higher initial work stresses, or who saw themselves as having a more comfortable financial status seemed to cope with stress better. Nurses who had a most favorable outcome to handling stress employed a professional orientation as a coping style, expressed their emotional responses to job-related stress, and used more cognitive coping strategies.

Ceslowitz (1989) examined the relationship between the use of coping strategies and burnout and found that nurses who experienced increased levels of extreme stress (burnout) used the coping strategies of escape/avoidance, self-control and confronting; and nurses who experience decreased levels of burnout used the coping strategies of planned problem solving, positive reappraisal, seeking social support, and self-controlling behavior.

In a similar study Oskins (1979) identified the situational stressors and coping methods used by intensive

care nurse specialists. The participants in this study identified five extremely stressful situations: poor staffing patterns, an experienced ICU nurse working with a high percentage of inexperienced medical pool personnel, families threatening to sue the hospital and staff, counseling needs of the families, and an ICU nurse with a personal crisis. In an effort to handle these stressors, four coping strategies emerged 50% of the time. These coping behaviors were to talk it out with others, to take definite actions on the basis of present understanding, to draw upon past experiences in similar situations, and to become anxious.

Studies by Lukacs (1982) and Thibodeau and Hawkins (1989) revealed that nurse practitioners experience additional stress related to adjustment period to the new nurse practitioner role and stress related to knowledge and confidence levels.

There is no indication in the literature that a study of coping behaviors and effectiveness has been conducted with nurse practitioners. Nurse practitioners experience stress on a daily basis, and in order to function at optimum level effective coping strategies must be employed to alleviate the encountered stress. Therefore, it is important to understand how nurse practitioners cope and how effective these coping methods are in managing stress.

## Chapter III

### The Method

This study identified the coping styles used by nurse practitioners and the effectiveness of these coping styles in managing stress. The design of this research was a descriptive, correlational study.

Polit and Hungler (1987) described descriptive research as studies "that have as their main objective the accurate portrayal of the characteristics of persons, situations, or groups, and the frequency with which certain phenomena occur" (p. 528). Correlational research "explores the interrelationships among variables of interest without active intervention on the part of the researcher" (Polit & Hungler, 1987, p. 528). In this study the Jalowiec Coping Scale was used to identify the coping styles utilized by nurse practitioners and evaluate the effectiveness of these coping styles in managing stress relative to the nurse practitioner functioning in the expanded role.

#### Variables

For the purpose of this study, the coping styles and effectiveness are the dependent variables, and nurse practitioners are the independent variables.



### Research Question

The research question that guided the investigator in this study was what are the coping styles used by nurse practitioners and how effective are these styles in managing stress?

### Limitations

The limitations for this study are these:

1. The sample size is limited to two states and thus prevents generalization.
2. It is difficult to accurately predict the beliefs, perceptions, and responses of the human subject.
3. It is impossible to control the intervening variables of each individual which would have a direct influence on how one answers the questionnaire.

### Setting, Population, and Sample

The setting for this study are the two southeast states of Mississippi and Tennessee. The population consisted of 482 certified registered nurse practitioners obtained from a list provided by the Mississippi and Tennessee Nurses' Association. The research sample of convenience was drawn from a random selection of 100 nurse practitioners from Mississippi and 100 nurse practitioners from Tennessee. The number of subjects in this study was 72.

### Instrumentation

Two instruments were utilized in this study to measure the dependent variables of coping styles and effectiveness. The first, a researcher-designed 12-item survey questionnaire identified pertinent demographic information (age, sex, race, marital status), educational background, and professional experience (see Appendix A).

The second instrument, which identified coping styles and their effectiveness, was the Jalowiec Coping Scale (JCS) (see Appendix B). Permission was obtained from Anne Jalowiec to use the JCS (see Appendix C). The scale was developed in 1977 and revised in 1987 by Jalowiec, for the purpose of identifying specific coping styles of individuals and the effectiveness of these styles in reducing stress.

At the beginning of the JCS questionnaire, space is provided to state a stress-related situation in which the researcher is interested. For this study, "functioning in the role of nurse practitioner" was the identified stressor. The subjects were asked to rate how often each of the strategies to cope with the identified stressor was used. A 4-point (0-3) rating scale (ranging from never used to often used) was used. An effectiveness rating scale was also part of the questionnaire. Subjects were asked to rate how helpful each strategy utilized had been in coping with the stressor listed on the front of the tool. A 4-point (0-3)

rating scale (ranging from not helpful to very helpful) was used to rate the coping effectiveness.

Jalowiec found that a dichotomous classification of coping strategies is too simplistic; thus a multidimensional approach needed to be used to characterize the richness and diversity of coping behavior. Therefore, when the JCS was revised, the coping items were examined conceptually to identify common themes shared by particular theoretical clusterings of the 60 coping strategies. Based on rational derivation of the conceptual content on the scale, eight coping styles emerged as being descriptive of the coping dimensions represented by the 60 items. These eight coping styles were labeled as confrontive, evasive, optimistic, fatalistic, emotive, palliative, supportant, and self-reliant.

The specific coping style and effectiveness score of each subject was determined by adding the scores of related questions:

Confrontive:	4, 13, 16, 25, 27, 29, 33, 38, 43, and 45 (possible range 0-30)
Evasive:	7, 10, 14, 18, 20, 21, 28, 35, 40, 48, 55, 56, and 58 (possible range 0-39)
Optimistic:	2, 5, 30, 32, 39, 47, 49, 50, and 54 (possible range 0-27)
Fatalistic:	9, 12, 23, and 60 (possible range 0-12)
Emotive:	1, 8, 24, 46, and 51 (possible range 0-15)
Palliative:	3, 6, 26, 34, 36, 44, and 53 (possible range 0-21)

Supportant: 11, 15, 17, 42, and 59 (possible range of 0-15)

Self-Reliant: 19, 22, 31, 37, 41, 52, and 57 (possible range of 0-21)

The overall score for the JCS was 0-180.

The JCS has undergone extensive psychometric testing. Test-retest reliability with a 2-week interval was .79 and with a 1-month interval was .78. The internal consistency of the total scale was .86 and .85 in two different samples. The construct validity of the scale was tested using data collected from 1,400 subjects. The overall measurement yielded a .95 coefficient of determination (Christman et al., 1988; Jalowiec et al., 1984). The raw coping style score was computed by adding the subjects' coping use ratings for all items within a given coping style. Likewise, the raw coping effectiveness score was computed by adding the subjects' effectiveness ratings for all items within a given coping style.

The mean use coping style score was then computed by dividing the subject's raw use score for a given coping style by the total number of items possible for that coping style. Similarly, the mean effectiveness score was computed by dividing the subject's raw effectiveness score for a given coping style by the total number of items possible for that coping style.

In addition to the JCS, two qualitative open-ended questions were asked. The questions were designed to

identify the most anxiety-producing aspect of the nurse practitioners' clinical and/or professional work experience and any other life stressor that the participant wished to identify.

### Data Collection

Permission to conduct the study was obtained from Mississippi University for Women's Committee on Use of Human Subjects in Experimentation (see Appendix D). Names of certified nurse practitioners were obtained from the state nurses' associations of Mississippi and Tennessee.

A research sample of 100 nurse practitioners from Mississippi and 100 nurse practitioners from Tennessee was randomly selected from these lists to participate in the study. A questionnaire was sent to each nurse identified as part of the random sample. Along with the questionnaire, a cover letter explaining the general purpose of the study was enclosed (see Appendix E). Informed consent was indicated by completion and return of the questionnaire. Anonymity was maintained by the absence of the participant's name on the questionnaire. A demographic and educational questionnaire was also sent to the practitioners which included two qualitative questions: What is the major source or cause of stress that you encounter in your work situation? What other life stressor are you presently experiencing that you feel contribute to your level of

stress? A self-addressed, stamped envelope was enclosed to facilitate the return of the questionnaire.

### Data Analysis

The data obtained from the demographic questionnaire and the JCS were analyzed using descriptive statistics including means, percentages, and frequencies. Descriptive statistics are used to accurately "portray the characteristics of persons, situations, or groups and the frequency in which certain phenomena occur" (Polit & Hungler, 1987, p. 528) and were appropriate for this study as the question sought to identify the coping styles used by nurse practitioners and the effectiveness of these styles in managing stress. Scores from the JCS were statistically analyzed through measures of central tendency and standard deviation. The measure of central tendency used with the JCS is the mean score. This score will determine the most frequently used coping styles and the most frequent levels of effectiveness. The standard deviation analysis will measure the degree of variability between the individual score and the total score. The Pearson  $r$  is a parametric test to determine the relationship between two or more variables (Polit & Hungler, 1987). For the purpose of this study, the Pearson  $r$  was used to test for correlations between specific demographic variables and coping use and coping effectiveness scores. Specific variables included age, level of education, years in nursing, years as a nurse

practitioner, years in current position, and hours worked per week. Other variables tested for correlation were coping use and coping effectiveness.

## Chapter IV

### The Findings

The purpose of this study was to identify the coping styles used by nurse practitioners and determine the effectiveness of these styles in managing stress relative to functioning in the expanded role of nurse practitioner. The coping style and effectiveness employed by the nurses who participated in this study were measured by the Jalowiec Coping Scale (JCS). A descriptive correlational design was utilized for this study. Major causes of work-related stress and other life stressors were determined by content analysis of the two qualitative questions:

1. What is the major source or cause of stress that you encounter in your work situation?

2. What other life stressor are you presently experiencing that contribute to your level of stress?

The sample for this study included 72 nurse practitioners from Mississippi (30) and Tennessee (42) who completed and returned the JCS and the demographic questionnaire. The subjects consisted of 4 (6%) males and 68 (95%) females. Ages ranged from 5 (7%) between the ages of 20-29, 23 (32%) between the ages of 30-39, 29 (40%) between the ages of 40-49, 13 (18%) between the ages of



50-59, and 2 (3%) between the ages of 60-69. Of the 72 respondents, 68 (94%) were white and 4 (6%) were black. Fifty-two (72%) of the participants reported being married, while 10 (14%) were single, 9 (13%) were separated/divorced, and 1 (1%) was widowed. Education, expressed in years, revealed that 11 (15%) respondents had 17 to 20 years, 4 (7%) had education levels of 21 to 25 years and another 11 (15%) did not respond. Five (7%) of the subjects had Associate Degrees, 9 (13%) had a diploma education, and 12 (17%) held a Bachelor of Science in Nursing. A greater percentage of the participants 44 (63%) held a Master of Science in Nursing while 1 (.05%) had an EdD, and 1 (.05%) had a DNSc.

Forty-three (60%) of the respondents reported Family Nurse Practitioner as a specialty area, with 4 (6%) in adult practice, 10 (14%) in pediatric practice, 8 (11%) in women's health practice, 1 (2%) in oncology practice, 1 (2%) in neonatal practice, and 5 (7%) indicating other. Years in nursing reported by the respondents were as follows: 14 (20%) had experience less than 10 years, while 11 (15%) had 11-15 years, 21 (29%) 16-20 years, 13 (18%) 21-25 years, 5 (7%) 26-30 years, 3 (4%) 31-35 years, and 4 (6%) more than 36 years.

The number of years reported in practice in the expanded role of the nurse practitioner were 18 (25%) 5 years or less, 18 (25%) 6-10 years, 27 (37%) 11-15 years,

and 9 (13%) 16-20 years. The majority of the respondents, 42 (58%), reported working in the current position less than 5 years, while 17 (24%) reported 6-10 years, 8 (11%) 11-15 years, and 4 (6%) 16-20 years, and 1 (2%) 21-25 years. The hours worked per week ranged from 17 (24%) less than 40, 44 (61%) 40 hours, and 11 (15%) more than 40 hours per week.

### Results of Data Analysis

Data were analyzed in order to answer the research question: What are the coping styles used by nurse practitioners and how effective are these styles in managing stress? Coping styles were reported as eight categories with a range and a mean being scored.

The standardized mean use score on the confrontive coping subscale ranged from 1.20 to 3.00, with a mean of 2.37. Evasive coping scores ranged from .08 to 2.23, with a mean of 1.28. Optimistic coping scores ranged from .67 to 2.89, with a mean of 2.01. Fatalistic coping scores ranged from .00 to 2.75, with a mean of 1.18. Emotive coping scores ranged from .00 to 2.60, with a mean of 1.70. Palliative coping scores ranged from .00 to 2.43, with a mean of 1.43. Supportant coping scores ranged from .00 to 3.00, with a mean of 1.89. Self-reliant coping scores ranged from .71 to 2.86, with a mean of 1.98 (see Table 1 and Figure 1).

Table 1  
Mean Coping Use and Effectiveness Scores

Coping Style	<u>M</u>	<u>SD</u>
<b>Use</b>		
Confrontive	2.37	.38
Evasive	1.28	.43
Optimistic	2.01	.46
Fatalistic	1.18	.56
Emotive	1.70	.48
Palliative	1.43	.44
Supportant	1.89	.56
Self-Reliant	1.98	.47
<b>Effectiveness</b>		
Confrontive	2.13	.52
Evasive	.87	.47
Optimistic	1.62	.52
Fatalistic	.66	.50
Emotive	.85	.42
Palliative	1.23	.44
Supportant	1.84	.57
Self-Reliant	1.67	.53

Note. N = 72. Range = 0 - 3.

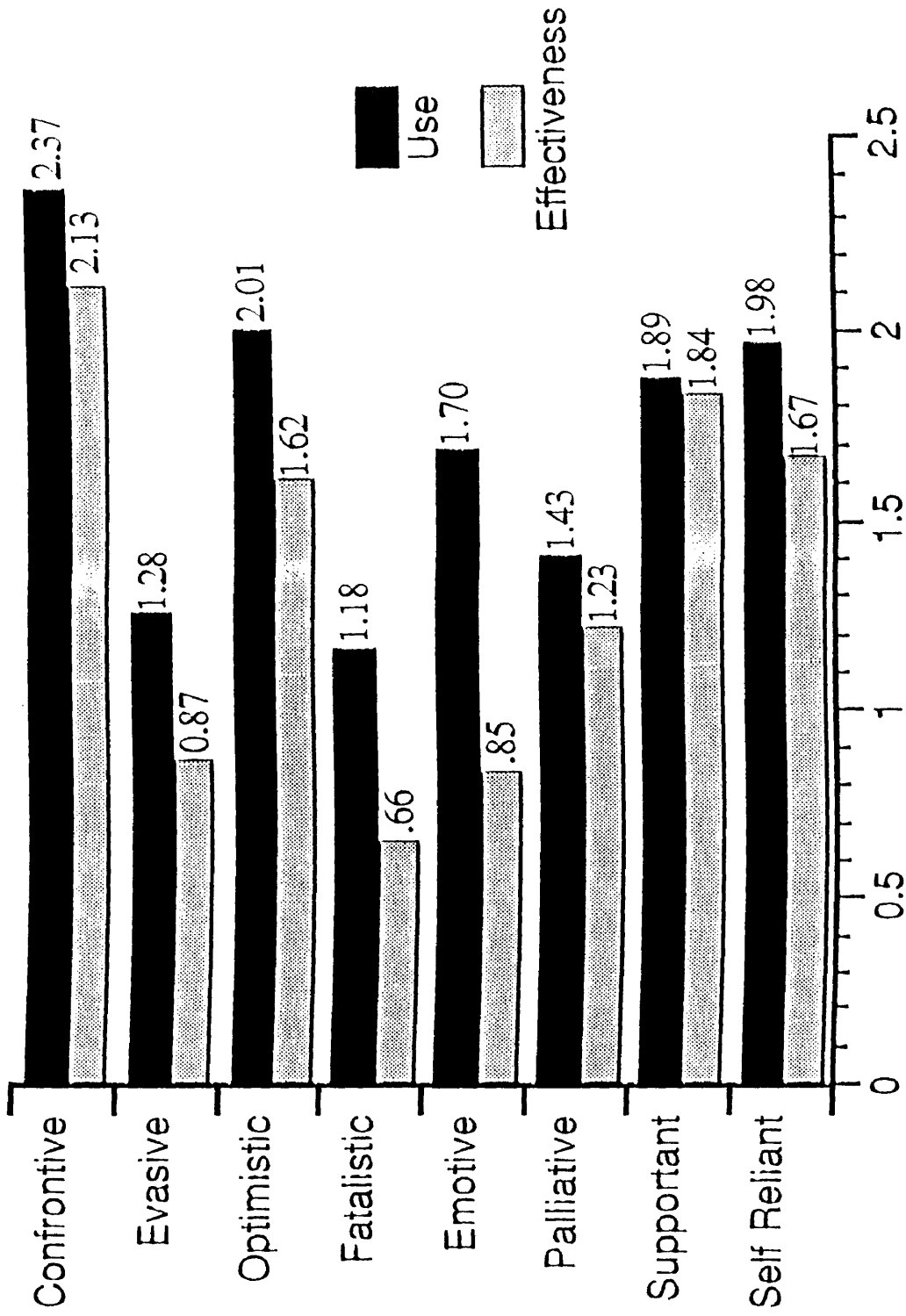


Figure 1. Coping use and effectiveness mean scores (range 0-3).

The effectiveness of the eight coping styles were reported in the same manner as utilization, with a range and mean being scored. The standardized mean effectiveness score for the confrontive effectiveness subscale ranged from .10 to 3.00, with a mean of 2.13. Evasive effectiveness subscale ranged from .15 to 2.0, with a mean of .87. Optimistic effectiveness subscale ranged from .11 to .26, with a mean of 1.62. Fatalistic effectiveness subscale ranged from .00 to 2.50, with a mean of .66. Emotive effectiveness subscale ranged from .00 to 2.00, with a mean of .85. Palliative effectiveness subscale ranged from .00 to 2.43, with a mean of 1.23. Supportant effectiveness subscale ranged from .40 to 3.00, with a mean of 1.84. Self-reliant subscale ranged from .00 to 2.86, with a mean of 1.67.

Tables 2 and 3 are provided to report the mean use and mean effectiveness scores of the demographic variables used in this study. These variables are identified as age groups, marital status, years of education, nursing education, years in nursing, years as a practitioner, years in current position, and hours worked per week.

Table 2

Mean USE Scores of Demographic Variables

Category	n	1 <sup>a</sup>	2 <sup>b</sup>	3 <sup>c</sup>	4 <sup>d</sup>	5 <sup>e</sup>	6 <sup>f</sup>	7 <sup>g</sup>	8 <sup>h</sup>
<b>Age</b>									
20-29	5	2.40	1.43	2.33	1.35	1.76	1.63	2.04	1.94
30-39	23	2.39	1.36	1.95	1.27	1.87	1.39	2.07	1.89
40-49	29	2.34	1.26	2.02	1.20	1.62	1.51	1.76	2.04
50-59	13	2.44	1.18	2.01	1.00	1.55	1.26	1.92	2.07
60-69	2	2.35	.88	1.83	.75	1.70	1.50	1.20	1.86
<b>Marital status</b>									
Single	10	2.33	1.27	2.08	1.17	1.36	1.50	1.86	1.87
Married	52	2.39	1.28	1.98	1.21	1.78	1.41	1.88	1.99
Separated/ divorced	9	2.34	1.27	2.14	1.16	1.57	1.49	1.97	2.06
Widowed	1	2.30	1.30	1.55	.25	2.00	1.14	1.60	2.14
<b>Years of education</b>									
16 & under	11	2.44	1.21	1.87	1.29	1.85	1.27	1.85	2.14
17	12	2.36	1.39	2.05	1.31	1.81	1.38	1.93	1.84
18	24	2.35	1.29	2.10	1.25	1.65	1.54	1.98	1.93
Over 18	14	2.36	1.09	1.84	.91	1.60	1.35	1.71	1.91
<b>Nursing education</b>									
Diploma	9	2.18	1.23	1.91	1.13	1.62	1.28	1.66	2.07
AD	5	2.58	1.23	2.17	1.30	1.80	1.54	1.64	2.31
BSN	12	2.45	1.16	2.12	.97	1.65	1.45	1.95	1.95
MSN	44	2.40	1.35	2.02	1.26	1.74	1.49	1.99	1.93
Other	2	1.80	.57	1.05	.50	.70	.71	1.00	1.92

<sup>a</sup>1 = Confrontive. <sup>b</sup>2 = Evasive. <sup>c</sup>3 = Optimistic. <sup>d</sup>4 = Fatalistic. <sup>e</sup>5 = Emotive. <sup>f</sup>6 = Palliative. <sup>g</sup>7 = Supportant. <sup>h</sup>8 = Self-reliant.

Table 2 - Continued

Category	n	1 <sup>a</sup>	2 <sup>b</sup>	3 <sup>c</sup>	4 <sup>d</sup>	5 <sup>e</sup>	6 <sup>f</sup>	7 <sup>g</sup>	8 <sup>h</sup>
Years in nursing									
10 & under	14	2.28	1.35	1.93	1.17	1.81	1.55	2.00	1.82
11-16	14	2.47	1.27	2.10	1.19	1.67	1.38	2.00	1.87
17-19	13	2.44	1.36	2.07	1.28	1.92	1.42	2.06	2.07
20-24	15	2.27	1.22	1.97	1.30	1.52	1.27	1.48	2.13
25 & over	16	2.39	1.20	2.02	1.01	1.61	1.54	1.94	1.96
Years as practitioner									
4 & under	15	2.50	1.42	2.16	1.23	1.96	1.48	2.10	1.97
5-7	13	2.32	1.20	1.80	1.15	1.63	1.53	2.06	1.86
8-12	18	2.37	1.32	2.16	1.22	1.81	1.50	1.77	2.07
13-15	17	2.38	1.25	1.94	1.13	1.64	1.31	1.75	2.07
16 & over	9	2.25	1.11	1.88	1.19	1.24	1.26	1.77	1.84
Years in current position									
1	16	2.47	1.34	2.02	1.23	1.91	1.38	1.92	1.95
2-3	16	2.45	1.37	2.18	1.17	1.71	1.67	2.00	2.00
4-6	14	2.27	1.32	1.99	1.30	1.65	1.45	1.97	1.94
7-10	13	2.39	1.20	1.86	1.01	1.49	1.32	1.67	2.17
12 & over	13	2.26	1.10	1.96	1.19	1.67	1.27	1.84	1.85
Hours worked per week									
Less than 40	17	2.16	1.40	2.11	1.33	1.51	1.45	1.83	1.84
40 hours	44	2.42	1.28	2.04	1.18	1.82	1.42	1.95	1.99
More than 40	11	2.50	1.07	1.74	.97	1.47	1.42	1.74	2.18

Table 3

Mean EFFECTIVENESS Scores of Various Demographic Categories

Category	n	1 <sup>a</sup>	2 <sup>b</sup>	3 <sup>c</sup>	4 <sup>d</sup>	5 <sup>e</sup>	6 <sup>f</sup>	7 <sup>g</sup>	8 <sup>h</sup>
<b>Age</b>									
20-29	5	2.18	.92	1.93	.60	1.00	1.40	2.12	1.80
30-39	23	2.23	.86	1.61	.68	.89	1.15	2.04	1.63
40-49	29	2.07	.91	1.71	.69	.81	1.30	1.73	1.73
50-59	13	2.15	.82	1.39	.67	.86	1.17	1.70	1.60
60-69	2	1.55	.61	1.05	.00	.70	1.14	1.30	1.28
<b>Marital status</b>									
Single	10	2.01	.75	1.78	.50	.66	1.24	1.66	1.72
Married	52	2.14	.88	1.60	.67	.87	1.22	1.89	1.63
Separated/ divorced	9	2.23	.97	1.59	.81	1.07	1.33	1.82	1.82
Widowed	1	2.00	1.00	1.33	.25	.00	.86	1.40	1.42
<b>Years of education</b>									
16 & under	11	2.24	.66	1.35	.66	.89	1.10	1.85	1.77
17	12	2.21	1.02	1.73	.83	.88	1.23	1.90	1.69
18	24	2.09	.83	2.71	.60	.83	1.19	1.79	1.67
Over 18	14	2.00	.75	1.49	.44	.74	1.22	1.84	1.46
<b>Nursing education</b>									
Diploma	9	1.90	.96	1.22	.75	.71	1.17	1.51	1.61
AD	5	2.34	.88	1.80	.60	1.08	1.40	1.68	2.00
BSN	12	2.25	.76	1.65	.60	.85	1.23	1.98	1.65
MSN	44	2.19	.90	1.71	.69	.88	1.27	1.92	1.69
Other	2	.85	.54	.72	.25	.30	.42	1.40	.42

<sup>a</sup>1 = Confrontive. <sup>b</sup>2 = Evasive. <sup>c</sup>3 = Optimistic. <sup>d</sup>4 = Fatalistic. <sup>e</sup>5 = Emotive. <sup>f</sup>6 = Palliative. <sup>g</sup>7 = Supportant. <sup>h</sup>8 = Self-reliant.



Table 3 - Continued

Category	n	1 <sup>a</sup>	2 <sup>b</sup>	3 <sup>c</sup>	4 <sup>d</sup>	5 <sup>e</sup>	6 <sup>f</sup>	7 <sup>g</sup>	8 <sup>h</sup>
<b>Years in nursing</b>									
10 & under	14	2.07	.76	1.69	.46	.80	1.24	1.94	1.55
11-16	14	2.35	.89	1.78	.82	.94	1.23	2.04	1.71
17-19	13	2.23	.90	1.58	.69	.83	1.18	2.01	1.74
20-24	15	2.02	.91	1.57	.78	.80	1.15	1.48	1.66
25 & over	16	1.99	.91	1.51	.55	.89	1.36	1.77	1.64
<b>Years as practitioner</b>									
4 & under	15	2.32	.94	1.71	.78	.92	1.31	2.09	1.79
5-7	13	2.15	.72	1.61	.52	.88	1.25	2.00	1.54
8-12	18	2.21	.94	1.75	.72	.91	1.19	1.72	1.84
13-15	17	2.09	.84	1.45	.60	.79	1.19	1.70	1.54
16 & over	9	1.68	.89	1.54	.64	.71	1.23	1.71	1.53
<b>Years in current position</b>									
1	16	2.28	.86	1.61	.66	.90	1.21	1.98	1.60
2-3	16	2.18	.86	1.79	.63	.75	1.37	1.86	1.80
4-6	14	2.22	.93	1.71	.82	1.06	1.27	1.88	1.71
7-10	13	1.91	.95	1.43	.69	.83	1.10	1.70	1.65
12 & over	13	2.00	.76	1.52	.50	.72	1.64	1.73	1.54
<b>Hours worked per week</b>									
Less than 40	17	1.94	.97	1.81	.76	.76	1.21	1.74	1.63
40 hours	44	2.20	.86	1.61	.66	.90	1.25	1.90	1.71
More than 40	11	2.16	.77	1.38	.50	.80	1.20	1.78	1.54

Data related to the two qualitative questions were analyzed using content analysis and were reported as emerging themes. The first question asked the respondents to cite the source(s) or cause(s) of work-related stress. Seventy-two (100%) of the respondents answered this question with many giving more than one response. Content analysis of this question revealed the following significant themes:

One theme identified as a source of stress was labeled as not enough time/work overload. This theme was derived from responses, such as "heavy patient load," "work overload," "deadlines to meet major productions," "too much to get done in number of hours worked," and "not being able to meet the needs of the whole person--social, physical, educational, emotional."

A second theme was labeled administrative/supervisory problems and was supported by comments, such as "lack of organization in the clinic," "bureaucracy of work place," "department politics," "poor management," "lack of understanding from the supervisor," and "frequent staff turnover" that were causes of work-related stress.

Conflict with support staff was a third theme identified. Examples of these responses included "inefficiency of staff," "personality conflicts with staff," "conflict with physician provider," "lack of professional nursing personnel," "staff does not put client first,"

"consistently provide poor care," and "tension between clerks."

A fourth theme was labeled role expectations/role performance and was derived from responses, such as "expectations beyond role," "supervising others," "isolated," "lonely," "staying current," and "lack of knowledge." Lack of financial resources, a fifth theme, was supported by comments as, "no money to care for identified medical problems," "problems with referral of medicaid clients," "inadequate funding for the program," "demands to see more patients to increase cash flow."

Noncompliance of client emerged as a sixth theme. Examples of this response included "noncompliance of patients," and "noncompliant mothers due to unconcern and/or ignorance." A seventh theme identified as a source of legal issues was derived from such responses as "pending liability," "fear of malpractice," and "fear of missed diagnosis" (see Table 4).

The second qualitative question asked the participants to identify what other life stressors that the respondents felt contributed to their level of stress. Fifty-nine (82%) of the respondents answered this question with several giving more than one response. Content analysis revealed two significant themes. The first theme identified was labeled family concerns and was further divided into three subheadings labeled responsibilities, illness/death, and

problems. The subheading identified as responsibilities was derived from responses, such as "family demands," "mother of three sons," "trying to be a good mother," "newly married," "trying to be an attentive wife/partner," "three children in college," "late life child," and "teenage daughters." The subheading illness/death included such responses as "brother with AIDS," "health problems," "mother seriously ill," "family illness," "death of parent," "miscarriage," and "husband with medical problems." The third subheading identified as problems was derived from such comments as "husband's job," "poor relations with family," "lack of understanding from husband," "separated from husband," "financial responsibilities" and "problem with adolescent male" (see Table 4).

Because of the unique nature of various individual responses, a second theme emerged which was labeled personal/individual concerns. This theme was derived from responses, such as "stress of being a single person," "sole supporter," "lack of personal time," "IRS audit," "loss of a friend," "working full time and going to school," "weight gain," "living in geographic area with different religion and mores that I'm accustomed to," "I don't like where I live," and "starting own business" (see Table 5).

Table 4

Work Stress Identified by Nurse Practitioners

Theme	<u>F</u> <sup>a</sup>	%
Not enough time/work overload	21	22
Administrative/supervisory problems	22	23
Conflict with support staff/peers	15	15
Role expectations/role performance	20	21
Lack of financial resources	6	6
Noncompliance of client	4	4
Legal issues	7	7
No stress	1	1

Note. Total responses = 96.

<sup>a</sup>F = How often the response was reported.

Table 5

Life Stress Identified by Nurse Practitioners

Theme	<u>F</u> <sup>a</sup>	%
Family responsibilities	29	36
Family illness	10	12
Family problems	11	14
Personal/Individual concerns	20	25
No other stress	11	14

Note. Total responses = 81.

<sup>a</sup>F = How often the response was reported.

Additional Findings

Reviewing the data led this researcher to question the possibility of a relationship between certain demographic variables and use and effectiveness of coping styles. Pearson's Product Moment Correlation analysis was employed to determine if a relationship did exist. An alpha level of  $p < .05$  was the level of statistical significance for this test.

There was no significant correlation between any of the demographic variables and coping style and effectiveness. However, there was a significant correlation between the eight coping use scores and the eight effectiveness scores.

The first correlations of confrontive coping and confrontive effectiveness resulted in  $\underline{r}(72) = .7088$ ,  $p < .05$ . Thus, those persons using the confrontive coping style found this style to be relatively effective in managing stress. Likewise, evasive coping and evasive effectiveness revealed  $\underline{r}(72) = .7397$ ,  $p < .05$ , and palliative coping and palliative effectiveness revealed  $\underline{r}(72) = .7068$ ,  $p < .05$ . These correlations indicate a strong relationship between the coping style used and the effectiveness of this style in managing stress for these subjects.

The correlation between the use of optimistic coping and optimistic effectiveness revealed  $\underline{r}(72) = .6038$ ,  $p < .05$ . When fatalistic coping use and fatalistic effectiveness were compared, the results revealed  $\underline{r}(72) = .5990$ ,  $p < .05$ , self-reliant coping and self-reliant effectiveness  $\underline{r}(72) = .5258$ ,  $p < .05$ , and emotive coping and emotive effectiveness revealed  $\underline{r}(72) = .3756$ ,  $p < .05$ . These correlations indicate a weak relationship between the coping style used and the effectiveness of this style in managing stress. Therefore, nurse practitioners found that confrontive, evasive, supportive, and palliative coping styles are more effective in managing stress than optimistic, fatalistic, self-reliant, and emotive coping styles (see Table 6).

Table 6

A Correlation of Coping Use and Coping Effectiveness in  
Nurse Practitioners Using Pearson Product Moment Correlation  
Coefficient

Variable	<u>N</u>	<u>r</u>	<u>p</u>
Effectiveness			
Confrontive	72	.7088	.000
Evasive	72	.7397	.000
Supportive	72	.7673	.000
Palliative	72	.7068	.000
Optimistic	72	.6038	.000
Fatalistic	72	.5990	.000
Self-reliant	72	.5258	.000
Emotive	72	.3756	.000

\*p < .05.

Summary

The results of this study revealed that nurse practitioners experience stress and utilize various coping styles in an effort to manage stress. The coping styles that were the most frequently used were confrontive, optimistic, self-reliant, supportant, and emotive; and the least used styles were palliative, fatalistic, and evasive. The effectiveness of these coping styles directly related to the frequency of use. The most frequently utilized coping



styles were the most effective in managing, and the least utilized coping styles were the least effective in managing stress. The two qualitative questions revealed that nurse practitioners experience a broad range of work-related stress and a significant number reported additional family and personal stress.

## Chapter V

### The Outcomes

The purpose of this study was to identify the coping styles used by nurse practitioners and the effectiveness of these styles in managing stress. The Roy Adaptation Model for nursing was the theoretical framework for this study. The research question which guided data collection was what are the coping styles used by nurse practitioners and how effective are these styles in managing stress relative to functioning in the expanded role?

#### Summary of the Findings

The sample of convenience consisted of 72 nurse practitioners from Mississippi (30) and Tennessee (42) who completed and returned the Jalowiec Coping Scale and the demographic questionnaire. The sample represented a 36% return of the questionnaire mailed to 200 nurse practitioners from Mississippi (100) and Tennessee (100).

The ages of the respondents ranged from 20 to 69 years, with the majority (40%) between the ages of 40-49 years, followed by 32% between the ages of 30-39 years. The subjects consisted of 95% female, 94% were white, and 72% reported being married.

Data were collected using the Jalowiec Coping Scale (JCS). A demographic questionnaire was used to identify variables, such as age, sex, years of employment, and level of education. Major causes of work-related stress and other life stressors were determined by content analysis of two qualitative questions:

1. What is the major source or cause of stress that you encounter in your work situation?

2. What other life stressors are you presently experiencing that you feel contribute to your level of stress?

Statistical analysis included descriptive methods of quantitative responses and content analysis for qualitative responses. Additional finding revealed significant correlations between the coping use and the coping effectiveness of nurse practitioners.

Findings indicated that the nurse practitioners most frequently used the confrontive ( $\underline{M} = 2.37$ ), optimistic ( $\underline{M} = 2.10$ ), self-reliant ( $\underline{M} = 1.98$ ), supportant ( $\underline{M} = 1.89$ ), and emotive ( $\underline{M} = 1.70$ ). The least used coping styles were evasive ( $\underline{M} = 1.28$ ), palliative ( $\underline{M} = 1.43$ ), and fatalistic ( $\underline{M} = 1.18$ ). The effectiveness scores indicated the nurse practitioners found the confrontive ( $\underline{M} = 2.13$ ), supportant ( $\underline{M} = 1.84$ ), self-reliant ( $\underline{M} = 1.67$ ), and optimistic ( $\underline{M} = 1.62$ ) styles to be most effective in managing stress. The least effective styles were palliative ( $\underline{M} = 1.23$ ), evasive

( $\underline{M}$  = .872), emotive ( $\underline{M}$  = .853), and fatalistic ( $\underline{M}$  = .660). The mean range for the coping use and coping effectiveness scores was 0-3, a score of 1.5 or above indicated frequent use and frequent effectiveness.

Content analysis of the nurse practitioners' response to the "work stress" qualitative question indicated not enough time/work overload, administrative/supervisory problems, conflict with peers, role expectations, financial resources, noncompliance, and legal issues as common sources of work stress. Content analysis of the "other life stress" qualitative question revealed family concerns and personal/individual problems as emerging themes of life stress other than that encountered in the work setting.

Additional finding revealed there was no significant correlation between any of the demographic variables, coping styles, and coping effectiveness. However, there was significant correlations between the coping use and the coping effectiveness scores. The coping styles most frequently used by the nurse practitioners were reported as the most effective styles in managing stress, whereas the coping styles used least frequently were reported as relatively least effective.

### Discussion

A review of literature did not contain any studies of coping behaviors and effectiveness with nurse practitioners; however, several related studies offer support for the

findings in this study. Jalowiec and Powers (1981) developed a rating scale in an effort to measure and assess coping responses to stress in their study of hypertensive and emergency room patients. The most common coping methods reported were hope, control, objectivity, problem solving, and prayer and were identified as adaptive (positive) behaviors. The least used coping methods were blaming, resignation, alcohol use, and ignoring identified as maladaptive (negative) behaviors. The results of this study support the efforts of Jalowiec and Powers (1981) since nurses in the expanded role most frequently employ the adaptive coping methods, such as confrontive, self-reliant, optimistic, supportant, and emotive which have been described as the coping styles that are most effective in managing stress.

The relationship between coping methods and situational stressors in staff nurses was studied by Oskins (1979). The nurses in this study reported five stress-producing situations: poor staffing patterns, high incidence of working with inexperienced staff, families threatening to sue the hospital and staff, counseling needs of the family, and personal crises of the intensive care unit (ICU) nurse. The coping methods initiated to manage these stressors were talking it out with others, taking action, draw upon past experiences, and taking action on the basis of present understanding. In this study nurse practitioners reported

the frequent use of confrontive coping (taking action), supportant coping (talking it out with others), and self-reliant (drawing upon past experiences) which supports Oskins' (1979) study of coping methods. Additionally, the emerging themes from the "work stress" were similar to the five situational stressors identified by Oskins (1979).

Studies by Lukacs (1982) and Thibodeau and Hawkins (1989) identified that nurse practitioners experience stress related to the new practitioner role and stress related to knowledge and confidence level. These findings are further supported by this researcher who found that role expectations/role performance were work-related stressors.

Larson (1987) identified eight common internal stressors which are not often discussed or shared among nurses. However, there is little significance between these eight internal stressors and the 11 external stressors identified by this researcher. Lack of confidence and role strain, as reported by Larson (1987), is the only internal stressor that directly relates to role expectation/role performance, an external stressor identified in this study.

Keane et al. (1985) found that ICU nurses do not differ in stress scores from nurses in other units. They concluded that nurses experience stress by nature of the complex demands of the professional role and perceived role expectations. The present study revealed that nurse

practitioners experience a wide range of work-related and life stress, thus supporting Keane et al.'s findings.

The results of this study further support the selection of the Roy Adaptation Model for Nursing as the theoretical framework for this study. The nurse practitioner emerges as the biopsychosocial being who is in constant interaction with the changing environment (Roy, 1970). In an effort to reduce stress, the nurse in the expanded role initiated a variety of coping behaviors that affects one or all of the four adaptive modes. These modes are identified as physiological, self-concept, role performance, and interdependence (Roy, 1980). The most frequently used coping methods of the respondents were the more adaptive (positive) styles. The least used methods were the maladaptive (negative) coping styles. The positive relationship between the use of adaptive (positive) coping methods and the effectiveness of these methods in managing stress further supports the theoretical framework of Roy's Adaptation Model.

### Conclusions

The participants in this study identified many methods of coping with stress which are utilized by nurse practitioners whose sources of stress are voiced. For the most part, stress was related to role-related concerns but a significant number of subjects in this study cited family and personal problems also. However, care must be taken

when generalizing the results due to the small number of subjects and limited geographical region represented by the participants.

Just as styles of coping vary so does the effectiveness of these styles. This study demonstrated that adaptive coping styles were most effective for the nurse practitioner. Roy describes adaptive and maladaptive processes and relates these to effective and ineffective mechanisms.

#### Implications for Nursing

Specific implications can be identified from the findings of this study. This researcher found that nurse practitioners employ a variety of coping methods to manage and alleviate stress. The coping styles reported as most effective by the respondents were those identified as confrontive (direct), optimistic (positive), self-reliant (self-controlling), and supportant (support seeking). The information gained from this study provides the basis for self-evaluation of personal coping methods and can allow for unique opportunities for stress management education for nurses in the expanded role. The identification of the significance of adaptive (positive) coping strategies as well as maladaptive (negative) coping strategies will enable the nurse practitioner to consciously attempt to select an appropriate coping strategy. The effective management of stress reduction can enhance professional practice and



improve overall health. In addition, the information gained from this study will provide additional data related to coping use and coping effectiveness and may help in developing strategies to promote and improve individual coping styles.

### Recommendations for Further Study

Based on the findings of this study, this researcher makes the following recommendations:

#### Research

1. Replicate this study using a larger, more representative sample size.
2. Include other geographical areas to allow for a more diverse population.

#### Nursing

1. Encourage the use of adaptive (positive) coping methods.
2. Identify maladaptive coping methods and intervene to avoid further problems with stress.
3. Provide and conduct stress management seminars for nurse practitioners in an effort to communicate effective coping strategies in order to increase the nurse practitioner's effective use of adaptive coping styles.

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## **APPENDICES**

**APPENDIX A**  
**DEMOGRAPHIC SURVEY**

## Demographic Survey

Age: 20-29\_\_\_\_ 30-39\_\_\_\_ 40-49\_\_\_\_ 50-59\_\_\_\_ 60-69\_\_\_\_

Sex: Female\_\_\_\_ Male\_\_\_\_

Race: White\_\_\_\_ Black\_\_\_\_ Hispanic\_\_\_\_ Oriental\_\_\_\_  
American Indian\_\_\_\_ Other\_\_\_\_Marital Status: Married\_\_\_\_ Single\_\_\_\_ Divorced\_\_\_\_  
Widowed\_\_\_\_

Level of Education: \_\_\_\_\_ (expressed in years)

Nursing Education: Diploma\_\_\_\_ AD\_\_\_\_ BSN\_\_\_\_ MSN\_\_\_\_  
Other\_\_\_\_

Occupation: \_\_\_\_\_

Job Title: \_\_\_\_\_

Number of Years in Nursing: \_\_\_\_\_

Number of Years as Nurse Practitioner: \_\_\_\_\_

Number of Years in Current Position: \_\_\_\_\_

Hours worked per week: \_\_\_\_\_

In the space provided, in your own words please answer the following questions:

What is the major source or cause of stress that you encounter in your work situation?

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What other life stressor are you presently experiencing that you feel contributes to your level of stress?

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**APPENDIX B**  
**JALOWIEC COPING SCALE**

## JALOWIEC COPING SCALE

This questionnaire is about how you cope with stress and tension, and what you do to handle stressful situations. In particular, I am interested in how you have coped with the stress of:

---

This questionnaire lists many different ways of coping with stress. Some people use a lot of different coping methods; some people use only a few.

You will be asked two questions about each different way of coping with stress:

### Part A

**How often have you used that coping method to handle the stress listed above?**

For each coping method listed, circle one number in Part A to show how often you have used that method to cope with the stress listed above. The meaning of the numbers in Part A is as follows:

- 0 = never used
- 1 = seldom used
- 2 = sometimes used
- 3 = often used

### Part B

**If you have used that coping method, how helpful was it in dealing with that stress?**

For each coping method that you have used, circle a number in Part B to show how helpful that method was in coping with the stress listed above. The meaning of the numbers in Part B is as follows:

- 0 = not helpful
- 1 = slightly helpful
- 2 = fairly helpful
- 3 = very helpful

**If you did not use a particular coping method, then do not circle any number in Part B for that coping method.**

COPING METHODS	Part A How often have you used each coping method?				Part B If you have used that coping method, how helpful was it?			
	Never Used	Seldom Used	Sometimes Used	Often Used	Not Helpful	Slightly Helpful	Fairly Helpful	Very Helpful
1. Worried about the problem	0	1	2	3	0	1	2	3
2. Hoped that things would get better	0	1	2	3	0	1	2	3
3. Ate or smoked more than usual	0	1	2	3	0	1	2	3
4. Thought out different ways to handle the situation	0	1	2	3	0	1	2	3
5. Told yourself that things could be much worse	0	1	2	3	0	1	2	3
6. Exercised or did some physical activity	0	1	2	3	0	1	2	3
7. Tried to get away from the problem for a while	0	1	2	3	0	1	2	3
8. Got mad and let off steam	0	1	2	3	0	1	2	3
9. Expected the worst that could happen	0	1	2	3	0	1	2	3
10. Tried to put the problem out of your mind and think of something else	0	1	2	3	0	1	2	3
11. Talked the problem over with family or friends	0	1	2	3	0	1	2	3
12. Accepted the situation because very little could be done	0	1	2	3	0	1	2	3
13. Tried to look at the problem objectively and see all sides	0	1	2	3	0	1	2	3
14. Daydreamed about a better life	0	1	2	3	0	1	2	3
15. Talked the problem over with a professional person (such as a doctor, nurse, minister, teacher, counselor)	0	1	2	3	0	1	2	3
16. Tried to keep the situation under control	0	1	2	3	0	1	2	3
17. Prayed or put your trust in God	0	1	2	3	0	1	2	3
18. Tried to get out of the situation	0	1	2	3	0	1	2	3
19. Kept your feelings to yourself	0	1	2	3	0	1	2	3
20. Told yourself that the problem was someone else's fault	0	1	2	3	0	1	2	3
21. Waited to see what would happen	0	1	2	3	0	1	2	3
22. Wanted to be alone to think things out	0	1	2	3	0	1	2	3
23. Resigned yourself to the situation because things looked hopeless	0	1	2	3	0	1	2	3

COPING METHODS	Part A How often have you used each coping method?				Part B If you have used that coping method, how helpful was it?			
	Never Used	Seldom Used	Sometimes Used	Often Used	Not Helpful	Slightly Helpful	Fairly Helpful	Very Helpful
24. Took out your tensions on someone else	0	1	2	3	0	1	2	3
25. Tried to change the situation	0	1	2	3	0	1	2	3
26. Used relaxation techniques	0	1	2	3	0	1	2	3
27. Tried to find out more about the problem	0	1	2	3	0	1	2	3
28. Slept more than usual	0	1	2	3	0	1	2	3
29. Tried to handle things one step at a time	0	1	2	3	0	1	2	3
30. Tried to keep your life as normal as possible and not let the problem interfere	0	1	2	3	0	1	2	3
31. Thought about how you had handled other problems in the past	0	1	2	3	0	1	2	3
32. Told yourself not to worry because everything would work out fine	0	1	2	3	0	1	2	3
33. Tried to work out a compromise	0	1	2	3	0	1	2	3
34. Took a drink to make yourself feel better	0	1	2	3	0	1	2	3
35. Let time take care of the problem	0	1	2	3	0	1	2	3
36. Tried to distract yourself by doing something that you enjoy	0	1	2	3	0	1	2	3
37. Told yourself that you could handle anything no matter how hard	0	1	2	3	0	1	2	3
38. Set up a plan of action	0	1	2	3	0	1	2	3
39. Tried to keep a sense of humor	0	1	2	3	0	1	2	3
40. Put off facing up to the problem	0	1	2	3	0	1	2	3
41. Tried to keep your feelings under control	0	1	2	3	0	1	2	3
42. Talked the problem over with someone who had been in a similar situation	0	1	2	3	0	1	2	3
43. Practiced in your mind what had to be done	0	1	2	3	0	1	2	3
44. Tried to keep busy	0	1	2	3	0	1	2	3
45. Learned something new in order to deal with the problem	0	1	2	3	0	1	2	3
46. Did something impulsive or risky that you would not usually do	0	1	2	3	0	1	2	3

COPING METHODS	Part A How often have you used each coping method?				Part B If you have used that coping method, how helpful was it?			
	Never Used	Seldom Used	Sometimes Used	Often Used	Not Helpful	Slightly Helpful	Fairly Helpful	Very Helpful
47. Thought about the good things in your life	0	1	2	3	0	1	2	3
48. Tried to ignore or avoid the problem	0	1	2	3	0	1	2	3
49. Compared yourself with other people who were in the same situation	0	1	2	3	0	1	2	3
50. Tried to think positively	0	1	2	3	0	1	2	3
51. Blamed yourself for getting into such a situation	0	1	2	3	0	1	2	3
52. Preferred to work things out yourself	0	1	2	3	0	1	2	3
53. Took medications to reduce tension	0	1	2	3	0	1	2	3
54. Tried to see the good side of the situation	0	1	2	3	0	1	2	3
55. Told yourself that this problem was really not that important	0	1	2	3	0	1	2	3
56. Avoided being with people	0	1	2	3	0	1	2	3
57. Tried to improve yourself in some way so you could handle the situation better	0	1	2	3	0	1	2	3
58. Wished that the problem would go away	0	1	2	3	0	1	2	3
59. Depended on others to help you out	0	1	2	3	0	1	2	3
60. Told yourself that you were just having some bad luck	0	1	2	3	0	1	2	3

If there are any other things you did to handle the stress mentioned at the beginning, that are not on this list, please write those coping methods in the spaces below. Then circle how often you have used each coping method, and how helpful each coping method has been.

61.	1	2	3	0	1	2	3
62.	1	2	3	0	1	2	3
63.	1	2	3	0	1	2	3

**APPENDIX C**  
**PERMISSION TO USE TOOL**

PERMISSION FOR USE OF JCS

PERMISSION IS HEREBY GRANTED TO

Carol Smith, RN, BSN

TO USE THE JALOWIEC COPING SCALE IN A RESEARCH STUDY

Anne Jalowiec 11/20/90

ANNE JALOWIEC, RN, PHD  
LOYOLA UNIVERSITY OF CHICAGO

**APPENDIX D**

**APPROVAL OF COMMITTEE ON USE OF  
HUMAN SUBJECTS IN EXPERIMENTATION**





MISSISSIPPI  
UNIVERSITY  
FOR WOMEN

Columbus, MS 39701

Vice President for Academic Affairs  
P.O. Box W-1603  
(601) 329-7142

May 28, 1991

Ms. Carol J. Smith  
c/o Graduate Nursing Program  
Campus

Dear Ms. Smith:

I am pleased to inform you that the members of the Committee on Human Subjects in Experimentation have approved your proposed study on "The Coping Styles Used by Nurse Practitioners and Their Effectiveness in Managing Stress."

I wish you much success in your research.

Sincerely,

A handwritten signature in cursive script, appearing to read "T. Richardson".

Thomas C. Richardson  
Vice President  
for Academic Affairs

TR:wr

cc: Dr. Blow  
Dr. Hill  
Dr. Barrar  
Dr. Rent

**APPENDIX E**  
**COVER LETTER TO PARTICIPANTS**

655 Eden Cove  
Cordova, TN 38018  
June 1, 1991

Dear Colleague,

I am a registered nurse and a graduate student at Mississippi University for Women. As my research project and thesis, I am studying the coping styles of nurse practitioners and the effectiveness of these styles in alleviating stress.

I am asking that you participate in this research project by completing the enclosed questionnaires.

When you have completed the questionnaires, please place in the enclosed return envelope and return to me as soon as possible.

Your participation in this study will be very useful to establish new findings in the field of stress management and coping strategies. Thank you for your cooperation.

Sincerely,

Carol Smith