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## The Relationship of Hardiness and Perceived Social Support to Nurses' Appraisals of Stress

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THE RELATIONSHIP OF HARDINESS AND PERCEIVED SOCIAL SUPPORT  
TO NURSES' APPRAISALS OF STRESS

By

Susan A. Groesser

A Thesis

Submitted to  
Grand Valley State University  
in partial fulfillment of the requirements for the  
degree of

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## ABSTRACT

### THE RELATIONSHIP OF HARDINESS AND PERCEIVED SOCIAL SUPPORT TO NURSES' COGNITIVE APPRAISALS OF STRESS

By

Susan A. Groesser

Lazarus' Stress and Coping Theory was used to examine the relationship between hardiness, social support, and nurses' appraisal of stress as a threat or challenge. This descriptive correlational design used a convenience sample of 40 registered nurses on orientation at a large West Michigan hospital.

Hardiness and social support were dichotomized by splitting them at the median. The proportion of the sample viewing orientation as a challenge versus threat was not significantly different regardless of their hardiness or social support status. The results were limited by lack of variation in stress appraisal (77% challenge) and hardiness levels, sample size, and limited sensitivity of measures. Additional significant findings indicated that (a) younger nurses viewed change as a challenge more frequently than older nurses and (b) more experienced nurses had a higher perceived satisfaction with social support than new nurse graduates. Implications for nursing are discussed.

## DEDICATION

To my husband, Terry, my son, Matthew, and my mother, Vivian, who have given me so much support and received so little of my time and energy in return. Also, to my Thesis Committee Chairperson, Patricia Underwood, Ph.D., R.N., who guided, encouraged, and mentored me through this challenging learning opportunity.

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## CHAPTER 1

### INTRODUCTION

Today's health care reform is causing a great deal of turmoil and "turbulence that is characterized by an unstable and rapidly changing clinical environment" (Salyer, 1995, p. 12). Fewer nurses are expected to deliver the same or higher level of quality care to patients who have high acuity levels. These high acuity levels are related to decreased length of hospital stays, severity of illnesses including Auto Immune Deficiency Syndrome, and the increasing age of the population. This pressure cooker environment may have a negative effect on nurses' job performance. Growing expectations of nurses may lead to decreased job satisfaction, frequent turnover, increased levels of stress, and burnout. Therefore, nurse administrators need to create and maintain clinical environments that support nurses' practice while helping decrease workplace stress and its' potentially debilitating consequences (Salyer, 1995).

Researchers have noted that some individuals appear to be more resistant to stress than others. These resistant individuals have been found to have high levels of hardiness. Hardiness has been associated with decreased reports of physical and mental symptomatology in individuals experiencing life events they consider stressful (Kobasa, 1982A). Hardiness, as proposed by Kobasa (1979A), "is a constellation of personality characteristics that function as

a resistance resource in the encounter with stressful life events and includes the personality dimensions of commitment, challenge, and control” (Kobasa, Maddi, & Kahn, 1982, p. 169). McCranie, Lambert, and Lambert (1987) pointed out that hardiness moderates the effects of stress by changing the perception of the situation and lessens the negative impact of stressful life events by influencing both cognitive appraisal and coping. The availability of resources such as social support may also affect stress appraisal (Folkman, Schaefer, & Lazarus 1979). Shumaker and Brownell (1984) further suggested that social support may serve to buffer the effect of a potentially stressful clinical experience. In addition, Parkes (1986) found that when there are supportive supervisors available to student nurses during major stressful episodes, the students are able to cope directly with serious work problems.

Nursing studies have found significant relationships between hardiness and decreased appraisal of stress with student nurses in an initial clinical nursing situation (Pagana, 1990) and between hardiness and decreased burnout with nurses working in all types of clinical units (Keane, DuCette, & Adler, 1985; Rich & Rich, 1987). A positive relationship between hardiness and the evaluation of challenge when using a workplace measure of social support was also supported (Pagana, 1990).

Lambert and Lambert (1987) proposed that nurse executives may find measures of hardiness to be a useful screening tool for nurses who might encounter high levels of stress in the workplace. They also suggest that hardiness measures could help to identify those nurses who need hardiness training to help decrease or prevent burnout and increase retention. Tartasky

(1993) reported that helping patients toward successful health behaviors is an important goal of nursing. She stated that if we can demonstrate that teaching hardiness to our patients will assist them to improve health seeking behaviors, it will result in nurses meeting one of their goals for intervention.

### Purpose

The purpose of this study was to examine nurses' initial appraisal of stress as a threat or challenge during orientation using Lazarus' Stress and Coping Theory. This study built on the previous studies relating hardiness and social support to cognitive appraisal of stress by examining these issues in relation to orientation of nurses to a new clinical position/role.

## CHAPTER 2

### THEORETICAL FRAMEWORK AND LITERATURE REVIEW

#### Theoretical Framework

Over the last twenty five years, as more and more stress related negative effects have been discovered, there has been a major increase in the amount of research done in the area of occupational stress (O.S.). In the Handbook of Stress, Holt (1993) states that “the basic proposition of the whole field of O.S. might be expressed thus: some aspects of many kinds of work have bad effects on most people under certain circumstances” (p. 344). Nurses, as previously discussed, are subjected to a great deal of work-related stress due to today’s turbulent and rapidly changing healthcare environment (Salyer, 1995). The literature is filled with research aimed at trying to alleviate the stress. Moderator variables discussed in O.S. research include physiologic, personality characteristics of individuals, social support from co-workers and supervisors, organizational structure, and support and involvement away from work (Holt, 1993). Two moderator variables, hardiness and social support, will be discussed following a presentation of Lazarus’ Stress and Coping Theory. His theory was used as the theoretical framework for this study.

Lazarus’ Stress and Coping Theory states that events are stressful when they are perceived by the individual in that way (Lazarus, 1966). Lazarus and

Folkman (1984) define stress as “a particular relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being” (p. 19). Along with their definition of stress, Lazarus and Folkman (1984) go on to describe two processes that occur in the person-environment relationship: cognitive appraisal and coping. Cognitive appraisal assists the individual in determining if a person-environment transaction is stressful. Coping is how the individual “manages the demands of the person-environment relationship that are appraised as stressful and the emotions they generate” (Lazarus and Folkman, 1984, p. 19).

According to Lazarus and Folkman (1984), cognitive appraisal is the evaluative process that focuses on the meaning or significance of the individual's person-environment transaction. They described two types of cognitive appraisal: primary and secondary. In primary appraisal the person evaluates whether he or she has anything at stake in the encounter (Folkman, Lazarus, Gruen, & DeLongis, 1986) and attempts to answer the question “am I in trouble or being benefited, now or in the future, and in what way?” (Lazarus & Folkman, 1984, p. 31). Secondary appraisal addresses the question “what, if anything, can be done about it?” (p. 31). These terms, primary and secondary, however, are not intended to indicate that one is more important than the other, or that one occurs before the other.

Lazarus and Folkman (1984) describe three types of primary appraisal: (a) irrelevant, (b) benign-positive, and (c) stressful. An irrelevant appraisal indicates that the transaction has no potential effect on a person's well-being. A benign-positive appraisal occurs when the transaction is viewed positively as

preserving or enhancing the person's well-being. Benign positive appraisals are characterized by pleasurable emotions such as joy, happiness, exhilaration, and peacefulness. Stressful appraisals are viewed as harm/loss, threat, and challenge. With harm/loss, some damage to the person has already occurred such as an incapacitating injury or illness, a negative effect on self- or social esteem, or loss of a loved one. Threat and challenge appraisals occur as an anticipatory view of a coming event. Threat appraisals are anticipated harms or losses that have not yet occurred and are associated with negative emotions such as fear, anxiety, and anger. Challenge stress appraisals focus on the potential for gain or growth as a result of the transaction and are associated with pleasurable emotions such as eagerness, excitement, and exhilaration. Threat and challenge appraisals are indirect indicators of whether an event is appraised as stressful. Threat and challenge appraisals are not mutually exclusive and can occur simultaneously. The relationship between threat and challenge appraisals can also shift during a transaction (Lazarus & Folkman, 1984). Situations that were previously viewed as more threatening than challenging can come to be viewed as more challenging than threatening through cognitive coping which helps the person view the situation in a more positive light or when changes occur in the environment for the better.

Harm and benefit appraisals are primarily retrospective and indicate the event has already occurred. The emotions associated with this type of appraisal are disappointment or happiness and are usually experienced when the outcome of the situation becomes clear (Folkman & Lazarus, 1985). Harm and benefit were not pursued here further because the focus of this paper was on the initial



appraisal of threat or challenge in a clinical situation.

Secondary appraisals of coping options are the aspect of the cognitive evaluative process during the person-environment transaction that help us determine what might and can be done. They include an evaluation that helps us decide what coping options are available, whether the options will accomplish what they are supposed to, and if the options could be applied effectively (Lazarus & Folkman, 1984). Secondary appraisal also evaluates constraints and coping resources including the person's health status, problem solving skills, social networks and support systems, generalized beliefs about self-efficacy and the environment, and utilitarian tools such as money or instructional manuals (Folkman, Schaefer, & Lazarus, 1979). Secondary appraisals interact with primary appraisals to shape the degree of stress experienced and the strength and type of emotional reaction. Other factors such as how high a stake a person has in the outcome and feeling helpless to deal with the demands encountered also affect the degree of stress experienced and the emotional reaction (Lazarus & Folkman, 1984).

Lazarus and Folkman (1984) discussed a third type of cognitive appraisal, reappraisal, which means a changed appraisal based on new information from the environment. This simply refers to another appraisal that follows an earlier one during the same transaction and modifies it. The reappraisal could also be the result of a cognitive coping effort.

Monat and Lazarus (1991) stated there is growing agreement among professionals that the definition of coping is "an individual's efforts to master demands (conditions of harm, threat, or challenge) that are appraised (or

perceived) as exceeding or taxing his or her resources” (p. 5). Folkman and Lazarus (1991) described two major categories of coping: problem-focused and emotion-focused. Problem-focused coping refers to efforts to improve the person-environment transaction by making changes such as obtaining information, refraining from problematic actions, and confronting persons responsible for the problems. Emotion-focused coping refers to mainly palliative thoughts or actions that are directed at relieving the emotional effect of stress but do not actually alter the threat or damage.

### Summary

The significance for nursing in using Lazarus' Stress and Coping Theory is threefold. People who tend to have challenge appraisals are more likely to have a higher morale because the emotions associated are more positive than with a threat appraisal. The quality of functioning may also be better with challenge appraisals because the individual feels more confident, less overwhelmed, and more able to draw on resources. Lazarus and Folkman (1984) also postulated that the physiologic stress responses with challenge appraisals would be different than with threat appraisals resulting in improved health due to fewer diseases of adaptation to stress.

Folkman and Lazarus (1991) further stated that the appraisals an individual makes are influenced by other variables including their own antecedent personality characteristics, beliefs, recognition of personal resources for coping, health, energy, the nature of the danger, and the existence and quality of social support. All these variables together help explain why two different individuals facing the same environmental encounters will appraise

them differently. Two of these moderating variables, hardiness personality characteristic and perceived satisfaction with workplace social support, were correlated with the cognitive appraisal of stress as threat or challenge in this study.

### Hardiness

Harris (1989), in her review of nursing stress, noted that there are many variables that affect the stress response and coping including the characteristics of the stressor, an individual's internal and external resources that effect his/her perception of the stressor, and the available coping mechanisms in the person's repertoire. Hardiness, an internal resource, is a personality characteristic that was conceptualized by Kobasa (1979A) based on the proposition that there were differences between the personality structures of persons who become ill when under a great deal of stress and persons who do not. Kobasa stated that hardy persons have three characteristics. The first is "the belief that they can control or influence the events of their experience" (p. 3). Hardy persons not only believe they can control the course of events but act that way as well (rather than helpless) when confronted with adversity. They have the perception that they can influence events and outcomes through their imagination, knowledge, skill, and choice so that these events are not experienced as overwhelming. Their coping actions are aimed at transforming events so they are more consistent with their overall life plan (Kobasa, Maddi, & Kahn, 1982).

The second characteristic of hardy persons (Kobasa, 1979A) is "an ability to feel deeply involved in or committed to the activities of their lives" (p. 3). Hardy persons have a tendency to become involved in encounters rather than feeling

alienated from them. They have a generalized sense of purpose and their cognitive appraisal of events leads them to identify with and find meaning in the events, things, and persons of their environment. These people do not give up easily and approach life directly rather than avoiding it (Kobasa, Maddi, & Kahn, 1982).

The third characteristic of hardy people (Kobasa, 1979A) is “the anticipation of change as an exciting challenge to further development” (p. 3). Events are viewed as stimulating rather than threatening. Coping behaviors lead to transforming oneself resulting in growth rather than trying to conserve or protect oneself (Kobasa, Maddi, & Kahn, 1982). It is important to clarify that challenge is used differently by Kobasa in describing hardiness than by Lazarus as an appraisal of stress. Kobasa refers to a challenge outlook as one that values change and unpredictability. Lazarus views challenge as a response to a particular stressful situation where there is opportunity for gain despite adversity (Pagana, 1990).

In recent years there has been some debate as to whether hardiness is a unidimensional construct as previously described or multidimensional. Hull, Van Treuren, and Virnelli (1987) reviewed hardiness research and found that the subscales of commitment, challenge, and control were not equally effective in predicting health. They suggested that the challenge component be eliminated. Florian, Mikulincer, and Taubman (1995) agreed because challenge showed no association with the other hardiness components and had no significant effect on mental health in their research. Ouellette-Kobasa (1993) conceded that improvements need to be made in measuring challenge.

Jennings and Stagers (1994) pointed out that an important consideration in measuring hardiness is to have the most appropriate tool. They suggested using Pollack's Health Related Hardiness Scale for individuals with chronic illness, the Family Hardiness Inventory for families, and Kobasa's instruments for the general population. Ouellette-Kobasa (1993) had a different suggestion. She recommended researchers go back to the original definition of "personality hardiness as a general orientation toward self and the world expressive of commitment, control, and challenge" (pp. 93-94) and use the appropriate tool to measure the correct concept. She views Pollack's work as "a measure of patients' attitudes toward health or a measure of patients' engagement in health promotion" (p. 94), not a measure of personality hardiness. Ouellette-Kobasa (1993) reaffirmed that the third generation hardiness test (Personal Views Survey) is the best measure available so far for personality hardiness. Other researchers also agree that the best way to measure hardiness is to use Kobasa's and Maddi's third generation hardiness scale (Personal Views Survey) (Duquette, Kerouac, Sandhu, & Beaudet, 1994). The Personal Views Survey was used in this study to measure hardiness.

### Social Support

Social support is an external resource that may also influence a person's appraisal of stress. Over the past 25 years there has been much written about social support in professional literature as a moderating variable for stress. Complicating the usefulness of the research on social support are the multitude of definitions of the concept.

In 1976 Cobb identified emotional support, esteem support, and network

support as three key aspects of social support. Kahn and Antonucci (1980) defined social support as “interpersonal transactions that include one or more of the following key elements: affect, affirmation, and aid” (p. 267). Affective transactions mean “expressions of liking, admiration, respect, or love. Affirming transactions refer to “expressions of agreement or acknowledgment of the appropriateness or rightness of some act or statement of another person”. Aid transactions refer to “transactions in which direct aid or assistance is given including things, money, information, time, and entitlements” (pp. 267-267).

Up to the 1980's social support was usually measured in terms of the presence or absence of supportive relationships including if the relationships were emotionally supportive (House, 1981). Kahn and Antonucci (1980) stated that research indicated the crucial difference in supportive relationships varied between the numbers zero and one. In other words, support from just one significant other was all that was needed to buffer stress effects on health and reduce the perception of stress that accompanies having to face stressful life events alone.

Shumaker and Brownell (1984) defined social support “as an exchange of resources between at least two individuals perceived by the provider or the recipient to be intended to enhance the well-being of the recipient” (p. 13). Harris (1989) stated that formal and informal support groups resulted in reduced stress. Lazarus and Folkman (1984) described social support as an emotion focused type of coping and discussed it's potential role as a buffer to stress as the most common description of it in the literature. They cautioned against making the assumption that having a social network is equivalent to getting support from it.

They pointed out that the relationships in the network may create social demands that could be interpreted as stressful rather than supportive.

House (1981) described social support as “an interpersonal transaction involving one or more of the following: (a) emotional concern (liking, love, empathy), (b) instrumental aid (goods or services), (c) information (about the environment), or (d) appraisal (information relevant to self-evaluation)” (p. 39).

Wortman (1984) discussed the types of support that were helpful for cancer patients including emotional support (reassurance that one is loved), the opportunity to discuss your feelings or the situation with someone, and the provision of information. She went on to say that “there is growing awareness that in many cases, well intentioned efforts of others to provide support may be regarded as unhelpful by the recipient” (p. 2347) and it is important to ask the recipient whether, in fact, the efforts or behaviors of others are helpful.

There are a wide variety of ways to measure social support due to the multiple definitions of this concept. As a result, researchers have been urged to use tools that measure specific aspects of the concept and then limit their discussions to what has been measured (Winemiller, Mitchell, Sutliff, & Cline, 1993). In this paper the aspects of love/caring, affirmation, information, listening, and aid were measured using the Perceived Social Support Scale developed by Underwood (1986) to measure the aspects of social support suggested as important by House (1981) and Wortman (1984).

### Literature Review

Stress. The following studies used Lazarus’ theory of Stress and Coping. Folkman and Lazarus (1985) conducted a study with 189 college psychology

students. The students completed a Stress Questionnaire that measured their appraisal of stress and social support and the Ways of Coping Checklist to assess their coping at three different times in relation to their mid term exam. The results showed that (a) stressful encounters should be viewed as a dynamic unfolding process, (b) that during any phase of an encounter people are likely to experience contradictory states of mind and emotion (both threat and challenge), (c) people cope in complex ways, (d) the type of social support (love/care, assistance, information) people use is determined by the demands of the stressful encounter and the changes in the demands as the encounter unfolds, and (e) at any phase of a stressful encounter there are substantial individual differences in emotion which reflect differences in cognitive appraisal and coping.

Folkman, Lazarus, Gruen, and DeLongis (1986) studied 150 adults to evaluate whether there was stability (consistency) in their use of primary and secondary appraisal and coping processes through many different stressful encounters. Their premise was that appraisal and coping processes would need to be fairly consistent across stressful encounters to have an effect on somatic health status and psychological symptoms. Their research indicated, on the whole, that there was more variability than stability in the processes. The results also showed that the more subjects had at stake and the more effort they put into coping, the more likely they were to experience psychological symptoms. There were no clear results related to somatic health.

Pagana (1988) studied the stresses and threats reported by baccalaureate nursing students during their first clinical experience. Her sample



consisted of 262 nursing students from different colleges and universities in Pennsylvania. Ninety four percent of the sample were female with a mean age of 22.4 years. Pagana modified Folkman's and Lazarus' 1985 Clinical Stress Questionnaire to measure the stresses and threats. The results showed that the students experienced 'quite a bit' of stress with a mean score of 2.7 out of a 0-4 score range. They identified six major appraisals of threat: (a) threat of inadequacy, 77.1%, (b) threat of making errors, 34%, (c) threat of uncertainty, 28.6%, (d) the clinical instructor as threat, 26%, (e) the threat of feeling scared, 19.5%, and (f) the threat of failure, 14.1%.

Pagana (1990) reported the results of her dissertation (Pagana, 1987) relating hardiness and social support to student appraisal of stress in an initial clinical nursing situation. This study had a sample comprised of 246 female nursing students with a mean age of 22.1 years. Male students were not included due to sex differences in the nature and function of social support. Challenge and threat were measured by Pagana's Clinical Stress Questionnaire, hardiness with Kobasa's and Maddi's third generation Hardiness Test, and social support with Norbeck's Social Support Questionnaire. The highest possible score for hardiness was 99.99 with actual scores ranging from 44.3 to 91.5. The mean score was 73.22 and the standard deviation was 8.17. Challenge and threat appraisals were identified by averaging the challenge (7 items) and threat scales (6 items) and determining mean scores for each. The study findings showed that hardiness was positively, but weakly, related to challenge appraisal ( $r = .23, p < .001$ ). Hardiness was not shown to be negatively related to threat appraisal ( $r = .10, p = .07$ ). Social support was positively related to challenge appraisal only

when a work-related measure of support was used ( $r = .11$ ,  $p = .05$ ). The fourth hypothesis, that there would be a negative relationship between social support and threat, was not supported. Pagana's (1990) fifth hypothesis, "those who have high levels of hardiness and social support will be more challenged and less threatened than those with low levels of hardiness and social support" (p. 257) also was not supported.

Pagana (1990) stated that she had expected her research to show more support for the hardiness theory than it did. She suggested that some of the difference between what she found and what she had expected to find could have been due to her use of the third generation hardiness tool. She noted that Kobasa (1979 A; 1979B) had used an earlier version of the tool in her prior research, which might have accounted for some of the unexpected results. Pagana also pointed out that her study had been conducted with all female subjects. She encouraged researchers to do more studies using female subjects to determine if females respond differently than males to measures of hardiness. Pagana's study was extended in the research reported in this paper.

Another study (Burns & Egan, 1994) used a convenience sample of 50 female junior level university nursing students with data collection occurring at the beginning of the term and immediately before the mid-term exam. The purpose of this study was to test the cognitive appraisal component of the Lazarus Stress Theory. The variables included: "(a) anticipated difficulty, harm, and benefit of the exam (primary appraisal of the situation); (b) anticipated control in the exam situation (secondary appraisal); (c) personal stakes (what is at stake for the person in the situation; a part of primary appraisal); (d) challenge

and threat perceptions (the nature of the stress appraisal); and (e) examination grade (the outcome of the situation)" (p. 23). The findings indicated the amount of control students perceived they had over the exam was related to their level of threat or challenge (more control equaled more challenge). Harm was significantly correlated with grade and was also correlated with threat.

These studies show that stressful encounters are dynamic in nature, that both threat and challenge may be experienced at the same time, that coping varies related to the type of stressful encounter, and that the greater the stakes the more psychological symptoms will be experienced. They also show that hardiness and work-related social support have been positively related to challenge appraisals. Limitations of the previous studies include (a) use of a convenience sample (Burns & Egan, 1994), (b) use of self-report measures (Folkman & Lazarus, 1985; Pagana, 1990), (c) only five stressful encounters were analyzed (Folkman, et al., 1986), and (d) subject bias due to related college course work (Folkman & Lazarus, 1985).

Hardiness. Kobasa (1979A; 1979B) conducted a retrospective study with two groups (based on illness signs) of middle and upper level male executives who had high degrees of stressful life events during the previous three years as measured by Holmes and Rahe (1967) Schedule of Recent Life Events and the Social Readjustment Rating Scale (Rahe, Lundberg, Theorell, & Bennett, 1971). One group ( $n = 86$ ) who had experienced high stress did not become ill, while another group ( $n = 79$ ) became ill after experiencing stressful life events. Wyler, Masuda, and Holmes (1968) Seriousness of Illness Survey was used to measure illness. The results showed that there were higher levels of hardiness (stronger

commitment to self, an attitude of vigorousness toward the environment, a sense of meaningfulness, and an internal locus of control) with those experiencing high stress/low illness as compared to those with high stress/high illness.

In 1981 Kobasa, Maddi, and Courington utilized a prospective longitudinal study design to evaluate the effects of the hardiness personality and constitutional predisposition for illness on the stressful life events-illness relationship. Self report surveys were used to measure hardiness, stress, and illness with middle and upper level managers ( $n = 259$ ). Constitutional predisposition data were obtained from the subjects' medical history. The results indicated that stressful life events and constitutional predisposition were positively correlated with the development of illness while hardiness was negatively correlated with illness.

Kobasa, Maddi, and Kahn (1982) reported on their five year prospective study that tested the hypothesis that hardiness functions to decrease the effect of stressful life events in producing illness symptoms. The results supported the hypothesis that hardiness functions as a resistance resource in preserving health.

Kobasa's (1982A) study of 157 lawyers failed to show the association that had been previously found between stress and illness. However, there was a significant correlation between their stressful life events and the measure of strain which lists physical and mental symptoms that are frequently seen with stress. The hardiness components of commitment and control were significantly correlated with decreased scores of strain.

Kobasa (1982B) tested the generalizability of hardiness and stress

resistance in women by evaluating the responses of 100 gynecology outpatients for stress, hardiness, and psychiatric symptomatology. She found that the 40 women who were high in stress and low in psychiatric symptoms scored high in hardiness. The 60 women who scored high both in stress and psychiatric symptoms had significantly lower levels of hardiness than the women who had low levels of psychiatric symptoms.

Keane, DuCette, and Adler (1985) conducted an ex post facto study in a large urban university hospital using a multiple correlation design to determine if nurses in ICUs experience more burnout than those in non ICUs and if nurses with higher levels of hardiness experience lower levels of burnout than those lower in this trait. In this study a convenience sample of 96 RNs from ICUs and general medical-surgical units was used without identifying their gender. The variables measured included: (a) age, marital status, education, years as a nurse, years in current position, and hours worked per week, (b) hardiness using Kobasa's Hardiness Scale, and (c) burnout with Jones' Staff Burnout Scale for Health Professionals. The findings showed that nurses in the ICUs did not differ in level of burnout from nurses in the other units. In addition, nurses with higher levels of hardiness experienced lower levels of burnout (multiple  $R = .56$ ,  $p < .001$ ).

McCranie, Lambert, and Lambert (1987) conducted a study with a convenience sample of 107 RNs from 18 clinical units at a large southeastern urban community hospital. Their sample was 95% female and had an average work experience of 6.8 years. They used a multiple correlation design for their study to examine further the relationship between hardiness and burnout and to

explore whether hardiness moderates the impact of perceived job stress on level of burnout. The variables measured were hardiness (using Kobasa's 1984 Abridged Hardiness Scale), perceived job stress (using the Nursing Stress Scale), and burnout (with the Tedium Scale). The findings showed that burnout was significantly associated with high levels of perceived job stress and low levels of hardiness. Hardiness did not appear to prevent high levels of job stress (especially workload) from leading to high levels of burnout. This finding differed from Kobasa's where she found hardiness to have a moderator effect. The difference may be explained in two ways. First, Kobasa had an entirely male sample. A study reported by Holahan and Moos (1985) reported a personality measure labeled 'self-confidence' (similar to hardiness) showed different results in males than in females. Males who had this personality measure and were under high life stress experienced low physical and psychological distress; whereas, females did not. It may be that females high in hardiness respond differently to stress than males. Secondly, Kobasa's studies looked at general life event stressors rather than work-related ones (Kobasa, 1979A; Kobasa, Maddi, & Kahn, 1982).

Also in 1987, Rich and Rich conducted a study with a convenience sample of 100 acute care staff RNs from a variety of clinical units at a western Pennsylvania hospital. The participants in this study were all female with one or more years work experience. This study also had a multiple correlation design measuring (a) demographic variables including gender, age, and experience, (b) hardiness using Kobasa's and Maddi's Hardiness Scale, and (c) burnout with the Staff Burnout Scale for Health Professionals. The findings showed a lack of

hardiness was related to staff burnout ( $r = -.39, p < .001$ ) and that younger inexperienced nurses had lower hardiness and higher burnout scores.

van Servellen, Topf, and Leake (1994) used a convenience sample of 237 nurses from 7 hospitals in California to evaluate the relationships between personality hardiness, work-related stress, and health in these nurses. The results showed hardy nurses reported less work-related stress, less emotional exhaustion, and fewer health problems than nurses with low levels of hardiness. The results also showed that greater health complaints were associated with higher levels of work related stress and emotional exhaustion ( $r = .21$  to  $.42, p < .01$ ).

Collins (1996) conducted a descriptive study with 113 nurse participants examining the relationships between work stress, hardiness, and burnout among full-time hospital staff nurses. The findings, based on a response rate of 49%, indicated a small negative correlation between hardiness and nursing stress ( $r = -.22, p < .01$ ), a moderate negative correlation between hardiness and burnout ( $r = -.56, p < .01$ ), and a positive correlation between nursing stress and burnout ( $r = .39, p < .01$ ).

Limitations of the previous studies included (a) Kobasa's initial samples were all male, (b) the samples from the nursing studies were almost entirely female, (c) data were collected on self-reported measures at a single point in time (McCranie, Lambert, & Lambert, 1987), and (d) data came from a hospital that may not be typical and from ICU nurses who may not be dissimilar from other nurses (Keane, DuCette, & Adler, 1985). Other limitations included (a) there was a lack of control for the combination or interaction of hardiness with

other stress resistors such as positive health practices, social support, or other personal stress buffers (Rich & Rich, 1987), (b) use of a convenience sample (van Servellen, Topf, & Leake, 1994), (c) inconsistent distribution of the surveys (Collins, 1996), and (d) self-selection for the study (Collins, 1996).

Social support. LaRocco, House, and French (1980) reanalyzed existing data sets of 636 male workers from 23 different occupations. The purpose of their study was to determine “when does perceived emotional support from others buffer the impact of perceived occupational stress on job strain and the impact of job stress or strain on mental and physical health” (p. 204). The participants completed surveys on perceived job stress, person-environment fit, job-related strain, general mental health strain, and social support. The results indicated that social support had a buffering effect (mobilization of support in response to stress or strain) for job stress on individuals’ psychological and physical health (anxiety, depression, irritation, and somatic symptoms) and direct effects on job-related stress and strain (job dissatisfaction).

Seckel and Birney (1996) studied the relationship between stress, age, and social support with 30 women prior to a breast biopsy. In this study the Norbeck Social Support Questionnaire was used to measure aid, affect, affirmation, and social network. The findings demonstrated that women did experience stress prior to their biopsy and that the stress was negatively correlated with social support.

Boyle, Grap, Younger, and Thornby (1991) studied hardiness, ways of coping, social support, and burnout with 103 critical care registered nurses from six intensive care units at a large south-eastern medical center. The nurses were



surveyed using the Staff Burnout Scale for Health Professionals, Kobasa's Hardiness Scale, and the Ways of Coping Checklist developed by Lazarus. House and Wells Social Support Scale was used to measure social support with the items categorized based on the source of social support (supervisor, co-worker, spouse, or friend and relative). In this study social support was defined as a person's belief that he is cared for, esteemed, and belongs to a network (Cobb, 1976). They found that both work-related ( $r = -.42, p < .001$ ) and non work-related social support ( $r = -.35, p < .001$ ) were negatively related to burnout. Hardiness was also negatively related to burnout ( $r = -.43, p < .001$ ). In addition, personality hardiness was positively related to both types of social support ( $r = .19$  to  $.24, p < .03$ ).

Norbeck (1985) tested the model of social support, occupational stress, and health developed by LaRocco, House, and French (1980) with 164 female critical care nurses. The Norbeck Social Support Questionnaire was used and is based on Kahn's definition of social support. The tool measures affect, affirmation, and aid, as well as network size, duration of relationship, and frequency of contact (Norbeck, 1985). Her study showed that social support was negatively related to perceived job stress. Pagana (1990) examined Lazarus' theory of cognitive appraisal of stress by surveying 246 nursing students. In her study social support was found to be positively related to the evaluation of challenge when a work-related measure of support was used. Social support was not demonstrated to be negatively related to the evaluation of threat as had been hypothesized.

Some of the limitations of the previous studies include (a) lack of

consensus as to what support is or how to measure it (LaRocco, House, & French, 1980), (b) a cross-sectional rather than longitudinal study form was used making it difficult for causal inferences (Boyle, Grap, Younger, & Thornby, 1991), (c) use of self-report measures (Pagana, 1990), and (d) all female subjects were used (Norbeck, 1985).

### Summary

In general, the studies reviewed demonstrated that different people may view the same situation as threatening or challenging, that hardiness is positively linked to the appraisal of challenge, and that hardiness and social support may moderate distressing psychological symptoms. The limitations from the literature review point to the need for more research related to hardiness and other variables (such as social support) that may buffer, moderate, or alter perceptions of stress with nurses in a variety of settings and roles. It would also seem important to do this research early in the work setting prior to the development of more advanced stress symptoms such as burnout. According to Harris (1989), burnout is a significant concern for nursing because it is work related and results from stress. She further states that "nurses with burnout have depleted or exhausted their emotional and physical energies coping with the stressors of the work environment" (p. 16).

This study extended the research in this area by looking at nurses' initial appraisal of stress during orientation to a variety of roles and settings and correlated both hardiness and social support to the nurses' appraisal of stress. In addition, the Perceived Social Support Scale (Underwood, 1986) evaluated the perceived satisfaction of the nurses with five forms of support (affect, affirmation,

direct help, information, and listening) from their most helpful co-worker and their supervisor.

### Research Questions

After reviewing the literature the following research questions were developed. What is the relationship between hardiness and perceived satisfaction with workplace social support? What differences are there in the frequency with which stress during orientation to a new role is appraised as threat versus challenge among nurses with high and low hardiness and high and low social support?

### Variable Definitions

For the purpose of this study the following are the variable definitions that were used.

1. Hardiness: the “constellation of personality characteristics that function as a resistance resource in the encounter with stressful life events” (Kobasa, Maddi, & Kahn, 1982, p. 169), including commitment to various areas of their life, control or the belief that they have some measure of influence over what happens in life, and viewing changes in life and demands for readjustment as a challenge and an opportunity rather than as a threat (Kobasa, 1979A).

2. Perceived Satisfaction with Workplace Social Support: interpersonal transactions in the workplace where there is perceived satisfaction by the nurse recipient with caring, affirmation, information, listening, and aid given by the most helpful co-worker (a staff person identified by the nurse as being most helpful to him/her on the clinical unit who does not have responsibility for overseeing their practice) and/or the supervisor ( a staff person identified by the nurse as

supervisor, not necessarily having the job title of supervisor, who has responsibility for the nurse's practice during orientation) (House, 1981; Wortman, 1984).

3. Cognitive Appraisal of Stress: the way the person/environment transaction is appraised, in relationship to that person's sense of well-being, either as overwhelming in the present as a threat with anticipation of harm or loss, or in the future as a challenge with a positive outlook and enthusiasm to address encounters/transactions and with the view that events hold the possibility for mastery or gain (Lazarus & Folkman, 1984).

#### Relationship Between Variables

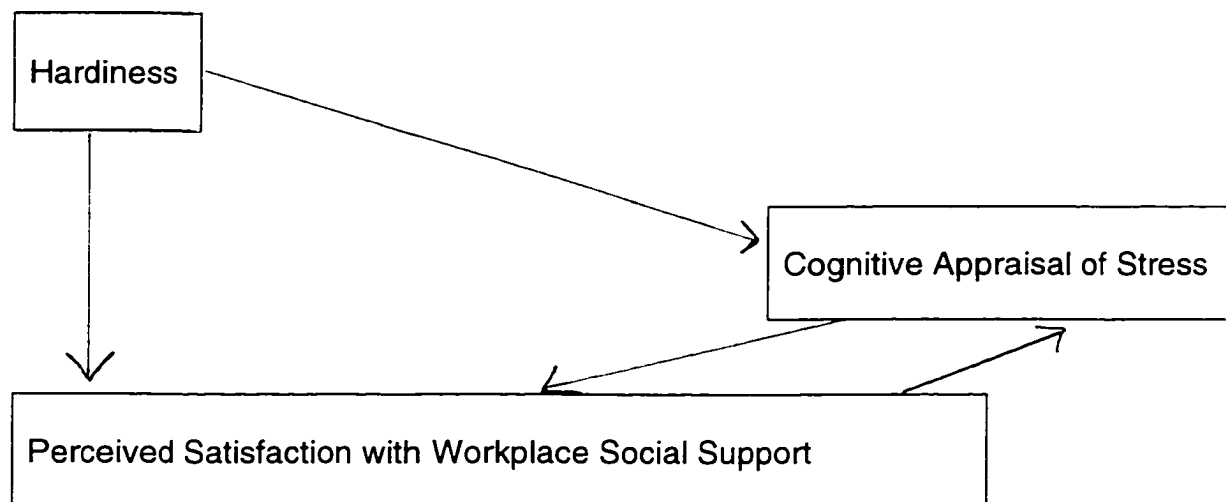


Figure 1. Relationship between Hardiness and Perceived Satisfaction with Workplace Social Support to Nurses' Cognitive Appraisal of Stress.

## Hypotheses

1. Nurses who have high levels of hardiness will more frequently appraise stress as a challenge than nurses with low levels of hardiness.
2. Hardiness will be positively related to perceived satisfaction with workplace social support.
3. Nurses who have high levels of perceived satisfaction with workplace social support will more frequently appraise stress as a challenge than nurses with low levels of perceived satisfaction with workplace social support.

## CHAPTER 3

### METHODOLOGY

A descriptive correlational study design, based on Lazarus' theory of Stress and Coping, was used to extend Pagana's findings on the relationships between hardiness, perceived satisfaction with workplace social support, and cognitive appraisal of stress. This was accomplished via completion of self-report instruments by nurses who were on orientation to a new clinical position/role. The study design facilitated recruitment of subjects into the sample and allowed for data collection in a timely manner. The use of a convenience sample, however, limits the generalizability of the results.

#### Threats to External and Internal Validity

The nurse's age, nursing education, and work experience (including if this was an internal or external agency change) were measured so their potential influence on the dependent variable (nurses' cognitive appraisal of stress as threat or challenge) could be evaluated. Younger nurses may view change as a challenge more frequently than older nurses. Nurses with more education in nursing may experience a greater sense of control than nurses with a lower degree or diploma. Other variables not measured that may also have affected the dependent variable include the cumulative effect of current life events, and the timing of measurement of the independent variables in relation to events (a)

on the unit (e.g., short staffed), (b) within the organization (e.g., major changes), or (c) in the nurse's personal life (e.g., divorce). Nurses who are already experiencing a great deal of stress in their personal life may view work encounters to be more threatening than nurses whose personal life is currently more stable. Nurses working in an organization in the midst of major change, may experience encounters in the work setting to be more threatening. In addition, a study sample of all nurses with data collection occurring at one point in time limits the conclusions regarding direction of influence among variables. Gender was not obtained in this study because it may have compromised the ability of the subjects to remain anonymous (due to low numbers of male nurses).

#### Setting and Sample

The setting for this study was in the midwest at a 529 bed, acute care, and teaching hospital located in a large, metropolitan city in West Michigan. The study utilized a convenience sample comprised of newly hired registered nurses and registered nurses transitioning to new roles at the hospital. The criterion for participation in the study was willingness by these nurses to complete the surveys on work stress, hardiness, social support at work, and demographic information. Since survey research provides subjects with the opportunity for anonymous responses (Pierce, 1995) and the nature of the questions on the instruments used for this research were not of a sensitive nature, there were no risks for the subjects. Return of the completed questionnaires constituted informed consent. The sample size aimed for was 40. In recent years there were approximately 60 new registered nurses hired into new clinical positions at this

hospital each year. A merger between this hospital and another hospital in the area was approved during the Fall of 1997. As a result, the number of nurses orienting was expected to decrease, so the sample number of 40 was chosen. Forty registered nurses agreed to participate. Of the 40 registered nurses who filled out the surveys, 39 met the pre-determined requirements for satisfactory survey completion and acceptance into the study.

### Instruments

Three survey tools (Pagana Clinical Stress Questionnaire, Personal Views Survey, and Perceived Social Support Scale) and a demographic form (Demographic Profile) were used to collect the data.

Cognitive appraisal of stress. Cognitive appraisal of stress was measured using Pagana's Clinical Stress Questionnaire, the PCSQ, (Pagana, 1987) which is based on Folkman's and Lazarus' Clinical Stress Questionnaire (1985). The PCSQ takes approximately two minutes to complete (see Appendix A). Pagana gave permission to use and print the PCSQ in this Thesis (see Appendix E). The tool has both quantitative and qualitative aspects that may be used together or separately. The quantitative portion has a 20 item, 5 point scale (0 = not at all, 4 = a great deal) that is used to determine threat and challenge, as well as harm and benefit. The threat scale measures six emotions (worried, fearful, anxious, overwhelmed, apprehensive, and intimidated), the challenge scale measures five emotions (excited, hopeful, eager, stimulated, and confident), the harm scale measures five emotions (angry, sad, disappointed, guilty, and disgusted), and the benefit scale measures four emotions (exhilarated, pleased, happy, and relieved). The data from the harm and benefit scales were not evaluated



because harm and benefit were not examined in this study. The mean scores for threat and challenge were used to determine which appraisal is higher. The reported alpha coefficients for threat and challenge are .84 and .85, respectively, and factor analysis supported construct validity (Pagana, 1989). In this study, the reliability alpha coefficient for overall stress was .84, for threat .94, and for challenge .71. The PCSQ tool has an additional seven open-ended questions which may be used for qualitative data. In this study only the quantitative aspect of the tool was used to determine challenge and threat appraisals (see Appendix E for scoring directions).

Hardiness. Hardiness was measured using the third generation hardiness test (Personal Views Survey) as used by Pagana (1987) and is a 50 item, 4 point scale (0 = not at all, 3 = completely true). The Personal Views Survey was developed from five separate scales (Ouellette-Kobasa, 1993); the Alienation Test (Maddi, Kobasa, & Hoover, 1979), the Internal-External Locus of Control Scale (Rotter, Seeman, & Liverant, 1962), the Powerlessness Scale from the Alienation Test, the Security Scale from the California Life Goals Evaluation Schedule (Hahn, 1966), and the Personality Research Form (Jackson, 1974). Florian, Mikulincer, and Taubman (1995) found the Personal Views Survey scale to have internal consistency with an alpha of .81 for the total 50 items and alpha's of .78 for the commitment items, .84 for the control items, and .75 for the challenge items. In this study, the reliability alpha coefficient for the total 50 items of the Personal Views Survey was .78. This survey takes approximately five minutes to complete (see Appendix B, scoring directions included). Ouellette-Kobasa gave permission to use the Personal Views Survey and to print it in this

Thesis (see Appendix E). As previously mentioned, there has been a debate in the literature as to whether hardiness is comprised of two or three concepts (Florian, et al., 1995; Hull, Van Treuren, & Virnelli, 1987; Jennings & Staggars, 1994; Ouellette-Kobasa, 1993). It has also been noted that Kobasa (Ouellette) has not reported content validity in her writings (Jennings & Staggars, 1994).

Perceived satisfaction with workplace social support. Perceived satisfaction with workplace social support was measured using a modification of Underwood's (1986) Perceived Social Support Scale (see Appendix C, scoring directions included). This tool was developed originally to measure the perceived satisfaction with love/caring, affirmation, information, listening, and aid given by salient providers (woman's partner, mother, most helpful friend, and most helpful professional) for Underwood's research related to support during pregnancy. Underwood's permission was obtained to use this tool, modify it, and print it in this Thesis (see Appendix E). The tool was modified in this study with salient providers referring to the most helpful co-worker (a staff person on the clinical unit identified by the nurse as being most helpful to him/her who does not have responsibility for overseeing their practice) and the supervisor ( a staff person identified by the nurse as supervisor, not necessarily having the job title of supervisor, who has responsibility for the nurse's practice during orientation), and the word love being dropped from the love/caring measure. This tool takes approximately five minutes to complete. Satisfaction with the particular form of support received is rated on a seven point scale in relation to each salient provider (most helpful co-worker and supervisor).

The content validity of Underwood's tool was supported by the literature

and by a panel of experts in the measurement of social support. Factor analysis separated items by provider instead of by form of support. The instrument was pilot tested on 26 women, similar in age to the study subjects. Test-retest reliability at a one week interval was examined for each provider category using paired *t*-tests (which all revealed no significant differences) and Pearson correlations. Subjects were asked to rate their satisfaction with support received over a designated period to time (past six months). The correlations were .90 (mothers), .64 (friends), .94 (husbands), and .39 (professionals). The women in the pilot study were not pregnant or otherwise seeking help from a professional which probably accounted for the low correlation for that provider category (Underwood, personal communication, 1996).

In this study, the reliability alpha coefficient for overall social support was .95. The alpha coefficient for coworker social support was .99, and for supervisor support .96.

The reliability of all three of these survey tools was examined using data from this study. Demographic information was collected through a Demographic Profile form (see Appendix D) that was developed to collect information about the sample nurses related to their nursing education, age, licensure, work experience, and the role they were orienting to. This demographic information is displayed in table format in Chapter 4 and Appendix H.

### Procedure

There were several steps followed to conduct the research that is outlined in this paper.

Human rights. As mentioned previously, there were no risks for the subjects or problems anticipated with the subjects' rights. The first step was to obtain approval from the Grand Valley State University Human Research Review Committee. The second step was to submit the thesis proposal to the Nursing Research Committee at the hospital and receive their approval. The proposal was then submitted to the hospital's Research and Human Rights Committee, and when their approval was obtained, the third step in the process was completed. Then the data collection process began.

Collection of data. At step four, the principal investigator met with the orientees on the third day of their Staff Development orientation which had been planned to follow three days orientation to the clinical unit. This plan worked for the majority of the subjects. Seven study participants had more hours (72-240) in patient care on their clinical units than was anticipated. Two participants indicated they had not yet had an opportunity to experience any workplace social support or lack of it. When the principal investigator met with the orientees, she explained to the orientees what the research study was about, in general, utilizing a script (see Appendix F) that provided them with informed consent information. They were invited to participate. At that time the survey tools, demographic form, and a cover letter (see Appendix G) were handed out to the orientees and directions were provided on how to complete the forms. The orientees were asked to complete the surveys and demographic form before they left Staff Development that day if they were interested in participating. They were directed to put the completed questionnaires in the Research Study Box in the Staff Development classroom. The participants were offered the opportunity

to complete a self-addressed envelope so they could have a summary of the study results mailed to them. Step five involved ongoing data collection until the desired sample size was reached. As previously stated, 40 registered nurses agreed to participate (the desired sample size). Of the 40, 39 registered nurses met the pre-determined criteria for acceptance into the study.

## CHAPTER 4

### DATA ANALYSIS

This study examined the relationships between hardiness (Personal Views Survey/PVS) and perceived satisfaction with workplace social support (Perceived Social Support Scale/PSSS) and the ability of these two variables to differentiate between nurses who viewed their orientation as a threat versus a challenge. Scores from the PVS (Ouellette-Kobasa, 1993), and PSSS (Underwood, 1986) were treated as interval data and the relationships examined using a Pearson Correlation Coefficient.

Hardiness and perceived satisfaction with workplace social support (PSWSS) were then turned into dichotomous variables by dividing their total scores at the median. This provided a way to make comparisons between groups that were designated as high or low in either PSWSS or hardiness. The dependent variable was nurses' cognitive appraisals of stress as a threat or challenge. This appraisal of stress was in response to orientation to a new clinical position/role and was measured with the quantitative portion of Pagana's Clinical Stress Questionnaire (1987). Chi-square tests were used to determine whether the proportion of the sample appraising orientation as threat versus challenge was significantly different on the basis of high or low hardiness or social support scores. All the data from this study were analyzed using the

Statistical Package for the Social Sciences (SPSS) software.

### Sample

A convenience sample comprised of registered nurses on orientation to a new clinical position/role at a large teaching hospital in West Michigan was used for this research. Forty nurses completed the necessary survey tools for this study. Of the 40 nurses completing the surveys, 39 met the pre-determined criteria for inclusion in the data analysis. Five of the 39 included subjects had one piece of missing data each. The five missing data pieces included a single response to PVS questions 4, 10, 12 and 22, and a single response to the PCSQ question 11. To maximize the sample, it was evaluated for randomness of the missing data. To maintain as large a sample as possible, the missing data were replaced by substituting the mean value as described by Polit and Hungler (1995).

The nurses' ages ranged from 22-45 years with 51.3% ranging from 22-24 years. The mean age was 28.4 years with a standard deviation of 7.3 (Table 1).

Table 1

### Nurses' Age

Variables	<i>f</i>	%
Age/Years:		
22-24	20	51.3%
25-31	8	20.5%
33-39	6	15.4%
40-45	5	12.8%

Note. *M* age = 28.4 Years, *SD* = 7.3

The amount of work experience (time employed as a nurse) ranged from 0-24 years with 33.3% having no nursing work experience (Table 2).

Table 2

Work Experience as a Registered Nurse

Experience	<i>f</i>	%	Cumulative %
0 months	13	33.3%	33.3%
1 to 5 months	6	15.5%	48.7%
6 months	1	2.6%	51.3%
7 months to 1 year	2	5.1%	56.4%
up to 2 years	5	12.8%	69.2%
up to 5 years	2	5.2%	74.4%
up to 10 years	5	12.8%	87.2%
up to 15 years	3	7.7%	94.9%
up to 20+ years	2	5.2%	100.0%

The most frequently listed highest earned nursing degree was a baccalaureate degree by 25 of the nurses (64.1%) as displayed in Table 3. Eight nurses had an associate's degree, 3 had a master's degree, and another 3 had a diploma.



Table 3

Highest Earned Degree in Nursing

Variables	<i>f</i>	%
Degree:		
Associates	8	20.5%
Diploma	3	7.7%
Baccalaureate	25	64.1%
Master's	3	7.7%

One-third of the nurses orienting were moving to a new position/role within the hospital, and the other two-thirds were from outside the hospital (Table 4). Of the 39 nurses, only one had spent anytime away from nursing (1 year).

Table 4

Nurses Moving from Within or Outside the Hospital

Nurses	<i>f</i>	%
Moving Within	14	35.9%
From Outside	25	64.1%

The number of hours the nurses had spent on orientation in direct patient care ranged from 0-240 hours. The mean number of hours was 33.2 hours with a standard deviation of 45.4 (Table 5).

Table 5

Hours in Direct Patient Care

Variables	<i>f</i>	%
Number of Hours:		
0	8	20.5%
1-16	9	23.1%
17-32	13	33.3%
40-80	5	12.8%
81-240	4	10.3%

Note.  $M = 33.2$ ,  $SD = 45.4$

The number of preceptors the nurses had ranged from 1-4 or more. The majority of the orientees had 2-3 (Table 6).

Table 6

Number of Preceptors

Variables	<i>f</i>	%
Number of Preceptors:		
1	1	30.8%
2-3	19	48.7%
4 or more	5	12.8%
Not Sure	3	7.7%

The following variables are also displayed in table format (see Appendix H);  
license, prior work experience, previous role, area orienting to, role orienting to,  
and shifts hired to work.

## Research Questions

The hypotheses were tested to answer the research questions:

1. What is the relationship between hardiness and perceived satisfaction with workplace social support?
2. What differences are there in the frequency with which stress during orientation to a new role is appraised as threat versus challenge among nurses with high and low hardiness and high and low social support?

The alpha level of significance for acceptance of all the hypotheses was a value of .05 or less.

## Hypotheses

Hypothesis 1. Hardiness will be positively related to perceived satisfaction with workplace social support. As stated previously, the range of the 39 nurses' total Hardiness scores varied between 61.2-90.7 with a mean of 78.4 and a standard deviation of 6.03. The range of the nurses' overall PSWSS was 22-70 with a mean of 54.5 and a standard deviation of 15.2. The total scores for hardiness and perceived satisfaction with workplace social support were used to examine the relationship between these two variables. Analysis indicated that these variables were independent factors; that is, there was no significant relationship between total hardiness and PSWSS ( $r = .09$ ,  $p = .58$ ).

Hypothesis 2. Nurses who have high levels of perceived satisfaction with workplace social support will more frequently appraise stress as challenge than nurses with low levels of perceived satisfaction with workplace social support. The total scores on Underwood's (1986) PSSS had a possible range of 10-70.

The actual range of scores in this study was 22-70 ( $M = 54.5$ ;  $SD = 15.2$ ). Scores above the median on the PSSS represented high PSWSS. Scores at or below the median represented low PSWSS. The mean scores for challenge and threat stress appraisals were used to determine which appraisal was higher. The nurses surveyed were then categorized as having a challenge or threat appraisal (challenge appraisal = 30 subjects; threat appraisal = 9 subjects) depending on which mean was higher. The nurses surveyed had little variance in their stress appraisals. The chi-square with Yates correction showed that having a high or low PSWSS made no significant difference in nurses' appraisals of stress as challenge or threat  $\chi^2(1, N = 39) = 2.05, p = .15$ .

Hypothesis 3. Nurses who have high levels of hardiness will more frequently appraise stress as challenge than nurses with low levels of hardiness. The possible range of scores on the Personal Views Survey is 0-100. The actual range of scores in this study was 61.2-90.7 ( $M = 78.4$ ;  $SD = 6.03$ ). Scores above the median on the PVS represented a high level of hardiness. Scores at or below the median represented a low level of hardiness. The mean scores for challenge and threat stress appraisals were again used to determine which appraisal was higher. The nurses scored relatively high on the hardiness scale with little variance in their scores. Having high hardiness or low hardiness made no significant difference in whether stress was appraised as a threat or challenge  $\chi^2(1, N = 39) = .45, p = .50$ .

The months of work experience as a registered nurse, with the statistical median of 6 months, was used to divide the sample into two groups to compare the mean of their overall PSWSS scores (new graduates  $M = 49.9$ ; more experienced nurses  $M = 59.4$ ). A  $t$ -test ( $t = 2.09$ ,  $df = 27.1$ ,  $p = < .05$ ) revealed a significant difference between the two groups. More experienced nurses perceived higher social support than new graduates (Table 7).

Table 7

Differences Between New Graduates and More Experienced Nurses on Perception of Overall Satisfaction with Workplace Social Support

$M$ Overall PSWSS	$t$ -test	$df$	$p$ value
New Graduates: 49.9	2.09	27.1	< .05
More Experienced: 59.4			

These two groups of nurses were used again to compare their co-worker PSWSS scores using the statistical mean (new graduates  $M = 22.4$ ; more experienced nurses  $M = 29.2$ ). The  $t$ -test ( $t = 2.26$ ,  $df = 25.1$ ,  $p = .03$ ) showed a significant difference with the more experienced group perceiving more co-worker support than new graduates (Table 8).

Table 8

Differences Between New Graduates and More Experienced Nurses on  
Co-worker Support

<i>M</i> Co-Worker Support	<i>t</i> -test	<i>df</i>	<i>p</i> value
New Graduates: 22.4	2.26	25.1	.03
More Experienced: 29.2			

Finally, these two groups' supervisor PSWSS scores were compared using their mean scores (new graduates  $M = 27.5$ ; more experienced  $M = 30.3$ ). The  $t$ -test showed no significant difference between the two groups. The two groups of nurses were also compared on the basis of hardiness (new graduates  $M = 78.1$ ; more experienced nurses  $M = 78.7$ ). A  $t$ -test showed no significant difference between the groups in relation to hardiness.

The nurses' cognitive appraisal of stress as threat or challenge was then compared on the basis of whether they were moving to a new position/role within the hospital or from outside the hospital. There were 14 nurses moving from within ( 2 = threat appraisal, 12 = challenge appraisal) and 25 coming from outside ( 7 = threat appraisal, 18 = challenge appraisal). Of these two groups a total of 76.9% had a challenge appraisal and 23.1% had a threat appraisal. A chi-square with a Yates correction showed no significant difference in appraisal based on the nature of the orientation.

Pearson's correlation coefficient was used to compare the nurses' actual threat and challenge scores to number of months worked and age to determine if there was a relationship. There was no significant relationship found between the number of months worked and threat appraisal scores. A significant, yet moderately weak negative relationship between months worked and challenge appraisal scores was found ( $r = -.31$ ,  $p = .05$ ). A strong, positive relationship was found between the number of months worked and their age ( $r = .66$ ,  $p = < .01$ ) (Table 9).

Table 9

Relationship Between Months Worked, Age, and Challenge Appraisal Scores

Independent Variable	Dependent Variable	$r$	$p$ value
Months Worked	Challenge Appraisal	-.31	.05
Age	Months Worked	.66	< .01

Age was not related to challenge or threat appraisal.

Summary

None of the hypotheses were supported. The subjects' responses reflected a limited variance on the study variables. This may have been due to a small sample size and/or to limited sensitivity of the survey instruments that were utilized in this research study.

## CHAPTER 5

### DISCUSSION AND IMPLICATIONS

#### Discussion

The purpose of this study was to examine nurses' initial appraisal of stress during orientation as a threat or challenge using Lazarus' Theory of Stress and Coping (Lazarus & Folkman, 1984). This study was an extension of research conducted by Pagana (1987) relating hardiness and social support to student appraisal of stress in an initial clinical situation. Similarly, in this study, the nurses' levels of hardiness and perceived satisfaction with workplace social support (PSWSS) were determined and examined with respect to their appraisal of stress as a threat or challenge. Lazarus' theory was chosen as the framework because it has been tested extensively (Burns & Egan, 1994; Folkman, 1985; Pagana, 1987) and it provides an opportunity to evaluate a person's stress appraisal of transactions/events, as either a threat (anticipated harm or loss) or challenge (potential for gain or growth). The homogeneity of the sample, however, was not a good test for the conceptual framework (Lazarus' Stress and Coping Theory).

Hypothesis 1. In this new study, the first hypothesis--hardiness will be positively related to perceived satisfaction with workplace social support--was not supported. As mentioned previously, the nurse orientees all scored high in



hardiness which may have made it difficult to find a significant relationship.

Pagana (1987) did not correlate these two variables, hardiness and workplace social support, so a comparison can not be made between the studies.

Hypothesis 2. There was no support found for the stress buffering effect of social support that other researchers have shown (Boyle, Grap, Younger, & Thomby, 1991; LaRocco, House, & French, 1980; Seckel & Birney, 1996). The findings of this new research study did not support the second hypothesis--that nurses who have high levels of PSWSS will more frequently appraise stress as challenge than nurses with low levels of PSWSS. Pagana's (1987) study found only a weak, positive, significant relationship between high PSWSS and challenge appraisal. She found this relationship only when the Work Number 2 Scale of Norbeck's (1985) Social Support Scale was used. The Number 2 Scale "refers to work support that enables a person to relax or re-energize after a clinical experience" (Pagana, 1990, p. 258). A specific question regarding this type of work support was not measured with Underwood's (1986) Perceived Social Support Scale (PSSS) in this new study. As presented in Chapter 4, the majority of the orientees viewed the orientation experience as a challenge rather than a threat. The limited variation in the subjects' appraisals of stress reduced the ability to differentiate proportionate appraisals on the basis of level of support and satisfaction.

Hypothesis 3. There also was no support found for Kobasa's (1982A) hardiness theory that was tested with the third hypothesis--nurses who have high levels of hardiness will more frequently appraise stress as challenge than nurses with low levels of hardiness. Again, the limited variance in stress appraisals

influenced the adequacy of the hypothesis testing. Other nurse researchers (Collins, 1996; Keane, DuCette, & Adler, 1985; Rich & Rich, 1987) have found an inverse relationship between hardiness and burnout and a progression from experiencing work stress to the development of burnout (Harris, 1989). Pagana (1987) found a weak, yet positive and significant relationship between hardiness and challenge appraisal scores. Pagana (1990) stated that even though the correlation's were low, significant differences were found because the sample size was large ( $n = 246$ ; six times the size of the one used for this new study).

Another difference between Pagana's (1987) study and this one was that the nurses on orientation in this new study scored higher in hardiness than did the student nurses. With less variance in the hardiness scores in the new study, along with most of the subjects viewing their orientation experience as a challenge, the chance of finding a significant difference between them was low. Another possible factor with the new study was that at least seventy-two percent of the sample subjects or more had a higher level of education than Pagana's student nurses. The better educated nurses may have had course work that taught assertive behavior and other 'hardy type' behaviors and perspectives that could have helped them score higher in hardiness.

Additional findings. There were some additional findings of interest in this study. A strong positive relationship was found between the number of months the nurse orientees had worked previously and their age. That result was expected and indicated that the more months the nurse orientees had worked the likelier they were to be older than nurse orientees who had worked less.

Also, a weak, yet significant, negative relationship was found between months worked as a nurse and a challenge stress appraisal. As suggested in Chapter 3, younger nurses (fewer months worked as a nurse) viewed change as a challenge more frequently than older nurses. Finally, there was a significant difference found in comparing new graduates' and more experienced nurses' PSWSS. The more experienced nurses had a higher PSWSS. There was also a significant difference found between the new graduates and more experienced nurses, with more experienced nurses perceiving more co-worker support than the new graduates.

#### Application of Findings

As a result of the finding that more experienced nurses perceived higher social support in this study, and specifically, higher co-worker support, the hospital may want to incorporate more opportunities for social support into the orientation program. It may be that the more experienced nurses are more readily able to perceive support than new graduates. Also, if the more experienced nurses were moving within the hospital, they may have already known some of the people on their units and perceived support from them.

Other studies have suggested that hardiness makes a difference with stress and burnout. If hardiness does buffer stress and could be taught, as suggested by Lambert and Lambert (1987), both nursing students and nurses (as well as others) could benefit by learning to increase their level of hardiness. When interviewing new nurses, Lambert and Lambert (1987) further suggested that hardiness testing could be helpful in determining who the most stress resistant (hardy) applicants are.

Nurses responsible for the registered nurse orientation program at the hospital where this study was conducted might find it valuable to give some consideration to the high levels of social support and hardiness of the nurse orientees. These results may suggest they are doing something in their orientation program that is influencing these findings.

### Limitations

The use of a descriptive correlational design coupled with a small, self-selected, convenience sample from one hospital limits the generalizability of the study results. The selection criteria used for hiring nurses at this large West Michigan teaching hospital may vary from those used at smaller community hospitals. This could have resulted in nurse orientees with a higher level of hardiness or increased ability to perceive satisfaction with workplace social support. As a result, the nurses in this sample may not be representative of the entire population of nurses.

Other variables not measured that may have affected the dependent variable include the cumulative effect of current life events, and the timing of measurement of the independent variables in relation to events (a) on the unit (e.g., short staffed), (b) within the organization (e.g., major changes like the merger), or (c) in the nurse's personal life (e.g., divorce or other major stressors). Gender was not measured in this study to help provide for anonymity of the subjects. It appeared, however, that this study used a sample of mostly or all female nurses (per the author's observation of those who volunteered to participate). When Kobasa (1979A; 1979B) did her initial work, the subjects were all male. As discussed in Chapter 2, it may be that females respond differently to

stress than males (Holahan & Moos, 1985). Also, a study of mostly female subjects limits the generalizability of the results. In addition, a study sample of all nurses with data collection occurring at one point in time limits the conclusions regarding direction of influence among the variables.

The PVS used to measure hardiness in this study was different from the Hardiness Test that Kobasa used early on. Ouellette-Kobasa (1993) stated that the PVS had not been utilized as much as the original Hardiness Test. She said that the earlier Hardiness Scales have been discussed in the literature at a ratio of four to one in comparison with the PVS, which still needs some revision and testing. Ouellette-Kobasa also stated that the PVS is an improved hardiness measurement tool, however, it continues to have a “lack of balance between positive and negative items with most of the items worded negatively” (1993, p. 89). This lack of balance could cause problems with the response from the subjects or result in confusing neuroticism or maladjustment with hardiness, which limits the conclusions that can be drawn from testing for hardiness levels.

Other factors related to hardiness that were not evaluated in this study that could limit this study include questions in the literature that are related to the measurement of hardiness. Some of these questions are: (a) is hardiness really composed of three interrelated concepts (control, commitment, and challenge?); (b) can hardiness really be viewed as a unitary entity?; (c) does the PVS measure the same construct that was measured in Kobasa's earlier work (because the subscales have changed)?; and (d) should the challenge component be eliminated? (Florian et al., 1995; Hull et al., 1987; Jennings & Staggars, 1994; Ouellette-Kobasa, 1993; Pagana, 1990; Tartasky, 1993).

Other possible limitations related to survey tools are: (a) only the quantitative portion of Pagana's (1987) PCSQ was used so there is no measure of the nurse orientees self-assessed level of stress; and (b) Underwood's (1986) PSSS had been originally developed to measure the perceived satisfaction with love/caring, affirmation, information, listening and aid given by salient providers (woman's partner, mother, most helpful friend, and most helpful professional) for her research related to support during pregnancy. The PSSS was modified for this study with salient providers referring to the most helpful co-worker's and supervisor's provision of support in the workplace.

### Suggestions

The quantitative portion of Pagana's (1987) PCSQ, based on Lazarus and Folkman's (1985) Clinical Stress Questionnaire, provided a helpful way of determining if the nurse was experiencing a stressful appraisal (threat or challenge). However, by not using the qualitative portion of the PCSQ, there was no way to determine (by self-assessment as Pagana had done) the overall level of stress experienced, which could have provided a helpful comparison between this study's findings and Pagana's. There seemed to be logical theoretical reasons for measuring appraisal as the outcome. When you look at the appraisal of stress only (threat or challenge), it limits the sensitivity of people's responsiveness to a situation. It would also fail to capture a sense of the emotional energy bound up in responding to the situation. In the future it would be helpful to use the qualitative portion of the PCSQ along with the quantitative portion so this type of comparison could be made.

Neither study (Pagana's 1987 study or this one) found much support for

work related social support buffering or moderating work stress. However, there has been research reported in the literature with evidence that social support, other than work related, does buffer the effect of stress (Boyle, Grap, Younger, & Thomby, 1991; LaRocco, House, & French, 1980; Norbeck, 1985). This indicates a need to continue researching the role that social support plays in buffering stress, especially work stress.

Even though this study did not find support for Kobasa's hardiness theory, we need to continue evaluating hardiness in these turbulent and chaotic times in health care (Salzer, 1995). Other studies have indicated that hardiness can moderate the effects of stress (Pagana, 1987; van Servellen, Topf, & Leake, 1994; McCranie, Lambert, & Lambert, 1987) before it gets too high. Hardiness has also been shown to moderate burnout (Collins, 1996; Keane, DuCette, & Adler, 1985; Rich & Rich, 1987). Other variables that are worthy of further research related to hardiness include: (a) gender, (b) questions discussed in chapter 5 related to measurement of hardiness, (c) timing of measurement of hardiness and social support related to personal and perceived work stressful events, (d) data collection occurring at several points in time, (e) measuring hardiness levels to determine which applicants to hire, and (f) surveying nurses from several sites to determine if the lack of variation in responses is site specific. It would also be interesting in a future study (a) to evaluate if nurses who have been in their new role for six months continue to report challenge appraisals (they may have initially been so grateful for a job due to decreasing vacant positions that they reported their stress appraisals as challenge versus threat), and (b) to determine if the nurses' perceptions of stress are actually

affected by their hardiness levels after their initial excitement about their new job has had a chance to wear off.

### Summary

In this study there was little variance in the nurse orientees' hardiness scores. In addition, most of the nurse orientees had a challenge appraisal of stress. The results of this study showed there was no support found for hardiness or perceived satisfaction with workplace social support as moderators of nurse orientees' appraisal of stress. The limited variation in the hardiness levels and nurse subjects' appraisal of stress reduced the ability to test for relationships between support and stress appraisals, hardiness and stress appraisals, and hardiness and support. These results may have been due to a small sample size and/or to limited sensitivity of the survey instruments that were utilized in this research study.

However, there were some additional significant findings including (a) that younger nurses viewed change as a challenge more frequently than older nurses and (b) more experienced nurses had a higher perceived satisfaction with workplace social support than new nurse graduates. As stated previously, we need to continue research to determine moderators of stress appraisal for nurses during these 'white water' times in health care (increased workload and demands; constant change) to prevent decreased job satisfaction, frequent turnover, increased levels of stress, and burnout.



## APPENDICES

## APPENDIX A

## APPENDIX A

### Pagana Clinical Stress Questionnaire (PCSQ)

Please relate all responses to your **MEDICAL-SURGICAL** Clinical Experience.

1. Please think about your clinical experience in the medical-surgical setting during this semester. How would you describe this as a new experience.
2. Some students have described their clinical experience as stressful. Please indicate the **AMOUNT OF STRESS** you are experiencing by circling a number from 0 to 4.

0	1	2	3	4
none	a little	moderately	quite a bit	a great deal

3. If you find it stressful, what is the stress?
4. Some students have described their clinical experience as challenging. What do you think?
5. If you find it challenging, what is the challenge for you personally?
6. What is challenging about your PARTICULAR clinical setting?
7. Some students have described their clinical experience as personally threatening. What do you think?
8. If you find it threatening, what is the threat for you personally?
9. What is threatening about your PARTICULAR clinical setting?

## APPENDIX A

### **Initial Appraisal of ORIENTATION Clinical Experience**

Listed below are emotions that nurses may experience in appraising a clinical experience. Think about your **ORIENTATION experience**. Please indicate the extent to which you are experiencing the following emotions.

Please circle one of the following alternatives for each emotion.

	NOT AT ALL	A LITTLE	MODER- ATELY	QUITE A BIT	A GREAT DEAL
1. worried	0	1	2	3	4
2. stimulated	0	1	2	3	4
3. angry	0	1	2	3	4
4. exhilarated	0	1	2	3	4
5. sad	0	1	2	3	4
6. hopeful	0	1	2	3	4
7. anxious	0	1	2	3	4
8. pleased	0	1	2	3	4
9. overwhelmed	0	1	2	3	4
10. eager	0	1	2	3	4
11. guilty	0	1	2	3	4
12. apprehensive	0	1	2	3	4
13. disgusted	0	1	2	3	4
14. excited	0	1	2	3	4
15. intimidated	0	1	2	3	4
16. relieved	0	1	2	3	4
17. disappointed	0	1	2	3	4
18. happy	0	1	2	3	4
19. fearful	0	1	2	3	4
20. confident	0	1	2	3	4

## APPENDIX B

## APPENDIX B

### Personal Views Survey

Below are some items that you may agree or disagree with. Please indicate how you feel about each one by circling a number from 0 to 3 in the space provided. A zero indicates that you feel the item is not at all true; circling a three means that you feel the item is completely true.

As you will see, many of the items are worded very strongly. This is to help you decide the extent to which you agree or disagree.

Please read all the items carefully. Be sure to answer all on the basis of the way you feel now. Don't spend too much time on any one item.

0 = Not at all true  
1 = A little true  
2 = Quite a bit true  
3 = Completely true

- |    |  |   |   |   |   |
|----|--|---|---|---|---|
| 1. | I often wake up eager to take up my life where it left off the day before.....       | 0 | 1 | 2 | 3 |
| 2. | I like a lot of variety in my work.....  | 0 | 1 | 2 | 3 |
| 3. | Most of the time, my bosses or superiors will listen to what I have to say.....      | 0 | 1 | 2 | 3 |
| 4. | Planning ahead can help avoid most future problems.....                              | 0 | 1 | 2 | 3 |
| 5. | I usually feel that I can change what might happen tomorrow, by what I do today..... | 0 | 1 | 2 | 3 |
| 6. | I feel uncomfortable if I have to make any changes in my everyday schedule.....      | 0 | 1 | 2 | 3 |
| 7. | No matter how hard I try, my efforts will accomplish nothing.....                    | 0 | 1 | 2 | 3 |
| 8. | I find it difficult to imagine getting excited about working.....                    | 0 | 1 | 2 | 3 |
| 9. | No matter what you do, the "tried and true" ways are always the best.....            | 0 | 1 | 2 | 3 |

0 = Not at all true  
 1 = A little true  
 2 = Quite a bit true  
 3 = Completely true

- |     |   |   |   |   |   |
|-----|---|---|---|---|---|
| 10. | I feel that it's almost impossible to change my spouse's mind about something.....                                    | 0 | 1 | 2 | 3 |
| 11. | Most people who work for a living are just manipulated by their bosses.....   | 0 | 1 | 2 | 3 |
| 12. | New laws shouldn't be made if they hurt a person's income.....  | 0 | 1 | 2 | 3 |
| 13. | When you marry and have children you have lost your freedom of choice.....  | 0 | 1 | 2 | 3 |
| 14. | No matter how hard you work, you never really seem to reach your goals.....   | 0 | 1 | 2 | 3 |
| 15. | A person whose mind seldom changes can usually be depended on to have reliable judgment.....                          | 0 | 1 | 2 | 3 |
| 16. | I believe most of what happens in life is just meant to happen.....   | 0 | 1 | 2 | 3 |
| 17. | It doesn't matter if you work hard at your job since only the bosses profit by it anyway.....                         | 0 | 1 | 2 | 3 |
| 18. | I don't like conversations when others are confused about what they mean to say.....                                  | 0 | 1 | 2 | 3 |
| 19. | Most of the time it just doesn't pay to try hard, since things never turn out right anyway.....                       | 0 | 1 | 2 | 3 |
| 20. | The most exciting thing for me is my own fantasies.....   | 0 | 1 | 2 | 3 |
| 21. | I won't answer a person's questions until I am very clear as to what he is asking.....                                | 0 | 1 | 2 | 3 |
| 22. | When I make plans I'm certain I can make them work.....   | 0 | 1 | 2 | 3 |
| 23. | I really look forward to my work.....   | 0 | 1 | 2 | 3 |
| 24. | It doesn't bother me to step aside for a while from something I'm involved in, if I'm asked to do something else..... | 0 | 1 | 2 | 3 |

0 = Not at all true  
 1 = A little true  
 2 = Quite a bit true  
 3 = Completely true

- |     |   |   |   |   |   |
|-----|---|---|---|---|---|
| 25. | When I am at work performing a difficult task I know when I need to ask for help..... | 0 | 1 | 2 | 3 |
| 26. | It's exciting for me to learn something about myself.....                             | 0 | 1 | 2 | 3 |
| 27. | I enjoy being with people who are predictable.....                                    | 0 | 1 | 2 | 3 |
| 28. | I find it's usually very hard to change a friend's mind about something.....          | 0 | 1 | 2 | 3 |
| 29. | Thinking of yourself as a free person just makes you feel frustrated and unhappy..... | 0 | 1 | 2 | 3 |
| 30. | It bothers me when something unexpected interrupts my daily routine.....              | 0 | 1 | 2 | 3 |
| 31. | When I make a mistake, there's very little I can do to make things right again.....   | 0 | 1 | 2 | 3 |
| 32. | I feel no need to try my best at work, since it makes no difference anyway.....       | 0 | 1 | 2 | 3 |
| 33. | I respect rules because they guide me.....  | 0 | 1 | 2 | 3 |
| 34. | One of the best ways to handle most problems is just not to think about them.....     | 0 | 1 | 2 | 3 |
| 35. | I believe that most athletes are just born good at sports.....                        | 0 | 1 | 2 | 3 |
| 36. | I don't like things to be uncertain or unpredictable.....                             | 0 | 1 | 2 | 3 |
| 37. | People who do their best should get full financial support from society.....          | 0 | 1 | 2 | 3 |
| 38. | Most of my life gets wasted doing things that don't mean anything.....                | 0 | 1 | 2 | 3 |
| 39. | Lots of times I don't really know my own mind.....                                    | 0 | 1 | 2 | 3 |
| 40. | I have no use for theories that are not closely tied to facts.....                    | 0 | 1 | 2 | 3 |



0 = Not at all true  
 1 = A little true  
 2 = Quite a bit true  
 3 = Completely true

41.	Ordinary work is just too boring to be worth doing.....	0	1	2	3
42.	When other people get angry at me, it's usually for no good reason.....	0	1	2	3
43.	Changes in routine bother me.....	0	1	2	3
44.	I find it hard to believe people who tell me that the work they do is of value to society.....	0	1	2	3
45.	I feel that if someone tries to hurt me, there's usually not much I can do to try and stop him.....	0	1	2	3
46.	Most days, life just isn't very exciting for me.....	0	1	2	3
47.	I think people believe in individuality only to impress others.....	0	1	2	3
48.	When I'm reprimanded at work, it usually seems to be unjustified.....	0	1	2	3
49.	I want to be sure someone will take care of me when I get old.....	0	1	2	3
50.	Politicians run our lives.....	0	1	2	3

## APPENDIX B

### Scoring Instructions for Personal Views Survey

1. CHALLENGE ITEMS = 2, 6, 9, 12, 15, 18, 21, 24, 27, 30, 33, 36, 37, 40, 43, 46, and 49.  
  
COMMITMENT ITEMS = 1, 8, 11, 14, 17, 20, 23, 26, 29, 32, 38, 39, 41, 44, 47, and 50.  
  
CONTROL ITEMS = 3, 4, 5, 7, 10, 13, 16, 19, 22, 25, 28, 31, 34, 35, 42, 45, and 48.
2. Items to be reversed: 6-21 and 27-50.
3. For CHALLENGE score, sum over all relevant items and divide by 51.  
For COMMITMENT score, sum over all relevant items and divide by 48.  
For CONTROL score, sum over all relevant items and divide by 51.
4. To create Hardiness composite, take three ratio scores, add together, multiply by 100, and divide by three.

## APPENDIX C

### PERCEIVED SOCIAL SUPPORT SCALE

Please circle the word(s) on the line below each question indicating how you would rate the support you have received from your most helpful co-worker (a person on your clinical unit who does not have responsibility for overseeing your practice on orientation).

1. How have you felt about the caring your most helpful co-worker has shown you?

Totally dissatis- fied	Dissatis- fied	Somewhat dissatisfied	Mixed 1/2 & 1/2	Somewhat satisfied	Satisfied	Very Satisfied

2. How have you felt about the information or advice your most helpful co-worker has given you?

Totally dissatis- fied	Dissatis- fied	Somewhat dissatisfied	Mixed 1/2 & 1/2	Somewhat satisfied	Satisfied	Very Satisfied

3. How have you felt about your most helpful co-worker's ability to agree with your point of view or make you feel you are doing the best job you can?

Totally dissatis- fied	Dissatis- fied	Somewhat dissatisfied	Mixed 1/2 & 1/2	Somewhat satisfied	Satisfied	Very Satisfied

4. How have you felt about your most helpful co-worker's willingness to take time and listen when you wanted to talk about your feelings or concerns?

Totally dissatis- fied	Dissatis- fied	Somewhat dissatisfied	Mixed 1/2 & 1/2	Somewhat satisfied	Satisfied	Very Satisfied

5. How have you felt about the assistance (ex. help with work assignment, finding things on the unit, using equipment) your most helpful co-worker has provided?

Totally dissatis- fied	Dissatis- fied	Somewhat dissatisfied	Mixed 1/2 & 1/2	Somewhat satisfied	Satisfied	Very Satisfied

6. What is the job title of your most helpful co-worker? \_\_\_\_\_

**For the next five questions, please circle the word(s) on the line below each question indicating how you would rate the support you have received from your supervisor on the unit (a person who has responsibility for overseeing your practice on orientation).**

1. How have you felt about the caring your supervisor has shown you?

Totally dissatis- fied	Dissatis- fied	Somewhat dissatisfied	Mixed 1/2 & 1/2	Somewhat satisfied	Satisfied	Very Satisfied

2. How have you felt about the information or advice your supervisor has given you?

Totally dissatis- fied	Dissatis- fied	Somewhat dissatisfied	Mixed 1/2 & 1/2	Somewhat satisfied	Satisfied	Very Satisfied

3. How have you felt about your supervisor's ability to agree with your point of view or make you feel you are doing the best job you can?

Totally dissatis- fied	Dissatis- fied	Somewhat dissatisfied	Mixed 1/2 & 1/2	Somewhat satisfied	Satisfied	Very Satisfied

4. How have you felt about your supervisor's willingness to take time and listen when you wanted to talk about your feelings or concerns?

Totally dissatis- fied	Dissatis- fied	Somewhat dissatisfied	Mixed 1/2 & 1/2	Somewhat satisfied	Satisfied	Very Satisfied

5. How have you felt about the assistance (ex. help with work assignment, finding things on the unit, using equipment) your supervisor has provided?

Totally dissatis- fied	Dissatis- fied	Somewhat dissatisfied	Mixed 1/2 & 1/2	Somewhat satisfied	Satisfied	Very Satisfied

6. What is the job title of the person you are referring to as supervisor?

\_\_\_Peer RN

\_\_\_Clinical Coordinator

\_\_\_Preceptor

\_\_\_Other

## APPENDIX C

### Scoring of the Perceived Satisfaction With Workplace Social Support Scale

For each question, score Totally Dissatisfied with 1 point, Dissatisfied with 2 points, Somewhat Dissatisfied with 3 points, Mixed 1/2 & 1/2 with 4 points, Somewhat satisfied with 5 points, Satisfied with 6 points, and Very Satisfied with 7 points.

Add all the points together for each question to get a total score (highest score possible = 70, lowest score possible = 10). A total score may also be calculated for Co-worker or Supervisor support by adding up the total points for each of the 5 questions that apply (highest score possible = 35, lowest score possible = 5).

## APPENDIX D

**Demographic Profile**

**Please answer the following questions so that the sample can be described.**

**Check All That Apply**

1. What is your highest earned degree in nursing?  
☐ 1. Associate Degree  
☐ 2. Diploma  
☐ 3. Baccalaureate Degree  
☐ 4. Masters Degree
2. What is your current status with regard to licensure?  
☐ 1. G.N. (Graduate Nurse)  
☐ 2. R.N. (Registered Nurse)
3. What area did you work prior to this orientation?  

<input type="checkbox"/> 1. Medical/Surgical	<input type="checkbox"/> 7. Pediatrics
<input type="checkbox"/> 2. Surgery/Recovery	<input type="checkbox"/> 8. OB/GYN
<input type="checkbox"/> 3. Adult Critical Care	<input type="checkbox"/> 9. Nursing Home
<input type="checkbox"/> 4. Emergency Department	<input type="checkbox"/> 10. Nursing Resource Center
<input type="checkbox"/> 5. Pediatric Intensive Care	<input type="checkbox"/> 11. No Previous Work as Nurse
<input type="checkbox"/> 6. Neonatal Intensive Care	<input type="checkbox"/> 12. Other (please specify)_____
4. What role did you have prior to this orientation?  

<input type="checkbox"/> 1. Staff Nurse	<input type="checkbox"/> 4. Administrative
<input type="checkbox"/> 2. Educator	<input type="checkbox"/> 5. No Previous Work as Nurse
<input type="checkbox"/> 3. Clinical Nurse Specialist	<input type="checkbox"/> 6. Other (please specify)_____
5. How many years and/or months have you practiced as a nurse (G.N. or R.N.)?  
\_\_\_\_years      \_\_\_\_months (list how many)
6. Immediately prior to taking this position, had you been away from nursing (not employed as a nurse) for a period of time?  
☐ 1. No  
☐ 2. Yes. If yes, How long have you been away from nursing?  
    \_\_\_\_a. 1 year    \_\_\_\_b. 2-4 years      \_\_\_\_c. more than 4 years
7. What area are you orienting to?  

<input type="checkbox"/> 1. Medical/Surgical	<input type="checkbox"/> 6. Neonatal Intensive Care
<input type="checkbox"/> 2. Surgery/Recovery	<input type="checkbox"/> 7. Pediatrics
<input type="checkbox"/> 3. Critical Care	<input type="checkbox"/> 8. OB/GYN
<input type="checkbox"/> 4. Emergency Department	<input type="checkbox"/> 9. Nursing Resource Center
<input type="checkbox"/> 5. Pediatric Intensive Care	<input type="checkbox"/> 10. Other (please specify)_____



## APPENDIX D

8. What role are you orienting to?  
\_\_\_1. Staff Nurse  
\_\_\_2. Other (please specify)\_\_\_\_\_
9. What shift are you going to work? (Check all that apply.)  
\_\_\_1. Days  
\_\_\_2. Evenings  
\_\_\_3. Nights
10. How many preceptors do you have?  
\_\_\_1. 1    \_\_\_2. 2-3    \_\_\_3. 4 or more    \_\_\_4. Don't Know
11. What is your age in years?  
\_\_\_years
12. Are you:  
\_\_\_ coming from outside the health system to a position in the health system?  
or  
\_\_\_ moving within the health system to a new role?
13. How many hours of orientation have you had on your clinical unit, in patient care activities, working either with or without a preceptor?  
\_\_\_Hours

## APPENDIX E



LYCOMING COLLEGE  
.....  
WILLIAMSPORT, PA 17701-5192

APPENDIX E      April 29, 1996

Permission

Susan Groesser, BSN, RNC  
5408 Hall S.E.  
Grand Rapids, MI 49546

Dear Susan:

Enclosed please find a copy of my Clinical Stress Questionnaire. The qualitative (pages 1 & 2) and quantitative (page 3) aspects of this scale can be used together or separately. The qualitative data analysis is described in "Stresses and Threats Reported by Baccalaureate Students in Relation to an Initial Clinical Experience" (*Journal of Nursing Education*, 27(9), 418-424, 1989). This article describes data collected on a large group of subjects. Predominant themes were determined by content analysis.

Quantitative data can be obtained by using the 20 item Likert scale. This is described in "Psychometric Evaluation of the Clinical Stress Questionnaire" (*Journal of Nursing Education*, 28(4), 163-174, 1989). The reliability and validity of this scale is described in this article. The alpha coefficients for threat and challenge are .84 and .85, respectively. The mean score of the Threat Scale can be determined by adding the scores for the 6 threat items shown in Table 4 (p 173) of this article and dividing by 6. The mean score for the Challenge Scale can be determined by adding the scores for the 7 challenge items shown in Table 4 and dividing by 7.

Please feel free to contact me if I can be of assistance. I'd love to see an abstract of your research.

Good luck.

Sincerely,

  
Kathleen Deska Pagana, PhD, RN  
Associate Professor of Nursing

KDP/amy  
Enclosure

## APPENDIX E

### Permission



LYCOMING COLLEGE  
WILLIAMSPORT, PA 17701  
DEPARTMENT OF NURSING

October 17, 1996

Susan A. Groesser, BSN, RNC  
5408 Hall SE  
Grand Rapids, MI 49546

Dear Ms. Groesser:

You have my permission to reproduce the Pagana Clinical Stress Questionnaire. Good luck and congratulations as you complete your research. I would love to see a copy of your results.

Sincerely,



Kathleen D. Pagana, PhD, RN  
Associate Professor of Nursing

KDP/amy



APPENDIX E

Date:

10/9/96

Permission

Dear

I am granting you permission to use the instrument, Personal Views Survey, as the measurement for the concept of hardiness in your research. Enclosed is the instrument that we are currently using in our studies in New York and the instructions for scoring. I have included several articles which provide a concept analysis of hardiness and a critique of the various hardiness instruments. For additional information about the construct and its measurement, please consult a recent chapter I contributed to L. Goldberger & S. Breznits (Eds.) (1993). Handbook of stress: Theoretical and clinical aspects. 2nd edition. New York: Free Press. As you will find in the chapter, I feel quite strongly that (a) improvements are needed in the scale and (B) other types of measurement approaches to hardiness need to be developed. Our group is currently working on both these tracks.

I would suggest that before selecting the Personal Views Survey that you review the literature and evaluate the reported reliabilities of the instrument both as a total scale score and its subscales, particularly with reference to the specific sample of your study. At this point in time, the use of a total score for hardiness has demonstrated greater consistency across samples. To further support your selection of this instrument, it is further recommended that you conduct a pilot study based on your specific sample to evaluate the reliability of the instrument. A Cronbach alpha of .70 or greater demonstrates acceptable reliability of the instrument.

I would appreciate your help in the further development of this instrument. Therefore, it is requested that upon completion of your pilot study or thesis that you submit an abstract of your study including a description of the sample and sample size, and the statistics related to the reliability of the instrument. If you have any suggestions for new items, item rewording or interview questions to tap hardiness, your feedback would be appreciated. I look forward to hearing from you about your work.

Permission is granted to include the Personal Views Survey in the appendix of your Masters' Thesis.

Sincerely,

Suzanne Ouellette (formerly, Kobasa), Ph.D.

## APPENDIX E

### Permission

Dear Ms. Groesser,

Here is the information on the support scale. The Perceived Social Support Scale was originally developed for my dissertation to incorporate the forms of support suggested as important by House (1981) and Wortman (1984). The perceived satisfaction with love/caring, affirmation, information, listening and aid given by salient providers was measured on a seven point scale. In the case of pregnancy, salient providers were determined to be the woman's partner, mother, most helpful friend, and most helpful professional. Content validity was supported by the literature and by a panel of experts in the measurement of social support. Factor analysis separated items by providers rather than forms of support. This indicated that satisfaction with various providers was relatively independent while the forms of support from a given provider were related. The instrument was pilot tested on a sample of 26 women who were similar in age to the intended subjects. Test-retest reliability at a one week interval was examined for each provider category using paired t-tests (which all revealed no significant differences) and Pearson r correlations. Subjects were asked to rate their satisfaction with support received over a designated period of time (past six months). The correlations were .90 (mothers), .64 (friends), .94 (husbands), and .39 (professionals). The women in the pilot study were not pregnant or otherwise seeking help from a professional which probably accounted for the low correlation for that provider category.

If you believe this scale would be useful in your study, feel free to use it. I would appreciate your sharing of your results with me. If you have any questions about this, please E-mail me or call me at (616) 327-5687.

Sincerely,

Patricia W. Underwood, PhD, RN  
6435 Rothbury  
Portage, MI 49002

House, J. (1981). Work stress and social support. Reading, MA: Addison-Wesley.

Wortman, C. (1984). Social support and the cancer patients conceptual and methodological issues. Cancer (Supplement), 53, 2339-2360.

Underwood, P. W. (1986). Psychosocial variables: Their prediction of birth complications and relation to perception of childbirth. Ann Arbor, MI: University Microfilms International.

## APPENDIX E

### Permission

March 20, 1998

Ms. Susan Groesser  
5408 Hall, S.E.  
Grand Rapids, MI 49546

Dear Ms. Groesser,

You have my permission to use the Perceived Social Support Scale in your study and to include a copy of the instrument in the Appendix of your thesis.

Sincerely,

Dr. Patricia W. Underwood, PhD, RN  
Kirkhof School of Nursing  
Grand Valley State University  
Allendale, MI 49401

## APPENDIX F



## APPENDIX F

### Verbal Script

Hello. My name is Sue Groesser and I am a nurse here at the hospital. My position at the hospital is Coordinator of the Nursing Call Center. I am also working on my Masters degree in nursing at Grand Valley State University.

I have worked at this hospital for 17 years and have been interested in how patients and families deal with stressful events. Recently, with many pressures related to health care funding, I have become interested in how nurses deal with stress.

I am conducting a study that will examine some of the factors which influence nurses' stress while orienting to a new clinical role. I am asking approximately 40 registered nurses who are orienting to new roles at this hospital to participate. Participation in the study will involve completing four questionnaires which take approximately fifteen minutes of your time. I would ask you to complete these by noon today during your break time (the third day of Staff Development orientation). The questionnaires will ask you about some emotions you experience while orienting, your most helpful co-worker's (a staff person on the clinical unit identified by you as being most helpful who does not have responsibility for overseeing your practice) and your supervisor's ( a staff person identified by you as supervisor, not necessarily having the job title of supervisor, who has responsibility for your practice during orientation) provision of support, what some of your general views are, and your work and educational

experience. When you complete these questionnaires, please put them in the Research Study Box in this room (also, put your address on the blank, letter envelope and put that with the questionnaires if you want to receive a copy of the study results).

Your participation in this study is strictly voluntary and will not affect your employment status here at the hospital. All responses are confidential and the data will be coded so that when it is compiled, identification of individual participants will not be possible. There are no risks for you to participate in this study. Informed consent to participate in this study is implied when you complete and return the questionnaires.

Completing the questionnaires may increase your awareness of how you are feeling and what some of your views are. Your participation in this study may help nurse administrators to make orientation a more comfortable time for nurse orientees.

Do you have any questions about the study?

Those of you who are willing to participate in this study may take a packet as they are passed around the room. If you choose not to participate, just don't take a packet.

Thank you for your time and attention.

## APPENDIX G

## APPENDIX G

September 3, 1997

Dear Registered Nurse,

I am a graduate nursing student at Grand Valley State University and am conducting a research study concerning the factors which influence nurses' stress while on orientation to a new clinical role. The identification of these factors is expected to help nurse administrators make this a more comfortable time for nurse orientees. This study is the basis for a Thesis to be completed as one of the requirements for the degree of Master of Science in Nursing.

To complete the attached research study questionnaires you will need to spend approximately 15 minutes during your third day of Staff Development orientation. If you would like a copy of the study results, please put your address on the blank letter envelope. When finished with the questionnaires, place the completed questionnaires (and self-addressed envelope, if desired) in the Research Study box in the Staff Development classroom. There is no risk involved with participation in this study and the benefit may be to make orientation a more comfortable time for nurse orientees.

All responses are confidential to the extent permitted by law and the data will be coded so that identification of individual participants will not be possible. Informed consent to participate in this study is implied if you complete and return the questionnaires. You may choose not to participate in this research study by not completing the questionnaires.

If you have any questions about this study you may contact the principal investigator, Sue Groesser, at 391-1964. If you have any questions about your rights as a study participant you may contact the Human Rights representative, Linda Pool, at 391-1291.

I would welcome your participation in this research study.

Thank you for your time and participation.

Sincerely,



Susan A. Groesser, B.S.N., R.N.C.

## APPENDIX H

## APPENDIX H

Table H1

Nurse Orientees' License Status and Shifts Hired to Work

Variables	<i>f</i>	%
License:		
GN	12	30.8%
RN	27	69.2%
Shifts:		
Days	7	17.9%
Evenings	16	41%
Nights	25	64.1%

## APPENDIX H

Table H2

Prior Work Experience

Prior Work	Frequency	Percent
No Previous Work	17	43.6%
Adult Critical Care (ACC)	3	7.7%
Public Health	2	5.2%
Medical-Surgical (Med-Surg)	2	5.2%
Camp Nurse	2	5.2%
Surgery-Recovery (PACU)	1	2.6%
Neonatal Intensive Care	1	2.6%
Pediatrics (Peds)	1	2.6%
Obstetrics/Gynecology (OBGYN)	1	2.6%
Med-Surg/ACC/Peds	1	2.6%
ACC/Nursing Home (NH)	1	2.6%
Diabetic Education (ED)	1	2.6%
PACU/ACC/ED/OBGYN	1	2.6%
Peds/OBGYN	1	2.6%
Med-Surg/NH	1	2.6%
Med-Surg/OBGYN	1	2.6%
Coronary Care Unit	1	2.6%

## APPENDIX H

Table H3

Area Orienting

Area	Frequency	Percent
Medical Surgical	8	20.5%
Adult Critical Care	8	20.5%
Obstetrics/Gynecology	6	15.4%
Neonatal ICU	3	7.7%
Pediatrics	3	7.7%
Surgery-Recovery	3	7.7%
Education	2	5.2%
Peds ICU	2	5.2%
Prevention Outreach	1	2.6%
Orthopedics	1	2.6%
Oncology	1	2.6%
Peds Specialty Clinic	1	2.6%



## APPENDIX H

Table H4

Orientees' Previous Role and Role Orienting to

Variables	<i>f</i>	%
Previous Roles:		
Staff Nurse	17	43.6%
No Previous Work	17	43.6%
Camp Nurse	2	5.2%
Educator	2	5.2%
Staff Educator	1	2.6%
Role Orienting to:		
Staff RN	35	89.7%
Nurse Clinician	1	2.6%
OR Circulating Nurse	1	2.6%
Clinical Nurse Specialist	1	2.6%
M.O.M.S. Nurse Coordinator	1	2.6%

## LIST OF REFERENCES

## LIST OF REFERENCES

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