THE ROLE OF CHARGE NURSES AS LEADERS IN THE CARE OF EMOTIONALLY DIFFICULT PATIENTS AND FAMILIES

by

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DEDICATION

To my wife Randee who has guided me for 26 years, provided balance, insights, support, kindness, love, appreciation for all that is good in life, and blessed me with two wonderfully creative, kind, and appreciative daughters. There are no *difficult* people in Randee's life for she always sees the good in others, essentially the personification of the message of this manuscript.

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It is difficult to acknowledge all the factors in the production of this manuscript without considering the Hermeneutic Phenomenological framework in which it was written. Heidegger (1962) suggested that humans are more than just the manifestation of their present state. Instead, Heidegger suggested that we are Desian, a collection of our past, present, and future experiences coupled with how we choose to be what we want to be and how we react to the conditions we are in. I am grateful to my Grandparents Israel and Lena who came to this great country as small children, with a dream of making a better life for their children and all the generations who were to follow them. My Grandfather was my first mentor and instilled in me the quest for knowledge as man's penultimate attribute, second only to living a life as a *mench* (a good person). My Father had a desire to continually learn new skills and my Mother was not only a passionate scholar, but a well developed editor, who gave me that gift. I have been blessed with many mentors from Dr. Philips who introduced me to the great philosophers in my early 20s, to my brother Rick a scholar in life, who introduced me to philosophy, Kaballah, and music. Alan Gruskin, an unparalleled Chief of Nephrology and a superb academician. My nephrology work team including Dr. Robin Johnson who first exposed me to the wonders of Family Systems Theory and shaped my framework for patient and family dynamics. My spiritual guides Rabbi Marc Margolius and Rabbi Miles Kressen, who introduced me to the spiritual foundations of Hermeneutics. Mentors in psychology, allowed me to walk with them on their journey: Dr. Anne Kazak and Dr. Stephen Simms, who designed the difficult family protocol and have worked tirelessly to maintain Minuchin's vision of Family Systems Theory. To Dr. Steven Leff who has provided me the opportunity to be

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CHAPTER 1: INTRODUCTION

Difficult[1] patients and families require excessive amounts of health care staff time, creating frustration and stress for nurses (Daum, 1994). Given the current shortage of nurses, it is imperative that nurses have the skills to handle situations in which they encounter emotionally difficult patients and families to reduce stress in their everyday work environment (Heller & Nichols, 2001). The study focused on the role charge nurses play as leaders when experiencing emotionally *difficult* patients and families in a hospital setting. The problem addressed in the study was how to increase understanding of the phenomenon of how nursing leaders react to emotionally *difficult* patients in hospital settings. The term *difficult* may be used by nurses to label what Daum (1994) described as disruptive antisocial patients who flagrantly disregard policies, are verbally abusive, exploitive, manipulative, and physically threatening. The population was charge nurses on several units in a pediatric urban academic hospital in Philadelphia, Pennsylvania.

Using a hermeneutic phenomenological research process, the study explored and described as accurately as possible the deepest meanings of human experience (Donalek, 2004). The significance is that there is limited information regarding effective methods for handling *difficult* patients and families. The nature of the study was an exploratory qualitative method, which has been chosen because there was limited understanding in the research community regarding the dynamics of emotionally *difficult* patients and families. It would be premature to conduct quantitative research on a phenomenon that is not fully understood. The specific research question was, how do charge nurses

[1] The word *difficult* appears in italics throughout the manuscript in an attempt to suggest that it is a label placed on an individual or group by others, and may not represent their true essence as a *being*.

experience and react to emotionally *difficult* patients and families. The analysis identified common patterns, factors, and elements of interest.

The study incorporated theories from various fields of philosophy, organizational dynamics, psychology, nursing, business, and leadership. Major theories that were explored were the philosophical foundations of hermeneutic phenomenology (Heidegger, 1962; Heidegger & Stambaugh, 2002); General Systems Theory (Bertalanffy, 1974); Family Systems Theory (Guerin & Chabot, 1997; Kazak, 2002); and a leadership theory of Middleness (Oshry, 1994, 1996). Definitions are provided for unique usage of terms.

Statement of the Problem

The general problem was that the shortage of nurses in the United States was increasing and the demand for new nurses would outpace the number of nurses retiring or leaving the profession (Heller & Nichols, 2001). One source of tension for nurses is emotionally *difficult* patients and families who require excessive amounts of staff time, create frustration, and stress (Daum, 1994). Given the shortage of nurses, it was imperative that nurses have the skills to handle emotionally *difficult* patients and families to reduce stress in their work environment.

The specific problem was how the nurse who is in charge (Charge Nurse) on a specific hospital unit for an eight-to-twelve hour shift experiences emotionally *difficult* patients and families. It was unclear how frequently charge nurses experience *difficult* patients and families as these cases are typically not reported to administration until they reach the point where they are disruptive to the smooth operation of the unit (Logan & Simms, 2002). The stress these patients and families create has an impact on staff satisfaction, which also is related to the retention of nurses. The qualitative study used a

hermeneutic phenomenological design, consisting of interviews with charge nurses to identify their emotional reactions and actions they take to resolve conflict with emotionally *difficult* patients. The purposive sample was charge nurses from several units in a pediatric urban academic hospital in the Philadelphia, Pennsylvania region.

Background of the Problem

In current literature, the lack of support from community services, the dynamics of the hospital environment, and the dynamics of the health care team have all been suggested as having an impact on the increase in emotionally *difficult* patients (Daum, 1994; Kazak, 2002; Logan & Simms, 2002; Sieben-Hein & Steinmiller, 2005; Sieben, Steinmiller, & Bertolino, 2003; Simms, 1995). *Difficult* patients and families require excessive amounts of staff time, creating frustration and stress for nurses (Daum). Given the current shortage of nurses, it is imperative that people understand emotionally *difficult* patients so they are not such an overwhelming burden to the nursing staff. Charge nurses must have the skills to handle emotionally *difficult* patients and families to reduce stress in their work environment.

The shortage of nurses in the U.S. is increasing, and the demand for new nurses will outpace the number of nurses retiring or leaving the profession (Heller & Nichols, 2001). Aiken, Clarke, Sloan, Sochalski, and Silber (2002) reported that 33% of nurses nationwide complained of inadequate staffing to provide safe and effective care and that job satisfaction of hospital nurses is 200% lower than the average for other U.S. workers. Twenty percent of nurses reported their intent to leave their job in the next year according to Aiken, et al. Suggestions for improving retention of nurses include: improving the work environment, mentoring programs for younger staff, increasing educational

opportunities and tuition reimbursement, less overtime work, and more respect (Buerhaus, Donelan, Ulrich, Norman, & Dittus, 2005). A historical review of past shortages of nurses in the U.S. suggested that a comprehensive nationwide effort is needed to address the problem (Smeltzer, Vlasses, & Robinson, 2005). Collaboration between the healthcare system, community, government, and educators has been suggested as one approach to improve the nursing shortage (Heller & Nichols, 2001).

Data were collected through interviews regarding the lived experience of charge nurses when faced with emotionally *difficult* patients and families. The interview data were analyzed to identify themes. These results may provide insight into the impact of difficult patient and family situations on charge nurses, which may be useful for training purposes or coping strategies, as was suggested by Connelly, Yoder, and Miner-Williams (2003).

Purpose of the Study

The purpose of the non-experimental, qualitative, hermeneutic, phenomenological interview research was to discover how nursing leaders, specifically charge nurses, experience emotionally *difficult* patients in in-patient hospital settings. The research relationships were the charge nurses' interpretation of *difficult* behaviors by patients and families and how this interpretation is related to the charge nurses' ability to deliver clinical care, their relationship with the family, and the impact on the charge nurses' relationships with co-workers. Common patterns, factors, and elements of interest were identified. The results can be used to develop interventions to address the impact of emotionally difficult patients and families on charge nurses.

The specific population for the study consists of nursing leaders in the charge nurse role. The sample was 15 charge nurses from several units in a pediatric urban academic hospital in Philadelphia, Pennsylvania. While the phenomenon of emotionally *difficult* patients and families may exist in other environments, the scope of this particular research project builds upon preliminary work (Logan & Simms, 2002; Sieben-Hein & Steinmiller, 2005; Sieben et al., 2003; Simms, 1995), which was conducted in pediatric locations but was not conclusive, nor did it explore the lived experience of charge nurses.

Significance of the Problem

The importance of the study was that the role of nursing is to care for the human response to illness (American Nurses Association, 2003). This means accepting patients' reactions to their illness, even if it is difficult for the care provider to do so (Simms, 1995). Emotionally *difficult* patients and families create stress for charge nurses and require significant amounts of time (Daum, 1994). Given the current nursing shortage, it is important to find ways of handling *difficult* patients and families in order to reduce nurse turnover. The focus of the study was on the role front line leaders (charge nurses) play in hospital settings when caring for emotionally *difficult* patients and families. Limited information was available regarding effective methods for managing *difficult* patients and families. Several authors have made suggestions for how health care workers can be more effective with emotionally *difficult* patients (Logan & Simms, 2002; Sieben-Hein & Steinmiller, 2005; Sieben et al., 2003; Simms, 1995).

Significance of the Study to Leadership

Front line leaders, such as charge nurses, can be integral in role modeling, mentoring, developing, and leading other nurses. It was important to understand the

influence that charge nurses may have on how *difficult* patients affect the system in which they work. Numerous authors have stated the need for transformational leaders to empower the lower levels of organizations (Bass, 1990, 1999; Buckingham, 1999; Vail, 1996), including leadership skills of charge nurses (Connelly, Yoder, & Miner-Williams, 2003). Several authors have attempted to improve nursing leadership skills (Garland, 2003; Parsons, 1998; Sherman, 2005). Oshry (1994, 1996) explored the role of the Middle coalition in organizations, and found that the power of workers in middle-level positions comes from their ability to process information from the Top and the Bottom and develop an independent Middle perspective. This Middle perspective can be used to develop an action plan that is realistic and to address the institution's needs (Oshry, 1994, 1996). The perspective of charge nurses, as Middles, could include how they experience situations with emotionally *difficult* patients and families. According to Oshry, Middles, by the nature of their work situation, find themselves feeling overworked, pulled in multiple directions, attacked, confused, isolated, and lonely.

Charge nurses may label patients and families as *difficult* because of a lack of understanding their true essence. Heidegger (1962) described *Dasein* as the essence of a human being, different from their appearance to others. Heidegger suggested that *being* is often confused and used interchangeably with presence. Presence refers to the present time, whereas *being,* according to Heidegger, is a representation of the past, current, and future of time (Heidegger). In some ways, *being* is a problematic word to use, because it conjures pre-existing connotations for most people. Heidegger preferred the term *Dasein,* a word used to describe the phenomenon of the whole essence of "being-in-the-world" (p. 78). There is no set way for the essence of a human being, Dasein, to be in the world.

Humans can choose from an infinite variety of ways to be and how they react to the situations they are in.

Nature of Study

Research Methodology

The proposed method of research for the study was qualitative. An exploratory qualitative method was chosen because there was limited understanding in the research community regarding the dynamics of the lived experience of charge nurses in caring for *difficult* patients and families. It would be premature to conduct quantitative research on a phenomenon that was not yet better understood. Previous studies have not fully explored the role of charge nurses in experiencing emotionally *difficult* patients and families, nor measured the success of interventions to reduce staff stress. Qualitative research techniques were used to collect information regarding the dynamics of situations in which charge nurses perceive patients as emotionally *difficult*.

Quantitative research methods were not considered because of limited research or understanding of the given phenomena. Quantitative research may limit a researcher's ability to uncover the full meaning and reality of subjective human experience (van Kaam, 1969). The preconceived set of questions in quantitative research, places restrictions and boundaries on the subjects' responses, which may distort and reduce the information they disclose (van Kaam).

Study Design

Several different qualitative research designs were explored; at least one other design, a case study, appeared to be applicable. A case study would have provided information on one particular *difficult* family or the experience of a single charge nurse.

Other forms of qualitative research would not have allowed for the interactive relationship between researcher and subject that is characteristic of hermeneutic phenomenological research. Given the lack of previous research on the impact of *difficult* patients and families on charge nurses, it was imperative to obtain a wealth of information on the subjective lived experiences of charge nurses in situations with emotionally *difficult* patients and families.

A qualitative study was appropriate because there was limited information available in the research literature about emotionally *difficult* patients. There was a need to achieve a deeper understanding of the dynamics of the phenomenon before conducting further research. The phenomenological study approach was used to help understand a lived experience from the participant's point of view. The topic was explored from the perspective of the participants, with the phenomenon described as it is typically lived and perceived by the participants.

The hermeneutic phenomenological design was used because qualitative research avoids any pre-given interpretative framework. It is important to remain true to the subjects' reporting of the facts from their perspective (Groenewald, 2004). Leedy and Ellis-Ormrod suggested that a purposive sample should range from 5-25 individuals. The study used in-depth, unstructured interviews from a purposive sample of 15 charge nurses, selected from several in-patient nursing units using snowball sampling, as described by Groenewald (2004).

Research Questions

Four research questions were identified which became the basis for 13 formal questions. The four research questions focused on the lived experiences of charge nurses when dealing with emotionally *difficult* patients and families:

The first research question was, What is the lived experiences of charge nurses when dealing with emotionally *difficult* patients and families?

The second research question was, What are the interactions of the charge nurse with other members of the hospital team when confronted with emotionally *difficult* patients and families?

The third research question was, How do charge nurses experience the dynamics of how other staff handle emotionally *difficult* patients and families? The study explored what knowledge, skills, and assistance charge nurses believe they need to care for emotionally *difficult* patients and families.

The fourth research question was, What do charge nurses experience as the dimensions of their leadership role in helping to resolve these *difficult* patient and family situations?

Theoretical Framework

Two theories, Family Systems Theory (Guerin & Chabot, 1997; Kazak, 2002) and the leadership theory of Middleness (Oshry, 1994) provide the conceptual framework for the study. Hermeneutic phenomenological research addresses the foundations of subjective experience that lie below layers of suppositions and presuppositions that are a part of our language and theoretical systems. The lived experiences of charge nurses with emotionally *difficult* patients and families was explored using a hermeneutic

phenomenological approach based on the conceptual frameworks of Family Systems Theory and Middleness Theory.

There was limited research literature that specifically addressed the issue of emotionally *difficult* patients and families in pediatric inpatient hospital settings. Theories from various fields of philosophy, organizational dynamics, psychology, nursing, business, and leadership was discussed in relation to the study. The majority of the literature on leadership in health care and business has been primarily descriptive, with little research on the effect of leadership on health care outcomes, changes in patient care, or improvements in organizations (Vance & Larson, 2002, p. 165).

Family Systems Theory (Guerin & Chabot, 1997; Kazak, 2002) was developed as a branch of General Systems Theory (Bertalanffy, 1974), and specifically focused on the dynamics of the family as a system. Families behave in consistent patterns, often based on faulty assumptions about other people (Kazak, 2002). These faulty assumptions can lead to mislabeling of people. Such mislabeling can result in patterns of behavior that reinforce the faulty assumption, leading to tension, arguments, and further stereotyping of people (Kazak). This conceptual model was consistent with Heidegger's (1962) work on the essence of beings. Heidegger suggested that people do not fully understand other human beings, which can lead to misconceptions regarding the motivations behind human behavior. Family Systems Theory, Heidegger, Middleness, and General Systems Theory may all explain the lived experience of charge nurses when they encounter emotionally *difficult* patients and families.

Oshry's leadership theory of Middleness, which is based on a general systems theory framework, described the way that people in roles in the various layers of an

organization behave in specific stereotypical and predictable patterns (Oshry, 1994, 1996). Middles tend to get caught between the Top executive layer of the organization and the Bottom layer of front line workers. The significance is that charge nurses are Middles and thus caught between the need to please the Tops, while simultaneously addressing the needs of the Bottoms. According to Oshry's theory, to please the Tops, charge nurses may disappoint the Bottoms or the inverse may occur. Oshry's Middleness theory may help to describe the dynamics of the lived experience of charge nurses when they encounter emotionally *difficult* patients and families.

Implications for Other Research

A lack of nursing leadership may complicate the current nursing shortage. This lack of leadership may affect charge nurses' ability to address *difficult* patient situations. One example of Middleness is the charge nurse's role in caring for emotionally challenging patients. Kazak, Simms, and Rourke (2002) purported that clinicians try to control patient's behavior rather than looking at the interplay of staff, patients, and families as one big system that is related to patient behavior. Logan and Simms (2002) found that psychiatric labeling of patients interfered with looking at situations systematically. Several models exist for addressing workplace situations in a systematic way (Senge, 1990; Senge et al., 1994; Senge et al., 1999, Senge, 2006).

One solution to the situation of emotionally *difficult* patients and families may be the development of charge nurses' leadership skills in the Middles role. The charge nurse may see his or her role as doing concrete tasks. In reality, the bigger role is to be a systems integrator, balancing the needs of the patient, family, care team, and the impact of the patient's medical plan of care (Kazak, 2002).

Gaps in the Literature

There are specific gaps in the literature regarding the impact of emotionally *difficult* patients and families on charge nurses. There was limited specific research on the topic of nursing leadership in caring for emotionally *difficult* patients and families; several authors have explored various aspects of the research topic (Logan & Simms, 2002; Sieben-Hein & Steinmiller, 2005; Sieben et al., 2003; Simms, 1995). A review of germinal literature was necessary to address this gap. A historical review of General Systems Theory, Family Systems Theory, and the leadership theory of Middleness provide the theoretical framework for the study, although much of that literature was greater than five years old. Several contemporary authors have also explored various aspects of the research topic. Connelly, Yoder, et al. (2003) studied the leadership characteristics of charge nurses. Daum (1994) identified the characteristics of *difficult* patients. Several authors reviewed approaches they found effective in handling *difficult* patients and families, although these were not research based studies (Logan & Simms, 2002; Sieben-Hein & Steinmiller, 2005; Sieben et al., 2003; Simms, 1995). A literature gap exists regarding the specifics of the impact of emotionally *difficult* patients and families on charge nurses.

Controversies in the Field

Controversies in the field exist regarding the ownership of the problem of the *difficult* patient. There is disagreement as to whether it is a problem that exists in the patient or an issue that must be addressed by the care team. Most of the existing literature consists of case studies and authors' opinions based on their experience. A hermeneutic

phenomenological study may be the first research study to explore the topic in depth, beginning with the unique perspective of charge nurses' lived experiences.

The main controversy in the field is whether disruptive behavior resides in the patient or whether it is a reflection of the dynamics of the patient, family, and health care team (Kazak, 2002). The basics of systems theory have also been explored in business applications (Senge, 1990; Senge et al., 1994; Senge et al., 1999, Senge, 2006).The controversy often manifests as a debate between members of the health care team about forcing the patient/family to receive therapy rather than the team examining their behavior and the role of the team in these situations. It is a question of control. Several authors suggested that we have limited control over other peoples' behavior and have ultimate control over ourselves, our circle of influence, and how we react to situations (Covey, 1990, 2004; Seligman, 1998).

Definition of Terms

The following definitions assisted the reader in understanding essential concepts.

Bracketing

Bracketing is a process used in phenomenological research in which an attempt is made to eliminate all preconceived notions from both the external world and the researcher's consciousness. Bracketing is not to doubt your existence in a situation, but to separate oneself from the pre-existing paradigms that control our thoughts (Koch, 1995).

Charge Nurse

The Charge Nurse is an individual responsible for the leadership of a team of nurses on a particular inpatient unit for one shift of work (Connelly, Yoder, & Miner-

Williams, 2003). The study participants must be in a leadership role as a charge nurse at least 50% of their scheduled workdays.

Dasein

Heidegger (1962) described *Dasein* as the essence of a human being, different from their appearance to others. Heidegger suggested that *being* is often confused and used interchangeably with presence. Presence speaks of the present time whereas *being,* according to Heidegger, is a representation of the past, current, and future of time (Heidegger, 1962). In some ways, *being* is a problematic word to use because it conjures pre-existing connotations for most people. Heidegger preferred the term *Dasein,* a word used to describe the phenomenon of the whole essence of 'being-in-the-world' (p. 78). There is no set way for Dasein to be in the world, as the Dasein of a human being can choose to be what they want to be and how they react to the conditions, they are in.

Difficult

The focus of the study was the role of the charge nurse as a leader in situations with emotionally *difficult* patients. The word *difficult* appears in italics throughout the manuscript in an attempt to suggest that it is a label placed on an individual or group by others, and may not represent their true essence as a *being*. The term *difficult* may be used by nurses to label what Daum (1994) described as disruptive antisocial patients who flagrantly disregard policies, are verbally abusive, exploitive, manipulative, and physically threatening. Nurses may feel angry, anxious, fearful, and helpless, but they may not necessarily understand the essence of these individuals and how this essence affects nurses' lived experience and interpretation of the *difficult* patient and families' behavior. *Emotionally* was used to differentiate the behavioral component of the *difficult*

patient, as opposed to patients who are clinically difficult and challenging due to the complications of their physical health and the disease process.

Expressive Emotion

Expressive Emotion (EE) is a term used to describe emotionally *difficult* patients and families. Families with expressive emotion exhibit high levels of criticism, hostility, or emotional over-involvement (Berman & Heru, 2005).

Hermeneutic Circle.

A hermeneutic phenomenological approach was used. The hermeneutic circle is a process of exploring a topic in depth. In hermeneutic research, a form of phenomenology, interview transcripts are reviewed and themes developed. The themes are verified with the participants and experts in fields related to the research, and the process is repeated until a saturation point is reached, where further inquire does not reveal any new themes of information. At that point it is determined that a thorough grasp of the meaning of the subjects lived experience is achieved (Bentz & Shapiro, 1998; Donalek, 2004; Koch, 1995, 1998; Moustakas, 1994).

Middleness

Oshry's (1994, 1996) theory of Middleness described the interactions of the various layers of an organization. Oshry described Middleness as a condition, rather than a position. Middleness is a condition in which an individual exists between two or more groups who exert pressure on the Middle to focus on their different priorities, perspectives, goals, and needs (Oshry, 1994). The Top is the upper layer of management in an organization or anyone who has responsibility for others in an organization (Oshry,

1994, 1996). Bottoms are defined as the lower layer of an organization or members who report to others of higher authority and responsibility.

Therapeutic Triad

One approach to emotionally *difficult* patients and families may be to develop a therapeutic triad. A therapeutic triad is a process in which the therapist brings together the patient, family, and health care team to engage in a process of working together. The process involves narrowing their focus to mutually agreed upon goals, promoting family competence, and emphasizing collaboration between the health care team and family, who are equally responsible for the outcome (Kazak, 2002).

Assumptions

There are two classes of assumptions; those foundational to a theory, and those foundational to the research procedures. The research involved interviews with subjects who are charge nurses. There is a basic research assumption that, as front line leaders, the lived experience of the charge nurses and their impact as leaders is reflective of typical leaders, and the results can be generalized to other populations. It is further assumed that the research participants were honest and accurate in describing their personal experiences, and that researcher bias was minimal in this phenomenological study.

The major theoretical assumption was that charge nurses and other staff are motivated to improve their skills in handling emotionally *difficult* patients and families. Individuals are often assigned to the charge nurse role and may not be motivated to be successful in the role by improving their skills. Research on charge nurses found that they often received limited training for the role and felt unprepared (Connelly, Yoder, & Miner-Williams, 2003).

The study took place in a pediatric inner city academic hospital. The results may be generalizable to other hospital situations. There may be factors unique to pediatrics and inner city academic medical settings that contribute to the phenomenon as it was explored in this particular study.

Limitations

The scope of the study was to interview charge nurses on several inpatient care units at The Children's Hospital of Philadelphia, an inner city pediatric academic in Philadelphia, Pennsylvania, to explore their lived experiences with difficult patients and their families. The Children's Hospital of Philadelphia is one of the largest pediatric facilities in the country and is part of an academic university.

The limitations of the study are that the results may add to the body of knowledge of leadership in pediatric academic inner city hospitals, yet they may not be generalizable beyond the boundaries of the particular facility studied. There may be dynamics unique to the facility that contribute to the phenomenon studied that are not present in other settings.

Another study limitation was the effect of social desirability on the participants. Social desirability has been described as the difference between an individual's intention and his or her perception of what he or she is expected to say (Chung, 2003). Charge nurses understand to some extent the socially acceptable, *right* thing to do when caring for patients. One limitation in asking participants to describe their behavior is that it is self-reported information that may not conform to their actual behavior in these situations.

The external validity of a research study is the extent to which the results can be applied to situations beyond the boundaries of the study sample, location, and context (Creswell, 2002). Generalizability of phenomenological findings is often weak due to the many factors involved in the context of the research study. The results may add to the body of knowledge and provide direction for further in-depth research that was more generalizable.

Delimitations

Charge nurses from at least two units, a general medical surgical unit and an intensive care unit, were interviewed. The participants must be in a leadership role as a charge nurse at least 50% of their scheduled work days. Prospective participants must have had regular interactions with staff nurses who directly report to them in their role as charge nurse. The participants must be willing to be open and honest in sharing their lived experiences in the research interview. The charge nurses were from a limited number of units, which may further limit the generalizability of the results.

Summary

Chapter one presented a brief background discussion of the growing shortage of nurses, followed by a statement of the problem to be researched. The shortage of nurses in the U.S. is increasing, and the demand for new nurses will outpace the number of nurses retiring or leaving the profession (Heller & Nichols, 2001). *Difficult* patients and families require excessive amounts of staff time, creating frustration and stress for nurses (Daum, 1994). Given the current shortage of nurses, it is imperative that charge nurses understand emotionally *difficult* patients so they are not such an overwhelming burden to the nursing staff.

The specific problem for the research was how to understand the phenomenon of how nursing leaders, specifically charge nurses, react to emotionally *difficult* patients in hospital settings. The study population was charge nurses in a pediatric urban academic hospital in Philadelphia, Pennsylvania. The research was conducted using an exploratory qualitative analysis approach. Using a hermeneutic phenomenological research process, the study explored and describe as accurately as possible the deepest meanings of human experience (Donalek, 2004). The significance of the research was that there was limited information regarding effective methods for managing *difficult* patients and families. Given the current nursing shortage, it is important to find ways of addressing the impact of emotionally *difficult* patients and families on charge nurses. An exploratory qualitative hermeneutic phenomenological method was proposed because there was limited understanding in the research community regarding the dynamics of emotionally *difficult* patients and families on charge nurses.

The specific research question was, How do charge nurses experience and react to emotionally *difficult* patients and families? The conceptual and theoretical frameworks are limited due to the lack of specific research literature that addresses the issue of emotionally *difficult* patients and families in pediatric inpatient hospital settings. Theories from philosophy, organizational dynamics, psychology, nursing, business, and leadership were incorporated in the literature review. Major theories explored included General Systems Theory, Family Systems Theory, and the theory of Middleness (Oshry, 1994, 1996). Definitions were provided for unique usage of terms. Assumptions are that qualitative research is based on interviews with subjects who were honest and accurate in

describing their personal experiences, and that the results may be generalized to other situations.

The scope was to interview charge nurses on several inpatient care units in an inner city pediatric academic hospital in Philadelphia, Pennsylvania in order to understand their lived experiences with *difficult* patients and their families. Data were collected through interviews with charge nurses from at least two units, a general medical surgical unit and an intensive care unit. The limitations are that the results may add to the body of knowledge of leadership in pediatric academic inner city hospitals, but may not be generalizable beyond the boundaries of the particular facility studied. There may be dynamics unique to the facility that may not be present in other settings that contribute to the phenomenon studied.

Chapter 2 will explore the literature regarding *difficult* patients and families and the impact of working with *difficult* patients and families on charge nurses. Limited research exists that describes the role of nursing leadership and the dynamics of caring for emotionally *difficult* patients and families. A review of the literature was essential to understanding the underlying theories. These theories may become a basis for new approaches to improve the effectiveness of leaders in assisting health care workers to overcome challenges in their relationships with *difficult* patients and their families to serve them more effectively. A hermeneutic phenomenological approach was used to explore how charge nurses in a pediatric hospital setting in the Northeast region of the United States experience their interactions in working with *difficult* patients and their families.

While there was limited research directly related to the research topic, several authors have explored various related aspects, including leadership characteristics of charge nurses, characteristics of difficult patients, and approaches other health care workers have found to be effective. These topics will be explored further in chapter two.

CHAPTER 2: LITERATURE REVIEW

The way charge nurses experience emotionally *difficult* patients and families in a hospital setting was the focus of the literature review. Chapter 2 presents a discussion of the process of the search; historical overview; current writings and research, controversies, and gaps; socio-cultural structures, patterns, and processes of interest; alternative viewpoints; and the conclusion. The general problem was the shortage of nurses in the United States was increasing and the demand for new nurses will outpace the number of nurses retiring or leaving the profession (Heller & Nichols, 2001). One source of tension for nurses was emotionally *difficult* patients and families who require excessive amounts of staff time and create frustration and stress (Daum, 1994). Given the current shortage of nurses, it was imperative that nurses have the skills to manage *difficult* patients and their families to reduce stress in the nurses' work environment, which may lead to nurse turnover. The specific problem for the study was how the charge nurse on a specific hospital unit for an eight to twelve hour shift experiences emotionally *difficult* patients and families. A hermeneutic phenomenological design using interviews with charge nurses will identify their emotional reactions and actions they take to resolve conflict with emotionally *difficult* patients and families in a hospital setting.

The focus was front line nurse leaders in hospital settings, the charge nurse. Given the nursing shortage, it was important that nurses have the proper tools to deal with *difficult* patients and their families to avoid further stress, which may result in nurses leaving the work setting (Heller & Nichols, 2001). Nurses and physicians often lack the skills to handle *difficult* patients and their families, and may avoid them, overreact, or retaliate (Daum, 1994). The focus of nursing is the human response to illness and/or its

treatment (American Nurses Association, 2003).This focus should include how people react to their illness, which may include being angry. Anger is also one of the stages of the grieving process, and may be a predictable way of reacting to hearing that one has a major illness (Kent & McDowell, 2004). The nurse's role is to help the patient and family, whether or not the patient is angry, difficult, cooperative, or behaves nicely. For example, Pediatric nurses also must care for adolescents, who are in a developmental stage where it is appropriate at times to be angry (Poa, 2006).

The significance of the study was that emotionally *difficult* families create stress on charge nurses and understanding their lived experience may assist in identifying interventions to improve the situation. There was a need to understand the impact on front line leaders, charge nurses, before interventions can be designed to assist them and other team members to overcome their challenges in working with emotionally *difficult* patients and families. As front-line leaders, charge nurses can play an important role in how other members of the team address these situations, but it was first necessary to understand the lived experience of the charge nurse in working with *difficult* patients.

The hospital is a system with a mission of healing. As a system, the hospital also has a natural tendency to protect and maintain its existence. The *difficult* patient and family may represent a challenge to the need for the hospital system to maintain smooth operations and the status quo. Many authors have developed theories that are applicable to the dynamics of these situations; no single theory has been researched and incorporated into a comprehensive approach to understanding *difficult* patients and their families. The way charge nurses experience emotionally *difficult* patients and families in a hospital setting was the focus of the literature review. Chapter 2 presents a discussion of

the process of the search; historical overview; current writings and research, controversies, and gaps; socio-cultural structures, patterns, and processes of interest; alternative viewpoints; and the conclusion.

Title Search

The literature search consisted of articles from peer-reviewed journals, primarily from the past five years, and books from significant experts in their given field. The title search began with a review of the literature on *difficult* patients and families in hospital settings. While over 200 articles were reviewed, 127 were used as specific references. A review of the literature revealed limited results; only one research group, Connelly, Nabarrete et al. (2003) examined the issue of *difficult* people and the relationship to charge nurses.

There are a variety of fields that provide insight into the reaction of nursing leaders to emotionally *difficult* patients and families. A literature review of family systems theory provided significant results. An expert in the field suggested a review of General Systems Theory as a foundation for explaining complex situations. An extensive review of General Systems Theory revealed that it was the foundation for family systems theories, which have been used to explain the dynamics of family and group interactions. Within the body of General Systems Theory, Oshry (1966, 1990, 1994, 1996; Schlesinger & Oshry, 1984) applied the concepts to the hierarchical levels of organizations in the theory of Middleness (Oshry, 1994), which may have applicability to the plight of charge nurses. While there were significant gaps in the title search, current findings include the work of psychology researchers such as Simms (Logan & Simms, 2002), Kazak (Kazak, Simms & Rourke, 2002) and nurses who have explored the impact of emotionally

difficult patients and families in hospital settings (Sieben-Hein & Steinmiller, 2005; Sieben et al., 2003). There was little literature on the role charge nurses play in these situations, although Connelly (Connelly, Yoder et al., 2003) has done some qualitative research and made suggestions for the training and development of front line nursing leaders (Connelly, Nabarrette et al., 2003).

Gaps in the Literature

The gap in the current literature pertains to the lack of research to explain the lived experience of health care workers, specifically leaders such as charge nurses, with *difficult* patients and families. Several researchers attempted to explain the situation and made suggestions for interventions; further research was needed to fully understand the experience from the perspective of the lived experiences of the subjects. There does not appear to be a definitive approach to understanding the phenomenon of working with *difficult* patients and their families. There was a need for qualitative research to provide better explanations of the situation from the perspective of subjects experiencing it in their daily lives.

Historical Overview

The discussion of the foundation of the research included a historical review of the literature, current findings in family systems theory and on *difficult* patients, a review of hermeneutic phenomenology, the impact for nursing leaders, and gaps in the current research. This section includes a discussion of the history of General Systems Theory, the subsequent development of Family Systems Theories in the psychosocial fields, Oshry's theory of Middleness, and the application of these various theories to the ways charge nurses care for emotionally *difficult* children and families. Systems Theories challenge

the mechanistic, compartmentalized thinking that has dominated the scientific era of management and clinical thinking in healthcare (Chapman, 2005). Systems theories may be useful in explaining why, despite policies, values, and common sense, results of efforts in the workplace may still be less than ideal, and may even include adverse effects (Chapman, 2005). Chapman cited a story by Plsek to show that comparing mechanistic thinking to systems thinking is like using the analogy of throwing a lump of coal versus throwing a live bird. Using physics, the trajectory of the coal can be calculated quite accurately, but predicting the destination of a live bird is more complicated. The bird's size, weight, color and chemical composition can be measured. While the bird's motion through the air is governed by the laws of physics, the bird is also a living organism with the potential to adapt and change direction, affecting the observer's ability to predict the final destination.

The workplace has been described as more analogous to a living organism than the clockworks of classical physics (Wheatley, 1994; Wheatley & Kellner-Rogers, 1996). Through the process of reduction, mechanistic thinking breaks down complex situations into manageable parts for ease of understanding, but at the cost of details and connections that may be essential to the meaning of the phenomena (Chapman, 2005). Systems thinking presumes that there is more than one correct, valid perspective to a situation, based on the multiple interactions of the parts that results in a final product that is greater than the individual pieces (Chapman). Systems theories have been adapted to a variety of fields of study and settings.

General Systems Theory

The beginnings of General Systems Theory is often attributed to Ludwig von Bertalanffy (Lewis, 2005). Bertalanffy's theory has been described as Weltanschauung or "worldview"; Lewis suggests an alternative translation of the German word as "philosophy of life," which would be more consistent with the rooting of Bertalanffy's theory in the classical philosophies. Bertalanffy credited the early philosophers with the concepts and foundation of General Systems Theory (Bertalanffy, 1974). Early humans conceived of the world as a chaotic, hostile environment, until the Greek philosophers began describing a world that was organized, intelligible, and controllable through thoughts and rational action (Bertalanffy). According to Bertalanffy, in 300 B.C., Aristotle first introduced the concept that the whole was greater than the sum of its parts. Nicholas of Cusa, a Catholic Cardinal, mathematician, and astronomer in the early 1400s, introduced the concept of coincidentia oppositorum, the dueling forces of the parts within a whole system (Bertalanffy). Bertalanffy stated that later work by Leibniz in mathematics, Hegel and Marx in philosophy, and Fechner on life communities, further emphasized a structured, causal, mathematical, systemic nature to the universe. While they used the language of their generation, the concepts were still the basis of systems theory (Bertalanffy).

In the late 1920s, Bertalanffy (1974) suggested that the fundamental character of living organisms is the organization and interaction of the parts. Bertalanffy suggested that a complete explanation of vital phenomena could not be captured by investigating only the single parts or processes. Bertalanffy's ideas later expanded to General Systems Theory, which included all types of organized entities, including social groups,

personality, and technological devices. In General Systems Theory, a system is made up of dynamic elements that are interconnected and maintain their integrity through mutual interactions (Lewis, 2005). An organism is not reduced to the sum of its individual parts; instead, the focus is on the relationships between the parts, which becomes the greater whole (Lewis). According to Lewis, Bertalanffy's early work sought to organize biology systematically in an open systems context. Bertalanffy's views were different from cybernetics theory, in which constraining forces provide feedback to maintain homeostasis (Lewis).

Cybernetics

Within the field of General Systems Theories, Cybernetics was perhaps the first interdisciplinary field to bring together research in engineering sciences and biology. Cybernetics combined research from communications, servomechanisms (devices that operate based on a continuous feedback loops), computers, and the nervous system (Rav, 2002). The foundations of Cybernetics took place in the early 1940s but received significant attention after the publication of Wiener's work in 1948 (Wiener, 1965). Cybernetics influenced other work and led to the fields of robotics, systems theory, artificial intelligence, neural networks, brain theory, cognitive science, and informatics (Rav, p. 781). Weiner was influenced by earlier researchers, including physiologist Cannon, who described the concept of homeostasis as the equilibrium produced by the balance of functions and chemical composition of an organism (Rav, p. 784). According to Rav, the concept of homeostasis was eventually extended to interactions between an organism and its environment, becoming the basis for the cybernetic concept of feedback.

The early work in cybernetics was conducted in an era in which the primary research in psychology was being conducted by researchers like Skinner (2002), who described the human organism as somewhat of a black box that was affected by external stimuli and passively reacted to the stimuli. Skinner attempted to reduce human behavior to a simplistic series of stimuli-response events that could be measured quantitatively, predicted, and consistently reproduced. In contrast, behavior in Cybernetics was described by Rosenblueth and Weiner (Rav, 2002) as purposeful and could be studied much like other mechanical objects, using mathematical models to describe human physiology and behavior.

The Early History and Organization of Systems Theory

By the 1950s, two major organizations had emerged: The Society for General Systems Research, which explored systems theory in the general sciences; and The General Systems Theory and Psychiatry task group of the American Psychiatric Society, which examined human behavior from a systems theory perspective (Bertalanffy, 1974). The Society for General Systems Research was founded by Bertalanffy, Boulding, Gerard, Miller, and Rapoport (International Society for the System Sciences, n.d.) and later included such notable members as Bateson, Mead, Wiener, Lewin (Jurish & Myers-Bowman, 1998), and Cadwallader (personal communication, February 5, 2006), currently a professor at the University of Phoenix. Three broad paths emerged in General Systems Theory applications: mathematics, technology, and philosophy (Bertalanffy).

Systems theories have also been applied to health care. One area that was explored was the application of systems theories to Family Systems Theory in the psychosocial fields. Systems thinking has applications to the ways in which charge nurses

work. Family Systems Theory provides a framework for understanding the way health care teams act and interact as they relate to patients and families.

As early as 1958, Cadwallader (1958) suggested there were at least three classes of social change: reproducing, non-reproducing, and mixed. Putney (1972) suggested that American society is structured in seven institutional sectors, from the family to organized societal structures. Putney suggested that institutions attempt to enforce family values and structures, with the mistaken assumption that families are functional. Goffman (1959, 1961) conducted extensive sociological research on the oppressive nature of health care institutions, primarily mental hospitals in the 1950s. The clash between family and institutions may result in conflicts and confusion for hospitalized patients and their family.

Cadwallader (1958) suggested that reproducing systems regenerate over time, producing clones of the previous generation of system. Non-reproducing systems evolve through learning and innovation, changing their character over time. Mixed systems change through a combination of learning, innovation, and systematic drift. The question is, how does change occur in a hospital environment, specifically as it relates to the hospital system colliding with the patient's family systems and the specific needs and contradictions of their separate and distinct systems?

The specific focus of the study was the reaction of nurse leaders to emotionally *difficult* patients and families. One theory may be that the hospital is an organized formal system, while the family is a somewhat less formal yet still organized system. Each of these separate and distinct systems is goal seeking, self-correcting, and system-maintaining (homeostatic). The elements (sub-systems) that make up the system are all

constrained by the system's prime directive, which is survival and maintaining the status quo. Families, while more informal organizations, are still goal-seeking and system-maintaining (homeostatic). These systems may be similar but also have conflicting agendas. While it is assumed that both systems are interested in the child getting better, it is how that goal is achieved that has the potential for conflict and perhaps misrepresentation of the family as *difficult.* The members of the hospital system may have dual agendas: what is good for the patient and what is good for the hospital staff. These agendas may compete with each other. This theory was one of the themes explored during the course of this phenomenological research study.

Communications Models

The Communications Models began with Bateson, an anthropologist who founded The Bateson Project in California in the early 1950s. Bateson explored communication patterns in families with a schizophrenic member. Bateson's focus was more on the process of communication than therapy. The foundation of Bateson's research was animal behavior, evolution, ecology, and cybernetics (Guerin & Chabot, 1997). Bateson was joined by Haley, a communications expert, Weakland, a chemical engineer interested in cultural anthropology, Jackson, a psychiatrist, and other notables such as Wiener. They interviewed schizophrenic patients and developed a double bind theory to explain how relationships are repeated experiences that maintain family homeostasis. Status quo in family relationships is maintained through multiple contradictory levels of communication, balancing the explicit meaning of communication and contradicting them with other implicit messages. The classic implied meaning is "Do not do X or you will be punished," which may be countered by a different message from other families

members. It is also implied that responses are demanded and individuals cannot escape the family. Eventually, victims become conditioned to perceive themselves as trapped in a world of double binds with no escape, leading to panic and rage (Bateson, 1956). Jackson and Bateson believed that behavior and communication were synonymous, that families resist change, and when challenged, families strive to maintain their status quo. Symptomology may eventually manifest in one or more family members. One example could be a child's psychological symptoms manifesting as a result of hidden parental conflict (Guerin & Chabot).

Bateson's original theories evolved into clinical patterns regarding the nature of family communication: Families tend to maintain the status quo even if it is a dysfunctional relationship. Individuals become trapped in unhealthy relationships, and any attempt to break free is met with counter-reactions, resulting in "friction, frustration, anxiety…and eventually symptoms" (Guerin & Chabot, 1977, p. 192). The goal of therapy is to overcome family resistance by shifting the behavioral cycle, resulting in resolution of symptoms. Guerin and Chabot credited Bateson's anthropological roots for the evolution of therapy as an art form, like other non-traditional healing methods attributed to shaman, as opposed to more linear models found in traditional medicine.

Haley's work with Bateson suggested that clinical symptoms and behavioral patterns were a strategy (power struggle) for obtaining control within the context of a relationship (Guerin & Chabot, 1997). Most of these thoughts were not on a conscious level. Given the natural homeostasis of families to maintain the status quo, direct confrontation by the therapist would only result in resistance. Haley's recommendation was to create therapeutic counterstrategies that bypass or confuse the family, create

chaos, and allow the opportunity for the family to reorganize their behavior patterns differently. Haley paid particular attention to the power distribution in families, especially their hierarchical nature, and created strategic interventions. Haley later worked with Minuchin to formalize Minuchin's theories into Structural Family Therapy. Haley believed directly educating the family was useless given the family dynamic to maintain status quo. Haley never explained himself to the families, and operated strategically and covertly to alter the power process within the relationship.

The Milan Associates

The Milan Associates consisted of Selvini-Palazoli, a psychoanalytically trained psychiatrist who began treating anorexic children and later worked with schizophrenic families using what the business literature would describe as a contingency theory (one that combines multiple theories). Selvini-Plazoli used concepts from Bateson, strategic therapy, Minuchin, Jackson, and Bowen (Guerin & Chabot, 1997). The Milan model is classified as a long brief therapy where sessions were held once a month (as opposed to the traditional weekly sessions) to allow time for processing of insights and reduced dependency on the therapist. The word "long" is meant to apply to the intervals between the sessions, which are typically once a month. The therapist tends to focus on making only small changes focusing on symptom relief, in order to increase the client investment in the therapy. This is consistent with Block's (2002) model in business settings, where overdependence on leaders fosters a lack of independence and autonomy in subordinates. The Milan model focused on the underlying family rules, power, and control. Of note was the use of circular questioning, a technique for framing questions to provide the potential for insight into how each family member perceives events and relationships

differently (Guerin & Chabot). Circular questioning is quite similar to the principles in the hermeneutic phenomenology research methodology to be used in the proposed study. Both the Milan and Bowen models emphasize therapist neutrality. The Milan model remained allied with all family members while Bowen remained allied with none. Both models also used the concepts of paradox and counterparadoxing, concepts in which the therapist takes and approach that is counter to their traditional approach, thus pushing the patient to rethink their traditional response.

Brief Therapy

Brief Therapy emerged as a model in which a clinical problem is identified as an attempt to solve a problem, which instead becomes a repetitive sequence of behaviors between the players in the relationship (Watzlawick, Ekavin, & Jackson, 1967). Disturbed behavior was described as a communication reaction to the particular situations in a family relationship situation rather than a manifestation of psychological disease in any one of the individual minds (Watzlawick et al.). The goal of brief therapy is to break the pattern of the cycle and provide an opportunity to react in a different manner. Watzlawick et al. later wrote about problem formation, resolution, first-order change, second-order change, and reframing.

These concepts were incorporated into business literature by Argyris (Korth, 2000). First-order changes occur within a system without changing the system, and are reactions to the situation. Second-order changes are a reframing of the situation and establishing a new pattern of behavior. It is particularly helpful to use therapeutic paradoxing to present "weird and unusual" solutions, which provide insight and re-pattern behaviors (Guerin & Chabot, 1977, p. 191). One example would be to ask the

staff to take a totally contrary approach with a *difficult* family such as asking them to leave the hospital. The therapist may not want them to necessarily take that approach, but it could prompt some new ways of thinking.

Multi-Generational Psychoanalytic Theory

Psychoanalytic Multigenerational Theorists defined the family unit as at least three generations. The traditional Freudian therapy community resisted family approaches except as a way of educating individuals about impact of their family of origin on their resistance to therapy, or to open communications around tension-filled issues within the family (Guerin & Chabot, 1977, p. 193). The concern of Freudian therapists was that involving the entire family could interfere with the therapist-patient relationship.

Nagy, a psychiatrist, and Framo, a psychologist, consolidated several theories into a psychoanalytical framework based on multi-generational family loyalty, coalitions, and alliances (Guerin & Chabot, 1997). Nagy suggested there is an implied "family ledger" of past obligations, debts, and perceptions of events as relationship atrocities that require some sort of retribution (Guerin & Chabot). The goal of therapy is to reframe these situations to provide "facesaving" insights, which can provide the opportunity to change the way members behave in their current relationships (Guerin & Chabot, p. 194).

Bell and Wynn were traditional psychoanalytical therapists who developed a group focus to their approach. Bell described seven stages of a therapeutic group relationship from initiation, through a power struggle with the therapist, to the actual therapeutic work and eventual separation from the therapist (Guerin & Chabot, 1997). Wynn described the concept of pseudomutuality, in which the family presents a surface

appearance of agreement and attachment to each other that masks their dysfunctional roles (Guerin & Chabot). The therapist, as an outsider, may experience difficulty engaging the family if certain unwritten rules are violated.

Bowen, another psychoanalyst, traced his roots to Freud but explained human emotional functioning with a systems orientation (Guerin & Chabot, 1997). Bowen is responsible for many theoretical concepts, but the core of his theory is differentiation of self and triangulation (Guerin & Chabot). Differentiation describes the way competing forces of emotional fusion interfaces with the individuation of family members. Emotional fusion is the automatic reflexive response that anxiety by the parent or child elicits in the other. The goal of a highly functioning individual is differentiation, breaking free of the cycle of emotional reactivity and behaving independently (Guerin & Chabot). Bowen suggested that if one family member broke free of the emotional fusion cycle, it would create a chain reaction of lowered anxiety throughout the family.

The goal of Bowenian therapy is to remain emotionally detached from the patient. The therapist needs to also understand relationship dynamics in the therapist's own family of origin (Guerin & Chabot, 1997). Bowen suggested that the therapist construct a family diagram including identification of the family's emotional functioning in each relationship; observing and learning to control one's own emotional reactivity to one's family; remaining non-reactive during periods of intense anxiety within one's own family system (detriangulation); and to develop person-to-person relationships with as many family members as possible (Guerin & Chabot, pp. 198-199). Remaining emotionally detached may prove valuable for hermeneutic phenomenological researchers seeking to bracket their own emotions and biases from the subjects they are studying.

Bowen discovered the triangulation phenomena when expanding the research beyond the mother-child relationship and began investigating fathers and their relationship to the process. Bowen found that these relationships were like a triangle in a dynamic process in which the emotional fusion-anxiety reaction cycle manifested itself in both parents with the child (Guerin & Chabot, 1997). At any point in time, the parents could potentially play opposite roles, with one's behavior producing the anxiety and the other trying to reduce the anxiety (Guerin & Chabot). Triangulation refers to the emotional process, while the triangle is the actual structure of the relationship, both of which can change over time. Bowen suggested that the most uncomfortable person in a triangle may try to lower his or her anxiety or emotional tension by moving toward a person or thing, which results in another person becoming the more uncomfortable one (Guerin & Chabot).

Experiential Therapy

Whitaker, an experiential therapist, did not believe in theories but believed the goal of therapy was to facilitate individual autonomy and a sense of belonging within the family by escalating the family's emotional experience rather than conceptual understanding (Guerin & Chabot, 1997). Whitaker escalated the family's *craziness* to a level of absurdity (Guerin & Chabot). Satir, another experiential therapist, saw the therapist as a mirror and teacher to the family. Satir described healthy families as individual members with positive self-esteem, clear communication, emotional honesty, and direct feedback (Guerin & Chabot). These experiential theories are consistent with Oshry's (1966) problem-oriented feedback process applied to workplace relationships, discussed in another section. According to Guerin and Chabot, Satir viewed symptoms as

blockages to growth and behaviors, which helped to maintain the dysfunctional status quo of the family. Dysfunctional families, by Satir's (1972) definition: Do not encourage family members feelings of positive self-worth; the family pattern of communication is generally indirect and vague; the family informal rules of behavior with each other are not flexible; the family tends to function as a closed system from an emotional standpoint, and they tend to be very defensive and negative toward other people within and outside the family. Satir's theory is consistent with Oshry's (1966) theory of Emotional Cycle in Avoidance Problem Solving in the workplace. Satir's therapy goals were to have each member of the family able to articulate what they experience (Guerin & Chabot). Each family member should be accepted as uniquely different, with equal contribution to the family unit (no power or hierarchy). People should be addressed and related to in terms of their uniqueness and contribution to the family's growth (Guerin & Chabot).

Structural Family Therapy

Adler, a psychoanalyst, laid the foundation for Structural Family Therapy, further developed by Ackerman and Ackerman's protégé, Salvador Minuchin (Guerin & Chabot, 1997). Ackerman's theoretical framework focused on the themes of nurturance and dependency; control and anger; and sexuality and aggression (Guerin & Chabot, p. 206). Ackerman studied families as early as 1931, and contributed to the typology of families (Guerin & Chabot).

According to Guerin and Chabot (1997), Minuchin, a child psychiatrist and psychoanalyst, was influenced early on by Bateson and was the most open to the ideas and work of the other Family Therapists. While Director of the Child Guidance Clinic in

Philadelphia, Minuchin hired Haley and Whitaker, two of the pioneering theorists discussed earlier. Minuchin believed that families were relationship systems and that individual symptoms represent structural failings within the family organization rather than a dysfunction of the individual. Guerin and Chabot described Structural Family Therapy as the most easily understood family therapy model, easy to teach, and reproducible. The theory has limited applicability to adults and/or working with individuals. Since the primary focus of this study was children and families, it was applicable to this literature review.

Family Systems Theory is a framework based on the assumption that human behavior is more than just what occurs within the individual. The family systems view is that families are an interactive system and any one individual's behavior is a reflection of the family's shared history and collective interactions (Kazak, 2002). Family Systems Theory is particularly relevant for children, who at younger ages are totally dependent on their parents and progressively become increasingly involved with their extended family, peers, school staff, their neighborhood, and other systems in the extended community. The child with a chronic illness has increasing interaction and dependency on the health care team. Minuchin was one of the first family therapists to treat children within the context of their families (Kazak).

The family systems model has also been applied to the interactive relationship between the patient, health care staff, and related systems, which are suggested to have an impact on the patient's behavior (McDaniel, Hepworth, & Doherty, 1992, as cited in Kazak, 2002). Despite the exposure to family systems theory in training programs, most of psychological consultation is still individual patient-oriented. Kazak attributes this

focus to the pressures to resolve problems quickly and constraints of reimbursement that are oriented toward individual therapy.

Navarre (1998) suggested that family systems approaches could be used by nurse therapists to achieve a better understanding of and respect for the lifestyles, values, and diverse backgrounds of the increasing variety of cultural and ethnic groups cared for by nurses. According to Navarre, focusing on the entire family rather than the individual patient provides the nurse with the potential to explore the unique cultural history of each family member its impact on the patient's current plight. Given the rich variety of ethnicity and culture in the U.S., it is possible that various factors have an impact on the outcome for an emotionally *difficult* patient, including the differences of the individual family members in terms of their ethnicity, values, history, and coping skills.

Ideally, the boundaries in a family include the marital subsystem to protect the spouses' privacy, the parental subsystem to create boundaries between parents and the children, and the sibling subsystem, which is organized hierarchically (Navarre, 1998). There are also boundaries between the nuclear family and other systems, such as grandparents, neighbors, friends, school, and health care workers. In modern society, the roles and boundaries have become less clear. Children are cared for by single parents, grandparents, foster parents, and day care workers, and chronically ill children may be hospitalized for long periods of time with limited parental interaction. What was particularly relevant was the impact of these non-traditional situations on the outcomes for emotionally *difficult* patients and families, especially as it relates to the role of nursing leaders.

The goal of family structured therapy is to reorganize the family's structure and behavioral patterns, thereby changing the ways the family members communicate (Vetere). Altering the position of family members changes the way they experience the world, their perceptions and communication patterns, and provides an opportunity to alleviate symptoms (Vetere). Several studies were conducted to confirm Minuchin's theories. For example, Minuchin conducted research on issues of parental authority and leadership in inner city African American single parents in 1967; families dynamics, such as enmeshment and disengagement in 1974; psychosomatic families, including conflict avoidance and parent-child relationships, in 1978; description of family therapy techniques in 1981; family systems thinking in 1984; and revision of earlier theories in 1996 (Vetere, 2001).

Minuchin was concerned with how families interact and less concerned with the history of how these relationships evolved. This is a sharp contrast to other traditional psychiatric approaches of the time (Vetere, 2001). In the family systems model, families are viewed as a psychosocial system within larger systems that affect patterns of interaction. Family tasks are carried out through the family subsystem. Individuals can be members of different subsystems and have different roles in each subsystem. Each subsystem may appear hierarchically organized; there are many complexities to relationships that affect the power within and between subsystems in non-hierarchical ways. As the members mature, this maturation is related to the cohesiveness, adaptability, balance, and emotional connectedness of the family group (Vetere, p. 134).

Clear boundaries define who participates and how, and are essential to the smooth functioning of the family system, as well as a hospital system. Clarity of the roles and

responsibilities is a foundation of family systems therapy. One major responsibility of the parental subsystem is the care and safety of its children. The family system is a small, informal, replicating system, unlike the hospital, which is a large, formal, non-replicating system. When more than one person is responsible for the children, there is a need for teamwork, adaptability, and negotiation of conflicting interests (Vetere, 2001). Working together can be especially challenging if the care of the child is delegated to another subsystem such as grandparents, babysitters, schoolteachers, or healthcare workers.

Hermeneutic Phenomenology: Research Method or Philosophy?

Phenomenology is more than just a research process; it is also a philosophical approach to life that is used to explore and describe as accurately as possible the deepest meanings of human experience (Donalek, 2004). Heidegger suggested that the purpose of philosophy is to offer a "worldly wisdom" and a "Way to the Blessed Life" (Heidegger & Stambaugh, 2002, p. 1). Phenomenological research is a mindful personal journey for researchers, who ideally become intimately linked to an awareness of themselves, the world around them, and a connection to their research topic (Bentz & Shapiro, 1998). Phenomenological research is important to nursing practice because of the rich relationship that exists between nurses and those for whom they care, thus providing insights necessary to care for patients sensitively and effectively (Donalek). What differentiates phenomenology from other qualitative research techniques is the avoidance of any pre-determined framework in order to remain true to the subjects' reporting of the facts from their perspective (Groenewald, 2004).

Heidegger and the History of Phenomenology

Heidegger is arguably one of the most significant thinkers in the literature on phenomenology and hermeneutics, as measured by the number of other important philosophers influenced by Heidegger and fields of science that have been shaped by Heidegger's work (Gadamer, 1976; Wrathall, 2005). Heidegger's work addressed the fundamental nature of human existence and raised philosophy to a level of empirical science rather than a "historical study of past philosophical positions" (Wrathall, p. 2). Philosophy can be an adjunct to traditional research methodologies by "clarifying its concepts, sorting out its theoretical confusions, perhaps even making us aware of limitations in the ways in which we represent the world in thought and language" (Wrathall, p. 2). According to Wrathall, Heidegger attempted to raise philosophy to the prominent role it held prior to the scientific era. Heidegger developed a methodology for thinking about human existence without "reducing it to natural scientific phenomenon or treating it as a ghostly mind haunting (of) the physical world" (Wrathall, p. 6). The current interest in qualitative research, especially in nursing, may be an indication of the limitations of quantitative scientific inquiry that Heidegger attempted to identify. Wrathall suggested that people rethink, through qualitative research approaches, the direction that the scientific and technological culture is moving, as Heidegger suggested.

Hermeneutics

Hermeneutics, the act of interpretation, is named for the Greek myth of Hermes, the winged messenger of Mount Olympus who was responsible for interpreting the sayings of the Oracle at Delphi (Honeycutt, n.d.). The Jewish tradition of Torah (Old Testament) study is based on the ambiguous nature of the Torah and finding multiple

interpretations of the same text (Telushkin, 1991). Hermeneutics has also been used to interpret Christian Biblical texts to find a single spiritual truth (Honeycutt). Heidegger developed the hermeneutical circle as an interpretative process in which a single text or event was investigated in a circular fashion, moving from one sub-process to another related to what was already known by the interpreter. The process continues until the interpreter believes he or she has satisfactorily explored and interpreted the phenomenon being studied (Honeycutt). Gadamer (1976), a student of Heidegger, questioned whether it was possible to ever describe the complexity of human experience through the limitations of language. Instead, Gadamer focused on the use of art as a means to discovering the truth about confusing and chaotic human circumstances. Campbell (1988) also studied the use of art and language. Campbell explored the myths, themes, and symbols of humans that have transcended time, first appearing in archetypical cave drawings, stories that later appeared in the Bible, then written literature, art, and music, and currently, in popular music and films.

The subject of language and interpretation of the meaning of words was an important part of Heidegger's contribution. As a student of Judaic readings, Heidegger knew that a unique characteristic of the Torah is the absence of vowels, which contributes to the complexity of interpretation. Without vowels, words can have different meanings and are subject to interpretation. At the same time, biblical scholars suggested that some of the ambiguity is intentional, such as the fact that God is described by various names in the Torah. In Judaism, God is that which cannot be explained. By using different descriptors for God, perhaps the reader is less prone to think of God as something that has been described previously rather than a phenomenon that defies description, given the

limitations of the human mind (Telushkin, 1991). Heidegger used a similar methodology in creating a language to describe certain phenomenon that defied previous interpretations.

An additional challenge was that of interpretation of foreign languages. Heidegger's original work was written in German, thus the English-speaking reader has the disadvantage of being subject to the interpreter's understanding of Heidegger's meaning and use of language, which has often been viewed as obscure and mystical (Wrathall, 2005). There was also considerable controversy related to Heidegger's relationship and participation in the German Nazi Party, which may have biased certain translators in their interpretation of his works (Strathern, 2002).

Heidegger and the Use of Language

The Greek word, Φαυόμενον, which is most commonly described as phenomenon, comes from another Greek word, φαίνεσθαμ, which means "to show itself" (Heidegger, 1962, p. 29). Heidegger differentiated something showing itself from its actual being. The outward appearance of something may be quite different from the true meaning of something. Heidegger explained this as the difference between showing itself as the "symptoms of a disease" (p. 30) and the actual manifestation of the disease in a human being, which can be significantly different. The difference is "appearance" vs. phenomenon (p. 33). Heidegger defined phenomenon as "the showing-itself-in-itself, which signifies the distinctive way in which something can be encountered" (p. 31).

Heidegger (1962) suggested that *being* is often confused and used interchangeably with presence. According to Heidegger, presence refers to the present time whereas *being* is a representation of the past, current, and future of time. *Being* conjures pre-existing

connotations for most people. Heidegger preferred the term *Dasein,* a word used to describe the phenomenon of the whole essence of "being-in-the-world" (p. 78).

The *being* of humans is different from the being of inanimate objects. According to Heidegger (1962), an inanimate object, such as a fork, has no meaning until it is used as an eating utensil, but even at that point, the fork cannot control its *being*. Dasein is not a characteristic of humans, it is the pure essence of what it means to be human: a collection of ones past, present, and future experience, laden with skills, knowledge, and all the genetic material that makes each human being unique. Dasein has an understanding of its place in the world and has the free will to alter its situation. Thus, unlike the fork, Dasein can alter the way it exists in the world, something an inanimate object cannot do. The inanimate objects of the world and other human beings provide a context that further complicates what it means to be a Dasein at this precise moment and context in time. There is no set way for Dasein to be in the world, as Dasein can choose to be what it wants to be and how it reacts to the conditions it is in. Thus, Dasein is a "being-toward-possibilities," which understands itself and its "potentiality-for-being" (p. 148). The challenge is to understand another Dasein with the limited information available for interpretation based on only that which people encounter.

Heidegger (1962) defined *distantiality* as the way people try to understand themselves through reference to other Daseins (p. 127). Through a process Heidegger called *averagenessm* people try to describe the world in terms of normality of behavior in which things are consistent in the arena of life Heidegger referred to as *publicness* (p. 128). *Publicness* is the structure of everyday living and provides an illusion that the world is consistent and predictable. *Publicness* is essential for certain aspects of daily

living. People must take certain things for granted and do not have the time to question everything in life people encounter, such as that a red light means the other driver will stop. There are situations where *publicness* can be a problem, such as the assumption that all dasein are the same, experience the same phenomenon as other dasein, and will react to life circumstances in the same manner (Heidegger, 1962).

Heidegger on Time and Death

Heidegger (as cited in Heidegger & Stambaugh, 2002, p. 16) believed that time was four dimensional: past, present, future and "what is about to be." Death is an example of what is about to be. Heidegger suggested that death provides relief from many of the anxieties of life, and allows dasein to become more authentic, but only if dasein does not become too focused on the physical steps and biology of the phenomenon of dying. Death provides finality to life and the potential for freedom from the anxiety of everyday existence. Thus, *dasein* can be free to live an authentic life. For hospitalized patients and families, death is a possibility that is ever present, and may impact on the essence of their *dasein*.

The Interconnectedness of Phenomenology and Hermeneutics

Phenomena are the building blocks of human science and the basis for all knowledge (Moustakas, 1994). The goal of phenomenology is to understand social and psychological phenomena from the perspective of the people involved in much the same way that poets and painters use words and images to convey meaning to everyday life (Groenewald, 2004). Ideally, the goal of the phenomenological process is a dialogue between the researcher and participants to achieve mutual understanding; reconstruction of the participants' experience of the phenomena into a robust story; creating advocacy

by bringing their voice to life; and resulting in activism of further ideas, theories, research, and practice changes (Koch, 1998). The process of the appearance or unfolding of information to describe something that is happening in the environment is, in essence, phenomenology.

Heidegger (1962) suggested that phenomena show themselves and that the goal of the research should be to allow the phenomenon to reveal what lies below the surface of outward appearances. Wrathall (2005) suggested reading Heidegger in much the same circular way that Heidegger believed people learn: read the material, allow Heidegger's descriptions to teach how to see things, and let the things guide the interpretation of the phenomenon. People should let the person's Dasein describe for them what their lived experience is and what it is like to be that particular Dasein within the context of that place in time.

Gadamer (1976), a student of Heidegger, described Husserl as the founder of Phenomenology, a method Husserl (as cited in Gadamer) saw "as the only way of elevating philosophy to the status of a rigorous science (p. 130). Heidegger's interest in phenomenology began with Heidegger's studies with Husserl, yet Heidegger (as cited in Heidegger & Stambaugh, 2002) experienced difficulty in understanding how Husserl intended to carry out the scientific process of phenomenology. It was in Husserl's essay, *Philosophy as Exact Science*, that Heidegger found the basis for Heidegger's own understanding of a new definition of phenomenology, a focus on the phenomenon revealing it rather than the researcher defining it. It was in this context that Heidegger (as cited in Heidegger & Stambaugh) saw phenomenology as transcending pure philosophical thinking toward a possibility of something greater (p. 82).

Phenomenological Hermeneutics as a Research Method

The philosophical underpinnings of modern hermeneutic phenomenological research are based on the work of Heidegger (hermeneutics) and Husserl (phenomenology). Although Heidegger and Husserl are often quoted interchangeably, there are major differences in their philosophical approaches. Heidegger's foundation was existentialism, while Husserl was Cartesian Duality (Koch, 1995). Heideggerian phenomenology (hermeneutics) asks the question "what does it mean to be a person," while Husserlian phenomenology asks the more basic question, "how do we know what we know"? (Koch, 1995). A student of Husserl, Heidegger, modified hermeneutics to include a more rigorous circular approach of studying subjects and continually reviewing their data to get closer to the essence of the *dasein*, their lived experience.

Phenomenological reduction is a process of connecting with *epoch,* by suspending all positing of the being for the purpose of studying the "pure" phenomenon (Gadamer, 1976, p. 146). According to Gadamer, the goal is to discover the richness of the phenomenon in an unbiased way. Husserl's intention was to go behind the quantitative scientific data to the pure phenomenological data, which were often richer and more likely to describe the true essence of lived experience (Gadamer). The challenge of any science is that all possible descriptions of the world begin with one's own perception of the world and what is valid for that person. According to Gadamer, in that process, there is always a question as to whether people truly know what people think they know. The specifics of the Hermeneutic process was discussed in greater depth in the methodology section.

Current Findings

Soft Systems Theory

Soft systems theory was described by Checkland (1999) as an approach that moves away from looking at problems that need fixing to situations labeled by people as a problem. Soft systems is an organizational learning model in which there are limited rules. One can look at the situation in any stage of the process, one can start anywhere, work at different stages simultaneously, and involve as many people as possible to view the various interpretations. Checkland described the world as "complex, problematic, and mysterious" (p. A10). In Checkland's model, the world is not systematic, but the word system is used to systematically inquire about complex systems, such as the hospitalized child. Hard systems thinking may be appropriate for well-defined technical problems, but complex, ill-defined situations involving human beings in complex cultural situations, such as a hospital, require a soft systems approach.

Checkland's soft systems model could be used by teams to assess and analyze situations with emotionally *difficult* patients and families. Checkland's model is a multi-step process of identifying a problem, looking at the expressed data, and comparing it to root definitions, and other conceptual models to arrive at potential solutions. Further information must be obtained by researching the lived experience of charge nurses before applying the situation to Checkland's model, as shown in Figure 1.

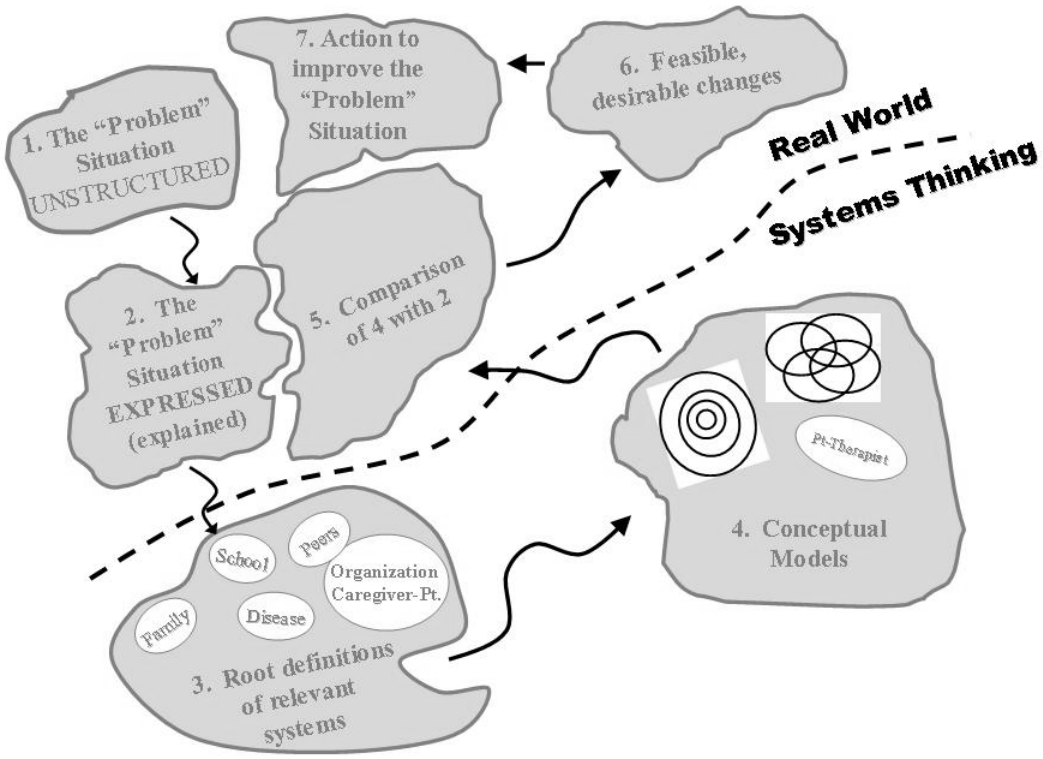

Figure 1. Soft systems model applied to hospital patient situation.[2]

History of Systems Theory in Health Care

The focus of health care in the 1900s was based predominantly on treatment of illnesses residing in individual patients (Rosenberg, 1987). Social work began in the 1890s as a discipline with a focus on families and how people functioned (Beels, 2002). Marital counseling began in the 1930s, and was developed by social workers and clergy focusing on families. In the 1950s, family therapy, based on general systems theory, became a discipline with therapists and psychiatrists including Ackerman, Bowen,

[2] Adapted from Checkland (1999)

Erickson, Minuchin, Whitaker, Boszormenyi-Nagy, Jackson, Beels, Wynne, and Steirlin, whose work was reviewed (Berman & Heru, 2005).

One application of general systems theory in psychiatry was Structural Family Therapy, a body of work attributed to Minuchin, a psychiatrist who headed the Child Guidance Clinic in Philadelphia. A study by Bor, Mallandain, and Vetere (1998) showed that 21% of family therapists in England practiced structural family therapy. Minuchin's theory, heavily influenced by von Bertalanffy's work, is grounded in relational therapy and the belief that distress can only be understood within the context of the relationship in which it manifests and continues to occur (Vetere, 2001). What is unique about structural family therapy is the belief that there is potential for relationships to cause distress through the way in which family members interact and communicate beyond just their language. These dynamics include: family rules, roles, coalitions, handling of conflict, the subsystems and boundaries of relationships, how they are organized, providing feedback, and the dynamics of stability and change (Vetere). Structural family therapy is a competence model in which it is assumed that individuals have the capacity to develop innovative approaches that challenge their beliefs and previous approaches to problems (Vetere).

Families have been a focus of psychotherapy dating back to Freud's published cases in the early 1900s; to Adler's focus on the impact of families on children in 1931; Ackerman's family therapy in 1937; and Allen's work at the Philadelphia Child Guidance Clinic in the 1920s, as chronicled by Minuchin, a pioneer in his own right (Guerin & Chabot, 1997). Guerin and Chabot developed a theory-based classification of family therapy, separating practitioners who based their clinical approach on traditional

psychoanalysis. Guerin and Chabot used the metaphor of a family tree to explain the organization of the theorists, yet a review of their history shows that many of them worked with each other at various points in their careers. Graphic presentations of this concept appear in Figures 2, 3, and 4 in an attempt to capture the dynamic interactive relationship of the various theorists. The family tree framework is presented in Figure 2 and Checkland's soft systems model appears in Figure 3. Figure 4, while somewhat complicated to view, shows the rich nature of human interaction, professional collaboration, and sharing of concepts and theories in an even more in-depth systems-like manner.

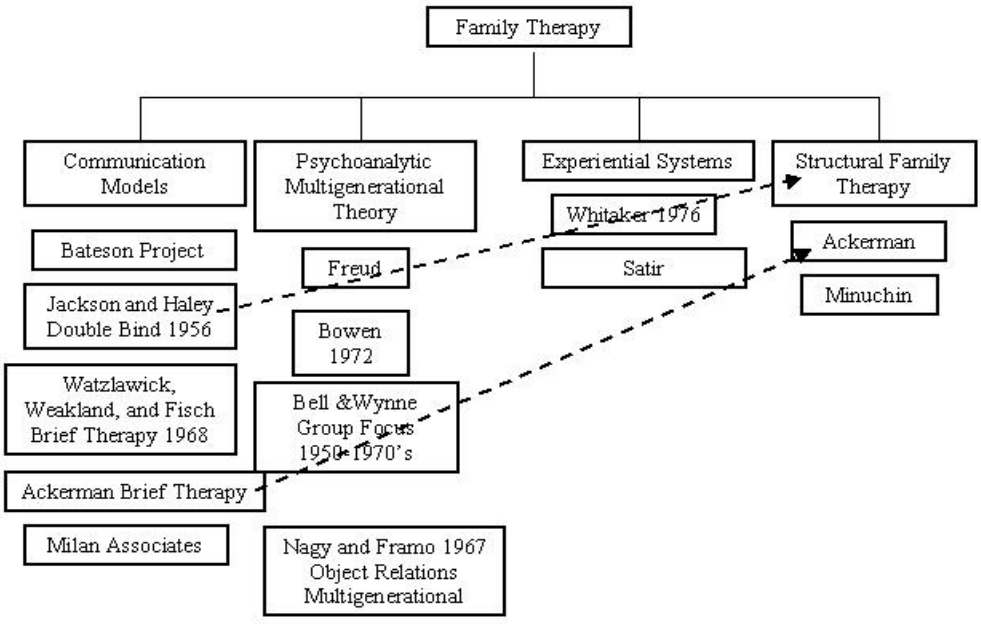

Figure 2. Theory-based classification of Family Therapy showing relationships of various theories as indicated by arrows. [3]

[3] Diagram based on the concepts presented by Guerin & Chabot (1997)

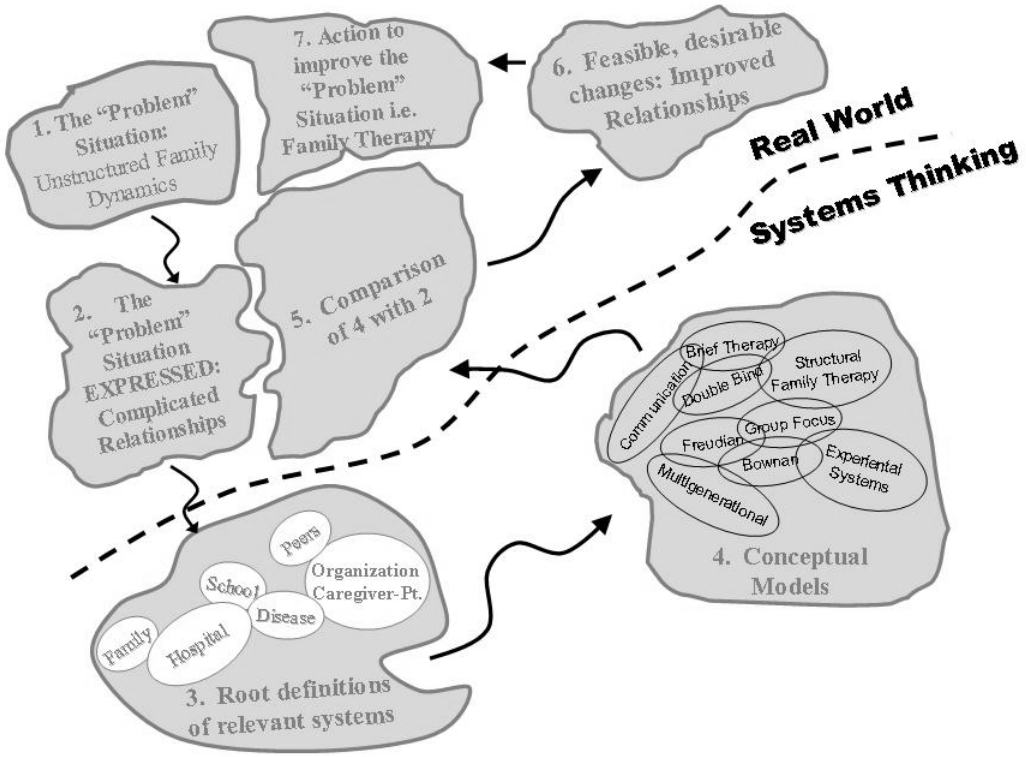

Figure 3. Soft Systems Model.[4]

[4] Modified to graphically present the overlapping nature of the development and application of Family Systems Models to human situations

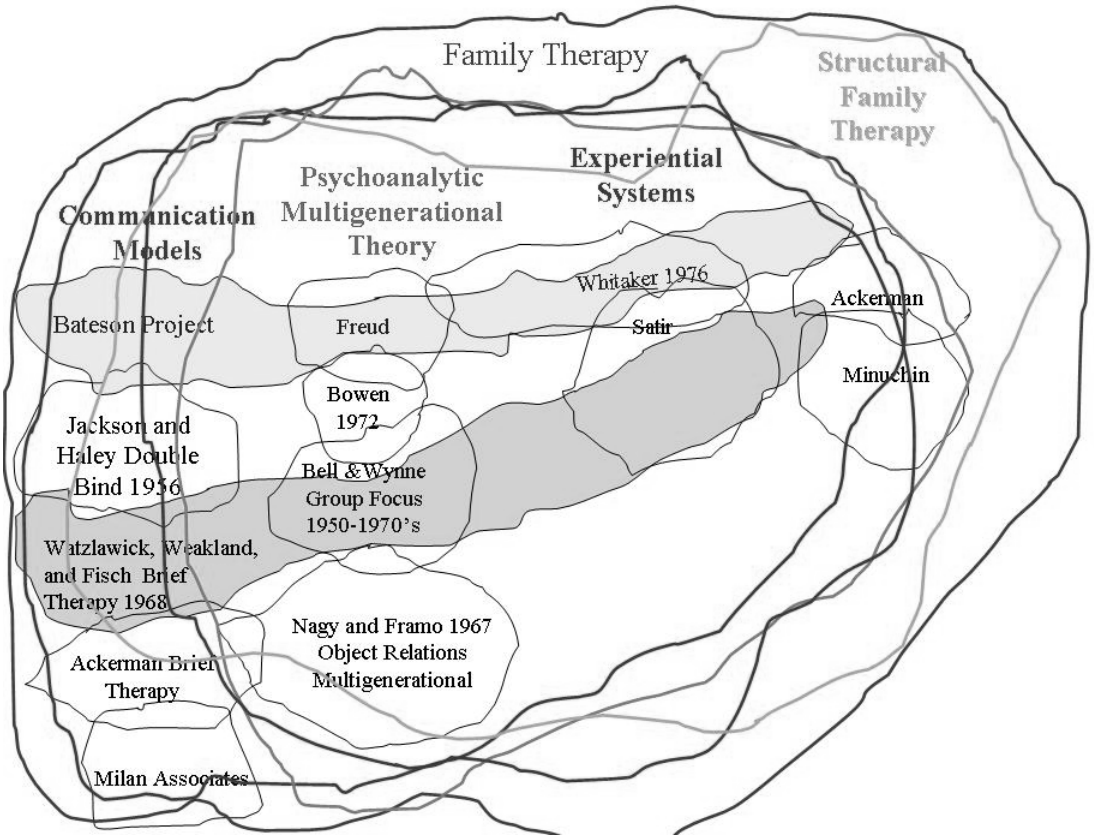

Figure 4. Soft Systems Model [5]

Expressive emotion (EE) is a term used to describe families with high levels of criticism, hostility, or emotional over-involvement (Butzlaff & Hooley, 1998). Expressive emotion is a significant predictor of relapses in psychiatric illness and may be a result of the ongoing stress of interacting with a disturbed family member (Berman & Heru, 2005). Research on family caregivers of psychiatric patients has shown a great deal of stress and high levels of caregiver morbidity, especially depression (Berman & Heru).

[5] Further modified to graphically present the overlapping nature of the development and application of Family Systems Models to human situations.

The therapeutic challenge in family therapy is a delicate balance of pushing for change while avoiding too much involvement and direction that may lead to the family withdrawing from therapy (Vetere, 2001). Therapy begins by working toward establishing a trusting relationship that can be used by the therapist to reinforce the principles of boundaries, communication, and distance to gain perspective; to explore conflicts; and to provide education, guidance, and support to try out some new solutions (Vetere).

Social ecology, a branch of sociology concerned with the relationship between human groups and their physical and social environments, is foundational to much of family systems theory (Kazak, 2002). The health care team is a part of the child and family's social ecology, especially in a hospital environment where the child and family are forced to interact with physicians, nurses, psychosocial and other health care providers (Kazak). According to Kazak, working within a therapeutic triad, the therapist joins the patient, family, and health care team in a process, working together to narrow their focus to mutually agreed upon goals, promote family competence, and emphasize collaboration between the health care team and family, who are equally responsible for the outcome. A consultation request to the psychosocial team should be a signal that there is a breakdown in one of the tasks for the family of an ill child. These family tasks are to remain calm and reduce anxiety in whatever way possible to face the emotional challenges; develop effective, trusting relationships with the health care team; and manage conflict within the family and between the family and the health care team (Kazak).

Kazak (2002) suggested that the patients' symptoms can be addressed quickly and effectively if therapists direct their attention to help the patient, family, and staff reestablish effective emotional responses and maintain trust to navigate the conflict and challenges ahead of them (p. 140). Kazak suggested several benefits to family systems practice. The benefits include emphasis on family strengths; viewing children in a broader family context, which is where they actually live and function; viewing families as part of the solution and experts on their child; assuming family actions are well-intended, based on the best knowledge and skills the family has; recognizing ethnic and cultural diversity, which may influence family well-being; assessing the impact of family's isolation versus connectedness with its members and the outside world; and anticipating ways in which change by the individual may not necessarily result in a change in the system (Kazak).

One major obstacle to Kazak's family systems consultation model may be the reluctance of the team to engage in the interactive inclusive family systems model, which is based upon an assumption that the treatment team making the referral maintains responsibility for the patient's care (Kazak, 2002). According to Kazak, it is often easier and less anxiety provoking for teams to assume that the psychosocial team will "fix" situations with *difficult* patients and their families. Kazak suggested most medical teams want to address the problem themselves, but lack the skill or past experience to do so effectively. Lack of skills may be a factor in the way charge nurses address emotionally *difficult* patients and families.

According to Vetere (2001), structural family therapy has been criticized as being biased toward race, culture, and gender, without enough attention to the impact of power.

Much of the criticism of systems theories may be due to lack of knowledge of systems theory (Spronck & Compernolle, 1997). The power dimension is important and illuminated by open systems analysis. By contrast, Navarre (1998) suggested that family systems approaches could be used by nurses to improve their understanding of and respect for the lifestyles, values, and diverse backgrounds of the increasing variety of cultural and ethnic groups for whom nurses provide care. Family Systems Models may overvalue context to the same extent that individual models undervalue context (Guerin & Chabot, 1997). Assessments may also be too oriented to the family and ignore other subgroups, such as the extended family, neighbors, peers, schools, and other institutions. Ignoring these other subgroups may affect the practicality of obtaining input from all systems that may affect the family (Vetere). The family systems approach includes an assumption that all families have the potential to be successful. For families that lack resiliency, this assumption may not be realistic. In certain situations, substitute care (i.e., foster care) may be necessary (Vetere). Some cultures and subsystems may not be very receptive to family systems therapy. There may be a question as to whether family systems therapy is an effective approach in traditional conservative academic medical institutions.

Family Systems Theory Education

While discussion about the development of psychiatrists may seem on the periphery of a research study on charge nurses and emotionally *difficult* patients, it does have implications for the development of charge nurses, a topic that has not been adequately explored. Much like psychiatrists, nurses may not have adequate education in caring for families. Many factors inhibited the spread of family systems theory in

psychiatry. In the 1960s and 1970s, the Child Guidance Center in Philadelphia was the leading center for structural family therapy, but it was also part of the psychiatry department of the University of Pennsylvania. Many of the faculty did not believe that family therapy could be integrated with more traditional forms of psychiatric treatment whose legitimacy was sought with other biologically based medical and surgical specialties (Berman & Heru, 2005). Another factor was the development of managed care insurance systems that refused reimbursement for problems that could not be defined as a biologically-based illness (Berman & Heru). While there have been philosophical tensions between psychiatrists and other types of therapists, since about 1990, the field of psychiatry has recognized the importance of families and family therapists have accepted that there are biological factors affecting mental illness (Berman & Heru). According to Berman and Heru, a more humanistic model of care has emerged in recent years, yet there is still an overemphasis on the biological and technical aspects of care, with the mind and family seen as minor factors related to illness.

Extensive research suggests that families are integral to the treatment of psychiatric patients, yet there was limited family skills training incorporated into the education of psychiatrists (Berman & Heru, 2005). Psychiatry is the dominant force in hospital settings and is primarily focused on individual diagnosis, an emphasis on inner fantasy rather than lived experience, and biological treatments (Berman & Heru). Researchers in psychiatry are unlikely to undertake a hermeneutic phenomenological exploration of patients and families. Biological factors, including genetics, may account for a vulnerability to mental illness, yet family behavioral factors are also critical to the manifestation of the actual illness (Tienari, et al., 2004). According to Berman and Heru

the lack of attention to families may be due to: the separate histories and cultures of psychiatry, psychology, social work, and family therapy; philosophical differences in approaches to patient care; time constraints to provide family therapy; lack of reimbursement by insurance companies; and resistance to change.

Berman and Heru (2005) suggested that psychiatric students learn the concept of family centered care, as opposed to family systems theory. In the family centered care model, young physicians are taught to understand how to assess and support the development of family skills to manage major mental illness in the family members, rather than to provide formal family therapy themselves. It may not be realistic, given the constraints of training time, for psychiatrists to spend as much time learning therapy as do other professions, such as psychologists, social workers, and family therapists. Thus, psychiatrists would be able to determine if a family needs more extensive family therapy and refer them accordingly. Berman and Heru also recommended that psychiatrists learn Systems theory as a skill set. As the leader of the medical team, team members often look to the psychiatrist for leadership beyond the individual patient pathology.

Nurses experience many of the same issues Berman and Heru (2005) described physicians experiencing in psychiatric residency training. Many physicians in training are young, single or newly married, have no children or young children, tend to be white middle class without an understanding of cultural diversity issues, are more sympathetic to adolescent issues than their parents, and have little appreciation for the dynamics of midlife and old age. This may also be true for a certain population of nurses. Training of psychiatrists and nurses has become increasingly focused on action and decision-making rather than cultivating the skills of listening to and understanding families. Of greatest

concern are supervisors who see families as obstacles to treatment and pass on these beliefs to younger staff. From a systems perspective, families and emotionally *difficult* patients are obstacles to treatment. In the idealized hospital system, there would be an optimum number of obedient patients who cooperate with staff, follow their care regime, and pay their bill.

Berman and Heru (2005) suggested that psychiatric resident training include interpersonal and communication skills; professionalism, including respect for families; cultural diversity; and systems theory. In order for students in psychiatric residency programs to achieve these insights and develop better communication skills changes must take place consistent with change theory and Rodgers' theories on innovation (described in a later section).

Chapman (2005) suggested several ways to incorporate systems thinking into nursing clinical practice to maximize success and avoid unintended consequences. The first way is to consider the interactions between various units, groups, and individuals when approaching a challenging situation in the workplace. Another way is to analyze the system from various perspectives, especially those with different goals and ways of explaining what is occurring, for example, talk to staff in other disciplines outside of nursing or nurses from other units. Other ways to incorporate systems thinking into nursing clinical practice are to explore proposed policy changes from the different perspectives of all individuals involved, identify feedback loops and how they will be affected, and attempt to predict what likely unintended consequences may occur and plan accordingly (Chapman).

Family systems approaches are appealing to pediatric psychologists from an intuitive perspective, yet there was limited comparative research on family systems practice compared to traditional psychosocial interventions, with little emphasis placed on the approach in training programs. While the care of families is foundational to the field of pediatrics, there may be difficulties in how caregivers interpret and execute family-centered care. Providing family-centered care may be even more difficult when the patient and family exhibit disruptive behaviors. Ideally, a family is defined by its members; the term *parent* has traditionally been used to describe the primary caregiver who is legally responsibility for the child (Osher & Osher, 2002). Nurses and other health care workers are often educated about traditional families with two parents of the opposite sex and appropriate boundaries between parent and child. Navarre (1998) suggested that these definitions do not apply in the current multi-cultural society. Nor do they apply, according to Osher and Osher, in diverse family constellations that include a variety of people caring for children with emotional difficulties, such as adoptive parents, foster parents and their partners, siblings, extended family members, and friends. These other caregivers provide care to the child and may also support the primary caregivers (Osher & Osher). According to Osher and Osher, the working definition of parent has been expanded by some authors to include non-custodial relatives who are responsible for the daily care of a child.

In an idealized world, the role of the family is to provide unconditional love, guidance, care, and support, and nurture all of its members (Osher & Osher, 2002). In reality, families present with a variety of structures, cultures, languages, values, spirituality, physical environments, and face a variety of challenges beyond raising an

emotionally *difficult* child (Osher & Osher). When a family is under stress, family members may look to their extended family, friends, community, school, social agencies, and health care institutions for support that may or may not be available. When family stress and outside supports are inadequate, the family may suffer and be unavailable to support its members (Osher & Osher). The family must care for itself, and the hospital must care for itself.

Historically, there has been significant stigma attached to people with mental disorders, which also includes families of children with emotional disturbances (Goffman, 1959, 1961; Osher & Osher, 2002). The anger of these families may be justified in terms of what they are experiencing and how members of the system who have failed to provide adequate assistance have labeled them. At the same time, there is a significant amount of pathology in society due to drug and alcohol abuse, high levels of divorce, social problems, and psychiatric disease in the general population, which may also contribute to the difficulties experienced by families with children with emotional disturbances.

The Dynamics of the Difficult Patient

Daum (1994) suggested that *difficult* patients and families require excessive amounts of staff time, creating frustration and stress for nurses. Given the current shortage of nurses, it is imperative that nurses have the skills to manage *difficult* patients and their families to reduce stress in their work environment that might lead to turnover. Emotionally *difficult* patients may be misunderstood or not fully listened to by staff who do not fully understand the patients' concerns or the dynamics behind why the patients behave the way they do. A certain population of emotionally *difficult* patients and

families have mental illness, but others may be reacting to having an ill child and feeling manipulated by a confusing health care system. The patients and their families may feel that health care workers are not able to help them or provide answers to their challenges, and offer them limited resources.

Nurses and physicians often lack the skills to manage the emotionally *difficult* patient and family, thus avoiding them, over reacting, or retaliating (Daum, 1994). Nursing has been defined as the: "protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities, and populations" (American Nurses Association, 2003, p. 6). Thus, the focus of nursing is the human response to illness and/or its treatment. Nurses should focus on how people are reacting to their illness, which includes venting anger. Venting anger is also one of the stages of the grieving process, one way that people react to hearing that they have a major illness. Parents move through three emotional stages while seeking to make the right decisions for their sick child: grieving, cynicism, and proactive parenting. The grieving stage of this process consists of: "denying the diagnosis, seeking alternative treatments, venting anger, experiencing emotional turmoil, expressing remorse, feeling depressed, and reaching a guarded acceptance" (Taylor, Donoghue, & Houghton, 2006, p. 111). The charge nurse's role is to help the patient and family, whether or not the patient is cooperative and behaves nicely.

In the 1980s, there was an aggressive movement in mental health services to develop family-focused care. The care may not be truly family driven in the current health care system (Osher & Osher, 2002). It is impossible to truly include families in

care if the workers do not respect the variety of factors that contribute to the diversity and variety of families, relying instead on stereotypical images of what a family is supposed to be (Osher & Osher, 2002). In the last 20 years, there has been a shift from provider-driven care to family-driven care. It is a gradual transition and still requires maturation (Osher & Osher, 2002).

Middleness Theory

Oshry's theory of Middleness may be useful in understanding how charge nurses experience emotionally *difficult* patients and their families. Oshry explored the role of the Middle coalition in organizations (Oshry, 1966, 1990, 1994, 1996; Schlesinger & Oshry, 1984). The Middle of a nursing department has many faces, including directors, managers, advanced practice clinicians, charge nurses, preceptors, and staff. Middleness is not a position, but a condition in which an individual exists between two or more groups who exert pressure on the middle to focus on their different priorities, perspectives, goals, and needs (Oshry, 1994). The charge nurse caring for an emotionally *difficult* patient may experience Middleness in the competing priorities of the parent, the child, extended family, other care workers, outside agencies, and upper management. The power of the Middle comes from the Middle's ability to process information from the Top and develop an independent Middle perspective, to develop an action plan that is realistic and addresses the institution's true needs (Oshry, 1994). An individual's role may vary based on the particular situation. One moment, a charge nurse is a Top when he or she is telling patients what they need to do and the next moment the charge nurse is a Bottom when the physician orders the charge nurse to do something. At the same time, the charge nurse might be a Middle who has to question the physician's decision, based

on the recent changes in the patient's clinical status, or the charge nurse might be a Middle in helping the patient to understand why the physician has changed the plan of treatment. According to Oshry, Tops are in control, work in isolation, receive limited information from Bottoms, and are accountable to far fewer people when making decisions. Bottoms feel powerless and control very little about what influences their lives, but at the same time they have the real information on what is working and not working, if only someone would listen to them.

The dynamics of Middleness are consistently present in all types of organizations, at various levels, and regardless of the complexity of the service or product produced (Oshry, 1994). The challenge for the Middles is often to be responsive to Tops and Bottoms in order to build enough trust to then act independently (Oshry). Oshry defined system power as actions that influence the system as a whole to survive and develop (p. 28). Middles exert system-centered power by influencing Tops and Bottoms to have functional interactions. In most cases, Tops and Bottoms will be more interested in Middles serving their particular interests than in doing what needs to be done to serve the interests of the whole system.

Middles, by the nature of their situation at work, find themselves feeling overworked, pulled in multiple directions, attacked, confused, isolated, and lonely (Oshry, 1994, 1996). Middles feel responsible for holding things together yet paralyzed to take independent action (Oshry). When things do not work out the way everyone expected, Middles tend to view it as a personal failure. When Middles do not receive enough attention, they burn out, become overly aligned with the Top or Bottom, or just become frustrated and present obstacles to the entire system (Oshry). Given the current

nursing shortage, organizations cannot afford to lose members of the Middle layer. A lack of leadership affecting charge nurses' ability to manage emotionally *difficult* patient situations may complicate the problem. Oshry's work may offer promise. Further research is needed to determine which interventions are effective in helping charge nurses with their experiences with difficult patients and families.

Oshry's theory of organizational Middleness was used to develop recommendations for executives to deploy subordinates to act strategically from the middle of the organization (Sales, 2002). While there are no formal research projects to support Oshry's theories, 40,000 people have participated in Oshry's programs and most reported a high-level of relativity of Oshry's theory to their own organizational experience (Sales). Oshry is most famous for the Power Lab, a ten day exercise in which a group of people participate in a simulated community where they take the role of Tops, Middles, and Bottoms (Garman, 2001). Other programs based on Oshry's theories have been performed by organizational development practitioners and managers, supporting the validity and utility of these theories (Sales).

Sales (2002) used Oshry's Middleness theory to explain the dynamics that exist between the leaders of an organization and their Middle managers when planning for the future. According to Oshry (Sales, 2002), the reactions to limited information vary depending on the roles in an organization. The traditional role of Top leaders is to manage the organization, its relationship to the environment (internal and external), and define the organization and where it should be going strategically (Schlesinger & Oshry, 1984). Bottom workers are closer to the main production or service of the organization and have the power to influence how the work is actually done, whether the Tops and

Middles support them and/or know what they are doing on a day-to-day basis (Schlesinger & Oshry). The Middles are responsible for integration of the various parts of the organization through information sharing, coordination, and providing feedback (Schlesinger & Oshry). According to Schlesinger and Oshry, when Middles are doing their job well, they enhance the jobs of Tops and Bottoms, which is necessary for the overall effective performance of the organization. It is necessary for Tops, Bottoms, and Middles to have insight and be cooperative with each other in order for the institutional climate to change (Schlesinger & Oshry, 1984).

Tops tend to get into turf issues based on a belief that those who are the most specialized should have the greatest power and input into the future strategy (Oshry, 1994, 1996). Bottoms tend to unite around their common feelings of suppression by higher authorities, who make decisions without input from them (Oshry, 1994, 1996). Bottoms also resent individual Bottom members who attempt to think and act differently than the group. According to Sales (2002), Oshry's theory primarily focuses on Middles, who tend to work in isolation from other Middles either by location, the uniqueness of their work, or how they react emotionally to the challenges. The result is that Middles tend to work in silos rather than in an integrated fashion. What is of concern is that Middles tend to feel alone, isolated, and unappreciated, all dynamics described by psychotherapists as the perfect set up for a dynamic that perpetuates less than ideal relationships (Logan & Simms, 2002; Simms, 1995).

Isolation and the lack of shared information are also factors in a theory about the perpetuation of unhealthy behaviors in organizations, described as the Emperors' Dilemma, which becomes a self-enforcing cycle (Centola, Willer, & Macy, 2005).

Middles are often distracted by matters they perceive as more important than interacting with each other, which results in Middles being disconnected as a group (Oshry, 1994, 1996). The disconnect of Middles may lead to perceptions that the Middles are "low power…weak, incompetent, unreliable, indecisive and/or prickly by both their superiors and their reports. Thus, they are also seen as the most expendable if and when the time comes to cut back on personnel" (Sales, 2002, p.374).

Sales (2002) suggested that the lack of integration of Middles may play a significant factor in the dynamics of disruptive innovations. Innovation will be discussed in a later section. Oshry (Schlesinger & Oshry, 1984) suggested that Middles have a shared intelligence from their position in the organization and their access to more information than any other layer of the organization. The benefit of Middles' knowledge cannot be realized unless their integration is enthusiastically endorsed by superiors by pushing for Middles to have private meeting time, make decision without superiors' input, encourage honest upward feedback, and avoiding the temptation by Tops to meddle in private dynamics of the Middle group (Sales, 2002; Schlesinger & Oshry, 1984). When Middles do integrate, they may perceive that they risk losing some of their individual freedom to act independently (Sales, 2002; Schlesinger & Oshry, 1984). What they gain is working effectively with other Middles, strengthening each other as leaders, increased information sharing, improved connectedness of various parts of the organization, increased sense of security by having the support of peers for their decisions and actions, and increased cohesiveness as a group, which increases the likelihood of Middles effectively impacting change in the organization (Schelsinger & Oshry). The paradox of integrating Middles is that if superiors ask them to integrate, it is

likely that Middles will react negatively, as if the Top is manipulating them once again. The key to change is that the insight must come from within the group needing to change (Schlesinger & Oshry).

Feelings tend to interfere with business, yet the suppression of feelings may be more detrimental to relationships than the expression of feelings (Oshry, 1966). Oshry's early writings focused on two behaviors used by managers faced with conflict: avoidance and problem-oriented feedback. Avoidance behaviors are usually based on an assumption that one's feelings are irrelevant or disruptive to the smooth functioning of the organization (Oshry). Oshry's theories are consistent with theories on the self-reinforcing cycle of repressed feelings that impact on organizational dynamics (Centola et al., 2005). Quinn (1996) stated that if an organization avoids deep changes, they are choosing by default to allow a slow decline of the organization. Managers tend to be intelligent, technically competent in their given profession, able to think quickly, problem solve and make decisions, but they tend to be output-oriented rather than seeking input from others (Oshry). Oshry described the phenomenon in a typical avoidance problem-solving work setting as communicating to others to produce ideas, which is something good; feelings are considered irrelevant and disruptive to the smooth running of the organization; feelings do exist as a result of work pressures, time, quality, personality styles, and competition; feelings are suppressed, expressed indirectly, or avoided; leaders emphasize individual effort to avoid interacting with others and dealing with their unresolved feelings about them; and there is no consideration of the impact of the emotional reaction or unexpressed feelings on the future functioning of the group.

Oshry found leaders did not listen to others, distorted the others' ideas, and attacked or withheld their own ideas. Leaders tended to annoy, irritate, and frighten others, which alienated the leader from other members of their group (Oshry). There may be implications for the way leaders' problem solve and react to emotionally *difficult* patients and families. The emotional cycle of behavior in avoidance problem-solving may be a self-perpetuating cycle that leads to continued escalation of emotion, repressed feelings, and more escalated emotion, as shown in Figure 5, based on Oshry's work.

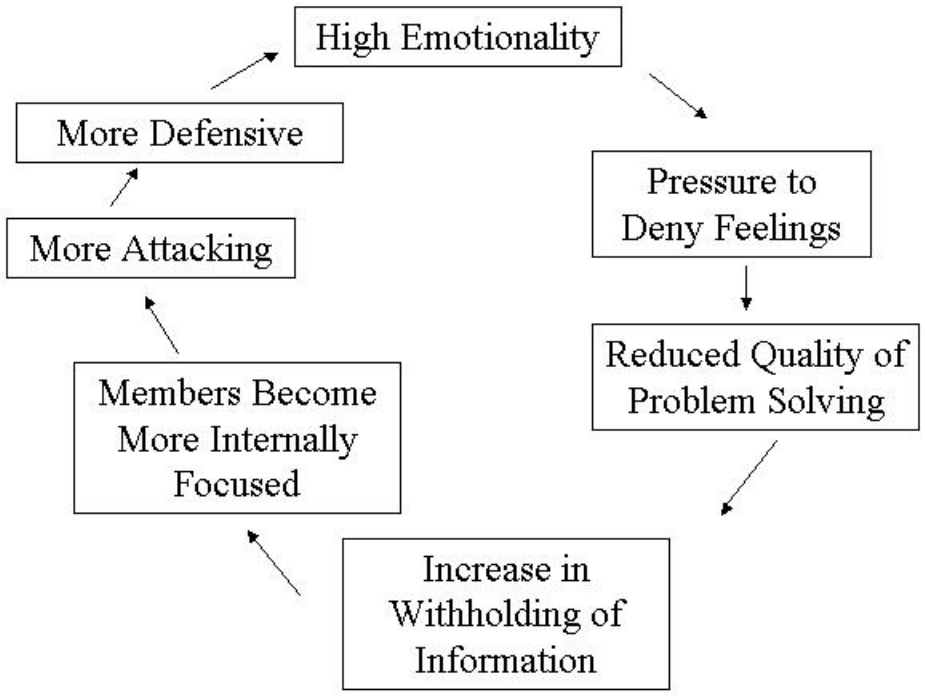

Figure 5. Emotional Cycle in Avoidance Problem Solving. [6]

[6] Adapted from concepts in Oshry (1966)

Oshry described a second process, problem-oriented feedback, as clear and direct expression of feelings that are specifically related to the situation that caused them. When giving problem-oriented feedback, emotional reactions are place in a historical perspective. Figure 6 shows how the problem-oriented feedback process has the potential for breaking the cycle of exaggerated emotionality found in avoidance problem solving.

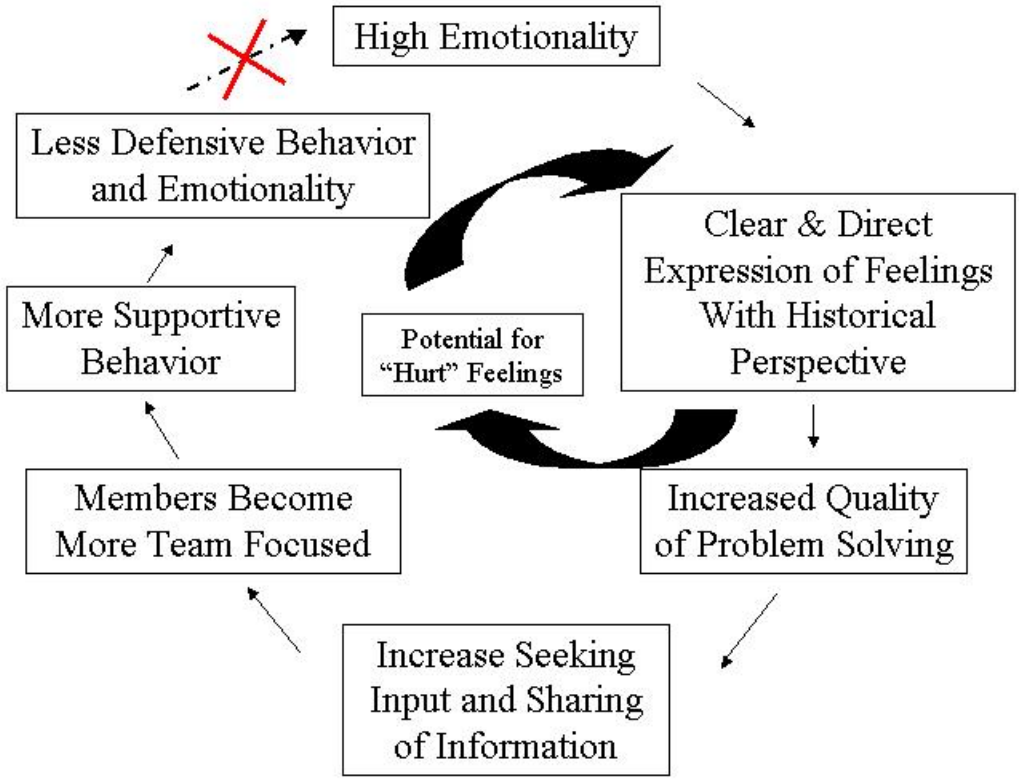

Figure 6. Problem-oriented feedback process has the potential for breaking the cycle of exaggerated emotionality.[7]

As an example, the problem-oriented message sender explains to the recipient why the recipient may have over-reacted emotionally to a simple occurrence. According to Oshry (1966), one reason is that it may be symptomatic of an enduring problem or the

[7] Adapted from concepts in Oshry (1966)

cumulative effect of several other previous encounters. Problem-oriented feedback provides valuable information and potentially improves the problem-solving ability of the group, yet is not the typical approach in work situations. Most groups use avoidance as their problem-solving approach, despite the fact that when feelings are suppressed, the manager and group's problem solving ability deteriorates (Oshry).

There is a difference between expressing one's feelings and assigning motivation to the recipient. According to Oshry (1966), blaming others for the way one feels and assuming it was intentional may lead to hurt feelings and further exacerbate the problem. Problem-oriented relations are not always happy or comfortable, but they are genuine, honest, richer relationships that provide an atmosphere that brings out the creativity and talents of all parties (Oshry).

In 1984, Oshry (Schlesinger & Oshry, 1984) examined the impact of leaders' efforts to empower employees through quality of work life measures such as quality circles, participative management, and total quality management. Of particular note is Schlesinger and Oshry's observation that attention that Top leaders pay to enhancing employee involvement has the potential side effect of the Middles feeling as if they had nothing to do with enhancing their employees work experience. A Top who is overly involved in day to day operations may also unwittingly encourage over-involvement of Middles in trying to align themselves with the Top leaders at the expensive of further distancing themselves from Bottom level employees. A major role of the Middle is to focus on the needs of the Bottoms and focusing on the needs of the Top may be in conflict with the needs of the Bottoms (Schlesinger & Oshry). Middles also may react to their perceived loss of power to lower level workers by undermining change initiatives,

often in subtle ways (Schlesinger & Oshry). Oshry's theory is consistent with Block's (2002) theory on stewardship, in which Block suggests that the concept of leadership implies a parent-child like relationship rather than a peer-peer mature, adult equal partnership approach.

Garman (2001) criticized Oshry's power lab workshops as being an analogy that may have limited applicability to real life situations, where options may be limited and there is not an opportunity to start over. According to Garman, Oshry's "nothing to lose" approach is not always applicable to real working situations where there are often personal risks related to employees' decisions. Having insight into ones behavior does not necessarily translate into the courage to act differently (Garman). This may apply to the situation of emotionally difficult patients, where charge nurses may have insight, but it may not translate into the courage to act differently.

The Symptomatic Cycle

An overarching theme to the dynamics of the charge nurse and emotionally *difficult* patients and families may be the symptomatic cycle, a concept that can be traced back to the work of Bateson (2000). The cyclical nature of human behavior was explained by Bateson as a systematic representation of a recurring cycle based on a repeating pattern of thought and behavior. Bateson termed this relationship *schismogenic*, meaning a competitive relationship between equals or a struggle for power and dominance by unequals.

Bateson (2000) suggested ritualistic patterns of behavior contributed to the perpetuation of schismogenic relationships. Bateson suggested a contributing factor was *ethos*, a Greek word for accustomed place. Other authors have drawn similar analogies to

the terms *family* and *familiar*, suggesting that although the patterns of behavior may seem abnormal to outsiders, they are *familiar* and predictable to the members of the family (Bradshaw, 2005). Bateson suggested schismogenic behaviors could be self-destructive to the parties involved and recommended that researchers identify methods to disrupt the schismogenic patterns before they reached a destructive stage.

Hoffman (1981) agreed with Bateson's (2000) description of the schismogenic nature of relationships and suggested the schismogenic nature could be changed only through appreciation that it was a recurrent, cybernetic system. Hoffman suggested first order change would alter behavior only within the existing limits of the family patterns of behavior. Second order change would entail a transformation of behavior, with a new set of rules in which the previous range of behaviors are no longer applicable, such as the rules of the relationship. Over time, by changing the rules of the relationship, an alteration in the patterns of behavior also occurs.

Brendler, Silver, Haber, and Sargent (1991) first described the symptomatic cycle as a pattern not only in the family, but also in the care providers. Brendler et al. described the symptomatic cycle as a predictable interpersonal sequence that maintains severe symptoms through a repetitive pattern of behavior that develops within the family and also between families and their care providers. Micucci (1998) criticized traditional symptom-based diagnostic approaches as missing the essence of the impact of relationships. Each member of a family looks at the situation through their own lens. By focusing on the individuals, one ignores the systematic relationship of all parties and its contribution to the outcomes.

Micucci (1998) suggested the language (or diagnostic labels) used to describe a family situation have the potential to create a blind spot to why the family is stuck and what approaches can be taken to move the family forward. Micucci suggested relationships were essential to changing behavior; the most important role of the therapist is to help the person to alter the patterns in the relationships in which they participate.

Micucci (1998) described the symptomatic cycle as a family stuck in a repetitive pattern of behavior that keeps the symptoms going. The father responds the way he does, because the wife responds the way she does, and the children respond the way they always do. The pattern can change if one person alters his or her pattern and sustains the change long enough for new patterns to emerge in the family.

The most profound change, according to Micucci (1998), is how one thinks or feels about oneself. An altered self-perception can result in a change in one's behavior. Changes in one's behavior can then lead to changes in the patterns of behavior within the family and other groups to which the individual belongs.

Micucci (1998) described the central themes of the symptomatic cycle as an overemphasis on symptoms in the identified patient (the child). A power struggle occurs in the family in an effort to *control* or eliminate the symptoms (Micucci). Family members become preoccupied with the symptoms and neglect important parts of their relationships (Micucci). According to Micucci, as relationships deteriorate, the family remains overly focused on symptoms and the patient develops increased feelings of being alone, misunderstood, and isolated.

The more the family members focus on the patient's symptoms, the more they see the child as the *problem*, which in most cases they have little ability to control (Micucci,

1998). The family members (and health care team) remain overly focused on *fixing* the child's symptoms. The more the family lacks control, the more powerless the members feel, and the more frustrated they get (Micucci). The child feels increasingly misunderstood, thus alone and isolated, so their symptoms escalate. The more the child's symptoms escalate the more frustrated the family gets, so their symptoms also escalate (Micucci).

There are situations in which psychopathology is manifested in the child or adolescent; therapy and medication may be necessary. It is important for the therapeutic team to be aware of the symptomatic cycle and avoid over-involvement with the patient to the point where the team members become overly invested in the patient's perception that the family is *dysfunctional* and avoid involving the family in any solution. By avoiding over-involvement the staff can contribute to a new pattern of behavior between the child, care team, and family that may be productive in producing a new pattern of behavior toward an optimal outcome for the patient and family.

The Symptomatic Cycle in Organizational Literature

Oshry's (1996) description of workplace dynamics strongly paralleled the symptomatic cycle concept from the psychosocial literature. The emotional cycle of behavior in avoidance problem-solving may be a self-perpetuating cycle that leads to continued escalation of emotion, repressed feelings, and more escalated emotion. This cycle is shown in Figure 5, based on Oshry's (1996) work. Most groups use avoidance as their problem-solving approach, despite the fact that when feelings are suppressed, the manager and group's problem solving ability deteriorates (Oshry, 1996).

The Impact for Nursing Leaders

The hospital is a system with a mission of healing. As a system, the hospital also has a natural tendency to protect and maintain its existence. The emotionally *difficult* patient and family may represent a challenge to the hospital system's need to maintain smooth operations and status quo. Many theories are applicable to the dynamics of these situations. No one theory has been incorporated into a comprehensive approach and fully researched. Family Systems Theory is the strongest theory to explain the phenomenon nurses use to label patients as *difficult*. Family Systems theorists would say the problem does not exist in the individual pathology of the patient but resides in a system consisting of the patient, family, and the caregivers. Oshry's (1996) theory about the layers of an organization and the dysfunctional way they approach problems is an excellent model for explaining the application of family systems theories to the workplace, which can be viewed similarly to a family. The best research regarding charge nurses was done by Connelly (as cited in Connelly, Nabarrete, & Smith, 2003; Connelly, Yoder et al., 2003).

Numerous authors have called attention to the need for transformational leaders to empower the lower levels of organizations (Bass, 1990, 1999; Buckingham, 1999; Vail, 1996). Research has indicated increasing difficulty convincing nurses to assume leadership responsibilities, including the charge nurse role (Sherman, 2005). Charge nurses were identified as key leadership staff, yet according to a study of 120 nurse managers in 24 health care agencies, most had not received formal training (Sherman, 2005). An examination of charge nurse decision-making skills around patient assignments found that experienced charge nurses consider a larger variety of factors compared to less experienced charge nurses (Bostrom & Suter, 1992, as cited in

Sherman, 2005). Connelly (Connelly, Yoder et al., 2003) called for the need to develop leadership skills in charge nurses. Gautam (2001) presented a variety of techniques for hospital leaders to encourage creativity in the labor force, based on Einstein's premise that the problems of the future cannot be addressed using the same approaches from the past. Based on their research on the thought process used by nurses in clinical decision-making, Higuchi and Donald (2002) made suggestions for improving nursing education to develop better critical thinking skills. Leadership development does not just take place in the work environment. Duemer, Chistopher, Hardin, and Olibas (2004) studied the emergence of leadership in graduate school learning experiences.

Connelly (as cited in Connelly, Yoder et al., 2003) recommended that charge nurses receive education in human relations, teamwork, resource allocation, critical thinking, and delegation. Connelly developed a workshop addressing leadership, human relations, and team-building skills needed for the charge nurse role (Connelly, Nabarrete et al., 2003). Sherman (2005) developed a similar workshop, including topics such as communication, supervision, delegation, conflict management, team building, scope of practice for RN and LPN, working with unlicensed assistive personal, and strategies to foster a sense of community. Garland (2003) developed an empowerment program for staff nurses to develop leadership skills, based on Oshry's principles of Middleness. Parsons' (1998) research on nurses' delegation skills found that nurses' job satisfaction increased after attending educational sessions to improve their delegation skills.

Hospital organizations generally function as social systems managed by consensus or conflict, and they always seem to be seeking a way to survive their particular circumstances (Scott, 1998). Hospitals are often conflict aversive

environments, yet conflict can actually be healthy (Morgan, 1989). The natural conflicts that arise between the vision (and those in favor of it) and the current reality (and those who wish to remain invested in the status quo) have been described as productive creative tension that can lead to positive change (Senge, 1990; Senge et al., 1994). Scott explained that conflict also may arise between the stated goals, the "real" goals (often described by participants as management's hidden agenda), and goals of the participants, which may alter their behavior. The unofficial rules based on history, the influence of informal leaders, actual results vs. those touted by leadership, and employee interest are often more important than the formal goals (Morgan, p. 47).

Galbraith (1974) suggested that it is not possible to make all decisions in advance, due to uncertainty created by limited information. Decision makers need as much information prior to execution, or the information must be processed during the actual execution. Quinn (1996) described this phenomenon as building the bridge as one walks on it. Thus, hospitals may need a model for handling the uncertainty of emotionally *difficult* patients and families. It may be necessary to provide employees with as much information as possible or place decision making at lower levels of the organization, where decisions can be immediately addressed based on environmental factors.

Conclusion

A review of the literature suggests the need for further research to understand the phenomenon of the impact of emotionally *difficult* patients and families on front line leaders. Given the nursing shortage, it is important that nurses have the proper tools to manage *difficult* patients and their families to avoid further stress that may result in their leaving the work setting (Heller & Nichols, 2001). Nurses and physicians often lack the

skills to manage *difficult* patients and their families. They may avoid them, over react, or retaliate (Daum, 1994). While there are gaps in the literature, several theories from the fields of philosophy, organizational dynamics, psychology, nursing, business and leadership serve as a foundation for the literature review. Major theories explored include the philosophical foundations of hermeneutic phenomenology (Heidegger, 1962; Heidegger & Stambaugh, 2002); General Systems Theory (Bertalanffy, 1974); Family Systems Theory (Guerin & Chabot, 1997; Kazak, 2002); the theory of Middleness (Oshry, 1994, 1996); and the Symptomatic Cycle (Brendler, Silver, Haber, & Sargent,1991; Micucci, 1998).

Limited research has addressed the role of nursing leadership in the care of patients and families labeled by staff as *difficult*. These families create stress on the health care team and there is a need to identify interventions to assist team members to overcome their challenges in these situations. As front line leaders, charge nurses can play an important role in how other members of the team manage *difficult* patients and their families. Further research is needed to explore the dynamic of emotionally *difficult* patients and families from the perspective of the lived experience of the charge nurse.

Summary

A historical overview of the literature began with a review of General Systems Theory, beginning with the work of Bertalanffy in the 1920s (Lewis, 2005). Bertalanffy's theories provided a foundation for theories of Cybernetics in the early 1940s, which received significant attention after the publication of Wiener's work in 1948 (Wiener, 1965). Early work in cybernetics took place in an era during which the primary research in psychology was based on Skinner's attempts to reduce human behavior to a simplistic

series of stimuli-response events that could be measured quantitatively, predicted, and consistently reproduced. By the 1950s, General Systems Theory had expanded in two major directions in the general sciences and behavioral sciences (Bertalanffy, 1974). Current literature on systems theory includes such notables as Checkland (1999), whose soft systems theory is an approach that deviated from looking at problems that need fixing to situations labeled by people as a problem. Systems theories have been applied extensively in health care, most notably in the behavioral fields as Family Systems Theory (Berman & Heru, 2005). A review of the various applications included structural family therapy (Bor et al., 1998), Communications Models and The Milan Associates (Guerin & Chabot, 1997), Brief Therapy (Watzlawick, 1967), Psychoanalytical Theory and Experiential Theory (Guerin & Chabot, 1997), and Family Systems Theory (Berman & Heru; Vetere, 2001).

A review of the current literature revealed that emotionally *difficult* patients may be misunderstood or not fully listened to by staff who do not fully understand the *difficult* patients' concerns or the dynamics behind why they behave the way they do (Daum, 1994). Nurses and physicians often lack the skills to handle the emotionally *difficult* patient and family. As a result, they avoid them, over react, or retaliate (Daum). Oshry's theory of Middleness may be useful in understanding how charge nurses experience emotionally *difficult* patients and their families. Oshry explored the role of the Middle coalition in organizations (Oshry, 1966, 1990, 1994, 1996; Schlesinger & Oshry, 1984).

Phenomenology is more than just a research process; it is also a philosophical approach to life used to explore and describe as accurately as possible the deepest meanings of human experience (Donalek, 2004). Heidegger (2002) suggested that the

purpose of philosophy is to offer a "worldly wisdom" and a "Way to the Blessed Life" (p. 1). Heidegger suggested a methodology for exploring the lived experience of other beings in order to appreciate their uniqueness. An approach that explores the lived experience of individuals may offer hope for charge nurses to understand the dynamics of *difficult* patients and their families.

The impact for nursing leaders is that, through understanding, nurses may have a greater appreciation for the plight of the *difficult* patient, which may provide solutions to working with them with less tension. The gap in current research was that limited research has addressed the impact of *difficult* patients and their families from the perspective of the lived experience of the charge nurse leader. This hermeneutic phenomenological research study may provide information that can contribute to greater understanding and possible solutions.

Chapter 3 will include a description of the methodology for a qualitative hermeneutic phenomenological study. Phenomenological research is appropriate when a subjective experience is not fully understood. The goal is to seek knowledge and understanding of a phenomenon from the subjects' perspective (Bentz & Shapiro, 1998; Koch, 1995, 1998; Moustakas, 1994). In-depth interviews, interactions between subjects and researcher, time for self-reflection, and input from experts in the field were part of the process (Bentz & Shapiro; Koch; Moustakas). The hermeneutic circle is used in hermeneutic phenomenological research to enhance the depth of the information and to avoid bias (Koch). The basis of hermeneutic phenomenology is an assumption that meaning can be derived from a thorough exploration of the lived experience of a people

by an objective observer standing outside the phenomenon.

CHAPTER 3: METHODOLOGY

The purpose of this non-experimental, qualitative, hermeneutic phenomenological study using interviews was to discover how nursing leaders experience emotionally *difficult* patients in in-patient hospital settings. A qualitative hermeneutic phenomenological method was appropriate because little was known about the dynamics of the phenomenon. Qualitative research is used when there is little known about a topic and an open-ended approach is needed to reveal new information about a phenomenon (Creswell, 2002; Meltzoff, 1998; Neuman, 2003; Salkind, 2003). Several different qualitative research designs were explored, including ethnography, historical research, and grounded theory. The hermeneutic phenomenological approach was chosen based on information from experts in the field under study. The research relationships are the charge nurses' interpretation of *difficult* behaviors by patients and families and how this interpretation may affect their own experience with *difficult* patients and families. It may also affect their ability to deliver clinical care, the charge nurses' relationship with the family, and how their experiences in working with *difficult* patients and their families has an impact on the charge nurses' relationships with co-workers. The analysis of interviews identified common patterns, factors, and elements of interest. The specific population for the study was nursing leaders in the charge nurse role. The purposive sample consisted of 15 charge nurses from several units in a pediatric urban academic hospital in Philadelphia, identified through snowball sampling.

The general problem was the shortage of nurses in the U.S., which was getting increasingly worse. The demand for new nurses will outpace the number of nurses retiring or leaving the profession (Heller & Nichols, 2001). One source of tension for

nurses is emotionally *difficult* patients and families who require excessive amounts of staff time and create frustration and stress (Daum, 1994). Given the current shortage of nurses, it was imperative that nurses have the skills to manage *difficult* patients and their families to reduce stress in their work environment.

The specific problem for this study was how the nurse who is in charge (Charge Nurse) on a specific hospital unit for an 8-to-12 hour shift experiences their work with emotionally *difficult* patients and families. Interviews with charge nurses used a qualitative hermeneutic phenomenological approach, with the goal to identify the charge nurses' emotional reactions and actions they take to resolve conflict with emotionally *difficult* patients.

Chapter 3 presents a discussion of the research method and design, and justification for its use. The population, sample, data collection methods, interview questions, validity and reliability, method appropriateness, feasibility, appropriateness, and data analysis are also presented in this chapter.

Research Design

Previous studies have not fully explored the role of charge nurse in situations with emotionally *difficult* patients and families nor measured the success of interventions to reduce staff stress (Connelly, Nabarrete et al., 2003; Connelly, Yoder et al., 2003; Daum, 1994). It would be premature to conduct quantitative research on a phenomenon that was not fully understood. Quantitative experimentation may limit the ability to uncover the full meaning and reality of a human experience because the preconceived set of questions places restrictions and boundaries on the subject's responses; and may distort and reduce the information the subjects disclose (Moustakas, 1994).

The qualitative study used interviews to collect information regarding the dynamics of situations in which charge nurses interact with emotionally *difficult* patients and families. An exploratory qualitative method was chosen because there was limited understanding in the research community regarding these dynamics involving charge nurses and *difficult* patients and their families. The results may provide greater understanding of the impact of emotionally *difficult* patients on nursing leaders. The findings may be used by future researchers to design interventions to assist charge nurses in managing the dynamics of emotionally *difficult* patients and families.

Appropriateness of Design

Several qualitative research designs were explored for this study. At least one other design, a case study, appeared to be applicable. A case study would have provided information on one particular *difficult* family or the experience of a single charge nurse. Other forms of qualitative phenomenological research would have allowed for the interactive relationship between researcher and subject that is a central quality of phenomenological research. Hermeneutics is a far more rigorous approach than other types of phenomenological research designs. Given the lack of prior research on emotionally *difficult* patients, it was imperative to increase understanding about the lived experience of charge nurses and how they experience emotionally *difficult* patients and families. A hermeneutic design was appropriate because it provides a methodology for rigorous exploration about a topic for which there was limited information available. The proposed study addresses the need to develop a better understanding of the phenomenon of emotionally *difficult* patients from the lived experience of those who care for them.

The hermeneutic circle required access to experts in the field to verify the findings. Results of the interviews were reviewed and discussed individually with the expert members of the hermeneutic circle. The experts are from the fields of General Systems Theory, Family Systems Theory, Nursing, Psychology, Social Work, Pediatrics, and Organizational Dynamics. A limited number of experts have explored the topic of emotionally *difficult* patients and families, but none through using a qualitative hermeneutic research process.

Phenomenological research is important to nursing practice because of the rich relationship that exists between nurses and those for whom they provide care; through a phenomenological research design, the findings may reveal insights necessary to care for patients sensitively and effectively (Donalek, 2004). What differentiates phenomenology from other qualitative research techniques is the avoidance of any pre-determined framework in order to remain true to the subjects' reporting of the facts from their perspective (Groenewald, 2004). Nursing phenomenological research differs from traditional phenomenological traditions because it does not focus on the purely objective original nature of occurrences. Rather, nursing phenomenological research focuses on subjective experience to understand the life-world of human beings by studying areas about which little is known or when the topic being explored has highly sensitive content (Donalek, 2004, p. 516). Phenomenology is more of a participative research process in which the subjects are co-researchers, not only by telling their story but working as co-researchers to create insight and meaning simultaneously from their experience (Donalek, 2004).

Research Questions

The study explored four general research questions. The first research question is, What is the lived experiences of charge nurses when dealing with emotionally difficult patients and families?

The second research question is, What are the interactions of the charge nurse with other members of the hospital team when confronted with emotionally *difficult* patients and families?

The third research question is, How do charge nurses experience the dynamics of how other staff handle emotionally *difficult* patients and families? The study explored what knowledge, skills, and assistance charge nurses believe they need to care for emotionally *difficult* patients and families.

The fourth research question is, What do charge nurses experience as the dimensions of their leadership role in helping to resolve these *difficult* patient and family situations?

Population

The hermeneutic phenomenological study approach helped to understand an experience from the participant's point of view. The topic was explored from the perspective of the participants, describing the phenomenon as it is typically lived and perceived by them. Leedy and Ellis-Ormrod (2001) suggested that hermeneutic phenomenology should consist of in-depth, unstructured interviews from a sample of 5-25 individuals. The proposed study used a purposeful sample of 15 subjects. Purposeful sampling allows the deliberate selection of subjects based on the value and usability of information they could provide (Patton, 2002).

The phenomenon of interest determined the selection and type of participants for the study. The specific population was nursing leaders in the charge nurse role. The sample was 15 charge nurses from several units in a pediatric urban academic hospital in Philadelphia.

Informed Consent

Subjects were given an informed consent form prior to the start of each interview (Appendix A). The informed consent form stated that the participant has voluntarily agreed to participate in the research study and may chose to withdraw at any time. All consent forms must be signed and returned prior to participation in the study. All consent forms will be was stored in a locked cabinet in the Department of Nursing Administration at the Children's Hospital of Philadelphia for a period of seven years from the time they are collected, after which they were destroyed, consistent with the hospital policies.

Sampling Frame

The sample consisted of 15 charge nurses, selected from several inpatient nursing units through purposive and snowball sampling, as described by Groenewald (2004). The snowball sampling technique identifies individuals to participate in a study based on the recommendation and referral of others. Managers were queried for charge nurses on their unit who meet the participant criteria. Once an initial group of participants are identified, the participants were asked for the names of other charge nurse who met the participant criteria.

The narratives of the interviews were analyzed to provide insight into the lived experiences of charge nurses with emotionally *difficult* patients and families. The results were used to make recommendations regarding the role of leaders with emotionally

difficult patients. Participants had first hand experience with emotionally *difficult* patients and families while serving in the role of charge nurse. Potential participants were contacted to discuss the study and set a date for the interview. The rights, needs, and values of the subjects were respected at all times. Face-to-face interviews took place whenever possible, with the other interviews conducted by telephone. Subjects were asked their permission to record the interview, with those participants not agreeing to the recording eliminated from the study.

Confidentiality

The identity of the participants remained confidential as well as the data sets. Data were collected through audio–taped interviews in a relaxed and private atmosphere to encourage dialogue and maintain confidentiality. Prospective participants received an introduction letter, which informed them of the purpose of the study, the nature of the study, their role in the study, the format of the study and the confidentiality of the study. Participants were asked to sign an informed consent form, which will remain on file to preserve confidentiality. Participants who refused to sign the informed consent were excluded from the study.

Geographic Location

All interviews were conducted at The Children's Hospital of Philadelphia in a private conference room, where the participants can feel comfortable. The conference room was in an isolated remote area on the 8th floor of the main building, which enhanced the ability of maintaining confidentiality of the participants. A pediatric setting was selected because of the rich foundation of literature in family systems theory, which looked at families. The impact of emotionally *difficult* may be significantly different in

pediatrics because of the interplay between the staff, the child (patient) and the parents. Charge nurses were selected as the subjects because of their potential impact as leaders. The Children's Hospital of Philadelphia was selected as it was the leading children's hospital in the United States.

Data Collection

Data were collected by the researcher, using a recording device in a live, face-to-face or telephone interview. The preparation phase of data collection involved identifying subjects and making initial contacts; scheduling time, date, and location of interviews; developing instructions for the interview based on informed consent criteria, and explaining the informed consent criteria to subjects prior to the interview. The atmosphere for the interviews were relaxed and free from distraction to encourage dialogue, and conducted in a private location to maintain confidentiality (Patton, 2002).

During data collection, rapport was established to assure subjects that confidentiality was maintained. Subjects were reminded that responses should be based on their own lived experiences, and that they should be truthful, accurate and specific to the structured interview questions. Subjects were provided with informed consent forms and were questioned to ensure that they understand the informed consent and have the opportunity to have any questions answered. All interviews were audio-tape recorded. Structured open-ended questions were used to promote an atmosphere of dialogue that encouraged participants to respond freely.

Data were collected through interview questions focusing on the participants' experiences, feelings, beliefs, and convictions, so that participants describe the experience they are living in their own language (Groenewald, 2004). As a result, hermeneutic phenomenology may lead in an unanticipated direction. At the completion of

interviews, the audio recordings were transcribed into narrative text. Transcription reduces the likelihood of errors, lapses in memory, or note-taking during the interview, which could be distracting to the subject. Interviews were conducted until new information on the topic reaches a saturation point and no new perspectives are offered by the subjects, a process described by Groenewald (2004).

Instrumentation

Interview questions (Appendix B) were developed based on the research questions. The interview questions served to collect information on personal demographics (gender, age, years as a nurse, experience as a charge nurse, and demographic data about their institution). Specific open-ended questions were collected providing data regarding the charge nurses' lived experience with emotionally *difficult* patients and families.

Interviews took place at the participants' employment site, a mutually agreeable and safe environment, or by telephone. The interview setting was familiar to the participant and allow for privacy from interruptions. Interviews were scheduled to take between one and two hours to complete. The audio-taped interviews were transcribed.

Data Analysis

Data were analyzed using NVivo7 computer software to identify themes and consistent patterns. The data should be consistent with the research questions. Analysis examined themes and patterns related to the research questions. These themes and patterns were then shared with the members of the hermeneutic circle and subjects to determine if the assumptions are correct. The final report explained why the topic was chosen, co-researcher reactions, and what passages appeared as a consistent pattern.

The goal of hermeneutic phenomenological research is to understand the history of a phenomenon from the subjects' lived experience and then conduct a hermeneutic circle to explore the topic fully and in depth from multiple perspectives (Koch, 1995). The hermeneutic circle involves several stages, beginning with an understanding of the background culture, pre-understanding, philosophical assumptions, interpretation of meaning, and finally, an understanding of what it means to be an individual actually experiencing this phenomenon (Koch, 1995). The circle of exploring the data and sharing observations with subjects and outside consultants continues until the topic has been sufficiently explored to reach a conclusion. The basis of hermeneutic phenomenology is an assumption that meaning can be derived from a thorough exploration of the lived experience of a people by an objective observer, standing outside the phenomenon.

Validity and reliability were enhanced by instituting a hermeneutic circle at the completion of interviews, transcription, and tabulation of themes. The hermeneutic circle involves several experts, identified based on their backgrounds related to the topic under study. The experts reviewed the collected data, themes, and be encouraged to comment on the results being suggested. The experts were selected because of their extensive background in topics which were covered in the literature review. All experts were recommended by other clinical experts in pediatrics and systems theory. The experts were queried for their interest in participation and availability to devote time to this project. The experts were consulted in the following order:

1. Mervyn Cadwallader, PhD-Sociologist and content expert in General Systems Theory and Cybernetics

2. Steve Simms, PhD-Clinical Psychologist and content expert in Family Systems Theory
3. Andrew Mozenter-Organizational Dynamics consultant and content expert in the theory of Middleness.
4. Kathy Murphy, Ph.D., R.N.-a Nursing expert in qualitative research, Family Systems Theory, and chronic illness.
5. Robin Johnson, DSW-Clinical Social Worker and content expert in pediatrics, teamwork, Family Systems Theory, and hospital team dynamics.

Donalek (2004) described the validity and rigor of phenomenological research as coming from spending considerable time with the subjects' information to extract themes that can be incorporated into ideas and theories to describe the phenomenon. The hermeneutic researcher provides a historical context and perspective in order to achieve the goal of understanding the subjects' experiences as closely as possible to the subjects' reality (Heidegger, 1962). It is impossible to remain completely distant from the process. Initially, subjects are approached objectively and in a non-biased manner to capture the full richness of their stories. The researcher's own interpretations are then added so that "the intention and meaning behind appearances are fully understood" (Moustakas, 1994, p. 9). Once a final description was identified, the findings were reviewed with participants, others who have experienced the phenomenon, and experts in the field.

In the hermeneutics tradition, interpretation is not viewed as a bias, but rather a basic structure of the process of fully appreciating and explaining an experience (Heidegger, 1962; Heidegger & Stambaugh, 2002). Validity was achieved through epoche, a term defined by Husserl as the elimination of suppositions and the raising of

intuitive and essence knowledge above empirical knowledge, which Bentz and Shapiro (1998) suggested could be achieved through Mindful Inquiry. Heidegger's work was based on the work of the rationalist philosophers including his mentor, Husserl. Heidegger believed all scientific knowledge rested on inner evidence the essence of which was one's being. To truly discover the nature and meaning of people's lived experience, researchers need to look within themselves and how they perceive the world as much as how the participant perceives it (Heidegger, 1962). Research bias cannot be avoided, but ideally, the hermeneutic circle helps to minimize the effects. It does so by correcting prejudgments in light of the information provided by the subject's text, which leads to new prejudgments that are validated through discussions with experts in the field. The process is comparable to the unfolding of history. An event takes place at a certain point in time. Over time, people gain additional information that provides a different perspective on history as they piece together new information and insights on the experience. Moustakas described the process for hermeneutic text interpretation as fixating on the meaning, dissociating from the mental intent of the subject, interpreting the whole (gestalt) of the text, and identifying multiple interpretations.

The goal is to allow data to emerge from the participants' perspective based on their rich descriptions, with minimal researcher bias (Kensit, 2000). The interview transcripts were analyzed using NVivo7 software to identify patterns. A certified NVivo7 consultant, Mary Anne Busby, MSN provided expertise in this area.

According to Groenewald (2004), it is necessary to exercise care in the interpretation of phenomenological data to avoid categorizing and analysis that may

potentially destroy the essence of the meaning. Groenewald described a process for data interpretation, as follows:

1. Bracketing and phenomenological reduction are performed to assure that the findings are describing the subjects' lived experience and to avoid interference from a heavily injection of the researcher's own perspective.
2. Delineating units of meaning to identify themes consistent from participant to participant.
3. Clustering of units of meaning to form themes, which can later be explored in greater depth to derive meaning.
4. Summarizing each interview, validating it, and where necessary modifying the information to more accurately reflect the subjects' response based on their feedback for clarity. In a hermeneutic design, it is common to return to the subjects for follow up information to validate the assumptions in the interpretations and make sure they are consistent with what the participant intended to express.
5. Extracting general and unique themes from all the interviews to identify patterns.
6. Making a composite summary for further discussion and conclusions.
7. Checking validity by returning transcripts and conclusions to the informant to determine if the essence of the interview has been correctly captured (Groenewald, 2004, p. 17).
8. Consulting experts in the field to see if they concur with the findings. The experts may also suggest a return to the subjects for further verification of information.

Bracketing is a process of controlling biases to avoid being unduly influenced when collecting data from subjects (Groenewald, 2004; Koch, 1995; Moustakas, 1994). A phenomenological hermeneutics researcher should go beyond bracketing but attempt to connect to the subjects at a deep Dasein level to grasp fully what is means to be in the lived experience of the subject. Through rigorous review of the textual material derived from the interviews, a set of data organized by themes is produced, capturing the rich essence of the subjects' collective lived experiences with a particular phenomenon.

Bentz and Shapiro (1998) drew from the traditions of phenomenology, hermeneutics, critical social science, and Buddhism to design mindful inquiry, an approach to bracketing. Mindful inquiry helps researchers to sustain their personal identity while being exposed to large quantities of data (Bentz & Shapiro, 1998). Mindfulness helps to maintain emotional control rather than being unduly influenced by new information and experiences. According to Groenewald (2004), good phenomenological research goes beyond the data to develop ideas and initial theories.

Appropriateness of the Data Analysis Method to the Research Design

Hermeneutics is a rigorous process, compared to the traditional phenomenological approach. By adding the hermeneutic circle, the data analysis process extends one step further to include another level of verifying data with the subjects and experts from the field. Although there are numerous experts in the field, a limited amount of formal research has been conducted on the proposed topic. The inclusion of experts added depth, rigor, and validity to the results. Experts came from nursing, psychology, social work, organizational dynamics, and systems theorists.

Validity and Reliability

There is no clear consensus regarding validity and reliability in qualitative research (Creswell, 2002). Research reliability relates to the degree to which a study can be replicated or reproduced in another context or point in time (Creswell, 2002). In hermeneutic phenomenological research, the validity of the data lies in the richness of the discussion, coupled with the rigor exercised by the interviewer. In qualitative research, reliability is enhanced by having a carefully delineated process for data collection that can be replicated in another setting (Moustakas, 1994). Heidegger was interested in raising qualitative research to the prominent position it held before the scientific era, when quantitative research became more in vogue.

It is important to provide an explanation of the qualitative inquiry process so that other clinicians can understand the process that was used to develop a theory about a nursing phenomenon (Chiovitti & Piran, 2003). Chiovitti and Piran suggested several techniques to promote credibility and auditability, as elements of rigor. Credibility is established by allowing the participants to guide the inquiry process; checking the participants' meanings of the phenomenon with the theory developed; and using the participants'words, views, and insights. Auditability is established by describing the research process in enough detail so that another researcher can understand the thinking and process behind the research approach, such as why the specific participants were selected. Auditability is important to rigor, credibility, and the ability for other researchers to replicate the study.

If the research process is well-documented, understanding of the world of the participants and their stories were revealed. The readers were able decide for themselves if the research is legitimate and can be replicated (Koch, 1998). Koch outlined several

actions which increase the likelihood of reliability, including: journaling to maintain a record of the research process, observing subjects, listening for unique information and vividly sharing it to call attention to voices of participants that have been marginalized, and writing to bring to life the participants' story. Rigor is achieved by presenting stories that are vital, provide context, capture information, hold the readers' attention, make the participants voice come alive, and present multiple points of view (Koch). These elements do not necessarily come from the research process but are a result of careful organization, creativity, and time for the co-researchers to comprehend the phenomenon fully (Koch, 1998). The research process incorporated all of Koch's suggestions, including maintaining a research journal.

The nature of hermeneutic phenomenological inquiry is to get closer to real experience than is possible through non-phenomenological inquiry, such as a quantitative survey. Quantitative inquiry is removed from lived experience by the nature of the approach that distances the researcher and the participant and does not provide an opportunity to explore specific responses in greater depth. In most quantitative studies, the subjects remain anonymous, which eliminates the possibility of clarifying data. The processes of bracketing, and the hermeneutical circle provide the hermeneutic phenomenological investigator with results that can be more valid than data obtained through a quantitative method in which the free flow of information between participant and researcher is restricted.

Internal Validity

Internal validity in a qualitative study is achieved by determining if there are other possible explanations for the results (Creswell, 2002). It is assumed that subjects

responded honestly in interviews. Validity was achieved through execution of the hermeneutic circle, described by Heidegger (1962) as an interpretative process, where a single text or event is investigated in a circular fashion, moving from one sub-process to another related to what was already known by the interpreter. The process continues until the interpreter believes he or she has satisfactorily explored and interpreted the phenomenon being studied (Honeycutt, n.d.).

External Validity

External Validity refers to the extent to which results can be generalized beyond the study population (Creswell, 2002). All research must deal with the issue of whether it is representational of the population and legitimate (Koch, 1998). Questions regarding the validity of phenomenological nursing research were addressed in the 1980s using quantitative language and thinking. The early nursing phenomenological approach erred in that the goal of phenomenological research was not necessarily to answer a quantifiable research question but rather to describe a previously unknown phenomenon by asking what it is like to be involved with the phenomenon (Koch). The credibility of phenomenological research is best addressed by showing how the research inquiry, rich stories from the subjects, and interpretation faithfully followed their design and process (Koch). Rigor in this study was achieved through journaling, observing, listening, and writing, as suggested by Koch.

The hermeneutic circle is one technique that helps to achieve external validity, as the topic is continually re-explored until the variation in the stories and themes reaches a point where little new information is revealed and it can be assumed to represent the population being investigated. One criticism may be how results can be generalized from

a limited number of subjects. Koch (1998) suggested that generalization may not be the focus of phenomenology, but rather the goal is to reach a new or better understanding through rich data regarding how the phenomena is experienced. Phenomenology is a research process that has been used to obtain authentic information about people and situations based on philosophy, feminism, multiculturalism and other post-modernism theories (Koch). Research should be an interactive process that is shaped by the participants and researcher and incorporates "personal history, biography, gender, social class, race and ethnicity, and…people in the setting" (Koch, p. 1182).

It has been suggested that phenomenology is closely linked to storytelling, which has a long history tracing back to humankind's original history, captured in the Torah, The Old Testament (Campbell, 1988). People live in stories which they tell, modify, re-create, and use to spur the imagination, understanding, empathy, and motivation of others to take action (Koch, 1998). Jung and Freud, two of the founders of modern psychotherapy, called attention to the fact that people think, dream, and store information in a stories format, which can be used to interpret life experiences (Rubin, 2003). Humans have a long history of storytelling, interpretation of stories, and use of stories to convey valuable information.

In the modern scientific era, quantitative approaches have received increasing attention. The increasing use of technology by nurses has impersonalized health care. When coupled with market forces and competition, technology has alienated nurses from each other and their patients, left them emotionally drained, and separated them from the basic humanity that is nursing (Koch, 1998, p. 1183). The contribution of nurses to the care of patients has often been difficult to describe and at times undervalued or devalued

by nurses (Koch). The wealth of nursing's contribution is imbedded in the "intensely personal, highly emotional, often brutal stories of everyday life as lived by clients and witnessed by nurse(s)" (Koch, p. 1183). The telling of a clinical story may have a therapeutic value for the teller. The telling of a clinical story can also be used to research health problems, describe situations where clinical interventions have failed, reveal ways to improve practice, evaluate community development, inform social policy, facilitate change in organizations, allow marginalized groups to have a voice, address diversity through understand, and facilitate self-help groups (Koch, p. 1183).

Summary

Chapter 3 presented a discussion of the research method, design, and justification for its use. The sample population, data collection methods, interview questions, validity and reliability, method appropriateness, feasibility and appropriateness, and data analysis were also presented. The specific population consisted of nursing leaders in pediatric nursing in the charge nurse role. The purposeful sample was 15 charge nurses from several units in a pediatric urban academic hospital in Philadelphia, who participated in in-depth, unstructured interviews. Purposeful sampling provides a process to deliberately select subjects based on the value and usability of information they could provide (Patton, 2002).

There is no clear consensus regarding validity and reliability in qualitative research (Creswell, 2002). The validity of the data lies in the richness of the discussion, coupled with the rigor exercised by the interviewer (Moustakas, 1994). Internal validity in a qualitative study is achieved by determining if there are other possible explanations for the results (Creswell). Validity was further achieved through execution of the

hermeneutic circle (Honeycutt, n.d.). The goal of data analysis is to allow data to emerge from the participants' perspective based on their rich descriptions, with minimal researcher bias (Kensit, 2000). Several authors presented methods for achieving academic rigor (Bentz & Shapiro, 1998; Groenewald, 2004; Koch, 1995; Moustakas, 1994). Hermeneutics is a rigorous process, compared to traditional phenomenological approaches. The inclusion of experts in the hermeneutic circle added depth and validity to the results. Experts came from such fields as nursing, psychology, psychiatry, social work, organizational dynamics, and systems theorists.

Chapter 4 will present the results of the data analysis and study findings. The data collection process was discussed, and direct quotes and themes from the subjects was presented to provide insight into the lived experiences of charge nurses when dealing with emotionally *difficult* patients and families.

CHAPTER 4: RESULTS

> *Participant 7:* It's hard to fix the emotional pieces and sometimes as nurses and doctors we don't like that . . . we like to take care of things and make it better and you can't always do that with difficult families, with big psychosocial issues.

The purpose of the non-experimental qualitative hermeneutic phenomenological interview research was to discover how nursing leaders, specifically charge nurses, experience emotionally *difficult* patients in in-patient hospital settings. The research relationships were the charge nurses' interpretation of *difficult* behaviors by patients and families and how this interpretation is related to the charge nurses' ability to deliver clinical care, their relationship with the family, and the impact on the charge nurses' relationships with co-workers. Common patterns, factors, and elements of interest were identified. The results may be used to develop interventions to address the impact of emotionally difficult patients and families on charge nurses.

The specific population for the study consisted of nursing leaders in the charge nurse role. The sample was composed of 15 charge nurses from several units in a pediatric urban academic hospital in Philadelphia, Pennsylvania. While the phenomenon of emotionally *difficult* patients and families may exist in other environments, the scope of this particular research project built upon preliminary work conducted in pediatric locations (Logan, 2002; Sieben-Hein & Steinmiller, 2005; Sieben et al., 2003; Simms, 1995) that was not conclusive and did not explore the lived experience of charge nurses.

Chapter 3 presented a discussion of the research method and design and justification for its use. The population, sampling, data collection methods, interview

questions, validity and reliability, method appropriateness, feasibility and appropriateness, and data analysis were also presented. Chapter 4 will present the results of the data analysis and study findings. The data collection process will be discussed, and direct quotes and themes from the participants will be presented to provide insight into the lived experiences of charge nurses when working with emotionally *difficult* patients and families. Two composites are presented, one for the novice charge nurse and a second composite for the experienced charge nurse, and their lived experiences when caring for emotionally *difficult* patients and families.

Review of the Problem Statement

Emotionally *difficult* patients and families create stress for charge nurses and require significant amounts of time (Daum, 1994). Given the current nursing shortage, it is important to find ways of handling *difficult* patients and families in order to reduce nurse turnover. This study is also important because while the role of nursing is to care for the human response to illness, this role also means accepting patients' reactions to their illness, even if it is difficult for the care provider to do so (Simms, 1995). The focus of the study is on the role front line leaders (charge nurses) play in hospital settings when caring for emotionally *difficult* patients and families. Limited information is available regarding effective methods for managing *difficult* patients and families. Several authors have made suggestions for how health care workers can be more effective with emotionally *difficult* patients (Logan, 2002; Sieben-Hein & Steinmiller, 2005; Sieben et al., 2003; Simms, 1995).

The study is significant for leadership because front line leaders, such as charge nurses, can be integral in role modeling, mentoring, developing, and leading other nurses.

It is important to understand the influence that charge nurses may have on how *difficult* patients affect the system in which they work. Numerous authors have stated the need for transformational leaders to empower the lower levels of organizations (Bass, 1990, 1999; Buckingham, 1999; Vail, 1996), including leadership skills of charge nurses (Connelly, Yoder, & Miner-Williams, 2003).

Several authors have attempted to improve nursing leadership skills (Garland, 2003; Parsons, 1998; Sherman, 2005). Oshry (1994, 1996) explored the role of the middle coalition in organizations. Oshry (1994, 1996) found that the power of workers in middle-level positions comes from their ability to process information from the top and the bottom and develop an independent middle perspective. This middle perspective can be used to develop an action plan that is realistic and to address the institution's needs (Oshry, 1994, 1996). According to Oshry (1994, 1996), Middles, by the nature of their work situation, find themselves feeling overworked, pulled in multiple directions, attacked, confused, isolated, and lonely.

The perspective of charge nurses, as middles, could include how they experience situations with emotionally *difficult* patients and families. In addition to the perception that comes from feeling overworked, charge nurses may label patients and families as *difficult* because the charge nurses lack an understanding of the true essence of such patients and family members as the other. This is what Heidegger (1962) described as *Dasein*, the essence of a human being, different from their appearance to others.

Review of Data Collection Procedures

Chapter 4 includes a review of data collection procedures, preparation of data for analysis, review of the process for transcription of participant interviews, analysis process

using Nvivo7 Software, graphic displays of the data, description of the results, and conclusions. Data were gathered over a four-week period beginning October 12, 2007. Potential participants were contacted individually using an exploratory E-mail explaining the purpose of the study and participant responsibilities (Appendix C). The goal was to interview 15 participants. Twenty participants were recruited and expressed interest in participation; however, only 15 charge nurses participated in interviews due to conflicts with scheduling. All participants gave informed consent using a consent form that was modified by the Institutional Review Board of The Children's Hospital of Philadelphia (Appendix A).

Data were collected using a recording device in a live, face-to-face or telephone interview. The preparation phase of data collection involved identifying participants and making initial contacts; scheduling time, date, and location of interviews; developing instructions for the interview based on informed consent criteria, and explaining the informed consent criteria to participants prior to the interview. The atmosphere for the interviews was relaxed and free from distraction to encourage dialogue, with interviews conducted in a private location to maintain confidentiality (Patton, 2002).

During data collection, rapport was established to assure participants that confidentiality would be maintained. Participants were reminded that responses should be based on their own lived experiences, and that they should be truthful, accurate, and specific to the structured interview questions. Participants were provided with informed consent forms and were questioned to ensure that they understood the informed consent and had the opportunity to have any questions answered. All interviews were audio-tape

recorded. Structured open-ended questions were used to promote an atmosphere of dialogue that encouraged participants to respond freely.

Data were collected through interview questions focusing on the participants' experiences, feelings, beliefs, and convictions so that participants described the experience they were living in their own language (Groenewald, 2004). At the completion of interviews, the audio recordings were transcribed into narrative text. Transcription served to reduce the likelihood of errors, lapses in memory, or note-taking during the interview, which could have been distracting to the participant. Interviews were conducted until new information on the topic reached a saturation point and no new perspectives were offered by the participants, a process described by Groenewald.

Thirteen interview questions (Appendix B) were developed based on four core research questions. The protocol of questions included requests for personal demographic data (gender, age, years as a nurse, experience as a charge nurse, and data about their institutional affiliation). Phenomenological data were collected using specific open-ended questions regarding the charge nurses' lived experience with emotionally *difficult* patients and families.

Interviews took place at the participants' employment site. Permission was obtained in advance from the Chief Nursing Officer to use the on-site location, and for the employees to be paid by their employer to participate in the interviews as part of their compensated work hours. All participants were informed of the interview site in advance and agreed to be interviewed in person at the site or participate in the interview by telephone. The interview setting was private to avoid interruptions. Interviews took one

hour or less to complete. The audio-taped interviews were transcribed immediately following the interview.

Data Gathering Process

Data were analyzed both manually and using NVivo7 computer software. NVivo7 was used to identify themes and consistent patterns. The data were consistent with the research questions. Analysis included exploring the themes and patterns related to the research questions. These themes and patterns were then shared with the members of the hermeneutic circle and participants to determine if the assumptions were correct.

The goal of hermeneutic phenomenological research is to understand the history of a phenomenon from the participants' lived experience and then conduct a hermeneutic circle to explore the topic fully and in depth from multiple perspectives (Koch, 1995). The hermeneutic circle involved several stages. These stages began with an understanding of the background culture, followed by pre-understanding, philosophical assumptions, interpretation of meaning, and finally, an understanding of what it means to be an individual actually experiencing this phenomenon (Koch, 1995). The circle of exploring the data and sharing observations with participants and outside consultants continued until the topic was sufficiently explored to reach a conclusion. The basis of hermeneutic phenomenology is an assumption that meaning can be derived from a thorough exploration of the lived experience of a people by an objective observer standing outside the phenomenon.

Validity and reliability were enhanced by instituting a hermeneutic circle at the completion of interviews, transcription, and tabulation of themes. The hermeneutic circle involved several experts who were selected because their backgrounds related to the topic

under study. These experts included a sociologist; a clinical psychologist; an organizational dynamics consultant; a nursing expert in qualitative research, Family Systems Theory, and chronic illness; and a clinical social worker.

Research bias cannot be avoided but, ideally, the hermeneutic circle helped to minimize its effects. Using the hermeneutic circle helped to minimize research bias by correcting prejudgments in light of the information provided by the participants' texts, which lead to new prejudgments that were validated through discussions with experts in the field. The goal was to allow data to emerge from the participants' perspective based on their rich descriptions, with minimal researcher bias (Kensit, 2000). Groenewald's (2004) procedure for data interpretation was used to avoid categorizing and analysis that may have potentially destroyed the essence of the meaning. This process was outlined in Chapter 3. The interview transcripts were analyzed using NVivo7 software to identify patterns. A certified NVivo7 consultant, Mary Anne Busby, MSN provided expertise in this area.

Bracketing is a process of controlling biases to avoid being unduly influenced when collecting data from participants (Groenewald, 2004; Koch, 1995; Moustakas, 1994). A phenomenological hermeneutics researcher should go beyond bracketing and attempt to connect to the participants at a deep Dasein level in order to grasp fully what it means to be in the lived experience of the participant. Through rigorous review of the textual material derived from the interviews, a set of data organized by themes is produced, capturing the rich essence of the participants' collective lived experiences with a particular phenomenon.

Collection of Transcripts

Audio recordings of interviews were transcribed into text within 48 hours of the interview. For reasons of confidentiality, recordings were kept in a locked file cabinet separate from another cabinet in which participant demographic data were stored. Participants were identified by number (Participant 1-15) on all transcripts. This procedure for protection of participant privacy was explained to all participants as part of the informed consent process.

Data Analysis

Preliminary themes were identified manually during the course of the interviews and transcription. A log was kept during the interviews and potential themes were added to the log as they emerged from the participants. During the transcription process additional potential themes were added to the list.

Transcribing the interview audiotapes provided an opportunity to reconnect with the voice of the participants. During transcription it was also noted that there were several points at which the participants revealed information that the researcher did not recall hearing during the original interview session. Murphy, one of the hermeneutic circle experts, said it was common in her experience as a qualitative researcher to hear things during the transcription process that she did not recall from the live interview. This is a reason she suggests doing your own transcription if it is possible time-wise (K. Murphy, personal communication, November, 17, 2007).

The potential themes were verified using the NVivo7 software to determine the frequency with which they occurred. Themes were also identified by listing all of the participant responses to the 13 formal interview questions. NVivo7 software was used to

organize the interview responses by question. As an example, all 15 participant responses to Question 5 were reviewed as a group. This review assisted in the emergence of the themes. From the 13 participant questions, 11 sub-themes emerged, leading to five core themes and a series of suggestions. The process for data collection and theme organization is depicted in Figure 7.

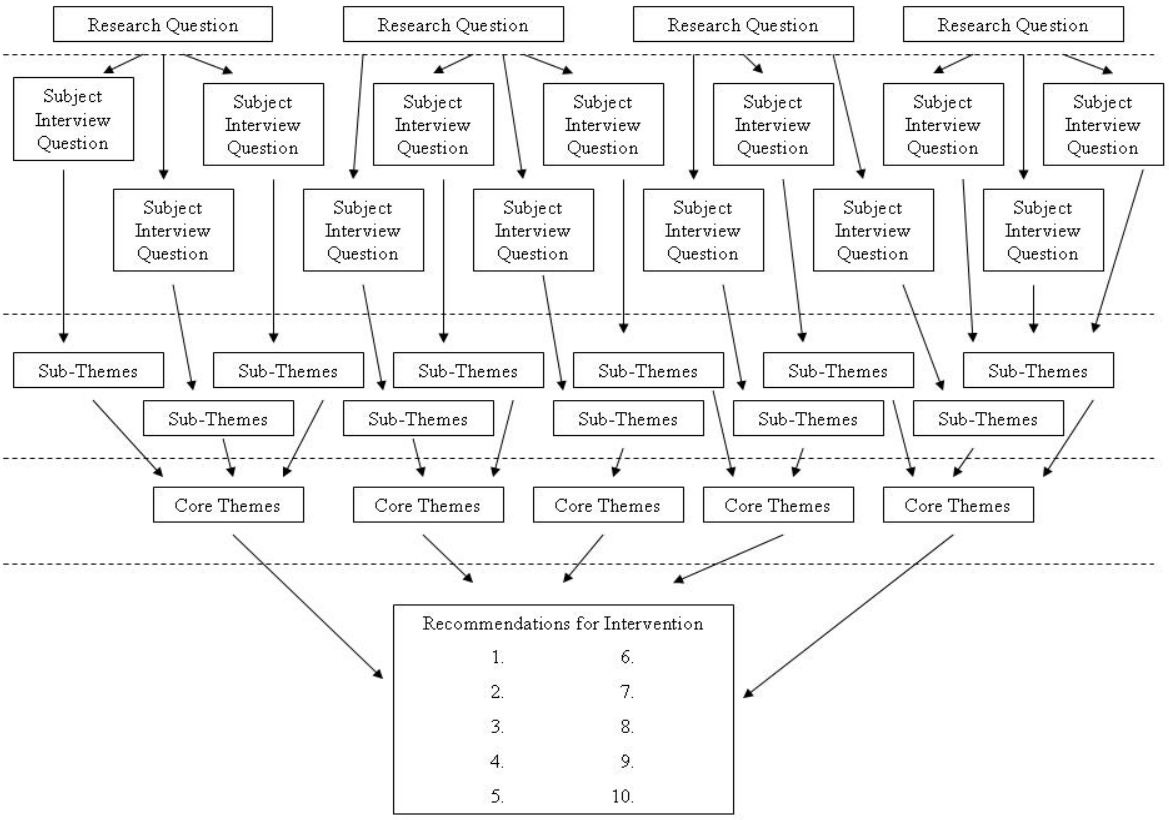

Figure 7. Five layers of flow of information from the four research questions to recommendations for interventions.

Participant Demographics

The 15 participants were all full-time employees of The Children's Hospital of Philadelphia. Participants were from eight different in-patient care units. Participants worked on four medical units, which were identified as Medical/Surgical Units, two

Intensive Care Units (ICU), one Intermediate Care Unit, and the Emergency Department (ED).

Table 1 shows a distribution of the participants by gender. The male participants (n=2) represents 13.3% of the total participants. The percentage of male nurses in the general nursing population at the hospital was 6%. Data on the charge nurse gender ratio was not available.

Table 1

Participant Demographics by Gender

Type of Unit	Total	Male	Female
Medical/Surgical	7	0	7
Intermediate	2	0	2
ICU	4	0	4
Emergency	2	2	0
Total	15	2	13

All participants were experienced charge nurses. Table 2 shows the total years of nursing experience for the 15 participants. Table 3 shows a breakdown of participants by age. Table 4 shows the regular working hours of each participant. Figure 8 shows the participants' average hours of work per week.

Table 2

Participant Demographics Years of Experience

Type of Unit	<5 Years	5-9 Years	>10 Years
Medical/Surgical	2	2	3
Intermediate	0	1	1
ICU	2	0	2
Emergency	0	1	1
Total	4	4	7

Table 3

Participant Demographics by Age

Type of Unit	25-30 Years	31-39 Years	>40 Years
Medical/Surgical	3	3	1
Intermediate	1	0	1
ICU	3	1	0
Emergency	0	2	0
Total	7	6	2

Table 4

Participant Demographics by Number of Hours Worked per Week and Shift

Type of Unit	36 Hours	40 Hours	>40 Hours	Days	Nights
Medical/Surgical	2	5	0	3	4
Intermediate	1	0	1	2	0
ICU	1	0	3	3	1
Emergency	0	1	1	2	0
Total	4	6	5	10	5

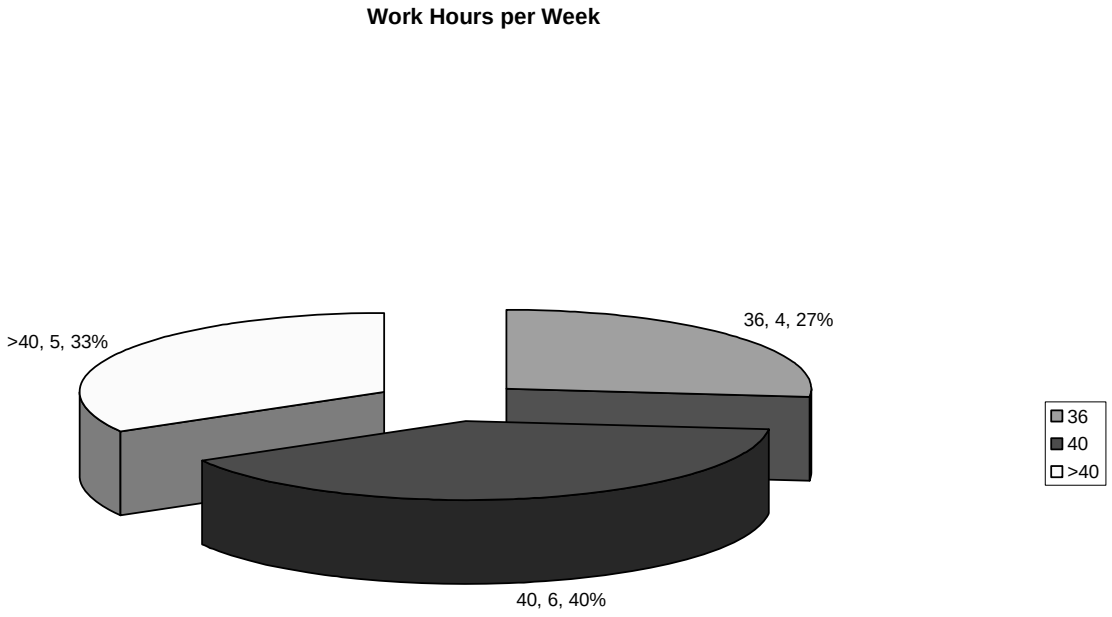

Figure 8. Participants average hours of work per week.

Participants were asked to identify the shift they primarily worked, days (n=10) or nights (n=5). Participant demographics are presented in tables 5 and 6; the number and types of staff who worked on the unit are presented in tables 7 and 8.

Table 5

Participant Demographics Part 1.

Participant	Nurse Level	Unit Type	Diagnosis	Gender	Age
1	3	General	Adolescent	F	38
2	4	ICU	All	F	38
3	4	Intermediate	Oncology	F	27
4	3	General	Pulmonary General Pediatrics.	F	27
5	3	ICU	Cardiac	F	30
6	3	General	G.I.	F	33
7	3	General	Hematology	F	35
8	2	General	Hematology	F	25
9	3	General	Adolescent	F	30
10	4	Intermediate	Oncology	F	40
11	3	ED	All	M	38
12	3	General	Gastrointestinal	F	40
13	3	ICU	Cardiac	F	26
14	3	ED/General	General Pediatrics	M	35
15	3	ICU	All	F	27

Table 6

Participant Demographics Part 2

Participant	Years Experience	Hours per Week	Percentage Charge	Beds	Average Daily Census	Primary Shift	Percent Shift
1	12	40	75%	22	20	Day	80%
2	16	36	50%	45	36	Day	100%
3	6	>40	50%	40	37	Day	75%
4	4	40	90%	24	22	Night	100%
5	10	>40	80%	25	23	Day	100%
6	11	40	100%	24	20	Day	100%
7	13	40	50%	22	20	Night	100%
8	3	40	50%	22	20	Night	50%
9	6	36	80%	22	20	Day	80%
10	20	36	50%	40	36	Day	100%
11	8	40	25%	72	72	Day	90%
12	6	36	100%	24	22	Night	100%
13	5	>40	50%	25	23	Day	50%
14	12	>40	80%	72	72	Day	70%
15	5	>40	100%	45	36	Night	100%

Table 7

Participant Demographics Other Staff on Their Unit Available as Resources Part 1.

Participant	Physician	Nurse	Ancillary	Social Worker
1	7	6	3	1
2	15	27	5	1
3	12	15	5	4
4	2	5	2	On-Call
5	6	18	5	3
6	12	8	3	3
7	2	4	2	1
8	1	4	1	0
9	7	6	3	1
10	12	15	5	4
11	5	12	12	2
12	2	6	2	0
13	6	18	5	3
14	5	12	12	2
15	5	28	5	0

Table 8

Participant Demographics Other Staff on Their Unit Available as Resources Part 2.

Participant	Environmental Services	Child Life	Advanced Practice Nurses	Case Management
1	2	1	2	1
2	4	2	2	2
3	4	3	6	2
4	1	0	0	0
5	2	2	3	1
6	3	1	3	1
7	1	0	1	0
8	1	1	0	0
9	2	1	2	1
10	4	2	6	2
11	5	1	3	0
12	2	0	0	0
13	2	2	3	1
14	5	1	3	0
15	2	0	0	0

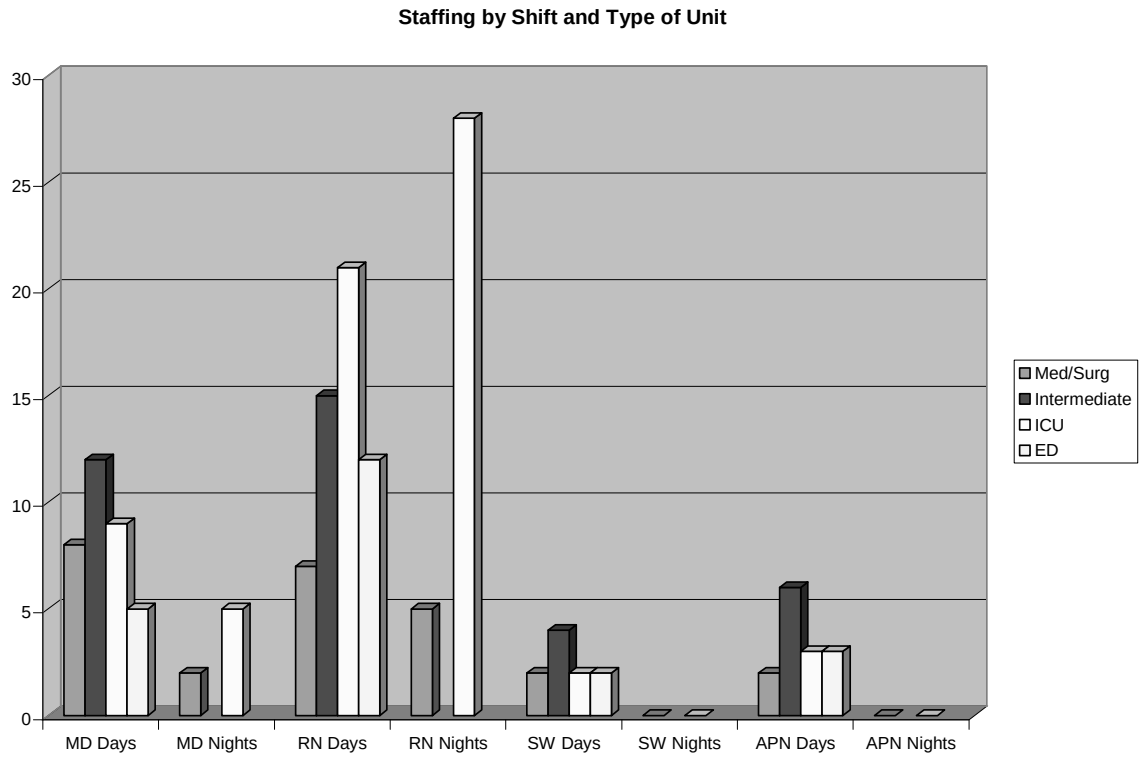

Figure 9. Staffing by shift and type of unit.

Description of Themes

Four research questions were identified and became the basis for 13 formal interview questions. The four research questions focused on the lived experiences of charge nurses when working with emotionally *difficult* patients and families. Eleven sub-themes emerged from the interview data. These eleven sub-themes were used to identify five core themes. Participants provided ideas for interventions. These ideas for interventions were combined with the five core themes to produce a master list of recommendations for improving the situation when charge nurses are confronted with emotionally *difficult* patients and families.

The four research questions focused on the lived experiences of charge nurses when working with emotionally *difficult* patients and families:

The first research question was, What is the lived experiences of charge nurses when dealing with emotionally *difficult* patients and families?

The second research question was, What are the interactions of the charge nurse with other members of the hospital team when confronted with emotionally *difficult* patients and families?

The third research question was, How do charge nurses experience the dynamics of how other staff handle emotionally *difficult* patients and families?

The fourth research question was, What do charge nurses experience as the dimensions of their leadership role in helping to resolve these *difficult* patient and family situations?

The following eleven sub-themes that emerged from the analysis of the participants' narrative interview data:

1. How emotionally *difficult* patients and families affect the ability to provide clinical care.
2. Definition of emotionally *difficult* patients and families.
3. Types of *difficult* patients (violence-angry, silence-devastated).
4. How the culture reinforces the behavior of patients, families, and staff.
5. Staff relationships, teamwork, rumors, and gossip.
6. The role and responsibilities of charge nurses.
7. Resources available to the charge nurse.
8. Factors related to greater understanding of emotionally *difficult* patients and families (Mature vs. Young Staff).

9. The impact of emotional intelligence.
10. Grief, loss, and end of life experiences with emotionally *difficult* patients and families.
11. How charge nurses maintain their emotional balance and that of their staff.

Participants responded to the four research questions with 11 sub-themes. These sub-themes are presented in response to the research questions and then further expanded upon in the following sections, where they are organized by the core themes.

1. Participants responded to the first research question regarding their lived experience, by defining emotionally *difficult* patients and families (sub-theme 2) and describing the types of difficult patients (sub-theme 3).
2. Participants responded to research question two regarding their interactions with other members of the team, by identifying factors related to greater understanding (sub-theme 8); explaining the impact of grief, loss, and end of life (sub-theme 10); how emotionally *difficult* patients and families affected their ability to provide clinical care (sub-theme 1); and the impact of staff relationships, teamwork, rumors, and gossip (sub-theme 5).
3. Participants answered the third research question by describing the impact of emotional intelligence (sub-theme 9); the resources available to the charge nurse (sub-theme 7); and how charge nurses maintain their emotional balance and that of their staff (sub-theme 11).
4. Participants answered research question four by describing their leadership role and responsibilities (sub-theme 6); and how the culture reinforces the behavior of patients, families, and staff (sub-theme 4).

In the following section the sub-themes are explained in greater detail as they relate to the five core themes which emerged.

From these 11 sub-themes, five core themes were identified:

1. Staff are vulnerable to being caught in a symptomatic cycle of behavior when working with *difficult* patients and families.
2. The defining and labeling of people as *difficult* may prove to be an obstacle to future interactions, communication, and relationship building.
3. The importance of how the charge nurse interacts with staff to create a culture that reinforces positive behaviors aimed toward resolution of conflicting relationships with *difficult* families.
4. Charge nurses are in a leadership role that places them in conflict with various systemic forces within the organization, staff, and families. The charge nurse's ability to navigate these situations is important to the outcome of the team's ability to interact successfully with *difficult* families.
5. There are a set of skills that can be taught to charge nurses, staff, and teams to improve their ability to work with *difficult* families.

The participant data that informed the development of the themes is presented in the following section. The titles of the core themes have been simplified and the sub-themes have been reorganized to align with the core themes. The core themes, sub-themes, and suggestions for intervention are outlined below in accordance with how they will be organized and presented in the following section. The transcripts of the

participants' suggestions for interventions have been included in Appendix G as a reference. Core themes, sub-themes, and suggestions for intervention:

1. Avoid the symptomatic cycle:
    a. Sub-theme 1: How emotionally difficult patients and families affect the ability to provide clinical care;
    b. Suggestion: Make psychosocial evaluation, planning, and intervention a priority.
2. Resist the temptation to label:
    a. Sub-theme 2: Definition of emotionally difficult patients and families;
    b. Sub-theme 3: Types of difficult patients (violence-angry, silence-devastated);
    c. Suggestion: Communicate with the family;
    d. Suggestion: Avoid making assumptions about people.
3. Create a positive culture with clear plans:
    a. Sub-theme 4: How the culture reinforces the behavior of patients, families, and staff;
    b. Sub-theme 5: Staff relationships, teamwork, rumors, and gossip;
    c. Suggestion: Early formal planning;
    d. Suggestion: Support each other;
    e. Suggestion: Work together as a team.
4. Be aware of your role as a middle:
    a. Sub-theme 6: The role and responsibilities of charge nurses;

b. Sub-theme 7: Resources available to the charge nurse;

c. Suggestion: Rotate assignments;

d. Suggestion: Support from leadership;

e. Suggestion: Communicate to the team.

5. Teach the skills:

a. Sub-theme 8: Factors related to greater understanding of emotionally *difficult* patients and families (mature vs. young staff);

b. Sub-theme 9: The impact of emotional intelligence;

c. Sub-theme 10: Grief, loss, and end of life experiences with emotionally *difficult* patients and families;

e. Sub-theme 11: How charge nurses maintain their emotional balance and that of their staff;

d. Suggestion: Training;

e. Suggestion: Mentoring;

f. Suggestion: Experience as a patient or parent.

Core Theme One: Avoid the Symptomatic Cycle

The symptomatic cycle (Brendler, Silver, Haber, & Sargent, 1991; Macucci, 1998; Simms, 2007) was reviewed in Chapter 2. The symptomatic cycle is a systemic process in which the family and health care team become overly invested in focusing on the patient's symptoms. The danger is avoiding important issues, which may cause the family and staff to reach an impasse in their ability to work together toward the improvement of the patient's condition. One suggestion for avoiding the symptomatic cycle is to focus on psychosocial issues as a priority. Participants suggested that

emotionally *difficult* patients and families affect their ability to provide care, which is discussed in the following section.

Sub-theme 1. The first sub-theme is how emotionally difficult patients and families affect the ability to provide clinical care. Nurses and physicians often lack the skills to manage *difficult* patients and their families. They may avoid these patients, overreact, or retaliate (Daum, 1994).

While there are gaps in the literature, several theories from the fields of philosophy, organizational dynamics, psychology, nursing, business, and leadership served as a foundation for the literature review. Major theories explored include the philosophical foundations of hermeneutic phenomenology (Heidegger, 1962; Heidegger & Stambaugh, 2002); general systems theory (Bertalanffy, 1974); family systems theory (Guerin & Chabot, 1997; Kazak, 2002); and the theory of middleness (Oshry, 1994, 1996).

Participants suggested that emotionally difficult patients and families placed an added burden on the staff and unit as a whole. Emotionally difficult patients and families take time and energy away from clinical care. Time is probably the biggest effect, because the psychosocial issues with families with families who are emotionally *difficult* take a lot of time and patience. Participant comments to illustrate these concepts are presented in the next section.

> *Participant 1*: Sometimes the morale of the nurses just goes down and the nurses become short with the family, confrontational, or back off and avoid them. Sometimes the nurses know they need more, but they pull back because they don't have the emotional resources to give anymore to this family. Backing off

manifests as just not getting back to the family, or the call bell goes off and they ignore it, or they just get busy with their other patients. The family may ask questions the nurse could help them with, but instead because everything gets blown out of proportion with the family, the nurse decides not to extend herself as much as she would normally because it's too emotionally draining for the nurse.

Participant 2: An emotionally difficult child is not hard to care for. An emotionally difficult family is very hard to care for. When patients are in distress, we're much more forgiving. When patients are irrational, combative, angry, sad, distressed, we're much more forgiving. Even if it's a teenager who was drunk and in a car accident, ran over somebody, drove into a parked car, jumped out of a police car window, has all kinds of multiple traumas, and is cursing you out. I'm still all right with that, even though he's in handcuffs and shackles. I'm still compassionate. You feel like when they get better, they'll be different because we'll do things so they'll be in a better situation. But we expect the family to be reasonable and manage using their best coping skills. The patient is sick, so they're allowed to misbehave, within limits. But I can't tolerate a family obstructing care their child needs to receive. With some families you can never ever do a good job. You worked harder than you ever worked and you go home feeling like you did nothing right. It doesn't make you feel like coming back for another round. That's why difficult families are so draining.

Participant 8: It's harder for me to deal with parents being difficult than it is when the patient is difficult. I'm there to help the patient, but it makes my job a lot harder when the parents are constantly against you. They brought the child in,

but then they don't want you to do anything. They don't want the vital signs taken, they don't want their medications given, they don't want them to get their treatment. But then they don't want to go home. Sometimes I feel like shouting, "what do you want me to do"? The child often feeds off the parent, so when the parent is upset, the child get upset, too.

Participant 10: It depends. The angry families take up so much of your time, it keeps you from your other patients. It can be because they constantly have another question or they want you to go over the same material again and again. Sometimes the nurse just gets to the point where she doesn't want to go into the room, because she's afraid she'll never get out of there. So you end up not spending as much time in the room, which means you're not watching that child as closely as you could be.

Participant 6: It can make people not want to come to work. It can make people not want to take care of that patient. We can love the patient but not the family. You have to have the right mix. You have to know who can take care of that family and not see the family as doing it toward them. Some people can take care of one difficult family and then another one will set them off.

Participant 5: Sometimes a nurse won't even want to go in a room of a difficult family. What the family doesn't realize is that when they mistreat the nurses it makes the nurses feel hesitant to be in the room with the family, which means the patient isn't getting as much attention.

Participant 9: Sometimes we have to scale down the nurse's assignment because she's spending so much time with the difficult family. That means other nurses have to pick up a bigger case load, which breeds some resentment from the other nurses. Over time, we cut back on that and developed a routine so that the nurse caring for the difficult patient could take a full case load of other patients.

Participant 12: They can create a barrier to our access to the patient. There's always the thought in your head that you're going to have to deal with them in order to get to the child. We had a patient who tended to seek a lot of pain medication. We had to plan out our day that she'd constantly be ringing the call bell for her nurse to give her more medication. You have three other patients your caring for and you can't keep running in there to give her meds or to argue with her that it's not time to get her meds. For a charge nurse it's hard depending on who the nurse is that's caring for that family. If it's a young nurse you don't want them to become overly frustrated in caring for them.

Participant 14: Some patients and families treat their room like it's their personal world. When you walk in, it's like you're walking into their universe and every time you walk in there's [sic] the same issues. They may feel powerless that we're not able to fix the patient's issue. So their parents are looking at you like, "What are you going to do for me now"? "How can you make things better"? Meanwhile, you were coming in the room to do your routine thing and you know you're not doing anything special to make any huge progress for the patient.

Core Theme Two: Resist the Temptation to Label

The defining and labeling of people as *difficult* may prove to be an obstacle to future interactions, communication, and relationship building. Kazak (2002) suggested people are often labeled based on faulty assumptions and that such mislabeling can result in patterns of behavior that reinforces the faulty assumption, leading to tension, arguments, and further stereotyping of people. Suggestions for avoiding the labeling of people and the participant data are discussed in the following section.

Sub-theme 2. The second sub-theme is the definition of emotionally *difficult* patients and families. Daum (1994) described emotionally *difficult* patients as disruptive antisocial patients who flagrantly disregard policies, are verbally abusive, exploitive, manipulative, and physically threatening. A review of the current literature revealed that emotionally *difficult* patients may be misunderstood or not fully listened to by staff who do not fully understand the *difficult* patients' concerns or the dynamics behind why they behave the way they do (Daum, 1994). Participants varied in their definition of emotionally *difficult* patients and families:

> *Participant 1*: An emotionally difficult patient or family is one who is not coping with the environment or with the disease process, whether it's due to just being in the hospital and the challenges and the stressors of the hospital, or whether they have an underlying diagnosis of behavioral or psychological problems.

Several participants took offense to the term *difficult:*

> *Participant 10*: I think there is a better term than difficult, but I don't know what it is. Maybe something like frustrated, but I don't think that totally captures it. Maybe it's the poorly communicate scenario, coupled with a poor listener (the

nurse). The issue is that they are angry or emotionally devastated and get labeled as difficult because sometimes the nurses aren't always good at seeing the whole picture of what's going on in the family's life.

Participant 12: I have difficulty with the term *difficult*, because I had a sick child and I see it from a different perspective. I don't use that term a lot because I could have been labeled a difficult family too. People are labeled as difficult if they are demanding of the nurses. It can be someone who is worried about their child's care and can be very demanding. They can seem nasty to some staff, who aren't doing things that they need to. That's how the majority of nurses would label a difficult family. Difficult people can be angry or just demanding.

Sub-theme 3. The third sub-theme is types of *difficult* patients (violence-angry, silence-devastated). Some authors suggested people react to stressful situations along a continuum from silence to violence (Patterson, Grenny, McMillan, & Switzler, 2005; Patterson, Grenny, McMillan, Switzler, & Covey, 2002).

Participants defined emotionally *difficult* patients and families as manifesting in a variety of ways. *Participant 10* described three categories of emotionally *difficult* patients and families:

Participant 10:. . . emotional and angry; emotionally devastated; difficult child. The angry families tend to be yelling. The devastated ones are either sobbing or withdrawn. When the child is the difficult one, it's a different dynamic. If it's a behavioral thing it's difficult to set rules if the parent is here. It's sometimes easier if the parent isn't here. If the parent is here, but they don't buy in to you

setting limits for the child it can be very difficult . . . most of the time, not all of the time they have very valid reasons for being angry.

Participant 12: A baby who is constantly crying, can't tell you why and you know something is going on with them. When you have a demanding teenager you want the parents to help with the situation, but they're not always here. If it's an older teenager you wonder why they're even in a pediatric hospital. If we're so horrible, why don't they go to an adult hospital?

Participant 11: They are people who angry or frustrated because of long waits or not know [*sic*] what is going on, or both. Their biggest concern is what's going on with their child, why isn't it being done more quickly, and then expressing that frustration to the care providers.

Participant 15: There are different kinds (of *difficult* people) from the dysfunctional people who are difficult at everything. That could be a personality disorder or drug and alcohol problems. Then there are the perfectly normal families who are dealing with the most emotional thing in their life and the only way they know to react is to be what we would label as difficult. There are also difficult patients who just suffered a traumatic brain injury and are acting out because of an injury to that portion of their brain.

Participant 14: Emotionally difficult families are difficult on the nurse's emotions and the patient's emotions. They are people who challenge you in a negative way. They're the kind of people who question everything you're doing. They question what you're doing, why you are doing it, if you are doing it the right way, is there somebody better than you to do it. They call you names. The majority of what

makes people difficult to deal with is around control. If someone's giving me a hard time about torturing their child with a treatment, it's probably because they are standing there allowing someone to hurt their child. They're the parent and it's their natural instinct to want to protect their child and control the situation. So they feel the need to step up and challenge the nurse.

Participant 8: Emotionally difficult families are the ones who are emotionally draining. They will suck you dry if you let them, and even if you don't let them. They are also the families who are not necessarily bad, they just have a lot going on. I haven't had many bad experiences with difficult families. I have had irate families who can't handle stress, so they want to tell everyone off and scream and yell. I have found if you don't feed into their anger and just listen to them and let them get it out, it's over. Then you can go back and have a conversation and reflect on what happened and reflect on what their major problem really is. It's usually not the thing they're complaining about.

Participant 9: "Emotionally difficult families who have new diagnoses or their condition has gotten worse and everything trickles down from that."

Participant 5: Difficult people don't have to be demonstrative; they just can be someone whose beliefs are in conflict with the nurses. They don't necessarily have to be mean toward staff, but the kid could be suffering because of the parent's refusal to stop care. In some situations nurses will refuse to care for a patient like that. As a charge nurse I will let the nurse take a different assignment if they are really having a difficult time caring for that child.

Participant 13: I think I would tell people to get to the root of the problem first, before trying to approach it from your point of view (as the clinician). You need to ask yourself, why are they so angry? Why are they so upset that they're taking it out on the nurses? What really happened to upset them? Families have a lot going through their heads. Their child is sick, they have financial costs, they may have other children at home they're not seeing, and there could be other family issues. It's usually not just one thing and you should look at it from their point of view and see what they're seeing, before you label them . . . When a patient dies some parents can get pretty violent. We've had trashcans thrown, holes punched in walls, crying in the hallway, or crying on top of the patient.

Participant 6: A difficult patient or family is anyone who is not in control of their emotions. If you have a child who is upset and a parent that's upset that the child is upset you have a problem. There are various levels of this from families that are just upset to the ones that are irate. There is a difference between being upset and being angry. Emotionally upset is when you get bad news, like your kid has a new diagnosis. Then we have families of patients with a chronic illness, whose families expect things done the way they do them at home, or they expect things to go as smoothly as they did on their previous hospitalization. When that doesn't happen, it's harder…The emotionally upset patients get upset, you help them through it, you sit with them, and they can usually refocus themselves. The angry ones can be angry for an entire hospitalization, if the first day doesn't go the way they wanted it to. Usually the first day precipitates their attitude about the rest of their stay.

Participant 14: There are times when we have no idea what's wrong with a patient and we're doing our best to figure out why something is happening, but we really don't know. That can be really frustrating for a parent who is in the room with the child 24 hours a day, and can't get an answer as to why their child is sick and what we can do to make them better. So if that manifests as anger, sadness, frustration, or any other emotion we need to take a step back and appreciate it from the parent's perspective.

Participant 2: Unfortunately, I think certain families come off as so mean and angry that the staff just shuts down and can't get past that. I knew this family from the beginning, so I know how they work a little bit better. (Participant 3) Angry people often start as someone who is quiet, and is sitting and watching everything. Then one day they get angry at us, but when you really talk to them they're angry because we waited an hour to do some minor task, while in reality they're angry about something bigger. They're angry because they're grieving whatever they've lost, control of the situation.

Participant 2 suggested that there is a different dynamic with an angry patient versus an angry parent: "We expect the family to be reasonable and manage using their best coping skills. The patient is sick, so they're allowed to misbehave, within limits. But I can't tolerate a family obstructing care their child needs to receive."

Participant 4: Sometimes an older adolescent patient will be very nice and suddenly turn nasty: cursing at the nurses, becoming physically violent, and refuse to participate in the care or allow you to administer the care. It becomes very difficult because it became a dangerous situation if the child is refusing care.

Participant 10 described families manifesting as quiet, withdrawn, or silent. “The devastated silent family tends to be in a protective mode. They say things like, “Suzie just fell asleep, do you really need to draw that blood right now”? Or, “Does she really need that medicine right now? She just fell asleep,” or “she’s finally eating, can’t we wait”?

Participant 2: Parents detach when they are in denial, their coping mechanism is to shut down, they’re quiet, they don’t yell, they don’t get angry, they just shut down. It’s very sad to watch and frustrating for the staff because it’s hard to know what they need.

The silent, detached families are the scariest. We don’t just treat children here, we treat the entire family in whatever form that is. If you can’t engage a parent, you can’t really treat the child. The child below the teenage level is so dependent on the parents for their emotional stability. Parents detach when they are in denial, their coping mechanism is to shut down, they’re quiet, they don’t yell, they don’t get angry, they just shut down. It’s very sad to watch and frustrating for the staff because it’s hard to know what they need. Do they need rest, time alone with their family, a chaplain? You tend to use all your resources to figure out what the family needs. If the parents detach from us, or even worse if they detach from their child emotionally you don’t know what the outcome will be. Most families don’t stay detached in our company too long, rarely more than a few days. They find other things to do like go home, go back to work, disappear, or they progress into the next stage of anger.

Participant 10: I think there is a better term than *difficult*, but I don’t know what it is. Maybe be something like frustrated, but I don’t think that totally captures it.

> Maybe it's the poorly communicate scenario, coupled with a poor listener (the nurse). The issue is that they are angry or emotionally devastated and get labeled as difficult because sometimes the nurses aren't always good at seeing the whole picture of what's going on in the family's life. A typical example is: Mom and dad both work; three kids at home; a child who was perfectly healthy and they went to the doctor with a sore throat and now has cancer. Their world is in a tailspin. Sometimes the parents may be focused on all the other things in their life, or they're just not able to hear anymore bad news about their child.

Core Theme Three: Create a Positive Culture with Clear Plans

It is important how the charge nurse interacts with staff to create a culture that reinforces positive behaviors aimed toward resolution of conflicting relationships with *difficult* families. Charge nurses varied in their appreciation of the importance of their role in shaping the culture. Suggestions for creating a positive culture and the participant data are discussed in the following section.

Sub-theme 4. The fourth sub-theme is how the culture reinforces the behavior of patients, families, and staff. The culture of an organization or individual nursing unit may be more significant than the individual members when it comes to managing emotionally *difficult* patients and families. Agazarian's Theory of Living Human Systems was used to explain developing organizational emotional intelligence as another way of describing a culture (Gantt & Agazarian, 2004). Team emotional intelligences that impact on the culture include: decision making, leadership, strategy, communication, relationships, teamwork, customer service, creativity, and innovation (Cooper & Sawaf, 1998, p. xii). For these reasons, Gantt and Agazarian suggested that groups and organizations be

viewed as whole rather than breaking things down into individual pieces. The impact of culture is described in the lived experience of the following participants.

> *Participant 4*: It's like it takes a whole village to raise a nurse that doesn't take it personally. When you have a whole staff who realizes it's not about you, it's about the parents' reaction to everything they've been through. When everyone on the staff has had to take care of the difficult family, then they are willing to listen to you when you say not to take it personally, because they know you've been through it yourself.
>
> *Participant 7*: The charge nurse role is mainly about creating a culture on the unit where the staff have what they need, feel supported, where teamwork is present, and you're just there for people as a resource.

A culture of role models helps to reinforce staff behaviors:

> *Participant 6*: I've seen younger staff mimic me in their next interaction if I've done a good job of mentoring them. I've seen nurses who used to grab me for help, now does [sic] it on their own. You can do all the in servicing and role playing you want, but until you're in the situation it's different.

Participant 11: ". . . we do a lot of education, like taping trauma codes and then reviewing how we did. I think that changes the culture to one where you are self reflective about everything."

> *Participant 7*: We've had a lot of deaths in the last month, about ten long term patients with strong relationship with staff. So we had a lot of debriefings and nurses from clinic came over, physicians, physical therapists, anyone who works with the patients. Everyone just sticks together because it's so hard you can't eat

your young staff. You couldn't survive in a tough situation like that if you didn't stick together, support each other, and help them to come back. (Participant 3) There are some consistent themes: consistency, communication, teamwork, designating a primary care team, partnership, focusing on the patients' and families' unique needs. Those things are easy to say, but not always easy to do in our environment of care. It takes a degree of asking: "What are the goals? What are we trying to achieve"?

Participant 9: (We) keep a focus on why we're really here. That really helps. We also have a lot of things we do together, like parties and that breaks the ice with people. Our shared governance council puts a lot of parties together or theme lunches that we can do together to create a nice work environment so we put all the bickering aside. We do that around the time when we're the most stressed out.

Participant 1: Everyone has a little different way of expressing themselves, but just giving them the chance to put it on the table in a non-threatening environment makes a difference. Nurses like to share stories and so when one person starts to share a story about something that happened to them, it helps the other nurses in the room to feel like they are not alone. The same thing can happen if you just communicate to people throughout the day, "How's your day going? You look tired, you look frustrated, are you o.k.? You look like you're ready to explode"? Being aware of what's going on with each person is very important. Take the time to talk to people before they reach the point where they can't come to work, because they're so frustrated, exhausted, and don't feel like they can do their job anymore. But when they feel supported and people will help them through, then

they feel much better about the whole situation. (We try to) lighten up the atmosphere. Sometimes you share stories of what you have done in the past and encourage the staff that they'll get through this situation and we'll try to give you a break from them on your next schedule. You try to keep the staff from falling apart by supporting the person when you know they're having a tough time with a family. You try to communicate that to the support staff also so they allow the caregiver to ventilate their frustration if they need to.

Participant 15: Your co-workers provide a little camaraderie. It really builds the team most of the time, unless the family is really trying to turn everybody against each other. But we're really good at identifying that early on, so it doesn't happen too much. We have a really fabulous nurse-physician environment, so that doesn't happen.

Participant 7: We identified a family need, a nurse challenge, and instead of saying, "well it's your patient, sorry YOU have to deal with it," we identified the best way in this particular situation to address the issue. It was partly a difficult family, they had legitimate issues, but it was also that they were being less understanding than they could have been about the situation.

Participant 2: The majority of nurses are still women and women by nature are caregivers, that's what we do. Although there are more women today in physician roles, it's still a male dominated culture, which is less nurturing and more medical task-oriented.

Participant 3: If there is questioning of a nurse's behavior or decisions, the majority of people would feel comfortable saying, "she did everything she could

have, should have done." There's nothing formal that's done to create this culture, it's just the culture we have. There's nothing in orientation or any classes on it. It's just how we treat each other.

We have a unique culture in Oncology. Maybe it's because you need a unique personality to care for kids with cancer. Maybe you need to be a different kind of person who can do this kind of work and enjoy it. We don't recruit any differently. I really don't know what it is.

The environment can give a mixed message to the charge nurse:

Participant 2: The environment (nursing peers, physicians, etc.), positively reinforces escalating behavior because you're busy, you're doing stuff, you're active, you recognize there are problems and things need to be done. Unfortunately, escalating behavior often backfires. Initially, people like you doing it, reinforce it and feed into it, and then they turn on you and say, "Hey, you're out of control." Then they recognize you've escalated beyond a helpful point and missed the opportunity to step back from the situation and put it in perspective. People turn on you when they realize they were really looking for leadership to set the tone for the situation. Initially, they're looking for action and all the reactive behavior looks good, because you're doing *stuff*. The more you escalate, the more they reinforce you doing stuff, and the more they reinforce it, the more you escalate. But then nobody is actually getting the help they really need. They begin to realize positive movement isn't happening, you're just kind of spinning, and people start to get the point that unless there's positive movement, the problem isn't really being addressed.

Two participants explained the importance of creating a safe environment:

Participant 15: "Providing a safe environment for patients on the unit is your number one priority".

Participant 6: When you have a difficult patient you have to let the young staff see how Security responds, so they feel comfortable in the future to call Security before things get out of hand. I had the head of Security come up recently and give a two-minute in-service. He also followed it by saying, "call us any time. We want you to call us, don't hesitate to call. We're here for you to keep a safe environment."

Participant 11: It's a different atmosphere in the ED than an inpatient unit. We pool our resources to deal with situations and move on. Younger nurses get overwhelmed, but the ED is so geographically spread out that it tends to be confined to one area. We also don't have to worry about who is going to be assigned the patient tomorrow, because they'll be gone.

Sub-theme 5. The fifth sub-theme is staff relationships, teamwork, rumors, and gossip. Staff relationships can be impacted severely by rumors, gossip, and second guessing of co-workers' behavior when it comes to caring for emotionally *difficult* patients and families. Rumors and gossip manifest as stereotyping and labeling of patients and families, as well as gossiping about other staff and their approach to *difficult* families.

Rumors and gossip are prevalent and dangerous in nursing organizations, yet have received little attention in the literature (G. Michelson & Mouly, 2000; G Michelson & Mouly, 2002). Rumors and gossip that focus on the workers can become harmful to the

organization when they translate into inaccurate information and innuendo, which can lower morale and undermine productivity. Rumors and gossip may also be used as a tactic in organizational politics when inaccurate information is transmitted knowingly to damage an opponent. Rumors tend to increase when members have limited control over events, where there is a poor organizational climate, mistrust of formal communication lines, uncertainty about change, and high levels of competition (G. Michelson & Mouly, 2000; G Michelson & Mouly, 2002). Participants varied on their responses to the issue of rumors, gossip, and the impact on teamwork:

> *Participant 2:* Nurses manufacture a lot of conflict. Often the people who are not directly involved with difficult patients and families have a lot of opinions and a whole lot of problem with what is going on. They keep talking about it, but do nothing to help the situation. Rather, they contribute to the situation becoming a division amongst the staff. They manufacture their own problem that they had nothing to do with other than to talk about it. It's not that they make up stories, they just disagree with the way the family wants to run things and instead of minding your own business and taking care of your own patients, they getting [sic] into talking about "those nurses" and what they're doing, "they're letting that family walk all over them." They may be right or they may be wrong, but it's really none of their concern. There's always time for these kinds of discussions on break, at lunch, during report. It becomes a form of organizational gossip, but it also allows those people the benefit of not having to take care of those difficult patients.

Participant 5: . . . generally it breaks down into to factions, because our staff is so big. I don't think all of the staff are effected by a difficult family. A kid could be in the unit for six months and I'd never take care of them. Geographically the unit is so big that something can be going on in one area and you don't know about it unless you're there. If it's something that keeps happening over and over again, eventually maybe you will hear about it, but most days if you're on one end of the unit, you won't know what's going on at the other end. People talk about this kind of stuff, whether they're involved in it or not. The stories also get embellished as it gets passed along, just like any gossip. It makes the story better, if you embellish it. Mostly the people involved in taking care of the family talk about it, but people who aren't even involved talk about it, too.

Participant 13: Our staff gossip about each other. They second guess each other about the care other people have given to the patient and the way they handle the family. They see it as feedback. They tell you that you should have talked to the family more, said it in a different way, you're being too tough, or too lenient with the family.

Participant 5: "Sometimes it can pull together the staff who are caring for the family routinely. They may come together and vent to each other or plan out the care more carefully"

Participant 10: Staff sometimes second guess each other on our unit. I even do it myself, because of the way I hear people talk about families, or it's the tone of an E-mail they send. I think to myself, I don't know what that nurse is seeing, because I don't see that picture at all. I see a very upset family; I see

> communications haven't gone well, I see people who don't seek first to understand the family. I don't think the nurses gossip too much about each other, because most nurses know that the family is difficult and it's hard to work with them.

Participant 15 suggested that "People gossip about each other, but it usually doesn't tend to be about difficult families . . . Once somebody else witnesses the difficult family, they don't generally gossip or second guess the nurse caring for them".

> *Participant 3:* We don't tend to gossip about our co-workers' decisions…We do it a little, but we don't dwell on it. Sometimes the staff is split, but we tend to talk it over. If there is questioning of a nurse's behavior or decisions, the majority of people would feel comfortable saying, "she did everything she could have, should have done." There's nothing formal that's done to create this culture, it's just the culture we have. There's nothing in orientation or any classes on it. It's just how we treat each other.
>
> *Participant 8*: Rumors and gossip are always a challenge on the unit. People gossip about the situation, but on our unit, we don't tend to second guess other nurses and the care they provide. Typically, this patient was cared for by really experienced nurses, not new nurses. So even though a nurse might doubt their skills when they were first attacked by the family, after they calmed down they realized the family was just trying to pit us against each other. They realized they were good nurses otherwise they wouldn't be working here. (Participant 8)
>
> We don't second guess each other too much. We have had so many difficult situations that pretty much everybody has been there and understands how

difficult it can be. You can never think that you can never be in that situation again yourself. Because one day you're going to have another difficult patient and you're going to need your teammates to back you up. On night shift we work with less staff so we have an added incentive to work together as a team.

Participant 6 was able to describe how he or she changed the culture on his or her unit to reduce the amount of rumors and gossip:

Participant 6: There was a time, about a year ago where that clique (whose members gossip) would go in the leadership office and shut the door and talk about people. The younger staff felt really felt uncomfortable around them. I brought it up in leadership meetings, that these people were going into this room and eating lunch and ignoring everyone else. I told them it was inappropriate and they stopped doing it. The manager also got involved… People stay away from that clique and pretty much ignore that negative clique. . . We don't tend to second guess each other. Most of our negative people left our unit, because we made it clear we weren't going to tolerate their behavior. You can tell during orientation who's going to fit in on our unit and who won't. People still gossip, but we know the ones who do that.

Participant 11: We don't have a lot of gossip or second guessing about other nurses. Some times the doctors do that, but the nurses don't. I think part of it is we do a lot of education, like taping trauma codes and then reviewing how we did. I think that changes the culture to one where you are self reflective about everything.

Participant 12: Our staff don't tend to talk about each other. They gossip occasionally but not much on our unit. Sometimes as a charge nurse you will make suggestions, but it's usually not criticism of the nurse caring for the patient. It's not a matter of one person's way be wrong. It's more that we've found something that has worked in the past, so why not try it?

Core Theme Four: Be Aware of Your Role as a Middle

The theory of middleness (Oshry 1994, 1996) was reviewed in Chapter 2. Charge nurses are in a leadership role that places them in the middle and in conflict with various systemic forces within the organization, staff, and families. The charge nurse's ability to navigate these situations is important to the outcome of the team's ability to interact successfully with *difficult* families. Suggestions for how to serve in the charge nurse role and the participant data are discussed in the following section.

Sub-theme 6. The sixth theme is the role and responsibilities of charge nurses. Connelly, Yoder et al. (2003) studied the leadership characteristics of charge nurses. Connelly, Nabarrete et al. (2003) examined the issue of *difficult* people and the relationship to charge nurses.

Research has indicated increasing difficulty convincing nurses to assume leadership responsibilities, including the charge nurse role (Sherman, 2005). Charge nurses were identified as key leadership staff, yet according to a study of 120 nurse managers in 24 health care agencies, most had not received formal training (Sherman, 2005). An examination of charge nurse decision-making skills around patient assignments found that experienced charge nurses consider a larger variety of factors

compared to less experienced charge nurses (Bostrom & Suter, 1992). Connelly, Yoder et al. (2003) called for the need to develop leadership skills in charge nurses.

Participants suggested that the charge nurse role consisted of a variety of tasks, including receiving report from the previous shift, assigning nurses to patients, making rounds with physicians, attending meetings, managing the flow of patients being admitted or discharged, keeping the manager informed, and answering any complaints from families. Several participants suggested that there was a hierarchy to their responsibilities:

> *Participant 10:* A larger responsibility falls onto the charge nurse. The charge nurse is set up to be the leader of the day on a particular unit. The charge nurse needs to maintain a facade of control, if not actual control. If the charge nurse doesn't maintain a certain level of maturity the younger, emotionally less mature staff will react to that. If it is very busy on the unit, and nurses react to it, it gets even more chaotic. If the charge nurse remains calm and starts to strategize, then everyone else remains calm and starts to strategize. (Participant 10)
>
> Charge nurses are basically clinical managers on the unit and if they feel like they have support they'll work through things, if you don't feel like you have good support you'll back off, won't get involved and want put in the time and energy into some of the tougher situations. The charge nurse is supporting everyone else on the unit so they need their own kind of support person to help them through.
>
> *Participant 15*: The charge nurse is like the guy at the airport with the two orange cones. You're the traffic flow operator and all you do all night is communicate with nursing staff, physicians, patients, families, other units. It's all about

communication. I don't think you necessarily have to have the answer to everything, but you need to know what your resources are and how to get the answers.

Participant 7: The charge nurse needs to insert themselves in situations even when they haven't been asked, to ask a question even if you haven't been sought out, and to be available when someone does need your help. There are also family issues on the unit that you constantly need to check out. You have to look for subtle clues like a lot of family in a room, a lot of family making outside phone calls, or teary-eyed people. Those clues alert you that those people need your support or their nurse's support. Unfortunately, a lot of charge nurses tend to be task-focused and miss all these subtle things they can do to help the unit run smoothly.

The charge nurse role is mainly about creating a culture on the unit where the staff have what they need, feel supported, where teamwork is present, and you're just there for people as a resource. The second goal is the operational pieces like bed flow, getting people discharged and new patients admitted, the beds cleaned, and putting kids in the appropriate rooms based on their age and diagnosis.

Participant 3 stated that "The greatest challenge is for everyone to have a good day. It's not possible to do, but I hate to see someone having a bad day".

Participant 6 discussed staffing: My number one thing is that staff are happy with their assignment and the work load is not too excessive, they'll be happier at the end of the day and able to take that last minute admission at the end of the day. So I make sure everyone's assignments are fair and helping out the ones who

do have a bad assignment or something goes wrong with one of their patients. I do that by checking in with them every half hour to hour with each nurse individually to make sure everything is going smoothly and to answer any questions. I usually sit in the nurses' station so they know where they can find me. Sometimes I have three or four nurses lined up to ask me questions, but then I always know everything that's going on all day long with each nurse and their patients.

Participant 7: The charge nurse role is mainly about creating a culture on the unit where the staff have what they need, feel supported, where teamwork is present, and you're just there for people as a resource. The second goal is the operational pieces like bed flow, getting people discharged and new patients admitted, the beds cleaned, and putting kids in the appropriate rooms based on their age and diagnosis.

Participant 13: The charge nurse plays a big role. If it's a busy day and people notice that you are flustered, and running around trying to get things done, then the whole unit is going to take on that tone. If you're more relaxed and calm, you can keep things running smoothly and the unit will take on a calmer tone. Then it won't be such a hectic day.

Participant 2: The greatest challenge for the charge nurse is managing people's personalities, people who escalate, people who maintain their composure, people who are factual, people who are overly directive, people who fail to direct, and people who don't communicate. These people are at all levels of the team from the new nurse right up to the medical director. Everybody comes with their own set of natural tendencies and you have to work within their differences. Every day

patients come in and every day patients leave and it's a matter of what personalities you're managing.

The charge nurse needs to allocate nurses based on their skill set:

Participant 2: As the charge nurse, you don't necessarily need to be good at taking care of dialysis patients, you just need to know who is and seek them out. You need to know which nurse is good at drawing blood from a tiny baby and other things like that. I am also an ECMO specialist, so I have spent a lot of time in the NICU, CICU, and PICU. So I get to see the best of each of these worlds. I have friends who work on the transport team, ED, and medical-surgical floors. So it is fascinating for me to see the different aspects of the world works.

Participant 5: There are benefits to talking about difficult families. Sometimes you just need to ventilate [sic] about it. Nurses sometimes need to just vent about it. It's stressful enough to take care of our patients, but then to add to it a difficult family on top of it is much more challenging. There's not much reward for taking care of these difficult families, other than becoming more skilled in taking care of them. Sometimes a charge nurse won't assign a nurse to a difficult patient because they don't want to deal with the attitude of the nurse, but usually we make everyone share in taking their turn.

Sub-theme 7. The seventh sub-theme is resources available to the charge nurse. Connelly, Yoder et al. (2003) suggested charge nurses needed administrative skills to perform in their role. The theme that emerged from this data suggested that charge nurses also needed resources in the form of other members of the team to support them in their role. Resources ranged from emotional support from other staff and peers to specific

members of the team, such as physicians, psychologists, psychiatrists, security officers, child life workers, and social workers. The charge nurse is the first line of resource available to staff, but the team itself also is a big factor.

> *Participant 7:* People are your greatest resource and your greatest challenge. A great team is a group that smiles and has a good time no matter what happens. A great team likes the work they're doing, even if it's hard. They help each other out. They aren't as interested in themselves as they are in the bigger picture, which is the work they have to do to care for the patients. I can name the best nights I have had, which were the nights that were the most challenging, but the team pulled together to accomplish things they couldn't believe they could do . . . .You get through it because of the team. It's bigger than just the one, you, the individual . . . . Great teams think about the collective work, not the individual work.
>
> *Participant 1*: You also may want to identify other resources for the young nurse, like using the social worker. Part of their (the young nurse) frustration may be they don't know about the other resources they have. Or you just try to support the young nurse by encouraging her, "I think you're doing a great job with this patient, it can be frustrating and stressful, and this is how I would advise you to set some limits with the family." Sometimes you need to go in the room with the nurse so that she feels like she has some support when she's talking with the family and if I'm there and she flounders or loses herself, I can help by verbally supporting her and help reiterate to the family what she's saying. That makes a

big difference to a new nurse to know she's not out there on her own, especially with a tough family that may be verbally aggressive towards her.

Participant 6: Our one social worker is very calm and reassuring with families, while our other social worker is more straight-forward, which doesn't always sit well with families. People tell social workers stuff they don't tell other people, which is good.

Participant 2: We probably have more resources than the typical institution and do a better job than most. We have social workers, chaplains, advanced practice nurses, and mental health clinical nurse specialists. I think the bigger issue is that sometimes we don't realize we're in trouble, so we don't use our resources.

Participant 9: They usually give me their opinion or help talk to the family for me. If the patient has an actually psychological problem I seek out Nina, our behavioral health clinical specialist nurse. We have also have Elizabeth Steinmiller, our mental health CNS who focuses more specifically on issues between the staff. Sometimes if families are aggressive we call in Security.

Participant 6: We also have our own behavioral health team on the unit: a psychologist, psychiatrist, and two clinical social workers. We contact them, when we have a patient who we feel might need outpatient behavioral health services. They will see those patients and set up connections outside the hospital. This program has helped a lot with difficult families by taking the pressure off of Social Work, who [sic] we always went to when stuff would happen like difficult families. So Social Work would have to drop everything to tend to the crisis, which would affect whatever family or patient they were working with at the

moment. So it would take longer for things to get done. Now that we have the behavioral health team, patients are presented to them by the charge nurse or physician and they get seen more quickly.

Participant 7: The biggest resources are co-workers, including ancillary staff, nurses, and physicians. Often with difficult families, we'll go in the room in twos (buddy system). It could be a nurse and a nurse, a nurse and an ancillary staff member, or it could be a nurse and a physician . . . . Our first line of defense is each other, which is good. That's what teamwork is all about. Our second line of defense is calling in additional resources who support us as care-givers, like mental health CNSs who don't necessarily go in the room with us, but they support us as we're working through our feelings, thoughts, and processing how to approach the situation, and better cope with the stress we have to deal with everyday. We also use Security. We try really hard not to use Security as a resource, unless we really have to, because it gives an appearance that we're using force, which can escalate the situation and create more antagonism between the family and us. But there are situations where families are being hostile and you can't take the threat of violence lightly. You have to let volatile people know that their behavior is unacceptable and will not be tolerated. Some of these families have psychiatric histories and in that case we have the behavioral health team involved (psychiatrist, psychologist, social workers).

Participant 6: What's nice about the behavioral health team is they don't let you not be involved. They come up to you and say, "I notice you put something in the database," and then they'll ask you what the patient did last night. They're very

good at involving the nurses, rather than (the behavioral health team) just fixing it themselves.

Participant1: The support for me has been the mental health CNSs, a hands-on manager who knows what's going on in the unit and supports your decisions, a peer or senior nurse you can vent to for support. Staff nurses can also be supportive when you're in charge. It doesn't work as well with new nurses, because you don't want them to see you in a vulnerable position. They don't have enough experience and knowledge to put it in perspective as to what you're feeling, because they've never been in the charge nurse role. But someone who has been in the charge nurse role knows what you're going through, can say, "I hear what you're saying. Hang in there. What can I do to help"? Staff nursing support is really dependent on where that nurse is in their experience.

Participant 2: The family may also be a resource to identifying additional resources to support themselves and the staff. As a charge nurse, "hopefully you assist the other nurses in finding the resources, pulling in other people to help. The key is to help the nurse to help the family to identify their own resources: extended family members, clergy, neighbors, church members.

Participant 14 suggested: "The Complex Care Consultation Team is also helpful in these situations. I've requested them a couple of times in the past to help our team work with some tough families".

The role of the physician as a resource varied by the type of unit. On a medical unit a participant reported:

Participant 9: Physicians can be a resource, but sometimes they make it worse. In a teaching hospital a lot of the physicians want to be the nice guy and they want to manipulate the rules to accommodate the family's demands. So they come off as the nice guy, and we come off as the bad guys. The doctors also hold more weight than the nurses with most families. So families will say to us, "The doctor said_____," and assume we'll just do whatever they ask. They (families) don't care about our policies or procedures, their doctor said they can do it so that's what needs to be done. So sometimes the doctors make things worse. Another thing that happens is doctors will go in at 8 a.m. and tell the family they're going to be discharged. So all day long that sets the nurse up, that the family keeps asking, "When am I going to get discharged." They don't realize that we have to wait for the doctors to put in all the orders. So then the family gets agitated and says, "I was supposed to be discharged at such and such a time." The attending physicians are better than the residents. They tend to seek out the charge nurse with difficult families and ask how we can work together to approach the family. We can always go to an attending for help with a difficult family and they're o.k. with that.

Participant 5: I had a case a few weeks ago where a family was mistreating a nurse and I tried to speak with the physician and he said to just let it go. I said, "it's easy for you to say, because you go in and spend five minutes with the family and leave and this nurse is being yelled at and cursed at, and then has to go back in and take care of the kid. Can you imagine doing that"? This was a medical doctor and he basically told me to keep my mouth shut.

Participant 1: Physician support tends to be very individual. A physician can be helpful if he's the kind of physician that is saying things like, "This is what I'm hearing from the nurses. This is my discussion with the parents. We need to put together a family meeting. I need you to go in and talk to the family with me." Usually the more senior physicians are more geared toward working with the emotionally difficult families. The younger physicians tend to be too focused on the medical tasks and are not that skilled in working with difficult emotional situations. Senior physicians know from experience the way that these situations can escalate. So they are much quicker to agree to have a family meeting. You don't need to convince them, they have the experience. Younger physicians often don't have the experience and even if you warn them they just don't appreciate the urgency of the situation. You can tell a physician who has had dealings with an emotionally difficult patient or family because when you alert them to the potential they quickly react because they know it's a potentially explosive situation.

Participant 6 stated: "Our attending physicians are usually awesome, but there are so many of them that there's a lot of variability. Some are supportive others are not".

Participant 11: (In the Emergency Department) the key resources are physicians, Social Work, Security, and the nursing supervisor. The physicians in the ED are very attentive to these kinds of situations. I can go to an ED doc and say, "this family is very upset, they're threatening to leave, they want to know what's going on," and the physician will agree to meet with the family and help calm them down. Ninety-nine-point-nine percent of these difficult situations are about

> communication. They just want to know what's going on, what's the plan, what are we waiting for, approximately how long will it take, and what we're going to do afterwards. Our physicians are very supportive, especially if the nurses do some prep work with the families beforehand. The physicians are much more available in the ED than on the inpatient units. It's much more of a partnership. They know what the nurses are experiencing and if I say to them, "I need you NOW," they will come into the room immediately. They're very busy, but they can sense when nurses need their help and they know we don't ask for help unless we really need it.

Resources varied by shift. On the night shift there are fewer resources beyond nursing. Participants reported less physician, social worker, child life, and psychosocial team availability:

> *Participant 15:* Other charge nurses are your best resource on night shift. I try to leave the bedside nurse out of it, because she needs to be in the room with the family already for 12 hours. If I feel like I need to involve another person (buddy system), I bring in another charge nurse. You have to set boundaries even if the family doesn't understand you're doing it to help their child. We also have a clinical resource nurse on each shift who is there to resource other nurses. She can also be useful with difficult families. The clinical resource nurse is a senior nurse who doesn't have an assignment and focuses on new nurses who need help with their patient as well as nurses who are in an experience they've never had before. You serve as a go-to person. They don't have a patient assignment, they just float

around. The charge nurse is floating around too, but in a 45-bed ICU, you need that kind of support.

Core Theme Five: Teach the Skills

There are a set of skills that can be taught to charge nurses, staff, and teams to improve their ability to work with *difficult* families. Suggestions for specific teaching of skills to other charge nurses and staff are reviewed in the following section, along with participant data.

Sub-theme 8. The eighth sub-theme is factors related to greater understanding of emotionally *difficult* patients and families (mature vs. young staff). Benner (1984) conducted phenomenological research to described the lived experience of nurses. Benner found nurses performed along a continuum from novice to expert. Maturity level of staff may be a factor in differentiating between the novice charge nurse composite and the expert charge nurse composite; however, participant data showed that there were other factors that contributed to the development of expert charge nurses, as discussed in this section.

Charge nurses varied in their opinion about the impact of age and experience as nurse:

> *Participant 1:* "The young nurse may not have the knowledge, training, or experience (to care for difficult families) . . . . After a while, the young nurse becomes frustrated and becomes short in their responses to the family, or they avoid them and not take care of the family's requirements . . . younger nurses may feel so overwhelmed and may feel like she's a bad nurse because she can't meet

their (the family) demands. She may then put that back on the family and label them as "impossible."

Participant 3: Young nurses tend to be task-oriented. They're trying to fill in the boxes and don't look at the bigger picture 'til they master their clinical skills. That bigger perspective comes with experience but mostly maturity. (Participant 2) Younger nurses felt like the families know more about their child's care than they do. They (families) question the medications, dosages, treatments, assessments, and it's easy for the nurse to become unsure of themselves and whether they're doing the right thing. At the same time, it makes the nurses super vigilant with parents to do everything right.

Participant 4 suggested: " . . . the longer you work with difficult people, the more you realize it's not you. When you're young you always feel like you have to prove yourself" *Participant* 11 stated: " . . . it's a developmental thing with younger staff, who don't fully appreciate. They tend to be task-oriented, and miss the bigger picture".

Participant 1: If the nurses have different opinions about the appropriateness of the patient or families requests you can have conflict between the nurses. Usually the more experienced nurses will say, "I can see where this family is coming from. I appreciate they are trying to advocate for their child." Whereas the younger nurses may feel so overwhelmed and may feel like she's a bad nurse because she can't meet their demands. She may then put that back on the family and label them as "impossible."

Participant 14: I try to tell young people to not take everything so personally. Try to develop a switch in your head to turn your emotions on and off. You also need

to have an outlet when you are upset. It might be a walk outside, or hitting a punching bag, or complaining to a friend who will listen. You also can't be too hard on yourself. You're never going to be perfect 100% of the time. When I was younger I thought I should be perfect, and I would get down on myself. But with maturity you become humble enough to know you're going to make mistakes, especially with interpersonal communication.

Participant 5: The younger nurses were totally devastated that the family complained to the nurse manager. They almost called in sick, because they were up all night worrying that they were going to be in trouble with the nurse manager. This family complained about everybody though, not just the younger nurses.

Participant 14: There is a maturity factor that affects one's ability to work with difficult families. A lot of young nurses are judgmental. Some people are more judgmental because they haven't experienced life. They don't fully appreciate what is going on in the patient's home and family dynamics.

Not all participants believed maturity was a factor. *Participant 2* stated: "There are nurses with lots of experience who still lack the maturity to step back and look at the bigger picture".

Participant 14: There are some senior nurses who make a personal choice to not be as understanding (with difficult families). It might be for their own emotional self protection . . . . The are a lot of difficult co-workers who are working two jobs, they work on limited amounts of sleep, they have children at home, and maybe a tough life of their own. A twenty-year nurse may have started out more

compassionate, but after a while they got tired of all the abuse from families and they just can't give anymore. Maybe it's situations like that where some senior nurses don't want to deal with people who are difficult or situations that suck so much out of you. Maybe they don't want to be in situations where they end up crying or putting a whole lot of effort in and maybe not with a sense of accomplishment or appreciation from the family. Maybe that's why someone who has 20 years' experience might not want to work with difficult families. Maybe they're just burned out from putting too much in?

The issue of the nurse age and level of experience becomes at times an issue for families:

Participant 8: We try to help the younger nurses by giving them a lot of support along the way. We let them know they're good nurses, and they do have skills to bring to the table. Sometimes we have families that make negative comments about nurses that is more about their own family dynamics and their need to just tear people down and has nothing to do with the actual nurse. So support and mentoring is very important.

In one situation the age of the nurses was used to enhance the response of a *difficult* patient:

Participant 7: We had a situation with one patient where we identified months into her care that she did better with younger nurses who were less parenting in style and more fun-loving and joked around. But that was because the patient and families' needs were changing. The kid was working differently with staff. Initially, she liked stronger, more directive nurses, supportive and parent-like. But

as she evolved with her illness, she wanted more of an older sister/babysitter-like relationship. A lot of that was about her own needs and her own maturity with her illness.

The issue of maturity was not limited to nurses. Participant 1 also discussed the issue of maturity with physicians:

Participant 1: The younger physicians tend to be too focused on the medical tasks and are not that skilled in working with difficult emotional situations. Senior physicians know from experience the way that these situations can escalate. So they are much quicker to agree to have a family meeting. You don't need to convince them (experienced physicians), they have the experience. Younger physicians often don't have the experience and even if you warn them they just don't appreciate the urgency of the situation. You can tell a physician who has had dealings with an emotionally difficult patient or family because when you alert them to the potential they quickly react because they know it's a potentially explosive situation.

Sub-theme 9. The ninth sub-theme is the impact of emotional intelligence. Emotional intelligence has been defined as "the ability to sense, understand, and effectively apply the power and acumen of emotions as a source of human energy, information, connection, and influence (Cooper & Sawaf, 1998, p. xii). Agazarian's theory of Living Human Systems was used to explain developing organizational emotional intelligence (Gantt & Agazarian, 2004). Emotional intelligence may be a dominant factor in the personality and skills of the expert charge nurse composite, as discussed in the following section.

Two participants suggested the issue of different reactions to *difficult* families was not about age or maturity but about emotional intelligence (EI):

> *Participant 7:* It all comes down to emotional intelligence (EI) versus task orientation. I think there are experienced nurses who have low EI and focus on tasks. There are also younger nurses with high EI who see the bigger picture. The staff see this too, and know who the good charge nurses are and the less successful ones.
>
> *Participant 6:* I think the more experienced people understand what families go through when they're hospitalized. But at the same time there, are also a lot of experienced nurses who don't get it. I think it's more about life experiences than your years as a nurse.

Sub-theme 10. The tenth sub-theme is grief, loss, and end of life experiences with emotionally *difficult* patients and families. Simms suggested grief and loss may be stressors and dramatic examples of what is going on with a family that serve to distract the family and staff from their real mission, to support the child who is ill (S. Simms, personal communication, November, 16, 2007). Death is a normal and expected part of the life process, yet in western cultures it has become a veiled topic until the drama of death unfolds (McBride & Simms, 2001). This was evident in the stories of many participants who described the loss of a sick child as the most dramatic example of the issues between staff and *difficult* families.

Grief and loss manifest in numerous ways, according to the participants. The patients and families have loss of control, grief over the child's illness, and at the far

extreme can experience death, the ultimate loss. Staff also experience their own grief in managing these situations:

> *Participant 2:* Grief is a very big factor in the ICU, watching grief, partaking in grief wears you down. The closer you are to the grief the tougher it is on you as a nurse. As a charge nurse you can get into the grief, or you can be standing aside from it and supporting the people who are in it. That is a fine line that you have to decide every day, every bedside, every patient and family. It's not just patients dying, it's also the human tragedy of a kid being in a car accident who may live, die, or just that the family has lost their happy, healthy home life. There's the team that's helping right at the bedside and then the other team at the next level that's helping the team that provides the direct care. The grief manifests in the staff depending on their coping skills, ranging from anger to quietness. Yesterday, a new nurse needed to be extricated from the bedside because he was sobbing as his patient died. That was his first patient to die. He said, "It's very different when you're at the bedside versus two rooms away from where you're working." If it's two rooms down or you're the charge nurse two steps away from it, you still somehow need to manage that grief for the staff and help that family to manage their grief. Some staff are totally unaffected by the grief because they don't witness it. The ICU is so big that you can hear things going on in other rooms, but you are so distant from it that you can choose to ignore it. The charge nurse has the flexibility to move from the grief area to another area where there may be a celebration that a kid survived surgery. You need to be able to celebrate as much as you grieve.

Participant 4: It's not about the nurse, it's about the family's loss of control, the bad news they're getting about their kid's care, so they just lash out at people to give themselves control over something. When you point it out to staff they usually appreciate the different perspective, but it still is difficult to come to work knowing you're going to get yelled at and feel like you're giving crappy care.

Participant 15: It's not that the parents want to get away with something, but it comes off like they're trying to seize control from us. You can't control your kid getting better, but you can at least get them a big single room.

Grief and loss can lead to stress on the unit:

Participant 2: …when you get two or more difficult families on the unit at the same time they exacerbate the staff and everyone is in a heightened state of tension. So 1 + 1 becomes 7. Much of this is about the loss of the normalcy of the family's life, so it's an easy place for this drama to take over. Why do you think so many television shows are in hospital settings? Drama on the unit can be very isolated to a location. Yesterday, we had four rooms with three dying patients, all clustered in one section of the unit. The rest of the unit was fine, but that little section was chaos, absolute chaos.

Participant 2: Parents tend to be coping o.k. until the death happens and then they just lose it. They throw themselves on the floor and cry or yell and scream. Sometimes staff have a problem with this. I feel like as long as they don't hurt themselves, just let them go. Those emotional displays don't last very long and then we take them to a private space to grieve.

Participant 15: (When a patient dies) . . . things escalate 100 times. They (the family) may pick an emotion and run with it. They can be yelling, screaming, laying [sic] on the floor, injuring themselves by hitting their head on the wall, or punching a wall. You see every extreme of emotion. Sometimes it even interferes with a resuscitation. We had a patient we were doing CPR on, and the doc asked me to stop to check their heart and the dad jumped in and started doing the CPR.

One of the most dramatic points in the care of a child is the moment of death:

Participant 5: We have had situations where a kid has a Do Not Resuscitate order (DNR) and at the moment of death the parent freaks out and changes their mind.

We have what we call an amended DNR that says to respect the parents' wishes at the point of death to do a partial resuscitation such as giving some meds or doing CPR, without defibrillation. There are also situations occasionally where the parent changes their mind and the nurse is pushed into starting a resuscitation. We had a situation where a kid was not (a candidate for further treatment). . . and there was some confusion during a resuscitation about whether he was or wasn't an ECMO candidate and the medical team got into a debate in the middle of the code about whether or not he was an ECMO candidate. The issue was if he wasn't an ECMO candidate there was no reason to continue to resuscitate. The bedside nurse was confused about this too, as she had been under the impression he was a candidate for ECMO and here when he arrests she finds out they're not going to resuscitate him. In that kind of situation the staff may second guess the doctors and nurses who were in that situation. They (the nurses) get angry and some will actually approach the physicians and ask why there was so much confusion at such a critical time and why that wasn't made more clear in advance. They (the family) usually don't question the nurse in a situation like that. They (the family) realize the nurse was just caught in the middle of that situation. In an ICU situation, physicians mostly do the resuscitation, the nurse may start chest compressions, but the physicians will be right in there and push you aside. A parent may be o.k. with a DNR, when they're away from their child in a private room having a theoretical discussion about him being a DNR, because he's suffering. But, when you're sitting next to your other child when it happens and

you want everything done. It's different. It's also the family that pushes it not just disagreement between the medical team.

Participant 3: The mother may be ready to make the child a Do Not Resuscitate (DNR), while dad is not there emotionally. But the kid's condition is worsening and the nurses need to know what to do if the child dies. Are we going to resuscitate the patient or let them die peacefully?

Participant 10: I had a mother who changed her mind in the middle of the night and decided she wasn't ready for her child to die. I was taking care of the child and she died, so I started CPR, even though the patient was a DNR. I called a code and the code team thought the child had overdosed on morphine. So they gave her Narcan to reverse the morphine, and brought the child back until the father arrived and could be with the mom and then we started the morphine again. I think that mom just was scared and didn't want to be by herself at the point the child died.

Participant 15: Sometimes we have chronic kids where the parents decide well in advance to make the child a DNR. Parents like that are more prepared for death, because they've had the time to think about it. Then there's the kid who comes in from an accident and is brain dead. We suggest that we make them a DNR, so if the child's heart stops we don't make them suffer anymore. The whole discussion of DNR can provoke emotional outbursts. Sometimes a parent will change their mind at the point of death. We look at each other and then do whatever they ask us to do. We have a lot of families who haven't really thought it through. Maybe, you started to discuss DNR, and the parents couldn't decide, so you agree to

discuss it late. Then, suddenly the kid stops breathing. We also have situations where someone has signed a DNR, but at the point of death they decide they want you to resuscitate the child, so you do. A lot of times that happens when the parents are not in the same place. Mom may be ready for the child to die, but dad is not. So at the point they stop breathing one of the parents starts yelling, "You have to do something, you have to do something." Sometimes the other parent will agree with them and other times it turns into an argument. Sometimes you also have a teenage mom making this decision who really didn't understand.

Participant 13: Sometimes a patient has been coded a couple of times and the parents sign a DNR, but the next time we go to code, the parents decide they do want them coded. You have to do whatever the families wants [*sic*], whether you think it's in the best interest of the patient or not, it's their child and comes down to what they want. This isn't talked about a lot. They go over it in the communication classes, but once you're on the floor it's not talked about much. It's a hard situation I'm not sure all parents know they can change their mind or the nurse know [sic] it's o.k. for the family to change their mind at any time. The issue is you never want to let a patient go, even though they may be suffering and you know it's time, it still doesn't feel right to give up and let them die. Families must have it 100 times worse, even though they know their child is suffering, and they know they're going to pass away, it's still difficult to sign a piece of paper saying I don't want anything done for my child, just let them die. I'm sure it's 1,000 times worse than what we feel as a clinician.

Participant 10: Sometimes I've looked at parents and wondered why they are allowing their child to continue to receive treatments that are uncomfortable. But then I realize they just aren't ready for their child to die. Sometimes the staff will second guess those situations. I usually tell them, "I don't think you really know how you would react until it's your child that's in that situation." I don't know what I would do if it was my child.

Participant 5: Sometimes we have very complicated patients and it's obvious to us the patient is not going to survive, but the parents don't want to stop care. The parents want everything to be done, even though they've been told the child's prognosis and doing the heroic measures won't change the outcome. I've never had to do anything clinical I didn't morally agree with, but I have seen other staff care for some of these kids where they feel they are doing something wrong, because the treatment is causing the kid to suffer more than if they were just left to die.

Sub-theme 11. The final sub-theme is how charge nurses maintain their emotional balance and that of their staff. The composite of expert charge nurses showed that they took care of themselves emotionally and physically so they could be available to help others. Covey (1990, 2004) has suggested that taking care of oneself in the physical, mental, social, and spiritual domains provides the greatest leverage to effectiveness as a human being. Participant descriptions of the importance of emotional balance are presented in the following section.

Participant 1 stated: "Sometimes as a charge nurse, you're overwhelmed yourself, so trying to get to everything is kind of difficult."

Participant 10 arrived at the interview at 2:30 p.m. She said she left for work at 5:30 a.m. and had not taken a break to go to the bathroom in nine hours. This is in contrast with Participant 7's comment about the importance of people getting breaks:

> *Participant 7:*. . . asking people if they need a break, especially when working with a difficult family. We work in teams with difficult families, so nobody should be in that intense situation for a week straight, but the team provides consistency, so the family isn't frustrated.

Participant 5 stated: "I also try to avoid having nurses care for a difficult patient for long periods of time. If they come to me and say they need a break, I'll grant that, as I understand the difficulty".

> *Participant 14:* I have a pretty balanced life. I make good money, I have a good spouse, I work hard, play hard and yet I still have tough days. So imagine what it's like for a worker who never sleeps well, has a horrible life at home, and is totally stressed out. Maybe there is more to why they're acting the way they are.
>
> *Participant 15:* Ask for help and advice. Don't let your ego keep you from reaching out for help. Don't be afraid to make suggestions to people that have the power to make changes. Help the younger nurses to develop skills with difficult people. Treat people like you would like to be treated.

The Composites

Groenewald (2004) described the composite as a summary that reflects the themes common to most of the participants interviewed while also devoting attention to unique participant information that could provide significant insight into the phenomenon. Participants tended to appear along a continuum from those who struggled with

emotionally *difficult* patients and families to those who had mastered the situation. This was consistent with work that suggested nurses perform along a continuum from novice to expert (Benner, 1984). Benner did not use novice or expert to describe years of service, but rather to reflect an individual's behavior within a specific context. Two composites will be presented, one for the novice and one for the expert charge nurse, which represent the two extremes along the continuum of behavior described by charge nurses. Consistent with Benner, the terms novice and expert reflect the nurses' description of their behavior as a charge nurse, rather then their years of service in the role. Novice nurses tended to be more concrete and task oriented. Expert nurse tended to see the bigger picture and understand the context and interrelationships of the dynamics of situations. Charge nurses described their behavior as somewhere between these two extremes of novice and expert, with varying degrees of focusing on concrete tasks and seeing the big picture.

Composite Novice Charge Nurse

Benner (1984) suggested novice nurses tend to be task-oriented and miss the big picture, context, and interrelationships of the dynamics of situations. This is an apt description of the novice charge nurse with emotionally difficult patients and families. The composite novice charge nurses saw the issue of difficult patients and families as emanating from the family. They tended to label patients and families as a problem, difficult, obnoxious, or psychiatrically unstable. Novice charge nurses tended to look to the psychosocial professionals to provide psychiatric diagnoses for these families and expected the social worker, psychologist, or psychiatrist to fix the family's behavior so the nurses and doctors could perform the necessary clinical work. Novice charge nurses failed to appreciate the distinction between silent families and those who were exhibiting

their anger. They tended to focus on the concrete behavior, rather than attempting to understand what could have led up to the parents' reaction, such as multiple hospitalizations, stress, frustration, and fear of the unknown.

The composite novice charge nurse was not just young or new to nursing. Novice behaviors were also exhibited by experienced charge nurses who never achieved mastery in their ability to handle emotionally difficult patients and families. Mastery with emotionally *difficult* patients and families may be more of a factor of emotional intelligence, than years of experience. Some experienced nurses were frustrated by years of caring for emotionally difficult families and resisted improving their capacity to care for them in order to avoid being assigned to care for them by the charge nurse.

Novice charge nurses tended to be focused on the tasks of being in charge, such as assigning patients, answering questions, and making sure the crash cart was checked. Novice charge nurses saw themselves having a role in keeping the staff happy, but avoided making controversial decisions or pushing staff to see a different perspective. This was especially apparent in working with emotionally difficult families, where the novice charge nurse sided with staff in asking the question, "Why are the administration and doctors making us take care of this difficult family"? Another dramatic example was how novice charge nurses addressed critical times for patients and families such as the point of death. Novice charge nurses tended to shy away from the dynamics of the impending death of a child despite the fact that it was a dramatic stressor that may exacerbate the family's emotional behavior.

The behavior of novice charge nurses often reinforced family behaviors. The charge nurses' behavior had an impact on the culture of a unit, which may have reinforce

negative behaviors toward difficult families, beginning with the initial labeling of the family as difficult, by spreading rumors about difficult family behavior, by engaging in debates or arguments, criticizing staff who attempt to remedy the situation, or by just avoiding the family. Novice charge nurses often did little to reduce gossip about families and, in fact, engaged in rumor and gossip spreading.

Many resources such as social workers and mental health nurses were available to charge nurses. Despite the availability of these resources, the novice charge nurses tended to want the resource personnel to make the problem go away or to just deal with it themselves so the staff could tend to the medical care of the child. Novice charge nurses tended to be frustrated by the difficult family who did not allow them access to their child.

Teamwork is an important aspect of caring for emotionally *difficult* families. Novice charge nurses tended to focus their attention more on keeping the assignments fair than on teamwork. Novice charge nurses had difficulty engaging staff to work as a team.

Novice charge nurses tended to have limited training in psychosocial and communication skills. Novice charge nurses often did not see psychosocial support to families as their job. Other novice charge nurses felt they were just not good at it.

The charge novice charge nurses were often overworked, stressed out, and felt overwhelmed. Novice charge nurses did not appreciate the importance of taking breaks and, when they were in charge, often did not make sure other nurses took necessary breaks. Novice charge nurses tended to work in isolation and have limited role models or resources they sought out for support.

Composite Expert Nurse

Benner (1984) suggested expert nurses tend to look at the bigger picture and understand the context and interrelationships of the dynamics of situations. This is an apt description of the expert charge nurse with emotionally difficult patients and families. Expert nurses reacted very quickly to the presence of a potentially *difficult* family.

Expert charge nurses had an intuitive sense of the potential for a parent to be stressed. Expert charge nurses talked to the parent, assign competent care providers, and tried to anticipate the family's needs. The composite expert charge nurses saw the issue of difficult patients and families as a dynamic of the patient, family, and staff.

Expert charge nurses avoided labeling patients and families as a problem and instead tried to find out what the issues were behind the family's behavior. Expert charge nurses saw the connection between the mind and the body and used resources like the social worker, psychologist, mental health nurse, or psychiatrist to help the nurses to develop better skills for working with families. Expert charge nurses appreciated that a family's silence may be a symptom of how overwhelmed the family members were, and that the silence could escalate quickly into anger and violence. Expert charge nurses also appreciated that listening to a *difficult* family could provide valuable information to fix a situation before it reached a critical state.

Expert charge nurses recognized that their primary role was to create a safe environment. Expert charge nurses focused on what was going on below the surface, searched for tacit information, and sought to help people before they asked for help. Expert charge nurses recognized that a parent may be talking about some minor issue, but

below the surface the parent may be feeling overwhelmed by multiple hospitalizations, stress, frustration, and fear of the unknown.

The composite expert charge nurse was not just a nurse with many years of experience. Expertise was also exhibited by young nurses who had high emotional intelligence or had illness in their family and appreciated the plight that patients and parents were going through. Expert charge nurses knew that the impending death of a child raised many family dynamics that may have exacerbated the family's emotional behavior.

As a charge nurse, expert charge nurses tended to be focused on the overall dynamics rather than the tasks of being in charge, such as assigning patients, answering questions, and making sure the crash cart was checked. Expert charge nurses saw themselves having a role in keeping the staff balanced. They did not shy away from making controversial decisions or pushing staff to see a different perspective. Expert charge nurses assessed the long-term effects of their decisions, especially with difficult families. Expert charge nurses appreciated that it is the nurses' role to care for the human response of the family to their child's illness.

Expert charge nurses took care of themselves physically and emotionally so they had the energy to care for difficult families. Expert charge nurses maintained their perspective by using other members of the team to discuss situations and maintained an objective perspective. Expert charge nurses availed themselves of opportunities for education, role playing, and testing new theories.

Expert charge nurses paid attention to the culture and avoided reinforcing negative behaviors toward difficult families. Expert charge nurses noted when staff

labeled families as difficult, spread rumors, engaged in debates or arguments, or just avoided families. Expert charge nurses had a no-tolerance policy for gossip about families or other staff.

Teamwork was an important aspect of caring for emotionally *difficult* families. The expert charge nurse made sure no one nurse was overly stressed by caring for a *difficult* family day after day. Expert charge nurses focused on making sure people worked as a team with a common goal of providing excellent care. Expert charge nurses had extensive training in psychosocial and communication skills.

The expert charge nurse had work-life balance and avoided being overworked, stressed out, and overwhelmed. Expert charge nurses appreciated the importance of taking breaks and when they were in charge, made sure other nurses took necessary breaks. Expert charge nurses tended to work closely with others and serve as role models or resources to others.

The Hermeneutic Circle

The goal of hermeneutic phenomenological research is to understand the history of a phenomenon from the participants' lived experience (Koch, 1995). A hermeneutic circle is conducted to explore the topic fully and in depth from multiple perspectives, including the use of experts in the field to provide greater understanding and interpretation of meaning (Koch, 1995). The basis of hermeneutic phenomenology is an assumption that meaning can be derived from a thorough exploration of the lived experience of a people by an objective observer standing outside the phenomenon. Validity and reliability are enhanced by instituting a hermeneutic circle at the completion of interviews, transcription, and tabulation of themes.

The hermeneutic circle included five experts from various fields. The first expert was Mervyn Cadwallader, Ph.D., who is an expert in the fields of sociology, general systems theory, and cybernetics. The second expert was Steven Simms, Ph.D., who is a pediatric clinical psychologist with expertise in the field of family systems theory. The third expert was Andrew Mozenter, M.S., who is an organizational dynamics expert in the theory of middleness. The fourth expert was Kathy Murphy, Ph.D., R.N., who is a nurse researcher with expertise in qualitative research, family systems theory, and chronic illness. The fifth expert was Robin Johnson, D.S.W., who is a doctoral-prepared clinical social worker with expertise in pediatric chronic illness, teamwork, Family Systems Theory, and hospital team dynamics.

The experts reviewed the collected data and themes and were encouraged to comment on the results. The first expert, Cadwallader, suggested the results indicated change in a hospital environment is difficult because of the hospital systems colliding with the patient's family systems. The challenge is the specific needs and contradictions of their separate and distinct systems.

The second expert, Simms, felt a major issue was the unnecessary labeling of people. According to Simms, labeling and diagnosing behaviors tend to stereotype families and prevent staff from gaining access to the dynamics of what the family is experiencing. Simms suggested further exploration be done into the dynamics of labeling, which are presented in a later section.

Simms also felt the results were indicative of the symptomatic cycle, a reflection of avoidance, abdication, gridlock, impasse, and lack of progress. Most of the time a family's patterns of behavior work well for them, but as the patient and family try to

manage extreme stress, symptoms may appear that are beyond their control. Simms suggested further work be done to explain the symptomatic cycle within the context of the results, which is presented in a later section.

The third expert, Mozenter, felt the results suggested a system out of partnership with a lack of inspired leadership and lack of technology for bringing people into partnership. Mozenter used the analogy of a three-legged stool, with one leg that is uneven and creates an imbalance. "It all starts with a strong united leadership if you really want to create culture change toward partnership. Just being aware of it is not enough . . . you need a process to also get there" (A. Mozenter, personal communication, November 30, 2007).

Mozenter was impressed with the participants who understood their larger role as middles to address the group dynamics rather than focus on the tasks of being a charge nurse. "There are too many people who are too mission based and don't understand the spaces of responsibility of the situations" (A. Mozenter, personal communication, November 30, 2007). The point of Oshry's work, according to Mozenter, is that the system is dynamic and reacts to any intervention to correct the imbalance. It makes it hard for the charge nurse to *fix* it, but by understanding their role and plight of being a middle, charge nurses can take better care of themselves and improve how they address the needs of patients, families, and other staff.

Mozenter suggested Oshry never set out to solve anything with Oshry's research, but to just explain it, and at the same time, to give people choices to move toward partnership. By knowing the system and how it functions, one has some choices and one can potentially change the dance between oneself and others. If one changes the patterns

of one's behavior, some things can shift and new patterns can develop that have the potential to improve the situation. Mozenter found the story of the charge nurse who worked with her manager to reduce rumors and gossip on her unit as a perfect example of this phenomenon. Mozenter suggested the story was one example of the courage of one person to take a stand and how it works much better if there is a system for shared leadership through partnership.

Mozenter did not like the term teamwork. Mozenter found teamwork to be too "fuzzy." Instead, Mozenter preferred the term partnership as it described a joint commitment, a give and take, and clarity of roles. Mozenter preferred language such as: common purpose, joint commitment, and partnerships, as these terms move people beyond thinking in groups to working with another. There is too much anonymity in a group. You can hide and say, "it's not about me, it's the groups responsibility" (A. Mozenter, personal communication, November 30, 2007). Mozenter suggested partnership needs to monitored, role modeled, and measured as the success factor, along with other metrics such as patient satisfaction. Partnership needs to be a core value that you measure, reward, and recognize, according to Mozenter.

The forth expert, Murphy, felt the key contribution of the research was the specific suggestions from charge nurses for interventions to handle situations with emotionally *difficult* patients and families effectively. "Nurses often do a good job of assessment, but the planning of care is where we often struggle". According to Murphy, the significant contribution to the body of nursing knowledge, was to not only understand the phenomenon of *difficult* people, but to outline the practical steps a nurse can take the next time she's confronted by an emotionally *difficult* family. Some of these skills can be

taught, some can be role modeled, and other factors, such as emotional intelligence, are just nice to be aware of so nurses can be assigned to *difficult* families based on their expertise.

The fifth expert, Johnson, was impressed with the depth of the participants' comments regarding their experience with emotionally *difficult* patients and families. Johnson suggested a better term for the participants would be "informants." Johnson was surprised at the ability of the participants to express themselves so readily and felt this was a reflection of the researcher's skill at creating a safe environment for communication, and the depth of how troubled informants are about this phenomenon.

With more than 30 years of experience working with pediatric patients and families, Johnson commented on the importance of this research and the contribution to the body of knowledge. Johnson felt the informants accurately described their experience and that of the families Johnson has worked with. Johnson said, "It cries out to be heard."

Johnson suggested there was some blurring in the informants' answers between their role as a charge nurse, staff nurse, informant of other nurses, a parent to their own chronically ill child, and an informant for patients and families. There is a clear distinction between the experience from the patient/family perspective and that of the various levels of care providers. Some informants discussed the phenomenon from a variety of perspectives. An area for further research would be to focus on these specific groups individually, with a similar set of research questions.

The recommendations of the members of the hermeneutic circle were used to pursue concepts further to explain the results. The symptomatic cycle, issues of labeling,

and interpretation of participant themes are discussed in Chapter 5. Conclusions and a summary are presented in the following sections.

Conclusion

Chapter 4 presented the results of the data analysis and study findings. The data collection process was discussed, and direct quotes and themes from the participants were presented to provide insight into the lived experiences of charge nurses when working with emotionally *difficult* patients and families. From the four research questions and 13 participant questions, 11 sub-themes emerged, leading to five core themes and a series of suggestions.

Summary

Chapter 4 provided an overview of the findings and data analysis of the research study. Eleven sub-themes emerged from the four research questions, leading to five core themes and a series of suggestions from the participants for improving the situation with emotionally *difficult* patients and families. The purpose of the non-experimental qualitative hermeneutic phenomenological interview research was to discover how nursing leaders, specifically charge nurses, experience emotionally *difficult* patients in in-patient hospital settings. The research relationships are the charge nurses' interpretation of *difficult* behaviors by patients and families and how this interpretation is related to the charge nurses' ability to deliver clinical care, their relationship with the family, and the impact on the charge nurses' relationships with co-workers. Common patterns, factors, and elements of interest were identified. The results may be used to develop interventions to address the impact of emotionally difficult patients and families on charge nurses.

The specific population for the study consisted of nursing leaders in the charge nurse role. The sample was composed of 15 charge nurses from several units in a pediatric urban academic hospital in Philadelphia, Pennsylvania. While the phenomenon of emotionally *difficult* patients and families may exist in other environments, the scope of this particular research project builds upon preliminary work (Logan, 2002; Sieben-Hein & Steinmiller, 2005; Sieben et al., 2003; Simms, 1995) that was conducted in pediatric locations but was not conclusive and did not explore the lived experience of charge nurses

In Chapter 5, the core themes are analyzed further and discussed. Two central theories, the symptomatic cycle and the issues of labeling people, will be discussed in greater depth. Implications, patient care suggestions, and recommendations for further research derived from the data are explained.

CHAPTER 5 CONCLUSIONS, IMPLICATIONS, AND RECOMMENDATIONS

The purpose of the non-experimental qualitative hermeneutic phenomenological interview research was to discover how nursing leaders, specifically charge nurses, experience emotionally *difficult* patients in in-patient hospital settings. The research focus was the charge nurses' interpretation of *difficult* behaviors by patients and families and how this interpretation is related to the charge nurses' ability to deliver clinical care, their relationship with the family, and the impact on the charge nurses' relationships with co-workers. Common patterns, factors, and elements of interest were identified. The results may be used to develop interventions to address the impact of emotionally difficult patients and families on charge nurses.

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Chapter 5 will present an overview of the research findings, focusing on the research questions. The four core research questions, 11 sub-themes, five core themes, suggestions for interventions, and recommendations will be discussed. The over-arching conclusion and recommendations in Chapter 5 come from the four original research questions, which were explored in an attempt to generate answers through participant

data, input from members of the Hermeneutic Circle, previous theories, and research in the literature. Interpretations of the findings are discussed and impacts for leadership, study recommendations, and future research recommendations are presented.

Discussion of the Themes

Four research questions were identified and became the basis for 13 formal interview questions. The four research questions focused on the lived experiences of charge nurses when working with emotionally *difficult* patients and families. Eleven sub-themes that emerged from the interview data, which were related back to the research questions in Chapter 4. The eleven sub-themes were then used to identify five core themes. Participants provided suggestions for interventions, which were combined with the core themes to produce a master list of recommendations for improving the situation when charge nurses are confronted with emotionally *difficult* patients and families.

Three major theories were related to the participant data and themes: symptomatic cycle, labeling of patients and families; and middleness. These theories are discussed in Chapter 5. The five core themes are again used as the platform for the discussion.

Implications from the Composites

Two participant composites were described in Chapter 4, presenting the two extremes of how charge nurses experience emotionally *difficult* patients and families. Novice nurses tended to label patients and failed to understand the dynamics behind the families' reactions to life experiences. Expert nurses tended to approach families in a manner suggested by Heidegger (1962), seeking to connect with their Dasein and to understand the deep essence of their being.

Participants responded to the four research questions with 11 sub-themes. These sub-themes are presented in response to the research questions and then further expanded upon in the following sections, where they are organized by the core themes.

1. Participants responded to the first research question regarding their lived experience, by defining emotionally *difficult* patients and families (sub-theme 2) and describing the types of difficult patients (sub-theme 3).
2. Participants responded to research question two regarding their interactions with other members of the team, by identifying factors related to greater understanding (sub-theme 8); explaining the impact of grief, loss, and end of life (sub-theme 10); how emotionally *difficult* patients and families affected their ability to provide clinical care (sub-theme 1); and the impact of staff relationships, teamwork, rumors, and gossip (sub-theme 5).
3. Participants answered the third research question by describing the impact of emotional intelligence (sub-theme 9); the resources available to the charge nurse (sub-theme 7); and how charge nurses maintain their emotional balance and that of their staff (sub-theme 11).
4. Participants answered research question four by describing their leadership role and responsibilities (sub-theme 6); and how the culture reinforces the behavior of patients, families, and staff (sub-theme 4).

Further review of the themes is presented in the following section.

Core Theme One: Avoid the Symptomatic Cycle

Staff are vulnerable to being caught in a symptomatic cycle of behavior when working with *difficult* patients and families. One suggestion from the participants was to

make psychosocial care as much a priority as the patient's medical care. An introduction and review of the symptomatic cycle theory was presented in Chapter 2 and is expanded further based on the informed information provided by the participants in Chapter 4.

The essence of every symptomatic cycle is a reflection of avoidance and abdication (Simms, 2007). Figure 10 shows a graphic presentation of the typical patient-family-care provider relationship. Most of the time this pattern works well as the patient and family try to manage the symptoms.

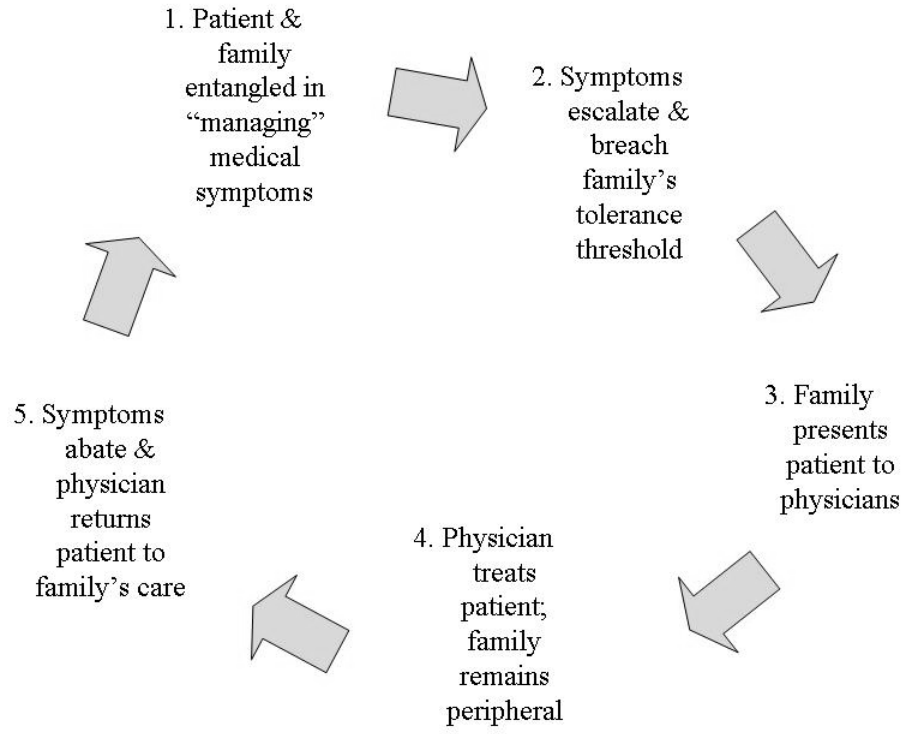

Figure 10. Typical patient family physician pattern (Simms, 2007)

When symptoms are unresolved, the family presents the child to the care team members, who react by making a diagnosis and suggested treatments. Ideally, the treatment works, symptoms are resolved, and the family goes home happy. Figure 11

shows this cycle expanded as the family complains that the child's symptoms have not been resolved in step 6. The family and health care team become engaged in a symptomatic cycle. The patient or family behavior is defined as symptomatic, which staff attempts to change or control. If successful, the matter is resolved. More commonly, the symptoms persist or escalate and more individuals (family members and staff) become involved in the symptomatic cycle.

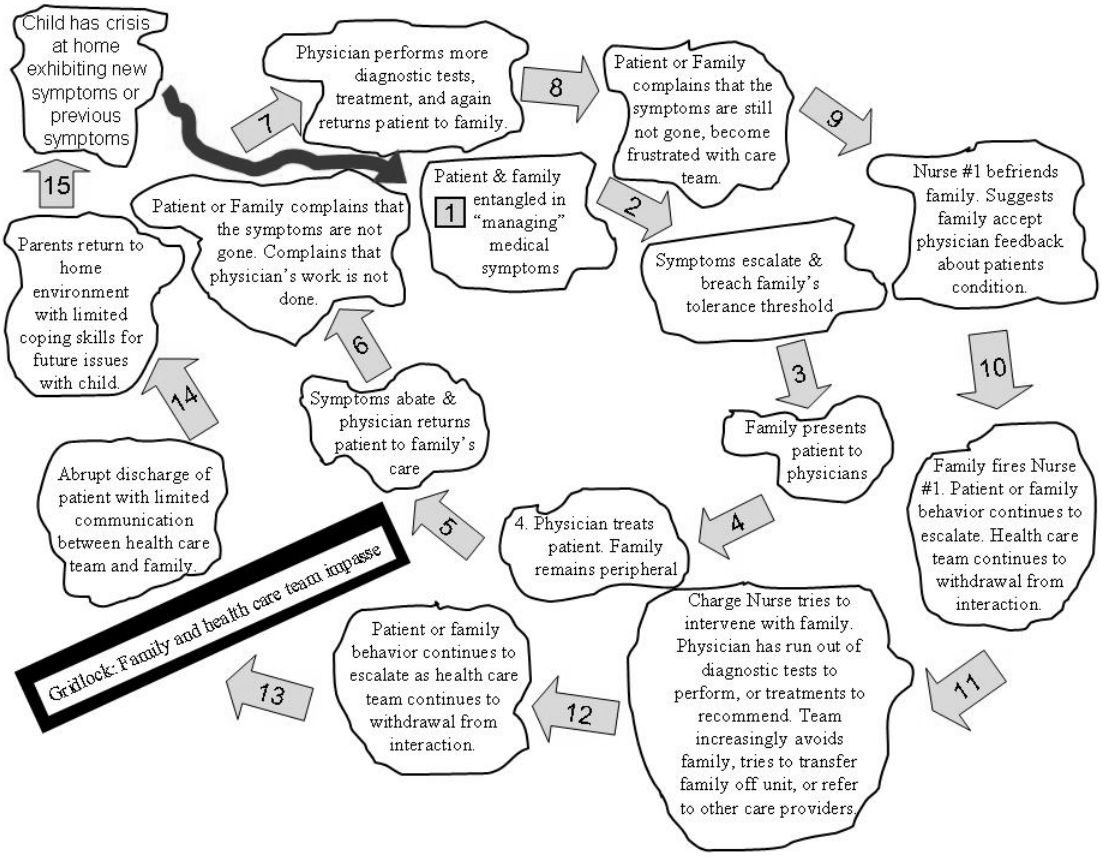

Figure 11. Symptomatic cycle depicted in soft systems theory model format[8]

"Everything emanates from the symptomatic cycle. The patient, family and staff are ensnared in a negative cycle. It's the interaction of them all that causes the pattern to repeat itself, which is the foundation for it to escalate. It's like a steam engine without a

[8] Adapted from Simms (2007) and Checkland (1999)

governor that's out of control till [*sic*] it explodes. When it explodes it brings the situation to the attention of everyone, who then spring into action of some sort. Increasing energy is expended in attempts by staff to control the patient's symptoms" (S. Simms, personal communication, November, 16, 2007).

Charge nurses cited several examples where parents altered the rules of the family, leading to new insights regarding their patterns of behavior. In several dramatic examples, participants described situations where the dynamics of the child's death altered the family's thinking about resuscitation. Many participants described this in their patterns of relating to *difficult* families in a consistent yet non-productive manner. The manner of relating to difficult families was non-productive in the sense that it did not alter the situation. When parents are resistant to engaging with the staff, it becomes difficult to treat the child. Parents may withdrawal, become overly protective, or just shut down emotionally, making it difficult for staff to understand what the parents need.

In some situations there is psychopathology in the child or adolescent and therapy and medication may be necessary. It is important for the therapeutic team to be aware of the symptomatic cycle and avoid over-involvement with the patient to the point where the team members become overly invested in the patient's perception that the family is *dysfunctional*, and avoid involving the family in any solution. By focusing on fixing medical symptoms, and excluding family involvement in the solution, the same dysfunctional pattern of behavior continues. By contrast if the staff develops a new pattern of recognizing the relationship between the child, care team, and family that may be productive in altering the pattern of behavior, break the symptomatic cycle, and move everyone toward an optimal outcome.

Several participants related stories of staff being too close to families and losing their perspective. The loss of perspective may cause staff to be vulnerable to the symptomatic cycle. Maintaining one's objectivity and perspective was also a reason participants suggested rotating who was taking care of the *difficult* family, so no single nurse had to care for them over and over again.

Participants described the role the charge nurse can play in setting the tone for the unit. Staff emotions tend to escalate, but staff are often too close to it the situation to realize what is happening. It is often a struggle for control between staff and families, according to several participants. Control can manifest around who is caring for the child today, how the care is performed, and what limits will be set on behavior. The charge nurse potentially can be an objective party who is not as emotionally involved in the day-to-day dynamics and can make recommendations such as assigning a different care provider, or seeking assistance from a psychosocial professional.

The family in a symptomatic cycle avoids the reality of the situation, coupled with abdication of its role as leader of the family (parent). The staff parallels this pattern by avoiding the reality of the presence of the difficult family and the need for an intervention to break the cycle. Likewise, the charge nurse who avoids the situation with the *difficult* family is an example of abdication of the charge nurse's role and responsibility as a leader to address the situation. The results showed that staff nurses often deny the existence of the *difficult* family, especially early in the admission. As nurses avoid relating to the *difficult* family, they abdicate their responsibility as a middle to push the tension toward resolution of the situation.

Core Theme Two: Resist the Temptation to Label

The defining and labeling of people as *difficult* may prove to be an obstacle to future interactions, communication, and relationship building. Families react along a continuum from silence to violence; however, the nurse should avoid the temptation to label these behaviors. Instead, the nurse should remain consistent in seeking to understand the unique experience of each patient and family, which will be explored in the following section. Suggestions from expert charge nurses included listening to families to understand their situation more fully, avoiding making assumptions, and providing frequent communication with families to avoid misunderstandings.

Kazak (2002) suggested people are often labeled based on faulty assumptions and that such mislabeling can result in patterns of behavior that reinforce the faulty assumption. This can lead to tension, arguments, and further stereotyping of people. Novice charge nurses' described their experience with emotionally *difficult* patients and families in very similar language, expressing how the labeling and stereotyping of families by other staff led to further tension and reinforcement of the original faulty assumption.

Psychiatric labels are especially problematic due to the significant stigma attached to people with mental disorders, which also includes families of children with emotional disturbances (Goffman, 1959, 1961; Osher & Osher, 2002). The anger of these families may be justified in terms of what they are experiencing and how members of the system who have failed to provide adequate assistance have labeled them. At the same time, there is a significant amount of pathology in society due to drug and alcohol abuse, high levels of divorce, social problems, and psychiatric disease in the general population,

which may also contribute to the difficulties experienced by families with children with emotional disturbances.

Phenomenologists avoid focusing within individuals (as traditional psychiatrists and psychologists do), but instead see people primarily as social beings and see their role as making sense of experiences through an appreciation of their social context (Langdridge & Butt, 2004). One example of social contexting is the way health care workers apply stereotypical labels to patients. In an effort to make quick diagnoses, health care workers often fall prey to stereotypes by seeing wrong patterns or patterns where they do not really exist (Smith, 2005).

Smith suggested health care workers often use uncomplimentary stereotypes such as blaming patients for their illnesses or the situation they find themselves in because of non-compliance or other behavioral patterns. One description of this is ascertainment bias, when thinking is shaped by prior expectations (Smith, 2005). Fundamental attribution error, another descriptor, has been defined as a process where people search for causes of an event by looking internally, such as at personality, rather than to environmental influences that may be producing the behavior (Weigel, Langdon, Collins, & O'Brien, 2006).

Participants suggested that emotionally *difficult* families could affect their child's care if the nurses were reluctant to enter the room for fear of a disruptive encounter with the parent. This is consistent with Weigel et al., who examined the behavior of workers caring for patients with challenging behaviors and suggested that the emotions these patients provoked could lead to inconsistent care interventions. One explanation is the fundamental attribution error, in which a person's behavior dominates perception by

others more so than the effects or context of the situation (Langdridge & Butt, 2004). Langdridge and Butt explored other theories, including perception is learned and increases with experience with different types of stereotypical people; perception is altered when people are busy and preoccupied; and behavior is often not intended to be malicious but is perceived that way by others. These misperceptions could account for costly negative behavior toward the patient of a family labeled as *difficult.*

Looking at it from a phenomenological perspective, Langdridge and Butt (2004) suggested humans are pragmatic and try to anticipate others' actions in terms of what they can do for them or how their behavior will impact on them. When a patient is labeled as *difficult* there are a corresponding set of stereotypical expected behaviors to anticipate and corresponding approaches for coping and responding to those behaviors. While people know they are ever growing and changing, they approach others as if they are in a static state in which their past behavior is an indicator of exactly how they will perform in subsequent situations.

People see others' behaviors as meaningful, purposeful, and intentional. People assume that their actions are a continuation of a series of preconceived organized behaviors intended to achieve a specific outcome (Langdridge & Butt, 2004). For the worker caring for a *difficult* patient, the fundamental attribution error is that the patient is doing the behaviors to make the worker's life miserable, rather than the behaviors being a reaction to the external circumstances the patient and family are confronting.

Family reactions silence to violence. Difficult patients and families were described by participants as having reactions ranging from silent to angry and violent. Hermeneutic circle expert Johnson suggested silence was as strong a violent reaction as

more demonstrative anger reactions. A model for crucial conversations suggested that people toggle between silence and violence in their reaction to stress (Patterson, Grenny, McMillan, & Switzler, 2005; Patterson, Grenny, McMillan, Switzler, & Covey, 2002).

Participants described *difficult* patients and families exhibiting behaviors ranging from devastated and quiet to angry and demonstrative. What was striking was that some participants described all of this behavior as having an underlying foundation of anger: *Participant 2* suggested: "Angry people often start as someone who is quiet, and is sitting and watching everything. Then one day they get angry at us . . . they're angry about something bigger. They're angry because they're grieving whatever they've lost: control of the situation". Several participants suggested quiet families may be internalizing the most anger, whereas with the angry families one knows what is upsetting them, because they verbalize it. The implication is that staff must pay equal attention to either reaction as symptomatic of underlying issues that need resolution.

Core Theme Three: Create a Positive Culture with Clear Plans

How the charge nurse interacts with staff to create a culture that reinforces positive behaviors aimed toward resolution of conflicting relationships with *difficult* families is important. One important aspect of a positive culture is to address the issue of *difficult* patients and families as soon as possible in their hospital stay. The culture is often influenced by patients, families, and staff; charge nurses must assert themselves in a proactive manner to push the other staff toward resolution of conflict to avoid an impasse with families. Expert charge nurses suggested several interventions: attention to developing formal plans for the *difficult* family, focusing attention on staff relationships, supporting one another, and encouraging teamwork.

The role of the charge nurse in creating a positive culture. Controversies exist in the field about the ownership of the problem of the *difficult* patient. There is disagreement as to whether it is a problem that exists in the patient or an issue that must be addressed by the care team. Kazak, Simms, and Rourke (2002) purported that clinicians try to control patients' behavior rather than looking at the interplay of staff, patients, and families as one big system that is related to patient behavior. Logan and Simms (2002) found that psychiatric labeling of patients interfered with reviewing situations systematically. Several models such as the soft systems model and Senge's vision versus current reality models, exist for addressing workplace situations in a systematic way (Senge, 2006; Senge, Kleiner, Roberts, Ross, & Smith, 1994; Senge, Ross, Kleiner, Roberts, & Roth, 1999).

The family and the hospital may have conflicting agendas. In an idealized world, the role of the family is to provide unconditional love, guidance, care, and support, and nurture all of its members (Osher & Osher, 2002). In reality, families present with a variety of structures, cultures, languages, values, spirituality, physical environments, and face a variety of challenges beyond raising an emotionally *difficult* child (Osher & Osher). When a family is under stress, family members may look to their extended family, friends, community, school, social agencies, and health care institutions for support that may or may not be available. When family stress and outside supports are inadequate, the family may suffer and be unavailable to support its members (Osher & Osher). Staff often lose sight of this dynamic when they get caught reacting to the day to day dynamics and drama of a *difficult* family.

Participants varied in their description of the role of the charge nurse. The novice charge nurses tended to be task oriented. Expert charge nurses clearly saw their top priority as tending to the culture to create safety, accountability, and professionalism in the staff. The ways in which the culture reinforces the behavior of patients, families, and staff is discussed in the next section.

How the culture reinforces the behavior of patient, families, and staff. The members of the hospital system may have dual agendas: what is good for the patient and what is good for the hospital staff. These agendas may compete with each other. The nurse's role is to help the patient and family, whether the patient is angry, difficult, cooperative, or behaves nicely. For example, pediatric nurses also must care for adolescents, who are in a developmental stage in which it is appropriate at times to be angry (Poa, 2006).

Participants described numerous examples where the culture reinforced negative behaviors toward *difficult* families, beginning with the initial labeling of them as *difficult;* spreading rumors and gossip about families; and treating *difficult* families differently, including limiting the amount of care and attention they receive. The more evolved charge nurses recognized their role in addressing the culture; however, their attempts were often affected by the organizational dynamics and their own role as a middle.

Hermeneutic expert Mozenter suggested partnership was a better goal than teamwork, because teams are prone to avoiding accountability. Diffusion of responsibility refers to assuming other reasons and people are in place to assume responsibility (Zimbardo, 1969). Diffusion of responsibility was a term first used in the

1950s to describe how group-think and lack of personal identity existed when a crowd witnessed an event (Festinger, Pepitone, & Newcomb, 1952).

When individuals are part of a group there is a tendency to avoid individual responsibility by diffusing the responsibility onto others in the group and assuming someone else will resolve the problem. This process, called diffusion of responsibility, is based on the assumption the individual cannot be singled out for blame (Wendel, Winter 2006). There is also a tendency for individuals to look to the behavior of other members of the group and assume that if they are not doing anything about it, then why should I?

Three factors contribute to the phenomenon of diffusion of responsibility: anonymity, dispersion of responsibility, and arousal (Zimbardo, 1969). People are more expressive, criticize others more readily, and say things they would not normally say because they feel a certain protection in the anonymity and shared responsibility of the group (Lacks, Gordon, & McCue, Fall 2005). Individuals in groups can also be aroused more easily to engage in antisocial behavior, such as rioting and looting (Berkowitz, 1983; Ferguson & Rule, 1983). These results may account for various phenomena related to employee misconduct and why it is not reported by individuals.

How emotionally difficult patients and families affect the ability to provide clinical care. Several participants expressed concern about their ability to provide appropriate care to the child when the parents are being difficult. Nurses may be reluctant to go in the patient's room, families may not realize that their mistreatment of nurses is affecting their child's ability to receive care, and the challenging family may also take time from the nurses' busy schedule, which has implications for other patients and

families. These dynamics affect staff relationships and teamwork and contribute to excessive rumors and gossip.

Rumors and gossip manifest through stereotyping and labeling of patients and families, as well as gossiping about other staff and their approach to *difficult* families. Rumors and gossip are prevalent and dangerous in nursing organizations yet have received little attention in the literature (G. Michelson & Mouly, 2000; G Michelson & Mouly, 2002). Rumors and gossip that focus on the workers can become harmful to the organization when they translate into inaccurate information and innuendo, which can lower morale and undermine productivity. Rumors and gossip may also be used as a tactic in organizational politics when inaccurate information is transmitted knowingly to damage an opponent.

Rumors tend to increase when members have limited control over events, where there is a poor organizational climate, mistrust of formal communication lines, uncertainty about change, and high levels of competition (G. Michelson & Mouly, 2000; G Michelson & Mouly, 2002). Several participants suggested rumors and gossip were often manifested the most in the people who were not caring for the patient, but speculated about how they would have done things differently if they were in control of the situation. A dramatic finding from one participant suggested a non-tolerance policy for rumors and gossip because of the long term negative consequences related to teamwork.

Limiting beliefs can greatly hinder a team, especially if the limiting beliefs are reinforced by the culture that reinforces them in an endless loop, according to LaRue et al. (2004). Individuals and groups can learn to be optimistic or can slip into a pattern of

reinforcing their limited self esteem and perform in a negative way that reinforces the negativity known as learned helplessness (Seligman, 1998). Numerous authors have explored the topic of optimism and how individuals and groups learn to reframe situations in an optimistic self motivating pattern (Frankl, 1984; Hillman, 1997; Seligman, 1998).

When people unite around a belief system, those beliefs become reality itself and their entire world builds around those beliefs (Anderson, 1992). These beliefs become their reality. Others in the organization who do not conform to those beliefs are labeled as distorting reality and may feel pressure from the group to conform our make the choice to leave. This could account for the pattern of staff stereotyping certain patients as *difficult*.

Team dynamics may play a role in the way health care workers address emotionally *difficult* patients and families. Lencioni studied the functioning of teams and found five dysfunctions that seem to impede team performance (Lencioni, 2002, 2005): absence of trust, fear of conflict, lack of commitment, avoidance of accountability, and inattention to results. Teams can overcome their dysfunctions by: building trust, mastering conflict, achieving commitment, embracing accountability, and focusing on results (Lencioni, 2002, 2005).

Core Theme Four: Be Aware of Your Role as a Middle

Charge nurses are in a leadership role that places them in conflict with various systemic forces within the organization, staff, and families. The charge nurse's ability to navigate these situations is important to the outcome of the team's ability to interact successfully with *difficult* families. The theory of middleness (Oshry, 1994, 1996) has implications for the way that charge nurses approach their role and the way the care for

themselves to avoid stress and burnout, as will be discussed in the following section. Expert charge nurses suggested rotating staff assignments so no one is over burdened with the *difficult* family, communicating frequently with staff, and utilizing resources and leadership to provide support and direction.

The role and responsibilities of charge nurses. The participant data were consistent with previous work on the role and responsibility of charge nurses by Connelly, Yoder et al. (2003). Participants cited the importance of paying attention to the culture to create a safe climate in which nurses could practice. Charge nurses described the need to be role models, especially to younger staff. While there are many concrete tasks to being in charge, the more evolved charge nurses suggested that paying attention to the culture and creating a team atmosphere were most important to the success of staff in caring for emotionally *difficult* patients and families.

Research has indicated increasing difficulty convincing nurses to assume leadership responsibilities, including the charge nurse role (Sherman, 2005). Charge nurses were identified as key leadership staff, yet according to a study of 120 nurse managers in 24 health care agencies, most had not received formal training (Sherman, 2005). Connelly (Connelly, Yoder et al., 2003) called for the need to develop leadership skills in charge nurses.

Participant charge nurses made numerous suggestions regarding training. Participants suggested that courses in critical thinking, teamwork, collaboration, and communication would all be helpful. More important was the suggestion that charge nurses needed support from leadership to be successful. This support should include mentoring from other charge nurses and the manager.

The charge nurse leadership role: Caught in the middle. Charge nurses are in a leadership role that places them in conflict with various systemic forces within the organization, staff, and families. The charge nurse's ability to navigate these situations is important to the outcome of the team's ability to interact successfully with *difficult* families. Oshry (1994, 1996) described the concept of middle workers in organizations. Charge nurses are middles and thus caught between the need to please the tops, while simultaneously addressing the needs of the bottoms (Oshry, 1994, 1996).

One solution to the situation of emotionally *difficult* patients and families may be the development of charge nurses' leadership skills in the middle role. The charge nurse may see his or her role as doing concrete tasks. In reality, the bigger role is to be a systems integrator, balancing the needs of the patient, family, care team, and the impact of the patient's medical plan of care (Kazak, 2002). What is of concern is that middles tend to feel alone, isolated, and unappreciated, all dynamics described by psychotherapists as the perfect condition for a dynamic that perpetuates less than ideal relationships (Logan, 2002; Simms, 1995).

Resources available to the charge nurse. Participants described a variety of resources available to them, including their boss, other charge nurses, staff, social workers, psychologists, mental health clinical specialists, and physicians. Of most importance is the message from Participant 7:

> *Participant 7:* It's not an individual skill set, but a team skill. It's a skill that has to be applied to the entire team and that's the challenge. It's a delicate dance, the dance of teamwork and so much more. It's like your original question, What is a

good charge nurse? It's probably more than the individual pieces of the role. There's not a simple formula.

The key to success as a charge nurse is to use one's resources and not to attempt to do things on one's own. By working as a team, one avoids fatigue, gains perspective, and is open to multiple solutions to situations. Teamwork is essentially the most important factor to overcome the isolation of being a middle and in working with *difficult* patients and families. When charge nurses are feeling overwhelmed, alone, unappreciated, and isolated, they miss the clues to use the resources available to them.

Core Theme Five: Teach the Skills

There is a set of skills that can be taught to charge nurses, staff, and teams to improve their ability to work with *difficult* families. Expert charge nurses varied in their suggestions for what could be taught. Much of the expertise in working with emotionally *difficult* families may be a combination of pre-existing emotional intelligence skills in the staff and previous life experience as a patient or family member of a sick person. Several participants also suggested that classroom learning and role playing could not replace life experience; being a charge nurse or staff nursing caring for an emotionally *difficult* family was the best way to learn. Specific suggestions for teaching included: overview of the dynamics of *difficult* people, communication skills, and review of grief and loss theories.

Research on charge nurses found that they often received limited training for the role and felt unprepared (Connelly, Yoder, et al.). The results of this research, including specific suggestions from the participants, support that charge nurses can be trained to be better leaders in situations with *difficult* patients and families. Various authors have

explored the use of the workplace as a learning situation (Kerfoot, 2003; Senge, 1990; Vail, 1996). Difficult situations with families can be used as learning experiences to teach nurses ways in which to act as leaders to resolve these conflicts. Avolio (1999) recommended transformational leadership be exhibited at all levels of the organization and leadership assessment information be used as a basis for training and development. Participants recommended a variety of learning experiences ranging from classroom experiences, role playing, conflict management courses, coaching, mentoring, and debriefings after incidents with *difficult* families. Further research is needed to identify the affectiveness of these approaches.

Challenges such as the *difficult* patient can also be opportunities for growth. Several participants suggested that they had learned much about *difficult* people through their role as a charge nurse. Seligman suggested optimistic people use challenges as opportunities to learn and grow (Seligman, 1998). People often do not learn much from the good times in life, rather they learn from bifurcation points where time and circumstances collide to bring new input to their senses and provide the opportunity for people to take a fresh look at reality (Cooper & Sawaf, 1998, p. 260). It is not that people need to seek out adversity, but rather that if it occurs, they figure out how to manage it (Ram Dass, 1998).

Quinn (1996) stated if an organization's leaders avoid deep changes they are choosing by default to allow a slow decline of the organization. Quinn described slow death as the tendency to stay in a safe comfort zone rather than facing the challenges of life. Emotional intelligence plays a vital role in facing the challenges of life, as growth "is

the single process that unites the feelings, thoughts, actions, and energies of every living thing (Cooper & Sawaf, 1998, p. 256).

Five answers from participants explained the depth of the challenge for charge nurses to maintain their own emotional balance: Participant 10 arrived at the interview at 2:30 p.m. She said she left for work at 5:30 a.m. and had not taken a break to go to the bathroom in nine hours.

Participant 7 commented about the importance of people getting breaks: ". . . asking people if they need a break, especially when working with a difficult family. We work in teams with difficult families, so nobody should be in that intense situation for a week straight." Participant 5 said, "I also try to avoid having nurses care for a difficult patient for long periods of time. If they come to me and say they need a break, I'll grant that, as I understand the difficulty."

Participant 10 suggested the charge nurse needs to provide perspective for some nurses: "Nurses aren't always good at setting their own limits and Suzie will say it is o.k. for her to take care of the difficult patient again tomorrow when it really isn't." *Participant 14* suggested how individuals develop their own balance:

> Try to develop a switch in your head to turn your emotions on and off. You also need to have an outlet when you are upset. It might be a walk outside, or hitting a punching bag, or complaining to a friend who will listen. You also can't be too hard on yourself. You're never going to be perfect 100% of the time. When I was younger I thought I should be perfect, and I would get down on myself. But with maturity you become humble enough to know you're going to make mistakes, especially with interpersonal communication.

Maturity versus Emotional Intelligence. One interesting finding was the assumption by many participants that the ability to work well with emotionally *difficult* patients and families was a reflection of the maturity level of the nurses. However, upon further investigation, it appears that the ability for expert nurses to work more readily with these situations is a combination of previous life experience, such as being ill or having a sick family member. This may be a reflection of the charge nurses' emotional intelligence, which may predispose nurses to having greater skills with *difficult* families. The Emotional Intelligence of participants was not formally assessed and could be an area for further research.

Emotional intelligence (EI) or lack of EI may also account for some nurses' negative approaches to emotionally *difficult* families. Many of the components of EI are necessary for health care workers to see a situation from the *difficult* families' perspective. EI is also necessary for higher order moral and ethical development.

Gantt and Agazarian's (2004) theory is similar to Rossouw and Vuuren's (2003) theory in terms of emotional intelligence (EI) being a product of the function and energy of a system rather than the collective property of the individual members. Gantt and Agazarian suggested taking a systems approach to developing EI at all levels of the organization, rather than taking the traditional approach of developing individuals and assuming it will have an impact on the larger organization's EI. Gantt and Agazarian suggested that groups and organizations be viewed as whole rather than breaking things down into individual pieces.

There are also secondary gains for not caring for *difficult* families. Several participants explained that it was often easier to find a nurse willing to work with the

difficult family than to argue with someone who did not care to work with them. *Difficult* families are usually harder to care for, and many nurses would prefer not to care for them. By complaining overtly about *difficult* families, a nurse can make it known that she or he prefers not to care for them.

Grief and loss. Grief was cited by numerous participants as an underlying dynamic with *difficult* families. Simms suggested grief and loss may be stressors and dramatic examples of what is going on with a family that serve to distract the family and staff from their real mission, to support the child who is ill (S. Simms, personal communication, November, 16, 2007). Death is a normal and expected part of the life process, yet in western cultures it has become a veiled topic until the drama of death unfolds (McBride & Simms, 2001). This was evident in the stories of many participants who described the loss of a sick child as the most dramatic example of the issues between staff and *difficult* families.

Parents move through three emotional stages while seeking to make the right decisions for their sick child: grieving, cynicism, and proactive parenting (Taylor, Donoghue, & Houghton, 2006). The grieving stage of this process consists of: "denying the diagnosis, seeking alternative treatments, venting anger, experiencing emotional turmoil, expressing remorse, feeling depressed, and reaching a guarded acceptance" (Taylor et al., p. 111). The charge nurse's role is to help the patient and family, whether or not the patient is cooperative and behaves nicely.

McBride and Simms (2001) described a clinical framework for death and grief within the context of a family systems model. McBride and Simms suggested clinicians develop an awareness of the context in which the family is grieving. Clinicians should

also build relationships with the family around their unique ways of grieving and facilitate timely team interventions.

One of the most dramatic issues uncovered in this research was at the point of a child's death regarding the DNR orders. It was not surprising that issues with *difficult* families increased in intensity at the point of the child's death. What was dramatic was the inability of nurses to discuss with ease the topic of parents changing their mind at the point of the child's death regarding the status of the DNR. There were clearly issues in the organization regarding the DNR policy. Several participants discussed the issue reluctantly and questioned whether they had done the right thing. Following this discovery, the researcher brought this issue to the attention of several key administrative staff.

Suggested Applications

Leaders need a different approach to situations based on the team's makeup, organizational dynamics, and the particular situation. The symptomatic cycle is a model that helps to illustrate the dynamics at play in the family and the team caring for the family. Inquiry is one way to examine a group's strategy in terms of the major internal and external forces that drive them (LaRue, Childs, & Larson, 2004).

Inquiry is one way that the Complex Care Consultation Team has addressed the issue of *difficult* families at the Children's Hospital of Philadelphia (Sieben-Hein & Steinmiller, 2005; Sieben et al., 2003). Inquiry provides information on gaps in the organization. Gaps can be addressed most effectively through strategies, one of which is action-learning teams (LaRue et al., 2004).

Managing emotionally *difficult* families in a proactive way, early on in the admission, not only can resolve the issue, but it can serve as a team building experience. This benefit was exemplified in the better performing units in this study. Other interventions can be to develop a no-tolerance policy for rumors and gossip; specific protocols for *difficult* families, including rules for communication to other staff, a buddy system; implementing psychosocial rounds and debriefings; and formal education programs that address the dynamics of *difficult* families, communication skills, and teamwork.

Ideally, inquiry is conducted through a process that is perceived as *safe* by the participants, thus encouraging information previously hidden but essential for a successful change process (LaRue et al., 2004). Inquiry bridges a gap between the way leaders perceive reality and workers are experiencing it (LaRue et al.). One reason change initiatives fail is improper management of the change because of faulty assumptions and a lack of understanding by leadership of the actual dynamics, their context, and the organizational culture (LaRue et al., 2004).

A crisis provides the potential opportunity for an organization to respond in a way that differs from the existing culture and patterns of behavior. Using a crisis as an opportunity is also consistent with family systems theory and the way that a family can use a crisis as an opportunity to alter its approach to a situation. Inquiry is a way of viewing culture as an outsider, according to LaRue et al. (2004). By reevaluating the situation, norms, values, and assumptions, members can break the trance of the culture and its impacts on daily operations and decisions (LaRue et al., 2004).

During periods of rapid change, people become overwhelmed and confused by the excessive inputs from the environment and their brain finds ways to slow down the rate of change intellectually and emotionally through limited beliefs and simplistic solutions that do not consider all the factors (LaRue et al., 2004). This phenomenon could account for the reaction of health care workers to *difficult* patients and families. Also known as "quick fixes," these solutions provide temporary relief but usually come with a side effect (Senge, 1990; Senge et al., 1994; Senge et al., 1999). The quicker the fix, the greater the potential for side effects, according to Senge (1999).

Recommendations for Improving the Care of Emotionally Difficult Patients and Families

The care of emotionally *difficult* patients and families can be challenging for the charge nurse, team, and individual care providers. Numerous suggestions have been made over the course of this dissertation. The following comprehensive list summarizes the recommendations:

1. Avoid the symptomatic cycle by making psychosocial a priority for evaluation, planning, and intervention.
2. Resist the temptation to make assumptions and to label emotionally *difficult* patients and families.
3. Recognize that patients and families react in various ways, ranging from silence/devastated to violence/angry. Accept that this is their way of coping.
4. Keep the lines of communication open with families.
5. Create a positive culture, starting with clearly defined plans as early in the hospitalization as possible.
6. Support each other as a team.

7. Establish a no-tolerance policy for rumors and gossip about patients, families, and other staff.

8. Be aware of one's role as a middle balancing the tension between tops, bottoms, patients, and families.

9. Be clear on one's roles and responsibilities as a charge nurses: safety, resource allocation, quality patient care, teamwork, communication, and emotional support.

10. Teach the skills to others:

a. Understanding of the dynamics of emotionally difficult patients and families;

b. Communication skills;

c. The impact of emotional intelligence;

d. Buddy systems to support each other with *difficult* families;

e. Grief, loss, and end of life experiences;

f. The importance of maintaining one's emotional balance as a charge nurse and that of the staff;

g. Mentor other staff;

h. Provide learning experiences for staff; and

i. Use one's previous experience as a patient, caregiver, or parent to provide others with insight.

Limitations

The scope of the study was to interview charge nurses on several inpatient care units at The Children's Hospital of Philadelphia, an inner city pediatric academic hospital

in Philadelphia, Pennsylvania, to explore their lived experiences with *difficult* patients and their families. The Children's Hospital of Philadelphia is one of the largest pediatric facilities in the country and is part of a university.

The limitations of the study were that the results may add to the body of knowledge of leadership in pediatric academic inner-city hospitals, yet they may not be generalizable beyond the boundaries of the particular facility studied. There may be dynamics unique to the facility that contribute to the phenomenon studied that are not present in other settings. Examples include the amount of resources available to assist charge nurses, which may be greater than the typical hospital. Staff nurses at this institution had increased levels of education compared to national averages. The hospital also may care for more *difficult* families due to the location in the inner city and the fact that it draws patients internationally.

Another study limitation was the effect of social desirability on the participants. Social desirability has been described as the difference between an individual's intention and his or her perception of what he or she is expected to say (Chung, 2003). Charge nurses understand to some extent the socially acceptable, *right* thing to do when caring for patients. One limitation in asking participants to describe their behavior is that their self-reported information that may not conform to their actual behavior in these situations.

The external validity of a research study is the extent to which the results can be applied to situations beyond the boundaries of the study sample, location, and context (Creswell, 2002). Generalizability of phenomenological findings is often weak due to the

many factors involved in the context of the research. The results may add to the body of knowledge and provide direction for further research that will be more generalizable.

Recommendations

Organizational leaders collectively deceive themselves by using events that are clear and unambiguous as an example of what is normal (Bolman & Deal, 2003). In routine, uncomplicated situations that strategy works; people can agree on what is happening and determine what is the best solution. Most organizations are complex systems, with situations that defy simplistic interpretation. When attempts are made to apply simplistic interpretations and solutions, it is a recipe for disaster (Bolman & Deal, 2003).

Leaders in highly reliable organizations (HROs) are organized to lead and act in ways to manage the unexpected and unpredictable in effective ways through a collective state of mindfulness (Weick & Sutcliffe, 2001). HROs are mindful organizations whose leaders manage the unexpected better than in other traditional organizations through a focus on the potential for failures (Weick & Stucliffe). The better performing units with *difficult* families described organized and consistent systems which they had in place for addressing situations with *difficult* families. The approach by these teams was consistent with the literature on HROs.

One step to altering the interaction with the *difficult* patient and family may be to reduce the workers' resistance to changing their approach. Overcoming resistance to change enhances the likelihood of a successful change process. McShane and Von Glinow (2005) listed six methods to deal with resistance to change: communication, training, employee involvement, stress management, negotiation, and coercion. Applying

all or some of these methods can minimize the resistance to change, thus driving forces toward the change.

Checkland's (1999) soft system model may be an ideal model for exploring *difficult* family situations. The soft system model consists of several steps. These steps include identifying the situation, describing it, defining it, identifying conceptual models that could be applicable to the situation, comparing the conceptual models to the perceive reality of the current situation, exploring the feasibility of the desired changes, and taking action to improve the situation (Checkland).

One suggestion for coping with emotionally *difficult* patients is open communication and dialogue to share ones' feelings. Senge (2006) described this higher level of communication as reflective openness, a term derived from participative management, but with a deeper meaning. A higher level of dialogue is achieved through reflective openness, through which people learn together, actually listen to each other, look inward, become aware of biases, the limitations of our thinking, and how we contribute to the problem (Senge, 2006). That type of climate begins with top leaders who are truly committed to having their people grow, be a part of the vision, and share in the responsibility for success or failure (Senge, 2006). This approach may provide insight for teams challenged by emotionally *difficult* patients and families. Reflective openness may be difficult for control-oriented leaders because it requires them to look at their own behavior, correct their problems, alter their approach and be willing to walk the talk (Senge, 2006). Further interventions may be necessary to assist control-oriented leaders to use the reflective openness approach.

While rumors and gossip tend to be destructive, story telling can be an effective way of communicating favorable organizational information either formally or through the informal channels where rumor and gossip communication usually take place (Schultz, Hatch, Larsen, & Shaw, 2002). Prior to written language, story telling was a way that ancient cultures passed along their history to newer members. Storytelling could be a way to convey information regarding successful *difficult* patient and family interactions, to role model positive behaviors, and to demonstrate positive outcomes. Compared to the typical corporate strategic outline, a good story is more believable and memorable, and generates more enthusiasm, according to Schultz et al. Finding the right story to tell and expressing it clearly can be more challenging than just making a list with bullet points, but is worth the effort (Schultz et al.) and could be a step toward changing the culture of caring for emotionally *difficult* patients and families.

Finally, having insight into ones behavior does not necessarily translate into the courage to act differently (Garman, 2001). This may be the foundation for why nurses behave negatively toward *difficult* families, even though they know it is not the right thing to do. Ignoring *difficult* patients, working around them, and treating them differently are issues reported by nurses in this study that they felt were wrong, perhaps even unethical, but they had difficulty in changing their approach.

The use of rumors and gossip by nurses may be an example of seeking support from others to justify one's behavior and not holding other members of the team accountable for their own negative behavior. The results of this study, while interesting and comprehensive, do not resolve completely the issue of how to address emotionally

difficult patients and families. Areas for further research are discussed in the following section.

Future Research

There is a need for research to further validate the results of this study. The study could be expanded at the Children's Hospital of Philadelphia to include additional participants from the units surveyed, as well as additional participants from other areas of the hospital. The added sample size would add credibility and validity to the study. The study could also be replicated at adult and pediatric hospitals in other areas of the country. This approach would validate if there are regional differences in staff and patient behavior, if the hospital cultures are different, and if resources affect the ability of charge nurses to handle emotionally *difficult* patients and families.

The list of participant questions could be narrowed in future research. The research could be focused on specific groups (such as staff nurses, charge nurses, physicians) to identify how the phenomenon is experienced by other members of the team from their own lived experience. This focus might provide firsthand information on the experience from the perspective of various members of the health care team.

Another area for further research is to explore the impact of the intervention recommendations. Participants recommended a variety of learning experiences. These learning experienced ranged from classroom experiences, role playing, conflict management courses, coaching, mentoring, and debriefings after incidents with *difficult* families.

Tools for assessing emotional intelligence could be used to conduct further research on health care workers to determine the impact of emotional intelligence on their

ability to work with emotionally *difficult* patients and families. A focus on team development versus individual skill development could also be evaluated. The best practices cited by the expert charge nurses could be framed into a presentation and intervention to improve a team's ability to care for emotionally *difficult* patients and families. Following the intervention, research could be conducted to measure if there is an improvement in the team's performance as a result of the intervention.

REFERENCES

American Nurses Association. (2003). *Nursing's social policy statement* (2nd ed.). Washington, D.C.: American Nurses Association

Anderson, W. T. (1992). *Reality isn't what it used to be*. San Francisco: Harper and Row.

Argyris, C. (1994). Good communication that blocks learning. *Harvard Business Review, 72*(4), 77-85.

Bateson, G., Jackson, D., Haley, J., & Weakland, J. (1956). Toward a theory of schizophrenia. *Behavioral Science, 1*(25), 1-264.

Beels, C. (2002). Notes for a cultural history of family therapy. *Family Process, 41*(1), 67-83.

Benner, P. (1984). *From novice to expert*. San Francisco: Addison-Wesley Publishing.

Bentz, V. M., & Shapiro, J. J. (1998). *Mindful inquiry in social research*. Thousand Oaks, CA: Sage Publications.

Berkowitz, L. (1983). Collective behavior. *New Outline of the Principals of Sociology, 57*, 145–156.

Berman, E., & Heru, A. M. (2005). Family systems training in psychiatric residencies. *Family Process, 44*(3), 321-335.

Bertalanffy, L. V. (1974). The history and status of general systems theory. *Academy of Management Journal, 15*(4), 407-427.

Block, P. (2002). *The right use of power: How stewardship replaces leadership.* Louisville, CO: Sounds True.

Bolman, L. G., & Deal, T. E. (2003). *Reframing organizations: Artistry, choice, and leadership*. San Francisco: Josey-Bass.

Bor, R., Mallandain, I., & Vetere, A. (1998). What we say we do: Clinical practice patterns of UK family therapists. *Journal of Family Therapy, 20*(4), 333-352.

Bostrom, J., & Suter, W. (1992). Charge nurse decision making about patient assignment. *Nursing Administration Quarterly*, *16*(4), 32-38.

Brendler, J., Silver, M., Haber, M., & Sargent, J. (1991). *Madness, chaos, and violence: Therapy with families at the brink*. New York: Basic Books.

Buerhaus, P., Donelan, K., Ulrich, B. T., Norman, L., & Dittus, R. (2005). Is the shortage of hospital registered nurses getting better or worse? Findings from two recent national surveys of RNs. *Nursing Economics, 23*(2), 61-72.

Butzlaff, R. L., & Hooley, J. M. (1998). Expressed emotion and psychiatric relapse. *Archives of General Psychiatry, 55*, 547-552.

Cadwallader, M. L. (1958). Three classes of social change. *Pacific Sociological Review, 1*(1), 17-20.

Campbell, J. (1988). *The power of myth*. New York: Doubleday.

Centola, D., Willer, R., & Macy, M. (2005). The emperor's dilemma: A computational model of self-enforcing norm. *The American Journal of Sociology, 110*(4), 1009-1040.

Chapman, J. (2005). Unintended consequences. *Nursing Management, 12*(4), 30-34.

Checkland, P. (1999). *Systems thinking, systems practice: Includes a 30-year retrospective*. New York: John Wiley & Sons.

Chiovitti, R.F., & Piran, N. (2003). Methodological issues in nursing research rigour and grounded theory research. *Journal of Advanced Nursing, 44*(4), 427-435.

Chung, J., & Monroe, G. S. (2003). Exploring social desirability bias. *Journal of Business Ethics, 44*(4), 291.

Connelly, L. M., Nabarrete, S. R., & Smith, K. K. (2003). A charge nurse workshop based on research. *Journal for Nurses in Staff Development, 19*(4), 203-208.

Connelly, L. M., Yoder, L. H., & Miner-Williams, D. (2003). A qualitative study of charge nurse competencies. *Medsurg Nursing, 12*(5), 298-308.

Covey, S. R. (1990). *The 7 habits of highly effective people.* New York: Simon & Schuster.

Covey, S. R. (2004). *The 8th habit: From effectiveness to greatness*. New York: Free Press.

Creswell, J. (2002). *Educational research: Planning, conducting, and evaluating quantitative and qualitative research.* Upper Saddle River, New Jersey: Pearson Education.

Daum, A. L. (1994). The disruptive antisocial patient: Management strategies. *Nursing Management, 25*(8), 46-52.

Donalek, J. G. (2004). Phenomenology as a qualitative research method. *Urologic Nursing, 24*(6), 516-517.

Ferguson, T., & Rule, B. (1983). An attributional analysis of anger and aggression. *Aggression: Theoretical and Empirical Reviews, 1*, 12–35.

Festinger, L., Pepitone, A., & Newcomb, T. (1952). Some consequences of deindividuation in a group. *Journal of Abnormal and Social Psychology, 47*, 382-389.

Frankl, V. E. (1984). *Man's search for meaning*. Riverside, NJ: Simon & Schuster.

Gadamer, H.-G. (1976). *Philosophical hermeneutics*. Berkeley, California: University of California Press.

Gantt, S. P., & Agazarian, Y. M. (2004). Systems-centered emotional intelligence: Beyond individual systems to organizational systems. *Organizational Analysis, 12*(2), 147-169.

Garland, G. (2003). Building on the success of LEO. *Nursing Management, 10*(16), 16-18.

Garman, A. N. (2001). Leading systems: Lessons from the power lab. *Personal Psychology, 54*(1), 222-225.

Goffman, E. (1959). *The presentation of self in every day life*. Garden City, NY: Anchor Books.

Goffman, E. (1961). *Asylums*. Garden City, NY: Anchor Books.

Groenewald, T. (2004). A phenomenological research design illustrated. *International Journal of Qualitative Methods, 3*(1), 1-26.

Guerin, P. J., & Chabot, D. R. (1997). Development of family systems theory. In P. L. Wachtel & S. B. Messer (Eds.), *Theories of psychotherapy: Origins and evolution* (pp. 181-225). Washington, DC: American Psychological Association.

Heidegger, M. (1962). *Being and Time*. New York: Harper Row

Heidegger, M., & Stambaugh, J. (2002). *On time and being*. Chicago: The University of Chicago Press.

Heller, B. R., & Nichols, M. A. (2001). Workforce development in nursing: Priming the pipeline. *Nursing and Health Care Perspectives, 22*(2), 70-75.

Hillman, J. (1997). *The soul's code*. New York: Jossey Bass

Honeycutt, L. (n.d.). *Hermeneutics*: Retreived on September 12, 2005 from the World Wide Web at http://www.public.iastate.edu/~honeyl/derrida/hermeneutics.html.

International Society for the Systems Sciences home page. (n.d.). *Retrieved on February 10, 2006 from the World Wide Web at http://www.isss.org/*.

Jurish, J. A., & Myers-Bowman, K. S. (1998). Systems theory and its application to research on human sexuality-the use of theory in research and scholarship on sexuality. *Journal of Sex Research, 35*(1), 72-87.

Kazak, A. E., Simms, S., & Rourke, M. T. (2002). Family systems practice in pediatric psychology. *Journal of Pediatric Psychology, 27*(2), 133-143.

Kensit, D. A. (2000). Rogerian theory: A critique of the effectiveness of pure client-centred therapy. *Counseling Psychology Quarterly, 13*(4), 345-351.

Kent, H., & McDowell., J. (2004). Sudden bereavement in acute care settings. *Nursing Standard, 19*(6), 38-43.

Koch, T. (1995). Interpretive approaches in nursing research: The influence of Husserl and Heidegger. *Journal of Advanced Nursing, 21*, 827-836.

Koch, T. (1998). Story telling: Is it really research? *Journal of Advanced Nursing, 28*(6), 1182-1190.

Korth, S. J. (2000). Single and double-loop learning: Exploring potential influence of cognitive style. *Organizational Development Journal, 18*(3), 87-89.

Lacks, R. D., Gordon, J. A., & McCue, C. M. (Fall 2005). Who, what, and when: A descriptive examination of crowd formation, crowd behavior, and participation with law enforcement at homicide scenes in one city. *American Journal of Criminal Justice, 30*(1), 1-20.

Langdridge, D., & Butt, T. (2004). The fundamental attribution error: A phenomenological critique. *British Journal of Social Psychology, 43*(3), 357-369.

LaRue, B., Childs, P., & Larson, K. (2004). *Leading organizations from the inside out: Unleashing the collaborative genius of action-learning teams*. New York: Wiley.

Lencioni, P. M. (2002). *The five dysfunctions of a team: A leadership fable*. San Francisco: Jossey-Bass.

Lencioni, P. M. (2005). *Overcoming the five dysfunctions of a team a field guide*. San Francisco: Jossey-Bass.

Lewis, S. (2005). Who was Ludwig Von Bertalanffy? *Biologist, 52*(3), 174-175.

Logan, D. E., & Simms, S. (2002). Rational approaches to crisis and conflicts in pediatric medical settings. *Family Systems & Health, 20*(1), 61-73.

Macucci, J. (1998). *The adolescent in family therapy: Breaking the cycle of conflict and control*. New York: Guilford Press.

McBride, J., & Simms, S. G. (2001). Death in the family: Adapting a family systems framework to the grief process. *The American Journal of Family Therapy, 29*(1), 59-73.

Meltzoff, J. (1998). *Critical thinking about research*. Washington, DC: American Psychological Association.

Michelson, G., & Mouly, S. (2000). Rumor and gossip in organizations: A conceptual study. *Management Decision, 38*(5), 339-346.

Michelson, G., & Mouly, V. S. (2002). You didn't hear it from us but: Towards an understanding of rumor and gossip in organizations. *Australian Journal of Management, 27* (Special issue), 57-67.

Moustakas, C. (1994). *Phenomenological research methods*. Thousand Oaks, CA: Sage Publications.

Navarre, S. E. (1998). Salvador Minuchin's structural family therapy and its application to multicultural family systems. *Issues in Mental Health Nursing, 19*(6), 557-570.

Neuman, W. L. (2003). *Social research methods* (5th ed.). Upper Saddle River, NJ: Prentice Hall.

Osher, T., & Osher, D. M. (2002). The paradigm shift to true collaboration with families. *Journal of Child and Family Studies, 11*(1), 47-60.

Oshry, B. (1966). Clearing the air in human relations. *Business Horizons, 9*(1), 35-47.

Oshry, B. (1990). Finding and using a manager's power to improve productivity. *National Productivity Review, 10*(1), 19-27.

Oshry, B. (1994). *In the middle*. Boston: Power & Systems.

Oshry, B. (1996). *Seeing systems: Unlocking the mysteries of organizational life*. San Francisco: Berrett-Koehler Publishers.

Parsons, L. C. (1998). Delegation skills and nurse job satisfaction. *Nursing Economics, 16*(1), 18-27.

Patterson, K., Grenny, J., McMillan, R., & Switzler, A. (2005). *Crucial Confrontations.* New York: McGraw-Hill.

Patterson, K., Grenny, J., McMillan, R., Switzler, A., & Covey, S. (2002). *Crucial conversations: Tools for talking when stakes are high.* New York: McGraw-Hill.

Patton, M. Q. (2002). *Qualitative research and evaluation methods* (3rd ed.). Thousand Oaks, CA: Sage Publications.

Poa, E. (2006). Trapped in transition: The complex young adult patient. *Bulletin of the Menninger Clinic, 70*(1), 29.

Putney, S. (1972). *The conquest of society.* Belmont, CA: Wadsworth.

Quinn, R. E. (1996). *Deep change discovering the leader within.* San Francisco, CA: Jossey Bass.

Ram Dass. (1998). *Experiments in truth* [Audio cassettes]. Louisville, CO: Sounds True.

Rav, Y. (2002). Perspectives on the history of the cybernetics movement: The path to current research through the contributions of Norbert Wiener, Warren McCulloch, and John von Neumann. *Cybernetics & Systems, 33*(8), 779-804.

Rosenberg, C. (1987). *The care of strangers: The rise of the American hospital system*. New York: Basic Books.

Rubin, J. B. (2003). Psychoanalysis and creative living. *Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry, 31*(2), 361-381.

Sales, M. (2002). Futures thinking by middle managers: A neglected necessity. *Systems Research and Behavioral Science, 19*(4), 367-376.

Salkind, N. (2003). *Exploring research* (5th ed.). Upper Saddle River, NJ: Prentice Hall.

Satir, V. (1972). *Peoplemaking.* Palo Alto, CA: Science and Behavior Books.

Schlesinger, L. A., & Oshry, B. (1984). Quality of work life and the manager: Muddle in the middle. *Organizational Dynamics, 13*(1), 5-19.

Schultz, M., Hatch, M. J., Larsen, M. H., & Shaw, G. G. (2002). Chapter 11: Planning and communicating using stories. *Expressive Organization*, 182-196.

Seligman, M. (1998). *Learned optimism: How to change your mind and your life*. New York: Free Press.

Senge, P. (1990). *The fifth discipline the art & practice of the learning organization*. New York: Bantam Doubleday Dell.

Senge, P., Kleiner, A., Roberts, C., Ross, R., & Smith, B. (1994). *The fifth discipline fieldbook: Strategies and tools for building a learning organization.* New York: Doubleday.

Senge, P., Ross, R., Kleiner, A., Roberts, C., & Roth, G. (1999). *The dance of change: The challenges to sustaining momentum in learning organizations*. New York: Random House.

Senge, P. (2006). *The fifth discipline the art & practice of the learning organization*. New York: Currency.

Sherman, R. O. (2005). Don't forget our charge nurses. *Nursing Economics, 23*(3), 125-133.

Sieben-Hein, D., & Steinmiller, E. A. (2005). Working with complex care patients. *Journal of Pediatric Nursing, 20*(5), 389-395.

Sieben, D. E., Steinmiller, E. A., & Bertolino, J. (2003). Nursing interventions for a chronically ill, nonadherent teenager with a psychiatric diagnosis. *Journal for Specialists in Pediatric Nursing, 8*, 121-129.

Simms, S. G. (1995). A protocol for seriously ill children with severe psychosocial symptoms: Avoiding potential disasters. *Family Systems Medicine, 13*(2), 245-257.

Simms, S. G. (2007). The symptomatic cycle. Unpublished manuscript.

Skinner, B.F. (2002). *Beyond Freedom and Dignity.* Indianapolis, IN: Hackett Publishing.

Smeltzer, C. H., Vlasses, F. R., & Robinson, C. R. (2005). "If we only had a nurse"… historical view of a nurse shortage. *Journal of Nursing Care Quality, 20*(2), 190-192.

Smith, M. S. (2005). Thinking about thinking. *The Physician Executive, 31*(3), 79-81.

Spronck, W. E. E. C., & Compernolle, T. H. L. (1997). Systems theory and family therapy: From a critique on systems theory to a theory on system change. *Contemporary Family Therapy, 19*(2), 147-175.

Strathern, P. (2002). *Heidegger in 90 minutes*. Chicago: Ivan R. Dee, Publisher.

Taylor, M., O'Donoghue, T., Houghton, S. (2006). To medicate or not to medicate? The decision-making process of Western Australian parents following their child's diagnosis with an attention deficit hyperactivity disorder. *Development & Education*, *53*(1), 111-128.

Telushkin, J. (1991). *Jewish literacy: The most important things to know about the Jewish religion, its people and its history*. New York: William Morrow.

Tienari, P., Wynne, L. C., Sorri, A., Lahti, I., Laksy, K., Moring, J., et al. (2004). Genotype-environment interaction in schizophrenia-spectrum disorder: Long-term follow-up study of Finnish adoptees. *British Journal of Psychiatry, 184*, 216-222.

Van Kaam, A. (1969). *Existential foundations of psychology.* Garden City, NY: Doubleday.

Vetere, A. (2001). Structural family therapy. *Child Psychology and Psychiatry Review, 6*(3), 133-139.

Watzlawick, P., Ekavin, J., & Jackson, D. (1967). *Pragmatics of human communication.* New York: Norton.

Weick, K. E., & Sutcliffe, K. M. (2001). *Managing the unexpected*. San Francisco: Jossey-Bass.

Weigel, L., Langdon, P. E., Collins, S., & O'Brien, Y. (2006). Challenging behavior and learning disabilities: The relationship between expressed emotion and staff attributions. *British Journal of Clinical Psychology, 45*(2), 205-216.

Wendel, W. B. (2006, Winter). Ethical lawyering in a morally dangerous world. *Georgetown Journal of Legal Ethics, 19*(1), 299-313.

Wheatley, M., & Kellner-Rogers, M. (1996). *A simpler way*. San Francisco, CA: Berrett Koehler Publishers.

Wheatley, M. J. (1994). *Leadership and the new science: Learning about organization from an orderly universe*. San Francisco, CA: Berrett-Koehler.

Wiener, N. (1965). *Cybernetics, second edition: Or the control and communication in the animal and the machine*. Boston, MA: MIT Press.

Wrathall, M. (2005). *How to read Heidegger*. New York: W.W. Norton & Company.

Zimbardo, P. (1998). *Psychology & life*. San Francisco: Addison Wesley.

APPENDIX A: INFORMED CONSENT FOR PARTICIPANTS 18 YEARS OF AGE AND OLDER

Dear Participant,

I am a student at University of Phoenix, working on a Doctor of Management in Organizational Leadership. I am conducting a research study entitled *The Role of Charge Nurses as Leaders in the Care of Emotionally Difficult Patients and Families*. The purpose of the research study is to collect information through participant responses to interview questions about their lived experience with this phenomenon. Your participation will involve responding to open-ended questions in a semi-structured interview.

There are no right or wrong responses. It is anticipated that your responses to the interview will take no more than two hours. Your participation in this study is voluntary. If you choose not to participate or to withdraw from the study at any time, you can do so without penalty or loss of benefit to yourself. The results of the research study may be published, but your name will not be used and your results will be maintained in confidence. In this research, there are no foreseeable risks to you.

Although there may be no direct benefit to you, the possible benefit of your participation is to identify the factors present in this phenomenon, which may lead to further study, training, and interventions that might benefit other health care workers, patients, and families.

If you have any questions concerning the research study, please call me at (215) 590-3177. This study uses an interview, which will be tape recorded for further study.

Sincerely,

Michael B. Grossman, MSN, RN, Doctoral Candidate

By signing this form I acknowledge that I understand the nature of the study, the potential risks to me as a participant, and the means by which my identity will be kept confidential. My signature on this form also indicates that I am 18 years old or older and that I give my permission to voluntarily serve as a participant in the study described.

_____ _____

Participant Signature Date

APPENDIX B: INTERVIEW QUESTIONS

Research Participant: _____
Registered Nurse (RN):_____
Title: _____
Institution: _____
City/State: _____
Total number of beds of institution: _____
Average daily census institution: _____
Please select one:

General Adult Hospital [ ]
Academic Adult Hospital [ ]
Pediatric Hospital [ ]
Pediatric Academic Hospital [ ]

What type of diagnoses does your primary work unit care for? _____

Section One Participant Demographics:

1. Gender: Male _____ Female _____
2. Number of years licensed as a Registered Nurse: _____
3. Number of years of nursing experience in each area:
   Medical/surgical _____
   Critical Care _____
   Ambulatory _____
   Specialty Practice (What type?) _____
   Other _____
4. Participant Age _____
5. Average number of hours worked per week:
   1. Less than 20 [ ]
   2. 36 hours [ ]
   3. 40 hours [ ]
   4. More than 40 hours [ ]
6. How many shifts do you generally work as a Charge Nurse in a week? _____
7. What percentage of the time do you work as a Charge Nurse? _____
8. How many beds does your regular unit have? _____
9. Average Daily Census? _____
10. How many RNs work on a typical shift? _____

11. How many total staff (Physicians, Nurses, Ancillary staff, Social Work, Case Management, Housekeeping, Child Life, Advanced Practice Nurses) work on a typical shift? _____

12. What shift do you typically work? _____

13. What percentage of time do you work your most common shift?

Section Two

1. Describe your typical workday, roles, and responsibilities as a charge nurse?
2. What are your responsibilities in terms of the smooth running of the shift you are in charge of?
3. What challenges do you face as a charge nurse?
4. How would you define an emotionally *difficult* patient or family?
5. Have you ever encountered an emotionally *difficult* patient or family?
6. In as much detail as possible, describe your experience with the emotionally *difficult* patient or family?
7. What resources were available to help you with the emotionally *difficult* patient or family?
8. How did it feel to be in charge when there is an emotionally *difficult* patient or family on the unit?
9. How does the emotionally *difficult* patient or family have an impact on staff relationships on the unit?
10. How does the emotionally *difficult* patient or family affect your ability to provide clinical care?
11. How does the emotionally *difficult* patient or family affect your ability to serve as a charge nurse?

12. What suggestions do you have that might help to improve the situation of caring for emotionally *difficult* patients or families?
13. Do you have any other comments?

APPENDIX C: LETTER OF INQUIRY

Michael B. Grossman, MSN, RN
The Children's Hospital of Philadelphia
34th and Civic Center Blvd.
Philadelphia, PA 19204
Main 8580
MikeGrossman@email.phoenix.edu
Grossman@email.chop.edu
215-590-3177

Salutation
Date
Dear _____

I am a student at University of Phoenix, working on a Doctorate of Management in Organizational Leadership. I am conducting a research study entitled *The Role of Charge Nurses as Leaders in the Care of Emotionally Difficult Patients and Families*. The purpose of the research study is to collect information through participant responses to interview questions about their lived experience with this phenomenon. Your participation will involve responding to open-ended questions in a semi-structured interview.

There are no right or wrong responses. It is anticipated that your responses to the interview will take no more than two hours. Your participation in this study is voluntary. If you choose not to participate or to withdraw from the study at any time, you can do so without penalty or loss of benefit to yourself. The results of the research study may be published, but your name will not be used and your results will be maintained in confidence. In this research, there are no foreseeable risks to you.

Although there may be no direct benefit to you, the possible benefit of your participation is to identify the factors present in this phenomenon that may lead to further study, training and interventions which can benefit other charge nurses. If you have any questions concerning the research study, please call me at (215) 590-3177. This study uses an interview, which will be tape recorded for further study. Your consent will be included in the recording.

As an enclosure with this letter, you will find a return postcard on which you may indicate your willingness to cooperate by being interviewed for this study. A self-addressed, stamped envelope is also included. Thank you for the courtesy of your assistance.

Sincerely yours,

Michael B. Grossman, MSN, RN

APPENDIX D: PERMISSION TO USE PREMISES

The Children's Hospital *of* Philadelphia

34th Street and
Civic Center Boulevard
Philadelphia, PA 19104-4399
215-590-1000
www.chop.edu

March 26, 2007

Michael B. Grossman, a student of University of Phoenix and an active employee at The Children's Hospital of Philadelphia has requested permission to conduct a research study: *The Role of Charge Nurses as Leaders in the Care of Emotionally 'Difficult' Patients and Families.* This project will require I.R.B. approval. If the project is approved by our I.R.B. he will have access to the premises, names and/or subjects requested to conduct the study.

Peggy Gordin

Peggy Gordin, RNC, MS, CNAA, FAAN
Interim Chief Nursing Officer
Children's Hospital of Philadelphia
gordin@email.chop.edu
267-426-6912

APPENDIX E: RESEARCH SITE INFORMED CONSENT FORM

The Children's Hospital *of* Philadelphia®

Consent to Participate in a Research Study

The Role of Charge Nurses as Leaders in the Care of Emotionally Difficult Patients and Families

Study Key Name: GrossmanM07-085480

IRB #: 2007-8-5480

Date: July 23, 2007

Principal Investigator: Michael B. Grossman MSN, RN. Telephone: (215)590-3177

Affiliations: The Children's Hospital of Philadelphia, Department of Nursing

You, may be eligible to take part in a research study. This form gives you important information about the study. It describes the purpose of the study, and the risks and possible benefits of participating.

If there is anything in this form you do not understand, please ask questions. Please take your time. You do not have to take part in this study if you do not want to. If you take part, you can leave the study at any time.

Why are you being asked to take part in this study?

You are being invited to take part in this research study because you have experience as a Charge Nurse at the Children's Hospital of Philadelphia (CHOP), which is a focus of this study.

What is the purpose of this research study?

The purpose of the research study is to learn how Charge Nurses understand and deal with emotionally difficult patients and families. I am a student at University of Phoenix, working on a Doctor of Management in Organizational Leadership. The research study is entitled *The Role of Charge Nurses as Leaders in the Care of Emotionally Difficult Patients and Families*.

What is involved in the study?

If you agree to take part, your participation will last for one interview session, taking approximately one hour. The interview will take place at CHOP or via telephone at your convenience. About 15 people at The Children's Hospital of Philadelphia will take part in the study. You will be asked a series of open ended interview questions, which will be audio tape-recorded. The tape will only be reviewed by the researcher and will be destroyed after a written transcript is made by the researcher. You will also be asked to provide information about yourself, such as your years of experience and educational background.

CHOP IRB
IRB Approval: 10/1/07
IRB Expiration: 5/30/08
Effective Date: 10/1/07

Discontinuation

You do not have to answer any questions that you do not want to and you may elect to withdraw from the study at any time.

What are the risks of this study?

It is possible that talking about difficult patients and families might reawaken some emotional memories. If a topic is difficult, you do not need to discuss it. The other risk in this study is breach of confidentiality of study data. We will destroy the tapes immediately after they are transcribed into text. We will also use an ID code rather than your name. All information will be kept in a locked file cabinet in a locked office to protect your confidential information.

Are there any benefits to taking part in this study?

You will not receive any direct benefit from this study. The knowledge gained from this study may help to provide a better understanding of the impact emotionally difficult patients and families have on nurses.

Do you need to consent in order to participate?

You do need to give your consent in order to participate?

Once you understand the study, you will be asked to decide if you wish to participate. If you wish to participate in this study, you must sign this form. A copy will be given to you to keep as a record.

What happens if you decide not to take part in this study?

Participation in this study is voluntary; you do not have to take part as a condition of employment. Your current and future role as a nurse at CHOP will not be affected if you decide not take part.

What about privacy and confidentiality?

We need to collect certain demographic data about you in order to conduct this study. We will do our best to keep your personal information private and confidential. However, we cannot guarantee absolute confidentiality. Your personal information may be disclosed if required by law.

The results of this study may be shown at meetings or published in journals to inform other nurses and health professionals. We will keep your identity private in any publication or presentation about the study.

People and organizations that may inspect and/or copy your research records to conduct this research, assure the quality of the data and to analyze the data include:

Members of the research team at CHOP;

People who oversee or evaluate research and care activities at CHOP;

People from agencies and organizations that perform independent accreditation and oversight of research;

By law, CHOP is required to protect your personal information. By signing this document, you are authorizing CHOP to use and/or release your demographic information for this research. Some of the organizations listed above may not be required to protect your information under Federal privacy laws. If permitted by law, they may be allowed to share it with others without your permission.

There is no set time for destroying the information that will be collected for this study. Researchers continue to analyze data for many years and it is not possible to know when they will be completely done.

What are my rights as a research subject?

If you decide to participate, you are free to withdraw your consent without effect to you or effect on your medical care.

You can withdraw your authorization to use and disclosure your demographic information. If you ask that we no longer collect your information you will have to leave the study.

If you choose to leave the study, but will let the researchers use or share your personal demographic information, you will be asked to fill out a form, called the "Withdrawal From Study" form.

If you do not want us to collect, use or share your demographic information anymore, you must send a letter to Michael B. Grossman, MSN, RN. In the letter you must say you changed your mind and that you will not allow us to use and share your demographic information anymore. We will then ask you to fill out a form, called a "Withdrawal of Study Participation and Consent/Authorization" form.

Even if you take back your permission for us to use your information, we may still use the information about you that we collected before you left the study.

Financial Information

The study funding is being provided by the researcher and the Department of Nursing.

What if you have questions about the study?

If you have questions about the study, call Michael Grossman at 215-590-3177.

The Institutional Review Board (IRB) at The Children's Hospital of Philadelphia has reviewed and approved this study. The IRB looks at research studies like these and makes sure your rights and welfare are protected. You can talk to a person from this group if you have questions about your rights as someone taking part in a research study. You can call the IRB Office at 215-590-2830 if you have questions or complaints about the study.

Consent to Take Part in this Research Study

The research study and consent form have been explained to you by:

Person Obtaining Consent	Signature of Person Obtaining Consent Date:

By signing this form, you are saying that have had your questions answered and you agree to take part in this research study and that you are legally authorized to consent to your. You are also agreeing to let CHOP use and share your information as explained above. If you don't agree to our collecting, using and sharing your information, you cannot participate in this study.

Name of Subject	Signature of Subject (if applicable)

APPENDIX F: RESEARCH SITE INSTITUTIONAL REVIEW BOARD APPROVAL TO PERFORM RESEARCH

The Children's Hospital of Philadelphia
Founded 1855
The Committees for Protection of Human Subjects
Institutional Review Boards (FWA 0000459)
Suite 1200, 3535 Market Street
Philadelphia, PA 19104-4318
ph: (215)590-2830 fax: (215)590-4927

Mark Schreiner, M.D.
Chair, Committees for the Protection of Human Subjects
Barbara LoDico, B.S., CIP
Director, Human Subject Research
Janine Beal-Larr, B.S., CIP,
Analyst II
Diane Cain
Resource Coordinator

Kim Davis, M.A., CIP,
Analyst II
Heather Ferrante, B.A., CIP,
Analyst II
Lorraine Kelly, B.S., CIP,
Analyst II
Kelly Riordan, B.A.,
Analyst I

October 1, 2007

Michael B. Grossman

Effective: 10/1/2007

RE: Expedited Approval of Response to stipulations
IRB No: 2007-10-5480
Title: The Role of Charge Nurses as Leaders in the Care of Emotionally Difficult Patients and Families
Sponsor: Unsponsored

Dear Investigator:

The IRB has reviewed your protocol and determined it meets the criteria for expedited approval for the one-year period **October 1, 2007** to **September 30, 2008**. Upon expiring, this protocol will automatically be terminated and archived by the IRB, as the data collection and analysis should be compiled. If you wish to continue the project past the one-year approval, please submit the request for continuing review form to the IRB no later than August 6, 2008.

Expedited approval is given to this study under Category #6 and 7 of the categories authorized under 45 CFR 46.110. The listing of research studies qualifying for expedited review can be reviewed via the following link:
http://www.hhs.gov/ohrp/humansubjects/guidance/expedited98.htm

Informed Consent: The attached consent form should be used for future enrollment purposes.

Subpart D Risk Evaluation: 45 CFR 46, 404.

Please refer to the attached Investigator Responsibility sheet for further instructions and guidance.

Sincerely yours,

Heather Ferrante

Heather Ferrante, CIP
IRB Analyst II

Mark Schreiner

Mark Schreiner, M.D.
Chair, Committees for the Protection of Human Subjects

attachment

APPENDIX G: PARTICIPANT SUGGESTIONS FOR INTERVENTIONS WITH EMOTIONALLY DIFFICULT PATIENTS AND FAMILIES.

Participants suggested a variety of interventions including training, mentoring, early planning when difficult patients were on the unit, avoiding assumptions about people, working as a team, communication with families, making psychosocial a priority, and support from leadership:

> *Participant 6:* The first thing I would do is find out why the unit is struggling so much with patients and families. It's part of the big picture of nursing to accept people where they are. Their heads are connected to their body and if the staff doesn't get that, it's symptomatic of larger issues that are making the staff hostile toward families and second guessing each other.
>
> *Training.*
>
> *Participant 1:* Training in working with difficult families is very important. I had some good training in (a course)Verbal Judo, which has come in really handy with patients and families. We also have a complex care class where nurses get to talk about working with difficult families. Nurses need to talk about their experience with difficult patients and to role play, listen to each other, and practice doing things differently in the future. Constant training in different ways of working with difficult people is important to sustaining their skills.
>
> *Participant 14:* Educational experiences are helpful: books, manuals, training sessions all are helpful, but actual experience is needed. Being a parent is a big part of having the compassion to appreciate that when a child is hurting the parent also hurts. I think the most important way to learn this is through role models.

You probably need a blend of coursework and reinforcement with role models who are good with difficult people.

Participant 3: The concepts in the Crucial Conversations course could help, but I think it's something you really have to experience to appreciate and have other staff around you that support you in doing the right thing, as hard as it may be.

Participant 8: I think classes for the staff would be helpful. It would be nice to have case studies that help you to problem solve. You could ask people, "What would you do in this situation? How would you handle this situation differently?

Participant 9: There are some courses that also helped like The 7 Habits of Highly Effective People, some leadership courses, and the Conflict Resolution course. I picked up some good habits from those courses and then as I matured it reinforced what I learned in class.

Participant 13: We have classes for our new nurses on communication, therapeutic relationships, how to give feedback, and therapeutic communications. We do a lot of classes on communication in the first 18 months of a nurse's experience. You may go to a day for clinical training but there is always something about communication thrown in.

Participant 7: It might be a good idea to offer a course in this. There is some value in discussing these things outside the acute crisis situation, when emotions aren't so high. You could do role playing, and tape them. It's good to learn concepts when you're not really living it and stressed out. The best way to learn long term is to experience something. It's certainly better to have some information up front and then to have continual reinforcement while you're living

through it. It's a skill set, but a very integral one. The important thing is it's not an individual skill set, but a team skill. It's a skill that has to be applied to the entire team and that's the challenge. It's a delicate dance, the dance of teamwork and so much more. It's like your original question what is a good charge nurse? It's probably more than the individual pieces of the role. There's not a simple formula.

Participant 1: We also do psychosocial rounds if we've had a patient of family who's been there for a long period of time and people have had a hard time working with them. Having a psychosocial round at the end of the week or during the week, just an ad hoc thing where everyone gets together to talk about what's going on can really open up great doors for insights. One person may have a tip for what worked for them. It also helps people to not feel so isolated working with the difficult family.

Participant 6: We have weekly Behavioral Health rounds, so nurses who take care of difficult patients are encouraged to come to rounds to get ideas on how to work with them. We discuss ways to get things done with the difficult patients. There are psychologists, psychiatrists, social workers, and child life workers there. Sometimes it helps for nurses to hear how other disciplines handle these situations. We do the meetings at lunch time on a weekly basis. We often order out for food, and set up the food in the conference room. So, in order to get the food, they come in the conference room and then we have them stay for rounds.

Participant 7: Child life workers can also be helpful, and Ronald McDonald House can be a great resource to give families a break from the hospital environment and have a less stressful place to sleep at night.

Participant 3: Usually after a child passes away or we have a difficult encounter, we'll have a debriefing (psychosocial rounds). Usually a lot of things come out in those forums. A big split between staff often comes up around end of life issues. The family may want the child on a monitor and the staff feels like it's not necessary if they're a Do Not Resuscitate (DNR). The staff feels like the family will focus too much on the ups and downs of the monitor. We had a patient who had a stroke in the ICU. Two days earlier she was perfectly fine, neurologically and now she was on a monitor. The staff wanted to know why she was on a monitor. The family wanted her on a monitor because she couldn't communicate because of her stroke and they only way they (the family) could tell she was in pain, was because her heart rate would go up and usually they (the family) were correct. The family was also afraid she would die in her sleep, and they wouldn't even know. The only way the family could get a good nights sleep, was knowing the monitor would alarm if her heart rate slowed down and it would wake them. When you hear that coming from them it makes a lot more sense. When you hear their reasoning it helps you to understand. Unfortunately people are too quick to judge families. It gets back to the original question: who are we taking care of the family, the patient, or both?

Participant 5: We have a bereavement committee made up of staff nurses, mental health CNSs, physicians, Child Life, and Social Work. The main focus is

debriefings after a child has died, but you can also call a meeting to discuss a general care issue. It's hard to get people to these given our staffing challenges. We have also consulted the Ethics committee about some of these cases.

Participant 2: Not everyone agreed things can be taught in the classroom:

I don't think this can really be taught in the classroom. Even role playing is too safe. It's different when you're in the middle of the drama. Some of it you can't see until you have the maturity level to see it.

Participant 3: "I don't think you can teach this in a course".

Participant 4: "I'm not sure you can teach this to people in a classroom".

Participant 6: "The best way to train people about this is on a one to one basis. You need to role model how to treat families and talk to nurses one at a time".

Training alone is not sufficient to developing skills as a nurse with emotionally *difficult* patients and families. The expert charge nurses reported that real life experience as a patient or parent was valuable in gaining a perspective about what patients and families were experiencing.

Experience as a patient or parent.

Participant 14 explained how he learned from his own son's illness:

My son was once having blood drawn and the nurse wasn't using good technique and I made her stop. It was stressful for me. It made me anxious to watch my son going through unnecessary pain, but I also realize it was uncomfortable for the nurse and made her anxious. But, I needed to do what was right for my son as a parent. So maybe I was a difficult parent to that nurse, but it's o.k. from my perspective that I did that. It's also o.k. from my perspective if a parent wants to

step and challenge me or it should be o.k. I realize that people act out when they have no control.

Participant 15 discussed her chronically ill brother, which provided her with insight into difficult families:

I have a brother who is 19 and sick. He's actually followed here as a patient. Over the years I watched my mother deal with doctors who didn't understand things and would want to do things that had already been done. I think having a sick brother impacted on my impressions of difficult people, because I was probably a difficult family to my brother's care providers. He was initially treated at another hospital. My parents were happy that I had clinical knowledge, and the whole unit knew within minutes where I was from and who I was, because I walked in and looked at his pumps instead of staring into space. Thinks went fine until he had complications and I quickly understood why families get frustrated so fast. He was unresponsive after surgery and I asked a few questions. I was very calm, but I wanted things done. I wanted some physicians in there and the nurses got defensive. I wasn't yelling and screaming, but I still think it upset them that I was crying and couldn't calm down enough to have a normal conversation. But, I was very frustrated with them because things were going wrong and I felt helpless. I think that might be why someone makes an issue of having a single room. You can't control your kid getting better, but you can at least get them a big single room.

Participant 2: …nurses also need to experience what it's like to be a patient. You might not get this by observing a family. You need to actually experience a few

> days in a hospital on the other side to fully understand it. People who have been a patient or had a loved one in the hospital are more compassionate, empathetic, more patient and understanding, with families.

Participant 6 did not have a sick sibling growing up, but still learned the importance of caring for younger siblings:

> I have always been interested in this kind of stuff. Some of it I think was because when I was eleven I went to the state soccer championships by myself and I had to learn to be resourceful. I was the only girl in my family and was raised to take care of myself and be in charge of my brothers when my parents weren't around.

Teamwork was found to be important, when caring for emotionally *difficult* patients and families. One important aspect of teamwork is the mentoring of other nurses in the best practices of caring for these families, which is discussed in the next section.

Mentoring.

> *Participant 2:* You learn the skills of a Charge Nurse by doing the job, going to team meetings, watching other Charge Nurses, learning what works with one family and what doesn't work with another family. It's like a constant debriefing session. You ask yourself, what really went well here and what didn't go so well. Charge nurses need to spend time observing other Charge Nurses. The Charge Nurse shouldn't be picked by them, but should be picked based on Charge Nurses who have the desired skill set. The important thing is they have to work with a Charge Nurse on a day when there's a lot of drama going on so they can see how the Charge Nurse handles it. But, nurses also need to experience what it's like to be a patient. You might not get this by observing a family. You need to actually

experience a few days in a hospital on the other side to fully understand it. People who have been a patient or had a loved one in the hospital are more compassionate, empathetic, more patient and understanding, with families.

Participant 4: I wouldn't just throw people in charge because nobody else will do it. I would assess it first and see who they currently have in charge and whether they're the best people in terms of their conflict resolution skills. (Participant 9) The biggest thing that helped me was becoming a charge Nurse. Knowing you're the go to person makes you take the time to understand situations. The more people come up to you for advice the more you realize you need to be a role model for others. The more successful you are in helping the team, the more you want to be a role model. I'm not sure you can teach this to people in a classroom. What helped me was senior nurses, charge nurses, and CNS's communicating with us right as it was happening was the most effective intervention. Discussing these stories at staff meetings really helps. The more you talk about it the more you feel like you're not alone.

Participant 15: I learned to be a charge nurse from another senior charge nurse. She instilled in me the concept of being a resource and not necessarily having to know everything yourself. You don't need to know it all yourself, you need to know who your resources are. In our ICU we get all kinds of patients with all sorts of diagnoses. So if I need help I'll call the referring unit that specializes in that diagnosis, for help.

A key concept the expert charge nurses mentored novice nurses about was that emotionally *difficult* patients and families need to be identified early on in the

hospitalization process so a plan can be established and minimize distress for the family and staff. This topic is discussed in the next section.

Early planning.

Participant 4: Often we think they're only going to be here a short time, but then they end up staying longer. When we realize they're not going away we start to take it seriously and develop a plan.

Participant 6: "When a difficult family comes in you realize it immediately on admission or when the first stressor comes".

Participant 7: …we identify very early on that this is a patient/family that need an extra level of support. They need a primary care team. We ask for volunteers, and sometime strongly encourage other people who we know would be good in this kind of situation. When we work as a team, you don't have to go through the long family history again and again, because the team knows the history and you can focus on what's happen in the last few days. Then everyone else isn't focused on this patient. Their job is to take care of the rest of the unit, so that the primary care team can do their job of focusing on that challenging patient.

Participant 10 described their units Difficult Family Protocol:

The difficult family protocol is a set of actions, but the primary one is the buddy system. The family may or may not know they have been labeled as difficult. Usually there are multiple people involved in setting up the system and the family is told that we feel like there has been some miscommunication so we are going to send in a buddy with anyone who meets with you, so we can keep the lines of communication clear…Once a family is identified as difficult, by nursing or

another member of the team, we meet as a team, discuss it in rounds, and put in place the buddy system. The way it works is anytime you go in the room, you bring someone with you, the buddy. So you leave rounds in the conference room, and go in to tell the Mother what was decided at rounds regarding the patients care. Later the team does walking rounds and comes to see the patient and they change their mind. So, they tell the Mom a different plan than what I told her this morning. The team didn't tell me the plan changed. Now I come back in the room, not knowing the team just met with her and explained a different plan. The mother tells me we're doing things differently. I'm not aware there was a change. The mother is mad because I don't know what the rest of the team is doing. Now with the buddy system, every time someone goes in the room, a buddy goes in with them so they hear what is being said. The Mother may also have misinterpreted what was said. The buddy is like a second set of ears. The other thing the buddy can do is help the nurse to extricate herself from the room if there is too much tension between the family and the nurse. This is not just a nursing buddy system. Anybody on the team who goes in the room takes with a buddy. It needs to be done consistently to avoid any friction or miscommunication.

Participant 1: If I know there's a difficult family I introduce myself as the Charge Nurse, so that if there's an issue later, they know who I am and our first encounter isn't them yelling and screaming. We do team nursing and let the rest of the team know, so they can support the nurse with the difficult family. We like to partner nurses with certain personalities that will work well with the family. Some parents

just want continuity, so we try to put the same nurses with them. Other families need stronger, more senior nurses to handle them. (Participant 15)

There's often a snowball effect, where you can trace back to the original problem that started and it may have just been two days ago someone was rude to them and they've harbored that resentment toward the staff and it just keeps going on and on. So if you recognize from the beginning that you have a tough patient or family that has issues, setting up a very clear plan with limitations and communications with every member of the team really stops things from getting to an explosive situation. But, that takes a lot of work and a lot of organization in the beginning, first to recognize it and to get the pieces in place. It can take a whole shift or a whole day to get together. If everyone is not on the same page at all times the plan can fall apart. The time it takes in the beginning seems like a lot, but in the long run it's far less than the amount of time you spend if the situation blows up.

Participant 6: I make a list of this is who the patient is, this is their diagnosis, and this is what I feel is going on. The Behavioral health team makes rounds every morning and asks if there are any cases they should see. So I refer the ones who have potential issues.

Participant 4: The more difficult patients you have, the better you get at caring for them, but it never gets any easier. Every situation is unique and every time is a unique learning experience. You learn what to do: call a staff meeting; involve Social Work, Psychology, Psychiatry; make a plan; communicate the plan to everyone; hold each other accountable; and have follow-up meetings if the situation changes. If you don't see difficult patients a lot it's more difficult to

mobilize yourself. With us we realize in about a week that we have another difficult patient and we need to kick our plan into gear.

Participant 7: We have an E-mail list and we send an E-mail to everyone on the team saying: these are the things that really worked on this shift, and these are the things that we found were problematic and we should avoid. It's a way of saying: these are the things I did that the Mom really liked and she'd like to see more of, and when I did this one thing, or the Mom told me about this one thing and it's something that is a source of tension or stress that's not helpful. So it's a way of externalizing it such that it's not person.

Participant 8: Many of these cases come from difficult families and building a schedule of routines, providing therapy and treatments at specific times daily is important. A lot of times that goes a long way with the patient's temperament. At first they may resist it but over time they get used to having a routine.

Participant 4: It's like the grieving process. When they first come in you're in denial. You can't believe you have another difficult family and you're hoping they'll just go away. But then you realize a few days or a week has gone by and they're still there. Now you get angry, maybe start to retaliate. Then you try to bargain: if only I don't have to care for them, or maybe we can transfer them to another unit? Finally you accept that situation and at that point, you accept the fact the child's not leaving anytime soon and so you have to come up with a plan, have weekly meetings, and make sure everyone is consistent in what they're doing.

Despite early identification and intervention, it is important to appreciate the stress a family is under, which could be causing their reaction. Expert charge nurses avoiding making assumptions about people, which is discussed in the following section.

Avoid making assumptions about people.

Participant 3: The number one thing is don't jump to conclusions. Ask questions; listening to families; don't listen to other staff gossiping about families, seek the facts yourself. Talk directly to families, ask questions yourself, let the family talk, and listen. It's impossible to put yourself in their shoes, but if you're a little bit on edge today it's o.k. you just found out your kid was diagnosed with cancer. You go ahead and be who you are. Ask the family, "what can I do to make this easier for you? What can I do to help." I don't think I'm a unique nurse, I try to be appreciative of the parent's perspective, but sometimes I take it personally too. It's not easy to have people yelling at you or insulting your skills as a nurse.

Participant 15: I think the term difficult has a negative connotation to it, but people know what you mean. You could call them emotionally charged, because I feel like that's what they are. They're having an extreme of an emotion. Does it make our job more difficult? Probably it does. Sometimes in report we are told the parents dropped off the child and just left. It's not that they are demanding or angry, but their way of coping seems foreign to us. That can be just as difficult as the parent who's standing there yelling at you.

Participant 14: I once had a mother where I walked in the room and she immediately started yelling at me. Initially I felt like yelling right back at her. But,

then I thought I don't even know this woman? I've never seen her before and she's never met me. She couldn't be this angry with me. Something else had to be going on. So, I told her I forgot to do something and promised I'd be back in five minutes. I left the room and composed myself. Sometimes in that kind of situation I'll talk to another staff member to get it out of my system. Then I went back in the room, but started the conversation differently. This time I said, "You seem really overwhelmed, what's been going on." The Mom shared what she'd been going through with her chronically ill child, how she came to the ED, everything that had gone on in ED, how long it took to be seen, the long wait to get a bed, and how nobody knew what was wrong with her child. She was frustrated. It wasn't about me. I was just standing there when it all caught up to her and she exploded.

Participant 9: I've learned through experience to listen first before assuming and reacting to them. I watch senior nurses who get into it with families and I don't know why they don't get it. Maybe they just like to be confrontational. Maybe they think they know what's best and they defend it. Some of the older nurses had an attitude that you need to be tough with these difficult families or they'll walk all over you. But, that attitude has changed a lot on our unit in recent years.

Participant 14: Sometimes there is a suspicion of abuse and you just have to swallow your judgment at the time because you don't know. Somebody comes in to the ED and their child has been beaten or dead and nobody knows what has happened. It may be clearly pointing to one person, but you don't really know. We had a situation on the inpatient unit where a kid was beaten really badly and

everyone suspected it was the father. In change of shift report nurses would report rumors, that the father did it. The father was allowed to be at the bedside with the mother, and I tried to treat him normally. I kept saying to myself, "Just don't judge, just don't judge," over and over. I'm glad I did that because eventually it turned out that the babysitter had beaten the kid. I felt bad for the family for what had happened to the kid, but they must have felt like every person who came in their room was questioning whether they had hurt the child.

Participant 10: I think we ask a lot of parents and forget that they are stressed, that they need a break, and that they do this every day at home, so when they come in the hospital they don't want to do all their child's treatments. They do it every day at home. So for one night can't we give them a break and give their kid their treatment. So, that's why you need to ask. One parent wants a break, the other does it at home and wants to do it here. Nurses make a lot of assumptions about parents. Just because a mom is changing her kid's diaper, feeding the baby, changing the bed, doesn't mean she wants to do everything. The other day a new nurse came in and did nothing to make the mom happy. I came in as the Charge Nurse to hear the mother's complaints. She said she just wanted some help. The nurses had been reporting that the mother does everything for the child. The mom said, 'If my nurse's assignment is too busy, can you give me a different nurse or send in another nurse to help my nurse so I can get some help.

Participant 6: A lot of families are stressed on admission and you give them the benefit of the doubt, because you know that is a stressful situation. Some people just aren't going to follow the rules, you can tell that almost right away. The

behavioral health ones have pre-existing psychological problems. They may be a suicidal risk, the may be receiving behavioral health services outside the hospital. When a patient arrives and is agitated, I think right away that they probably had problems somewhere else in the system, maybe in the ED, maybe in the ICU, perhaps in clinic, or maybe they're still agitated because of something that happened on their last admission. So I'm thinking that the next thing we do may also set them off.

Participant 13: They might behave in a different way than how we might behave, but everyone is different. Most people don't look at it the way that I do. Most staff just get really frustrated and don't want to deal with it. Then they end up not updating the family, because they're too afraid that anything they say will cause more tension. Where if they did just speak to the family more often it would deescalate the tension.

Participant 7: I don't think you should label people because it impedes partnerships. By calling families "difficult," it sets up and us and them situation, it's not a partnership. If you're really interested in "difficult" families, the term sort of undermines the good work you're trying to do. Are they difficult or should we own some of it. Families are what they are and certain situations challenge our skill set. I'm not saying there aren't difficult families, because some people truly are difficult. But, a lot of times they just aren't able to articulate their needs and/or an inability of the nurse to elicit the patient or families needs. Frequently what we view in a non-difficult patient situation is read the parents mind, because we've been through this clinical situation a thousand times and we assume we know

what the Mom is thinking, because in the past, that's what Mom's thought. We say, "I bet you'd like this, wouldn't you?

Participant 5: Some nurses aren't so quick to judge people because they've had a sick kid themselves. I mean what could be worse than having a sick child dying in the hospital? But others are quicker than others to judge a family. Sometimes you have to remind them of that, as a charge nurse. Sometimes when you're away from the heat of the situation, you can take a step back and appreciate what the parent is going through. Other staff feel like there is no reason (for families) to ever treat people (the nurse) badly.

Participant 14: Sometimes it helps to just pretend that everyone you're dealing with is a toddler. Some days I just pretend that everyone is a child or I try and think of what they were like when they were an innocent child. That gives me a little more patience to deal with them. It's a silly little trick, but that sometimes that gets me through some tough moments with difficult people.

Participant 3: Nurses also have their own internal struggles, for instance a nurse could have lost three special patients in the last year and doesn't want to make the effort to get extra close to somebody. So maybe if you know that, you realize the nurse and patient are not going to connect on a deeper more meaningful level.

Participant 15 attended a funeral where the family revealed that they knew they were difficult:

That was the only patient funeral I ever went to and they gave a eulogy that was just incredible about how they knew they were difficult and they knew that sometimes when they yelled it hurt the staff's feelings, but that they were just

doing it for their daughter. I think that is one type of emotionally draining family. It does affect you. You leave and you think about them. On your days off something reminds you of them. I think with that particular family it was the cumulative effect over time of all the things they went through.

Participant 6: Cultural diversity can also be a factor in the assumptions staff made about difficult families. "I think there are different types of difficult people. There are the ones who are just annoyed because they didn't get what they wanted. Some are culturally different than what we're used to. So I look up information about their culture to try and understand them better. It may not be that they're being mean. For instance a female Muslim can't be in the room with a male nurse, without their wrap on. It's not that they don't like the male nurse. I look to see if they're having a bad day or there are deeper emotional issues. The important thing is just getting to know each person individually. Every person is unique. You could have three Indian families, but each one is from a different region of India, so what applies to one doesn't apply to the other.

Sometimes you'll have nursing complaining about a mother who doesn't do any of her child's care. But the Grandmother is the primary care giver at home.

Participant 14: One of the experiences I had was being a Home Care Nurse for 5 years with chronically ill kids. I gained an appreciation of what it's like for a family to have a chronically ill child 24/7. The chronically ill child becomes the number one priority for the family and everything revolves around that. It's really sad and when you've seen that, you're not as quick to judge the parent's behavior. You want to be a little more patient with them, when you know they're never

living that kid's side and you get to. As hard as that child is, you get to leave and go home to your own life. They never get to leave. I give them a little more empathy, treat them a little more kindly, or a little more patient. That comes from experience and maturity I think.

The dynamics of labeling patients and families will be discussed in greater depth in Chapter 5. Labeling can lead to rumors and gossip, which can undermine the team's ability to work together cohesively. The following section will review the participants experience regarding the importance of teamwork.

Working together as a team.

Participant 7: . . . the teams that are successful are interested in how can we work as a team to figure out the system of care that works for the family, so that we can teach that to everyone else so they can do it too. Isn't that what health care is all about? It's not about me (the nurse) it's about them (the patient). It's me going home at the end of the shift and the next nurse being able to provide the same care. It's just that difficult patients and families are harder to figure that out with. Most patients and families you make a care plan, we all do the same things, and it doesn't matter who your care provider is. With difficult patients and families, their needs are so specific and intricate, and not explicit enough, so it's harder to figure out the plan.

Participant 1: You need to join together as a team so that everybody is on the same page. You need to have a meeting where the full plan is discussed and everybody is clear on the plans. That way if any physician, nurse, or anyone on the team speaks to the patient or family it won't be different than what the next

person goes in and says. Sometimes you'll go in a room and tell the family something that you didn't realize is contradictory to what another staff member told them and it leads to a confrontation. If you're not on the same page it creates a very difficult situation with an increased potential for one saying one thing and another saying something different. You can also have the situation where the family hears one thing from the physician but says something different to the nurse, which then can cause splitting between the doctor and nurse if the nurse assumes what the family is saying is what the doctor really said, which it may not be. So if everyone is on the same page and communicates it physically together, the likelihood of issues with miss-communication are minimized. Ideally the nurse and doctor are in the room at the same time, and the nurse can repeat back to the family, 'So this is what I hear the doctor saying and this is what we are going to do for the plan.

Participant 3: Sometimes if we're having difficulty with a family we'll send in the nurse who has the best rapport with them to talk to them. The family may be more receptive to hearing feedback from someone they trust. Today's family incident is just a snapshot it time. If I've been with the family all along I understand all the dynamics and today is not a normal day for them. I understand all the things behind it because I've seen the other side of the family. The family also knows me as more than just the nurse. They know what I'm really like and so they're able to hear me when I say whatever I say.

Teams work together to provide the best experience for emotionally *difficult* patients and families. One aspect of teamwork is sharing in the stress of working with emotionally *difficult* families, which is discussed in the following section.

Rotating assignments.

Several participants described the need to rotate assignments so no one nurse was with the difficult family day after day:

> *Participant 5:* It can impact to the point where the nurses don't want to take care of that patient anymore. Some nurses may have a good rapport with the family and they get stuck in there all the time. Parents will come to the Charge Nurse and request certain nurses. Some people make lists of who can care for their patient. Some nurses are thankful not to be on the list, so they don't have to care for the "difficult" family. Other nurses feel bad their not on the list. So you have a group of people the family wants, a group they don't want, a group they want and the nurse doesn't necessarily want to take care of the patient. I may be on the list because the family likes me, but I don't want to be on the list. But at a certain point you can have only a small group of people that can care for this patient and none of them are here today. So I go in and you don't know the kids routine, the family says, "We do it this way," and you don't know what to do. The problem is the family gets used to the small group of nurses doing things in a very specific way, because they really know the kid and then I get thrown in there and I've never taken care of the kid who's been there for six months and now I'm doing something different because I don't know the routine and the family is frustrated with me. Then I get frustrated. Sometimes the nurses who were caring for the

> patient had bent the rules and done something in a different way and then you come in there and you're the new person doing it according to policy and the family gets all upset because they've been doing it another way. You also don't know if the parents are being honest with you. The may say the nurse was doing it this way, but the nurse wasn't really doing it that way. So now the family is splitting the staff, because you may believe what the family said about the other nurses, which may not be true.

Teamwork is not just about sharing who will care for the emotionally *difficult* patient and family today. Another dimension of teamwork is supporting each other in day to day interactions with the emotionally *difficult* patient and family, which is explored in the following section.

Support each other.

Participant 15: Sometimes families need to talk to someone in authority. It can be a physician in a white coat, a Charge Nurse, or the Nursing Supervisor. It can be someone with the same training as me, and the same amount of experience, but that's who the parents want to talk to. So alerting those people and having them in place and available, is important. Security does a great job. Sometimes they'll just wander around the unit and make sure the parents see them. We also have a panic button we can push and Security will come up immediately. They may just walk around the unit, or help us clear out too many visitors in the patient's room. It's hard to walk in a room with 50 people, by yourself and ask them to leave. Security is helpful in those situations.

Participant 5: "Nurses need to talk about it and support each other. They need to get a break so they don't have to take care of the difficult family over and over again".

Participant 7: There are some concrete things you can do like making sure people get breaks both during the shift and that they're not taking care of a difficult family endlessly. People need a break from the difficult family for a day or two periodically.

Participant 10: I usually ask the nurse if she can take the difficult patient again tomorrow or does she need a break. People can't take care of the emotionally charged patients day after day. It's easy to keep using the same people, but the Charge Nurse needs to pass along to the next charge nurse, that Suzie (the nurse) needs a break. Nurses aren't always good at setting their own limits and Suzie

will say it is o.k. for her to take care of the difficult patient again tomorrow when it really isn't.

Participant 12: Our nurse manager is very good at dealing with families. She has a philosophy that you just need to deal with it. I think that's good, because people don't let it go. Things get worse if you don't handle it early on. We have some strong, experienced leaders who just handle it because they've had a lot of experience with those kinds of families.

Participant 6: I make sure everyone's assignments are fare and helping out the ones who do have a bad assignment or something goes wrong with one of their patients. I do that by checking in with them every half hour to hour with each nurse individually to make sure everything is going smoothly and to answer any questions. I usually sit in the nurse's station so they know where they can find me. Sometimes I have three or four nurses lined up to ask me questions, but then I always know everything that's going on all day long with each nurse and their patients.

Participant 4: Sometimes the families try to question you about why the other nurses do things differently. You have to be care what you say or you end up with the staff making judgments about each other. Nurses will start gossiping about each other and you can get into believing the families and altering who takes care of them based on the stories. But, at some point you need to realize you're a team and we all have to share taking care of the difficult families. Otherwise everyone starts refusing to care for them.

Participant 1: Having immediate support at the end of a tough day or a rough week with a difficult family is invaluable. Saying things to nurses like, "How's everyone doing? Melissa you look like you've been having a tough day? Are there ways we can help you? How are you feeling about what's going on?" Sometimes people will explode and cry and other times they will vent and be angry. Everyone has a little different way of expressing themselves, but just giving them the chance to put it on the table in a non-threatening environment makes a difference. Nurses like to share stories and so when one person starts to share a story about something that happened to them, it helps the other nurses in the room to feel like they are not alone. The same thing can happen if you just communicate to people throughout the day, "How's your day going? You look tired, you look frustrated, are you o.k.? You look like you're ready to explode?

Participant 3: Our staff is very close and very supportive in Oncology. We do some very hard stuff and you really need to stick together, because it is so hard. After a difficult situation we have a debriefing with a psychologist, social worker, Mental health CNS, or someone from the Palliative Care Team. All the staff get together, talk it through, figure out what went well, and how are we going to take care of ourselves. These debriefings are especially helpful for younger staff because they've been traumatized and it's helpful for the more senior nurses to say, "One time this happened to me and here's what I did. You did what you had to do in this situation, you did the right thing."

Participant 4: I try to tell staff it's not personal, these families are generally lashing out at everyone. They don't single out one single nurse to pick on. But the

nurses still feel like, “I’m the worst person. They hate me.” It’s not about the nurse it’s about the family’s loss of control, the bad news they’re getting about their kids care, so they just lash out at people to give themselves control over something. When you point it out to staff the usually appreciate the different perspective, but it still is difficult to come to work knowing you’re going to get yelled at and feel like you’re giving crappy care. The staff just need encouragement, which is sometimes all you can do as a charge nurse.

Participant 9 reported that their unit held a lot of parties:

“We do that around the time when we’re the most stressed out”.

Participant 3: A lot of our nurses have relationships with each other outside of work, because our own families can’t understand the intensity of what we see and do everyday. It helps having people (other staff) you can call after work and tell them what happened today at work.

Participant 1: Our psych. care specialists often do 1:1 with patients and have their own ideas about how to manage things. Often the communication between the psych. Care specialist and the nurse is not great. Other times the communication is great, which can alleviate a lot of potential issues.

The foundation of supporting each others is communication. Communication manifests in many forms from one-to-one communication, to communications to the entire staff via formal mechanisms. The specifics of staff communication are explored in the following section.

Staff Communication.

Participant 7 discussed the importance of communication with a particularly difficult patient on their unit: “They sent E-mails during the week so everyone knew the plan, were consistent, and could give the best care to this child and family”.

Participant 3: It is important to communicate information to the entire team, so everyone knows the latest information about what is going on. That information was giving in between shift report, but it’s like “whisper down the lane.” Each person that tells the story embellishes it a little bit and the story changes. I would hear the story and it had changed again, so I would retell the original version. People forget, they alter the story, they get busy.

Participant 5:People talk about this kind of stuff, whether they’re involved in it or not. The stories also get embellished as it gets passed along, just like any gossip. It makes the story better, if you embellish it. Mostly the people involved in taking care of the family talk about it, but people who aren’t even involved talk about it too.

A major goal of communication with the staff and team is how information is conveyed back to the emotionally *difficult* patient and family. The details of how communication with the family is ideally achieved is explored in the following section.

Communicating with the family.

Participant 7: You have to all communicate. The more consistent the communication with the family, the more you partner with families, the more everyone is on the same page, and the better things go. This is true for anybody, but is especially important with ‘difficult’ families.’

Participant 3: …it's important to get to know the family, to know the reason behind why they feel the way they do, and then you know how to approach them. So, I sat in the end of a family meeting we had with them, when the physician was reviewing with the mother how she (the patient) would die, and he said she would stop taking deep breaths, and she would build up C02 to the point where she would become less with it. So I was then able to go back to the Mother afterwards and remind her of what the doctor said, that if we keep giving her pain meds it will further depress her breathing, which will hasten her death. Knowing how much the Mom loves her daughter, that she wants it to be painless, but also wants her to be comfortable reaffirms that there is a fine line. We want her comfortable, but we don't want to sedate her so much that she stops breathing from the medication. We know they want to get back home and be with the rest of their family and spend time with everybody else. Mom also has a friend how adds to this. When the Mom is too tired to fight, the friend takes over arguing with the staff. The night the patient almost had a respiratory arrest, I said to the friend right up front, before she could argue, 'Look she was on too many pain meds and she could have stopped breathing and died.' The friend responded, 'Oh thank you, thank you,' instead of arguing with me. Then I went to other nurses and told them what was going on. I told the other nurses, 'this is why they're so anxious, this is why they're hyper-vigilant. Maybe if you took an approach of talking to the family outside the room, not in front of the patient, because she's already anxious: this is why she (the patient) is so anxious…' The issue is the patient gets anxious, then the Mother gets anxious, they feed off of each other and then they both get

anxious. So getting to know the patient, getting to know the family, talking to them, all contributes to understanding the reason behind they do what they do leads to an open dialogue where you don't necessarily tolerate the situation more, but you can handle it better because you become more patient because you know they're just scared and there are different approaches for helping them to be less scared.

Participant 13: We have a patient right now, where the mother is very relaxed and laid back, but the father needs a lot more communication. It seems like the father needs to be updated more than the one time a day that the doctors feel is all anyone needs. Sometimes once a day is not enough depending on the acuity of the patient and other factors. They have a five year old also, so they take turns as to who is at the hospital. When mom is here it's a better day. When the dad is here it's a little more difficult. When they are here together, the mom tries to deescalate the dad, but it doesn't always work.

Participant 1: . . . give the family realistic timelines, of when things will happened then the family will be more relaxed because their expectations aren't unrealistic. So when you think of the dynamics that happen to someone who may already be emotionally challenged, or have psychological issues, it's not surprising that lack of information will send them over the edge. With younger patients it's often fear, not having realistic limitations set, and not having developmental appropriate activities for them to do while they're in the hospital. Having Child Life involved early in the admission is helpful to create diversionary activities for the patient, to avoid an escalating situation. The key

with parents is communication with them. But, if you have a parent who has underlying psychological issues it may be more difficult. If situations truly escalate you may even have to bring in Security. Those people may no longer be in control of their behavior and are beyond the point of talking to them.

Participant 7: …families are very supportive of you, as a charge nurse if you're sincere and honest with them. If you go to them and say, "I'm really sorry I don't have a private room for you, but I'm going to put you first on the list to get you one." Even if they're unhappy, if they believe you are sincere, they will smile and be o.k. with it. They feel like you really care.

Sometimes the lack of availability of physicians hindered family communication:

Participant 5: They (physicians) come in and make rounds very early in the morning, when parents aren't around and usually aren't out of the O.R. till later in the afternoon. So, if the families aren't there or the family is only in on the weekend because they work they don't even see them. The nurses get very frustrated by this, but I'm sure it's also frustrating to the physicians too. A physician can go in and update a family in five minutes, and the nurse is at the bedside for 12 hours with the family. The nurses are the ones who have to deal with it. One of the other challenges is our attending physicians change weekly, so it's hard to build the momentum to have a formal plan.

Participant 8: Physicians are different depending on their level of seniority. The Resident Physicians were not as engaging as they could have been, with this particular family. They never said it, but it felt like they wanted nursing to just deal with it. Sometimes a physician would say, "She's (the patient) flipping out,

you might want to go in there." Or they would purposefully avoid the patient when she need needed some specific information. They would say to the nurse, 'Can you tell them blah, blah, blah?' I felt like the physicians pretty much avoided the room unless they had to speak to the nurse about something. The Attending level physicians were fairly involved, but the residents are the ones who are really there day to day, and they tended to avoid it all. If you asked an attending to meet with the family they were fine with that.

Participant 15: We also have fellows who are physicians in a three year program after completing their residency. They really run the ICU. They are very helpful since they spend a lot of time on the unit and really know the patients and families. Sometimes all it takes is a person in a white coat to get the parents calmed down. We don't tend to use the Residents (physicians) because we have a stronger bond with our fellows and they're always there. The Fellows are also the ones who are really involved with the sicker kids. The Fellows really follow the care and the resident may not even know what's going on with the patient and have a knowledge base enough to deal with the issue.

Participant 6: Many of our patients are chronically ill and are used to seeing the same doctor on their outpatient visits. When they are admitted to the hospital they are often surprised that their doctor isn't the in-patient doctor and he has twelve other patients he's caring for, and he's doing procedures. A lot of these patients get upset that they're not the only focus of the physician's attention. It's not just the long-term patients. Even some of our newer patients or parents who manage

their child's care at home want things done a certain way and don't understand when it's not done in their time range.

Participant 7: Generally our physicians are very involved in these cases. If we go to them and ask for help, the have a range of responses. Some physician's will say, "I'm not really interested, this is a psychosocial issue." For some physicians if it's not a specific medical issue it's not what they're here to do. Then there are other physician's who are totally partnered with the staff to the point where they can influence the family to have a breakthrough or to help the staff to see how they are contributing to the difficulty by triangulating the family. Sometimes the physician helps families to see their demands are unrealistic and perhaps they need to find another health care provider. The physician relationship can make or break these situations. If the physicians doesn't partner with the staff to resolve issues with families, it can feed into the family's issues. Where as, if the physician is involved with the staff in designing a plan in partnership with the family it tends to go better.

Participant 1: We also use message boards in the room so there are several means of communicating the same message clearly to both the family and other team members. That works really well when it's done. But, when messages are not clear the nurses feel frustrated that they have a family yelling at them because they weren't aware of the plan or didn't have all the information of what the physicians told the family. So when the communication between the doctors and nurses isn't on the same page, it can lead to a very negative situation if you have an emotionally difficult patient or family. With those kinds of patients and

families starting off with everyone on the same page, going into the room at the same time, using the buddy system, really alleviates a lot of issues.

Participant 7: We always assign two caregivers per shift with the difficult families, either an aid and a nurse or an experienced student, like a co-op and a nurse. That way if you need to go in the patient's room, say to do a painful procedure, the nurse isn't going in alone and the family felt like they had two care givers supporting them. Also, the nurse now has a partner supporting them in the physical and emotional care the family required.

Participant 1: "We also make patient care rounds at the bedside at the change of shift and go over the plan for the next shift right in front of the family".

Communications with families is certainly important. The expert charge nurses suggested that psychosocial care must be a priority that is incorporated into the all aspects of patient care. The concept of making psychosocial a priority is explored in the following section.

Making psychosocial a priority.

Participant 6: For some nurses psychosocial is incorporated into their nursing care. For other nurses they hear about the patients who have behavioral health issues, but they don't necessarily make a connection that it was the same Mom who was crying in the waiting room an hour ago. They don't make the connection that they should talk to the mom who's crying while holding her baby and talking to her boyfriend on the phone. Maybe that Mom needs someone else to talk to.

Participant 7: . . . we assume the Mom will respond by saying, "Oh yes thank you so much, that's exactly what I wanted." We do that all the time, because we're

running so much from patient to patient and family to family, that a lot of times we don't listen to or watch the clues and say, "you look like you could use a break? Do you want me to sit in here for a half an hour while you go take a walk?" All to often, we want to get out of the room, or don't want to be there in the first place if we perceive the family as difficult. And once we make that kind of judgment, the Mother's not going to tell you she wants a break, because either she doesn't know it, or can't articulate it, or doesn't want to ask, because she doesn't want that to also be perceived as another example of why she's difficult and demanding a break. These families are intense, but sometimes we're not listening to the clues or not attending to them.

Participant 2: Psychosocial is not seen as a task that people value enough, because there's not a big spot in the chart for psychosocial. There is a spot but if you look at the documentation flow sheet in the ICU, there are all these little boxes to fill in and psychosocial doesn't have as big a spot. Nurses learn the importance of psychosocial through experience. They go to psychosocial rounds, and training sessions, but you really learn it by being around, observing it, and realizing what happens if you don't pay attention to psychosocial issues.

Participant 6: Eighty percent of the nurses see the interrelationship of psychosocial and medical issues. The BH team did a lot of in-services with our nurses about psychosocial issues. I don't think we'll ever reach a point where nurses see it totally incorporated into their care. They still see psychosocial issues as something separate just like physical therapy or nutritional services.

One unit had piloted a comprehensive behavioral health program:

Participant 6: There are psychosocial questions on the nursing database that is completed on admission. Those questions give you a good baseline of information regarding patients with potential to be a problem or to have a crisis. By having the nurses ask the questions it helps them to incorporate it into their care.

Psychosocial dynamics can be very intense and complicated at times. The team can not work in isolation and there are times when the team needs support from higher leadership, which will be explored in the following section.

Support from leadership.

Participant 7: The charge nurse role is mainly about creating a culture on the unit where the staff have what they need, feel supported, where teamwork is present, and you're just there for people as a resource. The second goal is the operational pieces like bed flow; getting people discharged and new patients admitted; the beds cleaned; and putting kids in the appropriate rooms based on their age and diagnosis.

Participant 1: The charge nurse needs to feel like she has support from her boss too. She needs to feel like she can take this role on in helping with everything that is going on especially when you have a tough family. Not everyone is perfect,

there are people who are going to do things different ways. Some options or choices are better than others, but when you feel like you have support as a charge nurse to make the decisions that need to be made, then you feel very strong and definitely want to jump in and take a risk to do something that is exhausting, or stressful, or tough. You still feel like you're doing a good job. As a charge nurse if you don't feel like you have that support, people tend to back of in making decisions. They won't jump in and make judgment calls if they don't feel like they're going to be supported. So that's an important piece for a charge nurse.

Participant 7: If you tell a staff person "you have to take two more patients, I know we don't usually take that many on this unit, but I don't have a choice, a nurse is sick and has to go home I have nobody else." If the nurse feels support, that you care, then they'll do it.