NURSES' ATTITUDES TOWARD CARING FOR RELATIVES IN THE HOSPITAL SETTING

A THESIS

SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS

FOR THE DEGREE OF MASTER OF SCIENCE

IN THE GRADUATE SCHOOL OF THE

TEXAS WOMAN'S UNIVERSITY

COLLEGE OF NURSING

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DECEMBER 1995

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10/31/95
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To the Associate Vice-President for Research
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I am submitting herewith a thesis written by

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titled Nurses' Attitudes Toward Caring for Relatives in the Hospital Setting

I have examined the final copy of this thesis for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Master of Science, with a major in Nursing.

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DEDICATION

I would like to dedicate this thesis to my family members who were a source of support and encouragement to me during the pursuit of my master's degree. I would especially like to thank my wonderful husband, David. He has been so very supportive, encouraging, and helpful to me. Without his support and encouragement, I would not have had the strength to reach this milestone.

ACKNOWLEDGEMENTS

I would like to express my sincere appreciation to the members of my thesis committee, Dr. Oneida Hughes and Dr. Pat Stein, for their time and support during my thesis project. But most of all, my gratitude goes to Dr. Rose Nieswiadomy for her unequalled help, support, and unending devotion to her students, and for the expertise she lends to the science of nursing.

I would also like to express appreciation to the subjects who responded to my study and made it possible.

Thank you all!

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ABSTRACT

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DECEMBER 1995

The problem of this study was to determine nurses' attitudes toward caring for patients in a hospital setting who are relatives compared to patients who are not relatives. The Perri Patient Care Questionnaire Part II was used to measure nurses' attitudes. A convenience sample of 33 registered nurses practicing in three community hospitals was used in this ex post facto study.

Descriptive and inferential statistics were used to analyze the data. The largest percentage of nurses (33.3%) were between 41 and 50 years old, and 84.5% of the subjects had at least 10 years of nursing experience. A significant difference (t = -2.515, p = .008) was found between nurses' attitudes toward caring for patients who are relatives and patients who are not relatives. Therefore, these data support the directional hypothesis that nurses would have a more positive attitude toward

caring for patients who are not their relatives compared to patients who are their relatives.

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CHAPTER I

INTRODUCTION

Peplau (1989) stated, "the crucial elements in nursing situations are obviously the nurse, the patient, and what goes on between them . . . the nurse-patient relationship" (p. 5). The nurse-patient relationship is the essence of the nature of nursing. One variation of the nurse-patient relationship is when the patient happens to also be a relative of the nurse. Implications of this dual and possibly conflicting role relationship may be an important consideration in the nurse-patient relationship.

A review of the literature revealed no research on the topic of nurses caring for relatives. This study focused on the nature of the nurse-patient relationship when the patient is also a relative of the nurse.

Problem of Study

The problem of this study was to determine nurses' attitudes toward caring for patients in a hospital setting who are relatives compared to patients who are not relatives.

Justification of Problem

No studies could be found in the literature on nurses' attitudes toward caring for their relatives. Perri (1989), however, studied nurses' attitudes toward patients who were social acquaintances. She found that nurses had more positive attitudes when caring for strangers than when caring for social acquaintances. She indicated that quality of care might be negatively influenced when nurses care for relatives.

When a nurse is caring for a relative, she or he may be trying to fulfil two roles at the same time. In fulfilling both the role of nurse and family member at the same time, professional and personal responsibilities may conflict (Purtillo & Cassel, 1981).

Travelbee (1971) asserted that there is a difference between the professional relationship found among nurses and their patients and the relationship found between friends or family members. This difference is primarily inherent in the obligations that the participants have towards each other. The roles of nurse, patient, and family member are accompanied by different sets of role expectations (Hardy & Hardy, 1988).

This study focused on nurses working in small communities. Sanders (1975) pointed out that the size of a community has a great influence on the type of interaction

people have. In a large community there is a greater amount of anonymity than is found in a small community. Individuals in large communities center more of their interaction around professional and other social groupings, rather than around neighbors or families. On the other hand, in small communities individuals interact more frequently with relatives, family members, and neighbors. With this in mind, it seemed that nurses practicing in a small community hospital setting would be more likely to find themselves providing care for relatives who were also their patients than would nurses in a large urban area.

Nurses who provide patient care could use the results of this study to better understand feelings that may arise when they are assigned to care for a relative in a hospital setting. The results of this study could also be used by nurse managers in making decisions about assigning nurses to care for their relatives.

The Conceptual Framework

This study was guided by Hardy and Hardy's (1988) discussion of role and role conflict. According to these authors, a role generally refers to the expected and the actual behaviors that are associated with a position. The person in a social system who holds a particular position or role is a role occupant. There are certain expectations

that are specific to a particular position. These expectations identify the attitudes, behaviors, and cognitions that the occupant should have.

According to Hardy and Hardy, role conflict is a condition in which existing role expectations are perceived as contradictory or mutually exclusive. One source of conflicting role expectations may be one's reference group or groups. Hardy and Hardy cited the works of several authors to support this statement. One of these works (Simpson, 1979) indicated that reference groups such as the family and the profession may each have their own set of values and expected role behaviors.

Hardy and Hardy (1988) also indicated that when a person occupies more than one position, role conflict may exist. An interpositional conflict arises because each position has its own separate set of role expectations. An example of this is when one holds the position of staff nurse and also the position of a family member.

Because of a disparity in the role expectations, values, and expected behaviors associated with the two separate positions of family member and nurse, role conflict may occur. Thus, it was proposed that nurses' attitudes would differ when caring for patients who are relatives compared to patients who are not relatives.

Assumptions

The assumptions of this study were:

1. A nurse's attitude about taking care of a patient affects the nurse-patient interaction.

2. Nurse-patient interactions will affect the nursing care that patients receive.

3. Role conflict affects behavior while in that role.

4. The respondents in the study will provide honest answers concerning their attitude towards caring for relatives.

Hypothesis

The hypothesis tested in this study was:

Nurses' attitudes toward providing care for patients in the hospital setting who are not relatives are more positive than their attitudes toward providing care for patients who are relatives.

Definition of Key Terms

The key terms used in this study were defined as follows:

1. Nurses--refers to registered nurses who were currently licensed to practice nursing at the time of the study and were practicing in a hospital in a small city within the large southwestern state where the study was

conducted. Additionally, to be included in this study, these nurses must have provided care for a relative.

2. Relative--refers to one who shares a common ancestry with the nurse or the spouse of the nurse. In this study, relatives included parent, grandparent, child, grandchild, brother, sister, aunt, uncle, cousin, niece, or nephew of the nurse or the nurse's spouse. The relationship to the patient was self-reported by the nurse on the demographic questionnaire.

3. Not a relative--refers to one who does not have common ancestry with the nurse or the nurse's spouse.

4. Providing care--refers to giving general nursing care to a person who is a patient in the hospital. It may include giving daily care, treatments, and/or performing assessments. The nurses in this study reported if they had provided care for a relative or not and, if so, what relative. This information was self-reported on the demographic questionnaire.

5. Attitude--refers to a disposition or feeling toward a person, object, or idea. Attitude is comprised of cognitive, affective, and behavioral components (Steele & Harmon, 1983).

6. Attitude towards providing care--refers to a measurement of attitude using the Perri Patient Care

Questionnaire. The higher the score, the more positive is the attitude toward caring for the patient.

7. Hospital setting--refers to an acute care hospital. In this study, nurses in three small (53, 98, and 112 beds) community hospitals were surveyed.

Limitations

The following limitations may have influenced the study results:

1. A small convenience sample was taken from one geographic area rather than a wide representative area, which limits the ability to generalize the study results.

2. The quality of the previous relationships between the nurses and their relatives could not be controlled. Additionally, the quality of the relationships was not measured by the instrument used in the study.

3. Data were gathered through a self-report paper and pencil questionnaire. No observation was made of the actual interactions between the nurse and the patient who was a relative or the patient who was not relative.

4. The severity of a relative's physical condition may have influenced the nurse's attitude toward caring for this patient in the hospital.

Summary

Nurses are involved in many different kinds of interactions. They are part of a family and part of a profession. Their interactions with other people are of a different nature while in each of these roles. At times these roles merge in one setting. The nurse is expected to act in both positions at the same time. Because the role expectations and values are different between the role of a nurse and that of a relative, role conflict may occur. If there is role conflict, it may impact the effectiveness of the nurse-patient relationship.

There is a dearth of literature concerning nurses caring for relatives in the hospital setting. Therefore, it seemed important to examine whether there was a difference in nurses' attitudes toward caring for patients who were relatives as opposed to patients who were not relatives.

CHAPTER II

REVIEW OF THE LITERATURE

A review of relevant literature is presented in this chapter. Professional ethics for both nurses and physicians will be examined as it relates to providing care for their family members. The literature search did not produce any studies of nurses providing professional care for their relatives. Much has been written about family members providing care in an informal setting. A survey of the literature on this topic will be presented as it relates to attitudes and feelings of the caregiver toward the care receiver and the family dynamics involved in the caregiver/care-receiver relationship. Although no studies were found on the topic of nurses providing professional care for their relatives, some anecdotal type articles about nurses caring for their relatives and two related studies of nurses and their relatives' care were found. Additionally, one study (Perri, 1989) that examined nurses' attitudes toward caring for social acquaintances will be examined. Finally, a few studies were found dealing with physicians providing care for their relatives.

Professional Ethics

The Code for Nurses (American Nurses Association [ANA], 1985) states that it provides guidance for the conduct and relationships necessary to carry out nursing responsibilities. Yet, it does not make mention of whether or not nurses should or should not provide care for relatives. Rather it does state that need for health care is universal and transcends all differences. Nursing care is to be delivered without any prejudice. It also states "individual value systems and lifestyles should be considered in the planning of health care with and for each client" (ANA, 1985, p. 7). The nurse must understand and consider the attributes of a client that may influence nursing care.

Statements such as these would seem to encourage nurses to provide care for their relatives. In most cases, the nurse would know the values and attributes of a relative better than they could know those aspects for a patient who is not a relative. Therefore, the nurse would be able to plan more individualized care for a relative.

The second statement of the code, however, deals with the client's right to privacy. When the nurse is also a relative of the client, privacy of patient information may be an issue.

Because the nursing profession has developed alongside, though separate from, the medical profession, it seemed relevant to look at the physician's code of ethics as well. Additionally, while the physician's code of ethics has been formally in place since 1847 (American Medical Association [AMA], 1981), nursing has only had a formal written code since 1950 (ANA, 1985). Prior to forming its own code, nursing may have looked at the physician's code as a guide.

The ANA has made revisions to its code periodically, the last revisions being made in 1985. Seward (1978), in a historical review of the code, gave no indication that the code has ever made reference to nurses providing care for family members.

The physician's code has also had periodic revisions, with radical revisions made in 1957 and 1977 (AMA, 1981). La Puma, Stocking, LaVoie, and Darling (1991) cited a statement from an earlier version (1901) of the Code of Ethics of the AMA that "a family members illness tends to obscure [the physician's] judgement and produce timidity and irresolution in his practice" (p. 1290). La Puma et al. noted the admonition had been revised at some point and was dropped entirely in 1977 as an "outmoded matter of medical etiquette" (p. 1290). The Current Opinions of the

Judicial Council of the AMA (a guide for the medical code of ethics) did not make any reference to whether physicians should or should not provide care for their family members (AMA, 1981).

Family Caregivers

Reverby (1987) noted that family caregivers preceded formal nursing in the provision of care to relatives. Additionally, family members continue to provide a significant amount of care to their relatives. It, therefore, seems relevant to examine some of these informal family caregiver/care receiver relationships.

Bowers (1987) pointed out that "intergenerational caregiving is becoming a significant issue for nurses practicing in a variety of settings" (p. 20). She interviewed 27 parents and 33 of their caregiving offspring. She divided the caregiving activities, which were performed by the children, into several categories. These categories were anticipatory, preventive, supervisory, instrumental, and protective care. The instrumental care is the hands-on caregiving, which she stated is what is commonly recognized as caregiving and commonly the only activity recognized as caregiving. She then discussed the protective category in-depth.

Bowers stated that many family caregivers consider their most important work for their ill member to be that of protection. This protection is primarily aimed at the self-image of the ill parent and at maintaining the role relationship. There are efforts exerted to prevent a role reversal, or the perception of such, from occurring. The caregivers often expressed feeling a role reversal, but tried to protect their parent from feeling or perceiving this as well.

Bowers noted that this protective work caused a great deal of stress for the caregiver. Often the protection of self-image and role maintenance was perceived as more important to caregivers than lack of physical care for their relative. Health care providers generally perceive provision of physical care as more important than protection of self-image and role maintenance.

Baillie, Norbeck, and Barnes (1988) conducted a study with family caregivers of elderly persons to investigate the effects of perceived caregiver stress and social support on the psychological distress of the caregiver. They found that the mental condition of the elderly, level of functioning of the elderly, hours of care needed by the elderly, and years of caregiving provided did effect the caregiver's level of perceived stress and psychological

distress. Another finding was that the satisfaction from social support received by the caregiver was negatively correlated with psychological distress.

Cantor (1983) examined the type of relationships between the caregiver and care receiver. One hundred and eleven caregivers were interviewed for the study. The caregivers came from four identified types of informal caregivers: 33%--spouses, 36%--children, 19%--other relatives, and 12%--friends/neighbors. The study found that the closer the relationship between caregiver and care-receiver and the closer the bond between them the greater was the emotional strain felt by the caregiver.

Cantor (1983) noted that "feeling close to the person one cares for is probably in most cases a precursor to assuming the task" (p. 599). Spousal caregivers were much more affected with physical and financial strain than the other groups. However, when looking at emotional strain, all the categories of relatives were equally effected. Additionally, the closer the bond the greater was the strain and perceived stress. Those who valued family relationships more highly also experienced greater stress and strain. Cantor (1983) further noted that a major contributor to the strain was a "reversal of long-established roles and life patterns" (p. 599), especially

among spouses, but also among children caregivers. Finally, she noted that the emotional strain of family caregiving is often greater than the physical effect.

Robinson and Thurnher (1979) did a longitudinal (5-year) prospective study of 49 middle-aged adults who had a living parent. The focus was on the impact to the child of care provided for a parent. They found two major sources of stress as the parent aged. The first source involved the change or deterioration of the role in their parent-child relationship. The child was now stepping out of his/her role as a child to the parent and providing care for the parent. This perceived role reversal or deterioration was stressful for the caregiver. The more closely involved the child was in the care of the parent, the more stressful was the situation.

The second major source of stress noted by Robinson and Thurnher was the confinement experienced in the caregiving role. Findings indicated that the activity of caregiving was less stressful than the personal restrictions imposed by it. The study indicated men were as likely as women to help a parent, but they also appeared to have greater ability to distance themselves emotionally and physically from their parents. Men also tended to

experience less guilt and greater acceptance of the idea that they could not make the parent much happier.

Beach (1993) interviewed 10 family caregivers to examine their caregiving experience. The caregivers' experiences fell into three major categories. Role strain was the central category, which in turn affected both of the other two categories--the caregiver's sense of self and the caregiver's coping ability. Most of the caregivers had a strong sense of responsibility to provide care to a family member. Especially the spousal caregiver believed that it was a normal role or stage in life. The women in this study reported a greater degree of social limitation in the caregiving role than the men did. A majority of the caregivers found it difficult to balance caregiving and working at their regular jobs. This conflict led to changes in their work performance and/or change in work schedule.

Abraham and Berry (1992) interviewed 41 family caregivers of elderly people. They found that for the majority of caregivers there was a cumulative stress from the continuous caregiving. This stress had a negative effect on their lifestyles. They noted that often the family caregiver had unmet learning needs in terms of the

type of care that needed to be provided for the family member.

Macera, Eaker, Jannarone, David, and Stodkopf (1993) studied the perceived burden of caregivers of persons with dementia. They measured the burden of actual task performance and found it to be low. They indicated much of the stress felt by caregivers may be caused by other factors, such as coping style, rather than by the performance of tasks.

Bull (1990) examined 55 caregivers of chronically ill patients following an acute episode. She found that income, patient and caregiver physical health, patient's functional level, and size of the caregiver's social network were inversely correlated to the amount of burden associated with the caregiver/receiver relationship. Associated with their burden, caregivers reported fatigue, back strain, and household accidents from fatigue. Caregiver burden was also associated with depression.

Callahan (1988) discussed some of the factors that should be considered when a family member is considered as a (potential) caregiver in a long-term caregiving situation. He noted there is a widespread belief that family care can be superior because it is more kind, sensitive, and attuned to the patients needs, but that this

expectation may be burdensome. Callahan noted that the demands of caring for a family member can be strenuous and may require new self-understanding for both caregiver and receiver. The caregiver may feel trapped because of the care the family member requires. The caregiver may also be angry and feel rebellious. These feelings may, in turn, cause the caregiver to feel guilty. If the care receiver is a stranger, Callahan noted, it is easier to distance oneself, thereby lessening the emotions involved. Love and affection in the family relationship can act as a noose in the care-giver/receiver relationship. When hope for relief from the situation is real and time involvement is limited, the burden of caregiving is lessened.

Mui (1995) compared the caregiving experience of sons and daughters of elderly people for the level of emotional strain due to the caregiving. Results showed daughters felt significantly more emotional strain than sons. Daughters also reported poorer health, less respite help available, more involvement in caregiving, and more interference with their personal and social life than sons did. These were variables that appeared to affect the felt strain. For daughters, Mui further noted, higher emotional strain was associated with work interference and poor quality of relationship with the parent. Caregiver

perception about interference between caregiving and personal and social life is a more significant factor in role strain than the caregiving workload.

Spousal caregivers were studied by Given, Stommel, Collins, King, and Given (1990) to evaluate the causes of various caregiver responses. The responses included: negative emotional response to the situation, feeling of responsibility to be the caregiver, feeling of abandonment by other family members, and concern about the impact the caregiving had on their schedules. The major variables that appeared to cause the negative emotional response were negative patient behaviors and the emotional health of the caregiver. Given et al. noted that feelings of responsibility were positively influenced by the patient's positive behavior, the patient's poor health, and the patient being younger. Also the caregiver having better emotional health; being older; receiving less assistance, but more affective support; and providing more hours of care caused a greater feeling of role responsibility. Feelings of abandonment went along with negative patient behavior, incontinence, amount of assistance, and number of hours of care. Overall, the patient characteristics had the greatest impact on negative caregiver responses. The

cognitive impairments and negative or antisocial patient behaviors had the biggest impact on caregivers.

Oberst, Thomas, Gass, and Ward (1989) assessed 47 family caregivers of cancer patients to determine stress responses in the caregiving relationship. Sources of stress included caregiving tasks, relationship and interpersonal support, lifestyle, and emotional and physical health. They assessed the extent to which caregivers experienced a sense of harm/loss, threat, or challenge in the caregiving situation or the amount of benign affect it had. Oberst et al. found that when the caregiver perceived a higher caregiving load, the degree of harm/loss and threat was also higher. The degree of harm/loss and threat perceptions were also higher for the older, more closely related, and less healthy caregiver; fewer benign perceptions were found among these individuals.

Wallhagen (1992) studied the impact of various aspects of elderly caregiving demands on caregiver well-being, as measured by life satisfaction, depression, and subjective symptoms of stress. The caregiving demands included objective care tasks (the frequency of tasks), objective personal demands (such as care receiver's needs were always on their minds, or having to make changes to make it easier

for the caregiver), and subjective care task demand (the degree to which the caregiver perceived the effects of task performance) and subjective personal demands (such as feeling communication was not as good with the care receiver as it used to be). She found that while toileting the patient was the third most frequently performed task it was perceived as the most difficult to perform. The next most difficult was helping with prescribed treatments, which was the least frequently performed task. Overall, Wallhagen reported task performance, both subjectively and objectively, was much less taxing than personal demands of caregiving. Objectively, 95% of caregivers reported patients' needs were always on their minds. Also having to make changes in the way things were done, feeling one could not leave the patient alone, having their time schedule revolve around the patient, and experiencing poorer communication with the patient were true for more than 80% of the caregivers. Wallhagen noted that while the objective data indicated that generally life appears to revolve around the patient, subjectively caregivers indicated that the deterioration in communication was a more negative personal care demand than was having life revolve around the patient. The subjective demands of caregiving were negatively correlated with life

satisfaction and stress and positively correlated with symptoms of depression. The subjective aspects of caregiving had an overall greater impact for the caregivers than the objective or actual caregiving tasks.

Bramwell and Whall (1986) found that wives' performance of a support role to their husbands who had suffered a myocardial infarction had a negative effect on the wives' anxiety levels. The majority attributed this to their uncertainty in the situation, either in the present or in regard to the future. They most feared insufficient recovery of the spouse and a recurrence of the condition.

Brody (1985) has been involved in numerous studies of elderly care over approximately 20 years. She summarized her findings by stating that parent care is viewed as a normal process. While normal, it is a stressful experience for the individual and the family. This concept and its implications is still not well understood. She further noted that health care expectations include increased reliance on children to provide care for their parents. Therefore, there is more stress for the child caregiver. Brody noted that over half of the daughters studied had either quit their jobs, or thought they needed to, in order to care for their parent. They were experiencing strain in this caregiving relationship. They felt tied down and as

if they were missing part of life. Many had deterioration in their physical and/or mental health. Yet 60% of these caregiving women said "somehow they felt guilty about not doing enough for their mothers" (Brody, 1985, p. 26). She noted that she heard over and over in her studies "I know I'm doing everything I can for my mother, but somehow I still feel guilty" (Brody, 1985, p. 26).

Health Care Professionals Caring for Relatives

Very little research was found concerning the topic of health care professionals providing care for relatives. Most of the literature concerns anecdotal accounts of individual health care providers experiences.

The authors of the anecdotal accounts gave a description of their experiences in providing care for a family member. They all addressed the difficulty they experienced in fulfilling the roles of a family member and a nursing professional at the same time.

Ozaki (1995), a retired nurse, spoke of her caregiving relationship with her elderly mother. She indicated that at times she felt uncomfortable in the relationship. She stated that while they had a wonderful relationship, she felt embarrassment when washing her mother's genitals. At times Ozaki felt she needed a break from her caregiving

duties, but felt guilty. She dealt with the guilt by reasoning that a short break was good for both. She also indicated that at times she and her mother experienced a feeling of role reversal. At times, she verbally reminded her mother that she was her daughter, although also her caregiver.

Agne (1993), a rehabilitation nurse, discussed her experiences with her mother while she was undergoing rehabilitation at home following an accident. Agne stated there was an underlying conflict and a reversal of roles in this situation. This led to a feeling of tension. It was particularly difficult for the mother to accept the professional services of her daughter. The mother perceived the actions as a daughter bossing her mother, rather than a professional advising/instructing a client. Agne (1993) stated that if "practicing your professional skills on a loved one, be prepared for a draining experience" (p. 24). She suggested that nurses should ask other professionals, relatives, and friends for their emotional support.

Couch (1991), an ICU nurse of many years, wrote of her experience with her daughter. The daughter was in an accident and experienced severe head injuries. As a nurse, Couch was able to objectively assess the seriousness of her

daughter's injuries, but as a mother she tried to find only positive signs of potential recovery. The scene was so familiar to her, yet so foreign. She stated "she was and would remain a divided person, the parent lagging considerably behind the nurse" (p. 48). She spoke of being torn between the two roles of mother and nurse, even though she was not actually on duty.

Two nurses related their experiences when their infants were hospitalized (Majkowski & Russell, 1990). Majkowski was a pediatrics nurse. Russell was a special care nursery nurse. Both nurses found their role as a nurse was questioned by the staff where their infants were hospitalized. Both admitted to feeling frustrated because they had professional knowledge to understand their child's condition, prognosis, and plan of care, and yet limited information was provided them by the staff, even when they asked questions. Majkowski was the nurse for Russell's child later in his illness and they were able to develop a good rapport. This rapport enabled Russell to more adequately fulfil both roles. Both nurses expressed feeling isolated from their peers when their infants were hospitalized. They were now treated as the patient's relative, not as a nurse. They stated that in some nurse-parent situations the role of parent may dominate, in

others the role of nurse may take precedence, and in some situations the nurse may vacillate between the roles of parent and nurse.

Tisdale (1988), a long-term care nurse, was accustomed to using therapeutic communication to help terminally ill patients and families work through stages of anger and denial associated with the terminal illness process. However, she found that she lost all of her objectivity as a nurse when her mother was dying of cancer. She noted that her mother refused her attempts at therapeutic communication. This caused Tisdale to feel angry and frustrated. She also felt like a failure as a daughter and a nurse and was unable to reconcile performing both roles. Near the end of her mother's life, Tisdale tried to help her move up in bed and suddenly could not remember what to do to perform the routine task. Reflecting on this incident, she realized she had lost objectivity as a nurse. She recognized that her attempts at therapeutic communication were also affected. She had subconsciously been trying to work through her own feelings of loss and denial, which interfered with helping her mother resolve her feelings. She found it difficult to talk of death and dying with her mother, while it was routine in her dealings with other patients.

Parnell (1982) discussed a situation where a visiting nurse cared for a client who was a neonatal nurse with a new baby. When the visiting nurse learned her background, she started to leave, assuming the client did not need her help or advice. In reality, the new mother felt very insecure in her abilities to perform the new role. The author noted the mother's professional background may cause her to worry more and anticipate more problems than the average person would because, as a nurse, she is aware of the problems that could occur.

An informal, "unscientific" questionnaire was administered by Knight (1985) to 50 nurses. These nurses had previously had a relative in the hospital, not under their own care. The questions dealt with the nurse relatives' interactions with the nurse who was providing care for a family member. Sixty-four percent of the nurse relatives reported their belief that the nurses providing care assumed the nurse relative did not need any explanation about the condition and treatment of their relative. Another 24% stated that they were directed to the head nurse or the physician for explanations. Forty-eight percent of the nurse relatives were embarrassed or apprehensive about "bothering" the staff, and 42% were "hypercritical" of the staff providing care to their

relative. In summary, Knight stated that the staff's communication skill deteriorated and attitudes toward the nurse changed when the nurse was in the relative role.

The relationship between oncology nurses and their parents with cancer was studied by Baird (1988). Ninety-three percent of the nurses served as a source of information and 67% provided advice to their parent. The majority (70%) expressed experiencing a change in their role in the family in relation to the illness. Sixty percent of the nurses reported there was a role conflict. Most of these indicated that the parent expected too much from them in regard to interpreting what was happening. The parent got "upset when the nurse/daughter didn't have all the answers for them" (Baird, 1988, p. 14). The nurses reported that interpreting or conveying bad news was especially difficult. The author noted that although these nurses were accustomed to dealing with death in their job, they were relatively unable to handle their dying parent. They experienced frustration and anger in dealing with this situation.

Perri (1989) examined nurses' attitudes toward caring for patients who were also social acquaintances. She found, in a survey of 56 registered nurses, that nurses had more positive attitudes toward caring for patients who were

not their social acquaintances. Additionally, Perri found that certain items on her questionnaire were rated more positively when the respondents were describing their attitudes toward caring for patients who were not social acquaintances in comparison to those who were social acquaintances. These items concerned feeling at ease in interpersonal nurse-patient relationship, discussing death or terminal illness, discussing topics related to sexuality, being comfortable with patient assignment, providing care for bathing/elimination needs, administering uncomfortable treatments, and assisting patients to cope with body image alterations. The items that she indicated were rated slightly more positively in regard to social acquaintances were feeling the nurse met the expectations of the patient and met the expectations of the patient's family.

In a study of physicians treating their family members, La Puma et al. (1991) looked primarily at the rate of occurrence of physicians providing care for their family members. Ninety-five percent of the physician respondents reported almost always or sometimes providing care to family members, when requested to do so. However, 57% had refused to provide requested care, for some reason. Almost half of those who gave a reason for why they had refused

care reported feeling uncomfortable in granting a request to provide care for a relative. This discomfort was due to a variety of reasons, including that the medical problem was not in their area of expertise, they were not able to do an adequate examination and/or follow-up, there was no medical indication for the request, and they perceived lack of objectivity. The physicians reported sometimes feeling embarrassed and frustrated when their relatives asked for treatment that they were not prepared to provide. The primary cause of discomfort was that they did not have enough previous medical information and/or the results of diagnostic procedures/tests to make appropriate treatment decisions.

The data suggested that physicians try to limit their emotional involvement in caring for a family member as well as the actual medical care they provide. This limit setting may reflect their recognition of the emotional complexity of dual roles or problems anticipated when a family relationship is involved rather than a therapeutic physician-patient relationship. La Puma et al. noted that the physicians had difficulty providing reassurance to family members when a serious illness is suspected or problems are anticipated.

The incidence of physicians treating their minor children was examined by Dusdieker, Murph, Murph, and Dungy (1993). They found that 74% did provide care for their child's minor illnesses. No attempt was made to examine the physician parent's (PP) attitude toward providing care for his or her child. However, respondents were asked to rank five reasons they treated their own child. These reasons in rank order were convenience, confidence in own skills, quality of care concerns, concerns about confidentiality, and cost. With confidence in their own skills receiving second highest ranking, it may indicate the PPs believe they are able to provide comparable care to their child as they would to an unrelated patient. Dusdieker et al. questioned the objectivity of the PP, though they did not specifically test this variable. They did find the PPs often prescribed medications in the absence of a physical exam or laboratory test that a physician would normally have done before prescribing such medications.

Reagan, Reagan, and Sinclair (1994) stated that although health care professionals are often confronted with choosing whether or not to participate in the care of their family members, this problem is rarely mentioned in training programs or by professional licensing boards.

These authors examined which relatives (mother, child, etc.) that 1,292 physicians had provided care for, which of these relatives they were most and least comfortable providing care for, and what types of care were provided for their relatives. The findings indicated that physicians were most comfortable providing care for their children. The physicians were least comfortable in providing care for grandparents. This study indicated the "physicians are less willing to treat their family members as the level of complexity, seriousness, and potential for conflict with privacy increase" (Reagan et al., 1994, p. 601). The study also found that rural physicians provided more care for family members (61%), than suburban (50%) or urban (41%) physicians. In addition to the structured questionnaire, comments were solicited. Reagan et al. (1994) stated that the topic of caring for family members generated a great deal of expressed feelings. A major theme was the physician's perceived lack of objectivity and associated negative feelings. Role conflict was another significant theme. Several had provided care and then regretted it, wishing they had remained relatives and not tried to be in both the relative and physician role. Relatives pressuring the physician for care caused feelings of concern and frustration. On the positive side, several

physicians noted that when caring for a relative, one has better knowledge of the person and cares more about him or her. This could lead to provision of better care. Some of the physicians were honored by their family's trust in them and desire to receive their care.

Summary

The review of the literature has presented a discussion of the family member as a caregiver. A majority of the literature concerned the informal family caregiver. A major focus of this literature deals with the reports of stress and strain or feelings of burden from the caregiving relationship.

Various studies had different focusses, but several indicated the stress and/or burden was more from emotional sources than from the actual physical aspects of caregiving (Brody, 1985; Cantor, 1983; Macera et al., 1993; Mui, 1995; Robinson & Thurnher, 1979; Wallhagen, 1992). The confinement of the caregiving situation was one source of emotional strain (Brody, 1985; Robinson & Thurnher, 1979). The caregiving relationship was noted by some (Beach, 1993; Brody, 1985) to have a negative effect on work performance and/or job status. Several researchers (Bowers, 1987; Cantor, 1983; Mui, 1995; Robinson & Thurnher, 1979) noted negative effects of caregiving on the roles in the family.

Most of the literature on nurses caring for family members (Agne, 1993; Baird, 1988; Couch, 1991; Majkowski & Russell, 1990; Ozaki, 1995; Tisdale, 1988) referred to the difficulty of acting concurrently in the roles of family member and nurse. As a result of the dual roles of nurse and family member, many feelings were expressed. These feelings included embarrassment (at washing mother's genitals) (Ozaki, 1995), emotionally draining (Agne, 1993), frustration (Baird, 1988; Majkowski & Russell, 1990; Tisdale, 1988), anger (Baird, 1988; Tisdale, 1988), loss of objectivity (Tisdale, 1988), and increased worries because of professional knowledge (Majkowski & Russell, 1990; Parnell, 1982). Additionally, communication difficulties were also identified (Knight, 1985; Majkowski & Russell, 1990; Tisdale, 1988).

In studies of physicians caring for their family members, the focus was more on what care was provided than the affective nature of it. However, physicians did report embarrassment (La Puma et al., 1991) and frustration (La Puma et al., 1991; Reagan et al., 1994) at being asked to provide certain services for their family member. Lack of objectivity was noted as a problem for some physicians in caring for their relatives (La Puma et al., 1991; Reagan et al., 1994).

While providing care for relatives can have positive benefits, there are many negative effects as well. These negative effects include stress, strain, frustration, reversal of roles, and communication difficulties. Providing professional nursing care can be emotionally draining for many reasons, but providing care for a relative may increase the strain for nurses.

CHAPTER III

PROCEDURE FOR COLLECTION AND TREATMENT OF DATA

This study used an ex post facto design. "Ex post facto research attempts to understand relationships among phenomena as they naturally occur, without any researcher intervention" (Polit & Hungler, 1991, p. 176). The study was conducted by means of a self-administered questionnaire to examine nurses' attitudes toward caring for patients who are relatives and those who are not relatives.

Setting

This study was conducted in three community hospitals. Each of these hospitals is located in a different small city in a large southwestern state. The respondents completed the questionnaires in the setting of their choice.

These hospitals had 53, 98, and 112 beds, respectively, for a total of 263 beds. They employed 48, 65, and 77 registered nurses, respectively, for a total of 190 registered nurses employed at the three hospitals.

Population and Sample

The target population for this study was all registered nurses who had cared for a relative in the hospital setting. The accessible population was the nurses employed at the three hospitals where data were collected and who had cared for a relative in the hospital. These nurses had to have a current license to practice nursing in the state at the time of the study. A convenience sampling method was used. The sample consisted of all eligible nurses in the accessible population who filled out and returned the survey. Although a total of 190 nurses was reported to be working at the three hospitals used in the study, 178 questionnaires were actually distributed at these locations. It is possible that some nurses had left the agencies by the time the questionnaires were distributed or there may have been nurses on vacation or sick leave at the time of the study. The researcher was unable to determine how many were eligible to participate in the study. Forty-three nurses returned questionnaires. Of this number, 33 respondents met the study criteria and returned usable questionnaires.

Protection of Human Subjects

The rights of the subjects were protected throughout this study. This study was classified as Category I, based

on the federal guidelines for research involving human subjects because data were gathered through the use of anonymous questionnaires. Therefore, the study was exempt from review by the Human Research Review Committee (Appendix A).

The cover letter (Appendix B) that was distributed with the questionnaire packets indicated that the study concerned nurse-patient interactions and was being conducted by a graduate student as a part of the requirements for a master's degree in nursing. The cover letter also pointed out that there was no obligation to participate and that employment at the hospital would not be affected by the nurses' participation or nonparticipation in the study. The prospective respondents were assured that their responses would remain anonymous. They were told that the results of the study could be beneficial for nurses in the future in relation to their interactions with patients. They also received information about how to reach the researcher if questions arose and about how to obtain the results of the study. Finally, the following statement was printed on all questionnaires: "RETURN OF THIS QUESTIONNAIRE WILL BE CONSIDERED TO BE YOUR CONSENT TO BE A RESEARCH SUBJECT IN THIS STUDY."

Instruments

The two questionnaires (Appendix C) and the cover letter were distributed to the nurse participants. The first questionnaire obtained demographic data. The second tool, the Perri Patient Care Questionnaire Part II, measured nurses' attitudes toward caring for relatives.

Demographic data obtained included age and years of nursing practice. Additionally, information was obtained concerning which relative or relatives (i.e., mother, child, brother) the subject had cared for.

The second questionnaire was the Perri Patient Care Questionnaire Part II. Permission to use the instrument was obtained (Appendix D). The instrument was designed by Perri (1989) for a study of nurses' attitudes toward patients who are social acquaintances. Permission was obtained to adapt the questionnaire for use in this study. The column headings were changed to reflect that this study concerned patients who were relatives and those who were not relatives instead of social acquaintances and nonacquaintances.

The questionnaire contained 20 statements that relate to nurse-patient interactions. There were two columns of Likert-type responses. The first column was for responses to the statements concerning providing care for a patient who was a relative. The other column was for responses

concerning providing care for a patient who was not a relative. The Likert-type scale was scored as follows: 1 = strongly disagree, 2 = disagree, 3 = uncertain, 4 = agree, and 5 = strongly agree.

The mean was computed for each column. The possible range of scores is from 20 to 100. A higher score means a more positive attitude.

Perri (1989) established content validity of the questionnaire by means of a panel of judges. They examined the tool for clarity, comprehensiveness, and its ability to elicit the desired data. Perri further assessed these qualities by means of a pilot study. Test-retest reliability was established by administering the instrument to the pilot study group on one day and then again 1 week later. Perri (1989) found the "reliability coefficient computed on the means of the two sets of scores to be r = .968, by using the Spearman-Brown split half technique" (p. 23).

Data Collection

After permission was obtained from the facilities where the study was conducted (Appendix E) and the Graduate School at Texas Woman's University (Appendix F), the data were collected in the following manner. The two questionnaires, together with a cover letter of explanation

of the study, were distributed to all nurses at the facilities. After agency approval, nursing administration in each of the hospitals distributed the questionnaire packets with the nurses' paychecks to all registered nurses employed at the time of study. The outside of the sealed packet had the following instructions: "IF YOU HAVE EVER TAKEN CARE OF A RELATIVE IN THE HOSPITAL SETTING, PLEASE OPEN THIS ENVELOPE AND CONSIDER PARTICIPATING IN THE STUDY DESCRIBED IN THE COVER LETTER. IF YOU HAVE NEVER TAKEN CARE OF A RELATIVE IN THE HOSPITAL PLEASE RETURN THIS ENVELOPE TO THE NURSING OFFICE." The packet contained a cover letter, two questionnaires, and a stamped and pre-addressed envelope. The respondents completed the questionnaires in the setting of their choice. They were instructed to mail the completed questionnaires, in the envelope provided, within 10 days.

Treatment of data

Descriptive statistics were used to describe the characteristics of the sample. This information included the subjects' ages, years of nursing practice, number of times they had cared for a relative, and the types of relatives the subjects had cared for.

A dependent *t*-test was computed to test the hypothesis that nurses' attitudes towards caring for patients in the

hospital setting who are not their relatives are more positive than their attitudes towards caring for patients who are their relatives. Prior to computing the dependent *t*-test, the respective columns for relatives and not relatives of the Perri Patient Care Questionnaire Part II were summed. The level of significance for testing the hypothesis was set at $p = .05$.

CHAPTER IV

ANALYSIS OF DATA

This study examined nurses' attitudes toward caring for patients who were relatives in comparison to patients who were not relatives. The Perri Patient Care Questionnaire was utilized to measure the nurses' attitudes. Data on selected demographic variables were collected and used to describe the sample. A dependent *t*-test was used to test the study hypothesis.

Description of Sample

One hundred and seventy-eight questionnaires were distributed to the potential subjects, which included the nurses employed at the three hospitals in the study. Forty-three questionnaires were returned. Two of the returned questionnaires were left blank. Five of the respondents answered "no" to the questions asking if they ever had a relative who was a patient on the floor where they were working at the time and if they had ever cared for a relative who was a patient on the floor where they were working at the time. Three additional nurses responded "no" the item pertaining to whether they had

cared for a relative who was a patient on their floor. These 10 questionnaires were eliminated and the remaining 33 were considered the sample for the study. It is not possible to say exactly how many subjects were eligible to participate in this study. No previous assessment had been made of the nurses who worked in the three hospitals to determine who had cared for a relative and were eligible to participate in the study. Therefore, it is difficult to establish the response rate accurately.

The demographic data questionnaire solicited information related to age, number of years of nursing practice, whether the nurses had previously had a relative on their floor, whether the nurses had ever previously cared for a relative on their floor when they were working there, and which, if any, relatives the nurses had provided care for. These data are described in the following section.

For the age category, data were collected in 10 year increments--20 or younger to 61 or older. The 41 to 50 year range was the mode, with 11 (33.3%) subjects. The 31 to 40 year range was close in size with 10 (30.3%) of the sample. There were 7 (21.2%) in the 51 to 60 year range. In the 61 or older range, there were 3 (9.1%) subjects.

The smallest category was the 21 to 30 year range, with only 2 (6.1%) of the sample in this group.

The years of nursing practice were ascertained, with categories ranging from less than 1 year to over 20 years. All of the subjects had at least 1 year of nursing practice. The majority (28 or 84.5%) had over 10 years of nursing practice, with more than half (18 or 54.5%) of the sample having over 15 years of nursing practice. The mode category was over 20 years, with 12 (36.4%) of the respondents in this group. The second most frequently given response was the 11 to 15 years category, with 10 (30.3%) in this range. Six (18.2%) respondents had 16 to 20 years of experience, and 3 (9.1%) had 6 to 10 years of experience. Only 2 (6%) respondents had from 1 to 5 years of experience.

A majority of subjects had cared for a relative 1 or 2 times (18 or 54.5%). Two categories tied for the mode for the question pertaining to how many times the respondent had cared for a relative. These categories were once and twice (9 each or 27.3%). Seven respondents (21.2%) had cared for a relative five or more times. Five (15.2%) respondents had cared for a relative three times. Three respondents (9.1%) indicated that they had cared for a relative four times. Two subjects (67%) had cared for eight different relatives. One (3%) subject indicated

many as nine different relatives. It was also apparent that some respondents had cared for a particular relative on more than one occasion.

The question pertaining to which relatives the respondent had cared for had 80 total responses marked (Table 1). The most frequently given response was that of mother, with 12 (15%) indicating this response. Child was the next most frequent response with 9 (11.3%) giving this response. Spouse, grandparent, aunt, and father were each listed by five or more respondents. Four marked the category of "other." Three respondents wrote in cousin and the other entered cousin's wife.

Findings

The directional hypothesis tested in this study was that nurses' attitudes toward providing care for patients in the hospital setting who are not relatives are more positive than their attitudes toward providing care for patients who are relatives. The Perri Patient Care Questionnaire Part II was completed by 33 nurse respondents. Column A was summed for each nurse respondent, providing a total score for the nurses' attitudes toward providing care for relatives. Column B was summed similarly to provide a score for nurses' attitudes toward providing care for patients who were not

relatives. The possible range was from 20 to 100. The higher the score, the more positive was the attitude.

Table 1

Frequencies and Percentages of Types of Relatives Who Received Care

Relative	Frequency	Percentage
Mother	12	15.00
Child	9	11.25
Spouse	8	10.00
Grandparent	6	7.50
Aunt	6	7.50
Father	5	6.25
Brother	4	5.00
Spouse's mother	4	5.00
Spouse's father	3	3.75
Spouse's sister	3	3.75
Sister	2	2.50
Uncle	2	2.50
Nephew	2	2.50
Grandchild	2	2.50
Spouse's aunt	2	2.50
Niece	1	1.25
Spouse's grandparent	1	1.25
Spouse's brother	1	1.25
Spouse's uncle	1	1.25
Spouse's nephew	1	1.25

(table continues)

Relative	Frequency	Percentage
Spouse's niece	1	1.25
Other	4	5.00
Total	80	100.00

Scores for the nurses' attitudes toward caring for patients who were relatives varied from a minimum score of 68 to a maximum score of 97, with a range of 29. The mean was 81.94, with a standard deviation of 6.89.

Scores for the nurses' attitudes toward caring for patients who were not relatives ranged from a minimum of 69 to a maximum score of 96, with a range of 27. The mean for this column was 83.79, with a standard deviation of 6.65.

A dependent *t*-test for related samples was then calculated to test the hypothesis. The analysis of column-A scores (relatives) compared to column-B scores (not relatives) revealed a mean difference of $t = -2.515$, $df = 32$, which was significant at the $p = .008$ level. Therefore, the directional hypothesis that nurses would have a more positive attitude toward caring for patients in the hospital setting who were not their relatives than for patients who were their relatives was supported by the statistical data.

Additional Findings

Eleven items had a mean difference in ratings of .15 or more (Table 2) when comparing attitudes toward caring patients who were relatives and patients who were not relatives. For certain items the nurses apparently had more positive attitudes when providing care for patients who were not relatives compared to patients who were relatives. These eight items were #4--feel at ease in interpersonal nurse patient relationship, #5--discussing death/terminal illness, #7--discussing topics related to sexuality, #12--providing care for bathing/elimination needs, #14--administering uncomfortable treatments, #16--caring for patients with sexually transmitted disease, #17--discussing "No Code," and #18--communication is therapeutic.

Table 2

Nurses' Attitudes According to Items on the Perri Patient Care Questionnaire

Item Number	Means	
	Relatives	Not relatives
1. I feel that I meet patients' expectations of me.	4.42	4.30
2. I feel that I have confidence in myself and my nursing skills.	4.61	4.64

(table continues)

Item Number	Means	
	Relatives	Not relatives
3. I feel that I meet the expectations of the patients' families.	4.39	4.24
4. I feel at ease in the interpersonal nurse-patient relationship.	4.24	4.39
5. I feel comfortable when discussing terminal illness or death.	3.36	3.61
6. I feel that I provide appropriate reassurance to patients.	4.21	4.27
7. I feel at ease discussing topics related to sexuality.	3.33	3.64
8. I feel comfortable with my patient care assignments.	4.21	4.36
9. I feel at ease in discussing spiritual needs.	4.25	4.00
10. I feel that I carry out adequate patient teaching.	4.27	4.33
11. I feel satisfied with the quality of my nursing care.	4.50	4.53
12. I feel comfortable in meeting personal care needs such as bathing or elimination.	4.12	4.55
13. I feel capable of keeping privileged information confidential.	4.67	4.70
14. I feel at ease in the administration of an uncomfortable, but necessary procedure.	4.03	4.42
15. I feel that I devote sufficient time to the nursing process.	4.09	4.12
16. I feel comfortable caring for patients with sexually transmitted diseases.	3.35	3.61

(table continues)

Item Number	Means	
	Relatives	Not relatives
17. I feel at ease in discussing the medical decisions of "no code/DNR" with the families of patients.	3.85	4.06
18. I feel satisfied that my verbal communication is therapeutic.	4.06	4.24
19. I feel capable of assisting patients to cope with body image alterations.	3.94	4.06
20. I feel comfortable discussing ethical issues such as euthanasia or abortion.	3.94	3.94

There were three items for which the nurses appeared to have more positive attitudes when caring for a patient who was a relative as compared to a patient who was not a relative. These items were #1--meet patient's expectations, #3--meet patient's family's expectations, and #9--discussing spiritual needs.

Summary of Findings

The findings of this nonexperimental study of 33 registered nurses who completed the demographic data survey and Perri Patient Care Questionnaire supported the hypothesis. The Perri Patient Care Questionnaire measured nurses' attitudes about nurse-patient interactions when the patient was a relative or was not a relative. The results showed that nurses have a more positive attitude toward

providing care for patients in the hospital setting who are not relatives than towards providing care for patients who are relatives. The findings are significant at the p = .008 level, as determined from the statistical analysis.

Most of the nurses who responded to the study were from 31 to 51 years of age. Most of the respondents had been in nursing practice for more than 10 years. The most frequently cared for relatives in this sample were the nurses' mothers, children, spouses, grandparents, and aunts. Although a majority had only cared for a relative once or twice, seven nurses had cared for a relative at least five different times. One respondent had cared for as many as nine different relatives, while two others had cared for at least eight.

CHAPTER V

SUMMARY OF THE STUDY

This study was conducted to determine whether nurses have a more positive attitude towards caring for patients who are not their relatives in comparison to caring for patients who are their relatives. Selected demographic variables were examined in conjunction with the nurses' attitudes. This chapter includes a summary of the study and a discussion of the findings. The conclusions, implications, and recommendations for further study are also presented.

Summary

This ex post facto study was based on a conceptual framework guided by Hardy and Hardy's (1988) discussion of role and role conflict. According to Hardy and Hardy, a role generally refers to the expected and actual behaviors that are associated with a position. Role conflict is a condition in which existing role expectations are contradictory. This may happen when one is occupying two different roles at the same time and is expected to function in both roles at the same time.

Because there is a disparity of role expectations, values, and expected behaviors associated with the two positions of family member and nurse, role conflict may occur. This may cause nurses to have a less positive attitude toward caring for patients who are relatives than for patients who are not relatives.

A review of the literature indicated that in the informal family caregiving situations, the perception of role conflict is often voiced. There is often a great deal of stress in providing care to family members. One source of this stress indicated in the literature was from role conflict or the perception of it. Additionally, stress often comes from the emotional involvement rather than from the actual provision of care. In the case of the nurse providing professional care to his or her relative, there would be the emotional involvement in addition to the involvement in physical care.

The Perri Patient Care Questionnaire Part II, a demographic questionnaire, and a cover letter were distributed in a packet form by the nursing administration in the agencies used. The subjects in this study were 33 registered nurses employed at three community hospitals. All data obtained in the study were anonymous and the results were reported as group data.

Demographic results indicated most of the respondents were from 31 to 51 years of age. A majority (28 or 84.5%) of them had been in nursing for more than 10 years. Most had only cared for a relative once or twice, but seven had cared for a relative five or more times. Twenty-three different categories of relatives were indicated. The most commonly cared for relatives were mothers, children, spouses, grandparents, and aunts.

Nurses' attitudes toward providing care for patients who were their relatives as compared to patients who were not relatives were determined by completion of the Perri Patient Care Questionnaire Part II. This questionnaire consisted of 20 statements with Likert type responses in two columns corresponding to attitudes when caring for patients who were relatives and patients who were not relatives.

A dependent *t*-test was calculated after the columns were summed for all subjects. The test revealed a mean difference of $t = -2.515$, $df = 32$. This was significant at the $p = .008$ level. These data supported the directional hypothesis that nurses would have more positive attitudes toward caring for patients in the hospital setting who were not their relatives than for patients who were their relatives.

Discussion of Findings

Results of this study indicated that there may indeed be a role conflict, as described by Hardy and Hardy (1988), involved when the nurse cares for a relative. This role conflict may explain the less positive attitudes nurses have when caring for patients who were their relatives as compared to caring for patients who were not their relatives.

A majority of the literature on informal caregivers indicates there is significant stress or strain associated with caring for relatives. This comes from a variety of sources. Emotional sources such as confinement (Brody, 1985; Robinson & Thurnher, 1979), and role changes in the family (Bowers, 1987; Cantor, 1983; Mui, 1995; Robinson & Thurnher, 1979), were more significant than actual physical care. The anecdotal articles also supported this negative effect of role changes (Agne, 1993; Azoki, 1995; Baird, 1988; Couch, 1991; Majkowski & Russell, 1990; Tisdale, 1988).

Beach (1993), Brody (1985), and Mui (1995) indicated that caregivers had difficulty balancing their caregiving and their regular job. This could be supported by this study, which indicate nurses apparently feel less positive in providing care on the job to their relative. The emotional involvement of caring for a relative could effect

their job performance, as was indicated by Beach (1993) and Mui (1995).

Oberst et al. (1989) noted that the more closely related the individuals were, the greater the difficulty was in providing care for relatives. In this study, the relatives cared for most were closer in relation, such as mothers, children, and spouses, as opposed to more distant relatives. There was, however, no attempt in this study to determine the quality of the relationship between the nurse and the relative cared for.

Additional findings indicated that some of the items had a less positive directional pattern for the relative category. Most of the additional findings of this study were similar to those reported by Perri (1989) in a similar study of nurses' attitudes toward caring for social acquaintances.

Perri found that for certain items nurses apparently had more positive attitudes when caring for nonsocial acquaintances compared to social acquaintances. These items were: feeling at ease in interpersonal nurse-patient relationship, discussing death or terminal illness, discussing topics related to sexuality, being comfortable with patient assignment, providing care for bathing/ elimination needs, administering uncomfortable treatments, and assisting patients to cope with body alterations. In

this study, nurses also appeared to have a more positive attitude, on certain items, when caring for patients who were relatives compared to patients who were not relatives. These items were feeling at ease in interpersonal nurse-patient relationship, discussing death or terminal illness, discussing topics related to sexuality, being comfortable with patient assignment, providing care for bathing/ elimination needs, administering uncomfortable treatments, providing care for patients with sexually transmitted diseases, discussing "no code," and therapeutic communication with the patient.

Perri also found two items were rated positively for the patients who were social acquaintances. These items were feeling one met the expectations of the patient and the patient's family. In this study nurse respondents also indicated more positive responses to these two items when rating care for patients who were relatives compared to those who were not relatives. The respondents in the present study also reported more ease in discussing spiritual needs with relatives.

Some of the additional findings in this study also supported the literature. In this study, providing care for bathing/elimination needs had the widest variation in scores and the least positive score in regard to caring for relatives. Azoki (1995) noted embarrassment at washing her

mother's genitals. Wallhagan (1992) noted toileting the patient was subjectively the most difficult task of caregiving.

Discussing death was noted by Baird (1988) and Couch (1991) as more difficult for the nurse with her relative than it was with patients who were not relatives. It was also one of the less positive items for nurses in this study.

Respondents in this study indicated effective patient communication was rated less positively in regard to caring for a relative. This supported Knight (1985), Majkowski and Russell (1990), and Tisdale (1988) who also indicated difficulty in communication between nurses and their relatives.

Conclusions and Implications

Based on the findings of the present study, this researcher concluded that nurses are more comfortable caring for patients who are not their relatives than they are in providing care for patients who are their relatives. The findings imply that nurses' attitudes toward their patients may be negatively affected when the patient is a relative. The quality of the interpersonal nurse-patient relationship may thus be affected.

Nurses providing patient care should be aware of the negative attitudes that may arise if caring for a relative. It could be suggested that the quality of nursing care rendered to the patient may be negatively affected when the patient is also a relative. Nurse managers should also be aware of this in making their staff assignments. Nurse educators should consider advising students and staff of the study results.

Because overall scores were lower for the items relating to death, sexuality, spiritual needs, sexually transmitted diseases, "no code," body image, and ethical issues, nurse educators may need to revise curriculums to include more instruction regarding the nurses' role in these areas.

Recommendations for Future Study

Based on the findings of this study, the following recommendations for future research are suggested:

1. Because of the limited research related to nurses caring for their relatives, it would be advantageous to replicate this study with a larger sample size and in a different geographic area.

2. A similar study should be conducted that attempts to identify the quality of the nurse-patient relationship when the nurse is providing care for a relative.

3. More research should be done in those areas where the greatest difference existed in nursing attitudes toward caring for patients who are relatives versus patients who are not relatives. Nurses had less positive attitudes toward discussing death, sexuality, and sexually transmitted diseases with patients who are relatives than with patients who are not relatives. Two other areas of difficulty involved providing personal care for relatives and administering uncomfortable treatments to relatives.

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APPENDIX A

Human Research Review Committee
Exemption Form

TEXAS WOMAN'S UNIVERSITY
DENTON DALLAS HOUSTON
DALLAS CENTER

PROSPECTUS FOR THE THESIS

This prospectus proposed by: Janice Bannister

Social Security Number: 465-15-7621

Titled: Nurses' Attitudes Toward Caring for Their Relatives in the Hospital Setting

Has been read and approved by the members of his/her research committee.
This research (check one):

xx Is Exempt from Human Subjects Review Committee review because:

Data will be gathered through the use of anonymous questionnaires.

_____ Requires Full Human Subjects Review Committee review because:

_____ Requires Expedited Human Subjects Review Committee review because:

Research Committee: Type name	Signature
Rose Nieswiadomy (Chair)	Rose Nieswiadomy
Pat Stein	Pat Stein
Oneida M. Hughes	Oneida M. Hughes
Dean, College of Nursing	Carolyn S. Shannon 3/7/94
	Signature Date

APPENDIX B

Written Explanation to Subjects

301 A Eastern
Keene, Texas 76059

February 10, 1994

Dear Registered Nurse,

I am a graduate student working on my master's degree in nursing at Texas Woman's University. I am conducting a study concerning nurses' attitudes towards caring for their relatives in the hospital setting. Nurses who provide patient care could use the results of this study to better understand feelings that may arise when they are assigned to care for a relative in a hospital setting. Nurse managers may use the study results in making decisions about assigning nurses to care for their relatives.

I have received the appropriate approvals from your agency, as well as my university's research committee, to conduct this study. All information will be kept anonymous. Please do not place any identifying marks on the questionnaire. There is no known risk to you. Participation is voluntary, and your participation or non-participation will not affect your employment.

If you agree to participate, please complete the questionnaire. Part I asks for demographic information and Part II deals with your interactions with patients. Completion of this survey should take 10 - 15 minutes. When you have completed the questionnaire, please mail it to me using the enclosed stamped, pre-addressed envelope, within 10 days. Completion and return of the questionnaire will be considered your consent for participation in the study.

If you have any questions, you may contact the researcher at the address on the top of this letter, or you may reach me by phone at Results of the study will be available in the nursing office at your hospital when the study is completed.

Thank you for your time, interest, and participation in this project.

Sincerely yours,

Janice Bannister RN

Janice Bannister
Graduate Student
College of Nursing
Texas Woman's University

APPENDIX C

Demographic Data Form
and
Perri Patient Care Questionnaire

RETURN OF THIS QUESTIONNAIRE WILL BE CONSIDERED TO BE YOUR INFORMED CONSENT TO BE A RESEARCH SUBJECT IN THIS STUDY.

Demographic Data

Directions:

Please answer the following as accurately as possible. Place a check mark (✓) on the appropriate line.

1. Age:
   - ___ 20 years or younger
   - ___ 21 to 30 years
   - ___ 31 to 40 years
   - ___ 41 to 50 years
   - ___ 51 to 60 years
   - ___ 61 years or older

2. Years of nursing practice:
   - ___ Less than 1 year
   - ___ 1 to 5 years
   - ___ 6 to 10 years
   - ___ 11 to 15 years
   - ___ 16 to 20 years
   - ___ over 20 years

3. Have you ever had a relative who was a patient on the floor where you were working at the time?
   - ___ Yes
   - ___ No

4. Have you ever cared for a relative who was a patient on the floor where you were working at the time?
   - ___ Yes
   - ___ No

5. How many times have you cared for a relative?
   - ___ 0
   - ___ 1
   - ___ 2
   - ___ 3
   - ___ 4
   - ___ 5 or more times

6. Place a check mark by any relatives that you have cared for in the hospital. (Mark ALL that apply.)
   - ___ spouse
   - ___ mother
   - ___ father
   - ___ grandparent
   - ___ child
   - ___ brother
   - ___ sister
   - ___ aunt
   - ___ uncle
   - ___ niece
   - ___ nephew
   - ___ grandchild
   - ___ other_____
   - ___ spouse's mother
   - ___ spouse's father
   - ___ spouse's grandparent
   - ___ spouse's child
   - ___ spouse's brother
   - ___ spouse's sister
   - ___ spouse's aunt
   - ___ spouse's uncle
   - ___ spouse's niece
   - ___ spouces nephew
   - ___ spouse's grandchild

RETURN OF THIS QUESTINNAIRE WILL BE CONSIDERED TO BE YOUR INFORMED CONSENT TO BE A RESEARCH SUBJECT IN THIS STUDY.

Perri Patient Care Questionnaire

DIRECTIONS:

Please respond to the following statements on the left by choosing the best response in both columns A and B, according you the following key:

1--strongly disagree
2--disagree
3--uncertain
4--agree
5--strongly agree

	A When caring for patients who are relatives.					B When caring for patients who are not relatives.				
	strongly disagree	disagree	uncertain	agree	strongly agree	strongly disagree	disagree	uncertain	agree	strongly agree
1. I feel that I meet patients' expectations of me.	1	2	3	4	5	1	2	3	4	5
2. I feel that I have confidence in myself and my nursing skills.	1	2	3	4	5	1	2	3	4	5
3. I feel that I meet the expectations of the patients' families.	1	2	3	4	5	1	2	3	4	5
4. I feel at ease in the interpersonal nurse-patient relationship.	1	2	3	4	5	1	2	3	4	5
5. I feel comfortable when discussing terminal illness or death.	1	2	3	4	5	1	2	3	4	5

		A When caring for patients who are relatives.					B When caring for patients who are not relatives.				
		strongly disagree	disagree	uncertain	agree	strongly agree	strongly disagree	disagree	uncertain	agree	strongly agree
6.	I feel that I provide appropriate reassurance to patients.	1	2	3	4	5	1	2	3	4	5
7.	I feel at ease discussing topics related to sexuality.	1	2	3	4	5	1	2	3	4	5
8.	I feel comfortable with my patient care assignments.	1	2	3	4	5	1	2	3	4	5
9.	I feel at ease in discussing spiritual needs.	1	2	3	4	5	1	2	3	4	5
10.	I feel that I carry out adequate patient teaching.	1	2	3	4	5	1	2	3	4	5
11.	I feel satisfied with the quality of my nursing care.	1	2	3	4	5	1	2	3	4	5
12.	I feel comfortable in meeting personal care needs such as bathing or elimination.	1	2	3	4	5	1	2	3	4	5
13.	I feel capable of keeping privileged information confidential.	1	2	3	4	5	1	2	3	4	5
14.	I feel at ease in the administration of an uncomfortable, but necessary procedure.	1	2	3	4	5	1	2	3	4	5

		A When caring for patients who are relatives.					B When caring for patients who are not relative.				
		strongly disagree	disagree	uncertain	agree	strongly agree	strongly disagree	disagree	uncertain	agree	strongly agree
15.	I feel that I devote sufficient time to the nursing process.	1	2	3	4	5	1	2	3	4	5
16.	I feel comfortable caring for patients with sexually transmitted diseases.	1	2	3	4	5	1	2	3	4	5
17.	I feel at ease in discussing the medical decisions of "no code/ DNR" with the families of patients.	1	2	3	4	5	1	2	3	4	5
18.	I feel satisfied that my verbal communication is therapeutic.	1	2	3	4	5	1	2	3	4	5
19.	I feel capable of assisting patients to cope with body image alterations.	1	2	3	4	5	1	2	3	4	5
20.	I feel comfortable discussing ethical issues such as euthanasia or abortion.	1	2	3	4	5	1	2	3	4	5

Adapted from Perri, D. (1989). Nurses Attitudes Toward Patients Who Are Social Acquaintances.

APPENDIX D

Permission to Use Questionnaire

15914 Archwood Lane
Dallas, Texas 75248

November 20, 1992

Ms. Janice Bannister
301 A Eastern
Keene, Texas 76059

Dear Janice,

I appreciate your interest in my thesis and request for use of the instrument that I developed, "The Perri Patient Care Questionnaire." You have my full permission to use the tool as it is or with modifications appropriate for your study.

Please do not hesitate to call me at home or at work if I may answer any questions or provide additional assistance. I will be happy to sign and return any required release forms if necessary.

I am interested to know the results of your study and would appreciate a copy when your study is concluded. Best wishes on the research and writing of your thesis.

Sincerely,

Dottie Perri

Dorothy G. Perri

APPENDIX E

Agency Permission Forms

TEXAS WOMAN'S UNIVERSITY
COLLEGE OF NURSING

AGENCY PERMISSION FOR CONDUCTING STUDY*

THE ______________________________

GRANTS TO Janice Bannister

a student enrolled in a program of nursing leading to a Master's Degree at Texas Woman's University, the privilege of its facilities in order to study the following problem.

Nurses' attitudes toward caring for their relatives in the hospital setting.

The conditions mutually agreed upon are as follows:

1. The agency (~~may~~) (may not) be identified in the final report.
2. The names of consultative or administrative personnel in the agency (may) (~~may not~~) be identified in the final report.
3. The agency (wants) (~~does not want~~) a conference with the student when the report is completed.
4. Other: #3 - Written and/or inservice for the nursing personnel would be beneficial & supportive to the research process in a clinical setting -

February 21, 1994
Date

Helen T. LeClair, RN, MSN
Signature of Agency Personnel

Janice Bannister RN CS
Signature of Student

Rose Nieswiadomy PhD
Signature of Faculty Advisor

* Fill out & sign 3 copies to be distributed:
Original: Student, 1st copy: Agency
2nd copy: TWU College of Nursing

TEXAS WOMAN'S UNIVERSITY
COLLEGE OF NURSING

AGENCY PERMISSION FOR CONDUCTING STUDY*

THE_____

GRANTS TO Janice Bannister

a student enrolled in a program of nursing leading to a Master's Degree at Texas Woman's University, the privilege of its facilities in order to study the following problem.

Nurses' attitudes toward caring for their relatives in the hospital setting.

The conditions mutually agreed upon are as follows:

1. The agency ~~(may)~~ (may not) be identified in the final report.
2. The names of consultative or administrative personnel in the agency ~~(may)~~ (may not) be identified in the final report.
3. The agency ~~(wants)~~ (does not want) a conference with the student when the report is completed.
4. Other:

_____

_____

_____

2-24-94
Date

_____
Signature of Agency Personnel

Janice Bannister RN
Signature of Student

Rose McSwiveny, Ph D
Signature of Faculty Advisor

* Fill out & sign 3 copies to be distributed:
Original: Student, 1st copy: Agency
2nd copy: TWU College of Nursing

TEXAS WOMAN'S UNIVERSITY
COLLEGE OF NURSING

AGENCY PERMISSION FOR CONDUCTING STUDY*

THE Harris Methodist Erath County Hospital

GRANTS TO Janice Bannister

a student enrolled in a program of nursing leading to a Master's Degree at Texas Woman's University, the privilege of its facilities in order to study the following problem.

Nurses' attitudes toward caring for their relatives in the hospital setting.

The conditions mutually agreed upon are as follows:

1. The agency (may) (may not) be identified in the final report.
2. The names of consultative or administrative personnel in the agency (may) (may not) be identified in the final report.
3. The agency (wants) (does not want) a conference with the student when the report is completed.
4. Other:

2-21-94 — Date

Barbara Taylor — Signature of Agency Personnel

Janice Bannister — Signature of Student

Rose Nieswiadomy PhD — Signature of Faculty Advisor

* Fill out & sign 3 copies to be distributed:
Original: Student, 1st copy: Agency
2nd copy: TWU College of Nursing

APPENDIX F

Graduate School Permission to Conduct Study

TEXAS WOMAN'S UNIVERSITY
DENTON DALLAS HOUSTON
THE GRADUATE SCHOOL
P.O. Box 22479, Denton, Texas 76204-0479 817/898-3400 FAX 817/898-3412

May 9, 1994

Ms. Janice Bannister
301 A S Eastern
Keene, TX 76059

Dear Ms. Bannister:

I have received and approved the Prospectus for your research project. Best wishes to you in the research and writing of your project.

Sincerely yours,

Leslie M Thompson

Leslie M. Thompson
Associate Vice President for Research
and Dean of the Graduate School

dl

cc Dr. Rose Nieswiadomy
Dr. Carolyn Gunning