DISENGAGEMENT FROM PATIENT RELATIONSHIPS:
NURSES’ EXPERIENCE IN ACUTE CARE

by

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ABSTRACT
Nursing is uniquely demanding work and occupational stress in the nursing profession has been well-documented. Many theories of stress-related disruptions among helping professionals have been proposed. Although these theories differ slightly in their origin of stress, they share similarities in nurses’ response to the patient relationship. Depersonalization, withdrawal, and avoidance all serve to create relational distance between the nurse and the patient. Despite the prevalence of these responses, there are not any theories on the nurses’ process of disengagement from patient relationships. Using Strauss and Corbin’s (1990) grounded theory method, this study explored acute care nurses’ experience of disengagement in patient relationships. The purpose of the study was to develop a mid-range theory of nurses’ process of disengagement from patient relationships as it occurred in acute care. Through purposive and theoretical sampling, 12 acute care nurses participated in open-ended individual interviews. The process of open, axial and selective coding discovered seven categories related to nurses’ experience of disengagement from patient relationships. These categories were emotional experience, behavioural expression, environmental influences, relational distance, professional identity and work spillover. Although these categories were exclusive, conceptual elements were interwoven into more than one category. The categories were interrelated around the core category, ‘Doing and Being’, and the process of nurses’ disengagement from patient relationships was delineated. Participants in the study experienced dissonance when they were unable to act in accordance to their caring beliefs. Conditions in the work environment, such as the lack of time, the culture of productivity and patient characteristics influenced and promoted their process of disengagement. Disengagement was manifested in the nurse-patient relationship by decreased eye contact, increased physical distance and increased task focused behaviour.
These behaviours increased relational distance between the nurse and the patient. Nurses’ experience of dissonance had the potential to foster feelings of professional dissatisfaction and alienation from self, leading to increased turnover behaviour and depression. Implications and recommendations for practice and future research are discussed.
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Definition of Concepts and Terms

Acute Care: Typically short-term medical and/or surgical treatment for patients experiencing an acute illness or injury or recovering from a surgery.

Burnout: A syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that occurs in people engaged in helping work (Maslach, 1982).

Compassion Fatigue: A state of tension and preoccupation with the traumatized patients by re-experiencing the traumatic events, avoidance/numbing of reminders, and persistent arousal associated with the patient (Figley, 1995).

Disengagement: The process by which nurses’ retreat physically and emotionally from the patient relationship. This process is influenced by nurses’ caring beliefs and conditions in the work environment.

Dissonance: An aversive psychological state that arises in the presence of conflicting thoughts, emotions and behaviours (Festinger, 1957).

Nurse: The term nurse refers to registered nurse (RN). The classification of nurse (i.e. student nurse, licensed practical nurse, nurse’s aide) is specified when necessary.

Moral Distress: Psychological disequilibrium and negative feeling state experienced when a person makes a moral decision, but does not follow through by performing the moral behaviour indicated by that decision (Wilkinson, 1987).

Secondary Traumatic Stress Disorder: The natural consequent behaviours and emotions resulting from knowing about a traumatizing event experienced by a significant other- the stress of wanting to help a traumatized or suffering person (Figley, 1993).

Snowed: A colloquial term used by nurses to describe the effects of large amounts of sedative medication.
Trached: The presence of a tracheostomy, the surgical opening of the trachea.

Vicarious Traumatization: The transformation in a therapist’s (or other trauma worker’s) inner experience resulting from empathic engagement with client’s trauma material (McCann & Pearlman, 1990).
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Dedication

For Scott,

Without you, this would not have been possible.
CHAPTER ONE: INTRODUCTION

The nurse-patient relationship is the soul of the nursing profession. It is the vehicle through which nursing care is delivered; it is the essence of nursing practice. The nurse-patient relationship has been extensively philosophized and researched, however, a cohesive theory of nurse-patient relationships is absent from the literature.

The concept of care is a defining feature of the nurse-patient relationship. Specifically, the nurses’ physical and emotional presence is a critical component in caring relationships. However, a paradox exists in nursing practice. Modern medicine rejects the notion of presence in caring in favour of clinical objectivity. According to Schultz and Carnevale (1996), this objectivist stance is the crisis of modern medicine and the consequence is disengaged care. It has been revealed that professionals and patients alike suffer from disengaged care (Gadow, 1980; Schultz & Carnevale, 1996). Despite the deleterious implications of disengaged care, nurses’ experience of this phenomenon has not been studied.

The literature on stress-related disruptions in helping relationships offers some insight into nurses’ experiences of disengagement. Over the past 30 years, there has been much research on stress-related disruptions in helping relationships. Maslach’s (1982) theory of burnout is one of the most notable theories of occupational stress in the nursing literature. The Maslach Burnout Inventory (Maslach & Jackson, 1981) holds high reliability in nursing populations (Evans & Fischer, 1993), thus supporting the occurrence of the burnout syndrome among nurses. According to burnout theory, nurses objectify or depersonalize patients in response to occupational stress.
The theory of moral distress originated in the field of nursing and numerous authors have contributed to its theoretical development (e.g., Rodney, 1988; Storch, Rodney, Pauly, Brown, & Starzomski, 2002; Wilkinson, 1987). Nurses’ experiences of moral distress occur when their moral beliefs are incongruent with their moral action. Withdrawal and avoidance of patient relationships have been identified as responses to moral distress.

The field of traumatology has also significantly contributed to several conceptualizations of stress arising from patient relationships. Figley (1993; 1995) developed the theory of secondary traumatic stress based on his research with traumatized populations. Compassion fatigue is a type of secondary stress reaction among trauma counsellors. Similar to nurses’ response to moral distress, withdrawal and avoidance are often responses associated with secondary traumatic stress disorder and compassion fatigue.

Based on their constructivist self-development theory of trauma, McCann and Pearlman (1990) conceptualized vicarious traumatization in trauma therapists. They assert that with exposure to clients’ trauma, therapists experience shifts in their psychological foundations. Vicarious traumatization is similar to secondary traumatic stress disorder and compassion fatigue, however, the focus of vicarious traumatization is on the alterations of the therapists’ cognitive schemas rather than objective symptoms of the stress response.

Nursing has long been recognized as uniquely intimate and stressful work. For nearly three decades, researchers have studied occupational stress in the nursing profession. Psychological characteristics of the health care environment, such as time constraints, conflicting demands, and involvement in life and death situations have been shown to precipitate job stain and emotional exhaustion (e.g., Comeau, Vezina, & Dion, 1998; Gaudine, 2000; Gray-Toft & Anderson, 1981; McGillis Hall & Kiesners, 2005). The acute
care environment is a particularly stressful work environment as nurses are exposed to multiple stressors and treatment goals are often ambiguous (Holly, 1993).

**The Rationale and Purpose of the Study**

Based on the literature review, it is evident that acute care nursing is uniquely demanding work. The call for emotional presence in an objective and chaotic work environment fosters occupational stress and the development of stress-related disruptions among nurses. The majority of occupational stress research has been quantitative, with few qualitative studies on nurses’ experiences of stress. More qualitative research is necessary to deepen our understanding of occupational stress for nurses.

The literature provides some information on the nature of stress arising from helping relationships, however, much of the research is not relevant to nurses’ experiences of working in acute care. Most theories of stress-related disruptions stem from work with traumatized populations, specifically psychologically traumatized individuals. Acute care nurses work with patients who are not only potentially psychologically traumatized, but physically as well. Responsible for providing both physical and psychological patient care, nurses are faced with challenges unique to their area of practice.

Without an empirically grounded and cohesive theory of nurse-patient relationships, we are unable to understand the dynamics of this relationship in various contexts. The literature identifies numerous, potentially synonymous, responses to emotionally demanding relationships including depersonalization, withdrawal and avoidance, however, the causes, conditions and consequences of these responses are not clearly delineated. There were no studies found in the literature that explored nurses’ experience of these responses to patient relationships as they occurred in their work environment.
The Research Question

Given the paucity of research on nurses’ experience of disengagement in patient relationships and the potential implications of disengagement, the following question must be posed: “What is nurses’ process of disengagement from patient relationships in acute care?” The purpose of this study is to explain the acute care nurses’ experience of disengagement from relationships with patients as they occur in their work environment. The research objective is to develop a mid-range theory of disengagement in nurse-patient relationships in acute care.
CHAPTER TWO: LITERATURE REVIEW

This study explored nurses’ experiences of disengagement from patient relationships in acute care settings. Although many related studies have been conducted, no research could be found that specifically addressed the phenomenon of disengagement in nurse-patient relationships as it occurred in acute care.

In the following literature review, I integrate writings on several topics related to the phenomenon of disengagement in nurse-patient relationships and draw on research from numerous fields of study, including organizational behaviour, nursing and traumatology. The occupational stress literature illuminates the types of stressors experienced by nurses and the literature on stress-related disruptions identifies potential responses to these stressors. Theories of nurse-patient relationships offer some insight into the relational development between nurses and patients. From these theories and research on stress in helping professions, the theme of emotional withdrawal, or disengagement, emerges as a response to caring for others.

I begin with a review of theories of nurse-patient relationships and a discussion of concepts related to disengagement. I then review the research on occupational stress in the nursing profession, followed by the literature on stress-related disruptions in helping relationships. Finally, I discuss the unique challenges encountered by nurses working in acute care settings.

Nurse- Patient Relationships and the Phenomenon of Disengagement

Theories of Nurse-Patient Relationships

The nurse-patient relationship (NPR) is the soul of the nursing profession. The relationships that develop between the nurse and the patient are the foundation of nursing
practice (Layton, 1994; Williams, 1990). By definition, the word ‘nurse’ describes a specific relationship involving a giver and a receiver of care. Sally Gadow, a prominent nurse philosopher, has extensively discussed the centrality of the nurse-patient relationship in nursing (Gadow, 1980; 1989), proclaiming, “nursing ought to be defined by the ideal nature of the nurse-patient relationship” (Gadow, 1980, p. 80).

There are various theories of nursing and conceptualizations of the nurse-patient relationship (e.g., Benner & Wrubel, 1989; Leninger, 1984; Orlando, 1961; Peplau, 1952; Travelbee, 1971; Watson, 1985), however, it seems as though the nursing profession has not yet achieved consensus on the role and the dynamics of the nurse-patient relationship. While several theorists agree that nursing is an interpersonal process (e.g., Orlando, 1961; Peplau, 1952; Travelbee, 1971), there has not been agreement as to what this process entails.

Peplau (1952) was the first theorist to conceptualize nursing as an interpersonal process. Her theory of interpersonal relations described four overlapping phases of the nurse-patient relationship: orientation, identification, exploitations and resolution (Peplau, 1988). While Peplau’s theory does acknowledge nurses experience of the nurse-patient relationship, her theory focuses primarily on the experience of the patient in the relationship. In addition, her theory is static in nature and does not consider the context in which the nurse-patient relationship occurs.

Peplau’s theory, as well as other theories of nurse-patient relationships (e.g., Travelbee, 1971, Watson, 1985), seem to be derived from unstructured observations rather than systematic research. Inductive research on nurses’ experiences with patients is clearly needed to further our understanding of the process of nurse-patient relationships.
Responding to the paucity of information about the developmental process of nurse-patient relationships, Morse (1991) conducted a grounded theory study to investigate the types of nurse-patient and patient-nurse relationships. A total of 86 interviews were held with 44 nurses in eight clinical areas. Morse extended her sample to include patients’ perspectives, gathering data from nurses who had also been patients. The emerging theory of nurse-patient relationships was validated with 59 secondary informants. According to Morse’s research, nurses and patients overtly and covertly negotiate the development of mutual and unilateral relationships. Mutual relationships ascend in level of involvement and intensity from clinical relationships to therapeutic relationships, to connected relationships, and finally, to over-involved relationships. In unilateral relationships, either the nurse or the patient is unwilling or unable to develop the relationship further. Morse identified strategies used by both nurses and patients to inhibit involvement in the relationship, such as depersonalization of the patient, maintaining an efficient attitude, and avoidance of eye contact.

Morse’s (1991) developmental model offers some insight into nurses’ experience of disengagement from patient relationships, indicating that nurses will depersonalize patients as a strategy to inhibit the development of the relationship. This study did not reveal, however, nurses’ motivation to decrease relational involvement with patient. Although Morse’s study indicated that nurses’ ability to establish relationships with patients differed across the eight clinical areas, these differences were not explicated. In addition, Morse sought to identify both nurses and patients experiences of nurse-patient relationships, therefore, these unique perspectives are enmeshed in her theory. Clearly, further research is required to isolate and identify acute care nurses’ psychological experience of disengagement from patient relationships.
Hagerty, Lynch-Sauer, Patusky, and Bouwsema (1993) inductively and deductively derived a theory of human relatedness in response to the need for a framework to understand patient behaviour. They concurrently reviewed the literature and conducted focus groups with patients to develop the concept of relatedness. The authors proposed four states of relatedness: connectedness, disconnectedness, parallelism, and enmeshment. These four states were located along two dimensions, involvement-noninvolvement and comfort-discomfort. Of significance to the current study on disengagement, Hagerty et al. stated that disconnectedness was experienced when a person was not actively involved with another person. This lack of involvement was associated with psychological discomfort.

While Hagerty et al’s (1993) study furthers our knowledge of nurse-patient relationships, their theory emerged primarily from patients’ experiences of the relationship for the purpose of understanding patient behaviour. Their theory does not further our understanding of nurses’ experiences and nurses’ behaviours associated with nurse-patient relationships. Hagerty et al’s theory is therefore limited in its applicability. Future research is necessary to explore nurses’ experience of involvement and psychological well-being in relationships with patients.

Competing Paradigms: Caring versus Objectivity

Caring has been described as the defining characteristic of nursing (Leninger, 1984). Florence Nightingale first used the concept of caring in relation to nursing in the 1800’s (Nightingale, 1986). Although the terms caring and nursing are often used synonymously, the concept of caring in nursing has never been fully explicated. Existing definitions of caring are diverse, but all involve some form of relationship and the concept of presence (Gilje, 1992; Schroeder, 1992).
Two components of presence in nursing have been identified: the physical and the psychological (Patterson & Zderad, 1988). Gardner (1985) describes nurses’ physical and psychological presence as “being there” and “being with.” From both the nurses’ and the patients’ perspectives, presence is a necessary component to caring (Forest, 1989; Riemen, 1986). The absence of presence has been regarded as the absence of relationship and the absence of soul (Buber, 1965; Daly, 1984; Riemen, 1986).

A paradox exists in nursing practice. Presence is an essential component to caring, however, modern medicine opposes presence and asserts that health care professionals must maintain a “safe distance” between themselves and their patient (Gadow, 1980; Schultz & Carnevale, 1996). Patient subjectivity is avoided in favour of clinical objectivity (Gadow, 1989). The medical values of objectivity, quantifiability and efficiency, however, do not lend themselves well to understanding the meaning of patient relationships (Schultz & Carnevale, 1996).

Gadow (1989) coined the term disembodiment to describe the process of patient objectification. By regarding their own bodies as objects, nurses are, in turn, able to objectify patients, thus denying their subjective experience. Working in an overwhelmingly objective environment fosters nurses’ tendency to disembody from their relationships with patients (Gadow, 1989).

According to Schultz and Carnevale (1996), health care professionals recoil from patients’ suffering to escape confronting their own fragility and morality. This escape response is referred to as disengagement (Shultz & Carnevale, 1996). Disengaged care fosters ethical dilemmas because the caregivers fail to understand their patients’ subjective
experience. Irreverence for patients’ experience impedes responsible care giving (Schultz & Carnevale, 1996).

**Emotional Demand of Nurse-Patient Relationships**

Nursing is inherently emotional work. Nurses witness, alleviate, and inflict patients’ pain and suffering. Acknowledging the unique emotional demand of nursing work, several authors have explored nurses’ responses to emotional labour (Henderson, 2001), the demands of caring (Montgomery, 1993; 1997), and the process of inflicting pain (Schroeder, 1992). From this research, the theme of disembodiment, or disengagement, emerges as a response to caring.

Nursing has been described as emotional labour (Henderson, 2001; Smith 1992). The concept of emotional labour depicts an occupation where employees must portray emotions in a genuine and authentic manner (Hochschild, 1983). Henderson (2001) explored nurses’ approach to the emotional labour inherent to their profession. As part of a larger study, fifty nurses working in various clinical settings were interviewed to elicit personal and professional experiences that may have an impact on their provision of care. The nurses in this study were eager to discuss emotional engagement and detachment as a response to caring. Nurses had difficulty balancing engagement and detachment in emotionally demanding circumstances. Although the nurses valued emotional engagement in relationships with patients, engagement involved personal and professional costs. Nurses’ willingness to engage with patients was influenced by support within their work environment. According to Henderson, emotional engagement and detachment in caring work are under-theorized concepts.
Using grounded theory, Montgomery (1993) investigated the communication of caring among health care professionals. She initially sampled nurses as participants and then extended her sample to include a diverse group of caregivers. In total, 45 interviews were conducted. From this research, she developed a model illustrating how caregivers cope with the emotional demands of caring. Montgomery discovered that nurses who ascribe negative meaning to their caring experiences became emotionally depleted. Emotional depletion then resulted in the caregivers withdrawal or detachment from caring.

While Montgomery’s (1993) work furthers our understanding of caregivers’ responses to emotional depletion, nurses’ responses are enmeshed with other health care professionals. She acknowledged the influence of contextual factors on caregivers experiences of caring, however, she did not explicate these effects. Given the unique demands nurses confront in acute care settings, it is necessary to conduct further research on nurses’ responses to emotional depletion within this specific context.

In her review of the literature, Schroeder (1992) analyzed the structure of torture and the infliction of pain in nursing. She identified nurses tendency to disemboby (Gadow, 1989) when inflicting pain as an attempt to avoid suffering with patients. According to Schroeder, torturers also disemboby to deny their victims suffering. Schroeder claimed that when nurses disemboby, the relationship with patients is severed. She continued to state that if nurses remained in relationship with patients while inflicting pain, the structure of torture would not occur. This provocative examination of the literature indicates that nurses retreat from patient relationships in response to the infliction of pain. Evidently, further research is required to understand nurses’ process of retreating from patient relationships and the potential implications of this response.
Morse, Botoroff, Anderson, O'Brien and Solberg (1992) produced a model of nurses emotive engagement with suffering patients in response to inappropriate models of communication used in nursing curriculum. In their model, the authors describe four types of communication patterns: engaged responses, anti-engaged responses, pseudo-engaged responses and a-engaged responses. According to Morse et al., nurses’ level of engagement with patients is determined by whether they are focused on themselves or on the patient. Of relevance to the current study, nurses in the a-engaged pattern of communication are self-focused, typically responding in a detached manner. The authors contend that detached responses are professionally learned responses. They argue that although reflexive and intuitive responses are more therapeutic for patients, nursing devalues intuition and promotes professionally conditioned detached or a-engaged responses.

Although Morse et al’s (1992) model of communication deepens our understanding of nurses’ level of engagement with patients, their model seems to be derived from previous research and clinical observations rather than systematic inductive research. In addition, nurses’ psychological experience of disengagement is not explored in depth. Future research on nurses’ experience of disengagement from patient relationships is necessary to further our understanding of this process.

**Research Implications**

Although several authors have discussed nurses’ response of disengagement from caring relationships with patients, there is no consensus in the literature as to whether this response is harmful or helpful. Disembodiment objectifies patients (Gadow, 1980) and severs human relationships (Schroeder, 1992). By distancing from patient relationships, nurses are unable to adequately address patients’ psychological and emotional needs (McQueen, 2000;
Schultz & Carnevale, 1996). According to Schultz and Carnevale (1996), disengaged, or instrumentalized, care is “fundamentally inconscionable” because it jeopardizes not only the quality of patient care, but the life and character of the health care professional as well (p.198).

The majority of nurses in Henderson’s (2001) study felt that emotional engagement is a requirement for excellence in nursing. Emotional engagement fosters positive outcomes for patients and there is evidence that patients agree (McQueen, 2004). Other authors contend that disengagement in response to overwhelming stress is perceived as protective, promoting nurses’ well-being (Figley, 2002; Hagerty, 1993; Morse et al, 1992). While most encouraged emotional engagement, some of the nurses in Henderson’s study (2001) emphasized the need for detachment to ensure effective nursing.

The study of nurses’ experience of disengagement from patient relationships is critical to further our understanding of nurse-patient relationships. Although the importance of disengagement has been acknowledged, the literature is comprised of theoretical and philosophical discussions, with little empirical research on the process of disengagement. Existing research is inconsistent and inconclusive. While some authors contend that disengagement is harmful (Gadow, 1980; Schroeder, 1992; Schultz & Carnevale, 1996), others assert some level of disengagement serves a protective function for nurses (Halpern, 2003; Morrison, 1989; Morse et al., 1992). Given the potentially harmful implications of disengagement for both nurses and patients, further research of this phenomenon is critical to the delivery of health care.
Occupational Stress in Nursing

Over the past two decades, stress-related illnesses have become a serious health issue in our society. Recent research shows that occupational stress contributes significantly to physical and mental illnesses, imposing a considerable financial burden on society (Advisory Committee on Health Resources [ACHR], 2002; O’Brien-Pallas et al., 2004). Health care providers have been recognized as particularly vulnerable to the development of occupational stress. Compared to other occupations, health care providers are one-and-a-half times more likely to be absent from work due to illness or disability (O’Brien-Pallas et. al., 2004). In the province of British Columbia, stress and burnout account for an estimated 40% of disability costs among health care providers, with nurses suffering from the highest rates of workplace disabilities (O’ Brien-Pallas et al., 2004). Evidently, occupational stress in health care and the nursing profession has serious implications for individual employees, health care organizations and society.

Occupational stress in nursing has been extensively researched. Using a variety of methodologies, researchers have sought to understand the characteristics of nurses’ work environments that foster stress. In general, three main themes of occupational stress emerge repeatedly: job control, workload and the emotional demands of caring (Bourbonnais et al., 1998; Gaudine, 2000; Gray-Toft & Anderson, 1981a, 1981b; Landsbergis, 1988; McGillis Hall & Kiesners, 2005; Parkes, 1985).

Job Control

Karasek’s (1979) research on job demand and job control furthers our understanding of occupational stress in nursing. Based on survey research of Swedish and American adult male populations, Karasek developed the Job Demand-Control Model (JD-C). The model
postulates that psychological strain results from the interactive effects of job demands and the decision-making latitude of employees (Karasek, 1979). Job demands are the psychological stressors involved in accomplishing the work, such as conflicting demands, task interruption and time constraints. Decision-making latitude is defined as the employee’s control over work tasks. According to Karasek’s model, high job demands combined with low decision-making latitude results in job strain (Karasek, 1979).

Several studies have supported Karasek’s JD-C model of job strain in health care settings (Bourbonnais et al, 1998; Landsbergis, 1988; Laschinger, Finegan, Shamian, & Almost, 2001). Landsbergis (1988) studied the relationship between job characteristics and burnout to test Karasek’s model. Using the Job Content Questionnaire (JCQ, Karasek, 1985) and the Maslach Burnout Inventory (MBI, Maslach & Jackson, 1981), he surveyed 289 health care workers from two hospitals and one nursing home-- 177 of whom were registered nurses. The JCQ measures job characteristics (i.e., decision-latitude) and psychological strain (i.e., job dissatisfaction) and the MBI assesses a syndrome of emotional exhaustion and cynicism, known as burnout (Landsbergis, 1988). His findings revealed a significant relationship between job strain and emotional exhaustion, thus supporting Karasek’s JD-C model among health care workers.

Bourbonnais, Comeau, Vezina and Dion (1998) used Karasek’s model of job strain to determine the nature of the relationship between high job strain and the prevalence of emotional exhaustion and psychological distress among nurses. They used Karasek’s (1985) JCQ to measure job strain and the Maslach and Jackson’s (1981) MBI to measure emotional exhaustion. Psychological distress was assessed using the Psychiatric Symptom Index (PSI),
which measures the degree of anxiety, aggressiveness, depressive symptoms, and cognitive problems experienced during the previous week (Ilfeld, 1976).

All three questionnaires were translated to French, validated and distributed to nurses employed in six acute care hospitals in the province of Quebec. Sixty-two percent (1891) of nurses responded and the sample was representative of the population. Based on their responses to the questionnaires, nurses in the study who were exposed to high psychological demands and low decision latitude experienced psychological distress and emotional exhaustion. These results supported the association between job strain, psychological distress and emotional exhaustion.

**Workload**

Increasing patient acuity and critical nursing shortages have led to increased workload for nurses (ACHR, 2002). Gray-Toft and Anderson (1981a) developed the Nursing Stress Scale (NSS), a 34 item likert scale to measure the frequency of potentially stressful situations. In their study (1982b), the authors administered the NSS (Gray-Toft & Anderson, 1981), the IPAT Anxiety Scale (Krug, Scheier, & Cattell, 1976) and the Job Description Index (JDI) (Smith, Kendall, & Hulin, 1969) in their study (1981b) of 122 nurses in five patient care units to determine the cause and frequency of stressors experienced by hospital nursing staff. Their results revealed that nurses on all of the units reported workload as the most frequent cause of stress.

Healy and McKay (2000) also used the NSS (Gray-Toft & Anderson, 1981a) in combination with the Ways of Coping Questionnaire (WOCQ) (Folkman & Lazarus, 1988), the Job Satisfaction Scale of the Nurse Stress Index (Harris, Hingley, & Cooper, 1988) and the Profile of Mood States (POMS) (shortened version, Shacham, 1983) to examine the
relationships between nursing work-related stressors, coping strategies, job satisfaction and mood disturbance. They administered the four measures to 129 nurses employed in a variety of health care settings. As in Gray-Toft and Anderson’s (1981b) study, their findings identified workload as the highest reported stressor. In addition, they revealed an association between mental distress and higher levels of perceived nursing stress, and in particular workload.

Although quantitative studies provide valuable information about the volume of work, they do not explore the meaning nurses ascribe to the term workload. Recognizing this gap, Gaudine (2000) interviewed 31 nurses and explored the meaning of the concept of workload. Their content analysis revealed nine categories of workload characteristics, demonstrating the variety of meanings that nurses attributed to the word “workload”. Of particular interest, many nurses in their study equated the word “workload” with the concept of exhaustion. The nurses reported feeling emotionally exhausted because of the nature of their work and, consequently, their emotional exhaustion confounded their perception of their workload.

In their narrative study of eight hospital nurses, McGillis Hall and Kiesners (2005) explored issues of importance in nurses’ working lives. Their interviews yielded three main themes: (1) patient acuity, (2) workload and, (3) understaffing and adequacy of patient care. Although all three themes were interrelated, workload and understaffing dominated the nurses’ narratives. The nurses in the study felt a tremendous burden of guilt when factors in the work environment, such as workload, impaired their ability to provide quality care.
Emotional Demands of Caring

Nursing is both physically and emotionally demanding work. Repeatedly confronted with patients’ needs and suffering, the emotional demands of caring arise out of nurse-patient relationships (Henderson, 2001; Smith, 1992). The emotional demand of caring for ill and dying patients has been identified as a major source of occupational stress for nurses (Gray-Toft & Anderson, 1981b; Parkes, 1985). Regardless of the hospital unit, all of the nurses in Gray-Toft and Anderson’s (1981b) study experienced stress resulting from attempts to meet the emotional demands of patients and their families and exposure to death and dying.

Although all of the nurses reported death and dying as a source of stress, the mean score differed across the hospital units. The nurses working on a medical unit reported the highest levels of stress from exposure to death and dying, whereas, the nurses working in a hospice reported the lowest levels of stress from this source. The authors hypothesized that this difference is related to the high levels of uncertainty and ambiguity in medical settings compared to low levels in hospice settings.

Parkes (1985) examined stressful episodes reported by student nurses during the early part of their training. She conducted interviews with 150 student nurses and asked them to describe a recent stressful event occurring in the course of their work. Three major categories of stressful episodes emerged from the data, accounting for nearly two-thirds of the total episodes. Issues concerned with the care of dying patients were the most frequently reported stressful episodes (29.6% of total episodes). The student nurses in the study were particularly distressed with their observations of nurses’ responses to dying patients. Feeling ill equipped to work with dying patients; the student nurses coped through the use of avoidance.
Research Implications

Although Karasek’s (1979) JD-C model of job strain has been supported in nursing research, I believe the model neglects to consider the emotional aspect of nursing work. For example, the job demand scale measures psychological stressors in the work environment, such as time constraints and conflicting demands (Karasek, 1979), but the characteristics of these stressors are unclear. Nurses enter into the profession because of a desire to care for others (George, 1995) and they may feel constrained when they do not have time to provide emotional support to patients and families. The job demand scale does not address the meaning of psychological stressors.

Several researchers have studied workload stress; however, the majority has used quantitative measures, which do not capture the subjective experience of workload stress. As Gaudine (2000) and McGillis Hall and Kiesners (2005) discovered, nurses experienced feelings of emotional exhaustion and guilt in relation to the term “workload.” These findings indicate that the emotional aspects of nurses’ work significantly influence their experience, and perhaps reporting, of workload stress. Therefore, it is possible that quantitative studies on workload are not measuring work volume in isolation; they may also be measuring the emotional stress involved when caring for others.

Clearly, nurses experience stress from the emotional demands of caring for others. The nurse-patient relationship is fraught with feelings of emotional exhaustion and guilt when nurses are unable to meet patients’ needs. Although research on occupational stress has identified the emotional stress of caring, the nurses response to this stress remains unclear. The literature on stress-related disruptions in helping relationships furthers our understanding of nurses’ responses to emotional stress and the impact on the nurse-patient relationship.
Stress-Related Disruptions in Helping Relationships

Over the past thirty years, several conceptualizations have been proposed to explain the unique emotional costs of caring for others. Research on burnout, moral distress, compassion fatigue, secondary traumatic stress disorder, and vicarious traumatization abound the occupational stress literature (e.g., Corley, Eiswick, Gorman, & Clor, 2001; Evans & Fischer, 1993; Maslach & Jackson, 1981; Maytum, Bielski Heiman, & Garwick, 2004; Storch, Rodney, Pauly, Brown, & Starzomski, 2002). Regardless of the label applied, stress-related disruptions impact the helping relationship. I introduce the various stress-related disruptions and discuss the implications for the nurse-patient relationship.

Burnout

The term burnout has been widely incorporated into the occupational stress literature since Herbert Freudenberger first introduced it in 1974 (e.g., Langle, 2003; Leiter & Laschinger, 2005; Pines, 2000; Maslach, 1982; Wright & Bonnet, 1997). Freudenberger, a clinical psychologist, observed a series of characteristic symptoms such as exhaustion, irritability and cynicism, occurring in himself and his colleagues while working for aid organizations (Kahill, 1988). Freudenberger attributed the development of these symptoms to the emotional demand of working with people in need (Kahill, 1988). Burnout is therefore understood as a unique type of job stress.

Maslach (1982) extended Freudenberger’s work on burnout and her conceptualization is widely cited and researched in occupational stress literature. Maslach (1982) defined burnout as, “a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment” (p.3) that can occur in people working in helping professions. Burnout
differs from other sources of job stress as it arises within the social interaction of the helping relationship (Maslach, 1982).

Emotional exhaustion is characterized by feelings of fatigue and an inability to give of one’s self to others any longer (Maslach, 1982). Depersonalization, the second dimension of the burnout syndrome, is the development of a detached and cynical response towards clients, colleagues and the organization. Clients are dehumanized and objectified as a self-protective attempt to create distance in the helping relationship (Maslach, 1982). The final dimension of the syndrome, personal accomplishment, is characterized by negative self-evaluations and feelings of professional inadequacy. Increased absenteeism and job turnover may be indicative of feelings of reduced personal accomplishment (Landstrom, Biordi, & Gilles, 1989; Maslach, 1982). The burnout syndrome is generally regarded as a developmental process, beginning with emotional exhaustion, followed by depersonalization, and finally leading to reduced personal accomplishment (Maslach, 1982).

Maslach and Jackson (1981) developed the Maslach Burnout Inventory (MBI) to measure the burnout syndrome. Since its’ development, researchers have almost exclusively used the MBI to measure burnout (Leiter & Laschinger, 2005). The MBI is a 22-item likert scale questionnaire measuring the three dimensions of the syndrome: emotional exhaustion, depersonalization and personal accomplishment. The 7-point items range from 0=never to 6=every day and these items are summed to create the three subscales. Higher scores on the subscales reflect greater degrees of emotional exhaustion, depersonalization, and personal accomplishment (Maslach & Jackson, 1981).

Several studies have demonstrated psychometric soundness of the MBI and support for the occurrence of burnout among helping professionals (Evans & Fischer, 1993; Maslach
& Jackson, 1981), however, the usefulness of certain aspects of the tool has been critiqued (Kalliath, O’Driscoll, Gillepsie, & Bluedorn, 2000). The emotional exhaustion subscale of the MBI has demonstrated the greatest predictive validity and, therefore, is recognized as the core dimension of the burnout syndrome (Maslach, 1982; Wright & Bonnet, 1997). Interestingly, research on non-human service samples indicates that only human service providers experience depersonalization and reduced personal accomplishment (Evans & Fischer, 1993). These findings suggest that depersonalization and reduced personal accomplishment are unique to the work of helping professionals.

Nurses are particularly susceptible to the development of burnout. The profession is plagued by numerous work conditions that foster burnout (Demerouti, Bakker, Nachreiner & Schaufeli, 2000; McVicar, 2003) and nurses’ vulnerability is reflected by the vast amount of literature on the topic. There has been much research on burnout, including the potential antecedents of burnout (e.g., Ekstedt & Fagerberg, 2005; Meltzer & Huckabay, 2004), the existential meaning of burnout (e.g., Langle, 2003; Pines, 2000) and nurses’ responses to burnout (e.g., Bengtsson & Brink, 2003; Rafii, Oskouie, & Nikravesh, 2004). While this provides useful information for possible prevention and treatment, there has been relatively little research on the relational outcomes of burnout.

**Research Implications**

Burnout arises within the context of helping relationships, implying that the syndrome is relational in nature. According to burnout theory, depersonalization precedes emotional exhaustion. Caregivers become emotionally exhausted when they feel overwhelmed by the needs of others. Depersonalization, or objectification, occurs as a result of the need for self-protection and the consequential development of a detached, callous and dehumanized
response to patients (Maslach, 1982). Depersonalization is similar to the notion of disembodiment (Gadow, 1989) and disengagement (Schultz & Carnevale, 1996) because all three responses are an attempt to create emotional distance in the helping relationship. It seems intuitively reasonable that depersonalization would impact nurse-patient relationships; however, this has not been explored.

There have been a few studies exploring the relationship between nurses’ burnout and patient satisfaction (Gravlin, 1994; Leiter, Harvie, & Frizzell, 1998; Vahey, Aiken, Sloane, Clarke, & Vargus, 2004). All three studies identified an inverse relationship between nurse burnout and patient satisfaction. Higher scores on the MBI correlated with lower scores on the patient satisfaction measures. In addition, two of the three studies (Gravlin, 1994; Leiter, Harvie, & Frizzell, 1998) discovered that depersonalization was related negatively to patient satisfaction, while the other dimensions of burnout were not. This relationship between depersonalization and patient satisfaction indicates that depersonalization may affect nurse-patient relationships. Vahey, Aiken, Sloane, Clarke, and Vargus (2004), however, did not identify the same association between depersonalization and patients’ dissatisfaction with the care they received. The research findings on the relationship between depersonalization and nurse-patient relationships are scarce and inconsistent.

There is a paucity of research on the relational outcomes of burnout. The burnout research has indicated that nurses’ level of depersonalization is variable across hospital units (Murji, Gomez, Knighton, & Fish, 2006); however, the reason for this finding is unknown. Depersonalization has not been studied independently of the other dimensions of burnout. Due to its variable reliability, the usefulness of the depersonalization subscale of the MBI has
been questioned (Evans & Fischer, 1993). These authors caution that it is possible that studies using the MBI to measure depersonalization may be inaccurate and unreliable.

Burnout is generally regarded as the outcome of occupational stress, however, as Maslach (2001) identified, it is not the final outcome. She calls for more extensive research on, “how burnout actually affects a person’s work behaviour, personal life and well-being” (Maslach, 2001, p. 609). Given the potentially deleterious and far-reaching implications of depersonalization, there clearly exists a need for further research on nurses’ experience of stress and nurse-patient relationships.

**Moral Distress**

Philosopher, Andrew Jameton, first defined moral distress in nursing practice in 1984. According to Jameton (1984), “moral distress arises when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action” (p. 6). Wilkinson (1987) further explored the relationship between moral aspects of nursing practice and the quality of patient care, specifically the incongruence between moral decisions and moral behavior. Her research identified several situations that lead to feelings of moral distress among nurses. Wilkinson (1987) then refined the definition of moral distress as the, “ psychological disequilibrium and negative feeling state experienced when a person makes a moral decision, but does not follow through by performing the moral behaviour indicated by that decision” (p.16).

Nearly two decades after Jameton (1984) first introduced the phenomenon of moral distress, Corley, Eiswick, Gorman, and Clor (2001) developed the Moral Distress Scale (MDS) to measure moral distress among nurses. They reviewed research on moral distress and interviewed a panel of experts to establish content validity. A convenience sample of 214
hospital nurses was used to test the instrument. The 32-item likert scale demonstrated high validity and reliability in measuring moral distress among nurses working in hospital settings (Corley et al., 2001). Since the introduction of moral distress and the MDS, researchers have extensively studied the phenomenon of moral distress in nursing practice (e.g., Elpern, Covert, & Kleinpell, 2005; Gutierrez, 2005; Storch, Rodney, Pauly, Brown, & Starzomski, 2002). Elpern, Covert and Kleinpell (2005) used the MDS and open-ended questionnaires to study moral distress among nurses working in a medical intensive care unit. The purpose of their study was to assess nurses’ level of moral distress and identify situations associated with significant moral distress.

Twenty-seven nurses responded to the questionnaires. Nurses reported high levels of moral distress, both in intensity and frequency, when they felt they were providing aggressive medical treatment to patients who would not benefit. High levels of moral distress had profound implications on nurses’ job satisfaction, interaction with patients and colleagues, and both psychological and physical functioning. The nurses spoke of “blocking” or avoiding interaction with patients when they experienced moral distress.

In her qualitative study, Gutierrez (2005) sought to understand critical care nurses’ experience of moral distress. She explored the types of moral conflicts leading to distress, nurses’ interpretations of these conflicts, constraints and support for moral action, and the effects of moral distress on patient care. Purposive sampling was used to recruit twelve critical care nurses working in surgical intensive care. In open-ended interviews, she addressed the three interacting moral concepts, which provide the foundation for moral distress: moral conflict, moral judgment, and moral action (Gutierrez, 2005). The majority of nurses (92%) identified overly aggressive medical treatment as the most distressing type of
moral conflict. The nurses experienced intense negative feelings in response to moral conflict. These negative feelings caused nurses to emotionally and physically withdraw from patients and colleagues. Although the nurses initially denied that moral distress had any effects on patient care, they later revealed their reluctance to engage in relationships with patients involved in moral conflicts. As discussed, nurses’ reluctance to engage in relationships with patients causes the patient additional suffering (Gadow, 1989).

**Research Implications**

Elpern, Covert, and Kleinpell (2005) and Gutierrez (2005) both identified nurses’ reluctance to engage in relationships with patients who triggered feelings of moral distress. According to Peter and Lischenko (2004), nurses attempt to escape the proximity of patient relationships in order to alleviate their feelings of moral distress. This escape may be achieved by leaving the nursing profession (Sumner & Townsend-Rocchiccioli, 2003; Peter & Lischenko, 2004), or, as the authors identified, by withdrawing emotionally from the nurse-patient relationship. Although these studies identified nurses’ responses of withdrawal, the process and implications of withdrawal were not discussed.

**Compassion Fatigue, Secondary Traumatic Stress Disorder, and Vicarious Traumatization**

The term compassion fatigue was first coined by Joinson (1992) to describe nurses’ experience of emotional exhaustion. She cited three core issues of compassion fatigue: the deliverance of self, that insatiable nature of human need and the psychological conflict of multiple care-giving roles. According to Joinson, the development of compassion fatigue mimics typical responses to stress and, therefore, may not be recognized. She advised nurses
to assess their emotional health and nurture themselves to prevent the deleterious consequences of compassion fatigue (Joinson, 1992).

Figley (1995) expanded the definition of compassion fatigue and incorporated it into his work on secondary traumatic stress (STS) and secondary traumatic stress disorder (STSD). In his work with traumatized populations, Figley identified STS responses, “the natural consequent behaviours and emotions resulting from knowing about a traumatizing event experienced by a significant other- the stress of wanting to help a traumatized or suffering person” (Figley, 1993). STSD is the progression of STS responses into a syndrome characterized by feelings of helplessness, confusion, isolation and disconnection (Figley, 1995; Valent, 1995). Symptoms of STSD develop suddenly and without warning (Figley, 1995). STSD is nearly identical to post traumatic stress disorder (PTSD) as they both involve re-experiencing, avoidance and arousal. The only differentiation between PTSD and STSD is whether the traumatizing stressor is primarily or secondarily experienced (Figley, 1995). Therefore, an understanding of this construct may be useful in our understanding of nurses’ disengagement from patient relationships.

Figley (2002) defines compassion fatigue as, “a state of tension and preoccupation with the traumatized patients by re-experiencing the traumatic events, avoidance/numbing of reminders, and persistent arousal associated with the patient” (p.1435). He uses the terms STS and compassion fatigue interchangeably to describe secondary stress reactions among helping professionals. According to Figley (1995), the use of empathy in client relationships is one of the reasons why trauma workers are particularly vulnerable to compassion fatigue.

In their descriptive qualitative study, Maytum, Bielski Heiman and Garwick (2004) sought to identify the characteristics of coping strategies used by nurses to manage
compassion fatigue and prevent burnout in their work with children and their families. They conducted open-ended interviews with a purposive sample of twenty key informants, all of whom were currently working with chronically ill children. The sample consisted of nurses with various levels of training, including licensed practical nurses, registered nurses and advanced practice nurses.

The nurses identified four categories of work-related stressors that trigger compassion fatigue and burnout. Sixty percent of the participants cited excessive workload as a trigger and felt distraught when they were unable to provide quality care as a result. The majority of participants used personal short-term strategies to cope with compassion fatigue and burnout, such as journaling and exercise. All of the participants indicated a balance between work and personal life as critical to managing compassion fatigue and burnout.

The authors claim they identified a trigger for compassion fatigue and burnout unique to pediatric nurses working in chronic care settings: the witnessing of patients’ suffering and dealing with the emotional demands of the family. This finding is not new. Several authors (e.g., Gray-Toft & Anderson, 1981; Schroeder, 1992) have identified these emotional stressors among nurses working in other care settings. Therefore, it is possible that nurses experience similar triggers to compassion fatigue and burnout, regardless of the patient population and the health care setting.

Maytum et al., (2004) identified several coping strategies used by nurses to manage compassion fatigue and burnout. Interestingly, the nurses did not identify any negative or unhealthy coping strategies (e.g., use of alcohol); they were all positive, healthy coping behaviours (e.g., journaling). I believe the interview questions (e.g., “How did you get through feeling burnt out?”) were presumptuous and leading and possibly prevented nurses
from responding openly. Nurses who did not ‘get through’ feeling burned out or who used less favourable coping strategies may have not felt comfortable responding openly.

Vicarious traumatization is another stress-related disruption arising from helping relationships and is regarded as a unique and inevitable consequence of trauma work (McCann & Pearlman, 1990). Based on their constructivist self-development theory of trauma, McCann and Pearlman (1990) define vicarious traumatization as, “the transformation in a therapist’s (or other trauma worker’s) inner experience resulting from empathic engagement with client’s trauma material” (p.151). Both the characteristics of the trauma work and the personal characteristics of the helping professional contribute to the development of vicarious traumatization (Pearlman & Saakvitne, 1995). Vicarious traumatization develops insidiously and is characterized by significant changes in the psychological foundation of those affected (Pearlman & Saakvitne, 1995). Whereas STSD focuses on the development of observable symptoms, vicarious traumatization is concerned with alterations in cognitive schemas and personal meaning (McCann & Pearlman, 1990).

Research Implications

Since the roots of compassion fatigue, secondary traumatic stress disorder and vicarious traumatization are located in the field of traumatology and clinical psychology, most research on these disruptions has been with helping professionals exposed to trauma, such as trauma therapists and emergency responders (e.g., Collins & Long, 2003; Figley, 2002; Jenkins & Baird, 2002;). The literature in nursing is mostly anecdotal and discussional in nature (e.g., Clark & Gioro, 1998; Sabo, 2006; Schwam, 1998), with little qualitative and quantitative research on these stress-related disruptions. Only one qualitative research study investigating compassion fatigue among nurses was found (Maytum et al, 2004). Many of the
existing studies and reviews (Maytum, Bielski, Heiman, & Garwick, 2004; Pross, 2006; Sundin-Huard & Fahy, 1999) combine more than one stress-related disruption with various other concepts, thus confounding the discussion. Given the paucity of research on the nurses’ experience of the relational consequences of compassion fatigue, secondary traumatic stress disorder and vicarious traumatization, further research on nurses’ process of disengagement from patient relationships is warranted.

**Acute Care Experience**

Acute care is typically a hospital based short-term medical and/or surgical treatment unit for patients experiencing an acute illness, injury or recovering from surgery (The American Heritage Dictionary, 2006). The composition of patients in acute care is distinctive from other hospital units. With an aging population and technological advances, patient acuity and complexity in acute care is increasing (O’Brien-Pallas et al., 2004). Compounding the problem, patients are remaining in acute care units longer than medically necessary due to shortages of extended care beds in the community (McGrail, Evans, Barer, Sheps, Hertzman, & Kazanjian, 2001; Ostry, Tomlin, Cvitkovich, Ratner, Park, Tate, & Yassi, 2004). The patients are therefore in varying stages of illness and recovery and, correspondingly, at different stages of treatment. Patients may be receiving active medical treatment, rehabilitation or end-of-life comfort care.

Early studies of occupational stress in nursing indicated that the most powerful predictor of stress frequency was the type of hospital ward (Dewe, 1988). Intensive care, emergency and palliative units are typically considered the most stressful and the literature reflects this assumption. There have been numerous studies of the various stress-related disruptions in these hospital settings (e.g., Gutierrez, 2005; Meltzer & Huckabay, 2004), with
little attention given to acute care settings. Gray-Toft and Anderson (1981) discovered that the level of nurses’ stress did not differ; rather it was the relative frequency of the types of stressors that differed across the units. The nurses in their study experienced the same sources of stress, regardless of unit (Gray-Toft & Anderson, 1981).

As discussed, the emotional demand of care is a significant stressor for nurses. Inflicting pain and witnessing suffering have been identified as particularly difficult aspects of nursing care (Holly, 1993; Schroeder, 1992). Although all nurses must inflict pain and suffering on their patients, I believe nurses in acute care encounter this stressor more frequently than nurses in many other units. Compared to palliative care, for example, where the goal is to ensure patients’ comfort and dignity, the treatment goals in acute care are often unclear. Treatment ambiguity often presents nurses with moral and ethical dilemmas (Holly, 1993; Peter & Liachenko, 2004). Patients in acute care are typically undergoing active, usually aggressive, medical treatment. Aggressive medical treatment usually involves painful, invasive and dehumanizing procedures. Holly (1993) discovered that nurses’ greatest concern with nursing care was the emotional and physical harm inflicted on patients by aggressive treatment plans. Given the emotional demands of working in acute care, it is important to explore the process nurse-patient relationships within this context.

**Summary of the Literature Review**

As revealed by the literature review, much research has occurred on various aspects of the nursing profession in the past 30 years. Nurses have been identified as particularly susceptible to experiencing occupational stress due to the unique demands of their work. Job control, workload and emotional demands of caring have been repeatedly reported as significant stressors for nurses.
Research in occupational stress has been primarily quantitative, with few qualitative studies exploring the nurses’ meaning of stress. Although these studies have provided valuable information on the types of stressors nurses’ experience, they do not offer insight into nurses’ experience of these stressors. The few existing qualitative studies of occupational stress in nursing have suggested that the meaning of the stressor influences the frequency (McGillis Hall & Kiesners, 2005). Further qualitative research is needed to deepen our understanding of nurses’ experience of occupational stress.

The literature on stress-related disruptions in helping relationships arises from numerous disciplines. Although the term differs for each theory, a common theme of withdrawal emerges as a response to the emotional demand of caring relationships. Based on the research, it remains unclear whether withdrawal from helping relationships is harmful or helpful for nurses’ emotional well-being. Given the potential implications of withdrawal from helping relationships, there is a need for more research on the phenomenon of disengagement.

Most of the research on stress-related disruptions has been conducted in the field of trauma. Although these theories provide insight into the acute care nurses’ experience of nurse-patient relationships, they do not consider the unique challenges nurses encounter in this setting. Clearly, future research must explore acute care nurses’ experience of disengagement.
CHAPTER THREE: METHODOLOGY

Strategy of Inquiry

Given the lack of empirical research on the topic of disengagement in nurse-patient relationships, I followed a grounded theory methodology to explore nurses’ experience of this phenomenon. Grounded theory is an inductive approach to the development of theories. Inductive reasoning is exploratory in nature, beginning with specific observations of patterns to formulating tentative hypotheses (Trochim, 2000). From these hypotheses, broader generalizations and theories are then developed. Im and Meleis (1999) claim that traditional quantitative approaches that rely on assumptions of normality and statistical reliability are not useful for understanding and developing knowledge in situations where the researcher is attempting to capture the intricacies of interactions. Grounded theorists collect unique and individual meanings people have and their social processes involved in a substantive area, and then conceptualize the experience based on the data. The goal of grounded theory is to inductively derive a theory that is grounded in the data from the field.

Two sociologists, Barney Glaser and Anselm Strauss (1967), developed the methodology of grounded theory. Their postpositivist theory was influenced by the interactionist and pragmatist writings of Blumer (1969), Dewey (1922), and Meade (1932) to name but a few (Strauss & Corbin, 1990). Glaser and Strauss (1967) believed that theories should be ‘grounded’ in the actions, interactions and social processes of people in the field under investigation (Creswell, 1998). After many years of collaboration, Glaser and Strauss parted ways, with Strauss joining Juliet Corbin, and two different methodologies emerged. Discovery is at the heart of both the Glasserian (1978) and the Straussian (1990) method, however, differences are found in the interventions and activities used by the researcher.
during the discovery process (Walker & Myrick, 2006). In brief, Glaser emphasizes patient emergence of data, whereas Strauss and Corbin (1990) prescribe a more systematic approach (Annells, 1997; Boychuk & Morgan, 2004).

As a novice researcher, I was apprehensive about analyzing a large amount of data without the use of detailed procedures and techniques. Strauss and Corbin’s (1990) version of grounded theory provided a structured approach to data analysis and was, therefore, the primary methodology used in this study. It was necessary, however, to adapt the methodology to meet academic requirements. While a literature review is a mandatory component of a thesis, the aim of grounded theory is to approach the phenomenon with an open mind to foster the process of discovery. To limit imposition of existing concepts and theories, the researcher does not review the literature prior to data collection (McLeod, 2001). A literature review was conducted prior to collecting the data, however, it was not assumed to be inherently true. As the concepts and relationships emerged, the literature was used to stimulate theoretical sensitivity (Strauss & Corbin, 1990).

**Issues of Representation**

The representation of the researcher in qualitative inquiry is inevitable (Mantzoukas, 2004). Postpositivist research that does not include the researcher is violating the integrity of the paradigm (Mantzoukas, 2004). Consequently, the lack of researcher representation has a direct effect on the rigour of the research endeavor (Koch, 1994). To produce rigorous research, qualitative researchers should identify their epistemological and ontological beliefs at the beginning of their studies (Manzoukas, 2004).

Postpositivism refers to the epistemological thinking after positivism and challenges traditional assumptions of knowledge and truth (Creswell, 2003). As a postpositivist, I do not
believe in the existence of an absolute truth or reality when studying human behaviour. Even if truth and reality exist, the human mind could not rationally legitimize such claims. I believe reality and truth are subjective experiences. Throughout my exploration of the phenomena, I strived to capture the intricacies of participants’ individual meanings, while acknowledging the inextricable nature of my role within the research.

Researchers should have some knowledge of the world they are exploring, whether through past experience or experience gained during the study. It is this experience in the setting that assists the researcher to acquire contextual knowledge needed for analysis of the data (Bowers, 1988). As a nurse who has worked in an acute care setting, I have experienced disengagement in patient relationships. I have also observed what I believe to be disengagement among my colleagues and students. These experiences provided insight and increased my sensitivity to the participants’ experience of the phenomenon. Throughout the research process, I monitored the significance of my voice and ensured participant representation through the use of memos, member checks and peer debriefing sessions.

**Data Collection**

**The Sample**

The participants in a grounded theory study must have experience with the social process under investigation so they can reflect on and talk about their experience (Creswell, 1998). Initially, purposive sampling was used to obtain nurses who currently worked in acute care, had 1-10 years nursing experience and resonated with the term disengagement. Studies have revealed gender differences in emotional expression and responses to occupational stress (Krajewski & Goffin, 2005; Simpson & Stroh, 2004). Given the potential for gender difference to confound the results, I restricted my sample to female nurses. Participants were
recruited primarily by circulating the recruitment poster over the intranet accessible to all employees at a large general hospital. Recruitment posters were also placed on three acute care units and other locations within the hospital.

Theoretical sampling is used in grounded theory to guide data collection on the basis of emerging concepts that have proven theoretical relevance to the evolving theory. Theoretical sampling is continued until saturation is achieved (Strauss & Corbin, 1990). The theory is saturated when the researcher ceases to gain new information or insights from the data being collected (McLeod, 2001). Although sample size is not predetermined in grounded theory, typically large samples ranging from 20-30 are required to saturate the theory (Creswell, 1998).

A total of 12 nurses participated in the study and data were collected over a period of six months. After a few participants were obtained through purposive sampling, further sampling was guided by the emerging categories. It became apparent that years of nursing experience was not relevant to the evolving theory and was subsequently removed as an inclusion and exclusion criterion. Theoretical sampling, therefore, guided the selection of future participants. While saturation was achieved in some categories and contexts, it was not achieved in all categories due to imposed constraints of time, energy and availability of participants.

All of the participants were female and ranged in age from 21-59 years, with a mean age of 38 and a median of age of 33.5. Of the 12 nurses, 3 held a nursing diploma, 9 held baccalaureate degrees in nursing and one was pursuing a master’s degree in another field. Years of experience ranged from 9 months to 37 years, with a mean of 13.6 and a median of 7.5. The participants had experience in many clinical areas including general medicine,
oncology, burns and plastics, labour and delivery, renal dialysis, rehabilitation, emergency room, operating room, intensive care unit and an abortion clinic. At the time of the study, all of the participants worked in an acute care setting at a large hospital.

The Method

Individual interviews were the primary method of data in collection in the study. They were conducted at a private location, either at the hospital site, the university or the participants’ home, and ranged from one to two hours in duration. Prior to the interview, participants were asked to reflect on their experience of disengagement in patient relationships and to recall a particular story to share during the interview. The research purpose was explained and written consent was obtained at the beginning of each interview. To limit the influence on participants of previous theoretical constructs of disengagement, the interviews began with open-ended, exploratory questions about the participants’ experience of disengagement (Strauss & Corbin, 1990). Questions were modified as needed based on theoretical relevance (Appendix C, Interview Guide).

Interviews were audio-taped and a denaturalized approach to transcription was adopted (Oliver, Serovich & Mason, 2005). In contrast to naturalized speech, denaturalized transcription does not depict idiosyncratic elements of speech (Oliver et al, 2005). Denaturalized transcripts attempt a verbatim depiction of speech, however, it is the meanings and perceptions within speech that construct reality (Oliver et al, 2005).

A participant focus group was conducted during selective coding to validate the evolving theory of disengagement. The group was held at a private location located in the hospital. Due to schedule conflicts and attrition from the study, only four nurses participated in the focus group. The average age of participants in the focus group was 41 years and the
median age was 41.5 years. In brief, the evolving theory of disengagement in nurse-patient relationships was validated by the participants. The data gathered from the focus group were integrated and analysed and these findings are embedded in the presentation of the results in chapter four.

In addition, two expert interviews were conducted to verify the theory. Both of the experts interviewed had worked in the health care field for over 30 years. With a background in nursing, one of the experts currently works at the director level in the development and implantation of mental health programs for health care professionals. The other reviewer had clinical experience in social work and currently practices as a mental health practitioner for health care professionals. In brief, the reviewers validated the findings of the study and underscored the importance of conducting research on the mental health of health care professionals.

Memoing was the secondary method of data collection in this study. Throughout the research process, I recorded my ideas about the codes, the categories and the categorical relationship. The memos served to keep the emerging theory of disengagement in nurse-patient relationships grounded in the data (Strauss & Corbin, 1990). The media, informal observations on the hospital unit and informal discussions were other sources of data that influenced the research findings. In total, data were collected over a period of 18 months.

Data Analysis

Data collection and data analysis is a simultaneous process in grounded theory methodology. Data analysis begins with the first interview and then the information gathered guides further data collection (Strauss & Corbin, 1990). I will describe the data analysis in a linear fashion; however, the analysis was performed in an on-going, circular manner.
Open Coding

Open coding is the initial step of analysis in grounded theory. It is the process through which data are fractured, examined, compared, conceptualized and categorized (Strauss & Corbin, 1990). Through line-by-line analysis, over 200 concepts emerged from the words of participants in the study. The concepts became categories by grouping like concepts with other like-concepts as they related to the phenomenon of disengagement. Categorization was guided by asking the data the following questions: (1) “What is this?” (2) “What does it represent?” (Strauss & Corbin, 1990, p.63) and, “How does this relate to the research question?” Using the constant comparison method, data were compared with emerging categories and grouped accordingly.

Axial Coding

Axial coding is the second step of Strauss and Corbin’s (1990) version of grounded theory. The purpose of this step is to re-connect the categories and identify the relationships between them (Strauss & Corbin, 1990). This process is directed by the paradigm model, which focuses on three aspects of the phenomenon: the conditions in which the phenomenon occurs, the actions and interactions taken in response to the phenomenon, and the consequences of those actions (Strauss & Corbin, 1990). As will be portrayed in chapter four, a paradigm model of nurses’ experience of disengagement in patient relationships was developed during axial coding.

Selective Coding

Selective coding, the process of integrating and refining a theory, is the final step of data analysis in this method (Strauss & Corbin, 1990). In this process, researchers
selectively code around a core category that has been identified in the data (Walker & Myrick, 2006). After the core category of nurses’ experience of disengagement was identified, the remaining categories were ordered in relation to the core. The conceptual ordering of the categories was then translated into narrative form as the “story line”.

In grounded theory, researchers engage in discriminant sampling during selective coding. Discriminant sampling is performed to obtain data needed to support or refute the categorical relationships and the story line. This sampling process may involve returning to the participants or the literature to verify the evolving theory. As discussed, a participant focus group and two expert interviews were conducted during selective coding.

Based on the story line, a conceptual model was developed to display the categorical relationships. The story line and the conceptual model were then compared against the data to determine the fit of the evolving theory. According to Strauss and Corbin (1990), the researcher is assessing for a general fit and it is not expected that every single case will fit exactly (Strauss & Corbin, 1990). While there was one case of disengagement that did not fit as well as the others, the majority of cases did fit the story line and conceptual model of disengagement in nurse-patient relationships.

**Mid-range Theory of Disengagement in Nurse-Patient Relationships**

The three-step analysis of open, axial and selective coding produced a middle-range theory of nurses’ experience of disengagement in patient relationships in acute care. Middle-range theories, as coined by the sociologist Merton (1968), are theories that, “lie between the minor but necessary working hypotheses that evolve in abundance during day-to-day research” (p.39). Middle-range, or mid-range, theories can be developed either deductively from grand theory or inductively from empirically grounded concepts (Lasiuk & Ferguson,
They are more concrete than grand theories and are applicable across several, but not all, practice settings (Lasiuk & Ferguson, 2005). Although they are less abstract and more limited in scope, mid-range theories have the capacity to describe, explain, and make predictions about concrete phenomenon of interest to a discipline (Lasiuk & Ferguson, 2005).

**Rigour**

Multiple perspectives exist regarding the criteria and techniques required to establish rigour, however, the pursuit of common goodness criteria is both necessary and worthy in qualitative research (Emden & Sandelowski, 1998). Criteria are the standards adhered to establish rigour and techniques are the methods used to adhere to these standards (Whittemore, Chase & Mandle, 2001). Using a variety of techniques, I drew from Beck’s (1993) three main proposed criteria for rigour: credibility, auditability, and fittingness (Chiovitti & Piran, 2003).

**Credibility**

Credibility in qualitative research refers to the trustworthiness of the research findings (Beck, 1993). To meet the standard of credibility, I allowed participants to guide the process of inquiry to ensure that their experience of disengagement in patient relationships was accurately identified and delineated. As concepts emerged from the data, I modified the interview questions and shifted the focus of inquiry to reflect nurses’ experiences. Participants’ language was used during coding to minimize the potential for distortion and misrepresentation. According to Lincoln and Guba (1985), “member checks are the most critical technique for establishing credibility” (p. 314). The focus group conducted during selective coding functioned both as discriminant sampling and member checking. By conducting a member check, I invited participants to, “refine, develop and revise the
emerging theoretical structure” of disengagement in nurse-patient relationships (Chiovitti & Piran, 2003, p. 341).

Researcher’s biases have the potential to influence data, threatening the credibility of the study (Creswell, 2003). I limited my influence on the data by identifying my past experiences as a nurse and nurse instructor. By writing memos throughout the research process, I monitored my insights and ideas as they occurred. I also engaged in peer review debriefing sessions with colleagues to “keep me (the researcher) honest” (Creswell, 1998, p.202).

**Auditability**

Auditability reflects the consistency of the research study (Chiovitti & Piran, 2003) and is measured by the ability of another researcher to follow the audit trail (Beck, 1993). To establish an audit trail, I recorded my ideas and decisions in the form of memos. The paradigm model established during axial coding also served as a trail allowing other researchers to follow the emergence of categorical relationships (Chiovitti & Piran, 2003).

**Fittingness**

The standard of fittingness in qualitative research refers to transferability of the findings generated from the research (Beck, 1993). Theoretical and discriminant sampling are verification procedures embedded within the grounded theory method designed to establish fittingness. As discussed, sampling was guided by the theoretical relevance of the data collected and the fit of the categories and the categorical relationships were verified.
Ethical Concerns

Multiple Roles

Multiple role relationships are ethically problematic in research. Multiple role relationships arise when the researcher is simultaneously or sequentially involved in two or more relationships with another person (Kitchener, 2005). Conflicting obligations and expectations lead to feelings of confusion and frustration among participants and researchers alike (Kitchener, 2005). Researchers need to consider potential role conflicts and evaluate their ethical implications.

As a counsellor to health care professionals, an acute care nurse, a clinical nurse educator, and a researcher, I am aware that I engaged in multiple roles. Nurses with whom I have current or have had previous relationships may have felt coerced to participate in the study. To minimize the risk of harm, I excluded participants with whom I had a counselling relationship, who currently worked in acute care neuroscience at Vancouver General Hospital and nurses whom I had instructed.

Confidentiality

Maintaining confidentiality is grounded in the foundational ethical principles of autonomy, fidelity, beneficence and non-maleficence (Kitchener, 2000). Qualitative research poses certain challenges to maintaining participants’ confidentiality. Characterized by specific details of the participants’ experience, qualitative data is difficult to disguise (Haverkamp, 2005).

To respect participants’ confidentiality, audiotapes and transcriptions were coded numerically and participants selected pseudonyms. All identifying information, including third party information, was removed from the research documents. The documents were
stored in a locked filing cabinet and on a computer hard drive protected by a password. Only individuals directly involved in the research had access to the research documents. Participants were informed that, although their identity would remain confidential, the research results would be included in a public document, a thesis in the University of British Columbia library system.

**Informed Consent**

In accordance with the ethical principle of autonomy, informed consent to participate in the study was obtained. Participants were asked to provide written consent by signing the consent form developed based in the Research Ethic Board guidelines (Appendix A). The participants were informed of the purpose of the study, the nature and form of data collection, the time commitment required, individuals involved in the research, and the limits of privacy and confidentiality. Participation was voluntary and participants had the right to refuse or withdraw from the study at any time.

Qualitative research imposes certain inherent risks to the participants. The unpredictable nature of qualitative interviewing may uncover experiences and intense emotions relevant to the participants’ decision to consent (Haverkamp, 2005). To mediate this risk to the participants, I monitored the research process and renegotiated the consent as needed. Participants were informed of this potential risk and they were provided with contact information for psychological resources. In the event that participants’ involvement in the study had posed a significant risk to their well-being, the research relationship would have been terminated (Haverkamp, 2005).
CHAPTER FOUR: RESEARCH FINDINGS

The transcripts from 12 interviews with nurses were analyzed using the grounded theory method. During selective coding, a participant focus group was conducted to validate the evolving theory. In addition, two expert interviews, memos, the media (e.g., news releases), observations (e.g., on the hospital unit) and informal discussions influenced my interpretation of the data.

The broad research question that guided conceptual development and ordering was: “What is nurses’ process of disengagement from patient relationships in acute care settings?” During open coding, seven categories emerged as significant to nurses’ experience of disengagement in patient relationships. These categories were emotional experience, behavioural expression, environmental influences, patient characteristics, relational distance, professional identity and work spillover. Axial and selective coding revealed the core category of ‘Doing and Being’ in nurses’ experience of disengagement. The paradigm model delineated the process of disengagement by identifying the relationships between these categories, allowing for the development of the story line. The conceptual model is a visual representation of the mid-range theory of disengagement.

I will first discuss the findings by presenting the seven categories and their related subcategories. Then, I will discuss the relationships between the categories using the paradigm model. I will conclude the chapter with a presentation of the story line of disengagement and a description of the conceptual model.
Categories

In the following section, I describe each category discovered in the data and use direct quotes from the participants to illustrate the conceptualization of the category. I then identify and describe the core category. Quotes have been edited to complete coherent sentences and words have been bolded to indicate a participant’s emphasis of her words. Participants are identified by self-selected pseudonyms. Responses are discussed according to the following descriptors: (a) the words, “generally”, “most”, “often”, “the majority”, “typically”, “many”, or “the nurses in this study” indicate a characteristic response on the majority (8 or more) of the participants; (b) the words “some”, “a number of”, or “several” indicate responses from 3-7 participants; and (c) the words “a few” indicate responses from 2 or fewer participants.

Emotional Experience

“I mean, I can feel when I’ve stopped being me.” (Erin)

Dissonance was the most significant emotional experience for the majority of participants in their process of disengagement from patient relationships. Dissonance is an aversive psychological state that arises in the presence of conflicting thoughts, emotions and behaviours (Festinger, 1957). The nurses in this study experienced dissonance when their caring behaviours were incongruent with their beliefs about patient care. They described this discrepancy in terms of inauthenticity.

Participants felt significant distress when they were inauthentic in their patient relationships. Erin believed “you have to be authentic when you’re caring for people” and stated, “you can experience both guilt and sadness when you don’t engage, because you’re like, agh, that’s not who I am. I didn’t want to do that.” Similarly, Elizabeth shared that
disengagement from her patients “would just affect everything. It means you’re not really being yourself so… and that doesn’t feel good at all.”

Although engagement with patients could be “painful” for Christine, she expressed, “it’s so much more difficult knowing that I’m not being who I am in that (relationship)” because “me as a person, like outside of that, I would never do that. I’m so not the type of person to do that”. When unable to be authentic with her patients, Christine could not provide the care she wanted to provide:

But more often than not, I would say 90% of the time, I just feel empty, like I’m not myself. I’m not able to be myself when I’m doing this. And I don’t feel that I’m giving what I’d like to be giving to my patients, I guess.

Geraldine described inauthentic patient care as “acting,” as follows:

And they’d say, ‘Oh you’re so cheery, Geraldine.’ And I’m thinking, ‘Oh my god, if you only knew.’ You know? So it’s acting. I think a lot of nursing is acting. We’re good. I’m a pretty good actor. I don't think you’d know that you just feel sick inside. I’ve been doing it for a long time.

Geraldine, like many other participants in this study, clearly experienced dissonance when “acting” and not authentically engaging with patients. As will be discussed further in the ‘professional identity’ and ‘work spillover’ categories, not being able to behave authentically may have implications for nurses’ professional satisfaction and mental health.

Authenticity is an attribute of presence, a concept that emerged as significant to nurses’ experience of disengagement in patient relationships. Presence in nursing can be understood as emotionally ‘being with’ or attending to a patient in a way that is authentic for the nurse (Parse, 1990; Gilje, 1992). Without authenticity, participants were unable to establish presence in their relationships with patients.

The nurses spoke of being physically present, yet emotionally absent during their care for patients. Feeling exasperated with cleaning up her patient “for the eighteen thousandth
time that day,” Shawanda recognized she was disengaged from the relationship when she noticed “not so much that I don’t want to be here, but just… I could feel my… I could just feel I’m not here.” She differentiated the types of presence by stating she was “still mentally there with the task at hand, but emotionally not at all.”

Emotional absence had implications for patient care, as revealed by Erin:

Because when you’re not there, you’re not knowing. Like, I mean, you just start to do things, become task-oriented again. And the patient’s like, ‘Ah, you’re hurting me!’ and you’re like, ‘Oh, sorry.’

When emotionally absent from the caring relationship, nurses focused on the physical tasks of caring. This task-oriented behaviour was one of the subcategories in the category behavioural expression and will be further discussed in the following section.

**Behavioural Expression**

“From a person who’s not a nurse in the medical field, disengagement would definitely look mean.” (Monica)

The nurses in this study discussed a number of behaviours related to their experience of disengagement. During the interviews, I asked, “If a video camera was recording you being disengaged, what would it look like?” Decreased eye contact with patients was the behaviour most frequently identified by the participants. Speaking about her initial response to the term disengagement, Clare stated, “Well, I was thinking, and eye contact. I will, depending on what’s going on, I’ll avoid eye contact with them.” When disengaged from the patient relationship, Monica was aware she was “not necessarily looking at them straight in the eyes but, like, looking at their colostomy while I’m talking, or looking at their vital signs when I’m talking to them.”

The nurses in the study observed decreased patient eye contact in colleagues as well as themselves. Christine observed co-workers interacting with patients and noticed “it was
really the eye contact thing that stuck out for me, because nobody really makes eye contact at all.”

The participants spoke of avoiding eye contact to preclude interaction with patients. When describing a situation where she was disengaged from the patient relationship, Elizabeth stated she “wouldn’t look them in the eye as much, no. No, definitely not, because then the relationship is becoming more intimate, closer.”

By avoiding eye contact, the nurses were able to avoid acknowledging patients’ relational needs:

Then you can’t, you won’t call me if I don’t make eye contact; you won’t call me. So you know you… if they see anybody that actually makes eye contact with them, they want to ask questions, because, you know, ‘Ahh, she’s acknowledging me by making eye contact.’ (Rebecca)

Nurses also avoided eye contact with “difficult” patients, as experienced by Emma:

If they were difficult, we’d all pull away and suddenly we’re all in a corner talking and, you know, we’re trying not to look at him and, ‘Oh god, is he in pain? Let’s hope not. Is he due for a check?’

Here, Emma mentions “pulling away” from the patient, another common behavioural expression of disengagement. The nurses increased their physical distance from the patient when they were disengaged from the relationship. Increased physical distance included avoiding patients’ rooms and bedsides, using body positioning to create distance (e.g., turning away from the patient), and less direct physical contact with the patient (e.g., touch).

Jennifer stated that disengagement from the patient relationship would be apparent by her “limited interaction, like, if I don’t have to go to that bedside, I’m going to stay away from it. I think you would know from that.” Christine has “watched (her)self inch towards the door and try to get out of this patients room” when she had “a million other things to do.”
Elizabeth describes herself as “a very tactile nurse” and noticed “there wouldn’t be as much of that” if she were disengaged from the relationship with the patient. She also noticed her “body language would be… I probably wouldn’t get as close to patients as I usually do. (I would) be standing further back, yeah, because I know this is something I don’t want to get too involved with.”

Becoming task-focused was another significant behaviour expressed by the nurses in the study. They described their behaviour as “factual” and “business-like.” Ashlea stated she becomes “a lot more factual with patients. Yeah, just, you know, factual. Like just assessing what I have to look at and asking questions. Very straightforward.” Similarly, Emma will “become much less talkative” when she is disengaged from patients:

I won’t talk to them. I’ll just go and do what I have to do. Quite often, I won’t even, you know… usually I’ll go and explain the treatment, I ask, do the full nursing thing, but with patients, I’ll just, you know, ‘You have to roll over right now because I’m going to have to (give you this suppository).’

By focusing on the tasks, nurses avoided “more of a personal interaction” with their patients. Although being focused on the tasks was occasionally warranted, Christine disclosed:

A lot of it I could do without focusing on it so intensely. But I choose to make it seem as though I really do need to focus, that it’s important, so that wall stays there, I guess.

As shared by Christine, participants’ behavioural expressions served as a “wall” between the nurse and the patient, preventing meaningful engagement.

**Environmental Influences**

“We don’t have time for sad.” (Erin)

The category ‘environmental influences’ emerged as significant to most nurses’ experience of disengagement in patient relationships. This category included characteristics
of nurses’ work environments that influenced their relationships with patients. The most significant environmental influence discussed by participants was the lack of time. Current conditions in health care, such as the shortage of health care workers, increasing patient acuity, and advancements in medical technology, establish a fast-paced work environment. Nurses are faced with competing demands and are challenged with prioritizing patients care needs. As a result, the nurses in the study felt they only had time to perform the “mechanical part” of nursing care:

With the increased acuity and decreased staffing, people are more happy to do, or are allowing themselves to be contented with simply doing the mechanical parts of nursing. Really caring is completely being lost because you can’t. You don’t have the time to show caring. All you have time to do is the mechanical part of what the person is here for. (Rebecca)

Rebecca continued to speak about being unable to provide patients with emotional care:

They come to us overwhelmed because they didn’t know there was anything going on or they’re starting to lose ground and now they’re thinking, ‘Is this life worth living?’ And you just don’t have the time to try and be there for them.

Although nursing education promotes the provision of emotional care, Erin revealed the discontinuity between education and practice when she stated that nursing practice is:

Very task oriented for sure. I mean they (nursing instructors) talk about sitting and just being sad with your patient. And I’m like, ‘Well, we don’t have time for sad. Like if you have an issue, we need to get to the talking. Like come on, let’s go.’

The shortage of time to care for patients emotionally is related to the necessity to prioritize their medical needs over their emotional needs. As stated by Jennifer, “the treatment needs to be done. And my priorities…‘You know what? That pillow can wait to be fluffed. I’ve got to go get some blood.’”
Erin experienced frustration when she felt she did not have time to engage with her patients because she “really want(ed) to have a relationship with every one of (her) patients.” She felt this was not possible “because, obviously, their physical needs have to be my priority. They have to be alive at the end of the shift!”

Due to the shortage of nurses, the participants were responsible for caring for many patients, often feeling like they were “being pulled in five different directions” (Rebecca). Christine felt she did not “have time to really be engaged with people” because she “had a million other things that (she) had to do.” Similarly, Clare experienced disengagement as:

> a time thing. I just wish we had more time because mostly I think a lot of people just need your time. The reason they’re ringing, the reason they’re doing this is because they don’t really want (medical care). Sometimes they just want someone to talk to. And, you know, you can’t deliver because the phone is ringing, the doctors are calling.

This fast-paced nature of health care fosters a culture of productivity. In this environment, nurses felt that, “there’s just so much doing” (Monica), “everybody just constantly needs to be productive, to be like, ‘Go, go, go’ kind of thing. Need to be as efficient as possible” (Christine). The nurses in the study spoke about working in a system that valued productivity over caring:

> It just feels like the environment doesn’t value caring. I feel like they should take caring out of the health care system word. And I’ve heard other people, I’ve even heard, you know, I’ve heard other people say the same thing. You know, that caring, there’s no longer caring in health care. The caring is lost. If the caring is lost, it’s all about what mechanically we need to do for you and how fast we can get you out of this hospital. (Rebecca)

When they did have time to engage with patients, the participants felt that their co-workers would not support “just sitting and talking with patients”:

> And I know that they must say things about me in regards to work. ‘Oh, they’re lazy. Oh, they don’t do this. Oh…’ you know, what not. So maybe
that’s the pressure I feel too. It’s almost like a peer pressure, I suppose, that you have to be doing. You have to be looking busy. (Monica)

Here, Monica exposed the belief held by participants that nurses must constantly be ‘doing’ patient care and that ‘being’ with patients is an ineffective use of time. This belief engendered a perceived lack of time for relational engagement, when actual time for engagement may have been available.

During the individual interviews, the majority of participants attested to the need to constantly be ‘doing’ and the fear of judgement from colleagues. Interestingly, however, this finding was not as strongly supported in the participant focus group. Although it is possible the work environment had changed during the time between the interviews and the focus group, I believe this discrepancy is reflective of nurses’ reluctance to share their fear of judgment in a group setting.

As previously discussed, ‘being with’ patients is an indication of nurses’ authentic presence in relationships. The tension between ‘doing’ and ‘being’ and the implications for authenticity will be explored further in the discussion of the paradigm model.

**Patient Characteristics**

“…judging their behaviour as being not appreciative, and so then pulling myself away.” (Emma)

During the interviews, many nurses spoke of patient-related characteristics that influenced their process of disengagement from patient relationships. The most frequently mentioned patient characteristics were lack of appreciation, lack of motivation, challenges with communication, and poor prognosis. After conducting the focus group, the patient characteristic of poor prognosis was deemed insignificant by all of the participants.
Nurses’ perception of patients’ appreciation of care influenced their level of engagement in the relationship. As experienced by Christine, nurses were more inclined to engage with patients who expressed gratitude for the care they provided:

Just saying ‘Thank-you’ or making some sort of positive eye contact or body language. You know, that they know that you’re there and they’re happy that you’re there. I think it’s really subtle things as well. Obviously like saying thanks, yeah, ‘That’s great, thanks for doing that.’ It helps and it makes you want to engage more.

Emma found herself “pulling… away” from unappreciative patients and noticed that nurses “just wouldn’t give (them) the care that, you know, that an appreciative (patient) would (get). They would) be danced all over.”

Several participants discussed the patients’ level of motivation to care for themselves and to recover. Emma, “loved, loved nursing… patients who are highly motivated.” Similarly, Monica “celebrated every step” of recovery with a motivated patient.

Conversely, several nurses had difficulty connecting with patients who did not participate in their own care or who engaged in self-defeating or self-destructive behaviour. As expressed by Shawanda, “I can’t engage with this person because they don’t care...

They’re not interested. Then I can’t help (them).” Erin also felt she could not engage with an unmotivated patient, stating, “if they’re not willing to be an active participant, how can I engage with them?” She shared her experience caring for an unmotivated patient and said it was “difficult to engage with her because her behaviour (was) self-destructive.”

Challenges with communication also influenced nurses’ ability to engage with patients. These challenges included language barriers, patients with tracheostomies, and patients who were unconscious. According to Shawanda, “the language barrier and the communication barriers are definitely a challenge for me in being engaged.” When nurses
encountered communication barriers, it was difficult for them to establish a relationship with their patients:

I find a trached patient or someone that’s unable to communicate; it takes a lot longer to connect with them, right? Like maybe by the end of the shift, I’ll start to feel like I’m connecting with them and I’m understanding what their needs are, like their emotional needs. But, yeah, it definitely takes a lot longer to really know how to connect with them (Ashlea).

Like Ashlea, Erin had to understand her patients’ needs to be able to engage with them. As nurses’ ability to understand their patients increased, their level of engagement increased:

I’m finding my level of engagement is increasing because I’m having an easier time understanding him and partly because I’m getting to know him. So I’m having an easier time understanding him. But it was like a tendency before just to kind of be quiet, not engage with him because I felt so bad that I couldn’t understand him. (Erin)

Sarah spoke about establishing a relationship with an unconscious patient, stating:

It’s definitely more difficult. You certainly don’t engage on the same in an intellectual way. I think it’s very possible to emotionally engage with a patient who’s not communicating, but it’s very one-way.

Here, Sarah indicated that nurses form a different kind of relationship with patients who are unable to communicate and reciprocate with the nurse. This notion of reciprocity is elaborated in the next category, relational distance.

**Relational Distance**

“So that’s one of the reasons why I wanted to come into nursing, because it’s so relational. And it’s about relationships.” (Monica)

The category ‘relational distance’ comprised nurses’ experience of proximity and distance with their patients. Although physical distance is included in the category ‘behavioural expression’, ‘relational distance’ included nurses’ interpersonal distance from
patients. This interpersonal distance is, in part, determined by the reciprocity of the relationship, similarities between the nurse and the patient, and nurses’ use of empathy.

Several of the participants spoke about “one-way” and “two-way” relationships with patients. “Two-way,” or reciprocal, nurse-patient relationships fostered engagement, whereas “one-way,” or non-reciprocal, relationships were associated with disengagement. “One-way” relationships occurred with patients who were unable or unwilling to engage in a relationship with the nurse:

If they’re not going to let you in, if they’re not going to allow me to be a part of what’s going on for them, I don’t think you can meaningfully engage with them, because it’s not… it can’t be one sided. (Erin)

When patients demonstrated a willingness to engage in a relationship, Jennifer was able to “engage a little more”:

If there’s a good response, then you can give a little more or engage a little more because they’re engaging back. (It’s important) that they’re interacting as well. Whether it’s physical or verbal, whatever way, they’re kind of responding to you. You might see it in their heart rate or how they’re fidgeting, settles down after you interact with them.

As mentioned by Jennifer, patients could express reciprocity either verbally or physically through changes in vital signs or behaviour. These physical signs indicated the patients’ responsiveness to the relationship, which fostered the nurses’ ability to engage.

Similarities between the nurse and the patient emerged as a significant feature in nurse-patient relationships. The nurses in the study were more likely to engage with their patients when they shared common life experiences. “Self-in-other” is the term I have applied to nurses’ recognition of themselves in their patient. Age, where they lived, and extracurricular interests were some of the commonalities shared between the nurse and the patient. Monica, a 23 year-old nurse, felt more engaged with younger patients:
And I think when I talk to someone younger… I’m more interested in relating and wanting them to relate to me. And so I become more receptive to their character.

As revealed in the focus group, participants purposefully sought to discover similarities with their patient to foster engagement in the relationship. Ashlea accomplished this by, “asking them questions about their background and finding commonalities that we could talk about, whether it was they lived somewhere that I used to live or something.” When patients were unable to communicate, Sarah connected with information gathered from their medical history report:

I’ve had plenty of patients who I felt emotionally engaged with, who couldn’t really talk back to me… Most often it’s because I’ve been told something about them from their history. So, they fell off a mountain, they were snowboarding. And you’re like, ‘Oh gee, that’s really too bad. Snowboarding is something that I like to do or being out in the sun is something I like to do.’ And they’re about the same age as you, or the same age as somebody you know. And you think, ‘Oh, well, you know, they’re kind of like this person.’ And you form a picture of who that person might be and you sometimes get attached to those people. And you’re almost attached to an imaginary person at that point.

When these similarities were not discovered, the participants spoke of projecting similarities to foster relationship. Jennifer shared the story of a patient who “really struck a chord” with her:

Here’s this young man, tri-athlete, and I thought to myself, ‘My god, that could have been my husband training for something.’ And he’s got kids and I just thought, ‘Ahhh, I can’t imagine.’ And he would elicit almost the best care possible… He was totally snowed, like he wasn’t interacting with me verbally or anything like that, but there was that recognition that this could be my husband, and very easily, so he needs this.

In this example, the nurses’ projection of her husband’s identity onto her patient cultivated emotional engagement in their relationship.
In cases where differences between the nurse and the patient were apparent, interpersonal distance between the nurse and the patient was increased. Participants spoke about disengaging from patients who held different values and beliefs. Jennifer, who strongly valued physical health, disclosed she had difficulty engaging with patients who were morbidly obese:

I know definitely that there’s a patient population that I just, I, agh, I have so much trouble with and it’s the morbidly obese patient and they’re there because of the morbid obesity.

Jennifer believed morbid obesity was a self-inflicted diagnosis and was therefore reflective of patients not valuing their health. Similarly, Shawanda felt disengaged from patients with “lifestyle-related” illnesses:

Many, many, many of our patients’ illnesses are lifestyle related and that is very difficult for me because I appreciate health. Obesity is one that just drives me bananas because I can’t understand… I feel very disengaged towards obese, morbidly obese, grossly obese people who are like bariatric, like over five hundred pounds. Like you didn’t see yourself getting here? Like, really? I find that very hard to care for somebody (like that).

She hoped by acknowledging these feelings she would be able to recognize “when I go into a patients room, that I have this prejudice against you. And I’ve got to get around that and get engaged.”

Erin noticed her colleagues did not engage in caring for patients who they perceived to have a lifestyle-related illness, such as substance misuse:

Like ‘I’ll do their care, but I don’t care about them.’ That’s frustrating to hear. I mean you can’t (choose). If you go into a job where you’re caring for people, how can you selectively choose who you’re going to care for? Like good patient versus bad patient? And engage with the ones who are good?

Erin believed in engaging with all patients, regardless of their condition, and was disturbed by her colleagues’ approach to patient care.
Emma had difficulty engaging with patients whose political views were “diametrically opposed” to her own and found it “really hard to take in all of that and be a compassionate caregiver for them”:

Having to deliver care to people, where your political beliefs and your morals, everything about you, is just in complete contrast. (Having) to now, like, you know, having to have some compassion for this person… Well, then the resentment that, if that’s your belief, then I didn’t want to give them the care. I didn’t want to provide them with that service. Like, get out of here.

When nurses did not share similar values and beliefs with patients, interpersonal distance was increased and disengagement was more likely to occur.

Related to the phenomenon of “self-in-other” is the phenomenon participants described as “in their shoes.” In addition to identifying similarities, nurses spoke about imagining themselves in their patients’ situations. Sarah believed, “if you put yourself in that persons’ position…, I think you’re much, much more aware (of their emotional needs).” Similarly, Jennifer felt it was important to “put yourself in (your patients’) shoes; try to understand what’s going on and where they’re coming from.”

Projecting themselves onto their patients’ experience decreased the interpersonal distance between the nurse and the patient. “In their shoes” can be understood as nurses’ use of empathy when caring for patients. The relationship between empathy and disengagement will be explored further in chapter five.

**Professional Identity**

“That’s when I get the most reward out of in my work: is really connecting with people.” (Ashlea)

Nurses’ professional identity was discovered to be an important category related to their experience of disengagement. Most significantly, their beliefs about caring and their definition of their role as a nurse influenced their level of engagement in patient
relationships. Although they did not always act on these beliefs, all of the nurses in the study believed providing emotional care was equally important as providing physical care. For Shawanda, “the definition of providing care is doing more than… the tasks.” As expressed by Elizabeth, “the emotional caring is as important as the physical caring of people. I think if you care for their emotional well being, everything else will fall into place.”

For many of the nurses, engaging with patients and providing emotional care provided them with meaning in their work. Erin stated, “I need to stay focused on why I’m here. And that it is to be interactive and meaningfully engaged.” She shared an experience where she had “never felt more like a nurse” because she was able to engage in a meaningful relationship with her patient. Similarly, Ashlea felt she received “the most reward out of (her) work by really connecting with people and somehow making their experience better in some way.”

Engagement with patients was a priority for Sarah and she could not “imagine doing it any other way. I don’t want to go to work and not engage in that level.” She believed if she were to become consistently disengaged from patients:

You would end up feeling that you’re failing in that what I consider to be a very important nursing responsibility and nursing role. So I take providing comfort and engagement… You know, in order to provide comfort, it’s important to engage.

The nurses in the study experienced disturbances in their professional self-concept when they were unable to meaningfully engage with their patients and felt as though they were a “bad nurse”:

I’m, you know, I’m a bad nurse basically. To me, that isn’t nursing. Delivering care in that manner, is not nursing… You’re just consumed with guilt. Why didn’t I rise above? Why didn’t I have the strength? I’m not a…
you know, why can’t I be a better person, a stronger person? …I wish I were a better person. (Emma)

Ashlea also did not feel she was being a “good nurse” when she disengaged from patient relationships:

I’m not able to engage with patients in the same manner as I would like to be able to. And so that gives me a lot of guilt because I just don’t feel like I’m a very good nurse.

When the participants could not enact their caring beliefs, they questioned their professional purpose, as revealed by Monica when she stated, “(my experience of disengagement) makes me question nursing. It makes me question what I want to do. And it makes me understand why people leave the profession or change jobs.” Geraldine believed a “lack of job satisfaction… goes hand in hand with disengagement.” She spoke about “getting a different gig,” stating that she and her colleagues checked the job postings daily.

Christine’s experience supported the relationship between professional satisfaction and participants’ inability to engage with patients:

I’m questioning whether to stay in it because I’m not able to be the nurse that I want to be in the given situation and it’s not satisfying, I don’t think… to nurse in the way that I am. (Christine)

A desire to change hospital units or leave the nursing profession entirely was a common experience for the nurses in the study. Emma “remember(ed) thinking, ‘Oh god, I have to get out of this business. This isn’t really why I went into this; this isn’t what I want to be doing.’”

Nurses’ professional satisfaction and turnover behaviour were undeniably linked to their ability to honour their caring beliefs. Alterations in their professional self-concept had potential implications for participants’ personal lives, as will be explored in the next category.
Work Spillover

“I mean you could cry all the way home in your car every day.” (Geraldine)

During the interviews, nurses spoke about their experience of disengagement spilling over into their personal lives. When she was aware she had disengaged from the relationship with her patient, Emma shared she would “usually go home and, you know, the guilt and the shame and, you know… because I’m not a good nurse. It’s just, it’s icky”. Here, Emma revealed her distress when she did not honour her caring beliefs. Clare shared her experience of guilt when she disengaged from patients, stating, “Yeah, I’m going to pay for it. It’s just… do you want to have that rewinding in your head when you’re trying to get to sleep? No.”

As Elizabeth reveals, nurses “carried” home feelings of guilt and dissonance:

Yeah, I do carry them with me for quite a while, actually. That’s a very good question and I do carry them with me, which isn’t healthy. So even once the labour is over, the delivery is over, and I’ve moved on and away from that situation, I still feel the same. I carry that. I don’t know if that’s a female thing mostly, but I do carry feelings around. I guess it’s called baggage. Yeah, I carry it around for a little while. It’s not healthy to be in those situations as a nurse. It’s not healthy for me; it’s not healthy for the psyche, the mind, the body. And it’s not healthy for the patient.

Similarly, Christine shared that “often (she) will, continue maybe afterwards when (she’s) outside the hospital when (she’s) upset about something, it will stay with (her) for quite some time.”

The spillover of dissonance into nurses’ personal lives seemed to have implications for their mental health. Erin shared, “a lot of nurses I’ve discovered recently are on antidepressants because they’re carrying around so much of what is going on. They don’t find an outlet, they just carry it all inside.” Participants’ spoke about feeling depressed when they were unable to authentically engage with their patients. For Christine, “having to be that other person for so long… was having its toll on (her).” She disclosed that:
by the end of (a set of four shifts), I usually feel like I’m starting to feel depressed. And I often attribute that to lack of sleep or just being exhausted. But I wonder now, just sitting here, if there’s more to it than that.

Like Christine, Erin, asserted “if I was consistently disengaged, I think that would be depressing for me. I would be like ‘Okay, this is wrong. I need to find another place to work because this is depressing for me.’”

Analysis of the data did not find a significant spillover from nurses’ personal lives to their work environment. When this finding was discussed during the focus group, participants postulated this finding reflected nurses belief that they should be, “leaving their stuff at the door” when they arrive at work. This belief supports the finding of nurses’ experience of inauthenticity in their work. The spillover effect of work experiences into nurses’ personal lives has implications for research and practice, as will be discussed in chapter five.

**Core Category**

The core category is the central phenomenon around which all of the other categories are integrated (Strauss & Corbin, 1990). It is identified during selective coding as the story about the phenomenon is developed. The core category can be a category that has already been discovered during open coding or it can be named during selective coding (Strauss & Corbin, 1990).

As none of the existing categories were abstract enough to encompass all that had been described in the story of disengagement, I chose the term ‘Doing and Being’ to identify the core category. ‘Doing’, meaning the performance of tasks and ‘Being’, meaning with authentic presence. Nurses’ state of ‘Doing and Being’ was influenced by the context in which it occurred. The relationship between the categories and subcategories to the core
category shape the context. In the following section I will depict the nature of these relationships through the description of the paradigm model.

**Categorical Relationships**

In grounded theory, a paradigm model is used to articulate the relationships between the categories and subcategories (Straus & Corbin, 1998). The model identifies the phenomenon under study, the causal conditions for the occurrence of the phenomenon, the action and interactional strategies devised to manage the phenomenon, the intervening conditions bearing on the use of these strategies, the context in which the phenomenon occurs and the consequences of these strategies. In this section, I will identify the features of the paradigm model for the core category, ‘Doing and Being’. To limit redundancy from the previous section, one participant quote will be given to exemplify each feature.

Inevitably, any attempt to separate a complex experience into discrete concepts will result in oversimplification. Categories and subcategories can represent multiple features of the paradigm model. Furthermore, categories have the potential to overlap within each feature of the model. For example, lack of time can be understood both as a causal condition to ‘Doing and Being’ as well as an intervening condition influencing the strategies used to manage ‘Doing and Being’. Within the feature of causal conditions, both dissonance and lack of time can factor into to the occurrence of the phenomenon ‘Doing and Being’.

Given the complexity of life experiences, grounded theory aims to provide a general understanding of the phenomenon under study (Strauss & Corbin, 1990). This model will therefore delineate a broad overview of nurses’ experience of disengagement in patient relationships with flexibility for variation within the framework (Table 1).
<table>
<thead>
<tr>
<th>(A) CAUSAL CONDITIONS</th>
<th>Dissonance</th>
</tr>
</thead>
<tbody>
<tr>
<td>(B) PHENOMENON</td>
<td>Doing and Being</td>
</tr>
<tr>
<td>(C) CONTEXT</td>
<td>Incongruence between caring beliefs and caring behaviours</td>
</tr>
<tr>
<td>(D) INTERVENING CONDITIONS</td>
<td>Patient characteristics, lack of time, culture of productivity</td>
</tr>
<tr>
<td>(E) ACTION/INTERACTIONAL STRATEGIES</td>
<td>Decreased eye contact, increased physical distance, increased task-focused behaviour</td>
</tr>
<tr>
<td>(F) CONSEQUENCES</td>
<td>Relational distance, professional dissatisfaction, turnover, depression</td>
</tr>
</tbody>
</table>

Table 1: Paradigm model of disengagement in nurse-patient relationships in acute care

**Phenomenon**

The phenomenon is the central idea, event, happening or incident (Strauss & Corbin, 1990). As discussed, ‘Doing and Being’ was identified as the core category, or the phenomenon, about which the action and interactional strategies were directed at managing. It was discovered by asking, “What are the data referring to?” and, “What is the interaction all about?” (Strauss & Corbin, 1990). During the interviews, it became apparent nurses’ actions were directed at managing their state of ‘Doing and Being’. Monica highlighted this process when she described the behaviours related to disengagement:

Not necessarily looking at (the patient) straight in the eyes but, like, looking at their colostomy while I’m talking, or looking at their vital signs when I’m talking to them. Agh, I hate it when I do that! I try not to.

Although she was performing caring tasks, Monica was aware she was not relating emotionally with her patient. She also spoke about experiencing dissonance when she stated, “I hate when I do that!” Dissonance has been identified as the causal condition of the phenomenon in the specific context where disengagement occurred.
Causal Conditions

Causal conditions refer to the incidents or events leading to the occurrence of the phenomenon (Strauss & Corbin, 1990). Although several conditions preceded ‘Doing and Being’, nurses’ experience of dissonance was the most significant condition in nurses’ process of disengagement from patient relationships. Not being a “good nurse” and behaving incongruently to their caring beliefs created feelings of dissonance. Ashlea revealed her dissonance when she stated, “I’m not able to engage with patients in the same manner as I would like to be able to. And so that gives me a lot of guilt because I just don’t feel like I’m a very good nurse.”

Subtle differences between participants’ caring beliefs did not affect the outcome. Despite their beliefs, if these beliefs were incongruent with their behaviours, nurses’ experienced dissonance. When nurses experienced dissonance in providing care, they modified their behaviours to accommodate their inability to provide the care they believed they should provide. These behaviours can be understood as action and interactional strategies.

Action and Interactional Strategies

Action and interactional strategies are purposeful, goal-oriented tactics devised to manage or carry out the phenomenon as it exists in a specific context (Strauss & Corbin, 1990). Nurses’ expressed behaviours can be understood as the action and interactional strategies employed to carry out and handle ‘Doing and Being’. These behaviours can also be understood as causal conditions to the phenomenon. For simplicity, however, this discussion will focus on their function as action and interactional strategies.
As discussed, the most significant behaviours associated with nurses’ experience of disengagement were decreased eye contact, increased physical distance, and increased focus on tasks. When describing disengagement, Clare spoke about avoiding eye contact with her patient and focusing on the nursing tasks:

Well, I was thinking, and eye contact. I will, depending on what’s going on, I’ll avoid eye contact with them. And it is very… in response to a call bell, I will respond but I will be direct without any flowery conversations, and just avoid more of a personal interaction with them. It is just business, task oriented.

By using these strategies, the participants were able to perform their duties without engaging in a meaningful relationship with their patient. The use of these strategies was facilitated by particular environmental conditions and patient characteristics, as will be discussed in the following section.

Intervening Conditions

Strauss and Corbin (1990) define intervening conditions as the broad structural conditions that act to either facilitate or constrain the action and interactional strategies taken within a specific context (Strauss & Corbin, 1990). In this study, these broad conditions included the lack of time, the culture of productivity, and several patient characteristics.

The lack of time in the current health care environment facilitated and justified nurses’ use of decreased eye contact, increased physical distance, and increased task-focused behaviour. As stated by Geraldine, “we’re in big trouble… when it gets to the stage that people who are in this profession have to deliberately and intentionally sort of distance (themselves) because (they) don’t have the time to really engage with these people.”
The culture of productivity was another broad structural condition that facilitated the use of the action strategies. As previously discussed, participants felt they had to maintain the appearance of being busy, even if they were not:

There’s different things that I think you pick up, you start doing, to give yourself a constant image of being super busy, so as to ward people off from actually trying to talk to you. Even just like, you know, as you’re in the room and as they’re talking to you, you’re playing with their IV pump, you’re taking their blood pressure, or you’re reading the sheet, and ‘uh huh, uh huh,’ kind of thing. And I think, like, ‘I'm not really needing to read this right now…’ A lot of the time we are legitimately busy. But there’s also, you just have to keep this air of being super busy so people don’t try and engage with you. (Christine)

The appearance of “busy-ness” was one of the influencing conditions precluding nurses’ engagement with their patients.

Patient characteristics also fostered the nurses’ use of action strategies. When patients demonstrated certain characteristics, such as differing beliefs or lack of appreciation for care, the participants were more likely to decrease eye contact and increase physical distance. Emma stated she became disengaged from patient relationships by “judging their beliefs or judging their behaviour as being right or wrong, or as being appreciative or not appreciative and so then pulling myself away.”

These influencing conditions fostered and facilitated the use of the action and interaction strategies within the four action contexts of ‘Doing and Being’.

Context

The context represents the particular set of conditions within which the action and interactional strategies are taken (Strauss & Corbin, 1990). The properties and the dimensions of the phenomenon are arranged to form patterns providing the context for the phenomenon to occur. Two major properties of ‘Doing and Being’ were identified as
“incongruence between beliefs and behaviours” and “emotional presence. “Incongruence between beliefs and behaviours” varied along the dimension of incongruent to congruent and “emotional presence” varied along the dimension of present to absent. These properties and dimensions combined in various patterns to form four action contexts of ‘Doing and Being’, as represented in the four-fold table below (Table 2):

<table>
<thead>
<tr>
<th></th>
<th>Incongruent</th>
<th>Present</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Incongruent</td>
<td>Absent</td>
</tr>
<tr>
<td>2</td>
<td>Congruent</td>
<td>Present</td>
</tr>
<tr>
<td>3</td>
<td>Congruent</td>
<td>Absent</td>
</tr>
</tbody>
</table>

Table 2: Action contexts of ‘Doing and Being’

In action context 1, incongruent and present, nurses’ beliefs about caring and their caring behaviours were incongruent and they were emotionally present in the patient relationship. This action context rarely occurred in the data, however, because nurses’ emotional presence was temporary when they experienced incongruence. Intervening conditions fostered the use of action and interactional strategies, making it difficult for nurses to align their behaviours with their beliefs. Nurses then experienced dissonance in response to their incongruence and retreated emotionally from the relationship in an attempt to relieve their dissonance. Action context 1, therefore, was promptly followed by action context 2, incongruent and absent.

Action context 2 was the context most commonly discussed by participants. Under conditions when nurses were both incongruent and emotionally absent, disengagement from patient relationships occurred. Nurses’ experience of dissonance was the causal condition to the phenomenon within this context. As in context 1, intervening conditions promoted
nurses’ use of the action and interactional strategies. Shawanda shared her experience of disengagement while caring for a non-communicative patient:

…not making eye contact, looking out the window. I would hope that my body language would still be towards the patient and open. But I… definitely, my face would be looking away. Trying to be somewhere else, but knowing that you can’t be somewhere else. So still mentally there with the task at hand, but emotionally not at all.

Here, her patients’ inability to communicate acted as an intervening condition facilitating Shawanda’s use of decreased eye contact and increased physical distance. These action strategies were used to manage her state of emotional absence in this context. Shawanda believed in providing emotional patient care through relational engagement, however, she was unable to enact these beliefs in this context.

The participants in the study rarely spoke about action context 3, congruent and present. This context occurred when nurses were able to enact their caring beliefs and be emotionally present. Monica described an experience of engagement she had as a nursing student:

…just thinking about it, I think I could start tearing because, you know, it was… I had a really good relationship. But I was in there for an hour and I wondered, too, because thinking now, what I know now as how nurses think about you and how they analyze you and assess you and judge you, me being in there for an hour, I know they would have been like, ‘Where is she? What’s she doing? Why is it taking her so long?’ You know? ‘She shouldn’t be in there for an hour,’ or something like that. Even though I was maybe doing something… you know, if I was doing something… you know. But that’s stuff that I enjoyed, but I don’t have time to do it.

As a student, Monica was not significantly influenced by the actual and perceived lack of time in health care. She had not yet been indoctrinated into the culture of productivity and was not sensitized to colleagues’ judgments of her use of time. Monica’s experience of congruence and emotional presence as a student draws attention to the significance of
intervening conditions in the process of nurse-patient engagement. In the absence of these intervening conditions, nurses were more likely to experience congruence between caring beliefs and caring behaviours.

There were no cases of action context 4, congruent and absent, in the data. For the nurses in this study, emotional presence was a significant attribute of their beliefs about patient care. Without emotional presence, the participants experienced incongruence between their beliefs and their behaviours. Therefore, congruence and emotional absence did not occur simultaneously for these participants.

These four action contexts of ‘Doing and Being’ were dynamic and transient in nature. Nurses’ experience of disengagement in patient relationships shifted from patient to patient and moment to moment as the conditions within the context changed.

Consequences

In grounded theory, the outcome or result of action and interactional strategies are referred to as consequences (Strauss & Corbin, 1990). The participants experienced many short-term and long-term consequences of their action and interactional strategies, most of which were not predicted or intended. Relational absence between the nurse and the patient resulted when the strategies were used in the context of emotional absence. Participants described relational absence as “weird blank screen”:

Like (disengagement) is just a blankness. And it almost makes you kind of void of any kind of extreme of anything. Like you can’t, you don’t really get extremely sad, you don’t really get extremely happy. It’s just this weird blankness that’s in between. And you’re still, you know, you can still talk and you can still smile and have facial expressions, but it’s just not one hundred percent there. (Christine)
Christine continued to say that “being so disengaged and being just like a robot, it allows you to avoid (engaging in a relationship with the patient).” Similarly, Erin described her experience of relational absence:

Like when your thoughts are negative or when you’re just totally somewhere else and you’re not even… and the patient is talking and you’re like, ‘uhmh, yep’ like you’re not even listening; you’re not there at all. You’re not there anymore. I mean you’re just doing things, but you’re not there, I don’t think.

For nurses who believed in the importance of engaging with patients, the absence of relationship further exacerbated their experience of dissonance. Relational absence and dissonance then established a self-propagating cycle, with relational absence potentiating dissonance and dissonance fostering relational absence.

The action and interactional strategies precluded nurses’ enactment of their caring beliefs. As previously discussed, participants questioned their professional meaning when they were unable to carry out these beliefs. Feelings of doubt lead to dissatisfaction with the nursing profession and a desire to “jump off the boat and try something else”. Most of the participants in the study had changed work environments during the course of their career and all of them had contemplated leaving the profession.

Perhaps the most significant consequence of the action and interactional strategies was the impact on nurses’ mental health. When the strategies were used, nurses were not authentically present in their caring relationships. Participants’ experience of inauthenticity and dissonance caused distress, as expressed by Christine:

I feel like I step into nurse role once I step in the hospital. And it’s not, there’s pieces of me within it, but I’ve shaped this whole other being or something. That I, like I’m this way and it may not be ideal, or it may not be something I like, but it has to be this way.
An inability to behave authentically may cause an individual to feel false and hypocritical and in the long run may lead to the alienation from one’s own emotions, poor self-esteem and depression (Zapf, 2002). As revealed by the participants of this study, depression was a consequence of disengagement from patient relationships.
The Story of Disengagement in Nurse-Patient Relationships in Acute Care

In grounded theory, integration of the categories is achieved by the development of a
descriptive narrative about the phenomenon under study (Strauss & Corbin, 1990). The story
is then conceptualized analytically, becoming the story line. It is during the conceptualization
of the story line that the core category is named. As discussed, the core category was named
‘Doing and Being’. After conceptual analysis of the story, the following narrative was
developed:

Many nurses believe in subjective, holistic care of others. These beliefs about caring
relationships inform their caring behaviours with patients. In an acute care setting, nurses’
encounter multiple barriers to acting on their caring beliefs. Certain patient characteristics,
such as their level of motivation, their level of appreciation of care and their ability to
communicate may trigger the nurses’ feelings of frustration, anger, grief and hopelessness.
The fast-paced nature of acute care and the culture of productivity lead to actual and
perceived lack of time for patient relationships. Under conditions when nurses feel they are
unable to act in accordance to their caring beliefs, they experience incongruence between
these beliefs and their behaviours, thus resulting in feelings of inauthenticity and dissonance.
To manage the incongruence, nurses will attempt to leave the relationship, physically and/or
emotionally. When nurses are emotionally absent from the patient relationship, their
behaviours appear mechanical and “robotic”. They become task-focused, decreasing eye
contact and increasing their physical distance from the patient. Relational absence in
response to dissonance further exacerbates their dissonance. If dissonance is experienced
over a long period of time, nurses may have a desire to leave the immediate work
environment and/or the nursing profession. Their feelings of inauthenticity and dissonance
have the potential to spill over into their personal lives, causing nurses to question their professional and personal purpose. In the long-term, these feelings may lead to the alienation from one’s own emotions, resulting in depression.

The analytic story of ‘Doing and Being’ integrated the seven categories identified in the data and provided sequential ordering of the categories. Laying out the theory in narrative form facilitated discriminant sampling by providing the means to verify the theory against the data, allowing for further refinement of the story. Validation of the story of disengagement in nurse-patient relationships was achieved through a participant focus group and two expert interviews. According to participants, the story accurately reflected their experience of disengagement and provided “huge affirmation.” With tears in her eyes, Emma sighed and declared, “This story hits the nail on the head. This is it. This is it.”
Description of the Conceptual Model

The conceptual model is a visual representation of the paradigm model illustrating nurses’ experience of disengagement in patient relationships (Figure 2). (1) Nurses enter the profession with pre-formed caring beliefs. (2) In the health care environment, their ability to enact these beliefs is influenced by several conditions, including patient characteristics, the lack of time and the culture of productivity. (3) When unable to enact their caring beliefs, nurses’ experience incongruence between their beliefs and their caring behaviours, (4) resulting in dissonance. Dissonance triggers the use of the action and interactional strategies, (5) fostering relational absence. (6) Relational absence further exacerbates dissonance, thus establishing a self-propagating cycle between dissonance and relational absence. (7) When dissonance spills over into their personal lives, (8) nurses question their professional and personal meaning. (9) This questioning may result in professional dissatisfaction and, consequently, increased turnover behaviour. Dissonance may also cause (10) nurses to feel alienated from their own beliefs, (11) resulting in depression.
Figure 1: Conceptual model of disengagement in nurse-patient relationships in acute care.
CHAPTER FIVE: DISCUSSION

The final step in the discovery of a grounded theory is to establish its usefulness and relevance to research and practice. The merit of this research will based on two parameters: (a) the effectiveness of the grounded theory methodology to explain nurses’ experience of disengagement from patient relationships, and (b) the contribution of the findings to existing knowledge in areas relevant to nurse-patient relationships and the process of disengagement.

In this chapter, I will first discuss the effectiveness of the grounded theory method in the development of a mid-range theory of disengagement in nurse-patient relationships. This discussion will be followed by an examination of the research findings and a comparison to the literature in the areas relevant to nurses’ experience of disengagement in patient relationships. Some of the literature reviewed in chapter two will be readdressed in light of the findings of this study. Additional literature will also be introduced to enrich the discussion of nurses’ process of disengagement from patient relationships. I will then discuss the strengths and limitations of this research. Finally, I will explore the potential implications of this study and discuss recommendations for future research and practice.

Effectiveness of the Grounded Theory Method

With roots in symbolic interactionism, grounded theory was an appropriate methodology to use in the study of nurses’ experience of disengagement in patient relationships. In contrast to phenomenology, which seeks to uncover the essential meaning of a lived experience, grounded theory identifies the psychological and social-psychological realities through discovering the social processes at work (Baker, Wuest & Stern, 1992). Nurses’ experience of disengagement occurred in the context of their work environment and was influenced by conditions within this environment. Grounded theory methodology
furthered understanding of the interactions that engender disengagement by identifying the multiple relationships between the nurse and the practice environment.

The necessity of theoretical sampling ensured the data collected were based on the theoretical relevance to the emerging theory of disengagement in nurse-patient relationships. In this study, the inclusion criteria were modified in response to their relevance to the theory. Sampling on the basis of theoretical relevance typically requires prolonged data collection as “researchers cannot produce a solid grounded theory through one-shot interviewing in a single data collection phase” (Charmaz, 2000, p. 519). The data for this study were collected over a period of eighteen months and was guided by theoretical relevance.

Grounded theory methodology is “a complete package of procedures, techniques, and assumptions related to the discovery of a practical theory” (Walker & Myrick, 2006, p. 557). As a novice researcher, these prescribed procedures and techniques provided the structure necessary to complete analysis. Strauss and Corbin’s (1990) version of grounded theory analysis, however, has been critiqued as unnecessarily rigid and complex (e.g., Boychuk & Morgan, 2004; Charmaz, 2000; Dey, 1999; Heath & Cowley, 2004; Walker & Myrick, 2006). Known as the ‘emergence versus forcing’ debate, the Straussian method of analysis is criticized as forcing the theory rather than allowing the theory to emerge, as espoused by the Glasserian method. While I appreciated the structure, there were occasions when I felt I was imposing a specified framework on the data. The mandatory use of the paradigm model dictated the ‘discovery’ of the causes, intervening conditions, and consequences of disengagement in nurse-patient relationships. As a result, sensitivity and insight to nuances in nurses’ experiences may have been compromised.
According to Glaser and Strauss (1967), a grounded theory must have ‘fit’, ‘work’ and ‘grab’. ‘Fit’ means the categories and the categorical relationships generated must be indicated by the data and readily applied to the data. To ‘work’, the theory must provide an explanation for the relationship between categories and be used to guide future action. Finally, to have ‘grab’, the theory must make sense to those who participated in the research and to those in the practice setting (Boychuk & Morgan, 2004).

The mid-range theory of disengagement in nurse-patient relationships was inductively derived from nurses’ experience in their practice environments. The fit of the theory was established through the constant comparative method and theoretical and discriminant sampling techniques. It provided a possible explanation for nurses’ disengagement from patients as well as the potential to predict the occurrence of disengagement. The theory accurately reflects participants’ experience of the phenomenon. Participants and practitioners alike were ‘grabbed’, feeling immediate affinity with the theory. In summary, the grounded theory methodology was effective at discovering a mid-range theory of nurses’ experience of disengagement in patient relationships in acute care.

**Contribution to the Extant Literature**

The results of this study support and contribute to the existing literature in the areas relevant to nurses’ experience of disengagement from patient relationships, including psychology, organizational behaviour, and nursing. The discovery of nurses’ experience of dissonance, the importance of their caring beliefs, and the environmental conditions influencing their process of disengagement from patient relationships are the most significant contributions of this research.
Nurses’ Experience of Dissonance

Nurses’ experience of dissonance was a major finding in the study of disengagement in nurse-patient relationships. Dissonance was experienced when nurses’ caring behaviours were incongruent with their caring beliefs. As a result of their dissonance, participants attempted to retreat both physically and emotionally from the patient relationship. Nurses’ who experienced dissonance over the long-term questioned their professional purpose, leading to professional dissatisfaction and increased turnover behaviour. Some of the nurses in the study also questioned their personal meaning in response to dissonance and expressed feeling alienated and depressed.

Cognitive dissonance is a theory of human motivation first proposed by Leon Festinger in 1957. The theory asserts that psychological discomfort is experienced when contradictory cognitions are held (Baron & Byrne, 2000). The psychological discomfort motivates the mind to acquire new thoughts, or modify existing thoughts, to reduce the discrepancy between cognitions. Related to the theory of cognitive dissonance is the concept of emotional dissonance. Although not well-defined in the literature, emotional dissonance has been described as the discrepancy between authentic and displayed emotions (Bakker & Heuven, 2006). Both cognitive and emotional dissonance have been observed to motivate change in beliefs, actions, or perception of actions (e.g., Festinger, 1957; Abraham, 1999a). A review of the conceptualization of cognitive and emotional dissonance is beyond the scope of this discussion; therefore, the term dissonance will be used broadly to discuss the concept.

Dissonance, as it occurred in this research, can be understood as nurses’ psychological discomfort in response to a discrepancy between their beliefs about care and their behaviours associated with the provision of care. It is unclear whether nurses
experienced cognitive dissonance or emotional dissonance, or a combination of the two. Whether cognitive or emotional, participants were motivated to alleviate their dissonance. According to Festinger’s theory (1957), dissonance can be resolved in three basic ways: change in beliefs, change in behaviours/actions, or a change in the perception of the behaviour/action. This process is illustrated in Figure 2.

Nurses in the study experienced dissonance when their caring beliefs were incongruent with their caring behaviours. While changing their beliefs may have been the simplest resolution, nurses’ caring beliefs were fundamental to their identity and, therefore, did not readily change for the participants in this study. Behavioural change is another possible resolution to dissonance. The intervening conditions, such as the lack of time, necessitated and facilitated the use of the action and interactional strategies. In Festinger’s theory (1957), the final possible resolution to dissonance is changing the perception of the behaviour. Changing the perception of their behaviour would entail nurses rationalizing the need for their action and interactional strategies. This response was not explicit in the present research. In the absence of a change in their beliefs, their behaviours, or their perception of their behaviours, the nurses in this study remained in a state of dissonance.
Current literature on emotional dissonance is found primarily in the field of organizational behaviour. The research has identified relationships between dissonance and occupational stress (Tewksbury & Higgins, 2006), psychological strain (Brotheridge & Lee, 1998), professional dissatisfaction and turnover intentions (Abraham, 1999a), emotional exhaustion (Abraham, 1999b), and professional burnout (Bakker & Heuven, 2006). Of these studies, only one was conducted with nurses. The findings of these studies have potential implications for the nursing profession.

Abraham (1999a) investigated the impact of emotional dissonance on organizational commitment and the intention to turnover among customer service representatives. The principle finding of the quantitative study was that dissonance induced professional dissatisfaction and had a direct influence on turnover behaviour. Abraham’s results support the findings of the present study on disengagement in nurse-patient relationships. Nurses expressed professional dissatisfaction and exhibited increased turnover behaviour in response to dissonance.

With the same data set, Abraham (1999b) quantitatively examined the relationship between self-esteem, emotional dissonance, and job tension. Of importance to the present study, Abraham found that emotional dissonance induced job tension, which progressed rapidly to emotional exhaustion. Emotional exhaustion is a characteristic of burnout syndrome, which, as discussed in the literature review, is prevalent among nurses (e.g., Bourbonnais et al, 1998; Landsbergis, 1988; McGillis Hall and Kiesners, 2005). Although emotional exhaustion was not explored specifically in the current research on disengagement, participants in the study did reduce their emotional and physical contact with patients. Avoidance of the patient relationship is a response to emotional exhaustion (Maslach, 1982).
Abraham’s study on the relationship between dissonance and emotional exhaustion suggests it is possible participants in the present study on disengagement were also experiencing emotional exhaustion as evidenced by their avoidance of patient relationships.

Using quantitative measures, Bakker and Heuven (2006) examined the relationship between emotional dissonance, burnout, and in-role performance among nurses and police officers. The findings were consistent with their hypothesis that emotional demands are related to burnout, mainly through emotional dissonance. Nurses and police officers’ experience of emotional discrepancy lead to emotional exhaustion. As in Abraham’s study (1999b), Bakker and Heuven’s research supported a link between dissonance and the burnout syndrome. These findings underscore the potential implications of dissonance in the workplace.

In the present study, nurses’ experience of dissonance was related to feelings of inauthenticity. When they were unable to act on their beliefs, participants felt they were not being authentic in their relationships with patients. As will be discussed in the following section, nurses’ experience of inauthenticity has the potential to harm their psychological well-being. Despite the implications for mental health, little has been studied on dissonance among healthcare professionals. This research contributes to the understanding of possible causes and consequences of nurses’ experience of dissonance in the workplace.

**Nurses’ Caring Beliefs**

The nurses in this study experienced dissonance in patient relationships when their caring behaviours were incongruent or inconsistent with their caring beliefs. Participants valued holistic patient care and believed patients’ emotional needs were equally important as their physical needs. These beliefs were in conflict with the perceived values of their working
environment. The need for productivity and efficiency in the current health care environment superseded emotional engagement in patient relationships. The participants valued relationships with patients and, therefore, experienced distress when they felt unable to enact these beliefs.

The findings of this study are similar to nurses’ experience of moral distress. As previously discussed, moral distress arises when “one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action” (Jameton, 1984, p. 6). In both this study and studies on moral distress, nurses experienced psychological discomfort in response to an inconsistency between their beliefs and their behaviours. In her study on moral integrity, Kelly (1998) discovered nurses avoided patient interaction as a method of coping with moral distress. While avoidance decreased moral distress initially, Kelly revealed this relief was temporary and caused some nurses to question their professional identity, which further contributed to their moral distress.

Nurses’ ability to enact their beliefs, whether caring or moral, was influenced by conditions in the working environment. Moral distress can, therefore, be understood as dissonance caused specifically by a discrepancy between nurses’ moral beliefs and their moral behaviours. Similarly, the nurses in the current study experienced dissonance in response to inconsistency between caring beliefs and caring behaviours. The similarity between this research and research on moral distress suggests dissonance may be a common experience for nurses in response to incongruence between their beliefs and behaviours.

Authentic presence in patient relationships was an important feature of participants’ caring beliefs. Authenticity, which entails congruence between beliefs and behaviours, is necessary for nurses’ true presence with patients (Bugental, 1987; Parse 1990). As reviewed
in chapter two, presence is fundamental to caring. The nurses in this study intuitively recognized the importance of presence and experienced psychological distress when they were not authentically present in their patient relationships. Being inauthentic in their work was associated with the questioning of their professional and personal purpose, which had the potential to foster feelings of alienation and depression.

These findings support the current literature on emotional labour and psychological well-being. In his review of the literature, Zapf (2002) identified that being inauthentic at work may lead to feelings of hypocrisy, alienation from self, poor self-esteem, and depression. Erickson and Wharton’s (1997) study with interactive service workers yielded similar conclusions, discovering that inauthenticity was a strong predictor of depressed mood. Conversely, Liu and Perrewe (2006) discovered that hospice workers perceived authenticity was positively related to their affective well-being and increased professional satisfaction. The findings from the study on nurses’ experience of disengagement in patient relationships contribute to understanding the relationship between inauthenticity and depression among helping professionals and indicates a need for further research in this area.

Empathy has been regarded as a key feature of the concept of care. From the field of psychology, Carl Rogers (1951) described empathy as occurring when the therapist is able to assume the internal frame of reference of the client. An analysis of the use of empathy in nursing practice is beyond the scope of this discussion. However, it has been generally accepted that empathy is an essential feature to care in nursing (e.g., Kristjansdottir, 1992; Peplau, 1952; Travelbee, 1971). Nurses’ experience of engagement in patient relationships was fostered when participants were able to “put themselves in their patients’ shoes.” As Rogers would explain, nurses were identifying with the world from their patients’
perspective to develop empathic understanding. The current research on disengagement in nurse-patient relationships highlights the importance of nurses’ use of empathy to foster engagement in nurse-patient relationships.

The concept of care has been identified as the essence and unifying domain of nursing practice (Cohen, 1991; Leninger, 1984). While caring has been extensively theorized (e.g., Gadow, 1980; Heidegger, 1962; Paterson & Zderad, 1988; Watson, 1988), the translation of caring theories into nursing practice is poorly described in the literature (Dyson, 1996). Dyson’s (1996) study supported the concept that nursing care is a combination of nurses’ caring beliefs and caring behaviours. Having time for patients and appearing unhurried were identified as key features of caring behaviours. Similarly, the findings of the present study on disengagement in nurse-patient relationships suggest nurse’s believe physical presence is a significant characteristic of caring. This study reveals the importance of nurses’ conceptualization of care and the potential consequences when these beliefs cannot be honoured.

Nurses’ Work Environment

Nurses’ ability to enact their caring beliefs and authentically engage in patient relationships was influenced by conditions in their work environment. The actual and perceived lack of time fostered nurses’ use of the behaviours associated with disengagement from patient relationships, such as decreased eye contact, increased physical distance, and increased task-focused behaviour. Working in an acute care environment, participants were challenged with competing demands and the task of prioritizing patients’ care needs. On the occasion they were not actually busy, however, the nurses in the study felt as though they had to appear busy for fear of judgment by their colleagues. In this research, the observance of
this phenomenon has been coined the culture of productivity. The lack of time and the culture of productivity fostered nurses’ process of disengagement.

Psychological characteristics of the health care environment, including time constraints and conflicting demands, have been well documented as antecedent conditions to psychological distress (e.g., Comeau et al., 1998; Gray-Toft & Anderson, 1981; McGillis Hall & Kiesers, 2005). The findings from the current study qualify nurses’ distress as the inability to enact their caring beliefs. For the nurses in the study, engaging with patients was an important attribute of their caring beliefs. The lack of time to engage with their patients therefore resulted in incongruence between nurses’ beliefs and behaviours, triggering dissonance.

The culture of productivity in health care exacerbated nurses’ psychological distress. The perceived need to appear busy for fear of judgement from colleagues precluded participants’ engagement with patients. This finding is not surprising given the paradox in nursing practice: caring versus objectivity. Nurses are challenged to engage in meaningful relationships with patients in an environment that traditionally values objectivity and “detached concern” from patients (Halpern 2003; Schultz & Carnevale, 1996). As experienced by the nurses in the study, engagement in patient relationships was not valued and, therefore, not deemed an effective use time.

The findings of the current study support the literature that reports that nurses’ psychological distress is a response to time constraints in health care. The actual amount of time available for patient care was not the cause of their distress. Nurses experienced distress as a consequence of being unable to enact their caring beliefs. This research underscores the importance of qualitatively exploring nurses’ occupational stress in the future.
Strengths and Limitations of the Study

The present study provides a valuable contribution to the existing literature on nurses’ experience of patient relationships in an acute care environment. The research on many of the stress-related disruptions among helping professionals alludes to the caregiver’s response of depersonalization, detachment, withdrawal, and avoidance. This process, however, has not been specifically studied from the nurses’ experience in an acute care context. Little is known about nurses’ experience of disengagement and the grounded theory method was, therefore, appropriate for studying this phenomenon. Using this methodology, the social process of disengagement was identified, revealing the impact of work conditions on nurses’ experience of disengagement in patient relationships.

The discovery of nurses’ experience of dissonance is a valuable finding of this study. The research suggests several personal and systemic implications of dissonance, including alienation from self, depression, professional dissatisfaction, and attrition from the nursing profession. Incongruence, the antecedent condition to dissonance, is known to occur in other stress-related disruptions, such as moral distress. This study reveals the importance of dissonance and has the potential to shed light on nurses’ experience of other stress-related phenomenon.

The mid-range theory of disengagement in nurse-patient relationships describes nurses’ process of disengagement from patient relationships and illuminates the environmental conditions influencing this process. This theory provides a conceptual template to explore the phenomenon of disengagement with other populations and in different work environments.
There were several limitations to this study that need to be identified. While the focus of the research question was nurses’ experience of ‘disengagement’, the data collected also included nurses’ experience of ‘engagement’ and ‘lack of engagement’ in patient relationships. Participants spoke about the causes, conditions, and consequences of engaging with patients, not engaging with patients, and disengaging from patients when they had once been engaged. All of these findings were considered during analysis and integrated into the mid-range theory of disengagement in nurse-patient relationships. As discovered in the data, the three processes of engagement share many characteristics, however, it should not be assumed they are a mirror image of the phenomena.

The nurses who participated in the study resonated with the term disengagement and experienced a certain level of psychological distress in response to their process of disengagement from patient relationships. It can be postulated that their distress and their desire to speak about their distress in a quasi-therapeutic environment prompted them to seek participation in the study. This supposition is supported by the absence of cases of the action context ‘congruent and absent’. For the nurses in the study, authentic engagement in patient relationships was an important facet of their caring beliefs. If they were not present in the caring interaction, it followed that their behaviours were incongruent with their beliefs. It is possible that nurses who do not believe presence is an essential feature to care do not experience incongruence when they are absent from the patient relationship. These nurses would, therefore, not experience psychological distress in response to disengagement and would likely not seek participation in a study of this nature. Given this consideration, the mid-range theory of disengagement in nurse-patient relationships is only applicable to nurses
who believe in authentic engagement with patients and is not relevant to nurses with different caring beliefs.

The sample imposed certain limitations on the applicability of this research. A sample size of twelve is relatively small for a grounded theory study and, consequently, the theory of disengagement in nurse-patient relationships may not have been fully developed in terms of variation and density (Strauss & Corbin, 1990). A small sample size, therefore, limits the transferability of the findings. In addition, this study reflects a bias towards Western culture as the majority of participants were Caucasian and had been raised in Canada. Finally, the sample did not include men. While research suggests men and women differ in their emotional experiences, the theory developed is limited to female nurses’ experience of disengagement from patient relationships.

Implications and Recommendations for Research and Practice

Implications and Recommendations for Research

The current study has begun to illuminate the importance of researching nurses’ experience of disengagement from patient relationships; however, further research is needed to develop the mid-range theory. The participants in the study resonated with the term disengagement and their experience was related to their inability to enact their caring beliefs. Future research needs to study the experiences of nurses who have not become disengaged from patient relationships, exploring potential differences in caring beliefs. The theory developed explains the phenomenon as it occurs in the context of acute care. To test variation of the theory, research on disengagement in nurse-patient relationships needs to be conducted in other work environments. Future research on this process should include men in the sample to explore potential gender differences in nurses’ experience of disengagement.
The findings of this research did not reveal any potential benefits of nurses’ disengagement from patient relationships. Some literature suggests disengagement or detachment from patient relationships is a desired response to the emotional demands of providing care (Halpern, 2003; Henderson, 2000; Morrison, 1989). While some of the participants did refer to disengagement as a “survival strategy” necessary for “self-protection,” this finding was insignificant in comparison to the findings of the harmful effects of disengagement. Future research should explore further the helpful and harmful effects of disengagement on both nurses and patients.

Nurses’ experience of dissonance, and the potential repercussions of dissonance, warrants further research. According to the findings in the study, nurses did not change their beliefs, their behaviours, or their perception of their behaviours and, consequently, remained in a state of dissonance. It could be postulated that nurses who have not experienced disengagement were successful in changing either their beliefs, behaviours, or their perception of their behaviours. It may even be possible that describing disengagement as a survival strategy is evidence of a change in the nurses’ perception of their behaviours related to disengagement. While these are reasonable hypotheses, there is an obvious need for further research in this area.

The present study on disengagement in nurse-patient relationships suggests several implications of dissonance on nurses’ psychological well-being and the health care system. Further research on nurses’ experience of disengagement is required to gain a better understanding of the relationship between dissonance, inauthenticity, and depression. The systemic consequences of dissonance, including turnover and attrition, necessitate research
exploring how nurses manage dissonance in the workplace. In a time of nursing shortage, this research is imperative.

**Implications and Recommendations for Practice**

As discussed, the psychological outcomes of dissonance are similar to those of other stress-related disruptions among helping professionals. Alienation from self, decreased self-esteem, emotional exhaustion, and depression may result when nurses are unable to be authentically present in their caring relationships. In their meta-analysis of occupational stress interventions, van der Klink, Blonk, Schene, and van Dijk (2001) concluded the most effective interventions were those that focused on the individual employee. Counselling psychologists need to be aware of nurses’ experience of dissonance arising within a specific context and assist them to explore the incongruence between their beliefs and behaviours. Cognitive restructuring could be taught to help nurses alter their negative self statements, such as, “I’m a bad nurse,” and to consider the influence of their working environment. Counsellors could also apply existential techniques to assist nurses in discovering their professional and personal meaning in their work. When nurses do not have the opportunity to create meaning in their work, they may have little choice but to disengage (Montgomery, 1993).

Educational strategies need to be considered as a preventative measure for disengagement. This research underlines the importance of self-awareness training in order to prepare nurses for the demands of their profession. For nurses, self-awareness enhances congruence between one’s behaviours and deeply held beliefs (Drew, 1997). Having a strong sense of self could possibly shield nurses from some of the environmental conditions in the workplace. While there is evidence that nursing is moving towards including self-awareness
in educational curricula, most of the nurses in this study did not feel adequately prepared to emotionally engage in nurse-patient relationships in their working environment. Given the potentially significant implications of dissonance and eventual disengagement, it is imperative for nursing education to develop self-awareness training that appropriately prepares nurses for the current practice environment.

Although, to a certain extent, disengagement may be an inevitable consequence of working in a highly demanding acute care environment, it may be possible to minimize the impact on nurses’ psychological well-being. By creating a climate that supports engagement in patient relationships, nurses will be able to enact their caring beliefs. It is essential for unit managers to encourage the development of nurse-patient relationships, allowing nurses to prioritize patient care based on caring rather than task completion (Montgomery, 1993). Finally, individual counselling for nurses should be readily accessible and the use of these services should be promoted.

**Concluding Remarks**

This study revealed the complexity of nurses’ experience of disengagement from patient relationships. Disengagement is a social process, experienced within the context of nurses’ work environments. Through close engagement with nurses’ experiences, this seminal research encouraged the emergence of a compelling and valid mid-range theory of disengagement in nurse-patient relationships. It has laid the groundwork for further research in this substantive area. The significance of this work lies in its potential to enhance nursing education and practice as well as current counselling practices. Improvements in these areas ultimately promote nurses’ well-being.
In a time of health care crisis, it is imperative to preserve the most valuable commodity in the system: the health care professionals. Recognition and support of nurses’ uniquely demanding work is critical to the health of the nurse, the patient, and the system as a whole. In the words of Sarah, a participant in this study, “unhappy nurses leave.” The question is, “Why are nurses unhappy?” The nurses in this research experienced psychological distress when they were unable to fulfill their caring beliefs and engage in meaningful patient relationships. Nurses realized their meaning through authentic presence in their relationships with patients. It is essential to foster a health care climate that promotes wholeness and integrity in order to support and sustain nurses’ ability to care. Without recognition of the whole, everything falls to pieces.
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Maslach, C. (2001). What have we learned about burnout and health? *Psychology and


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*Nursing Forum, 23*, 16-29.


Consent Form
Disengagement in patient relationships: Nurses’ experience in acute care

Principal Investigator: Dr. Marla Buchanan
Education and Counselling Psychology and Special Education
(604) 822-4625

Co-Investigator: Alana Newton, B.Sc., R.N.
Master’s of Arts candidate
Education and Counselling Psychology and Special Education
(778) 895-5169

You are being invited to participate in a research study exploring the experience of disengagement from patient relationships based on the experiences of nurses working in acute care. The investigator is interested in discovering a theory of disengagement from the perspective of the nurse. This research is part of a thesis for the completion of a graduate degree in counselling psychology. The thesis will be published as a public document.

If you consent to participate, your involvement will consist of one one-hour interview and a few e-mail correspondences. The co-investigator of this study will conduct the interviews and engage in e-mail correspondence. The information for the study will be collected over a period of approximately four months. The interviews will be conducted in a place where privacy can be maintained and distractions minimized. This may be at Vancouver General Hospital, Providence Health Care, or the University of British Columbia.

Because the investigator is interested in the experience of the nurse, it is important that your words be recorded as accurately as possible. The investigator will take notes during the interviews, which will be audiotaped and transcribed. Your identifying information (i.e. name, place of employment) will never be associated with the audiotapes or transcriptions. All documents will be identified using a numerical code. Notes, transcriptions and audiotapes will be stored in locked filing cabinet and on a password protected computer hard drive.
Even though we will emphasize to all participants that comments made during the focus group session should be kept confidential, it is possible that participants may repeat comments outside of the group at some time in the future. Therefore, we encourage you to be as honest and open as you can, but remain aware of our limits in protecting confidentiality.

Although the risk to participants is felt to be minimal, you may feel some discomfort after recalling a distressing incident. The investigator will provide each participant with phone numbers of available counsellors should the need for assistance arise during the study or in the future.

If you have any questions or desire further information with respect to this study, you may contact Alana Newton at (778) 895-5169. If you have any concerns about your rights as a research participant, you may contact the Research Subject Information line in the UBC Office of Research Services at (604) 822-8598.

**Consent:**

Your participation in this study is entirely voluntary and you may refuse to participate or withdraw from the study at any time. Refusal to participate or withdrawal from the study will not jeopardize your employment.

Your signature indicates that you have received a copy of this consent form for your own records. Your signature indicates that you consent to participate in this study.

_______________________________________________________________
Participant Signature                                                        Date

_______________________________________________________________
Printed name of the participant

_______________________________________________________________
Principal Investigator Signature                                                      Date

_______________________________________________________________
Printed name of the principal investigator

_______________________________________________________________
Co-Investigator Signature                                                      Date

_______________________________________________________________
Printed name of the co-investigator
APPENDIX B

INCLUSION AND EXCLUSION CRITERIA
INCLUSION AND EXCLUSION CRITERIA

Inclusion

1. Registered nurse.
2. At least one year of work experience in an acute medical/surgical setting.
3. Age 22-60 years old.
4. Female.
5. Able to articulate experiences.

Exclusion

1. LPN, RPN.
2. Less than one year work experience in acute medical/surgical setting and currently neurosciences at VGH.
3. Less than 22 years old
5. Unable to articulate experience.

Rationale

1. Relationship with patients and duties vary depending on the discipline.
2. May not resonate with phenomenon under study with less than one-year experience in acute medical/surgical setting.
3. Ethical conflict in interviewing participants working in neurosciences (multiple roles).
4. Participants less than 22 years old are unlikely to have worked at least a year.
5. Females and males differ in their experience of occupational stress and coping strategies.
6. Informants need to be able to articulate their experiences to participate in interviews.
APPENDIX C

INTERVIEW GUIDE
INTERVIEW GUIDE

Charmaz (1990) outlines framing and ordering of interview questions.

1. Short face-sheet.
   Neutral, factual and limited to necessary information.

2. Informational.
   Bring respondent into the interview and establish chronology, types of events, degrees of awareness, cast of participants.

3. Reflective.
   May serve as transitions to address direct issues about self.

   Often directly elicit data about self.
   Reflective and feeling questions are asked when trust and rapport have developed.

5. Ending.
   Designed to complete the interview on a positive note. The more intense the interview, the more questions and comments needed to end the interview with the participant feeling positive about self. These questions also elicit self-awareness and symbolic meanings.

Sample Questions:

1. In preparation for our interview, please recall a story of disengagement.

2. What meaning do you make out of this experience?

3. What feelings are associated with this experience?

4. If a video camera were recording you being disengaged, what would it look like?

5. What happens to this experience at the end of the day?

6. Where do you derive your strength?
APPENDIX D

RECRUITMENT POSTER
Disengagement in Patient Relationships: Nurses’ Experience in Acute Care

Principal Investigator: Dr. Marla Buchanan
Associate Professor

Co-Investigator: Alana Newton, R.N., B.Sc.
Master's Candidate

Have you ever felt disconnected or distant from your patients?

Have you wondered how this feeling impacts you and your patients?

If you are a female registered nurse with acute care experience, we want to hear from you!

We are looking for acute care nurses to participate in our study of disengagement in patient relationships. This research is part of a thesis for the completion of a graduate degree in counselling psychology.

Your participation will involve a one to two hour interview and a one-hour focus group.

As a token of our appreciation, you will receive a $5 gift card for your participation.

For further information, please contact:

Alana Newton

Version: September 13, 2006
APPENDIX E
ETHICS APPROVAL CERTIFICATE
# Certificate of Approval

**PRINCIPAL INVESTIGATOR**
Buchanan, M.

**DEPARTMENT**
Counselling Psychology

**NUMBER**
B06-0777

**INSTITUTION(S) WHERE RESEARCH WILL BE CARRIED OUT**
Providence Health Care, UBC Campus, Vancouver General Hospital

**CO-INVESTIGATORS**
Newton, Alana, Counselling Psychology

**SPONSORING AGENCIES**
Unfunded Research

**TITLE**
Disengagement in Patient Relationships: Nurses Experience in Acute Care

**APPROVAL DATE**
OCT 23, 2006

**TERM (YEARS)**
1

**DOCUMENTS INCLUDED IN THIS APPROVAL**

The application for ethical review of the above-named project has been reviewed and the procedures were found to be acceptable on ethical grounds for research involving human subjects.

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*Approved on behalf of the Behavioural Research Ethics Board by one of the following:*

Dr. Peter Suedfeld, Chair,
Dr. Jim Rupert, Associate Chair
Dr. Arminee Kazanjian, Associate Chair
Dr. M. Judith Lynam, Associate Chair

This Certificate of Approval is valid for the above term provided there is no change in the experimental procedures.
CERTIFICATE OF APPROVAL - MINIMAL RISK AMENDMENT

PRINCIPAL INVESTIGATOR: Marla Buchanan
DEPARTMENT: UBC/Education/Counselling Psychology
UBC BREB NUMBER: H06-80777

INSTITUTION(S) WHERE RESEARCH WILL BE CARRIED OUT:

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<tr>
<td>Vancouver Coastal Health (VCHRI/VCHA)</td>
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<tr>
<td>UBC</td>
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<tr>
<td>Vancouver Coastal Health (VCHRI/VCHA)</td>
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<td>St. Paul's Hospital</td>
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CO-INVESTIGATOR(S):
Alana J. Newton

SPONSORING AGENCIES:
Unfunded Research - "Disengagement in Patient Relationships: Nurses Experience in Acute Care"

PROJECT TITLE:
Disengagement in Patient Relationships: Nurses Experience in Acute Care (B06-777)

Expiry Date - Approval of an amendment does not change the expiry data on the current UBC BREB approval of this study. An application for renewal is required on or before: October 23, 2007

AMENDMENT(S):

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<tr>
<td>Questionnaire, Questionnaire Cover Letter, Tests: Interview protoco;</td>
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The amendment(s) and the document(s) listed above have been reviewed and the procedures were found to be acceptable on ethical grounds for research involving human subjects.

Approval is Issued on behalf of the Behavioural Research Ethics Board and signed electronically by one of the following:

Dr. Peter Suedfeld, Chair
Dr. Jim Rupert, Associate Chair
Dr. Arminee Kazanjian, Associate Chair
Dr. M. Judith Lynam, Associate Chair