The use of humor to relieve stress in psychiatric nurses

Joanne Kwandt

College of William & Mary - School of Education

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The use of humor to relieve stress in psychiatric nurses

Kwandt, Joanne, Ed.D.
The College of William and Mary, 1992

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THE USE OF HUMOR TO RELIEVE STRESS
IN PSYCHIATRIC NURSES

A Dissertation
Presented to
The Faculty of the School of Education
The College of William and Mary

In Partial Fulfillment
Of the Requirements for the Degree
Doctor of Education

by
Joanne Kwandt
April 1992
USE OF HUMOR TO RELIEVE STRESS
IN PSYCHIATRIC NURSES

by

Joanne Kwandt

Approved April, 1992 by

Fred L. Adair, Ph.D.
Chairman of Doctoral Committee

Charles O. Matthews, II, Ph.D.

Kevin E. Geoffrey, Ed.D.
THIS DISSERTATION IS DEDICATED

TO MY HUSBAND

DENNIS CHARLES KWANDT

The man who never stopped believing in my dream even when I did.

The man who makes my days easier and my nights special.

The man who scrimped, saved, and sacrificed for my education for nineteen years.

The man who put up with my temper tantrums, tears, and fears.

The man who made each step of my victory a celebration.
ACKNOWLEDGEMENTS

This research study was a team effort. Many people have helped me and supported me in this effort. My father, John Mahady, taught me how to be a team member and to problem solve. My mother, Ann Mahady, encouraged my academic pursuits and assured me that my dreams could become reality.

At Charter Colonial Institute from 1982 to 1985, I had the pleasure of working with my mentor, Wayne Martin, LCSW. He shared with me his belief in the psychotherapy process and he taught and encouraged me as a counselor. He acted as a resource person and allowed me to use his unpublished notes. Most of all, Wayne introduced me to the use of humor as a therapeutic tool.

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answered the countless technical and structural questions I had as I began putting my research together as a dissertation.

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thirty-three RNS an a special opportunity to broaden their nursing education.

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could go to college and gave up trips and outings to help me when I had
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through all the trials and tribulations.

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academic/clinical excellence that challenges all his students to
stretch themselves to new levels of professional growth. Dr. Adair has
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inspired in me a sense of self-confidence, work pride, and integrity.
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The purpose of this study was to investigate the effectiveness of humor as a coping mechanism to relieve work stress of psychiatric registered nurses (RNs). The population was selected from 31 volunteer RNs who worked thirty-two to forty hours a week in psychiatric hospitals in the Norfolk-Tidewater-Williamsburg-Richmond areas of Virginia. The RNs completed three pretest self-report measurements on stress. The Social Readiness Rating Scale (SRRS) was given to assess preexisting life stress. The Work Environment Scale (WES), and the Psychiatric Nurses' Occupational Stress Scales (PNOSS) were given to measure for pretreatment work stress.

The RNs were then randomly assigned to one of three workshop groups. The treatment groups had workshops on the use of humor or an alternative coping skill (progressive relaxation) to relieve environmental stress. The control group workshop was on the use of neurological assessment. Each workshop lasted three hours. The first segment taught the basic theory and introduced the skill. The second segment taught the RNs how to use what they learned. The third segment allowed the RNs to practice their new tool. All RNs in all the groups were encouraged to practice their new skills within the hospital environment. The progressive relaxation RNs had a relaxation tape and tape recorder available to use on breaks.

Six week after the workshops, the RNs were mailed a packet containing a certificate stating they attended the workshop and two self-report measurements on the WES and PNOSS which were completed and returned to the researcher.

The pretest and posttest measurements were scored by hand. Descriptive statistics were used to measure the central tendency or average and the amount of dispersion or spread. The hypotheses were analyzed by one-way analysis of covariance.

The findings were not significant to the p > .05 confidence level. With the particular sample population and the groups, it was concluded that the treatment were not successful in reducing work stress or occupational stress or in changing attitudes in the workplace. However, the study indicates that with a greater sample size and more specificity concerning what work stress is to be measured, significant findings are possible.
Throughout this paper, there will be various cartoons presented. Like all humor, these cartoons are designed to entertain. However, they are included in this research project because they represent examples of "gallows humor". This type cartoon has stress relieving qualities for female psychiatric nurses. The Beetle Bailey comic on the next page provides an introductory statement about why humor plays such an important role in our society. Figures 1.0, 2.1, 2.2, 2.3, 2.4, 2.5, and 2.6 will also demonstrate gallows humor.
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USE OF HUMOR TO RELIEVE STRESS IN PSYCHIATRIC NURSES
CHAPTER ONE

Introduction

Statement of the Problem

The purpose of this investigation is to study the effectiveness of humor as a coping mechanism to relieve stress in full-time, hospital employed, female psychiatric registered nurses (RNs).

Justification for Study/Central Theme

World Wars I and II employed women in jobs traditionally considered for men only. Each year since those wars, women have begun to enter the work force in greater and greater numbers. Professions that were not readily open to women, such as pilots, jockeys, race car drivers, and even high ranking military leadership positions, are now being held by competent and successful women. However, nursing, the one field that is traditionally considered an acceptable profession for women, is encountering serious problems in recruitment. Nursing journals, professional periodicals, and popular news magazines all report a crisis of major proportions nationwide because of high vacancy rate (13.6% in total RN positions) and RN turnover rates of 30% to 70% (Fenner, 1988). From 1985 to 1987 there was a 13% decline in full-time baccalaureate nursing enrollments (Neathawk, Dubuque, & Kronk, 1988). Thus, a severe shortage of RNs now exists. In the 1990s it will present a real threat for the medical facilities providing patient care. There will be projected vacancies of approximately 600,000 RNs
by year 2000 because of attrition, a decrease in number being trained, and expansion of needs (Neathawk, Dubuque, & Kronk, 1988; Fenner, 1988; Ringold, 1988; Clark, et al., 1987; McCarthy, 1989).

Problems that nursing administrators are citing as reasons for the shortage include, (1) high stress and burnout, (2) problems with professional acceptance and status, and (3) increased professional standards and demands placed on fewer RNs. Additional female stressors are linked with menstruation, pregnancy, and child care. Also, juggling family responsibilities, housework, and a career increases pressure on RNs (Phillips, 1982; Kuhlman, 1987; Cox, 1988).

The specialty field of psychiatric nursing is particularly affected by these factors. First, psychiatric RNs experience the same basic problems encountered by all practicing nurses. Second, the nature of the professional role of psychiatric RN’s means that they deal daily with crisis conflicts like physical altercation, aggression, verbal abuse, and emotional upheaval. In addition, they work in an environment involving dangerous and unpredictable patients (Phillips, 1982; Kuhlman, 1987; Cox, 1988). Such conditions result in stress related illnesses (McGhee, 1983; Benson, 1984).

Psychiatric nursing management has to compete with other local medical facilities to attract qualified personnel by increasing pay, benefits, and scheduling flexibilities. In addition, they must find innovative ways to reduce the stress of those already employed because absenteeism from stress-related illnesses is taking its toll on staffing and productivity (McGhee, 1983; Benson, 1984). Absenteeism further burdens the manager who then has to pay out more money in sick leave. Also, managers have to augment staffing from a dwindling work
"But I specifically asked for this day off six months ago."
pool of relief RNs or put a heavier work load on those RNs on staff who are well (Phillips, 1982; Fenner, 1988, Clark, et al., 1987; Ringold, 1988). One innovative approach to stress reduction is the use of humor. Used properly, humor could offer hospital administrators an effective and cost-efficient way to relieve nursing stress. Experts have recognized the anxiety-relieving qualities of humor for centuries. However, using humor clinically to relieve stress is a relatively new practice. Research studies have shown that humor has tension-relieving qualities (Martin & Lefcourt, 1983; Fry, 1979; Kaplan & Boyd, 1965; Fox, 1959). Clearly, empirical evidence showing that humor reduces RN tension within a psychiatric hospital setting, could open new cost-effective avenues for administrative prevention of RN stress.

Theoretical Rational

No one particular theory explaining humor has gained general acceptance. McGhee (1979) feels this situation exists because no one theory adequately explains the multifacets of humor. McGhee has designed a theory of humor based on the aspects of humor and its development in children. He combines the known humor theories of Kant, Berlyne, Freud, Bergson, and Koestler in a way that allows a higher level of understanding. He also includes findings of the more recent and renowned humor scholars such as Pallio, Fry, Shultz, Suls, and Rothbart, to name only a few. McGhee's model is simple and involves the idea that a stimulus will result in a response (laugh or smile) under certain conditions. He elaborated on this model by discussing the four aspects of humor: the stimulus, the recipient, the reaction, and influences.
Figure 1.2
Paul McGhee’s Humor Model

Stimulus ---> Recipient --------------> Reaction

2. Structure 2. Psychodynamic changes 2. Verbalization

Influences or functions

1. Motivational
2. Personality
3. Social

A general model of qualities accounted for in psychological theories of humor (McGhee, 1979, p. 9).
The first aspect of McGhee's (1979) model is stimulus characteristics. He includes qualities of humor that he believes led to laughter. The first quality is content. There seems to be agreement by all humorists that incongruence is a necessary content for mirth in any form. Incongruence, or the "unexpected, out of context, inappropriate, unreasonable, illogical, or exaggerated must serve as a basic vehicle for the humor of an event" (p. 10).

Koestler (1964) saw creating humor as a mental process called bisociation. He defined bisociation as a mental process that perceives an idea in two self-consistent yet habitually incompatible frames of reference. Incongruency causes emotions to build up, resulting in a release of laughter.

The second quality of stimulus characteristics is structure. McGhee (1979) describes stimulus structure when he writes, "One of the most popular approaches to explaining humor consists of an attempt to isolate the particular qualities of stimulus that lead to the perception of humor. This is not surprising because much of the humor encountered in everyday living is in the form of specific jokes, cartoons, behavior of others, and so forth" (p. 9).

The third quality of a stimulus is complexity. If a joke is too simple, it may appeal to a child but not to an adult. Complicated humor detracts from the incongruence and is no longer funny. When the complexity is optimal or average, the humor is more likely to cause amusement (McGhee, 1979).

The qualities of the recipient comprise the second aspect of the McGhee model. The recipient aspect includes the all-important area of cognitive processing. Mental processing begins in infancy and
progresses as the child gradually masters his environment. The development of a sense of humor corresponds with and is part of that mental mastery process. McGhee (1971, 1977) and Shultz (Cited in McGhee, 1979) propose that incongruity-based humor is an early form of humor. In young children around age two, the creation of mirth depends on the development of the toddler’s symbolic play capabilities. Smiling and laughing may result from attempts to alter existing structures to fit the novel events but these reactions may be for mastery and not humor. Symbolic play represents a child’s awareness of make-believe and pretense. According to Piaget (Cited in McGhee, 1979), as symbolic play develops and children produce fantasy play, they symbolically apply familiar structure to new and unrelated objects, causing incongruity. As the child matures, the theme, style, and forms of humor mature.

McGhee (1979) lists psychodynamic changes as necessary for humor. Freud (1960) said laughter was a means of releasing psychic energy. Tension is relieved when humor allows the expression of material normally deemed unsuitable for direct verbalization. Individuals then feel more relaxed and can better cope with stress. In other words, the physiological aspects entwine with psychological changes: a joke or funny situation causes muscles to tense, which then relax after the punch line. The changes in respiratory, muscular, and limbic systems causing tension and release influenced by humor appreciation are the same changes psychologists are now using in teaching relaxation exercises (McGhee, 1979; Fry, 1979).

The third aspect is the reaction to humor. Laughter and smiles are well known reactions to comic expression. It is assumed that the more
intense and extended the laughter, the greater the level of
dislike experienced (McGhee, 1979). McGhee also claims that
verbal statements and physiological arousal are also ways to react to
humor. These responses are measured by researchers who calculate the
reaction and/or intensity level of the response to humor (Fry, 1979;
McGhee & Goldstein, 1972).

The last aspect of McGhee's model is influences. Influences
include all the miscellaneous factors that help explain why a joke is
or is not funny. Motivation, personality, and social factors are
listed as reasons why jokes vary in acceptability. Research has
investigated the kinds of humor various people and groups prefer
(Mindness, et al., 1985; Pallio, 1983; Martin & Lefcourt, 1986). For
example, if a person is basically passive in personality, aggressive or
superiority jokes could excite the weak area and seem very funny. On
the other hand, these jokes could be unpleasant for the individual,
especially if they concern an area or situation that he/she has been
unable to master. Sex jokes often embarrass people in groups but the
same jokes may be perceived as humorous when they are alone, or vice
versa. However, almost all people will laugh at incongruity if it is
familiar or meaningful to them in some context. Bergson (1921) says
all humor is social and must be seen in its natural environment.

**Definition of Terms**

**Humor Term**

**Gallows Humor.** Macabre humor, used by individuals under great stress
from prolonged periods of fear, humiliation, battlefield syndrome,
and/or daily uncertainty to deal with the chaos in their lives.
Gallows humor is often termed "medical humor" as it is especially

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prevalent in high-stress medical service professions. Professionals use levity to make serious subjects bearable, thus lowering stress and reducing the size of the threat.

Nursing Terms

Psychiatric and mental health nursing. A specialty area of nursing practice, psychiatric nursing employs theories of human behavior as its science and sees the purposeful use of self as an art. Psychiatric and mental health nursing are directed toward both preventive and corrective impacts on mental disorders and their sequelae and are concerned with the promotion of optimal mental health for society, the community, and the individuals who live in it (ANA, 1976).

Psychiatric nurse. Psychiatric nurses may be either a licensed practical nurse (LPN) or a registered nurse (RN). The LPN has approximately one year of basic nursing studies while the RN has two to four years of academic and clinical studies. However, for sake of clarity, when this study refers to a nurse, it is referring to registered psychiatric nurses (RNs). All though there are both male and female RNs in all areas of nursing, this study refers only to female psychiatric RNs.

Research Hypothesis

The purpose of this research was to study the effects of interventions (workshops on humor and progressive relaxation) on psychiatric RN occupational and work-related stress. Also, it investigates pretreatment and post-treatment occupational attitudinal changes of these nurses. It was hypothesized that:

1. Female psychiatric RNs who attended the progressive relaxation workshop will report less work-related stress than the control group.
2. Female psychiatric RNs who attend a humor workshop will report less work stress then RNs who attend a progressive relaxation group and significantly less stress than RNs who attend a control group.

3. Female psychiatric RNs who attended the humor workshop will report a more positive occupational attitude than those attending the progressive relaxation group and significantly more than the control group.

Sample Description and General Data Gathering Procedures

The sample population was drawn from volunteer female psychiatric RNs who reside in the Norfolk-Tidewater-Williamsburg-Richmond areas in the state of Virginia. These RNs were employed thirty-six to forty hours a week in psychiatric facilities, and they worked predominately on the day shift or a day-evening shift rotation. The RNs' ages ranged from 24 to 63 years of age. Administrative RNs, general ward RNs, and clinical RNs were used as subjects, since they all represent psychiatric nurses in the general population.

The researcher obtained permission from the area hospitals to solicit volunteers. Forty-two (42) RNs volunteered for the study, and they were randomly assigned to one of three experimental groups. Group 1 was a workshop on the use of progressive relaxation techniques to aid in coping within the hospital environment. Group 2 was a workshop on the use of humor to relieve stress in the workplace. Group 3 was designated as the control group. The control group was given a workshop on the use of the Neurological Assessment. Each group had fourteen subjects. The research assistant informed each selected RN and her employer by letter of the workshop assignment, date, time, location, and other data concerning the workshop.
All subjects in all three groups completed three self-report instruments prior to receiving the workshop intervention. Measurement reports used were the Social Readjustment Rating Scale (SRRS) by Holmes & Rahe, et al. (1967), Psychiatric Nurses' Occupational Stress Scale (PNOSS) by Dawkins, et al. (1985), and the Work Environment Scale (WES) by Moos (1986). The SRRS measured stress experienced by the subjects outside their hospital environment. The PNOSS measured psychiatric hospital stress, while WES measured general work stress.

The workshops were conducted by experts in their field (see Appendix H). Steve Kissell, B. S. provided the humor workshop. Marilyn L. Spiro, Ph.D., gave the progressive relaxation workshop. John F. Lavach, Ed.D., conducted the Neurological Assessment workshop. After receiving the workshops, all subjects were urged to utilize their new skills when they return to the workplace. They were also informed that they would receive two more self-report inventories within six weeks. They were to complete them and mail them back to the researcher in self-addressed envelopes provided by the researcher. Once the testing was completed, the scores were calculated and evaluated using two statistical methods. Descriptive statistics were used in reporting data on the experimental variables. An analysis of co-variance was used to determine posttest difference between groups after controlling for pretest variables. The confidence level was set at 0.05.

Limitations of the Study

This study had four basic limitations: The research involved RNs who were instructed to use their new skills within a hospital setting. When human subjects are used and a non-laboratory controlled environment is involved, there is less opportunity to ensure proper
experimental controls. McGhee (1979) pointed out that it is extremely
difficult to observe and collect data in a natural environment. It is
even harder to collect data from overworked and overstressed RNs. They
do not welcome any more work, even pleasurable work, assigned to them.
These conditions risk precipitating a negative attitude even for
volunteer subjects.

A further limitation on humor research in any natural setting is
what Fry (1963) refers to as its thoughtfulness vs spontaneity balance,
or the paradoxical nature of comic thought. In other words, planned
humor is not always funny.

Individual perceptions and taste influence what is funny (Pallio,
1986; McGhee, 1979). Designing any study that tries to standardize
humor appreciation or creativity is therefore difficult (Pallio, 1986;
McGhee, 1979). Success has been achieved, however, when the researcher
can use the subjects' own abilities to appreciate the comical side of
life (Mindness, 1971).

A study requiring six weeks between the test and retest risks an
increased attrition rate and a chance of contamination of the empirical
process due to staff-to-staff communication regarding the research.
Other variable factors include differences of age, race, professional
experience, and education among the RN's in the study, but these can be
evaluated statistically. Theoretically, all subjects should have an
equal chance to develop and work with stress. However, the type of
stress may differ. For instance, a new psychiatric RN may feel stress
with combative patients and in learning the techniques and paperwork,
whereas veteran psychiatric RNs might be aggravated by poor management,
community apathy, or problems within the staffing team. A young RN may
feel the responsibilities of parenthood more when trying to pursue her nursing career. An older RN may be plagued with health problems. Some stressors in the workplace may come from cultural or racial differences. The WES and PNOSS have addressed some stress-related racial issues. However, these differences are not emphasized and the controls may not be sufficient to allow generalization to the general population.

**Ethical Considerations**

Efforts were made to ensure that all the ethical considerations outlined by the Committee for Research and Human Rights at the College of William and Mary had been followed to protect the rights of all subjects participating in the study. The proposal was submitted to the committee for review and was approved.

Verbal and/or written permission to solicit RNs within the hospitals for volunteer subjects and for these RNs to attend a free workshop was obtained from local psychiatric facilities. Participant consent forms informed the subjects that they were participants in a research project and asked permission to use self-report scores for experimental purposes. Consent forms stressed that only general findings would be utilized and these findings would be available to any subject through her personnel office upon completion of the study. Individuals could obtain their stress scale scores upon request. The researcher offered to personally provide interpretation and consultation for any RN whose scores indicated that she was at the burnout point, job-wise, after the study was completed.
CHAPTER TWO

Review of the Literature

Historical and Theoretical Development

Humor has always been part of recorded history. Plato and Aristotle both wrote of comedy and humor. Throughout the ages, poets and writers have composed humorous literature and the populace have continued to enjoy the jokes, riddles, and incongruence of life. It was not until Sigmund Freud began publishing his works and his psychoanalytical view that the world’s outlook about humor and its significance psychologically and clinically changed. Freud (1960) saw humor as a counseling tool. He wrote that jokes were a way to release psychic energy built from suppressed sexual or aggressive instincts. Around the same time, Henri Bergson (1921) recorded his thoughts on humor. He saw humor as having an anesthesia effect on individuals. These two men plus the philosopher Kant caused controversy and began generating humor research in the medical, psychological, and sociological fields.

Dixon (1980) suggests that humans developed humor to aid in coping with stress. He wrote, "the uniquely human capacity for being amused represents the evolving of a mechanism that substitutes for the primitive adrenalergic responses one more appropriate to the sort of stressors with which humans have had to contend" (p. 281). He further theorizes that if one sees humor in a stressful environment one can
reduce the threat because that which is mirthful cannot be perceived as fearful.

Data from recent research finds that the humorous response is physiological as well as emotional, consisting of lower skin resistance, increased heart rate, irregular respiration, and tensed muscles (Fry & Storf, 1971; Fry, 1977, 1978; Charney, 1978). The same liberating or physiological relaxing laughter response that Freud (1960) wrote about also provides the basis for behavior relaxation exercise theories.

One theory of relaxation currently used is the muscular theory. This theory was developed by Edmund Jacobson and earned him the name "Father of Relaxation". Jacobson (cited in Poppen, 1988) defined relaxation as the "quiescence of skeletal muscle activity as measured by the EMG or electromyograph" (p. 2). During a relaxed state motor-neuron output is reduced and the magnitude and increase of spinal reflexes are also reduced, causing decreased automatic and cortical arousalment. Simply put, progressive relaxation techniques have been proven to cause neuromuscular relaxation.

Wolpe (cited in Poppen, 1988) utilized Jacobson's relaxation technique but stressed the autonomic rather than the muscular aspect and created a behavior modification tool called systematic desensitization. Wolpe saw relaxation as a parasympathetic antithesis of sympathetically-mediated anxiety. However, other authors feel that relaxation is not all physical or all motorical. Thus dualistic or multimodal theories were developed from the works of Jacobson & Wolpe (Poppen, 1988). Benson (1984) used both meditation and parasympathetic relaxation techniques. In these relaxation exercises advocated by
Jacobson, Wolpe, and Benson behavioral changes are most often visceral (Poppin, 1988).

Critique:

Clinical awareness of the use of humor to relieve stress is growing. Today books laud the use of humor in counseling, and clinical humor therapy is a growing specialty field in psychology (Fry & Salameh, 1987; Klein, 1989; Ascher, 1989). Some therapists, such as Ascher (1989), Fry & Salameh (1987), and Martin (1985) advocate the use of humor clinically. Whitaker & Bumberry (1988) and Minuchin & Fishman (1981) acknowledge the use of humor in therapy and apply it automatically because it is part of their therapeutic style.

Progressive relaxation has been employed for centuries, but its use with scientific research is relatively new. One research difficulty is the lack of an objective measurement system for a subjective state. Researchers have therefore focused on the relation between treatment procedures and symptom change. Poppin (1988) presents a good argument for objective measuring via the multimodal concept. The multimodal concept is relaxation as a complex behavior involving responses in the motoric, visceral, verbal, and observational behavior modalities. Assessment of relaxation should reflect this complexity. He feels there is a need for further research on the assessment of relaxation.

By choosing to use either humor or relaxation exercises as a coping skill, a RN can gain confidence in her ability to handle work stress. Even the perception of that she can be "in control" can relieve stress. Benson (1987) summarized this theoretical concept by writing: "If the universe is indeed interconnected, we may be able to
use our minds to understand and perhaps influence the reality outside our bodies. Then, we might greatly expand our control not only over our bodies but also over the physical reality around us" (p. 24).

**Environmental Stress**

The most generally accepted theory of stress today is the "General Adaption Theory" of Hans Seyle (Levi, 1967; Donnelly, 1984). Seyle (cited in Levi, 1967) sees stress as body adaption in three phases. The first phase is the alarm reaction: stress is encountered and the body reacts with somatic disturbances firing trouble impulses to the hypothalamus and pituitary sections of the brain. In the second phase, the brain causes release of adrenalin and prepares the body for fight or flight, and the body begins adjusting to the stressor. The last phase Seyle calls exhaustion. If the stressor continues, the body defenses give way and the body loses the ability to adjust to the changes from the assault. The same somatic signals are sent to the brain but the body is no longer able to ward off the stress. It works similarly to data overload in a computer. When stress reaches phase three, the body becomes susceptible to disease and infection (Levi, 1967; Donnelly, 1984).

The theories of Phillips (1982) and Cox (1978) present simple and plausible explanations of work stress. Cox defines stress as a constraining force acting upon a person, who exerts or strains himself in attempting to cope with this force, and then feels fatigued and distressed. Phillips essentially applies Seyle's theory in the work situation. In his theory an employee experiences a stressor or, more likely, several stressors, such as, a poor evaluation, long hours, unplanned overtime, work overload, and/or personality conflict with the
supervisor. Anxiety over past unpleasant work experiences causes anticipation of problems in the future. A "what if" or "how will it turn out" pattern develops and this type of anxiety pattern allows an individual to react generally rather than act specifically to the stressor. The adrenalin flow of the employee begins and causes his or her body to prepare for Seyle's fight-or-flight syndrome. Once this preparation happens, fatigue quickly sets in. As the stress gradually increases, the employee loses a sense of control over his or her environment. The adrenalin flow becomes steady and often continuous for long periods of time. Eventually the employee begins staying out with colds, bronchitis, infections, or migraines, etc. (Phillips, 1982). The continuation of this cycle leads to burnout and even depression.

Lerner (1985) studied women's anger which she sees as a significant factor contributing to stress. Women are allowed to cry in American society but they have not been encouraged to be openly angry. Instead, society expects that women will be the placaters or peacemakers of the world. Lerner theorized that women been rewarded for their nonaggressiveness, pacifist behavior so many women have learned to fear and avoid anger and to deny all such feelings. She believes that stifling anger at all costs is a serious mistake (Lerner, 1985). RNs often have trouble expressing anger because they are taught not to display their emotions around the patients.

Gunderson & associates (1977) theorized that psychiatric RNs become caught in a stress cycle when they repress anger. The RNs unmet expectations cause feelings of varying intensities. These feelings cause the RN to feel squeezed or pressured by policy, order,
time, etcetera. The pressure and feelings cause free-floating anxiety, and the RN feels powerless to reconcile the problem, her frustration increases, and she experiences anger. The cycle continues to repeat itself unless broken by constructive action. As the anger continues to build, immune systems break down and the RN becomes physically and emotionally exhausted (Gunderson, et al., 1977).

Mackay & Cox (1978) believed the feelings that causes powerlessness and begins the somatization or physical response process are called coping mechanisms. Furthermore they theorize that physical illness, burnout, and anger are actual and perceived consequences of the coping process. As these consequences become evident and often compounding, they generate more stress at work, until work is interrupted when absenteeism and/or work termination occurs.

Critique:

The theories described above aid in understanding stress and give an overview of how females may become stressed in their environment. The past century has been a productive one for expanding knowledge as to the nature, cause, and effects of stress. It is important to also point out that there are inherent problems with stress research and caution must be used when interpreting the data. Lazarus & Folkman (1984) cite three major problems in environmental stress studies. First, people differ and each person handles stress differently. Secondly, each person perceives and interacts with the environment differently. Lastly, the therapeutic interventions designed to treat stress differ in effectiveness. Such complexities make accurate testing and measurement difficult.
Another criticism of stress studies pointed out by Lazarus & Folkman (1984) was that studies often look at the individual or the environment but fail to emphasize the relationship between the two. They feel there is no way to accurately predict environmental stress without understanding the personality of the worker and knowing the physical setting of the job site. To make this prediction, they try to assess the worker's psychological environmental stress. They define psychological stress as the amount of stress appraised by the worker when he sees the workplace as taxing, the job too difficult to accomplish with current resources, or too dangerous for his well being. The judgment that a particular person-environment relationship is stressful hinges on cognitive appraisal. This may be why stress inventories so often utilize the self-reporting method of measurement.

Stress Level of Working Women with Special Emphasis on Psychiatric RNs

A great deal has been written about the stress encountered by women generally and RNs in particular. Witkin-Lanoil (1989) lists stress-related diseases that are encountered mostly or exclusively by women as anorexia nervosa, bulimia, and loss of menstruation. She then expounds on stressers that women claim as their own:

"The stresses associated with their physiology ... breast development, menstruation, pregnancy, and menopause.

The stresses that can be associated with their life changes ... becoming a wife, becoming a mother, being either during the divorce boom and economic bust, being female after
Figure 2.1

SEXIST GALLOUS HUMOR

The woman who strives to be equal to a man
LACKS AMBITION

Behind every great woman, there's a man trying to stop her.

They've found something that does the work OF 5 MEN
one woman

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forty in a youth-beauty culture, becoming a not-so-merry widow, or reorganizing after children have grown.

The psychological stresses often felt by the supposedly swinging single who was raised in an old-fashioned way, the home maker who is pressured to get out of the home and develop herself, the career woman who is pressured to get back into her home lest she lose her family, and the life-long nonassertiveness expert.

The hidden stresses that distract, distress, and deplete ... tokenism, chauvinism, subtle sexism practiced by both men and other women, entertaining, chauffeuring, and talking to two-year-olds.

And the stresses of life crises, which fall largely on female shoulders ... caring for an ill or dying parent, parenting a handicapped child, and making sure that life goes on" (Witkin-Lanoil, 1989. p. 5).

Furthermore, Witkin-Lanoil (1989) related symptoms of stress that are applicable to men and women but are more often found in women than men. These involve crippling panic attacks, transient headaches, and chronic depression. She further points out female stress that develops from strong messages perpetuated by American society. Some of these messages are: Girls need to be protected, it is important for women to look pretty, women are less logical than men, and women are too emotional for the business world (p. 74). She feels these messages cause some women to develop a unique kind of stress. She calls it the female stress syndrome. This stress syndrome is defined as "a head on collision between a women's need for achievement and her fear of failure" (p. 72). Witkin-Lanoil feels this syndrome involves a
Figure 2.2

SUPERWOMAN
The Common Traps

no wrinkles
always says the right thing
no plaque

The Perfect Wife and Mother

always smiling
perfect make-up

Always Gets Things Done

no cellulite

Involved in Community Affairs

flat tummy

Financially Independent

dressed for success by day, Frederick's of Hollywood by night

never has a run in her panty hose

home-made cookies

sweet-smelling feet
psychological kind of stress encountered when a woman steps out of a
traditional homemaking and caretaking roles. With the traditional
roles, women had a sense of achievement vicariously through the
accomplishments of their husbands and kids. Some women have even had
power and prestige through charity work. However, when these same
women stepped into the work force to satisfy their own goals, the
messages (listed above) caused them to doubt their ability to succeed.
To counteract this fear, they felt compelled to do more and work harder
setting a quick paced life style which is stressful. Braiker (1986)
and Dowling (1988) also researched this kind of stress and reported
similar findings.

The female psychiatric RNs have all the stressors that are unique
to women but they also have tensions specific to their profession.
Some of these tensions are called outside nursing stressors. These
stressors include working under a bureaucratic system with a medical
model where supervisors are skilled clinically but often untrained in
management. Internal strife occurs over programmatic and theory
differences, archaic policies, personnel systems, and interdepartmental
communication (Phillips, 1982). RNs have more stress with fewer
offsetting compensations than any other health profession. They are
professionals yet always are subordinate to physicians. Their power
and status has been hindered. Their struggle to obtain recognition has
spanned two decades and is a major source of frustration for ambitious
RNs (Graves, 1971; Ringold, 1988).

There are also stressors inside the profession that compound
tension for RNs. Inside factors include RNs' idealistic motives for
going into nursing to help mankind versus the reality of a career that

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Figure 2.3

IDEAL NURSE
includes hard physical work, caretaker duties, cleaning, deferential status, and administrative dominance (Phillips, 1982; Graves, 1971; Ringold, 1988). Changing soiled sheets, emptying bedpans, dealing with body secretions, and other duties that are never considered pleasant are part of the RNs' normal routine. In fact, the very nature of their job invites burnout. Shelby (1989) summarizes the situation:

Staff nurses provide the bulk of day-to-day health care. They are at the bedside around the clock, providing comfort, care, and compassion. They fight to improve the quality of patient care in an environment that includes continuing nursing shortages and an industry wide move to contain health care costs. Theirs is a monumental and often thankless job (p. 1).

Psychiatric RNs have even greater stressors. Each year thousands of patients and staff are physically injured in American psychiatric facilities. Physical assaults will always be a problem in mental health settings because behavior disturbances involving aggression are symptoms of psychiatric disease. Compassionate and intelligent care of the mentally ill requires that staff members be involved in providing safety for the patients, co-workers, and the workplace. To do that the workers must be involved in aggressive interactions, physical restraint, and use of the seclusion room (Lion, 1987). The aggressive psychiatric patient population is increasing rather than decreasing despite new medications, techniques, and technology. The patients are younger, more hostile, rebellious, and non-compliant (Lion, 1987; Mirabi, et al., 1985). Additionally, mental health staffs are encountering greater and greater restraints concerning appropriate and therapeutic interventions and patient advocacy programs often tightly
"They gave me a choice. A raise or a parking space."
govern staff-patient interactions. Psychiatric RNs have to deal with their own fears of encountering physical harm as well as addressing those of their staff (Cronin-Stubbs, et al., 1985). Often RNs and mental health professionals feel that they walk a tightrope because of alleged patient abuse incidents. Even when the staff is found free of wrongdoing, such experiences cause high employee stress, staffing shortages, and a negative attitude by the staff, who perceive themselves in a no-win situation.

Verbal abuse is another type of assault that patients and staff encounter in a psychiatric hospital. Psychiatric RNs report experiencing intense interpersonal involvement and frequent verbal conflict with patients and families. They conflict on theories, management, policy and clinical issues with doctors and colleagues (Cox, 1988; Cronin-Stubbs, et al., 1985). These verbal clashes are intensified in psychiatric areas where such conflict is often perceived as affecting the safety of team members or the conflict is interpreted as co-worker mistrust or lack of support.

Other significant stress factors include feelings by psychiatric RNs that they receive less social support and experience less on-the-job and off-the-job affirmation than other high stress nursing fields. Much of the care of psychiatric patients involves one-on-one interactions and the RNs’ clinical interventions are not readily observed or lauded. Patient outcomes are not concrete and progress is difficult to measure (Cronin-Stubbs, et al., 1985). Insurance policies often dictate patient discharges before the mental health staff feel that patients are ready to leave.
Figure 2.5

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Mental health professionals, including RNs, feel they do not receive adequate training to care for their patients, especially with chronic patients. Many patients have dual diagnoses or have organic problems and/or physical illnesses as well (Mirabi, 1985). Furthermore, there is a serious lack of effective, integrated programs to deal with the chronic patients. Community resources, funding, and support is often poor. The population of patients is not considered desirable psychiatry does not get the professional status enjoyed by other medical modalities. Moreover, clinicians feel frustration over the public view of psychiatric patients and especially the chronic, long-term institutionalized patients as undesirable (Mirabi, 1985; Knowlton, 1987).

Doctors and RNs sometimes feel they lack power to make an impact administratively. They are constantly pressured to attend meetings and do tasks that take them farther from the patient area. They also feel extreme pressure because of the time factor involved in getting everything done (Mirabi, 1985). These stressors are not limited to individuals in the psychiatric field. Yet they have a greater impact there because staff shortages or staff mental preoccupation could result in failure to recognize patient escalation early. This would jeopardize the safety of both the patient and the staff (Clark, 1987; Knowlton, 1987; Cronin-Stubbs, et al., 1985). All this information provides evidence that RNs are subject to severe stressors.

**Critique:**

Studies involving the female and nursing stress contain some subtle biases or inconsistencies that may not be immediately evident. For instance, Mirabi (1985) is an M.D. and speaks from a physician's
point of view and Mirabi and Phillips (1982) both write male observations. All the other authors are women and are naturally more sensitive to the female point of view. This subjectivity, however, seems pertinent when considering the female perspective in measuring female stress in the environment, because the RNs speak from an emotional and personal framework, as well as from a professional one. While supportive of the nursing personnel stress dilemma, the physician and male more often address the issue with objective rather than subjective professional perspectives. However, all these opinions help support the nursing stress theories.

Research on burnout also supports the fact that RNs experience high stress. For instance, Jones (1985) found that the work setting contributes to burnout but his data were inconsistent in showing that psychiatric or operating room nursing rather than trauma or intensive care nursing predicts burnout. He suggests that individual involvement or degree of conflict may account for the differences. In fact, psychiatric RNs report highly intense degrees of personal involvement and the psychiatric and operating room RNs report a high degree of conflict. What complicates measurement of stress and burnout is whether the personal involvement or conflict is seen as productive or non-productive or as pleasant or painful. These hidden variables may explain the inconsistent data (Jones, 1985).

The Ability of Humor to Relieve Stress

Numerous experiments and/or observational studies indicate that humor does have the cathartic or liberating effect which Freud described (1953, 1960). A case study by Cousin (1979) that appears to have considerable credibility in medical and psychological circles was
not an empirical research study but rather a personal case accounting. Cousin claimed that humor was instrumental in curing his debilitating collagen disease. Unable to receive pain medication, he utilized a series of humorous movies to cause laughter. He claimed that for every ten minutes of belly laughs he could get two hours of pain free sleep. He also had blood sedimentation levels drawn before and after humor therapy and found a significant drop in the blood levels after laughing.

Cousin (1979) and Fry (1975) also conducted interviews and/or observational studies about how comedians or famous people use humor. One common thread through all the writings is that humor relieves the comedian's personal stress. Cousin reports that Albert Schweitzer employed humor with his staff to help "combat equatorial temperature, humidity, and tensions" (p. 82). Schweitzer's "use of humor was, in fact, so artistic that one had the feeling he used humor like he would a musical instrument" (Cousin, 1979, p. 82).

John Callahan, a 38 year old paraplegic comic artist, relieves his own stress and anger by using gallows humor to laugh at handicapped people (Aries & Lund, 1989). Paul Wynn, a TV reporter with the AIDS virus, used his television journal accounts to poke fun at the lethal disease. Wynn, who died on July 5, 1990 claimed humor kept him fighting and relieved stress (People, 1990). It also made the disease seem less awesome on a day-to-day basis. Trudeau, in his Doonesbury cartoons uses gay gallows humor to "attack fear and ignorance by laughing in its face" (Chua-eoan, 1989, p. 54.)

Safranek & Schill (1982) conducted research to see if humor has a moderating effect on stress over time. Their work showed positive
Figure 2.6

tendencies in the direction hypothesized but offered no conclusive evidence. Schill & O’Laughlin (1984) conducted a test to see if humor preference was related to stress. They found that sexual humor in men allows the release of sexual energy in a socially acceptable way. These findings was consistent with Freud’s humor theories (Freud, 1960).

As previously stated, Dixon (1980) contends that human creative ability for humor represents a basic attempt to cope with life stress. He further contends that the potential for humor is inherent in people and can be developed by learning and modeling. Dixon based his theory on studies he conducted concerning the use of humor to relieve stress during military disasters. He gave three components of this type of humor process. In the first component, the leader’s message was the same one issued by Wynn, Callahan, and Trudeau i.e., if one can joke about the situation, there is less to fear. The second component was based on a study by Farris (cited in Dixon, 1980), in which he proposes that when one jokes about significant authority figures, such as the all-powerful drill sergeant in basic training, the person seems less fearful and more human. Furthermore, many people, and especially leaders, tend to develop and/or use the cognitive skill of humor construction and execution when exposed to prolonged stressful situations (Dixon, 1980). Thirdly, when used aggressively, humor can be a threat. Cartoonists would draw cartoons giving bombs faces or ladies’ names. They tended to humorously stereotype the enemy (Dixon, 1980).

Other research involving disasters also reveal people have a predisposition to laugh ((Kline, 1980; Dixon, 1980). Gallows humor,
the type mentioned often within this report, is the cognitive aspect of this phenomenon.

It is important when clinically using humor to relieve stress that it is used as a coping skill and not as a defense mechanism. Some people laugh during stress so often that laughter becomes habitual. Used this way, humor is a defense mechanism. High anxiety triggers laughter and it becomes uncontrollable even in inappropriate situations (McGhee, 1979, 1983; Johns, 1990). Individuals who have habitual nervous laughter often suffer embarrassment and even shame but are unable to stop it. This creates another aspect to the use of humor under stress. It also points out one way that humor can be destructive rather than constructive. Ridicule and scapegoating of others are other negative uses of humor.

Critique:

Research done on humor is consistent with the studies of Fry (1971, 1977), in which he demonstrates that humor can and does cause physiological changes. His studies lend credence to tension reduction theories and Cousin's case report and presents evidence supporting the use of humor as a physical stress reliever. (Freud, 1960; Bergson, 1921; McGhee, 1979; Cousin, 1979).

Most of the research on humor and stress are weak in validity and reliability. Sample sizes are often small and the sample population is usually psychology students or at least collegiate personnel because of their convenient availability. Nevertheless, the works of McGhee, Moody, Dixon, Schill & O'Laughlin, and Sanfranek & Schill back up the theories presented by Fry, Bergson, Freud, and Cousin, making a strong argument for using humor to relieve stress. Furthermore, the
research provides positive indications that the stress relieving qualities of humor can be effective over time in any given population (McGhee, 1971, 1977, 1979, 1980, 1983; Moody, 1978; Dixon, 1980; Schill & O’Laughlin, 1984; Sanfranek & Schill, 1982).

Recent studies link the use of humor with stress relief (Martin & Lefcourt, 1986; Levine 1971, 1977). Martin & Lefcourt conclude that there is a significant moderating effect in the relationship between recent negative life events and current levels of mood disturbances. In their research, those students who scored high on humor measures have lower scores on the Life Situation Events Measurement and mood disturbances than those with low humor scores. Martin & Lefcourt (1986) found support for the relationship between the sense of mastery and humor. Those subjects with internal control were more apt to exhibit mirthful responses than those with external control. Levine (1977, cited in McGhee, 1972) linked humor to pleasure derived from cognitive mastery. Regardless of the nature of the humor, Levine says that the relationship between humor and mastery of the object or situation within the environment can be tested and duplicated. This sense of mastery relieves stress, because the humor is substituted for a painful state of helplessness.

The use of humor in a stress reduction program poses problems because it involves individual preference. It requires certain conditions to be funny, and it must be relevant to the audience. These factors were considered when Mindness, et al., constructed a test called The Antioch Humor Test, which examined what individuals considered were funny. Mindness, et al. also contend the test provides information on personality and how the examinee interacts with people.
Their conclusions state that humor appreciation is related to personality. Other factors that influence whether material is funny include how the joke is told, the mood of the listener, how clever the joke is, and how the joke is related or perceived. Considering all these factors, there seems to be evidence that mature, warm, easy-going individuals often possess a good sense of humor. Mindness (1987) says that the more appreciation one has for humor of all kinds, the better adjusted one is likely to be.

The Use of Humor to Relieve Stress in a Psychiatric Environment

More and more data is being circulated concerning the use of humor with health care professionals within the hospital setting. Joel Goodman (1983) founded the Humor Project in 1977. This nonprofit organization trains and educates the public about humor under the sponsorship of Sagamore Institute. The Project has two goals: (1) to help people learn, practice, and apply skills for tapping their sense of humor, and (2) to develop and disseminate practical uses of humor that managers, teachers, parents, health professionals, business people, and adolescents can integrate into their work and their lifestyle. The institute provides workshops to meet these goals. Wallen (1989) also conducts humor workshops but limits his in-services only to medical facilities. Wallen provides a valuable syllabus for use in his humor workshops. The syllabus is a detailed and lengthy tool in itself, and it outlines goals and suggestions that are in agreement with those of Goodman (1983). Goodman, Wallen (1989), McGhee (1983), Robinson (1970, 1977, 1983), Martin (1985), and Kane, et al. (1977) all believe that humor is a good physiological and psychological tool that can be used to relieve stress and change attitudes.
positively. They agree with Allen (1960), Minuchin (1981), Koestler (1984), and May (1953), who contend that humor allows those under stress to alleviate or significantly decrease the stress level, enabling them to function more productively.

Humor can also be a bonding tool in employee relations. Humor is an agent for social change because it provides a way to communicate with and promote wellness for patients and staff (Kane, et al., 1977).

Current research showing empirical evidence that humor can relieve nursing stress is scarce. Robinson (1970, 1977, 1983) was the pioneer in providing nursing research on the use of humor in a health care setting. She identified the functions of humor in a health care setting and its application to nursing. She did continued studies which provided guidelines for the use of humor in the hospital.

Many unpublished works, especially on the master and doctoral level, deal with nursing humor research, but published studies are rare. However, some studies report the use of humor with psychiatric patients. Such studies indicate that humor is used to create a sense of belonging, to supply a scapegoating mechanism, to act as a stress reliever, and to aid in changing negative to positive attitudes concerning the environment by laughing at the illness, situation, or environment (Kaplan & Boyd, 1965; Robinson, 1977; Moody, 1978).

Nussbaum & Michaux (1963) did some empirical studies which indicate that severely depressed patients are able to grasp humor. Lorenz (cited in McGhee, 1979) and Fry (1963) cite research regarding humor and the "pecking order" and its use in aggression. Cosner (cited in McGhee, 1979) studied the social functions of humor in the hospital.
staff meeting and found that humor seems to lower social distance, aid cohesion, and provide support.

Gallows humor has been the subject of some research, especially with subjects such as psychiatric workers, doctors, and minorities (Kulhman, 1989; Robinson, 1977; Frankl, 1963). Gallows humor has merit and creditability when preservation of human dignity is maintained even when fun is being poked at a situation, patient, co-worker, system, or environment. As previously stated, if a patient or co-worker becomes a victim or is scapegoated by the use of wit, then gallows humor is destructive.

Studies on people with auditory deficits reveal a phenomenon that has relevance to this study. Hearing impaired people have a great deal of difficulty understanding verbal humor. Humor requires an individual to be able to change references and go into an analytic mode. This ability requires acoustic and probabilistic processes of speech perception. However, the hard-of-hearing or hearing-impaired individual cannot always achieve this understanding because of his inability to process auditory information. Thus the person, because he is hearing-impaired, has problems in social and especially work situations because of the role humor plays in society. A humorous person is perceived as intelligent and a humorless person is perceived as dull and/or antisocial. Just because of their inability to transfer auditory processes properly to comprehend a joke, the hearing impaired person suffers from difficulty in making and keeping friends, getting dates, and achieving promotional progression and proper recognition in the workplace. Thus humor is not only helpful for relieving stress at work, but it is apparently an essential social ingredient for
professional interfacing and acceptance. This fact has been so obvious with hearing impaired people that audiologic habilitation programs are teaching them listening strategies necessary to deal with humorous verbalization (Tobin, 1982).

**Critique:**

Much of the humor research done in work settings has been highly criticized for low sampling numbers, weak validity and/or reliability, and/or questionable ability to generalize across populations. Most of the studies have not been tested under scrutiny or duplication and even fewer were studied within the natural health care environment (McGhee, 1979, 1983). Robinson (1983) writes that "so much more investigation and research is needed in the application of humor to health, not only to interventions in mental health, but to the healing process in disease, in the prevention of disease, and in the promotion of health" (p. 124).

Almost all the stress research has been conducted in university laboratories and extensively with university students. There have been only a few incidents of testing RNs stress relief by humor within a work setting (McGhee, 1978, 1983; Robinson, 1977, 1980, 1983). Nevertheless, the data presented by Kaplan & Boyd (1965), Robinson (1983), and Cousin (1979) indicates that humor relieves stress.

There seems sufficient evidence both in research and in practice to indicate that humor can relieve stress caused in the psychiatric setting. The use of humor in clinical therapy has increased considerably in the last twenty years. Klein (1987, 1989) has written about the healing power of humor and advocates self-help to relieve stress by turning the negatives into positives. Fry & Salameh (1987)
have presented clinical cases and various clinical styles using humor in counseling. When using humor in counseling, Goldstein (1987) warns that humor is ambiguous and could be pathologic as well as healing. "It can be used as a defense against anxiety, for self-deprecation, hostility towards others, closed mindedness, or preoccupation with sex or superiority" (p. 7). In other words, laughter is ambiguous in its ability to reflect extremes in attitude and adjustment.

Pallio (1983, 1986) conducted a study indicating that forced laughter is usually due to tension or embarrassment. Pallio and Allen (1960) found that comedian use of subjects such as sex is not always well received because of varied audience perceptions. Allen felt that incongruity is safer when an audience preference is unknown. Fry & Salameh (1987) also found that there are differences in respiration with various types of laughter. This suggests that some laughter is relaxing while other kinds produce physiological symptoms similar to those caused by tension.

Progressive Relaxation and Its Ability to Relieve Stress

General Information

Progressive relaxation is a broad term that encompasses a variety of techniques used to aid in the reduction of human stress. The basic theories of Wolpe, Jacobson, and Benson concerning relaxation exercises have been discussed. Unitary, dualistic, and multimodal theories have also been presented. Poppin (1988) summed all the theories up in what he labels the Four Modality Theory. Motoric behavior functions to move the body and manipulate the physical environment. Structurally it involves the skeletal/muscular system. In this group there are basically three common motoric relaxation exercises. Progressive
Figure 2.7

A Taxonomy of Behavior with Examples of Relaxation

<table>
<thead>
<tr>
<th>Behavior Modality</th>
<th>Function</th>
<th>Relaxation Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Motoric</td>
<td>Manipulates physical environment</td>
<td>Overt: relaxed postures</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Covert: low muscle tension</td>
</tr>
<tr>
<td>Verbal</td>
<td>Manipulates social environment</td>
<td>Overt: rating scale</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Covert: silent mantra</td>
</tr>
<tr>
<td>Visceral</td>
<td>Maintains internal environment</td>
<td>Overt: slow respiration</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Covert: low heart rate</td>
</tr>
<tr>
<td>Observational</td>
<td>Seeks and differentiates environment</td>
<td>Overt: close eyes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Covert: ‘calm’ imagery</td>
</tr>
</tbody>
</table>

(Poppen, 1988, p. 9)
relaxation training is Jacobson's procedure, which systematically
tenses and relaxes dozens of muscles throughout the body. Individuals
require training with an instructor for this method. They also need to
practice the techniques on their own as well, to insure competency.
Poppen (1988) reported that Bernstein & Borkovec have utilized
abbreviated methods to allow the trainee to localize the relaxation. A
tape with the instructor's voice may be used during practice. Slow
breathing methods are also employed. The goal is to combat stress by
producing responses in the body that are incompatible with stress

Behavioral relaxation training emphasizes behavior. It is an
adaptation of Benson's (1975) relaxation response. The trainee is taught
to observe overt posture and covert sensations and feelings of
relaxation. Visceral behavior involves slow or diaphragmatic breathing
and the trainees are taught mentally to repeat the word "calm" or
"relax" to themselves when exhaling.

In an EMG biofeedback training procedure the trainee is taught to
alter covert muscle activity and observe the changes via external
signals. This observation of change is often as reinforcing as the
relief of symptoms. The trainee is eventually weaned from using
external signal controls by learning feedback free trials and being
instructed to continue what was done when using external signals
(Poppen, 1988).

Thermal biofeedback training focuses on visceral behavior and
specifically vascular dilatation. "The trainee is provided with a
public signal that reflects minute changes in peripheral temperature"
Verbal behavior involves mediating social reinforcement by behavior modification techniques (Poppen, 1988). A common verbal method that also involves breathing and observation behavior is meditation. The trainer provides a syllable called a mantra and the trainee repeats the syllable with exhalation and observes his breathing and verbal activity. Progress is judged on self-report and psychological measures. Other techniques that involve both verbal and observational methods are autogenic training and guided imagery. Autogenic training provides verbal statements concerning heaviness, warmth, or calmness. The trainee repeats the phrase and observes the sensation. Poppen (1988) reports that there is supposed to be visceral response from the verbal and observational activity, but little empirical data supports this.

Guided imagery is a technique used by a trainer to direct scenes and actions in which the trainee imagines himself engaging. The trainee constructs a scene and pays attention to sight, sound, temperature, etcetera. Individuals can learn to do this on their own with practice and use imagery to slow breathing, lower the pulse, and feel in a relaxed state (Poppen, 1988).

Hypnosis is another form of relaxation technique but it usually requires a trainer to aid in the intervention. It is not suggested for use in a stressful work session by a RN to lower her stress.

Critique:

Research on controlled observational studies substantiate many of the claims made by Benson, Jacobson and others. Burish, et al. (cited in Michelson & Ascher, 1987) conducted a research project to test the effectiveness of progressive muscle relaxation with imagery to control
anticipatory side effects of chemotherapy. The data showed a reduction in pulse, blood pressure, anxiety, and nausea by those with relaxation training. The control group showed no reductions. Follow-up results without a leader-therapist are less promising (Michelson & Ascher, 1987; Poppin, 1988; Schillings, et al., 1983). Wolpe's use of the relaxation techniques with systematic desensitization is known worldwide, and his techniques are accepted as effective and useful by clinicians.

Visceral behavior involves slow or diaphragmatic breathing (Poppin, 1988; Schillings, et al., 1983). Benson (1987) reports several case histories to prove the effectiveness of this method in relieving anxiety and psychosomatic symptoms.

Michelson & Ascher (1987) report research by Burish, et al. involving the use of EMG biofeedback to augment the relaxation training during chemotherapy drug infusion. Once the trainee could lower the psychological arousal state, he could maintain a quiet state and utilize relaxing images and distress and nausea were reduced. Also, studies using thermal biofeedback to reduce vascular dilatation have been numerous. Poppen (1988) states that research by Bacon & Poppen, King & Montgomery, Olton & Noonberg, and Taub & Emurian all report positive results.

Verbal behavioral relaxation meditation is not widely accepted in medical circles. Physicians claim that the placebo effect and/or the rest break will provide the changes and not the meditation. Some of the basic relaxation methods are reputed to be more effective than others as evidenced by empirical or observational research. Verbal
relaxation meditation seems to have real or perceived merit in lowering anxieties and/or psychosomatic symptoms (Poppin, 1988).

Authorities who use relaxation techniques do laud their effectiveness. Humor therapists such as Joel Goodman (1982, 1983) use imagery clinically and to relieve personal stress. McGarvey (1990) suggests the use of mental imagery and rehearsal on the job to enhance performance. He writes, "Just breathe slowly for 60 seconds and for another 60 seconds see yourself performing with great confidence, then see the event you’re envisioning end on a positive note" (p. 37). Gawain (cited in McGarvey, 1990) said "the most important thing to remember in creative visualization is to make it a regular part of your life. Most people find practicing it a little each day works best, especially when you are first learning" (p. 37).

**Progressive Relaxation and Environmental Stress**

Lazarus (1966) theorizes that stress is a person-environment transaction in which any given stressor has psychological characteristics. His explanation of this transaction, in the context of this study, would have an RN assessing a situation to see if it is harmful, threatening, or challenging based on her previous experiences. Then she decides if she’s capable of handling the situation. Stress comes if the RN is unsure that she can control the situation adequately.

In 1972, Glass & Singer (cited by Maier & Laundenslager, 1985) exposed people to loud noises. One group had a possible avoidance control mechanism to prevent the noise while the other group did not. In a test situation, the group who did not have an avoidance tool made more errors on the task than those who felt in control. The study on
learned helplessness by Maier (1985) supports this theory. Learned helplessness is a psychological condition caused from prolonged exposure to uncontrollable stressors. It describes animals or humans that have endured so much stress that they tend to react passively to stress and do not learn to avoid stress. They often do not even try to escape it. They have learned that they cannot control the situation so they give up. "However", reports Maier (1985), "sometimes just thinking control is possible, even when it is not, can prevent adverse stress effects" (p. 47). Essentially, people's beliefs that they can control a situation will affect how they will react (Maier & Laudenslager, 1985).

Maier & Laudenslager (1985) cited a study by Weiss at Duke University School of Medicine, in which animals were subjected to various continued environmental stressors. The animals that were allowed an avoidance or escape control over the situation did not develop ulcers, depressed appetites, sleep disorders, or brain chemistry change characteristic of stress responses. The other animals, not allowed control, developed the cited symptoms.

The leaders in the progressive relaxation movement contend that this same phenomenon explains the effectiveness of mental relaxation techniques. Regular use allows the individual to have a tool available to control a high anxiety situation. Benson (1987) explains that the purpose of relaxation is to block the action of the sympathetic nervous system much like drugs called beta blockers do. These medications, commonly called Inderal, Corgard, or Lopressor, are commonly used for treating panic attacks, severe headaches, blood pressure problems, and minor psychosomatic complaints. Progressive relaxation works as
effectively as drugs but has no side effects, is economical, and gives a sense of peace and tranquility. In conclusion, Benson (1987) and his followers says that relaxation techniques can do the following:

- Break anxiety cycle and relieve anxiety-related symptoms.
- Combat hyperventilation especially due to panic attacks.
- Alleviate minor headache, backache, general malaise symptoms.
- Treat minor blood pressure problems.
- Alleviate insomnia.
- Prevent harmful effects of stress.
- Enhance creativity (p. 6).

Critique

To provide proof of all Benson’s contentions would be lengthy and redundant. Thus, a few key environmental studies presented by Matteson & Ivancevich (1987) back up Benson’s theories on progressive relaxation. Orme-Johnson measured the difference in skin responses between meditators and nonmeditators exposed to intermittent loud noise. The meditators stopped reacting to the noise after an average of eleven repetitions, while the nonmeditators were still reacting after thirty or forty exposures. An experiment by Goleman & Schwartz found that those who used the autogenic or Jacobson method of meditation recovered from stress much more quickly than nonmeditators.

Progressive Relaxation with Females and Especially Female RNs

Behavior can be changed if the motivation to change the stress cycle is greater than the reinforcement to continue using previous coping mechanisms when under pressure. Behavior can be changed if illness is debilitating enough to motivate the RN to find new coping skills that will decrease or eliminate psychosomatic complaints.
Progressive exercises can be effective as a coping skill to relieve work-related stress if the individual is sufficiently motivated to learn, practice, and use the techniques. Furthermore, the exercises can benefit females. This can be assumed since the sex, age, and race of a person are not factors in behavior modification. Anyone will make cognitive decisions to change his or her behavior if the consequences to stay stressed become too painful to allow the behavior to continue (Poppen, 1988; Donnelly, 1984; Benson, 1987).

Donnelly (1984) suggests that progressive exercises are particularly suited to RNs. Many RNs encounter high stress daily on their job. These same nurses seem unable to fully unwind at home. Consequently, they set themselves up to be susceptible to the type of psychosomatic disorders progressive relaxation exercises are designed to help (Donnelly, 1984).

RNs are familiar with tools and treatments that are task-oriented and have measurable goals, because this is what RNs are trained to do when planning patient treatment plans. Progressive relaxation is goal-oriented and measures behavior. Furthermore, it provides positive and immediate self-reinforcement when it does lower anxiety.

Progressive exercise training has appeal and validity with RNs since it is a familiar concept and it is easy to learn. Furthermore, if a manager provides progressive relaxation education to both patients and staff, they provide each group with a tool to aide in coping with stress. RNs are also more likely to try an intervention that would enhance their professional competency rather than embrace a strategy that would only relieve their personal stress (Donnelly, 1984).
Critique:

Most forms of progressive relaxation require practice. Some methods require use of a trainer and/or feedback before one gets adept with its use. A drawback of this approach is that nurses who are already overworked and overwhelmed will not welcome anything that requires more of their time. Only if the stress level becomes too painful for them will the RNs normally become motivated and make the effort to practice relaxation techniques and utilize the skills on their own. RNs may know the skills and they may even like the methods and want to use them. However, this coping tool would be ineffective if RNs let other work commitments take priority over doing the mental exercises. Other factors such as nonavailability of the equipment or a quiet area to concentrate could also reduce the effectiveness of progressive relaxation.

Matteson & Ivancevich (1987) report positive physiological changes in the research studies using relaxation techniques to help psychosomatic illnesses. Meditation allowed hypertensive patients to lower their blood pressure. They also reported that meditators had reduced heart rate and oxygen consumption and showed increased alpha waves, which increases with relaxation. Based on these findings, they indicate that there is substantial empirical support for using progressive relaxation techniques to relieve psychosomatic stress.

Summary:

"Minds do what they are programmed to do" reports Zilbergeld (cited in McGarvey, 1990). "Mental rehearsal isn't a substitute for action, but a supplement to and an enhancement of work. In a nutshell, mental training is simply a way of reprogramming the mind to achieve
the more positive behaviors, feelings, and results" (p. 36). It has been documented that successful leaders use gallows humor to lower stress and provide a temporary sense of mastery in a threatening environment. The same theoretical concept behind the use of gallows humor also applies to progressive relaxation. These exercises, especially ones utilizing deep breathing, mental rehearsing, and/or mental imagery, can aid a RN in lowering environmental stress.

Caution must be used when using humor or progressive relaxation as stress relievers. They are only for temporary use for job related stress in RNs. These tools should be used to augment not substitute for, good health habits. Moderation in lifestyle and good overall health practices such as eating nutritiously and getting adequate rest and exercise should be encouraged.
CHAPTER THREE

Procedures

Sample Population and Description of Interventions

Nurse managers of local psychiatric hospitals were asked for permission to solicit volunteer female RNs for the study. The psychiatric RNs were employed thirty-two to forty hours on a day shift or day-evening rotation shift and worked in a hospital setting. Subjects were solicited via flyers (See appendix A) placed strategically around the hospital areas or were recruited during informal hospital staff meetings. Each volunteer was provided with a packet which contained an introductory letter, a consent form, and three self-report measurements (See Appendixes B, D, & E). These measurements were the Social Readjustment Rating Scale (SRRS), the Psychiatric Nurses' Occupational Stress Scale (PNOSS), and the Work Environment Scale (WES) (Holmes & Rahe, 1967; Dawkins, et al., 1985; Moos, 1986). The introductory letter thanked the nurses for volunteering and provided the testing instructions. The consent form told each RN exactly what commitments she was asked to fulfill, the time involved for those commitments, and what assurances she would have concerning confidentiality. Each RN was informed (1) that she was offered a free three-hour workshop, (2) that she would be given three self-report tests that must be completed before any workshop could be assigned, and (3) that she would have to take two more self-report
tests six weeks after the workshop. No RN was accepted as a subject until she signed the consent form.

The RNs were cautioned to complete all testing data as soon as possible because workshop assignments was not given until after the pretest data was collected. Once the data was collected, the subjects were then randomly assigned to one of three workshops.

There were forty-two participants who began the study. Nurse Directors from Cumberland Hospital, Peninsula Hospital, Norfolk Psychiatric Hospital, John Randolph Hospital, Medical College of Virginia, Hampton Veteran's Administration Hospital, Eastern State Hospital, Central State Hospital, Riverside Hospital, and The Barry Robinson Center gave the researcher verbal permission to solicit RNs for the study. Fourteen randomly assigned RNs were in each group. Group 1 received the progressive relaxation workshop. Group 2 had the humor workshop. Group 3 was the control group and received a workshop on the use of the neurological assessment.

Last-minute scheduling problems, illness, and family emergencies caused the attrition of eleven participants. Twelve RNs actually attended the Group 1 workshop. Eleven attended the Group 2 workshop and ten attended the Group 3 workshop. The mean age of the thirty-one subjects was forty-three. Their minimum age was twenty-four and the maximum age was sixty-one. Eight RNs had Associate Degrees in Nursing. Ten were nursing school diploma graduates. Nine reported having a Bachelor of Science degree. Six had Master’s degrees in nursing or nursing-related subjects and one RN had a Master’s degree plus sixty graduate hours. The years of general nursing experience ranged from
two years to thirty nine years with a mean average of twenty-two years' experience.

Twenty Caucasian RNs, ten black RNs, and one Asian RN had a mean average of 9.7 years of psychiatric nursing experience. There were twenty general duty nurses, ten supervisor-administrators, and three clinicians in the subject sample.

A list of names of the RNs, their hospital, and their selection number was compiled. The RNs' corresponding numbers rather than their names were used to represent the subjects when the statistical data were analyzed. This control avoided the use of names and ensured the confidentiality of each volunteer.

To control for experimental bias, the researcher did not have knowledge of the subject composition of each group. Neither the researcher or statistician knew the identity of the three groups until all the data were compiled, and the research assistant had no access to the computer-compiled statistical data.

The workshops were taught by experts, see credentials listed in Appendix H. Steve Kissell, B.S. conducted the Humor workshop. Marilyn L. Spiro, Ph.D., conducted the progressive relaxation workshop and John F. Lavach, Ed.D., conducted the neurological assessment workshop. Each of the workshops, programs listed in Appendix I, lasted three hours. To maximize the learning experience, each workshop had a forty-five minute lecture period that explained the theory and/or skills being presented, forty-five minutes for teaching the procedures, and forty-five minutes when the RNs learned how to apply what the RNs had learned.
After the workshops, the subjects in all groups were urged to use their new skills in the workplace but were not given any specifics. Those RNs who received the inservice on the progressive relaxation techniques were told that there would be relaxation tapes and tape recorders available in their hospital to check out for use during their breaks if the RNs desired to use them.

The PNOSS and the WES were mailed to the subjects six weeks after the last workshop intervention. The purpose of the posttests was to measure the degree of environmental stress relief and/or temporary attitudinal changes toward the workplace after the intervention. All the pretest and posttest scores were compiled for statistical analyses. The results of the analyses are reported in detail in Chapter 4. The final subject size for all three groups was thirty-one. Two RNs did not return the posttest data. The final composition of the groups was eleven RNs in the progressive relaxation group, ten RNs in the humor group, and ten RNs in the control group.

Measurements

The Social Readjustment Rating Scale (SRRS)

The Social Readjustment Rating Scale (SRRS), sometimes known as the Schedule of Recent Experiences (SRE) or Life Event Scales (LES), was authored by Holmes & Rahe (1967) and is the most widely used scale in life stress research. The instrument is a self-administered questionnaire that contains forty-three events. Lazarus & Folkman (1984) and others consider "the scale the best known measurement of stress as it assesses life stressors from the previous year" (p. 111). A score is assigned that shows the individual's coping and adaptability to those stressors.
In creating the SRRS, subjects were asked to complete forms identifying how many units of adjustment an anticipated event would require for maintaining emotional equilibrium. Holmes & Rahe (1967) recorded the accumulation of these units over time and correlated them with subsequent illness. Marriage was given the arbitrary value of 500 and subjects were asked to rank the events listed using two questions as criteria. They then utilized a statistical research method that generated a ratio scale known as the Social Readjustment Rating Scale. The SRRS theoretical perspective was based on the research of Meyers and his life chart. Meyers (cited in Holmes & Rahe, 1967) felt that one could measure the process of health and illness in individuals by looking at their biological, sociological, and psychological schema. Holmes & Rahe (1967) demonstrated via their scale that the higher the number of stress units accumulated during a one year period, the higher was the possibility for the existence of illness processes. Holmes, Rahe, and their associates have continued to do research relating stress to various single psychosomatic illnesses since the publication of the SRRS in 1967. Sarason et al. (1978) says "the SRE development represents a valuable initial attempt at the quantification of the impact of life change" (p. 933). Zarske (1989) suggests that the SRE is one of the best-known methods for determining the frequency of occurrence of various stress-producing events in an individual's recent past.

Holmes & Rahe's questionnaire was based on Wolff's work with 5,000 patients in a study concerning quality and quantity of life events. Wolff's list set the format which helped develop the 43 items of events used by Holmes & Rahe (1967). Holmes & Rahe contend that their scale
pertains to the major areas pertinent to American lifestyles. These areas include marriage, the family unit, the job, relationships, religion, recreation, and health.

The SRRS was normed with a sample of 394 people. Of these 394 subjects, 215 were female. Of the 215 female subjects, 137 were ages 30 to 60. Fifty-one of the female subjects were over 60. Validity was presented by retrospective and prospective studies of life events effecting the health changes of two medical students and young medical residents. Correlation is .20 to .30 in life changes to health changes. The reliability coefficient for the SRE is .78 to .83 for short-term test-retest. Reliability decreases after two years (Stone, 1989).

**Psychiatric Nurses' Occupational Stress Scale (PNOSS)**

The Psychiatric Nurses' Occupational Stress Scale (PNOSS) was developed on the same principle as Holmes and Rahe's Social Readjustment Rating Scale (Holmes & Rahe, 1967). Dawkins, Depp, & Selzer (1985) believed that by studying certain work events that were stressful, it was possible to predict burnout and psychosomatic illness in psychiatric nurses. One hundred RNs were randomly selected from the staffing roster of a psychiatric hospital. These RNs were asked to submit a list of stressful events related to their practice. Out of two hundred events, seventy-eight were finally selected after screening all the events for redundancy, specification, and clarity. Only eleven represented psychiatric issues specifically and these issues dealt with seclusion of patients, convalescent leaves, and working with hostile patients. The other sixty-seven items were those stressors probably encountered by most RNs.
A panel of three expert RNs in the fields of nursing and research reviewed the items for face and content validity. To further check the stress tool for validity, the investigators compared it to the Daily Hassle Scale developed by Lazarus & DeLongis. This scale describes the kind of irritating, frustrating, and distressing demands and troubled interactions and relationships that plague RNs daily. The two scales were found to have a high correlation (Dawkins, et al., 1985).

Another random sampling of 43 RNs from the same hospital were asked to rank the items for stressfulness. Of the 43 RNs, 41 were women, 14 were staff RNs and 29 were supervisors. The nurses worked an average of ten years in a hospital.

To emphasize the multifaceted nature of a psychiatric nurse's position, two of the investigators grouped the items into categories. The following is a list of six thematic category groupings: (1) Negative characteristics of patients, (2) Administrative/organizational issues, (3) Limited resources, (4) Staff performance, (5) Staff conflicts, and (6) Scheduling issues.

Items one through twenty-six were considered high stress items, twenty-seven through fifty-two were medium stressors, and events from fifty-three to seventy-six were mild stressors.

The PNOSS was believed to be the first published study of its kind, so reliability studies are not available. The authors caution that until the study is replicated in other similar studies, the results of the PNOSS should be viewed with caution. However, they also write that with regional validation, "the PNOSS can be a useful tool for monitoring stress and predicting turnover for RNs in a mental health setting" (Dawkins, et al., 1985, p. 15).
The PNOSS study was conducted in a Washington D.C. hospital. This location is close to the Norfolk-Tidewater-Williamsburg-Richmond areas of Virginia. Therefore, the RN sampling used in the PNOSS should be appropriate for generalization with the subjects in this research project. The major concern in using the PNOSS is the fact that it was normed using a population from one hospital.

To detect changes in RN’s attitudes correlating stress in the workplace, the PNOSS measurement was modified to allow the responding RNs to rate the amount of stress they felt they encountered per each stressor. Each stressor was weighted according to the PNOSS stated severity of the issue. The high stressors (items 1-26) each had a weight of three. Medium stressors (items 27-57) had a weight of two. Low stressors (58-79) had a weight of one (Dawkins, et al., 1985). The weighted numerical value of all stressors were totaled to give a score similar to the SRRS. Interpretation of the stress score levels was based on the RNs individual PNOSS category profiles. Zero to 110 indicates low stress. One hundred eleven to 120 indicates average stress and 121 to 130 indicates moderate stress. One hundred thirty-one and up indicates high stress which could lead to burnout. Figure 3.1 provides the detailed scoring procedure.

The RNs’ attitudes toward the job and workplace was measured by the RNs ranking the amount of temporary stress perceived for each item in the PNOSS. The RNs were instructed to choose between NA (not applicable), N (no stress), 3 (high stress), 2 (medium stress), 1 (low stress). The test items were then grouped according to the six thematic categories described by Dawkins, et al. (1985). The six groups were assigned a number which represented the maximum stress
Figure 3.1

PNOSS Stress Scoring Procedure

Any circled item 1-26 is worth 3 points. Items 1-26 represent the situations nurses in the sample population found most stressful.

Any circled item 27-57 is worth 2 points. Items 27-57 represent situations nurses in the sample population found moderately stressful.

Any circled item 58-78 is worth 1 point. Items 58-78 represent situations nurses in the sample population found somewhat stressful.

Interpreting Stress Results

26 high stress items X 3 points = 78 possible points
30 moderate stress items X 2 points = 60 possible points
20 somewhat stressful items X 1 point = 20 possible points
Total points possible = 158

Based on the thirty-one profile mean percentages, the levels can be related to occupational stress as follows:

0 - 110 = low to average job stress
110 - 120 = average job stress
120 - 130 = moderately high job stress
130 - up = high job stress; probable burnout

PNOSS Attitude Assessment Scoring Procedure

Total up all stressor points in each category (See Figure 3.2 for category descriptions and examples).
Total number of points possible per category are as follows:

N = 24, R = 75, A = 54, SP = 12, SC = 39, S = 30

The numerical stress score for each category is then divided by the maximum score multiplied by 100 which results in a percentage for each category. Plot the scores on the graph profile as shown in Appendix E.
level of that category if all those grouped items were given a three. The maximum score for negative characteristics of patients (N) was 24. The maximum score for administrative/organizational issues (A) was 75. The maximum score for limited resources (R) was 54. The maximum score for staff performance (SP) was 12. The maximum score for staff conflicts (SC) was 39. The maximum score for scheduling issues (S) was 30. The numerical stress score the RN reported for each category was then divided by the maximum score multiplied by 100 which resulted in a percentage for each category. These percentages for each category were plotted on a profile graph. See Figure 3.2 for detailed scoring procedure.

Work Environment Scale (WES)

The Work Environmental Scale published by Rudolf Moos (1981) is part of a series of ten tests Moos calls the Social Climate Scales. All the scales were designed by Moos and his associates and are published by Consulting Psychologists Press, Inc.

The social scales are based on the theory that the social climate can have a strong influence on people in a setting. This is the same rationale used by Holmes & Rahe (1967) and Dawkins, et al. (1985) for their theoretical formulation on their scales.

The WES has ten subscales. These included involvement, peer cohesion, supervisor support, autonomy, task orientation, work pressure, clarity, control, innovation, and physical comfort. All the subscales showed internal consistency and inter-correlations within acceptable ranges (Moos, 1981). Kanunago (1989) argues that no empirical evidence is provided for the classification scheme and some items are weak and redundant. Also, Kanunago indicated "theoretical
Figure 3.2

Psychiatric Nurses' Occupational Stress Scale Profile

Interpretation Examples

Profile includes six thematic categories: N (Negative Characteristics of Patients); A (Administrative/Organizational Issues); R (limited resources); SP (Staff Performance); SC (Staff Conflict); and S (Scheduling Issues).

<table>
<thead>
<tr>
<th>Category</th>
<th>N</th>
<th>A</th>
<th>R</th>
<th>SP</th>
<th>SC</th>
<th>S</th>
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<tbody>
<tr>
<td>Most points possible</td>
<td>24</td>
<td>75</td>
<td>54</td>
<td>12</td>
<td>39</td>
<td>30</td>
</tr>
</tbody>
</table>

Example

Low Stress/Score 101

<table>
<thead>
<tr>
<th>Score</th>
<th>N</th>
<th>A</th>
<th>R</th>
<th>SP</th>
<th>SC</th>
<th>S</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 110</td>
<td>7</td>
<td>24</td>
<td>17</td>
<td>4</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>%</td>
<td>.30</td>
<td>.35</td>
<td>.32</td>
<td>.33</td>
<td>.28</td>
<td>.23</td>
</tr>
</tbody>
</table>

Example

Avg. Stress/Score 117

<table>
<thead>
<tr>
<th>Score</th>
<th>N</th>
<th>A</th>
<th>R</th>
<th>SP</th>
<th>SC</th>
<th>S</th>
</tr>
</thead>
<tbody>
<tr>
<td>110 - 120</td>
<td>10</td>
<td>39</td>
<td>17</td>
<td>5</td>
<td>19</td>
<td>10</td>
</tr>
<tr>
<td>%</td>
<td>.42</td>
<td>.52</td>
<td>.32</td>
<td>.42</td>
<td>.39</td>
<td>.30</td>
</tr>
</tbody>
</table>

Example

Med. Stress/Score 124

<table>
<thead>
<tr>
<th>Score</th>
<th>N</th>
<th>A</th>
<th>R</th>
<th>SP</th>
<th>SC</th>
<th>S</th>
</tr>
</thead>
<tbody>
<tr>
<td>120 - 130</td>
<td>9</td>
<td>50</td>
<td>15</td>
<td>7</td>
<td>19</td>
<td>9</td>
</tr>
<tr>
<td>%</td>
<td>.38</td>
<td>.67</td>
<td>.28</td>
<td>.58</td>
<td>.49</td>
<td>.30</td>
</tr>
</tbody>
</table>

Example

High Stress/Score 133

<table>
<thead>
<tr>
<th>Score</th>
<th>N</th>
<th>A</th>
<th>R</th>
<th>SP</th>
<th>SC</th>
<th>S</th>
</tr>
</thead>
<tbody>
<tr>
<td>130 up</td>
<td>12</td>
<td>53</td>
<td>36</td>
<td>9</td>
<td>25</td>
<td>11</td>
</tr>
<tr>
<td>%</td>
<td>.50</td>
<td>.71</td>
<td>.67</td>
<td>.75</td>
<td>.64</td>
<td>.37</td>
</tr>
</tbody>
</table>

Example

Very High Score 154

<table>
<thead>
<tr>
<th>Score</th>
<th>N</th>
<th>A</th>
<th>R</th>
<th>SP</th>
<th>SC</th>
<th>S</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burnout</td>
<td>20</td>
<td>56</td>
<td>40</td>
<td>12</td>
<td>33</td>
<td>23</td>
</tr>
<tr>
<td>%</td>
<td>.63</td>
<td>.75</td>
<td>.74</td>
<td>100</td>
<td>.85</td>
<td>.77</td>
</tr>
</tbody>
</table>

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.
rationale for inclusion of scales under specific domains is unclear" (p. 1398). By publishing the development criteria, Moos disclaims Kanunago's argument. The items were developed several ways. Some were constructed from structured interviews with employees from different work settings. Some dimensions and items were adapted from other scales. Other items were compiled from an initial 200 item Form A WES pretest used to develop the present scale. The choice of wording was developed from the other social scales. The items were the average choices rather than isolated or unusual ones.

The sample population in item selection was taken from 624 employees and managers in 44 work groups. The WES was normed with 1,442 people in general work settings and 1,607 employees in health care work groups. Moos (1981) states the fact that those in the general work setting had a higher overall rating than those in health care settings. He writes "the differences may be due to staff morale and burnout problems related to the stressful and emotionally draining nature of the health care setting and the problems involved in bureaucratic organizations" (p. 4). Kanunago (1989) states the instrument is weakened due to poor and unclear data on construct and criterion-related validity. The reliability is satisfactory. Test-retest reliabilities were all reported in the acceptable range in the test manual. The WES stability over a year's time is .61. The WES reflects stability but still shows environmental change (Moos, 1981). It is this ability to reflect perceptions of environmental change that makes it a useful tool for use in this study.

The WES is also a quick, easy, and convenient way to measure a work environment. It does appear to have merit in use for research,
clinical applications, and organization enlightenment. The WES manual cites many research projects that used the scales (Kanunago, 1989; Moos, 1981).

Research Design

The research design for this study is a pretest-posttest control group design that is represented in the following diagram (Campbell & Stanley, 1963):

\[
\begin{align*}
R & 0 X_1 0 \\
R & 0 X_2 0 \\
R & 0 0
\end{align*}
\]

Two experimental treatment groups were used. \(X_1\) represented Group 1 or the group receiving the progressive relaxation workshop. \(X_2\) represented Group 2 or the group receiving the humor workshop. Group 3 was the control group and received no treatment but had a workshop on the use of the Neurological assessment. The RNs were randomly assigned to the groups by the research assistant. Each group was close in (N) sample size (Group 1, \(N = 11\); Group 2, \(N = 10\); Group 3 \(N = 10\)). Pretests and posttests were administered to all the treatment groups.

Statistical Analysis

In preparation for statistical analysis the self-report measurements were hand-scored.

Descriptive statistics were used to report demographic and experimental variables. The hypotheses were analyzed by a SPSS ANOVA generated design using analysis of covariance. This statistical method determines whether posttest scores differ significantly between treatment groups after controlling for pretest differences among groups. All tests for statistical significance were based on a .05 level of probability (Kirk, 1968).

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Specific Null Hypothesis

The following null hypotheses (HO) provided the basis for testing whether or not there were significant differences (p > .05) in pretreatment and post-treatment of nursing stress and/or attitude in the workplace between the group using humor as a coping skill, the group using progressive relaxation as a coping skill, and a control group.

\( H_{O1} \) – There will be no statistically significant differences in posttest dimension means of the Work Environment Scale (WES) among the treatment and control groups after controlling for pretest differences among the groups.

\( H_{O2} \) – There will be no statistically significant differences in the posttest stress means of the Psychiatric Nurses’ Occupational Stress Scale among the treatment and control groups after controlling for pretest differences among the groups.

\( H_{O3} \) – There will be no statistically significant differences in the posttest category means of the Psychiatric Nurses’ Occupational Stress Scale among the treatment and control groups after controlling for pretest differences among the groups.

Summary of Methodology

The population was selected from 31 volunteer RNs who worked thirty-two to forty hours a week in psychiatric hospitals in the Norfolk-Tidewater-Williamsburg-Richmond areas of Virginia. The RNs completed pretest self-report measurements on stress. They were then randomly assigned to one of three workshop groups. The treatment groups had workshops on the use of humor or progressive relaxation to relieve environmental stress. The control group workshop was on the
use of neurological assessment. All RNs in all the groups were encouraged to practice their new skills within the hospital environment. The progressive relaxation RNs had a relaxation tape and tape recorder available to use on breaks.

Six weeks after the workshops, the RNs were mailed a packet containing a certificate stating they attended the workshop and two self-report measurements which were completed and returned to the researcher.

The pretest and posttest measurements were scored by hand. The hypotheses were analyzed by one-way analysis of covariance and descriptive methods.
CHAPTER FOUR
Statistical Analysis

The two statistical analyses used for this study were generated from the SPSS ANOVA program on the Mainframe computer at the College of William and Mary. Descriptive statistics is "a word applied to the procedure of data collection, classification, summarization, and presentation" (Sanders et al., 1976. p. 7). It was used in this study to measure the central tendency or averages and the amount of dispersion or spread. The method used to determine whether posttest means scores differed significantly among treatment groups was called analysis of co-variance (Borg and Gall, 1983). The statistical significance was at a confidence level of 0.05 (p<.05).

Analysis of variance validity relies on three assumptions: (1) the sample was drawn randomly from the population, (2) that population is distributed normally, (3) variances in the sample groups being compared are equal (Avery, 1984). The subject samples of this study were volunteers but they were randomly assigned to a treatment group. The subject population is assumed to be normally distributed. The variance in population can be violated without risk since group compositions were almost equal.

The independent variables were described as follows: (1) the treatment group that received the Progressive Relaxation Workshop as Group 1, (2) the treatment group that received the humor workshop as
Group 2, and (3) the control group that received the workshop on Neurological Assessment as Group 3. The results of the statistical analyses will be shown according to the hypotheses.

The Social Readiness Rating Scale (SRRS) was administered prior to the workshop interventions to assess for preexisting life stress. The posttest means were 186.00 for group 1, 247.70 for group 2, and 154.89 for group 3. The adjusted means were 186.00 for group 1, 247.23 for group 2, and 154.89 for group 3. There was no significant difference between the groups (F = 1.366 and Sign. of F = .272) thus it can be indicated that life stress was not a major confounding variable that influenced the treatment.

Hypothesis One

HO₁ - There will be no statistically significant differences in posttest dimension means of the Work Environment Scale (WES) among the treatment and control groups after controlling for pretest differences among the groups.

To test this hypothesis, posttest data was subjected to analysis of covariance which adjusted for pretest differences between each group for each relationship dimension. The F ratios were determined by comparing WES dimension posttest mean scores between groups covarying for pretest scores and are shown in Table 4.1. None of the F ratios were significant at the .05 confidence level. Not having sufficient evidence to reject it, null hypothesis 1 was accepted.

Hypothesis Two

HO₂ - There will be no statistically significant differences in Psychiatric Nurse Occupational Stress Scale (PNOSS) posttest stress
Table 4.1
Hypothesis One -- Analysis of Covariance of the Treatment and Control Group Dimension Scores on the Work Environmental Scales

<table>
<thead>
<tr>
<th>WES Dimensions</th>
<th>GR1</th>
<th>GR2</th>
<th>GR3</th>
<th>F</th>
<th>SIGN of F</th>
</tr>
</thead>
<tbody>
<tr>
<td>I-Involvement</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Posttest mean</td>
<td>52.82</td>
<td>41.40</td>
<td>53.40</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adjusted mean</td>
<td>50.23</td>
<td>47.70</td>
<td>48.70</td>
<td>.214</td>
<td>.809</td>
</tr>
<tr>
<td>CP-Peer Cohesion</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Posttest mean</td>
<td>53.09</td>
<td>40.50</td>
<td>47.80</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adjusted mean</td>
<td>47.70</td>
<td>45.99</td>
<td>48.30</td>
<td>.114</td>
<td>.892</td>
</tr>
<tr>
<td>SS-Supervisor Support</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Posttest mean</td>
<td>52.04</td>
<td>48.30</td>
<td>47.30</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adjusted mean</td>
<td>49.88</td>
<td>48.04</td>
<td>49.99</td>
<td>.070</td>
<td>.932</td>
</tr>
<tr>
<td>A-Autonomy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Posttest mean</td>
<td>52.00</td>
<td>46.90</td>
<td>45.90</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adjusted mean</td>
<td>49.45</td>
<td>48.21</td>
<td>47.41</td>
<td>.097</td>
<td>.908</td>
</tr>
<tr>
<td>TO-Task Orientation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Posttest mean</td>
<td>51.55</td>
<td>38.70</td>
<td>49.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adjusted mean</td>
<td>48.87</td>
<td>44.47</td>
<td>46.16</td>
<td>.276</td>
<td>.761</td>
</tr>
<tr>
<td>WP-Work Pressure</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Posttest means</td>
<td>54.91</td>
<td>45.70</td>
<td>52.10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adjusted means</td>
<td>52.57</td>
<td>47.28</td>
<td>53.09</td>
<td>.945</td>
<td>.401</td>
</tr>
<tr>
<td>C-Clarity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Posttest means</td>
<td>53.09</td>
<td>50.50</td>
<td>51.90</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adjusted means</td>
<td>53.54</td>
<td>51.23</td>
<td>50.67</td>
<td>.172</td>
<td>.843</td>
</tr>
<tr>
<td>CTL-Control (Mgmt)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Posttest means</td>
<td>54.64</td>
<td>47.00</td>
<td>56.10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adjusted means</td>
<td>52.30</td>
<td>50.59</td>
<td>55.10</td>
<td>.405</td>
<td>.671</td>
</tr>
<tr>
<td>INN-Innovation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Posttest means</td>
<td>55.00</td>
<td>38.20</td>
<td>52.30</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adjusted means</td>
<td>44.57</td>
<td>50.53</td>
<td>51.42</td>
<td>1.332</td>
<td>.281</td>
</tr>
<tr>
<td>COMM-Physical Comfort</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Posttest means</td>
<td>49.00</td>
<td>41.90</td>
<td>40.60</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adjusted means</td>
<td>47.61</td>
<td>41.32</td>
<td>42.71</td>
<td>1.387</td>
<td>.267</td>
</tr>
</tbody>
</table>
means among the treatment and control groups after controlling for pretest difference among the groups.

The statistical investigation of hypothesis 2 utilized an analysis of covariance to analyze the occupational stress posttest scores which had been adjusted for pretest differences between the groups. Table 4.2 shows posttest scores and adjusted scores. Note that the F ratio for the PNOSS is 1.033 with a confidence level of .370. Since the difference between groups is not at the 0.05 level, null hypothesis 2 is accepted.

Even though no statistically significance differences was found, the adjusted posttest means scores show the treatment groups tend to report more stress than the control group. The research hypothesis predicted that the posttest PNOSS stress scores of the Group 2 would be lower than the scores of Group 1 and significantly lower than those of Group 3. This trend was unexpected.

Hypothesis Three

H03—There will be no statistically significant differences in Psychiatric Nurses’ Occupational Stress Scale (PNOSS) posttest category means among the treatment and control groups after controlling for pretest differences among the groups.

Once again, analysis of covariance was the statistical method used to test the hypothesis. Table 4.3 lists all the posttest and adjusted PNOSS attitude category means, F ratios, and F levels of significance. There was no difference among adjusted posttest category means scores that satisfy 0.05 level of significant so null hypothesis 3 was accepted.
Table 4.2

Hypothesis Two -- Analysis of Covariance of the Treatment and Control Group Stress Scores on the Psychiatric Nurses' Occupational Stress Scale

<table>
<thead>
<tr>
<th></th>
<th>GR 1</th>
<th>GR 2</th>
<th>GR 3</th>
<th>F</th>
<th>SIGN. of F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Posttest means</td>
<td>138.45</td>
<td>129.40</td>
<td>124.50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adjusted means</td>
<td>137.90</td>
<td>128.87</td>
<td>125.64</td>
<td>1.033</td>
<td>.370</td>
</tr>
</tbody>
</table>

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Table 4.3

Hypothesis Three -- Analysis of Covariance of the Treatment and Control Group Attitude Scores on the Psychiatric Nurses' Occupational Stress Scale

<table>
<thead>
<tr>
<th>PNOSS CATEGORY</th>
<th>GR1</th>
<th>GR2</th>
<th>GR3</th>
<th>F</th>
<th>SIGN. of F</th>
</tr>
</thead>
<tbody>
<tr>
<td>N-Negative Characteristics of Patients</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Posttest means</td>
<td>11.55</td>
<td>12.40</td>
<td>10.90</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adjusted means</td>
<td>12.19</td>
<td>12.05</td>
<td>10.61</td>
<td>.188</td>
<td>.830</td>
</tr>
<tr>
<td>A-Administrative/Organizational Issues</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Posttest means</td>
<td>42.73</td>
<td>39.90</td>
<td>34.60</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adjusted means</td>
<td>42.67</td>
<td>39.87</td>
<td>34.68</td>
<td>1.597</td>
<td>.221</td>
</tr>
<tr>
<td>R-Limited Resources</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Posttest means</td>
<td>25.27</td>
<td>25.70</td>
<td>24.30</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adjusted means</td>
<td>24.99</td>
<td>26.54</td>
<td>23.78</td>
<td>.321</td>
<td>.728</td>
</tr>
<tr>
<td>SP-Staff Performance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Posttest means</td>
<td>6.00</td>
<td>6.20</td>
<td>5.80</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adjusted means</td>
<td>6.21</td>
<td>6.06</td>
<td>5.71</td>
<td>.175</td>
<td>.840</td>
</tr>
<tr>
<td>SC-Staff Conflict</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Posttest means</td>
<td>23.73</td>
<td>20.20</td>
<td>18.80</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adjusted means</td>
<td>24.02</td>
<td>19.50</td>
<td>19.18</td>
<td>1.412</td>
<td>.261</td>
</tr>
<tr>
<td>S-Scheduling Issues</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Posttest means</td>
<td>12.55</td>
<td>12.10</td>
<td>10.08</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adjusted means</td>
<td>11.41</td>
<td>12.09</td>
<td>12.06</td>
<td>.044</td>
<td>.957</td>
</tr>
</tbody>
</table>

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However, the same trend seen in the adjusted mean group scores in Hypothesis 2 is also seen in the adjusted category mean group scores in Hypothesis 3. The research hypothesis predicted that RNs in Group 2 would report more positively post-treatment effects than would the RNs in Group 1 and significantly more positively than the RNs in Group 3. The opposite was seen. The RNs in the treatment groups had greater negative post-treatment adjusted category mean scores than did the control group. The RNs in Group 1 had a higher negative adjusted post-treatment category mean scores than Group 2 or Group 3.
CHAPTER FIVE

Summary, Findings, Conclusions, Discussion and Recommendations

Summary

Literature has documented humor's ability to temporarily anesthetize emotional pain and reduce stress (Freud, 1960; Bergson, 1921). The use of humor clinically as a coping skill is a twentieth century concept and, while much has been written about its use to relieve stress, few studies have tested its effectiveness in a hospital environment (McGhee, 1983; Robinson, 1977). Using a non-student population in a setting where variables are difficult to control has compromised efficacy studies. Still, the theory that humor can relieve the stress of medical personnel has gained acceptance. There is even a type of macabre or gallows humor which is sometimes referred to as medical humor because it is used frequently to relieve the work stress of health care workers. By poking fun at death, disease, long work days, staff shortages, combative patients, or severe staff conflict, the situations seem less fearsome and RN tensions are lowered (Dixon, 1980). Humor can even temporarily change negative attitudes when RN laughter allows her to perceive she is in control of the stressful situation. Utilizing these indicators as a theoretical basis, this study was designed to investigate the effectiveness of humor and an alternative coping skill as work stress relievers for psychiatric RNs.
To research this hypothesis, a quasi-experimental design was utilized (Borg and Gall, 1983). Thirty-one volunteer female RNs who worked thirty-two to forty hours a week in a psychiatric facility were randomly assigned to one of three groups. Treatment Group 1 received a workshop on the use of progressive relaxation to relieve environmental tensions. Treatment Group 2 had a workshop on the use of humor to relieve work stress. Control Group 3 attended a workshop on the use of the neurological assessment. Each workshop lasted three hours. In the first segment of all workshops, the RNs were taught the basic concepts, in the second segment, they learned how to use the skill, and in the last segment, they practiced the techniques they learned. All the RNs were told to utilize their new skills in the workplace.

Pretests on occupational and work stress were given to all participating RNs. Six weeks after the workshop interventions, the same two self-report tests were administered again. Descriptive statistics provided the mean scores. Analysis of covariance was used to compare posttest means between groups after controlling for pretest differences. The 0.05 confidence level was used as criterion to reject the null hypothesis.

The following three hypothesis were tested to examine the effectiveness of the interventions:

1. There will be no statistically significant differences in the posttest dimension means of the Work Environment Scales (WES) among the treatment and control groups after controlling for pretest difference among the groups.

2. There will be no statistically significant differences in Psychiatric Nurses' Occupational Stress Scale (PNOSS) posttest stress
means among the treatment and control groups after controlling for pretest differences among the groups.

3. There will be no statistically significant differences in the Psychiatric Nurse’ Occupational Stress Scale (PNOSS) posttest category means among the treatment and control groups after controlling for pretest differences among the groups.

The test used to measure environmental stress was the Work Environment Scale (WES) (Moos, 1981). These pretests and posttests were handscored by the research assistant and yielded standard scores for ten work dimensions. The Psychiatric Nurses’ Occupational Stress Scale (PNOSS) is a self-report measurement with items consisting of 78 stressors encountered in the workplace by most psychiatric RNs (Dawkins, et. al., 1985). This tool was modified to yield a single stress score level and six category scores. The PNOSS pretest and posttests were scored by the researcher. Descriptions of the categories and scoring directions are in Figures 3.1 and 3.2. To control for the life stress variable, a Social Readiness Rating Scale (SRRS) (Holmes & Rahe, 1967) was also measured prior to treatment.

**Statement of Findings**

Analysis of the statistical data showed the following results:

1. There were no statistically significant differences in posttest dimension scores of the Work Environment Scale among the treatment and control groups after controlling for pretest differences among groups.

2. There were no statistically significant differences in Psychiatric Nurses’ Occupational Stress Scale posttest stress means among the treatment and control groups after controlling for pretest differences among the groups.
3. There was no statistically significant differences in Psychiatric Nurses' Occupational Stress Scale posttest category means among the treatment and control groups after controlling for pretest differences among the groups.

Conclusions

With this sample population and with these groups, it can be concluded that the treatment interventions were not successful in reducing work or occupational stress or in changing attitudes about the workplace.

Discussion

The data and the analysis did not provide evidence to support the claims found in literature that humor or progressive relaxation can reduce psychiatric RN environmental or group stress. Some plausible reasons for the inability of the data to show treatment effectiveness are provided by those researchers who have previously studied the effects of similar treatments on stress such as McGhee (1983), Lazarus and Folkman (1984), and Johns (1985). McGhee (1979) consistently cites small sample populations as an ongoing problem found in on-site research. When the sample size is small, the score variance is increased and chances of statistical significance is decreased. Furthermore, he states that when human subjects are used and a non-laboratory controlled environment is involved, there is less opportunity to ensure controls. All these problems were inherent in this study and could have reduced the chances of accurately measuring treatment effects on stress in the groups.

Other researchers, such as Jones (1985) and Lazarus and Folkman (1984) reported investigation difficulties that have relevance to this
study. In a study comparing the work environment and stress levels of psychiatric RNs and three other high stress RN specialty areas, Jones' (1985) findings did not empirically conclude that the workplace can predict burnout. However, he did suggest non-significant differences in his research could be explained, in part, by RN personality variables. Psychiatric RNs reported high personal involvement and intense degrees of conflict. Measuring involvement and conflict variables were complicated by the fact that the involvement and conflict were perceived differently, i.e. productive or non-productive and pleasant or painful.

Folkman and Lazarus (1984) also reported difficulties in their stress research. They felt that measurements evaluating stress were complicated by the different degrees of individual perception and reaction to stress. Treatments also differ in effectiveness.

Some of the most successful investigative studies of humor have been by Fry (1971, 1977, 1979). He was able to demonstrate the body's physiological responses to laughter. Cousin (1979) was able to demonstrate a lower blood sedimentation rate after ten minutes of laughter. Michelson & Ascher (1987) provided examples of similar research done with progressive relaxation. Apparently, using a simple, cause and effect type study with few variables improves the chances of statistically finding treatment changes.

The results of the studies of McGhee (1979, 1983), Lazarus & Folkman (1984) and Jones (1985) point out the difficulty of measuring so many variables, especially those of a psychological nature. Evidence suggests that stress measurements must be very sensitive to these hidden variables and the instruments should measure very specific
effects. Thus, it is possible this research design was trying to measure too many variables. Modifying the instrument to measure both stress levels and attitudes may have decreased its efficiency.

The research reported by Fry (1971, 1977, 1979), Cousin (1979) and Michelson & Ascher demonstrate the need to be specific and selective in what is to be measured. This study was looking at the effects of the treatments on many different areas of environmental and occupational stress making the measurement less accurate and the chance of random error explaining the differences greater. Measuring the effects of the treatment on only one or two variables, such as work pressure or staff conflict, would increase the chances of statistical significance.

The research problems with on-site subjects, measurement of stress, and sample size have been discussed. One other important factor needs to be addressed when looking for plausible explanations for non-significant findings. That factor is what McGhee (1979) calls the multifacets of humor. McGhee presented his humor theory model (seen in Figure 1.2) because he felt that no one theory adequately described the multifacets of humor. Responses to humor are both physical and psychological. Humor and laughter have many documented uses. Laughter provides an anesthesia effect for emotional pain, humor tends to cause bonding and positive social relations in groups, laughter temporarily lowers stress in tense situations, and, of course, humor entertains. These aspects of humor represent a basic stimulus-response type of reaction. The effects of humor on a subject should be measured shortly after the intervention because the relief is only temporary or short term.
The clinical use of humor is more complex. It involves using humor on a day-to-day basis to cope with stress. This requires learning and a gradual sense of mental mastery over environmental stress by continued successful use of humor as a coping tool. This research suggests the mental mastery concept cannot be taught in one workshop. A workshop setting can be used to teach fundamentals. However, additional experiences in the use of humor or progressive relaxation to relieve stress must follow the workshop to develop the degree of mental mastery needed to promote change. Robinson (1983) conducted a pilot study using a guide for incorporating humor into the teaching-learning process. Collective data was too limited for statistical analysis but positive responses were noted. She suggests "the health educational system must consider the use of humor in four interrelated aspects: enhancing the learning process itself through humor, facilitating the process of socialization, teaching the concept of humor as a communication tool, and modeling the use of humor as a vehicle for facilitating the other three" (p. 122).

Many of the investigative studies using humor as a coping skill report nonconclusive findings with weak validity and reliability. Few studies are ever duplicated (McGhee, 1979, 1983). Nevertheless, literature strongly supports the theories that humor and progressive relaxation can reduce stress. Failure to prove statistical significance does not decrease the importance of this or other research studies. Robinson (1983) wrote "recognizing the value of humor in health, the question is raised of how one goes about cultivating that sense of humor, that humorous attitude, and incorporating the humor into the therapeutic, healing, and health promoting process. There are
theorizing, suggestions, individual applications, and anecdotal accounts but little scientific research on the process itself and the clinical application of humor" (p. 122). She cites Levine as saying "extensive work on the origins and development of the sense of humor and other children's studies has contributed to two primary clinical areas: developmental assessment and psychotherapy with children" (p. 122). Robinson and McGhee (1979, 1983) both encourage any research on the clinical application of humor and humor as a coping skill. Research in these areas are scarce.

**Recommendations**

Based on the literature review and the findings and conclusions of this research, the following recommendations are offered for future investigations:

1. A larger number of subjects be assigned to each group.
2. Continue to have a control group that also learns a skill which can be utilized in the workplace. The fact that all three groups could be given standardized instructions helped the empirical process.
3. Select workshop instructors carefully. Assure that they are qualified to teach the subject and that they can impart the knowledge in a way that is interesting and motivating. The relaxation techniques must be done right to be effective. It is important that the subjects are taught correctly and they understand the use of the tapes, etcetera. The humorist must emphasize how humor can be harmful as well as useful and be certain that the subjects understand the difference. The instructor teaching the use of the neurological assessment must stress that the knowledge can be a useful evaluative tool but that they are
not to try to interpret data or profess to be qualified to make assessment decisions based on knowledge given in a three hour workshop.

4. The PNOSS is a newly developed instrument. Any interpretation of scores must be done within this sample group only. Even then caution must be used because of the lack of evidence concerning its reliability and validity. If all the cautions mentioned above are carefully considered, the PNOSS may be useful in future research to assessing negative patient characteristics or staff conflict.

5. Instead of measuring all ten treatment differences of the WES dimensions, confine the measurement to only one or two specific dimensions. The dimensions of work pressure or control by management are recommended because the literature shows that these are two areas known to cause work stress in RNs.

6. Some changes in the design are suggested to help the RN subjects develop the use of humor or progressive relaxation as a coping skill for day-to-day stress relief. The same quasi-experimental pretest-posttest design is recommended, but the posttest should be given in two weeks. Another treatment is then given at four weeks. Suggested treatments included having the RN review the skills portion of the workshop on video or have the RN teach what she learned to someone else. Two weeks after that intervention, administer posttests. This will increase learned skills attained through the previous workshops and help overcome some of the problems cited in the discussion section.

7. The use of progressive relaxation and/or humor as coping skills are only tools and are designed to augment and enhance a healthy lifestyle.
Appendix A

Flyer
PSYCH NURSES WANTED

TO HELP DOCTORAL STUDENT COMPLETE A
RESEARCH PROJECT THAT COULD BENEFIT ALL
PSYCHIATRIC REGISTERED NURSES WHO WORK IN
A HOSPITAL ENVIRONMENT

REQUIREMENTS
1) Be a female psychiatric registered nurse employed
(preferably) full-time in a hospital setting.
2) Complete three self-report inventories which should
take only about 45 minutes to complete.
3) Attend a free three-hour workshop on topics of
global interest to all psychiatric nurses. The
leaders of the workshops are renowned speakers from
the local communities.
4) Six weeks after the workshop, complete two more self-
report inventories.

TO BE ABLE TO TAKE PART IN THE FUN BEING OFFERED,
PLEASE MAKE YOUR INTEREST KNOWN TO YOUR DIRECTOR OF
NURSING OR TO JOANNE KWANDT AT 804-843-2231.
Appendix B

Pretreatment Cover Letter
Dear ________________,

Thank you for volunteering to assist me with my research. I know that time and energy are valuable commodities for all to nurses. That is why I'm so grateful you are willing to share some of that precious time and energy in a project that is important to me. I plan to use the information generated from your personal investment to complete my doctoral dissertation.

Your commitment to this study will be rewarded three ways. First of all, you will receive a free, three hour workshop designed just for psychiatric RNs. Besides being fun and useful in and of itself, the workshop will offer you professional growth and help fulfill staff development requirements. Secondly, you will gain a new tool that benefit you and your patients. Lastly, by volunteering to assist in this study, you and your many RN colleagues will have the satisfaction of knowing that your participation has helped expand knowledge about nurses and coping skills in an area where there is a severe shortage of nursing research.

While you are under no obligation to do so, I would appreciate your response on all questions and items. I do ask some personal data such as your name, age, and education level. Completion of this information is required to assure success of the study. However, all data will be kept highly confidential. The conclusions that will be published will be from collective statistical data only. Also, your test profile sheets can be made available to you upon request. A copy of the research study will be made available for public reading in the personnel office of each participating hospital.

Enclosed in this packet is a consent form explaining your voluntary commitment in more detail. Please sign it and mail it with the completed three self-report tests in the self addressed envelope provided. Once this packet of information has been completed and returned to the researcher's assistant, you will be eligible for random selection as a participant. You will also receive your workshop date.

I thank you again for your assistance.

Sincerely,

Joanne Kvandt
804-843-2251
Appendix C

Post-treatment Cover Letter
December 15, 1991

Dear ________,

I want to thank you for assisting me in my dissertation research study. Hopefully, being a subject proved to be a pleasant experience and the workshop you attended was informative and useful. I felt honored to have such outstanding speakers for the presentations and having you there reaping the benefits made all my hard work worthwhile.

Please notice that your packet contains two self-report inventories just like the ones you took six or eight weeks ago. Please complete these tests as soon as you receive them to avoid delays or misplacing the packet during this holiday season. I have provided a self-addressed envelope to allow for free, convenient return of the data.

A certificate of attendance has been provided for you which can be shown to your administrative personnel to validate your attendance. However, my research assistant has written your Director of Nurses and informed her of your workshop attendance, so you may just want the certificate for your own personal files.

Also enclosed is a complimentary badge. It's simply a token of my appreciation for your help and interest in this research project.

Copies of the research study will be sent to your personnel offices when the dissertation is completed sometime this Summer(1992). Again, thank you so very much for your part in this study on stress in the workplace. Such research could help all nurses in the future.

Sincerely,

Joanne Kwande, RNCS, MA, Ed.S
Doctoral Student Researcher
School of Education at William & Mary College

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Appendix D

Consent Forms
CONSENT FORM

Hospital agrees to the following:

To allow Joanne Kwandt, a doctoral student in the Education (Guidance and Counseling) Department at the College of William and Mary, to solicit for her research female, psychiatric registered nurse (RN) participants. The RN must be ages eighteen through sixty-five who are employed (preferably) full-time during the day or day/evening shift in our facility. Ms. Kwandt will use flyers and/or word of mouth via nurse meetings to recruit the nurses.

To make every effort to allow any registered nurse (RN) who is randomly selected to participate in the study to attend a free three hour workshop on a topic pertinent to psychiatric nurses. The workshop will be conducted by licensed professionals who are experts on the subjects they will be presenting. This hospital understands that the nurse cannot change the workshop assignment because of the random selection process and the RN must attend the workshop on the day assigned. If there is a foreseeable problem and one of the RNs cannot attend, the facility will notify Ms. Kwandt as soon as possible to allow another RN the privilege of attending the workshop.

To allow cassette tapes and recorder to be held in a central location in the hospital so nurses can check out the equipment for use while on break in the work place.

The hospital understands that all volunteer registered nurses will be asked to complete three brief self-report inventories which will require about one hour to complete. When the first three self-report tests are received by the researcher's assistant, the volunteer will become eligible for random selection in the study. Those subjects selected to participate will then be randomly assigned to one of two treatment groups involving coping skills workshops or to a control group involving a workshop on another topic to be announced. Regardless of what group the participant may be involved in, the subject will receive a free, three hour workshop as promised. Six to eight weeks later, the RN subjects will be asked to complete two more self-report measurements which will require about forty-five minutes of their time.
The RN can request a copy of her test scores at the end of the study. A published document showing conclusions drawn from collective data only will be made available for public reading in the personnel department of each mental health facility. Confidentiality will be strictly maintained. When individual scores are compiled for statistical analysis, numbers rather than names will be used to ensure that there is confidentiality at all levels.

Participation in this research study is strictly voluntary and any randomly selected RN or her participating hospital may discontinue assistance and participation in the research project at any time without penalty, bias or loss of benefit. Participants will be requested to complete all the items in the reports, to include personal data such as name, age, and years of psychiatric nurse experience. The RN is under no obligation to do so. Anytime the nurses wishes to omit something from a measurement or to sit out of a part of workshop, she may do so without penalty, bias, or loss of benefit. However, refusal to complete such items could hinder the validity of study. Also, all volunteers who were not chosen for the study will be invited to attend a similar workshop after the research is concluded.

Each nurse volunteer is being asked to sign a consent form. Enclosed is a copy of this form. It expresses in more detail the participation requirements. Please note that there are no documented risks involved in participation in any part of this study. However, the research has benefits for the nurse and nurse management. It goes without saying that when nurses successfully use their coping strategies to relieve stress, the nurse, the management, and the benefits. When RNs feel “in control” they give better patient care and have lower absentee rates.

This study by Ms. Kwandt is for a doctoral dissertation. She can be reached at 804-843-2251. The office phone number for the College of William and Mary faculty advisor, Dr. Fred L. Adair, is 804-221-2321. Please feel free to call either of these individuals if you have any questions, concerns, or complaints regarding the research study.

SIGNED: ___________________________ DATE: __________
TITLE: ___________________________
HOSPITAL REPRESENTED: ___________________________

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CONSENT FORM

I agree to participate in this research project voluntarily according to the conditions and requirements mentioned below:

I understand that all participants of this study must be female, psychiatric registered nurses and who preferably who work full-time. All RNs must be between the ages of eighteen and sixty-five who work day or day/evening shifts within a hospital consenting to participation in this study.

I volunteered to participate in this study with the understanding that I can change my mind and withdraw from that participation without penalty, bias, or loss of benefit. I may discontinue participation at any time during the study without penalty, bias, or loss of benefit of future participations.

I understand that participants for this study will be chosen through random selection from all qualified volunteers that apply and meet eligibly requirements. I also understand that participants will be randomly assigned to one of two treatment groups or a control group. I realize that this is a experimental research project and I cannot change the group assignment, the workshop topic, or the workshop presentation date once the random selections have been made.

I will be asked to complete three brief self-report inventories relating to stress which will take less than one hour of my time. Upon completion of these inventories, I will mail them within the allotted time frame to the location indicated on the self-addressed package. I understand that no workshop assignments will be made until the first three self-report measurements are returned to researcher's assistant. Shortly thereafter I will be notified of the workshop and date and location I have been assigned. The workshop topics will include humor, progressive relaxation, and a yet undecided topic that will be designed especially for psychiatric nurses. All workshops are three hours long and will be conducted by renowned local lecturers. Approximately six to eight weeks I attend the workshop, I will be sent two more self-reports on stress that will take thirty to forty-five minutes for completion. These will be the only things I will be asked to do for the research project.
I will be asked some data such as my name, age, and years of experience as a psychiatric RN. The researcher would appreciate completion of all forms and personal data since the information is necessary for the experimental study. However, I may omit any part of any form or testing instrument or sit out any portion of the workshop without penalty, bias, or loss of benefit.

If I am randomly selected to be a participant, both my hospital personnel office and I will be notified of my workshop assignment and date. All volunteers selected for participation will attend a free, three hour workshop regardless of whether assignment is in a treatment or control group.

Confidentiality concerning individual test results and any aspect of the study which involves nurse cooperation will be strictly maintained. Individual scores may be obtained by request after the research is completed. The completed research data will be provided to each hospital personnel office for public reading. Only conclusions from group statistical data will be published. When individual scores are compiled for statistical analysis, numbers rather than names will be used to ensure that there is confidentiality at all levels.

I am assured that there are no documented risks involved in either the taking these self-report tests or workshop participation. However, participation in this research project may benefit me directly by providing me with new coping strategies or new psychiatric knowledge which will be useful for me and for my patients. Participation may benefit nurses collectively and psychiatric nurses specifically by generating needed research concerning psychiatric RNs and stress.

This research project is conducted by Joanne Kwandt, RNCS, MA, Ed.S for a doctoral dissertation in the School of Education at the College of William and Mary. The faculty committee chairman is Dr. Fred L. Adair. Ms. Kwandt may be reached at 804-843-2251 and Dr. Adair's office number is 804-221-2321.

SIGNED: __________________________ DATE: ____________

HOSPITAL REPRESENTED: __________________________
Appendix E

Study Measurements and Scoring Tools
Copyrighted materials in this document have not been filmed at the request of the author. They are available for consultation, however, in the author's university library.

University Microfilms International
PSYCHIATRIC NURSES' OCCUPATIONAL STRESS SCALE (PNOSS)
by
Joan E. Dawkins, Ph.D, Frederick C. Depp, Ph.D, Nancy Selzer, MA

Name............................  Age.............
Hospital Affiliation.......................  
Nursing Title..............................  
Years of RN experience....................

DIRECTIONS:
This is a self report measurement. Read each item and decide if it is an item which causes stress at work.

Circle the appropriate response.
NA - Does not apply/not applicable.
No - No stress
(3) - Very stressful
(2) - Moderately stressful
(1) - Little stress

EXAMPLES:
1. Having a patient shout at me. NA No (3) (2) (1)
   Usually a patient being aggressive is stressful so you would circle box marked 2 or 3.

2. Having to take vital signs. NA No (3) (2) (1)
   This is a normal RN duty that is usually not stressful. So you would circle no.
PSYCHIATRIC NURSES’ OCCUPATIONAL STRESS SCALE (PNOS)
by
Joan E. Dawkins, Ph.D., Frederich C. Depp, Ph.D., Nancy Selzer, MA

Name....................... RN Title..................

How often did you utilize the skills you learned at the workshop while you were on the job?
None ...... Some ...... Quite a bit ...... Not useful ......

Years of RN experience ...... Years of Psychiatric RN experience ...... Did you have any related training similar to what you received from the workshop? ........................

DIRECTIONS:

This is a self report measurement. Read each item and decide if it is an item which causes stress at work.

Circle the appropriate response.

NA - Does not apply/not applicable.
No - No stress
(3) - Very stressful
(2) - Moderately stressful
(1) - Little stress

EXAMPLES:

1. Having a patient shout at me. NA No (3) (2) (1)
   Usually a patient being aggressive is stressful so you would circle box marked 2 or 3.

2. Having to take vital signs. NA No (3) (2) (1)
   This is a normal RN duty that is usually not stressful.
   So you would circle no.
PSYCHIATRIC NURSES' OCCUPATIONAL STRESS SCALE (PNOSS)

by
Joan E. Dawkins, Ph.D, Frederick C. Depp, Ph.D, Nancy Selzer, MA

<table>
<thead>
<tr>
<th>ITEMS</th>
<th>CATEGORY</th>
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</thead>
<tbody>
<tr>
<td>1. Not being notified of changes before they occur.</td>
<td>A</td>
</tr>
<tr>
<td>2. Dealing with people in key management positions who aren't able to make a decision.</td>
<td>A</td>
</tr>
<tr>
<td>3. Lack of support from administration.</td>
<td>A</td>
</tr>
<tr>
<td>4. Having excessive paperwork.</td>
<td>A</td>
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<tr>
<td>5. Working for an administrator who believes in change for the sake of change.</td>
<td>A</td>
</tr>
<tr>
<td>6. Being responsible for too many widely divergent things.</td>
<td>A</td>
</tr>
<tr>
<td>7. Not having suggestions acted on in a timely manner.</td>
<td>A</td>
</tr>
<tr>
<td>8. Trying to do job in spite of fact that no one is listening.</td>
<td>A</td>
</tr>
<tr>
<td>9. Receiving no recognition for a job well done.</td>
<td>A</td>
</tr>
<tr>
<td>10. Having inadequate work interfering with patient care.</td>
<td>A</td>
</tr>
<tr>
<td>11. Working in the &quot;system&quot; that never listens to suggestions from peers.</td>
<td>A</td>
</tr>
<tr>
<td>12. Lack of adequate staffing in potentially dangerous environments.</td>
<td>R</td>
</tr>
<tr>
<td>13. Working with hostile patients on an inadequately staffed ward.</td>
<td>R</td>
</tr>
</tbody>
</table>
14. Having a shortage of patients' clothing.  
15. A physical threat by a patient.  
16. Having an employee reassigned to another ward against his wishes.  
17. Working with unskilled, non-professionals who resent new ideas.  
18. Working with poorly motivated staff.  
19. Lack of communication between disciplines.  
20. Having a doctor fail to notify staff of changes in patient orders and yet still being held responsible.  
21. Convincing doctors to order adequate medication.  
22. Dealing with the hassle that occurs when you try to take action against an incompetent staff.  
23. Finding out what warehouse does not have ward supplies.  
24. Having another take credit for an idea I initiated and worked hard on.  
25. Receiving no response from complaints to Chief Nurse after going through channels.  
26. Covering other wards because of unscheduled absences of other RNs.  
27. Shortage of male staff.  
28. Providing adequate coverage for entire building.

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<td>NA</td>
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<td>28</td>
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<tr>
<td>29. Having no say about the staff assigned to me.</td>
<td>A</td>
<td>NA No (3) (2) (1)</td>
<td></td>
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<tr>
<td>30. Not being able to obtain repairs and get job orders completed in a timely fashion.</td>
<td>A</td>
<td>NA No (3) (2) (1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>31. Working with uncooperative staff.</td>
<td>SC</td>
<td>NA No (3) (2) (1)</td>
<td></td>
<td></td>
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<tr>
<td>32. Dealing with an employee disciplinary problem.</td>
<td>SC</td>
<td>NA No (3) (2) (1)</td>
<td></td>
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<tr>
<td>33. Attending too many meetings.</td>
<td>A</td>
<td>NA No (3) (2) (1)</td>
<td></td>
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<tr>
<td>34. Feeling unable to meet my supervisor's expectations for a job performance in an impossible situation.</td>
<td>SC</td>
<td>NA No (3) (2) (1)</td>
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<td>35. Having inadequate night security.</td>
<td>R</td>
<td>NA No (3) (2) (1)</td>
<td></td>
<td></td>
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<tr>
<td>36. Discrepancy that exists on all levels of nursing in the way male and female employees are utilized, even though their job descriptions are the same.</td>
<td>A</td>
<td>NA No (3) (2) (1)</td>
<td></td>
<td></td>
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<tr>
<td>37. Not being able to get small equipment repaired.</td>
<td>R</td>
<td>NA No (3) (2) (1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>38. Working with a hostile staff member.</td>
<td>A</td>
<td>NA No (3) (2) (1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>39. Making administrative decisions for a unit when there is a unit director getting paid for it.</td>
<td>A</td>
<td>NA No (3) (2) (1)</td>
<td></td>
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<tr>
<td>40. Giving injections in seclusion to a struggling and kicking patient.</td>
<td>N</td>
<td>NA No (3) (2) (1)</td>
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<tr>
<td>41. Not being able to enrich myself more educationally on the job because of the heavy work load.</td>
<td>A</td>
<td>NA No (3) (2) (1)</td>
<td></td>
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<tr>
<td>42. Working with an employee who treats adult or teen patients like children.</td>
<td>SP</td>
<td>NA No (3) (2) (1)</td>
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</tbody>
</table>
43. Working several different shifts in one month. S NA No (3) (2) (1)
44. Finding people to work overtime. S NA No (3) (2) (1)
45. Working in an acute care area with less than adequate coverage. R NA No (3) (2) (1)
46. Participating in a staff meeting in which conflict among the disciplines is played out. S NA No (3) (2) (1)
47. Lack of funds for program projects. R NA No (3) (2) (1)
48. Employees calling in for emergency leave 1/2 hour before scheduled duty time. S NA No (3) (2) (1)
49. Working with suicidal patients who are obsessed with committing suicide. N NA No (3) (2) (1)
50. Working with improperly trained staff. SP NA No (3) (2) (1)
51. Working with a staff member who is unwilling to focus on patients' strength to encourage maximum level of functioning. S NA No (3) (2) (1)
52. Having a shortage of linen. R NA No (3) (2) (1)
53. Having a client returned from convalescent leave for an insufficient reason. SP NA No (3) (2) (1)
54. Not having suggestions acted on, especially agreed-upon-team meeting suggestions. SC NA No (3) (2) (1)
55. Working in an environment with poorly maintained supplies. R NA No (3) (2) (1)
56. Having an employee refuse to follow a posted assignment. SC NA No (3) (2) (1)
57. Assigning (Regular days off) RDO's so that ward is adequately covered.

58. Having a medical doctor make rounds at his convenience.

59. Having inadequate transportation for field trips.

60. Working with staff who do not want to be on the ward.

61. Working in an unclean environment.


63. Working with staff who use patients as pawns to resist administration.

64. Having no bathroom for employees in the immediate area.

65. Having an employee ask for a substantial amount of leave after the time has been posted.

66. Having to seclude a patient without the presence of a male staff.

67. Lack of support from head RN.

68. Participating in a crisis meeting which is not really a crisis.

69. Racial discrimination, eg. staff-patient, staff-staff.

70. Having a teenage patient take advantage of an older patient.

71. Not having any choice on selection of shifts.
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<tbody>
<tr>
<td>72.</td>
<td>Having my request to attend a hospital sponsored workshop ignored.</td>
<td>A</td>
<td>NA No (3) (2) (1)</td>
</tr>
<tr>
<td>73.</td>
<td>Working on a noisy ward.</td>
<td>R</td>
<td>NA No (3) (2) (1)</td>
</tr>
<tr>
<td>74.</td>
<td>Having a case of discrimination brought to the attention of higher administration and nothing is ever done.</td>
<td>A</td>
<td>NA No (3) (2) (1)</td>
</tr>
<tr>
<td>75.</td>
<td>Having a patient returned from convalescent leave after extensive community preparation.</td>
<td>N</td>
<td>NA No (3) (2) (1)</td>
</tr>
<tr>
<td>76.</td>
<td>Being required to sign in daily at supervisor's office before reporting to the ward regardless of the weather.</td>
<td>A</td>
<td>NA No (3) (2) (1)</td>
</tr>
<tr>
<td>77.</td>
<td>Caring for terminally ill patients.</td>
<td>N</td>
<td>NA No (3) (2) (1)</td>
</tr>
<tr>
<td>78.</td>
<td>Having inadequate light at the nursing station desk.</td>
<td>R</td>
<td>NA No (3) (2) (1)</td>
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</table>

******************************

The six thematic categories are N (negative characteristics of patients); A (administrative/organization issues); R (limited resources); SP (staff performance); SC (staff conflict); and S (scheduling issues).
PSYCHIATRIC NURSES' OCCUPATIONAL STRESS SCALE (PNOSS)
by
Joan E. Dawkins, Ph.D, Frederich C. Depp, Ph.D, Nancy Selzer, MA

Name ____________________________

Profile includes six thematic categories: N (Negative Characteristics of Patients); A (Administrative/Organizational Issues); R (limited resources); SP (Staff Performance); SC (Staff Conflict); and S (Scheduling Issues).
Appendix F

Permission to modify the PNOSS
May 22, 1990

Joanne Kwandt, RNCS, Ed.S.
HCR 01 Box 118
West Point, Va. 23181

Dear Ms. Kwandt:

Please feel free to modify the Psychiatric Nurse's Occupational Stress Scale (PNOSS) to suit your dissertation needs. My colleagues and I have done no further work with the PNOSS since its publication in 1985. We do not have copyrights on the form.

We would certainly appreciate it if you would send us a summary of your dissertation findings so that we may begin to accumulate information on the tool.

Good luck!

Joan E. Dawkins, Ph.D.
6012 Nebraska Ave., NW (home)
Washington, D.C. 20015
373-6687 (202)-Work
966-2549 (202)-Home
Appendix G

Group I Workshop Measurement
SELF-SURVEY OF STRESS RESPONSES IN THE BODY

Each person has an individual pattern of physical responses to situations of continued stress. This survey is designed to determine your pattern, to guide you in determining which portions of the exercises (that is autonomic, somatic motor, or central nervous system) should be given extra attention. Write a number zero to five in the parentheses after the question. If there are two sets of parentheses, place the same number in both.

Zero means never
One means almost never
Two means seldom
Three means occasionally
Four means frequently
Five means almost always

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<tr>
<td>A</td>
<td>M</td>
<td>C</td>
</tr>
<tr>
<td>1. I tap my feet or fingers.</td>
<td>( )</td>
<td></td>
</tr>
<tr>
<td>2. I clench my teeth or grind them.</td>
<td>( )</td>
<td></td>
</tr>
<tr>
<td>3. I stammer or stutter.</td>
<td>( ) ( )</td>
<td></td>
</tr>
<tr>
<td>4. My stomach flutters.</td>
<td>( )</td>
<td></td>
</tr>
<tr>
<td>5. I kick my foot or bounce it.</td>
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<tr>
<td>6. I bite my nails.</td>
<td>( )</td>
<td></td>
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<tr>
<td>7. I pick at things (lint, hair, etc.).</td>
<td>( )</td>
<td></td>
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<tr>
<td>8. I feel nausea.</td>
<td>( ) ( )</td>
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<tr>
<td>9. I have pain in my chest or feel like a strap is tight across my chest.</td>
<td>( )</td>
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<tr>
<td>10. My hands tremble or my head quivers.</td>
<td>( )</td>
<td></td>
</tr>
<tr>
<td>11. My hands feel cold.</td>
<td>( )</td>
<td></td>
</tr>
<tr>
<td>12. My hands sweat.</td>
<td>( )</td>
<td></td>
</tr>
<tr>
<td>13. My heart beats very fast.</td>
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15. I continuously have the same or many thoughts running through my head.

16. I move awkwardly, bump into things, or drop things.

17. I cannot concentrate.

18. I must be aware of everything around me to keep control.

19. My head aches, usually on one side (temple or jaw), with a steady ache.

20. My head aches with a pounding either behind my eyes or on one side of my head.

21. My forehead aches or the back of my head aches with a kind of pulling ache.

22. The muscles running from my shoulder blades across my shoulders to my neck ache on one side or both sides.

23. My face flushes.

24. I get dizzy.

25. I want to be very close to someone.

26. I tend to have lapses of awareness.

27. I feel like I want to smash something.

28. I have to go to the toilet often.

29. I have difficulty eating or holding down food.

30. My calves, thighs, or feet get tense.

31. I breath rapidly and shallowly.

32. I have to check things again and again.
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<tr>
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<th>A</th>
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<th>C</th>
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<tr>
<td>33.</td>
<td>I keep forgetting things.</td>
<td>( )</td>
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<tr>
<td>34.</td>
<td>I want to retreat and sleep, safe at home.</td>
<td>( )</td>
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<tr>
<td>35.</td>
<td>I busy myself putting everything in order.</td>
<td>( )</td>
<td></td>
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<tr>
<td>36.</td>
<td>I have to eat and eat.</td>
<td>( )</td>
<td></td>
</tr>
<tr>
<td>37.</td>
<td>I produce gas (burp or other).</td>
<td>( )</td>
<td></td>
</tr>
<tr>
<td>38.</td>
<td>My mouth gets dry.</td>
<td>( )</td>
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Appendix H

Speaker Credentials
STEVE KISSELL

Steve Kissell, B.S. conducted the humor seminar. Steve is co-founder of Circus Magic and the Virginia Clown Club of Norfolk, Virginia. He has presented courses on the "The Clown in You" and assists in workshops with his "Laugh Starters". Steve is also Director of Mirthworks, Inc. This is an organization which promotes the use of humor to develop and maintain a healthy lifestyle. Steve Kissell is a Norfolk Public School teacher. He trains other teachers throughout the school system on the use of humor as a teaching tool. Steve is pursuing a Master’s Degree in Counseling at Old Dominion University, Norfolk, Virginia.
Dr. Marilyn Spiro conducted the inservice on progressive relaxation techniques. She got her B.S. in Education from the University of Cincinnati, Cincinnati, Ohio and her M.S. and Ph.D. in Clinical Psychology from Virginia Commonwealth University, Richmond, Virginia. Dr. Spiro has had extensive post graduate training. Her teachers have included Arnold Lazarus, Joseph Wolpe, Laura Perls, Ralph Reitan, Erika Fromm and Daniel Brown, Aaron Beck and Irvin D. Yalom. She attended a three year training program at the Gestalt Institute of Richmond, Richmond, Virginia.

In 1981-84, Dr. Spiro served as a resident and then as a staff psychologist at Charter Westbrook Hospital, Richmond, Virginia. From 1985-87, she was director of psychological services at the Center for Pain Control at Metropolitan Hospital, Richmond, Virginia. In 1988, she began two weekly cognitive behavioral psychotherapy groups (Self Expression and Stress Management) on the Women's Unit at the Psychiatric Institute of Richmond. Since 1982, Dr. Spiro has been in private practice in Richmond as a clinical psychologist working with adults, older adults, and couples. She conducts weekly psychotherapy groups for men and women and professional women's groups.
JOHN F. LAVACH

The non-stress relieving workshop was entitled "The Neurological Assessment". Dr. John F. Lavach, a professor of Education in the School Psychology Program at the College of William and Mary, conducted the control group session. Dr. Lavach is also a staff member at the Head Trauma Rehabilitation Center of Hampton Roads, Hampton, Virginia. There he utilizes neuropsychological assessment techniques on patients suffering from head trauma, strokes, aneurysms, tumors, etc. Additionally, Dr. Lavach is a consultant with the Children's Neurological Services in Richmond and Newport News, Virginia in the capacity of school psychologist. He's a member of the American Psychological Association, Division Forty, clinical neuropsychology as well as regional and statewide organizations. He has published in the area of head injuries and made presentations at national and regional professional conferences.

Dr. Lavach's academic background includes degrees from Montclair State College (NJ), Fairleigh Dickinson University (NJ) and Duke University (NC). He has taken post-doctoral work at the University of Pittsburgh (PA), Williams College (MA), and Columbia University (NY). Additionally, he has maintained certification as a school psychologist in the Commonwealth of Virginia.
Appendix I
Workshop Programs
RESEARCH STUDY FACULTY ADVISOR

FRED L. ADAIR Ph.D.

Dr. Adair graduated from the University of North Carolina, Chapel Hill with a doctorate in Counselor Education and minors in Psychology, Educational Psychology, and Higher Education. He's a professor in the counseling program of the School of Education at The College of William and Mary. A licensed professional counselor in the Commonwealth of Virginia, Fred is a member of the Board of Directors for the VA. Association of Clinical Counselors and the National Board of Directors for Certified Counselors. He specializes in Marriage and Family Counseling. Fred has written many publications and has done research in several diverse areas. He has developed a scale to measure the service orientation of librarians to Career and conducts studies on Management Development for NASA. In 1989 Drs. Adair and Collins co-authored the Manual for the Adjective Check List Interpretive Summary which is published by Consulting Psychologists Press. Dr. Adair can be reached for questions concerning this study at (804) 221-2321.

RESEARCHER

JOANNE KVANDT RNCS, H.A., Ed. S.

Mrs. Kvandt is a Registered Nurse Clinical Specialist in Child and Adolescent Mental Health. She has worked with psychiatric children and pre-teens at Charter Colonial Institute. She was a nurse manager in the adult chronic care area at Eastern State hospital and in the adolescent open and closed wards and chemical dependency units at the Psychiatric Institute of Richmond (PIR). Presently she's a RNCS on the 11-7 shift on the Woman Unit at PIR. Joanne (Jo) is also pursuing her goal of becoming a Licensed Professional Counselor. She sees clients under the supervision of Dr. Fred L. Adair and Dr. Patricio Torres-Liboa. Jo has her secondary school teaching certification and counseling endorsement and is finishing her doctorate in Education: Guidance and Counseling at the College of William and Mary. Jo also is a co-owner of a small business.
ABOUT THE SPEAKER
MARILYN LOEY SPIRO, Ph.D

Dr. Spiro got her B.S. in Education from the University of Cincinnati and her M.S. and Ph. D in Clinical Psychology from Virginia Commonwealth University. Her dissertation was "External Inhibition of Snake Phobia." Her specialized practicum training included the following: Stress Management with CHD Patients, Sex therapy/Biofeedback for stress related disorders. She did internships at The Behavioral Medicine Center, U. Of Va. Medical School and McGuire V.A. Medical Center.

Dr. Spiro has had extensive post graduate training. Her teachers have included Arnold Lazarus, Joseph Wolpe, Laura Perls, Ralph Reitman, Erika Fromm and Daniel Brown, Aaron Beck and Irvin D. Yalom. She attended a three year training program at the Gestalt Institute of Richmond and taught Humanities 313 (Holocaust) at VCU.

In 1981-84 Dr. Spiro served as a resident and then as a staff psychologist at Charter Westbrook Hospital. 1985-87 she was director of psychological services at the Center for Pain Control at Metropolitan Hospital. In 1988 she began two weekly cognitive behavioral psychotherapy groups on the Women's Unit at the Psychiatric Institute of Richmond and taught Humanities 313 (Holocaust) at VCU.

THE RELAXATION ROUTE TO STRESS MANAGEMENT
6:30 – 9:00
Coffee and Juice/Welcome

Material Distribution

Self Survey of Stress Responses in the Body (SSRB) Take test and score.
9:00 – 9:15
Discussion of Mind/Body Connection

Introduction to Relaxation Training

Progressive Relaxation and Breath Control
9:15 – 9:55 Break

9:55 – 10:45
Autogenic Training I

Lecture: The Stress Management Model, Stressors, Stress Responses, and Stress Management

10:45 – 10:55 Break

10:55 – 11:30
Autogenic Training II

Discussion of Stress Buffers
11:30 – 11:55
Three Strategies for "What to do when the nursing station is full, the lights are flashing, the phones are ringing, and there's no time for anything"

1. Quick Progressive Relaxation
2. Quick Autogenic Relaxation
3. Quick, Quick Calming Response

Dr. Spiro is a Diplomate of the American Board of Medial Psychotherapists. She has been on the advisory board for Chronic Pain Outreach and Agoraphobics Building Independent Lives. Dr. Spiro also has published in the Psychopharmacology Bulletin and presented professional papers.
RESEARCH STUDY FACULTY ADVISOR
FRED L. ADAIR - Ph. D.

Dr. Adair graduated from the University of North Carolina, Chapel Hill with a doctorate in Counselor Education and minors in Psychology, Educational Psychology, and Higher Education. He is a professor in the counseling program of the Education Department of the College of William and Mary. A licensed professional counselor in the Commonwealth of Virginia, Fred is a member of the Board of Directors for the Virginia Counselors Association and the National Board of Directors for Certified Counselors. He specializes in Marriage and Family Counseling. Fred has written many publications and has done research in several diverse areas. He has developed a scale to measure the service orientation of librarians to Career and conducts studies on Management Development for NASA. In 1989 Drs. Adair and Collins co-authored the Manual for the Adjective Check List Interpreting Report which is published by Consulting Psychologists Press. Dr. Adair can be reached for questions concerning this study at (804) 221-2321.

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"HUMOR IN THE WORKPLACE"

STEVE KISSELL, BS ED

Workshop presented on Friday, October 25, 1991 at College of William and Mary Campus Center Rooms A & B

In today's fast-paced world there is relief and a cure for stress...LAUGHTER! Learn how to use humor to ease the pressures and burdens of work, home, and play.
ABOUT THE SPEAKER

STEVE KISSELL - B.S. ED

Steve is co-founder of Circus Magic and the Virginia Clown Club, Norfolk, Va. He is a gifted performer and his humor has an ageless appeal that reflects polished techniques from years of clowning and comedy emphasis. He has presented courses on the "The Clown In You" and assists in workshops with his "Laugh Starters".

A noted humorist, educator, author, and keynote speaker, Steve is also Director of Mirchworks, Inc. This is an organization which promotes the use of humor to develop and maintain a healthy lifestyle. He works in the humor field to share his belief in the benefits of using therapeutic laughter in education, health care, business, and homes.

Mr. Kissell is a Norfolk Public School teacher. In the classroom, Steve has integrated humor with school lessons to increase retention and improve classroom involvement. In his "spare" time, this talented man is pursuing a Master's Degree in Counseling and he trains other teachers throughout the school system on the use of his techniques.

PRESENTATION OUTLINE

8:30 - 9:00 Coffee or Juice Served.

9:00 - 10:00 Keynote Presentation.

1. What is Stress
   A. Define stress.
   B. How does it affect us?
      1. Psychologically
      2. Physiologically
   C. Understanding Stress in the Body.
   D. Recognizing the Personal "Early Warning" Signs.
   E. Analyze Current Stress and Its Sources.

11. How does Laughter Offset Stress?
   A. How Does Laughter Affect Us?
      1. Psychologically
      2. Physiologically
      3. Spiritually
   B. Is it for you?
   C. The Humor Challenge.

10:10 - 10:15 Break.

10:15 - 11:00 Workshop Portion.

   A. Stress Game with Ropes.
   B. Problem Solving/Working Together for the Solution.

11:00 - 11:10 Break.

11:10 - 12:00 Workshop Continues.

   D. Activity Games.
   E. Juggling for Stress Reduction.
   F. Workshop Closure-The Tools for Stress
   G. Evaluation
RESEARCH STUDY FACULTY ADVISOR

FRED L. ADAIR, Ph.D.

Dr. Adair graduated from the University of North Carolina, Chapel Hill with a doctorate in Counselor Education and minors in Psychology, Educational Psychology, and Higher Education. He's a professor in the counseling program of the School of Education at The College of William and Mary. A licensed professional counselor in the Commonwealth of Virginia, Fred is a member of the Board of Directors for the Va. Association of Clinical Counselors and the National Board of Directors for Certified Counselors. He specializes in Marriage and Family Counseling.

Fred has written many publications and has done research in several diverse areas. He has developed a scale to measure the service orientation of librarians to Career and conducts studies on Management Development for NASA. In 1989 Drs. Adair and Collins co-authored the Manual for the Adjective Check List Interpretive Report, which is published by Consulting Psychology Press. Dr. Adair can be reached for questions concerning this study at (804) 221-2321.

RESEARCHER

JOANNE KWANDET, R.N.C.S., M.A., Ed. S.

Mrs. Kwandt is a Registered Nurse Clinical Specialist in Child and Adolescent Mental Health. She has worked with psychiatric children and pre-teens at Charter Colonial Institute. She was a nurse manager in the adult chronic care area at Eastern State hospital and in the intermediate open and closed wards and chemical dependency units at the Psychiatric Institute of Richmond (PIR). Presently she’s a RNCS on the 11-7 shift on the Women Unit at PIR. Joanne (Jo) is also pursuing her goal of becoming a Licensed Professional Counselor. She sees clients under the supervision of Dr. Fred L. Adair and Dr. Patricio Torres-Lisboa.

Jo has her secondary school teaching certification and counseling endorsement and is finishing her doctorate in Education: Guidance and Counseling at the College of William and Mary. Jo also is a co-owner of a small business.

The College Of
WILLIAM & MARY
SCHOOL OF EDUCATION

Presents as a part of a Dissertation Research Study

THE NEUROPSYCHOLOGICAL ASSESSMENT

by

JOHN F. LAVACH, Ed.D

Professor of Educational Psychology

School Psychology Program

College of William and Mary

Workshop held on Friday, October 18, 1991
From 9:00 A.M. to 12:00 P.M.
at The College of William and Mary Campus Center Room C
ABOUT THE SPEAKER
John F. Lavech, Ed.D.

John is a Professor of Education in the School Psychology Program at The College of William and Mary. He is currently a staff member at Head Trauma Rehabilitation of Hampton Roads where he utilizes neuropsychological assessment techniques on patients suffering from head trauma, strokes, aneurysms, tumors, etc. Additionally, John is a consultant with Children's Neurological Services in Richmond and Newport News in the capacity of school psychologist. John is a member of the American Psychological Association, Division 40, clinical neuropsychology as well as regional and state-wide organizations. He has published in the area of head injury and has made presentations at national and regional professional conferences. John's academic background includes degrees from Montclair State College and Fairleigh Dickinson University (New Jersey) and Duke University. He has taken post-doctoral work at the University of Pittsburgh, Williams College (Massachusetts), and Columbia University in addition to maintaining certification as a school psychologist in the Commonwealth of Virginia.

THE NEUROPSYCHOLOGICAL ASSESSMENT

8:30 - 9:00 Coffee and Juice
9:00 - 9:50 The Neuropsychological Status Examination
9:50 - 10:00 Break
10:00 - 10:30 Aphasia Screening Test
10:30 - 11:00 Quick Neurological Screening Test
11:00 - 12:00 The Neurological Examination Including the Mental Status Examination
Appendix J

Workshop Certificates of Attendance
Certificate of Attendance

THIS CERTIFIES THAT

HAS ATTENDED THIS THREE-HOUR WORKSHOP

THE NEUROPSYCHOLOGICAL ASSESSMENT - John F. Lavach, Ed.D : Speaker
Friday, October 18, 1991 at College of William & Mary Campus Center

Fred L. Adair Ph.D.
Faculty Advisor
School of Education
The College of William and Mary

Joanne Kwanidt, RNCN, MA, Ed.S.
Doctoral Student Researcher
School of Education
The College of William and Mary
Certificate of Attendance

THIS CERTIFIES THAT

HUMOR IN THE WORKPLACE - Steve Kissell, B.S.; Speaker
Friday, October 25, 1991 at College of William & Mary Campus Center

Fred L. Adair Ph.D.
Faculty Advisor
School of Education
The College of William and Mary

Joanne Kwanilt, RNCS, MA, Ed.S.
Doctoral Student Researcher
School of Education
The College of William and Mary
Certificate of Attendance

THIS CERTIFIES THAT

HAS ATTENDED THIS THREE-HOUR WORKSHOP

THE RELAXATION ROUTE TO STRESS MANAGEMENT - Marilyn L. Spiro, Ph.D. Speaker
Wednesday, October 16, 1991 at Psychiatric Institute of Richmond Annex

Fred L. Adair, Ph.D.
Faculty Advisor
School of Education
The College of William and Mary

Joanne Kwandt, RNCS, MA, Ed.S.
Doctoral Student Researcher
School of Education
The College of William and Mary
Appendix K

Permission to Use Cartoons
May 3, 1991

Ms. Joanne Kwandt
HCR 01, Box 118
West Point, VA 23181

Dear Ms. Kwandt:

Thank you for your letter requesting permission to use one BEETLE BAILEY cartoon.

Permission is granted to use this cartoon in your doctoral dissertation and as a teaching tool in your humor workshops.

Please be sure the copyright notice appears on each reprint. You must also include the following credit line with each reprint:

"Reprinted with special permission of King Features Syndicate"

Due to the nature of your request, we are waiving the usual reprint fee.

Should you decide to have your work published in book form, please contact this office for proper authorization.

Sincerely,

Mary Anne Miller
Permissions

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.
May 16, 1991

Editor of American Nurse
American Nurses' Association
2120 Pershing Rd
Kansas City, Missouri 64108

Dear Sir:

I would like to request permission to use the enclosed cartoon in my doctoral dissertation on "The Use of Humor to Relieve Stress in Psychiatric Nurses". The American Nurse and the American Nurses' Association would be referenced in the bibliography.

I would also like to use the example of gallows humor as a teaching tool in my humor workshops. This might consist of a copy of the referenced material in the syllabus or verbal reference of the cartoon.

I would not receive monetary gains from use of your cartoon. If by some chance my dissertation research would be published in book form for profit, I would not use your cartoon without again securing permission.

I thank you, in advance, for your time and consideration in this matter.

Sincerely,

[Signature]

JOANNE KWANDT, RNCS, MA, Ed.S
Education Department
HCR 01, Box 118
West Point, Virginia 23181
804-849-2212

[Attachment]
May 24, 1991

Joanne Kwandt
HCR 01, Box 118
West Point, VA 23181

Dear Ms. Kwandt,

Thank you for your interest in the cartoon published in Executive Female magazine Sept/Oct 1989.

We have not been able to reach the artist, but we can give you the rights for use in your doctoral dissertation. We can not, however, give you the rights for publication in a book. You would have to get permission from him for that.

Best wishes for your success.

Sincerely,

Melissa Wahl
Editorial Assistant
Dear Grandma,

Hope you have our permission to use it.

Cautions that you asked for. But always appreciate any kind of a "secret" - as we are still trying to sell books.

This is an actual that's upstairs. The other one is of the interest if you have not seen it.

We are still looking for a trade publisher to take over. If you know of anyone (or even an agent) that is interested in Human - we would be grateful to hear from you.

Did you enjoy the book of hands?

Sincerely,

[Signature]

Edamere P.M.
June 7, 1991

Joanne Kwandt
William & Mary College
HCR 01, Box 118
West Point, VA 23181

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Thank you for your interest in Universal Press Syndicate.

Sincerely,

Mary C. Suggett
Permissions Director

NOTE: The Crisis Clinic cartoon belongs to Chronicle Features Syndicate, 870 Market Street, San Francisco, CA 94102. Contact Hilda Bloom for reprint permission.
Appendix L

Descriptive Statistics
DESCRIPTIVE STATISTIC FOR MEASUREMENTS

Psychiatric Nurses' Occupational Stress Scale

Stress Means
N=31

Pretest Mean = 126.290
Posttest Mean = 131.032

Attitude (Category) Means
N=31

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<th>Pretest Means</th>
<th>N</th>
<th>A</th>
<th>R</th>
<th>SP</th>
<th>SC</th>
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<td>6.935</td>
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| Posttest Means | | 11.613 | 39.194 | 25.097 | 6.000 | 21.000 | 11.839 |

Work Environment Scale

Dimension Means
N=31

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<td>48.710</td>
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Social Readiness Rating Scale
N = 30 Mean = 197.233
REFERENCES


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Humor Book or Cartoon References


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Birthplace: Camden, New Jersey

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