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RECOMMENDATIONS FOR A RESEARCH-BASED TRAINING PROGRAM FOR ONCOLOGY NURSES AT THOMPSON CANCER SURVIVAL CENTER

A Thesis

Presented for the

Master of Science Degree

The University of Tennessee, Knoxville

John H. Stuhl

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ABSTRACT

The purpose of this study was to recommend steps or components needed for a successful stress management program for oncology nurses. An extensive review of the literature was conducted, and the results reported around eight organizing principles or needed coping mechanisms. These coping mechanisms were social support, participatory management, educational programs, role definition, doctor/nurse relationship, improved patient/nurse relationship, education and information for the patient and family, and patient and family participation in treatment.

From these eight coping strategies, six steps to implement a training program were recommended: (1) placement or employment of an Oncology Clinical Nurse Specialist; (2) development of an educational program; (3) redefinition of the role of oncology nurse; (4) placement of a Psychiatric Liaison Nurse; (5) development of informational materials; and (6) development of educational training for patients/families which focuses on self-care.

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CHAPTER I

INTRODUCTION

Statement of the Problem

Stress has long been identified as a major factor in the life of the patient, and the patient's family, resulting from the diagnosis of cancer. In the recent research and literature, there has also been a growing awareness of the stress placed upon the oncology professional, arising out of the demands and conditions of the work (Holland, 1987). The Thompson Cancer Survival Center has identified a need for a training program for oncology nursing staff to address the effects and needs with regards to stress, burnout, coping and effective stress management. This training program will be designed to teach effective coping to oncology nurses, and to teach oncology nurses effective methods to assist patients and patients' families in more effective coping with the stressors of cancer. This study is designed to research the field of stress and coping as it is related to oncology, and to research the field of training programs for cancer treatment centers. From this research a model training program for the TSCS will be written.

Purpose of the Study

This study has been undertaken for the purpose of bringing to bear the discoveries from research upon the need of the Thompson Cancer Survival Center for a training program for its staff. This cancer center is but a year old, and at the time of its inception had neither the means nor the time to devote to such a program. This is not to say that Thompson felt no need for such a program, but rather that the efforts of the center were required elsewhere.

Objectives

The objectives of this study were to:

1. Review and synthesize research related to (a) stress, (b) general training principles, and (c) continuing education in the nursing profession; and
2. Make recommendations for developing a stress management training program for oncology nurses at Thompson Cancer Survival Center.

To assess the need for a model training program for an outpatient cancer center, the twenty-four comprehensive cancer centers within the United States were contacted. These twenty-four centers were derived from an August, 1988 listing of comprehensive and clinical Cancer centers

obtained from the National Cancer Institute. Each center was contacted by mail (Appendix A & B), asking them (a) if they had in printed form a training program or component for effective stress management for oncology nursing, (b) it they had an interest in and saw a need for such a program or (c) if they had no interest and saw no need for such a program. Of the twenty-four cancer centers contacted, seventeen responded to the inquiry. One cancer center responded by indicating that it was solely a research institute, and inaccurately identified as a comprehensive center. Of the other sixteen centers, eight indicated that they had no such program in place, and seven of these expressed an interest in and saw a need for such a program. The other 50% of respondents indicated that they were aware of the need for an effective stress management program for oncology nursing and were responding to that need. Response took the form of a fully developed and specified program for stress management, or stress management taught as one part of a larger orientation or education program.

Such a response clearly indicates such a need exists. The purpose of this study, then, is to develop such a program, specifically tailored to the setting of the Thompson Cancer Survival Center. The development of this program will be based upon the research on stress and

effective coping found in recent literature.

Definition of Terms

The following terms are used in this study.

Stress. A person's response or reaction, either controlled or unconscious, phsyiologic, psychologic or emotional, to the demands of life.

Burnout. The response of an individual to stressors in the job situation. This response is marked by physiologic and psychologic exhaustion, decreased satisfaction with work, depression with regards to work, usually accompanied by increased mistakes and absenteeism, and a narrowed view of choices and options (McElroy, 1982).

Cope/coping. The process by which an individual seeks to respond or react to stressors in his or her environment.

Social support. Interactions at the work place which evoke positive feelings, a sense of security, mutual respect, and collegiality.

Limitations of the Study

There are several limitations of this study which require identification. The first limitation is to recognize that this program development is designed for the particular setting of the Thompson Cancer Survival Center, a comprehensive outpatient treatment center. Due to this

specificity, the results and recommendations coming forth in this work may not be readily generalized to other centers. While there are some discoveries from the literature which may benefit other cancer centers as they seek to address the issue of stress in oncology, some modification may be required to translate the training program offered herein to other settings.

A second limitation of the current work is that it is not a tested model. This program is derived from an extensive review of the literature, and developed in response to the results reported there. It is not the result of an experimental design which has been controlled for and statistically analyzed; nor, is it the result of studies done upon human subjects.

Yet a third limitation of this study is related to the former; having not been tested, the recommendations offered here are in need of testing and evaluation. However, it is not within the scope of this study to test and evaluate this model; that work must be left for another study.

In spite of these limitations, this study does fill a need. It brings together the results and recommendation within recent literature regarding stress and coping in oncology, both for nurses, patients, and patients' families. It then develops a program, putting these recommendations into a framework which will enable

incorporation by the nursing staff at the Thompson Cancer Survival Center.

CHAPTER II

REVIEW OF LITERATURE

Stressors for Oncology Nurses

The task of reviewing literature on the topic of stress can be overwhelming. Since late in the fourth decade of this century, stress has been an object of study and examination. Beginning with the seminal work of Hans Selye (Selye, 1976), who first studied the physiologic effects of stress upon the human organism, stress and its concomitant issues (i.e. coping, burnout, stress reaction) have been extensively investigated.

While there has been greater clarity and definition added to the field, some disagreements still remain. For example, one author has identified in the literature over 300 definitions of stress (Dobson, 1982)!

For this work, the definition of stress will be that stress is related to but not equal with pressure. Stress is the person's response or reaction, either controlled or unconscious, to the demands of life, which for the purposes of this study will be limited to the demands resulting from acting in the role of oncology nurse. These responses or reactions can be physiologic, psychologic or emotional, and can either be effective or ineffective in reducing stress. These responses are called a person's coping mechanisms.

That stress is a factor influencing oncology nursing is well documented (Motowildo, S.J., Packard, J.S., Manning, M.R.,1986; Hockey, J. 1987; Pyne, R. 1987; Holland,S. 1987; Adey, C. 1987; Bargagliotti, L.A., Trygstad, L. N. 1987; Wadsworth, N.S., Clark, N.L., Hollefreund, B., 1986; Douglas, S. 1986; Ford, R. 1983; Kirschling, J. M., Pierce, P.K., 1982; Larson, D.G. 1987). In one study, 70% of oncology nurses questioned reported feeling a need for help with stress related problems, and 92% felt that there was a need for a counseling or social support system (Adey, 1987). In this same study, 93% of the oncology nurses responding to the investigation reported suffering symptoms of stress, at least infrequently. In yet another study, Steward, Meyerowity and Jackson (1982) reported attempts to study long term stressors in an outpatient oncology unit, but found no nurse who had been in the field longer than two years. What is more, nurses contacted expressed ambivalence about staying in oncology, due to the demands of the job and its particularly stressful nature. When reviewing the nursing press literature, Douglas (1986) observed that publications recognized oncologic nursing as subject to higher levels of stress. The reasons given by nurses interviewed were the added stress of communicating and caring for the dying cancer patient.

Stress in the field of oncology nursing is a reality,

then, at least as recognized through the literature. But where does this stress originate? There are at least two main areas from which stress originates in oncology nursing, each conceived of in different ways by different researchers. Within each area, there are several factors which also affect the issue of stress.

The two areas of origination for stress are the physical or environmental, and the psychological. It is important to determine between these two origins of stress, for responses to each will be different (Linder-Pelz, 1986). There are some stressors within the physiological or environmental arena which cannot be changed by the oncology unit nurse, and therefore must be adapted to.

Physical or Environmental Factors

It is important to identify, as have Veatch, Marshall, and Sivesind (1985), that the pressures of a work situation or working conditions are not automatically synonymous with stress. In fact, these authors reported research which showed that work gives most people a sense of satisfaction, usefulness, structure and personal identity. However, while this lends support to the concept that work is not automatically stressful, this factor must be balanced with the identification that physical aspects of the job of oncology nursing are important stressors. Those physical

aspects include understaffing (Adey, 1987), volume of work that is asked of the cancer staff nurse in light of this understaffing (Hockey, 1987) as well as the actual physical demands of the job, coupled with the seemingly growing gap between the needs of patients and human and physical resources available to respond to those needs (Pyne, 1987).

These factors within the physical environment of oncology nursing have been shown to be significant stressors. If these were the only factors which bore upon the oncology nurse, there is some belief that the stress resultant from the work place would be of negligible effect. However, these factors are not the sole stressors, but are compounded by the psychological factors which also bear upon the cancer nurse.

Psychological Factors

Pyne (1987), in her research, showed that not only is much asked of the nurse in the work setting, but the demands often place the nurse in a position of tremendous internal tension. This is due to the fact that most nurses enter the profession to help people, but because of the limitations on their time while at work, they feel unable to deliver to the patient the good care which they entered the profession to provide. Hockey (1987) showed that resulting from this internal conflict over having to choose

less than their values for professionalism, oncology nurses responded with feelings of guilt and distaste for the profession, which developed into frustration and finally into anger. Nurses perceived their work as a race against time, and their job demands as frustrating their desire to provide for patients warmth, love and nurturance. In a related study, Yasko (1985) showed that incompatible goal expectations with job demands were a big stressor for oncology nurse specialists.

There are other psychological factors which affect the oncology nurse's ability to respond to the stress of the job. Motowildo, Packard and Manning (1986) found that individual characteristics had an impact upon a nurse's response to stress. The characteristics of age, Type A personality or behavior, self-esteem or the fear of negative evaluation all affected the perception of stress and its management on the unit. Motowildo, et al. (1986) report that the greater the job experience of a nurse, the less likely it is stress will be experienced; the stronger the Type A behavioral style of the nurse, the more the nurse is likely to feel stress; and the stronger the nurse's fear of evaluation, the more intensely stress is likely to be felt. The results of their study showed that job related stress lowers job performance, that stressful events occur more frequently to nurses with strong Type A

behavior styles, due in part to the fact that Type A nurses feel more stress regardless of how strongly or frequently they experience the 45 stressful events used in this study. This increased level of felt stress results in affective states of anxiety, hostility, and depression.

Certain job performance behaviors were also examined in this study, and were shown to be affected by the perceived stress of the oncology nurse. Those behaviors were the ability or inability to tolerate frustration, clerical accuracy, interpersonal sensitivity, and altruism.

In a related study, Larson (1987) identified causes of psychological stress in oncology, naming a tendency towards self blame, unrealistic self-expectations, discrepancies between real and ideal image of the self as helper, and a fallacy of uniqueness as reasons behind oncology nurses' feelings of stress and burnout. The resultant cognitive behaviors of nurses included unspoken thoughts of anger, withdrawing and distancing from patients, and consideration of leaving the field of nursing.

This is consistent with the findings of Pierce and Kirschling (1982) and Ford (1983) who show that while emotional commitment to good terminal care is essential, it is also potentially exhausting, making the vocation both rewarding and stressful.

Two other sources of stress are identified within the

literature. Wadsworth, Clark and Hollefreund (1986), reported on the work of Adams who categorized psychological stressors in two groupings, one being chronic stress and the other episodic stress. Chronic stress results from day-to-day life issues and pressures, and is related to long term habits, group norms and work norms. Episodic stress, on the other hand, results from change, novelty, diversity, and is usually acute. It is intensified by surprise and change. It is this type of stress that Adams found as proportionally higher than chronic stress among oncology nurses, mostly due to the pervasive nature of change within the work setting of nursing, and within the nursing organization (Wadsworth, Clark, and Hollefreund, 1986).

Bargagliotti and Trygstad (1987) conceptualized stressors in the field of oncology nursing differently. For these researchers, stress was seen as having two major sources, a qualitative source resulting from relationships with unit staff and a quantitative source deriving from issues with management. Rather than categorize stress into physiological and psychological sources, the above categories were used. The former identified interactional processes associated with an event, what is here being categorized as a psychological stressor, the latter identified the event itself, herein categorized as a

physiological source of stress.

To summarize, the stressors upon oncology nurses are many, but may be classified under two main or broad categories, physiological sources of stress and psychological sources of stress. Within the broad category of physiological sources of stress are factors such as the physical demands of the job, the multiple, specific task demands of the job description, the limitations of human resources, and the shortage of staffing. Within the broad category of psychological sources of stress are factors such as oncology nurses' contrasting images of ideal and realistic fulfillment of the job demands, staff relations, personality type of the nurse, ability to tolerate frustration, unrealistic role expectations, a sense of being overwhelmed or out of control. To manage these stressors poorly is to affect both job satisfaction, absenteeism, turnover rates, and the quality of care given (Veach, Marshall, & Sivesind, 1987). It is therefore vital to assist nurses to learn effective coping mechanisms, and to identify what is shown to be helpful in responding to the stress of oncology nursing.

Burnout--Consequences of Stress

Before looking at the coping strategies identified in literature, it is beneficial to examine the negative

consequence of the stressors elucidated above. This response is generally referred to as burnout. Burnout has been defined in several different ways by different researchers (Cherniss, 1980; Freudenberger, 1974; Friel & Tehan, 1982: Douglas, 1986) but generally accepted as a natural extension of stress, and a progressive condition of physical and emotional deterioration which is characterized by a loss of idealism, energy, and purpose (Holland, 1987). Resulting from this deterioration are negative self-concepts, job attitudes and loss of care, compassion and concern for the patient. Yasko (1983) has stated that the degree of burnout is greater for nurses who perceive the level of stress to be higher, and this identification, coupled with Douglas' finding (1986) that the average period before burnout or leaving for an oncology nurse was one and one half to three years, shows the seriousness of the issue for the oncology nursing professional.

There are several factors to consider when looking at the issue of burnout. Firth, McKeown, McIntee, and Britton (1987) show that one's personality has an important influence on the response developed to burnout. Yasko (1983) has also correlated high burnout among oncology nurses with low staffing on oncology units. It is one author's opinion that stress arising from the nurse's personal life also impacts her or his professional

functioning, and that this is especially true for women, who are also the majority of the time the main caretakers at home (Holland, 1987). Coping mechanisms for managing burnout have been explored, and will be discussed in the following section.

There is in the literature a recognized pattern to burnout. The pattern is often described in three stages. The first stage is characterized by loss of idealism, mounting irritation, fatigue, and feelings of restraint being insuperable. The second stage is characterized by irritation increasing into anger and resentment with a resultant decline in self esteem and increased guilt for the resentment towards the job. The final stage is characterized by extreme personal distress accompanied by physical symptoms, reluctance to go to work, feelings of failure, and depression (Holland, 1987). Lammert (1981) reported a more simplified development of burnout which was reported by Christina Muslach and discussed by Schubin. Burnout was marked by fatigue in three areas; physical fatigue, psychological fatigue, and spiritual fatigue. At the third stage, spiritual fatigue, the individual begins to think of escape.

The short preceding review of burnout is to identify the seriousness of this issue as a consequence of stress within the field of oncology nursing. That burnout is a

real consequence is not, however, the significant issue. For this study, the significant issue is identifying effective responses to stress. Clarifying the patterns of burnout help to establish negative responses to stress, and to show the consequences of poor adaptation. One researcher (Douglas, 1986) has shown that consequences of badly adjusted nurses, i.e. nurses experiencing burnout, are promotion of poor patient care, and lower morale with an increase in depression among their coworkers and patients. As Stevie Holland (1987) reports, the task is not only to recognize burnout as an issue to be dealt with for oncology nursing, but also to emphasize the element of personal challenge to enhance self awareness, to learn, to adapt and change as appropriate in order to negate and/or prevent the consequence of burnout. This review now turns to look at the methods identified and being developed for oncology nurses to manage stress in their profession.

Coping Mechanisms

A great deal of research and study has been done on stress management (see Holland's review of the history, footnotes 5,6,7; 1987), the response mechanisms with which an individual seeks to cope with the stress they feel. Within the literature, there are two types of coping which have been identified -- direct coping and indirect or

palliative coping (Lazarus, 1975). Within these two types of coping there are different strategies, which will be explored below.

Direct coping is defined as specific actions which confront or reduce the sense of threat felt. Indirect coping, or palliative coping, is defined as reducing the feelings of discomfort rather than altering the source of discomfort. The distinction between the two is that in the former, the actions seek to affect the source of the threat, whereas in the latter the actions of the individual do not seek to affect the stressor itself but rather to alter the way it is perceived for a time. For far too long, it was assumed that an individual should adopt and practice a single coping strategy. However, recent study has shown that such is no longer the best option. In fact, one author's recommendation is for the individual to adopt and develop both indirect and direct coping mechanisms, to gain insight upon their traditional coping mechanisms, and to adopt and develop a wider range of coping strategies (Holland, 1987)

There are factors within the structure of a hospital which affect the success of direct coping and have major influence on nurse satisfaction and thus, patient care. These factors are the scheduling, orientation, and continuing education provided for nurses (Ford, 1983).

When hospital administration's plan and implement adequately for these needs, stress is reduced in oncology nurses.

There are also three variables which are important predictors of direct coping (Parkes, 1986); the type of person the individual is, the environment in which the stress occurs, and the specific nature of the stressful event.

Direct coping is seeking to change or affect the source of the stress, be it the staffing shortages and schedule on a unit or the need for continuing education on the changing procedures of administering medications and treatment. Indirect coping is the altering of one's perception of the stress for a time, for example allowing oneself a pleasurable treat or a mental or physical distraction. While it has been shown that reliance on only one form of coping can actually lead to an increase in stress, the indirect method of coping is potentially harmful. Holland (1987), reporting on the work of Lazarus, shows that indirect coping all too often takes the shape of mental defense mechanisms, used unconsciously and which may not lead to effective coping. Such mental defense mechanisms include the strategies of denial, escape, displacement, and intellectualism. This is not to negate the potential benefits of indirect coping but rather to identify that

such benefits prove more effective when done consciously, cognitively, and by choice.

Whether direct or indirect, there are some factors which bear upon the strategies nurses use to manage the stress of their work environment. Parker (1986) identified research that showed coping is often influenced by the resources available in the environment, by the nature of the stressful event, and by the individual skills, abilities and capacities of each person.
Parker went on to describe three types of factors which are relevant in relation to coping: situational factors, environmental factors, and intraindividual factors. To cope effectively, Parker suggests that one must be able to develop responses in regards to all three factors.

An individual's collection or group of coping mechanisms is identified by Rosenbaum (1983) as "learned resourcefulness." It is this group of responses to the stressors of oncology nursing work which are of utmost importance to this study. As has been shown earlier, it is more effective to develop a variety of coping mechanisms, both direct and indirect, with strategies within each type, and strategies which are able to respond to both situational, environmental and intraindividual factors. In their study, Gribbons and Marshall (1982) identified that using different and multiple strategies was often a

function of experience, and their study also confirmed the findings of Holland that multiple response strategies were more effective. Chiriboga (1983), in studying coping within the nursing profession, was able to list nine different strategies employed by nurses.
These strategies differed in name but were similar in kind to the six strategies identified by Dewe (1987) which were (1) problem oriented behavior, (2) trying to unwind and put things into perspective, (3) expressing feelings and frustrations, (4) keeping the problem to one's self, (5) accepting the job as it is, and (6) trying not to let it get to you.

Following are five strategies which have been investigated and reported in the literature. These strategies are the basis for this work, and provide the support for one major component of the training program to be developed. It is believed that through their development and use, the stress of oncology nursing can be more effectively managed. It will not be relieved altogether, nor should it be. But with these strategies in place, the chance for disaster, or burnout, are minimized (Barber, citing the work of Miller [1975], 1985). Effective stress management thus becomes not the removing of stress from the work place, but balancing the various aspects of work to allow for enough but not too much stress

(McQuade, 1986).

Social Support

While not specifically a coping mechanism which an individual can cause to be developed, the strategy of social support has been shown to help ameliorate the effects of stress in oncology nursing (Jennings, 1987). Its identification as a coping strategy here is to reflect the findings of the literature, even though social support by its very definition requires the participation of others from whom the individual seeks support. It is also an aspect of organization that a hospital will do well to consider, for as will be shown shortly, there is good evidence that social support helps to minimize the effects of stress.

The need for social support in the field of oncology nursing is well documented (Jennings, 1987; Pyne, 1987; Adey, 1987; Lammert, 1981; Veatch, Marshall, Sivesind, 1987; Dewe, 1987). This need is identified in different fashions within the literature, from Pyne's (1987) elucidation that nurses without social support feel that they are working in isolation, which then in turn causes stress, to Dewe's (1987) recommendation that hospital administrations develop and promote support structures which allow nurses to deal with the emotional aspects of

nursing. Barber (1985) has reported that the need for this social support can be seen in the subject matter with which oncology nurses have to deal--pain, death, difficult relationships with patients and their families, and grief. These subject matters provoke anxiety in the health professionals, anxieties for which they are ill prepared or equipped to handle, and against which individual and institutional defenses have been developed.

In response to this assessed need, Veatch, Marshall and Sivesind (1987) have recommended that oncology nursing staff be enabled to develop open supportive relationships with the work group, or as Lammert (1981) described it, relationships which are interdependent, and marked by collaborative work as well as the practices of valid sharing and trust.

To leave this process solely to the oncology nurses is not doing enough, for it is these very nurses who are either unpracticed or unable to establish for themselves the kind of social support which would negate stress. Adey (1987) reports research which shows a need for a recognized system of support which is local, part of the hospital setting and managed by the hospital structure.

Prior to a review of the support for establishment of a social support systems as an effective coping strategy, it will be beneficial to more clearly define this concept.

Jennings (1987) work on social support is informative here, where it is described as reciprocal interpersonal exchanges which are marked by or enhance the experience of positive feelings, security and mutual respect. In more common terms, social support is human contact within the working environment which evokes, elicits and carries the expression of caring.

Jennings goes on to identify three types of support through which this human contact and caring is communicated: affective support, which is the experience or feeling of being liked or loved; affirmative support, which is the experience of feeling or receiving a positive endorsement of one's behaviors, views, perceptions or insights; and support through aid, which is the receipt of either material, physical or symbolic assistance.

In yet further clarification of the concept of social support, Jennings offers the following as examples of the cognitive and actual behaviors which are seen to be supportive in social relationships at work: one's demonstrations of concern, understanding and trust; problem solving skills which one is willing to use in cooperation with another; relevant knowledge and competent skills; active, nonjudgmental listening and attentiveness and tolerance; constructive feedback; a relational style marked by emotional warmth, assertiveness, flexibility,

perceptiveness and patience; and self confidence.

In support of developing social support structures to counteract the stress of oncology nursing, Hockey (1987) reported finding that a major feature which helped with the stress oncology nurses expressed was respect for their fellow colleagues. This respect is heightened through social support structures. Similarly, Linder-Pelz (1986) identifies that social support is one positive strategy for coping with stress. Lammert (1981) reported Luft and Ingram's finding that openness in individual and group interpersonal styles was positively associated with productivity in relationships, and in task accomplishments. This openness was marked by two aspects or dimensions, the willingness to self disclose one's own thoughts, feelings and beliefs, and the willingness to solicit and accept feedback from others. In a related work, Pines and Malach (1978) reported that when group work on a unit was good, the staff reported many "good" days and few "bad" days, and that staff reported feeling more positive towards patients than those who reported poor working relationships.

Finally, Billings and Moos (1981) and Mitchell, et al. (1983) show that the nature of the work environment can be either a resource or a constraint in coping strategies, particularly in the coping strategy of social support. If the work environment supports this strategy, then coping by

withdrawal is less likely to occur, and more effective stress management strategies are employed (Newton and Keenan, 1985). Jennings (1987) states even more strongly that support in the work place appears to be the important deterrent to work engendered stress, and that this should be an especially viable option for the nursing profession, a field where social support can be optimized because of the predominance of females and the more readily acceptable attitudes towards the behaviors which underlie social support.

With the value of social support clarified, a brief look at its components can be attempted. In the work by Firth, McKeown, McIntee, & Britton (1987), some of the aspects or components of support were purported to be the prompt passing on of information to staff from nursing managers, giving time to staff, encouraging discussion before giving one's own views, consulting staff before taking action, being encouraging even in difficult situations, and thanking people. Such acts can be seen as efforts by nursing managers to relate to staff using those behaviors identified above as contributing to social support.

Besides these particular behaviors, there are several components to establishment of social support. Adey (1987) shows a need for regularly scheduled and organized staff

meetings, to help nurses feel a part of a team. Pines and Malach (1978) suggest using staff meetings to both share emotional, or social, support and to confer more openly about self perceptions and those of patient and family.

As a companion component to the establishment and more effective use of staff meetings to promote social support, Holland (1987) recommends that nurses be encouraged to explore and express their feelings more, and to do this at work. It is the researcher's suggestion that there is a need for staff meetings to structurally and organizationally assist nurses to unlearn repression techniques, and to encourage the expression of feelings and ideas. All too often, Bond (1986) reports, the emotions of the oncology professional are looked upon as negative. The feelings of distress, sadness, fear and others have been considered "bad," and repression rather than expression of these feelings has been encouraged. Alteration of this perception, to identify, validate and express emotions, is one component of social support.

Veatch, Marshall, and Sivesind (1987), citing numerous documentation, also recommend the components of structured staff meetings and the open expression of thought and feelings to establish social support. They go on to recommend the development of joint problem solving techniques, and educational opportunities to learn these

skills as well as use of these techniques in the weekly staff meetings.

Finally, Oskins (1979), in investigating strategies which nurses used most often for coping, identified that one of the strongest strategies was "I talk it over with someone." This would support the effectiveness of social support as an already existing coping mechanism, and the development of an organized structure would thus strengthen a present resource.

Participatory Management

A complimentary coping strategy to the social support strategy identified above is the organizational adjustment with regards to management of oncology nurses. As was noted above, the process of coping is technically an intrapersonal process; that is, coping is a set of behaviors or responses to stressors which are essentially chosen by the individual. A hospital cannot make a nurse cope with the stress of the environment. However, a hospital can institute some mechanisms which have been shown to increase the capacity or strengthen the nurses likelihood to cope more effectively. Establishing social support structures systemically is one such response: nurses may be able to establish these social support structures on their own, but they hold more power and

effectiveness when organizationally sanctioned and developed.

Similar to social support, and essentially connected to it, is the establishment of participatory management. Turney and Cohen (1980) reported research that showed positive effects on the well being of staff through use of participatory management. Parkes (1986), reporting on the work of Menzie, showed that the social structure of the oncology unit encouraged the use of defense mechanisms such as detachment, projection and denial, and restricted the use of latently valuable coping behaviors by oncology nurses, including the use of authority and discretion. Wadsworth, Clark and Hollefreund (1986) also encourage the use of holistic, or participatory, management principles, for they report these help to minimize certain specific stressors and buffer the cumulative effects of stress on the oncology unit. By providing for stress management through this specific strategy on an organizational level, the organizational goals are balanced with the assessed needs of its members, especially as related to stress. Such a position then promotes proactive, constructive management, with managers and administrators taught to see stress and coping in a broader perspective than just an individual issue with individualistic solutions.

This concept, that coping is not determined solely by

intraindividual processes and perceptions of particular incidents, is supported by the work and reports of Parkes (1986) and Holland (1987). Both researchers report that it is not just individual but organizational structures as well that protect against stress, and that effective coping is determined by external factors, especially the nature of the environment in which it occurs. Thus, the need for participatory management which acts as a organizational strategy and support in the coping process, is clearly shown. One researcher goes so far as to report that nursing administrations hold the key to patient wellness through the ability to enhance more effective coping by oncology nurses (Johnson and Roberts, 1987).

There are several aspects of this coping strategy of participatory management. One aspect identified by Jennings (1987) is supervisory leadership that is considerate, which is concerned with the needs of the nurses, and especially as these needs are shown for social support within the work environment. Jennings cites research showing that such considerate styles of leadership reduce stress and burnout among oncology professionals, and protect against stress.

Several other aspects of participatory management were identified by Firth, et al. (1987). One was a need for supervisory leaders to assist in role clarity for oncology

professionals. Such role clarity, achieved through face to face contact and discussions between staff and supervisors, helped reduce stress.

Another aspect of participatory management was the absence of defensiveness on the part of leadership. This meant giving direct, not evasive answers to questions, being straightforward in dealing with staff, openness with regards to the supervisor's own doubts, mistakes and faults, and avoiding defensiveness when criticized.

Yet a third aspect of participatory management identified by Firth and colleagues was the need for supervisory leadership to develop good listening skills and empathy. Such skills would include avoiding interrupting, granting time to lead up to important points in a discussion, acknowledging the feelings behind the words used, and avoiding making jokes out of something important, even if it holds less importance for the supervisor. These researchers supported the need for participatory management by showing strong positive correlations between the amount of personal respect charge nurses felt from their supervisors and the empathy and attention ward nurses felt from their charge nurses. The reverse of this was also shown to have a high correlation.

Several researchers (Larson, 1987; Adey, 1987; Barber, 1985) recommend participatory management should include

more effective use of staff meetings. Larson (1987) calls for staff meetings to be reorganized for the inclusion of staff support issues, while Barber (1985) recommends staff meetings twice monthly to deal with care of the patient as reported by the unit staff, and to use the opportunity for joint problem solving and focusing on the relationships of patient/staff and staff/staff in providing care.

Whether in staff meetings or at another specified time, such as structured times for social support, a need was shown for group building (Adey, 1987; Lammert, 1981; Veatch, Marshall, and Sivesind, 1987; Douglas, 1986; Wadsworth, Clark, & Hollefreund, 1986). Adey (1987) calls for those in leadership positions to help nurses feel part of a team, whereas the results of Wadsworth, Clark and Hollefreund's (1986) work affirmed the value of an organizational structure that emphasizes staff development as well as individual development. Douglas (1986) recommends a change in attitude on the part of management and supervisors to support and encourages development of the interpersonal skills which have been identified above in the social support section. From the earlier citation of his work, Dewe (1987) recommends that responsibility for such a change lies with hospital administration.

There is another aspect of participatory management which Veatch, Marshall and Sivesind (1987) recommend.

Having identified the need for social support within the work environment, these researchers go on to call for supervisors and nursing leaders to adopt a stance of construing reality for others, a term developed through the work of McLaulin and Pattison. Such a practice would mean that nursing leaders help to construct and convey an overall sense of goals and purposes of the hospital organization, without minimizing those of the oncology nurses, and also help to give clarification to the meaning of events, especially in times of role conflicts and role ambiguity. Such a practice, construing reality for staff nurses, would entail the activities of identifying misconceptions, clarifying values of the unit and the nurse, assisting in the setting of priorities, and offering guidance in achieving desired outcomes.

Finally, within the coping strategy identified here as participatory management, one paper identifies that there is within the hospital organization a need for improved communication, and recommends the institution of a Staff Nurse Practice Committee which would have direct access to organizational planning and decision making (Wadsworth, Clark and Holefreund, 1986). Conjointly with this is the recommendation for a nursing vice president, and quarterly meetings with staff. This person's role would be partially to promote prompt and constructive conflict resolution and

to train nursing supervisors to be more effective in the kinds of behaviors and relational skills which have been identified above.

In a related article, Welch-McCaffrey (1986) identifies such a role within the field of oncology as that of the Oncology Clinical Nurse Specialist (OCNS). It is this person's responsibility to assist oncology nursing staff to manage, perform, adjust and cope. The person filling this position is to be an expert in and resource for (a) management, to assist with effective responses to symptom distress of cancer, (b) patient and patient family education, (c) psychosocial support, and (d) resource facilitation. The OCNS role then is educator, researcher and consultant, and the person is to be a skilled leader, role model and change agent. The most effective way to minimize conflict, this researcher reports, is through repeated personal interaction, modeling the behavioral and relational skills necessary for an environment of social support to exist i.e. participatory management, to demonstrate knowledge and skills, and to exhibit confidence and competence in clinical matters.

Educational Programs

The two strategies for aiding or enabling effective coping which have already been identified and clarified,

social support for oncology nurses and participatory management within the hospital, are both filled with behavioral and relational specifics detailing their enactment. For example, in the preceding literature review there have been several recommendations for use of problem solving techniques, and also for greater identification and disclosure of affect. For both nursing staff, administrators, and supervisors to develop these behavioral and relational skills, educational process will need to be established. One researcher has identified that the establishment and effective use of such a program has a major positive influence on both patient care and on oncology nurse satisfaction (Ford, 1983). The program recommended by Ford would entail both an orientation program for newly hired oncology staff, coupled with an ongoing inservice program. The entire program would be run by a Continuing Education Coordinator (CEC), who would begin establishing the educational program from the very first interview, emphasizing stress and effective management.

Ford's recommendations are that the initial orientation would last six-to-eight weeks, depending upon the needs of those in the class, and in the first week would cover all non-patient material such as tours, classroom work, labs, policy manual reviews. In this first week, no patient care

would be included.

The second week of the orientation program would include direct basic care of patients, working with the supervisors and emphasizing skill development and setting up daily routines. The last three weeks of the program would integrate the newly employed nurse into the full functioning of the unit. At the end of the six weeks, the nurse would evaluate the orientation program.

To continue this initial educational work, a regularly established inservice program would be maintained, complete with inservice records being kept on all nurses, presentations during those inservices by the oncology staff themselves dealing with their own specialties or conferences they attend, and full evaluations of each one.

In a report of another orientation program, of which one of its components was designed to help oncology nurses deal effectively with stress, specifics which were developed were teaching nurses how to lower their feeling levels in order to improve higher cognitive functioning; how to recognize physiologic signs of stress , i.e. headaches, muscle tension, changing sleep patterns; how to do structured relaxation techniques -- progressive muscle relaxation, autogenics, guided imagery; and the skill of problem solving (Lara and Buyuk, 1987).

These authors reported that gaining the skills of stress

reduction and problem solving techniques gave nurses an effective way to increase their own security, and to reinforce their ability to control themselves and the way they relate to the environment.

In their work related to organizational stress, Wadsworth, Clark and Hollefreund (1986) recommended education for nursing leadership on the nature and impact of stress and how to minimize it. They also recommended role and performance expectations be clarified, with stress mediation activities identified as explicit performance expectations.

Through the educational program reported by Barber (1985), where the focus of the group was on relationships between nurses and patients, patients' families, or colleagues and where the group members were themselves the presenters, there was a noted increase in containing anxiety, a concept identified and developed by Gustafson and others. It was suggested that in this manner, nurses identified and clarified some of those relational skills the use of which have been called for as coping strategies.

Other specific components of an educational program for oncology which are suggested in the literature include an assessment program during orientation which identifies behavioral dispositions and reactions to stress, and then provides training to strengthen and broaden the

individual's learned coping repertoire (Motowidlo, Packard, & Manning, 1986), the teaching of listening skills (Firth, et.al, 1987), training on how to better communicate with dying patients (Adey, 1987), teaching realistic goal setting, identification of one's own needs and limitations (Malach and Pines, 1978), interpersonal skills training (Douglas, 1986), teaching the cognitive behaviors needed for analyzing situations and for problem solving (Dewe, 1987), and assertiveness skills training(McQuade, 1986).

Role Definition

There is a fourth strategy recognized in the literature which has been identified as impacting effective coping. This is the strategy of assisting oncology nurses to better define their professional role and what it means to be successful as an oncology nurse (Firth, McKeown, McIntee, & Britton, 1987; Welch-McCaffrey, 1986; Douglas, 1986). As has been noted above in the section on sources of stress, unrealistic role and goal expectations have been identified as a significant stressor for oncology nursing, leading to a recommendation for more complimentary role delineation.

One work which dealt specifically with the role of the oncology nurse identified that significant stress felt by the nurse was due to the heavy exposure to pain and suffering of the patient while the nurse felt little or no

sense of control of the situation (Donovan, 1981). The recommendation which followed this discovery was greater freedom for nurses to prescribe flexible doses of analgesic, e.g. morphine, giving nurses both a greater degree of autonomy and some sense of control.

In related findings, it is reported that more clarity and realistic goals are needed for the role for nursing, for nurses tend to set for themselves goals that are idealistic, and when they fail to live up to these idealized goals, disillusionment and disappointment follow (Friel and Tehan, 1980).

Douglas (1986) reported an aspect of this whole issue as endogenous fear (fear or stress which originates from within the individual), which begins with pressure the nurse places on him- or herself, is closely linked with idealism, and which is fed by the fact that most measurements for success in oncology nursing are task oriented measurements. A final aspect of this endogenous fear is that there is a felt pressure for increased involvement with patients, which while fulfilling the need identified as an effective coping strategy, is yet also identified as a current stressful aspect of the role of nursing. Such a dilemma will be addressed in the following sections of this work, where the program is developed.

Douglas (1986) recommends that in response to these

discoveries, a new role definition is needed, one which is more patient oriented rather than task oriented, which includes as a primary function of the work the nurses relationship with the patient and family unit (Friel and Tehan, 1980), and based upon a philosophy of life that is compatible with the realities of mortality and death in life. Support for such a role definition, or more accurately, role redefinition, come from work by Steward, Meyerowitz, and Jackson (1982), who show that greater involvement with patient's leads to better identification and more effective care, from Newlin and Wellish (1978) who identified that success for nurses passing through a period of adaptation depends on the quality of the relationship and the care provided that patient, and not on the survival of the patient. Other support for a more patient oriented role definition for nurses is offered in Yasko's (1983) report that increased communication and more open relational sharing did not correlate with increased burnout among nurses, but rather that nurses learned how to identify, cope and resolve their issues, and from Rowden (1984) who showed that professional detachment was more stressful than open communication. This is not to say that professional detachment and palliative responses to stress arising from the relation of nurse to patient or family are never to be used, or are to be written out of the role

definition completely, for as Dewe (1985) showed, passive solutions or palliatives are a legitimate part of the process of effective coping, for there are times when the stressor cannot be changed, and the professional must simply take a break from it.

One reason for the redefining of roles for oncology nurses to include more patient oriented measures is that several researchers have suggested that patients are actually a source for nurses in developing coping strategies (Adams, 1984; Drummond and Hagenstad, 1987; Ford, 1983; Pyne, 1987;). It is noted by these reporters that relationships with patients and their families are a source of stress for nurses, but they are also reported as sources of confidence building, strength and support.

Other recommendations with regards to role definitions are more precisely written guidance structures, including job descriptions made accurate for the staff achievements strived for, a clear statement of mission or philosophy throughout the entire organization, identification of minimum achievements to be expected and what represents particularly major or successful achievements, and two-way clarification of roles, with responsibility and authority more clear and supported by more positive feedback (Firth, et al., 1987); movement from the sole or exclusive measurements of success based on absence of accidents and

errors, absenteeism and sickness to more positive measures (Holland, 1987); and identification of nurse's needs which are being met through fulfillment of the job responsibilities (Malach and Pines, 1978).

Through such role definitions, the oncology nurse gains a greater sense of clarity and purpose, a stronger sense of control and more accurate perspective on what is within the nurses control and what is not. Also, the oncology nurse is structured by role definition towards more effective coping mechanisms, through more patient oriented, relational behaviors being described as specific job functions.

Doctor/Nurse Relationship

A final focus for this section reports research conducted on the relationship between physician and nurse, how this may be a source of stress for nurses, and recommendations for effective coping.

The professional relationship and interactions between doctor and nurse have often been cited in the research as marked by tension or conflict (Baggs & Schmitt, 1988; Fagin, 1987; Katzmann & Roberts, 1988). In a review of the research, Katzmann and Roberts (1988) identified four themes which impact this relationship in a way that may cause conflict. These themes are the subordinate role

nurses accept, subordinating their professional judgment about patient care to that of the doctor; role definition, in which nurses acted in stereotypical behaviors of passivity and acquiescence to physicians when implementing their job functions; nurses deference and demeanor to physicians; and a lack of interaction between nurses and physicians. The research surveyed consistently identified nurses reporting expressed feelings of inferiority with regards to physicians, passivity in behavior, with nurses largely unaware of their behavior.

In a similar study, Friedman (1982) reported nine problems nurses encounter when dealing with physicians. These problems are: condescending attitudes from physicians towards nurses, nurses' lack of respect as either a person or professional from physician, public humiliation or embarrassment through being confronted by a physician in front of others, temper tantrums of physicians, scapegoating or using nurses as targets for blame or responsibility by physicians, physicians' failure to read or consider nurses' suggestions, physicians' refusal to share information, physicians' lack of understanding or appreciation for the skills and functions of nursing, and disparaging remarks made publicly.

In studying the problem of nurse/physician relationship, Helen Cox (1987) surveyed nurses to clarify

the frequency of abuse and its effect on nurses. Cox (1987) reports that over 80% of nurses surveyed experienced verbal abuse from physicians, and over 70% of nursing directors had such experience. Further, Cox (1987) found that 18% of the turnover rate in those nurses surveyed was due to verbal abuse.

Following these findings, Cox (1987) recommended nurses be taught assertiveness skills, conflict resolution skills, and how to effectively deal with anger. Cox further recommended nurses receive education on their rights as employees, and that collegial support for assertiveness be instigated and promoted. While noting that some nurses did try assertiveness techniques, these quickly changed to avoidance practices when confronted by physicians because of the perception of little support, the view by nurses that such verbal abuse was part of the territory, and a sense by nurses the conflict was having a negative impact on patient care. With these restrictions noted, Cox (1987) made her recommendations.

However, Cox is not alone in calling for changes within nursing with regards to nurse/physician relationships. Katzmann and Roberts (1988) recommend nurses overcome what they describe as the image of handmaidens to physicians, and Damrosch, Sullivan and Haldeman (1987) recommend nurses use more direct, rational tactics in their dealings with

doctors.

In recent years, these recommendations have been implemented in what has come to be known as collaborative practice (Crowley & Wollner, 1987). According to these researchers, collaborative practice between nurses and physicians can improve professional communication, trust and respect. Such practice also facilitates a collegial atmosphere, resulting in better understanding of each role and responsibility by the other, a greater consideration of each other's time and efforts, a reduction in interprofessional tension, and ultimately better patient care and reduced cost to hospitals (Crowley & Wollner, 1987). The recommendations were echoed by Fagin (1987), who identifies collaborative work as a means to meet the mounting medical demands and pressures.

Key factors needed for initiation and facilitation of collaborative practice are: (1) A hospital environment receptive to change; (2) proper timing; (3) staff desire to improve the quality of patient care; and (4) inter-professional communication (Crowley & Wollner, 1987).

As collaborative practice is effectively established, Crowley and Wollner (1987) conclude that the patient will benefit. These patient benefits are the result of a more relaxed attitude on the unit and the perception of a more coordinated, efficient, cohesive system working for

her/him. Such an atmosphere enables the patient to better cope with his or her diagnosis, and increases the patient's confidence, augmenting the patient's satisfaction, retention and participation in treatment.

Linda Lindsey Davis (1986) also studied collaborative practice between nurses and physicians. Davis (1986) concurs with other researchers, reporting the need for development of collaborative practice, referring to collaborative models as mechanisms of organizational change which improve the quality of health care, both for patients and nurses. By learning and practicing the skills of bargaining, accommodation, and negotiation without personalizing, nurses are able to relieve some of the tension from the nurse/physician relationship, and reduce a source of their own stress (Davis, 1986). Resultant from this, patients receive better care.

From this review of coping strategies to assist oncology nurses in more effective stress management, the focus turns to review the literature as it relates to the assistance of coping strategies which may be offered by the oncology professional to patients and family units.

Coping Strategies for Patients and Patients' Families

In the previous section, the issue of stress and effective coping strategies for oncology nurses has been reviewed, presenting the different strategies reported in the literature as supporting or enabling effective coping. In this section, the focus shifts from the coping strategies helpful to the nurse to coping strategies which the oncology professional can offer and assist the patient and the patient's family in using to meet the crisis of cancer.

As was stated above, the initial work done on stress and cancer had as its focus and main concern helping the patient to deal effectively with his or her diagnosis and subsequent disease. For the nurse to be competent to assist a patient and his or her family to cope with cancer is a valuable dimension to health care, for, as Rindler (1984) reported, the patient who had better help, and received assistance to have more control, lived better and tolerated treatment better.

The need and value of such skills would seem obvious. In fact, in one report Clarke (1984) recommended that nurses should learn ways in which to enhance the patient's ability to cope. The task now is to identify what the sources of stressors are for patients and family units, and what has been shown to be effective in mitigating the stress of cancer.

Before the literature is reviewed, it is important to take note of a particular issue--the inclusion of family units as recipients of the oncology nurse's communication of stress management strategies. In the work of Kirschling and Pierce (1982), it was noted that many authors identified including the family in care of the cancer patient as a positive factor in both treatment and recovery. Borley (1985) went so far as to say that families needed to be seen as a legitimate focus of concern and treatment, for it is oftentimes easier to be the patient than the family. In related research, Hinds (1985) reports that families of cancer patients are a high risk group who are more vulnerable to deteriorating mental health functioning, but that they are also more likely to benefit from help. Hinds also showed that, when studying the families of cancer patients who were assisting in the treatment of family members with cancer, 31% of those families were coping poorly. For these reasons, the family is recognized in this work as a needed target to which oncology nurses can offer help in the area of stress management, for if the family is functioning at a more effective level, the patient's treatment is aided rather than frustrated.

It has been identified in research that the perception for many people is that cancer means death (Martocchio,

1985). This is not surprising, for Reed-Ash (1981) also identified that even for the nursing profession, the perception was that working with oncology patients was often equated with depression and death, and was unrewarding.

Such an identification, that cancer means death, leads to what Martocchio (1985) identifies as a psychologic crisis in the patient and family. Crisis theory, Martocchio reports, says that after diagnosis, reactions are fashioned by the patient and family within one-to-four weeks. Then, coping strategies develop, which include mastery, control or resolution. For this author, helping the patient and family develop effective coping strategies is essential to avoid a crisis state, where the patient and family are ineffective to participate in their own treatment.

This crisis state has three factors which bear upon it: the hazardous event which threatens the individual; the threat as it is interpreted through past experiences; and the strength of coping strategies which influence the outcome. For the family, there are two more factors which are involved--the experience in coping as a supportive team, and the ability to participate in the patient's care.

Sources of stress which Martocchio (1985) identified as arising out of this crisis state brought on by the

diagnosis of cancer include strains within relationships resulting in overprotectiveness by the family on the part of the patient or withdrawal from the patient; the multiple demands of both normal daily activities coupled with the demands of treatment and regimen of the oncology patient; changes in family goals and activities such as less flexibility with time, limited career options, restrictions on parent's time with children, et cetera.; the increased responsibilities by other family members due to the limitations placed upon the cancer patient; and the financial burdens and record keeping needs arising out of treatment.

Another source of stress identified by Hehemkis, Gerber, and Charter (1984) was that often both oncology physicians and nurses overemphasized certain losses, and overrated the importance of pain to patients. At the same time, oncology professionals underrated the importance of disrupted leisure activities and the loss of ability to do routine household chores and daily activities while overestimating the change in physical appearance for the patient. These authors reported that the experience of pain must pale in the face of more profound psychological and existential issues, such as the meaning of one's life, imminent loss, and anticipation of death. The result of this overestimation and undervaluing is that

the staff, through doing such, may turn the patient's psychological and emotional stress into more easily treated physical symptoms, leaving the patient's more strongly felt issues frustrated and unfulfilled. The patient's greatest concerns may be selectively avoided in order to avoid topics which are uncomfortable, causing the patient even more stress.

One of the difficulties which accompany these misconceptions on the part of oncology professionals is the highly individualized experience of suffering. In the work by Kahn and Steeves (1986), suffering is defined as an individual's experience of threat to self, and is a meaning or lack of meaning given to events such as loss or pain. For these authors, it is too simplistic to simply identify suffering by the level or degree of pain. In fact, pain may or may not involve suffering. Rather, it is the individual's evaluation of the significance of the meaning of that pain. Suffering has not been widely studied in the literature (Copp, 1974), but it is helpful to note that these authors report several experiences which are related to suffering: changes in body image; loss of function; the degree of integrity of a person's perceptual field; and changes in the patient's social roles or identity. Such a list is quite compatible, in fact, nearly synonymous, with sources of stress enumerated above. Also, it is valuable

to identify that what constitute threats to one' self--death or the extinguishment of self, loss of function, change in body image, imaginary events such as the continuance of pain and pain yet to come, loss or change of roles intrinsic and meaningful to the individual--are the types of experiences oncology patients and their families often must endure. Suffering, then, though not well defined nor broadly studied, can be seen as a stressor. The difficulty with suffering as a source of stress for patients and their families is that with its highly individualistic characteristics, it is not easily assessed by the oncology nurse. Each person's suffering must be understood within his or her own text and context. For this reason, the nurses' difficulty of interpreting the meaning of the patient's experience, and of the patient's suffering, may also be a source of stress to the patient and family.

In other work studying the sources of stress and needs of families, Hinds (1985) identified that the physical care for the patient and a need for a place where the family members could discuss their fears were stressors in the cancer experience. Hinds reported that less than one fourth of the families interviewed knew of the existing community services and resources available to them for help. She also reported that for even those families who

did know the resources, seldom did families seek out assistance for those social and emotional needs. Citing Bloch's work in 1984, Hinds reports several factors which affect the family as they seek to be a health care provider to the cancer patient. These factors include the ability to shift roles flexibly within the family, the ability to work through painful feelings, the ease and openness with which the family can communicate with health care professionals, the degree of comfort with which the family members can observe the physical functions of the patient, the ability to tolerate loss of function on the part of the patient, as well as being able to adequately mourn losses. Hinds thus concludes that a family's ability to adapt and cope with the stress of cancer to one of its members depends not solely upon its own resources with the family unit, but those resources with the larger social structure as well.

Finally, citing the work of Kubler-Ross, Lev (1985) reported that the stages of adaptation or the coping mechanisms used by both patients and family members have been identified. While it is true that a diagnosis of cancer is going to produce stressors for an individual and her or his family unit, it is also possible that this crisis resulting from cancer is also an opportunity for the promotion of emotional growth and strength (Lev, 1985).

Accepting Lev's report of Caplan's identification that the essential factor which shapes the effective coping with such a crisis is having and knowing about the resources needed and available to deal with it, the focus turns now from the sources of stress for cancer patients and their family units to coping strategies or resources oncology nurses can use in assisting them.

Coping Strategies

The need to assist both the cancer patient and her or his family in effectively coping seems obvious. Support for the obvious was shown by Taylor, Falke, Shoptaw and Lichtman (1986), where they reported that while the cancer patient's most important need from the family was social and emotional support, it was found that if this was the wrong kind of support or from the wrong person, such support would actually increase stress rather than help mitigate it. If such coping isn't assisted and enabled, then problems which have been identified as likely to occur are depression, anger or giving up (MacNeil-Zimberg, 1985). Support in assisting patients and families to cope is also identified as a legitimate function for oncology professionals to fulfill (Clarke, 1984), for it has been demonstrated that nursing personnel could predict patients who would have difficulty coping (Lev, 1985).

This is also especially important in an outpatient clinical setting, for as Wellisch (1984) reported, outpatient treatment usually is longer in duration, and emotional stress has been shown to be linked to longer term treatments. There is then, reports Wellisch, a need to program for longer term care of the psychological needs of the outpatient and her or his family unit. The recommendation of Martocchio (1985) for oncology nurses who are developing strategies to enhance family coping is that the goal be defined as promoting adaptive coping which will help relieve acute anxiety, hopelessness and confusion, restore hope and a sense of the future, enable creative problem solving and identification of alternatives by both the patient and the family, and which will lead to larger and more effective coping behaviors. Martocchio goes on to identify several specific strategies for the oncologic nurse, which will be elaborated below, and to recommend that in the development of hope for the patient and family the nurse help to establish hope firmly in reality, structure it to withstand uncertainty, assist the patient and family to use it as a guide for establishing priorities and through it to encourage commitment to something specific.

Finally, Martocchio (1985) recommends that oncology nurses alter perceptions concerning the assessment of

effective coping from a dichotomous either/or determination to one reflecting a continuum bounded by the concept "partner" on one end and "recipient" on the other. In this way, families and patients can change their perceptions from that of either "succeeding" or "failing" in their coping strategies, to seeing themselves as moving back and forth on a continuum, at some times needing more help than at others, but not as failing if acting at one end of the continuum.

In a related work, Frank-Stromborg (1986) sought to show that cancer and health are not incompatible concepts, and recommended that oncology nurses expand their perceptions of their role from just illness prevention to include health promotion strategies. Using the work of Sorochan and Oelbaum, Frank-Stromborg (1986) sought to show that health and illness are not two ends of the same continuum but are separate realities. If this is the case, then the concept of health promotion becomes a strategy for assisting patients and families cope with cancer. However, Frank-Stromborg (1986) also reported that little is known about health promoting activities of ambulatory patients, even while recognizing that wellness behavior is one of the most if the most significant factor in determining a person's health status. Such is even more clearly seen when faced with the definition of health promoting

behaviors--actions taken by a patient or family member which are directed toward sustaining or increasing the levels of well being, self actualization and fulfillment of an individual. The author identifies six dimensions of health promotion which include exercise, self-actualization, interpersonal support, health responsibility, nutrition and stress management, some of which are strategies identified below as recommended coping mechanisms of viable assistance to cancer patients and families.

Avery Weismann (1979), in his seminal work on cancer and coping, reported that patients least vulnerable to the stress of the disease and most effective in coping employed some certain strategies. Identification of these strategies is beneficial, for it gives oncology nurses guidance in what is effective for cancer patients. Those strategies employed included active problem solving, confrontation of the problem, making one's own decision, seeking information, verbalizing one's fears and anxieties, maintaining an optimistic attitude towards life, and cooperating with treatment.

Weismann (1979) also identified the processes used by patients who were more vulnerable to the stress of diagnosis of cancer and less effective in their coping abilities. These strategies included a passive and

defensive coping style marked by withdrawal, suppression of feelings, anxieties and fears, a greater number of complaints, inflexible behaviors, pessimism, limited family or social support and a tendency to engage in nonproductive, impulsive behaviors. By identifying these productive and nonproductive strategies employed by cancer patients, oncology nurses are better able to assist in effective coping and direct patient's and families away from ineffective coping.

While Weissmann has identified numerous strategies used by cancer patients in coping, Derdiarian (1987) has identified several variables that affect coping. These variables fall into two categories, person-related variables and situation-related variables. Within the former category, such things as personal traits, disposition to a single pattern of coping, internal or external locus of control, gender, age and stage of life, and marital status all effect coping. In the latter category, the three variables which impact coping are the type of cancer, the stage of the cancer, and the treatments recommended. Oncology nurses must be aware of these factors as well as the specific strategies used by patients and families in assisting them.

Other reports from the literature help the oncology professional to enable effective coping in patients and

families. One author reported that patients whose diagnosis was life threatening used the confrontational method of coping more that did those patients who had non life threatening diagnosis (Feel, Strack and Nagy, 1987). These researchers went on to report that the situational context of a life threatening diagnosis was more important in shaping the coping response than was the personal style of the patient. When the patient knows the seriousness of the disease, depression and loss of hope are not inevitable. Rather, greater and more accurate disclosure may well help to provoke a marshalling of life forces and resources to cope. Finally, these authors report, as do others (Nehemkir, Gerber and Charter, 1984; Wellisch, 1984) that the coping strategies employed by the patient and family may differ at different stages of the disease. Thus, it is important for oncology nurses to evaluate cancer patients and their families on an individual basis with regard to their coping patterns within the course of the disease.

Finally, Hinds (1985) investigated the needs of families who care for oncology patients. She reported that such families needed guidance in patient care, assistance in understanding the disease process, what to expect in their participation of medical care for the patient, how to reassure the patient, and the side effects of treatments.

Families also had needs in the psychosocial area such as financial needs and what resources were available, emotional contact and communication during the disease process, a means to discuss both the patient's and family's fears, the need for release of pent up emotions, and respite needs. By identifying and acknowledging these needs on the part of the patient and family, the oncology nurse is better able to assist in seeing they are met, and thus in reducing the stress the family feels resultant from them.

Immediately following the diagnosis of cancer, Mages and Mendelsohn (1979) identified that there were two tasks which were important for the patient and family. One was to appraise the significance of the diagnosis, and the other was recognizing and coping with the realities of the situation, regulating the emotions and integrating the experience of illness into life. Oncology nurses alert to these needs are more competent to assist their fulfillment and thus reduce the stress on patient and family. In related work, Cassal (1982) and Taylor (1983) reported that patients who were able to attribute particular meaning to their experience of pain or distress helped to relieve the suffering or stress of that experience. While oncology professionals must be cautious and not seek to force patients and families, it is of assistance to the patient

and family if they can be assisted to make meaning out of the experience.

Having identified several of the factors which bear on effective coping and the assistance of such for the oncology patient and family, attention can now be turned to a few specific strategies for oncology nurses.

Improved Patient/Nurse Relationship

One of the ways in which patients and families can be aided in coping with the diagnosis and treatment of cancer is through the positive, helpful relationship they share with professional staff. This positive relationship is termed by Trygstad (1986) as the role of professional friend, and involves a redefinition of goals on the part of nursing staff from quantitative progress to qualitative care. This reorientation then creates a new environment for the patient/nurses relationship. Through the author's own study, report is made which shows oncology nurses seeing their work as rewarding through perception changes on two levels, that of professional and that of friend. The results of this study were that oncology nurses showed more attachment and affect reporting about patients than did non oncology nurses, and that the oncology nurses differed in their focus or goals for work, using more qualitative measurements for determining satisfaction and

using more qualitative language in dealing with patients. This shift from quantitative to qualitative evaluation and measurement is marked by a move away from interpreting one's job as marked by counting, i.e. vomiting and diarrhea occurred how many times?. Instead, the goal of work became care and caring, and the time focus shifted from then, when the patient would be "well," to now. This does not mean the quantitative functions of a nurse's job are eliminated from work, but rather they take a secondary role to the more qualitative functions. The manifestations of this reorientation on the part of oncology staff was in a quality of life for the patient which included more freedom from pain, being treated with greater courtesy, a respect for the patient's choices and helping to establish and respect the independence of the patient.

Trygstad was quick to point out that the qualitative and quantitative roles of nursing are not in competition, but that both are needed and valued. The nurse must still serve the quantitative functions of the job, but that aid is given to the patient and family in coping when the nurse also accepts the more qualitative role of professional friend. The nurse in this role still remains professional in that he or she has limits upon the time spent with any one patient, the relationship is goal oriented, patient centered, and the professional knowledge and skills of the

oncology nurse are brought to bear upon the patient for his or her behalf. However, as professional friend, there is a level of reciprocity that is missing from the more traditional nursing practice; the role of the nurse is not authoritarian, scorekeeper and decision maker, but advocate and facilitator of the patient's choices, a collaborator with the patient.

Other researchers have also found that more and more, oncology patients are considered to have not only the right but an important responsibility to contribute to their own health care (Derdiarian, 1987; Wellisch, 1984). Ersek (1986) recommends that oncology nurses relay to patients and their families how effective management of stress can assist in the treatment of cancer, while Webster (1986) reports that the best way for oncology staff to assist the patient in coping is through modeling effective coping behaviors on the unit and with the patient and family. In so doing, the nurse helps to guide the patient away from maladaptive coping patterns or behaviors and towards effective ones.

Finally, another aspect of a more effective patient/nurse relationship for the management of stress is the role of the community health nurse outside the hospital or the psychiatric liaison nurse within the hospital. This is especially important in an outpatient setting, for

contact with the patient is limited. Wellisch (1984) cites several responsibilities for this role, which include identifying patients and families who need help but don't know how to ask, guiding patients and families who are obviously unable to cope into direct therapeutic groups, and acting as liaison and educator for those professional staff working with and counseling the patient. The importance of this role is that due to the more limited contact with outpatients, the community health nurse can ascertain and report how the family is functioning at home (Hinds, 1985).

Within the hospital, the psychiatric liaison nurse often performs the roles of consultant and educator to both nurses and families (MacNeil-Zimberg, 1985). In this role, pragmatic, task oriented solutions for crisis are identified, enlisting both patients, families and nurses in the problem solving. Nurses are also taught to be consultants to patients and families, and through this form of help to implicitly communicate to those patients and families that they have within their means many solutions to their stress and difficulties. The role of this psychiatric liaison nurse is also to teach nursing staff how to recognize timing and readiness of patients and families to receive help.

A final recommendation with regards to the relationship

of nurse to patient and family is that family survivors be contacted within 72 hours of the death of the patient (Lev, 1985). In this way, the family is shown support and assistance through the entire disease process, from diagnosis to death if the cancer is not arrested.

Education and Information for the Patient and Family

There is another coping strategy which oncology nursing can offer to patients and families that is closely linked with the above developed strategy of improved relationships. This strategy is intentional planning to meet the educational and informational needs of the patient and family when a diagnosis of cancer occurs.

It has been shown that education and information have positive effects on decreasing stress for people (Lawrence, Lawrence, Lee and Becker, 1985). It is the recommendation of these authors that through cognitive learning strategies, taught by means of intentional education and shared through informational resources, stress can be reduced for patients and families.

In a work targeted specifically at the informational needs of patients and families, Derdiarian (1987) cited growing evidence that educating patients is no longer simply an option for hospitals, but is looked upon as a basic part of treatment, the exclusion of which inhibits

care. Derdiarian goes on to identify that patients studied showed a lack of information on diagnosis, treatment, hospitalization, remissions and what the expected prognosis could be. Citing this lack of information, this researcher recommends that information is needed by patients and families in four categories: disease, personal, family and social.

The most important informational need about the disease of cancer which patients identify is the physical survivability of it. Following this, there are needs concerning cancer's diagnosis, treatments and prognosis.

Within the personal arena, patients surveyed expressed a need for information relating to their own physical well being, whether they would have the ability to function and how well, their psychological well being, the impact cancer would have on their career, plans and goals.

In the category of family, Derdiarian identified informational needs relating to the effect cancer would have on a spouse or significant other, children, parents, siblings, and how to communicate within the family about cancer, the patient's prognosis, and the feelings and fears it evokes.

Finally, within the social concerns area, the informational needs included how to communicate and interact with friends and how to maintain a satisfactory

life style.

While these informational needs are clearly described by Derdiarian, it is important to recognize that they cannot and should not all be met at the same time. Too much information can be as overwhelming and stressful as not enough. Wellisch (1984) suggests that any program which seeks to provide for the patient's and family's coping should balance both educational and emotional support, and that the balance of these needs will shift during the course of treatment. This author goes on to recommend a program equally weighted between structured material (informational resources and specific didactic educational opportunities) and patient and family discussion of the material.

Some specific recommendations for such informational resources are providing a fact sheet to the patient and family which has on it the names of personnel and their job functions, and the different resources within the hospital and community (Martocchio, 1985). At the time when this fact sheet is given, the patient and family would be encouraged to ask questions, and to raise concerns. Another recommendation is that the patient and family, early in treatment or right at the time of diagnosis, be given a handbook listing the services offered by the hospital or community, when they are available and where

they can be found (Hinds, 1985). In this way, the patient and family are able to take this handbook home and use it at their convenience and times of need or leisure (Borley, 1985). This same author calls for the exploration of the feasibility of a 24-hour hotline, and the establishment of an effective referral system.

Such informational and educational programs help to establish what Lev (1985) reports as preventive interventions. These are intended to utilize both the psychological resources in the medical and health community and the reduction in stress through better knowledge to enable effective management of stress before maladaptive coping occurs.

Finally, there is in the literature a recommendation to teach relaxation techniques to patients and families in order to reduce or mitigate the effects of stress (Sims, 1987; Bailey, 1980). The principle of relaxation techniques is that changes in either the psychological or physical state are accompanied by a change in the other. Therefore, if a person learns to establish a state of relaxation, that person will both facilitate the healing process of treatment and help to mitigate the stressful effects of cancer. Sims, while citing literature that shows encouraging results from relaxation used as a coping mechanism among cancer patients, also warns that it is not

without limits. Often, the skills are hard to learn, especially for cancer patients in the midst of treatments, the skill development can be very fatiguing for the weak, and an overuse of relaxation techniques will lead to withdrawal.

Patient and Family Participation in Treatment

In addition to the nurse/patient relationship, and development of educational and informational resources, a third coping strategy is increasing patient and family participation in treatment. Consistently in the literature, there is the call for the patient and patient's family to be involved from the very beginning in the treatment plan, and to see the decisions as their own (Trygstad, 1986; Martocchio, 1985; Borley, 1985; Frank-Stromborg, 1986; Feel, Strock, and Nagy, 1987; Hinds, 1985; Kirschling and Pierce, 1982). One group of authors, in studying the differing coping mechanisms of patients, found that when faced with a concrete, specific threat to life, patients responded in ways that included active, increased information seeking, a cognitive redefinition of the illness, and a greater desire and participation in the treatment process (Feel, Strack, and Nagy, 1987). Such an involvement in the treatment plan and decision making concerning treatment of cancer is a significant coping

mechanism for the patient and family, for it assists them in gaining a sense of control, and of being active and of some effect upon their own health.

Another author suggests that this participation of patient and family in the decision making and treatment plan process is further aided when there is an effort to focus on wellness rather than sick role behavior (Frank-Stromberg, 1986). The recommendation from this researcher is that an optimum quality of life is achieved when the patient and family change their focus in such a manner, and assume more self responsibility for those health promoting behaviors as well as resisting dependence.

This same author reports that the oncology nurse can help to effect this reorientation and participation by listening to, guiding, encouraging, enabling and accepting the patient's desires to participate in treatment and wellness (Frank-Stromberg, 1986). This recognition of the role of the oncology nurse is identified by several other researchers as well. Borley (1985) calls for not only intentionally involving the family and patient in treatment whenever possible, but also for an education program for the patient and family to train them in self care. Martocchio (1985) reports that through the efforts of the oncology nurse to encourage and promote patient and family participation and question asking, trust is developed. As

the nurse helps the patient and family to participate in the care, shows them ways to monitor the patient's progress, shares insights into the positive coping patterns and strategies of the family, and helps them identify resources to finish tasks which the family can't, the patient and family feel they are maintaining a sense of control, and the likelihood of ineffective coping strategies is reduced.

Conjoint to the nurse's role of assisting the patient and family in participation in treatment is the discovery by one researcher that oncology nurses who act in such a way describe their work as 'real nursing'--nursing which involves a more holistic approach, includes and respects the patient and family input, and thus manifests itself in courtesy and respect towards the patient/family and their choices, decisions and opinions, and which fosters in the patient and family independence (Trygstad, 1986). Thus, the very structure which research recommends as aiding patients and families in coping, encouraging participation in treatment and in the decision making process, is a structure which is also an aid to the effective coping for oncology nurses, and one which oncology nurses themselves identified as important to their role (Craytor, Brown and Morrow, 1978; see Role Definition section above).

A final recommendation from the literature with regards

to assisting patients and families to maintain control and participate in the decision making of treatment entails the social supports needed by these families. The research cited by Taylor, Falke, Shoptaw and Lichtman (1986) shows that social support can clearly reduce psychological distress and can reliably enhance the prospect of recovery. This support is defined as relationships and interactions which involve emotional support, instrumental aid such as assisting in achieving some goal or service, information dissemination, or appraisal of the patient or family's condition which helps in evaluation. Such support can come from many sources, nurses, health staff, organized support groups, doctors, family, friends.

Two effects of this social support are that it is beneficial during nonstressful times as well as stressful times, and that it has a buffering effect, the benefits of which are most evident during time of crisis, such as with the onset, diagnosis and treatment of cancer. The authors do report this support does have some limitations. One such limitation identified is negative, unhelpful coping for the patient when family members offer information with regards to treatments and procedures. These informational needs seem to be best met, and most helpful to the patient's coping, when met by the medical and nursing staff.

Taylor, Falke, Shoptaw and Lichtman (1986) go on to report that social support groups have shown to be beneficial to patients and families and to counterbalance some of the psychosocial stresses of cancer. Unfortunately, only about 10% of cancer patient's utilize such groups, with males reluctant to participate when groups are not educational and when spouses don't attend with them. These authors show that while social support is a viable coping mechanism for patients and families with cancer, and while groups are a major mental health service delivery system, the resource for those who will take advantage of it may already be in place. What is needed is more effective ways to deliver social support through groups to those groups of cancer patients and families who are in need of this resource but do not take advantage of the existing help.

Another author, in looking at social support needs, identifies some specific, essential functions of a group which would purport to address this need. Lev (1985) reports that social support groups must provide a nurturing environment for participants, enabling them to support each other, ventilate their feelings and fears, and experience catharsis. Such groups must essentially be led by a professional, and the author follows this specification with a recommendation to train nurse counselors who would

specialize in such a support system as well as identifying nurses with more proficient skills in effective coping so that they might be coupled with patients and families which are having greater difficulty managing their cancer.

Oncology nurses, then, have a role in seeing the social support needs of patients and families are met. While they will be unable to meet these needs totally themselves, their activities in relaying both nursing care and personal concern as well as assisting patients to deal with their uncertain future, adjust to the fact of having cancer, and develop effective resources for their psychosocial needs will impact the patients response in treatment.

The nature of the problem has been defined, and its exploration reported. Review of the literature related to stress and coping has produced shaping factors which will the recommendations for this training program. Before the program recommendations can be detailed, general training principles must be identified, and needs of the program with regards to meeting continuing education requirements specified.

General Training Principles

There is a great wealth of research conducted on training, and what makes for effective training programs. The research covers a wide variety of areas in which

training takes place: hospitals, businesses, on-the-job skill training, occupational training, management training, training conducted in settings removed from the place of work, et.cetera. For this study, research was sought which identified key strategies for success in training programs, to be applied in the development of the model training program for oncology nursing.

One researcher (Spitzer, 1989) reviewed training programs and reported reasons why programs failed as well as training success factors. Spitzer (1989) reported nine reasons for the failure of training programs, any one of which could cause the goals of a program not to be met. These reasons are: the limited training resources of the organization are not focused on the most promising projects, but are spread out; the real reasons for training are not clear; training alone is never powerful enough to lead to long term, verifiable performance improvement; training is aimed at the symptoms, rather than the causes, of performance problems; critical non-training factors are ignored; management support is lacking; the central role of the supervisor is not recognized; too few employees are trained, and those are poorly chosen; and there is little or no preparation or follow-up. Some of these reasons for training failure are similar if not the same as sources of stress for oncology nursing, most notably management

support being needed and the central role the supervisor plays.

Spitzer (1989) goes on to report five training success factors. The first factor is value--a training program must have value and be seen as valuable to both employee and management. The second factor is focus. This includes capacity of the trainee to learn and acquire that which is being taught, focus both on the knowledge and skill of the subject, consideration of the trainee's job design, feedback, incentives for training, the skills and resources needed to teach/acquire the subject, and clearly defined expectations.

The third factor for success is power, described by Spitzer as the means of training to effect the aspects which are the targets of focus.

The fourth factor is mass. The greater the number of employees trained, the higher the rate of success.

The fifth factor is duration. Spitzer reports that training, to be successful, requires time and cannot be done in one-shot training programs. Longer programs with more detailed components must be used for optimal success.

Any one of the reasons for training failure, when present in a program, are enough to offset gains in that program (Spitzer, 1989). However, all five success factors must be present for positive results from training.

Other researchers would argue with Spitzer concerning effectiveness (Austin, K. & Titus, A., 1988; Norvell, N., Beller, D., Brody, S., & Freund, A., 1987; Price, R., 1985). Price (1985) agrees in principle with the factors identified as needed for success, though she uses other terms to define them. Price does report there can be some success even if all five factors aren't present; success is reduced without emphasis on all five factors. Her own structure emphasizes the teaching component of a structure. This teaching must include instruction of underlying knowledge, skills and perspective for those being trained, not just specific behaviors. Training must be conducted across many sensory channels, and emphasize both participation and feedback (Price, 1985). Without these components, the material will be less successfully assimilated into the workplace.

Austin and Titus (1988), in work critiquing performance based training, also recognize the limitations for success in training, and factors needed for success. In agreement with Price (1985), these authors report limited success in training programs which consider only a behavioral change for employees. The authors identify five assumptions which limit training success when it is performance based. These assumptions are reported as: the assumption that the learner needs to be fixed, is somehow broken or wrong; the

assumption that the learner can and should be manipulated; the assumption that successful performance can be investigated and defined specifically, with a single performance response identified; the assumption that personal development is nice but not necessary; and the assumption that culture is not the problem of management (Austin and Kristin, 1988).

Over against these success limiting assumptions, Austin and Price (1988) recommend three types of learning as the basis for training programs. Self reflective learning, action learning, and double loop learning are the recommended structures for effective and successful training programs. These methods of training resolve the limitations of performance based training by inclusion and use of the trainee's own perceptions and insights, greater positive regard for the one being trained, and integrative participation in his/her own learning.

Norvell, Berber, Brody, and Freund (1987) reported assessment of a pilot program for stress management with health care professionals. The goal of the program studied was to teach techniques which enabled workers to exert more control over physiological and psychological reactions to stress. Norvell and group reported (1987) that participants who successfully developed the two skills taught, relaxation skills and problem solving skills,

showed greater control over stress reactions. Further, through self report, participants in the pilot program reported generalization of use of these skills to areas outside the worksite, i.e. use with spouses and children, weight control, et.cetera.

Several limitations were identified by the authors. One was that such stress management programs are less effective if established by management when management is seen as a significant stressor. Another limitation is that stress management programs cannot alleviate all stress from a worksite. In establishing the program, those responsible must be cautious to communicate this limitation.

From review of this program, Norvell and group (1987) offer four recommendations for effective training programs. The first recommendation is to begin the program by getting employee's perceptions of the stressors at their worksite. The program can then be tailored to meet these perceived needs.

The second recommendation is to establish incentives for encouraging participation in the training program. These incentives could be CEU credits, or time spent in the program recognized as overtime or credited as comp time.

Norvell and group's (1987) third recommendation is to keep group size small. This encourages better participation and better skill development. Conjointly,

these reporters recommend that supervisors not be included in groups with subordinate personnel.

The training group is not to be an intense group experience, but rather focus on skill development and cognitive understanding behind the principles. This is the last recommendation made by the authors.

Finally, Norvel and group (1987) report training programs, and specificly stress management programs, can be effectively implemented with health care professionals. However, these programs need to consider the above factors to optimize positive results.

In another study investigating factors which guarantee transfer of training skills from the session to the workplace, Kelley, Orgel, and Baer (1985) reviewed results of training programs. From this review, seven strategies were reported which produce more rapid acquisition, retention and transfer of work skills (Kelley, Orgel, and Baer, 1985). The strategies identified deal with teaching three basic factors of program development: identifying, analyzing and defining the skills and concepts which are needed for positive job performance; teaching both the basic skills and the general principles underlying those skills, using both correct and incorrect examples in instruction; and making follow-up relevant and related to skill assimilation and transfer. The better these factors

are addressed by a training program, report the authors (Kelley, Orgel, and Baer, 1985), the more rapid acquisition, retention and transfer of skills will occur.

Bonita Long (1988) recommended the same needs of a training program. Her work focused on the success of stress inoculation training (SIT), as it was used in a school setting. Long (1988) found this stress management program effective, especially when coupled with exercise. Significant for this study is the reported components of SIT, which include presentation of a conceptual framework in which the skills being taught are shown to fit, skill acquisition enabled using the techniques of cognitive restructuring and self statement modifications, and rehearsal and application of the skills. These components coincide with factors or strategies recommended by other researchers; a need for teaching concepts behind the skills, the development of specific skills functional to the needs identified, practicing of those skills and confirmation of the skill's acquisition and transference to the work setting.

Finally, Mark and Wells (1988) reviewed training programs and their development. From this review, these authors report the common linear model which is used for program development and which has seven sequential steps (Mark and Wells, 1988). These steps are present in every

linear design model, though not always by the same name. Mark and Wells (1988) offer an alternative to the linear model used most frequently in training program development. Their model is called a systems approach model (SAM), has five components, and can be entered at any component. This is in contrast to the linear model, which requires following steps one through seven in sequence without variation. Therefore, SAM is more flexible as a design development, and more usable.

While there is some overstatement of support for such distinctions between a linear model and SAM, the authors five components are instructive for this research. The components are: assessing the needs the training program is to meet; development of instructional plans and how to meet the demands of the program; development of administrative and budget support; implementing the program; and evaluating the program (Mark and Wells, 1988). The authors report that with a systems approach model, a program developer could start a program with any of the five components. However, this appears untenable. How can a program be developed if the needs it is to meet are not accurately assessed? Even given this limitation, the components reported concur with essential factors needed for successful training as reported by other researchers. Especially significant is the inclusion of budgetary and

administrative development. This inclusion parallels one of the identified needs of stress management for oncology nursing.

From review of the literature on general training principles, several factors or strategies can be identified as guidelines which shape the development of this program. The first is accurate needs assessment by which to target the program, including employee's identification of stressors. The second principle for this training program is the teaching of both skills and the concepts by which the skills are chosen and by which they are applied. The third principle is inclusion of administrative and budgetary concerns, so that the program has the support it needs for success, both managerial and fiscal support. The fourth principle is evaluation of program that is connected with program continuance; that is, evaluation procedures which enable the program to assess both competencies and success gained, and stress management needs still unmet. Through this principle, the program will reestablish itself, developing its next emphasis out of the work accomplished.

These four principles, identified within the literature, will serve as the guidelines for developing the

model training program for stress management for oncology

nursing.

Certification for Continuing Education Units (CEU)

The Tennessee Nurses' Association (TNA) grants approval for CEU'S through several different programs. The two most applicable to this work are the Program of Continuing Education in Nursing and An Offering of Continuing Education in Nursing. Instruction packets including application of both are found in Addendum C; these application forms can be obtained from the TNA.

Both the program and the offering of continuing education meet needs of the training model. However, the program of continuing education is more comprehensive in nature, and more useful for the goals of this work. Criteria for approval of a program of continuing education are divided into two parts. The major areas of emphases are here reported; specifics for each major emphases can be found in the application.

I. ADMINISTRATIVE CRITERIA

- A. Resources
- B. Program Theme
- C. Target Audience and Needs Assessment
- D. Program Goals
- E. Program Content/Time Frame
- F. Physical Facilities

G. Program Evaluation

H. Verification of Attendance

I. Coprovidership

J. Record-Keeping System

II. PLANNING THE SINGLE EDUCATIONAL SESSION/OFFERING WHICH IS PART OF THE PROGRAM

A. Resources

B. Target Audience and Needs Assessment

C. Objectives

D. Content/Time Frame

E. Faculty

F. Teaching Methods

G. Evaluation

This model training program is designed to meet the TNA'S criteria for a program of continuing education in nursing.

The review of related literature concludes here. In Chapter III, a report on the procedures of this study will be made and a distillation of the results of the literature will be presented.

CHAPTER III

PROCEDURES

The brevity of this chapter results from the design of this research. The design involved an extensive literature review, from which salient points were extracted to form the research base for development of the training program.

In summary, the following procedures were used:

1. Initiated research because of problems identified when author dealt with nursing staff and family during the time a child of that family was dying from neuroblastoma.
2. Met with TCSC Executive Director, Associate Executive Director, and TCSC accountant, the mother of the deceased child, for exploration of interest with regards to research on stress management for oncology nurses.
3. Contacted National Cancer Society for list of comprehensive cancer centers in the U.S.
4. Surveyed needs of twenty-four comprehensive cancer centers in the continental United States.
5. Searched CancerLit Database for research on stress.
6. Searched Medline Database and PsychLit Database for research on stress, coping, and oncology nursing.

7. Searched the Hospital Literature Index and the Cumulative Index to Nursing and Allied Health for research on stress, coping, and oncology nursing.
8. Searched ERIC Database for general training principles.
9. Reviewed manual and computerized searches for references.
10. Acquired continuing education requirements from the Tennessee Nurses' Association.
11. Reviewed and synthesized literature into the following categories:
    A. stressors for oncology nurses
        1. physical or environmental factors
        2. psychological factors
    B. burnout
    C. coping mechanisms
        1. social support
        2. participatory management
        3. educational programs
        4. role definition
        5. doctor/nurse relation
    D. stressors for patients and patient's families
    E. coping strategies for patients and patient's

families

1. improved patient/nurse relationship
2. education and information for the patient and family
3. patient and family participation in treatment

F. general training principles

G. continuing education requirements

12. Reviewed TSCS organizational structure and existing programs
13. Met with Associate Executive Director of TCSC in charge of Support Services for review of recommendations and needs of TCSC

These procedures will now be described in more detail.

In the spring of 1987, a member of the church this researcher served had a child who was diagnosed with neuroblastoma, a cancerous tumor of the brain. Survival rate of neuroblastoma is 5%, and unfortunately, within one year of diagnosis, this child died as a result of her cancer. Through this experience of working with the family and hospital staff, this researcher observed the differing responses of family and nurses to the stress of cancer. Because of this initiating incident, contact with a newly established cancer treatment center was made.

In the summer of 1988, this researcher had a meeting

with the executive director, the associate executive director and the accountant of the Thompson Cancer Survival Center. The accountant was the mother of the child diagnosed with cancer, and the arranger of the initial meeting. At that meeting, the development of a training program for oncology nursing was discussed. This meeting was requested for several reasons. At the time of the meeting, TCSC was not yet fully operational, though it had hired some employees. Its physical facilities were still under construction, and its programs and departments were still being developed. Because of the center's unique position of inception, it was felt that Thompson Cancer Survival Center might have some needs which, due to the extensive efforts required just to bring the programs and facilities on line, the hospital would not have resources to meet. Those needs were explored at the initial meeting, and with this researcher's interest in stress management and the identified need of the center for such a program for its oncology nursing staff, the direction for this work was determined and agreed upon.

Following establishment of the direction, work then progressed to meet the needs of the program. As reported in Chapter I, the need for such a program was assessed through the means of contacting the twenty four comprehensive cancer centers in the continental United

States. These centers were taken from a list supplied by the National Cancer Institute, a list of all comprehensive and clinical cancer centers supported by that institution.

Through response to the inquiry, it was assessed that such a program, while an expressed need of this particular institution, was also a recognized need of other cancer centers. It was also determined that there was no single or dominant training program for teaching oncology nurses effective coping. Such determination cleared the way for the next stage of development of this work.

Following the determination of need, an extensive literature review was conducted. Several sources were used in this review, including computer searches of the CancerLit Database, the Medline Database and the PsychLit Database. This researcher also manually researched the Hospital Literature Index and the Cumulative Index to Nursing and Allied Health Literature.

From these searches, a body of material was gathered and studied. While this body of material represents the literature base for this study, it is not intended to be promoted as an exhaustive list of research in the field.

The literature base for this work was thoroughly studied, and from it several salient factors were identified. Though these factors are stated above as part of the review of related literature, recapitulation of them

here will be of benefit as the recognized basis for the program development to follow.

Within the broad category of coping strategies for oncology nurses, five strategies were identified: the need for social support for oncology nurses, developed systemically within the recognized structure of the hospital; the need for participatory management; the need for ongoing educational programs; the need for role definition; and the need for positive nurse/physician relationships. Within each strategy there were factors which impacted the need and shape of the strategy. These factors have been identified in the preceding chapter, and will be reiterated in the development of the program below.

Under the broad category of patient and family coping, and the aid which oncology nursing may give to them, three strategies were identified: a need for positive patient/nurse relationships; a need for education and information for the patient and family; and a need for patient and family participation in treatment of cancer. Once again, within each strategy there were factors identified which impact the development of the strategy, and these factors will be used to shape the program which follows.

A review of the Educational Resources Information Center (ERIC) Database was conducted to identify principles

for training. The discriptors used were: training, stress, management, and strategies. Results of this review begin chapter four.

The standards and requirements for continuing education units for nurses were identified using the American Nursing Association's guidelines, and the requirements of the state of Tennessee licensing agency, the Tennessee Nurses' Association. These findings are also reported in Chapter IV.

Finally, the existing programs and facilities of the TCSC were reviewed, and findings were incorporated into the training program. This review included examination of the organization, and study of printed materials identifying support and assistance offered to nurses, and that offered to patients and families.

Compilation and consolidation of these different reviews form the basis for the training program offered.

CHAPTER IV

RECOMMENDATIONS FOR TRAINING PROGRAM TO TEACH EFFECTIVE STRESS MANAGEMENT

The needs of oncology nurses relative to stress and coping have been assessed through the extensive literature review. These results are recorded in Table 1. The recommendations for the proposed training program are based on these results, incorporate general principles for successful training, and follow CEU guidelines.

The literature review revealed that significant factors must be addressed to successfully train oncology nurses to effectively cope with stress. It is recommended that in the training of oncology nurses, they must be trained to:

1. identify and accept affective responses arising from work;
2. learn positive coping responses to these feelings, including skill acquisition of assertiveness, problem solving, conflict management, compromising, empathy, active listening, etc.;
3. comprehend the shift in role definition and role responsibilities;
4. become familiar with informational resources; and
5. conceptualize and accept shift in focus from

Table 1

Salient Points Identified in Literature Review

	Implication for Recommendations for Training			
	Training		Administrative	Organizational
	Nurses	Supervisors	Policies	Structures
Social Support				
Management down factors		x		x
Encouragement of affective identification/clarification/acceptance	x	x		
Staff meetings structured to enable affective identification/acceptance	x	x		
Participatory Management				
OCNS		x	x	x
Management promotes group building		x		x
Construing reality		x		
Considerate leadership, i.e., listening skills, lack of defensiveness, role definition for nurses		x	x	
Staff meeting with joint problem solving	x	x		
Educational Programs				
Orientation program with assessment of coping mechanisms	x	x	x	
In-service training	x	x		
CEC			x	x
Case studies format for in-service	x	x		
Role Definition				
Interaction with patient included			x	
Job descriptions with minimal achievement standards and major/ successful achievements			x	
Nurse/Physician Relationship				
Nurses learn assertiveness skills	x	x		
Nurses learn conflict resolution	x	x		

Table 1 (continued)

	Implication for Recommendations for Training			
	Training		Administrative	Organizational
	Nurses	Supervisors	Policies	Structures
Collaborative practice	x	x		
Hospital environment ready for change				
Timing				
Staff desire				
Interprofessional communication				
Nurses learn skills	x	x		
Bargaining				
Accommodation				
Negotiation without personalization				
Positive Patient/Nurse Relationship				
Qualitative role definition			x	
Modeling effective stress management	x	x		
Psychiatric Liaison Nurse			x	x
Education and Information for the Patient/Family				
Fact sheet of personnel and job functions			x	
Handbook of services in hospital and community			x	
Information with regards to diagnosis, survivability, and imput on life			x	
Teach relaxation techniques	x	x	x	
Patient and Family Participation in Treatment				
Focus on wellness and health promoting behaviors	x			
Self care training			x	
Encouraged/enabled by oncology nurse	x			
Enabling social support	x	x	x	

disease treatment to wellness and health promotion.

There are many changes for oncology nursing; there are even more for supervisors and administrative policies. Recommendations for the training of supervisors include:

1. development of those skills identified for staff nurses;
2. acceptance of conceptualization changes targeted for staff nursing;
3. education and training of skills supervisors will need to promote and maintain the new environment; and
4. training in team building, active listening skills, effective leadership methods, and consultation techniques.

Administrative policies must be altered. Recommendations for administrative policies are:

1. placement or employment of an Oncology Clinical Nurse Specialist;
2. development or restructure of an orientation program;
3. establishment of systemic support for in-service training and education for stress management;
4. rewrite job descriptions and role

definitions for nurses, emphasizing qualitative responsibilities;

5. establishment of policies for evaluating nurse achievement with regard to the new qualitative roles;
6. development of educational and informational resources;
7. development of a handbook of services;
8. creation of educational program teaching self care to patients and families; and
9. restructure of goals and foci of the institution to reflect the emphasis of wellness and health promotion.

Within the organizational structure, the OCNS must be placed and vested with authority, responsible for training of both staff and supervisory nurses, continuing education, consulting with nurses and supervisors, and research. The OCNS should be a liaison between staff and management, and assist in the development of the orientation program. Another implication for the organizational structure is identification of a Psychiatric Nurse Liaison, who would assist in the development of the informational and educational material for use with patients and families.

There are few, if any, implications for the physical facility. Office space for staff and meeting room space

for in services will need to be arranged. Assessment of the resources of the center should be done, and incorporation of those resources into the entire program accomplished.

With these implications noted, the components of the training program are presented.

Steps to Implement a Training Program

It is recommended the first step of the training program should be the placement or employment of an Oncology Clinical Nurse Specialist (OCNS). Establishment of this position would respond to many of the identified needs for effective stress management. The OCNS, as identified by Welch-McCaffrey (1986), would have responsibility for being educator, researcher, and consultant. The person filling this position would oversee the entire program, giving it structure and content, and directing research done through the program.

The person filling this position would have a master's degree in nursing, thus fulfilling the requirements of the Tennessee Nurses' Association Criteria for Approval of a Program of Continuing Education in Nursing, I.A.2. The OCNS would work with at least one other RN to develop the educational sessions/offerings which are part of the program, meeting the requirements set forth in II.A. of the

Criteria for Approval of a Program of Continuing Education in Nursing.

One of the responsibilities of the OCNS would be to interpret the needs and value of effective stress management to administration, and to enable a systemic responsive climate to stress and coping. This function of the OCNS addresses the needs Adey (1987) identified, the need for recognized support from administration for social support of nurses. The OCNS would teach administration how to affectively and affirmatively support nurses (Jennings, 1987), resulting in heightened respect and mutual admiration (Hockey, 1987). The OCNS would train administration as well as nurses in the value and skill of affective expression (Holland, 1987), and in positive use of staff meetings (Veatch, Marshall, and Sivesind, 1987).

As seen above, the OCNS would be a link between administration and staff, with particular responsibility for promoting and enhancing the working environment for both. While training for staff nurses is needed, it will be the OCNS's particular responsibility to train supervisor's and administrator's in effective listening skills (Firth, et.al., 1987) and considerate leadership (Jennings, 1987).

Another role responsibility of the OCNS would be to meet with RN's elected from among staff, for the purpose of

providing input on organizational planning and decision making (Wadsworth, Clark and Holefreund, 1986). Such a structure would assist in creating a positive, responsive working environment where management of stress is optimized, and where support from administration is tangibly witnessed by staff.

As educator, the OCNS would have responsibility for management of this training program. As such, the OCNS would fill the role of Continuing Education Coordinator (CEC) identified by Ford (1983). Not only does the OCNS determine the shape of the training program for stress management, but other educational needs of the hospital can be placed within this structure for a more complete, comprehensive program of education for oncology nursing.

One aspect of this educational responsibility would be development of assessment techniques for use during orientation. Such assessment measures would identify which coping strategies nurses in orientation already practice (Motowildo, Packard, & Manning, 1986). With this information, the OCNS is better equipped to assist nurses to broaden and strengthen their coping repertoire.

In keeping with the current expectations of the OCNS, it is recommended the OCNS be integrally involved in research, both with this program as a whole, with research aspects of different components of the program, as well as

ongoing research at the hospital. Such research efforts enhance both the position, the facility, and affect positive change on oncology nursing in the broader medical community.

A second step in implementing the training program would be the actual development of the educational program. This educational program would have three tracks:
(1) training of supervisors and administrators;
(2) training of oncology nurses, i.e. staff;
(3) education and training for patients and patient's families. There may be times when an educational session can be offered to all three tracks in the same class; however, there will also be times when each track will need to meet separately.

Skill identification and development would be a major aspect of this ongoing educational program. This will be true for all three target groups. Some of the skills which would make up the educational program are listening skills (Firth, et.al,. 1987), effective communication with the dying (Adey, 1987), realistic goal setting with identification of one's own needs and limitations (Malach and Pines, 1978), interpersonal skills (Douglas, 1986), problem solving (Dewe, 1987), assertiveness skills (McQuade, 1986) and relaxation techniques (Bailey, 1980; Sims, 1987). The amount of time and effort given to each

of the identified components, as well as the order of components chosen for training, will be determined by the assessed needs of the oncology nurses.

The presentation and development of these skills should be planned in accordance with the identified training principles for greatest success. They should be recognized as valid and valued by those receiving the training; learning should incorporate both cognitive understanding of the principles presented as well as behavioral practice and acquisition of the skills; budgetary and administrative support must be present for the program; and evaluation which impacts the direction and goals of the program must be present.

The methods for this education should be multivarite. Training would not occur exclusively within a classroom setting, but will occur on the floors as well. Staff meetings with case study presentations and joint development of problem solving and affective/behavioral response would be used (Barber, 1985; Larson, 1987).

The OCNS would assure the program is structured in such a way that CEU's are earned for participation, in agreement with the Tennessee Nurses' Association Guidelines. The OCNS has responsibility to negotiate with administration for time and placement of the educational program, and to negotiate compensation for participating employees.

A third step in implementing the stress management training program is the redefinition of the role of oncology nurse (Douglas, 1986; Firth, et.al., 1987; Welch-McCaffrey, 1986). This redefinition will not delete the quantitative measures which are currently guiding principles of job definition. The redefinition will include a positive relationship with the patient and family as a primary function of the role of oncology nurse (Friel & Yehan, 1980; Trygstad, 1986). This redefinition will be the responsibility of administration, in conjunction with the OCNS and the RN's elected for input on decision making.

A fourth step of implementation would be the placement of a Psychiatric Liaison Nurse (MacNeil-Zimberg, 1985; Wellisch, 1984). This position would work in conjunction with the OCNS, preferably out of the same office. The Psychiatric Liaison Nurse would have responsibilities as consultant and educator to both nurses and families, helping to develop pragmatic, task-oriented solutions to crisis situations, and enabling the cooperation and participation of nurses and patients/families together. In effect, the individual in this position would elicit and enable the use of coping skills and techniques in practical application.

A fifth step in the training program would be the

development of informational material for patients and families. These materials will include a single sheet on each disease, communicating clearly and simply what a patient/family can expect with regards to physical survivability of disease, physical limitations, relational impairments, emotional side effects, and typical impact upon work (author's own recommendation, Dertiarian, 1987). Another informational resource to be developed is a fact sheet providing the names of personnel and their job functions to the patient/family (Martocchio, 1985). The Psychiatric Liaison Nurse would also have a handbook for patients/families listing services offered by the hospital and community, when the services are available and where they can be found (Hinds, 1985). The handbook and other informational resources would be developed under the supervision of the OCNS.

The last step in the development of the stress management program is educational training for patients/families which focuses on self care (Borley, 1985; Feel, Strock, and Nagy, 1987:; Hinds, 1985; Kirschling and Piece, 1982; Martocchio, 1985; Trygstad, 1986) and health promoting activities (Frank-Stromberg, 1986). This component differs from the skill development identified in step two. In step six, patients and families will learn the physical skills necessary to participate in treatment

and self care. Nurses would be trained to teach and encourage patients/families to accept more responsibility for treatment, choices and decisions. Patients and families will be encouraged to focus on those issues under their control, i.e. health promoting activities, rather than the uncontrollable aspects of the disease.

It is recommended that these six steps be used to establish the stress management program. The steps are not linear; establishment of the program can begin with any one of the steps, and in fact all steps should be established conjointly for success of the program.

The steps recommended are both systemic and comprehensive. They are not a 'cookbook' formula, which when followed precisely will yield a single final result. Rather, they are essential ingredients without which a stress management program would be incomplete. Application of this stress management program will not eradicate all stress from the working environment of the hospital. Nor will it assure that oncology nurses never suffer from stress. What this program will do is maximize coping and management of stress from a systemic perspective, organizationally structuring for effective coping at an optimal level.

CHAPTER V

RECOMMENDATIONS FOR ADDITIONAL RESEARCH

The recommendations for developing and implementing a stress management training program for oncology nurses were based on a review of existing research on stress, training principles, and continuing education requirements for nurses. So often, this critical step is overlooked in the development of education and training programs. Recommendations for further research can be grouped into two categories: (a) additional related research that might be useful prior to testing the program and (b) testing the program for its effectiveness.

Additional Research Prior to Testing of Program

It is recommended that prior to testing of the program:

1. A thorough review of the literature should be conducted on program assessment principles and methods;
2. A thorough review of the literature should be conducted on the availability of print and nonprint educational and training materials on stress management; and
3. Characteristics of effective OCNS personnel should be identified.

Recommendations for Testing the Recommended Program

There are several recommendations which should be considered when the program is implemented:

1. A research-based evaluation model should be designed for assessing program effectiveness;
2. Objectives for the training program need to be clearly delineated and communicated to the entire staff of TCSC;
3. Outcome measures need to be based on program objectives;
4. Evaluation measures should be compatible with the redefinition of roles recommended; and
5. A variety of micro research efforts could be conducted as part of a larger program evaluation design and might include such topics as: staff turnover and absenteeism trends prior to, during, and following implementation of the program, and affect of the training program on oncology nurses' attendance and participation in other continuing education and TCSC activities.

The presence of a new facility such as the Thompson Cancer Survival Center represents a unique opportunity for developing outstanding staff training and education programs which are based on research evidence. The review of literature and recommendations presented in this thesis

represents only a portion of what is needed to develop effective stress management programs. However, this study should be very useful in identifying the content to be covered and the procedures that need to be considered in developing the training program. Perhaps implementation will be easier as a result of this study; however, that remains to be seen.

APPENDICES

Appendix A

Letter to the twenty-four comprehensive cancer centers.

6220 Flint Road
Knoxville, Tennessee 37921
October 24, 1988

To: The Director/Vice President of Nursing:

My name is John Stuhl, and I am a master's student at the University of Tennessee, working on a degree in Community Counseling. Currently I am researching the area of oncology nursing for my thesis, and this is the reason for my letter, and for requesting your assistance.

My master's thesis is designed in the following manner. Here in Knoxville, Tennessee, a new cancer center is being built, the Thompson Cancer Survival Center. My thesis is to research, design and write a model training program for the nursing staff of this new cancer center, tailored to the specific needs of oncology nursing. The program I will write will be two tailed; it will train nursing staff how to most effectively identify and manage patient and patient-family stress, and it will train nursing staff how to identify and effectively manage personal stress resulting from their role as professional care giver.

My request of you is in the following form. I am seeking to identify other training programs currently in place and use at other cancer centers, to use them as a basis and reference for the design of the program which I will write. Therefore, could you send me a copy of your training program for oncology nursing, if it is in printed form. If you do not have a training program for effective patient management and stress management for oncology nursing but incorporate this into an orientation program, could you send me that component dealing with stress management. If you have neither of these, would you respond using the enclosed postcard, identifying that you have neither, and identifying whether or not you have a need for such.

For the sake of clarity, let me outline my requests.

1. A copy of your training program for patient management and stress management for oncology nursing.

or

2. A copy of the component of your orientation program for oncology nursing which encompasses the above.

and

3. The enclosed postcard, indicating you do not have either of the above in printed form and whether or not you see a need for such a program.

Your cooperation is greatly appreciated, and I will look forward to your response.

Sincerely yours,

John H. Stuhl

Enclosure

Appendix B

Response card enclosed with letter to comprehensive cancer centers.

☐ We do not have in printed form a training program or component for effective stress management for oncology nursing.

☐ We have an interest, and see a need, for such a program.

☐ We have no interest and see no need for such a program.

Name: _____

Cancer Center: _____

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VITA

The third of four children, John H. Stuhl was born and raised in Orlando, Florida. Undergraduate education was begun and completed at Maryville College, Maryville, Tennessee, where Mr. Stuhl was graduated cum laude in 1976 with a BA in Psychology. The Master of Divinity degree was earned in 1979 from Columbia Theological Seminary in Decatur, Georgia.

The past eleven years, Mr. Stuhl has worked as an ordained minister in the Presbyterian Church, U.S.A. He has also written extensively for the Presbyterian Publishing House, the Westminster Press, and as a free lance writer. Pursuit of higher education will continue with doctoral work in Counseling Psychology.