

This study reveals the effect of professional socialisation on mental health nurses

How do nurses cope when values and practice conflict?

In this article...

- Development of professional ideals in mental health nurses
- The effect of conflict between ideals and organisational constraints
- Strategies for responding to these conflicts

education and their ability to apply them in the workplace. (Kelly, 1998). Integral to this is professional socialisation.

Davis (1975) proposed a model known as “doctrinal conversion”. This has been frequently criticised as it does not adequately recognise the influence of students’ values and assumptions about the profession when they start training (Fitzpatrick et al, 1996; Du Toit, 1995). However, part of Davis’ model is generally accepted. This involves nurses internalising the values, norms and expectations of the profession.

Simpson and Back (1979) suggested that socialisation has three stages. It begins with pre-socialisation, where values are shaped by societal groups and public perceptions of nursing. This is followed by formal socialisation, where students learn to behave in a professional manner. The process is completed during post-socialisation, where the outcomes of formal socialisation are applied to practice.

Du Toit (1995) said that values changed through professional socialisation. When these changes occur, the individual’s idea of self also changes to such an extent that a “nursing identity” is developed, as part of a collective.

Bradby (1990) maintained that, when student nurses qualify, they move from one social status to another. This process results in a “reality shock”, where they experience a loss of personal identity before making sense of the process some months later.

This early role conflict has been observed in some depth. The transition to qualified nurse is ill defined (Holland, 1999). The nurse’s sense of role identity is challenged by issues including a lack of

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Abstract Stacey G et al (2011) How do nurses cope with values and practice conflict? *Nursing Times*; 107: 5, 20-23

Background A lack of opportunity to express values in nursing practice and a conflict of ideals with organisational constraints are associated with low job satisfaction and high attrition rates.

Aim To explore the stories of mental health nurses to find how values influence their experience of nursing practice.

Method Twelve participants, who had between six months’, and three years’ experience of post-registration practice, were interviewed.

Results Nurses’ values were often established before they started training. Participants described values that were consistent with a commitment to person-centred care and professional and ethical principles expected by governing bodies.

Conclusion Mental health nurses are aware of the dissonance that arises when there is a conflict between their values and their

practice. They respond to this in a variety of ways, notably through acceptance, rejection or innovation.

Values have a major influence on the actions of practitioners and are integral to socialisation and the consequent development of professional identity (Woodbridge and Fulford, 2005; Fagermoen, 1997). It is unsurprising, therefore, that the significance and role of values in mental health practice has gained momentum in UK policy (Department of Health, 2006a; 2004).

A lack of opportunity to express values in nursing practice and a conflict between values and organisational constraints have been strongly associated with low job satisfaction and high attrition rates (Forsyth and McKenzie, 2006; Takase et al, 2006). While there has been much commentary on the low morale of the nursing workforce in general (DH, 2004), there is less on mental health nursing. This study was undertaken to improve understanding of this issue by exploring nurses’ stories about meaningful events early on in their practice.

Background

Nurses often experience conflict between the values they hold and develop during

5 key points

1 The values nurses hold when they enter the profession remain intact

2 Workplace constraints and resistance may prevent nurses from applying these values

3 Having to cope with conflict over values may affect capacity to work with people in distress

4 Strategies to cope include acceptance, rejection and innovation

5 Conflict over values could explain the high levels of stress and attrition in mental health nursing

Table 1. Types of professional value

	Other-oriented values	
Process		Outcome
Upholding humaneness		Rights preserved
Upholding rights of others		Trust fostered
Upholding trust		Help recognised
Attending to needs for help		Protection assured
Attending to needs for protection		
	Self-oriented values	
Intrinsic		Extrinsic
Independence		Colleges
Intellectual stimulation		Leadership
Personal stimulation		Reward structure
Creativity		Nursing as profession
Achievement		
Source: Fergamoen (1997)		

This table shows the different types of values held by nurses, and how they know if they've been applied in practice

Method

The study took a narrative approach to identify the influence of values on mental health nurses' experiences of their practice. A narrative is a story that tells a sequence of events. These events are significant to both the narrator and audience (Denzin, 1989).

Narrative inquiry is a research method used to understand how people think through events and what they value. It looks closely at the story constructed by the storyteller, and the information and meaning it portrays (Chase, 2005).

Ricoeur (1984) suggested that stories have an inherent morality, so asking nurses for stories about their practice is important; their choice of stories provides a way to disclose embedded meanings and values that reflect what they want to convey about themselves as professionals.

During one-to-one interviews, participants were asked to tell stories of events that were meaningful to them in their work. The interviews were unstructured and designed to encourage storytelling. This allowed participants to give free responses and encouraged them to explore in detail their personal experiences and perspectives.

The NHS National Research and Ethics Service granted ethical approval and all participants gave written informed consent. Nurses were assured of anonymity – the names are pseudonyms.

We employed a purposive sampling technique, which involved distributing a letter via clinical team leaders that invited all mental health nurses with between six months' and three years' experience in adult mental health inpatient settings to participate. This criterion was used as evidence that nurses' early career experiences are highly influential in socialising. Twelve nurses agreed to take part.

The data analysis began with reading

and re-reading the verbatim transcripts of the interviews. Value-based event narratives were then extracted. In these extracts, the nurse described where events took place and the context, explained actions and interactions, and evaluated or concluded the story. A value-based event narrative was identified if it related to any expression of a value as defined by Fergamoen (1997) (Table 1).

A thematic analysis of these extracts identified common areas. This was carried out independently by two researchers then validated through collaborative discussions with a multidisciplinary group of mental health professionals and academics.

The group collated the common themes into three main areas:

- » Values embedded in practice;
- » Dilemmas and conflict of values in practice;
- » Coping with conflict – three types of stories were identified and named: acceptance; rejection; and innovation.

Findings

Values embedded in practice

The findings consistently showed that the values of newly qualified nurses were formed before they started training. These were reinforced in practice through admiration of inspirational role models or criticism of observed practice.

The values expressed corresponded with those described by Fergamoen (1997). This included a person-centred approach that emphasised the importance of the therapeutic relationship, working towards each client's goals and improving services for their benefit.

One participant, Florence, said: "My job was to work with people... it was all about supporting people and relationships."

Professional values determined by external governing bodies, management and colleagues were expressed at least once by eight participants. These were external, self-oriented values; participants did not see these values as external but considered them as their own.

Alice said: "[It's about] being able to justify what you're doing, how to give out meds, how to do injections, how to do a care plan and a risk assessment, and all of those things that you have to take responsibility for as a qualified nurse."

Dilemmas and conflicts of values

Participants described a range of organisational constraints that they felt restricted the expression of their values.

Lack of resources was reported as an obstacle in 11 narratives.

support, poor nursing role models, time pressure, role constraints, staff shortages and work overload (Maben et al, 2006).

Kelly (1998) identified the importance of "preserving moral integrity" as the basic psychosocial process when newly qualified nurses adapt to the "real world" of work. Kelly suggested that, if newly qualified nurses believed they were not living up to their moral convictions, this could lead to moral distress and self blame. Here, they become aware of the discrepancy between their perception of what constitutes good nursing and what they observe in practice, and they cope with this by redefining their perceptions of their role.

Several studies recognise the danger of newly qualified nurses becoming desensitised to poor practice habits and adopting them (Mackintosh, 2006; Holland, 1999). It has been suggested that this can lead to students shifting their self identity to justify the loss of ideas and become proficient in their new role (Mackintosh, 2006).

Jowett et al (1991) warned that newly qualified nurses may lose their skills as "knowledgeable doers" and "confident analytical thinkers", as they become socialised into a culture where routine and task-based approaches are valued.

Ben said: "I think that it's a culture from the workforce... we've had problems and it's to do with resources."

The conflict between promoting client choice while being restricted by an organisational reluctance to take risks was mentioned in seven narratives. This appeared to be when self-oriented values conflicted with the other-oriented values. For example, professional regulations were viewed as restricting service users' rights to autonomy.

As Chris said: "Supposing you're dealing with a service user who does have a particular risk history... sometimes, you need the go ahead to just simply try out something like an interview, like getting on a bus, learning how to do all those things that can get a person to an interview, to a job, to a sense of self-esteem, without being impaired in any way. But I meet too much institutionalism."

Six participants spoke of low staff motivation. Colleagues were resistant to participants' attempts to change and improve practice, which restricted their values of creativity and independence.

Adam commented: "You're always mindful that... they're thinking, 'just a minute, I've been doing this for the last 25 years and who the hell are you?'"

Of these six participants, four spoke of feeling unsupported in their new roles and said this affected them emotionally to such an extent that they sometimes questioned their view of their role.

Veronica said: "I kind of remember going home, just thinking, 'is it really worth it?' I don't think anyone should be exposed to those sorts of things - I did question what I was doing."

Coping with conflict

Participants appeared to cope with conflict in a variety of ways. Three types of stories related to coping strategies. Participants did not consistently adopt one of these coping strategies, but adapted their response depending on the event.

Acceptance

All participants acknowledged that their values were challenged at times but had chosen not to raise this. In these cases, they accepted they would continue to work within the constraints, despite the personal conflict they were experiencing.

James noted: "There's nothing much I can do if that's the decision to be made. You have to go with it and you have to do it. In here, you're thinking it's wrong, you can argue that you think it's wrong, but you don't seem to get anywhere."

Rejection

Four participants strongly questioned the organisational philosophy and the limitation this placed on expressing their values in practice. The personal difficulty this conflict produced appeared to result in them considering working elsewhere.

Hazel said: "I will probably just end up feeling like leaving... because I think I can't cope with that stress, or I end up thinking I can't follow this through so I can't promise this to this client. And I can't continue to do it."

Innovation

Seven participants had worked to initiate change, despite resistance, potential separation and hostility from the team. Four of these had been promoted at an early stage in their career.

Leila noted: "Probably having a bit of a rebellious streak helps, [as does] challenging some of their preconceived beliefs about what's the best way to nurse people with mental health problems, but also,

"Having a rebellious streak helps, as does challenging some preconceived beliefs about what's the best way to nurse people with mental health problems"

having, hopefully, having sensitivity not to make people defensive... where people don't really want to listen. But also, a passion for making sure that people don't feel disrespected, whether it's staff or residents - and I've still got that passion."

Discussion

The narratives support the literature, which suggests that student nurses enter education with person-centred values already established (Fitzpatrick et al, 1996; Du Toit, 1995; Simpson and Back, 1979).

Participants focused on the importance of caring, relationships and altruism, as identified by Fagermoen (1997). Their values were reinforced by positive role models, who they perceived to be good nurses.

Participants did not internalise practice that did not reflect their values. Instead, they recognised it as conflicting with their own values, and reinforced their belief in their own view of good practice. This contradicts with Mackintosh (2006), who found that the maintenance of caring values only occurred in the minority of cases.

The person-centred values identified in participants' stories were accompanied by the expression of values associated with

professional responsibility and organisational expectations. These findings echoed those of Woodard-Leners et al (2006), who identified clusters of nursing values that related not only to the person-centred aspects of nursing but also to accountability and responsibility, competence and legal issues.

A large proportion of the stories were about conflict and barriers that prevented nurses from applying person-centred values in practice. They included the impact of limited resources on nurses' ability to apply these values on a one-to-one basis with service users. These frustrations appeared to reduce job satisfaction.

Supporting this, Robinson et al (2005) found that burnout and attrition in mental health nursing were related to a lack of contact and positive interaction with patients, while Takase et al (2006) suggested mental health job satisfaction was related to care-giving opportunities. This suggests that, where ideals are not upheld in reality, nurses are less satisfied.

Further conflicts related to resistant attitudes from some colleagues. Nurses are a disempowered group, within both medicine and the professional arena as a whole (Matheson and Bobay, 2007). Freire (1970) suggested a consequence of this was "horizontal violence", whereby the powerlessness nurses experienced led to them to direct their anger and hostility towards each other.

Participants' stories highlighted a need for support from colleagues and other professionals. The conflicts they described suggested this was not necessarily occurring in practice. Although person-centred values were emphasised in relation to working with service users, it appeared that the nurses did not always demonstrate that they valued each other.

The psychological needs of mental health workers need to be met (Gray et al 2005; Sainsbury Centre for Mental Health, 2006). As Maslow (1954) suggested, if safety and wellbeing needs are not met, it is difficult if not impossible to achieve fulfilment and success. The implication of this may be that nurses feel less able to support others.

Stories relating to how nurses dealt with conflict revealed variations. Responses were put into three categories: acceptance; rejection; and innovation.

Participants appeared to justify their acceptance by regarding their powerlessness as an inevitable consequence of their position within the system.

On the surface, these accounts may seem to support the literature regarding conformity in nursing socialisation. However,

the nurses were acutely aware of this dissonance and did not appear to adopt these conflicting values. It is possible the strain of working with this dissonance could make future burnout, disillusionment and horizontal violence more likely, as Forsyth and McKenzie (2006) suggested.

Participants who told stories of rejection were considering whether conflicts would lead them to compromise their values to a degree that was unacceptable to them. This could relate to the experience of reality shock identified by Bradby (1990) or the self-criticism recognised by Kelly (1998), resulting from individuals' perception that they were not living up to their moral convictions.

Resolution of conflict was told through stories of innovation. Here, nurses saw themselves as having the autonomy to take control of their practice, working creatively within constraints and conflict to foster change. This supports Clouder's (2003) assertion that nurses were not necessarily passive accepters of change. Jowett et al's (1991) concern that newly qualified nurses may lose their skills as knowledgeable doers and confident analytical thinkers was not upheld here.

Those who innovated despite resistance showed high levels of confidence in their practice. This is supported by Bradby (1990), who said that reality shock on entering the profession has less influence on those with high self-esteem.

Recommendations

These findings are significant in the light of the strategies to improve workforce retention that feature highly in mental health service policy (DH, 2006b).

McKenna (2003) suggested employers should ensure that support services were available to all new graduates to prevent the psychological impact of horizontal violence. Primary prevention should begin with education to enable staff to cope with difficult working relationships.

From an educational perspective, the findings suggest the importance of raising awareness of values and their role in influencing the experience of nursing practice. This should involve discussion and questioning values; it could be guided by the work of Woodbridge and Fulford (2005).

In practice, support strategies should be in place during the transition from student to practitioner; this supports the Nursing and Midwifery Council's proposals for a mandatory preceptorship.

We are planning a five-year study to explore the consequences of coping with a conflict of values after registration.

Study limitations

Voluntary participation may have led to a sample bias, as those who might have formed and changed their values may not have wished to take part. The experience of conflict may also have been too painful for some to share.

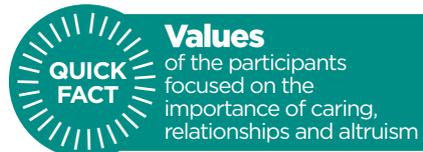
The general nature of the questioning and the unstructured method of data collection meant that the values examined were somewhat loosely defined.

We considered structuring interviews to relate to a set of defined values, but felt that this may have led to participants narrating stories they felt the researcher wished to hear, rather than those that were most relevant to them.

Conclusion

The values held by the participants when entering the profession remained intact. However, the application of these values is tempered by confounding factors.

The narratives add to the professional socialisation literature by suggesting that nurses do not necessarily conform to social



pressures, but respond in a variety of ways – accepting, rejecting or innovating. None of these involved the total loss or alteration of their values.

The long-term implications of coping with conflict in this manner could explain the high levels of stress, burnout and attrition in mental health nursing.

Within mental health in particular, having to cope with conflict could affect a nurse's capacity to work with people in emotional distress, as their own emotional needs are not being adequately met. Preventive support strategies in education and practice may go some way to counteracting these difficulties. **NT**

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