Conflict Resolution Among Terminally Ill Cancer Patients and Their Families: How Nurses Intervene

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Governors State University

Conflict Resolution Among Terminally Ill Cancer Patients and Their Families: How Nurses Intervene

A Thesis Submitted to the Division of Nursing in Partial Fulfillment of the Requirements for the Degree Master of Science

Division of Nursing

By

Mary Ann Wolfenson

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University Park, Illinois

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Abstract

All interpersonal relationships have conflict as well as peace and harmony. An otherwise healthy family who has a member with terminal cancer of the breast or prostate will experience increased conflict because of all the changes that occur with this prognosis. The problem explored in this study was how nurses facilitated conflict resolution among terminally ill patients and their families. The research design consisted of presenting nurses with two scenarios demonstrative of a family conflict with pain control and anorexia as the foci. Each scenario had five responses which each nurse was asked to rank order in terms of nursing interventions. These responses represented nursing interventions by: 1) authoritarian action; 2) turning conflict over to physician; 3) ignoring the conflict by taking the side of the caregiver; 4) ignoring the caregiver's perception; and 5) facilitating conflict resolution. The sample consisted of ten home health nurses who had a baccalaureate degree in nursing. The results suggest that the majority of nurses might in actual situations insight choose to intervene by facilitating conflict resolution as their first choice. Taking the side of the caregiver was the least desirable intervention selected by these nurses.
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Chapter I

Introduction

Conflict is an inescapable feature of our existence. The least we can do is contribute to the knowledge and wisdom about conflict (Bercovitch, 1984). All interpersonal relationships have conflict as well as peace and harmony. A healthy family who finds that a member has a terminal illness will experience increased conflict because of all the changes that occur with this prognosis. The patient and family are in crisis because of the anticipatory grief everyone is experiencing at this time. However, there are practical problems developing as well due to the need to decide where and how the patient is to be cared for while her physical condition deteriorates. The questions and problems become more and more complex and the decisions to be made are difficult. Some studies have been conducted that demonstrate the difference in perceptions between caregivers and patients. These differences in perceptions make conflict inherent in the relationship. No published studies have examined whether or not nurses intervene in these normal, but conflictual situations. For this reason, this study addresses the question of how do nurses intervene in normal family conflicts.

Statement of the Problem

The problem explored in this study was how nurses facilitate conflict resolution among terminally ill cancer patients and their families. The conflict centered around two of the most common problems
of the terminally ill which are pain control and anorexia.

**Statement of the Purpose**

The purpose of this study was to determine what nurses do to inter­vene when confronted with conflict between care needs identified by terminally ill cancer patients and care needs identified by their families. Care needs centered around pain control and anorexia.

**Conceptual/Theoretical Framework**

This study was based on Kriesberg's (1973) conflict theory and Travelbee's (1971) theory of illness, and Deutsch's (1977) theory of conflict resolution. According to Kriesberg (1973), conflict theory is based on the assumption that conflict is inherent in all human relations. Kriesberg states that "Conflicts vary in their bases, their duration, their mode of settlement, their outcomes and their consequences" (p. 1). All of the aforementioned characteristics relate to the conflicts seen with terminally ill patients and their families.

According to Deutsch (1977), conflict resolution will be strongly influenced by the context within which the conflict occurs such as the cooperative or competitive context. Deutsch makes four points about conflict resolution:

First of all, the conflicting parties must themselves be organized . . . So long as conflicting forces are diffuse, incoherent aggregates, regulation is virtually impossible. Second, each party to a conflict must be willing to recognize the legitimacy of the other party and be committed to accepting the outcome of the regulated conflict, even
if it is considered to be unfavorable to his interest. Third, it should be noted that the conflicts that are regulated are not likely to be the unprecedented ones. Finally, and perhaps most importantly, the regulation of conflict is most likely to develop when both sides to a conflict are part of a common community (pp. 377-378).

According to Travelbee (1971), patients and families must realize that life consists of conflict. They must face, confront, and endure conflict which is the core of the human condition. Travelbee believes that nursing's role as supporter and sustainer must be emphasized when dealing with the terminally ill. The ability to intervene effectively and assist an individual in a time of crisis requires study and a disciplined intellectual approach. It cannot be left to chance or intuition. This framework provides the basis for studying family conflict and how nurses intervene in this phenomena.

Definition of Terms

Conflict: whenever two or more people differ with regard to facts, beliefs, feelings, or opinions.

Conflict resolution: the process whereby a solution is decided upon and no major resistance is encountered.

Facilitate: to make something easier to understand.

Family: a group of people who share a past and experience some degree of emotional bonding.

Terminally ill: those persons who have a prognosis of 12 months or less to live.
Significance of the Problem

Bercovitch (1984) argues for the adoption of a broader perspective on conflict which suggests the centrality of conflict to all social situations. The author reports that parties in a conflict situation are not usually in a mood for cooperation, indeed they may often wish to withdraw or cease communicating. Amenta & Bohnet (1986) report that nurses need to acknowledge that conflict exists between terminally ill patients and their families and use appropriate techniques to manage conflict. Conflict resolution can promote change, motivate people to examine themselves, and strengthen relationships. This will improve the quality of life experienced by the patient and the family by intervening in a manner to promote conflict resolution.

This study will benefit nursing by determining if nurses facilitate conflict resolution with terminally ill patients and families. The nursing profession needs to know how the members intervene in order to evaluate their effectiveness in patient care.

Assumptions and Limitations

Assumptions

1. It is within the nurse's role to resolve conflicts.

2. Conflicts are common in families where one member is terminally ill.

Limitations

1. The small sample population does not represent nursing at large.
2. The original data collection tool does not have established reliability or validity.

3. The research tool consists of contrived situations which project how nurses might practice, but not how nurses in fact really do practice.
Chapter II

Review of Literature

A review of literature was derived mainly from the disciplines of nursing and psychology. Literature which addressed both conflict resolution and the terminally ill was non-existent. The researcher reviewed literature relating to conflict and conflict resolution; perceptions of the nurse, caregiver, and patient in terminal illness, and denial of death with the patient, family, and nurse.

A sound foundation was laid by the above literature to perform an exploratory study of conflict resolution. The literature supported the assertion that conflict was inevitable in these relationships.

Perception of Patient, Family, and Nurse in Terminal Illness Relationships

Since many primary caregivers are spouses, it is appropriate to cite a study by Beach and Arias (1983) on perceptual discrepancy of the spouse. These authors found that both spouses in a distressed marriage agreed on how poorly they communicated, while the spouses in non-distressed marriages reported they were better communicators.

This raises the possibility that positive distortion can be a healthy and useful aspect of a well functioning marriage. Conversely, the fact that spouses in non-distressed relationships have more positive self perceptions than one would expect on the basis of their
spouse's perceptions of them may reflect the power of a satisfying relationship to enhance self esteem (Beach and Arias, 1983, p. 315).

From this study one could expect that a happily married couple would have difficulty perceiving conflict. Moreover, if the couple did perceive conflict they would believe they possessed the communication skills to resolve the conflict between themselves.

In 1982 a needs assessment study for terminally ill cancer patients and their families was performed by Grobe, Ahman, and Ilstrup. The four areas researched were: 1) the need for family education regarding caring for a terminally ill family member; 2) the terminally ill person and family member's need for services; 3) how effectively symptoms were being managed; and 4) the subject's preference for location at time of death. In general, it was found that families needed more services than patients, which suggested that the family warrants increased attention. A high level of disagreement was found between patients and families about perceived needs. The authors attributed this discrepancy to poor communication in these relationships.

Three studies looked at the family members as the primary caregivers and found that they wanted nursing to focus on the patient's needs and not their needs (Freihoff & Felton, 1976; Kirschling, 1986; Skoupa & Bohnet, 1982). Kirschling found that caregivers prefer to center attention on the physical and psychological needs of the terminally ill. The caregivers verbalized their needs as follows:
1) to be with the dying person; 2) to be helpful to the dying person; 3) to receive assurance of the dying person's comfort; 4) to be informed of the dying person's condition; 5) to be informed of the impending death; 6) to ventilate emotions; 7) to receive comfort and support from family members; and 8) to receive acceptance, support and comfort from health care providers (p. 124).

The researcher found that caregivers perceived the first, second and fifth needs as being met fifty percent of the time or more. The other needs were met less than fifty percent of the time. This study confirms that nurses are not perceiving the caregiver's needs for the majority of physical and psychological needs.

Skoupka and Bohnet (1982) studied twenty primary caregivers in a home care and hospice setting. "A Q-sort was used to rank seventy-five nursing behaviors from those being most helpful to those being least helpful" (Skoupka & Bohnet, p. 371). This study found that the primary caregiver valued nursing behavior which focalized on the patient's physical and then psychological needs and lastly on the needs of the primary caregiver.

A study of bereaved primary caregivers found that the least desired nursing behaviors were to encourage the caregiver to cry or hold their hand or to remind them that the patient's suffering was almost over (Freihoff and Felton, 1976). Again, these authors found that the primary caregiver wanted the physical and psychological needs of the patient to be the focus of attention.
A study on the expected and observed behaviors of nurses and terminal patients found that half of the nurses thought idiosyncratic behavior of terminal patients was tolerable (Keith & Castle, 1979). These patients thought cooperative behavior should be expected. Keith and Castle divide nursing behaviors into expressive and instrumental behaviors. Expressive nursing behavior is not directed toward attainment of a functionally specific goal. It is behavior which organizes the flow of emotional gratification and wards off deprivations. Expressive actions are related to maintaining emotional equilibrium. Instrumental behavior is directed toward the future attainment of a specific goal. It was found that nurses expected expressive nursing behavior to take preference; however, the patients expected instrumental nursing behavior. Keith & Castle state:

Responses of nurses indicate the potential for conflict which could involve both patients and colleagues. These data which revealed somewhat disparate professional expectations and perceived deviations among nurses, provide some empirical support for the descriptive literature which suggests that skills and behavior involved in the care of terminal patients lack clarity (pp. 26-27).

Another study was conducted on the caregiver's frequent misperceptions to determine if they accentuated or minimized the patient's feelings. The caregiver in this study was the nurse. The purpose of the study was to determine whether there was congruence between the caregiver's evaluation of an oncology patient's level of anxiety,
hostility, and depression, and the oncology patient's reported level of these three affective states (Jennings & Muhlenkamp, 1981, p. 485). The study consisted of 28 terminally ill hospitalized oncology patients who were asked to complete a Denial Test and the Multiple Adjective Affect Check List. Jennings and Muhlenkamp state, "The findings showed that caregivers rated the patients as feeling considerably worse than the patients reported" (p. 485).

Kirschling and Pierce (1982) conducted a study with ninety-seven nurses in six practice settings (adult intensive care, cardiac intensive care, pediatric intensive care, oncology, psychiatric, and hospice) on their perceptions of care with the terminally ill. The mean score for nurses practicing in a hospice setting was significantly lower for the thought that nursing was more stressful and depressing when caring for the terminally ill. Also, the hospice nurses scored significantly higher on measuring how rewarding they found their career. "Caring for a patient who is going to die has all the elements of threat, failure, and helplessness that are often associated with the process of dying itself" (Kirschling & Pierce). This study indicates that perceptions among nurses differ depending on the area in which the nurse practices.

Conflict and Conflict Resolution

Conflict and conflict resolution has been studied and described by many authors who consider conflict as normal and to varying degrees helpful to relationships (Amenta & Bohnet, 1986; Fischer, 1980; Friedman, 1986; Deutsch, 1977; Kreisberg, 1973; Scanzoni & Polonko, 1980; Simmel, 1955; and Strauss, 1979). According to Kriesberg (1973),
conflict theory is based on the assumption that conflict is inherent in all human relationships. The author states, "Conflicts vary in their bases, their duration, their mode of settlement, their outcomes and their consequences" (p. 1).

Suppression of conflict can result in stagnation and a failure to adapt to changed circumstances (Strauss, 1979). Strauss (1979) believes that conflict erodes group bonds when hostility is not expressed. This author contends, nonetheless, that people fear conflict and try to avert it. Moreover, professionals concerned with families treat conflict as something to be avoided.

A schematic description of conflict has been described by four nursing authors and can be applied to any relationship (Sundeen, Stuart, Rankin, & Cohen, 1985). These conflicts are: 1) approach-approach arises when two goals are equally attractive at the same time; 2) avoidance-avoidance involves two negative goals; and 3) approach-avoidance is the most difficult to cope with because the person is both repelled and attracted by the same goal (Sundeen, et al. 1985). Certainly the approach-avoidance conflict is found in care of the terminally ill because the family wants to care for the patient, but may be repelled by the physical deterioration.

One of the founding fathers of sociology, George Simmel (1858-1918) was the first scientific observer of the role that conflict played in human interactions (Friedman, 1986). Simmel (1956) stated,

Conflict is designed to resolve divergent dualisms; it is a way of achieving some kind of unity . . . Conflict is often necessary to keep an ongoing relationship going
without ways of ventilating hostility toward each other, and expressing dissent, family members may feel completely powerless and demoralized with withdrawal the usual outcome ... close; intimate family relationships are likely to contain both converging and diverging motivations, both love and hatred. In relationships where people are deeply involved, where they are engaged with their total personalities rather than a segment ... When conflict does occur, the closer the relationship, the more intense the conflict ... The more we have in common with another as whole persons ... the more easily will our totality be involved (pp. 13 & 125).

These observations address relationships of the terminally ill and how conflict could be exaggerated because of deep personal involvement. Simmel (1955) thought that the absence of conflict was not normal in a family and suggested that there was an underlying strain and insecurity in these families.

A specific type of conflict frequently discussed in nursing is role conflict. Friedman (1986) purports that role conflict develops when a person is confronted with incompatible expectations. The author described three types: 1) Inter-role conflict develops when two roles are incompatible; 2) Intersender conflict occurs when two or more people hold conflicting expectations; 3) Person role conflict develops between internalized values and external values communicated by others (Friedman, 1986). The role changes which occurs in families during terminal illness
would predispose all involved to the above role conflicts and contribute to conflict in care needs.

According to Bertman (1980), frequently there are conflicting ideas between the patient and family during the final stages of life. Bertman views nurses as often being the first ones involved in the conflict. For instance, the family may request that nurses withhold information from the patient at the same time that the patient may be requesting this very information. Kirschling & Pierce (1982) found that oncology nurses were more aware of conflicts between patients and families than nurses in other specialties and were more willing to combat conflict with open, honest communication.

Finally, Travelbee (1971) thought that patients and families must recognize conflict as an inevitable reality which should be studied in order to understand the complexities of relationships. The study of conflict will assist nursing in the process of assessment and intervention, thus providing better service to patients and families.

Denial of Patient, Family, and Nurse

Many authors have studied how modern man has developed the widely accepted attitude that denies death as long as possible (Amenta & Bohnet, 1986; Corr & Corr, 1983; Epstein, 1975; Schneidman, 1976; and Weisman, 1972). "It is not surprising that people find it difficult to accept the fact of their own dying. The self cannot seem to perceive its own nonexistence, and our culture reinforces this inability and even encourages it" (Epstein, 1975, p. 21). Everyone has their unique way of coping with death and these differences in perspective make
conflict inherent. Denial is by far the most common human reaction to an unpleasant problem.

Anna Freud (1948) is credited with identifying the mechanisms of defense, most notably the defense mechanism denial. Freud described denial as a primitive response to danger which avoids a threatening portion of reality. Glaser and Strauss (1968) described their dying patients as having degrees of closed and open awareness which varied from moment to moment.

Denial has been characterized in different ways but Kubler-Ross's description is one of the most popular. Kubler-Ross described five stages which patients may experience when told they have a terminal disease. These five stages are: denial, anger, bargaining, depression, and acceptance. Denial is described as the first reaction to a terminal disease and continues to be used intermittently throughout the dying process. Families also use these five defense mechanisms (Kubler-Ross, 1974). Families and patients are unlikely to be experiencing the same needs at the same time, thus the defense mechanisms being used will be different. The use of different defense mechanisms will make conflict inevitable.

Weisman (1972) describes three degrees or orders of denial of facts. First order denial is unequivocal because the discrepancy between the patients' perceptions and the observer's perceptions are so great (Schneidman, 1976). The patient disavows the primary facts of the illness (Schneidman). Second order denial refers to patients who accept the primary facts of illness, even the diagnosis, but cannot visualize the implications (Schneidman). Third order denial is experienced when
the patient accepts the diagnosis with its complications and hazards, but refuses to believe illness is incurable.

Pattison (1977) differentiated three forms of denial called existential, psychological, and nonattention denial. "Existential denial refers to the universal capacity to suppress awareness of the hazards inherent in everyday life" (Corr & Corr, 1983, p. 199). Psychological denial is a defense against anxiety which is unconscious. "Nonattention denial differs from psychological denial in that it is at least partly conscious and not usually accompanied by undue anxiety" (Corr & Corr, 1983, p. 199).

Much of the literature focuses on the patients' denial, but the family is experiencing many of the same emotions and reactions. According to Kutacher, Klagsburn, Torpie, DeBellis, Hale, & Tallmer (1983), "the family may deny the imminent death of the loved one and the effect it is having on all of them, but the worker must help them face it before the actual death occurs" (p. 151). Amenta and Bohnet (1986) reported that partial denial, coexisting with other coping responses, was needed to contain strength. Amenta & Bohnet stated, "Some parents may maintain almost complete denial to the end . . . Parents who exhibit continued signs of denial are often difficult to work with because of their mood swings . . . Their negation or reality should never be confronted without careful consideration of the possible consequences" (p. 208).

Harmful denial has been described as absolute and persistent by Smitheran (1981). Beneficial denial is a protective mechanism which is temporary and minimal allowing the person to function. Smitheran thought that if the denial was deemed beneficial then the nurse should
limit her response to sympathetic listening and not encourage or reinforce denial. If the denial is considered harmful the nurse should at first just spend more time with the individual because this recognizes that there is a problem. Reality reminders acknowledge the discrepancy gently such as "I'm glad you're feeling better, but you're still quite ill, you know" (Smitheran, p. 71).

Nursing staff who work with the terminally ill have been observed to experience denial. Epstein (1975) reported that practitioners have a tendency to avoid confronting the fact of death and can be trapped into concurring with the patient's denial. This prevents the patient from moving to a more realistic stance. The nurse needs to hold up a reference point in reality. If the nurse cannot face reality then she cannot give the needed support to the family and patient.

Pearlman, Stotsky, and Dominick (1969) studied the relationship between nurse's experiences with death and their behavior. The author found that, for the 68 nurses interviewed, as experience caring for dying patients increased, so did avoidance behavior. The experienced nurses were also uneasy discussing death with dying patients.

Nurses have been thought to have a more caring attitude toward dying patients because of the great deal of physical contact they have with patients (Thompson, 1979). Such intimate contact enhances a confidential relationship, but makes it more difficult to escape from the reality of death (Thompson, 1979). Also, nurses are given the duty of after death care for the human body. Thompson believes this helps nurses face the reality of their own shock and bereavement and the ending of these relationships.
In summary, the literature has shown how individual perceptions affect how and if a conflict is perceived. Family caregivers perceive the patient's physical and psychological needs as taking priority. Nurses tend to perceive patient's symptoms as considerably worse than does the patient. Perceptions play a significant role in conflict and conflict resolution by helping define the term for each individual.

Denial of death was found to be a defense mechanism widely used by patients and families throughout the dying process. Finally, conflict has been shown to be a normal, healthy phenomenon in families which needs to be confronted in order to resolve the conflict. The condition of the terminally ill cancer patients necessitates changes in roles causing conflict. The nurse's role is to resolve conflict among patients and families. This study presented the nurse with scenarios which demonstrate conflict and asked how they would intervene.
Chapter III

Methodology

Research Design

The research design for this study was exploratory in nature. The study is a level one, descriptive study because no previous literature could be found which linked conflict resolution in families experiencing terminal cancer and subsequent nursing intervention.

Population and Sample

The sample used was a convenience sample from two community based agencies; namely, the Park Forest Health Department and St. James Home Health Service. These two agencies were chosen because they both provide health service and because Governors State University's Division of Nursing has a contract to allow students to use their facilities. Another reason these agencies were used was that they had a reputation for employing baccalaureate-prepared nurses which was a criteria for this study. The Park Forest Health Department requires a baccalaureate in nursing as part of their job description. St. James Home Health Service recommends a baccalaureate in nursing as part of their job description.

The researcher contacted by phone the directors of both agencies to arrange appointments to meet with them to discuss the research study. At these meetings, the researcher explained briefly the proposal and purpose of the study. A willingness to share the results with the agency director was promised by the researcher. Both directors agreed
to participate in the study. A date and time was arranged to administer the research tool in a private area of the office. Letters were sent confirming the arrangements made with each director (See Appendixes A & B).

The sample consisted of ten registered nurses who met the criteria of having a baccalaureate in nursing and having cared for adult oncology patients. The nurses had a minimum of seven years experience in nursing and five years of experience in caring for adult oncology patients.

Informed Consent

Informed consent was obtained after the researcher explained the procedure for collecting the data. The researcher told the participants that the data was being collected to obtain information on nursing care of the terminally ill. Further, the researcher assured the participants that there were no right or wrong answers and that they could withdraw at any time. Lastly, the researcher informed the participant that there were no known risks and asked for their verbal agreement to participate. All the subjects agreed to participate.

Method/Instrument

The instrument was designed for this study because this particular question has never been the subject of published research. The researcher had a great deal of interest and experience with the care of the terminally ill. In consultation with the thesis committee, it was decided that two scenarios would be developed to describe what nurses do when confronted with conflict. These two scenarios were designed to
describe the same type of conflict and present the nurse with the
same type of nursing actions. Using two tools would help measure
reliability of the instrument.

The two scenarios were developed out of the experience of the
researcher and represented what was thought to be two typical families
experiencing typical conflicts, given their situation. The subjects
of anorexia and pain were chosen because that was the investigator's
expertise and an area where much conflict was expected. Five responses
were developed which the nurse was asked to rank as to which she would
choose first, second, third, fourth, and fifth. Again, the responses
were developed out of the experience of the researcher. The following
thoughts were considered while developing the nursing action options.
The facilitation of conflict resolution might be practiced by the nurse
through an educative process. Turning the conflict over to a physician
is usually an option because traditionally the nurse practices in
conjunction with a physician. An authoritarian action has a long
tradition in nursing, as well as medicine, and presumes the superiority
of knowledge or the possession of power by the authority. The last two
options, taking the side of the caregiver and ignoring the caregiver's
perceptions presented a dichotomy of perceptions. These options were
appropriate because the difference in perception between the patient
and the primary caregiver were the source of the conflict.

After the tool was examined by the chairman of the thesis committee,
the tool was presented to two more committee members in order to esta-
blish content validity. This jury of individuals confirmed that the
scenarios and their nursing action options appeared to describe a typical family experiencing conflict and how a nurse might intervene.

Procedure

The researcher began by introducing herself, explaining the procedure, obtaining an informed consent and collecting demographic data. All registered nurses in both home health agencies were given the opportunity to participate so as not to exclude nurses without bachelors. Both agencies were small and the administration of the research tool might draw attention if the researcher only questioned certain nurses. Since Governors State University has good relations with both agencies and their nursing staffs, the researcher thought it would be wise to include all nursing staff in order to continue good public relations. A baccalaureate was required because this is the recommended standard of practice for nurses in this field. The data collected on nurses who did not meet the criteria were discarded.

The subjects were given five minutes to read and respond to the research tool. A time limit was established to prevent the subjects from having too much time to consider the answer the subject thought the researcher would desire. None of the nurses had difficulty in completing the assigned task within the time period allotted. The researcher used a watch with a second hand to measure time.
Chapter IV

Analysis of Data

Sample Description

The sample criteria were met by ten subjects who had bachelor's degrees in nursing and experience in caring for adult terminally ill oncology patients. The demographic data collected included the number of years the nurse had practiced nursing and more specifically, the number of years the nurse cared for terminal cancer patients. The mean number of years the nurses practiced nursing was 13.7 with a range of 7 to 25 years. The mean number of years the nurses cared for terminal cancer patients was 8.3 with a range of 4 to 15 years.

Data Relating to the Purpose

Two scenarios with five nursing interventions to choose from were presented to the nurses. These scenarios are presented as they were to the participants (See Appendix C & D). The first response (A) presented to the participants in both scenarios demonstrated facilitating conflict resolution. The second response (B) presented to the participants in both scenarios demonstrated the nurse referring the conflict to the physician. The third response (C) presented to the participants in both scenarios demonstrated the nurse taking an authoritarian action. The fourth response (D) demonstrated the nurse taking the side of the caregiver, and the fifth response (E) demonstrated the nurse ignoring the caregiver's perception. The results for each scenario are discussed below, followed by a discussion
comparing the results and theories on why the respondents answered differently to each scenario.

**Research Results**

**Scenario 1**

The first scenario finds the nurse confronted with a conflict between the patient and the daughter over the problem of anorexia. The data demonstrated that a majority of nurses, seven would choose to facilitate conflict resolution as their first choice (Table 1). Six respondents chose to ignore the caregiver's perceptions as third option. No nurse chose to take the side of the caregiver or to ignore the caregiver's perception as a first choice. No nurse chose an authoritarian action or to take the side of the caregivers as a third option. Lastly, five of the respondents would take the side of the caregiver as their last choice as shown in Table 1.

**Scenario 2**

The second scenario finds the nurse confronted with a conflict between the patient and the daughter over the issue of pain. The data showed that four nurses would facilitate conflict resolution as their first choice and five nurses would facilitate conflict resolution as their second choice (Table 2). These data combined demonstrate that the nurse would choose to facilitate conflict resolution as one of her primary choices. An authoritarian approach was the third choice for eight of the nurses. Ignoring the caregiver was a first choice for six of the nurses. Turning the conflict over to the physician was a third choice for six of the nurses. Lastly, all ten of the nurses chose
Table 1

Ranking of Respondents' Choices to Scenario 1

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<thead>
<tr>
<th>Nursing Action</th>
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<th>3rd</th>
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<th>5th</th>
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<td>A. Facilitating conflict resolution</td>
<td>7</td>
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<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>B. Turning conflict over to the physician</td>
<td>0</td>
<td>3</td>
<td>2</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>C. Authoritarian action</td>
<td>1</td>
<td>3</td>
<td>0</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>D. Taking side of caregiver</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>E. Ignore caregivers' perception</td>
<td>1</td>
<td>1</td>
<td>6</td>
<td>2</td>
<td>0</td>
</tr>
</tbody>
</table>
### Table 2

Ranking of Respondents' Choices to Scenario 2

<table>
<thead>
<tr>
<th>Nursing Action</th>
<th>1st</th>
<th>2nd</th>
<th>3rd</th>
<th>4th</th>
<th>5th</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Facilitate conflict resolution</td>
<td>4</td>
<td>5</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>B. Turning conflict over to physician</td>
<td>0</td>
<td>2</td>
<td>6</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>C. Authoritarian action</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>8</td>
<td>0</td>
</tr>
<tr>
<td>D. Take side of caregiver</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>E. Ignore caregivers' perception</td>
<td>6</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
the side of the caregiver as their last nursing action. This indicates that the nurse would choose the patient's perspective over the caregiver's perspective.

Generally, it can be said that the nurses value conflict resolution as a first choice and taking the caregiver's perspective as a last choice. This group of nurses were experienced both in nursing and in the care of the terminally ill. Experience in these areas probably influenced the responses.

Comparing data from Scenario 1 and 2

These scenarios were designed to determine what nurses would do when confronted with conflict between care needs identified by the terminally ill cancer patients and care needs identified by their families. The researcher expected similar results to both scenarios, but the results demonstrated some differences in responses. The researcher will point out the differences below and speculate on why they occurred.

Although facilitating conflict resolution was the first or second choice for the majority of nurses in both scenario one and two, the nurses in scenario two chose it less often as their first choice compared with the choices in scenario one. Both scenarios have a patient, a primary caregiver, and a conflict between the two individuals. The major differences found between the two scenarios in retrospect is that the physician had an active involvement in the second scenario, but medical intervention in the first scenario had been exhausted. It could be speculated that the nurse is not as likely to choose to
facilitate conflict resolution as a first option when the physician is involved.

Turning the conflict over to the physician was not the first choice for nurses in either scenario. However, the nurses did choose to turn the conflict over to the physician as a second or third choice more often in the second scenario. The researcher speculates that the nurses are more likely to choose this intervention with scenario two because the presence of physician involvement represents an authority to turn to in time of conflict. Another consideration might be that the nurse feels more comfortable making decisions with anorexia than with pain.

An authoritarian action was more likely in the first scenario which addressed anorexia, than with the second scenario which addressed pain. Again, speculation might contend that the nurse feels more control and power over anorexia than with the issue of pain. The physician holds the power in the second scenario because of his active involvement in pain management.

Nurses in the second scenario unanimously chose last to take the side of the caregiver in the second scenario. The majority of nurses chose to take the side of the caregiver as a fourth or fifth option in the first scenario. This demonstrates a strong agreement with the two scenarios to rank low the nursing action of taking the side of the caregiver. Some speculation for why the nurses chose these actions might be that the nurses felt superior in their knowledge about anorexia and pain and the ability to assess and intervene on the patient's behalf in these conflicts because the primary caregiver might be viewed
as having little knowledge or power in these situations.

Not surprisingly, the majority of nurses chose to ignore the caregiver's perspective as a first or second choice in the second scenario. In the first scenario the majority of nurses chose it as a first, second, and third option. Again, it could be speculated that the nurse does not value the caregiver's perspective as much as their own perspective.

As stated previously, the two scenarios were designed to describe how nurses would intervene when confronted with conflict. The expectation was that ranking of choices would be similar in both scenarios. However, equivalency in reliability failed evidenced by some wide variations in raw data. This means that the instrument did not solicit the same responses from both instruments for all the possible choices to be ranked. The investigator speculates that the active involvement of the physician skewed how the nurses would intervene when confronted with conflict.
Chapter V
Discussion

Findings in Relation to Review of Literature

This study does not support Strauss's (1979) contention that professionals concerned with families avoid conflict. This study found a majority of nurses indicating that they would facilitate conflict resolution as their first or second choice.

Simmel (1955) asserted that conflict was normal but intense in intimate relationships and must be valued as needing attention. Again, the nurses in this study chose the nursing action which facilitated conflict resolution. Also, it could be suggested that nurses perceived conflict as a routine problem, otherwise a greater percentage of nurses might have turned the conflict over to the physician.

The study by Kirschling (1986) found nursing not meeting many of the needs of the primary caregiver. This study suggests support of that finding because the nurse chose the caregivers' perspective last in both scenarios.

Findings in Relation to Conceptual Framework

The results of the study suggest that nurses view conflict as normal and as something in which they can successfully intervent to find a solution. Deutsch (1977) purports that conflicts have similarities and are recurring in families which was also found to be true in this study. Nurses responded similarly when they ranked facilitating conflict resolution and taking the side of the caregiver.
The nurses in this study were experienced patient caregivers and this supports Travelbee's contention that conflict resolution requires study and a disciplined intellectual approach. Of course, experience does not guarantee a nurse can resolve conflict. However, these nurses have had a great deal of time to learn how to effectively intervene in patient/family conflicts.
Chapter VI

Summary, Conclusions, and Recommendations

In summary, conflict is found among patients and families because of differing perspectives. Denial is a common defense mechanism used by the patient, family, and nurse to protect themselves in order to function. This denial is most often temporary and helpful to the individual, but can become problematic if used too persistently. Nurses using denial can mislead patients and cause patient or family denial to be reinforced. Certainly, denial by the nurse would impact on the ability of the nurse to resolve conflict.

Conflict resolution was the action valued by the majority of nurses in this study. The caregivers' perspective was the nurses last priority according to the study. Traditionally, the nurse has focused on the patient as the object of care, but the trend is to view the total family as the recipient of nursing care. The literature suggested that the family has many unmet needs.

In conclusion, this study found that nurses experienced in the care of oncology patients valued conflict resolution as a nursing action to take priority over other nursing actions. The last nursing action chosen by the nurse was to take the side of the caregiver.

The review of literature suggested that families want nurses to focus on patients, however, it was also found that family needs are not being met. The question raised by this dilemma is whether nurses can resolve...
conflict in patient and family perspectives? This is an admirable goal which nurses are exploring in order to attain the excellence they strive to achieve. Conflict resolution may provide the technique nurses need to achieve this goal. This goal provides the impetus for further research in this area of nursing care.

Since this was a small study performed in a narrow geographic area with a group of experienced oncology nurses, no generalizations could be made about the entire nursing population interventions in situations of conflict. Using a group of nurses within both a wider geographic area and with less experience in oncology nursing might be more representative of how nursing is actually practiced. Further research could be conducted on conflict resolution other areas involving terminal illness such as preference of location during illness or time of death and how much information to give a patient about their condition. For instance the nurse could intervene by educating the family on how the patient is going to die, what the need might be and an estimated time frame for when the death will occur. It would be interesting to know if this information influenced a family to keep someone home to die and how the family felt about the experience several months after the death of the loved one.

The concept of conflict resolution is relatively new to the field of psychology and appears to have some value for nursing because it offers the possibility of reconciling family perspectives. These families will be more united and committed to the perspective they choose to deal with the terminal illness they are experiencing. The goal of nursing has
always been to provide emotional comfort as well as physical comfort. Conflict resolutions offers the possibility of emotional comfort to patients and families experiencing terminal illness.

Some recommendations to improve the study would be to focus on enhancing the validity. Improvement in the validity of this study could be achieved in a variety of ways. One way would be to present the nurse with a similar scenario which is based on a current family situation and then observe the nursing action used when confronted with conflict. Construct validity could be established on the concept of conflict resolution by using a group of independent judges to observe and record evidence of this behavior. Some unsolicited comments by the research subjects during this study confirmed that these conflicts were typically found, but there were other options to be considered in addition to the ones presented. Future researchers might consider exploring the range of interventions a nurse might use in a given situation. These are just a few ways to improve the validity of this instrument. Instrument development in itself is the subject of extensive research.

Some questions raised by this study which could be explored in future research are as follows: a) Does the nurse feel more competent in the area of anorexia than in the area of pain control? 2) Does physician involvement affect how a nurse views her competence in conflict resolution? 3) is the nurse less or more authoritarian when the physician is involved? 4) Does the nurse feel superior over the primary caregiver and how does this affect conflict resolution? 5) What types of nursing interventions are used to resolve conflict? These are just some of the
questions that this research study has raised and it is hoped that future research will explore these questions in order to enhance nursing's knowledge of conflict resolution through nursing intervention.
References


Appendix A

Mary Ann Wolfenson  
Governors State University  
Graduate Candidate

Ms. Lois Coxworth  
Director, Park Forest Health Dept.

Dear Lois,

It was such a pleasure to meet with you again. I am grateful for the time and attention you granted me. I feel it an honor to have an opportunity to implement my thesis in your setting, because of the reputation your agency has for giving quality nursing care.

As we discussed, I will be in your office on August 23rd to meet with your staff. I will arrive at 9:00 a.m. and plan to stay until I meet with most of the staff. I will meet with each nurse individually and privately. You have seen the instrument and know it will not be lengthy. I hope it will not be too inconvenient to you or your staff.

Again, I must thank you for all the hospitality you have shown me. I look forward to being at Park Forest Health Department on August 23, 1988.

Sincerely,

Mary Ann Wolfenson  
Governors State University  
Graduate Candidate
Appendix B

Mary Ann Wolfenson
Governors State University
Graduate Candidate

Ms. Ruth Topping
Director, Home Health
St. James Hospital

Dear Ruth,

It was such a pleasure to have met you. I am grateful for the time and attention you granted me. I feel it an honor to have an opportunity to implement my thesis in your setting, because of the reputation your agency has for giving quality nursing care. I support your struggle to survive these turbulent times because of the nursing shortage and the economic cut-backs.

As we discussed, I will be in your office on August 2 & 3 to implement my thesis with your staff. I will arrive at 8:30 a.m. and plan to stay until approximately 10:30 a.m. This should be enough time to meet with all the staff available. You have seen the instrument and know it will not be lengthy. I will need to meet each nurse individually and privately.

Again, I must thank you for all the hospitality you have shown me. I look forward to meeting with your staff.

Sincerely,

Mary Ann Wolfenson
Governors State University
Graduate Candidate
Appendix C

Scenario One

The patient in question is a 72 year old female with breast cancer which has metastasized to the bone. This woman is 5'6" tall and weighs 90 lbs. The primary physician has given her a prognosis of two months or less. The physician wants comfort measures. The community health nurse makes her second visit and finds that the issue of eating has become a great source of conflict between the patient and daughter, age 40, who is acting as the primary caregiver. The patient ate a half a slice of toast and a cup of coffee yesterday morning, a soft boiled egg and a 6 ounce glass of 7 UP for lunch and 3 tablespoons of oatmeal and 6 ounces of 7 UP for dinner. There were sips of water with Zantac bid po and MS Contin tid po. The patient reports pain is in good control and that she is eating plenty. All the antiemetics have been tried along with Dramamine which has been unsuccessful in improving appetite and the primary physician reports nothing else can be done. The patient reports she has no nausea, but if she pushed herself to eat she would vomit. The daughter reports that she tries all day long to get her mother to eat. She tries 6 small meals per day and will prepare her anything she wants. The daughter "just can't understand why she won't eat."

Rank the following responses from one to five in terms of how you would treat the situation.

1. Explain the cancer disease process and how it affects the ability to eat and stimulates the vomiting center.
Contact the primary physician to discuss the client's inability to eat and the daughter's constant insistence that she tries to eat.

Tell the daughter to stop pushing food on her mother because she is dying and cannot eat more than she is presently eating.

Suspect that the patient is being a little stubborn and a power struggle has developed. Make a list with six times of the day and tell the patient she must eat something at this time.

Further assess the client's anorexia.

Explanation of above responses (not included with original tool)

First response represents facilitating conflict resolution.
Second response represents turning conflict over to the physician.
Third response represents authoritarian action.
Fourth response represents taking the side of the caregiver.
Fifth response represents ignoring the caregiver's perception.
Appendix D

Scenario Two

A 63 year old male patient who has prostate cancer which has metastasized to the lumbar section of the spinal column. The primary physician gives him a prognosis of 3 months. A community health nurse is making her third visit. This nurse has developed a good rapport with both the patient and the 30 year old daughter who is the primary caregiver. On the last visit the client's pain was not being treated effectively with Tylenol #3 two tablets every three hours. The physician started the client on Morphine 10mg every 4-6 hours po around the clock and Motrin 200 mg tid po.

Today the nurse is assessing the effectiveness of the new drug regime. The patient is still complaining of pain in the mid-back region. The numerical value is a 6 on a scale of 0-10 (0=no pain and 10=most severe pain imagined). The patient is sleeping fairly well at night, but is no longer able to tolerate sitting up as he was able to one week ago. The nurse gathers further assessment data from both the caregiver and the patient. The daughter states emphatically that her father does not have pain because he does not complain and sleeps good at night.

Rank the following responses from one to five in terms of how you would treat the situation.

_____ Explain to the daughter that many times patients try to protect their families by not verbally expressing their pain and why it is important to acknowledge and treat their pain.
Contact the primary physician and give him all the assessment data including the fact that the daughter does not believe he has pain.

Tell the daughter that if the patient says he has pain, then he has pain.

Suspect that this pain is not as bad as the client claims and reassesses next visit.

Further assess the client's pain by determining how it affects all his activities.

Explanation of above responses (not included with original tool)
First response represents facilitating conflict resolution.
Second response represents turning conflict over to the physician.
Third response represents authoritarian action.
Fourth response represents taking the side of the caregiver.
Fifth response represents ignoring the caregiver's perception.