MEASURING THE IMPACT OF ORGANIZATIONAL DOWNSIZING AND RESTRUCTURING ON GENERAL DUTY NURSES IN A LARGE ACUTE CARE HOSPITAL

by

Ingrid Cheryl Olson

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MEASURING THE IMPACT OF ORGANIZATIONAL DOWNSIZING AND RESTRUCTURING ON GENERAL DUTY NURSES IN A LARGE ACUTE CARE HOSPITAL

BY

INGRID CHERYL OLSON

A Thesis submitted to the Faculty of Graduate Studies of the University of Manitoba in partial fulfillment of the requirements of the degree of

MASTER OF NURSING

Abstract

A quantitative study design was developed to measure the impact of organizational downsizing on nurses, in a hospital setting, who continued to be employed during the restructuring process. A conceptual framework developed by Davy, Kinicki, and Scheck (1991) guided the research. The model states that, as global process control (GPC) increases, so does perceived fairness of layoffs and job satisfaction. It further states that as job security increases, so does job satisfaction. Behavioural intent to withdraw decreases with higher job security. Perceived fairness, job satisfaction, and organizational commitment are viewed as mediating factors to behavioural intent to withdraw. Measures of health, stress and supports were also incorporated in this research. Goldberg's (1972) General Health Questionnaire (GHQ 12) was used as a standardized measure of psychological health.

Subjects (N = 93) were self-selecting and included 26 nurses who had been displaced as a result of restructuring. Data analysis did not support the relationships as proposed by Davy et al. (1991). However, some significant relationships ($p=<0.05$) were confirmed between GPC and job satisfaction, and between job security and job satisfaction. New correlations were found between perceived fairness and job security, GPC and organizational commitment, and job security and organizational commitment. Stress and GHQ were positively correlated to each other and negatively correlated to job satisfaction.

The results of this study indicate that the impact of downsizing and restructuring on nurses is significant and requires a revised theoretical framework from the one applied. More sensitive measures and the inclusion of health are recommended in future studies.

Acknowledgements

The process of completing a graduate degree is always a challenging learning experience by all reports. For me this presented an even greater challenge as I relocated to another province, assumed a new job, and continued with my thesis research work on a long-distance basis. I am fortunate to have been supported in my efforts by many colleagues and friends both in Winnipeg and in my new home in Victoria. You all know who you are and have all been helpful in too many ways to mention.

My thesis committee provided support, expertise, and guidance through out the process. They accommodated me during my quick trips to Winnipeg and in the many faxes, phone calls, and e-mails. Dr. Erna Schilder, chairperson of the committee, allowed me to be myself and encouraged me to be my personal best.

Professor E. (Betty) Thomlinson provided editorial expertise and kept me grounded with a balance of expectations and reality. Dr. John Arnett provided valuable guidance in the area of research tools and reporting of the quantitative results.

A special thanks to my sister, Karen, who helped me overcome some of the long-distance challenges by taking my work off computer disks, printing and copying 26 ethical research proposals and 200 questionnaire packages, and allowing me to stay with her and her family during my trips to Winnipeg.

Finally, I would like to thank the nurses who took the time to respond to the questionnaire and the hospital for allowing me access, you know who you are.

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INTRODUCTION AND APPROACH

Chapter I

Statement Of The Problem

At the National Nursing Symposium held in Winnipeg in 1990 a gathering of invited delegates discussed some of the issues and concerns facing the nursing profession. One challenge consistently identified by speakers was a shortage of nurses to meet the needs of the health care system. Curran (1991) reported that 63 % of hospitals in the United States were experiencing serious nursing shortages with 10 to 12 % of their permanent fulltime positions remaining vacant. Similar shortages were being experienced in Canada. With enrollments in nursing schools down by as much as 22 % and the popularity of nursing as a career choice falling from one of the two most common choices in 1970 to 92nd in a list of 100 in 1990, an influx of nurses entering the job market was not anticipated (Pringle, 1991).

One year later, rising health care costs coupled with personal tax burdens and increased provincial and federal deficits brought provincial health ministers together. While they made a renewed commitment to the principles of the Canadian health system: universality; accessibility; comprehensiveness; portability; and public administration, the ministers also pledged to manage the system within the constraints of the resources available.

The result of the assembly was a new approach to meeting the health care needs of Canadians through reform to the system. The intent of reform was to deliver health care in a better way. The proposed reforms included plans to review health related services. It was not intended to be solely a cost cutting

exercise. The goal of these changes was to implement care delivery models in a more creative, efficient, and effective way which would better utilize human, fiscal and technological resources as well as provide for delivery of services in the community or home whenever possible (Manitoba Health, 1992). An implicit assumption was that, through implementation of this plan, hospital based services could be decreased, reorganized, reallocated, or in some cases be completely eliminated. The plan was quickly implemented and was evidenced by bed reductions in many hospitals, closure of some hospitals across the country, and the movement of some hospital based services into the community.

By 1992 the Manitoba government, labour unions, and urban hospitals were meeting to establish a cooperative plan to manage the labour adjustment issues that would accompany the health care system restructuring that was about to be implemented in that jurisdiction. In the fall of 1992, one chief executive officer wrote in an open letter to hospital staff, that the restructuring process would not be painless but there was an organizational commitment to make the necessary changes as easy as possible for each employee. In an effort to be true to this statement, middle and upper management staff were given training on how to deal with the effects of downsizing on staff. When displacements began early in 1993, additional skilled counsellors were added to an already well established employee assistance program, specifically to offer support to staff who were laid off or whose positions were deleted.

As health care restructuring was implemented, bed closures and

alternative methods of care delivery within hospitals led to displacements, bumping, layoffs, position deletions, and termination of staff. This generally affected all departments and all levels within reorganizing hospitals. For unionized staff members, there was some degree of job security within the terms of their respective collective agreements but this did not protect those with little or no seniority or those outside of collective bargaining units.

Nurses comprise the largest single classification of direct patient care workers in a hospital. This fact puts nurses at risk for layoffs or displacements as they are most likely to be affected by restructuring and bed closures that occur in any hospital. While some nurses have been laid off, many others have been displaced and have exercised their seniority and bumping rights in order to maintain employment within the organization. For nursing staff, this was a new experience and was in sharp contrast to the nursing shortage trend noted just two years earlier by speakers at the National Nursing Symposium. Despite the organizational commitment to facilitate the downsizing in one large acute care setting, this process was *not* painless for staff.

Research Questions

The purpose of this study is to measure the impact of organizational downsizing and restructuring on general duty staff nurses in a large acute care hospital. Specifically:

1. Have the nurses been directly or indirectly affected by this process?
2. Is this process affecting the nurses' professional commitment?
3. Is this process affecting the nurses' commitment to the organization?
4. In which way does this affect overall job satisfaction?
5. What is the impact on the nurses' general health status?
6. What supports/coping mechanisms, if any, have the nurses found helpful in dealing with any stress that has resulted from this process?

Objective of the Study

The researcher developed the investigation tool based on previous research on the impact of unemployment and surviving a layoff. In this study, the investigator will use this tool to measure the survivors' responses to layoffs and displacements in a health care setting. As nurses face the prospect of continued displacement and threats to job security, it is vital that researchers know more about the ways in which nurses are affected so that they may manage and cope with these stressful, but unavoidable changes.

It is expected that this study will provide direction for nurses, managers, and organizations in decreasing the stress associated with involuntary job changes in an acute care hospital setting. This study will add to the sparse

literature on the topic of layoff survival, specifically as it applies to nurses. It is anticipated that this study will provide an empirical basis for further research on the topic of displacement and layoff survivors' reactions in nurses. This research also has the potential to be theory generating.

Definitions of Terms

Bumping is a commonly used term among unionized employees. This refers to the process where an employee with seniority is displaced out of his/her existing job. He/she then exercises his/her seniority rights to displace or "bump" a less senior employee out of his/her position. The domino effect can occur but this ensures that the most senior employees continue to have a job while the employees with the least seniority are laid off.

Displacement is the process whereby an employee is displaced from his/her current position and forced to move into an alternate position. This may be a result of restructuring or bumping. In a unionized setting, the least senior employee may be displaced to a layoff list and would be subject to recall.

Layoff is a term used generically to refer to all involuntary employee reductions for causes other than performance. Layoffs in a unionized setting imply that the employee may be recalled and generally has some rights related to the process of recall when jobs become available.

Layoff survivors are those people who remain in the organization after involuntary employee reductions.

Layoff survivor syndrome/ illness/sickness are terms used interchangeably to describe a common set of symptoms that emerge in layoff survivors. These symptoms include guilt, anxiety, fear, insecurity, anger, and in more severe cases, depression or other emotional and physical ailments.

Organizational downsizing is a process whereby the organization reduces its size to maintain economic viability. Downsizing can be related to mergers, poor economy, advancing technologies, and obsolete products or services to name only a few motivating factors. Other terms applied to the same process are "right sizing" and "restructuring".

Position deletions result when programs and/or departments are reduced in size or closed completely. The employee's position is deleted and the individual is displaced from his/her job, laid off, or terminated. The employee's status may be dependent on union membership and/or seniority.

Restructuring is a broad term used to describe the activity that results when an organization reorganizes itself in the attempt to do more with less. This may result in redefining the work that is to be done, how it is to be done, and who will do it. Organizational structures for management and line staff may also change as a result of the restructuring.

Termination implies a reduction in work force where there is no likelihood of return to work. It does not imply poor performance.

Survivor guilt can generally be defined as a feeling of responsibility or remorse for some offense. In the case of layoff survivors, this can be attributed

to the good regard held for employees who are laid off or terminated by those who have survived them. This leaves the survivors feeling angry, guilty, doubting their own job security, and can lead to depression in some cases. These feelings are also symptoms of layoff survivor syndrome.

Chapter II

Conceptual Framework

In this study, the researcher will test a conceptual framework proposed by Davy, Kinicki and Scheck (1991). This model was based on previous work by Brockner and Greenberg (1990) in which justice framework provided the theoretical grounding for predicting survivors' reactions to layoffs. Brockner and Greenberg proposed that the justice literature was a good fit with the layoff process, as it represented a series of events in which survivors were likely to evaluate the fairness of the organization in carrying out the layoffs. Some of the key elements that were seen by employees as contributing to a just decision by management were (a) how decisions of who was to be laid off were made, (b) how the news of layoffs was conveyed to those who had lost their jobs as well as to those remaining in the workplace, (c) the relationship the survivors had with the laid off workers, and (d) the kind of supports and benefits the company provided to exiting employees.

Davy et al. (1991) incorporated the procedural justice portion of Brockner and Greenberg's framework into their own model. Procedural justice was defined as the fairness of the processes used to arrive at an outcome. Where individuals have had input into the decision making process, even negative outcomes are better received (Brockner & Greenberg, 1990). This concept has also been called process control.

Davy et al. (1991) built on this procedural justice framework and developed a model to test an extended number of concepts in the responses of survivors to layoffs. The authors identified global process control as a predictor of perceived fairness of layoffs and job satisfaction. Job satisfaction was in turn seen as a mediating factor on organizational commitment and behavioural intentions to withdraw. Job security was conjointly identified as a predictor of job satisfaction. Job security was also seen to directly impact behavioural intent to withdraw.

Global process control was defined as the degree to which individuals are given opportunities to express their views or have a voice in how decisions are made (Davy et al., 1991). Global process control was defined as a separate concept from the perceived fairness of layoffs. This differs from Brockner and Greenberg's (1990) work which included how individuals perceived the fairness of layoffs in their definition of procedural justice or process control. Procedural fairness or global process control have consistently been demonstrated to have a positive relationship with job satisfaction. Davy et al. proposes that as global process control increases, so does the perceived fairness of layoffs (See Figure 1).

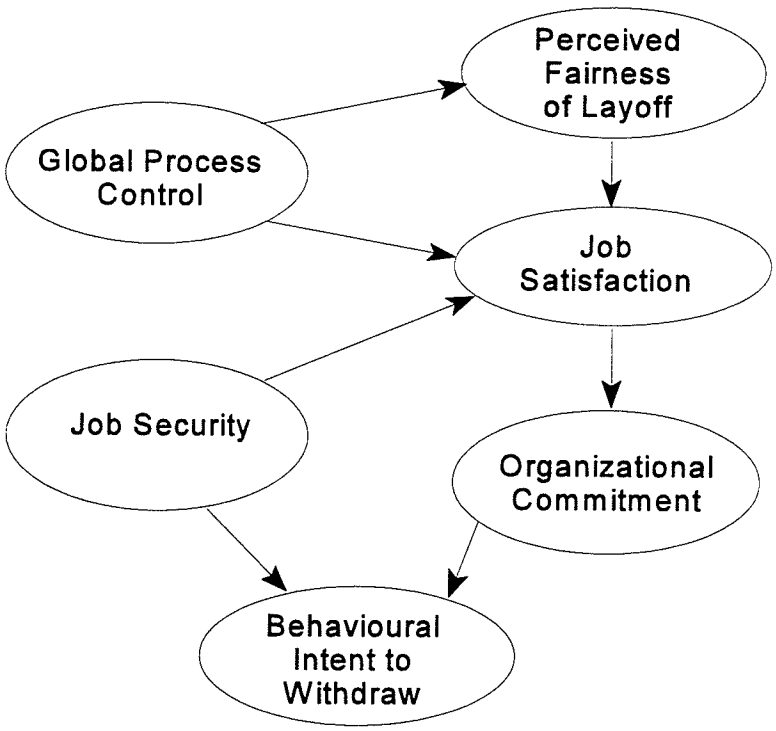

Figure 1. A theoretical model proposed by Davy, Kinicki, and Scheck (1991).

Perceived fairness of layoffs was defined as the individual's assessment of whether a procedure to enact a layoff was fair or not. Factors that contribute to processes being seen as fair include (a) following a consistent procedure, (b) decisions that were made without self-interest, (c) decisions that were based on accurate information, (d) decisions where there was an opportunity to correct the decision, (e) decisions were made with the interests of all parties in mind, and (f) decisions follow moral and ethical standards. Perceptions of fairness are increased where individuals are able to provide input into the decision making process. Perception of fairness of a current decision are also placed in the context of previous decisions in which the individual has been able to provide input. Thus, if previous decisions were positive and were based on the consideration of information provided by the individual to the decision maker, then the current decision is likely to be perceived as fair, even if no input was provided in the current decision. This perception is based on past positive experiences of the individual with that decision maker. Davy et al. (1991) hypothesized that if the individual perceived the layoff as fair, this would be an indication of higher global process control, thus leading to higher job satisfaction.

Job satisfaction has been demonstrated to have a direct and positive relationship to organizational commitment. Organizational commitment in turn has been demonstrated as a mediating factor on behavioural intent to withdraw (Davy et al., 1991).

Job security was also seen as having a positive relationship to job satisfaction. Employees who survived layoffs were often left with feelings of job insecurity. They believe that their jobs are at risk and that they may be the next to go as the layoffs continue. Davy et al. (1991) propose that reduced job security results in decreased job satisfaction which in turn affects organizational commitment. Both job security and organizational commitment are mediating factors on behavioural intent to withdraw. Behavioural intent to withdraw is most frequently identified as the individual actively seeking employment elsewhere and/or as being less productive and more withdrawn in the work setting.

Chapter III

Review Of The Literature

A recessed economy has led to business and plant closures in the United States that displaced over 11.5 million people between 1979 and 1984 (Hamermesh, 1989; Hoffman, Carpentier-Alting, Thomas, Hamilton, & Broman, 1991). Overall involuntary unemployment in the United States affected 7.6 million people between 1983 and 1986 (Davy, Kinicki, & Scheck, 1991). Keefe (1984) believes this figure is low and would agree with Hoffman et al. (1991) that the true number of people actively looking for work in the United States is closer to 12 million. Others estimate that actual loss of a job, affects nearly 10 million people annually in the United States (Caplan, Vinokur, Price, & van Ryn, 1989).

In Canada the official unemployment rate has run over 10 % for many years (Statistics Canada, 1994). In 1991, the unofficial, real rate, of unemployment was estimated to be approximately 19 % (Canadian Mental Health Association, 1992). This unofficial estimate included discouraged workers who had stopped looking for a job and those who were underemployed. This translates into over a quarter of a million unemployed Canadians.

In spite of this high rate of unemployment, jobs in the health care sector have traditionally been relatively safe from the spiralling downward slide of the economy that has affected most other industries. Statistics Canada (1994) reported that in 1990, unemployment in the medicine and health care category was at a ten year low of 2.4 %. Unemployment rates in this category rose to

3.6 % in 1993. This was still minimal in contrast to other classifications of workers, such as construction trades, where the unemployment rate was 21.6 % during the same period. The comparatively low unemployment rate in the health care sector, coupled with the previously documented nursing shortages, would lead most to believe that jobs in this field, represented a secure career choice (Curran, 1991; Pringle, 1991). As health care reforms were implemented in Manitoba suddenly no job in the hospital setting seemed secure (Suderman & Dyck, 1994). Hospitals began the arduous process of restructuring and right-sizing. Manitoba, was not alone in this task. Hospitals across the country were experiencing similar challenges associated with downsizing (Arndt & Duchemin, 1993; Corelli, 1994; Davis, 1988).

To gain an understanding of the impact of downsizing and restructuring on employees who have survived a company layoff, one must first look to the literature on organizational downsizing and unemployment. Through an increased knowledge of downsizing and restructuring on individuals who have left the workplace, one can better understand the effect of the threat of unemployment and the outcome of job insecurity to those individuals who remain in the organization.

Downsizing and Restructuring

How does a company or business economically stay viable in the corporate jungle of lost profits and increasing costs? The answer is through downsizing, restructuring, and productivity improvement programs. An economy

in recession, mergers, acquisitions, profit losses, increased costs, increased competition, advancing technology, and obsolescence are all motivating factors for organizations to downsize and restructure. In the hospital setting, advancing technologies have contributed significantly to productivity improvement by decreasing surgical stays which in turn have led to widespread bed closures (Corelli, 1994). Funding that did not keep pace with the rising costs or actual decreases in some funding packages from provincial and federal governments also affected most hospitals. This represents just some of factors that are affecting hospitals in their restructuring process. As hospitals and businesses accommodate for these various factors and try to do more with less, the end result is the same: a smaller workforce; attained through permanent deletion of positions, layoffs, attrition, and for a lucky few early retirement packages (Noer, 1993; Wallfesh, 1991).

From a management perspective there are numerous sources that provide descriptive reports on lessening the impact of job loss that results from organizational downsizing and restructuring on laid off employees (Arndt & Duchemin, 1993; Bonner, 1992; Kazemek & Channon, 1988; Veninga, 1987; Veninga, 1990; Wallfesh, 1991; Weinstein & Leibman, 1991). The advice offered includes delivery of layoff notices with sensitivity to the employee, supportive out placement services including pension and benefits counselling, and the need to provide all employees with information. These authors note the difficult process of managing employees' reactions to downsizing and

acknowledge the challenge of rebuilding confidence in the organization following layoffs.

Bonner (1992) likens the loss of job experience to that of grieving. Not only does the employee lose his/her job status but there is loss of supportive work relationships, loss of financial security, loss of self esteem, and loss of social status. Initial reactions are often that of shock, disbelief or betrayal. Employees often believe that because they have been loyal to the company, in turn, the company would be loyal to them. Noer (1993) suggests that the greater the trust of the employee that the company will take care of him/her, the greater the sense of violation when layoffs occur.

Management can ease the transition though extended benefits packages, job placement services, and career counselling. Employee assistance programs are also seen as playing a vital role in offering emotional support. Wallfesh (1991) echoes these recommendations but sees a greater role for the Human Resources department in planning and implementing job terminations. Of the companies studied, fewer than half had planned to downsize a year in advance. The author noted that had long term planning occurred, interventions to the "bloodletting" (Wallfesh, 1991, p. 179) could have been perceived as a tourniquet instead of a Band-aid. The use of outside consultants including out placement services, benefit and actuarial firms, labour lawyers, and retirement planning advisors was advocated for a variety of tasks. Communicating the vision of where the organization was going was also seen as vital. Public relations and

communications consultants were seen as beneficial in facilitating this aspect of the downsizing process.

Veninga (1987) approaches the management of downsizing as an organizational crisis. Keeping people informed and being honest was highly valued. Involving the most talented staff within the organization in problem solving and future planning was seen as extremely important in building trust and moving towards reestablishing equilibrium.

Most studies that measure the impact of displacement following restructuring are focused on those who are unemployed as a result of the reorganization (Hamilton, Broman, Hoffman, & Renner, 1990; Hoffman, et al., 1991; Romero, Castro, & Cervantes, 1988). Romero et al. (1988) found that 75 % of 114 female factory workers remained unemployed 18 months following layoff. Their largest stressors were reported as financial, fear of not being able to find another job, and stress on family relationships. Those who had valued the job they lost, experienced higher levels of stress.

In a large study of plant closures, 1,597 men and women were surveyed for their response to anticipated and actual unemployment. Those anticipating layoffs showed slight increases in depression, anxiety, and somatic complaints compared to their non-closing plant counterparts. Scores in the laid off group were significantly higher with women suffering more distress than the men (Hamilton et al., 1990; Hoffman et al., 1991). While women may suffer more, they are no more likely to be displaced than men (Hamermesh, 1989). Financial

and family stress was also experienced in the anticipating layoff group and was approximately mid-point between the stress experienced by the non-closing plant subjects and the laid off workers.

Some studies that examine populations that are considered white collar, professional workers reported that this group appeared to cope better with unemployment, at least in the short term (Jacobson, 1987; Little, 1976; Mallinckrodt, & Fretz, 1988). Little (1976) found that 48 % of laid off technical professional workers expressed a positive attitude towards job loss. These workers viewed the layoff as an opportunity to leave an undesirable job; a decision that had been considered previously but not acted upon. As length of unemployment increased, so did financial strain but this did not affect those who held a positive view of job loss. Families adapted to decreased financial resources with the spouse taking a more active role in supporting the family. Those who had difficulty occupying their free time had greater difficulty coping with unemployment.

Jacobson (1987) found that technical professional workers assigned meaning to their job loss according to their ability to meet their needs. These needs were seen primarily as financial. The better the worker was able to meet these needs, the less stressful job loss was for this class of workers. Mallinckrodt and Fretz (1988) reached a similar conclusion and also found that social supports decrease the perceived stress associated with job loss.

Studies that measure the impact of layoff on health workers who are in the anticipatory phase of losing their jobs is sparse (Dencker, 1989; Farley, 1991). Farley studied 39 multidisciplinary staff from a closing psychiatric unit that included nurses, social workers, and degree certified counsellors. Many of the employees had heard the rumours of pending layoffs. Some staff were assured that there was no truth to these rumours by administration or were promised that they would be assisted in finding alternative jobs within the organization. The initial response of the staff to their layoff notices was shock, disbelief and anger. Thirty of the 39 employees reported significant disturbances in sleep, appetite, headaches, back pain, and anxiety attacks. Several weeks following the layoffs, employees reported anger, depression, anxiety, and feelings of betrayal and devaluation of the work they did.

The laid off employees were given varied amounts of notice to leave their jobs ranging from one to six weeks. Job counselling was offered to just eleven employees. No effort was made to help the staff cope with the feelings associated with job loss nor were staff asked what supports they might need in making the transition out of the organization. The most effective coping strategy for the staff during the second to fourth week of the layoff notices was talking to their peers or others who had previously been laid off. Physical activity and support of family and friends were also important. Farley suggests that the layoffs were poorly managed by the institution involved. The author further hypothesised that administration panicked and assumed a defensive posture,

thus blaming the employees for problems related to the layoffs.

Dencker (1989) studied 221 mental health nurses and support workers in a closing psychiatric institution. Staff were surveyed on their views about (a) job security, (b) information needs, (c) job qualifications and training, (d) job satisfaction including the importance of working in teams, and (e) coping. The results indicated that staff who had worked more years were more worried about being unemployed than those who had been working fewer than two years. Employees were worried about having to work in different positions and possibly having to travel further to work. An overwhelming majority of the respondents felt that they received little or no information about the consequences of the closure for them. Rumours provided the greatest source of information. The greatest source of stress among the staff was the breakup of their team. This was closely followed by the anticipated stress of establishing new working relationships.

In the above study, it is interesting to note that the highly educated nursing staff left the hospital in droves prior to the scheduled closure, whereas support workers remained. This resulted in problems in recruiting replacements, early closure of some units, and increased financial costs for the institution as nurses were paid a special premium for staying on until full closure was completed. Surprisingly, approximately 60 % of the staff reported good or above average job satisfaction.

Clearly the impact of layoffs is significant for most people. Those with better financial means seem to cope better than others. Most suffer physical and psychological symptoms related to the anticipation of layoffs and the stress of unemployment. Those who were middle aged often feared they were under-qualified to find another job and were fearful of prolonged unemployment. While family and social supports were a significant mediating factor in coping with the stress of layoff and unemployment, this same stress jeopardized those relationships. In all companies where downsizing was occurring, the employees felt they received little or no information about the process or the impact this would have on them. It should be noted that in all but one study, employees were given regular information in the form of newsletters, special meetings, and other communiques.

This need for information is not a factor that has been studied in traditional research on unemployed subjects. However, in examining the body of literature on the impact of unemployment, one finds that all other aspects are similar to those identified in the impact of layoffs. In fact, most unemployed groups studied have often come to be unemployed through downsizing and restructuring. In the following studies, the impact of unemployment on individuals will be examined with particular attention being given to measurement scales that have been used consistently in this research. These tools have a demonstrated reliability in this area of study.

Unemployment Studies

Eisenberg and Lazarsfeld (1938) reviewed over 100 studies of unemployment conducted during the Great Depression of the 1930's. "The general conclusion of practically all workers in the field is that unemployment tends to make people more emotionally unstable than they were previous to unemployment" (Eisenberg & Lazarsfeld, 1938, p. 359). Today, the research literature on the psychological impact of involuntary job loss and unemployment continues to be extensive (Dew, Penkower, & Bromet, 1991; Dooley & Catalano, 1988; Frost & Clayson, 1991; Hamilton et al., 1990; Kasl, Gore, & Cobb, 1975; Linn, Sandifer, & Stein, 1985; Johoda, 1988; Romero, Castro, & Cervantes, 1988).

An increase in stress associated with unemployment has been consistently demonstrated in numerous studies (Frost & Clayson, 1991; Jahoda, 1988; Keefe, 1984). Baum, Fleming and Reddy (1986) found that unemployed subjects had higher levels of catecholamines in their urine. This physical response has been demonstrated to be a major indicator of the stress response.

Most studies have not gone to this extent to measure stress and the psychological impact of unemployment but have alternatively relied on self-reported responses to questionnaires. One frequently used tool is the General Health Questionnaire (GHQ) (Goldberg, 1972). This tool was first developed to detect non-psychotic mental illness. Shorter versions of the questionnaire were later developed and adapted by Goldberg for use in detecting impaired levels of

psychological well-being and mental health. It is important to note that low levels of mental health do not necessarily equate to mental illness (Jahoda, 1988).

Ensminger and Celentano (1988) used the 20-item GHQ in a sample of 269 unemployed men and women. They found that unemployed subjects were more distressed than either employed or reemployed individuals, regardless of gender. The authors also found that subjects who suffered from minor psychiatric distress while unemployed, recovered once they were reemployed.

In an earlier study Layton (1986) reached similar conclusions using the 60-item GHQ. In a six month follow-up study of 101 men who lost their jobs, those who remained unemployed at six months continued to show high levels of psychological distress. Those who were reemployed experienced significant improvement to their mental status.

Leana and Feldman (1991) studied 157 laid off aerospace workers. The average length of unemployment in this group was four months. Using the GHQ 12-item scale, the women in the study were found to suffer from higher levels of depressed affect, more somatic complaints, and more overall psychological distress than did the males in the study. This difference was not statistically significant and largely disappeared between the genders when similar job classifications were compared.

In a study by Ostell and Divers (1987) 63 male managers responded to a questionnaire that included the GHQ 12-item scale. These managers had all been unemployed for at least six months. Sixty-five percent of the managers

had a mean score on the GHQ that was more than double that defined by Goldberg (1972) as representative of poor mental health. Eighty-four percent reported a high need for a job. This high need for a job was a significant predictor of poor mental health. The need for a job was seen primarily as financial but strain on family relationships was also noted as a negative consequence of unemployment.

In a social class comparison study of unemployed blue collar and white collar working men, Payne, Warr, and Hartley (1984) found no difference between the working classes and their psychological distress. The authors used the GHQ 12-item scale and found that both groups of men had scores four times above the norm. The working class men were more frequently the sole wage earner of the household and suffered more financial strain than did the middle class workers. There were no differences between the groups in commitment to work. The middle class men were more likely to see opportunity in unemployment, while the working class were more likely to fear not being qualified to find another position, and to face permanent unemployment.

In a large British study Jackson and Warr, (1984) and Warr (1984) analyzed responses from 954 working class men. Age and length of unemployment varied. The GHQ 30-item scale was used to measure psychological ill health. Both the younger and older groups of men fared better than did the middle-aged group in the level of their psychological distress and physical ill health. However, all groups scored well above the norm on the GHQ.

Ill health was positively correlated to length of unemployment in the middle-aged group. The researchers did not find any relationship between poor health and length of unemployment in the younger and older groups. Financial strain on the family seemed to be a major stressor and contributed to poor mental and physical health in the middle-aged group.

Mallinckrodt and Fretz (1988) demonstrated that fewer financial concerns and stronger social supports decreased the number of stress symptoms experienced by the unemployed. For those who were able to retire or were near the end of their working lives, no relationship between duration of unemployment and poor mental health was found (Frese & Mohr, 1987; Jackson & Warr, 1984).

Warr and Jackson (1985, 1987) conducted two follow-up studies of their large group. Of the original 954 men, only 711 were interviewed in a nine month follow-up. A third set of interviews was held approximately ten months later. Four hundred and eleven men remained in the study. The mediating effects identified in the original study were not sustained over time. The results indicated that although all groups continued to have above average scores on the GHQ 30-item scale, indicating impaired mental health, there was an improvement in these scores from the original study. This was indicative of some level of adaptation to unemployment. Financial strain and social supports were no longer predictors of GHQ scores when unemployment exceeded 18 months. Poor physical health was the only predictor of reduced psychological adaptation. Similar results were previously found by Sommer and Lasry (1984)

in a longitudinal study of 101 Canadian men.

Findings of Broomhall and Winefield (1990) supported Warr (1984) and the Jackson and Warr/Warr and Jackson studies (1984, 1985, 1987). Thirty-three men were questioned on several aspects of their experience of unemployment. The average length of unemployment was 18 months. The GHQ 12-item scale was utilized to measure psychological distress. The younger group fared much better than the middle-aged men. The older group had significantly poorer mental health, less life satisfaction, and lower levels of social supports. In both groups, the best predictor of psychological well being was social support. The conclusions however are limited due to the small sample size.

Rowley and Feather (1987) investigated effects of unemployment in 107 young and middle-aged males. The GHQ-12 item scale comprised part of the study's questionnaire. The results indicate that middle-aged men experience more psychological distress than younger adults. In both groups more financial strain, less self-esteem, lack of structured time, and increased psychological distress all worsened with increased length of unemployment. Contrary to the Warr and Jackson studies (1985, 1987) the researchers did not find any evidence of adaptation to unemployment or decreasing GHQ scores in those who were without work for more than 18 months.

Winefield, Tiggemann, and Goldney (1988) and Winefield, Tiggemann, and Winefield (1992) conducted a longitudinal study of young people. They

surveyed 742 male and female students prior to their leaving school and followed the subjects for a seven year period. During follow-up interviews various versions of the GHQ were used to measure psychological distress. The researchers concluded that the GHQ 12-item scale was the most practical and reliable when used in combination with other measurement scales. In the follow-up period the authors defined three comparison groups as unemployed, employed, and employed but dissatisfied with the job. Pre-leaving school scores did not differ significantly between the groups or genders. The authors found that the unemployed and the dissatisfied employed groups did not differ significantly in their scores on the GHQ. Both groups were psychologically worse off than their happily employed counterparts regardless of gender. However, within these two groups, meaningful use of spare time appeared to be a mediating factor in helping people cope with unsatisfactory employment and unemployment. Using the GHQ 12-item scale Hesketh, Shouksmith and Kang (1987) also found that being employed did not decrease the adaptive GHQ score if one was unhappy in one's job.

Another factor strongly correlated to physical and psychological well being is job security (Kuhnert, Sims, & Lahey, 1989). However, job insecurity has not been widely researched. Greenhalgh and Rosenblatt (1984) identified consistent relationships between job insecurity and reduced work effort, intent to leave, and resistance to change. In a more recent study Kuhnert and Palmer (1991) demonstrated that perceived job security was a significant factor in

measuring the debilitating effects of unemployment. They further suggest that the threat of job loss represents more than just financial stresses. An individual's work role is incorporated into his/her sense of self. Individuals who define themselves by their work are more likely to suffer physical and psychological ill health when their jobs are in jeopardy. The authors advocate the provision of information to all employees where there are questions of job security in the organization. Kuhnert and Palmer (1991) found that employees who felt they were being given information by management in an open and honest manner, felt less threatened even if their jobs were in jeopardy. Greenhalgh and Rosenblatt (1984) found that the sense of powerlessness increased job insecurity.

Regardless of the group of people studied, there is an overwhelming agreement that the impact of job displacement, layoff, and unemployment has a negative effect on individuals and their families (Baum, Fleming, & Reddy, 1986; Canadian Mental Health Association, 1992; Dooley & Catalano, 1988; Ensminger & Celentano, 1988; Hagen 1983; Kasl, Gore & Cobb, 1975; Kessler, Turner, & House, 1988; Liem & Liem, 1988; Warr, 1984; Whelan, 1992). These negative effects include feelings of shock, anger, fear, powerlessness, increased physical health problems, increased mental health problems, particularly depression, anxiety, grieving and loss of self-esteem, financial worries, social isolation, and family and relationship difficulties.

For those who remain in the workplace, the threat to job security, anticipation of financial strain, and fear of the unknown, contribute to physical and psychological distress. The literature targeting survivors will now be reviewed to determine the full extent of similarities between those who are unemployed and those who have survived a layoff and remain employed in the workplace.

Layoff Survivors

The impact of involuntary displacement and layoffs on those who remain behind in the work site is an area which has not previously been widely studied. Noer (1993) refers to the remaining workers as layoff survivors. There is a growing recognition that the impact of layoffs on survivors can be severe and long lasting. Layoff survivor sickness, illness, or syndrome has been described as a set of attitudes, feelings, and perceptions that occur in employees who remain in the organization following involuntary job reductions. This is usually accompanied by physical and psychological distress.

In extensive field research, Noer (1993) found that survivors' feelings could be grouped into several major categories. Job insecurity was prevalent in all groups interviewed. The old employment contract which Noer defines as a psychological contract, where the employee who performs and fits into the culture could count on a job until he/she retired or chose to leave, was no longer the norm. Job insecurity seemed to be particularly high in those who had come up through the ranks under the old employment contract. These people often

felt they were ill prepared to enter the job market because of age, limited education, or limited skills.

Perceptions of unfairness were high and fell into two subgroups. Many were concerned that the choice of who stayed and who left was unfair while others were concerned that the decisions about who left were not equitably distributed throughout all levels of the organization. This was particularly true of line workers who felt that the top management and executives were either not being laid off or, if they were displaced, the executives left with large severance packages which were not extended to other classifications of workers.

Depression, stress, fatigue, reduced risk taking and motivation, anger, distrust, and a sense of betrayal were common to all groups. Most were frustrated by a perceived lack of management credibility and lack of strategic direction. They saw the reduction of the workforce as being profit oriented in the short term with no concerns for the loss of workers. The workers were dissatisfied with the planning process, lack of information, and just wanted the downsizing and restructuring to be over. In spite of this, there were some people in some groups that remained optimistic and continued to be committed to the company.

Kuhnert, Sims, and Lahey (1989) found increased symptoms of ill health were present in those who survived a layoff. Bonner (1992) noted that employees who remain feel guilt, anger, resentment, and ongoing anxiety about their own job security. Noer (1993) did not identify guilt as a major theme in his

study. He hypothesized that anger at management and feelings of betrayal may have been external projections of internal guilt feelings.

Alevras and Frigeri (1987) found that people who are terminated as a result of downsizing are generally regarded as good employees by their peers. This leads to thinking in the survivors that if the good employees are not safe, how can the survivors expect to be safe and have secure jobs? This thought process supports the old employment contract beliefs. Also, when merit does not appear to be a factor in how decisions are made in determining who is let go perceptions of unfairness and job insecurity increase. Almost all groups in Noer's (1993) study could identify someone who they thought should have been terminated based on job performance versus who was actually laid off.

Alevras and Frigeri (1987) stated that lack of recognition of the problems related to survivors is a major downfall of many companies. Survivors can become avengers. They can operate on a "get even" premise, avenging their perceived losses and pain (Alevras & Frigeri, 1987, p. 30). The avenger may be overtly destructive drawing on personal power and demeaning others, or the organization, or quietly waiting for the right moment to strike. Noer (1993) would argue that any overt behaviours to get even are symptoms of survivor sickness. Both studies agree that survivors are also victims who wait out the rough ride of reorganization, not taking chances, and not willing to move out of their familiar role (Alevras & Frigeri, 1987; Noer, 1993).

Wallfesh (1991) stated that "organizational change was bound to dampen employee morale" (p. 177). This dampened morale is seen to be manifested in many ways. Loyalty and psychological bonds to the company are shaken and the sense of job security is eroded. Employees: (a) feel they are under more stress; (b) feel less in control; (c) show more impatience; (d) may be unusually quiet; (e) may have difficulty concentrating; (f) may make strong statements about management, the company, or terminated employees; (g) express more grievances; or (h) may be overly eager to please. Most authors do agree that counselling, training, and getting survivors involved in the restructuring process were all valuable in rebuilding morale and confidence in the workplace.

Research measuring the impact of downsizing and restructuring on those who survive a layoff is a relatively recent field of study and has generally been limited to business and manufacturing organizations. Nurses have only recently become victims of downsizing and restructuring and thus have been the subject of limited studies in this area. Two research based studies that relate to nurses who survived displacement or layoff will be reviewed.

Nurses as Layoff Survivors

Barnes, Harmon, and Kish (1986) studied two groups of nurses. Ten non-displaced nurses were defined as a control group and were compared with a second group of ten displaced nurses. Individual mood states or feeling states, social supports, and social environment characteristics were measured. Initially the displaced group could not be recruited because of their distrust and extreme

anger with administration. These nurses were approached again three months after displacement and were then agreeable to participate in the study. Displaced nurses also had high absenteeism from work during the initial phase of the displacement.

A displacement orientation program (DOP) was offered to all displaced nurses. This program was comprised of four one hour sessions held over a two month period. Topics included adjustment factors, socialization processes, working relationships, and the larger health care perspective. The authors determined that the DOP was effective in reducing negative mood states and increasing group membership behaviours in the displaced nurses. Absenteeism was not seen as a problem behaviour during the first two months of displacement but rather as an adaptive coping mechanism that may actually have enhanced job performance rather than diminish it.

Non-displaced workers experienced apprehension and had the potential for anger and hostility while others suffered from survivor guilt syndrome. Units accepting displaced workers experienced disruption to their cohesive work patterns. While the authors declared the DOP to be successful, one might question whether this was truly a success or an attribute of time given the displaced nurses' initial hostile feelings and unwillingness to participate. In addition, the control group of non-displaced nurses suffered significant negative effects as a result of a disruption to their established work relationships as displaced nurses joined the unit. No support was offered to this group and there

is no report of long term effects on either group.

Sears (1992) studied displaced Canadian nurses. Three categories represented nurses whose positions were deleted, those who remained in a job but were forced to relocate to a new unit in another hospital, and those who were not affected. The relocated nurses experienced higher levels of stress than either the laid off group or the unaffected group. This was an unexpected result that was attributed to powerlessness. The relocated group tried more coping strategies with less success than the other two groups. The relocated nurses also experienced higher levels of burnout and lower levels of hope than the other nurses. There were no significant differences in scores between the laid off nurses and the unaffected nurses. The unaffected nurses continued to worry about their own job security. It is important to note that scores for all groups appeared to be relatively high.

It was assumed that the group of nurses who had been laid off would be experiencing the most stress. Additional support was provided to that group by the pastoral care department. No support was provided to the relocated or unaffected nurses as management believed that the nurses had job security and therefore would have less stress. The lack of choice was the only factor that could be identified in the group of displaced nurses as contributing to their decreased ability to cope with the relocation. All nurses felt that sharing feelings and support from others were helpful. Supports included peers, supervisors, union, and friends and family. Timely and accurate information was also

important.

Qualitative responses also indicated that some nurses felt that the layoffs were unfair. The bumping process was not well understood by some nurses and most who were able to exercise these rights hated having to displace another nurse in order to maintain their own employment.

Summary of the Literature Review

Although the research is limited in the area of the impact of surviving a layoff, it appears that the effects are significant and similar to those of unemployment. Mood states of shock, anger, disbelief, and anxiety are initial reactions to notice of layoff. For those who become unemployed poor mental and physical health, financial strain, social isolation, and fears of permanent unemployment are common. Middle-aged employees, or those who have been with an organization longer, are impacted more severely than for those who are younger or about to retire. For those who are financially secure or unhappy in their jobs, the impact of unemployment or layoff is less significant regardless of age.

For those remaining in the workplace, threats to job security, powerlessness, perceived lack of fairness, lack of organizational commitment, decreased job satisfaction, and growing intentions of leaving the organization are common. Many subjects reported symptoms that included depression, anxiety, sleep disturbances, fatigue, and labile mood states. None of the research on survivors utilized a standardized measure of health but all reported disturbances

in physical and mental well being. Caring for the remaining employees and rebuilding confidence in the organization represents a challenge to management.

Based on the theoretical model of Davy et al. (1991) and the review of the literature, a questionnaire was developed to study the impact of organizational downsizing and restructuring on general duty nurses in a large acute care hospital.

Chapter IV

Methodology

Design of the Study

A questionnaire was developed by the researcher utilizing the theoretical framework developed by Davy et al. (1991). The concepts examined were (a) global process control, (b) perceived fairness of layoffs, (c) job security, (d) job satisfaction, (e) organizational commitment, and (f) behavioural intent to withdraw. Information was also collected on perceptions of stress related to displacement and reorganization, supports, general physical and mental health, and demographics (See Appendix A). These components were repeatedly used in unemployment and layoff survival studies and were incorporated into this study. A short focused group interview was proposed to flesh out data that was not clear from the questionnaire results.

Study Sample

Nurses at a large acute care hospital were accessed directly and indirectly by the researcher. The inclusion criteria were:

1) nurses who were currently employed at the hospital;
2) nurses who were classified as general duty staff nurses;
3) nurses who may or may not have been the victim of a previous displacement; and
4) nurses must consent to participation in the study, and to return the questionnaire.

Exclusion criteria were:

1) nursing support workers, ie: nursing aides and unit clerks; and

2) nursing staff who were classified as a head nurse, equivalent to head nurse, or higher categories.

It was anticipated that 60 to 100 nursing staff would respond to the questionnaire.

Ethical Considerations

Ethical considerations required that nurses voluntarily participate in the study. No risks were anticipated for those who participated but the researcher was prepared to suggest support services in the event any individuals experienced emotional distress in rating the impact of downsizing and restructuring on their lives.

Prior to data collection, permission to access the hospital environment and nursing staff for the purpose of conducting this study was obtained from the centre's Research Committee (See Appendix B). The application to the centre was submitted simultaneously with the proposal to the Ethical Review Committee of the Faculty of Nursing, University of Manitoba (See Appendix C).

Recruitment

Prior to attending at the hospital, the researcher distributed a brief explanation of the study to the directors of nursing who in turn distributed the information to the head nurses (See Appendix D). Head nurses were requested to make staff aware that the researcher would be visiting the nursing units in the

coming weeks. This was intended to increase awareness of the project. A prepared invitation to participate which could be used by the researcher or the head nurse to introduce the study to staff nurses was also developed and circulated (See Appendix E).

The researcher visited nursing units on a daily basis for three days to distribute questionnaire packages and to provide a verbal explanation of the study to nursing staff. A written invitation to participate and introduction of the researcher had been previously distributed. An explanation of the study which assured nurses of the voluntary nature of their participation was attached to the questionnaire package (See Appendix F). Consent was implied by return of the questionnaire to the researcher.

The researcher made herself available in person and by phone to the nursing staff who required any additional explanations or information about the study. The same information was also given to the head nurses of the units who agreed to assist by bringing the study to the attention of their staff.

Questionnaires were left on the units with instructions to either return them to a designated collection spot on the unit or to deposit the completed form in the hospital mail. Self-addressed return envelopes were provided and no postage was required. Each unit was given between eight and twelve questionnaires depending on the number of nurses employed in each specific area. In total 200 questionnaires were distributed to medical, surgical, oncology, paediatric, orthopaedic, cardiology, and psychiatric units. All of these areas had

either lost staff members through the bumping process or had received new nurses in the area as a result of displacements. One week following the original distribution of the questionnaire a reminder notice was sent out to all participating nursing units (See Appendix G).

The nurses were self-selecting participants. The researcher did not have a random distribution list of previously displaced and non-displaced nurses. Responses were subjective self-reports with no pretest or post-test comparison ratings made on the responding group of nurses. A comparison group or nurses not experiencing downsizing and restructuring in their organization was not available at the time of this study.

Data Collection

During the initial three days of distribution of the questionnaire approximately 70 completed packages were returned to the researcher either directly on collection from the units or indirectly via the hospital mail system. During the following week another 20 completed questionnaires were returned through the mail. The reminder notice generated a return of only a few more questionnaires. In total, 93 questionnaires of the 200 distributed were returned to the researcher.

A decision was made not to conduct focus group interviews for several reasons. First, the number of respondents who were willing to identify themselves and participate in an interview was limited. Secondly, those who positively responded were not representative of the general nursing population.

Eight were personally well known to the researcher and were from the same work area. During the three days of regular visits to units several of these nurses verbally indicated they would participate in an interview if it would help the researcher's work. It was felt that this motivation had the potential to bias the interview process. Thirdly, the interview had been proposed to flesh out any unclear results. The data showed strong trends and while further exploration of these concepts may have provided descriptors it was not seen as having the potential to change the outcome of the study.

Data Analysis

Data was analyzed on several levels. After the initial recording of raw data the variables were tabulated by mean, mode and frequency. Analysis of variance (ANOVA) was performed on these responses to determine any significance in raw scores. Bar charts were used to visually establish trends. The individual variables were then grouped by concept. This required some re-coding as several of the questions had been negatively phrased and thus were scored in reverse. The groupings included, (a) global process control, (b) perceived fairness of layoffs, (c) job security, (d) job satisfaction, (e) organizational commitment, and (f) behavioural intent to withdraw. A mean score for each category was tabulated by adding the numeric score of each individual's responses in that category and then dividing by the number of questions in the category (Davy et al., 1991; Mowday, Steers, & Porter, 1979). This resulted in each nurse having an overall score in each of the separate

groupings. These scores were later reduced to positive and negative categories based on the lack of differentiation between the disagree and undecided responses and the significant gaps between the negative or undecided groups and the positively coded responses.

McGehee and Tullar (1979) state that the questions used in this research, measure job satisfaction and have high reliability and validity. However, the questions that ask directly about the individual's decision to join the profession of nursing or recommend it to others is viewed by this researcher in a different light. These questions are seen not only as a measure of job satisfaction but of commitment to the profession. In the analysis, these questions were grouped with job satisfaction for an overall score as well as being identified as a separate variable of professional commitment.

Psychological distress was measured using Goldberg's GHQ 12-item scale. This tool was purchased and permission was obtained for using copyrighted material. The GHQ is scored quite differently from the above groupings (Goldberg, 1972; Layton & Rust, 1986; McDowell & Newell, 1987). The tool asks subjects to respond to a four point Likert scale. The GHQ score replies are coded as 0-0-1-1. Responses can also be coded as 0-1-2-3 but little advantage to this method has been demonstrated and correlations of the two methods are between 0.92 and 0.94. The sum of the scores is calculated for each individual to obtain on overall GHQ score. Any scores above three on the 12 item scale are a likely indication of psychological distress with scores above

nine indicative of severe distress.

General physical health and overall stress ratings were also measured (Quinn & Shepard 1974). Present physical health was compared with self-rated conditions prior to downsizing. Stress of downsizing and restructuring was rated on one question based on the nurse's perceptions of the impact this process had on her/him. Raw scores for both variables were grouped into positive and negative categories. This was based on little variance being demonstrated in the negative and neutral categories while a significant gap existed between the latter conditions and the positive conditions.

Demographic data collected was limited to years of experience as a nurse and years of seniority within the present organization. Both experience and seniority were initially grouped into four categories. These categories were later reduced to two conditions for each variable. Experience was defined as nurses with four years or less experience and nurses with five years or more experience. Seniority was defined as those with less than 5,000 hours and those with 5,000 hours seniority or more. Full time employment equates to approximately 2,000 hours of seniority in each year. Nurses working full time could expect to earn approximately 8,000 hours of seniority in four years. For respondents in the 5,000 hours or less seniority group this equates to about two and one-half years of full time employment. The rationale for these distributions was based on natural groupings that emerged.

Nurses were also asked if they had been displaced from a previous job in the hospital as the result of restructuring or bumping. If nurses had been displaced they were asked how many times and if they were able to move to a similar area of work. The displaced versus non-displaced nurses were used as comparison groups. Nurses were also asked what supports they accessed and found helpful in dealing with the stress associated with downsizing and restructuring. Multiple responses were possible in this grouping.

Missing data were not included in the tabulation of mean scores. Where data were missing the mean was calculated based only on the number of questions answered in a specific category. Missing data was minimal ranging from 0 to 1.1 % for all categories except the GHQ where missing data accounted for 3.2 % of the returned questionnaires.

PART II

FINDINGS

Chapter V

Results

A 47 % response rate (N = 93) was obtained in the three week period following distribution of 200 questionnaires. The respondents included 26 nurses (28 %) who had been displaced from at least one position as a result of downsizing and restructuring. Of those displaced, 16 had been displaced once, eight nurses had been displaced twice, and one nurse had been displaced four times.

Years of experience ranged from 1 to 37 and the average length of experience was 10.8 years. Only 14 respondents had four years or less of experience with the remaining 79 reporting to have been a nurse for five years or more. Of those nurses in the large group, 38 had between five and nine years experience, 19 nurses were in the 10 to 14 year grouping, and the remaining 22 nurses had 15 years or more experience. Seniority varied among the nurses. Thirteen respondents (35 %) had less than 5,000 hours of seniority. The average accrued seniority was 13,308 hours. Sixty-five percent of the nurses had more than 5,000 hours of seniority.

Most nurses found the restructuring process required them to seek out supports both on a formal and informal basis. On a list of potential supports nurses were asked to check off as many as applied to their individual situation. A blank area allowed for comments and other supports to be listed. The largest group of respondents, 74 nurses, accessed their co-workers as a source of

support. Sixty-two nurses relied on their families, while 52 nurses sought out their friends. Exercise was an effective support or coping strategy for 30 nurses, some of whom wrote descriptors on the questionnaire like "vigorous" and "lots and lots of exercise helps". Fourteen nurses turned to their head nurse or boss. Four nurses found comfort in spiritual counselling or prayer while another individual sought counselling from a nurse therapist. Three nurses visited their doctors. It was not specified if these visits were related to medical concerns, as a result of stress, or were for supportive counselling. Only one nurse accessed the hospital's Employee Assistance Program (EAP) while another nurse cited the union as a source of support. Two nurses found involvement in other interests and hobbies helpful, while three nurses wrote they felt supports were not required. Another nurse wrote that the stress being experienced was not related to hospital activities but rather to personal problems. Nine nurses left this area of the questionnaire blank and it was not known if they felt they did not need supports or if they did not access any supports.

Global process control (GPC) was measured by questions 16, 17, and 24. Nurses were asked to respond to a five item Likert scale ranging from strongly disagree to strongly agree. Nineteen nurses moderately agreed with statements indicating some GPC while 73 nurses were either undecided or disagreed that they possessed GPC. Of the large negative grouping, 35 were undecided. None of the nurses scored in the strongly agree category of GPC. The negative and positive groupings for the concepts included in the Davy et al. (1991) model

are illustrated below (See Figure 2) and frequency distributions are also noted in Appendix H.

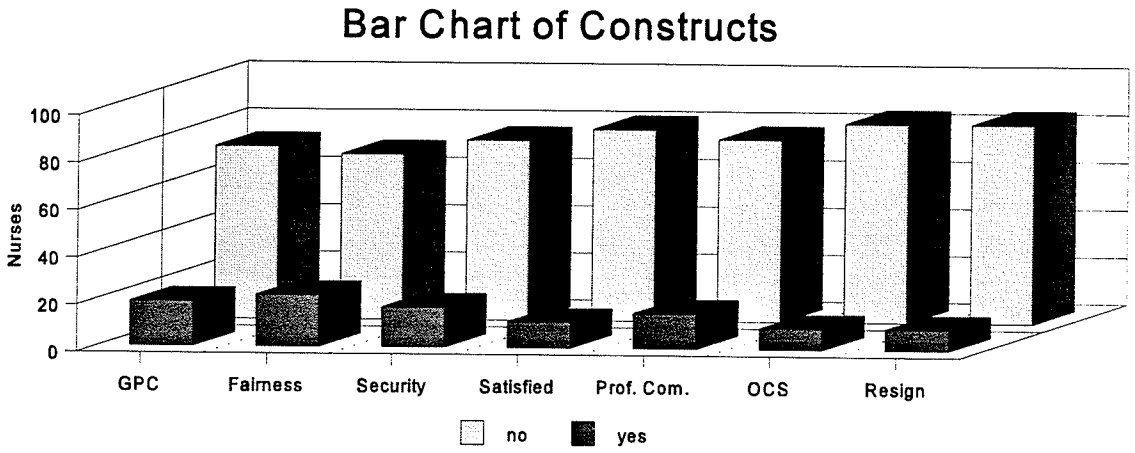

Figure 2. Bar chart of GPC, perceived fairness of layoffs, job security, job satisfaction, professional commitment, organizational commitment, and behavioural intent to withdraw.

Included in the measures of GPC nurses were asked if they received adequate information about the restructuring process. Forty nurses agreed they were receiving enough information. The remainder disagreed and felt the amount of information they received was inadequate.

Perceived fairness of layoff was measured by questions 21 and 22. A total of 70 nurses viewed the process as unfair. Of that grouping, 27 were undecided. Only 22 moderately agreed that the process was fair. None of the respondents strongly agreed that the layoffs were perceived as fair.

All nurses responded to measures of job security. This construct was measured by questions 18, 19, and 20. One question asked nurses to estimate, in percentages, the likelihood they would be laid off. These responses were treated in the same manner as the Likert scales and assigned corresponding numeric values in tabulating the results. Seventy-six nurses felt they had little or no job security. Of the large group, 39 nurses were unsure of their level of job security, while 37 nurses felt they had no security at all. Only 17 nurses indicated moderate to high job security.

Few nurses were happy in their jobs. Job satisfaction was measured based on three items, questions 27, 29, and 30. The majority of nurses, 81, were grouped in the negative category. The negative group was composed of 58 nurses who rated themselves as very dissatisfied to dissatisfied. Another 23 were unsure of their level of job satisfaction. Only 11 nurses responded with any level of positive job satisfaction.

Two of the questions that measured job satisfaction were viewed by this researcher as indicative of professional commitment. Nurses were asked about their decisions to become a nurse as well as the likelihood that they would recommend this career choice to others. The results were extracted from the raw data and grouped into a separate variable and named professional commitment. Only 15 nurses responded positively to this measure. The majority of respondents, 77, stated they would not choose to become a nurse again or recommend it to others. Of those in the large negative group only 18 nurses

were undecided.

Organizational commitment was measured using Mowday, Steers, and Porter 's (1979) 15 item organizational commitment scale. This study replicated the tool in questions one through fifteen. Readers should note that questions 3, 7, 9, 11, 12, and 15 were negatively phrased and scored in reverse. None of the respondents scored in the highly committed range and only nine nurses reported being slightly committed. The remaining 84 nurses were grouped together as uncommitted. Of the large uncommitted group, 33 were unsure or undecided about their commitment and the remainder were definitely uncommitted to the organization to varying degrees.

Behavioural intent to withdraw was measured on a single item, question 23. Eighty-four nurses had no intentions of leaving the organization. The remaining nine nurses were almost certain to leave. This result was surprising in light of the equally high number of uncommitted nurses.

The above results reflect the variables which measure concepts that were proposed by Davy et al. (1991) in the theoretical framework which guided this research. Based on the unemployment and layoff literature, the researcher used several other measures as indicators of overall health. These variables include physical health, psychological health as measured by the General Health Questionnaire (GHQ) 12-item scale, and an overall stress indicator. The results are reported below.

Stress and Health Results

Stress related to downsizing and restructuring was measured by one item, question 28. An increase in the stress experienced as a result of downsizing and restructuring was reported by 80 respondents. Of those experiencing increased stress, 21 reported a slight increases, 39 nurses reported moderately high stress, and 19 experienced extremely high levels of stress. One nurse reported the stress to be unbearable. Only 12 respondents reported no more stress than usual. An overview is illustrated below (See Figure 3).

Nurses were asked to rate their overall physical health at the time of data collection and prior to the downsizing and restructuring in questions 25 and 26. Groups were defined as those who had better health before and those who experienced no change or worse health prior to the restructuring in the hospital. This resulted in 61 nurses rating themselves to be in the same or worse health prior to restructuring, as compared to the present, and 31 who experienced better health prior the restructuring, as compared to the present. In other words, the latter group rated themselves as experiencing negative effects on their current health status which they attributed to the downsizing. Of the large unaffected group, 56 nurses rated themselves as having no changes in health status, while another five nurses reported an improvement in their health status since the downsizing had commenced.

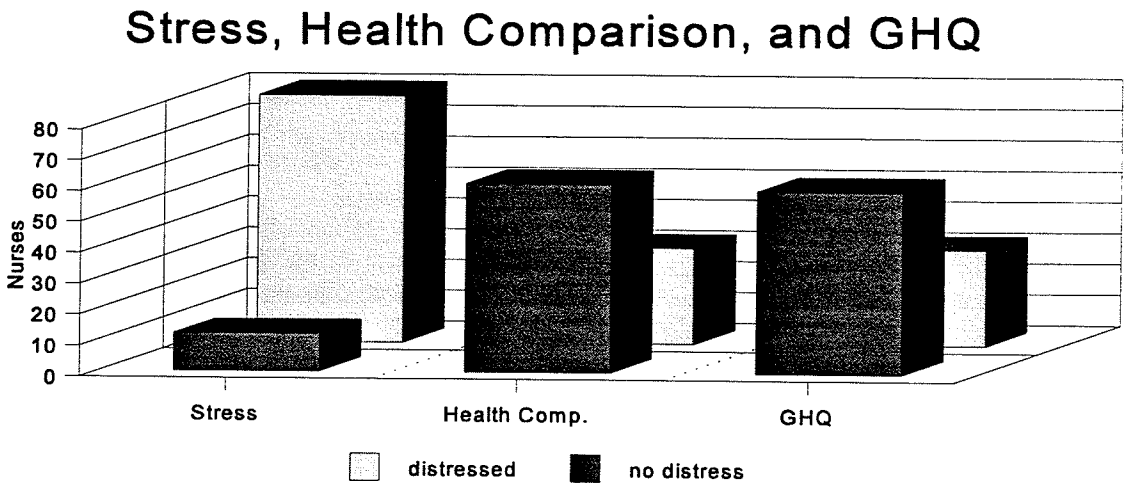

Figure 3. Bar chart of stress, health comparison and GHQ.

The GHQ 12-item scale was used to measure psychological distress. As noted earlier the scoring method is quite different from the other measures used in this study. The sum of scores for each respondent indicates the overall GHQ score. Two or three positive responses on the 12-item scale are considered average or normal. For the purposes of this study normal, or no distress, was defined as three or less positive responses. Fifty-nine nurses fell into the normal or no distress category. The remaining 31 nurses had scores of four or greater. Of those nurses in the distressed group, 21 were found to be experiencing moderate to high levels of psychological distress with raw scores between four and eight. The remaining 10 nurses scored nine or greater. Of those respondents, three nurses scored 12 out of 12, four nurses had 11 positive responses, and another two scored 10 on the 12 item scale. Clinically, these scores are an indication of severe psychological distress.

Correlation coefficients of the variables of health, displacements, seniority, years of experience, GPC, job security, job satisfaction, professional commitment, perceived fairness of layoffs, organizational commitment, and behavioural intent to withdraw yielded the following significant relationships illustrated below (See Figure 4).

GPC was positively related to organizational commitment (.3190, p = .002) and job satisfaction (.2258, p = .03). A positive effect between perceived fairness of layoffs and job security was found (.3478, p = .001). Perceived fairness of layoffs was not significantly correlated to any other variables.

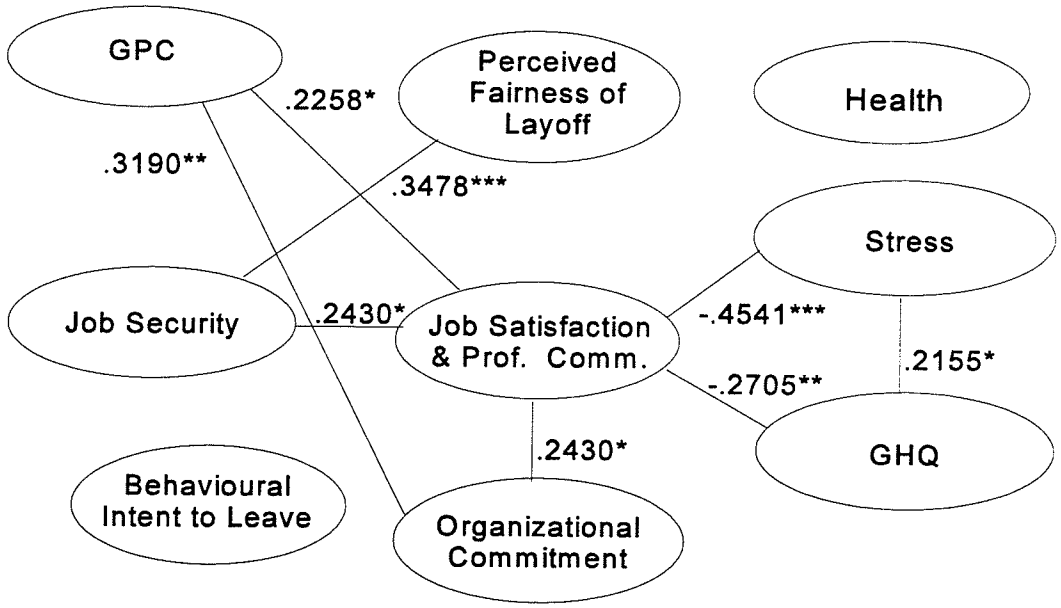

Figure 4. Correlations found in nurses' responses to questionnaire. Significance: *p < .05 , **p < .01 , ***p < .001.

Job satisfaction was positively related to organizational commitment (.2430, p = .02), professional commitment (.8349, p = .000), job security (.2728, p = .009), and negatively related to stress (-.4541, p = .000). Job security had a positive effect on organizational commitment (.4098, p = .000), job satisfaction as noted above, and professional commitment (.2633, p = .011). A negative effect was noted between GHQ scores and job satisfaction (-.2705, p = .01) as well as professional commitment (-.3242, p = .002). A positive effect was found between GHQ and stress (.2155, p = .041). Stress and professional commitment were negatively related (-.4406, p = .000). As was expected, years of experience and seniority were positively correlated (.2534, p = .014). Correlations when controlling for displacement, years of experience, and hours of seniority yielded results that were almost identical to the relationships identified above in strength and direction.

ANOVA of the above variables did not reveal any significant results. Using Chi-Square to measure independence of the same variables the results indicated significant findings between stress and job satisfaction (1, N = 92) = 18.79, p <.00001, and stress and professional commitment (1, N = 92) = 17.86, p=.00002. Given that these results are based on ordinal measures not real number system measures, the true significance of these results is questionable.

Some additional information was volunteered by nurses in the form of written comments on the questionnaires as well as verbal comments during the distribution phase of this study. The following is a summary of the qualitative

data that was noted at the time of data collection.

Qualitative Data Results

The letter of explanation of the study was confusing to some. After discussions with these nurses, this confusion could be attributed to the statement noting approval from the hospital to conduct the study in their organization. Several nurses interpreted the approval by the hospital Research Impact Committee as an indication that the research was being sponsored and/or initiated by the hospital rather than permission being given to the researcher to access the population and hospital environment. This resulted in the researcher encountering several nurses who were very suspicious about why the study was being conducted. A few nurses initially responded to the researcher in an angry and resentful manner with comments questioning if "this was another one of those things intended to make the hospital look good?". Another nurse questioned the researcher on the validity of a particular question. The question related to the staff being asked for input prior to changes being implemented that would affect the staff. The nurse commented "sure they're asking for our input, but they aren't listening to it". She further explained that she felt in somewhat of a dilemma as answering the question honestly "would not reflect what was really going on".

The researcher was able to clarify with those nurses the role of the hospital in the research and offer a verbal explanation of the study. This clarification satisfied the nurses who then agreed to examine the package and

consider completing the questionnaire. Nurses who had concerns about specific questions were encouraged to write comments on the questionnaire. Written comments included the following:

a) on the GHQ 12-item scale;

-related to loss of sleep due to worry, the nurse's score indicated no symptom but the comment "with problems I sleep more than usual" indicated that the nurse felt this, in fact, was a problem,

-related to feeling like you are playing a useful part in things the nurse responded much more so than usual and wrote "only because of union involvement",

-related to two items about happiness and depression, the nurse rated self as being more unhappy and depressed and wrote "related to work" beside both variables,

-a nurse did not complete the GHQ and wrote "this is not a good form because I just got married, this reflects on physical and mental health more than work",

-the nurse did not complete the form and wrote "sorry, but I'm worrying about other things now, ie: my son's health and some of these will apply to that",

b) on the commitment scale;

-related to the organization inspiring the best in the individual, the nurse moderately disagreed and wrote "self-inspired",

-in response to could be working for another organization just as well if the work was similar, the nurse moderately agreed and wrote "and a job was available",

-another nurse who strongly disagreed to the same question as above wrote "not in this economic climate",

c) related to employee input into changes;

-the respondent moderately agreed, but wrote "not actually implemented though",

-another respondent also moderately agreed but wrote "yes, but nothing changes. They do what they "*WANT*" (nurse's emphasis),

d) related to professional commitment;

-in response to would you decide to become a nurse if you had it to do over again, the nurse reported probably not, and wrote "not in this facility",

-another nurse wrote "would recommend business" instead of becoming a nurse,

e) related to receiving adequate information;

-the nurse responded strongly agree and wrote "at least on our unit",

-another nurse moderately disagreed and wrote "it changes so often",

f) supports accessed;

-the nurse responded that co-workers were used as a support and wrote next to both the categories of Employee Assistance Program and doctor "HA!" (nurse's emphasis),

g) related to seniority and job security;

-the nurse wrote "no seniority, I'm in the casual float pool" and later wrote "float pool staff are never laid off",

-a nurse was undecided about security and wrote "there is talk re: government implementing or should I say encouraging our union to take away our bumping clause in our contract",

-a nurse with nine years of full time seniority wrote in relationship to the chance of quitting the job in the next year "100 % chance of being laid off",

h) in relationship to perceived fairness of layoffs;

-an undecided nurse wrote "yes, layoffs are fair but displacements are not", and

i) in relation to displacements;

-a nurse wrote "just been hired" in this hospital but "experienced layoff in a previous job".

In addition to the written and verbal comments made by general duty nurses at least 10 head nurses expressed disappointment at being excluded from the study. They stated that the downsizing was very stressful for them. Head nurses commented that they found acting as a support and leader for the nursing staff was a difficult role for them to fulfil. Several head nurses commented that "it was difficult to convey a positive attitude about the downsizing and restructuring to staff nurses when they were not sure themselves

about their own futures". Another head nurse suggested that interviewing the head nurses might provide more insight into the impact of downsizing on general duty staff nurses as the head nurses were having to "deal with the fallout" on a day to day basis. Several head nurses also expressed concerns about their own workload and their increased levels of stress related to restructuring. The downsizing process was extremely time consuming and was an "add on" to the regular and already demanding workload.

Summary of Findings

The findings of the frequency measures are summarized below. Seventy-nine percent of nurses did not feel they had GPC. Eighty-two percent felt very insecure in their jobs, even though 85 % had five or more years of experience, and 65 % had 5,000 hours or more of union seniority hours. The majority, 88 %, were dissatisfied in their jobs and 84 % were not committed to the profession of nursing. Seventy-six percent of nurses did not perceive the layoff process as fair. An astounding 90 % were not committed to the organization yet the same number were not prepared to leave. Most nurses, 87 %, found the process of downsizing and restructuring stressful at some level, but only 34 % of the group experienced some negative effects on their physical and psychological health. Most nurses, 80 %, accessed at least one source of support in an effort to cope with the additional stress related to downsizing and restructuring.

Correlation coefficients identified relationships between job satisfaction, GPC, organizational commitment, job security stress, GHQ, and professional

commitment. GPC was related to organizational commitment as well as job satisfaction. Job security was related to perceived fairness of layoffs, organizational commitment, and job satisfaction. Stress and GHQ were related to each other and both were related to job satisfaction and professional commitment. No relationships were established between physical health and any of the variables. No significant differences could be found between groups when controlling for displacement, seniority, or years of experience in the frequency or correlation coefficients of the variables noted above.

PART III

DISCUSSION AND CONCLUSIONS

Chapter VI

Interpretation of the Findings

Demographic Data

The majority of nurses who responded to the questionnaire had many years of experience and union seniority. However, the researcher had expected a larger number of nurses in the four years or less experience grouping based on reported hours of seniority. Only 14 nurses reported having four years or less of experience yet 49 nurses reported having seniority up to and equivalent to four years of full time employment. This indicated that some nurses may not have had continuous employment, may have been employed elsewhere, worked part time, or were in positions which did not allow them to earn seniority.

No data were collected on age, marital status, education, or financial status. Based on reported years of experience one could assume that the majority of nurses were at least 25 years of age or older. It was also assumed that the majority of respondents were women as the nursing population is generally accepted to be 97 % female. The minimum education level of those who were included in the study criteria was diploma nursing. All respondents were registered nurses. None of the general duty nurses were known to have educational preparation above a bachelor's degree.

The relatively high response rate of 47 % was not expected. This seemed to indicate that nurses were motivated to respond and were perhaps even looking for an avenue to vent their feelings. Personal contact with the

researcher in the distribution of the questionnaire has also been demonstrated to increase response rates (Polit & Hungler, 1987). The initial confusion regarding the sponsorship of the study and the ability of the researcher to provide a verbal explanation of the study seemed particularly important to some nurses. Questionnaire results and written comments indicated that nurses were suffering from overall low morale. The sample size was statistically small (N = 93). The results would have a greater likelihood of being generalizable to other nursing populations experiencing downsizing and restructuring if a higher response rate or larger sample had been obtained.

No differences could be found between nurses when controlling for seniority, experience, or displacements. The majority of nurses acknowledged the additional stress they were experiencing related to the downsizing and restructuring. Co-workers, family, and friends were seen as common supports. Farley (1991) and Sears (1992) also found co-workers to be a strong source of support to nurses experiencing downsizing. Exercise was reported as a coping strategy by approximately a third of the sample. Other sources of support or coping strategies were cited less frequently indicating that co-workers, family and friends were valued as significant supports by nurses. Unemployment studies also found that family and friends were a significant support in decreasing the stress subjects experienced (Broomhall & Winefield; 1990 Mallinckrodt & Fretz, 1988; Warr & Jackson, 1985, 1987).

Most nurses accessed more than one support but only one nurse reported seeking out assistance from EAP. Another nurse appeared quite pessimistic and wrote "HA!" beside the EAP category of support. Management literature suggests that supportive counselling is needed in any downsizing organization (Arndt & Duchemin, 1993; Bonner, 1992; Kazemek & Channon, 1988; Veninga, 1987, 1990; Wallfesh, 1991; Weinstein & Leibman, 1991). The hospital heeded this advice and skilled counsellors were added to the already established resources of the EAP department. The researcher doubts the benefit of providing additional services with only one nurse in this study accessing EAP and at least one nurse having a pessimistic opinion about the counselling service.

The researcher questions if the respondents in this study were representative of the general population with regards to viewing EAP as a source of support. A further analysis of employees who accessed EAP and their satisfaction with the service would be of benefit in determining the cost effectiveness of the hospital continuing to supplement EAP with additional resources.

It was interesting that head nurses were motivated to be involved as subjects in the study. The head nurses who expressed an interest in participating seemed to view the study as a means of venting their feelings and opinions. Just prior to the data collection a decision had been made by the facility to delete unionized head nurses in favour of non-unionized unit

managers. The new job description required an advanced education of a bachelor's degree in nursing. Many of the head nurses did not possess a degree. Several of the head nurses spoke of the challenges that pursuing a bachelor's degree would hold for them. This included loss of income if taking an educational leave of absence or trying to juggle a demanding job, children, and household responsibilities. The potential impact returning to school would have on personal relationships was mentioned by several head nurses. Fear of the ability to succeed in returning to university was also a factor related to the new role. Loss of job security and union seniority, workload, and the stress of managing nurses who were not coping well with all the changes was a concern to many head nurses who stated they were considering returning to general duty work.

Global Process Control

Few nurses felt they had GPC. This indicates that nurses did not feel they had a voice in how decisions were being made. Davy et al. (1991) proposed that there was a positive correlation between GPC scores and perceived fairness of layoffs as well as with job satisfaction. The Davy et al. research established these relationships and additionally found a positive correlation between GPC and job security. This study did not replicate these findings. A correlation between GPC and perceived fairness of layoffs or job security was not established in the current research. A positive correlation between GPC and job satisfaction as proposed by Davy et al. was supported in this current research.

Scores for both variables indicated low GPC and low job satisfaction.

Another unexpected finding of this study was a strong positive correlation between GPC and organizational commitment. Davy et al. (1991) concluded that organizational commitment was mediated by job satisfaction and they could not establish any direct relationship between organizational commitment and GPC. Noer (1993) suggests that lack of empowerment and low organizational commitment are typical of survivor behaviour.

Dencker (1989),Farley (1991), Noer (1993), and Veninga (1987) all noted an insatiable need for information by those who were facing layoffs and downsizing. While only 43 % of nurses surveyed felt they were well informed this seems to be a vast improvement over studies that cite rumours as the greatest source of information (Dencker, 1989; Farley, 1991). Some continued to see rumours as the greatest source of information (Suderman & Dyck, 1994). The hospital's attempt to provide accurate information served to generate continuing speculation and additional questions. Open forums, newsletters, and a phone information line appeared to meet some of the staff member's information needs, but not all.

There also appeared to be some interpersonal factors that affected the perception of being informed as indicated by the nurse who stated "at least on my unit" (I feel informed). This may have been related to the head nurse's level of coping and leadership skills. The need to communicate a vision or direction (Wallfesh, 1991) was also articulated by a nurse who stated "it changes so

often". This comment indicates that the nurse was unaware of any vision the hospital may have been trying to communicate and alternately was relying on information about the day to day changes in the organization.

Perceived Fairness of Layoffs

Davy et al. (1991) proposed and demonstrated a positive correlation between perceived fairness of layoffs and job satisfaction. This relationship could not be established in this research, however, an alternate and strong positive correlation was found between perceived fairness of layoffs and job security. A result that differed from the Davy et al. work. The majority of nurses scored low on both measures which was surprising to the researcher as most nurses had high seniority and were protected by a union agreement that governed the layoff and bumping process.

Brockner and Greenberg (1990) proposed that when layoffs were implemented based on seniority which releases individuals with the shortest length of employment in the organization the process was more likely to be perceived as fair. A nurse's written comment that layoffs were fair but displacements were not indicates that there were at least two different process that were impacting the perception of fairness and job security.

Most displacements occurred as a result of bed closures and program reorganization. This resulted in nurses, regardless of seniority, being displaced. Those nurses were then entitled to bumping rights under the terms of their union contracts. A displaced nurse was not required to bump the least senior nurse in

the hospital but rather had the right to displace any nurse in the organization that had less seniority than the originally displaced nurse. The result of this process meant that even nurses with significant amounts of union seniority were displaced. In this study two nurses with 20 years of full time seniority were displaced while another 20 nurses with five years or more seniority had been displaced. In turn, displaced nurses were put in the position of having to bump someone with less seniority than themselves thus creating a domino effect. Clearly this process was very different from a layoff where the least senior staff member was released. Sears (1992) reported that nurses hated having to make the decision to displace another nurse in order to maintain their own employment.

Brockner and Greenberg (1990) further suggested that merit and specialized skills were a factor in considering the layoff process as fair. If these factors were not considered then the process was not seen to be fair. The existing bumping process did not consider the performance of individuals in their current jobs, any specialized skills displaced nurses may have possessed, or any specialized skills that may have been required in a new position that a displaced nurse selected. Displaced nurses could bump anyone with less seniority and potentially could make this decision based on such things as a more desirable shift schedule or a more desirable area of work. There were few restrictions as to where displaced nurses could choose to move through the bumping process.

Job Satisfaction

Job satisfaction was positively correlated to GPC, job security, and organizational commitment which supports the results found by Davy et al. (1991). Scores for these variables were low indicating that low job satisfaction, low organizational commitment, low GPC, and low job security were being experienced by the majority of nurses surveyed. In addition, a negative effect correlation was found between job satisfaction, stress, and GHQ. That is, the lower the job satisfaction the higher the stress and GHQ scores.

Professional commitment was factored out of job satisfaction during the analysis phase of the study. The correlation coefficient to job satisfaction was extremely high and did not support the isolation of professional commitment as a separate variable. This high correlation was expected as professional commitment was measured by extracting the results for two of the three questions which comprised the measure of job satisfaction. Regardless, it is important to discuss the results.

Only 15 nurses responded positively to this measure indicating the majority of nurses were uncommitted to the profession. Pringle (1991) noted that in 1970 choosing to become a nurse ranked amongst the top two career choices. By 1990 this choice had dropped to 92nd out of a list of 100 and nursing school enrollments were reported to be down by as much as 22 %. With a scant 13 % of nurses surveyed willing to recommend this career to a friend, daughter, or son, coupled with an already established decline in the popularity of the

profession, the trend indicates there is a potential for a severe nursing shortage in the years ahead.

Organizational Commitment

Mowday et al. (1979) demonstrated internal consistency in the test - retest reliability of the organizational commitment questionnaire (OCQ) which was replicated in this research. Norms were calculated for males and females based on a sample of 2,500 subjects. The norms for men were slightly higher but for the purposes of this study the female norms will be cited. Mowday et al. found that 20 % of the female population scored in the moderately to highly committed range while another 30 % were slightly committed to the organization. Thirty percent were undecided and only 20 % were uncommitted.

These norms differ significantly from this study's results. Fifty-five percent of the nurses were uncommitted, 35 % were undecided and only 10 % reported being slightly committed. No one was highly committed. Noer (1993) suggests that this response is normal and typical of survivor syndrome. In extensive field interviews Noer (1993) found the majority of subjects were angry, felt betrayed, and were not committed to the organization. Only a few individuals remained committed and held optimistic views of their future within the organization.

Mowday et al. (1979) suggest that the OCQ is not disguised in any way and respondents could easily manipulate their scores. The authors state that if employees are threatened about completing the OCQ or are unsure of how the responses will be used there is a risk that the subjects' responses will not

accurately reflect their true feelings. Caution should be used in both the administration of the questionnaire and interpretation of the results.

The researcher would like to suggest that if common attitudes and feelings of survivors are anger and a sense of betrayal, then negative scores on the OCQ could represent an acting out of that anger and/or revenge for perceived betrayal. Wallfesh (1991) and Alevras and Frigeri (1987) would support this view and caution managers to beware of those seeking to "get even" (Wallfesh, p. 30). Noer (1993) would also support the researcher's theory of cause. However, Noer would propose that behaviours that may look like retaliation are not an active attempt at some sort of revenge but rather a symptom of survivor syndrome.

Noer (1993) suggested that employees believe in the old employment contract where those who have been loyal to the company could, in turn, expect that the company would be loyal to them. Noer further suggested that for those who had been with the company for the longest periods of time, the impact of layoffs was most severe. The data did not support this supposition. No differences could be found based on years of experience or hours of seniority and commitment to the organization.

Organizational commitment was positively correlated to job satisfaction, GPC, and job security. The direct correlation to GPC was not expected. No correlation between organizational commitment and behavioural intent to withdraw could be established as proposed in the theoretical framework.

Mowday et al. (1979) are careful to point out that although there is a high correlation between OCQ and job satisfaction there is no evidence of specific behaviours that result with any given score. In other words, it has not been demonstrated that low organizational commitment has a negative impact on job performance.

Job Security

Most nurses had significant amounts of union seniority which was expected to increase their sense of job security. This did not prove to be the case. As outlined above the bumping process is proposed to significantly impacting not only perceptions of fairness but job security. Bonner (1992) and Sears (1992) both found that non-displaced surviving employees experience ongoing anxiety about their job security. Noer (1993) also found that job insecurity was prevalent in all groups of survivors interviewed. Employees had traditionally been seen as resources to be nurtured and developed. Noer states that the old employment contract is no longer the norm. The new employment contract views the employee as a task-specific, disposable resource in a cost conscious organizational system. This view does little to enhance an individual's sense of job security nor is it expected to make an employee feel secure.

Alevras and Frigeri (1987) found that when good employees are displaced or laid off the security that others feel is shaken. The survivors' belief is related to perceived fairness where merit is considered. When valued employees are affected by layoffs and displacements no one feels secure.

Behavioural Intent to Leave

Davy et al. (1991) demonstrated that high organizational commitment was negatively correlated to behavioural intent to leave. That is to say, the higher the commitment the less an employee would intend to leave. The results of this study did not find any correlational relationships with behavioural intent to leave. However, the trend indicates that most nurses were not happy in their jobs, were uncommitted, did not feel secure, and did not feel they had any control over organizational decisions that affected them. In spite of this only 10 % were intending to leave.

Written comments addressing some of the OCQ items indicated that some nurses were feeling trapped in the job by the current economic climate and lack of availability of other jobs. Downsizing and restructuring were not isolated to their hospital. Job opportunities were limited. Another consideration for nurses in leaving a unionized job was that accepting employment elsewhere would put them at the bottom of a new organization's seniority list. This would increase job insecurity making the nurse vulnerable to be the first target of layoffs in any future bed closures. No one believed the downsizing was over and future job security was a concern to many (Suderman & Dyck, 1994).

Loss of benefits may be another factor influencing the nurses' intentions to remain at the hospital. With seniority comes an number of benefits such as higher rates of pay, higher vacation entitlements, and accrual of sick time and pension plans. Given the economic climate and lack of opportunities elsewhere

it is not surprising that nurses were not intending to leave. Mowday et al. (1979) and Davy et al. (1991) noted that employees who are unhappy in their jobs and are uncommitted to the organization withdraw psychologically long before they withdraw behaviourally.

This researcher suggests that regardless of the level of psychological withdrawal, the current economic climate would make it unlikely that nurses would withdraw by resigning en masse. One might expect other forms of withdrawal such as increased use of sick time credits, lack of motivation or enthusiasm about the job, and/or reluctance to become involved in the restructuring process.

Stress, Physical Health, and Psychological Health

Overall stress scores indicated that 87 % of nurses surveyed were experiencing increased levels of stress which they attributed to the downsizing and restructuring. No statistical difference could be found between displaced nurses and non-displaced staff in overall stress scores.

One could argue that lack of job security had a major impact on the level of stress that nurses were experiencing. Nurses were aware that there were many changes still to come and the process by which decisions were being made was threatening to many people (Suderman & Dyck, 1994). One could also argue that the bumping process was a great source of stress and increased the insecurity that people felt. Even those with high seniority were being displaced. The domino effect of bumping, where a displaced nurse bumps a less

senior nurse, and that nurse, in turn, bumps someone else less senior, had the potential to displace many people for each original displacement notice, before the process reached the least senior nurse. This potentially made everyone in the system a target to be bumped.

Veninga (1987) likened the downsizing process to that of a crisis. By definition a crisis can represent an opportunity or can be a time where increased stress exceeds coping strategies rendering the individual unable to cope. Sears (1992) found higher levels of stress in those who were displaced and did not have any choices about relocation, versus those who had choices, or those who were unaffected. This was attributed to the nurses' perceived loss of control over destiny. The highly stressed displaced group of nurses in Sears' study had job security but they did not have any choice about where they were being assigned. Sears concluded that this lack of choice was a significant factor in the level of stress nurses experienced. Laid off nurses and unaffected nurses all experienced similar increased levels of stress but this was lower than the stress experienced by displaced nurses without choices. The nurses in this current research had choices through the bumping process. Increased stress in all nurses is supported by Sears' work.

Nurses working in an organization where downsizing and restructuring is occurring do not appear to suffer psychological distress to the same extent as those who are unemployed. Numerous studies found that the majority of unemployed subjects experienced significant psychological distress as

measured by the GHQ (Broomhall & Winefield, 1990; Ensminger & Celentano, 1988; Jackson & Warr, 1984; Layton, 1986; Leana & Feldman, 1991; Ostell & Divers, 1987; Payne, Warr & Hartley, 1984; Rowley & Feather, 1987;). Several other studies demonstrated that being employed did not reduce GHQ scores if one was dissatisfied with the job. Unhappily employed subjects scored abnormally high on the GHQ scale (Hesketh, Shouksmith & Kang, 1987; Winefield, Tiggemann & Goldney, 1988; Winefield, Tiggemann & Winefield, 1992).

Current literature on downsizing acknowledges that survivors do suffer psychological distress (Kuhnert & Palmer, 1991; Kuhnert, Sims & Lahey, 1989; Noer, 1993). However, the impact does not appear to be as severe for the majority of subjects experiencing downsizing when compared to their unemployed counterparts. Additionally, studies that found no difference in GHQ scores between those who were unemployed and those who were unhappy in their jobs could not be substantiated by these results. This study found a third of the nurses surveyed reported GHQ scores that were above average with 10 nurses found to be experiencing symptoms indicating severe psychological distress. The severely distressed group was not anticipated and represented a source of great concern to this researcher.

Individuals who participated in this study could likely benefit from further professional assessment, support and treatment. The design of the study did not identify the respondents and there was no way to provide feedback to

individual nurses for the purpose of suggesting professional supports. The hospital did have an active Employee Assistance Program (EAP) with additional resources to address the needs of individuals suffering from the impact of layoffs and displacements. Head nurses had identified themselves as being aware of the "fallout" and were encouraged by management to refer staff to EAP. The question remains as to why nurses did not access this assistance when clearly some could have benefitted from the support.

Stress and GHQ were positively correlated. Sears did not use the GHQ to measure psychological distress but did find that the group that experienced the greatest stress tried the most coping strategies yet had the least success in finding those strategies helpful. Those experiencing the greatest stress were also the least hopeful and had the highest burnout scores. Wallfesh (1991) found that employees surviving downsizing and restructuring experienced more stress. They were also more likely to have difficulty concentrating which was one of the GHQ measures.

No correlation between stress and GHQ and physical health could be found. Approximately a third of the nurses experienced a decrease in their physical health which Kuhnert et al. (1989) believe is expected. Barnes et al. (1986) also found increased absenteeism in the months immediately following displacement notices. Presumably this increase was due to illness but regardless, absenteeism was seen as an adaptive coping mechanism by Barnes et al. (1986).

Qualitative Data

Qualitative data were limited to written comments on the questionnaire and verbal comments made to the researcher at the time of the questionnaire distribution. These comments proved valuable in providing some insights into the results. Interviews either on an individual or group basis would have provided additional valuable information. It is unfortunate that those who volunteered to participate in an interview did not appear to be representative of the population. They also appeared to be biased in their motivation to participate because of their previous relationship with the researcher.

It should also be noted that the researcher had unexpectedly been the victim of downsizing shortly after embarking on this research topic. The researcher initially was concerned that personal experiences might bias interpretation of the results. Experience, however, appeared to be an asset not a bias in the interpretation of the results. In addition, time, distance, and a new position in a hospital that has survived amalgamation, downsizing, and restructuring has left this researcher with a belief that a positive outcome is possible. The conclusion and synthesis of the results will be summarized in the following chapter.

Chapter VII

Synthesis

The purpose of this research was to measure the impact of organizational downsizing and restructuring on general duty nurses in a large acute care hospital. Constructs of a) global process control, b) perceived fairness of layoffs, c) job satisfaction, d) job security, e) organizational commitment, f) professional commitment, g) behavioural intent to leave, and h) overall health and stress were measured. The results indicate that the impact of downsizing and restructuring on nurses is significant but not unexpected. Noer (1993) suggests that the pattern of responses found in this research is typical of survivor syndrome. Specific research questions that motivated this study are addressed below.

Question #1 Have the nurses been directly or indirectly affected by this process?

Twenty-six nurses were directly affected by the bumping and displacement process related to downsizing and restructuring. The low number of directly affected individuals was proportional to the nurses in the organization that had been displaced. While the number of directly affected individuals was relatively low the indirect effect on others was staggering. No statistically significant differences between the displaced and non-displaced nurses could be found in any of the measured constructs. Further, there was little variability within the groups. The majority of nurses were found to be experiencing low GPC, low perceived fairness of layoffs, low job security, and increased levels of

stress related to the downsizing and restructuring. The researcher concluded that the majority of nurses were directly affected by the downsizing and restructuring process regardless of their displacement status.

Question #2 Is this process affecting the nurses' professional commitment?

The majority of nurses stated they likely would not choose to become a nurse if they had it to do all over again nor would they recommend nursing as a career choice to a friend, daughter, or son. Only 16 % rated themselves as committed to nursing. This may be related to the overall decline of nursing as a career choice and to other opportunities now available to women (Pringle, 1991).

The extremely high correlation to job satisfaction did not support the continuation of this construct as a separate measure. The researcher was unable to conclude if low professional commitment was in any way related to the downsizing and restructuring process and no previous measure of professional commitment or job satisfaction were available for the surveyed group of nurses.

Question #3 Is this process affecting the nurses' commitment to the organization?

Ninety percent of nurses were uncommitted to the organization. Of the 10 % who were committed no one scored in the highly committed range. Qualitative data suggested that a great deal of anger, fear, and a sense of betrayal existed within the organization and at least some nurses felt trapped by their perceived lack of choices. Caution should be used in making any

inferences to job performance or attendance based on low organizational commitment as this study did not solicit any evidence to support such a conclusion. The researcher did conclude that low commitment was representative of the nurses' feelings and was related to the downsizing and restructuring. This was seen by the researcher to be a normal defence mechanism, consistent with survivor syndrome.

Question #4 In which way does this affect overall job satisfaction?

Eighty-eight percent of nurses were dissatisfied with their jobs. In spite of the low job satisfaction and lack of organizational commitment, 90 % of the nurses surveyed had no intentions of voluntarily resigning in the coming year. This led the researcher to conclude that regardless of job satisfaction, health care reforms and the general economic climate limited alternative job choices that are available to nurses.

Based on strong correlations between low GPC, low organizational commitment, low job security, high stress, and job satisfaction the researcher also concluded that low job satisfaction was, at least in part, related to the downsizing and restructuring. No previous measure of job satisfaction in this population was available therefore the degree to which downsizing and restructuring impacted job satisfaction was not known. This conclusion is supported by previous studies describing survivor syndrome. As in the measure of organizational commitment caution should be used in the interpretation of these results as there is no indication of the behavioural effects of low job

satisfaction on job performance in this study.

Question #5 What is the impact on the nurses' general health status?

Most nurses experienced some level of stress associated with the downsizing and restructuring. Only 12 nurses or 13 % report no more stress than usual. The remaining 87 % experienced some level of additional stress with the majority of that group defining the stress as moderate to high.

In spite of this high level of stress most nurses seemed to be coping better than might have been expected. Sixty-six percent had no significant psychological symptoms as identified by the GHQ 12-item scale. The remaining 34 % experienced varied levels of distress with approximately a third of that group scoring in the severely distressed category. Several nurses commented by writing on the GHQ that the symptoms were directly related to the workplace while another, who did not complete the form, wrote that these measures reflected personal stress unrelated to work.

Thirty-four percent of nurses surveyed reported a negative impact on their physical health. These nurses stated they felt their overall health was better before the restructuring and downsizing began. Physical health was not correlated to any constructs. The researcher therefore concluded that although some nurses experienced negative health effects, the downsizing and restructuring could not be demonstrated to have a significant impact on the physical health of nurses. Stress and GHQ were positively correlated to each other and to job satisfaction. The researcher concluded that downsizing and

restructuring were very stressful for most nurses. Some nurses also experienced an increase in psychological distress, symptoms which are typical of survivor syndrome.

Question #6 What supports/coping mechanisms, if any, have the nurses found helpful in dealing with any stress that has resulted from this process?

The majority of nurses accessed more than one resource for support related to the downsizing and restructuring. Co-workers were, by far, rated as the most accessed support. Family and friends were also common sources of support. Approximately a third of the nurses reported exercise was helpful. Other resources were cited less often. One comment was particularly critical of EAP and did not view a doctor as a source of support. Nine nurses did not report accessing any resources and another three wrote that no supports were needed. This research concludes that nurses felt it was necessary to seek out supports related to the stress experienced as a result of the downsizing and restructuring process. No evidence was solicited related to the nurses' perception of effectiveness of supports accessed.

Summary of Synthesis

Nurses had little job security, felt they had little control, were dissatisfied in their jobs, uncommitted to the organization, did not see the downsizing process as fair, and experienced high levels of stress accompanied by psychological distress. Nurses specifically identified that their stress and the need to seek out

supports was directly attributed to downsizing and restructuring. This study did not collect data on the impact of downsizing and restructuring on job performance, attendance, or perceived helpfulness of supports.

No differences could be found between displaced and non-displaced nurses. Furthermore, no differences were found when controlling for years of experience or hours of seniority indicating that all nurses were affected negatively by the downsizing and restructuring process. These results confirm that nurses were exhibiting a set of symptoms referred to as survivor syndrome.

The results also confirmed some, but not all, of the relationships proposed in the theoretical framework which guided this research. Additionally, several new relationships were established in this study. A new theoretical framework will be proposed in the following chapter but first the limitations of this study will be discussed.

Limitations of the Study

The results of this study are significant but there are some methodological limitations. First, the researcher can not with authority reject or accept the theoretical framework which guided this study. This study did not replicate the original Davy et al. (1991) work. The researcher viewed the framework as limiting and therefore incorporated other variables in the questionnaire. In addition, constructs that were identical were not always measured in the same way as the original Davy et al. research.

A second concern is the small sample size of 93. A larger sample size would have increased the likelihood of being able to generalize responses to other nursing populations. A small sample size decreases the power of the statistics and increases the likelihood of a Type I error. The level of significance for this study was established at $p = .05$. However, it is unlikely that a Type I error occurred as statistically significant results appeared at $p > .03$ for all but one correlation, which was positive at $p = .041$.

Thirdly, in all return-mail questionnaire design studies it is difficult to assume that the sample is representative of the general population. Nurses who returned questionnaires were self-selecting and may have been committed to having their opinions heard. A response rate greater than 60 % is generally acceptable in decreasing the risk of serious response bias in this type of research design although lower response rates can be acceptable. An additional concern with the sample was that less than a third of the respondents had been displaced. However, this was representative of the proportion of displaced nurses in the general population of the hospital.

A fourth concern was the validity of the questionnaire which requires further examination. Ten of the 42 questions included in the questionnaire were developed by the researcher based on the literature. These questions were intended to measure such concepts as job security related to being a union member, overall health, overall stress, and information needs. The remaining 32 questions were extracted from widely tested measures and had high validity and

reliability.

The last concern is related to the use of Likert scale measures. Regardless of the established reliability of the above questions the issue of measuring attitudes is less reliable than the measurement of real number systems. The use of a Likert scale or attitudinal measure does not allow for each respondent to hold the same terms of reference for each variable. For example, there is a clear and common understanding of constructs such as height and weight. However, when nurses are asked to estimate their level of stress, respondents may rate the same level of stress exposure very differently dependent on personal tolerance and ability to cope. As in the perception of pain, one can argue that perceived stress is whatever the individual says it is. This still does not provide any real measure to how much stress exists or how much is too much.

As a result of the findings, discussion, conclusions and limitations of this study, implications for nursing practice, education, health care management and further research have been identified. These implications are outlined in the recommendations that follow.

Chapter VIII

Recommendations

Recommendations for future directions can be considered in four areas; 1) nursing practice, 2) nursing education, 3) health care management, and 4) future research. Each of these areas will be discussed below.

Nursing Practice

Downsizing and restructuring have implications for nursing practice. As beds are reduced, and innovative care practices are implemented in hospitals, nurses are caring for patients who are often more acutely ill. Nurses also have to provide more care in less time as lengths of stay are decreasing. Open heart surgery is a case in point. Until recently the average length of stay for open heart surgery was just over two weeks in most hospitals. Today, approximately 50 % of open heart surgery patients are sent home in five or six days. Some patients even come into hospital on the same day of surgery (Young, 1995).

These changes in practice require education not only of nurses but for the public. Nurses must learn to priories their care differently. They must provide the essentials during shortened hospital stays. Developing patient and family teaching skills to provide clients with the "need to know" (emphasis of author) information is essential to the success of early discharge programs and shortened lengths of stay. Nurses must also be adept in advanced nursing skills and constantly changing technologies in caring for today's patients.

The public can no longer expect that a hospital experience will be a restful one with a long-term rehabilitation period. Involving the patient, significant others, and community supports in the discharge planning even prior to hospitalization is a good strategy for changing the expectations that patients often have. The public also needs to be educated about the changing role of hospitals in providing acute care within the context of health care reform and the continuum of care in the community.

Changing practice also involves the movement of services and nursing jobs into the community. Nurses should be preparing themselves to engage in careers outside of hospitals in health promotion and supportive home nursing services. These changing practices have implications for nursing education.

Nursing Education

Current nursing education programs prepare graduate nurses to be generalists. They are often regarded as inadequate in providing nurses with the relevant and specialized skills required for today's job market. Expertise is gained only through experience and/or with advanced training and education. With a patient population that is generally more acutely ill while in hospital, many institutions feel an obligation to supplement the education of new graduate nurses with extensive orientation and buddy programs. In the current economic climate hospitals are increasingly viewing the extensive orientation required by new graduates as a major gap between nursing education programs and the hospital's need for safe and competent nurses. Knowledge of community care

and health promotion also varies among education programs, leaving novice graduates ill prepared to assume new and expanding roles in the community.

Health Care Management

The implications of this research for health care management are significant. The communication plan that was established by the hospital proved to be reaching a large number of staff. However, consideration should be given to expanding the communication network as the majority of nurses surveyed still felt they were not receiving enough information. The vision should be clearly articulated to all staff in a manner that they will hear and understand.

It will take some time for the organization to regain the confidence of the staff. Continued involvement of staff in the strategic planning and restructuring process is supported. Staff need to be able to observe the outcome of restructuring before they can start to believe they truly have a role in the decision-making process. Wherever possible, consideration should be given to slowing down the process. A common concern was the rapid pace of the changes that were occurring; where the managers themselves did not have all the answers.

The bumping process appeared to be a significant factor in the level of job insecurity and perceived of lack of fairness of layoffs that nurses were experiencing. Should this assumption prove accurate, exploring the potential to re-opening discussions with the labour unions about the bumping process could greatly enhance staff members' perception of job security and fairness of the

downsizing and restructuring process. For nurses who are displaced every effort should be made to relocate the employee in a similar area of practice.

A review of EAP services provided to staff related to the downsizing is suggested. Reallocation of these resources to enhance the communication network, or to provide general education and health promotion, may prove to be more beneficial to staff in coping with the stress of downsizing.

While suggesting that EAP may not have reached the staff as the hospital had intended, some consideration should be given to developing a method of identifying those nurses and other staff who are not coping well with the stress of change. Head nurses felt they were in a position of "dealing with the fallout" on a daily basis and no doubt referred many staff to EAP. A collaborative effort between EAP, occupational health, human resources, labour unions, and managers to develop criteria to assess those at risk, and to develop a mandatory referral system with follow-up, may have provided assistance to those who were in severe distress.

Research

This research did not replicate the Davy et al. (1991) theoretical framework (illustrated on page 17), but did incorporate those constructs with stress and general health. This researcher is recommending an alternate theoretical model to guide further research. This model is illustrated below and suggests that the level of job security and job satisfaction experienced by nurses plays a primary role in their level of stress and ability to cope (See Figure 5).

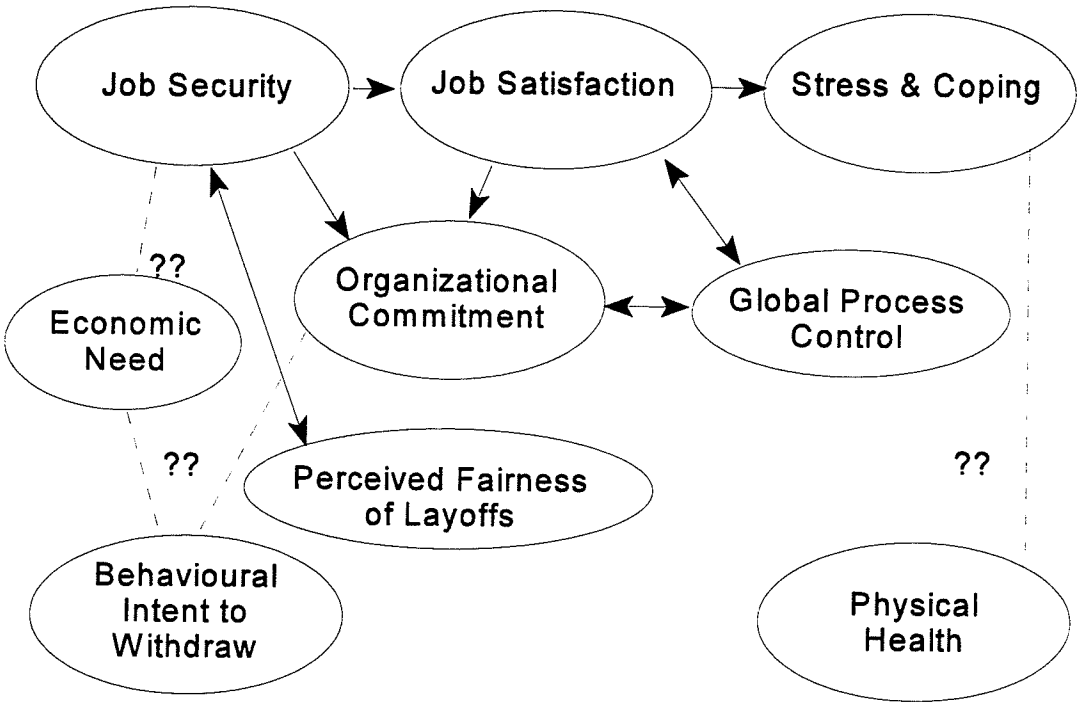

Figure 5. A proposed theoretical framework based on re-priorising the Davy et al. (1991) model and incorporating stress and general health.

Both job security and job satisfaction are seen as impacting organizational commitment. GPC is viewed in a less prominent position in thismodel, and as having a reciprocal relationship with job satisfaction and organizational commitment. Perceived fairness of layoffs is not linked to GPC in this model but has a reciprocal relationship with job security. The relationship of behavioural intent to leave, and physical health, to other variables is still in question. Also in

question is the economic needs of the nurse and the relationship this has to job security and behavioural intent to withdraw.

Further research is recommended to confirm this proposed model and the direction of the relationships between constructs. Of primary importance would be to measure the extent to which negative attitudes and high stress impact nurses' job performance and direct patient care.

This research examined health on a general, global level. More extensive research in this area would be of benefit to establish an in-depth, accurate, measure of health, and to define its relationships to job security and job satisfaction.

A longitudinal or follow-up study would be beneficial to measure the change in respondents' attitudes over time. The hospital has included staff in the restructuring process. Will nurses feel they have a part in the decision making? Will this change the level of GPC, job satisfaction, and organizational commitment over time?

A qualitative study would be helpful in exploring a number of concepts. Why are so many unsatisfied nurses choosing to remain in their jobs? Would staff perceive the displacement process as fair if all nurses were not potential victims of bumping? Would changing the process of bumping increase job security and decrease stress? As young nurses join the employment force do they hold different expectations with regard to the permanence of their employment? Will they be more accepting of constant changes and

innovations? What do nurses view as their education requirements in order to competently meet the challenges of a changing health care system both in the hospital and the community?

Conclusion

In conclusion, downsizing and restructuring is having a significant and negative impact on the majority of nurses surveyed. Numerous opportunities exist for future research in this area. Validation of the proposed model and qualitative research would both contribute to our understanding of nurses' survival of layoffs. Of the numerous research opportunities, one significant question presents itself. That is, in what way, if any, does the nurse's experience of increased stress and dissatisfaction in the workplace, as it relates to downsizing and restructuring, have an effect on patient care?

It is the hope of this author that nurses will choose to be active participants in this time of constant change. It is the belief of this author that nurses will continue to demonstrate care and compassion in their interactions with patients and significant others. Health care reforms have the potential to hold exciting and expanding roles for nurses. We should not be fearful of embracing those often difficult and challenging roles.

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APPENDICES

APPENDIX A

Questionnaire

Demographic Data

1. **How many years have you been a nurse?**_____

2. **How many hours of union seniority have you earned at this hospital?** Approximately_____hours. Earned over _____years.

3. **Have you been required to change jobs within this hospital as a result of bed closures or reorganization?** Yes_____ No_____
   3-1. If you answered **Yes** to the above question, how many times in the past two years has this happened to you?_____
   3-2. Were you able to move into a similar area of practice? _____

4. **What supports, if any, have you found helpful in dealing with the stressors related to displacement and reorganization?** Check as many as apply.

Employee Assistance Program	Family
Co-workers	Priest, Rabbi, spiritual counselling
Friends	Supervisor or boss
physical activities	doctor

Other (describe)_____

PLEASE CONTINUE AND COMPLETE THE REST OF THE QUESTIONNAIRE

INSTRUCTIONS

Listed below are a series of statements that represent possible feelings that individuals might have about the company or organization for which they work. With respect to your own feelings about the particular organization for which you are now working please indicate the degree of your agreement or disagreement with each statement by circling one of the seven alternatives below each statement.

1. **I am willing to put in a great deal of effort beyond that normally expected in order to help this organization be successful.**

strongly disagree	moderately disagree	slightly disagree	neither disagree nor agree	slightly agree	moderately agree	strongly agree

2. **I talk up this organization to my friends as a great organization to work for.**

strongly disagree	moderately disagree	slightly disagree	neither disagree nor agree	slightly agree	moderately agree	strongly agree

3. **I feel very little loyalty to this organization.**

strongly disagree	moderately disagree	slightly disagree	neither disagree nor agree	slightly agree	moderately agree	strongly agree

4. **I would accept almost any type of job assignment in order to keep working for this organization.**

strongly disagree	moderately disagree	slightly disagree	neither disagree nor agree	slightly agree	moderately agree	strongly agree

5. **I find that my values and the organization's values are very similar.**

strongly disagree	moderately disagree	slightly disagree	neither disagree nor agree	slightly agree	moderately agree	strongly agree

6. **I am proud to tell others that I am part of this organization.**

strongly disagree	moderately disagree	slightly disagree	neither disagree nor agree	slightly agree	moderately agree	strongly agree

7 **I could just as well be working for a different organization as long as the type of work was similar.**

strongly disagree	moderately disagree	slightly disagree	neither disagree nor agree	slightly agree	moderately agree	strongly agree

8. **This organization really inspires the very best in me in the way of job performance.**

strongly disagree	moderately disagree	slightly disagree	neither disagree nor agree	slightly agree	moderately agree	strongly agree

9. **It would take very little change in my present circumstances to cause me to leave this organization.**

strongly disagree	moderately disagree	slightly disagree	neither disagree nor agree	slightly agree	moderately agree	strongly agree

10. **I am extremely glad that I chose this organization to work for over others I was considering at the time I joined.**

strongly disagree	moderately disagree	slightly disagree	neither disagree nor agree	slightly agree	moderately agree	strongly agree

11. **There's not too much to be gained by sticking with this organization indefinitely.**

strongly disagree	moderately disagree	slightly disagree	neither disagree nor agree	slightly agree	moderately agree	strongly agree

12. **Often, I find it difficult to agree with this organization's policies on important matters relating to its employees.**

strongly disagree	moderately disagree	slightly disagree	neither disagree nor agree	slightly agree	moderately agree	strongly agree

13. **I really care about the fate of this organization.**

strongly disagree	moderately disagree	slightly disagree	neither disagree nor agree	slightly agree	moderately agree	strongly agree

14. **For me this is the best of all possible organizations for which to work.**

strongly disagree	moderately disagree	slightly disagree	neither disagree nor agree	slightly agree	moderately agree	strongly agree

15. **Deciding to work for this organization was a definite mistake on my part.**

strongly disagree	moderately disagree	slightly disagree	neither disagree nor agree	slightly agree	moderately agree	strongly agree

16. **Employees are asked to give input on implementing major changes in the hospital.**

strongly disagree	moderately disagree	neither disagree nor agree	moderately agree	strongly agree

17. **My supervisor asks for input from people in my department regarding procedural decisions that will directly affect them.**

strongly disagree	moderately disagree	neither disagree nor agree	moderately agree	strongly agree

18. **How certain are you about your future career with this hospital?**

extremely certain	moderately certain	neither certain nor uncertain	moderately uncertain	extremely uncertain

19. **What are the chances you will be laid off or displaced within the next year?**

0% chance	25% chance	50% chance	75% chance	100% chance

20. **Being a union member offers me job security?**

strongly disagree	moderately disagree	neither disagree nor agree	moderately agree	strongly agree

21. **Decisions on who is to be laid off or displaced are made fairly**.

strongly disagree	moderately disagree	neither disagree nor agree	moderately agree	strongly agree

22. **Do you feel that the methods used for reassigning displaced nurses is fair to all concerned?**

strongly disagree	moderately disagree	neither disagree nor agree	moderately agree	strongly agree

23. **What are the chances you will quit this job within the next 12 months?**

0% chance	25% chance	50% chance	75% chance	100% chance

24. **I received an adequate amount of information from management about the restructuring process and had a clear understanding of the impact for me.**

strongly disagree	moderately disagree	neither disagree nor agree	moderately agree	strongly agree

25. **How has your physical health been recently?**

perfect health	good health	average health	fair health	poor health	bad health	totally disabled

26. **In relationship to your recent health, what would you say your physical health was like prior to organizational restructuring and downsizing in your hospital?**

much better	somewhat better	no different than before	somewhat worse	much worse

27. **All things considered, how satisfied would you say you are these days with your job?**

very good	pretty good	average	pretty bad	very bad

28. **Overall, would say the process of restructuring and downsizing has been stressful for you?**

stress has been unbearable	extremely stressful	moderately stressful	slightly stressful	no more stress than usual

29. **Knowing what you know now, if you had to decide all over again whether to become a nurse, what would you decide?**

definitely be a nurse	probably be a nurse	uncertain	probably not a nurse	definitely not a nurse

30. **If a good friend, daughter or son of yours told you that she/he was interested in enter the nursing profession, what would you tell her/him?**

definitely be a nurse	probably be a nurse	uncertain	probably not a nurse	definitely not a nurse

31. **Would you be willing to participate in a small group interview? If so please print your name, address and phone number so that I may contact you to arrange this.**

_____

_____

_____

PLEASE CONTINUE AND COMPLETE THE REST OF THE QUESTIONNAIRE

Please read this carefully:

Please answer all the questions on the following pages simply by underlining the answer which you think most nearly applies to you. Remember that we want to know about present and recent complaints, not those that you had in the past. It is important to try to answer all the questions.

Thank you very much for your co-operation.

HAVE YOU RECENTLY:

1.. been able to concentrate on whatever you're doing?	Not at all	Same as usual	Less than usual	Much less than usual
2.. lost much sleep over worry?	Not at all	No more than usual	Rather more than usual	Much more than usual
3.. felt that you are playing a useful part in things?	More so than usual	Same as usual	Less than useful than usual	Much less useful
4.. felt capable of making decisions about things?	More so than usual	Same as usual	Less so than usual	Much less capable
5..felt constantly under strain?	Not at all	No more than usual	Rather more than usual	Much more than usual
6..felt you couldn't overcome your difficulties?	Not at all	No more than usual	Rather more than usual	Much more than usual
7..been able to enjoy your normal day-to-day activities?	More so than usual	Same as usual	Less so than usual	Much less than usual
8..been able to face up to your problems?	More so than usual	Same as usual	Less able than usual	Much less able

9..been feeling unhappy and depressed?	Not at all	No more than usual	Rather more than usual	Much more than usual
10..been loosing confidence in your-self?	Not at all	No more than usual	Rather more than usual	Much more than usual
11..been thinking of yourself as a worthless person?	Not at all	No more than usual	Rather more than usual	Much more than usual
12..been feeling reasonably happy, all things considered	More so than usual	About same as usual	Less so than usual	Much less than usual

(Please note that this is a sample only. This tool is copyrighted and was purchased from a publishing house for use in this study with the permission of the author. The purchased tool is clearly formatted on a single page.)

APPENDIX B

Hospital Research Setting

Research Committee

Request and Approval

Ingrid Olson, Graduate Student

Victoria, British Columbia
V

May 20, 1994

Research Department, Attention: xxxxx
Research Committee
xxxxxxxxxxxxxxxxxxx
xxxxxxxxxxxxxxxxxxx
xxxxxxxxxxxxxxxxxxx

Dear Committee Members:

Please accept the enclosed Impact Analysis Form and copy of my thesis proposal for your consideration. I have not included a budget as there are no direct or indirect costs to the organization. The researcher will incur some costs for photocopying, postage and purchase of one component of the questionnaire. I would be happy to supply you with more detailed information on these costs if you feel it is necessary.

I hope to be able to collect my data this summer and therefore I am requesting that this submission be considered at your next meeting.

I look forward to your response so that I may begin to plan for the data collection. As I will have to make travel arrangements, your earliest reply would be appreciated.

If you require any additional information I can be reached by phone at home or work or by E-mail .gov.bc.ca.

Thank you.

Ingrid Olson

OFFICE OF THE DIRECTOR OF RESEARCH

June 30, 1994

Ms. I. Olson

Victoria, British Columbia
V

Dear Ms. Olson:

RE: **Measuring the Impact of Organizational Downsizing and Restructuring on General Duty Nurses in a Large Acute Care Hospital.**

ETHICS #: N#94/14

The above-named protocol, **has been evaluated and approved** by the Research Impact Committee.

If your study is receiving funds, please contact the Finance Department for an application for a Specific Purpose Account. It is imperative that you submit a copy of this letter along with your application to: Supervisor, Ancillary Services, Finance Division, so she is aware this has been approved by the Research Department.

PLEASE NOTE: THIS SPECIFIC RESEARCH ACCOUNT NUMBER CAN ONLY BE USED FOR THIS PARTICULAR STUDY.

My sincere best wishes for much success in your study.

Sincerely,

Director of Research

cc: Supervisor, Ancillary Accounts
Finance Division

APPENDIX C

Ethical Review Committee Approval

Faculty of Nursing, University of Manitoba

The University of Manitoba

FACULTY OF NURSING
ETHICAL REVIEW COMMITTEE

APPROVAL FORM

Proposal Number N#94/14

Proposal Title: "MEASURING THE IMPACT OF ORGANIZATIONAL DOWNSIZING AND RESTRUCTURING ON GENERAL DUTY NURSES ON A LARGE ACUTE CARE HOSPITAL."

Name and Title of Researcher(s): INGRID C. OLSON
MASTER OF NURSING GRADUATE STUDENT
FACULTY OF NURSING
UNIVERSITY OF MANITOBA

Date of Review: JUNE 06, 1994.

APPROVED BY THE COMMITTEE: JUNE 06, 1994.

Comments: APPROVED WITH SUBMITTED CHANGES OF JUNE 16, 1994.

Date: June 16, 1994

Linda J. Kristjanson, PhD, RN — Chairperson
Associate Professor
University of Manitoba Faculty of Nursing

Position

NOTE:
Any significant changes in the proposal should be reported to the Chairperson for the Ethical Review Committee's consideration, in advance of implementation of such changes.

Revised: 92/05/08/se

APPENDIX D

Introduction to Researcher and Study

Please Post/Circulate

YOU ARE INVITED TO PARTICIPATE

June 20, 1994

My name is Ingrid Olson and I am a Graduate Student in the Faculty of Nursing. I am currently conducting research to complete my Master's Degree. I am interested in the concepts of stress, coping and adaptation. The title of my research is:

Measuring the Impact of Organizational Downsizing and Restructuring on General Duty Nurses in a Large Acute Care Hospital.

I am inviting general duty nurses to participate in the study and will be in Winnipeg July 27, 28, and 29 to distribute my questionnaire. During this time, I will be visiting nursing units and will be available to answer any questions you might have.

Should you need to contact me, I am available evenings at . . until July 26 1994, and after August 15 1994. While in Winnipeg, I can be reached at xxx-xxxx. You may also call Dr. Erna Schilder, Thesis Chairperson, with questions or concerns at the University of Manitoba, 474-9664.

This research project has been approved by the Faculty of Nursing Ethical Review Committee and the xxxxxxxxxxxxxxxxxxx Research Committee.

Yours sincerely,

Ingrid Olson,
Graduate Student

APPENDIX E

Prepared Invitation to Participate

Ingrid Olson is (I am) a Graduate Student in the Faculty of Nursing. She is (I am) currently conducting research to complete her (my) Master's Degree. She is (I am) interested in the concepts of stress, coping and adaptation. The title of her (my) research is **Measuring the Impact of Organizational Downsizing and Restructuring on General Duty Nurses in a Large Acute Care Hospital**.

Ms. Olson is (I am) inviting general duty nurses to participate in this study. If you wish to consider participating, a questionnaire package and a further letter of explanation is available to you in the staff conference room on your unit. You are under no obligation to participate. If you choose to participate please return the questionnaire in the pre-addressed envelope provided. If, after examining the package you choose not to participate, please leave the package intact for another nurse's consideration and use. If you would like to participate and cannot find a package, please contact another nursing unit or Ms. Olson (me).

If you have any questions Ms. Olson (I) will be available July 27, 28 & 29 by phone at xxx-xxxx or after August 15, 1994 by calling collect (604)370-1909 in the evenings. You may also call Dr. Erna Schilder, Thesis Chairperson, with questions or concerns at the University of Manitoba, 474-9664.

This research project has been approved by the Faculty of Nursing Ethical Review Committee and the xxxxxxxxxxxxxxx Research Committee.

APPENDIX F

Explanation of Study

July 26, 1994

Dear Colleague:

Recently health care facilities across Canada have been grappling with rising health care costs and decreased funding from Federal and Provincial governments. This has resulted in a variety of changes in many hospitals including bed closures and organizational restructuring. The outcome has altered ways in which institutions deliver health care and utilize their resources. Many hospital staff have been affected in this process of organizational downsizing and restructuring. The purpose of this study is to determine how these changes have affected general duty nurses in your hospital.

You are being invited to voluntarily participate in a study **"Measuring the Impact of Organizational Downsizing and Restructuring on General Duty Nurses in a Large Acute Care Hospital"** by responding to this questionnaire. By responding to the questionnaire you will be consenting to participate in the study. You are not required to put your name on the questionnaire nor is the questionnaire coded in any way that will identify you. The questionnaire should take 10 to 15 minutes to complete. You may choose not to answer some of the questions. You are not obligated to participate in this study and there are no risks anticipated from your participation. If after examining the package you choose not to participate, please leave the package intact for another nurse's consideration and use.

Following analysis of the questionnaires the researcher may require additional information to add depth to the statistical data. This will be done in a small focused group interview. It is anticipated that a group interview would take about one hour. The group would be expected to maintain anonymity of its members. If you are interested in participating in a focus group interview please

include information requested on page 5 of the questionnaire. *This will be used by the researcher only for the purposes of contacting you to arrange the interview.* You are under no obligation to participate in the interview portion of the study and may withdraw at any time. There are no known risks in participating in the interview portion of the study.

This research project has been approved by the Faculty of Nursing Ethical Review Committee and the xxxxxxxxxxxxxxx Research Committee.

Thank you in advance for your time,

Ingrid Olson, RN
Graduate Student
Faculty of Nursing, University of Manitoba

(Note: This letter was originally formatted on a single page.)

APPENDIX G

Reminder Letter

Ingrid Olson, RN

Victoria, British Columbia
V

August 8, 1994

Dear Colleague:

My name is Ingrid Olson and I am a graduate student in the Faculty of Nursing, University of Manitoba. I am currently conducting research to complete my Master's Degree. A few weeks ago a questionnaire package was circulated in your area requesting your participation in a study **Measuring the Impact of Organizational Downsizing and Restructuring on General Duty Staff Nurses in a Large Acute Care Hospital.** If you have submitted your completed survey, thank you. If you have not yet considered participating in this study would you please take a moment to read the information sheet attached to the questionnaire package. If, after examining the package, you choose not to participate, please leave the package intact for another nurse's consideration and use. Your response will be helpful in completing this research. A pre-addressed envelope has been provided for your convenience and no postage is required.

This research project has been approved by the Faculty of Nursing Ethical Review Committee and the xxxxxxxxxxxxxxxx Research Committee.

Should you have any questions regarding this research please do not hesitate to contact me at the address above or by phoning collect, after August 15, 1994. Thesis Chairperson, Dr. Erna Schilder, Faculty of Nursing, University of Manitoba, may also be contacted at 474-9664.

Thank you for your time.

APPENDIX H
FREQUENCY TABLES

Years of Experience as a Nurse

Value Label	Value	Frequency	Percent	Valid Percent	Cum Percent
1 to 4 Years	1.00	14	15.1	15.1	15.1
5 to 9 Years	2.00	38	40.9	40.9	55.9
10 to 14 Years	3.00	19	20.4	20.4	76.3
15 or More Years	4.00	22	23.7	23.7	100.0
	Total	93	100.0	100.0	

Hi-Res Chart # 31:Bar chart of years recoded

Mean	2.527	Mode	2.000	Std dev	1.017
Variance	1.035	Skewness	.179	S E Skew	.250
Range	3.000				

Valid cases 93 Missing cases 0

Hours of Seniority in the Research Setting

Value Label	Value	Frequency	Percent	Valid Percent	Cum Percent
0 to 4999 Hours	1.00	33	35.5	35.5	35.5
5000 to 7650 Hours	2.00	16	17.2	17.2	52.7
7651 to 10000 Hours	3.00	13	14.0	14.0	66.7
10001 to 18000 Hours	4.00	16	17.2	17.2	83.9
18001 Hours or Great	5.00	15	16.1	16.1	100.0
	Total	93	100.0	100.0	

Hi-Res Chart # 30:Bar chart of seniority recoded

Mean	2.613	Mode	1.000	Std dev	1.511
Variance	2.283	Skewness	.339	S E Skew	.250
Range	4.000				

Valid cases 93 Missing cases 0

Global Process Control (GPC)

Value Label	Value	Frequency	Percent	Valid Percent	Cum Percent
Strongly Disagree	1.00	3	3.2	3.3	3.3
	1.33	4	4.3	4.3	7.6
	1.67	6	6.5	6.5	14.1
Moderately Disagree	2.00	7	7.5	7.6	21.7
	2.33	10	10.8	10.9	32.6
	2.67	8	8.6	8.7	41.3
Undecided	3.00	11	11.8	12.0	53.3
	3.33	14	15.1	15.2	68.5
	3.67	10	10.8	10.9	79.3
Moderately Agree	4.00	13	14.0	14.1	93.5
	4.33	4	4.3	4.3	97.8
	4.67	2	2.2	2.2	100.0
	.	1	1.1	Missing	
	Total	93	100.0	100.0	

Hi-Res Chart # 23:Histogram of global process control

Mean	2.957	Mode	3.333	Std dev	.923
Variance	.853	Skewness	-.309	S E Skew	.251
Range	3.667				

Valid cases 92 Missing cases 1

Perceived Fairness of Layoffs

Value Label	Value	Frequency	Percent	Valid Percent	Cum Percent
Strongly Disagree	1.00	9	9.7	9.8	9.8
	1.50	9	9.7	9.8	19.6
Moderately Disagree	2.00	15	16.1	16.3	35.9
	2.50	10	10.8	10.9	46.7
Undecided	3.00	14	15.1	15.2	62.0
	3.50	13	14.0	14.1	76.1
Moderately Agree	4.00	20	21.5	21.7	97.8
	4.50	2	2.2	2.2	100.0
	.	1	1.1	Missing	
	Total	93	100.0	100.0	

Hi-Res Chart # 20:Histogram of perceived fairness of layoff

Mean	2.761	Mode	4.000	Std dev	1.028
Variance	1.058	Skewness	-.206	S E Skew	.251
Range	3.500				

Valid cases 92 Missing cases 1

Job Security

Value Label	Value	Frequency	Percent	Valid Percent	Cum Percent
No Security	1.00	2	2.2	2.2	2.2
	1.33	4	4.3	4.3	6.5
	1.67	2	2.2	2.2	8.6
Little Security	2.00	7	7.5	7.5	16.1
	2.33	9	9.7	9.7	25.8
	2.67	13	14.0	14.0	39.8
Some Security	3.00	13	14.0	14.0	53.8
	3.33	11	11.8	11.8	65.6
	3.67	15	16.1	16.1	81.7
Moderate Security	4.00	7	7.5	7.5	89.2
	4.33	5	5.4	5.4	94.6
	4.50	1	1.1	1.1	95.7
	4.67	3	3.2	3.2	98.9
High Security	5.00	1	1.1	1.1	100.0
	Total	93	100.0	100.0	

Hi-Res Chart # 19:Histogram of job security

Mean	3.056	Mode	3.667	Std dev	.892
Variance	.795	Skewness	-.198	S E Skew	.250
Range	4.000				

Valid cases 93 Missing cases 0

Job Satisfaction

Value Label	Value	Frequency	Percent	Valid Percent	Cum Percent
Very Dissatisfied	1.00	2	2.2	2.2	2.2
	1.33	12	12.9	13.0	15.2
	1.67	5	5.4	5.4	20.7
Dissatisfied	2.00	16	17.2	17.4	38.0
	2.33	10	10.8	10.9	48.9
	2.67	13	14.0	14.1	63.0
Undecided	3.00	7	7.5	7.6	70.7
	3.33	12	12.9	13.0	83.7
	3.67	4	4.3	4.3	88.0
Satisfied	4.00	2	2.2	2.2	90.2
	4.33	2	2.2	2.2	92.4
	4.67	5	5.4	5.4	97.8
Very Satisfied	5.00	2	2.2	2.2	100.0
	.	1	1.1	Missing	
	Total	93	100.0	100.0	

Hi-Res Chart # 18:Histogram of job satisfaction

Mean	2.630	Mode	2.000	Std dev	.995
Variance	.990	Skewness	.561	S E Skew	.251
Range	4.000				

Valid cases 92 Missing cases 1

Professional Commitment

Value Label	Value	Frequency	Percent	Valid Percent	Cum Percent
Definitely Not	1.00	17	18.3	18.5	18.5
	1.50	9	9.7	9.8	28.3
Probably Not	2.00	23	24.7	25.0	53.3
	2.50	10	10.8	10.9	64.1
Undecided	3.00	11	11.8	12.0	76.1
	3.50	7	7.5	7.6	83.7
Probably a Nurse	4.00	8	8.6	8.7	92.4
	4.50	1	1.1	1.1	93.5
Definitely a Nurse	5.00	6	6.5	6.5	100.0
	.	1	1.1	Missing	
	Total	93	100.0	100.0	

Hi-Res Chart # 17:Histogram of professional commitment

Mean	2.451	Mode	2.000	Std dev	1.158
Variance	1.341	Skewness	.621	S E Skew	.251
Range	4.000				

Valid cases 92 Missing cases 1

Organizational Commitment (OCS)

Value Label	Value	Frequency	Percent	Valid Percent	Cum Percent
	1.40	1	1.1	1.1	1.1
	1.87	1	1.1	1.1	2.2
	1.93	1	1.1	1.1	3.2
Moderately Uncommitt	2.00	1	1.1	1.1	4.3
	2.13	3	3.2	3.2	7.5
	2.20	1	1.1	1.1	8.6
	2.40	3	3.2	3.2	11.8
	2.60	1	1.1	1.1	12.9
	2.67	1	1.1	1.1	14.0
	2.80	3	3.2	3.2	17.2
	2.87	1	1.1	1.1	18.3
Slightly Uncommitted	3.00	4	4.3	4.3	22.6
	3.07	5	5.4	5.4	28.0
	3.20	2	2.2	2.2	30.1
	3.27	2	2.2	2.2	32.3
	3.33	5	5.4	5.4	37.6
	3.40	2	2.2	2.2	39.8
	3.47	2	2.2	2.2	41.9
	3.53	1	1.1	1.1	43.0
	3.60	1	1.1	1.1	44.1
	3.64	1	1.1	1.1	45.2
	3.67	2	2.2	2.2	47.3
	3.73	2	2.2	2.2	49.5
	3.87	2	2.2	2.2	51.6
	3.93	3	3.2	3.2	54.8
Undecided	4.00	2	2.2	2.2	57.0
	4.07	1	1.1	1.1	58.1
	4.13	3	3.2	3.2	61.3
	4.20	3	3.2	3.2	64.5
	4.27	5	5.4	5.4	69.9
	4.36	1	1.1	1.1	71.0
	4.40	1	1.1	1.1	72.0
	4.47	3	3.2	3.2	75.3
	4.53	3	3.2	3.2	78.5
	4.60	2	2.2	2.2	80.6
	4.73	3	3.2	3.2	83.9
	4.80	2	2.2	2.2	86.0
	4.87	1	1.1	1.1	87.1
	4.93	3	3.2	3.2	90.3
Slightly Committed	5.00	2	2.2	2.2	92.5
	5.07	2	2.2	2.2	94.6
	5.20	1	1.1	1.1	95.7
	5.80	1	1.1	1.1	96.8
	6.33	1	1.1	1.1	97.8
	6.43	1	1.1	1.1	98.9
	6.50	1	1.1	1.1	100.0
	Total	93	100.0	100.0	

Mean	3.791	Mode	3.067	Std dev	1.028
Variance	1.057	Skewness	.178	S E Skew	.250
Range	5.100				

* Multiple modes exist. The smallest value is shown.

Valid cases 93 Missing cases 0

Behavioural Intent to Leave

Value Label	Value	Frequency	Percent	Valid Percent	Cum Percent
Definitely Will Stay	1.00	59	63.4	63.4	63.4
Likely Will Stay	2.00	15	16.1	16.1	79.6
Undecided	3.00	10	10.8	10.8	90.3
Likely Will Resign	4.00	6	6.5	6.5	96.8
Certain to Resign	5.00	3	3.2	3.2	100.0
	Total	93	100.0	100.0	

Hi-Res Chart # 39:Bar chart of intend to voluntarily resign within a year

Mean	1.699	Mode	1.000	Std dev	1.101
Variance	1.213	Skewness	1.525	S E Skew	.250
Range	4.000				

Valid cases 93 Missing cases 0

Perceived Stress Related to Downsizing and Restructuring

Value Label	Value	Frequency	Percent	Valid Percent	Cum Percent
No More Stress than	1	12	12.9	13.0	13.0
Slightly Stressful	2	21	22.6	22.8	35.9
Moderately Stressful	3	39	41.9	42.4	78.3
Extremely Stressful	4	19	20.4	20.7	98.9
Unbearable Stress	5	1	1.1	1.1	100.0
	.	1	1.1	Missing	
	Total	93	100.0	100.0	

Hi-Res Chart # 2:Bar chart of stress of restructuring

Mean	2.739	Std err	.101	Mode	3.000
Std dev	.971	Variance	.942	Kurtosis	-.584
S E Kurt	.498	Skewness	-.261	S E Skew	.251
Range	4.000	Minimum	1.000	Maximum	5.000

Valid cases 92 Missing cases 1

Health Comparison

Value Label	Value	Frequency	Percent	Valid Percent	Cum Percent
Much Better	1	12	12.9	13.0	13.0
Somewhat Better	2	19	20.4	20.7	33.7
No Change	3	56	60.2	60.9	94.6
Somewhat Worse	4	4	4.3	4.3	98.9
Much Worse	5	1	1.1	1.1	100.0
	.	1	1.1	Missing	
	Total	93	100.0	100.0	

Hi-Res Chart # 1:Bar chart of health comparision

Mean	2.598	Std err	.085	Mode	3.000
Std dev	.813	Variance	.661	Kurtosis	.418
S E Kurt	.498	Skewness	-.512	S E Skew	.251
Range	4.000	Minimum	1.000	Maximum	5.000

Valid cases 92 Missing cases 1

General Health Questionnaire (GHQ)

Value Label	Value	Frequency	Percent	Valid Percent	Cum Percent
	.00	28	30.1	31.1	31.1
	1.00	13	14.0	14.4	45.6
Average	2.00	11	11.8	12.2	57.8
	3.00	7	7.5	7.8	65.6
Mild Distress	4.00	7	7.5	7.8	73.3
	5.00	3	3.2	3.3	76.7
Moderate Distress	6.00	1	1.1	1.1	77.8
	7.00	8	8.6	8.9	86.7
Serious Distress	8.00	2	2.2	2.2	88.9
	9.00	1	1.1	1.1	90.0
Severe Distress	10.00	2	2.2	2.2	92.2
	11.00	4	4.3	4.4	96.7
	12.00	3	3.2	3.3	100.0
	.	3	3.2	Missing	
	Total	93	100.0	100.0	

Hi-Res Chart # 21:Histogram of general health questionnaire

Mean	3.178	Mode	.000	Std dev	3.596
Variance	12.934	Skewness	1.105	S E Skew	.254
Range	12.000				

Valid cases 90 Missing cases 3