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Exploring Organizational and Professional Commitment, Servant Leadership, Occupational Stress, and Humor Perspectives: How Nurses Manage

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EXPLORING ORGANIZATIONAL AND PROFESSIONAL COMMITMENT, SERVANT LEADERSHIP, OCCUPATIONAL STRESS, AND HUMOR PERSPECTIVES: HOW NURSES MANAGE

by

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ABSTRACT

The primary research objective of this study was to explore how nurses' communication influences organizational commitment, professional commitment, servant leadership, occupational stress, and humor use. These concepts were approached qualitatively to obtain deep and rich information about communication influences on nurses' work lives.

A total of 34 nurse participants from network sampling and snowball sampling techniques were interviewed for this study, most from a medium-sized southeastern hospital. Specifically, semi-structured interviews were conducted where participants were asked to provide perspectives regarding communication events of organizational commitment, professional commitment, servant leadership, occupational stress, and humor use. These perspectives were analyzed using Strauss and Corbin's (1990) guidelines.

Conclusions were reached based on grounded theory analysis that followed from asking five research questions. First, participants sought out their coworkers and patients because of organizational commitment characteristics. Second, participants uncovered valuable unique aspects of nursing that frame nursing as more than just giving medicine. Third, participants revealed servant leadership qualities in their charge nurse. Fourth, participants revealed stress-filled experiences and ways in which they remedy them. Fifth, the humor as relief phenomenon shed light into humor use by nurses to manage their work. Collectively, these results extend valuable communication tools to both scholars and healthcare personnel.

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DEDICATION

I would like to thank my grandparents, mom, step-dad, sister, aunt and uncle, who have instilled motivation and support to me throughout this experience and the value of education. I cannot thank you enough. I also want to thank my kitten and friends for their support.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF ILLUSTRATIONS

CHAPTER I - INTRODUCTION

Registered nurses have a profound influence in medical care, are the most important human resource in the hospital, and are the first line care giver (Chun-Chen, Ching-Sing, & Ming-Tien, 2012). Researchers contend that the United States demand for RN's is expected to exceed supply by 2020, thus creating a shortage (Chun-Chen, Ching-Sing, & Ming-Tien, 2012). Getting and keeping registered nurses on the job is an ongoing challenge for hospitals and other medical practices.

Commonly, hospitals face nursing shortages, uneven quality of care, and rapidly changing environments (Aiken et al., 2001). Work design and management interactions threaten nursing care (Aiken et al., 2001). Moreover, while nursing shortages have been cyclical, hospitals now seem ill prepared, and thus hospital nurse shortages are destined to worsen long term (Aiken et al., 2001). With nursing being a crucial and important field, nurses' communication is vital and needs more intense study. Nurses are at the forefront of patient care and because nurses play such a major role, they need to communicate well. Exceptional patient outcomes depend on nurses providing high-quality care (Kane et al., 2007). Patients receive more attention when the nurse-to-patient ratio is acceptable (Kane et al., 2007). In other words, when there are enough nurses to care for patients frequently, patients got better quicker. Patient outcomes, then, are related to a high commitment to collaborative clinical practices, and adequately staffing nurses (Kane et al., 2007).

By the year 2020, nursing jobs will have increased 26%, making it the fastest growing occupation (BLS, 2016). One reason to study the communication of nurses is because it is such a big field. Researching one of the fastest growing occupations should

yield fruitful outcomes. With so many people entering nursing, communication becomes especially important to convey procedures, patient plans, or help others in the nursing role. With nurses commencing work, getting comfortable with their role and context will make them as efficient and effective as possible.

Being a committed nurse may increase the likelihood that the nurse stays with the organization. With healthcare reform, a lot of people coming into the nursing field, and an aging population, organizational commitment should be a fruitful concept to explore. Moreover, nurses put themselves on the line because they are constantly serving the needs of others and may come into contact with deadly diseases and make decisions that can impact the life of a patient. It only makes sense that nurses in leadership roles would want to promote loyalty from nurses who are front-line caregivers, so that there is a connection with the hospital's mission and bedside care (Aiken et al., 2001). What is problematic for nurses is that rather than management addressing healthcare organization deficiencies in nursing care, management emulated a productivity model (Aiken et al., 2001). With implementation of a productivity structure, nurses became dissatisfied with working conditions because patient care was not being exceptionally demonstrated, making retaining nurses difficult for organizations (Aiken et al., 2001). Another problem is that older nurses are retiring, and the young nurses are leaving hospitals to go work in clinics or private care (Aiken et al., 2001).

Since nurses take care of people when they are sick and make decisions that impact people, occupational stress may hinder nurses' ability to perform their role or desire to stay in the organization. For nurses, constantly seeing people with illness or injury may increase stress. Dealing with stressful situations may jeopardize a nurse's

commitment. Likewise, stress goes beyond a nurse's individual role to the organization as a whole. If stress is not dealt with effectively, it may hinder both the nurse and the organization. Nurses make a big impact on patient's lives. Nurses come into contact with blood, broken bones, patient sadness, and even death, not to mention communicating with the patient's family, which may also be stressful. Nurses put themselves last for eight hours a day or more. Nurses are on their feet serving patients even when they may not feel well, have feet and back aches, or are hungry.

Nursing is a practice that has a profound impact in the care of patients' pain and well-being (Cioffi, 2012; Donkor & Andrews, 2011; Gondeck, 2011; Riley, Beal, & Lancaster, 2008). Likewise, nursing is a tough profession because of health-related constraints (nurses not taking care of themselves), leadership quality, and stress-related health outcomes (physical demands of the profession), which can lead to turnover (Simon, Hans-Muller, & Hasselhorn, 2010). This may be problematic because nurses then have a greater case load and patients may not be getting as much care and attention. Moreover, the nursing practice is challenged immensely due to the fast-paced environment, limited resources, and various demands, not to mention reducing care for sick patients with a higher patient-nurse ratio (Gondeck, 2011; Riley, Beal, & Lancaster, 2008). The American Institute of Stress contends that 40 % of employees feel stressed at work (Sauter et al., 1999). Work-related stress has been shown to decrease the vitality of both the nurse and the organization because stress affects the individual's physical and psychological processes (Sarp, Yarpuzlu, & Onder, 2005).

Research is needed to identify occupational stress early so its effects are managed (McVicar, 2003). Because stress continues to challenge healthcare, organizational

interventions to reduce stress should be examined in order to understand its implications (McVicar, 2003). Research has illustrated that stress-related illness in healthcare impacts and strains nurse coverage (Glegg, 2001). Work overload, uncooperative patients, and supervision not being supportive all impact nurses greatly (Motowidlo, Packard, & Manning, 1986). These occupational strains with added frequency and intensity affects all aspects of an individual (Motowidlo, Packard, & Manning, 1986).

Humor serves stress-relieving purposes for nurses such as bonding about common concerns and problems, reducing tension, and acting therapeutic (Yoels, & Clair, 1995); humor has also been researched in a nursing student context (Chauvet, & Hofmeyer, 2007). Nursing researchers concluded that humor enhances positive relationships, improves performance, and reduces sadness in nursing students (Chauvet, & Hofmeyer, 2007). Humor helped nurses with difficult situations and patients that created cohesiveness between nurse and patient as well as between nurses, which decreased patients' anxiety (Tatano-Beck, 1997).

Humor in high-stress occupations may benefit nurses because they can make light of situations in order to not become so stressed out that they are constantly on edge. Communicating humor for nurses may strengthen bonds between each other and reduce an external threat that causes stress (Francis, 1994). Likewise, humor may provide social support for nurses (Cann, Zapata, & Davis, 2009). Humor in the organizational context for nurses may create a remedial device for experiencing the difficulty of dealing with emotion and tragedy (Kangasharju, & Nikko, 2009). Humor researchers contend that humor is used to enhance the self and relationships with others (Martin, Puhlik-Doris,

Larsen, Gray, & Weir, 2003). For nurses, it may be beneficial to use humor to increase the well-being of other nurses in order to strengthen individual ties (Martin, et al., 2003).

Just as humor serves as a pro-social communication that strengthens instructor-student relationships, it should also strengthen the relationships of nurses (Sidelinger, 2014). Little is known as to how humor is considered in the unique context of nursing (Saroglou & Scariot, 2002). Horan, Bochantin, and Booth-Butterfield (2012) argued that humor use regains a feeling of control and reinforces shared values for people. In other words, humor is an effective interpersonal communication form that enhances a sense of balance, perspective, and clarity in a situation (Horan, Bochantin, & Booth-Butterfield, 2012; Maki, Booth-Butterfield, McMullen, 2012).

Similarly, organizational commitment is socially exchanged and influenced by its role in identification (adopting the organization's values and goals), involvement (psychological role immersion), and loyalty (organization affection and attachment) (Buchanan, 1974; Eisenberger, Huntington, Hutchison, & Sowa, 1986; Mathieu & Zajac, 1990; Meyer & Allen, 1984). Organizational commitment in a nursing context warrants further exploration because effective long-term experienced nurses may improve patient outcomes and reduce costs (Gurzick & Kesten, 2010). Moreover, high levels of high organizational commitment increase operating efficiency of organizations (Angle & Perry, 1981). Likewise, being committed to a nursing role should be explored to find out what role characteristics are important in nursing. DeCicco, Laschinger, and Kerr (2006) found that organizational commitment in nursing homes had increased when nurses were empowered. Researchers suggested that the aging population, work overload, and lack of strategies to empower nurses are going to continue to disrupt their organizational

commitment (DeCicco, et al., 2006). If research has primarily looked at how organizational commitment predicts turnover, burnout, or job satisfaction, a researcher should wonder why. Turnover seems to be a popular concept to research in a nursing context; however, looking at organizational commitment aspects more deeply seems to be fitting in order to find out how organizational commitment is communicated before turnover happens.

Liden, Wayne, Zhao, & Henderson (2008) contended that "servant leadership is based on the premise that to bring out the best in their followers, leaders rely on one-on-one communication to understand the abilities, needs, desires, goals, and potential of those individuals" (p. 162). Leadership undoubtedly determines effective nursing performance (Kane et al., 2007). Nurses' value communicating with leaders so that an allocation of resources and a conducive high-quality nursing context are created (Aiken et al., 2001). In the nursing context, a servant leader is going to look at a follower not just as a nurse fulfilling a role, but a person in a whole sense. In other words, a servant leader cares about all aspects of the follower and seeks the follower growing to be exceptional. Thus, it is worthwhile to explore how charge nurses are communicating servant leadership characteristics from the perspective of their nurses in this research study.

The plan of this research was to study organizational commitment, professional commitment, servant leadership occupational stress, and humor styles through nurse interviews in order to analyze qualitative data. By conducting interviews, I sought to develop a communication model that describes how these aforementioned concepts affect nurses' communication. Taken together, exploring these concepts qualitatively opens the window to nurses' voices. With such an expanding occupation, it is intriguing to see how

nurses communicate relating to these specific concepts. The intent of examining a nursing context is twofold. First, examining these specific concepts expands understanding of how nurses communicate. Secondly, the results from this nursing context exploration may be used by nurses to reflect upon how they communicate with one another, which impacts not only themselves, but their occupation. The following chapter will explain background research in organizational and professional commitment, servant leadership, occupational stress, and humor followed by five proposed research questions. Chapters on methods, results and discussion follow.

CHAPTER II– LITERATURE REVIEW

This chapter summarizes organizational commitment, professional commitment, servant leadership, occupational stress, and humor in relation to applying them in a nursing context. Additionally, this chapter provides definitions, concept summaries, and scholarly findings based on previous research. To start, each concept will be discussed and related to existing theory and research.

Organizational Commitment

At the heart of commitment is a consideration of personal experience that intersects systemic needs, positioning a person positively and negatively both emotionally and intellectually to organizational situations (Kanter, 1968). Organizational commitment is a multidimensional phenomenon that relates to a person receiving rewards from the system and the experiences that person went through to obtain those rewards (Gouldner, 1960; Grusky, 1966). Interestingly, individuals commit themselves to organizations in diverse ways, thus exploring these methods is fruitful (Gouldner, 1960). Commitment is a process that entails people enacting socially organized patterns of behavior, norms, and aspects of a social system (Kanter, 1968).

Organizational commitment is defined as "a person's affective reactions to characteristics of an employing organization. It is concerned with feelings of attachment to the goals and values of the organization, one's role in relation to this, and attachment to the organization for its own sake rather than for its strictly instrumental value" (Cook & Wall, 1980, p. 40). That said, quality outcomes of organization may lead to positive well-being and commitment (Cook & Wall, 1980). Interestingly, Kanter (1968) defined commitment as "the willingness of social actors to give energy and loyalty to social

systems, and the attachment of personality systems to social relations which are seen as self-expressive" (p. 499). This definition allows envisioning a willingness to work by nurses because of the need to enhance loyalty to the cause of what they do as well as to their particular organization (Cook & Wall, 1980; Kanter, 1968). Likewise, Porter, Steers, Mowday, and Boulian (1974) referred to organizational commitment "in terms of the strength of an individual's identification with and involvement in a particular organization" (p. 604). Indeed, these multiple and psychologically attached organizational commitment definitions show how one can link an individual both to the organization and to a profession (Mathieu & Zajac, 1990; O'Reilly & Chatman, 1986; Reichers, 1985).

Organizational commitment consists of three behavioral aspects (Kanter, 1968). Buchanan (1974) defined *continuance* as "member dedication to system survival...stimulated by requiring personal investments and sacrifices of members, such that it was costly and difficult for them to leave" (p. 534). Secondly, Buchanan defined *cohesion* "as member attachment to the social relationships which comprise the community...secured by such techniques as verbal public renunciation of previous social ties and engaging in ceremonies which enhanced the sense of group cohesion and belonging" (p. 534). Lastly, Buchanan (1974) defined *control* as "attachment to norms which shape behavior in desired directions...encouraged by requiring members to publicly disavow previous norms and to reformulate their self-conceptions in terms of system values" (p. 534). These organizational commitment aspects convey a strong belief in and acceptance of the organization's goals and values, and a willingness to exert effort on the organization's behalf with a clear desire and motivation to partake in

organizational membership (Angle & Perry, 1981; Meyer & Allen, 1984; Porter, Steers, Mowday, & Boulian, 1974). The organizational commitment aspects of *continuance* (a social role in the system), *cohesion* (positive orientations toward community involvement), and *control* (upholding group norms through the positive binds of personality) likely influence nurses' professional lives (Kanter, 1968).

Research on organizational commitment in hospitals found that affective and normative commitment increased when the organization's climate was ethical (Chun-Chen, Ching-Sing, & Ming-Tien, 2012). Peng et al., (2016) found that satisfied nurses were loyal to their organization. Affective commitment is an apt term for the employee's emotional attachment to the organization; whereas, normative commitment reflects an obligation to the organization (Meyer & Allen, 1991). Although Chun-Chen, Ching-Sing, & Ming-Tien (2012) found that nurses both wanted to be there and felt obligated because of the ethical climate, this result related to job satisfaction and organizational citizenship behaviors, suggesting that more research should address deeper reasons why nurses could have increased affective and normative commitment. Employees will display commitment if they believe their work is recognized (Meyer & Allen, 1991). If nurses believe that performing at a high performance level will continue their employment, they will do so**.** Affective and normative commitments both play a role in the nursing context (Meyer & Allen, 1991). Researchers speculate that affective commitment largely stems from work experiences, a wide range of organization-relevant behaviors, and employees' values aligning with organization values (Meyer & Allen, 1991). For instance, a nurse's affective commitment may increase toward a healthcare organization because they both value caring for patients. Normative commitment reflects a socialization process that

entails observing role models and a reward/punishment continuum that is dependent upon loyalty and it is guided by a reciprocity mechanism (Meyer & Allen, 1991). Reciprocity turns into a normative commitment from wanting to contribute to the organization. If nurses receive exceptional accolades for performance, they would want to reciprocate that, which in turn builds a normative commitment to the organization. In sum, the three organizational commitment characteristics are vastly subjective in how they are performed and important, thus exploring how these characteristics may emerge in a nursing context should be fruitful. In light of prior research the following research question was asked:

RQ1: How does communication in nurses' organizations influence their organizational commitment?

Role Theory and Professional Commitment

Role theory provides a theoretical grounding for a professional commitment perspective. Role theory concerns self-motivated behaviors in an organization along with social life features that are based on a communicative reciprocal process (Biddle, 1986; Burke & Reitzes, 1991; Solomon, Surprenant, Czepiel, & Gutman, 1985). Solomon, Surprenant, Czepiel, and Gutman (1985) defined role theory as "a cluster of social cues that guide and direct an individual's behavior in a given setting" (p. 102). Within role theory, patterned behaviors and expectations for behaviors are understood by performers (Biddle, 1986). In other words, behaviors are communicated interdependently in relation to the social structure (Solomon et al., 1985). Affective (the result from a satisfying experience) and normative (an engagement of positivity within the profession) commitment contribute to professional commitment (Nogueras, 2006). Solomon et al

contended that a service provider's occupational role is salient in their self-concept, thus commitment to effective performance is strong. Professional commitment has been applied to various settings. Based on the professional commitment theoretical framework, researchers have explored athletic training in a secondary school (Pitney, 2010), athletic training programs (Mazerolle & Dodge, 2015), and the social work context (Clements, Kinman, & Guppy, 2014). In a secondary school setting, Pitney asked how athletic trainers working in a high school setting perceive professional commitment, and what influences athletic trainers to maintain their commitment over the course of their career. The researcher analyzed 17 interviews through a phenomenologic tradition and found that professional responsibility, rewards, respect, and rejuvenation affected commitment (Pitney, 2010). Professional responsibility entailed being responsible to their patients' well-being and being knowledgeable in their area of expertise (Pitney, 2010). Rewards meant being appreciated, valued, and an enjoyment of their role (Pitney, 2010). Respect entailed receiving appreciation from co-workers about their role competence (Pitney, 2010). Rejuvenation was constructed from the athletic trainer emotionally recharging, addressing personal needs, and interacting with fellow peers (Pitney, 2010). These themes contributed to a positive experience for athletic trainers. Similarly, professional commitment researchers interviewed 17 participants in an athletic training program (Mazerolle & Dodge, 2015). These researchers explored how athletic trainers were developed by their preceptors (Mazerolle & Dodge, 2015). Preceptors play an important role in developing a professional commitment in training athletic trainers. Through grounded theory analysis, researchers concluded that *strong mentorship, realism, professional commitment of the preceptor, and clinical skill integration* positively

influenced students' experiences (Mazerolle & Dodge, 2015). Specifically, training students appreciated their mentors taking the time to discuss student life, career aspirations, and accomplishing goals, which built *strong mentorship* (Mazerolle & Dodge, 2015). In *realism*, participants developed enthusiasm and passion for their career from seeing their preceptor's passion (Mazerolle & Dodge, 2015). *Professional commitment of the preceptor* emerged from the data from preceptors constantly being positive in their interactions with students, co-workers, and patients (Mazerolle & Dodge, 2015). Students felt a sense of *clinical skill integration* when they applied classroom knowledge into real-world settings (Mazerolle & Dodge, 2015). These researchers developed a holistic understanding of being committed to the athletic training role. Even though this research explored a mentor-mentee relationship, it still constructs the importance of professional commitment. To be committed to a profession takes development.

In a social work context, researchers found that *defining the profession, commitment,* and *support* emerged from qualitative data to address retention issues (Clements, Kinman, & Guppy, 2014). Participants put a value on supporting and empowering marginalized people in *defining the profession* (Clements, Kinman, & Guppy, 2014). *Commitment* for both a student and lecturer in social work meant being dedicated by investing their time and resources and being fully engaged in social work education (Clements, Kinman, & Guppy, 2014). *Support* was conveyed by the faculty being there for students' in placement areas and fellow students' being there to work through student issues (Clements, Kinman, & Guppy, 2014). These themes construct positive influences that proactively challenge potential commitment issues.

For instance, if a nurse's self-concept includes caring, that part of the self-concept should align with being a strong caring performer of the nursing role. When nurses are confident that they are performing well, they should feel satisfied (Solomon et al., 1985). These concepts are important in shaping a nurse's professional role. Moreover, a nurse's commitment may be shaped by the affective factors that foster positive feelings, generate a gratifying involvement with organizational members and patients, and morally commit nurses' with a sense of pride, self-worth, self-esteem, and confidence in their values and goals (Burke & Reitzes, 1991). Professional commitment, from looking through a role theory lens, is important because the situations that nurses' face may stress their occupational commitment. Reflecting on what nurses are going through may help understand their role as nurse, and their own commitment to the profession. Thus, the following question was asked:

RQ2: How does professional commitment influence nurses' communication about their roles?

Servant Leadership

Robert Greenleaf (1977) is the theoretical father of servant leadership, who contended that servant and leader are infused into one person. The servant leader idea stems from a natural inclination people have to serve—first, persons serve others, then they lead them. A servant leader prioritizes people in a high regard to make sure they are served (Greenleaf, 1977). The leader makes a deliberate and conscious choice to enact a philosophy of serving others.

Walumbwa, Hartnell, and Oke (2010) contended that "servant leadership emphasizes listening, empathy, stewardship, and awareness to develop followers

holistically as an end in itself" (p. 519). Likewise, Liden, Wayne, Zhao, & Henderson (2008) held that "servant leadership is based on the premise that to bring out the best in their followers, leaders rely on one-on-one communication to understand the abilities, needs, desires, goals, and potential of those individuals" (p. 162). Servant leadership relies on a theoretical framework that elicits a focus on individuals' holistic morals, ethics, and a character demonstrating commitment to the service of others. Servant leadership creates positive employee attitudes in organizations, increases communication between leaders and followers, and helps nursing leadership show compassion and understanding for nurses, patients, and the community the leaders serve (Parris & Peachey, 2013; Walumbwa, Hartnell, & Oke, 2010).

Likewise, through the pursuit of an altruistic calling, six characteristics of servant leadership may convey a unique learning organization for nurses (Sendjaya, Sarros, & Santora, 2008; Van Dierendonck, 2011). These six characteristics include *empowering and developing people* (through a proactive and self-confident attitude, that fosters personal power), *humility* (the facilitation of performance, support, and modesty), *authenticity* (being courageous and honest in challenging circumstances), *interpersonal acceptance* (cognitively adopting warmth, compassion, and forgiveness even when mistakes and arguments are experienced), *providing direction* (tailoring to others' abilities, needs, and contribution), and *stewardship* (acting as a role model that cares) that transcend self-interest to foster a social contextual framework of prosocial behaviors (Van Dierendonck, 2011; Walumbwa, Hartnell, & Oke, 2010; Russell & Stone, 2002).

A service orientation of social responsibility is instilled in servant leaders with ten characteristics (Northhouse, 2010; Spears, 2002; Liden, Wayne, Zhao, & Henderson,

2008). Servant leadership, unlike traditional leadership approaches, emphasizes personal integrity and a long-term relationship focus (Liden, Wayne, Zhao, & Henderson, 2008). This long-term relationship emphasis (Liden, Wayne, Zhao, & Henderson, 2008) may be developed with nurses with listening (valuing receptive and reflective listening), empathy (understanding others good intentions), healing (healing others emotional hurts), awareness (understanding the ethical and values of situations), persuasion (convincing others through group consensus), conceptualization (thinking beyond the day-to-day realities), foresight (to foresee the situation outcome), stewardship (a commitment to serving others), commitment to the growth of people (believing in the intrinsic qualities of other people), and building community (identifying a means to create true community in an organization or business) (Spears, 2002).

Servant leadership principles foster less direction of others and instead focus on the shared effort of personal development and empowerment, which serves as an opportunity to provide job resources and support, to improve others' skills and role effectiveness, without the expectation of acknowledgement (Tate, 2003; Smith, Montagno, & Kuzmenko, 2004; Neill, Hayward, & Peterson, 2007). Moreover, servant leadership fosters interest in servant-like behaviors that convey nurturing, advice, feedback, and resources for role models to change and develop the organizational context (Bass, 2000; Babakus, Yavas, & Ashill, 2011; Ebener, & O'Connell, 2010; Smith, Montagno, & Kuzmenko, 2004). Highlighting the unique talents of nursing and servant leadership scholarship in a nursing context may be fruitful (Liden, Wayne, Zhao, & Henderson, 2008). In a servant leadership sense, regardless of one's title on an organizational chart, leaders are not born, they are made (Wolins, 2012).

Walumbwa, Hartnell, and Oke (2010) found from 815 employees that servant leadership influences both individuals and work groups in organizational settings. These researchers contended that more servant leadership research is needed to understand how it influences employee attitudes and behaviors qualitatively (Walumbwa, Hartnell, & Oke, 2010). Likewise, Neill, Hayward, and Peterson (2007) found that 114 students in a health-related field in college over four years were successful because servant leadership was applied to teamwork, involvement, and student growth. By exchanging skills and knowledge between theory and practice, faculty and students were able to collaborate on elderly care (Neill, Hayward, & Peterson, 2007).

Serving others is a servant leadership attribute (Ebener, & O'Connell, 2010). Researchers performed a case study at three Catholic parishes that included focus groups and interviews based around the question: "how do you measure the life of a parish?"(Ebener, & O'Connell, 2010). Invitation, inspiration, and affection in Catholic parishes emerged when servant leadership was communicated (Ebener, & O'Connell, 2010). Invitation consisted of servant leaders encouraging helping, initiating, participating, or other self-developing behaviors that were done on the behalf of the parish (Ebener, & O'Connell, 2010). Servant leaders created inspiration by placing themselves at the service of others in which parish members reciprocated service to the congregation (Ebener, & O'Connell, 2010). Lastly, affection meant showing care and support for other parish members (Ebener, & O'Connell, 2010). The servant leaders in this research invited acts of service (Ebener, & O'Connell, 2010). Servant leadership is contagious.

Servant leadership in nursing is an apt leadership model because it focuses on serving others. If nurses are serving patients, charge nurses should be serving their subordinates because it is the role of the charge nurse as a leader. Health care researchers contend that the current health care system is lacking an effective leadership model (Trastek, Hamilton, & Niles, 2014). Servant leadership is urged in healthcare because it guides the healthcare system, is important in a network of peers, which include staff and charge nurses, and helps to meet goals and overcome challenges (Trastek, Hamilton, & Niles, 2014).

Servant leadership is the dominant model to consider in healthcare because its characteristics contribute to strong interpersonal interactions. The leader puts the physical and emotional needs of others first with the skill sets of listening, empathy, awareness, healing, and persuasion (Trastek, Hamilton, & Niles, 2014). Servant leadership is the tool that creates elements of teamwork in healthcare delivery, builds community among the team, and builds trust and empowerment with healthcare provider teams, which may achieve high-quality and value patient care (Trastek, Hamilton, & Niles, 2014). Exploring servant leadership characteristics may improve how staff nurses' look to their superiors (charge nurses) as servants, not just as bosses. Being that nurses serve patients, and charge nurses' should serve staff nurses, servant leadership should be explored in the healthcare landscape to see how effective it is. In short, it is imperative that leaders in this case, nurse leaders (charge nurses) communicate these strong and empowering qualities (Wolins, 2012). In order to obtain a painted picture of nurses' experiences, the following research question was proposed:

RQ3: How does a charge nurse's use of servant leadership influence nurses' communication about work?

Occupational Stress

Folkman and Lazarus (1985) defined stress "as a relationship between the person and the environment that is appraised by the person as relevant to his or her well-being and in which the person's resources are taxed or exceeded" (p. 152). Because stress is an ever increasing organizational concern, there is conceptual divergence and opinion on its definition (Motowidlo, Packard, & Manning, 1986; Richardson & Rothstein, 2008). Stress researchers argued that stress is both costly and common in the workplace of modern life (Schuler, 1982; Williams & Cooper, 1998). Nurses responding to many stress-filled instances may be constantly stressed out. Understanding how health clinicians respond to stress is growing (Sansbury, Graves, & Scott, 2015).

Stress is a key component and consequence in the workplace (Sansbury, Graves, & Scott, 2015; Vagg & Spielberger, 1999); it is response-based in accordance with situational forces (Nikolaou & Tsaousis, 2002). Moreover, lacking understanding of the emergent area of stress research may be problematic for nurses because managing work stress is instrumental in the nature of high stress occupations (Kolvereid, 1983; Williams & Cooper, 1998). Since stress definitions may be imprecise, it is imperative to define stress, specifically as applied to nurses (Schuler, 1982; Williams & Cooper, 1998).

Beeher and Newman (1978) defined job stress as a "situation wherein job-related factors interact with a worker to change (i.e., disrupt or enhance) his or her psychological and/or physiological condition such that the person (i.e., mind-body) is forced to deviate from normal functioning" (p. 669 & 670). Succinctly, environmental demands outweigh

individual abilities (LaRocco, House, & French, 1980). Breaking down this definition and applying it to a nursing context may prove fruitful in examining important stress aspects (Schuler, 1982). From a health phenomena perspective, job stress is viewed with characteristics that contribute to ill health, environmental factors that are causal agents of stress, and an interaction between person and environment (Beeher & Newman, 1978). In other words, stress is an interactional process (Kolvereid, 1983).

Stress that is presented in dynamic sociopsychological conditions (potential stressors) disrupts physiological and/or psychological homeostasis (Schuler, 1982). Gugliemi and Tatrow (1998) contended that stress may lead to strain (the psychological and physiological dysfunction). Furthermore, stress and strain are an interactional result between the individual and the context (Gugliemi & Tatrow, 1998). In other words, the work environment, person, and strain interact to create occupational stress (Gugliemi & Tatrow, 1998). Collectively, stress leads to variable job stressors, strains, and health outcomes (Hurrell, Nelson, & Simmons, 1998). First, job stressors (the work-related environmental conditions that impact the workers well-being and health) are followed by strains (the worker's psychological and physiological exposure reactions) and health outcomes (the negative health result from repeated job stressor exposure) (Hurrell, Nelson, & Simmons, 1998). Responding to stress effectively for nurses may alleviate strains for the individual (Schuler, 1982).

Enduring stress is an individual process (Schuler, 1982). Constructively, this process contains a person-environment interchange and the response to stress that is experienced (Schuler, 1982). In other words, stress is both influential in dynamic situations and evokes individual responses over time (Schuler, 1982). Indeed,

environmental stressors, individual characteristics, and individual responses are parts of a transactional process (Schuler, 1982). Severe and frequent stress contributes to stress-related disorders, which may be problematic for nurses (Vagg & Spielberger, 1999). Collectively, occupational stress researchers have argued that stress in the workplace is increasing while continuing to foster anxiety and decreasing job performance (Motowidlo, Packard, & Manning, 1986; Richardson & Rothstein, 2008).

Occupational stress was found to impact a nurse's decision to think about quitting more than once a week (Yoon & Kim, 2013). Deductive evidence suggests that nurses' are at high-risk for job-related stress (Chang et al., 2005), and more so if they are not shown appreciation, have unreachable expectations, lack of interest, and nurse-to-patient ratios (Yoon & Kim**,** 2013). Similarly, researchers investigated 870 nurses on occupational stress who found that job demands and extrinsic effort influenced anxiety and depression (Mark & Smith, 2011). These researchers argued that since 45% of nurses believe work stress directly influences their health, it is imperative to further study the complex process of occupational stress from a transactional standpoint of nurse to their environment (Mark & Smith, 2011).

Occupational stress is related to but not the same construct as burnout (Carlson, Anson, & Thomas, 2003). While stress is normal in daily living, adapting to stress demands moderate its consequences (Carlson, Anson, & Thomas, 2003). If stress is not contained from daily occurrences, it may turn into burnout. Prolonged work-related stress exposure is characterized by emotional exhaustion, physical fatigue, and cognitive weariness if stress is not dealt with, it will lead to burnout, depression, and even cardiovascular related-events and disease (Melamed, Shirom, Toker, Berliner, & Shapira,

2006). While burnout is a detrimental result of stress, research is also needed on what is happening before burnout is reached. Burnout takes time to achieve. Furthermore, burnout relates to a lack of commitment (Carlson, Anson, & Thomas, 2003).

Continued stressful events may lead to burnout. In other words, burnout is the culmination of stress. This research will look at how stress is handled before burnout is reached. Wisniewski and Gargiulo (1997) argued that "occupational stress is the effect of task demands that…people face in the performance of their professional roles and responsibilities" (p. 325). In a nursing context, serving patients may increase stress. Stress researchers contend that periods of stress lead to attributional, behavioral, physiological, and psychological responses (Wisniewski & Gargiulo, 1997). These types of responses are instrumental in addressing stress in a nursing context. Researchers contend that stress in a teaching context reduces the quality of educational services, and the physical, and mental health of teachers (Wisniewski & Gargiulo, 1997). Teachers that were stressed out responded negatively to students, and were less able to concentrate (Wisniewski & Gargiulo, 1997). Secondly, teachers were not available emotionally to their students (Wisniewski & Gargiulo, 1997). Likewise, long-term stress produced physiological symptoms such as elevated blood pressure and a lack of energy; teachers also felt anxious, depressed, and helpless (Wisniewski & Gargiulo, 1997). These stressful responses lead to teacher burnout (Wisniewski & Gargiulo, 1997). This research intends to explore possibilities of reducing such responses to the stress-related context of nursing by finding out how stress affects nurses and how it can be effectively managed so burnout does not happen. Likewise, occupational stress needs to be further understood, so it may be reduced for nurses. Stress, if not handled, may lead to burnout and leaving the

profession altogether. This research looks to explore ways to reduce stress before burnout and before nurses leave the profession. The following research question is posed:

RQ4: How does occupational stress influence nurses' communication?

Humor

Morreall (1983) contended that understanding the social phenomenon of humor resides in the theories of superiority, incongruity, and relief. Conceptually, superiority theory entails the feeling of superiority over other's misfortunes (Ferguson & Ford, 2008). For example, a medical doctor may laugh at a medical student's lack of knowledge to feel superior over her/him. The humor in this situation reinforces rules through laughing at others (Wilkins & Eisenbraun, 2009). In other words, the medical student's inadequacies are being laughed at by the doctor (Lynch, 2002). Incongruity theory explains the humor of surprise that violates an accepted pattern (Wilkins & Eisenbraun, 2009). From an incongruity perspective, laughter is based on intellectual activity rather than relieving tension (Lynch, 2002). The incongruity comes from an inconsistency between a perceived event, the individual's perception of that event, and a norm violation (Lynch, 2002). For instance, a person may expect a regularly performed task to be done the same way over and over, but when someone does the task differently, an inconsistency is created, which may be humorous. While superiority and incongruity theories look at humor from a superior and a norm violation perspective, they do not address the relief of tension from humor.

Relief humor is a mental trait that uniquely has positive health benefits among health care providers (Martin, 2001; Ramachandran, 1998). Cooper (2008) argued that humor protects the self from suffering. In other words, humor used to release tension

protects the self from physiological ailments (Cooper, 2008; Lynch, 2002). Wilkins and Eisenbraun (2009) concluded that negative health conditions are increased from stress while humor reduced such physiological problems as asthma. Lynch (2002) contended that the medical profession uses humor to reduce stress. Because humor use for reducing stress is a relief function (Lynch, 2002), it seems fitting to utilize the relief theory lens in the current research. Moreover, sharing relief humor in a workplace context of nursing is an interpersonal dynamic fruitful for organizational relationships (Cooper, 2008).

Relief Theory of Humor

Shurcliff (1968) argued that relief is obtained "from an anticipated unpleasantness involving heightened arousal reduced to nothing, which is referred to as relief theory" (p. 360). Relief theory, in seeking to explain humor creation, stemmed from an interest in the psychology of emotions (Rancer, 2012). Meyer (2000) concluded that relief is experienced from tensions and nervous energy being vented by the use of humor. Since humor is dependent upon relief, humor and laughter provide a perspective shift on stressful situations (Martin, 2007; Rancer, 2012; Shurcliff, 1968). Interestingly, humor may play a role in overcoming threats to nurses' well-being (Dziegielewski, Jacinto, Laudadio, & Legg-Rodriquez, 2004; Martin, 2007). Because laughter is the common ingredient in releasing repressed or unused energy, this phenomenon allows for a therapeutic relationship along with self-esteem improvement, and stimulates creative thinking opportunities (Dziegielewski, Jacinto, Laudadio, & Legg-Rodriquez, 2004; Graham, Papa, & Brooks, 1992). In the nursing context, the stressful events may create high emotional arousal; thus the tension-releasing function of humor is a defining

characteristic in the socialization and communication of coping with adversity (Dziegielewski, Jacinto, Laudadio, & Legg-Rodriquez, 2004; Martin, 2007).

Francis (1994, p. 147) defined humor in relation to emotion as:

> an interaction process that is a cultural performance, which strengthens or restores the feeling norms of the situation and creates amusement in the self and others, generating positive sentiments among members of an interacting group by bonding with them and or/reducing external threat, often at the expense of some excluded person (s), event(s), or object(s).

Because humor plays a role in nearly every human interaction, it may prove successful in a nursing context, as it is an effective communication form (Dziegielewski, Jacinto, Laudadio, & Legg-Rodriquez, 2004). Not only is humor effective, it also serves a positive consequence in their socialization through group humor appreciation (Cann, Zapata, & Davis, 2009; Dziegielewski, Jacinto, Laudadio, & Legg-Rodriquez, 2004). The ways that individuals use humor are important for their psychological well-being (Martin et al., 2003).

Humor is a tool that may generate positive outcomes in a nursing context (Cann, Zapata, & Davis, 2009). In other words, perceptions and behaviors that are associated with humor may enhance nursing relationships (Cann, Zapata, & Davis, 2009; Martin et al., 2003). Even though humor may be intended to be positive, it may be viewed as negative depending on the humor style utilized (Martin et al., 2003). Distinctively, benevolent humor is tolerant and accepting, whereas detrimental humor is either injurious to one's self or one's relationship with others (Martin et al., 2003). In other words, humor

can serve a positive purpose (reducing tension and providing support) or negative one (creating tension and demeaning others) (Cann, Zapata, & Davis, 2009).

With positive humor, its psychological function may benefit nurses both cognitively and socially by relieving tension, regulating emotions, and coping with the high stress that these individuals face daily (Cann, Zapata, & Davis, 2009; Martin, 2007). Conversely, if humor is negative, it may create tension and demean the self and relationships with others (Cann, Zapata, & Davis, 2009). Humor is essentially an emotion in the cognitive process that may create a unique feeling of well-being for nurses (Martin, 2007). In essence, the relief of built-up emotional energy through the use of humor may help nurses (Morreall, 1983).

Humor Styles

Relationally, there are four dimensions of humor styles (Martin et al., 2003). Self-enhancing humor enhances the self in a tolerant way to others (Martin et al., 2003). Self-enhancing enhances the self to have a humorous outlook. For instance, a person may find a way to think about a stressful time in a funny way. Secondly, aggressive humor communicates detriment with other's relationships (Martin et al., 2003) and puts down others negatively. Affiliative humor affiliates with others in a self-accepting way (Martin et al., 2003) or connects people with joke telling or teasing (Dyck & Holtzman, 2013). Lastly, self-defeating humor occurs at an expense to the self (Martin et al., 2003), bringing down one self to make others laugh. For example, if a person makes a mistake, they may call themselves stupid in which the other person laughs. The interpersonal nature of humor is communicated through these styles (Dyck & Holtzman, 2013). Relevant to behaviors, the affiliative humor style engages humorous stories and jokes

(Cann, Zapata, & Davis, 2009). The self-enhancing humor style is useful in maintaining a humorous perspective while being in events that may be particularly stressful (Cann, Zapata, & Davis, 2009). Conveying an aggressive humor style directs sarcasm and ridicule at others (Cann, Zapata, & Davis, 2009). Encouraging ridicule from others to highlight one's own deficiency is conceptualized as self-defeating humor (Cann, Zapata, & Davis, 2009).

Humor researchers argue that humor styles both positively and negatively influence social interactions (Fitts, Sebby, & Zlokovich, 2009; Frewen, Brinker, Martin, & Dozois, 2008). Positive humor styles such as affiliative and self-enhancing contribute to adapting and adjusting to responding social demands (Fitts, Sebby, & Zlokovich, 2009; Kuiper & McHale, 2009). Interestingly, affiliative and self-enhancing humor styles may suggest an individual's well-being in a nursing context (Kuiper & McHale, 2009). Prior research suggested that using the affiliative style positively influenced self-evaluative standards, higher social self-esteem levels, and lower depression levels (Kuiper & McHale, 2009). Conversely, research has shown that self-defeating humor led to lower levels of self-esteem and higher depression levels (Kuiper & McHale, 2009). Likewise, self-defeating humor may result in a lower or declining sense of well-being (Kuiper & McHale, 2009). In other words, aggressive and self-defeating humor may prove maladaptive in a nursing context, since such styles may hurt, put down and amuse others at an individual's expense (Kuiper & McHale, 2009).

Humor style research has concluded that self-enhancing humor was related to coping (Martin et al., 2003). In other words a humorous life outlook with self-enhancement humor benefited individuals (Martin et al., 2003). Given the contrast

between positive and negative humor styles, it seems plausible to assume that self-enhancing and affiliative styles of humor (friendly teasing humor types) have a positive outcome while self-defeating and aggressive humor styles have a negative outcome such as feeling put down in front of others (Martin et al., 2003).

Humor Styles at Work

Researchers noted that humor reduced stress (Mesmer-Magnus, Glew, & Viswesvaran, 2012). Using humor in the workplace promoted openness, new ideas, and relaxed people (Deshpande, 2012). Understanding what humor is used and how it affects nurses may be fruitful. In a context where stress can be dominant, humor may combat and reduce stress feelings. Humor in the workplace is purposeful as well as perceived in two ways, positive or negative. Humor type, timing, and whether it is positive or negative play a crucial role in humor's outcome (Smith & Khojastech, 2014). Indeed, workplace humor deserves more attention as it an understudied phenomenon (Blanchard, Stewart, Cann, & Follman, 2014). Communicating humor, positively, reduces stress, enhances cohesiveness, improves communication, and assists employee bonding (Smith & Khojastech, 2014). Semi-structured interviews showed that humor reduced tension and stress among crime scene investigators (Vivona, 2014). Research suggested that affiliative and self-enhancing humor styles build and strengthen relationships, and are associated with emotional intelligence (Al Obthani, Omar, Bakri, 2013; Gignac, Karatamoglou, Wee, & Palacios, 2013). Even though humor has been explored in workplace contexts, it has not been explored collectively with stress in a nursing context. Therefore, this research seeks to explore nurse's humor use as related to stress. Exploring

the facets of humor may unveil powerful strategies to deal with the stressful context of nursing, thus, the following research question was asked:

RQ5: How does humor use influence nurses' communication about occupational stress?

Research questions

In summary, this study will explore nurses' communication about organizational commitment, professional commitment, servant leadership, occupational stress, and humor. Conceptually, communication entails understanding other's perceptions in order to clearly express your perception (du Pre, 2005). Communication ties all of these research questions together. Seeking instances of communication in each of the five research questions may yield a process (understanding one another), personal goal (being a nurse), shared meaning (two people sharing the meaning of an interaction), and interdependence (relying on each other) for further understanding (du Pre, 2005). The following research questions aim at gaining in-depth insights into nurses' perceptions of organizational and professional commitment, their leaders (charge nurses), how stress is felt by nurses, how humor affects nurses, and how communication is central to the effects of all.. These research questions are based on theoretical constructs of organizational commitment, servant leadership, occupational stress, and humor styles.

RQ1: How does communication in nurses' organizations influence their organizational commitment?

RQ2: How does professional commitment influence nurses' communication about their roles?

RQ3: How does a charge nurse's use of servant leadership influence nurses' communication about work?

RQ4: How does occupational stress influence nurses' communication?

RQ5: How does humor use influence nurses' communication about occupational stress?

CHAPTER III METHODOLOGY

The goal of the current study was to explore nurses' organizational and professional commitment, servant leadership, occupational stress, and humor. The research questions were analyzed through grounded theory. The interview guide was generated to address the research questions through collecting qualitative data. This chapter describes the research design including seeking participants, procedures, and data analysis.

Qualitative Methods

Understanding the complex communication process of the nursing context justified qualitative research. Philosophically, qualitative research stems from an interpretive framework (Creswell & Poth, 2018). The intent of conducting qualitative research was to seek an understanding of the nursing world through nurses' subjective meaning, experiences, thoughts, and interpretations of organizational commitment, professional commitment, servant leadership, occupational stress, and humor in this study. Socially constructed meaning is, thus, built from interaction with others' (Creswell & Poth, 2018).

In order to fully obtain a detailed understanding of organizational commitment, professional commitment, servant leadership, occupational stress, and humor, collecting nurses' perspectives were essential. For instance, understanding how organizational commitment is socially constructed, the researcher must talk directly to the participant (Creswell & Poth, 2018). Qualitative research is useful for understanding the interactional relationships in situations, uncovering the meaning of phenomena, and

gaining intricate details that are not revealed with quantitative methods (Strauss & Corbin, 1990).

Interviewing nurses on how they construct, socially exchange, and interpret organizational commitment, role commitment, servant leadership, occupational stress, and humor use should illustrate how communication shapes these experiences. In other words, interviewing participants constructs a communication platform for inquiry into how communication influences organizational commitment, professional commitment, servant leadership, occupational stress, and humor, thus learning about the participants' world.

Qualitative methods were utilized in order to obtain participants' voices. Conducting semi-structured interviews captured nurses' experiences. A semi-structured interview guide (Appendix A) sought to encourage participants to talk about experiences of work commitment, role commitment, leadership characteristics, job stress, and humor. Transcripts were used to analyze the data for emergent themes to evaluate theoretical assumptions. Interviewing nurses created an organic path to discovery, understanding, and a reflection of how nurses communicate about the aforementioned concepts (Tracy, 2013). Moreover, having participants' describe their experiences gave the researcher a chance to ask expanded and elaborated questions, to "get to the heart of the matter" (Tracy, 2013).

Creswell (2007) contended that 20-30 interviews are typically conducted to saturate emergent categories in a grounded theory analysis. Upon Institutional Review Board (IRB) approval from the researcher's institution, registered nurses (RN) were contacted through network and snowball sampling. First, data collection began with the

researcher networking with potential nurse participants at the researcher's church. Network and snowball sampling grew from the first participant asking fellow registered nurse friends to be participants.

Participants

Research participants were 31 women and three men, with ages ranging from 24 to 61. Two participants were African American, and the remainder were Caucasian. While all participants were registered nurses, 15 held an associate's degree while 19 held a bachelor's degree in nursing. Participant tenure at their hospital workplace ranged from two to 37 years. Nursing participant interviews ranged from 25 minutes to 75 minutes. Interviews were audio-recorded then transcribed. For a visual depiction of demographic and participant characteristics, see Table 3.1. Interview transcripts totaled 265 double-spaced pages with the average transcript length being eight pages.

These participants were contacted conveying information about this research along with a 10-dollar gift card incentive to Starbucks for participating. Eight nurses agreed to interviews at a public place convenient to them such as a public library. These eight nurses worked in clinics. The rest of the research participants were recruited through network and snowball sampling at a medium-sized southeastern hospital after IRB approval was granted from that healthcare institution. In the process of finding 26 interviewees at the healthcare institution, the director of nursing walked with the researcher up to nursing stations introducing me to all of the nurses and informed them that I was available in the department break room for interviews. Participants would come in the break room on their break to be interviewed. Waiting for interviewees in the break room ranged from five minutes to a couple of hours. Before each interview, the

scope of the study was discussed as well as data confidentiality. After the consent form was filled out and signed by the participant, the audio-recorded interview started.

Because of time constraints at the medium-sized healthcare institution, interviews were conducted in participant break rooms; interviews ranged from 20 minutes to an hour or so. Time was constrained because nurses had to get back to patient care. Participants' charge nurses were aware of interviews in which some did cover their patients for interview time. To enhance the diversity of participating nurses while exploring the richness of qualitative data, interviews were conducted in the Emergency Department, the Neonatal Care, the Intensive Care Unit (ICU), the Medical Surgical wing, and Obstetrics and Gynecology. Because interviews were conducted in a common room such as a department's break room, the researcher mentioned to each participant that if someone walked in, and the participant did not feel comfortable answering any questions, that the interview would pause. The researcher felt it was important to mention pausing the interview in thinking about making the participant feel comfortable in answering interview questions. Interviewing RN's about their experiences with organizational and professional commitment, servant leadership, occupational stress, and humor was interesting.

Interviewing in each department had its share of benefits and drawbacks; however, all departments were fruitful in data collection. The principal investigator (PI) interviewed five participants in the Emergency Department (ED) that were on different shifts. The benefit of interviewing in the ED was that the PI gained a perspective on nurses' stories about caring for patients on a short-term basis. In the ED, patients are either treated and sent home, or are admitted to the hospital for further care. Because the

ED is so busy, there are a lot of RN's staffed. The benefit of interviewing participants in the ED was that participants had more time to be interviewed because there was more patient coverage. The drawback to interviewing in the ED was the participants see so many people a day, that recalling situations was difficult for some participants. In other words, some participants could not recall a situation about stress, for instance, enough to explain it fully. Interviewing three nurses in Obstetrics and Gynecology and two in the Neonatal Care Unit was beneficial because they are different from other nursing specialties in which the PI gained different nursing perspectives. It was interesting listening to participants' stories about delivering babies and taking care of mothers. Obstetrics and Gynecology was well-staffed so interviews lasted longer; and participants easily recalled stories with which to answer interview questions. Both of these departments did not have as many nurses as the ED which the PI could interview, thus fewer OB and Neonatal nurses could be interviewed. The three participants, that were interviewed, in the ICU had only one or at the most two patients because patients are in critical condition there, thus stories involved vast perspectives and experiences which were a benefit to the PI. Even though participants needed to closely watch their patients at all times, each nurse took a turn watching the other's patients', so they could be interviewed by the PI.

Thirteen participants were also interviewed from the many nursing stations in the Medical Surgical wing to enhance sampling diversity. Interviewing nurses there was different than other areas because patients were staying in the hospital longer, and nurse-to-patient ratios are higher, making it busier. Ailments that the Medical Surgical wing treated were heart disease, diabetes, open heart surgery, and other surgery recoveries. The

benefit to interviewing nurses there was that nurses interacted with patients and their families on a longer-term basis. Patients were moderately serious meaning they needed more care. The drawback to the Medical Surgical wing was that nurses typically had 6-8 patients, thus making interview times shorter. Nurses would come in on their lunch break, which lasted 30 to 45 minutes. Sometimes their lunch break would be interrupted, which meant interviewing was interrupted. Being able to interview nurses in all of these departments was fruitful, overall, because listening to participant perspectives about organizational and professional commitment, servant leadership, occupational stress, and humor was intriguing.

Table 3.1 *Demographic and participant characteristics*

(N = 34)	
Characteristics	*n*
Gender	
Male	3
Female	31
Age (years)	
20-30	7
31-40	12
41-50	6
>50	9
Medical experience (years)	
<5	4
5-10	7
11-20	17
>20	6
Current clinical practice	
Clinics	8
Emergency department	5
Obstetrics and Gynecology	3
Neonatal care	2
Intensive care unit	3
Medical surgical	13

Data Analysis

Analyzing the qualitative data was done with a grounded theory approach. Grounded theory promotes discovery from participants' experiences in an effort to construct theory and develop it for future research (Creswell, 2007). Grounded theory was useful in analyzing all research questions because themes were generated from the nurses' experiences. Grounded theory is good for discovering relevant categories from both participants and researchers to explain phenomena that relate to theoretical frameworks (Strauss & Corbin, 1990). In answering these research questions, categories were identified that established new ties to theories to explain the five key concepts characterizing the phenomena being studied relating to nurses' work life: organizational and professional commitment, servant leadership, stress, and humor. Grounded theory allows the capacity to be creative through open, axial, and selective coding (Strauss & Corbin, 1990).

Open coding involves the initial process of comparing, conceptualizing, and categorizing data (Strauss & Corbin, 1990). Using open coding in answering these research questions was beneficial because concepts were experienced in many ways. For instance, comparing stress differences among nurses painted a picture of the many ways stress is happening. Secondly, once phenomena were categorized, axial coding made connections between categories (Strauss & Corbin, 1990). For example, categories relating to occupational stress were refined by axial coding. Strauss and Corbin (1990) conveyed that conditions, context, action/interactional strategies, and consequences surrounding the data are incorporated through axial coding. Next, selective coding denotes a process of category refinement (Strauss & Corbin, 1990). In selective coding,

occupational stress categories, for instance, emerged by systematically relating categories to key quotes from participants. In other words, quotes that explain an emergent stress category were picked.

Applying grounded theory to organizational contexts was rewarding. Researchers have argued that software developers, healthcare providers and patients, and nursing students' understanding of communication experiences were generated through grounded theory (Adolph, Kruchten, & Hall, 2012; Curtis, Horton, & Smith, 2012; Poteat, German, & Kerrigan, 2013). In one instance, when researchers wanted to look at the social process of software developers, grounded theory was a good fit for understanding their experiences (Adolph, Kruchten, & Hall, 2012). Practicing compassion in nursing is expected; thus nursing researchers utilized grounded theory to recognize how nursing students experience their dissonance between professional ideals and reality (Curtis, Horton, & Smith, 2012). Through interviewing nineteen participants, Curtis, Horton, and Smith, (2012), found that compassion requires having time to empathize. These participant interviews revealed that student nurses made time to empathize and communicate compassion (Curtis, Horton, & Smith, 2012). Curtis, Horton, and Smith,'s (2012) findings may resonate with participants' making time to communicate compassion in the current research. Likewise, transgender people and their medical providers participated in interviews through which grounded theory helped comprehension of the interpersonal stigmas that function in a transgender-medical provider interaction (Poteat, German, & Kerrigan, 2013). In other words, grounded theory illustrated emerging themes of uncertainty and ambivalence in provider-patient relationships (Poteat, German, & Kerrigan, 2013). Just as grounded theory proved fruitful for these prior researchers, it

proved abundant in exploring the experiences of nurses' stress, humor impacts, servant leadership, and factors of organizational and professional commitment. Next, the results chapter will communicate a breakdown of themes generated by utilizing grounded theory, which answered research questions.

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CHAPTER IV RESULTS

Because qualitative research affords the opportunity for participants to open up about communication perspectives, this results chapter explains those perspectives with participant quotes that emerged using grounded theory, beginning with answering research question one along with how specifically grounded theory was used. Participant checks are important in qualitative research in order to ensure that theme quotes match theme descriptions. Hosek and Thompson (2009) contended that participant checks successfully serve to verify quote accuracy. Five participants were provided theme quotes to check theme accuracy.

Research Question One

Research question one sought to explore how communication in nurses' organizations influence their organizational commitment. Themes of *Teamwork, Work Family Support, Patient Connection,* and *Patient Appreciation* emerged from data analysis in response to research question one. Based on Strauss and Corbin's (1990) framework from the present investigation, a grounded theory model for nurses' organizational commitment is presented. For a visual depiction of organizational commitment themes- see Figure 4.1 at the end of research question one.

Analysis

Each theme encapsulated several concepts that were grouped together to form that theme. These themes emerged from open, axial, and selective coding (Strauss and Corbin, 1990). First, in open coding, a line-by-line analysis (which examines words, phrases, and sentences) was conducted with two open coding questions (what does the word, phrase, or sentence represent? what is the major idea in this word, phrase, or sentence?) (Strauss and Corbin, 1990). By breaking apart the data, a comparison examination was performed to find similar phenomena. For instance, *Teamwork* was found to be a consistent phenomenon among most of the participants in the causal condition of *working together,* the strategy of *not letting anyone drown,* and *nurse interdependence*. Then, in the axial coding phase, the paradigm model was used to put emergent strategies together to form a theme such as *Teamwork* (Strauss and Corbin, 1990). The paradigm model analyzes data by asking: what is the data referring to? Looking at what causes a phenomenon to happen within the context is followed by seeking an outcome of how the phenomenon is manifested (Strauss and Corbin, 1990). The paradigm model analyzes the data in a linear fashion by beginning with causal conditions (events that lead to the development of a phenomenon), the phenomenon (the central idea with which a set of actions are directed), context (a specific set of properties), intervening conditions (structural conditions that pertain to the phenomenon), interactional strategies (strategies that manage the phenomenon under a set of conditions) and consequences (the outcome of the interaction) Strauss and Corbin, 1990). By using the paradigm model, this model saturates categories (Strauss and Corbin, 1990). In order for a theme to become a theme, messages need to consistently fill all of the paradigm model components. Secondly, categories were saturated when the 10 initial transcribed

interviews conveyed no new categories from the rest of the participants (Creswell, 2007). Lastly, selective coding relates the central phenomenon in a story that is constructed around its sub-themes. Selective coding, in other words, puts it all together in a laid out narrative form (Strauss and Corbin, 1990). *Teamwork* was an outcome of paradigm model with components such as *working together, not letting anyone drown,* and *nurse interdependence*. The full theme narratives are expressed in the following pages.

Teamwork

First, themes describing *Teamwork* emerged out of *working together, not letting anyone drown,* and *nurse interdependence*. The strategies are important to focus on because they illustrate how the phenomenon was communicated. *Working together* defined providing patient care as a common goal. Nurses came together to help each other do whatever was needed for the patient. The nurses' roles were fluid in what they did to provide teamwork. Secondly, *not letting anyone drown* provided a sense of co-worker security in which each nurse knew they would not be alone in taking care of the patient. If a nurse had a lot of medical things going on with their patient, they knew they would receive teamwork from their peers. *Nurse interdependence* defined team dependence between nurses. Not only was a nurse taking care of his or her own patients, but they were looking after their co-worker to make sure they were managing their workload. The nurses knew that to receive help with their patients, they needed to help their co-workers as well. Direct quotations help to illustrate how the themes uncovered in research question one informed participants' construction of *Teamwork.*

Nurses saw teamwork as a communicative process (each direct quotation from participants is identified by a designated participant # following):

> Everybody has a role that they fall into. For example, when we're getting a new patient from the ER, everybody just dives in. One nurse is asking family members questions as far as history and what medications the patient is on; and another nurse draws blood while another nurse is hooking up all of the monitors. And another nurse could be getting labs. We have a really good team. The teamwork is phenomenal in the ICU. Everybody really works well as a team back here; better than anywhere I have experienced. We have really good teamwork; we don't let anyone drown. I feel like in this environment, it is vital; if you are in an environment that you are just made to feel like you sink or swim on your own, and that you cannot rely on your coworker, that is not a place I would like to stay. A typical patient load in ICU is two; sometimes a patient may take a turn for the worst, or something happens throughout the shift that makes their acuity level higher. My patients may be closer to being discharged to the floor; if I don't help him today when his patient load is harder, how can I expect help on the days when my load is harder. So, you have to give-and-take.

(P20)

Teamwork was similarly illustrated by others as crucial in nursing; and when there is a staffing problem, *Teamwork* was hindered. Communication could be either implicit or explicit in how teamwork was achieved:

> If you work with a group of people that realize that you are sinking or drowning, whether you say so or not, they are there to help. Teamwork means everything that can make your day; we have a good group of nurses here. Let's say if there is a staffing problem one day; and everybody has their own sick patients, and they are all very busy, then it can make for a very long day. (P19)

Participants discussed *Teamwork* as working together to take care of patients, to look out for each other, so they would not get behind on patient care, and thus were interdependent on each other.

Work Family Support

Work Family Support emerged based on the paradigm model from the causal condition of *family coworker,* an intervening condition of *calling in sick,* and the strategy of *not letting anyone down*. Participants discussed communicating support by spending long periods of time with each other and the obligation of being at work even when perhaps they were not well. The notion of calling in sick was letting down not just a coworker, but a family member and the patient. Participants perceived their coworker relationships as more important than a paycheck and more like a family.

> The people I work with are my work family. Being that I have been here for 10 years, I have gone through a lot of work families. The people that you spend 12 hours a day with become your work family. You don't want to let people down. I don't like to let people down outside of work too. If someone calls in because they don't feel like going to work, it is like letting

> your family down. And when this happens, other people are having to work twice as hard because you were not here, so it really commits you to staying in it and coming to work to do your job because you don't want other people to work harder because it is already hard work. This place is busy every day; it is not going to be an easy day; it is hard to let your coworkers and patients down. If someone calls in sick, instead of taking care of three patients, someone is taking care of four patients; and already that fourth patient is left out because you do not have time for them; so essentially, you are letting everyone down. (P11)

Having a good support system such as a work family is a two-sided process. Family supports one another and receives support. Similarly, another participant noted how important coworkers are:

> My coworkers are the best part of my job; we are really close. My coworkers are family. We have a good support system here. My coworkers rely on me; the paycheck is important, but I cannot let my work family down. (P28)

These themes illustrated how nurses formed work families to look out for one another and held each other accountable to the work family.

Patient Connection

Patient Connection emerged with a causal condition of *the needs of patients,* was conveyed with the *going the extra mile* strategy, and had an outcome of *making a difference for patients.* Participants recognized the needs of their patients- beyond doing the

minimum of administering medicine. In an environment (causal condition) of patient needs, participants saw exceptional differences they made going above their scope of care, clearly *making a difference for patients.* Participants created an empathy experience for the patient. Perhaps participants were gravitating towards taking care of patients the way that they would want to be treated if they were a patient. Perhaps participants treated patients like their own family. Participants went above the expected scope of care by doing more than what was required:

> For example, some patients that come do not have any clothes. They just have the clothes on their back; sometimes their clothes get ripped in an accident. So going the extra mile means doing something out of the ordinary that you would not normally do, and that you know what's going to make the patient very happy. So, I say to my supervisor that this patient does not have anything to wear home; and that can you get them a T-shirt or some scrubs. So, it is just the small things. Our transport team gets backed up a lot. When we have to discharge patients, sometimes the patient is number 10 on the list. Even though our floor is busy, you just have to take the time to just stop and go the extra mile. Even when I am up to my eye balls with being busy, I go off the floor to find me a wheelchair and I will wheel the patient out. Doing this makes a world of difference to the patients. Instead of having the patient wait 45 minutes to an hour for a wheelchair, you get them out in two minutes yourself. (P7)

Similarly, another participant afforded the patient extra care by *going the extra mile*:

> For example, you have some nurses that think they are only going to give medication or nursing things. If my patients need a bath, I will give them a bath. I do not mind giving them a bath. I will feed my patients. I even went and bought food for my patients' family. It is expensive being in the hospital. I have bought personal care items for my patients. If the patient does not have a ride home, I try to go the extra mile for my patients and talk to my supervisor and say this patient needs a ride home, what we can do. I like doing things like that. I don't mind helping the patient. (P2)

Going the extra mile for participants seemed natural. Participants felt that bringing in items or doing something extra themselves fostered patient connectivity. *Going the extra mile* for the nurse communicated the theme *patient connection*.

Patient Appreciation

The phenomenon of *Patient Appreciation* evolved from *patient requests,* the strategy of *patient gratitude, and* an outcome of motivation from the patient. Having patients that are repeat customers created an environment of commitment because it helped nurses feel like they made a difference for the patient. When patients treated nurses to remembering them and showing them gratitude such as a "thank you," it motivated them to remain committed to the organization.

> Patients would remember you and request you. I feel like if someone remembers you enough to request you again, then it means that your work is appreciated. It kind of makes you more committed because you can get burned out and frustrated. You

> get frustrated with administration and procedures. It makes you know you are doing something better for the greater good and that helps you to recommit yourself. And realize that it is not all negative, and that there's more positives involved. (P12)

Similarly, the following participant illustrated how patients' kind remarks were more motivating than a paycheck:

> My patients appreciate me. I think everybody works for a reward. A paycheck is not really that motivating in this field. But I think patient gratitude goes a long way. When I have worked really hard and stayed late to do an emergency C-section; and that patient says "thank you so much." That is motivation enough. (P10)

This theme, *Patient Appreciation*, captures the essence of just how much influence patient actions can play in a nurses' day.

Summary of Themes

These themes present organizational commitment components. *Teamwork* expressed continuance commitment because communicating teamwork for nurses is instrumental in their survival and that of the organization (Kanter, 1968). *Work Family Support* created cohesion and control commitment (Kanter, 1968). Participants felt control commitment among coworkers because making each other accountable for showing up for work created a social norm of not wanting to call in sick and let your coworkers down (Kanter, 1968). Participants shaped cohesion commitment by supporting their coworkers in patient care and going above-and-beyond their scope of practice to make a difference and connect with their patients'. *Patient Connection* and *Patient Appreciation* shaped cohesion commitment because even though nurses endure long hours, a big patient load, and limited rest, hearing comments of value

and gratitude gave them the motivation to keep going. Normative and affective commitment aspects were also communicated among participants. Normative commitment is related to *Teamwork* and *Work Family Support,* which came from coworkers giving and receiving support, not from the organization itself. Affective commitment was portrayed in *Patient Connection* and *Patient Appreciation* from the value of caring for patients.

In the context of "patient care," "working together" was a causal condition that lead to the theme of" teamwork." A strategy of teamwork was "not letting anyone down," which resulted in "worker security." "Nurse interdependence" facilitated "teamwork" in the "patient care" context. Secondly, "work family support" emerged from "coworkers as family" in the "supportive workplace relationship." "Being supportive" was a strategy that fostered "feeling taken care of from coworkers." "Calling in sick" hindered "work family support," because other coworkers were not at work to support one another. Thirdly, "patient help" framed a condition of the "needs of patients" in which "patient connection" became a key theme. The strategy of "going the extra mile" in the intervening condition of "patient acuity" was a factor in "making a difference for patients." Lastly, "patient appreciation" emerged out of "patient requests," in the context of "being rewarded from the patient." The outcome of "motivation from patients" was facilitated from "patient gratefulness." These explanations are mapped out below in figure 4.1:

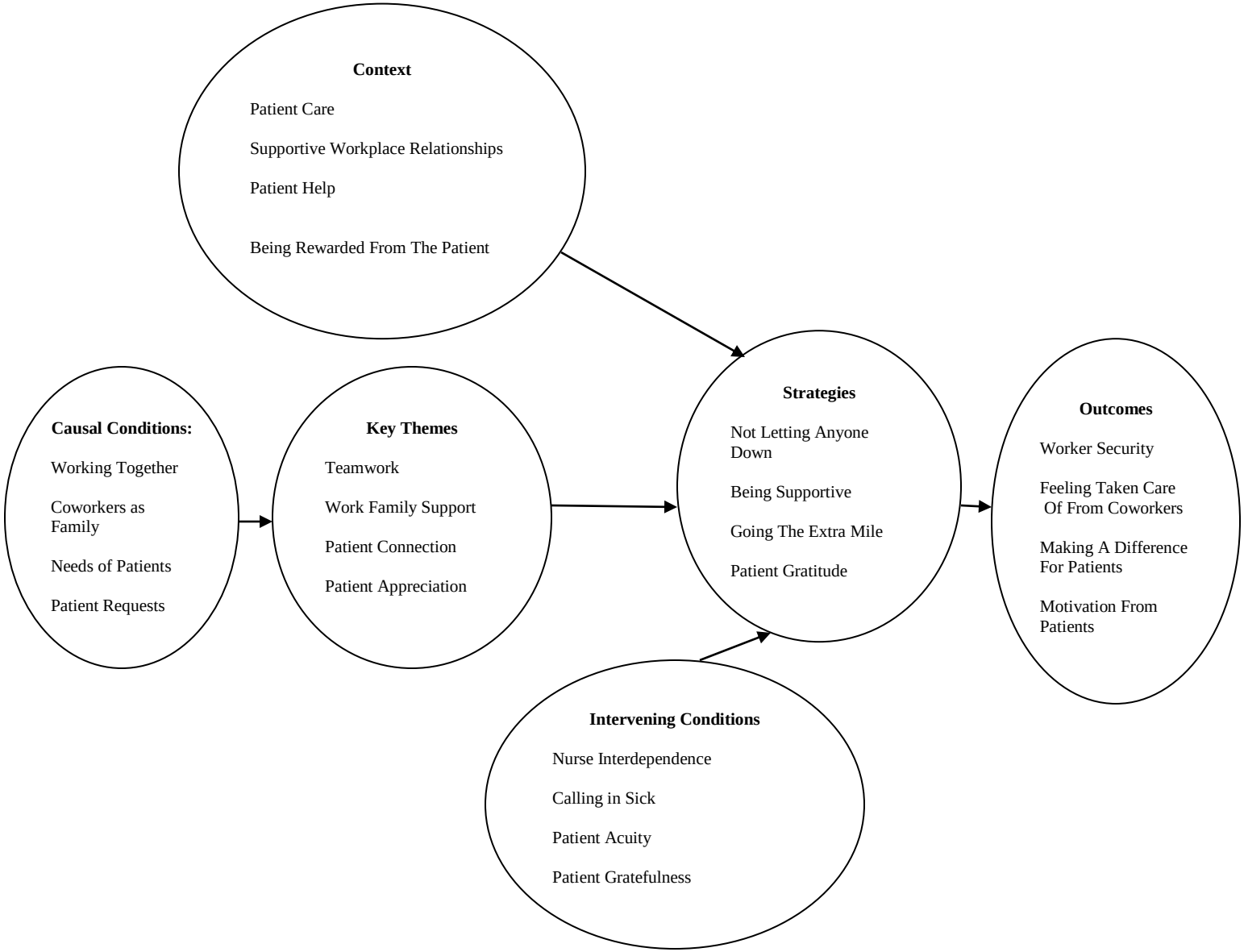

Figure 4.1 Theoretical Model for Organizational Commitment

Research Question Two

Research question two sought to explore how professional commitment influences nurses' communication about their roles. *Compassion as Medicine, Patient Teacher,* and *Patient Care Advocate* emerged from data analysis in response to research question two. Grounded theory was used to construct a model for nurses' professional commitment (Strauss and Corbin, 1990). For a visual depiction of professional commitment themes- see Figure 4.2 at the end of research question two.

Compassion as Medicine

Compassion as Medicine became a theme based on the phenomenon of *seeing the patient emotional*. The result of *using compassion to be humanizing* was accomplished with the strategy of *making the patient comfortable*. Participants revealed that being there for patients with human supportive attributes included in the theme *Compassion as Medicine* is just as important as being there with medicine. Participants realized that patients sometimes actually do not need medicine but a human being with *Compassion* by their bedside to create a satisfying experience for the participant. The following participant illustrated *Compassion as Medicine* emotionally:

> The patient is entrusted in my care; and I look at them and I assess them and if I see that their needs are not being met; for instance if someone is in agonizing pain, I am going to administer a pain med; and when I go back later and they are smiling

> and saying I feel so much better, I know that I am fulfilling my role. It's not only with medicine; maybe you go in a patient's room and they are crying; and you say what's the matter? How can I help you? And at first, they will say no; and then you say what has got you so unhappy? Then they will open up and talk to you because they sense that you really do care. It's more than giving pills or sitting at the desk charting; that is the least thing that I do. To me nursing is the most humanizing thing that you can do. It's just what I feel. (P25)

Even though the nurse felt role fulfillment from seeing the patient feel better, the patient was experiencing emotions that resulted not only from medicine but compassion involved in treating the patient. The nurses viewed being there for the patient, emotionally, as more important than "giving pills." Making the patient feel comfortable led to a humanizing bond between the nurse and patient. One nurse determined that being there emotionally for the patient is the ultimate human attribute a nurse should possess. Another participant described *Compassion as Medicine* by letting the patient write down his worries:

> I was back in the ICU out of orientation. My first ventilated patient was getting off of sedation. His blood pressure was a little on the low side, so I did not have him on much sedative as he was waking up. He had been a little disoriented prior to being intubated; when he woke up and realized where he was at; he wanted to write so I got a piece of paper and pencil; I let him write and he wrote out that he was scared from the breathing tube and that he was scared he was going to stop breathing; and he wrote, please take care of me; that patient played a big role for me because I wasn't able to do anything at that moment

> medically for him, but it was about making him feel comfortable. He was scared. And so I was able to stay in the room with him and spend some extra time with him and make him feel better; at that point it was not the medicine, it was just compassion. (P20)

The nurse in the preceding narrative illustrated *Compassion as Medicine* through action taken when seeing the patient scared of not being able to breathe. *Making the patient comfortable* was obtained by just being there, so the patient did not feel alone and scared. The act of letting the patient write down his thoughts and spending extra time created a compassion moment. The *Compassion as Medicine* direct quotes represent just how important nurses believe they are to all aspects of patient care. Compassion is developed from participants being committed to their role. The participants in *Compassion as Medicine* did more than just administer pills to their patients, they conveyed deep commitment to being there emotionally. *Compassion as Medicine* became key to nurses' professional commitment because being there for patients is more than just giving medicine; it is connecting as human beings.

Patient Teacher

Patient Teacher became a theme based on the phenomenon of *the patients' lack of situation knowledge*, which led to a response and strategy of *communicating with the patients*, which led in turn to an outcome of the *patient being informed*. Participants explained the importance of conveying medical information about the patient. Participants saw explaining medical information as rewarding because it put patients at ease and increased patients' knowledge:

> So, for example, last week a patient was frustrated with the level of care she was getting and she did not feel like anybody was communicating with her. She knew that they were running tests; but she did not know what the tests were for and she did not know the results of them; she did not know what they were looking or what they were planning to do. And the doctor did not have a chance to come in and explain things to her yet, which happens a lot of the time if with the doctors are doing procedures all day; so when I came into that, that's where I really needed to focus; I spent a lot of time with her and her husband going over every test that had been done and explaining what they were for, explaining what they found, as I was able to access that information on the computer. He had a stress test and a heart catheterization; so they were looking for blockages; but no one had told him if they found blockages or what they would do about it. I was able to explain to her what these tests were for; I could not tell her exactly what the doctor found but I could tell what they may be looking for. I could say the doctor was in the clinic until such and such time; and I could help her with a list of questions to ask the doctor. I gave her a piece of paper and we sat down to write the right questions for when the doctor did come in; so by the end of the shift she felt a lot more informed; her husband felt more informed; and they felt more confident in the care that they were receiving. Part of my role is education. Education is definitely a big part of the nurses's' role. (P23)

The aforementioned nurse saw that informing the patient and loved one was a key part of being a nurse. Being able to educate the patient on their tests enhanced patient confidence and nurse confidence. Communicating with the patient enhances a nurse's role in

patient care. Having the testing information about heart blockages being conveyed helped the patient feel cared for. Similarly, another participant illustrated excitement from seeing the patient understand their lifestyle adjustments:

> Well, I tend to be a teacher; I love teaching patients and families; doing that is a big part of my role because I do admissions and discharges; I help orient them; and teach them what is going on; what to expect; and how to take care of themselves when they go home. And what their diagnosis means. So when I see that light bulb going off on their face, and then they start asking the right questions, it shows that they are hearing what is being said and how to make plans to adjust their life accordingly to their illness or medication; when I see that, I know I am fulfilling my role; that is what gets me going. (P30)

Being a *Patient Teacher* addressed the fulfillment of a nurse's role by spending time with the patient and making sure the patient understands their medical situation. Participants felt a sense of well-being when patients understood their diagnosis, which resulted in a positive experience for the nurse. *Patient Teacher* seemed to enhance nurses' sense of professional commitment. Participants also felt that teaching patients is part of being a nurse, more so than just giving a pill and leaving the room.

Patient Care Advocate

Patient Care Advocate encapsulated a key challenge to nurses based on *doctors questioning decisions*. Nurses *challenged doctors' orders* following which they *were looked down upon*. When nurses would question the care of their patient, doctors would question the nurses' knowledge and procedures. Being that nurses spend more time with patients, the nurses' anticipated problems that

may surface. Even though nurses have extensive medical knowledge, they were made to feel inferior by doctors, which prompted nurses to advocate for their patients. One participant illustrated the struggle with a doctor's communication style:

> It gets challenged a lot by the doctors, unfortunately. There's a struggle sometimes depending on what department you work in. You are looking at the patient all day; and you know more about what they need; and the doctor walks in for just a couple of minutes, and tries to blow off whatever you think; the doctor needs more one-on-one time with the patient; and the patient just needs to be heard. That is a big struggle, getting the doctor to listen. They are bad about being in and out of the patients' room; they just have their eyes on medicine and fixing them, that they don't talk and communicate with the patient; the patient just wants to hear if they are okay, and ask a lot of questions. It has gotten to the point where the doctor runs in and out, and the nurse answers the questions; the patient does not always want to hear it from the nurse. So, you have to learn how to be an advocate for the patient; you have to learn how to advocate without annoying and aggravating the doctor; because if they get annoyed, they won't do anything. So you have to learn how to talk to the physician. When I was working nights, a patient needed a Tylenol, and lots of little things. I did not want to call the doctor at 2am just for that. So the other nurses and I decided to make a list and call the doctor every couple of hours; so before I called the doctor, I would ask the other nurses if they needed anything from the doctor because we had to wake him up. Doctors can get mad when you wake them up. (P12)

The nurse in the aforementioned exemplar would group patient requests together so as to try to avoid a doctor clash by minimizing the amount of times the doctor had to be woken up. Even though the doctor would challenge the nurse on what the patient needed, the nurse knew it was best for the patient, so the nurse would call the doctor anyway; even if the nurse was *looked down upon,* the nurse still felt committed enough for the patient.

Similarly, another participant advocated for their patient over giving blood pressure medication:

> When the doctors question my personal decisions, such has not giving certain medications. One doctor in particularly likes his patient's medication given despite lab orders and likes to do things his way; he does not care. Let's say a patient had a systolic blood pressure of 80 over 90. Some people can be okay there, but you do not want to do anything to drive it lower; so if the patient was to be given Lasix for example, which is a fluid diuretic medication that draws off fluid, which could have an effect on the blood pressure; you think about it, less fluid, less pressure and more fluid, more pressure. These patients that come in with congestive heart failure CHF is very common medicine for them. And they tend to go into fluid overload; so they are usually on a daily regimen of Lasix. But if their blood pressure is dropping that low, I am not going to give them that medication because if they lose too much fluid too quickly they're going to pass out; and if you give them too much fluid, they will go into fluid overload, which will stress their heart out. So, I have clashes with doctors over that. That is absolutely in my role as a nurse when medications are given appropriately based on their vital signs because I am the one that has eyeballs on

> them the most often; the doctor can be a little pigheaded. He challenged my personal right to question his orders; which was essentially challenged; he does not like to be questioned. Anytime I have had to question his orders, he's going to challenge me. I just need to stand up even though it is hard sometimes; sometimes I am going to get yelled at and cussed at, but I still have to do it because that is what is best for my patient. (P23)

The nurse in the preceding quote looked at the patient's well-being as more important than being demeaned by the doctor. Contending with the doctor was seen as an obligation but also as a rewarding part of the job to be a patient advocate. Participants became used to *being looked down upon* but advocated for their patient anyway because they knew the patient would benefit. In other words, the nurse was selfless about repercussions that came from interacting with doctors.

Patient Care Advocate participants felt committed to challenging doctors when they needed something for their patients and when they saw that something was not right.

Summary of Themes

The themes of *Compassion as Medicine, Patient Care Advocate and Patient Teacher,* emerged from grounded theory and suggested a possible explanation related to Solomon, Surprenant, Czepiel, and Gutman's (1985) definition of role theory as "a cluster of social cues that guide and direct an individual's behavior in a given setting" (p. 102). Such cues and roles have affective and normative commitment dimensions (Pitney, 2010). The nursing context served the participants well in social cue development. The

social cues that directed nurses' experiences guided them (Solomon et al., 1985). *Compassion as Medicine* illustrated being present with their patients on a human level. Participants provided the importance of inquiring about all aspects of their patients so as to address situations that no medicine may fix, but being a human being may. A *Patient Care Advocate* must care wholeheartedly for patients. Whether it was learning how to communicate with doctors or telling a doctor they did not agree with administering medication at a certain time, participants communicated caring behaviors and a sense of responsibility for their patients'. Participants felt loyal to patient care- thus advocating for their patient became a norm for those in their role. Another part of a nurse's commitment is being the *Patient Teacher*. Participants revealed that because patients still have questions regarding their medical situation, they look to nurses who are ever-more-present. Nurses emphasized the need to be the *Patient Teacher*, so that patients understand their situation and know what they need to do at home, upon discharge. Nurses found this role to be integral in patient care, and thus to their level of professional commitment. Participants achieved well-being in an environment of many dangerous situations for the patient; being able to influence the patient outcome created a sense of accomplishment and job satisfaction. These themes serve as important role commitment markers for nurses because they play a lot of roles in patient care. Commitment was accomplished through nurses' experiences of showing compassion, being there for the patient emotionally, and standing up for their patient when the doctor and nurse did not agree on certain care plans or when the patient needed more attention. In other words, nurses felt that they were fitting into their role by being committed to fulfilling these key aspects of their role.

The theme of “compassion as medicine” emerged out of the causal condition of “seeing the patient emotional,” in the context of “treating patients.” The strategy of “making the patient comfortable” resulted in “using compassion to be humanizing.” “Being too busy” could hinder “compassion as medicine,” because of a lack of time. Secondly, “patient teacher” became key from the causal condition of “patients lack of situation knowledge” in the “informing patients” context. “Communicating with patients” was a strategy that resulted in the “patient being informed.” “Making patients active knowledge seekers” was an intervening condition that facilitated participants to be a “patient teacher.” Thirdly, “patient care advocate” emerged as a key theme from the causal condition of “doctors questioning decisions” within the context of “doctor-patient interactions.” A strategy for “patient care advocate” was “challenged doctors’ orders,” which had an outcome of “were looked down upon.” “Not being listened to” was an intervening condition of not being able to be a “patient care advocate.” These paradigm model links are shown below in figure 4.2

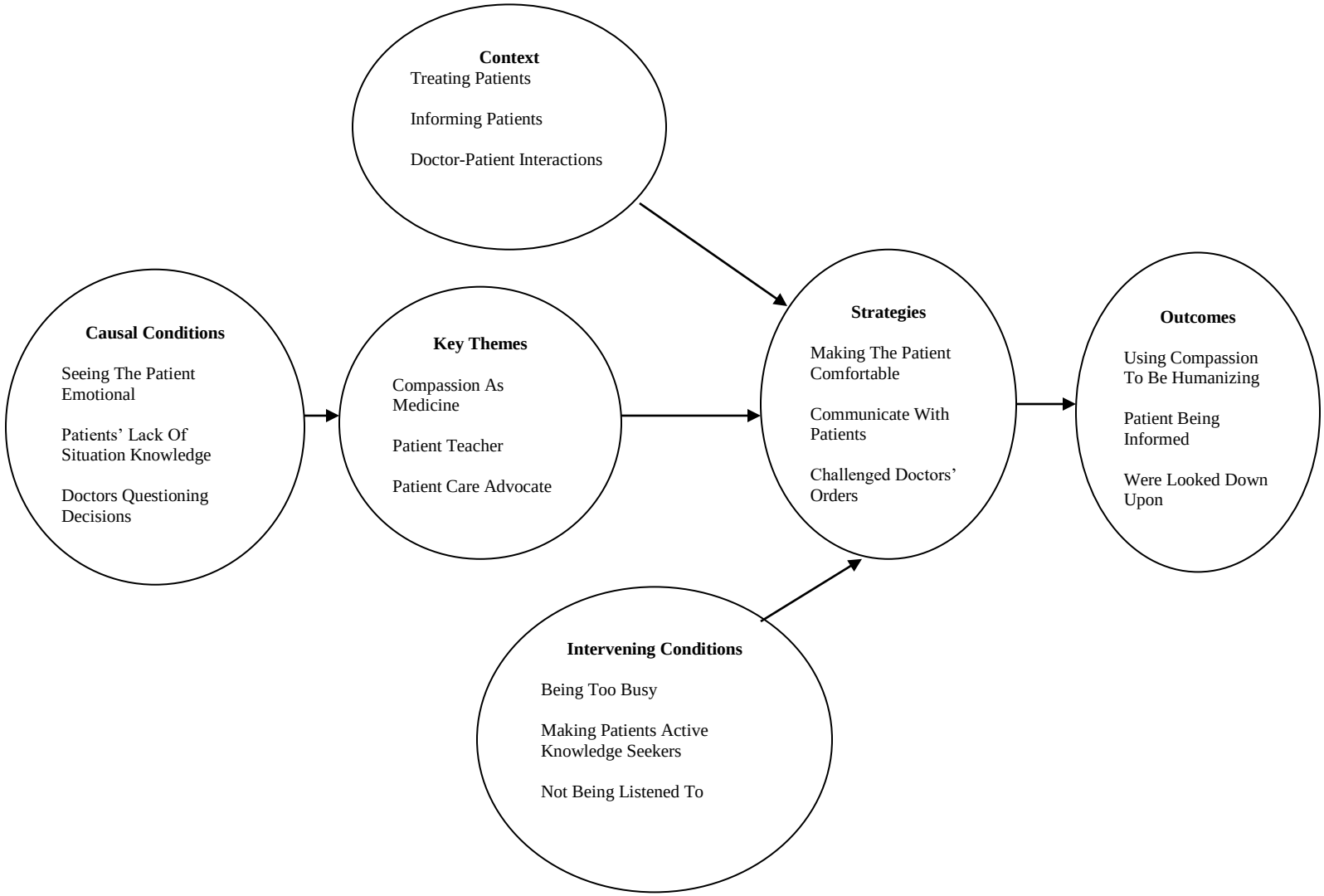

Figure 4.2 Theoretical Model For Professional Commitment

Research Question Three

Research question three sought to explore how a charge nurse's use of servant leadership influences nurses' communication about work. Key aspects of servant leadership emerged in the present investigation through thematic coding; these aspects are presented in this section. For a visual depiction of the servant leadership theme- see Figure 4.3 at the end of research question three.

Charge Nurse Backup

Charge Nurse Backup was constructed as a theme based on paradigm model elements that emerged as participants first *felt a need for help with patient care* from their charge nurse in which their charge nurses backed them up, which resulted in the participants *feeling cared for* by their charge nurses. Participants' charge nurses guided them through new nursing tasks and situations, essentially backing them up along the way. The following participant needed help with a c-section in which her charge nurse was there to back her up, which resulted in trust of her leadership:

> Doing a vaginal c-section, at first, I did not know a lot of things, policy wise about what to do. She gave me just the vaginal c-section to do and just walked behind me; she would ask me a question like what if the uterus ruptures; and how are you going to know if it ruptures. Instead of her saying you need to watch for abdominal or sharp lower back pain, or a feeling of impending doom, she let me think through the process and was right there if I needed anything. She let me wade water, but she did not let me sink. She was right there when it went terribly bad. Even though the patient had an epidural in, she had severe

> left side pain. My charge nurse called anesthesia, NICU, and ICU; she did all of that background work while I was with the patient. After that, we all rolled the bed together. She also helped me with the charting. When it is chaos like that, you are not writing down your timeline; she was good at writing the timeline; she is a born leader; she was not intimated; she took charge when needed to, and she had the skills to back it up; and I trusted her. (P10)

The above description of a leadership situation in which the nurse could ask her charge nurse questions in the moment, created a learning experience, a rapport between both of them, and the participant could also see the charge nurse work and learn from that. By being in a position of learning about patient c-section care, the participant was able to experience both performing a role and learning directly from their charge, thus having a servant leadership interaction.

Similarly, another participant described *Charge Nurse Backup* as having her charge nurse readily available to work right alongside her. The charge nurse communicated leadership by quickly appearing:

> I had a patient that had a funky chest rhythm in the 30s and they need a pacemaker and they are diuretic; and you are trying to manage this patient by yourself getting the EKG pads on and now the patient coded. And you are in there by yourself knowing that you need somebody else. So, you yell, I need some help; and your charge nurse is the first one through the door; that is how it needs to be; not your charge nurse sitting at the desk, telling other people to go in there with someone that has less experience; your charge nurse has a lot of experience. The charge nurse can walk in the room and know exactly what they

need. As a charge nurse, they know their nurses' personalities. A charge nurse is someone that leads by example and does not stand there barking orders at you, or micromanage people. I cannot stand to be micromanaged. The very first charge nurse I had was very much of a leader. She would say there is medicine to give patients in room 12 and 14. And she would go start an IV in room 18. It wasn't like she was telling you what to do while she went and sat down. She was working just like you were. It was very much a leadership role. Also, we would all be sitting around at 3 AM whenever it is really slow. She would say let's go empty the linens and stock everything so then we can sit down and chitchat; she would be up doing all of that with us. She was always trying to get us to do things better. She also wanted you to be a good nurse. She would leave you in a room with a chest pain patient by yourself while she sat at the nurse's station; that was the only patient that you had; she would let you work it up from start to finish because if its busy, you might be the only person in that room. She wanted me to be able to start and finish the patient in a timely manner. It was a learning experience because she wanted you to be better. (P11)

The above quote describes the participant needing help with a patient that coded, seeing the charge nurse help with different patients-, working alongside her staff, and developing the participant to handle patients alone if need be. By the charge nurse being present and working alongside the participant, the participant felt that the charge nurse communicated leadership, thus creating a context of empowerment and betterment**.** Next, another example showed *Charge Nurse Backup* with responses to patient drama:

> She is calm under pressure. She will pick up the slack when there's a lot going on; she will make sure we have what we need. If there is baby daddy drama going on, she will resolve the conflict and call security; this way I don't have to worry about that and I can take care of my patients. A baby daddy came up to see his ex-girlfriend's child with his new girlfriend. So you can imagine how that went over; there was a lot of cussing and screaming. My charge nurse separated them; the protocol is to get security; it never gets extremely violent just dramatic; my charge nurse makes me feel good because she is watching your back. My charge nurse is also one of my best friends. I can tell that she genuinely cares because she is my friend. She wants us to have a good day. (P28)

The previous illustration painted *charge nurse back up* with the patient's visitors so that the participant could primarily focus on patient care and not patient visitor drama. The participant felt *backed up* from the charge nurse because the charge nurse took control of the situation, making the participant feel cared for.

In summary, these sub-themes illustrated *charge nurse back up*. Learning new patient care procedures or dealing with visitors of patients, participants mentioned instances of charge nurses communicating servant leadership principles. Phrases such as "walked behind," "ask me a question," "right there if I needed anything," "took charge if needed," and "knows exactly what they need," communicated servant leadership characteristics such as *humility, empowering and developing people, providing direction, and stewardship* (Van Dierendonck, 2011; Walumbwa, Hartnell, & Oke, 2010; Russell & Stone, 2002). *Humility* was communicated

throughout the quotes as participants mentioned their charge nurse promoting role growth through performing nursing duties; doing a c-section or taking care of different tasks, participants viewed their charge nurse as active in the nursing and leadership process. Participants painted *empowering and developing* instances of their charge nurse's leadership such as in the c-section example where the charge nurse let the participant do the task while being there to develop their nursing knowledge. Letting the c-section participant "think through the process" while having the charge nurse there fostered empowerment and self-confidence because the participant had a proactive leader. Likewise, *providing direction* was illustrated by participants' leadership accounts with their charge nurse. Participant experiences demonstrated *providing direction* ranging from the charge nurse letting the participant think through a nursing process, assisting with patient care, to working alongside the nurse. Lastly, *stewardship* was communicated because participants felt that their charge nurse was a role model and cared about them.

"Charge nurse back-up" emerged from "felt a need for help with patients," in the context of "needing help with patients." The strategy of "charge nurse guidance" fostered an outcome of "feeling cared for," and "learning from charge nurses." The intervening condition of "charge nurses being there along the way," facilitated "charge nurse backup." Below is the Charge Nurse Backup model:

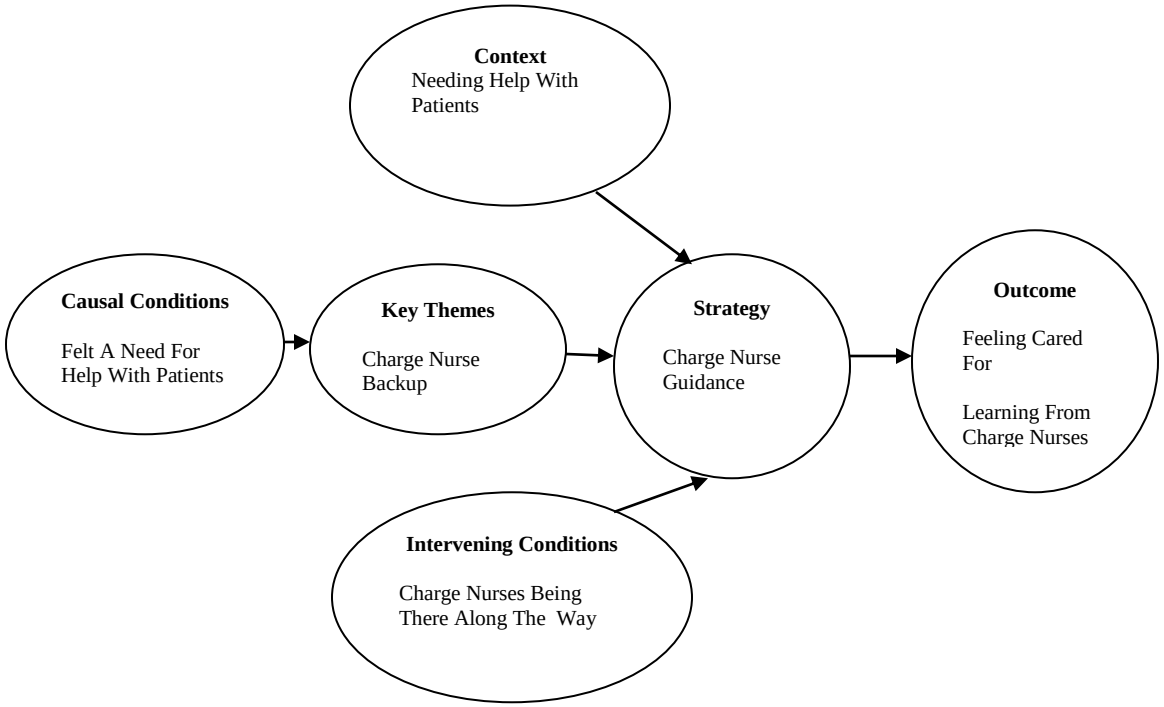

Figure 4.3 Theoretical Model For Servant Leadership

Research Question Four

Research question four sought to explore how occupational stress influences nurses' communication. *Stress from Doctors,* and *Managing Stress* emerged from data analysis as themes in response to research question four. Based on Strauss and Corbin's (1990) framework from the present study, a grounded theory model relating nurses' occupational stress to communication is presented. For a visual depiction of occupational stress themes- see Figure 4.4 at the end of research question four.

Stress from Doctors

Stress from Doctors was caused from *doctors not listening* to nurses often resulting in nurse participants *battling with doctors* in order to get *doctors to listen*. Participants described instances where the nurse knew an action plan for the patient but had to stand aside and let the doctor make a decision about patient care. Nurses became especially stressed out when they had more medical experience than the doctor; and when their voiced concerns were overlooked in which they had to *battle with the doctor* to get the doctor to do what was recommended. The following exemplar paints a picture of stress because had the resident (doctor in training) listened to the more experienced nurse, patient care could have been quicker:

> Doctors can be frustrating which stresses me out terribly. When I need a central line put in a patient, but the doctor wants to do ultrasound guided IV. I don't want the doctor doing the ultrasound guided IV; I want them doing a central line. It stresses me out when the doctor does not do what I want them to do. Sometimes the doctors just don't listen to us. Some of these doctors

> have been a resident for three years. I have been a nurse for 10 years. I know this patient is sick, let's just put in a central line instead of keeping the patient for two hours and then putting in a central line right away. I can walk into a patient's room that has diabetic ketoacidosis and know that the patient is going to the ICU, that they are getting a central line, and that they are getting insulin without me even touching the patient; their heart rate is 135; their blood pressure is fine usually; you can smell the juicy fruit from the doorway. Whenever they breathe, the patient has a juicy fruit smell; their CO2 is jacked. A lot of times diabetics don't have peripheral access unless they take care of themselves. We nurses are very proactive; sometimes I wonder how doctors think. In the end, the doctor put a central line in. (P11)

The preceding exemplar explained how stress with a doctor not listening led to battling with them in order for the doctor to realize what the correct pathway of patient care was. Interacting with the doctor was frustrating for the nurse because she had experience but had to let a less-experienced doctor lead because he is a doctor and she is a nurse. The nurse's ability to help the patient was hindered because of the doctor.

Similarly, another participant explained the need to battle with the doctor about the level of care needed for the patient:

> It is always stressful if the patient is really really sick. A borderline patient looks and sounds bad; I get feelings like something is going to happen with my patients. I can walk in a patient's room and can tell they look sick; the doctor says "no" they are not. Sometimes I have to battle with the doctor and let them know, which stresses me out. The doctors see the patients for 5 to

> 10 minutes. We see them for 12 hours a day. So sometimes we have to battle with the doctor and let them know that the patient needed to be in ICU. (P29)

Stress from Doctors was explained above because the doctor in this interaction did not consider that the nurse is around the patient longer. Because the doctor is not listening to the nurse, the nurse must debate with the doctor.

Managing Stress

Managing Stress emerged as a theme based on having to cope with how *stress is tiring*. *Socializing with coworkers* resulted in being *de-stressed*. Participants felt more emotionally than physically drained from stress. To address being emotionally drained and tired, participants would discuss work-related problems to de-stress. These exemplars paint a picture of how participants related to each other in dealing with stress. Participants felt that keeping stressful discussions at work was better for both them and their home family. Keeping stress discussions at work was also better because coworkers could relate to work situations more than family at home and participants felt it was better to not bring home stressful discussions.

> It wears me out; I have had stressful days like the last two weeks. Those days have made me question why I am here. Stress makes me tired, wears me down, and not exactly depressed, but emotionally drained. I am much more emotionally drained. In my work family, we bitch at each other. I cannot go home and talk to my husband because he does not understand my work, so I talk to my work-family about problems. My coworkers know exactly what I am talking about. (P11)

The previous exemplar explained how stress made the participant feel and how the participant de-stressed. Relating stress to coworkers was the preferred method of de-stressing. Another participant similarly discussed being tired and how socializing was a de-stressor:

> Stress makes me tired. Working in the ICU, I developed relationships with the other nurses, so a lot of times after work or once in a seven day shift on the last evening, we would go eat and have drinks after work to kind of de-stress; we would not necessarily talk about patients, but how our day went; talking to coworkers was a way to get it out because you don't really want to go home to your family and talk about it. My husband, not that he does not care about my day, cannot hear about the sight of blood; you don't want to bring home death and sadness and people dying and trauma to your house; you want to get it out before you go home. Being with work friends and drinking and having dinner are good stress relievers. (P21)

This participant illustrated how not only socializing about job-related experiences helped with stress but how meeting up with coworkers further relieved stress. Socializing outside of work was an informal way to get problems out in the open.

Summary of Themes

Stress from Doctors and *Managing Stress* were important themes in nurses' experiences. Dealing with doctors that would undermine participants by not listening was a major stressor. Being able to discuss stressors with coworkers was a way to vent their experiences and "de-stress." The lack of listening was a concern in nurse-doctor communication. Because doctors communicated a

superior role in health care while not listening to nurses, the interaction led to bouts of stress for nurses. To remedy these stressful encounters, participants viewed socializing as a way to de-stress. De-stressing with coworkers was a prominent way to *manage stress*. Essentially, nurses were seeking *supportive communication* (MacGeorge, Feng, & Burleson, 2011).

The causal condition of "doctors not listening," lead to "stress from doctors," in the context of "debating with doctors over patient care." A strategy of "battling with doctors" lead to an outcome of "patient care being impacted." An intervening condition of "doctors working with nurses," hindered stress between doctors and nurses. Secondly, the key theme of "managing stress," emerged from the causal condition of "stress being tiring," in the "job stress" context. The intervening condition of "keeping stressful discussions with coworkers," facilitated the strategy of "socializing with coworkers," which had an outcome of "being de-stressed." Below is the model for occupational stress:

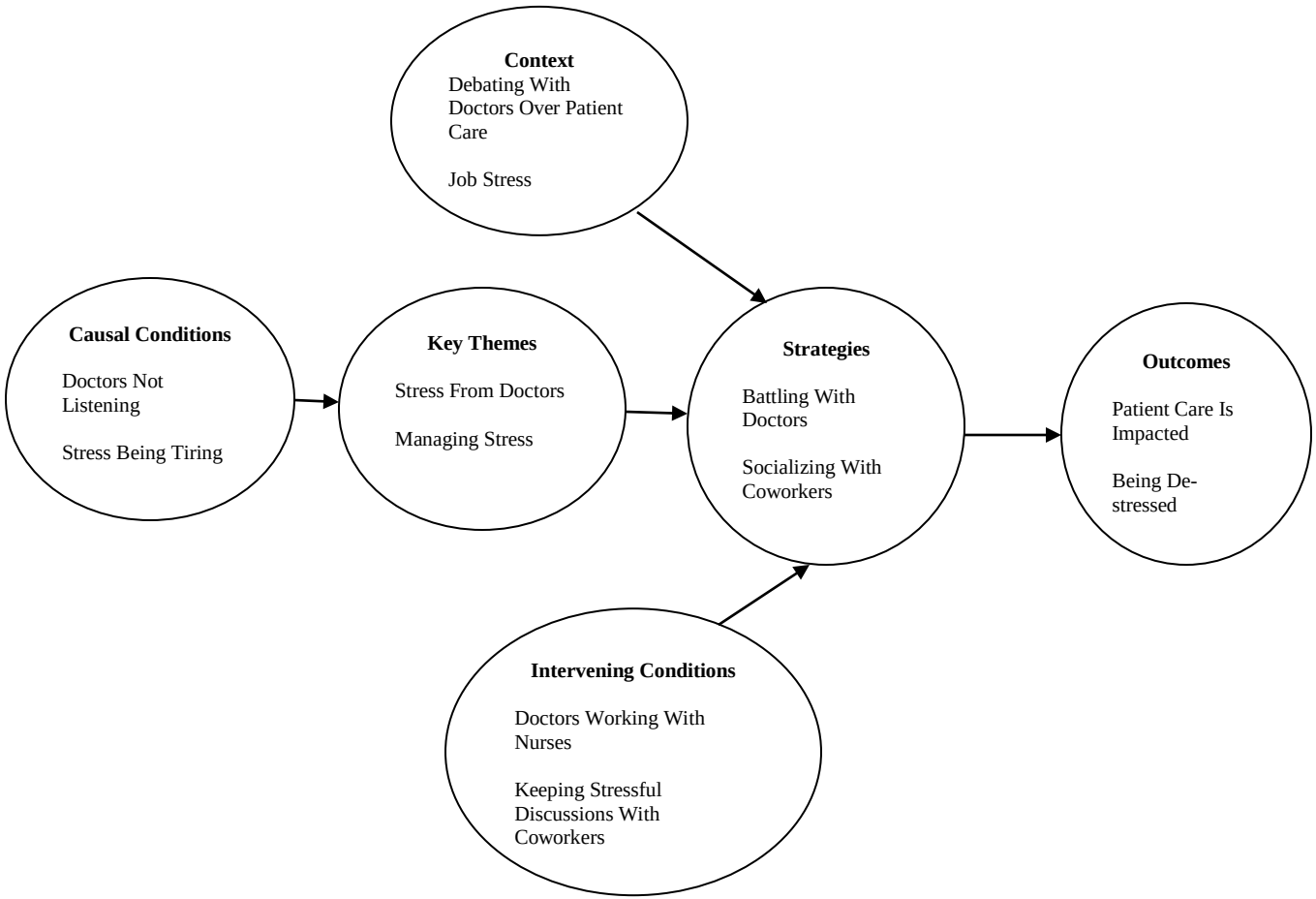

Figure 4.4 Theoretical Model For Occupational Stress

Research Question Five

Research question five sought to explore how humor use influences nurses' communication about occupational stress. *Using Humor to Cope with Stress,* and *Team Humor* emerged from data analysis as themes in response to research question five. Based on Strauss and Corbin's (1990) framework from the present study, a grounded theory model relating nurses' humor use to communication about occupational stress is presented. For a visual depiction of humor use themes- see Figure 4.5 at the end of research question five.

Using Humor to Cope with Stress

Using Humor to Cope with Stress was strategized from *making light of the situation* which resulted in humor *taking your mind off of stress*. Participants regarded crazy situations as a place to *make light of situations* so they could take their *mind off of stress*. Making a joke or laughing about a crazy situation was a remedy for occupational stress. Redirecting stress *took stress off of* participants' minds, thus reducing the tensions of stress. Finding a remedy for stress for the following participant meant looking at family pictures:

> Being in the ICU can be quite stressful. I have pictures of my daughter on my phone. And so I'll talk about the funny things that she does to my coworkers. Just recently she started rolling over and I'll show my coworkers how she eats. So, I'll use my phone as a means to get rid of stress. When I get stressed up here, I'll just look at my phone and look at pictures of her to take

> my mind off of what is going on and kind of re-focus what means the most. It makes me feel better because anytime you can laugh at the situation, whether it is related to the situation or related to something totally different, laughter releases endorphins that make you feel better. (P19)

The preceding quote explained *using humor to cope with stress* in the ICU setting. Having the participant look at family pictures *took their mind off of stress* by laughing at something funny a family member does. Laughing helped the participant feel better psychologically and physiologically. Another participant went through a crazy situation of having a coworker not show up for work:

> Well, there is one nurse that I never really hit it off with; she put in her month notice. She is halfway through the month notice; and she did not show up this morning; so we had one tech to twenty three patients; that is a stressful situation to begin with, and then we are short a nurse; that creates a bad and stressful start to a day; so the best way that we know how to deal with that is joke about it, which makes light of it; we said mean things about her. She never fit in with our rotation. Humor just takes your mind off of it when you can joke about a situation; making light of a situation keeps you from really being upset about it because it is not going to change anything; whether you are pissed off about it or whether you are laughing about it; laughing and joking is the better option of the two. (P22)

Using humor to cope with the coworker not showing up was a participant's alternative to getting mad. Instead of getting upset, the nurse *made light of the situation* by joking, thus not thinking, or *taking their mind off of the situation*. The following participant described a patient going into cardiac arrest in which humor followed the scary situation:

> A patient coded; and one of the things that you have to do is put a board underneath the patient; a nurse who is seven months pregnant ran in there and picked up the patient; this was a big guy; but you get adrenaline which makes you stronger. So she just lifted him up so we can start compressions. We all look back at that and say that beast came in here and just picked him up out of nowhere; and that is inappropriate, but we don't go telling the family that. But we have to make light of the situation because if you do not, you would leave here crying every single day. It helps in relieving it because it takes your mind off of things sometimes. (P29)

The previous quote started with a patient fighting for their life to a pregnant nurse lifting up a patient to save them. *Using humor to cope* was utilized with the *crazy situation* from the *making light of the situation* with calling the other nurse a "beast." *Using humor to cope* was used to *take their mind off of* the poor patient almost passing away. *Making light of the situation* was important in controlling other emotions such as "crying." The next participant described a setting that was chaotic but ended okay with *using humor to cope*:

> Humor always helps. You may not laugh during the actual situation; when we think about bad stuff, I think we use humor as a coping mechanism. I think about stat c-sections in the OR when the person comes in bleeding; and we can't find the heart rate

> and we know it's going to be bad; we are starting an iv and someone rips an IV out by accident when they're running to the back; at that time you are pissed and mad; and are scared because this is important; later after words when so-and-so ripped that IV out by accident; and point to who did it. Afterwards we process things by using humor. That is how we relate to each other. My coworkers and I are close and like to laugh. By using humor, it takes our mind off of it, and helps us to deal, relate, and process. (P28)

In the midst of an IV getting ripped out, it was not funny, but afterwards nurses *used humor to cope* with that stress by joking with the person who did it, to *make light of the situation* and to *take their mind off of* the situation they just went through.

Team Humor

Team Humor emerged from a *stressful situation* which was strategized from *sharing with coworkers* which resulted in *going through a stressful situation together*. Being able to relate a bad situation with coworkers created a sense of togetherness. Sharing humor meant that one nurse was not alone in a bad situation. Using humor made the work less stressful as the following participant explained:

> We would occasionally have to go to the ICU, where there's a lot of intubated patients to change diapers. So you just figure out how to make it work for you; we kind of made a game out of it; we would say, who is on the code brown troop today.

> Using humor makes you feel more a part of a team and work well together; and it takes the stress out, which makes it easier to get through the day. (P12)

Making the comment "code brown troop" created *team humor*. Being able to *share with coworkers* that statement brought the nurses together in that stressful situation. The next participant described a patient that had a leg amputated:

> There was one lady that we just discharged home and she came right back the next day; she had an amputation on her left leg so she only had the right leg. The surgeon had to fix all of the vascular stuff in the right leg and then we discharged her home; apparently on the way home, one of the family members made her upset that was in the car, so she jumped out of the moving car onto her one leg; so she had to come back to the hospital and have that leg amputated because it was really damaged; we just thought that was the funniest thing. It was a really sad situation because it was a bilateral amputee; we just kept imagining jumping out of the car on that one leg; it was frustrating for the doctor because he spent probably eight hours repairing the other leg. He thought it was hilarious too. People do the craziest things. That was hilarious to me. It makes you feel understood and that you are all in this together in a frustrating situation because you are trying to help the patient that did something crazy and did not take care of themselves and having some somebody there to share it with. (P26)

This exemplar painted a picture of *team humor* because not just the participant but other medical workers took care of the patient, thus making it a moment of *sharing with coworkers*. Because the heath care team takes care of patients together, they share situations together; and one way to relate and share that experience is *team humor*.

Theme Summary

Using Humor to Cope with Stress and *Team Humor* are important in nurses' communication about occupational stress. Both themes provide a scope for relieving tension. In line with relief theory research (Cooper, 2008), self-enhancing humor was painted as a tension-reliever (Martin et al., 2003). Participants revealed that *using humor to cope with stress,* and *team humor* were psychological and physiological remedies against occupational stresses that encompass being a nurse. Nurses understood that laughing makes them feel better mood wise and that laughing is good for their bodies. Equally important, nurses constructed a team mentality with humor. In other words, humor was the bridge between nurses connecting through the situations that they faced. Using humor, they could face occupational stress together. The key theme of "using humor to cope with stress," developed out of the causal condition of "crazy situations," within the "going through stress," context. The "making light of situations," strategy, had an intervening condition of "situation perceptions," that facilitated an outcome of "takes your mind off of stress." Secondly, the "team humor" theme emerged from "critical situations," within the "feeling tension" context. The intervening condition of "relating to one another with humor,"

facilitated the “sharing with coworker,” strategy, which resulted in an outcome of “in the situation together.” These paradigm model links are shown below:

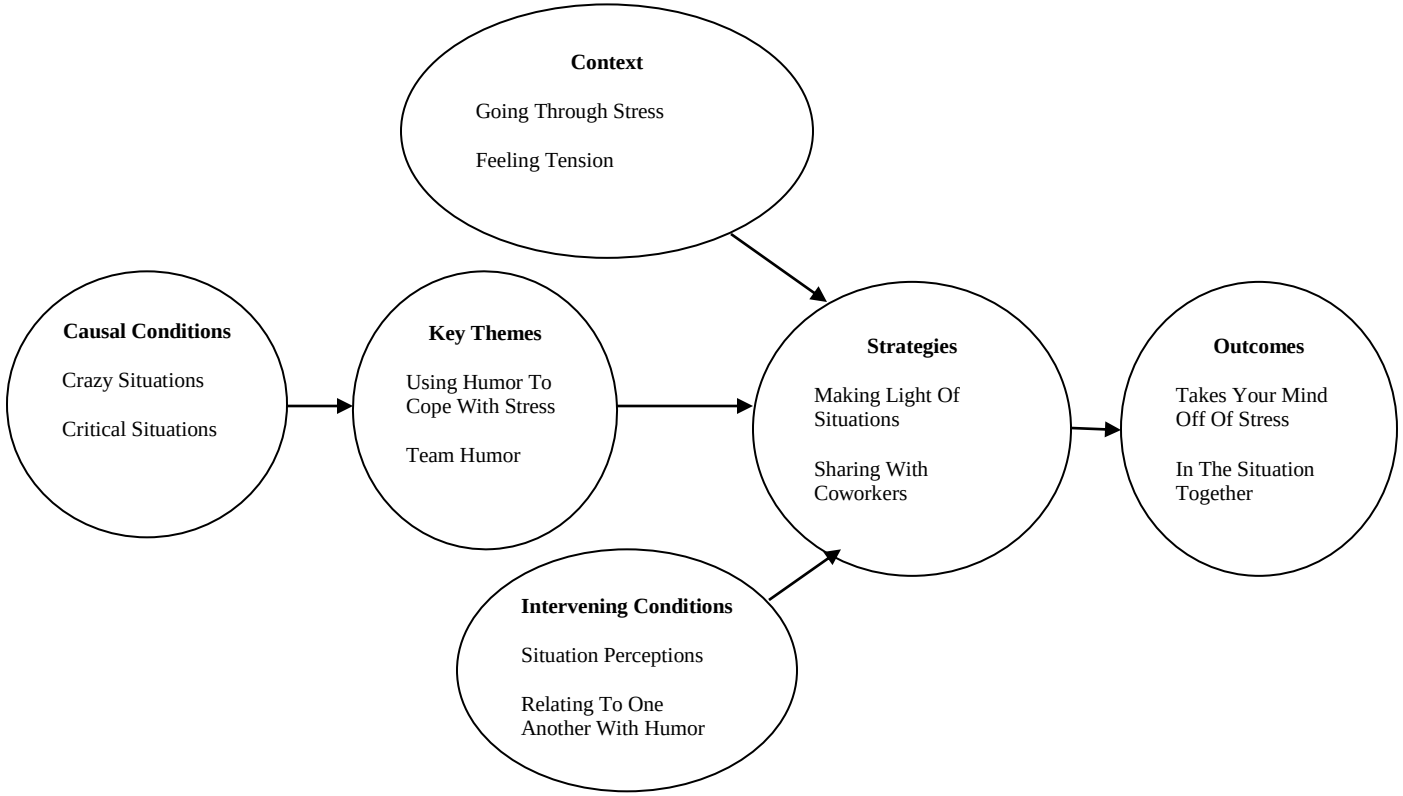

Figure 4.5 Theoretical Model Of Humor Use

Summary of Results

In sum, the study's first research question focused on how nurses' communication influenced organizational commitment. The themes resulting from each research question are diagrammed in Figure 4.6. Four noteworthy themes, *Teamwork, Work Family Support, Patient Connection,* and *Patient Appreciation* depicted nurses' organizational commitment influence. *Teamwork* and *Work Family Support* relate to a collectivity among coworkers. Participants conveyed the importance of working together and watching out for one another in order to achieve the common goal of patient care. *Patient Connection,* and *Patient Appreciation* revealed the other side of the collectivity coin; *Patient Connection* being an attribute of both nurse and organization, and *Patient Appreciation* being an earned value from patients.

Research question two saw *Compassion as Medicine* emerge as a major theme relating to communication about professional commitment, along with *Patient Care Advocate* and *Patient Teacher*. These themes communicate individual nursing tactics that reflect nurse-to-patient interactions. Nurses' saw patients as more than patients; they saw them as a person lying in that bed. Nurses' recognized the importance of being there compassionately for their patients, standing up for their care, and teaching the patient what to do when they go home. These patient care tactics create specific nursing commitments.

Research question three explored how a charge nurse's use of servant leadership influences nurses' communication at work. *Charge Nurse Backup* emerged as the one key theme here, indicating the "servant stance" that charge nurses used to enhance nurses'

motivation and performance. Subthemes here indicated by quotes included consistent references to *humility, providing direction, empowerment, stewardship,* and *authenticity,* the key elements that emerge in defining servant leadership (Spears, 2002; Van Dierendonck, 2011). These prominent servant leadership tactics through participant voices provided a safety net for which participants felt guided in a world of medical uncertainty. In other words, nurses' felt more comfortable doing nursing tasks when they had the guidance of a charge nurse taking a "servant stance" with participants.

Research question four focused on how occupational stress influences nurses' communication. *Stress from Doctors* and *Managing Stress* were two key emergent occupational stress-related themes. Nurses battled doctor superiority and lack of listening as major stressors in their role, which led to nurses socializing about these stressors together. In other words, doctors undermining their patient care abilities led to nurse cohesion. In essence, nurses revealed the importance of bonding with coworkers in order to battle back against stressors.

Research question five pursued how humor influences nurses' communication about occupational stress. *Using Humor to Cope with Stress* and *Team Humor* were the two themes that emerged as key uses of humor by the nurses. Participants saw the usefulness that humor communicated in coping with stress and building up the team. While medicine may alleviate pain, humor lessons stress by re-directing stress and bringing people together. Using humor in such an uncertain context as nursing makes what nurses endure

manageable. While humor is not in pill form, it sure brings out the goodness in nurses. Using humor is that humanistic communication component.

CHAPTER V- DISCUSSION

This qualitative research was conducted to construct a window into understanding how nurses' communicated perceptions of organizational commitment, professional commitment, servant leadership, occupational stress, and ways that humor use influences occupational stress. In chapter two, the theoretical frameworks of organizational commitment, professional commitment, servant leadership, occupational stress, and how humor influences occupational stress were explored applying these useful lenses to these phenomena in nursing, with data gathered and analyzed through the process described in chapter three to answer research questions in chapter four. Chapter four illustrated themes pertaining to nurses'experiences. Chapter five discusses key findings that create a view of influences of communication on nurses' organizational commitment, professional commitment, servant leadership, occupational stress, and humor's influence on occupational stress, thus making significant contributions. Study limitations and future research directions are also discussed. First, implications drawn from this study must be explored.

Organizational Commitment Themes

The study's first research question focused on how nurses' communication influenced organizational commitment. Four noteworthy themes, *Teamwork, Work Family Support, Patient Connection,* and *Patient Appreciation* depicted nurses' organizational commitment influence. *Teamwork* was apparent among participants' narratives. At the core of continuance commitment *Teamwork* communicated aspects of "member dedication to system survival, and personal investments and sacrifices of members" (Buchanan,

1974). With a participant stating: “we’re getting a new patient from the ER, everybody just dives in,” and “my patients may be closer to being discharged to the floor; if I don’t help him today when his patient load is harder, how can I expect help on the days when my load is harder. So, you have to give-and-take,” are displaying continuance commitment aspects because “everybody diving into help” is “member dedication” as well as helping out others to receive help is both a “personal investment” and member sacrifice” (Buchanan, 1974). The findings in this study suggest that *teamwork among nurses* builds synergy (Rafferty, Ball, & Aiken, 2001), as well as being interpersonally effective (Solheim, McElmurry, & Kim, 2007). Participants felt able to count on each other. Moreover, Estryn-Behar et al., (2007) indicated that teamwork allows for member needs to be met. Having the opportunity to have teamwork with fellow nurses resulted in help with each other’s’ patients. The participants in this study felt similar to Manser (2009), who concluded that coordination of interdependent tasks leads to smooth team performance. Participants felt that teamwork helped performance, and having an organizational culture centered around teamwork was also important in retention (Dasgupta, 2014).

Work Family Support, the second emergent theme, displayed cohesion commitment characteristics. Because participants felt an attachment to each other socially, they felt committed to support one another as a family, which enhanced group cohesion and organizational commitment. In other words, being close and supporting each other as family created group cohesion. Similar research found that cohesion was beneficial to nurses (Li, Early, Mahrer, Klaristenfeld, & Gold, 2014). Likewise, having peer support was important for nurses (Han, Trinkoff, & Gurses, 2015).

Patient Connection evolved from participants being eager to connect with patients. Whether it was making sure they had a bath or got a wheelchair to be discharged faster, participants felt committed to their patients. In line with similar research, forming relationships with patients has been known to facilitate well-being among nursing home patients (Haugan, 2013). Participants felt that making patients' happy and doing everything they could, would make a world of difference, thus perhaps enhancing their patients' well-being. Furthermore, participants may feel more accomplished when connecting with patients as well as meeting participants' expectations about the importance of a caring relationship with patients (Hullett, McMillan, & Rogan, 2000; Wiechula, Conroy, Kitson, Marshall, Witaker, & Rasmussen, 2015).

Patient Appreciation was important for participants to enhance organizational as well as professional commitment. Being remembered by former patients and hearing "thank you" from patients told participants they were doing something right. Making an impact on patients' lives was more important than getting a paycheck. Although dealing with administration was frustrating, making a difference and having patients communicate *Patient Appreciation* kept commitment from being hindered enough to leave. Research contends that a "lack of appreciation" results in a lack of organizational commitment leading nurses to leave an organization (McNeese-Smith, 2001). Going back to *Patient Appreciation*, participants' possible reasons for getting appreciated from their patients' was using patient-centered communication with them (McCabe, 2004). Patient-centered communication focuses on a positive nurse-patient relationship which results in quality nursing care (McCabe, 2004). Participants felt committed when they focused more on the

patient rather than on administration. Patient-centered communication may have been a favorable approach leading to greater commitment.

In sum, the findings of research question one extend the importance of communicating organizational commitment characteristics. Being committed to an organization from participants' perspectives came from coworkers rather than supervisors and the organization itself. Because participants spent so much time together, it became apparent that being committed to a workplace was constructed by being committed to each other. Aspects of organizational commitment were continually interwoven throughout participants' experiences. Nurses held each other accountable to be at work, which enhanced commitment. Participants also supported one another in a caring way that fostered a work family. Communication between nurses is a bridge to nurse interdependence, which created important commitment moments. Because nursing involves being a part of a team, creating *Teamwork* and *Work Family Support* are instrumental for being committed to a workplace. As such, these findings assist understanding of what helps nurses stay in organizations. Additionally, these findings benefit both nurses and employers because nursing cannot be done independently; it is a team career. Being committed to a workplace begins with commitment to each other. Reflective of the current study, past research on continuance and cohesion organizational commitment characteristics have shown to enhance working together and supporting one another. Succinctly, nurses were loyal to each other. These themes of *Teamwork* and *Work Family Support* were prominent patterns that relate to what (Kanter, 1968) described as "socially organized patterns of behavior, norms, and aspects of a social system." Nurses

viewed a commitment to each other as important to their social system (Kanter, 1968). In other words, the self-expressions of *Teamwork* and *Work Family Support* led to a collective loyal system of nursing practice (Kanter, 1968).

Patient Connection and *Patient Appreciation* themes yielded their own fruitful findings in regards to organizational commitment. Participants saw benefits when connecting with patients leading them to "recommit" themselves. Being connected to patients may have been instrumental in committing participants to workplaces. Nurses' viewed *Patient Appreciation* importantly as part of being more committed to patients and not worrying about administration. *Patient appreciation* created well-being and a sense of optimism that helped commitment for nurses. These themes relate to Kanter's (1968) continuance and cohesion commitments because nurses showed a dedication to patients, which led to a community of nursing and an organization in the business of patient care. These communication experiences from participants' suggest ways to further guide nurses and organizations to use messages to positively influence organizational commitment. Prior research has shown that organizations that create a communicative nature of caring, support, and an appreciation of their employees will enhance commitment (Kurtessis, Eisenberger, Ford, Buffardi, Stewart, & Adis, 2015; Nazir & Islam, 2017). Practically, healthcare organizations that value these themes that participants shared should have a committed workforce.

Perceptions of Role Commitment

Research question two sought to explore how nurses' communication influenced perspectives of professional commitment. *Compassion as Medicine* as a theme illustrated perspectives such as: "compassion fulfills my role," "seeing a patient crying," "nursing is humanizing," "and "making the patient feel better," that coincide with relevant research that has supported that using compassion for nurses is gratifying and sharing a human experience (Heffernan, Quinn-Griffin, McNulty, & Fitzpatrick, 2010; Simon, Pryce, Roff, & Klemmack, 2005). Moreover, research found that nurses who used compassion with older chronic disease patients' displayed-attentiveness, listening, confronting, involvement, helping, presence and understanding (Cingel, 2011). Cingel's research resonates with the present study findings because participants were attentive with patients in that they cared for their patients more than just giving medicines; they listened to the needs of their patients, such as when they were crying, and they helped patients feel more at ease when they were scared in the ICU. These acts of compassion enhanced role fulfillment for participants; *Compassion as Medicine* was a prominent role fulfillment characteristic.

Patient Teacher became an important role for nurses' fulfillment. Nursing research has concluded that teaching patients about complex treatments after being discharged from the hospital is a crucial aspect of a nurse's role (Barber-Parker, 2002). Participant examples resonated with this finding from instances such as informing the patient about diagnosis tests, which calmed the patients because they now knew what was being tested and seeing the excitement of patients' understanding what to do once they go home. Research has shown that teaching patients contributes to patients' health and wellness in that patients have fewer symptoms and

hospitalizations (Kruger, 1990). Nursing educators argue that educating patients is critical for nurses (Blevins, 2015). Nursing researchers provided evidence in line with this study's research by conducting a counseling skills workshop to teach nurses how to support their patients about wound care (Hollinworth, & Hawkins, 2002). These researchers found that- reflection sharpens practice, and knowing the patient was important in providing psychological support for wound care (Hollinworth, & Hawkins, 2002). In a similar vein, participants being a *Patient Teacher* described instances of being there emotionally for the patient by teaching them about what was going on, which calmed down the patient. Because participants were around patients longer, they knew the patients better which came in handy when it came time to educating them because patient rapport had already been built between nurse and patient.

Patient Care Advocate as a theme emerged from nurse perspectives as another important role fulfillment characteristic. Participants were prompted to become advocates because doctors were challenging nurses when they would question a doctor's plan or call them for patient needs. Participants did not seem to mind quarrelling with doctors in order to obtain what they needed for patients. Whether it was grouping doctor requests together or telling doctors when they thought giving medication was not the best idea, they did what was right even though they faced backlash for it. The idea of nurses being patient advocates is actually nothing new. Nurses for years have been designated as primary advocates for patients (Morra, 2000). Because patients and families put their care in the hands of nurses, being a patient advocate has become emphasized in nursing (Iacono, 2007; Xiaoyan & Jezewski, 2007). In

other words, the day-to-day needs and concerns of the patients have been voiced through nurses (Morra, 2000). Patient advocacy research found that nurses are perceived to be the communication agents in bridging patients' concerns to the heath care environment and culture, sometimes at the risk of personal anguish, conflict, and confrontation (O'Connor & Kelly, 2005). These given implications coincide with current findings because participants voiced their concerns to doctors because they needed to do what was best for their patients' despite the potential conflict with the doctor. Although this could reinforce their professional commitment by advocating for patients, the downward treatment and questioning of their expertise by doctors could demoralize nurses and cause their professional commitment to decline.

Overall, the findings of research question two reveal important role fulfillment implications. Whether it was using *Compassion as Medicine*, or being a *Patient Care Advocate* or a *Patient Teacher*, participants constructed useful experiences that may be further utilized to understand what commits a nurse to the role. The messages that nurses shaped are powerful illustrators of what it means to be a nurse. Communication shaped nurses' self-concept about their role commitments. Participants suggested several nurse-patient communication guides, encapsulated in the theme labels. *Compassion as Medicine*, *Patient Care Advocate*, and *Patient Teacher* are beneficial because being a nurse is more than just giving medicine to patients. Additionally, these findings portray special qualities that empower nurses, including compassionate caregiver and advocate. In sum, because commitments to an organization and the profession shaped a commitment to others, *Teamwork* and *Work Family Support*, served as specific instances of collective

commitment to the nursing team; whereas, *Compassion as Medicine, Patient Care Advocate,* and *Patient Teacher* shaped individual nursing role commitments.

Servant Leadership Perceptions

Research question three sought to explore how a charge nurse's use of servant leadership influences nurses' communication about work. *Charge Nurse Backup* as a theme illustrated servant leadership characteristics. Participants felt their charge nurses were communicating servant leadership characteristics through examples such as: "genuinely cares about me," "makes me feel good because she watches my back," "wants me to be better," as well as charge nurses consistently "being there" to help. These perceptions coincided with servant leadership aspects such as, *humility, empowerment, providing direction, stewardship,* and *authenticity* (Spears, 2002; Van Dierendonck, 2011), more so than *interpersonal acceptance* which had earlier been found to be an aspect of servant leadership. *Interpersonal acceptance* (compassion, warmth, forgiveness) did not emerge in participant quotes about their charge nurse. In other words, participants did not illustrate how compassion, warmth, and/or forgiveness were communicated from their charge nurses. While p*roviding direction* was hinted at in participant quotes, *Stewardship* shone through predominantly with instances of caring. Conceptually, nursing researchers have argued that servant leadership fits nursing practice because it encompasses a caring disposition (Neill & Sanders, 2008).

Participants perceived *humility* and *providing direction* from their charge nurse from on-the-job learning and guidance of nursing tasks. It seemed clear that participants felt their charge nurses' *humility* and *providing direction* with "being there if I needed anything," and "letting me wade water, but not sink." These quotes also demonstrated *empowering* (being proactive and fostering personal power) by participants feeling that their charge nurses were proactive by letting participants learn by trying which fostered personal power in learning what to do. Whether it was learning what to do in a c-section or a patient coding (when their heart stopped), participants felt empowered by their charge nurses. These experiences resonate with consistent research that found "humility" and "empowerment" to be supportive servant leadership qualities (Hanse, Harlin, Jarebrant, Ulin, & Winkel, 2016). Likewise, participants viewed *stewardship* (caring role model) qualities from interactions with their charge nurses with instances of "genuinely cares," "makes me feel good because she's watching my back," and "replacing linens together." Consistent with these perspectives, researchers contended that servant leadership considers others as partners in which they share a glorifying team spirit (Neill & Sanders, 2008). Lastly, *authenticity* (being courageous in challenging circumstances) was noted with "taking charge when needed" and the "skills to back it up." When things went wrong with the c-section and the patient coding, participants described the *authenticity* quality of servant leadership in their charge nurses. In line with the current study findings, community health researchers found that servant leadership valued supporting personal growth and nurse empowerment (Sturm, 2009). Servant leadership also served as encouraging connectedness between charge nurse and nursing participants which supported collegiality and learning

(Jackson, 2008). Servant leadership was clearly portrayed in charge nurse interactions. Having these servant leadership interactions enhanced participants' capacity to do their job and learn from their charge nurse. Neill and Saunders (2008) contended that servant leadership builds employee capabilities and inspires a collection of opportunities for growth.

In a context where nurses are serving patients, it seemed fitting to extend the literature on servant leadership, which is conducive to a working environment that values and develops people while promoting productive research communities (Jackson, 2008). Studying servant leadership promoted a closer look into the serving nature of healthcare. Servant leadership is suggested as a relevant leadership style in healthcare (Campbell & Rudisill, 2005). This study extended application of servant leadership concepts in an important context of serving people. By studying servant leadership in a service field, such as nursing, the dimensions of servant leadership are better understood along with how they are applied. Scruggs-Garber et al. (2009) suggested that servant leadership implications in healthcare are just beginning.

In sum, the findings of research question three extend servant leadership literature as applied to communication-filled instances of nurse-charge nurse interactions. *Charge Nurse Backup* was a significant theme found because participants felt taken care of in an environment with a lot of uncertainties--specifically patient status changes and learning how to care for patients. Participants said that their charge nurses created an environment of growth, connection, and servitude. Participants described communication instances that helped them grow in their role. Participants also felt a connection with their charge nurse because their charge nurses connected with

them by being there and guiding them through nursing endeavors. Additionally, because charge nurses exhibited servant leadership characteristics with participants, participants were able to adequately care for patients. As such, caring for patients is essential for both nurses and charge nurses because communicating aspects of servant leadership create a context of openness. This finding may be instrumental for nurses, charge nurses, and healthcare organizations; nurses found servant leadership to be an essential aspect of knowing they were cared for. In advocating for *empowering* and *developing people*, *humility*, *authenticity*, *interpersonal acceptance*, *providing direction*, and *stewardship*, nurses would appreciate a leadership ideology that works in such a high-demanding field. Nursing and healthcare organizations should utilize servant leadership because making their staff feel cared for is going to rub off on patients. In other words, when nurses feel cared for from servant nurse leaders, they may feel empowered in patient care. Promoting servant leadership for nurse managers will create a climate of servitude.

Perceptions of Occupational Stress

Research question four sought to explore how occupational stress influences nurses' communication. *Stress from Doctors* and *Managing Stress* were two emergent occupational stress-related themes. Participants felt stress when doctors would not listen to nurses' recommendations for the patient. Occupational stress researchers in nursing argue that doctors often do not treat nurses as equals (Lim & Yuen, 1998). Participants felt stress from not being listened to by doctors. In other words, nurses had knowledge of what to do and doctors would not take that knowledge from nurses into account. Because doctors did not listen to nurses, patient care

was hindered. In one key instance found here, instead of getting a central line for a patient quickly, it took a while, which was "frustrating" and stressed out the participant.

Communication researchers argue that poor communication between nurses and doctors is a leading cause of preventable patient care events (Manojlovich, Harrod, Holtz, Hofer, Kuhn, & Krein, 2015). These researchers found doctors avoiding communication with nurses by putting orders in the computer or having medical students rather than doctors discuss patient care with nurses (Manojlovich, Harrod, Holtz, Hofer, Kuhn, & Krein, 2015). Likewise, nurses would avoid doctor-patient interactions and also medical team rounds (Manojlovich, Harrod, Holtz, Hofer, Kuhn, & Krein, 2015). These implications resonate with the current research because the communication patterns between doctors and nurses are not coalescing into a team pattern. In other words, nurses perceive doctors in one-way and vice versa, which creates stress and frustration for the healthcare team. In line with this implication, researchers found that nurses were not comfortable communicating with physicians (Manojlovich, Harrod, Holtz, Hofer, Kuhn, & Krein, 2015). Because nurses were not listened to, stress increased. Digging deeper, these stressful doctor-nurse interactions may result from power or leadership struggles over patient care implementations. Researchers contend that physicians are trained to assume a leadership role in many settings and thus feel challenged when they have to share that leadership care role with nurses (Hall, 2005). These challenges led to stress from these communication encounters between nurses and doctors, thus influencing nurses' communication about occupational stress.

Managing stress for participants was done by socializing with fellow coworkers to de-stress. Researchers found that supportive coworkers helped reduce stress (Johansen & Cadmus, 2016). Social support, specifically peer support among healthcare professionals, reduced occupational stress (Manning-Jones, De Terte, & Stephens, 2016). Peer support benefits health professionals (Naturale, 2007). Having social support for nurses has been shown to increase life quality (Aycock & Boyle, 2009). MacGeorge, Feng, and Burleson (2011) argued that there is a link between supportive communication and well-being because it reduces emotional distress. Participants sought support with coworkers as a coping strategy for the occupational stress they faced. Participants felt better when they expressed stressful conditions to fellow coworkers. Because participants knew their coworkers would understand their problems, they found seeking support of their coworkers to be a great benefit. Li and Yang (2009) found that selection of coping style was partly based on self-efficacy. Rather than participants going home for support seeking communication, they went to their coworkers for self-efficacy reasons. Because participants felt close with coworkers, participants choose coworkers for relating and understanding stressful discussions.

In sum, the findings of research question four reveal key implications about understanding stress-filled instances nurse encounter. Participants pinpointed a specific stress-filled interaction between themselves and doctors. Resident doctors stressed out participants because of a lack of training; and regular doctors stressed out nurses because doctors were not spending enough time with patients. These findings are useful to remedy stressful interactions between nurses and doctors. Addressing concerns of not being

listened to and collaborative healthcare decisions may construct positive communication and less stressful interactions between nurses and doctors. Doctors being proactive in changing nurse-doctor communication patterns may have an influence on nurses' stress levels. Preventing emotionally-draining stress for nurses would be easier to address with the help of the whole healthcare team rather than with just a team of nurses. In other words, both doctors and nurses would be better served working together to not stress each other out. Moreland and Apker (2015)'s thematic analysis, similarly, found that disrespectful communication--not listening and perceived lack of support from doctors--contributed to unwanted stress**.** Reducing the hierarchy between doctors and nurses can improve cooperative efforts and communication satisfaction (Haig, Sutton, &Whittington, 2006). Placing value on nurses and communicating attentive listening would be beneficial to reducing stress between doctors and nurses because being respectful lowers stress (Moreland & Apker, 2015). Also essential would be doctors realizing that nurses do spend more time with patients and in relation to resident doctors do have more training, thus utilizing nurses knowledge and intuition would be beneficial to the healthcare team and patients.

Finding the support of coworkers to *manage stress* was significant among participants. Nurses felt that coworkers would understand their experiences because they worked alongside each other. Participants also found it useful to de-stress with coworkers before going home. These findings highlight a window into specific recurring stress from doctor interactions, and a good way to manage stress by being with coworkers.

Perceptions of Humor to Combat Stress

Research question five sought to explore how humor influences nurses' communication about occupational stress. *Using Humor to Cope with Stress* and *Team Humor* as themes emerged from data analysis. Participants chose humor over crying or getting mad as a way to cope with stress. A nursing researcher held that finding humor in situations while laughing with others is a powerful stress antidote (Wooten, 1996). Dicioccio (2012) argued that self-enhancing humor is a form of protection against stress. Throughout stressful perspectives of participants, humor was a coping method used to "take their mind off of stress." Vivona (2014) suggested that "gallows or dark humor is often used to make fun of what emotionally threatens people" (p. 131). "Taking their mind off of stress" may have been a gallows humor form. Carver (1997) further contended that humor is a distraction to stressful contexts. Whether it was looking at family pictures on a cell phone, making fun of a coworker that called in sick or because the coworker did not fit in, the participant stating a fellow pregnant coworker lifted a patient, or later joking about a coworker ripping out an IV of a patient, gallows humor was used as a distraction to emotional events that participants experienced. Consistent with CSI research, participants used humor as an "emotional reset to distract or deflect" the strains of stressful situations (Vivona, 2014). In line with alternative medicine researchers, humorous interventions in medical settings served as stress-relievers while improving quality of life (Friedler, Glasser, Levitan, Hadar, Sasi, & Lerner-Geva, 2017). With participants experiencing negative events in nursing, humor was used to "take their mind off of stress," which coincides with emotion researchers who contend that humor is a distraction of negative thoughts thus reducing peoples' emotional experience (Strick, Holland, Van Baaren, & Knippenberg, 2009). Participants used humor about

otherwise stressful situations to bond. In other words, participants were able to share stressful experiences with humor. Buxman (2008) contended that humor establishes relationships. Finding humor together releases tension (Vivona, 2014). Participants found using humor as a distraction from the stress they endured together. Van Dillen and Koole (2007) defined distraction as "an act that involves intentionally or unintentionally drawing one's attention away from a focal event" (p. 715). Organizational humor provides amusing messages that foster positive emotions for individuals, groups, and organizations (Romero & Cruthirds, (2006), and it also promotes group cohesion (Romero & Pescosolido, 2008). Romero and Cruthirds (2006) suggested humor is a tool to promote organizational values and norms. Holmes and Marra (2002) contended that humor provides insights into distinctive work cultures. Participants felt that using humor brought them together, they felt understood, and made the day easier, which resonates with prior research. Humor functioned as social bonding, enhancing participants' relationships with one another. Within Meyer's (2000) model of humor, identification resonates with participants' experiences of *Team Humor* because identification enhances mutual understanding between communicators. Romero and Pescosolido (2008) argued that a strong organizational culture engenders shared emotional interpretations of humor. Participants shared their experiences with the communication of humor. Lastly, results brought to life pleasant humorous experiences from socializing with coworkers about stressful situations, which is in line with relief theory (Shurcliff, 1968).

In sum, the findings for research question five extend humor literature by seeing what and how messages with humor influence nurses' communication in stressful events. Humor was a communication tool to look past stress and to bond with fellow coworkers. As such, humor appears essential in keeping positive in an uncertain environment. Identification and self-enhancing humor served participants well.

Limitations and Future Research

A limitation of this qualitative research study was that data collection was primarily collected at one medium-sized southeast healthcare organization, thus findings cannot be generalized to a region or broader nursing culture based on this study alone. Therefore, in order to obtain a broader picture of these phenomena explored, nurses at more organizations, such as smaller clinics, doctor's offices, and outpatient clinics should be interviewed, to obtain their insights; and compare those results with these to see how nurses' are communicating these phenomena. Enhancing the richness of the data would help compare nurses' experiences in different health care organizations, urban or rural settings, and regions to obtain a bigger picture of the phenomena studied.

An additional limitation was recalled experiences to answer interview questions. Although some participants were registered nurses in the field for more than three years, some participants had gone on to higher nursing levels such as a nurse practitioner or had retired. It may be beneficial to interview more participants who have worked the same day or a couple days prior so as to enhance experience recall. The majority of participants did not seem to have issues recalling work events, however.

Future Research

Future research could focus on how specific organizational commitment components influence nurses to stay at a particular organization. Several participants were at one organization for more than 20 years. The themes that emerged revealed more coworker commitments than what the organization itself did to influence commitment. Administrators could be interviewed to see what they are doing to keep nurses. Likewise, future research could interview other demographics than just Caucasians since the current study had a large majority of Caucasians.

Further professional commitment research could explore how the themes that emerged in this study develop over time. Because participants hinted at "learning to advocate," what influences them to want to do this besides just for the patients' well-being? Research from patients' perspectives based on this study's themes may be advantageous. Furthermore, are these themes learned on the job, in college, or communicated by just a few nurses? These questions could be answered in further research pathways.

Without hinting at servant leadership characteristics during participant interviews, characteristics did emerge. Genuine care was prominently desired and found among participants. Future research could explore how charge nurses are cared for, which is thus passed on to their subordinates. In other words, where and how charge nurses are learning their leadership style could be explored. Because there are so many components to servant leadership, initial descriptions of the concept to participants became more a lecture than an interview. Interview questions were changed to "describe a leadership interaction with your charge nurse." Future research

could further explore how all servant leadership characteristics are communicated with better interview questions in which participants do not need coaching on concepts, charge nurse interviews, and or a focus group to possibly obtain more perspectives. Even better may be participant observation--observing interactions between charge nurses and their subordinates. Some participants mentioned leader trust. Future research should explore trust dynamics between nurses and their leaders because it is not a servant leadership tactic but may be important in how servant leadership tactics are communicated.

Future research should also explore nurse-doctor interactions to further understand why they are inherent with stress, conflict, and lack of listening from doctors. Future research could also explore what messages de-stress nurses. Observing nurses in the moment may capture occupational stress at its peak. In other words, watching nurses go through stressful days to understand these communication patterns may paint a clearer picture. Also, nurses would complain to one another about nursing stuff. What staff would they complain about and were those messages effective or not in addressing stress? Future research should explore what messages were communicated that developed nurse rapport for stressful encounters. Future research could explore messages that encouraged support among nurses. Lastly, emotions may be communicated between nurses and doctors, thus influencing emotional vested nurses. Future research could explore how stress enhances or hinders an emotionally vested nurse.

Humor study proved to be enlightening in this study. Participants mentioned many times that humor beneficially “took their mind off of stress.” Future research should conduct participant observation to find out what particular humorous messages did in fact

"take their mind off of stress." Were these messages affiliative, self-defeating, self-enhancing, or aggressive? Participants discussed communication events that did construct self-enhancing humor aspects but did not convey specific messages that constructed the rest of the humor styles. Because self-enhancing aspects were constructed, further research should peek into where this style originated in participants because it is a positive type of humor. The aspect of dark humor was mentioned and hinted at but participants were reticent to discuss that type of humor in this study for fear of outsider perceptions. Future research should conduct an ethnography that may get at dark humor messages. Participants did hint that dark humor helps them deal with what they encounter. Future research should also look deeper into what messages created humor amongst nurses. Since there are varied positive and negative types of humor, some may be more effective than others.

Conclusion

This research sought to present a clear view of how organizational commitment, professional commitment, servant leadership, occupational stress, and humor influence communication in a nursing context. The use of grounded theory provided a deep foundation that explores, understands, and explains phenomena to pave the way for a better healthcare system through communication. Assembling a potential theory relating communication to occupational stress and professional commitment provides new ways to build a profession, better serve patients, and create proactive stress reducers for nurses. Understanding these concepts should serve staff nurses, charge nurses, patients, doctors, and the healthcare system well.

The significance of this study, then, resides in the interpretations of these concepts explored qualitatively. For instance, applying the results to nurse leaders showing how their subordinates perceive them may change how nurse leaders communicate and shape their subordinates' roles as well as reflecting on how occupational stress affects them. Each of these concepts examined is a link to exploring effective communication for nurses, extending theory, and promoting opportunities for effective communication in healthcare. Healthcare organizations benefit from an understanding of organizational and professional commitment, servant leadership, occupational stress, and humor styles because they would have information not only about how nurses perceive their leaders but also about their attempts to laugh at work.

In terms of organizational commitment, in a nutshell, *Teamwork* and *Work Family Support* themes suggest that the bond occurring between nurses' is enriching how nurses are operating within the organization. Being there for one another helps nurses tackle the situations that they face. Healthcare organizations that emphasize these types of communication messages should be well-served. In other words, organizations that promote communication about teamwork and being supportive to one another will have committed nurses. Secondly, *Patient Connection,* and *Patient Appreciation* offer positive commitment characteristics that healthcare providers could emulate. Because participants knew they had a vital support system established amongst coworkers, they were able to excel at connecting with patients and going above their scope of care for patients.

Compassion as Medicine, patient care advocate, and *patient teacher* are proven professional commitment characteristics. Some practical implications from participants are important for nurses to learn in nursing school and throughout nursing careers, in hospitals or other nursing contexts. First, learning about being compassionate, being an advocate for their patients, and patient education in nursing school will teach new nurses that it takes more than just giving medicine to patients. In other words, nurses must be emotionally vested, look out for their patients, and teach the patient about their diagnosis. Having these communication skills could help nurses that lack these skills be better-rounded as a nurse. Secondly, nurses with a lot of experience know that these characteristics are important, thus can be role models for new nurses to develop these communication skills on the job.

In this study, *Charge nurse backup* as a theme exemplified servant leadership characteristics. Being in such a high-demand field, nurses do a lot for their patients and go through a lot for their patients. So, backing up subordinates with guidance and showing a sense of caring-communicates to nurses from leaders that "I am here for you." A sense of servanthood goes a long way. A charge nurse's role encompasses wearing many hats, one of which is to be there for their subordinates. A charge nurse that communicates empowerment, humility, stewardship and authenticity to their staff will inherently provide confidence to their subordinates in that they have a humanistic leader--a leader who is there for them. Participants saw servant leadership characteristics in their charge nurses as fruitful. Healthcare providers should look to servant leadership as a proactive communication tool.

Regarding sources of stress, *Stress from Doctors* carried a definite negative connotation from participant experiences. Even though doctors play a key role in directing the treatment of patients, being mindful of the stress they put on nurses warrants more thought. Participants contended that taking care of patients when they are sick is stressful enough, so bringing to light the fact that doctors cause nurses more stress needs to be evaluated and remedied because the bottom line is doctors and nurses are important mutual components in healthcare. Being mindful of communicating stress to each other on a healthcare team would be a suggested path of discovery to reduce stress.

Managing stress was best remedied with peer support. Having camaraderie amongst the nursing team is important in dealing with stress. Talking about it with fellow coworkers is a proactive way to deal with stress because coworkers understand one another because they go through similar nursing situations together. Finding ways to talk out stressful situations and knowing that coworkers have each other to talk to are proactive socializing pathways to managing occupational stress in healthcare organizations.

Humor has long been found to serve as a great prescription for stress. Participants viewed laughing as a remedy to a bad situation during and after the bad situation happened as well as using humor as a communication tool to relate to each other in response to stress. *Using Humor to Cope with Stress* is a great way to give the mind a break from stress. Nurses realized that using humor took their mind off of stress. Choosing the path of laughing it off instead of getting upset is clearly the better pathway to better physiological and psychological health. Sharing humor as a team is also a great suggestion for healthcare organizations because humor

brings nurses together. Utilizing humor messages that bring nurses together is clearly desired as effective communication. Relief humor was used to reduce stress. Nurses also saw stressful encounters as incongruous opportunities to laugh at. In line with Lynch's (2002)'s incongruity definition, nurses viewed humor as a way to intellectually process an event. Nurses collectively viewed humor as a communication tool to process event perceptions and norm violations. Nurses' revealed that humor is a way to "process things" and to "relate to each other." That said, superiority humor was seen in one instance where nurses made fun of a nurse that did not get along with others. The nurse explained that because "she did not fit in with our rotation, we said mean things about her." Ferguson and Ford (2008) similarly stated superiority humor brings a superior feeling over other's misfortune. Because the nurse did not fit in, other nurses saw those misfortunes as opportunities for superiority humor. Humor, finally, had its time and place. Participants explained that humor after stressful events was appropriate while humor during a stressful event was not appropriate. Inappropriate humor during a stressful time may increase stress because nurses are focused on the task-at-hand.

Communication is the core component to nursing interactions. A nursing model (Figure 5.1) illustrates how communication is related to organizational commitment, professional commitment, servant leadership, occupational stress, and humor. These multiple concepts were abundant in multiple nursing areas, including the emergency department. Because communication entails a process of understanding and shared meaning (Pearson & Nelson, 1991), the emergent themes found in the current study may be transparent to one another. In other words, the interactions that shaped themes in organizational commitment may be related to professional

commitment themes, for instance. The themes of both organizational commitment and professional commitment are shaped by positive characteristics. *Teamwork, Work Family Support, Patient Connection,* and *Patient Appreciation* could also be instilled as nurses' professional commitment attributes. For example, *Patient Connection* could be a characteristic of the nursing team as well as each nurse. In other words, *Patient Connection* could be committing nurses organizationally as well as professionally. These themes communicate both personal goals (professional commitment themes) and interdependence (organizational commitment themes). Nurses communicated all of these emergent themes in interactions they had with other nurses, doctors, and patients. From *Teamwork* to *Managing* Stress, nurses negotiated these communication processes together. Nurses' work lives involve fruitful communication interactions. Nursing organizations that apply the *Nursing Communication Model* will be able to suggest fruitful pathways to address problems that happen in nursing. For instance, a fruitful pathway to not working together would be *Teamwork* and *Work Family Support*. Having insights and details about how the *Nursing Communication Model* promoted these themes, provides a guide to other nursing situations. Likewise, seeing how important *Compassion As Medicine* is in nursing provides a powerful component to the model because nurses that apply this theme see

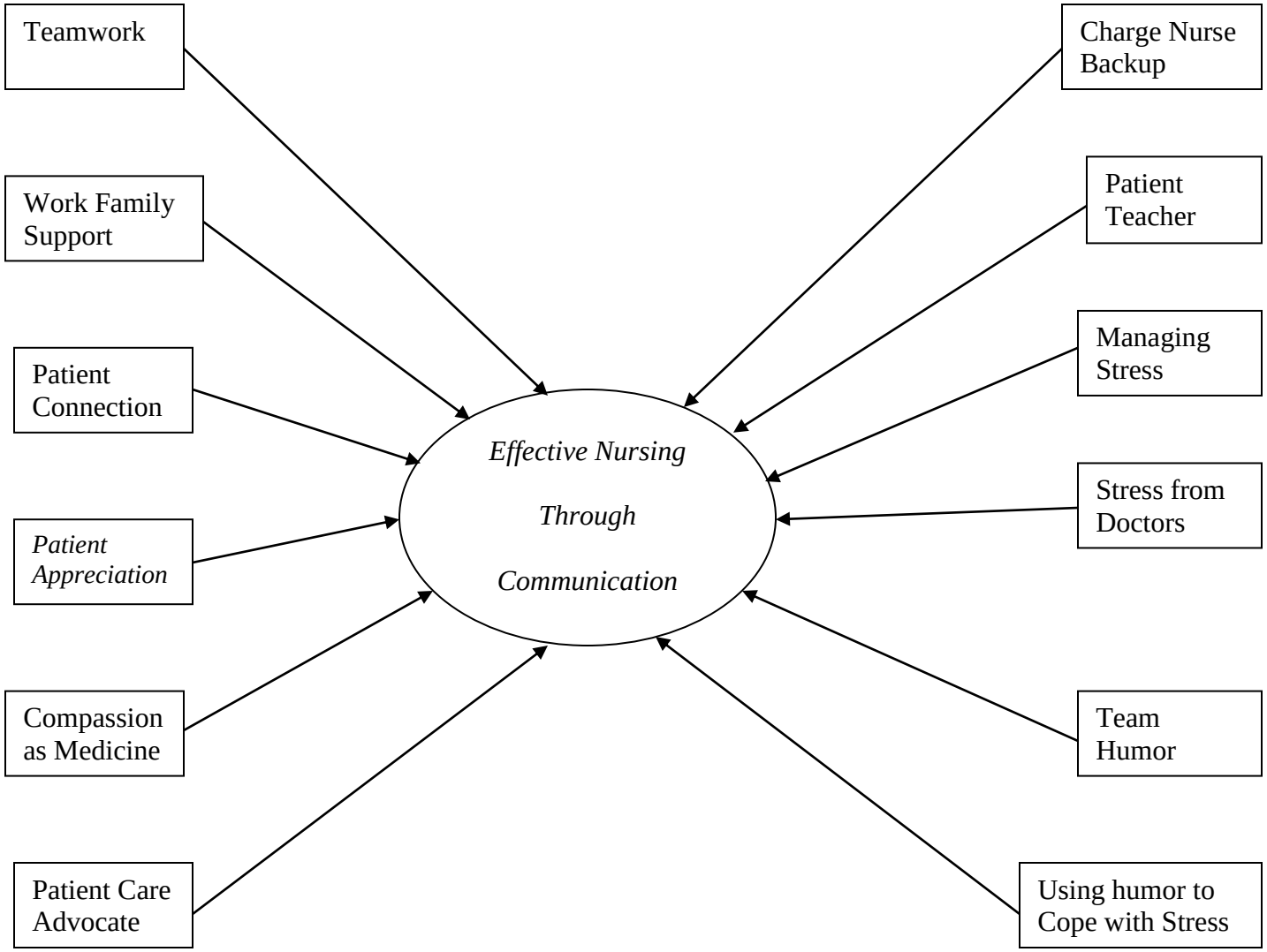

Figure 5.1 Nursing Communication Model

how fruitful it is in nurse-patient relationships. While these themes add important aspects to the model, communication is at the core of the model. Succinctly, communication is the tool that connects these themes together. Nursing organizations that apply the *Nursing Communication Model* will understand the importance of communication and its impacts to nursing situations. Medical organizations that instill communicators that are interdependent, work together, and mutually influence one another, will be fruitful. Medical organizations that adopt the *Nursing Communication Model* will have guidance in those endeavors and an advantage in understanding how communication works. Likewise, the *Nursing Communication Model* creates a tool to understand sharing and creating meaning how socializing with fellow coworkers and using humor distracts stress.

Medical organizations that instill servant leadership qualities will see a team of servants. Charge nurses that work alongside their team will see the importance of serving others. Likewise, nurses' that communicate servant leadership qualities may become leaders in their role. While these qualities are important to perhaps becoming a charge nurse, *humility*, would be the most important because nurses that communicate support to one another will not feel as stretched to the limits of their ability. Nurses are stretched thin because they are constantly doing a lot of tasks at one time. *Humility* is a valuable leadership characteristic. Nurses that communicate these serving characteristics, especially *humility*, may have a greater chance at becoming a charge nurse.

In short, this qualitative research explored the work lives of nurses' encompassing their communication about organizational commitment, professional commitment, servant leadership, occupational stress, and humor. In so doing, this study fostered both

theoretical implications and practical applications. Theoretically, the research conducted in this study extended an understanding of communication patterns pertaining to the aforementioned five explored concepts. Additionally, it provided valuable understanding of the experiences that nurses endure. These experiences shed light on what is keeping nurses committed, what they think of their charge nurses, and how they communicate about stress, and how they use humor to deal with stress. These nurses' accounts, thus, become narratives encompassing practical advice for healthcare teams for maintaining the commitment, morale, and effective teamwork of nurses.

APPENDIX A - Semi-Structured Interview guide

Thank you for taking the time to talk about your perception of your nurse leader, occupational stress, humor, and commitment.

A. Please tell me your title, and how long you have been in the organization.

B. How long have you have been a nurse?

What motivated you to become a nurse?

What do you most like about it?

What do you least like about it?

C. Tell me about a typical day in your organization.

2. Describe your commitment to your company.

What commitment attributes do you find valuable to be committed to your company?

How do these commitment attributes help you to be committed to your company?

In what kinds of situations do you willingly go that extra mile for your company?

In what ways, if any, was your work recognized?

How does this situation change your perception of being committed to your company?

In what kinds of situations does your company weaken your company loyalty?

How does this situation change your perception of being committed to your company?

3. Describe your commitment to your role as a nurse.

What characteristics do you find important to be a nurse?

Who in nursing has had your biggest influence on becoming a nurse?

What role model attributes do you find valuable in this person?

In what kinds of situations do you know you are fulfilling your role as nurse?

What did you learn in this situation about your nurse role?

In what kinds of situations does your role of nurse get challenged?

What did you learn in this situation that about your nurse role?

4. Describe how you perceive your charge nurse or supervisor.

What do you most like?

What do you most dislike?

A. Describe the ways that person leads-(their leadership characteristics).

B. What are their strengths?

C. What are their weaknesses?

D. What makes a good leader to you?

How does your leader help you to be the best you can?

How does your leader support your performance?

How does your leader help you get past mistakes?

How is your leader proactive in guiding you?

How does your leader show that they care about you?

In what kinds of situations does your leader show exceptional listening skills?

In what kinds of situations does your leader understand your intentions?

In what kinds of situations does your leader convey doing the right thing?

In what kinds of situations does your leader persuade the staff to change how something was done?

How, if ever, does your leader think beyond being a nurse?

How, or how much, does your leader believe in helping people grow in their jobs?

How much does your leader help the nurses' work together as a team?

In what kinds of situations does your leader create nurse cohesion?

5. Describe how occupational stress affects you at work.

How can you tell when you are stressed out at work?

What kinds of situations stress you out?

How does stress affect you?

In what ways do you manage stress?

6. Describe how you use humor in your role of nurse.

What kinds of things do you find funny at work?

In what kinds of situations do you find yourself joking or laughing with fellow nurses?

What kinds of things do you not find funny at work?

How does your humor use affect your work?

How does humor strengthen your relationship with fellow nurses?

In what kinds of situations does humor strengthen your nurse relationships?

How does this humor use in the situation strengthen nurse relationships?

How does the humor used in the situation increase stress?

How does the humor used in the situation decrease stress?

How does humor weaken nurse relationships?

In what kinds of situations does humor weaken nurse relationships?

How does this humor use in the situation weaken nurse relationships?

How does the humor used in the situation increase stress?

How does the humor used in the situation decrease stress?

7. Is there anything else that I have not asked that you feel should be included to help me understand how you perceive your charge nurse, handle stress, communicate humor, and feel about your commitment to your organization, or your work as a nurse?

APPENDIX B – IRB Approval Letter

THE UNIVERSITY OF
SOUTHERN MISSISSIPPI

INSTITUTIONAL REVIEW BOARD
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NOTICE OF COMMITTEE ACTION

The project has been reviewed by The University of Southern Mississippi Institutional Review Board in accordance with Federal Drug Administration regulations (21 CFR 26, 111), Department of Health and Human Services (45 CFR Part 46), and university guidelines to ensure adherence to the following criteria:

- The risks to subjects are minimized.
- The risks to subjects are reasonable in relation to the anticipated benefits.
- The selection of subjects is equitable.
- Informed consent is adequate and appropriately documented.
- Where appropriate, the research plan makes adequate provisions for monitoring the data collected to ensure the safety of the subjects.
- Where appropriate, there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of all data.
- Appropriate additional safeguards have been included to protect vulnerable subjects.
- Any unanticipated, serious, or continuing problems encountered regarding risks to subjects must be reported immediately, but not later than 10 days following the event. This should be reported to the IRB Office via the "Adverse Effect Report Form".
- If approved, the maximum period of approval is limited to twelve months.
  Projects that exceed this period must submit an application for renewal or continuation.

PROTOCOL NUMBER: 16102602
PROJECT TITLE: Exploring Organizational Commitment, Professional Commitment, Servant Leadership, Occupational Stress, and Humor Perspectives: How Nurses Manage
PROJECT TYPE: New Project
RESEARCHER(S): Brian Perna
COLLEGE/DIVISION: College of Arts and Letters
DEPARTMENT: Communication Studies
FUNDING AGENCY/SPONSOR: N/A
IRB COMMITTEE ACTION: Exempt Review Approval
PERIOD OF APPROVAL: 11/30/2016 to 11/29/2017

Jennifer Downey, MA, CIP
Institutional Review Board

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