

**Structure du travail en matière  
de soins aux malades chroniques :  
conséquences possibles sur la santé mentale  
du personnel infirmier**

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La présente étude avait pour objet d'enrichir l'ensemble des connaissances sur le cadre de travail des infirmières et des infirmiers, de manière à mieux comprendre leur expérience collective ainsi que l'origine de leurs problèmes de santé mentale. Une approche psychodynamique du travail a été adoptée. Les résultats montrent que la principale source d'insatisfaction par rapport au travail est leur sentiment que la direction et les autres professionnels ne leur accordent pas la reconnaissance, l'autonomie et l'autorité professionnelle qu'elles et ils méritent. Cette situation résulte en grande partie d'une organisation inappropriée du travail du personnel infirmier, dont les responsabilités ne correspondent pas à leur niveau de reconnaissance, d'autonomie et d'autorité professionnelle. L'auteure conclut qu'il faut transformer l'organisation des soins infirmiers, pour non seulement réduire le taux d'absentéisme mais aussi améliorer les soins infirmiers et en renforcer la professionnalisation.

Mot-clé : organisation du travail

# **Work Structure in the Chronic Care Setting: Possible Consequences for Nurses' Mental Health**

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The purpose of this study was to add to the body of knowledge on nurses' work environment in order to better understand their collective experience and the reasons for their mental health issues. A psychodynamic approach to work was used. The results show that the main source of nurses' dissatisfaction with their work is the perceived failure of management and other professionals to accord them due recognition, autonomy, and professional power. This situation is largely the result of an inappropriate organization of nurses' work, with nursing responsibilities unmatched by their degree of recognition, autonomy, and power. The author concludes that the organization of nursing must be transformed, not only to lower the rate of absenteeism but also to improve nursing care and enhance the professionalization of nursing.

Keywords: nurse roles, long-term care, work organization, occupational health

## **Background**

In the mid-1990s economic constraints led many industrialized countries to restructure their health-care systems (Bergeron & Gagnon, 2003; Blythe, Baumann, & Giovanetti, 2001; Parker Shannon, 2002). Canada was no exception, embarking on a war against the deficit. It announced a 15% reduction in the amounts transferred to the provinces for their health-care systems (Turgeon & Gauthier, 2002). Since this measure meant a loss of revenue for the provinces, the government of the province of Quebec initiated an overhaul of its health and social services network by closing a number of hospitals, merging various health-care institutions, establishing walk-in clinics, and offering health professionals a retirement incentive (Bergeron & Gagnon, 2003). Efficiency became the mantra (Aiken, 2002; Aiken & Fagin, 1997). The number of hours of care set by the Quebec government as part of its restructuring program, however, was insufficient to meet the growing intensity and complexity of care required by the population. A true overload followed in the field of health care, which gradually affected the work satisfaction of nurses, increasing the rate of absenteeism and eroding the quality of care provided (Armstrong-Stassen et al., 2001; Canadian Nursing Advisory Committee, 2002; Gadbois & Parker, 2000). The restructuring of nursing

staff by reducing the nurse-patient ratio and mass hiring non-qualified employees (Norrish & Rundall, 2001) had an impact. This staffing model, also known as “skill mix,” involves the hiring of a small number of nurses to supervise a large and growing number of less-qualified employees (Scholaski, Estabrooks, & Humphrey, 1999). The drastic reduction in the number of nursing positions led to a reconfiguration of the role of nurses, which resulted in ambiguity, confusion, and stress. At the same time, it caused great concern among nurses about the quality of care being provided. Quality of care is central to the level of satisfaction among nurses. The more quality goes down in the eyes of nurses, the greater the stress experienced by nurses (McGillis Hall et al., 2001). The findings of a study by Aiken, Clarke, Sloane, Scholaski, and Silber (2002) illustrate the effects of redefined nursing staff on quality of care: in general surgery, vascular, and orthopedic units, a significant link was found between the nurse-patient ratio and the rate of mortality and adverse effects, as well as the level of satisfaction and burnout among nurses; with a nurse-patient ratio higher than 1:6, for each additional patient the risk of mortality and adverse effects increased by 7%, while job dissatisfaction and burnout increased by 15% and 23%, respectively.

The Canadian Nurses Association (2006) reports that during the period 1987–2005 more nurses were absent from work than ever before, and in 2005 an average of 16,500 nurses were absent each week due to illness or trauma, for 20 hours on average — a total loss of 340,000 hours per week or 17.7 million hours per year, the equivalent of 9,754 full-time nursing jobs.

It has also been found that the health problems invoked for absenteeism are more psychological than physical. Psychological distress is the number one cause of absenteeism by health professionals. Between 1993 and 1999, the period of health and social services reform in Quebec, the costs of salary insurance increased by 25%, primarily due to burnout and depression (Ministère de la Santé et des Services Sociaux, 2001). Similarly, a study with 2,006 nurses in acute-care and long-term-care settings in Quebec found that mental health problems were the most frequent reason for absences sanctioned by a medical certificate (Bourbonnais, Malenfant, Viens, Vézina, Brisson, et al., 2000); the number of absences due to mental illness quadrupled between 1993 and 1999 and the length of the average absence related to mental health went from 51.6 days in 1993–95 to 78.1 days in 1998–99.

Such an increase in mental health diagnoses warrants an examination of the work experience of nurses. It is known that structural and organizational changes associated with Quebec’s health-care reform have resulted in the reorganization of nursing care, including a reduced number of supervisory positions, increased workload, disrupted team

dynamics, and disrupted work policies (Bourbonnais, Malenfant, Viens, Vézina, & Côté, 2000). The consequence of this reform was that diverse work cultures, professional training programs, and different work routines had to inadvertently coexist. All of these changes threatened the nurses' sense of belonging and professional identity, as manifested in their reluctance to work together and their general lack of enthusiasm for the profession (Baumann et al., 2001; Bourbonnais, Malenfant, Viens, Vézina, & Côté, 2000; Dicaire, Pelletier, Durand, Dubé, & Lepage, 1997).

The purpose of this study was to examine the processes by which nurses' mental health is weakened; the approach used was the psychodynamics of work, addressing the following question: *What is the subjective experience of work, in terms of pleasure and displeasure, for nurses employed in long-term-care units in the province of Quebec, Canada?* The study was intended to throw light on those elements of nursing practice, as it is currently structured, that are a source of collective pleasure or displeasure for nurses, by identifying the factors that do and do not have meaning for nurses and that therefore serve to either support or threaten their mental health. The chronic care setting was chosen since nursing research on stress and burnout has been concentrated in the acute-care sector while the number of studies in geriatric and chronic care settings has been modest (Dicaire et al., 1997). The Quebec government (Gouvernement du Québec, 2000) predicts that the enhanced life expectancy, the aging of the population, and the transformation of family life will result in a constantly rising need for nursing home and chronic care. It is thus reasonable to assume that a growing number of nurses will, for decades to come, find work in nursing homes and chronic care facilities. The present study on the experience of nurses working in long-term care is based partly on this conclusion.

### **Theoretical Framework**

The psychodynamics of work was developed in France in the 1970s by Christophe Dejours, a psychiatrist and specialist in workers' health. This approach was suitable for the present study as it permits a global analysis of the relationship between the organization of work and the mental health of workers. The psychodynamics of work refers to the organization of work as a source not only of pleasure or displeasure but also of defensive strategies as workers attempt to cope with the demands of their employment situation. This method fits with the global approach of the subjectivist paradigm. In order to analyze complex work relationships, it adopts an interdisciplinary approach to the work experience, one that draws from the sociology of work, health, and communication. It elicits the psychic charge of a nurse's work, a charge that is naturally subjective,

qualitative, and essentially defined by the significance of the work for the nurse. The elements of the psychic charge that are of interest in the psychodynamics of work are those that speak to workers as a group, even though individuals in the group may be affected to varying degrees.

Three theoretical premises (Vézina, 2000) clarify the psychodynamics of work and permit a better understanding of the dynamics between the subject, work, and society, the three forces that must be balanced if mental health is to be preserved. The first premise refers to the subject's desire to achieve. Each person has an instinctive desire for self-fulfilment; it is part of one's constant search for identity, a search that inspires and moves the person to contribute to the society or the community. The second premise refers to one's work, which always encompasses more than indicated in the written job description. Work that engages one's intelligence and creativity allows for a degree of autonomy and thus offers an opportunity for self-fulfilment and for the development of identity. The third premise is that the opinion or perception of others is essential to the development of one's identity. The formation of identity through work is based on the way people see each other, whether in terms of the group or in terms of belonging to a community. Recognition for one's work is a determining element in self-fulfilment and the development of a professional identity (Dessors, 1995). Thus, in terms of the psychodynamics of work, mental health is the result of a dynamic equilibrium between the person's desire to achieve, the social norms to which he or she must conform, and the work itself, with its requirements for productivity within a given framework (Vézina, 2000). Work is an activity that involves a triple bond: to the object of the activity, to the other people concerned, and to oneself. It is around these three dimensions (utilitarian, inter-subject, and intra-subject) that the meaning of the work for the individual who is doing it will be constructed (Vézina, 2000).

According to this psychodynamic approach to work, pleasure is a state of psychic well-being experienced when a person's work fulfils his or her desire for recognition, power, autonomy, achievement, and identity. Pleasure in one's work includes the experience of confidence, cooperation, solidarity, and sociability. The concept of psychic displeasure at work describes a state of boredom, monotony, fear, anxiety, anguish, disappointment, dissatisfaction, anger, and the absence of pleasure, cooperation, and solidarity (Dejours, 1987a).

The psychodynamics of work is a framework for action research. The goal of this approach is the appropriation of the study's conclusions by the participants themselves, as a means of transforming the work situation (Dejours, 1987b).

## **Method and Procedure**

### ***Method: The Psychodynamics of Work***

The chosen method of inquiry is based on a qualitative design that flows from hermeneutic philosophy. The qualitative approach allows for the emergence of the internal logic of the phenomenon under study; also, the global hermeneutic approach provides access to the real meaning, as constructed by the participant. For the psychodynamician, access to the meaning of work is gained through the words of the participants, which reflect their experience (Dejours, 1993b). This method calls for the participation of researchers from different disciplines (Dejours, 1993b), thus permitting the convergence of ideas as well as the complementarity of different disciplinary viewpoints, the basis for a large part of the heuristic capacity of the psychodynamics of work. For the present study, the researcher was joined by a health sociologist and a psychoanalyst.

With this method, data collection invariably comprises two steps. The first step is the pre-inquiry, which includes meetings with institutional administrators, explanations to the head nurses and staff nurses on the units chosen for the study, and non-participatory observation by the researcher. This observation is not intended to provide a detailed description of the observed dimensions; rather, it is meant to give the observer an understanding of the situation so that, during the interviews, the statements of the participants will be fully understood by the researcher. An observation guide indicated the main dimensions to be observed: the characteristics, environment, organization, constraints, context, and climate of the work; horizontal and vertical social relationships; physical, psychological, and socio-organizational risks; and the nurses' behaviour with regard to the risks.

The second step is the actual data collection, from the group interviews to the final research report. The interview method is based on a process of taping the conversation, interpreting the content, and, finally, discerning the meaning by comparing the interpretations of the interdisciplinary researchers with those of the participants. The purpose is to develop a common and shared understanding of the collective experience of work. An interview guide suggested by the frame of reference reminds the researcher of the dimensions to be discussed with the participants so that a global understanding of the work experience can be developed. The themes were as follows: the nature and specifics of the work; the sources of displeasure at work; the risks, fears, and anxieties at work; defensive strategies; enjoyment of work; support at work; and solutions suggested by the participants. The guide and the interview process were flexible, in order to ensure spontaneous comments from the nurses, thus revealing the meaning they gave to their work experience.

### ***Inclusion Criteria***

Since results are not to be generalized, this research method does not require a representative sample. The participants in the group interviews took part on a voluntary basis, thus ensuring authentic witnessing. In order to participate, the nurses had to meet the following inclusion criteria: be a nurse working days or evenings on a long-term-care unit; understand and speak French; agree to take part in a collective interview; and agree to forego any financial remuneration for participation. Since on the one hand employment implied a willingness to participate in research and on the other hand the study concerned collective experience, no inclusion criterion specified part-time or full-time employment, on-call or regular staff, or degree of seniority.

### ***Setting and Sample***

The study was carried out in a long-term-care institution in Greater Montreal, Quebec, Canada. A total of 33 nurses volunteered to be interviewed and made up nine groups, eight consisting of nurses on day duty and one consisting of nurses on evening duty. Night nurses did not participate because of the impracticalities of night-time interviewing. The participants had between 2 and 28 years' experience; a small number had worked in an acute-care setting and the majority had long-term-care experience in the institution chosen for the study. The great majority had a college diploma; almost all were married and had children. Nearly all were born in Quebec with French as their mother tongue. All but the oldest participants had been on-call nurses before joining the regular staff. The youngest participants worked part-time and also on call. A great many of the day nurses had previously worked evenings and nights. Most of the nurses who worked evenings had chosen that shift; their previous experience included day duty.

### ***Procedure***

For each group, the researcher conducted three 2-hour interviews — two to collect data and one to validate, with the participants, the interdisciplinary interpretations of the data. Audiotapes of the interviews were copied for the sociologist and the psychoanalyst. The researcher's content analysis and written interpretations were submitted to these two collaborators, who, after individually analyzing the tapes, confronted the researcher's subjectivity, thus prompting a rich exchange of ideas. The interpretations to which the majority gave consent were then returned to the nurse participants in preparation for the validation interview with them. After completion of the third interview with all nine groups, the researcher wrote the preliminary report, using material common to all

groups. This report was given to the nurse participants for their approval and comments, which were then incorporated into the final report.

## **Results**

### ***Responsibility versus Recognition, Autonomy, and Power***

The analysis and gradual clarification of the relationship between pleasure/displeasure and the organization of work resulted in the emergence of a "common feeling." This common feeling fell under three themes (recognition, autonomy, and power), which are summarized below.

In this particular chronic care setting, the principal source of displeasure appeared to be the nurses' perceived lack of professional recognition, autonomy, and decisional power (Alderson, 2001). The nurses perceived themselves as having more responsibility than recognition, autonomy, or power. While autonomy and power are closely linked, clinical studies have found differences between the two concepts. Autonomy refers to freedom of action within the limits set by the structure of the workplace. For example, when a nurse writes a nursing care plan, she is "autonomous" if she is free to carry out the plan in the sequence of her choice. The notion of power goes further, to include the dimensions of responsibility and accountability. To return to the same example, the nurse has real power if she not only has the freedom and the responsibility to prepare the care plan but also is accountable for the choices she has made. Power appealing to an individual's creativity and ingeniousness implies the freedom and ability to contribute to the institution's success in achieving its goals. Autonomy without power is a trap. The participants pointed out that the responsibilities they were expected to assume in primary nursing must necessarily be accompanied by professional autonomy and decisional power. In the absence of recognition, autonomy, and power, the nurses viewed their responsibilities not as a source of professional pride but as a source of anxiety.

### ***Lack of Recognition by Management, Other Professionals, and Peers***

The nurses' perception of a failure, on the part of management, to recognize their particular competencies reveals their conviction that nursing's contribution to the institution's reputation is not acknowledged: "We don't want them to say thank you; we want them merely to recognize that we are a part of the institution and that we contribute significantly to its excellent reputation." The recognition of nurses by other health professionals, including doctors, is scarcely greater: "The physicians are more likely to listen to others than to us"; "The goals of the other professionals take precedence over ours."

It was much the same with peers, especially among nurses on different shifts: “I wouldn’t say that solidarity among nurses is strong”; “If a nurse finds herself facing a serious problem, she is deserted by her colleagues.” The heavy workload and resultant lack of discussion were often blamed for the absence of group work and common goals: “There’s no time or place for nurses to talk to each other. As a result, it’s very difficult to act as a group.” The nurses therefore knew that they were partly responsible for their lack of enjoyment of work. In the absence of confidence, solidarity, and cohesiveness, they remained silent, lamenting the failure of any collective attempt at change.

### ***Lack of Managerial Support for the Search for Identity***

In their quest for professional identity, the nurses deplored the absence of managerial support and consideration for the nurses’ needs, the lack of any effort to improve working conditions, the lack of transparency with regard to reorganization of the workplace, and the lack of any real attempt to consult nurses or have them participate in decisions about their work: “I’d say that we are perhaps consulted, in that we can express ourselves at meetings and give our opinion about various things, but we’re rarely listened to, or even heard.” As an example of a recent lack of consultation, the nurses cited management’s decision to introduce a homelike atmosphere on the units, a change that would affect the nurses’ work: “They didn’t consult us. They simply informed us that the patients would now be able to have visitors 24 hours a day.” The nurses were also disillusioned with how the concept of primary nursing was understood, with management providing no explicit definition of the roles, responsibilities, and tasks of the various members of the nursing team: “We have four different categories of nursing personnel: orderlies, nursing assistants, diploma nurses, and baccalaureate nurses — but we all end up doing the same thing.” This resulted in role ambiguity, overlapping responsibilities, and conflicting interpersonal relationships. The nurses felt that their work was seen as insignificant and that their nursing skills were underestimated and underused: “My tasks are not those of a nurse; I feel undervalued.” They said they lacked a sense of professional achievement and complained about their interchangeability with less-qualified personnel: “I have the feeling that I’m using 50% of my nursing knowledge... that I’m working as an orderly”; “My frustration is linked to the fact that management keeps me from assuming the role for which I was prepared.” The nurses also said that the increased workload prevented them from enjoying the satisfying feeling that comes from work well done: “We carry out our nursing tasks without any sense of satisfaction, because we have to rush through them”; “Because of time constraints, we can’t perform those tasks that are specifically nursing — establishing a relation-

ship with patients and families, making nursing assessments, revising nursing care plans, writing monthly reports." These frustrations served to restrict the nurses' enjoyment of their work, remove meaning from their work, shake their sense of professional identity, and threaten their mental health.

### ***The Helping Relationship: A Protective Factor***

The findings demonstrate that nurses' burnout and mental health problems are caused not by their helping role, attachment to patients, or grief over the death of a patient, but, rather, the way in which their work is structured: "The real source of burnout is the way the work is organized"; "The relationship we have with patients motivates and sustains us; if we didn't have the opportunity to connect with the patients, I don't know how we could endure what we sometimes have to." Investment in the helping relationship with patients and families emerged as the strategy chosen by the nurses to compensate for the frustration, dissatisfaction, and displeasure they experienced. It was in the nurse-patient relationship that the nurses perceived their real role in long-term care; it was there that they found meaning in their work, a sense of professional self-esteem, and the recognition that they considered indispensable. The helping relationship was at the heart of the nurses' psychic balance; it opened the door to meaning and enjoyment at work.

In short, it might be said that the participants experienced displeasure because their desire for professional recognition, autonomy, and power in the discipline for which they were trained was not being fulfilled. They felt that their skills, knowledge, and abilities were underused, that their mental potential was not being recognized. The image projected by the work they did compromised their identity, self-esteem, and sense of worth. However, the participants were able to sublimate their frustrations to their helping and supportive relationship, which is founded on caring.

### ***Solutions Proposed by the Participants***

***Creation of a framework for discussion.*** For all participants, the primary solution was to create a framework for discussion with respect to their practice, to allow them to talk about their feelings, bringing about more favourable conditions for working collectively and regaining a degree of control over their work situation.

***Enhanced recognition.*** Among other solutions suggested by the nurses was that management acknowledge their important role in fulfilling the institution's mission and upholding its reputation, by organizing the work such that it supported their skills and expertise while keeping the workload at a level that allowed them to perform their tasks properly; according them more autonomy and power; embracing organizational

transparency; and instituting a bona fide consultation process regarding their work and the decisions that affected their practice.

**Reorganization of primary care.** Given that the provision of quality care was central to their enjoyment of work, the nurses wished to retain this dimension as well as its underlying conditions. They also wished to retain the primary care model, which they considered a guarantee of quality. However, they expressed a need for a redefinition of the roles, tasks, and responsibilities of various health-care workers, such that those tasks that are not specific to nursing be assigned to other employees and that all nursing-specific tasks be assigned to nurses. They recommended that nursing assistants meet at certain times during the day to perform those tasks that do not require the presence of a nurse. This organization would enable nurses to focus on nursing tasks, such as charting, preparing and administering drugs according to the medical prescription, conducting evaluations, and forming helpful and supportive relationships with patients and their families.

With regard to nursing staffing practices, the nurses saw the prevailing situation as threatening to compromise the quality of care. They expressed a desire for head nurses to listen more attentively to their needs, be more supportive, resolve problems and conflicts more appropriately and effectively, and reinforce their leadership both on the unit and within the institution. Many nurses said they favoured a return of the annual evaluation process, stating that without an official evaluation process their expertise and skills would never be officially or explicitly recognized.

## Discussion

### *Implications for Nursing*

The findings suggest that the subjective rationality of work (linked to nurses' sense of achievement) is frequently sacrificed to the objective rationality of work (linked to production). This state of affairs leads to a loss of meaning in nurses' work and mental health problems for those who do that work every day. Aiken et al. (2001) report that recent health-care restructuring in the United States, Germany, England, and Scotland, as well as in the province of Ontario, is based on the industrial model of growth and productivity rather than addressing the situation of practising nurses. The levels of dissatisfaction found by Aiken et al. (2001) are akin to the sources of displeasure brought to light in the present study; this dissatisfaction is related to organizational shortcomings such as lack of nursing staff, lack of participation in decision-making, lack of recognition for nurses' contribution to patient care, lack of control over work hours, and lack of managerial attention and action regarding nurses' con-

cerns and career perspectives. The conclusion of a literature review by Cummings (2003) is consistent with the findings of the present study, citing decreased work satisfaction and increased emotional exhaustion<sup>1</sup> as the two main effects of restructuring on the health and well-being of nurses. These effects are largely the result of heavy workloads, nurses' loss of control over their practice, and reduced quality and quantity of time spent with patients (Cummings, 2003). Kiesners and McGillis Hall (2005) also report that nurses have insufficient time to talk with their patients.

The results also show that a helping relationship with patients and families enables nurses to reinforce their identity and preserve their mental health. This is an important finding in terms of knowledge about the determinants of mental health. Indeed, the findings suggest that investing in the relationship with patients and families is a means of transforming workplace tensions into a source of enjoyment and identity development. Jackson (2005) also reports that emotional proximity with patients and their families, the opportunity to comfort them, and the ability to meet their needs are major sources of satisfaction for nurses. The ability to spend time with patients and their families and the opportunity to offer personalized care contribute to a sense of accomplishment among nurses (Jackson, 2005). The present findings clearly demonstrate the importance of the patient-nurse relationship and its positive effects on nurses. It is essential that management create working conditions that promote this relationship.

The present results suggest avenues for developing models, theories, and transactions to help harmonize both the organization of the workplace and nurses' health, ambitions, and desire for self-fulfilment. They support the development of an appreciation of nursing personnel as a resource to be valued rather than as an expense to be controlled (Koehoorn, Lowe, Rondeau, & Schellenberg, 2002). They confirm the unfavourable influence of economic logic on nursing care. Economic logic has the effect of modifying values so that productivity takes precedence over holistic nursing imbued with caring, the very heart of the professional ideal for nurses. The results show that if authorities really wish to resolve the problem of nurse absenteeism they will grant nurses recognition in the form of professional autonomy and real power over nursing care. Management must cultivate collegial rather than hierarchic relationships. Increased nurse participation at the decision-making level is strongly recommended. The organization of nurses' work should allow nurses to use their specific skills and competencies and thus to feel productive and fulfilled. Overall, the findings indicate that shared governance would allow for collective autonomy and participation in decision-

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<sup>1</sup>One of the components of professional burnout, according to Maslach (1976).

making while also addressing the need for job satisfaction. This view is expressed by Kelly and Joël (1995) and by Moloney (1992). Many authors have recommended that nurses be involved in the restructuring of services (Aiken, 2002; Aiken & Fagin, 1997; Blythe et al., 2001; Johnston, 1998; Norrish & Rundall, 2001; Rosengren, Engstrom, & Axelsson, 1999; Scholaski, Aiken, & Fagin, 1997; Wunderlich, Aloian, & Davis, 1996). The positive impact of participatory strategies is expressed in terms of job satisfaction and organizational efficacy (Kusserow, 1988; Murray & Leatt, 1992), autonomy, sense of responsibility, and identification with the work setting (Macy, Peterson, & Norton, 1989; Skelton-Green, 1996; Spector, 1986). Marmot and colleagues (Bosma et al., 1997; Bosma, Stansfeld, & Marmot, 1998; Kuper & Marmot, 2003; North, Syme, Feeney, Shipley, & Marmot, 1996) report that the benefits of a setting that allows nurses to control their own work include physical health and well-being as well as decreased absenteeism and increased productivity. The American literature also discusses constructive work settings, called magnet hospitals, which represent the “gold standard” in nursing care. Nurses who work in these hospitals have lower rates of burnout (Aiken, Clarke, & Sloane, 2000; Aiken & Patrician, 2000; Aiken & Sloane, 1997a). Two of the organizational characteristics common to these settings are a decentralized structure and participatory management (Buchan, 1997, 1999; Kramer and Schmalenberg, 1991b), enabling nurses to make use of their entire skill set (Aiken, 1995). Professional autonomy is identified as one of the chief elements in clinical professional practice at magnet hospitals (Aiken, 1998; Aiken, Sloane, & Lake, 1997; Aiken, Smith, & Lake, 1994; Buchan, 1994; Chalfant, 1998; Kramer & Hafner, 1989; Kramer & Schmalenberg, 1991a). Professional autonomy is characterized as both the ability to make decisions on all clinical aspects of the nursing profession and organizational autonomy (planning and managing hospital operations) (Aiken, 1995). The freedom to make decisions positively influences the satisfaction of nurses (Kramer & Schmalenberg, 1991a) and serves to reduce burnout (Aiken & Sloane, 1997a), while also improving the quality of care (Aiken et al., 1994) and patient satisfaction (Aiken & Sloane, 1997b).

It is equally important that management provide opportunities for nurses to meet as a group to discuss their work; social exchange is the cement that holds a team together (Baumann et al., 2001). Also critical are administrative mechanisms promoting stability of the nursing team, the basis for effective group action.

Finally, the results of this study will alert health-care managers to the negative consequences of requiring several different categories of personnel to carry out similar tasks.

### ***Contribution to Our Understanding of the Phenomenon***

The originality of this study lies in its examination of nurses' work from the point of view of a paradigm, from an approach and a methodology that are different from those traditionally used in nursing research in the area of mental health in the workplace.

The results show that on-site research in the work setting, which is the basis for the psychodynamic approach to work and which originates in the actual experience of work, throws light on those phenomena that are of special interest to the nursing profession. The psychodynamic approach to work is very useful in those areas to which nursing decision-makers give priority: administration of nursing personnel, organization of nursing services, assessment of nursing interventions, and organization of intra- and interdisciplinary work. Because they concentrate on everyday work situations, studies using the psychodynamic approach obtain, from the participants themselves, viable solutions to workplace problems. The results of such research provide data that managers can use in their decision-making. In addition, the psychodynamic approach leads directly to the formulation of policies concerning nursing practice and the administration of nursing services.

During the interviews, the participants said how good it felt to talk with and listen to their colleagues. Through the act of "venting" and sharing their negative work experiences, many of the nurses discovered that they were not alone in what they were going through. This brought out feelings of empathy and solidarity, leading several participants to state that they would support each other from that point on. These results corroborate Trudel's (2000) conclusion that people really need to talk about what they experience at work.

### ***Limitations of the Study and of the Psychodynamic Approach***

One limitation of the study was the imposition, by the institution, of time constraints on the nurse participants. Another was the small size of the sample — three or four nurses per group, except for the evening group, with six nurses — thus limiting the opportunities for conversation among the participants. Because the interviews took place during working hours, some nurses were obliged to remain on the unit in order to ensure the availability of services.

Inherent in the psychodynamics of work is the impossibility of generalizing and reproducing the results. The approach allows for the transfer of conclusions from one setting to another on the condition that the workers in the recipient setting recognize themselves in the results and appropriate the results.

The psychodynamics of work does not always lead to immediate and rapid organizational change (Trudel, 2000). Concrete improvements may be spread out over time, depending not only on the determination of workers to bring about change but also on management's willingness and ability to let the workers reconcile their needs and ambitions with their work; the after-effects of a psychodynamic study depend on the quality of the social dialogue within the institution and on the degree of confidence that exists among all concerned (Vézina, 2000).

### ***Implications for the Future***

Nursing as a discipline and nursing as practice evolve within historico-political events and are part of the social movement of the society; they develop according to the rhythm of those great currents of thinking that lead to the evolution of knowledge (K  rouac, Pepin, Ducharme, Duquette, & Major, 2003). In this spirit, it is appropriate to consider nurses' work as a social construction intimately linked to the socio-historical process of the moment (Billiard, 1993), such as the supremacy of the economic logic underlying the reform of health and social services. According to Carpentier-Roy (2001), social finality has a place alongside economic finality. We must rethink nursing practice so that it will be experienced by nurses as an opportunity for personal growth as well as serving society.

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