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Conflict Management Styles Used By Nurses in Jordan

Zaid Al Hamdan, Peter Norrie and Denis Anthony

Aim. The aim of this study is to investigate the conflict management styles used by nurse managers in Jordan.

Background. There are five main styles which nurse managers use to deal with conflict. At present research into their utilisation is dominated by reports from Western countries. This research is the second to investigate their use by nurses in an Arab country and it illustrates both similarities and differences with this earlier work, allowing an initial profile to be constructed which may be applicable to the larger Arab world of health care.

Design. Cross sectional quantitative survey of nurse managers in Jordan.

Method. The Rahim Organisation Conflict Inventory (ROCI II) questionnaire was completed by 350 (83% response).

Results: The nurse managers were most likely to use an integrating style of conflict management, followed in rank order by comprising, obliging, dominating and avoiding.

Conclusion: A tentative model of the styles which nurse managers in Arab countries use to manage conflict is proposed, which suggests that these managers are likely to provide stable workplaces.

Key words: conflict management, nurses organisational behaviour, Jordan, Arab countries

Accepted for publication:

Introduction

Conflict is inevitable in everyday social, organisational, and professional nursing life (Al-Hamdan, Shukri et al. 2011). Conflict is a manifest condition of the nature and content of nurses' work, and according to Vivar (2006) it remains a very important subject in health care environments throughout the world. Researchers have argued that conflicts in the agency are expected, because organizations naturally consist of

human interaction, interdependence, and various levels of hierarchy (Bell and Song 2005). Conflict can be interpersonal, intra-personal, intra-group and intergroup (De Dreu and Van De Vliert 1997) such as physician-nurse, nurse-patient, nurse-nurse, and nurse-other health care professional. According to Kantek and Kavla (2007) the most important sources of conflict in nursing environments are the differences in management styles, the perceptions of employees, personnel inadequacies, and goal differences and competition between workgroups.

While conflict within the nursing profession has traditionally been reported as generating negative emotions (Jacinta 2006), conflict can also have positive effects such as the creation of new policy, increased competition and the improvement of the quality of nursing care; assuming that the conflict can be managed productively. Similarly, conflict can also be valuable to an organization since it promotes innovative and creative problem solving, clarifies issues, and allows underlying problems to rise to the surface; again assuming it can be managed effectively (Jamson 1999; Kunaviktikul, Nuntasupawat et al. 2000; Rahim 2000; Rahim 2001; Rahim 2002). Bousari et al (2009) go further and identify that conflict can help nurses achieve their goals, for example the attainment of better working conditions. As a positive force, conflict can help maintain an optimum level of stimulation and activation among organizational members, and properly managed conflict can facilitate organizational growth (Valentine 1995).

The majority of conflict management studies focus on investigation of samples of nurses from western cultures. Since conflict is a culturally defined incident (Hocker and Wilmot 1991), the management of conflict is likely to change from culture to culture. International studies of conflict management employing samples of nurses from non-western cultures are thus necessary in order to provide useful insight on conflict management for the globalized working environment. Within Arab countries only one study has been published which explores conflict management styles used by nurse managers in Arab countries, specifically in the Sultanate of Oman (Al-Hamdan, Shukri et al. 2011). This research aims to contribute to this by replicating this study in Jordan and comparing and contrasting findings, to produce an initial profile which may have larger currency throughout the wider Arab world of health care.

Literature Review

While conflict is conceptualized differently depending on the situation in which it happened, it is composed of consistent major components such as expressed struggle, interdependence, perceived incompatibility of goals, perceived scarce rewards, and interference (Domenici and Littlejohn 2001). In this context conflict is defined as an expressed struggle between two or more interdependent parties perceiving incompatible goals, scarce resources, and interference from others in achieving their goals (Hocker and Wilmot 2001). Furthermore, conflict management styles refer to the individual's characteristic modes of managing disputes in various interaction episodes (Ting-Toomey, Yee-Jung et al. 2000).

Managing conflict well is one of the challenges nurses frequently face. All nurses, regardless of their position, must effectively manage conflict in order to provide an environment that stimulates personal growth and ensures quality patient care (Forte 1997). Rahim (1986) pointed out that effective conflict management promotes motivation, improves morale and supports personal and organizational growth. Tjosvold et al. (2006) declared that managers and employees can use conflict to solve problems, advance their effectiveness and strengthen their relationships. Ineffective conflict management, in contrast, creates more conflict and negatively affects the organization as a whole. People react to and cope with conflict in a variety of ways, Adler and Towne (1990), for example, recognized three potential acts when dealing with a conflict and three styles of outcomes resulting from these approaches: accepting the current position, using force and mandating, and reaching an agreement by negotiating. By contrast Morrison (1998) suggested that people will react to possible conflict in one of four main ways: fight, flight, freeze and assertiveness. However, most studies report that people will react to conflict in one of five styles of conflict management in a two-dimensional framework (figure one) (Blake and Mouton 1964; Thomas and Kilmann 1974; Rahim 1983) Skjorshammer 2001; Cheung and Chuah 1999).

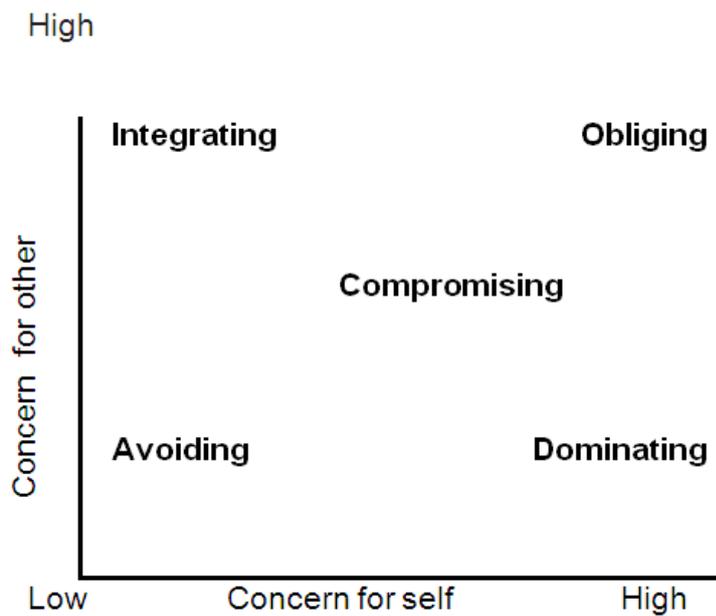


Figure 1: A two dimensional model of conflict management styles (Rahim 1985)

In the following summary, synonyms used by different authors are given in brackets, but the main categories employed by Rahim (1983) will be used:

Avoidance (denial, withdrawal): individuals simply pretend that the conflict does not really exist, and hope that it will go away.

Obliging (accommodating): Individuals emphasize the common points, and de-emphasize or even suppress any differences in viewpoints among themselves.

Compromising: Individuals try to solve the conflict cooperatively.

Dominating (forcing, competing): Individuals use the conflict to promote their goals at the expense of others.

Integrating (collaborating): Individuals directly confront conflict with a favourable attitude, which encourages solving the problem at hand and generating the best possible solution.

Previous studies in Arab Countries

Al Hamdan et al (2011) used the Rahim Organisation Conflict Inventory II (ROCI II) in Oman to explore conflict management styles amongst 275 nursing managers.

They found that, in descending order, preference of styles using median values was for: integrative, compromising, obliging, dominating and avoiding. They also found that some demographic characteristics were statistically significant in terms of chosen conflict management styles. These included nationality, for which Omanis and Jordanians had a slight preference for a dominating style, in comparison with Indians and Pilipinos. Those with a bachelor degree were less likely to be dominating, and those with bachelor and masters degrees scored lower for obliging. Working at higher levels of management tended to result in higher integrating styles, and lower obliging ones. In terms of gender, men were more likely to use a compromising style than women, but no other significant difference was found.

The study

This study was designed to explore the conflict management styles used by Jordanian nurses, and the relationship of the style to some demographic variables, such as, age, gender and educational level. The theoretical framework of this study is based on Rahim's model of conflict management. As with Al Hamdan et al (2011), it used Rahim's (1983) Organisation Conflict Inventory II (ROCI II).

The following specific questions were addressed to be answered in the study

- What are the conflict management styles used by nurses in Jordan?
- Is there a difference in conflict management style used with regard to nurses age, educational level, managerial position, years of experience, and years of experience as nurse manager

Design

Cross-sectional survey of nurse managers in Jordan.

Sample

Questionnaires were administered to 420 nurse managers in three hospitals in Amman, these are government, private and teaching in nature. Three hundred and fifty completed the questionnaire (83% response rate).

Data collection instrument

The Rahim Organization Conflict Inventory II (ROCI II) was used. The five subscales of conflict style have been tested for retest reliability and internal consistency and found to be both reliable and valid (Rahim 2004). ROCI-II has also been tested for build, convergent, and distinguishable validity and been found to be valid (Rahim 2000). It consists of a series of items with a 5-point Likert scale that reflect conflict management styles. The five conflict management styles reflect different combinations of "concern for self" and "concern for others" (dual-concern model). Demographic variables included information about the hospital type, age, educational status, total years of employment, and years of employment as a manager.

Ethical approval

This research was approved by both the Applied Science University of Ethics Committee and the ethical committee in each hospital.

Data collection

The staff development department within the hospitals distributed questionnaires to the nurse managers which were collected within four to eight weeks from the staff development department. The data were collected from June to September, 2010.

Descriptive findings

Demographic data are shown in table 1.

Table 1: Demographic data

	Frequency	Percentage
Gender		
Female	247	70.6
Male	103	29.4
Age band		

25 years or fewer	150	42.9
26-34 years	116	33.1
35-44 years	77	22.0
45-54 years	6	1.7
Nationality		
Jordanian	342	97.7
Other	8	2.3
Nurse Education		
General nursing diploma	53	15.1
Bachelor of science in nursing	283	80.9
Masters degree in nursing	14	4
Type of hospital		
Government	94	26.9
Teaching	149	42.6
Private	107	30.6
Current post		
Staff nurse	292	83.4
Head nurse	25	7.1
Hospital supervisor	20	5.7
Assistant head of nursing	11	3.1
Head of nursing	2	0.6
Years of experience		

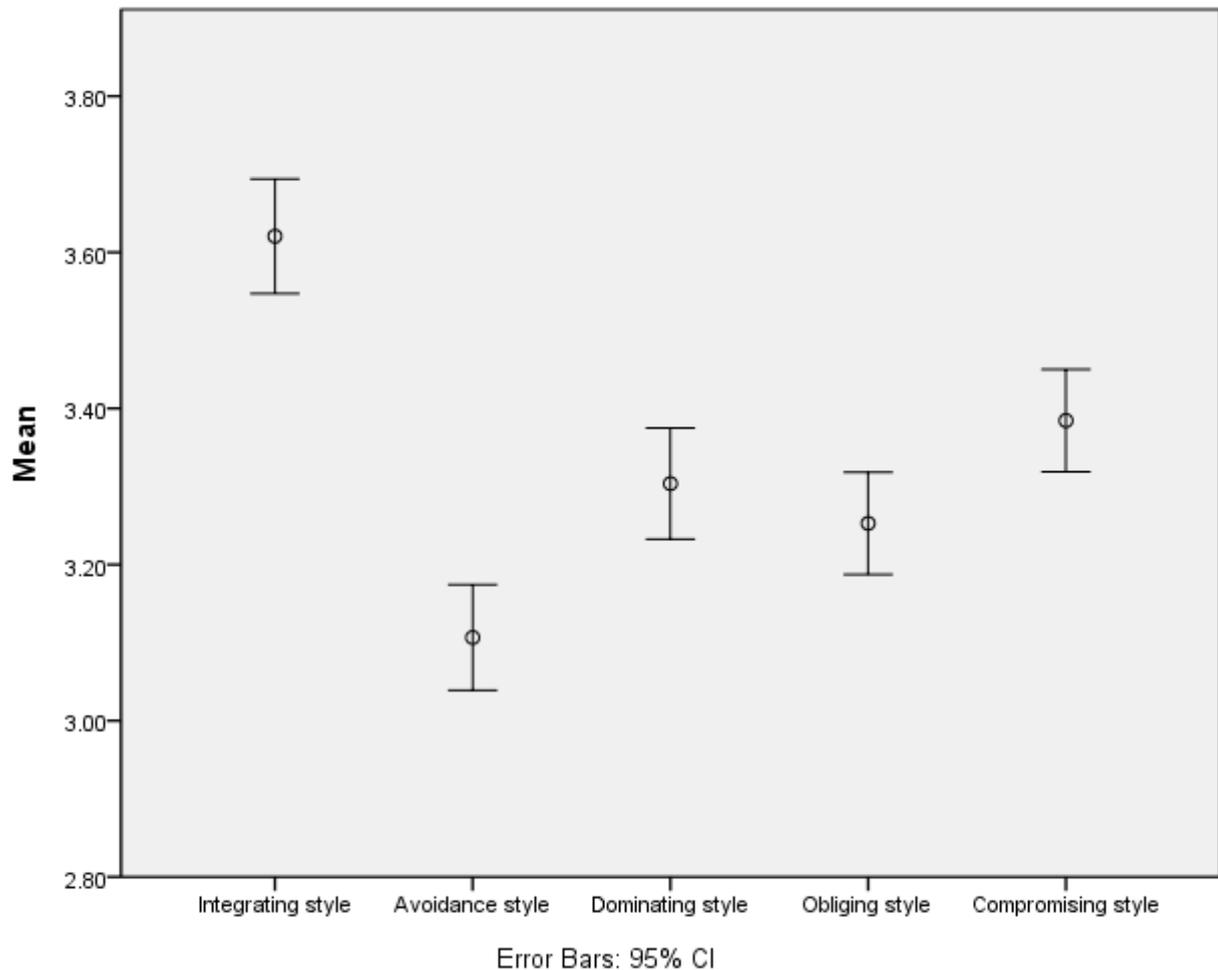
5 years or fewer	192	55.2
6-10 years	68	19.5
11-15 years	41	11.8
16-20 years	35	10.1
21 years or more	12	3.4

Table 2 gives the descriptive statistics for the five categories of conflict management style.

Table 2: Descriptive statistics for the five categories of conflict management style

Conflict management style	Integration	Avoidance	Dominating	Obliging	Compromising
Mean	3.62	3.11	3.30	3.25	3.38
Median	3.67	3.16	3.32	3.25	3.38
Standard deviation	0.70	0.64	0.68	0.62	0.62

Figure 2: Error bars illustrating the distribution of the means for the five categories of conflict management style:



Inferential Analyses

Data analysis used parametric techniques as inspection of histograms for the five management style variables showed approximately normal distributions, all means fitted within the predicted 95% confidence limits, comparison between means and trimmed means gave a maximum value of 1% difference for all five categories of conflict management style. A reliability analysis of the summated five sets of management style data using Cronbach's Alpha, gave a value of 0.784. This was further explored by both a rotated and an un-rotated exploratory factor analysis which confirmed that there were no identifiable subsets within the five different management styles.

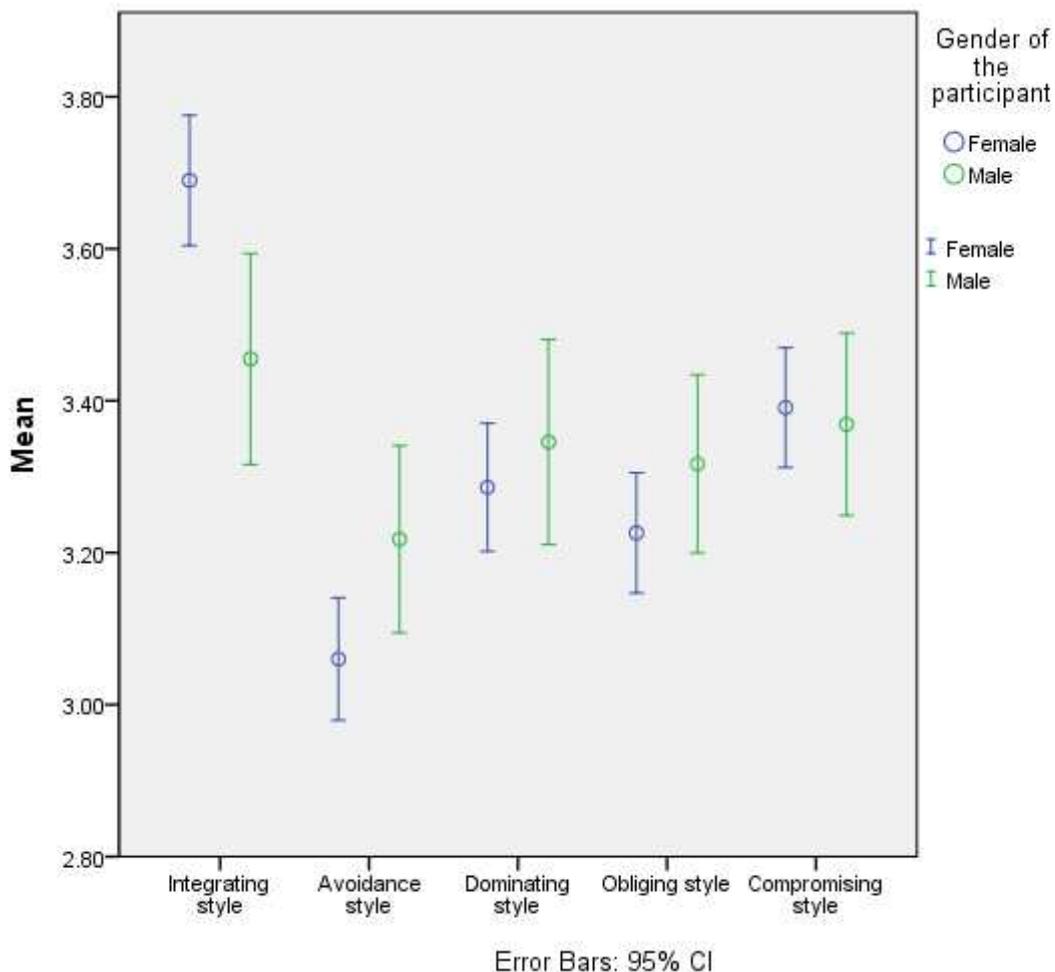
Inferential statistics were used to explore relationships between demographic variables and conflict management styles. Appropriate charts will be used to explore statistically significant relationships only.

Gender

T testing showed that there were statistically significant differences for two of the conflict management styles, according to gender; Integrating ($p= 0.005$) and Avoidance ($p= 0.039$). Referral to figure 3 shows that females gave higher scores for Integrating than males (means= 3.69 and 3.45 respectively), and lower scores for Avoidance than males (means= 3.06 and 3.45 respectively).

The other three styles were not statistically significant for gender; Dominance ($p=0.477$), Obligation ($p=0.222$) and Compromise ($p= 0.747$).

Figure 3: Scores for management of conflict styles according to gender



Age

Spearman's correlation co-efficient was used to explore the relationship between conflict management styles and the respondents' age band. No statistically significant relationship was found for any of the variables; Integrating ($p=0.751$), Avoidance ($p=0.884$), Dominating ($p=0.245$), Obliging ($p=0.433$) and Compromising ($p=0.558$).

Nationality

T testing showed that there were no statistically significant differences for conflict management styles, according to nationality; Integrating ($p= 0.322$), Avoidance ($p= 0.184$), Dominance ($p=0.826$), Obligation ($p=0.542$) and Compromise ($p= 0.244$).

Formal nursing education

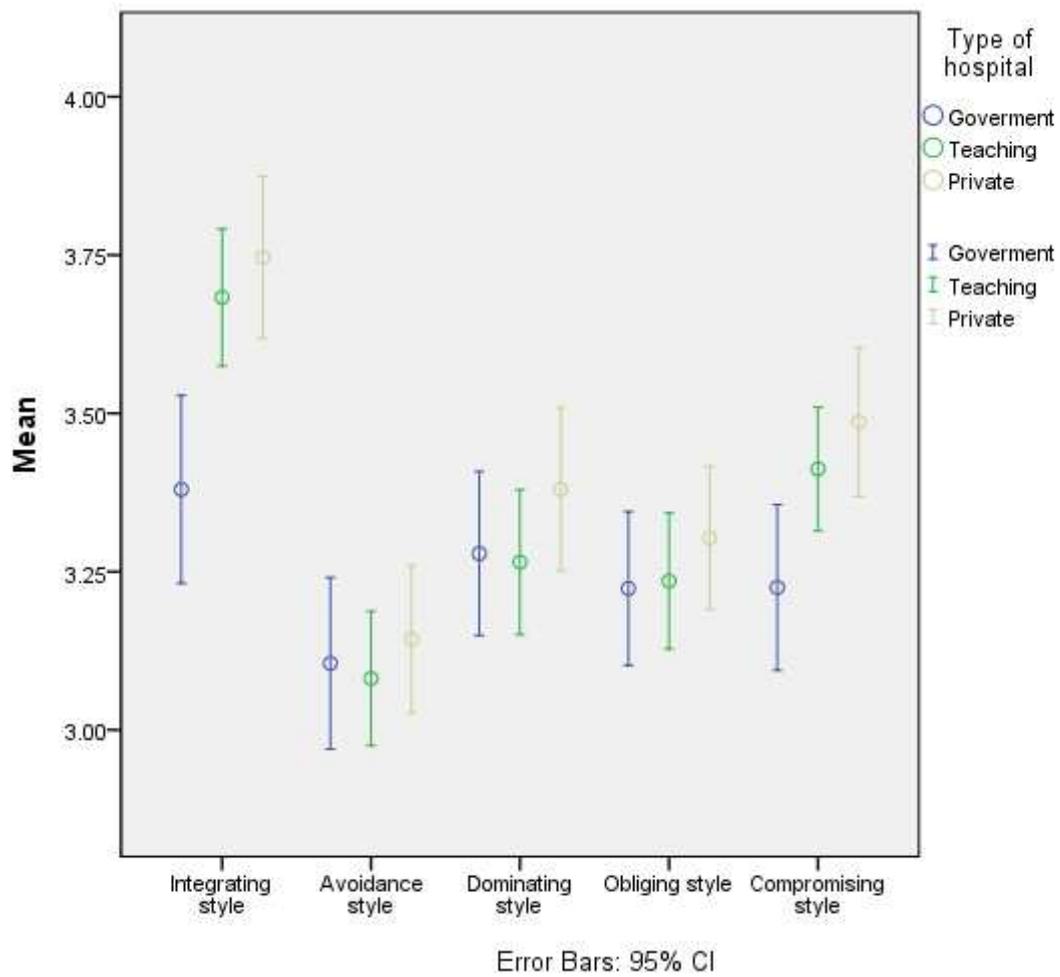
One way ANOVA omnibus testing showed that there were no statistically significant differences for any of the conflict management styles, according to formal nursing education; Integrating ($p= 0.764$), Avoidance ($p= 0.195$), Dominating ($p= 0.458$), Obliging ($p= 0.129$) and Compromising ($p=0.210$)

Type of hospital

One way ANOVA omnibus tests showed that there were statistically significant differences for two of the conflict management styles: Integrating ($p= <0.001$) and Compromising ($p=0.008$). For Integrating, post hoc testing using Sheffe's technique showed that the Government hospitals were significantly different from both Teaching and Private hospitals ($p= 0.004$ and 0.001 respectively). Mean values were respectively 3.38, 3.68 and 3.74. There were no significant differences between the latter two types of hospital ($p= 0.766$).

For Compromising, post hoc testing using Scheffe's technique again showed that the Government hospitals were significantly different from Private hospitals ($p=0.004$), but not Teaching hospitals ($p= 0.071$). However, there were no significant differences between the latter two types of hospital ($p= 0.615$). Mean values were respectively 3.22, 3.41 and 3.48.

Figure 4: Type of Hospital



Current post

One way ANOVA omnibus testing showed that there were no statistically significant differences for any of the conflict management styles, according to status of current post; Integrating ($p= 0.578$), Avoidance ($p= 0.431$), Dominating ($p= 0.877$), Obliging ($p= 0.583$) and Compromising ($p=0.096$).

Years of experience

Spearman's correlation co-efficient was used to explore the relationship between conflict management styles and years of nursing experience. No statistically significant relationship was found for any of the variables; Integrating ($p=0.564$), Avoidance ($p=0.856$), Dominating ($p=0.655$), Obliging ($p=0.212$) and Compromising ($p=0.414$).

Regression analysis

Replicating the methods of Hamdan et al 2011, stepwise multiple regression was used. Each of the management styles was used as a dependent variable. Most of the data could be included as ordinal variables, e.g. seniority, and years of experience, but the three different types of hospital were re-coded into dummy variables.

Integrative style: Two variables, employment in a Government Hospital ($p= 0.002$) and Gender ($p= 0.032$) were kept in the regression model, which had an R^2 value of 0.040. These showed that if the employee worked in a government hospital they were less likely to use an integrative style ($B= -0.262$) than those in other hospitals, and if they were female they were more likely to use an integrative style ($B= 0.177$) than men. A low value for Variable Inflation Factor (1.080) shows that multicollinearity was not present.

Avoidance style: One variable, Gender ($p= 0.041$) was kept in the regression model, which had an R^2 value of 0.012. This showed that men were more likely to use an avoidance style than women.

Domination and Obliging styles: No variables were kept in the equation.

Compromising style: One variable, employment in a Government Hospital ($p=0.004$) was kept in the regression model, which had an R^2 value of 0.024. This showed that if the employee worked in a government hospital they were less likely to use a compromising style ($B= -0.217$) than those in other hospitals.

Discussion

Demographic variables affected three of the styles only. Females were more likely to utilise an integrative style than men, but men were more likely to use avoidance. The type of hospital had some effect. Staff in Government hospitals were less likely to use an integrating or compromising style than those working in public or teaching sites. Although statistically significant, these effects are small. Gender and employment account for only 4% of the variance when predicting the use of an integrative style, and gender accounted for only 1.2% of the variance when predicting the use of an avoidance style. The affect of employment place and use of a compromising style was similarly 2.4%. Although statistically significant, these are unlikely to be clinically important as tools to predict behaviours.

The range of scores for the five styles are likely to be more important. The sample in this study were most likely to show an integrating style in their approach to conflict, and were least likely to use an avoiding one, with compromising, obliging and dominating falling in between (table 2 and figure 2). This has both similarities and differences with Al Hamdam's (2011) study undertaken in Oman (table 3).

Table 3 Comparison with Al Hamdam et al 2011

Rank	Conflict management style	
	Current study	Al Hamdam et al 2011
1	Integrating	Integrating
2	Compromising	Compromising
3	Obliging	Dominating
4	Dominating	Obliging

5	Avoiding	Avoiding
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The similarities are striking, showing that ranks one, two and five were taken by integrating, compromising and avoiding styles in both studies. The differences were between ranks three and four; with this study they were occupied by obliging and dominating respectively, with this reversed in the earlier study.

Thus a partial theoretical pattern can be proposed exploring conflict management styles in Arab countries, with the main poles identified. An integrating- compromising style shows both high to medium concern for self and also high to medium concern for others (figure 1). The least preferred management style, which is avoiding, shows the exact opposite of low concern for self and others. Avoiding simply refuses to address the conflict. Between the most preferred and least preferred were styles that showed low concern for one party and high for the other. Thus the rank preference is from high concern for both parties through medium concern for both, to low concern for one party and finally low concern for both, and this is the tentative model proposed to predict nurse managers' conflict management strategies in Arab countries.

While Rahim (Rahim 1986) suggests that all styles of conflict management are appropriate in one situation or another, integrating is considered one of the more effective ways of handling conflict to achieve long-term benefit (Thomas 1976; Marriner 1982; Rahim 1986; Marriner 1995). Thus the conflict management style shown in Jordan would appear to be compatible with good management and likely to result in, amongst other beneficial effects, good retention of staff.

We thought there might have been differences in Jordanians working in Jordan compared to Jordanians working in Oman. However any differences are minimal, and the picture is very similar in both countries. This could be explained by Oman and Jordan sharing some common cultural constructs, for example both being Arab countries, both mostly Muslim, both used to authoritative leadership and having a hereditary head of state, *inter alia*. However whatever the reasons, the consequence is probably stable nursing management in these countries, regardless of the nationality of the manager.

Limitations

This study has largely supported the earlier findings of Al Hamdan (2011), but the Arab world is large and thus far only two countries have been sampled. The earlier Omani study showed differences between managers from different nationalities, but the more homogenous and indigenously dominated sample from Jordan did not allow exploration of this. A study in an Arab environment with a more heterogeneous sample, for example in the Kingdom of Saudi Arabia, would go a considerable way to confirming or denying these emerging theoretical insights regarding Arab nurse managers' conflict management styles.

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