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Stress in nurse managers

PETER HINGLEY
CARY L COOPER
PHIL HARRIS

King Edward's Hospital Fund for London is an independent charity founded in 1897 and incorporated by Act of Parliament. It seeks to encourage good practice and innovation in health care through research, experiment and direct grants.

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STRESS IN NURSE MANAGERS

by Peter Hingley, Cary L Cooper and Phil Harris

King's Fund Centre

Nurses (Stress)

Mr Pavitt asked the Secretary of State for Social Services if he will institute a departmental inquiry into the prevalence and causes of stress among nurses.

Mr Kenneth Clarke: No. We do not consider that there is evidence which indicates that such an inquiry is justified. I am aware that the results of a survey by the *Nursing Mirror* purport to demonstrate that a majority of nurses suffer high levels of stress. However, I understand that the survey represents the views of a self-selected sample of only 1,000 nursing staff (out of a total nursing staff of 400,000 in England) who completed a questionnaire published in the *Nursing Mirror* at a time when we were awaiting the review bodies' recommendations on their pay. We cannot therefore accept that this is a representative and objective national picture.

Nursing is a demanding and sometimes stressful job, but nurses are trained to meet those demands. We have demonstrated the respect and high regard in which we hold the profession by our decisions on their pay and training. Between April 1979 and February 1986 nurses' basic pay rates will have risen on average by 111 per cent., which is over 30 per cent ahead of the forecast rise in prices over the same period. We have reduced their working week without loss of pay from 40 to 37½ hours. Between September 1979 and September 1984 an extra 39,500 whole-time equivalents have been employed in England.

We have also set up the United Kingdom Central Council for Nursing, Midwifery and Health Visiting and the four national boards so that the nursing profession could become largely self-governing in determining future patterns of education and training. All these statutory bodies are collaborating on proposals for change. The English national board has already produced draft proposals. We have encouraged the board to consult the profession, and are ourselves consulting health authorities on these proposals which will reduce the ward responsibilities of student nurses and give them more theoretical work in their first two years of training. This is aimed, in part, at reducing the stress amongst beginners exposed too early to heavy responsibilities as well as improving the quality of service given to patients.

Hansard, 16 July 1985

Foreword

It was the best of times, it was the worst of times. . .

Charles Dickens, *A Tale of Two Cities*

Few would dispute the notion that stress permeates our society and has a profound effect on daily work. We live in an age of fast change, uncertainty, technocracy and seemingly ever-increasing demands.

Recent changes in the administrative structure of the NHS seem to have been accompanied by a more marked degree of stress-related behaviour; but little attempt has been made to identify it or, more particularly, to suggest ways in which health authorities might effectively respond to the situation.

There has been specific concern about nurses and in 1983 the King's Fund awarded a grant to Professor C L Cooper, University of Manchester Institute of Science and Technology and Peter Hingley, Principal Lecturer, Bristol Polytechnic, to investigate the job-related problems of nurse managers, at ward sister level and above, in the belief that at the moment we can only guess at the factors which create stress and that it is important to identify some of the sources in order to develop ways to minimise or relieve the pressures. Unlike the situation in some other countries, particularly the USA, where stress in nursing has long been well researched, little has been done in Britain to respond to the problem. Consequently, our knowledge of the causes and results of occupational stress are minimal and our ability to alleviate the situation is seriously limited by lack of information.

This study is the direct response to a problem identified by the staff of the occupational health department and the district nursing officer of a large health authority. They noted that recent changes in the administrative structure were accompanied by a high incidence of stress in nurses and wanted this examined so that they might be able to consider effective ways of dealing with it.

It is clearly an important landmark and a second stage is being planned which will focus on the refinement of a job stress instrument generalisable as a construct in nursing. As much importance should be given to this subject as to the education of nurses and, indeed, it should be an integral part of it. Giving adequate priority to the matter is one of the best ways to secure better health care for all – staff and patients alike.

Hazel O Allen
Associate Director
King's Fund Centre

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Introduction

The study

Research into occupational stress has developed considerably over the past decade and there is now a growing body of evidence relating both physical and mental well-being to work pressures (Cooper, 1983).

The field is particularly well developed in the United States where the problem has long been recognised and stress in the 'caring professions' has been the subject of considerable concern. This has led to a number of in-depth studies and a variety of responses aimed at alleviating the situation (for example, Maslach, 1982; Lachman, 1983).

Interest in occupational stress is growing rapidly in this country and there have been a number of studies of specific occupations (Cooper and Marshall, 1980). However, there is a dearth of empirical evidence concerning stress within the nursing profession; the limited research that exists has focused almost exclusively upon the student nurse in the hospital setting (Birch, 1979; Parkes, 1980a and b).

Yet some studies have suggested that occupational stress could be an important factor in determining morbidity and levels of absence and wastage amongst nurses.

Evidence from government statistics reveals that nurses have cause for real concern. It appears that their average life-expectancy is comparatively low while rates of suicide and suicide-related causes of death are outstandingly high (OPCS, 1978).

Furthermore, there are suggestions that high levels of absence and wastage in nursing could be stress-related. These are costly to the service and to the individual, and ultimately will reflect upon the quality of patient care (Lunn, 1975: Clark. 1975: Clark and Redfern, 1978).

This project is a response to this lack of research, particularly among qualified staff. Its main aim is to identify the sources of occupational stress experienced by 'nurse managers'.

The term 'nurse manager' is used to refer to nurses having a managerial responsibility. In practice this included all nursing grades, from sister/charge nurse level to chief nursing officer, working in the community and in the hospital setting.

The report

Before occupational stress can be successfully alleviated or managed it must be

carefully located and identified. Consequently we see our research as the first stage in a problem-solving process in which data collection and analysis provide the diagnostic evidence on which to base subsequent action.

This problem-solving approach to stress management can be represented as the four stages shown in Figure 1.

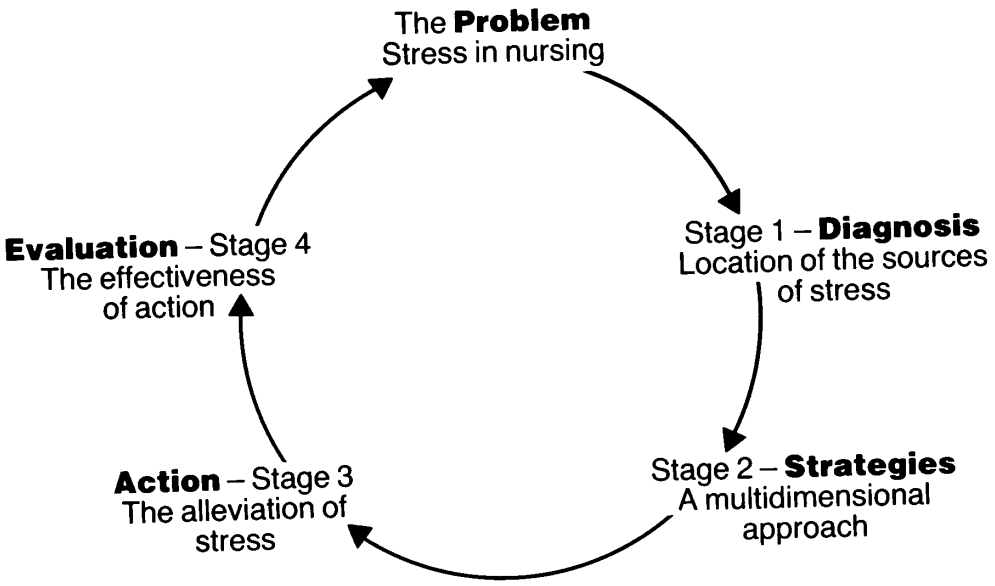

Figure 1 A problem-solving cycle

In essence this report represents the diagnostic step in this process and presents the initial findings of the study by addressing itself to two main questions:

1 What are the main sources of stress in nursing?

General sources of stress in the day-to-day work of 'nurse managers' are identified and discussed in detail.

Nine underlying sources of stress are located. The three most important sources revolve around the areas of:

i workload;
ii relationships with superiors;
iii the role of the 'nurse manager'.

2 Are nurses satisfied with their jobs?

The responses to measures of job satisfaction are presented and discussed and the relationship between occupational stress and job satisfaction is examined.

In the final part of the report we return to these questions, briefly discussing the major implications and outlining the future course of the project.

The views represented in the report are the personal responsibility of the authors.

Note: Throughout the report we refer to the nurse as 'she' because the large majority of our sample were women. We apologise to our out-numbered male nurse colleagues!

Stress in nurse managers – the project

Purpose

A primary aim of the project was to locate the sources of stress in the day-to-day work of the 'nurse manager'.

Method

The main survey took place in a health authority in the south west of England. The aims of the project were set out in a newsletter which was sent to all nursing personnel in the authority. In addition over 15 open meetings were held throughout the area to provide further details and answer questions about the project.

Approximately 650 questionnaires were distributed to all staff, from sister/charge nurse level to district nursing officer. A total of 521 questionnaires were returned, an 80 per cent response rate. Six of these were incomplete and the remaining 515 questionnaires were analysed for this report.

This data was augmented by material gathered from a number of meetings with groups and interviews with individuals from area health authorities across the country.

Data collection

The present report is largely based on information drawn from the first two sections of the questionnaire (see Appendix A).

Section 1 of the questionnaire explored personal and job details; for example sex, age, marital status, working environment, nursing grade, and so on. Section 2 was concerned with sources of pressure at work (potential stressors).

The pool of items included in this section was generated from earlier studies of nursing staff in other health authorities. A variety of methods was used to obtain this information; for example, stress diaries, brainstorming sessions, taped interviews, direct observation, and so on. This was supplemented by information from existing research findings.

The resulting instrument – the job stress questionnaire – was reviewed by a panel of 'experts' for clarity of wording and face validity, yielding the final format consisting of 71 items.

Sections 3 and 4 of the questionnaire were concerned with 'coping behaviour' and individual differences. These will be analysed at a later stage of the project.

Data analysis

This consisted of 4 stages:

1 The data obtained from the completed questionnaires was translated into numerical form for computation.

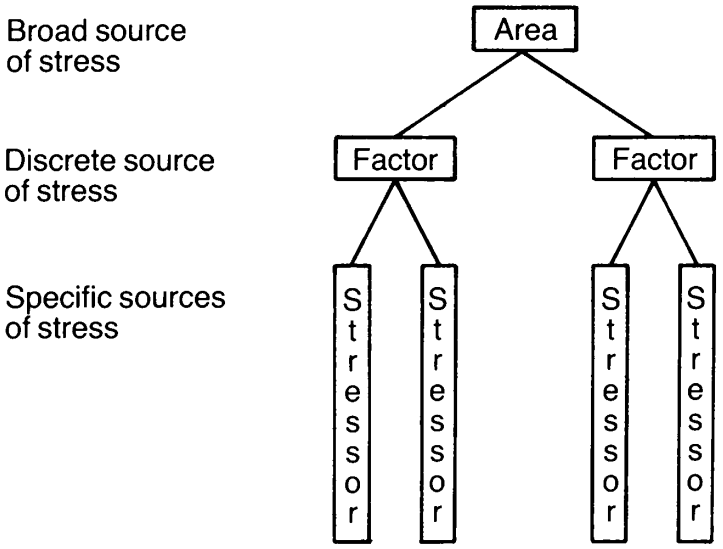

Figure 2 The grouping of stressors

2 The biographical information, from section 1, was analysed in terms of the frequency of response for each category (for example, *sex,* females 475: males 40). Using this information it was possible to build up 'profiles' of the groups under study.

3 Using the statistical technique of factor-analysis the information from section 2 – the job stress questionnaire – was reduced to form a number of identifiable *factors.* Each factor was made up of a number of specific *stressors,* each stressor reflecting a slightly different aspect of the problem. Finally, some factors were grouped together into *areas* which were taken to represent broader sources of occupational stress (see Figure 2). Other areas consisted of a single factor indicating a more discrete source of stress.

4 In order to obtain some measure of the degree of pressure in each area, the number of nurses reporting pressure was recorded. This frequency is shown as a percentage of the total population for all stressors making up an area.

The mean pressure reported was also calculated for each stressor. In the following discussion each of the stressors will have a measure of both *frequency* (per cent) and *intensity* (mean).

Findings

A description of the sample

Information from the whole sample indicated that the group was predominantly female (92 per cent) and had an average age of 40 years. They were more likely to be living with a partner (66 per cent) than living alone, and almost half the group had dependent children (45 per cent).

The majority (74 per cent) had obtained SRN as a first professional qualification. Most (68.5 per cent) had an additional post-professional qualification. Almost half the sample (47 per cent) had obtained GCE 'O' level/CSE as the highest educational attainment other than their nursing qualifications.

The average length of time spent in nursing was between 15 and 20 years. Most of the group (78 per cent) were employed full-time and the large majority worked at sister/charge nurse level (76.5 per cent). A little over half the respondents were hospital based (53 per cent). (A more detailed description and discussion of the sample is presented in Appendix B.)

The positive aspects of stress

In this study we have concentrated on identifying those areas which are most often associated with the pressures of the job. In the questionnaire *pressure* was defined 'as a problem, something you find difficult to cope with, about which you feel worried or anxious'.

In this way it can be seen that we have focused upon the negative aspects of stress by asking respondents to tell us what they felt was problematic in their jobs.

However, it is important to remember that stress can be positive. When asked about the positive aspects of stress in the job situation, over half our respondents had something to say about its usefulness. For example: 'Resolving a stressful situation either personally or professionally gives me a real sense of satisfaction and achievement'; 'I see stress as a very necessary aspect of my life. It helps me to strive for an improved level of achievement not only at work but in many areas of my life. At times stress provides me with real motivation.'

Many comments carefully distinguished between the effects of a little and too

much stress. As one nurse put it: 'Yes, I feel the need for some stress in my work. Life would be boring without it. Also I feel that I perform better under stress. I'm that sort of person. However there are times when stress becomes a too much. Then it can turn into a very negative experience and there is a cost to pay.'

Job satisfaction

Other aspects of our survey suggest that morale within the profession is high. Over 68 per cent of the sample indicated that they were satisfied, or very satisfied with their job. From our evidence it seems that nurses are confident about their clinical practice, are loyal to their profession and are conscious of the high priority given to professional competence.

On the other hand, some 17 per cent of our nurse managers stated that they were not satisfied with their job and a further 15 per cent were undecided. Furthermore, 16 per cent of the sample indicated that they frequently thought of moving to a different occupation, although the vast majority (75 per cent) wished to remain within the nursing profession.

We expected that there would be strong links between high degrees of pressure, thinking about leaving the nursing profession, and a lack of satisfaction with the job.

Indeed this was borne out when we compared the 84 nurses who were thinking of moving out of the profession with those who firmly intended to stay (229), a very striking picture emerged.

The 'potential leavers' reported significantly higher pressures than the 'stayers' on 56 of the 71 items on the job stress questionnaire. On 22 of these items the probability of this difference being due to chance was less than one in a thousand.

Perhaps not suprisingly this group of 'potential leavers' had a significantly lower level of job satisfaction than the rest of the sample ($p < .001$).

Clearly this vindicates the value of the job stress questionnaire, both as an indicator of low levels of job satisfaction and as a predictor of those staff who are likely to leave the profession.

The location of occupational stress

> 'Nursing poses a unique pattern of stress. The strains rooted in the conflicts of the changing role of women, the pressures for cost-effectiveness in health care, and disagreements on what the nurse does all result in a unique pattern of job stress. Nurses, while exerting their own expertise and independence, have to deal with others who expect them to do what they are told.
>
> They are expected to get more work done, more efficiently, and often with less staff in order to reduce the cost of health care. Finally, nurses

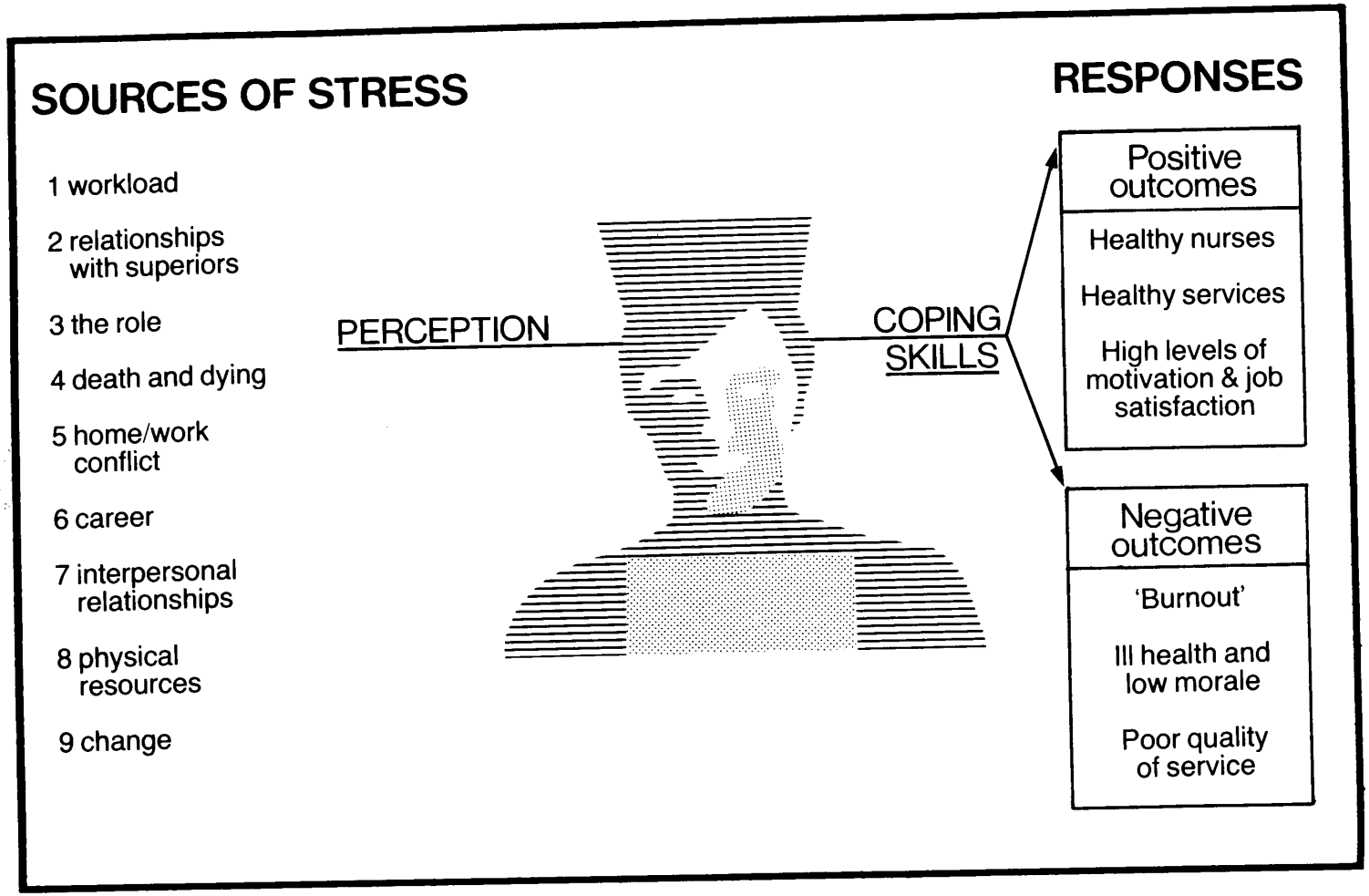

Figure 3 Sources of stress and possible outcomes

must deal with the role conflicts engendered by others' expectations, since there is wide diversity of opinion within and without the nursing profession as to what the nurse should do.' (Johnson, 1983)

In our study, computer analysis of the data identified 11 separate factors. These factors were grouped together to form nine areas or broad sources of stress as shown in Figure 3.

In the tables accompanying the discussion below, responses to each of the stressors in the nine areas are indicated in two ways:

i The number of nurses who reported some degree of pressure from that stressor is indicated as a percentage (%) of the total sample.

ii The actual degree of pressure reported is given as an average (mean) using the following categories:

2 - 3 = slight to moderate pressure;
3 - 4 = moderate to considerable pressure;
4 - 5 = considerable to extreme pressure.

For example in *area 1: workload,* we see that 85 per cent of the total sample reported some pressure due to 'work overload'.

The average pressure reported was 3.2, that is, falling within the range moderate to considerable.

So we can see that the stressor 'work overload' was identified as problematic by the large majority (85 per cent), causing them a moderate to considerable degree of stress (3.2).

Area 1: workload
(Factor 2)

Two aspects of work overload have been identified in the field of occupational stress (French and Caplan, 1973).

Quantitative

The first aspect, quantitative work overload having *too much* to do, has been strongly linked with a range of stress symptoms. Workers who perceive their task as being too demanding in this way tend to display significantly higher levels of stress symptoms than those experiencing lower levels of demands.

Symptoms evident as a consequence of prolonged overload include: coronary attack (Russeck and Zohman, 1958); escapist drinking, absenteeism, low work

motivation, and lowered self esteem (Margolis and others, 1974); and a general lack of feeling of control often resulting in mental depression (Cooper and others, 1982).

Qualitative

The qualitative aspect of work overload, on the otherhand, is concerned more with seeing the task as being *too difficult.* Again qualitative work overload has been shown to be linked with a number of physiological and psychological complaints (French, Tupper and Mueller, 1965; Dreyfuss and Czackes, 1959).

In the nursing profession

In the USA, Gray-Toft and Anderson (1981) found that workload was cited as the most frequent cause of stress in a sample of 122 nurses in a general hospital.

Our results also indicate that workload is perceived as a major source of stress. It seems that our sample experienced stress in this area regardless of their working environment or nursing grade, although the patterns of pressures reported do vary.

From Table 1 it is evident that the quantitative aspect of work overload predominates. This was usually expressed in terms of demands upon time. A typical phrase describing this type of work overload would be: 'I simply need more time to get through all my tasks'.

The problems of 'too little time' are likely to be exacerbated by conflicting demands and changing priorities in the work place. There appears to be a general feeling that work schedules are determined by crises rather than by planning.

Table 1

Stressors	*Reported pressure*	
	%	*mean*
Work overload	85	3.2
I have too little time in which to do what is expected of me	76	3.0
Other demands for my time at work are in conflict	66	2.8
Management expects me to interrupt my work for new priorities	58	2.7
I spend my time 'fighting fires' rather than working to a plan	55	2.6

Staff shortages

Two additional elements were associated with work overload; problems associated with staff shortages are of particular interest (see Table 2).

Table 2

Stressors	*Reported pressure*	
	%	*mean*
Time pressures and deadlines	83	2.9
Staff shortages	83	3.3

In a review of the stress literature in nursing, Marshall (1980) notes that work overload 'figures prominently in many accounts, especially when coupled with staff shortages'.

In the United States, Steffen (1980) has identified inadequate staffing as a major source of occupational stress. Quantitative problems (*inadequate* numbers of staff) as well as qualitative aspects (*incompetent* or poorly trained staff) were identified.

Recently in this country the *Nursing Mirror*'s stress survey (Campbell, 1985) reported understaffing as a major area of concern in the National Health Service (although it is unclear whether the respondents were simply 'concerned' nurses rather than a representative sample of the profession).

For these reasons it is worth examining the information of staff shortages in more detail (see Table 3).

Table 3

Category label	*Number*	*Percentage*
No pressure	83	16.1
Slight pressure	119	23.1
Moderate pressure	135	26.2
Considerable pressure	100	19.4
Extreme pressure	76	14.8
(No response)	2	0.4

It is evident that the number of nurses who perceived staff shortages as an *extreme* source of pressure was higher than for any other of the potential stressors

considered. The average pressure (mean = 3.3) was also the highest recorded.

These findings are echoed in the written comments of the nurses in the survey. When asked: 'What suggestions would you make to alleviate stress in nursing?', the most frequently cited suggestion made by over 40 per cent of the respondents indicated the need to alter staffing levels.

The comments were wide ranging and many reflected the quantitative aspects of the problem (that is, not enough staff). 'It seems plain to everyone here that shortages of staff at ward level is the main cause of stress . . . I find it impossible to balance existing resources with demands. We desperately need more relief staff for holidays and to cover periods of sickness . . . We should never expect one person to do two people's work for any length of time.'

Qualitative aspects (that is, not enough trained staff) were also of obvious concern. 'It's not so much the numbers of staff on the unit that is the problem. I'm more concerned about the quality of staff I am expected to work with . . . We need more trained staff in proportion to learners . . . At times some wards are almost completely run by learners.' 'Certainly within the hospital job stress would be best alleviated by more trained staff at working level. At the moment I feel there are far too many administrators and auxiliary nurses.'

Finally, a small percentage of nurses reported pressure due to 'work underload' (17 per cent) although a larger number found 'fluctuations in workload' (66 per cent) a specific source of pressure.

Undemanding work can lead to boredom and lack of interest and tends to reduce the worker's response to emergency situations. While sudden changes in the level of demand can have particularly detrimental effects on health. (McCrae and others, 1978; Davidson and Veno, 1980).

These findings may be of special relevance to nurses in units such as accident and emergency departments where the workload varies in an unpredictable way. Periods of reduced activity, largely occupied by repetitious and routine tasks (qualitative underload), are disrupted by emergency situations with high levels of demand (qualitative and quantitative overload).

Area 2: relationships with superiors
(Factor 1)

A second major source of occupational stress concerns the nature of relationships at work. Many studies have indicated that the quality of the working relationship is a crucial factor in determining individual and organisational health (Wardwell and Bahnson, 1973; Cooper and Melhuish, 1980).

A study of nursing personnel by Pearlin (1967) in the United States found there was a tendency for feelings of alienation to increase as the distance between nursing grades increases. Choice and control emerged as important variables.

Where the subordinate member is unable to exercise influence on her superiors, feelings of powerlessness and alienation are exacerbated.

In a study of 1800 ICU nurses, Bailey and others (1980) identified 'management of the unit' as a major source of stress. In particular 'unresponsive nursing leadership' and 'conflict with other health care providers' caused greatest levels of stress.

They conclude that: 'Nursing administrators need to recognize that stress, in a large measure, is a reflection of the impact of the organization, its leader, and the nature of the tasks on those who work there.'

Similarly, Numerof and Abrams (1984) identified the organisational environment as a major area of perceived stress. The lack of feedback from supervisors regarding job performance and the problems of meeting the perceived demands of immediate supervisors were particular sources of anxiety.

In the United Kingdom, little attention appears to have been paid to the organisational structure of the nursing profession as a potential source of stress. In our study, 'relationships with superiors' were clearly identified as problematic (see Table 4).

Pressures were associated with 'feelings of distance and isolation from those immediately above'. In particular the lack of involvement in decision-making and

Table 4

Stressors	*Reported pressure*	
	%	*mean*
Decisions or changes which affect me are made 'above' without my knowledge or involvement	71	2.9
Lack of support from senior staff	67	3.1
I lack confidence in management	56	2.7
Relationships with superiors	55	2.6
I only get feedback when my performance is unsatisfactory	55	2.9
Avoiding conflict with superiors	52	2.7
Management misunderstand the real needs of my department	49	3.0
Relationships with administrators	44	2.5

the absence of positive feedback from immediate seniors were highlighted as specific problems. This reflected a 'credibility gap' that appeared to exist between levels of the profession. 'What is needed is much more support, cooperation and understanding from my seniors. If I am to operate more effectively there needs to be much more open discussion and a real opportunity to share in decision making.'

Area 3: the role
(Factor 3)

> 'The nurse's role is therefore implicitly and chiefly one of handling stress. She is a focus for the stress of the patient, relatives and doctor, as well as her own.' Marshall (1980)

Writers on role theory suggest that 'when the behaviour expected of an individual is inconsistent and there is *ambiguity* and *conflict,* the individual will experience stress, become dissatisfied, and perform less effectively'. (Gray-Toft and Anderson, 1981). Problems of ambiguity and conflict revolving around the role of nurse managers may help to explain why workload and relationships with superiors are experienced as highly stressful.

A number of accounts of stress in nursing give a central place to the importance of role. In a Canadian study of 153 head nurses, Leatt and Schneck (1980) specifically identified role-ambiguity as a potential source of stress. The head nurses suffered from the difficulties of handling their dual role as clinicians and managers. The researchers suggested that stress related primarily to the administrative role rather than the clinical area.

From the results of their survey of 154 hospital-based nurses in the United States, Numerof and Abrams (1984) argued that: 'Organizations may unwittingly augment the supervisors' stress by failing to provide management training . . . These skills are quite different from the clinicians' skills, requiring new knowledge, new tools and a new way of thinking.'

In our study, two interrelated elements were evident; both were concerned with problems or role-ambiguity and conflicting expectations about the task.

'My expectations of my job'

Uncertainty about the standard demanded by the role and expectations about the level of performance were reported as areas of concern by a considerable number of the sample (see Table 5).

It seems that nurse managers consider they lack the specialised training that would enable them to feel more able and confident in their management role.

Another facet of role-performance was an expressed fear of coping with new

situations. This implies the need for clear expectations as to the content of the role.

The importance of confidence and competence in role performance is summarised in the words of the respondent who commented: 'In my experience, above all else, the chosen leader of any team must be contented and confident in their role. Only then can they hope to gain the respect and cooperation of their staff.'

In addition, the literature suggests that nurses seem to suffer from the pursuit of very high and often unrealistic standards – the 'angel syndrome' – in which the nurse seems unable to come to terms with her own limitations (Hingley, 1984). In fact Scully (1980) suggests that: 'Expecting too much from self can lead to burnout faster than any other single stressor'.

It is these in-built values, together with the problem shared by all 'caring-professions' of seldom knowing how effective or successful one has been, that makes this an area of considerable concern.

'Expectations of my job by others'

Pressure was reported when there was a mismatch between one's own expectations and the expectations of others. This was particularly evident when the expectations of others were perceived as being unrealistically high.

Feelings of ambiguity were often associated with (and exacerbated by) the lack of constructive feedback about work performance – thus emphasising the

Table 5

Stressors	*Reported pressure*	
	%	*mean*
Coping with new situations	69	2.6
Unrealistically high expectations by others of my role	56	2.7
Tasks outside of my competence	53	2.8
Uncertainty about the degree or area of my responsibility	49	2.5
Lack of specialised training for present task	39	2.5
I don't feel adequately trained for the job I have to do	34	2.5

individual's difficulty in assessing their professional worth. As one nurse manager put it: 'It is necessary to make sure that the right person is in the right job, with a clear understanding of what is expected of them and the knowledge that help and advice is always available. Unfortunately this doesn't happen as often as it should.'

Area 4: death and dying
(Factor 5)

> 'I knew that my first experience of a death on the ward would literally be a make or break experience for me and I lived in fear and dread of it. Either I would be able to see it through and cope or I would leave nursing completely. My training had not prepared me at all for dealing with the feeling side of death and I just did not know what to expect of myself. As it turned out I was lucky as I had a very understanding and supportive ward sister. I was able to talk to her both before and after my patient died. It *was* luck, a different shift a different sister and I wouldn't be talking to you now.' (nursing officer)

Coping with death and dying emerged as a clearly identifiable area of stress. Not surprisingly, our respondents found that direct involvement in life and death situations caused them a considerable degree of stress. On the other hand, simple 'exposure to death' was also perceived as stressful, although less frequently.

Marshall (1980) suggests that caring for life in the face of death and dying, the primary task of nursing, is fundamentally threatening to the nurse in two ways: 'as a skilled worker whose competence (to heal) is on trial and, even more fundamentally, as a human being who is herself vulnerable to the illnesses and death she is nursing'.

This is echoed by Gray-Toft and Anderson (1981) who argue that: 'death is a universal problem for health professionals since it threatens their role perceptions'. In their study, death and dying also emerged as a discrete stress factor.

Similarly, in a study of nurses working in an ICU, Steffen (1980) noted that: 'the event of sudden death . . . was viewed as a direct affront to the nurse's self esteem, whereby she questioned her nursing role'.

On the basis of a study of student nurses' experiences of death, Whitfield (1979) suggests that much of the stress and anxiety experienced stems from an inability to deal with their *own* feelings about death and dying. Bereavement counselling which requires the counsellor to have come to terms with her own feelings about death was also identified as a specific stressor by our sample (see Table 6). This raises basic questions about the scope and the effectiveness of training in this area.

Table 6

Stressors	*Reported pressure*	
	%	*mean*
Involvement in life and death situations	60	2.6
Bereavement counselling	55	2.6
Exposure to death	44	2.6

Area 5: home/work conflict
(Factors 7 and 9)

The number of married working women has increased substantially in this country. Twenty-five years ago only 25 per cent of working women were married, by 1980 this had increased to 60 per cent (Cooper and Davidson, 1982).

Involvement in both work and the family is likely to be stressful for the female nurse manager. Despite working full-time, women are often expected to continue to meet domestic commitments. Increasingly, there is evidence that conflicting demands from home and work can be particularly stressful.

Cooper (1982b) found that more and more married women are either divorcing, limiting their family size, or coping with both worlds at the expense of their physical and psychological health. Generally it seems that married female managers who have young children find themselves less able to relax at the end of the day than male managers, and they are more susceptible to feelings of guilt, role conflict, work overload, tiredness and ill health (Larwood and Wood, 1979; Bhagat and Chassie, 1981).

Many of our respondents have two full-time jobs (nurse manager and home manager) so it is not surprising that a conflict of interests can and does occur. As one nurse put it: 'When I get up in the morning I don't feel like going to work. But by 10 am the feeling has worn off. The cause of this feeling is two young children whom I have to dress and feed before I can get off to work.'

Two factors emerged in this area of home/work conflict.

Work 'overspill'
(Factor 9)

The first is concerned with the effect of work on home. It is evident that some individuals have difficulty in *switching off* from work, especially when they feel that they are over emotionally involved. Working unsocial hours may put an additional strain on social and family relationships (see Table 7).

Table 7

Stressors	*Reported pressure*	
	%	*mean*
Taking problems home	62	2.6
Over-emotional involvement	46	2.4

Home 'overspill'
(Factor 7)

The second factor has to do with the effect of home on work. A minority of nurses experienced a relatively high degree of pressure due to the feeling that their domestic commitments inhibited their career prospects (see Table 8).

Table 8

Stressors	*Reported pressure*	
	%	*mean*
Job versus home demands	62	2.7
Domestic/family demands inhibit promotion	20	2.9
I need to absent myself from work to cope with domestic problems	11	2.6

Area 6: career
(Factor 4)

Career advancement is particularly important to many professionals. Promotion up the career ladder not only determines material rewards but also provides enhanced status and new challenges. Psychological disturbances and frustrations resulting from an inability to achieve career aspirations have been linked to stress and disease (Wan, 1971).

It seems that those in middle management levels are more likely to suffer from dashed career hopes and aspirations since it is at this stage that many managers find their progress slowed and sometimes halted completely (Constandse, 1972). Cooper and Davidson (1982) found that career development blockages were particularly evident among women managers.

Mid-level managers found 'responsibility without authority' particularly stressful, while persons at or near the top have more control and power over the working environment and are more likely to have fulfilled their career aspirations.

In this study we have loosely labelled this area 'career'. It consists of a number

of stressors highlighting the negative aspects of the professional role.

About half our sample reported that they had experienced pressure due to a 'lack of job satisfaction', although only 12 per cent of the sample perceived this pressure as being considerable or extreme. This may reflect the ambivalence felt when promoted away from a direct clinical role into a more managerial position. In addition a number of respondents indicated their frustration with their low status and limited promotion prospects (see Table 9).

Table 9

Stressors	*Reported pressure*	
	%	*mean*
Lack of job satisfaction	50	2.9
Low professional status	37	2.8
Lack of promotion prospects	31	2.8

Area 7: interpersonal relationships
(Factor 8 and 10)

Social relations are often a source of satisfaction and support at work but, as we saw in the responses in area 2 (relationships with superiors), they can also be a source of pressure.

A number of studies have indicated the importance of positive relationships at work. Wardwell and Bahnson (1973), for example, found a link between poor relationships at work, high blood pressure and increased smoking levels.

Two factors were identified within this area:

Patients and relatives
(Factor 8)

In the first, problems with 'difficult patients', suggest that nurses felt that they lacked the skills needed to be assertive and to manage in these situations (see Table 10).

Table 10

Stressors	*Reported pressure*	
	%	*mean*
Difficult patients	65	2.6
Dealing with relatives	47	2.4

'Dealing with relatives' was also a problem. Marshall (1980) suggests that this is due in part to the fact that the nurses' role is often poorly defined in this respect.

The nurse's difficulty in dealing with distressed relatives may also be related to her own problems of coping with death and dying (see area 4).

Staff
(Factor 10)

Secondly, relationships with 'colleagues' and 'subordinates' were also identified as being potentially stressful (see Table 11).

This adds to the picture of a rigid hierarchical structure in which pressures are perceived amongst staff as 'filtering down' from above. Our respondents saw their relations with subordinates as being less stressful than their relations with colleagues and considerably less stressful than relations with superiors.

Table 11

Stressors	*Reported pressure*	
	%	*mean*
Relationship with colleagues	43	2.4
Relationship with subordinates	29	2.2

Area 8: physical resources
(Factor 6)

A number of studies have commented on the need for sufficient resources within nursing (Steffen, 1980; Leatt and Schneck, 1980).

Concern was evident both about the lack of essential resources and the poor quality of those which did exist (see Table 12). In particular there was widespread comment on the need for more 'suitable and adequate equipment'.

There were also negative responses concerning the lack of privacy, as well as the poor quality of supporting staff.

Table 12

Stressors	*Reported pressure*	
	%	*mean*
Shortages of essential resources	72	2.8
Poor physical conditions	58	3.0

Area 9: change
(Factor 12)

The information here suggests that change, particularly the problems of keeping abreast of professional developments and the frustrations of conflicting procedures, is perceived as stressful (see Table 13). This may be an indication of the strain engendered by the recent and continuing reorganisation within the National Health Service.

At a different level, coping with new technology was seen as stressful and it seems that the vagaries of technology were also perceived as threatening. 'I am always on edge when they introduce the latest technology into my unit. It is fine when it is working but when it goes wrong no one seems to want to know! Are we really technicians? Are we meant to be capable of fixing machines and discovering the causes of alarms due to malfunctions?'

Other studies within the profession have identified similar concerns. For example, Steffen (1980) found that: 'the quality and variety of complex technical equipment posed a tremendous demand on the knowledge base of the ICU nurses'.

Several respondents expressed a need for continuing education and training to keep abreast of new developments in the field.

Table 13

Stressors	*Reported pressure*	
	%	*mean*
Keeping up with professional developments	78	2.6
New technology	67	2.7
Frustration with conflicting procedures	66	2.6

Conclusion

Nine areas, or broad sources, of stress have been identified and discussed. It is interesting to note that there are marked similarities between the results of this project and recent studies of the American nurse (see Steffen, 1980; Leatt and Schneck, 1980; Gray-Toft and Anderson, 1981; Numerof and Abrams, 1984).

In particular, this study has found that nurses are less likely to feel stress from factors intrinsic to the primary nursing task than by working relationships, formal structures within the organisation, and factors external to their job.

Indeed, only one area of concern, 'death and dying', is directly related to patient care. The nurse is more likely to experience difficulties in coping with

interpersonal relationships, conflicts and ambiguities in her role, and in balancing the demands of home and work.

Finally, it should be remembered that these are general patterns of stress identified by the whole sample. This does not mean that all nurses have the same 'stress profile'. Individual differences in perception and response will influence the eventual outcome. Additionally, differences in the working environment will determine the source and intensity of potential stressors.

In the last analysis, stress must be seen as a product of a 'mis-fit' between the nurse and her work environment. From this perspective the individual is placed firmly in the centre of the 'stress equation', and as such can be seen as a potential source for positive change.

Summary and implications

There is little doubt that occupational stress is a problem within the nursing profession. Rates of occupational mortality, wastage and absenteeism all indicate that the cost, both to the individual nurse and to the service, can be considerable.

The study found that high levels of pressure were reported in a number of areas by a large proportion of the nursing personnel. If these pressures are sustained, they are likely to result in considerable strain and eventually lead to a range of negative outcomes.

Not surprisingly in the light of the scale (and frequency) of change within the National Health Service, the majority of our sample reported increases in the level of stress experienced in their job over the past few years.

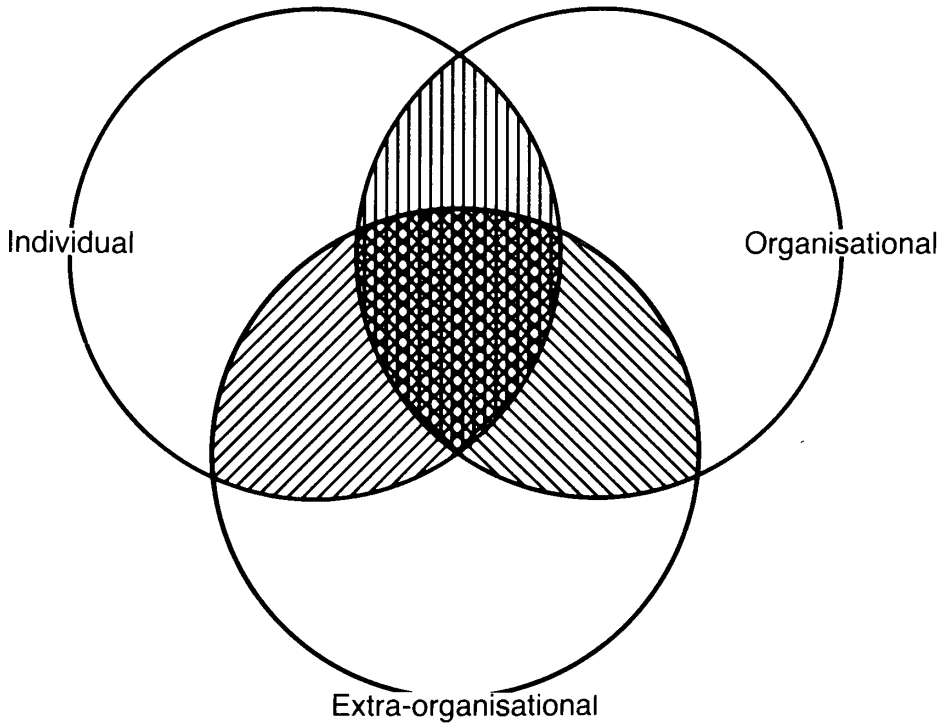

Figure 4 A multi-dimensional view of stress

The low level of stress awareness

In spite of this, the level of stress awareness and recognition of the problem by the profession is low. Rather than seeing stress as something which can be successfully dealt with, thus reducing its costs, the prevailing attitude seems to be that nurses should either put up with the difficulties or get out of the profession.

To begin to alleviate the effects of stress in nursing the profession must first acknowledge that there is a problem.

A multi-dimensional approach

> 'The individual nurse will suffer stress like all other nurses, like some other nurses and like no other nurse.'

Taking responsibility for those in our society who are ill and in pain means that nursing will always be a potentially high stress occupation and for this reason it is all the more important to locate and to minimise the pressures. The evidence from the project suggests that sources of stress are located at both individual, organisational, and extra-organisational levels (see Figure 4) and that action must be taken at all three levels if the problem is to be successfully alleviated.

Unfortunately it seems that the nursing profession tends to see stress primarily as an individual problem and alleviation as a personal responsibility. Attempts at stress management have aimed almost exclusively at increasing individual coping mechanisms with the inbuilt but unexpressed assumption that it is the individual who must change. Consequently very little attention has been given to organisational strategies for decreasing the effect of potentially stressful situations.

Yet it is apparent from our study that major sources of stress lie within the organisation itself. Therefore any attempt to ameliorate the negative effects of stress should not begin with the assumption that the problem lies only at the level of the individual. In addition, organisational and extra-organisational dimensions of the problem will need to be recognised and confronted.

Is it possible to identify the sources of stress in nursing?

Through our analysis we were able to identify a number of potentially stressful areas in nursing. There was general agreement about the nature of these areas and most of our respondents perceived the demands of the 'workload', 'relationships with superiors', and the conflicts and ambiguities of the 'role' as being particularly stressful.

Not all nurses responded in the same way. A number of differences between groups of nurses were found to be related to the type of setting in which they worked and with their level of nursing grade.

Sources of stress

In all, nine underlying sources of stress were located. The first three areas were identified as the most stressful by our respondents.

1 Workload

The more quantitative aspects of work overload (having too much to do) were much in evidence. Staff felt they had too little time to do what was expected of them and were often overwhelmed by conflicting priorities. Problems with staffing were seen as a source of considerable anxiety and, inevitably, staff shortages were identified as a major issue in many areas. However, concern was also expressed about difficulties caused by rapid fluctuation in demand which prevented effective manpower planning in the longer term.

Implications

Staffing levels

Some alleviation of this problem could be brought about by increases in staffing levels. Realistically in the current climate of financial stringency, substantial increases in staff seem unlikely. While in no way condoning this state of affairs it is one faced by most nurse managers at the present time. Consequently it seems that more attention could productively be given to increasing the effectiveness of existing resources.

Deployment of staff

By employing suitable research techniques it is possible to identify a number of 'black spots' where stress appears to be high and/or job-satisfaction low. Providing this information means that target areas can be identified which would warrant a shifting of resources within the institution.

Our findings suggest that the problem of work overload is more complex than simply having too much to do in the time available. It seems that unpredictability and sudden fluctuations in demand were equally problematic; indeed some 17 per cent of respondents expressed some concern about 'work underload' – again a reflection of rapidly changing levels of demand.

We feel that nurse managers need to explore the feasibility of encouraging more flexibility in their staff in order that more movement of resources can take place across traditional boundaries. The planning and control of staffing levels is currently a controversial issue and there is an obvious need for more sharing of information on current 'good practice' drawn not only from the National Health Service but from the private sector and from the USA.

Involvement in planning
There is a need for more involvement of staff in the planning process. Only through a process in which priorities are identified, shared, and then operationalised, can the crisis management response of simply 'fighting fires' (experienced by over half the sample) be counteracted.

Task analysis
Finally, as outsiders to the profession, we were often struck by the nature of many of the tasks carried out by the nursing staff. Many of these tasks did not appear to make good sense. They did not make sense professionally; nurses are trained in patient care yet many tasks could in no way be related to this objective and perhaps of particular importance in today's climate, they did not make sense economically. Paying a ward sister or charge nurse to carry out domestic duties or a nursing officer to perform clerical tasks is simply poor housekeeping.

Economic arguments
It is this last point which we believe can be particularly effective in today's economic climate. The profession will have to utilise sound financial arguments if they are to convince the new general managers that there is an economic pay-off in the reduction of occupational stress. For example, they would have to show that provision of more support services could reduce turnover and lead to more effective staff usage.

2 Relationships with superiors

Many of our respondents reported considerable difficulty in their relations with senior staff. Lack of involvement in decision-making and the absence of positive feed-back and support from immediate superiors were seen as especially problematic.

Implications

Numerous studies of a variety of occupations indicate that the quality of working relationships, particularly with immediate superiors, is an important factor in determining both individual and organisational health. Consequently, the results from this study must give cause for serious concern.

Three issues
The problem appears to revolve around three main issues:
i the lack of involvement;
ii the lack of support;
iii the lack of positive feedback.

The end result is seen as an absence of professional contact and support from senior staff. This lack of involvement with the next level of the management hierarchy is seen as leading to a general feeling of lack of involvement and distancing from the organisation as a whole.

Finally it is sad to recount that over half the total sample remarked that what little feedback they did receive concerning their professional performance was usually couched in negative terms. As many respondents remarked: 'the only feedback I ever get is negative feedback!'

Organisational structure

We see a need to ensure that the profession formally recognises the value of supervision at all grades, and that the organisation provides the opportunity for it to take place.

Professional attitudes

As outsiders to the profession, it was obvious to the researchers that there exists a high degree of ambivalence towards the purpose and practice of supervision. It was seen by many as a threatening experience centered largely upon criticisms of performance and competence. The profession needs to consider carefully the function and methods of supervision. All supervision will involve the potentially threatening area of assessment, but is this to be used for control, or for professional growth? At the moment we must report that the majority of our respondents tended to see it in the more negative light and it was seen more as a personal threat than as an opportunity for professional development.

Good practice

There have been a number of proposals aimed at providing a system of supervision which would be demanding, supportive and 'professionally enabling'. The proposals have usually been aimed at the more junior levels of the profession but could provide a useful model for all levels. Allen (1982) suggests the creation of the role of 'preceptor' and the linking of named experienced staff to newly qualified or newly appointed nurses. But unfortunately it seems that these proposals have had only limited impact on practice.

Perhaps the profession needs to be more outward looking; it needs to examine how other professions have responded to similar problems and to capitalise on their experience. For example, teachers have a probationary period in which they are linked to an experienced member of staff for the first year of practice. Obviously, the quality of support and supervision will depend upon the individuals concerned, but a system has been established which is accepted and, more importantly, expected by employer and employee alike. There is, also, a highly developed system of

supervision, reflecting the demands of the professional task, provided for all social workers. Practitioners, at every level, have regular supervision sessions with a designated senior member of staff. The task of the supervisor is to provide personal and professional guidance in a confidential setting. In addition, the service mounts its own training courses for the task of professional supervision.

3 The role

We have seen how problems in this area revolve around the difficulties of role ambiguity and conflict. Nurses often have unreal expectations of both themselves and others. It seems that ever present fears of 'failure', together with low self esteem, lead to defensiveness and a certain degree of professional rigidity in practice.

Implications

The provision of clear (and realistic) job specifications are an obvious first step in attempting to resolve the ever-present problems of role confusion and ambiguity. Some authorities actively involve the individual nurse in the formulation and clarification of her own job description and use this as a major focus of the appraisal process.

But no matter how careful and comprehensive these job specifications are, areas of difficulty will inevitably remain. To clarify and resolve these problems, opportunities should be provided to discuss them with the other individuals involved before they begin to affect performance. Such opportunities are likely to depend largely upon the awareness of senior staff of the problem and their willingness (and ability) to intervene in a positive way.

4 Death and dying

Many in our sample found that involvement in life and death situations was a considerable source of stress. It is understandable that caring for sick and terminally ill patients is fundamentally threatening to the nurse. In addition, bereavement counselling was also identified as a specific stressor.

Implications

Counselling

The nurse faces death and dying early in her practical experience and this may prove traumatic for many individuals. It is imperative, therefore, that she has an opportunity to discuss these feelings if they are to be successfully resolved. Provision needs to be made to enable this to take place in the immediate work-

place, with experienced staff and, if need be, with an independent counsellor who is able to offer longer term support.

Training
Opportunity should be taken during basic training to raise the learner nurses' awareness of the problems of coping with death and dying. At the post-basic level there is evidence of a particular need for training in bereavement counselling.

Good practice
Again, examples of good practice should be identified and utilised as appropriate. The recent developments in the hospice movement makes this a readily accessible centre of expertise well-suited to offering advice on methods of training and the provision of on-going support in this area.

5 Home/work conflict

The pressures of home and work were often felt to be conflicting. A large proportion of respondents had difficulty 'switching off' from the work situation particularly when they felt over-emotionally involved.

On a different level, a smaller number felt that their domestic commitments inhibited their career prospects.

Implications

In a profession such as nursing it is difficult to clearly demark the boundaries between work and non-work. The nurse working in a hospital setting, unlike her community-based colleague, has the advantage of being able to formally hand over the responsibility of her patients to other nurses at the end of her working day. We have evidence that 'switching off' is a greater problem for community-based nurses.

These problems need to be openly acknowledged and discussed. Again, the most appropriate forum would seem to be within a supportive supervisory relationship, but peer-support groups could also play a valuable role. The particular difficulties of over-emotional involvement should also be recognised and addressed during basic and post-basic training. For those who need additional support, access to a professional counselling service would seem appropriate.

Child-care facilities
More work-based nurseries and crèches, geared towards the unsocial hours often worked by nurses should be provided. This could help to reduce wastage within the profession as well as the nurses' expressed need to absent themselves from work in order to cope with domestic problems. Furthermore, this support would

ensure that nurses with dependent children (in this study 45 per cent of the total sample) would have a greater opportunity for further training and promotion.

The attitude of the profession

The increase in the number of married nurses, combined with the shortfall in experienced and qualified nurses, means that there will have to be a positive campaign to attract back into the profession the 'pool' of qualified nurses who have left the service. To begin to do this may require a change of attitudes within the profession itself. There is a need for more recognition (and acceptance) of the domestic commitments of married nurses if this 'pool' is to be successfully tapped. As one of our married respondents remarked: 'It is about time that the profession as a whole recognised that there is a life outside of the hospital walls!'

6 Career

A number of respondents saw themselves as having a low professional status and many were frustrated by what they saw as limited promotion prospects. Both these stressors were associated with a lack of job satisfaction.

Implications

Through talking with individual nurses it was apparent that many had difficulty in seeing a clear career path within the profession and that career problems were of general concern. While many of our respondents recognised the role of nursing personnel officers in giving career advice, and on an individual level found them well informed and sympathetic, they remarked that often they were not very accessible. Many nurses thought it would be difficult to approach them for general advice; rather they felt that they would need to go with a particular request or present a serious career problem. Consequently, on-going career advice was seen to be dependent upon contact with the individual's immediate superior, contact which we have previously mentioned was often perceived as problematic. Consideration needs to be given to supplementing and complimenting the career advice available to the nurse. In our discussions two suggestions seemed to emerge:

i On-going career advice could be provided as part of a wider staff-support system based on a personal/career counselling system. This could be organised at district or regional level.

ii Many respondents felt that if the problem of support from immediate superiors could be solved, then on-going career development would be an integral part of this relationship.

7 Interpersonal relationships

Managing difficult patients and coping with the needs of relatives were often experienced as sources of stress. Relationships with colleagues and subordinates were also identified as potentially stressful.

Implications

Training

In addition to the points discussed under 'relationships with superiors' there is evidently a need for greater knowledge of interpersonal skills. The medical model of care still underlies most initial training programmes with a concentration on the more clinical aspects of patient care. Often the nurse is left to develop her own interpersonal abilities and may find that as her career develops her competence in this area is insufficient to meet her growing responsibilities.

Curriculum content and methods should be reviewed. The first to ensure that the area of interpersonal skills is adequately covered; the second to introduce, where necessary, appropriate experiential methods and techniques in order that students may practise these skills in a 'safe' setting.

8 Physical resources

There was concern in this area about shortages of physical resources and the poor quality of existing resources. These deficiencies were seen as imposing additional demands on the nursing task.

Implications

Working conditions

Utilising a sound economic argument we were able to identify a number of problem areas where the outlay of modest financial resources could alleviate what are often seen as constant but unnecessary sources of stress.

The hospital-based nurses in our sample indicated their need for a stress-free area to retreat to during their breaks. The lack of such facilities is all too common in hospitals; rest rooms are often too far away to be used except for longer breaks.

For community nurses, transport problems proved to be of particular concern. The possibility of vehicle breakdown interfering with their work tended to be a constant source of anxiety. Access to an emergency pool of cars would be a simple and cost effective way of dealing with this problem.

9 Change

Many of our respondents expressed anxiety about the difficulties of keeping up

with professional developments. Coping with rapidly changing technology was identified as a particular stressor.

Implications

Training

In a profession where practice is continually and increasingly being influenced by rapidly changing information and technology, it is essential that the modern nurse is both willing and able to keep abreast of new developments in the field. Compared with other professions, individual opportunities for staff development appears to be sadly neglected. Authorities should recognise and respond to this problem by providing a staff development programme for all nurses and more short 'updating courses' which reflect the needs of specific areas.

Does this mean that nurses are dissatisfied with their job?

Job satisfaction

On a more positive note, and in spite of the extent of occupational stress identified in the study, the majority of our sample reported high levels of job satisfaction. This suggests that the relationship between the pressures and satisfactions of nursing is a complex one. Stress at work does not necessarily lead to low job satisfaction. The nurse reporting high degrees of pressure at work may also see her job as highly satisfying and rewarding.

However, morbidity figures, rates of absence and wastage indicate that the nurse is not immune to the strains of her occupation. Although most of the nurses in our sample were satisfied with their job, and had every intention of remaining within the profession, some 17 per cent expressed extreme dissatisfaction, and a similar number (16 per cent) were thinking of changing to an occupation other than nursing.

Our findings suggest that each individual appears to have an optimum level of stress – a 'stress threshold'. Nurses who exceeded this threshold were more likely to experience the negative aspects of stress, to have low levels of job satisfaction, and to think about leaving the profession. It seems that they had reached or exceeded their 'stress threshold' and found that the demands of the job outweighed the rewards.

As we have already noted (and of particular interest to researcher and employer alike), it was possible to identify a group of 'potential leavers' by their significantly higher stress profiles on the job stress questionnaire. If they *can* be identified, then planned support and staff development could prevent them being lost to the profession.

Finally, our research indicates that job pressures are not evenly distributed across the nursing profession. Absence and wastage figures alerted us to the fact that nurses appear to respond differently according to their particular work setting or their level of seniority. It was decided, therefore, to explore these differences in detail by conducting a separate analysis of the sample according to their working environment (that is, hospital-based *versus* community-based nurses) and nursing grade (that is, ward sister level *versus* nursing officer). We intend to report on the findings in this area at a later stage.

Further reading

The following annotated bibliography, lists some of the books which you may find useful.

General

1 Cooper C L (1982) Stress research. Chichester, Wiley.

Stress-related illness is on the increase and the last decade has seen a tremendous growth in the amount of research into many aspects of stress. In this book, Professor Cooper presents important current work and suggests directions for future research.

2 Cooper C L (1981) The stress check. New Jersey, Prentice Hall.

'Coping with the stresses of life and work'. An invaluable guide to improved personal health that gives the reader an important insight into the various factors that can lead to debilitating stress at work and at home. *The stress check* explores the nature and origins of stress, how it affects individuals, organisations, communities and society. The book also gives specific methods and strategies that can help reduce the amount of stress felt and thus enable the reader to cope more successfully.

3 Cox T (1978) Stress..London, Macmillan.

Stress, claims the author, is a threat to both physical and psychological well-being and to the quality of life itself. This book is a wide-ranging introduction to the subject and covers both the nature of stress and its effects, as well as its management. Dr Cox draws upon many disciplines including psychology, medicine, community health, and human engineering.

4 Dobson C B (1982) Stress: the hidden adversary. Lancaster, MTP Press.

Intended as a comprehensive introductory text, this book attempts to cover the topic of human stress from many perspectives. The wide ranging effects of stress on physical and mental well-being are examined in the young person as well as in the adult world.

5 Speilberger C (1979) Understanding stress and anxiety. London, Harper and Row.

An easily read, well-illustrated general guide to stress and anxiety. A useful introduction for the student nurse to the nature, causes and effects of psychological stress and strain. This book discusses the positive as well as the negative aspects of stress and suggests guidelines for learning to live with it.

Stress in nursing

6 Claus K E and Bailey J T (eds) (1980) Living with stress and promoting well-being. Missouri, C V Mosby.

June Bailey, a leading writer on stress in the US nursing profession, has co-edited this 'handbook for nurses'. With contributions by leading figures in the stress field this book examines the nature of stress, describes the results of a major study of stressors in intensive care nursing, and offers strategies for dealing with stress.

7 Jacobson F and McGrath H M (1983) Nurses under stress. New York, Wiley.

This book presents proven techniques to prevent, diagnose and manage the stresses that nurses experience. Coverage includes the various levels of stress and practical strategies for reducing them; the problem of stress in specific roles; professional and organisational dynamics and how these relate to stress.

8 Lachman V D (1983) Stress management: a manual for nurses. New York, Grave and Stratton.

A very comprehensive and rewarding book written especially for the practising nurse, the nurse educator and the nurse manager. 'This manual is designed to help nurses improve their careers so that the responsibilities and the problems don't drive them out. Several chapters are focused directly on the work climate, others address skills needed to function effectively and happily in their careers and homes.'

9 Marshall J (1980) Stress amongst nurses. In: Cooper C L and Marshall J (eds) White collar and professional stress. Chichester, Wiley.

Concerned with the personal cost to the nurse of providing patient care, Judy Marshall reviews a substantial section of the available literature. This chapter raises many interesting speculations and poses important questions about stress amongst nurses. Particular attention is given to intensive care nursing.

Burnout

10 Cherniss C (1980) Staff burnout. California, Sage.

As Cary Cherniss points out: 'Before 1974, the term burnout had not appeared in print.' This book examined the nature of this concept and discusses the reasons why it has become a major source of concern in the caring professions.

11 Edelwich J and Brodsky A (1980) Burnout. New York, Human Science Press.

This book portrays the four stages of disillusionment – enthusiasm, stagnation, frustration and apathy – that constitute the 'burnout syndrome'. Based on extensive interviews with social workers, psychologists, counsellors, teachers and other professionals, the authors explore the causes of burnout and propose constructive intervention methods for individuals and organisations.

12 McConnel E A (1982) Burnout in the nursing profession. Missouri, C V Mosby.

This anthology was compiled for the purpose of bringing together the information currently available about the burnout syndrome in nursing. It includes coverage of coping strategies for preventing burnout, signs and symptoms of burnout, potential causes of burnout (personal and organisational), and the costs of burnout. The narrative of each chapter is followed by selected readings and an annotated bibliography that augments the chapter content.

13 Maslach C (1982) Burnout – the cost of caring. New Jersey, Prentice Hall.

Christina Maslach is a leading researcher on burnout. In this book she uses illustrative examples and firsthand accounts to identify the causes of emotional exhaustion and suggests methods to prevent and cure the situation. Written for professional and informal caregivers, this guide endeavours to give the reader an understanding of burnout, thus re-motivating them in their role.

14 Paine W S (1982) Job stress and burnout. California, Sage.

Burnout stress syndromes, the consequence of high levels of job stress, personal frustration and inadequate coping skills have increasingly major personal, organisational and social costs. Understanding and intervening in these syndromes is the focus of this book.

Coping

15 Bailey R D (1985) Coping with stress in caring. London, Blackwell Scientific.

Addressing nurses and allied health care providers, this book aims to promote an understanding and awareness of stress and to introduce techniques for successful stress management. A number of 'practical stress check schedules' are included which can be used in combination with stress control techniques.

16 Bond M and Kilty J (1982) Practical methods of dealing with stress. Department of Educational Studies, University of Surrey.

This report is intended to serve three main purposes:
1 to be an *aide mémoire* and additional resource for participants of (stress) workshops;
2 to provide a modest resource for anyone wishing to extend their range of ways of dealing with stress or to help others to do so;
3 to stimulate others to creatively design similar activities by providing examples of ways of organising such workshops.

17 Eagle R (1981) Taking the strain. London, BBC Publications.

Though it has become popular to blame stress for many of our troubles, we can do a great deal to prevent ourselves falling victims to the unpleasant stresses of life. *Taking the strain* tells the reader how to recognise the physical and mental signs of stress and how to cope with them. Experienced teachers and therapists describe techniques the reader can learn to use – music relaxation, meditation, biofeedback, and so on.

18 Garland L M and Bush C T (1982) Coping behaviours and nursing. Virginia, Peston.

This book is designed to provide nurses with a conceptual approach for identifying and responding to frequently encountered coping behaviours. The authors distinguish between adaptive and maladaptive coping mechanisms and discuss psychological and physiological stressors and responses. It includes implications for education, consultation and research and can be of use to nurses at all levels.

19 Which? (1982) Living with stress. Hertford, Consumer Association.

Stress can cause illness and illness can cause stress. This book looks at the physical and emotional harm that can result unless stress is kept under control. It outlines the right and wrong ways to counteract stress and helps the reader to identify sources of stress in their own life.

Future publication

20 Hingley P and Cooper C L (in press) Stress in nurse managers. Chichester, Wiley.

Appendix A The questionnaire

Bristol Polytechnic

Department of Nursing, Health & Applied Social Studies

Dear Colleague

With the support of the Kings Fund we are carrying out the first large scale investigation of stress in the nursing profession.

It is generally accepted that nursing is a potentially high-stress occupation and that stress at work can be very costly both in terms of job satisfaction and in the maintenance of high standards of patient care. Unfortunately little has been done in this country to investigate the problem until now.

We hope that you have seen our recent newsletter setting out details of the project or have had the opportunity of meeting and talking with us in one of the meetings we have attended around the District.

Briefly the aim of our research is

a) to locate the sources of stress in the day to day work of the 'nurse manager'
b) to explore the effects of stress upon the individual
c) to see how different people cope in different ways with occupational stress

We are attempting the rather ambitious task of obtaining the views of all nursing staff in the District from Ward Sister level to the CNO. Through your participation in the survey you will be helping a project which we believe will have real and positive benefits to the whole profession.

Please complete the attached questionnaire and return it to us in the SAE by 21/2/84. We realise that by asking for about 30/40 minutes of your time we may be adding to your stress level but your view is essential to the project and we are counting on your support.

All the information you provide will be completely confidential to the undersigned. Completed questionnaires will be coded before computerisation and the results of the project will be analysed and expressed in general terms only. (You will have the choice to remain completely anonomous if you so wish.)

Once the data has been analysed the main results will form the basis of a report to the Kings Fund. All who have participated in the project will receive an outline of our results in the form of a newsletter. In addition we hope to hold a number of seminars later in the year in which we can meet with you and explore in more detail our findings.

Thank you for your time and involvement.

Peter Hingley C. L. Cooper

Peter Hingley
Director of Studies, Department of Nursing, Health & Applied Social Sutides,
Bristol Polytechnic

Cary L Cooper
Professor of Organisational Psychology
Department of Management Sciences
University of Manchester, Institute of Science and Technology

INTRODUCTION TO THE QUESTIONNAIRE

You will see that we have organised the questionnaire to save you as much time as possible. In most cases you will only be asked to either circle the appropriate answer or place a number in a box.

There are five separate sections in all dealing with different aspects of behaviour.

Section I - covers relevant personal and background details
Section II - focuses in some depth upon the sources of occupational stress
Section III - examines how individuals cope with stress in their work
Section IV - looks at certain patterns of individual behaviour and beliefs
Section V - is concerned with how you generally feel and act and also gives you the opportunity to give your views about stress at work

Interspaced throughout are a number of blank sections labelled 'comments'. We have provided these as we would value your opinion about specific sections of the questionnaire or about the project in general.

Finally don't spent too long on any one section but do please ensure that all the questions and sections are completed.

S E C T I O N I

BACKGROUND INFORMATION

For purpose of statistical analysis only, please answer the following questions about yourself. Your answers will remain anonymous and strictly confidential. However, this biographical data is crucial to the study.

Most of the questions below are answered by placing the appropriate number in the right hand column. e.g. Q 1 What is your sex? If you are female you would enter 1, if you were male you would enter 2.

		[ ][ ][ ][ ][1]
1. Name (optional)		[ ]
Location (optional)		[ ]
2. What is your sex? (please enter 1 or 2 in the right hand col.)		
Female 1	Male 2	
3. Year of birth. Please complete the last two digits		[1][9][ ][ ]
4. Were you born in the British Isles (i.e. U.K. & Eire)?		
Yes 1	No 2	
5. If no how long have you lived in this country?		
Under one year 1	Between 5 & 10 yrs 3	
One to 5 years 2	Over 10 years 4	
6. Are you:	Single 4	
Married 1	Divorced/Separated 5	
Re-married 2	Widowed/Widower 6	
Living with partner 3	Other, please state 7	[5][5][5]

(1)

Please enter code number

7. Number of children living at home (e.g. if 2 enter 02, if 10 enter 10 etc.)

   Please insert 00 if this does not apply to you

8. Age of children: Please enter appropriate codes

   Not applicable 1
   Pre-school age 2
   School age 3
   Post school age 4
   Others, please state 5

9. What is the highest educational level (if applicable) you have obtained, other than your nursing qualifications?

   G.C.E. 'O'Level/C.S.E. 1
   G.C.E. 'A'Level/Ordinary National Diploma 2
   Higher National Diploma or equivalent degree 3
   Post Graduate Diploma 4
   Higher degree, MA/MSc 5
   Ph D 6
   Other - please specify 7
   .....
   Not applicable 8

10. What was the first professional qualification you obtained?

    S.R.N. 1 O.N.C. 2 R.S.C.N. 3 R.M.N. 4

    Others (please state) .....

11. Do you have any post-professional qualifications? (e.g. S.C.M.)

    Yes 1 No 2

    If yes please indicate what qualification(s) you hold and the year obtained.

    .....
    .....

12. How many years have you spent in nursing, including training?

    Less than 10 years 1
    10 to 15 years 2
    15 to 20 years 3
    20 to 25 years 4
    More than 25 years 5

13. Please specify your job title and exact work location (e.g. Ward Sister - Male Surgical Ward).

    .....

14. Are you employed:

    Full time 1 Part time 2

    Others, please specify 3

    If part time approximate hours/week .....

6 6 6

(2)

Please enter code number

15. Please indicate the main pattern of your work:

Full time (day only)	1	Part time (day only)	4
Full time (shift)	2	Part time (shift)	5
Full time (night only)	3	Part time (night only)	6
Others, please specify			7

16. How long have you worked for this authority?

Less than 1 year	1	5 - 10 years	4
1 - 3 years	2	More than 10 years	5
3 - 5 years	3	Others, please state	6

17. Did you move to this authority from another area?

Yes 1 No 2

If yes, from .....

Why did you move? Please identify the most important reason only.

Promotion	1	Better living conditions	4
Better working conditions	2	Others - please state	5
Partners work	3	.....	

18. Approximately how many people do you supervise (i.e. how many staff in total are directly or indirectly under your management)?

Please state your answer in the form of a number.

.....

19. Which of the following most closely describes your working environment? (i.e. the area in which you carry out your work)

Central Administration/ Planning	1	Operating Theatres	5
		Outpatients or Clinics	6
Community based services	2	Wards or Special Units	7
Nurse Education	3	Others, please state	8
Accident & Emergency Dept.	4	.....	

20. Please indicate your nursing grade.

District Nursing Officer level and above	1	Clinical Nurse Managers level	3
Director of Nursing or Midwifery Services level	2	Sister/Charge Nurse level	4
		Others - please state	5
		.....	

21. If the majority of your time is spent in one hospital setting please indicate its approximate size.

Under 100 beds	1	301 and over beds	3
100 - 300 beds	2		

7 7 7

(3)

Please enter code number

22. If the majority of your time is spent in one hospital setting please indicate what type of hospital it is.

General Hospital	1	Rheumatoid Diseases Hospital	5
Community Hospital	2	Hospital for the Physically Handicapped	6
Geriatric Hospital	3		
Psychiatric Hospital	4	Hospital for the Mentally Handicapped	7
Others, please state			8

23. If the majority of your time is spent in the community is it in a mainly rural or urban area?

Rural 1 Urban 2

Approximately what is your average case-load? Express your answer as a number.

24. Do you consider that your work is in a generally recognised high stress area? (e.g. I.C.U., Theatre etc.)

No 1 Yes 2
Give details

.....

.....

8 8 8

Comments:

S E C T I O N II

OCCUPATIONAL STRESS

Would you please circle the number that best reflects the degree to which that statement is a source of pressure at work. Pressure is defined as a problem, something you find difficult to cope with, about which you feel worried or anxious. The greater the pressure the higher the number i.e.

1. causes me no pressure
2. slight pressure
3. moderate pressure
4. causes me considerable pressure
5. extreme pressure

- do not spend too much time pondering, as there are no right or wrong answers. You will find it easier to complete this section fairly quickly.

Remember
Circle the correct response.

		No pressure	Slight pressure	Moderate pressure	Considerable pressure	Extreme pressure	For office use only
1.	Time pressures and deadlines	1	2	3	4	5	
2.	Work overload	1	2	3	4	5	
3.	Work underload (needing to look busy)	1	2	3	4	5	
4.	Tasks outside of my competence	1	2	3	4	5	
5.	Fluctuations in workload	1	2	3	4	5	
6.	Unrealistically high expectations by others of my role	1	2	3	4	5	
7.	Coping with new situations	1	2	3	4	5	
8.	Uncertainty about the degree or area of my responsibility	1	2	3	4	5	
9.	Security of employment	1	2	3	4	5	
10.	Involvement with life & death situations	1	2	3	4	5	
11.	Coping with new technology	1	2	3	4	5	
12.	Exposure to death	1	2	3	4	5	
13.	Staff shortages	1	2	3	4	5	
14.	Poor physical working conditions	1	2	3	4	5	
15.	Lack of support from senior staff	1	2	3	4	5	
16.	Lack of privacy	1	2	3	4	5	
17.	Shortage of essential resources	1	2	3	4	5	
18.	Poor quality of supporting staff	1	2	3	4	5	
19.	Unsocial hours	1	2	3	4	5	
20.	Lack of specialised training for present task	1	2	3	4	5	
21.	Lack of participation in planning/ decision making	1	2	3	4	5	
22.	Difficult patients	1	2	3	4	5	
23.	Dealing with relatives	1	2	3	4	5	
24.	Bereavement counselling	1	2	3	4	5	

5 5 5
end of record

(5)

REMEMBER - the greater the pressure the higher the number

For office use only

							2

Please circle correct response

		No pressure	Slight pressure	Moderate pressure	Considerable pressure	Extreme pressure
25.	Playing a leadership role	1	2	3	4	5
26.	Bringing about change in staff/ organisation	1	2	3	4	5
27.	Low professional status	1	2	3	4	5
28.	Lack of job satisfaction	1	2	3	4	5
29.	Lack of promotion prospects	1	2	3	4	5
30.	Relationships with colleagues	1	2	3	4	5
31.	Relationships with subordinates	1	2	3	4	5
32.	Relationships with superiors	1	2	3	4	5
33.	Fear of appearing weak	1	2	3	4	5
34.	Promoted out of the 'caring' role	1	2	3	4	5
35.	Job versus home demands	1	2	3	4	5
36.	Over emotional involvement	1	2	3	4	5
37.	Taking problems home	1	2	3	4	5
38.	Trivial tasks interfere with my professional role	1	2	3	4	5
39.	Deciding priorities	1	2	3	4	5
40.	I have too little time in which to do what is expected of me	1	2	3	4	5
41.	Others demands for my time at work are in conflict	1	2	3	4	5
42.	I spend my time 'fighting fires' rather than working to a plan	1	2	3	4	5
43.	Decisions or changes which affect me are made 'above', without my knowledge or involvement	1	2	3	4	5
44.	I must attend meetings to get my job done	1	2	3	4	5
45.	I lack confidence in management	1	2	3	4	5
46.	Conflict between my unit & others it must work with	1	2	3	4	5
47.	Management expects me to interrupt my work for new priorities	1	2	3	4	5
48.	Others at work seem unclear about what my job is	1	2	3	4	5
49.	I only get feedback when my performance is unsatisfactory	1	2	3	4	5
50.	I must go to other departments to get my job done	1	2	3	4	5
51.	Management misunderstands the real needs of my department	1	2	3	4	5

6	6	6

(6)

REMEMBER - the greater the pressure the higher the number

For office use only

Please circle correct response

		No pressure	Slight pressure	Moderate pressure	Considerable pressure	Extreme pressure
52.	Difficulty in dealing with aggressive people	1	2	3	4	5
53.	My nursing and administrative roles conflict	1	2	3	4	5
54.	Avoiding conflict with superiors	1	2	3	4	5
55.	Difficulty in dealing with passive people	1	2	3	4	5
56.	I find problems allocating resources	1	2	3	4	5
57.	Frustration with conflicting procedures	1	2	3	4	5
58.	My professional expertise contradicts organisational practice	1	2	3	4	5
59.	Feelings of isolation	1	2	3	4	5
60.	Organisational change	1	2	3	4	5
61.	Lack of emotional support at home	1	2	3	4	5
62.	Relationships with administrators	1	2	3	4	5
63.	Relationships with consultants	1	2	3	4	5
64.	I expect too much of myself	1	2	3	4	5
65.	I don't feel adequately trained for the the job I have to do	1	2	3	4	5
66.	Difficulties with transport	1	2	3	4	5
67.	Keeping up with professional developments	1	2	3	4	5
68.	Sexual discrimination at work	1	2	3	4	5
69.	Domestic/family demands inhibit promotion	1	2	3	4	5
70.	I need to absent myself from work to cope with domestic problems	1	2	3	4	5
71.	My superiors do not appreciate my home pressures	1	2	3	4	5
72.	Others - please state	1	2	3	4	5

.....

.....

Comments.

7 7 7

Some jobs are more interesting and satisfying than others. We want to know how you feel about your job.

How far do these statements represent how you are feeling about your present job? There are no right or wrong answers. We would like your honest opinion on each one of the statements.

Please circle correct response

		Strongly disagree	Disagree	Undecided	Agree	Strongly agree
1.	I am satisfied with my job	1	2	3	4	5
2.	There are some conditions concerning my job that could be improved	1	2	3	4	5
3.	Most of the time I have to force myself to go to work	1	2	3	4	5
4.	Each day of work seems like it will never end	1	2	3	4	5
5.	I frequently think about finding another job	1	2	3	4	5
6.	I frequently think about finding an occupation other than nursing	1	2	3	4	5

7. Looking back over the year what percentage of total stress in your life results from your job?

Less than 10%	1	Between 50-75%	4
Between 10-25%	2	Over 75%	5
Between 25-50%	3		

8	8	8

end of record

Comments:

S E C T I O N III

COPING BEHAVIOUR

The purpose of this section is to find out the kinds of situations which trouble people in their jobs and how they deal with them.

Take a few moments and think about the events or situations which have been stressful for you during the last three months. By 'stressful' we mean a situation which was difficult or troubling to you, either because it made you feel bad or because it took effort to deal with it.

How did you usually cope with these situations?

For office use only [ ][ ][ ][ ][3]

Please circle correct response

	Never	Rarely	Sometimes	Often	Always
1. Blamed myself	1	2	3	4	5
2. Kept my feelings to myself	1	2	3	4	5
3. Wished I could have changed what happened	1	2	3	4	5
4. Got mad at the people or things which caused the problem	1	2	3	4	5
5. Let my feelings out in some way	1	2	3	4	5
6. Just concentrated on what I had to do next - the next step	1	2	3	4	5
7. Talked to someone about how I was feeling	1	2	3	4	5
8. Didn't let it get to me; refused to think about it too much	1	2	3	4	5
9. Went on as if nothing had happened	1	2	3	4	5
10. Avoided being with people in general	1	2	3	4	5
11. You went over the problem again and again in your mind to try and understand it	1	2	3	4	5
12. Talked to someone who could do something about the problem	1	2	3	4	5

Which of the following people do you feel you could turn to, to talk about a personal problem or crisis: Please tick correct response

13. Mother _____
14. Father _____
15. Partner _____
16. Son _____ (If more than one, state how many ....)
17. Daughter _____ (If more than one, state how many ....)
18. Relative _____ (If more than one, state how many ....)
19. Friend (outside of work) _____ (If more than one, state how many ....)
20. Work Colleague _____ (If more than one, state how many ....)
21. Others please state:

[5][5][5]

(9)

For office use only

Please circle correct response

How often do you use the following measures to relax?

		Never	Rarely	Sometimes	Often	Always
1.	Take aspirin	1	2	3	4	5
2.	Use tranquilisers or other medication	1	2	3	4	5
3.	Drink coffee, coke or eat frequently	1	2	3	4	5
4.	Smoke	1	2	3	4	5
5.	Have an alcoholic drink	1	2	3	4	5
6.	Use relaxation techniques (meditation,yoga)	1	2	3	4	5
7.	Use infomal relaxation techniques (i.e. take time out for deep breathing, imagining pleasant scenes, etc.)	1	2	3	4	5
8.	Exercise	1	2	3	4	5
9.	Talk to someone you know	1	2	3	4	5
10.	Leave your work area and go somewhere (time out, sick days, lunch away from organisation)	1	2	3	4	5
11.	Use humour	1	2	3	4	5
12.	Other	1	2	3	4	5

13. Over the past year, which of the following best describes your typical drinking habits? (one drink is a single whisky, gin or brandy, a glass of wine, sherry or port or a ½ pint of beer).

Teetotal	1	Regularly, 1 or 2 drinks a day	4
An occasional drink	2	Regularly, 3 to 6 drinks a day	5
Several drinks a week, but not every day	3	Regularly more than 6 drinks a day	6

14. If you are not teetotal, has the quantity of alcohol consumed increased or decreased over the past year?

Increased substantially	1	Decreased	4
Increased	2	Decreased substantially	5
Remained the same	3	Stopped	6

15. Re: cigarette smoking. Which of the following statements is most nearly true for you?

I never smoke regularly	1
I have given up smoking	2
I am currently smoking	3

6 6 6

For office use only

16. If you are currently smoking, please circle the number which constitutes your average daily consumption of cigarettes:

0 - 5 a day	1	20 - 30 a day	5
5 - 10 a day	2	30 - 40 a day	6
10 - 15 a day	3	40 plus a day	7
15 - 20 a day	4		

17. If you are a smoker has the quantity smoked increased or decreased over the past year?

Increased substantially	1	Decreased	4
Increased	2	Decreased substantially	5
Remained the same	3	Stopped	6

18. Hours of physical exercise engaged in per week:

Less than 1	1	7 to 9	4
1 to 3	2	10 to 12	5
4 to 6	3	Over 12	6

19. Over the past year, approximately how many days absence have you had to take? Express your answer as a number.

.....

20. Over the years, have you experienced changes in the level of stress experienced in your job? Indicate one.

Increased substantially	1	Decreased	4
Increased	2	Decreased substantially	5
Remained the same	3		

7 7 7
end of record

Comments

Please use this space to add any comments you wish:

(12)

S E C T I O N I V

GENERAL BEHAVIOUR

Could you please circle one number for each of the 14 questions below, which best reflects the way you behave in your everyday life.

For example on question 1., if you are always on time for appointments, you would circle a number between 7. and 11. If you are usually more casual about appointments, you would circle one of the other numbers between 1. and 5.

1. Casual about appointments	1	2	3	4	5	6	7	8	9	10	11	Never late
2. Not competitive	1	2	3	4	5	6	7	8	9	10	11	Very competitive
3. Good listener	1	2	3	4	5	6	7	8	9	10	11	Anticipates what others are going to say (nods, interrupts finishes for them)
4. Never feels rushed (even under pressure)	1	2	3	4	5	6	7	8	9	10	11	Always rushed
5. Can wait patiently	1	2	3	4	5	6	7	8	9	10	11	Impatient when waiting
6. Casual	1	2	3	4	5	6	7	8	9	10	11	Eager to get things done
7. Takes things one at a time	1	2	3	4	5	6	7	8	9	10	11	Tries to do many things at once, thinks what he/she will do next
8. Slow, deliberate talker	1	2	3	4	5	6	7	8	9	10	11	Emphatic in speech (fast & forceful)
9. Cares about satisfying him/herself no matter what others may think	1	2	3	4	5	6	7	8	9	10	11	Wants good job recognised by others
10. Slow doing things	1	2	3	4	5	6	7	8	9	10	11	Fast (eating etc)
11. Easy going	1	2	3	4	5	6	7	8	9	10	11	Hard driving (pushing self and others)
12. Expresses feelings	1	2	3	4	5	6	7	8	9	10	11	Hides feelings
13. Many outside interests	1	2	3	4	5	6	7	8	9	10	11	Few interests/out of work/home
14. Unambitious	1	2	3	4	5	6	7	8	9	10	11	Ambitious

(13)

This is a questionnaire to find out the way in which certain important events affect different people. Each question consists of a pair of alternative statements.

Please select one statement from each pair (and one only) which you more strongly believe to be the case as far as you are concerned, and ring your selection (ie 1 or 2).

Be sure to select the one you actually believe to be more true rather than the one you think you should choose or the one you would like to be true. This is a measure of personal belief; obviously there are no right or wrong answers.

Ring 1 or 2 of the following statements as being nearest to your belief.

I. Many of the unhappy things in people's lives are partly due to bad luck.	1
OR	
People's misfortunes result from the mistakes they make.	2
II. In the long run people get the respect they deserve in this world.	1
OR	
Unfortunately, an individual's worth often passes unrecognised no matter how hard he tries.	2
III. Without the right breaks one cannot be an effective leader.	1
OR	
Capable people who fail to become leaders have not taken advantage of their opportunities.	2
IV. No matter how hard you try some people just don't like you.	1
OR	
People who can't get others to like them don't understand how to get along with others.	2
V. Heredity plays the major role in determining one's personality.	1
OR	
It is a person's experiences in life which determine what they're like	2
VI. I have often found that what is going to happen will happen.	1
OR	
Trusting to fate has never turned out as well for me as making a decision to take a definate course of action.	2
VII. In the case of the well prepared student there is rarely if ever such a thing as an unfair test.	1
OR	
Many times exam questions tend to be so unrelated to course work that studying is really useless.	2
VIII. Becoming a success is a matter of hard work, luck has little or nothing to do with it.	1
OR	
Getting a good job depends mainly on being in the right place at the right time.	2
IX. There are certain people who are just no good.	1
OR	
There is some good in everybody.	2
(14)	6 6 6

Remember - please select only one statement

X.	The average citizen can have an influence in government decision. OR This world is run by the few people in power, and there is not much the ordinary person can do about it.	1 2
XI.	When I make plans, I am almost certain that I can make them work. OR It is not always wise to plan too far ahead because many things turn out to be a matter of good or bad fortune anyhow.	1 2
XII.	In my case getting what I want has little or nothing to do with luck. OR Many times we might just as well decide what to do by flipping a coin.	1 2
XIII.	Who gets to be the boss often depends on who was lucky enough to be in the right place first. OR Getting people to do the right thing depends upon ability, luck has little or nothing to do with it.	1 2
XIV.	As far as world affairs are concerned, most of us are the victims of forces we can neither understand, nor control. OR By taking an active part in political and social affairs the people can control world events.	1 2
XV.	Most people don't realize the entent to which their lives are controlled by accidental happenings. OR There really is no such thing as "luck".	1 2
XVI.	One should always be willing to admit mistakes. OR It is usually best to cover up one's mistakes.	1 2
XVII.	It is hard to know whether or not a person really likes you. OR How many friends you have depends upon how nice a person you are.	1 2
XVIII.	A good leader expects people to decide for themselves what they should do. OR A good leader makes it clear to everybody what their jobs are.	1 2
XIX.	Many times I feel that I have little influence over the things that happen to me. OR It is impossible for me to believe that chance or luck plays an important role in my life.	1 2
XX.	People are lonely because they don't try to be friendly. OR There's not much use in trying too hard to please people, if they like you, they like you.	1 2
XXI.	What happens to me is my own doing. OR Sometimes I feel that I don't have enough control over the direction my life is taking.	1 2
	(15)	7 7 7

Would you now please fill in the attached Crown Crisp Index and then come back to answer the questions below.

S E C T I O N V

Finally we would value your comments on the following questions.

1. What suggestions would you make to alleviate stress in nursing?

2. Overall stress has been seen as a negative phenomenon. For you are there any positive aspects of stress?

3. If you had heard of the project before you received your questionnaire please ring appropriate answer.

1. Newsletter
2. Meetings
3. Newspapers
4. Word of mouth
5. Other means (please state)

888

Thank you for completing the questionnaire. We hope that you have found it interesting and not too demanding of your time.

Appendix B Demographic details

1 Personal demographics

Sex

It can be seen from Table i that a total of 475 (92 per cent) females and 40 (8 per cent) males returned the questionnaire. Although it is not possible to make exact comparisons with national figures (as these are expressed in terms of 'whole-time equivalents') these figures seem to roughly reflect the balance within the profession. In 1982 there were 40,129 male nurses and 416,205 female nurses in the United Kingdom*, this represents a 9 per cent to 91 per cent division nationally.

Table i Sex of respondents

	%	*n*
Female	92.2	475
Male	7.8	40

Age

It can be seen from the age distribution that the overall profile of the sample is skewed towards the higher end of the continuum with a peak in the 35-39 age band, and then a gradual decline (see Table ii). As expected, a comparison with the national nurse population shows the group to be older as their more senior grade demands a number of years of preparatory experience.

It seems from the distribution that the careers of these senior nurses effectively commence in the 25-29 year age band. The mean for the whole group was 40 and the majority of respondents fell into the 35-45 year old category.

The pattern observed fits the typical career path of the nurse manager. Entering nurse training immediately after leaving school she is likely to spend a number of years gaining wider experience as a staff nurse before gaining her post-professional qualifications and being promoted to ward sister in her late twenties.

*Private communication with DHSS 12.12.84.

Table ii Age distribution

		% all registered nurses at 30 September (1983)		*(1982)*
Age range	*Sample % and (n)*	*Female*	*Male*	*Female/Male*
21-24	1.6 (8)	19.3	4.8	16.7
25-29	9.8 (51)	19.8	17.2	19.3
30-34	16.5 (85)	13.0	22.8	14.7
35-39	20.9 (107)	12.8	18.7	13.9
40-44	18.4 (95)	11.4	11.2	11.4
45-49	13.5 (69)	10.4	9.1	10.2
50-54	12.0 (62)	7.8	7.3	7.7
55-59	7.1 (37)	4.7	5.7	4.9
+60	0.2 (1)	0.8	3.2	1.2

Country of origin and length of time in the UK

A specific item was included in the questionnaire on national origin as it was considered that staff born and trained abroad were likely to experience different sources and levels of stress than British nationals trained in this country.

In point of fact, very few of our respondents (only 6 per cent of the total) fell into this category and of the 37 who had been born abroad 33 had lived in this country for more than 10 years (see Table iii). Because of these low numbers further investigation of this group was not pursued.

Marital status

From Table iv we see that 66 per cent (n = 341) of our respondents were married, remarried or lived with a partner, and 33 per cent (n = 171) were single, divorced/separated, a widow or a widower.

Thus, the majority of nurse managers had domestic commitments to balance against their professional role. Indeed these figures are likely to be somewhat of an underestimation as they do not include other forms of family responsibilities – caring for elderly parents, and so on.

Table iii Nationality/years in UK

	%	n
Born in British Isles	93.2	480
Not born in British Isles	6.2	32
Nil response	0.6	3
Length of time resident in this country if born abroad:		
under one year	0.2	1
one to five years	0.4	2
five to ten years	0.2	1
over ten years	6.4	33

Table iv Marital status

			UK female executives (n=696)*	
Marital Status	*%*	*n*	*%*	*n*
Married	58.3	300	51.6	359
Remarried	5.0	26	4.9	34
Living with partner	2.9	15	8.2	57
Single	24.3	125	24.0	167
Divorced or separated	7.4	38	10.2	71
Widow or widower	1.6	8	1.1	8
Other	0.6	3	0.0	0

* Source: Davidson and Cooper, 1983.

Unfortunately, it is not possible to compare this distribution with the national pattern within the profession due to the lack of data in this area. However, the overall pattern is similar to that found in Davidson and Coopers' (1983) sample of female executives (see Table iv).

It is interesting to note the general demographic changes in the role of women and how this is reflected in the predominantly female profession of nursing. Twenty-five years ago, only 25 per cent of working women were married but by 1980 this had increased dramatically to 60 per cent (Davidson and Cooper, 1983). (See also Table v.)

The OPCS report *Women and employment* (Martin and Roberts, 1984) noted that in the UK:

> 'There has been both an overall rise in levels of women's economic activity and the emergence of a bimodal or two phase work profile. These changes are related and are chiefly accounted for by the dramatic increase in the labour force participation of married women who have in growing numbers returned to the labour market after a period of domestic absence and who have done so after increasingly short absences from the labour market; a feature of most Western industrial societies over the last 30 years.'

Indeed Lockwood (1981) notes that the UK leads in this area and that 'more women who leave the labour force before or during the early years of motherhood re-enter it in Great Britain, than in any other country in Western Europe'.

Table v Current economic activity of all women except full-time students

	%
Working full time	35
Working part time	28
Unemployed	6
Total economically active	69

Source: Martin and Roberts, 1984.

Since the end of World War II there has been an increasing number of married nurses in practice. This increase has been viewed with a certain degree of ambivalence. It is still true to say that there exists a mythical stereotype of the nurse as someone who has sacrificed marriage and a family of her own in order to totally commit herself to a life of caring for others. A leading nursing academic noted, with some regret, that this change amongst members of the nursing profession was having 'far-reaching effects on both individual career structure and the composition of the profession as a whole'. (Baly, 1973)

Dependent children

As well as domestic commitments, it can be seen from Table vi that almost half the sample have dependent children living at home. Again these figures reflect general demographic trends. Data from the General Household Survey show that the number of working mothers increased from 45 per cent to 51 per cent between 1973 and 1980 and the OPCS report (Martin and Roberts, 1984) notes that 52 per cent of all working women had children under the age of 16 (that is, roughly corresponding to our 'at home' category).

It can be seen from Table vi that our results indicate a slightly lower percentage of respondents with dependent children (45 per cent) although this is explained in part by the fact that 9 per cent of our respondents were male. Compared with female executives it seems that nurse managers tend to have a younger family than their peers in commerce and industry.

Table vi Dependent children

			UK female executives (n = 696)*	
Number of children at home	*%*	*n*	*%*	*n*
One child	19.4	100	13.0	90
Two children	18.3	94	15.0	104
Three children	6.2	32	5.0	35
Four or more children	1.2	6	3.2	22
Total	45.1	232	36.2	251
Age of children	*%*	*n*		
Pre-school age	4.5	23		
School age	21.6	111		
Post-school age	18.4	95		
Other	5.4	28		
Total	49.9	257		

*Source: Davidson and Cooper, 1983.

Level of education

Traditionally nursing has been seen as a separate and self-contained career path often attracting candidates in their mid-teens. Almost half the sample (47 per cent) had 'O' levels as their highest educational qualification (see Table vii). Taking these together with the 21 per cent who had no educational qualifications, we see that the highest education level attained by 68 per cent of the sample was 'O' level. Only 20 per cent of the sample had 'A' levels or any higher educational qualifications.

Over one in five of the sample, therefore, had no formal educational qualifications other than their nursing qualifications.

Table vii Level of education

			UK female executives (n = 696)*	
Level	*%*	*n*	*%*	*n*
'O' level or equivalent	47.4	244	21.5	149
'A' level or equivalent	13.6	70	14.0	97
Degree or equivalent	1.9	10	31.0	215
Postgraduate	3.1	16	-	-
Higher degree	0.4	2	3.3	23
PhD	0	0	0.6	46
Other	12.4	64	6.6	46
NA	21.0	108	23.1	160

*Source: Davidson and Cooper, 1983.

Although it is true that nationally only 10 per cent of the general population obtain five or more 'O' levels, our sample was made up of the top strata of the nursing profession, and it is exceptional to find such a high proportion of middle and top managers without higher educational qualifications.

Compared with a national sample of female managers drawn from a variety of occupations it can be seen that the 'educational profile' falls well below their non-nursing peers, particularly in post-'A' level studies (see Table vii).

However, the majority of our sample (68 per cent) had obtained a post-professional qualification and it is likely that many of those respondents without educational qualifications would be those who had entered the profession before it was necessary to have obtained a minimum educational level.

The General Nursing Council were forced to introduce (as late as 1962) an entrance test for student nurse applications, so that there could be some screening of potential entrants before they started training since there were no minimum educational requirements at this time. Until that date the emphasis had been simply on recruitment rather than on screening entrants (Baly, 1973).

Traditionally, nursing tended to be thought of as a very 'practical' job, demanding little intellectual ability. Lack of formal educational qualifications did not prevent one from being professionally successful, and traditionally the stereotype of the potential trainee was of a practical rather than a thinking candidate. Indeed, the Royal College of Nursing make this very point in their recent proposals for a new form of nurse training. The report team was particularly critical of the message which it felt the present system of nurse education relays to the public in general and to school leavers in particular. 'That crude message is that a typical candidate should be drawn from that restricted band of school pupils clever enough to get five O-levels, but not so clever as to do really well at A-levels, who should not normally be boys or men . . . who should not be ambitious for a task of anything called higher education and who should be content often to be utilised as "a pair of hands".' (Royal College of Nursing, 1985).

Table viii Professional qualifications

Initial	*%*	*n*
SRN	74.0	381
ONC	7.0	36
RSCN	4.9	25
RMN	11.8	61
Others	2.3	12
Post		
With	68.5	353
Without	31.5	162

2 Professional demographics

Professional qualifications

Table viii shows the distribution of first and post-professional qualifications. The majority of respondents (74 per cent) had obtained SRN (now RGN) as a first professional qualification. Two per cent of the sample had obtained an alternative first qualification (for example, Fever Nurse Certificate). These respondents and the 7 per cent who had first obtained their ONC are likely to have started their nursing career before they were of an age to start their SRN training.

The majority of our sample (68 per cent) had qualification(s) in addition to their basic professional one, making them clinically well trained and well qualified. This contrasts strongly with attainments in general education and the level of higher educational qualifications.

Years in nursing

It is interesting to note that overall these figures represent an 'inverted pyramid' (see Table ix). This raises an important question concerning career advancement; is it a result of length of service or ability?

In a recent survey of women managers in the United Kingdom it was found that on average women managers had 15.5 years of previous employment (Davidson and Cooper, 1983). Our sample provided an average of about 19 years which is considerably higher than Davidson and Coopers' national figure.

Table ix Years in nursing

	%	*n*
Less than 10	8.5	44
10-15	18.1	93
15-20	20.4	105
20-25	24.5	126
Over 25	28.3	146

3 Job demographics

Full-time/part-time

The majority of the sample (78 per cent) had full-time contracts with the health district (see Table x) and this proportion of full and part-time staff closely reflects recent national figures for nursing staff.

Table x Showing patterns of work

	Full-time		*Part-time*	
	%	*n*	*%*	*n*
Days only	60.5	312	10.8	56
Shift	12.6	65	2.1	11
Nights only	4.5	23	8.0	41
Total	77.6	400	20.9	108

Hours per week worked by part-time staff

Of the 22 per cent (n = 110) of the total sample who had part-time contracts, it was possible to obtain full details of the work patterns of 18 per cent (n=95).

It was evident that 20-25 hours per week was the most frequent pattern worked. This was considerably more than the national average. The OPCS report (Martin and Robertson, 1984) notes that the national average part-time working week was 18.5 hours. This gives some indication of the dependence of the National Health Service on their part-time staff, particularly within the hospital setting.

During the interviews phase of the project, the difficulties of part-time, qualified staff returning to the profession after a number of years absence was highlighted. Recent advances in technology and methods of care mean that many 'returnees' found themselves feeling deskilled and out of touch. Although many authorities provide excellent inservice training and some 'return to nursing courses', part-time workers often find they are given low priority. In extreme cases this can lead to a rapid and negative downward spiral, as the following quote illustrates.

> 'I had looked forward for years, all the time my two children were growing up, to get back into nursing. When I finally managed it I found I was completely out of my depth and I couldn't let anyone know about the problems I was facing. Everyone assumed I could operate like the ward sister I was eight years ago. But things have changed so much that I was completely overwhelmed. It wasn't only the new treatment techniques or even the new technology. I had expected these. But I found even the names of some instruments and procedures that I thought I knew had changed! I felt completely useless and to some extent was there under false pretences. I couldn't get on the courses I wanted to either because they seemed to be too basic for me or because, as a part-timer, I came low down the priority list. In the end I left. Everyone suffered. The clinic had a member of staff who wasn't pulling her weight, the

patient got second rate treatment, the consultants didn't get the support they deserved, and I have lost my profession and my self respect.'

Patterns of work

This question confirmed that 78 per cent (n=400) of respondents worked full-time, and that 21 per cent (n = 108) worked part-time (see Table x).

A much higher percentage of part-time staff worked night duty (38 per cent), compared with only 6 per cent of full-time staff. There was some indication that this pattern is particularly attractive to those with dependents, as working night duty fits in better with domestic commitments.

Length of service with current employer

Table xi shows that about 60 per cent of respondents had been in post for at least five years and about 40 per cent for over ten years. It was further evident that 27 per cent (n=140) of the respondents had not moved from any other authority. Presumably this group were 'home-trained' (that is, they had completed their earlier training within the authority and remained until they took up their present post). This lack of movement can be seen as an indicator of stability or, more pessimistically, as stagnation. Unfortunately it is not possible to obtain any reliable information regarding staff movement at the national level. However, it raises fundamental questions regarding career advancement, staff development, and programmes of on-going staff training within the health authority.

Table xi Length of service with current employer

	%	*n*
< one year	6.6	34
1-3 years	12.4	64
3-5 years	10.3	53
5-10 years	30.1	155
> 10 years	38.8	200
Other	1.8	9

Reasons for moving to this area

From Table xii we can see that 72 per cent of the whole sample (n=373) moved to the district from another area. Almost a quarter of those who had moved had

done so as part of a 'positive' career step, to obtain promotion or to obtain better working conditions. However, 35 per cent of those who had moved (one-quarter of the whole sample) had done so because of their partners' work (that is, mainly for domestic rather than career reasons).

The majority of respondents who had moved had done so for reasons *other* than to improve their career or professional status. This suggests that their career is secondary to that of their partners' and raises interesting questions as to the level of motivation of this group and about the cost to their own careers of having to move for their partners' sakes.

Choosing between one's own career and one's partner's career is likely to become a growing source of conflict since, as already indicated, the number of married women within the profession is increasing.

Table xii Staff moving from other areas

Reason for moving	*%*	*n*
Promotion	11.1	57
Better working conditions	6.4	33
Better living conditions	5.4	28
Partner's work	25.0	129
Others	24.5	126
Total	72.4	373

Number of staff supervised

Several respondents remarked on the difficulty of accurately answering this question and the wide variety of responses seem to bear this out. Whilst it is relatively simple to identify the hierarchy and lines of responsibility in the ward situation, it is by no means as clear within the various specialisms. This is particularly so in small specialised units within the hospital (for example, stoma care) and generally within the community. Seventy-nine per cent of respondents saw themselves as being directly responsible for other staff.

Working environment

It can be seen from Table xiii that 52 per cent of the whole sample were hospital-based staff and that 37 per cent were based in the community. Five per cent of the sample described themselves as working in central administration and planning (the remaining 6 per cent working in 'other' areas).

Nationally, in 1982, there were 11 per cent (n=48,440) community-based nurses and 89 per cent (n=407,894) hospital-based nurses.* The difference between these figures and those obtained in our sample can be partly accounted for by the fact that the national figures include student nurses within the 'hospital-based' statistics, and our sample was of sister/charge nurse level and above only.

Table xiii Working environment

	%	*n*
Central administration	4.7	24
Nurse education	6.0	31
Accident/emergency department	3.1	16
Theatres	3.3	17
Outpatient/clinics	1.9	10
Wards/special units	38.4	198
Community based	36.9	190
Others	5.6	29

Nursing grade

Table xiv shows the distribution of the total sample by career grade. Two sub-groups were identified. The first group of 'first line managers' consisted of 394 staff at sister/charge nurse level. It represents the largest single group in the sample and includes both hospital and community based nurses.

The second group was made up of 80 'senior nurses'. A number of levels were represented in this group – clinical nurse managers (65), directors of nursing or midwifery services (10), and district nursing officers (5).

Forty-one of the respondents (8 per cent of the total) saw themselves as being on a different grade to those mentioned and were not included in any subsequent analysis.

*Private communication with DHSS 12.12.84.

Table xiv Nursing grade

	%	*n*
Sister/charge nurse level	76.5	394
'Senior nurses'	15.5	80
Others	8.0	41

Hospital-based staff – details of working environment

Table xv shows the distribution of all hospital-based staff by hospital size and specialist function.

Because of the low response rate on this item from people working in specialist units it was not considered viable to use individual specialist hospital types as a variable for data analysis.

Table xv Hospital size and type

Hospital size	%	*n*
< 100 beds	26.8	138
100-300 beds	7.2	37
> 300 beds	26.2	135
Hospital type		
General	27.6	142
Community (hospital)	7.0	36
Geriatric	10.9	56
Psychiatric	7.2	37
Rheumatoid diseases	1.9	10
Physically handicapped	0.2	1
Mentally handicapped	1.0	5
Other type of hospital	7.8	40
Not applicable	36.5	188

Community-based staff – details of working environment

Table xvi gives some indication of the environmental setting of community-based staff. There was some confusion caused by this question; in particular, the definition of 'caseload size' proved problematic. For this reason the information on the average caseload of community-based staff is not reported.

Table xvi Community-based staff – details of working environment

Setting	*%*	*n*
Rural	23.3	120
Urban	13.4	69

Do you consider that your work is in a generally recognised high stress area?

Seventy-one per cent of respondents (n=367) felt that their work area was not recognised as being a high stress area. Twenty-eight per cent (n=144) thought that their work area was recognised as being a high stress area. One per cent (n=4) did not answer this question.

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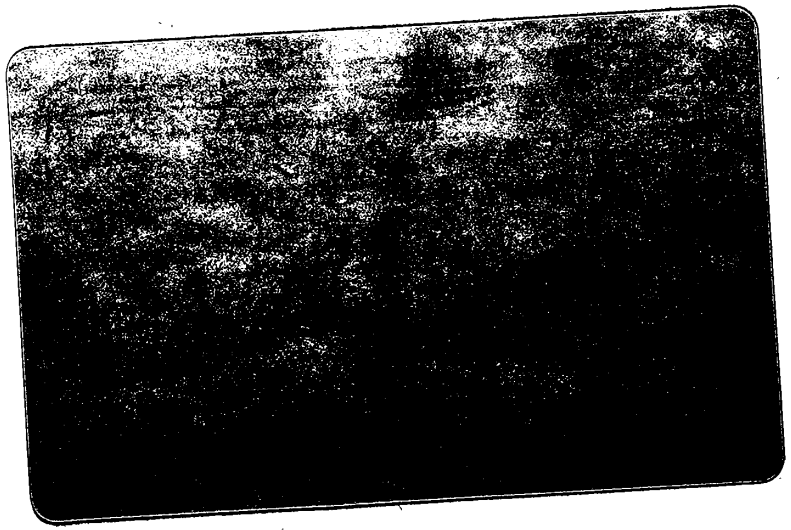
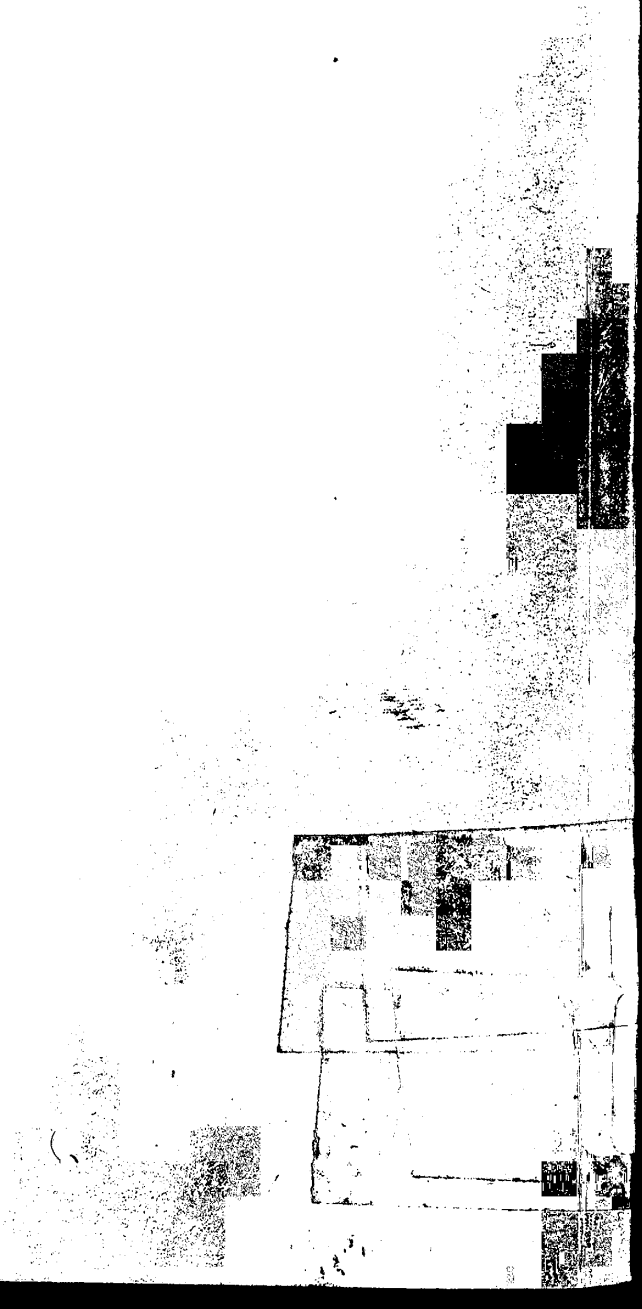


Peter Hingley was the Director of the King's Fund project on stress in nurse managers. He is currently Director of Studies in the Department of Nursing Health and Applied Social Studies, Bristol Polytechnic. He has a particular interest in the problems of stress in the 'caring' professions and in the management of professional change.

Cary L Cooper is Professor of Organisational Psychology at UMIST. He is the editor of the international quarterly *Journal of Occupational Behaviour*, a Fellow of the British Psychological Society and has been an adviser to the World Health Organization on psychological stress and occupational health.

Phil Harris is a psychologist working at Bristol Polytechnic. He has a particular interest in nurse education and in the methodological problems of stress research.



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