UNIVERSITY OF CAPE COAST

PERCEIVED OCCUPATIONAL STRESSORS, COPING STRATEGIES AND BURNOUT PERTAINING TO NURSES WORKING IN TAMALE TEACHING HOSPITAL OF NORTHERN REGION.

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BY

PRINCE GUNGUNI WINFRED JEBUNI.

Dissertation submitted to the Department of Educational Foundation of the Faculty of Education, University of Cape Coast, in partial fulfilment of the requirements for award of Master of Arts Degree in Guidance and Counselling.

AUGUST 2011

DECLARATION

Candidate's Declaration

I hereby declare that this dissertation is the result of my own original research and that no part of it has been presented for another degree in this university or elsewhere.

Candidate's Signature…….. Date……..

Prince Gunguni Winfred Jebuni

Supervisor's Declaration

I hereby declare that the preparation and presentation of the dissertation were supervised in accordance with the guidelines on supervision of dissertation laid down by the University of Cape Coast.

Supervisor's Signature…….. Date……..

Rev. Prof. J. K. Essuman.

ABSTRACT

This study was conducted to describe perceived occupational stressors, coping strategies, and burnout levels of nurses working in Tamale Teaching Hospital. Participants comprised of 123 males and 207 females (N =330). The study utilized a descriptive design, adapting the stress, coping, and burnout theoretic al frameworks of Seyle, Lazarus, Folkman, and Maslach.

One set of survey instrument was designed by the researcher to collect data from the target population. The instrument consisted of four parts, which were adapted and modified from: Devilliers, Carson, and Leary (DCL) stress scale; PsychNurse Methods of Coping Questionnaire (PNMCQ); Maslach Burnout Inventory (MBI)-Human Service Survey (HSS).

The results indicated that the majority of nurses in the study were experiencing moderate levels of stress or moderate levels of burnout. The findings suggested that quality care issues were important factors in determining stress levels, and informal approaches were preferred as methods of coping with these occupational stressors. This research becomes a baseline from which to address the problem of stress among nurses working in Tamale Teaching Hospital since it is the first of its kind.

To improve the quality of work–life for nurses, I recommend that Nurse Administrators in general and particularly those of Tamale Teaching Hospital

should pay attention to quality care issues since they are important factors determining stress levels of nurses. Finally, I recommend that the study could be replicated in other hospitals in the region and if possible the whole country.

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At long last the battle is ended, and no good work, especially one of this scope and magnitude, can be done alone. I wish to thank colleagues, friends, and loved ones who in the early days of this dissertation shared their time and knowledge with me.

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Finally, I am deeply grateful to my supervisor, Rev. Professor J. K. Essuman, who offered advice, support, and encouragement through the days of discouragement as well as the final days of optimism and accomplishment. His patience and tolerance coupled with his fatherly love energized me and spurred me to this successful completion.

DEDICATION

This dissertation is dedicated to Mary, my wife and best friend, and children who have been by my side every step of the way and have given me their time, and love.

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CHAPTER ONE

INTRODUCTION

Background of the Study

Occupation fulfils different needs of people such as getting money, seeking opportunity to communicate with others, purposeful physical and psychological activity, and enhancing self-esteem and usefulness. Hospitals and health centres, compared to any other industrial unit, consists of production factors, such as capital, workforce, technology and management. The hospital's activities are oriented towards the main products, which are saving life, restoring life and improving the health of the people, and nurses are the workforce of these centres. In other words, nursing hospitals and other health care centres aimed to produce a product named "human health" and one of the indispensable staff in these centres are nurses. In Ghana, about eighty (80) percent of staffs in the health care sector are nurses (MOH, 2006/7) who are in the front line for delivering health care services. They have a central role to play, making them the pivot of the sector. They have most workload because of the shortage of nurses in our hospitals, which results in early occupational, psychological and physical depreciation (White, 2006). Stress is one of the most common psychological issues confronting nurses, and its management is always an important concern for them. Occupational stress is considered as the most important occupational hazard in modern era. Most of the time when these adverse psychological and physical reactions manifest themselves in the worker at the

workplace, the supervisor does not hesitate to call it malingering, because the symptoms are associated with sickness and its attendant excuse duty chits and application for casual leave (Kutsienyo,1997). It results in decreasing productivity, absence of work, staff rotation in wards and a high expense of health care staffs. Although stress has relationship with most factors leading to death, such as heart disease, cancer, immune syndrome and so on, sometimes stress is considered as a normal reaction to some events, such as death of a love one, and in this circumstance it is not known as a psychological disorder (Mehrabi, Nap, Martins, Maliepaard & Lombard, 2007).

Every person experiences various forms of stress throughout his life span. The presence of stress can provide the stimulus for change and growth, and in this respect some stress can be positive. However too much stress can result in poor judgment, physical illness, and inability to cope with the stressor. Stress is, therefore caused by situational demands made on organizational staff and the origin of these demands may be in the work place or within the individual himself. However, for the purposes of this study, sources of occupational stress reside in the hospital. These sources exist within a hospital as an operating system that constantly interacts with hospital staff in ways that can induce occupational stress in the worker. Accordingly, occupational stress will be used in this study to refer to mental and physical exertion that will be caused by factors in the hospital environment.

Greenberg in his book, managing behaviour in an organization, pointed out that some jobs such as that of emergency room physicians, police officers, fire fighters,

and airline pilots, expose the people who hold them to high level of stress. This basic fact - that some jobs are much more stressful than others has been confirmed by the results of a survey involving more than 130 different occupations (Greenberg, 2005). What precisely, makes some jobs more stressful than others? According to Greenberg (2005), research has shown that several features of jobs determine the levels of stress they generate. Specifically, people experience greater stress the more their jobs require:

1 Making decisions

2 Constantly monitoring devices or materials.

3 Repeatedly exchanging information with others.

4 Working in unpleasant physical conditions

5 Performing unstructured rather than structured tasks.

The greater the extent to which a job possesses these characteristics, the higher the level of stress that job produces among individuals holding it he concluded. He emphasized that nurses and long distance bus drivers perform jobs that match this profile and not surprisingly, people doing these jobs tend to show many of these adverse signs of stress (Greenberg, 2005). Heller and Hindler (as cited by Greenberg, 2005) went further to draw a table showing sources of stress in everyday life. In this table, the jobs of doctors, nurses, pharmacist and physical therapists were named as jobs more stressful in the medical field. The common sources of stress to jobs in the medical field stated are:

1 When human lives are at stake;

2 When the pressure to make the right decision is great; and

3 When dealing with human distress is very difficult on people.

Potter and Perry (1985) in their book: Fundamentals of Nursing pointed out that rapid changes in society, health care technology and health care knowledge as well as changes in the nursing profession can all place stress on nurses. Most nurses experience stress within their work environment usually related to rotation of shifts, severity of patients' illnesses, number of patients and other health care workers and institutional polices. A nurse's reaction to a job related stressor depends on the nurse's individual personality, health status, previous experience with stress and coping mechanism. Stress, like beauty, is in the eye of the beholder. Each person perceives and reacts to situations and change differently depending on his personal characteristics, abilities and experiences, his external support system and characteristics of the stressor itself. According to Craven and Hirnles (2007), the stress response produced may be elicited by real, potential, or imagined threats leading to varied and multiple patterns of hormonal discharge. The goal is to mobilize the person's energy resources to cope with the stressor and to produce adaptive outcomes. During the literature review, many studies on stress in nursing have attempted to measure, or have speculated on, the effects of such stress on nurses' health and well-being. There appears to be general agreement that the experience of work-related stress generally detracts from the quality of nurses' working lives, increases minor psychiatric morbidity, and may contribute to some

forms of physical illness, with particular reference to musculoskeletal problems, stress and depression.

In 1987, in the first number of the international quarterly Work and Stress, Dewey, referring to Moreton-Cooper (as cited in Cox & Griffiths, 1996) wrote that: "If you wanted to create the optimum environment for the manufacture of stress, many of the factors you would include would be clearly recognized by nursing staff as events which they encounter in their daily routine. These include an enclosed atmosphere, time pressures, excessive noise or undue quiet, sudden swings from intense to mundane tasks, no second chance, unpleasant sights and sounds, and standing for long hours".

He concluded that nursing is, by all standards, a "stressful" profession. It is hardly surprising that nurses, confronted by such events and tasks have been reported to experience high levels of stress, and their difficulties appear to be further exacerbated by a range of organizational issues increasingly recognized, as being instrumental in the stress process. White (2006) stated that, the responsibility of hospital management for the health of their nursing staff is set within a framework of national and international law, which is largely based on the concept of the control cycle and the process of risk management. Such a framework he went on has been made explicit in the European Union's Framework Directive 89/391/EEC. Although much of this framework focuses on the direct effects of the more tangible hazards of work, it has been strongly argued that it can be extended to encompass psychosocial and organizational hazards, stress and stress management he concluded.

Stress and its negative outcomes have been recognized as financially costly to any health care institution. Negative outcomes of occupational stress among nurses include illness, decline in overall quality of care, job dissatisfaction, absenteeism, and staff turnover (Schwab as cited in Williams, 2007). Occupational stress describes the stress associated with the professional or work environment and tension is created when the demand of the occupational stress varies with each work environment.

Williams (2007), cited other studies like Hemingway & Smith (1999); Tovey & Adams (1999); Van Servellen & Topf (1994) which also identified heavy workload, urgency of work to be performed, dying and death of patients, role conflict, lack of autonomy in practice, lack of social support, poor job fit, insufficient knowledge base, unsafe workplace, and a rapidly changing health care environment as stressors for nurses. Cohen-Mansfield (cited in Williams, 2007) divided work related stressors in nursing into three categories:

1 Stressors at the institutional level,

2 Stressors at the unit level and

3 Stressors at the patient level.

The role of nursing is associated with multiple and conflicting demands imposed by nurse supervisors and managers, and by medical and administrative staff. Such a situation appears to lead to work overload and possibly to role conflict. One form of such conflict often mentioned in surveys of nurses relates to the conflict inherent in the instrumental and goal-oriented demands of "getting the patient better" and those related to providing emotional support and relieving the patient’s stress.

Role conflict of this kind may be most obvious when dealing with patients who are critically ill and dying. Indeed, one of the areas of nursing that has attracted particular attention has been critical or intensive care nursing. Health care is also a sector which suffers a high rate of violent behaviour and nursing practice in particular, often involves working in stressful environments, caring for patients in noisy or over-crowded spaces, visiting homes or situations that are depressing, adjusting to various work shifts, and being under staffed and these commonly affect nurses.

Statement of the Problem

It is now almost universally recognized that nursing is, by its very nature, a stressful occupation. Every day the nurse confronts stark suffering, grief and death as few other people do. Many nursing tasks are mundane and unrewarding. Many are, by normal standards, distasteful and disgusting. Others are often degrading; some are simply frightening Hingley (as cited in Cox & Griffiths, 1996) Even though stress is a fact of life, and a nurse like any other person, is exposed to stressors, the practice of nursing exposes the nurse to additional stressors. Cole believes that 93% of nurses experience occupational stresses frequently, which may affect their physical and psychological health. He went further to enumerate the various occupational stressors which nurses encounter as working in shifts, workloads, conflicts with co-workers, occupational responsibilities, frequent meeting of patients experiencing pain and death, lack of supportive supplies and not having enough time to support the patients emotionally (as cited in Mehrabi & et al, 2007). Mehrabi and colleagues further intimate that, the National Association of

Safety Professionals of America introduces nursing as a first stressful job among 40 stressful professions. To buttress the effects of occupational stress on nurses, findings of a cross sectional survey conducted among female nurses in Csongrad, Hungary revealed the frequency of common psychosomatic symptoms (for example, sleeping problems, tension, headache, chronic fatigue or palpitation), regular alcohol drinking, heavy smoking and frequent use of tranquilizers and sleeping pills as a further confirmation of nurses' work related stress level (Piko, 1999). In Ghana, nurses leave the government service for three reasons:

1 To the private sector.

2 To migrate outside the country for greener pastures, and

3 On account of age (retirement).

The Nurses and Midwives Council reported a loss of 328 nurses from the register in 1999 (up from 198 in1998) although this is only 2.6 percent of the entire nursing group, it is the approximate numerical equivalent of the entire output of State Registered Nursing (SRN) schools for the year 2000 (Ministry of Health [MOH], 2001). While there has been substantial increase in the production of nurses for the health sector, the wastage is almost equal to the rate of production and hence there have been only marginal increases in the numbers. This leaves the remaining few nurses with a heavy workload, which became compounded with the inception of the National Health Insurance Scheme (NHIS). This makes the nurse at the closed of the day's work, become emotionally, physically, and mentally exhausted (i.e. burnout). Coupled with feelings of low self-esteem or low self-efficacy, the nurse puts up a lackadaisical attitude to patients. As a result, there has been public outcry

and bad publicity about this attitude of nurses in recent times. A survey conducted by Ghana Health Service (2004) revealed that health care professionals, especially nurses are insensitive, rude, and unresponsive to the needs of patients. The Survey perceived this behaviour as a result of understaffing, ill motivation, poor remuneration and work overload. Could it also be that the nurses were experiencing signs and symptoms of burnout syndrome and tedium, this researcher wants to know? According to the Ghana MOH Report for 2006/07, the nurse/midwife: patient ratio was 1:1,537 as against World Health Organization (WHO) 1: 6. Also the MOH Human Resources National Division (HRND) Report for 2008 revealed that there were only 2, 880 professional midwives for the care of an estimated population of 22.9 million Ghanaians. One of Maslach's stress reactions is "Depersonalization", which results when nurses see their patients as objects rather than as human beings may be confirming this assertion. In depersonalization, the nurses become detached or callous and can even dehumanize their patients. This phenomenon is sometimes known as *detached concern*. Feelings of reduced personal accomplishment result when health-care professionals, particularly nurses feel that their actions are not producing positive results (Maslach, 1982).

Many of these studies cited in this study were either carried out in the Western World or the United States, and little is known of the phenomena in developing countries like Ghana. A review of current literature revealed that even though many studies have been done in this area, nothing of the sought has been done in Tamale Teaching Hospital. This is the more reason why this present study is undertaken to

investigate perceived occupational stressors, coping strategies and burnout among nurses of Tamale Teaching Hospital.

The Purpose of the Study

The purpose of the study is to investigate perceived occupational stressors, coping strategies and burnout among the nurses of Tamale Teaching Hospital. The study will also suggest strategies for the management and coping with occupational stressors if they turn out to be high.

Research Questions

The research questions to be addressed in this study are as follows:

1 Which kind of activities do nurses perceive as the most stressful in their work at Tamale Teaching Hospital?

2 Which top five activities do the nurses perceive as the most stressful in their work in Tamale Teaching Hospital?

3 Which top five activities do the nurses perceive as the least stressful in their work in Tamale Teaching Hospital?

4 Which coping strategies are utilized most frequently by nurses working in Tamale Teaching Hospital?

5 What is the degree of burnout pertaining to nurses working in Tamale Teaching Hospital?

Significance of the Study

This study will provide information to nurse managers, nurse clinicians and nurse educators related to perceived occupational stressors, coping strategies and burnout in the hospital setting in Tamale Metro of northern Ghana. The nurse managers in particular will be in a position to reduce stress in their staff if they understand occupational stress, coping strategies and burnout. Thus increased occupational stress increases the likelihood of job injury, absenteeism, and staff turnover. Tzeng therefore, (as cited in Williams, 2007) suggests that nurse managers should focus on those stressors which they have the most influence to change.

For nurses in clinical practice, the rapid turnover of staff due to stress, reduces the quality of care as a new staff nurse must be oriented and group cohesiveness is weakened by constant changes in the group membership on a nursing unit. Increased understanding of stress will prompt staff nurses to take personal measures to reduce stress, raise their level of expertise, and become proactively involved in improving the working environment of their organization, (Mee & Robinson as cited in Williams, 2007). So the knowledge learnt will be used by nurses to reduce or cope with stress.

For nurse educators, knowledge of occupational stress could be used in either basic nursing education setting or in continuing education. Teaching effective stress management techniques and organizational participation skills are channels for educators to be proactively involved in nurse retention before it becomes a problem. The findings of the study will suggest preventive coping strategies, interventions that

will build the capacity of health care managers, and to strengthen the ability of nurses to cope and manage stressors in the workplace.

Delimitations of the Study

Stress in general is so broad a topic that the researcher chose to study stress related to occupation. Similarly, there are various types of occupations that the study was limited to the nursing occupation. However, since nursing is delivered in many settings, the researcher had to narrow down the study to the hospital setting and Tamale Teaching Hospital is selected out of the fourteen hospitals for the study.

Tamale Teaching Hospital is the only teaching hospital in the three Northern Regions of Ghana. According to the Director of Nursing Service, the hospital has a nursing strength of 430 nurses, of which 352 are professionals and 78 auxiliaries at the time of conducting this study.

Limitations of the Study

It is necessary to identify the associated limitations of a particular research protocol when interpreting the study findings. This study has several limitations. Frustration in retrieving the questionnaires from participants was the major limitation the researcher encountered. The researcher had to make unfruitful rounds from ward to ward at any available time to retrieve administered questionnaires. The sample size was relatively small (N = 330). Another limitation of this study was the inability to retrieve all the questionnaires (the retrieval rate was 77%). The absence of information pertaining to the participants who did not return the questionnaires means that the generalization of findings from this study to the wider population

cannot be accurately determined. The researcher believes that a couple of possible explanations exist pertaining to the non-submission of questionnaires. First, the questionnaire with four parts may have been one reason for the low response rate, because the research required each respondent to complete all four questionnaires with a total of 100 questions. Another possible reason for the non submission is fatigue resulting from work as the hospital's nursing department is woefully under staffed. Specifically, the most stressed-out staff may have felt too exhausted or overworked to take additional time to participate in the study. If this were the case, then these results could be somehow misleading.

The use of self-report questionnaires stands a risk of measurement error in relation to defensive responses or bias. The generally accepted practice of measuring stress by simply asking subjects to comment on the degree to which certain situations are perceived as being present in their work results in a process of simplification that gives limited attention to the frequency, intensity, and meaning of the various stressors. In addition, utilizing the Likert-type scale as a form of gathering information can have negative consequences (Burns & Grove as cited in White, 2006). For instance, the instructions for the questionnaire simply ask the participant to rate the extent to which each activity causes stress. The rating scale also began at zero, meaning that a particular activity does not cause the respondent any stress. This seems rather unrealistic that certain activities listed in the questionnaire would not cause any stress. As previously mentioned, everyone experiences some degree of stress at all times (Selye, 1956). Another limitation of this study is the general nature of the questions on the coping strategies used by

nurses. Participants are instructed to record how they think they cope in certain situations rather than identify how they actually cope in practice. In other words, some individual nurses may convince themselves that they are coping more effectively in order to feel better about themselves. One finding on depersonalization has revealed another limitation. The nurses understood this question (*I can easily understand how my patients feel about things.*) as empathy instead of depersonalization. Therefore, it had the highest mean score of 4.5.

Definition of Terms

1 Occupation is a coherent set of jobs.

2 A job is a predetermined set of activities an individual is expected to perform.

3 Stress is any stimulus that either raises one's excitement or anxiety level beyond what one regards as above one's usual or personal capabilities. It is more so, if it is prolonged. It may jolt one to more or better activity or retard one's ability to cope with the event at hand.

4 Occupational stress will be used in this study to refer to mental and physical exertion that will be caused by factors in the hospital environment

5 Coping is a process a person uses to manage stresses or events that he or she encounters.

6 Stress and illness: stress increasing vulnerability to illness by altering health behaviours.

7 Strain, defined as deviation from normal states of human function resulting from exposure to stressful events.

8 Burnout- a syndrome of emotional, physical, and mental exhaustion coupled with feelings of low self-esteem or low self-efficacy, resulting from prolonged exposure to intense stress and strain

9 Tedium results from environmental factors that create conflicts or place demands on the nurse

10 A conceptual framework is a set of coherent ideas or concepts organized in a way that makes them easy to communicate to others.

Organization of the Rest of the Study

The rest of the study was centred on reviewing the relevant data, particularly ideas and theories related to the study. This enabled me to venture into the field to collect the actual data. The data was analysed, results discussed, and conclusions and recommendations made.

CHAPTER TWO

RELATED LITERATURE REVIEW

Introduction

This chapter reviews related literature in support of the goals of the study. The study is to investigate perceived occupational stressors, coping strategies and burnout among nurses of Tamale Teaching Hospital. There is such a wealth of literature on occupational stress that it would be too ambitious to attempt an elaborate review in this study. The literature review is divided into two parts: the theoretical or conceptual framework and the empirical studies on occupational stress.

Conceptual Framework

The conceptual framework chosen for the present study consisted of several theoretical works of four well-established theorists. A conceptual framework is a set of coherent ideas or concepts organized in a way that makes them easy for people to understand. The purpose of this study is to examine perceived occupational stressors, coping strategies, burnout and the relationship among the three concepts for nurses working in Tamale Teaching Hospital. In order to approach this study in an organized scientific manner, four theoretical models were used as a guide. These theoretical models include works by theorists Hans Selye, Richard Lazarus, Susan Folkman, and Christina Maslach.

What is Stress?

One can hardly pick up a newspaper or magazine or watch television without seeing or hearing some reference to stress. Stress is an unavoidable consequence of life and the term is difficult to define: It is used loosely and means different things to different people. Some use it to describe an upset feeling or response; others use it to describe the source of stimulus for their feeling upset (Brunner & Saddarth, 1988).

The term "stress'' is derived from the Latin word "string ere" , which means "to draw tight'' (Skeat as cited by Potter & Perry , 1985). Although the concept can be traced through the history of civilization, it became important in the science of physiology and health in the mid 1800s (Potter & Perry, 1985). Stress is usually defined from a demand, that is perception response, perspective (Bartlett, 1998), meaning that the way and manner the individual perceives the stress. Lazarus and Folkman (1984) integrated this view into a cognitive theory of stress that has become the most widely applied theory in the study of occupational stress management. The basic concept is that stress relates both to an individual's perception of the numerous demands being made on him by society and to his perception of his capability to handle those demands. A mismatch will mean that an individual's stress threshold is exceeded, triggering a stress response (Clancy & McVicar, 2002).

Historically, Cannon, (as cited by Brunner & Saddarth, 1988) described the ``fight or flights'' response that prepared the individual to cope with immediate danger. They quoted Selye, that ``stress is essentially the rate of wear and tear in the

body‘’. Hans Selye, a Canadian endocrinologist and renowned stress theorist, who is sometimes called ``father of stress'' first used the term in this context. He defined stress as the sum of all non specific effects of factors that can act upon the body. Later, he spoke of stress as being a ``non specific response meaning that regardless of the stimulus producing the stress, the physiological response of the body was always the same (Brunner & Saddarth,1988).

In 1956 Hans Seyle, noted that “No one can live without experiencing some degree of stress all the time” (as cited by White, 2006). According to Porter & Perry, (1985), Selye began his work in 1926 and developed a conceptual framework for describing stress and the body’s responses and adaptations. He called it the General Adaptation Syndrome (GAS), and it has three distinguishable phases: alarm, resistance, and exhaustion. These three phases occur sequentially. Simply stated, if the source of stress sounds the alarm and initiates the GAS and the stress is not removed or coped with, the body progresses to resistance and eventual exhaustion. However, recovery is an alternative outcome to exhaustion when the source of stress is either removed or coped with effectively.

An underlying concept in Seyle’s GAS model is his belief that all living organisms are equipped with a vital force that he called *adaptation energy* (Porter & Perry, 1985). This adaptation is stored in the body and is drawn on whenever organisms have to adapt to demands from outside forces. Seyle, Porter and Perry continued, describes the state of the body at the alarm stage as the *fight-or-flight response*. This refers to the options available in coping with stressors at this point in the stress response. Seyle, they said found that when his laboratory animals could

not fight or flee, the animals had to adjust to the stimuli by shifting to a lower level but more complex stress response. This response prompted various organs and glands of the animals to produce a variety of hormones, salts, and sugars needed to supply the energy necessary to resist the demands of the stimuli and keep the body in balance (Porter & Perry, 1985). He believed that the effects of the resistance phase of GAS result in the gradual wearing down of what he characterized as weak links, body parts, or systems that bear the brunt of adaptive attempts during the resistance phase. When his animals were no longer able to resist the stimuli acting on them, they broke down, became exhausted, and died (Selye, as cited by Porter & Perry, 1985).

In a nutshell, Cana van (2007), defines stress as the response the individual feels when things that are happening exceed his/her ability to cope. While Kutsienyo, (1997) on the other hand defines it as the adverse physiological and physical reactions that occur in individuals as a result of their being unable to cope with the demands being made on them. Stress is often confused with every day pressure. In fact, the individual actually needs the daily pressures to perform at his/her best. Think about an actor or an athlete - the pressure they feel before they perform helps them give a good performance and this is the same for any of us.

Lazarus is another well-accepted stress theorist. Lazarus (as cited by Akinade, 2007) defined stress as a very broad class of problems, which tax the system (physiological, social and psychological) and the response to that system. He is credited with developing a unique model explaining how our minds work when perceiving potential stressors.

Lazarus' theory of psychological stress revolves around the belief that people or things become stressors when they pose a threat to our well-being in some way. The threat may be either psychological or physical in nature, and the perception of the stimuli determines whether or not they become stressors (Lazarus, 1966). Lazarus called the perception of potential stressors, a *transaction* and called the actual evaluation of stimuli the *threat appraisal process*. His model involves a three-part appraisal of the potential stressor:

1 The first appraisal (primary appraisal) determines whether the stressor is a threat;

2 The second appraisal determines whether the individual is capable of coping with the threat; and

3. The third appraisal (the cognitive reappraisal) draws on the information from the first two appraisals (Lazarus, 1966).

In his later work, with colleague Susan Folkman, Lazarus expanded his work on threat appraisal. According to Lazarus and Folkman (1984), stress is a real or perceived imbalance between the environment and an individual's ability to cope or adapt to the imbalance. Individuals endure by continually coping with or adapting to the demands of a constantly changing environment.

When viewed as a stimulus, stress is defined as any event or set of events, (a stressor), that cause a response (Lazarus, 1998). Everyday, stressors associated with work or social relationships and uncommon events such as natural disasters, physical trauma, injuries, illness, divorce, death of a loved one, or loss of job are common recognized stressors. Therefore, stress is often thought of as negative or

``bad'' and is associated with events that cause distress. Thus, researchers in different disciplines have pursued study in the field of stress. Biologists have concentrated on physiology, while psychologists and sociologists have focused on the psychological and social aspects of stress. Each group has come up with a different approach or theory related to stress.

The Nature of Stress

To illustrate the nature of stress, imagine that you are in an office building when you suddenly see a fire raging. How does your body react? As a natural, biological response, your body responds in several ways - both immediately after experiencing the stressor (a ranging fire), a few minutes later, and after repeated exposure. For example, certain chemicals according to Greenberg (2005) are released that make it possible for us to respond ("fight" or "flight"). Adrenaline boots our metabolism, causing us to breathe faster, taking in more oxygen to help us to be stronger and run faster. Aiding in this process, blood flows rapidly (up to four times faster than normal) to prime the muscles, and other fluids are diverted from less essential parts of the body. As a result, people experiencing stressful conditions tend to experience dry mouths as well as cool, clammy, and sweaty skin. Other chemicals, according to Greenberg are activated and these suppress the parts of the brain that control concentration, inhibition, and rational thought. By the way, this is why people in emergency situations do not always think rationally or act politely. In short, when exposed to stressors the body kicks into a self-protective mode, marshalling all its resources to preserve life. However, when this happens frequently, the chronic responses can be dangerous. Such reactions are referred to as strain,

defined as deviation from normal states of human functioning resulting from exposure to stressful events. According to Kimle & Willenberg (as cited by Passer & Smith, 2001), linkages between long term stress and illness are not surprising, for physiological responses to stressors can directly harm other body systems. For example, the secretion of stress hormones by the adrenal gland is an important part of the stress response. These hormones affect the activity of the heart, and excessive secretions can damage the lining of the arteries. By reducing fat metabolism, the stress hormones can also contribute to the fatty blockages in the arteries that cause heart attacks and stroke.

People may view stressors as positive or negative and under normal circumstances; employees should be able to find new ways of responding to new situations. Stress is, therefore, not necessarily a negative phenomenon. It would be a mistake to concentrate only on the pathological (disease causing) aspect of stress without emphasizing its importance in the search for dynamic adaptation to a given situation. If health is considered as a dynamic equilibrium, then, stress is part of it for there is no health without interaction with other people and the environment. Only excesses are pathological. Negative connotations are usually ascribed to the term, yet some stress responses are of positive benefit (Bartlett, 1998). Selye referred to pleasant events as 'eustress' from the Greek prefix "eu" meaning good or positive (as cited by Craven & Hirnle, 2007). One example of eustress is going to college, which the person views as positive and desirable, but also stressful because of the changes in routine and adaptation involved. On the other hand, the term 'distress' appropriately describes negative aspects of stress, for example, being fired

from work or hospitalized. Therefore, stress should be viewed as a continuum along which an individual passes, from feelings of eustress to those of mild or moderate distress, to those of severe distress.

EUTRESS_____MODERATE_____DISTRESS

Fig 1: Diagram of Stress as a Continuum

Indicators of distress are recognized (Table 1), but those of mild or moderate distress may not be observed collectively, or may have differing degrees of severity, and so symptoms at this level of distress are likely to vary between individuals. In contrast, severe and prolonged distress culminates in more consistently observed symptoms of emotional 'burnout' and serious physiological disturbance (McVicar, 2003).

Table 1: Psychological and Physiological Indicators of Eustress and Distress

Type/Effect	Eustress	Distress	Severe distress
Psychological	Fear/excitement Increased level of arousal, And mental acuity	Unease Apprehension Sadness Depression Pessimism Listlessness Lack of self esteem Negative attitudes Short temper Fatigue Poor sleep Increased Smoking/alcohol Consumption	Burnout i. e. a) Emotional exhaustion b) depersonalization and disengagement c) decreased personal accomplishment
Physiological	Autonomic arousal (a) Increased arterial Blood pressure (b) Increased heart Rate	Persistently elevated hypertension arterial blood pressure Indigestion constipation	Clinical Coronary heart disease Gastric disorders Menstrual problems in women
Physiological	c) Quicker reaction Times	diarrhoea weight gain or	Increased asthma attacks in sufferers

Table 1 continued

	Release of Metabolic Hormones Especially cortisol a) Increased metabolic rate b) Mobilization of glucose, fatty acids, amino acids	loss	
Impact On the Individual	Adaptive: Increased alertness, Attention focused on The situation, Individual more responsive to changing Situations, Fear, fight, flight Preparation	Variable between individuals, but usually maladaptive	Variable Between individuals but usually Severely maladaptive possibly life Threatening

Table 1 continued

For activity:

'Energised'

Source: McVicar, (2003)

The evidence that both cognitive and physiological responses occur simultaneously is debatable, except in extremely distressful situations, but it is convenient to consider cognitive and physical responses separately. Physiological responses are based on the General Adaptation Syndrome Selye, (as cited by McVicar, 2003).

Some researchers like Gray-Toft and Anderson (as cited by Cox & Griffiths, 1996) have asked whether those sources of stress commonly cited in the scientific literature (see Table 1) are similar for all nurses employed in hospitals, irrespective of the type of ward or nursing speciality. The evidence to support the view that, together, factors inherent in the nursing role and in the organizational culture within which the nurse works are as important a determinant of the experience of stress by nurses as the type of nursing pursued Dewe (as cited in Cox & Griffiths, 1996). Yu (also cited by Cox & Griffiths, 1996) has concluded that stress in nursing reflects the overall complexity of the nurses' role, rather than any particular aspects of their individual tasks. One of the areas of nursing that has attracted particular attention has been critical or intensive care nursing.

Reviews of the literature on stress in this area of nursing tend to support the above conclusions. According to Cox & Griffiths (1996), Stehle concluded that there is no evidence that critical or intensive care nursing is more or less stressful than any other type of nursing. Irrespective of the specialized nursing involved, critical or intensive care nurses appear to be as vulnerable to workload issues, patient conflicts and the difficulties imposed by inadequate resources as nurses in other areas, he added. Not all the available studies support this general conclusion.

McVicar (2003) cited Healy & McKay (1999), McGowan (2001) and Shader, Broome, West & Nash, (2001) indicated that it is the transition to severe distress that is likely to be most detrimental for nurses, and is closely linked to staff absenteeism, poor staff retention, and ill-health. If severe distress is to be prevented, then it is important to understand what factors promote the transition. Nursing provides a wide range of potential workplace stressors as it is a profession that requires a high level of skill, team working in a variety of situations, provision of 24-hour delivery of care, and input of what is often referred to as 'emotional labour'(Philips,1996). McVicar (2003) reported that French, Lenton, Walters and Eykes in 2000 identified nine sub-scales of workplace stressors that might impact on nurses. These are, but not in any particular order:

1 Conflict with physicians,

2 Inadequate preparation,

3 Problems with peers,

4 Problems with supervisor,

5 Discrimination,

6 Workload,

7 Uncertainty concerning treatment,

8 Dealing with death, and dying patients,

9 Patients / their families.

As the transition from eustress to distress depends upon an individual's stress perceptions, it follows that variability between people in the identification of workplace stressors within these sub-scales might be expected. Additionally, temporal changes in the sources of stress might also be anticipated, as working conditions are not static. Indeed, recent years have seen a number of changes in the structure of Ghana's health delivery system. The establishment of the Ghana Health Service (GHS), the National Health Insurance Scheme (NHIS), Additional Duty Hour Allowance (ADHA) and its consolidation, the car loan revolving fund and the housing loan scheme are all in an attempt to improve, motivate and retain health staff, including nurses to give up their best. Mpiani (2009) confirmed this by suggesting that "Policies and strategies to enhance retention of highly trained workforce should be comprehensive and better focused… For Ghanaian nurses and midwives today need effective incentives which should include: an attractive salary; performance related pay; opportunities for further training; defined career development plan and structured promotion; adequate pension; assistance with ownership of cars and houses; and payment of children's school fees".

Nursing literature describes two conditions that commonly affect nurses: Burnout and tedium. Burnout results from working with people who are demanding and needy. These can produce conflict within the nurse and can lead to depleted energy and low morale. Tedium on the other hand results from environmental factors that create conflicts or place demands on the nurse. Physical and emotional depletion, negative self-concept, negative attitudes and feeling of helplessness and hopelessness characterize both burnout and tedium (Craven & Hirnle, 2007).

McVicar (2003), collating the evidence from the literature led to the identification of six main themes for the sources of workplace distress for nurses. Most sources of stress, that is workload, leadership/management issues, professional conflict and emotional demands of caring, have been identified consistently by nurses for many years. Perhaps this should not be surprising, as they relate to the main generic characteristics of practice.

Inexperienced nurses according to Charnley, (1999); Brown & Edelmann, (2000); (as cited in McVicar, 2003) are identified with similar clinical sources of stress, and low levels of confidence in their clinical skills as a further source. Hillhouse and Adler in 1997 (as cited by McVicar, 2003) suggested that it is the actual characteristics of the work environment, and workload, rather than any differences in practice requirements that are important in evaluating sources of stress for nurses. However, a small number of studies suggest that, whilst overall reported stress levels may be similar, their ranking may vary according to practice area. McVicar further reported that Foxall, Zimmerman, Stanley, and Bene confirmed this assertion in 1990, when they found that nurses working in intensive care ranked

coping with ‘death and dying’ more highly as a source of distress than did those in medical–surgical care, who ranked workload and staffing issues higher. Tyler and Ellison, (as cited by McVicar, 2003) also found that theatre nurses ranked emotional aspects lower than did those working in a liver unit, or in haematology or oncology.

Stordeur, D’Hoore, & Vandenhergbe, (as cited by McVicar, 2003) attempted to rank stressors in order of severity of impact. The main ones ranked are:

1 High workload,

2 Conflict with other nurses/physicians,

3 Experiencing a lack of clarity about tasks/goals,

4 A head nurse who closely monitors the performance of staff in order to detect mistakes and to take corrective action.

Most people spend more time at work than they do at any other activity. Not surprisingly, then, work can be a prime source of stress, and there is a great deal of evidence to show that on-the-job stress affects the physical and mental health of many employees. The statistics are staggering; In one study, Cooper and Marshall, (as cited by Stanhope & Lanchester,1992) estimated that cardiovascular disease, which is often linked to stress, accounts for 12 percent of worker absenteeism in the United States of America and adds up to an average loss of about $4 billion a year. Other physical and mental health problems that often stem from stress - migraine headaches, for example - resulted in a loss of 22.8 million workdays in just one year also in the United States of America.

What Causes Stress on the Job?

According to Nhundu (1999) several multi-disciplinary studies have generated some consensus on variables that cause occupational stress. These include career development factors (for example, job security and promotion prospects), role in the organization (for example job autonomy and participation in decision-making), reward system (poor salaries and recognition), intrinsic job factors (workload and challenging work) and interpersonal relationship. Reiterating this point, Stanhope and Lanchester (1992) stated that researchers have identified more than forty factors that can be occupational stressors, grouped into seven general categories:

1 *The nature of the job*: A worker may suffer stress reactions as a result of *working conditions* (temperature, humidity, noise, vibration, and lighting, for example) or *work overload* (a workload that is too heavy or too difficult); *under load* (too little work) can also be a stressor.

2 *Role in the organization.* An employee may suffer from role ambiguity or role conflict. Role ambiguity arises when the worker is unclear about what is expected of him or her. Role conflict occurs when the job demands that the worker do things that

(a) He or she dislikes or disapproves of or

(b) He or she thinks that things he/she does are beyond the scope of his/her job description.

(c) *Responsibility for other people* is another important role-related stressor. People in "*white-collar"* (managerial and professional)

positions seem most likely to be victims of this type of stress.

3 *Interpersonal relationships.* Research suggests that poor relationships between a worker and his or her superiors, subordinates, and colleagues may be stressful.

4 *Career development.* For many workers, especially those in the early phase of their careers, the desire to advance rapidly may be a stressor. For other workers, usually older ones fear and frustration can result when they reach a "career ceiling," the point at which they can no longer advance within the organization.

5 *Organizational structure and climate.* An organization that does not encourage a sense of belonging, worker participation in decision making, and good communication within its ranks is likely to generate stress. Margolis (as cited in Stanhope & Lanchester, 1992) found that lack of participation is the most important and consistent signal of on- the- job stress and subsequent stress reactions.

6 *Family and outside activities.* The worker's life away from the job can cause stress on the job. Burke and Weir, (as cited in Stanhope & Lanchester, 1992) found that a close, supportive marriage-in which an employee can informally discuss job problems with his or her spouse-is likely to prevent or reduce on-the-job stress and increase both occupational and marital satisfaction. In contrast, a less successful marriage can intensify, if not create, stress at work.

7 *Miscellaneous.* As we have seen, life changes can be significant stressors. Many life changes are work-related for example, a change of jobs, unemployment, and retirement (Cooper & Payne, as cited in Stanhope & Lanchester, 1992).

Healy and McKay according to McVicar (2003) also found workload to be most significantly correlated with mood disturbance. However, Payne did not find a significant relationship between workload and burnout, although levels of burnout in her study were lower than in related studies. McVicar further suggested that the reasons for this variation though unclear, are likely to include, differences for stress 'hardiness' (Simoni & Paterson, 1997); of coping mechanisms (Payne, 2001); of age and experience (McNeese-Smith, 2000); or of the level of social support in the workplace (Ceslowitz, 1989; Morano, 1983; Healy & McKay, 2000).

Inter and extra professional conflict continues to be an important source of stress for nurses. Inter professional conflict, particularly between nurses and physicians; appear to be more of a problem as pointed out by Hillhouse & Adler, 1997; Bratt, Broome, Kelber, & Lostocco,; Ball, Pike, Cuff,Mellox-Clark and Connell, (as cited in McVicar, 2003). The impact of professional conflict as a source of distress is supported by findings of Kivimaki, Ellovainnio, and Vahteera, (as cited in McVicar, 2003) that bullying is prevalent.

McVicar (2003) compiled a table which indicates the type of stressors which impacts on the work satisfaction of staff nurses studied by several researchers.

1 Stressors: Workload/Inadequate staffs cover/ Time pressure (Mc Gowan, 2001**;** Stordeur et al, 2001).

2 Stressors: Relationship with other clinical staff, (Stordeur et al, 2001; Bratt et al, 2000).

3 Stressors: Leadership and management style/Poor locus of control/ poor group cohesion/Lack of adequate supervision support (Mc Gowan, 2001; Bratt et al, 2000).

4 Stressors: Coping with emotional needs of patients and theirfamilies/Poor

Patients' diagnosis/Death and dying, (Demerouti, Bakker, Nachreiner & Schaufeli, 2000 ; Mc Gowan, 2001).

In addition to identifying sources of distress, McVicar (2003) also reported that, Demerouti and the colleagues in 2000 sought to distinguish between the factors that were most likely to result in emotional exhaustion and (job) disengagement, the two main components of burnout arising as a consequence of severe distress (see Table 1). They found that job demands (viz. workload, time pressure, demanding contacts with patients) were most associated with emotional exhaustion, whereas job resources (viz. lack of participation in decision-making, lack of reward) were most associated with disengagement from work. Workload, leadership/management, professional conflict, and 'emotional labour' have been the main collective sources of distress for nurses for many years.

Nurses are at risk for occupational stress as a result of three factors: according to Potter and Perry, (1985):

1 First, new graduates generally have high expectations which may not be accomplished in the work setting, leading to feelings of frustration;

2 Second, nurses usually work in close interaction with others, specifically, patients and other health care professionals; such continuous interaction can lead to conflicts and other stresses.

3 Finally, the work setting itself increases the risk for job stresses. Most nurses work in institutional settings that are frequently unable to meet all the individual needs of patients or nurses.

The variation between individual perceptions is most likely to arise from differences in personal factors as personal stress 'hardiness' influences ability to cope, (Simoni & Paterson 1997) as do the levels of companionship and social interaction at work, (Ceslowitz, 1998; Healy & McKay 1999 (as cited in McVicar, 2003). There will also be contributions from sources outside the workplace.

The study of Tyler and Ellison (1994) provides an illustration of this, as it identified that nurses living with a partner had fewer stress symptoms than those with no partner, and those with children experienced less stress from dealing with patients and relatives. The range of possible interactions between personal and workplace sources of distress is considerable, but under-researched, Schaefer, Moos, Jones & Johnston (as cited by McVicar, 2003).

In view of the importance of personal factors in influencing the perception of stress, it is important for nurse managers in our health institutions to consider just how individual nurses might be supported, enabling them to utilize the most effective coping strategies that work for them as individuals, supported by colleagues and senior staff. These emotion-focused dimensions are typically viewed as being negative and unhelpful, and are associated with burnout amongst nurses.

Burnout

Burnout is a psychological experience that manifests itself in the individual, particularly those individuals who are involved in difficult person-to-person relationships as part of their regular working experiences. According to White, (2006), a leading pioneer in research on burnout syndrome, Christina Maslach, reported, "Burnout is reaching epidemic proportions among North American workers." Maslach (as cited in Adali & Priami, 2006) maintained that burnout is a syndrome characterized by exhaustion, depersonalization and a low level of personal accomplishments, which primarily affects people who are somehow dealing with other people in their work. Burnout develops as a response to the chronic emotional strain, which is the result of dealing with other people and especially with people who cope with serious problems. Thus, burnout could be considered as a type of professional stress, which results from the social interaction between the person who provides help, and the person who receives that help.

Nurses are particularly susceptible to the development of burnout, mainly because of the nature and the emotional demands of their profession. Burnout is a serious problem, (Adali & Priami, 2006). They continued, it directly affects the

worker and it presents various symptoms, both somatic and psychological. It is related to the deterioration of relationships between the nurse and the patients, the co-workers, the family and the social environment.

Maslach's Concept of Burnout

There are three stress reactions, which occur in a very specific three-dimensional sequence according to Maslach (1982). These stress reactions are characterized by emotional exhaustion, depersonalization, and feelings of little personal accomplishment. Emotional exhaustion refers to excess emotional demands made on people at work, to the point of exhaustion.

Depersonalization results when people (nurses) see their clients (patients) as objects rather than as human beings. The person (nurses) become detached or callous and can even dehumanize their clients (patients). This phenomenon is sometimes known as *detached concern*. Feelings of reduced personal accomplishment result when people (nurses) feel that their actions are not producing positive results (Maslach, 1982).

Supporting Maslach, (Clause and Bailing as cited in Potter and Perry, 1985) state that job stress is frequently associated with a condition called "burnout" which is characterized by emotional, physical and spiritual exhaustions. In the work setting, an individual experiencing burnout may withdraw from others, exhibit negative feelings towards others, have increased absence from work and perform work tasks less effectively than he use to. Barker and colleagues, (as cited in Greenberg, 2005) confirmed this assertion when they stated that sometimes people find themselves worn down by chronic levels of stress. Such people are often described as suffering

from burnout – a syndrome of emotional, physical and mental exhaustion coupled with feelings of low self- esteem or low self- efficacy, resulting from prolonged exposure to intense stress and strain reactions following from them.

Claude Bernard, in 1867, was one of the first physiologists to recognize the potential consequences of stress for an organism. He proposed that changes in the internal and external environments disrupted the functioning of the organism (Porter & Perry, 1985). Other studies have investigated the effects of stress, including burnout, low job performance, job dissatisfaction and mental and physical health of the employee: (Dua, Johnson & Sarason, Kyriacon & Sutcliffe; Otto, Sarros & Sarros as cited in Nhundu, 1999).

Coping Strategies of Stress

Coping is vital for the survival of any person in today's fast-moving world, particularly in the healthcare environment. Lazarus and Folkman (1984) noted, "Coping serves two overriding functions: managing or altering the problem with the environment causing distress (problem-focused coping), and regulating the emotional response to the problem (emotion-focused coping)" (p. 179). Lazarus, in 1998 defined coping as: "not a single act but a constellation of many acts and thoughts, engendered by a complex set of demands that may stretch out over time" (as cited in White, 2006).

Walter Cannon introduced the term "homeostasis" in 1920, to describe how an organism successfully responds to stress. Cannon studied specific mechanisms that organisms use to adapt to stress and in turn to maintain a balance, homeostasis,

within the internal environment (Porter & Perry, 1985). Perhaps the most important contemporary researcher in stress according to Porter and Perry is Hans Selye. Selye, they reported developed a biochemical model of stress known as the "general adaptation syndrome" (GAS). The GAS model clearly describes what occurs in the human body during a stress response. According to them, Selye also introduced the concept of stressors, those internal or external stimuli that cause stress. Selye's research into stress and stressors has been important for the health care profession. The GAS model is readily applicable to all areas of nursing practice. As a nurse cares for patients experiencing various kinds of stress, the nurse helps them use their own adaptive resources – through various techniques, including crisis intervention – to return to their highest levels of wellness (Porter & Perry, 1985).

Identification of the need to cope with sick patients and their families as a source of distress for nurses, therefore, is not surprising (Smith & Gray, 2001). Smith and Gray suggest that new patterns in learning to care are required to enable nurses to cope better with the emotional demands of their work. Concerning the two principal coping strategies, research indicates that problem-focused coping, such as problem solving, is the more effective of the two at preventing burnout in nurses (McVicar, 2003). McVicar cited Ceslowitz, Tyler and Cushway (1995), Simoni and Paterson (1997), Healy, Morano, and McKay (2000), and Payne (2001) to buttress his assertion. Thus, employing positive reappraisal or self-control (that is, positive emotion-focused dimensions) effectively decreases burnout (Ceslowitz; Healy & McKay, Payne, (as cited in McVicar, 2003), and so a combination of problem-focused coping with the more positive emotion-focused dimensions ought to be most

effective. According to McVicar, Parkes refers to this combination as 'direct coping'.

Coping strategies utilized most often by the Community Mental Health Nurses (CMHNs) included peer support, supervision, good communication skills, and a broad range of personal approaches, such as relaxation and belief in one's own abilities.

Stress and Illness

What, finally, can we conclude about the connection between stress and illness? A review of the literature suggests that there is a relationship. Some stress, therefore, is normal and necessary. But if stress is intense, continuous or repeated, if the person is unable to cope or if support is lacking, then stress becomes a negative phenomenon leading to physical illness and psychological disorders. Martino and Musri (2001) agree with this suggestion when they stated that: from early disorders to real illness, the harmful consequences of stress cover a broad range from chronic fatigue to depression, by way of insomnia, anxiety, migraines, emotional upsets, stomach ulcers, allergies, skin disorders, lumbago and rheumatic attacks and can culminate in the most serious consequences of all: heart attacks, accidents and even suicides.

Stress affects health in a variety of ways. According to Camille and Wortman (1992), the first is the direct route: stress may produce physiological and psychological changes that contribute to the development of illness. For example, they stated that stress can lower immunity making a person more vulnerable to colds,

flu, and other diseases. But not everyone who is under stress gets sick, suggesting that pre-existing and/or intervening variables come into play. One pre-existing variable is personality. They also maintained that people who rate high on hostility or pessimism, for example, may be more vulnerable to stress and thus more prone to illness and injury.

Camille & Wortman, (1992) concluded that there was a possibility of stress increasing vulnerability to illness by altering health behaviours. For example, under the stress of examination week, students are more likely to sleep less, smoke more, eat poorly, and engage in other behaviours that can compromise their health. Stress may therefore promote health "illness behaviours." Thus, people who are under stress are more likely to treat fatigue, insomnia, anxiety and depression as symptoms of illness and seek medical care they concluded.

Empirical Studies on Stress

Relatively recent studies, according to Herschbach in 1992, conclude that, while different nursing groups report similar levels of stress, the profile of stressors associated with those similar levels differed somewhat between groups. Herschbach however, maintained that the inter-group differences reported in those studies and others are not sufficient to argue for the separate treatment of the various nurse groups, which exist in hospitals. Therefore, while strategies for stress management need to be tailored to the generic group, hospital-based nurses, the strategies do not need to be further tailored to distinguish between different types of hospital-based nurses Herschbach (as cited in Cox & Griffiths 1996).

Ball and the colleagues in a recent 'Working well' survey for the Royal College of Nursing, found that 30% of nurses on long-term sick leave reported harassment and intimidation arising from sex/gender, age, race, sexuality or personal clashes as the main cause of their absence (McVicar, 2003). This suggests that stress intensity from the most frequently recognized sources has increased, and/or additional sources are contributing to the cumulative effects. Ball and the colleagues (as cited in McVicar, 2003) further reported that inter professional conflict also appears to have increased in importance for many nurses during the last 10 years or so.

Another study (as cited in White, 2006) was conducted in 2000 by a group of European researchers utilizing questionnaires to explore stress, coping, and burnout among 301 Community Mental Health Nurses (CMHNs). Contrary to the findings of a study conducted by Pinkhahana and Happel 2004 (as cited in White, 2006) in which majority of CMHNs were found to be satisfied with their jobs and only a fraction of them were experiencing high levels of burnout, thus these results indicated that CMHNs were experiencing high levels of stress and burnout. For instance, one half of the participants were found to be emotionally overextended and exhausted and, therefore, unable to provide quality care to their patients. This level of exhaustion was greater for the CMHNs working in urban settings than with those working in rural ones. These psychiatric nurses reported perceiving the most stressful aspects of their job as being workload, poor resources, excessive paperwork, and management problems, as well as a broad spectrum of patient-related issues. White reported that the results of this study were presented in four

separate papers (Bernard, Edwards, Fothergill, Hannigan, & Coyle, 2000; Edwards, Bernard, Coyle, Fothergill, & Hannigan, 2000, 2001; Hannigan, Edwards, Coyle, Fothergill, & Burnard, 2000).

Snelgrove, (as cited in White, 2006) also investigated stress and job satisfaction in three diverse groups of nurses working in the United Kingdom. The sample included 68 health visitors, 56 district nurses, and 19 Community Psychiatric Nurses (CPNs). Health visitors are qualified nurses with further specialized training in the field of nursing working in various settings throughout the community. District nurses are highly qualified nurses who have undergone further training to enable them to specialize in providing high-quality care to patients in the community. CPNs work specifically with psychiatric patients living either at home or in community-based treatment homes. It is important to note that some stressors were found to be common to all three groups of nurses. These included organizational issues, lack of resources, and administrative duties. However, the researchers found significant differences in the stress levels for each occupational group; and the health visitors reported the highest stress scores and lowest job satisfaction scores. The results of this study highlight the importance of treating nurses according to their specialties as opposed to treating them as a homogeneous profession.

In a comparison study, Fagin, Brown, Bartlett, Leary and Carson in 1995 (as cited by White, 2006) collected data on stress levels pertaining to 250 CPNs and 323 ward-based psychiatric nurses (WBPNs) in the United Kingdom. This study, according to White, uncovered interesting findings and comparisons between hospitals based psychiatric nurses and their community-based counterparts**.** For

instance, a large proportion of both groups of nurses experienced high levels of stress and emotional exhaustion due to the demands of their work. Furthermore, the nurses experiencing high levels of stress were utilizing more sick time, experiencing lower self-esteem, and feeling unfulfilled in their work. Fagin and colleagues also discovered that WBPNs have greater feelings of depersonalization, or detachment from their patients, and a decreased sense of personal accomplishment with their work, as compared to their colleagues working in the community, White added.

White, (2006) cited three other studies that investigated occupational stress pertaining specifically to nurses working on acute mental health units. He reported that in one of these studies, Jenkins and Elliott in 2004 set out to examine the relationship between stress and burnout among 93 qualified and unqualified nursing staff working in acute adult mental health wards in the United Kingdom. The two groups of participants differed in their perceptions of stress. For example, the main stressor for qualified staff was lack of adequate staffing. On the other hand, the main stressors for unqualified staff were dealing with physically threatening, difficult, or demanding patients. Fifty percent of both groups demonstrated high levels of burnout. Other stressors reported by both groups included workload, client-related difficulties, organizational issues, conflicts with other professionals, lack of resources, professional self-doubt, and home–work conflict. These findings were consistent with the belief of job-related stressors' leading to staff burnout.

In another study, Sullivan (1993) researched into stressors identified by 61 nursing staff working in the acute psychiatric in-patient facilities, of two health authorities in the United Kingdom. He also sought to assess the effects of stress and

identify the types of coping strategies utilized by the nurses working in this type of setting. The results indicated that the stressors most often cited by the nurses were violent incidents, potential suicides, and observation of patients.

Other stressors reported less frequently included staffing levels, administrative duties, and feeling overworked. The most frequently utilized coping strategies were social support, problem-solving, and avoidance techniques. Consistent with the results of previous studies, a high level of burnout was discovered in a majority of the nurses. Most important, reliability and validity were not reported in the study.

Many studies on stress in nursing have attempted to measure, or speculate on, the effects of such stress on nurses' health and well-being. There appears to be general agreement that the experience of work-related stress generally detracts from the quality of nurses' working lives, increases minor psychiatric morbidity, and may contribute to some forms of physical illness, with particular reference to musculoskeletal problems, stress and depression (ILO, 2000). Plant, Plant and Foster (as cited in McVicar, 2003) also reported that the health impact may be compounded in nurses by health-risk behaviours, for example, excessive smoking and alcohol abuse.

Passer & Smith (2001) cited Cohen; Dougael & Baum that stress can combine with other physical and psychological factors to influence the entire spectrum of physical illness, from the common cold to cancer, heart disease, diabetes and sudden death. Leor, (as cited by Passer & Smith, 2001) in a study confirmed that on the day of the 1994 Los Angeles earthquake, the number of sudden deaths due to heart

attacks in that city increased from an average of 35.7 per day during the 7 previous days to 101 fatalities. To the extent that people appraise various situations as stressors, they are likely to have stress reactions. These can have damaging behavioural, psychological, and /or medical effects. Indeed, physiological and psychological stress reactions can be so great that eventually they take their toll on the body and mind, resulting in such maladies as insomnia, cardiovascular disease, and depression.

Wolff in 1993 (as cited in Craven & Hinle, 2007) described disease states resulting from life stress caused by disruption in lifestyles and relationships, deprivation of human needs, and failure to act in ways to eliminate the cause of the stress. Stressors he added are also events or behaviours that are considered ``good'' or are useful to promote well-being. Participating in athletic events, exercising, and soaking in a hot tub will activate physiologic stress responses, are examples of positive or beneficial stressors he concluded.

Holmes and Rahe in 1967(as cited again in Craven & Hirnle, 2007) studied the relationship between specific life changes, such as divorce or death of a spouse, and subsequent set of illness. They assumed these life-changing events, according to perceived stressfulness, and degree of adaptation required can cause illness. Other researches advice that variables such as genotype, age, gender, marital status, and ethnic origin can be critical influences on a person's appraisal and evaluation of stressful life events. More recently, Kaplan (as cited in Craven & Hirnle, 2007) stated that researchers have studied the effects or consequences of psychosocial accidents, on health and immune system functioning,

Shift working, particularly night shifts, traditionally attracts pay enhancements but can have a significant effect on personal and social life. Prolonged shift work, especially night shift work, also has a health risk as it produces symptoms that correspond closely to those of mild or moderate distress (Efinger, 1995). According to McVicar, (2003), long-term night shift working has even been suggested to increase the risk of cardiovascular disease. McVicar maintained that measures introduced for the majority of nurses within a hospital, or even within a single practice area, are therefore unlikely to meet the needs of some nurses, rather variation between individuals in their perception of the workplace must be addressed.

Summary of Literature Review

The review looked at pertinent data on what stress is, nature of stress, sources of stress, burnout, coping strategies and stress and illness. The literature review provided me with a greater understanding of the concepts of stress, coping strategies and occupation. It has also provided guidance and organization for the ideas and theories relating to occupational stress.

A substantial amount of research on occupational stress has been conducted in the field of nursing, particularly psychiatric nursing. However, the research is limited by various geographical and methodological problems. For instance, the majority of research was conducted in the United Kingdom, the United States of America and only a few in the third world. Little has been done in Ghana particularly Tamale Teaching Hospital.

Therefore, it is clearly evident that a significant gap in knowledge exists in today's literature pertaining to nurses working in Tamale Teaching Hospital, and this study was designed to help fill that gap. The review has helped me to compare and contrast findings of my research questions with other research findings in different cultural backgrounds.

The evidence from the literature led to the identification of the sources of workplace distress for nurses. Most sources of stress, that is workload, leadership / management issues, professional conflict and emotional demands of caring, have been consistent through out the review, particularly workload.

CHAPTER THREE

METHODOLOGY

Introduction

This section outlines areas that would be dealt with in this chapter which include research design, population, sample and sampling procedures, description of any instrument used, validity and reliability of this instrument, data collection procedure and method of its analysis.

Research Design

This study used descriptive survey design, which attempted to investigate perceived occupational stressors, coping strategies and levels of burnout among nurses working in Tamale Teaching Hospital by collecting data from them. According to Leedy and Ormrod (2005), descriptive survey involves acquiring information about one or more groups of people, perhaps about their characteristics, opinions, attitudes, or previous experiences by asking those questions and tabulating their answers. The ultimate goal is to learn about a large population by surveying a sample of the population; thus, we might call this approach a descriptive survey or normative survey. Reduced to its basic elements, a survey is quite simple in design: The researcher poses a series of questions to willing participants; summarizes their responses with percentages, frequency counts, or more sophisticated statistical indexes; and then draws inferences about a particular population from the responses

of the sample, Leedy and Ormrod concluded. An extensive descriptive and inferential statistical analysis was undertaken to determine whether perceived stressors, coping strategies, and levels of burnout actually exist among the nurses working in Tamale Teaching Hospital.

Population

It is incumbent on the researcher to clearly define the target population. There are no strict rules to follow, and the researcher must rely on logic and judgment. The population is defined in keeping with the objectives of the study. Ideally, the sample corresponds to the larger population on the characteristics of interest (Burns & Grove as cited in White, 2006).

The target population for this study is 430 and consisted of all registered nurses working in Tamale Teaching Hospital located in Tamale Metropolitan city of Northern Ghana. Each participant had to be (a) male or female, (b) 18 years of age or older, (c) employed full time, (d) currently working in Tamale Teaching Hospital, (e) a Tamale resident, and (f) currently licensed to practice nursing in Ghana. Participants who fall outside these criteria were excluded from the study.

Sample/Sampling Procedure

A sample is a subset of the population, selected such that it will be representative of the target population. It mirrors the population so that the results obtained pertain to the population. The process of selecting the sample is known as sampling. Developing the proper sampling technique can greatly affect the representativeness of the results. Sampling therefore, is a fundamental method of inferring information about an entire population without taking the trouble or

expense of measuring every member of the population. In this study however, the total population is so small that, the researcher instead of sampling, rather used the whole population in order to make the results more credible

Data Collection Procedure

A questionnaire constructed by the researcher was administered to all the 430 registered nurses working in Tamale Teaching Hospital. However, only 330 (77%) were retrieved because some of the nurses were on leave. The questions were structured and estimated to take about 1 hour 40 minutes to complete. The questions in the questionnaire were specific in nature and pertained to stressful events related to the professional practice of the nurse, how she deals with these stressful events, and how she feels about certain situations or stressful events in her daily work.

The participants were guaranteed confidentiality, which means they were assured that identifying information would not be made available to anyone who is not directly involved in the study. For this reason, the participants were instructed not to sign their names on any of the questionnaires. They were also informed that by completing and returning the questionnaires, they would be providing the researcher with their consent to participate in this study.

Once the questionnaires were received, each participant was assigned a code number for easy analysis of the data. All of the returned questionnaires were stored in a locked container in a secured location. Only the researcher had access to the participants' information, thereby maintaining strict confidentiality. No monetary reward was offered for participation in this research

Research Instrument

One set of survey instrument was designed by the researcher to collect data from the target population. The instrument consisted of four parts, which were adapted and modified from: Devilliers, Carson, and Leary (DCL) stress scale; PsychNurse Methods of Coping Questionnaire (PNMCQ); Maslach Burnout Inventory (MBI)-Human Service Survey (HSS).

Part one elicited information on potential sources of pressure/ stress at the work place using a modified DCL stress scale. The DCL Stress Scale is scored on a 5-point, Likert-type scale: 0 = no stress; 1 = a little stress; 2 = quite a bit of stress; 3 = very stressed; 4 = extremely stressed. This tool consists of 30 items in the form of statements related to the participants' work. The range of possible scores is from 0 to 4. The higher the score, the higher the level of stress the respondent is expected to be experiencing at the time the survey is conducted. Part two used a modified PNMCQ which contained items that represent some of the different methods a Nurse might use to cope with work related stress.

Part three used the MBI survey which contained modified items that elicited job -related feelings of the nurse. The purpose of this MBI- HSS is to discover how various persons in the human services or helping professions view their jobs and the people with whom they work closely. Because persons in a wide variety of occupations will answer this survey, it uses the term recipients to refer to the people for whom services, care, treatment, or instructions are administered to. When

answering this survey participants are urged to think of these people as recipients of the service they provide, even though they may use another term in their work.

As previously mentioned, burnout syndrome consists of three dimensions: emotional exhaustion, depersonalization, and lack of personal accomplishment. These three dimensions are measured by separate subscales. For instance, emotional exhaustion (EE) has nine items and assesses a person's feelings of being emotionally overextended and exhausted by job demands. Depersonalization (DP) consists of six items and measures someone's lack of feelings and impersonal responses to recipients or patients. Personal accomplishment (PA) includes eight items and measures feelings of proficiency and successful achievement in an individual's occupation that pertain to interacting with other people Maslach, (as cited by White, 2006)

The MBI-HSS is scored on a 7-point, Likert-type frequency scale: 0 = never; 1 = a few times a year or less; 2 = once a month or less; 3 = a few times a month; 4 = once a week; 5 = a few times a week; 6 = every day. Individuals considered to be experiencing low levels of burnout would score 0.6-2.5 on the EE subscale, 0.6- 2.5 on the DP subscale, and 0.6-2.5 on the PA subscale. Individuals experiencing moderate levels of burnout would score 2.6 – 4.5 on the EE subscale, 2.6;-4.5 on the DP subscale, and 2.6-4.5 on the PA subscale. Individuals considered to be experiencing high levels of burnout would score 4.6 and higher on the EE subscale, 4.6 and above on the DP subscale, and 4.6 on the PA subscale. Finally, part four contained ten items that collected data on the demographic characteristics of respondents.

Pre-test

To ascertain the reliability of the research tool, the researcher decided to pre-test it in the two sister hospitals in the Metropolis (i.e. Tamale Central Hospital and Tamale West Hospital). Forty nurses were sampled, 20 from each hospital, comprising of 14 females and 12 males. Permission was sought from the management of both hospitals before the questionnaire was administered. There were only six male nurses who qualified to take part in the study in each hospital and they were all chosen. However, there were more qualified females than the number required; so their names were alphabetically arranged and every second female nurse was selected to take part in the study. The questionnaires were collected after a week from the administration.

Validity

Burns and Grove (as cited in White, 2006) noted that the "validity of an instrument is a determination of the extent to which the instrument actually reflects the abstract construct being examined" (p. 399). Face validity for the questionnaire was established with the help of colleagues with expert knowledge in research who examined the items selected for inclusion.

Reliability

The Cronbach's coefficient alpha statistic was used to estimate the internal consistency reliability for the instrument. The reliability coefficient was 0.835. This high reliability coefficient of the scale demonstrates very high internal reliability.

Data Analysis

The Statistical Package of the Social Services (SPSS) for Windows, Student Version 13.0, was utilized to analyze the quantitative data. Once the questionnaires were received from the participants, the data were immediately coded and entered into SPSS. Descriptive statistics were utilized to describe the sample characteristics and to evaluate whether the results were normally distributed.

The modified DCL Scale was utilized to rate the extent to which each potential source of stress at work caused the participants stress. The participants were asked to rate each potential stressor on a 4-point, Likert type scale: 0 = *no stress* and 4 = *extremely stressed*. A statistical ranking process was undertaken to analyze the scores of all 30 items on all of the completed modified DCL Stress Scale questionnaires. The mean value for each of the item's scores was ranked in numerical order and scored as follow s: 0 – 0.5 = No stress, 0.6 – 1.5 = little stress, 1.6 – 2.5 = Quite a bit of stress, 2.6 – 3.5 = Very stressed, and 3.6 – 4.0 = Extreme stress.

On Coping Strategies, the scores of all 37 items on every completed questionnaire were analyzed by the researcher. The mean scores for the items were ranked in numerical order. The scoring was based on this criterion: 1 – 1.5 = Never, 1.6 – 2.5 = rarely, 2.6 - 3.5 = occasionally, 3.6 - 4.5 = Often, 4.6 – 5.0 = All the time.

Regarding burnout, the study samples mean scores for emotional exhaustion (EE), and personal accomplishment (PA) were based on the following criteria: 0 – 0.5 = Never, 0.6 - 1.5 = few times a year, 1.6 – 2.5 = once a month, 2.6 – 3.5 = few

times a month, 3.6 – 4.5 = once a week, 4.6 – 5.5 = few times a week, 5.6 – 6.0 = every day.

CHAPTER FOUR
RESULTS AND DISCUSSIONS

Introduction

This study looked into the perceived occupational stressors, coping strategies and burnout pertaining to nurses working in Tamale Teaching Hospital. The dzaata collected from these categories of subjects are presented and analysed in this chapter. Each research question is presented and the results discussed.

Demographic Data

A total of 430 copies of the questionnaire were delivered to the participants in this study. Three hundred and thirty (330) of them were returned. This number represents 77% response rate. Therefore, a sample of 330 nurses (N = 330) participated in this study, 207(62.7%) of whom were females and 123(37.3%) were males (as in table 3). All participants were employed full time (40 hours per week), and the majority of them were married (52.4% (table 4)). Out of the 330 participants, 229(69.4%) of them had a diploma in nursing, 45(13.6%) had State Registered Nurses' certificate, and only 47(14.2%) were auxiliary nurses, comprising Enrolled (23) and Community health nurses (24) (as shown in Table 7).

The majority of nurses were females (62.7%), with a mean age between 20-30 years (as in table 2). Most nurses were married (table 4) with children (tables 5) and they had a work experience of up to 10 years. The educational level of the majority of nurses, (69.1%) were senior high/senior secondary school (SHS/SSS)

graduates, whereas 15.8% of them were O' Level holders, and 8.5% were middle school leaving certificate (MSLC) holders.

Concerning the work experience, 75.7% of the nurses in the sample selected had a work experience of 1-10 years, 10.% had a work experience of 11-20 years, 8.3% were between 21- 30 years, and 6.0% between 31-40 years (table 9). Concerning the time that nursing personnel spend during its working hours in a week caring for the patients, it was found that 57.5% of the nurses dedicate 46 – 60 hours of their time and 24% of the nurses spend between 31-45 hours of their time (table 8). The 93.6 % of the total participants were simple clinical nurses (bedside nurses), 1.5% were performing administrative duties, while 4.9% were supervising other nurses (table11).

Table 2: Demographic Characteristics Showing Age Distribution of Nurses

Variable: Age	Frequency	Percentage
20 – 30	239	72
31 – 40	19	6
41 – 50	30	9
51 – 60	42	13
Total	330	100

Source: Field Data Collected on Nurses of Tamale Teaching Hospital April, 2009

Table 2 shows that participants ranged in age from 20 years to 59 years, with a mean age of 31.4 years. The majority of them 239 (72%) were in 20-30 age range, followed by 42 (13%) who were most experience and near retirement.

Table 3: Gender Distribution of Nurses

Variable: Gender	Frequency	Percentage
Male	123	37.3
Female	207	62.7
Total	330	100.0

Table 3 indicates that the hospital had 173 (40.2%) male nurses who were eligible for the study and were all sampled to take part. However, only 123 (71.1%) returned the completed questionnaire. Similarly, 207 (80.5%) females out of the 257 female nurses sampled returned the completed questionnaire.

Table 4: Marital Status of Nurses

Variable Marital Status:	Frequency	Percentage
Never married	144	43.6
Divorced	10	3.0
Widowed	3	0.9
Married	173	52.4
Total	330	100.0

From Table 4, the majority of the nurses (52.4%) were married, while 144 (43.6%) out of the 330 never married before. 0nly 10 (3.0%) of the nurses divorced

and 3 (0.9%) were unfortunately widowed. The study by Tyler and Ellison, (1994) identified that nurses living with a partner had fewer stress symptoms than those with no partner.

Table 5: Nurses With or Without Children

Variable: Children	Frequency	Percentage
Yes	184	55.8
No	146	44.2
Total	330	100.0

From Table 5, 184 (55.8%) out of the 330 participants had children, while 146 (44.2) had no children which impacts on our findings of moderate stress. The study of Tyler and Ellison (1994) also provides an illustration that nurses with children experienced less stress from dealing with patients and relatives than those without children.

Table 6: Distribution of Nurses, according to their Educational Level

Variable: Highest Educ. Level	Frequency	Percentage
MSLC	28	8.5.
SSS/SHS	228	69.1
O' Level	52	15.8
Diploma	22	6.7
Total	330	100.0

Table 6 indicates that, the majority of nurses 228 (69.1%) in the study were SSS/SHS holders while 52 (15.8%) held O' Level Certificates. Twenty-eight (8.5%) of the nurses had Middle School Leaving Certificate (MSLC). and 22 (6.7%) held Diploma.

Table 7: Distribution of Nurses, according to their Professional Qualification.

Variable Highest Professional Qualification	Frequency	Percentage
CHN	24	7.3
EN	23	7.0
HAC	0	0.0
SRN	45	13.6
DIPLOMA	228	69.4
BA/BSC	9	2.7
MA/MSC	0	0.0
Total	330	100.0

Table 7 indicates that, with professional qualification, Diploma holders were the majority 229 (69.4%), followed by State Registered nursing graduates 45 (13.6%). Other qualifications were: Enrolled Nurses 23 (7.0%), Community Health Nurses 24 (7.3%), and Degree 9 (2.7%)

Table 8: Distribution of Nurses according to Number of Hours spent Caring for Patients per Week

Variable: Hours/Week	Frequency	Percentage
1 – 15	33	10.0
16 – 30	13	4.0
31 – 45	80	24.0

Table 8 continued

46 – 60	190	57.5
61+	14	4.5
Total	330	100.0

Table 8 shows that, most of the nurses 190 (57.5%) spent between 46-60 hours a week caring for patients while the second largest, 80 (24%) spent 31-45 hours. The others 33 (10%) spent between 1-15 hours, 13 (4%) spent between16-30 hours, and the remaining, 14 (4.5%) spent more than sixty hours per week caring for patients.

Table 9: Distribution of Nurses, according to their Working Experience

Variable Years of working Experience	Frequency	Percentage
1 – 10	250	75.
11 - 20	33	10.0
21 – 30	27	8. 3
31 - 40	20	6.0
Total	330	100.0

Table 9 indicates that, the most experienced nurses, 31 – 40 years in the service were in the minority 20 (6.0%). While the second most experienced nurses 27 (8.3%) were in the range of 21-30 years. The majority of the nurses were between 1-10 and 20-30 years respectivel

Table 10: Distribution of Nurses, According to Their Length of Time Working in Tamale Teaching Hospital

Variable: Length of Time	Frequency	Percentage
1 – 10	223	67.5
11 – 20	26	7.9
21 – 30	79	24.0
31 +	2	0.6
Total	330	100.0

From Table 10, majority of the nurses 223 (67.5%) were within 10 years old in this hospital, while 81 (24.6%) were above 20 years old and will soon go on retirement.

Table 11: Distribution of Nurses, according to Task Performed

Variable: Task	Frequency	Percentage
Direct patient care	309	93.6
Administration	5	1.5
Supervision	16	4.9
Total	330	100.0

Table 11 indicates that, majority of nurses in this hospital 309 (93.6%) were bedside nurses or performed direct patient care. About 1.5% of the nurses did administrative work and 4.9% performed supervisory duties in addition.

Research Questions 1

Which kind of activities do the nurses perceive as the most stressful in their work in Tamale Teaching Hospital?

The objective of the first research question was to determine which kind of activities the nurses in Tamale Teaching Hospital perceive as the most stressful as they go about their work in the hospital. A modified DCL Stress Scale was utilized to rate the extent to which each potential source of stress at work caused the participants stress. The participants were asked to rate each potential stressor on a 4-point, Likert type scale: 0 = *no stress* and 4 = *extremely stressed*. A statistical ranking process was undertaken to analyze the scores of all 30 items on all of the completed modified DCL Stress Scale questionnaires. The mean value for each of the item's scores was ranked in numerical order and scored as follows: 0 – 0.5 = No stress, 0.6 – 1.5 = little stress, 1.6 – 2.5 = Quite a bit of stress, 2.6 – 3.5 = Very stressed, and3.6 – 4.0 = Extreme stress. This process enabled the researcher to identify the kinds of perceived sources of occupational stressors as rated by nurses in the sample (See Table 12 for a list of perceived stressors).

Table 12: Kinds of Perceived Sources of Occupational Stressors of Nurses in Tamale Teaching Hospital

	Activity	mean	SD
1	Lack of or inadequate equipment to work with in the ward or unit.	**3.1**	**1.1**
2	Conflict not being settled within the ward or unit.	**2.6**	**1.2**
3	Difficulties in taking action against in competent staff	2.3	1.3
4	The threat of losing your job (being sacked or unemployed	**2.7**	**1.3**
5	Lack of promotion prospects or delayed promotion	**2.9**	**1.0**
6	Inadequate security measures on wards or unit.	**3.0**	**1.2**
7	Lack of positive feedback from supervisors or superiors	**3.0**	**1.2**
8	Dealing colleagues who do not do their share of the Workload	**2.6**	**1.0**
9	Dealing with changes in the health service system	2.3	1.3
10	The discrepancy between your job description and actual work	2.5	1.1
11	Feeling inadequately trained to deal with violent patients.	2.4	1.2
12	Disagreements within the team about patient's treatment.	2.3	1.2
13	Staff sickness disrupting the continuity of the team function.	2.2	1.2
14.	Insufficient finances to attend training courses or workshops	**3.1**	**1.0**
15	The lack of an adequate financial reward or motivation for the job.	**3.2**	**1.1**
16	Physical and verbal abuse from patients and their relatives.	**2.9**	**1.3**
17	Not feeling you have the energy to initiate new changes any more.	2.1	1.3
18	Difficulty in working with certain colleagues.	2.2	1.2
19	Low morale and poor working environment within the ward or unit.	**2.8**	**1.1**
20	Inadequate staffing coverage in the ward or unit.	**3.2**	**1.1**
21	Insufficient or lack of specialist to work with certain patient	**2.9**	**1.2**
22	Lack of consultation about changes affecting the job.	**2.9**	**1.1**
23	Not having the appropriate mix or skilled staff on the ward or unit.	**2.8**	**1.2**
24	Meeting the demands of too many patients (workload).	**3.3**	**1.1**
25	Insufficient communication between staff professionally.	**2.8**	**1.0**
26	Patient care is being sacrificed due to lack of staff.	**3.2**	**1.0**
27	Having too little time to plan and evaluate treatment of the patient.	**2.7**	**1.2**
28	Not being notified of changes before they occur in the ward or unit.	**3.0**	**1.2**
29	Lack/ insufficient basic supplies to work with at the ward or unit.	**3.1**	**1.1**
30	Do you always feel bad or are you sick all the time?	2.0	1.5

Table 12 indicates that, out of the thirty perceived sources of occupational stressors, 21 (70%) of them caused the nurses in Tamale Teaching Hospital much stress (2.6 - 3.5). That is why they are bolded. Seven out of the twenty-one perceived

stressors had their mean scores above 3.0. The highest mean score being 3.3 and the lowest was 3.1. This means that these seven activities caused the nurses much stress.

According to White (2006), Jenkins and Elliott in 2004 examined the relationship between stress and burnout among qualified and unqualified nursing staff working in acute adult mental health ward in the UK, found that the two groups differed in their perceptions of stress. The qualified nurses perceived lack of adequate staffing as the main stressor, while the unqualified ones perceived dealing with physically threatening and difficult or demanding patients as the stressors.

Another study conducted by a group of European researchers (as cited by White, 2006) utilizing questionnaires to explore stress, coping and burnout among Community Mental Health Nurses (CMHNs) indicated that the CMHNs were experiencing high levels of stress and burnout.

McVicar (2003) collating the evidence from the literature led to the identification of six main themes for the sources of workplace distress for nurses. Most sources of stress, that is workload, leadership/management issues, professional conflicts and emotional demands of caring, have been identified consistently by nurses for many years.

Williams (2007), cited other studies like Hemingway and Smith (1999); Van Servellen and Topf (1994), which also identified heavy workload, urgency of work to be performed, dying and death of patients, role conflict, lack of autonomy in practice, lack of social support, poor job fit, insufficient knowledge base, unsafe workplace, and a rapidly changing health care environment as stressors for nurses.

The findings obtained as a result of this study are significant for hospital administrators and nursing management particularly, those of Tamale Teaching Hospital. For instance quality patient care was the most reported sources of stress among the nurses in Tamale Teaching Hospital: *having to meet the demands of too many patients (workload (3.3)* and *knowing that individual patient care is being sacrificed due to lack of staff coverage in the wards or unit (3.2)* which featured most often during the literature review. Therefore, quality care issues are important factors in determining stress levels of nursing in Tamale Teaching Hospital. Tzeng (as cited by Williams, 2007) suggests that nurse managers should focus on those stressors which they have the most influence to change.

Research Question 2

Which top five activities do the nurses perceive as the most stressful in their work in Tamale Teaching Hospital?

The second research *question* intended to find out which activities the nurses perceive as the most stressful in relation to working in Tamale Teaching Hospital. Ranking the mean scores of the 30 items of perceived occupational stressors in numerical order enabled the identification of the Top Five most stressful items rated by nurses in the sample.

Table 13: The Top Five perceived Stressors reported by the Nurses in Tamale Teaching Hospital

Rank	Activity	MEAN	SD
1	Having to meet the demands of too many patients (workload).	3.3	1.1
2	Knowing that individual patient care is being sacrificed due to lack of staff and equipment	3.2	1.0

Table 13 continued

3 Inadequate staffing coverage in the ward or unit.	3.2	1.1
4 The lack of an adequate financial reward or motivation for the job.	3.2	1.1
5 Lack of or inadequate equipment to work with in the ward or unit	3.1	1.1
	3.2	1.1
	N = 330	

From Table 13, the top five activities that caused the nurses in Tamale Teaching Hospital much stress are: *Having to meet the demands of too many patients (workload), Knowing that the individual patient's care is being sacrificed due to lack of staff and basic equipment, Inadequate staffing coverage in the ward or unit, The lack of an adequate financial reward or motivation for the job, and Lack of or inadequate equipment to work with in the ward or unit*.

Workload was identified as one of the stressors in Jenkins and Elliott's study in 2004. A study conducted by a group of European researchers (as cited by White, 2006) utilizing questionnaires to explore stress, coping and burnout among Community Mental Health Nurses (CMHNs) indicated that the CMHNs were experiencing high levels of stress and burnout. These nurses also reported perceiving the most stressful aspects of their job as being workload, poor resources, and others. Workload and inadequate resources have also been a source of stress in Tamale Teaching Hospital. Healy and McKay (as cited in McVicar, 2003) also found workload to be most significantly correlated to mood disturbance.

Stordeur and colleagues attempted ranking stressors in order of severity of impact (as cited by McVicar, 2003) and workload topped the list. It is not surprising

that the nurses in Tamale Teaching Hospital are also reporting workload as the topmost stressor because ever since the inception of the NHIS, workload in our health institutions has doubled.

Research Question 3

Which top five activities do nurses perceive as the least stressful in their work at Tamale Teaching Hospital?

The third research question sets out to find out which top five activities nurses perceive as the least stressful in relation to working in Tamale Teaching Hospitals. The five least stressors are shown in Table 14.

Table 14: The Least Five perceived Stressors reported by nurses in Tamale Teaching Hospital

Rank	Activity	MEAN	SD
1	Dealing with disagreements within the team about patient's treatment.	2.3	1.2
2	Staff sickness disrupting the continuity of the team function	2.2	1.2
3	Difficulty in working with certain colleagues.	2.2	1.2
4	Not feeling you have the energy to initiate new changes any more.	2.1	1.3
5	Do you always feel bad or are you sick all the time?	2.0	1.5

N = 330

Table 14 indicates that, the least five stressors were: *Dealing with disagreements within the team about patient's treatment, Staff sickness disrupting the continuity of the team function, Difficulty in working with certain colleagues, Not feeling you have the energy to initiate new changes any more*, and *Do you always feel bad or are you sick all the time?*.

Sullivan (1993) researched stressors identified by nursing staff working in acute psychiatric in-patient facilities of two health authorities in UK. Among others, he also found that other stressors reported less frequently included: *staffing levels, administrative duties, and feeling overworked.* The nurses in Tamale Teaching Hospital reported less frequently *interference from their colleagues with their work, could not initiate new changes even though were always healthy.* These differed from the other findings because workload was identified as a stressor in Tamale Teaching Hospital hence the nurses could not initiate new ideas. Secondly, they work as a team that is why there was less interference from their colleagues with their work.

Research Question 4

Which coping strategies are utilized most frequently by nurses working in Tamale Teaching Hospital?

The fourth research question asked which coping strategies are utilized most frequently by nurses working in Tamale Teaching Hospital. Table 15 shows the Top Seven Coping Strategies used most frequently by nurses in the hospital. The scores of all 37 items on every completed questionnaire were analyzed by the researcher. The mean scores for the items were ranked in numerical order. This provided a method for the researcher to identify the 7 most frequently coping strategies used as rated by nurses in this sample. The scoring was based on this criterion: 1 – 1.5 = Never, 1.6 – 2.5 = rarely, 2.6 - -3.5 = occasionally, 3.6 - -4.5 = Often, 4.6 – 5.0 = All

the time. (See Table 15 for a list of the seven most frequently reported coping strategies).

Table 15: The Top Seven Coping Strategies Utilized Most Frequently, by the Nurses in Tamale Teaching Hospital

Rank	Activity	MEAN	SD
1	By reminding myself that others have placed their trust in me.	5.0	5.7
2	By reminding myself that I am doing my best to help.	4.6	2.0
3	Through the satisfaction I derive from seeing a task completed successfully.	4.2	2.0
4	By having a sense of usefulness and purpose	4.1	1.1
5	By being optimistic that everything will work out in the end	4.1	1.1
6	By being optimistic that everything will work out in the end.	4.0	1.0
7	By having a stable home life that is kept separate from my work life	4.0	1.1
	Total	**4.3**	**2.0**
		N = 330	

Source: Field Data Collected from in Tamale Teaching Hospital in April 2009.

From Table 15, the most frequently used coping strategies by the nurses in Tamale Teaching Hospital are: *By reminding myself that others have placed their trust in me, By reminding myself that I am doing my best to help, Through the satisfaction I derive from seeing a task completed successfully, By having a sense of usefulness and*

purpose, and By having a stable home life that is kept separate from my work life. I think the nurses in Tamale Teaching Hospital want to maintain their professionalism and integrity by adapting the above coping strategies.

Sullivan (1993) reported that the most frequently utilized coping strategies were social support, problem-solving, and avoidance techniques. Burke and Weir (as cited by Stanhope & Lanchester,1992) found that a close, supportive marriage in which an employee can formerly discuss job problems with his or her spouse is likely to prevent or reduce stress and increase both occupational and marital satisfaction.

Research Question five

What is the degree of burnout pertaining to nurses working in Tamale Teaching Hospital?

This research question seeks to find out the degree of burnout amongst nurses working in Tamale Teaching Hospital. Regarding burnout, the study's sample mean scores for emotional exhaustion (EE), depersonalization, and personal accomplishment (PA) were based on the following criteria: 0 – 0.5 = Never, 0.6 - 1.5 = few times a year, 1.6 – 2.5 = once a month, 2.6 – 3.5 = few times a month, 3.6 – 4.5 = once a week, 4.6 – 5.5 = few times a week, 5.6 – 6.0 = every day.

This means that the participants of this study were expected to be experiencing a low degree of burnout if the mean fell between 0.6 – 2.5, moderate degree if it is 2.6 – 4.5 and high if from 4.6 – 5.5 (See Table 16).

Table 16: The mean and standard deviation scores of nurses' Emotional Exhaustion (EE) on job relatedfeelings.

	Activity	Mean	SD
1	I feel emotionally drained from my work	2.5	2.0
2	I feel used up at the end of the day's work	**3.8**	**2.3**
3	I feel fatigued (tired) when I get up in the morning and have to face another day on the job.	**4.3**	**1.7**
4	I feel working with people all day is really a strain for me	1.3	1.8
5	I feel burned out (exhausted) from my work.	**3.7**	**2.1**
6	I feel frustrated by my job	1.9	2.0
7	I feel working with people directly puts too much stress on me	2.2	2.0
8	I feel depressed at work	1.8	2.0
9	I feel like I'm at the end of my rope.	1.7	1.0
	Total	**2.6**	**2.0**

N = 330

Table 16 indicates that, the nurses in this study were experiencing a moderate degree of burnout as the.

Mean score is 2.6.

Demoerouti and colleagues in 2000 sought to distinguish between the factors that were most likely to result in emotional exhaustion and (job) disengagement. They found out that job demands (viz. workload, time pressure, demanding contacts with patients) were most associated with emotional exhaustion (as cited in McVicar, 2003)

A study (as cited in White, 2006) conducted by a group of European researchers on Community Mental Health Nurses (CMHNs) indicated that CMHNs

were experiencing high levels of stress and burnout. They also found out that one half of the participants were found to be emotionally overextended and exhausted and, therefore unable to provide quality care to their patients. This level of exhaustion was greater for the CMHNs working in urban settings than with those working in rural areas.

In a comparison study, Fagin and associates in 1995 collected data on stress levels of Community Psychiatric Nurses (CPNs) and Ward-based Psychiatric Nurses (WBPNs). They indicated that a large proportion of both groups of nurses experienced high levels of stress and emotional exhaustion due to the demands of their work (as cited in White, 2006)

Payne did not find a significant relationship between workload and burnout, although levels of burnout in her study were lower than in related studies. McVicar suggested that the reasons for this variation though unclear, are likely to include differences for stress 'hardiness' (Simoni & Paterson, 1997), of coping mechanisms (Payne, 2001), of age and experience or of the level of social support in the workplace (Ceslowitz, Healy& McKay, 2000).

Depersonalization as based on this criterion: mean scores of 0.6– 2.5 meant less depersonalization, 2.6 – 4.5 was associated with moderate depersonalization, and 4.6 –6.0 meant high depersonalization (See Table 17).

Table 17: The mean and standard deviation scores of Depersonalization (DP) on Job related feelings

Activity	Mean	SD
1 I can easily understand how my patients feel about things.	**4.5**	**1.**

Table 17 continued

2	I feel I treat some clients as if they were impersonal (having no existence as a person) objects.	1.0	1.0
3	I feel I've become more callous or indifferent to the feelings of people since I started working in this ward or unit.	1.6	1.9
4	I feel that this job is hardening me emotionally.	3.1	2.0
5	I feel I don't really care what happens to some patients.	0.4	0.9
6	I feel patients blame me for some of their problems	1.8	1.8
	Total	**2.0**	**1.6**

Table 17 indicates that, the nurses in Tamale Teaching Hospital were less depersonalizing their patients because the mean score is 2.0. One finding on depersonalization has revealed a limitation in the tool. The nurses understood question one (I can easily understand how my patients feel about things.) as empathy instead of depersonalization. Therefore, it had the highest mean score of 4.5 (Table17)

Fagin and associates in 1995, (as cited in White, 2006) also discovered that Ward-based Psychiatric Nurses (WBPNs) have greater feelings of depersonalization, or detachment from their patients, as compared to their colleagues working in the community.

The nurses in Tamale Teaching Hospital are not depersonalizing their patients because the turn over of patients in the hospital may be high, unlike psychiatric patients who had to stay longer periods before being discharged. The

psychiatric nurses become too familiar with the patients and doing the same things over and over, for days or even years that they tend to depersonalize their patients.

The mean scores for Personal Achievement were also based on the same criterion. That is 0.6 – 2.5 meant a low achiever, 2.6 – 4.5 stood for moderate achiever and 4.6 – 6.0 a high achiever (See Table 18).

Table 18: The mean and standard deviation scores of nurses' Personal Achievement (PA) on job related feeling

	Activity	Mean	SD
1	I feel I deal very effectively with the problems of my patients	4.2	2.1
2	I feel I'm positively influencing other people' lives through my work.	**5.1**	**1.7**
3	I feel very energetic	4.0	2.0
4	I feel I'm working too hard on my job.	4.0	2.3
5	I feel I can easily create a relaxed atmosphere with my patients	4.6	1.5
6	I feel exhilarated (filled with high spirits or made lively) after working closely with my patients.	4.6	1.5
7	I feel I have accomplished many worthwhile things in this job	4.3	1.8
8	I feel in my work, I deal with emotional problems very calmly.	4.1	2.0
	Total	**4.4**	**1.8**
		N = 330	

Table 18 indicates that, the nurses in Tamale Teaching Hospital are moderate achievers since the mean score is 4.4.

Fagin and colleagues in their study in 1995 (as cited by White, 2006) also found that ward based psychiatric nurses (WBPNs) had a decrease sense of personal

achievement with their work, as compared to their colleagues working in the community. This may be so because these nurses and their patients are most often confined to the ward and are always interacting with the same people unlike their counterparts in the community who move about interacting with different people freely. In the case of nurses in Tamale Teaching Hospital, the turn over of patients is very high hence they are always challenged with new diseases, variety of people with different cultures and backgrounds accounting for the moderate achievements.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Summary of the Study

The primary goals of this study were to determine (a) what kind of activities the nurses perceive as the most stressful in their work in Tamale Teaching Hospital (b) Which top five activities the nurses perceive as the most stressful in their work in Tamale Teaching Hospital; (c) Which least five activities nurses perceive as less stressful in their work in Tamale Teaching Hospital; (d) Which coping strategies are utilized most frequently by nurses working in Tamale Teaching Hospital; and (e) What is the degree of burnout pertaining to nurses working in Tamale Teaching Hospital

One set of survey instrument was designed by the researcher to collect data from the target population. The instrument consisted of four parts, which were adapted and modified from: Devilliers, Carson, and Leary (DCL) stress scale; PsychNurse Methods of Coping Questionnaire (PNMCQ); Maslach Burnout Inventory (MBI)-Human Service Survey (HSS).

The DCL scale elicited information on potential sources of pressure/ stress at the work place and scored on a 5-point, Likert-type scale: 0 = no stress; 1 = a little stress; 2 = quite a bit of stress; 3 = very stressed; 4 = extremely stressed. The higher

the score, the higher the level of stress the respondent is expected to be experiencing at the time the survey is conducted.

The PNMCQ contained items that represent some of the different methods a Nurse might use to cope with work related stress. It is scored on a 5-point, Likert type of scale: 1 = never; 2 = rarely; 3 = occasionally; 4 = often; and 5 = all the time.

The MBI survey contained items that elicited job -related feelings of the nurse and scored on a 7-point, Likert-type frequency scale: 0 = never; 1 = a few times a year or less; 2 = once a month or less; 3 = a few times a month; 4 = once a week; 5 = a few times a week; 6 = every day.

The mean scores for each of the items were ranked in numerical order and enabled the researcher to identify the most and least stressful items, coping and burnout issues as rated by nurses in this sample. Frequencies, rank order and tables were used in the analysis of data.

The analyses were put under five broad headings: *Kinds of perceived occupational stressors of nurses; the most perceived occupational stressors of nurses; the least perceived occupational stressors of nurses; coping strategies most frequently used by nurses and the degree of burnout among nurses*

Summary of the Findings

With regards to sources of occupational stressors, twenty-one out of the thirty perceived stressors, actually caused the nurses in Tamale Teaching Hospital much stress (2.6 – 3.5), and seven of them having their mean scores above 3.0. These reported sources of stress boarded on quality of patient care. Therefore,

quality care issues are important factors in determining stress levels of nursing in Tamale Teaching Hospital.

The numerical ranking from the management of stress indicated that nurses in Tamale Teaching Hospital favoured informal approaches to coping with occupational stress than other approaches.

Finally, the results of the statistical analysis of the data collected in this study indicated that the nurses in Tamale Teaching Hospital were experiencing relatively moderate levels of stress or moderate degree of burnout (2.6), were less depersonalizing their patients (2.0), and were moderate achievers (4.4). One finding on depersonalization has revealed another limitation. The nurses understood question one (1): *I can easily understand how my patients feel about things.* as empathy instead of depersonalization. Therefore, it has the highest mean score of 4.5

However, it is gratifying to note that the nurses in Tamale Teaching Hospital never used Alcohol, Drugs and Cigarettes to manage stressful situations, unlike their colleagues in other countries where similar studies were carried out as revealed in the literature review. These were the least coping strategies employed.

CONCLUSIONS

Based on the findings of this study, the following conclusions are drawn:

It is evident that nurses in Tamale Teaching Hospital are experiencing a moderate level of stress or a moderate degree of burnout as compared to results from the literature review in which stress was always high. The researcher anticipated similar results (high) but it turned out to be moderate. Perhaps this is so because of the cultural differences.

I am convinced that Tamale Teaching Hospital has a future because it has a young workforce, which is not using alcohol, drugs and cigarettes to manage stress.

RECOMMENDATIONS

On the basis of the research findings, the following recommendations have been made:

1 Nurse Administrators in general and in particular those of Tamale Teaching Hospital need to pay attention to quality care issues because these are important factors determining stress levels of nursing in Tamale Teaching Hospital. They should place a high premium on quality issues and other related problems pertaining to quality care in the work environment, to improve the quality of work-life for nurses.

2 The nurses in Tamale Teaching Hospital preferred informal approaches to coping with occupational stress. Therefore, building their capacity will increase the individual nurse's ability to cope effectively and as a result

reduce experienced levels of stress and burnout. Collaborative efforts by both managers and nurses must be emphasized.

3 The researcher recommends that since this study is the first of its kind in Tamale Teaching Hospital, it could be replicated in the other hospitals in northern region, other regions and if possible the whole country.

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APPENDIX A

QUESTIONNAIRE

Study Title: Perception of occupational stress, Coping strategies and level of burnout among nurses working in Tamale Teaching Hospital.

Investigator: **PRINCE GUNGUNI WINFRED J**

Purpose

You have been selected to participate in a research study in partial fulfilment of the requirements for my Master of Arts Degree in Guidance and Counselling, at Cape Coast University. This research will focus specifically on stress, its sources, coping strategies and burnout pertaining to nurses working in Tamale Teaching Hospital. The goal is to identify the most common work-related stressors, coping strategies and burnout pertaining to nurses working in Tamale Teaching Hospital. This useful information can then be utilized by other healthcare professionals and hopefully changes will be implemented that could possibly, reduce the amount of stress in the nurses' work environment. You may benefit from the items of the questionnaire, learning more about sources of stress and the coping strategies.

Procedures

The questions in the questionnaires are specific in nature and pertain to stressful events related to your professional practice, how you deal with them and feel about them. It may take about 20- 30 minutes to complete. After you have finished answering all the questions, return it to the office of Director of Nursing

Confidentially

Please **DO NOT** sign your name to any of the forms as all responses will be kept confidential. Questionnaires will be kept in a locked file, and shredded upon completion of the study. Only the research committee will have access to anonymous individual data. The results of the study will only be made available in a paper presented to Cape Coast University faculty. You are free to ask any question from my supervisor: Rev. Prof. J. K. Essuman.- Counselling Centre, UCC,

QUESTIONS ON STRESS

The following items have all been found to be potential sources of pressure/stress at the work place. Pressure/stress can be understood as problems you find difficult to cope with, resulting in you feeling worried or anxious. Please read through the questionnaire carefully; **circling the number** next to each item which best indicates the extent to which each item causes you stress. Be sure to answer every item.

0. = This activity causes me no stress
1. = This activity causes me a little stress
2. = This activity causes me quite a bit of stress
3. = I feel very stressed by this activity
4. = I feel extremely stressed by this activity

1. Lack of or inadequate equipment to work with in the ward or unit. 0 1 2 3 4
2. Conflict not being settled within the ward or unit. 0 1 2 3 4
3 Dealing with difficulties that occur when you try to take action against in competent staff working under you 0 1 2 3 4
4. The threat of losing your job (being sacked or unemployed 0 1 2 3 4
5. Lack of promotion prospects or delayed promotion 0 1 2 3 4
6. Inadequate security measures on wards or unit. 0 1 2 3 4
7. Lack of positive feedback from supervisors or superiors 0 1 2 3 4
8. Having to deal with colleagues who do not do their share of the Workload 0 1 2 3 4
9. Dealing with changes in the health service system 0 1 2 3 4
10 The discrepancy (differences) between your job descriptions and what you are expected to do or doing now. 0 1 2 3 4
11. Feeling inadequately trained to deal with violent patients. 0 1 2 3 4
12. Dealing with disagreements within the team about patient's treatment. 0 1 2 3 4
13. Staff sickness disrupting the continuity of the ward's or unit's team functioning 0 1 2 3 4

14. Not having sufficient financial resources to attend training courses Or workshops 0 1 2 3 4

How much stress does each of the following activities cause you?

15. The lack of an adequate financial reward or motivation for the job. 0 1 2 3 4
16. Dealing with physical abuse from patients and their relatives. 0 1 2 3 4
17. Not feeling you have the energy to initiate new changes your ward or unit any more . 0 1 2 3 4
18. Difficulty in working with certain colleagues. 0 1 2 3 4
19. Low morale and poor working environment within the ward or unit. 0 1 2 3 4
20. Inadequate staffing coverage in the ward or unit. 0 1 2 3 4
21. Insufficient or lack of specialized training to work with certain patients e.g. mental patients. 0 1 2 3 4
22. Lack of consultation from management about changes that affect the job. 0 1 2 3 4
23. Not having the appropriate mix or skilled staff on the ward or unit.0 1 2 3 4
24. Having to meet the demands of too many patients (workload). 0 1 2 3 4
25. Insufficient communication and consultation between staff at a professional level. 0 1 2 3 4
26. Knowing that individual patient care is being sacrificed due to lack of staff and basic equipment. 0 1 2 3 4
27. Having too little time to plan and evaluate treatment of the patient.0 1 2 3 4
28. Not being notified of changes before they occur in the ward or unit.0 1 2 3 4
29. Lack of or insufficient basic supplies to work with, at the ward. 0 1 2 3 4
30. Do you always feel bad or are you sick all the time? 0 1 2 3 4

QUESTIONS ON COPING STRATEGIES

The following items represent some of the different methods a Nurse might use to cope with work related stress. For each item, please **circle the number** which most accurately describes the extent to which you use the stated strategy.

The key is as follows; 1 = Never; 2 = Rarely; 3 = Occasionally; 4 = Often; 5 = All the time.

I DEAL WITH STRESS….

1. By taking a day off my official work to do my private work. 1 2 3 4 5
2. By having confidence in my own abilities to do the job well. 1 2 3 4 5
3. By having confidential 'one-to-one' supervision. 1 2 3 4 5
4. By knowing that there are those who care about me. 1 2 3 4 5
5. By discussing with colleagues problems as they arise at work. 1 2 3 4 5
6. By having a stable home life that is kept separate from my work life. 1 2 3 4 5
7. Through being able to draw upon my own knowledge and experience when necessary. 1 2 3 4 5
8. Through supervision from team members. 1 2 3 4 5
9. By reminding myself that others have placed their trust in me. 1 2 3 4 5
10. By knowing that, should I ever need, support and advice they will be available. 1 2 3 4 5
11. By having a satisfying sex life. 1 2 3 4 5
12. By believing in and feeling good about myself. 1 2 3 4 5
13. Through the support I get from my in-charge. 1 2 3 4 5
14. By taking a mature view of the situation. 1 2 3 4 5
15. By talking to people that are close to me. 1 2 3 4 5
16. By having a steady partner to turn to 1 2 3 4 5
17. By knowing that I can depend on other members of staff. 1 2 3 4 5
18. By having a sense of usefulness and purpose 1 2 3 4 5
19. By knowing that my life outside work is healthy, enjoyable and

worthwhile 1 2 3 4 5

20. By reminding myself that the work I do is being appreciated. 1 2 3 4 5

I DEAL WITH STRESS….

21. By detaching myself from work matters when necessary. 1 2 3 4 5

22. By making a concerted effort to keep myself relaxed and in control. 1 2 3 4 5

23. By having a good, positive atmosphere around me at work. 1 2 3 4 5

24. By talking to a friend or loved one. 1 2 3 4 5

25. By looking forward to going home at the end of each day. 1 2 3 4 5

26. By being optimistic that everything will work out in the end. 1 2 3 4 5

27. By having pastimes (eg games) and hobbies outside work. 1 2 3 4 5

28. Through sleeping restfully. 1 2 3 4 5

29. By having the freedom to express my views openly. 1 2 3 4 5

30. By finding out how others have coped in the same situation. 1 2 3 4 5

31 Through the satisfaction I derive from seeing a task completed successfully. 1 2 3 4 5

32. By reminding myself that I am doing my best to help. 1 2 3 4 5

33. By taking a moment of time to reflect over it. 1 2 3 4 5

34. By searching for a positive side to every problem. 1 2 3 4 5

35. By drinking alcoholic beverages when I feel tense 1 2 3 4 5

36. By taking tranquilizers (or drugs) to relax 1 2 3 4 5

37. By smoking when I feel tense 1 2 3 4 5

QUESTIONS ON BURNOUT

On the following page there are 23 statements of job-related feelings, divided into three parts: Emotional Exhaustion (EE); Depersonalization (DP); and Personal Achievement (PA). Please read each statement carefully and decide if you ever feel this way about your job. If you have never had this feeling, write a "0" (zero) before the statement. If you have had this feeling, indicate how often you feel it by writing the number (from 1 to 6) that best describes how frequently you feel that way. An example is shown below.

Example:

HOW OFTEN:

0 – 6 Statements:

_____ I feel depressed at work.

If you never feel depressed at work, you would write the number "0" (zero) under the heading "HOW OFTEN." If you rarely feel depressed at work (a few times a year or less), you would write the number "1." If your feelings of depression are fairly frequent (a few times a week, but not daily) you would write a "5."

HOW OFTEN: Statements 0 = Never, 1= A few times a year, 2 = Once a month or less, 3 = A few times a month, 4= Once a week, 5= A few times a week, 6 = Every day.

Emotional Exhaustion (EE)

1. _____ I feel emotionally drained from my work.

2. _____ I feel used up at the end of the day's work

3. _____ I feel fatigued (tired) when I get up in the morning and have to face another day on the job.

HOW OFTEN:

4. _____ I feel working with people all day is really a strain for me.

5. _____ I feel burned out (exhausted) from my work.

6. _____ I feel frustrated by my job.

7. _____ I feel working with people directly puts too much stress on me.

8. _____I feel depressed at work.

9. _____ I feel like I'm at the end of my rope.

Depersonalization (DP)

HOW OFTEN:

1. _____ I can easily understand how my patients feel about things.

2. _____ I feel I treat some clients as if they were impersonal (having no existence as a person) objects.

3. _____ I feel patients blame me for some of their problems.

4. _____ I feel I don't really care what happens to some patients

5. _____ I Feel I've become more callous or indifferent to the feeling of people since I started working in this ward or unit.

6. _____ I feel that this job is hardening me emotionally.

Personal Achievement (PA)

HOW OFTEN:

1. _____ I feel I deal very effectively with the problems of my patients

2. _ _____ I feel very energetic..

3. _____ I feel I'm positively influencing other people's lives through my work

4. _____ I feel I'm working too hard on my job.

HOW OFTEN:

5. _____ I feel I can easily create a relaxed atmosphere with my patients.

6. _____ I feel exhilarated (fill with high spirits or make lively) after working closely with my patients.

7. _____ I feel I have accomplished many worthwhile things in this job.

8. _____ I feel in my work, I deal with emotional problems very calmly.

Demographic Data Sheet

1. Your sex:

_____(a) male _____(b) female

2. Your age:

_____(a) 20 - 30

_____(b) 31 - 40

_____(c) 41 – 50

_____(d) 51 - 60

3. Marital status:

_____ (a) never married.

_____(b) divorced.

_____ (c) widowed.

_____(d) married.

_____ (e) other (please specify _____)

4. Children:

_____(a) yes _____(b) no

5. What was the highest level you completed in school? (Check/circle only one answer)

_____ (a) MSLC

_____ (b) SSS/SHS

_____ (c) O'LEVEL

_____ (d) other (please specify_____)

6. Please check/circle the highest professional qualification you have received:

_____ (a) CHN

_____ (b) EN

_____ (c) SRN.

_____ (d) DIPLOMA

_____ (e) BA/BSc

_____ (f) MA/MSc

7. How many hours per week do you work as a nurse?

_____ (a) 5 – 20hrs

_____(b) 21 – 40hrs

_____ (c) 41 – 60hrs

_____ (d) 61 – 80hrs

_____ (e) 81 – 100hrs

8. How long have you been working as a nurse?

_____ (a) 1 – 15 yrs

_____(b) 16 – 30 yrs

_____(c) 31- 45 yrs

_____(d) 46 – 60 yrs

9. How long have you been working in this hospital?

_____ (a) 1 – 10yrs

_____(b) 11 – 15yrs

_____(c) 16 – 20yrs

_____(d) 21 – 25yrs

_____(e) 26 – 30yrs

10. What tasks do you perform (at least 50% of the time)?.

_____ (a) Direct patient care.

_____ (b) Administration

_____(c) Supervision (in charge)

_____(d) Others (specify)

THANK YOU FOR YOUR CO-OPERATION!