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“An empirical investigation into a manager’s learning with respect to stress and burnout among mental health practitioners.”

K. J. Sexton.

July 1996.

Title of dissertation

**“AN EMPIRICAL INVESTIGATION INTO A MANAGER’S LEARNING
WITH RESPECT TO STRESS AND BURNOUT AMONG MENTAL HEALTH
PRACTITIONERS.”**

By Kenneth John Sexton.

**“Dissertation submitted for the Degree of Master of Education in the University
of Liverpool in part fulfilment of the Modular Programme.”**

July 1996.

ABSTRACT.

There is growing evidence that nursing is a stressful occupation, particularly mental health nursing. (Nolan 1995)

Objective.

To assess the degree and nature of occupational stress and burnout in psychiatric nurses.

Design.

Two questionnaires, The Professional Life Scale, (Fontana 1989), and Are you burning out? (Freudenberger 1980), were administered to a group of psychiatric nurses, (n=15). The data was supplemented by series of individual qualitative interviews (n=9). Additional statistical data regarding occupational sickness and leaver profiles was also evaluated and integrated into the main research outcomes.

Setting.

A National Health Service hospital trust, specialising in psychiatry.

Subjects.

There were 15 subjects in the quantitative study, representative of nursing staff from acute residential psychiatric admission wards, community psychiatric nurses, and staff from a therapy day hospital. There were five staff from each clinical area involved with the study, which represented approximately 10% of the staff from the clinical areas. Three female and two male staff were randomly selected for each study group. There were nine subjects involved in the qualitative study, two female, and one male from each clinical area.

Results

Freudenberger's questionnaire revealed few burnout factors in ward staff, and a low to moderate burnout factor in day hospital and CPN questionnaire respondents. Fontana's questionnaire did not indicate professional stress of any significance in any of the respondent groups but the CPN group scored a relatively higher professional stress factor.

A series of qualitative interviews (n=9) confirmed that the outcomes of the quantitative questionnaires were considered by subjects to be a reasonable indicator of stress and burnout.

Respondents felt that stress that they encountered was reactionary, not sustained, and normal. Non-occupational stress issues were considered by the staff groups as major influences in potentially creating occupational stress.

Other indicators, including low sickness and leaver rates led to a conclusion that the staff groups did not display occupational stress or burnout of any significance.

Supervision and training were consistently cited as positive variables in reducing stress and burnout factors, and were professionally valued.

DECLARATION.

“This Work is original and has not been submitted previously in support of any qualification or course.”

Signed ..

K. J. Sexton. ✓

Date..... *July 1996.*

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TABLE OF CONTENTS.

	<u>Page no.</u>
Abstract	ii
Personal introduction and background.	vii
 <u>CHAPTER ONE.</u>	
Stress, what is it ?	1
Models of stress.	4
Stress, the causes and effects.	5
Stress and personality type.	9
 <u>CHAPTER TWO.</u>	
Occupational stress.	13
Causes and consequences of occupational stress.	16
 <u>CHAPTER THREE.</u>	
Burnout, what is it ?	21
 <u>CHAPTER FOUR.</u>	
Selection of research methodology.	26
Research background.	28
Ethical consideration of research.	30
Quantitative research design.	31
Qualitative enquiry.-	
a) Burnout.	32
b) Professional stress.	33
Qualitative research outcomes.	
a) Are you burning out ?	35

b)Professional life stress scale.	36
Quantitative research design.	38
Quantitative interviews.	40
a) Ward staff.	41
b) CPNs.	44
c) Day hospital.. . . .	48
Staff sickness profile.. . . .	50
<u>CHAPTER FIVE.</u>	
Conclusion.	52
Appendices.	57
Bibliography.	62

PERSONAL INTRODUCTION AND BACKGROUND

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

I am a Clinical Service Manager, trained in General and Psychiatric nursing, and employed in a Mental Health National Health Service (NHS) Trust. I have professional and line responsibility for a number of staff and services, mainly psychiatric nurse related. Some staff associated with these services have contributed to the research in this dissertation.

It was my original intention to study aspects of stress, occupational stress, and burnout, particularly in relation to Mental Health nurses by conducting a literature review and a quantitative enquiry. Review of literature confirmed the complexity and importance of stress related subjects as noted by Monat and Lazarus (1985), and my early reflections began to challenge my personal assumptions about stress, and also inspired me to review my research framework. I had already canvassed a number of Mental Health Nurses in various specialities and had distributed an explanatory letter and appropriately selected questionnaires based on the work of Freudenberger and Richelson (1880), (appendix i), and Fontana (1989), (appendix ii).

The inquiry tools, which will be discussed in detail in a later chapter, were recommended by a Clinical Psychologist, who had field experience in using both questionnaires, and believed them to be reliable indicators of occupational stress and burnout.

It was, therefore, my intention to analyse the completed and returned samples from my enquiry groups, review the findings, and integrate the data into an academic literature review, as suggested by Mitchell and Jolley (1992). However, there were two issues occurring simultaneously that prompted me to review my research plan.

First, a number of research participants had asked for personal feedback from their returned questionnaires. I had not originally intended to do this and I had indicated in my explanatory correspondence that processed data would be destroyed.

Second, results indicated that the sample groups were only moderately occupationally stressed, and indeed suggested only a moderate burnout factor, as defined by Freudenberger (Freudenberger and Richelson 1980). Returned samples did not indicate the degree of stress or burnout that I had anticipated.

My assumptions of high stress factors and burnout of the sample groups were based on knowledge of staff from regular clinical supervision sessions I had conducted with them. This led me to conclude that the inquiry tools were either inaccurate, that participants' responses were 'guarded' or untrue, or that the staff were not as stressed or burnt out as I had assumed.

Basing my experience on personal interaction with the staff groups, I was intrigued to note that there was an obvious critical discrepancy between my assumptions and the early evidence of my enquiry. I approached my academic supervisor for advice, as Reason (1988) suggests that supervisor consultation is desirable during critical periods of a research process. As a result my considered conclusions were that my research

needed to re-focus and also needed to include a qualitative research aspect through research interviews, in order to test the validity of the quantitative research.

My organisation was beginning to take an interest in my enquiry, following receipt of various NHS circulars relating to stress litigation by employees. My organisation was keen to know whether there was evidence of stress in staff groups, whether there were variances of burnout between staff groups, and if stress was as significant as was believed by management.

Therefore, the purpose of this dissertation is to study stress and burnout in Mental Health Practitioners, and to achieve the following objectives:

- a) to define and identify various forms of stress and occupational burnout;
- b) to review which individuals may be most susceptible to stress;
- c) to examine the different sources of stress, and the impact on people and their occupational performance, particularly groups of staff from psychiatric nursing backgrounds;
- d) to collaborate with research participants and to share inquiry results as part of an informative process;
- e) to advise my organisation of my findings regarding aspects of occupation stress, and burnout in sample groups of Mental Health Practitioners.

In pursuit of my objectives, I consulted a wide and varied range of literature of clinical, professional, and managerial origin. From the research perspective, I have gathered

data from an inquiry that I have directed which evaluates professional stress, its effects, and potential burnout in various Mental Health practitioner occupational specialities.

The methodology uses both qualitative and quantitative data collection, and targets three distinct Mental Health Practitioner Groups:

- i) Community Psychiatric Nurses;
- ii) Community Day Hospital Staff;
- iii) Acute Psychiatric Wards Nursing Staff.

The distinction between the above occupational areas are described and discussed in later chapters. The quantitative research tools themselves take the form of two separate questionnaires. The enquiries are supplemented by qualitative methodology.

The findings are linked to other data relating to local professional sickness-rate profiles available to me, and examines the differential statistical data relating to absenteeism concerning the staff research groups.

CHAPTER ONE

Stress: What is it ?

The origin of stress research, according to the Health Education Authority (1988) originates from the 1930s. Newton *et al* (1995) suggest that:

most writers credit the academic emergence of the stress concept as lying partly with the work of Walter Cannon, but most importantly with that of Hans Selye (page 23) prior to the Second World War.

Since then much has been written and presented in published works and the media about stress and its effects. As a result, stress has become a commonly used term.

Stress, according to Bond (1990), is a Twentieth Century 'buzz-word', used to describe feelings and situations, when people cannot cope. However, as with many words in a common language, the word 'stress' has acquired a vague 'catch-all' meaning, used by different people to mean different things. It is used to describe both physical and mental conditions, and also the pressures which cause those conditions.

Stress may relate to thoughts, feelings, bodily conditions, health, behaviour, and work related issues (Bailey 1989). Appleby and Turnbull (1986) acknowledge stress as a complex process. Lazarus (1966) argues that stress is a natural phenomenon, but to most individuals, stress is rather unpleasant and undesirable, with unwanted symptoms such as anxiety, anger and depression, which can affect people in different ways.

According to Cox (1978) stress usually occurs when there is a significant internal or external demand that exceeds personally available human resources.

The Health Education Authority (1988) concurs with Cox's (1978) view that stress is a highly individualistic phenomenon. Cox (1978) further reminds us that stress of any origin results from people's perceptions of an imbalance in the various demands made, versus an ability to cope. The outcome (usually unpleasant) could lead to changes in behaviour, physiology and produce ill health.

Bailey (1989) contends that stress can be regarded in three main ways: as a stimulus or cause; as a response or effect; or as an interaction between the demands made on individuals or groups, and the degrees of coping available to them. There is increasing evidence linking stress, and its effects, to many different manifestations of ill health (Cherniss 1980). There is also widespread recognition that work, and the way in which it is organised can give rise directly to stress (Kalimo 1986). The costs of stress related illnesses to employers are increasingly being counted in terms of days lost through sickness, absence, poor worker morale, and low productivity, all of which can be attributed to stress (Cooper 1981). The consequences of stress to individuals and industry can be considerable. Bailey (1989) declares that manifestations such as heart disease, impaired judgement, and decision making ability, are just a few noteworthy components of the perception of stress. Bailey (1989), citing the *Employment Gazette*, notes that 328 million days were lost to industry in 1987, of which 111 million, just over a third, were related to stress.

Rudinger (1988) suggests that stress is inherent in the human condition, and that the twentieth century has intensified many stressors and added other new stressors of a

psychological or social nature. She further contends that stress in general refers to pressure placed on an individual which is in some way perceived to be excessive or intolerable. This might produce a psychological or physical change in response to pressures. Newton (1995) notes that stress is not a twentieth century phenomenon, and that stress has always been associated with and related to human history, with different periods in time offering different stressors.

Selye (1974) views stress as a non-specific response of the body to any demand made upon it. He further notes that stress is not merely nervous tension, but rather that everyone needs a different level of stress in order to live a happy, healthy, and successful life, - as complete freedom of stress is death!

Meichenbaum (1983) notes that stress can be indiscriminate and might be regarded as a personal response when an individual is placed in a challenging or threatening environment, usually of a social or physical nature.

The Health and Safety Executive (1995) whilst acknowledging the negative features of stress, defines stress as the reaction that people have to excessive pressure, or other types of demand placed on them. It concludes that it arises when people worry that they cannot cope.

The Health Education Authority (1988) offer the view that stress is divided into that which is constructive and provides stimulation, vital energy, and personal efficiency,

and that which is negative and destructive, and will have a negative effect on mental and physical health.

Cooper (BBC 1991) states that:

Pressure in life is good. It stimulates people, but some people have a different capacity to cope than others, and when the pressure of life, in whatever form it comes, whether at work, or your domestic relationships exceeds your ability to cope, then we are in the whole arena of stress.

To summarise, stress appears to be idiosyncratic and it can have positive effects. Most often, however, it is considered to be negative, manifesting itself when there is an imbalance perceived physically or psychologically, as a response to either too much or too little pressure.

Models of Stress

Review of literature suggests several varying models of stress, but all appear to be underpinned by the work of Selye (1956) and classically known as the General Adaptation Syndrome (G.A.S.). This model is often referred to as the '*Fight or flight syndrome*' (Livingston Booth 1988), and is based on an automatic physical reaction to a danger or demand (Speilberger 1979). The model is based on a three stage biological response (Gross 1993), it includes a physical alarm reaction, known as '*Flight or Fight*' syndrome. The body has been prepared physically to meet the threat and fight, or run away. The model also includes a resistance and exhaustion stage. There are potential psychosomatic problems if the exhaustion stage is encountered on a regular basis.

Stress, the Causes and Effects.

Because the effects of stress are considered to vary from one individual to another, there will be many differing causes and individual thresholds. For example, one person's personal stressor may be of little significance to another person. Public speaking causes stress to a great many people yet there are other groups of people who thrive, seek out, and relish its effects. This positive type of stress is usually referred to as Eustress (Cox 1978).

Major life events appear to be a significant contributing factor regarding stress. Dobson (1982) recognises the importance of the Social Re-adjustment Scale (Holmes and Rahe 1967), in which forty stress value life checks are listed. The list ranges from the death of a close relative and divorce as the two most stressful life events, to holidays or minor law violations at the opposite end of the scale. The table of life events itself is useful diagnostic and predictive tool, as people can be assessed against a formula which can predict serious illness. Heart disease and depression are examples (Dobson 1982).

Whilst the Social Re-adjustment Scale is undoubtedly a helpful working model of stressful life events, its merit and perception must be tempered with a view that some of the high marking events, such as the death of a close relative, or a divorce may not be the devastating life event that it might imply to someone who has seen the death of a loved one following a painful undignified illness, or who had a divorce following the ending of an acrimonious relationship.

Stress can be caused when high demands or expectations are placed on an individual by either themselves or their organisations. Working under difficult circumstances or conditions may lead people to become emotionally run down and stressed (Cooper and Davidson 1984). The cause of stress in an individual is any excess of demands, beyond a person's ability to cope at any given time. Dohrenwend and Dohrenwend (1974) note in their research - based contribution '*Stressful life events*' that culture, social change, and trauma, whether physical, psychological or spiritual, are major contributors to stress. These issues link stress as a major factor and antecedent of varying categories of physical illness, especially heart disease. Stress literature suggests many varying effects of stress, Fontana (1989) for example, explores three distinct effects of stress:

- a) cognitive effects: such as lack of ability to concentrate; reduced observation functioning; memory recall problems; and impaired judgement;
- b) emotional effects: including physical and emotional tensions; hypochondria; personality trait changes; defensiveness; hostility; and perhaps depression;
- c) general behavioural effects: for example, speech impediments; lack of interests; absenteeism; drug and alcohol abuse; scape-goating; cynicism; and generalised bizarre behaviour patterns.

Other researchers identify and develop similar models; for example, the Health Education Authority (1988) also acknowledges three core areas regarding the effects of stress. However, it outlines short term and long term effects, and categorise these as follows:

a) behavioural. Short term effects include over indulgence or abuse of alcohol, drugs and food, accident proneness, impulsive behaviour and poor relationships with others, either at home or at work, and emotional withdrawal. Behavioural (long term) effects are likely to be social isolation and marital and family breakdown. Short term physical effects are noted as headaches, backaches, indigestion, altered sleep patterns, chest pain, nausea and excessive sweating. The physical long term effects or consequences could be high blood pressure, heart disease, duodenal ulcers and generalised poor health.

b) emotional. Short term effects are likely to involve anxiety, tiredness, boredom, irritability, depression, inability to concentrate, low self esteem and regard, and apathy. The long term effects and consequences suggested are insomnia, chronic depression, anxiety and other psychiatric manifestations that may include neurosis, acute and chronic anxiety states and finally para- suicidal behaviour.

The above consequences of stress can, therefore, lead to disturbing symptomatology in an individual with the potential to cause that individual and others in that person's life major life problems. Fisher (1986) warns of the damaging consequences of neglected or untreated stress, either in the every day life of an individual, or in their occupation. The negative consequences of stress in an individual can subsequently have major effects on other people's lives. These may include children, wives, and parents in terms of a stressed individual becoming either mentally or physically ill,

losing their job or even taking their own life. Anger, torment, disillusionment, and devastation of others left behind following suicidal behaviour is well known in psychiatric literature. The International Classification of Diseases (ICD)(10) (1992) does not specifically classify Stress as a disease, only Post Traumatic Stress Syndrome, and defines it as acute stressful symptomatology associated usually with a single life event. It does, however, identify anxiety and anxiety states as a syndrome in its own right. It is worthwhile exploring the difference at this point as the two are often popularly confused.

Ender and Edwards (1982) claim research literature tends to use the terms stress and anxiety inter-changeably. It is interesting to note that (Ackner 1964) suggests that the term anxiety:

denotes the inner state of emotional disquiet or feeling of tension commonly aroused by some challenge or threat to physical or psychological well-being.
(Page 86)

This definition of anxiety is similar to the definitions of stress offered previously in this research; however, Stuart and Sundeen (1983) contend that anxiety is a state of apprehension associated with feelings of uncertainty and hopelessness. They describe it as an emotion without a specific object and is usually associated with anticipated doom or potential failure. The I.C.D.(10) (1992) suggests that stress, as a symptom, is a reactive response to a stressor, whilst anxiety is usually an enduring anticipatory response to a set of circumstances that may be real or imaginary. Stress itself can lead to an anxiety state, and symptoms may be constant and multi-faceted, and result in

neurotic syndromes such as phobias; mixed anxiety and depressive disorders; obsessional states; and somatisation disorders.

Stress and Personality Types

Analysis of texts of Victorian origin consistently bracket or label individuals referring to their constitution and resilience. William Sargant, a consultant psychiatrist at St. Thomas's Hospital, according to Norfolk (1977), made a detailed study of human behaviour under stress in times of war, and when undergoing scientifically applied brain washing procedures. He reported that persons of phlegmatic temperament and 'strong heavy body build', and who were also mentally well adjusted with a happy settled viewpoint of life, are likely to resist stress and brain washing longer than those who have few, or none of these assets. Sargant refers to an inner strength that can resist stress or the ability to cope in the face of adversity. Some people may be labelled as the 'worrying kind' or 'highly strung', other people may be said to have a 'nervous disposition'. Livingston Booth (1988) discusses personality types with high stress risk factors and describes the 'anxious worrier' whose defence systems become overwhelmed and can be in a constant state of worry with the least provocation. She further states that such personality types are more likely to suffer with depression, anxiety, and somatic disorders than individuals who are able to deal with life's difficulties in a more considered fashion. Kobasa (1982) describes what he calls the 'hardy' personality. Such a person is noted as being relatively resistant to stress. This type of personality displays three qualities:

- a) a sense of control of his/her life;

- b) a feeling of being committed to his/her work and environment;
- c) a sense of challenge that gives the capacity to take opportunities, and develop them positively as and when they occurs to maintain personal equilibrium.

Beck (1984) describes people who suffer from stress because of an internal origin, with a particular tendency to interpret events consistently in a negative way. Ellis (1995) discusses the maladaptive personality of people who hold unrealistic belief systems with unclear goals, who fail to make decisions, and who bottle up emotions that can create inner anxiety and anger, thereby leading to low self esteem and immense feelings of stress.

Contemporary research regarding personality theory has been pioneered by Hans Eysenck. He argues a personality model relating to neuroticism that suggests excitability and emotional responsiveness (Eysenck 1985). Personality type and stress appears to relate to particular typical behaviour type patterns associated with stress prone personalities described by Friedman and Rosenman (1974). Type A personality is described as stress-prone types, as opposed to Type B people who are less intense in their behaviour and do not appear stress-prone. They contend that the characteristics of Type A behaviour patterns are:

- urgency of speech;
- rushing to meet deadlines;
- interrupting conversations;

- engaging in multiple tasks;
- preoccupation with work;
- restlessness such as pacing;
- hard driving and ambitious need for control;
- obsession with multiple and often ill defined goals;
- idiosyncratic physical manifestations, i.e., clearing the throat and scratching.

Bailey (1989) describes this type of personality as relentless in the pursuit of anything.

Friedman and Rosenman (1974) feel that people with the above characteristics are likely to carry a greater risk of heart disease, and are also likely to have lower stress thresholds. People with type A personality may also exhibit symptoms of other physical disease, such as gastro-intestinal disorders. Ivancevich and Matterson (1980) theorise that in the same way that there is a Type A and Type B personality, that there is also Type A and Type B work environments. They note that the optimum type A working environment is controllable, fast paced and extremely challenging, whereas the optimum type B working environment is routine, moderately paced and non-challenging. They further develop their argument that mis-matches in Type A and B personalities employed in working environments of Type A and B can further be a factor in producing stress in an individual. However, Briner and Hockey (1988) whilst also noting the differences in personality, and recognising that some types of people handle stress better than others, comment that:

In fact predictions based on personality assessment have generally been rather disappointing, and this has been true also of computing stress. Such general approaches may be misleading (page 133).

They feel personality type identification, following psychometric testing, does not necessarily indicate the type of individual best suited to do a stressful job as other factors need to be taken into account. Newton (1995) contends that people needn't become stressed at all, as they can be trained, conditioned, and coached, into what he calls being 'stress fit' and that there are a variety of people who may be seen by their contemporaries as being 'nervous' or 'anxious' individuals, but who are quite able to manage the most complex and anxiety provoking jobs provided that certain boundaries, including adequate supervision, is available.

CHAPTER TWO

Occupational Stress.

The Health Education Authority (1988) review of stress in the public sector confirms that many major working environments or institutions, such as police forces, hospitals, and social services, are not only sources, but causes of occupational stress, and that the organisations themselves can display manifestations of stress. The report quotes low morale, poor productivity, high sickness rates, strikes, and upturn in industrial accidents as the most relevant examples of symptoms of occupational stress.

Gourney (1995) notes that about 8% of the population will suffer a significant anxiety state, and 20% in a life time can expect to suffer to a level which interferes with daily living functions and is likely to last for some time. He also notes that a precursor of anxiety states is stress, particularly industrial stress.

Stress in the workplace is likely to continue to present a major threat to the financial health and personnel welfare in organisations (Jenkins and Warman 1993). Stress, its effects and health consequences are a growing industrial concern, in terms of lost working days, health and safety legislation, and the increasing industrial fear of litigation. The Guardian (8.11.94) reported a High Court judgement which held a county council liable for a social worker's 'nervous breakdown'. The article, quoting legal sources, claimed that the case made British legal history, in so much that for the

first time, in law, it placed employers under notice that they have a duty to protect their employees from work related stress. The case has led to Occupational Health units in NHS environments to conduct risk assessments regarding stressful working environmental roles for employees.

Examination of numerous health professional related articles indicate a number of pending claims ranging from stressed doctors working too many hours, to the police officers who claimed post traumatic stress syndromes following the 'Hillsborough disaster'.

Axelby and Paxton (1994) claim that stress appears to have reached epidemic proportions in the NHS, referring to a Commissioners' investigation into occupational stress following a study using the General Health Questionnaire, a tool to detect mental health problems. The report concluded that staff showed high levels of stress, but that professionals perceived as being in control of their work indicated fewer health problems, whilst lower grade clerical staff reported the lowest level of job satisfaction and subsequent high levels of stress. The report quoted the major stressors as being increased work-load, changes in the NHS contract negotiations, deadlines, and staff shortages.

Secombe and Buchan (1993) undertook a large research project entitled '*Absent Nurses, The Costs and Consequences.*' They canvassed 4,000 qualified nurses (2200 respondents) who had reported any type of absence during the previous 6 months. They found that 56% agreed with the statement '*I often find my job too stressful.*'

The report concluded that generalised stress was a major primary or secondary factor in qualified nurse absenteeism.

O'Donnell (1996), reports a survey by Cox (1994) into work load in nurses, which indicated stress as a significant concern for nurses of all specialities. Low pay, violence, deadlines, technical skills or (lack of them), all figured highly as occupational stress factors. It is therefore noted, that in terms of mental health, occupational stress can exact a heavy toll (Doyal 1980). On reflecting on the above published data, the researcher agreed in most part with the findings, but was intrigued as to why some professional staff of similar personality type and professional background and experience have, in the researcher's view, major differing stress thresholds. It is this consideration that underpins his research.

Potrycus (1995) notes a recent increase in nurse suicides against an unacceptably high background of stress related para-suicidal incidents, and illness relating to nurses. In 1990-91, 153 British nurses, midwives, and health visitors, took their own lives.

Potrycus (1995) citing Highley and Cooper's research with nurse managers recognises that nurses are a high risk group for alcohol abuse, smoking, and para-suicidal behaviour itself, all of which are linked with stress.

Further published details of the consequences of occupational stress suggest that in 1990, in a U.K. labour force survey of 100,000 cases of stress related depressive illnesses, over 50% were thought to be caused rather than exacerbated by their individual working conditions (Goldman 1994).

Further recent alarming statistics, cited by Virginia Bottomley when Health Secretary, reported that the NHS employs 900,000 people, of whom 170,000 (18%) might suffer from some degree of mental illness, much of it stress related whilst employed by the NHS. (Jenkins and Warman 1993).

Causes and Consequences of Occupational Stress.

Bruffell (1995) notes that:

Stress (occupational) is defined as the way in which external, that is environmental, factors threaten an individual's physical or psychological state and well-being. (page 17).

Stress in the work place according to Hackman and Lawler (1971) has always resulted in its emotional, physical, and mental consequences of strain and tension.

Livingston Booth (1988) referring to research in Sweden, Canada, and the USA identified four work place elements as major industrial stressors:

- imposed restraints: with noise and high work load;
- organisational factors: including communication problems;
- role in organisation: that may include a lack of defined limits;
- Indifferent working relationships.

She further recognised that the above factors may affect individuals differently regarding personal vulnerability to occupational stress. The following factors are

considered important in determining stress vulnerability at any one time (Livingston Booth 1988):

- i) our experience for the job;
- ii) the support of a group or colleague at work;
- iii) the support of a caring home;
- iv) the number and degree of stressors at any one time;
- v) personality;
- vi) life style;
- vii) our ability to cope.

Payne (1988), offers three examples of personal variables that may influence occupational stress thresholds:

- i) Genetic: including physique, constitution, and gender;
- ii) Acquired: social class, education, and, age;
- iii) Dispositional: locus of control, coping style, and type A personality.

Hackman and Lawler (1971) state that because of financial insecurity and employment re-organisations, subsequent feelings of stressful insecurity were only felt by middle class professional workers. This is a contentious view that is not upheld by the more recent work of Wallace *et al* (1988), who feel that working class people are just as likely to experience the same manifestations of stress as other classes.

Fisher (1984) contends that there is evidence that job characteristics are likely to create varying types of stress in different categories of worker (professional or manual), and are likely to be linked with control and an accumulation of negative aspects of a job, whether blue or white collar related. Fisher further argues that workplace stress cannot be defined in isolation, as other external (non occupational) factors are also likely to have an impact.

Wallace *et al* (1988), whilst also acknowledging the distinction between blue and white collar workers and the implications of stress, extend the differential regarding stress as relative to educational differences, income, gender, ethnicity, and country of birth. It would appear that an individual is more likely to be able to deal with work place stress if he/she is stress free in other life areas.

Elliott-Binns *et al* (1992) agree that stress is not confined only to an individual but relates also to organisations. Jee and Reason (1988) contributing to the Education Authority pamphlet '*Action on stress at work*,' whilst noting that occupational stress is multi-faceted offer the following potential effects.

- They list:
- *low morale;*
 - *poor working relationships;*
 - *high long-term sickness rates;*
 - *lateness and absenteeism;*
 - *high accident rates;*
 - *increased disputes and strikes;*
 - *vandalism and sabotage;*

- *high labour turnover;*
- *high number of requests for early retirement.*

(page 9)

Stress influence on individuals or organisations can be gradual and insidious (Jee and Reason 1988).

Phillips (1994), representing a law firm which specialises in various forms of industrial litigation, has produced a useful, well researched pamphlet entitled '*Facing Stress Litigation*'. He discusses occupational stress as psychological, physiological, behavioural response, or reaction by persons to a situation where they are unable to cope with the demand imposed by their organisation, that lead, eventually to injury, illness, or incapacity. Phillips (1994) further argues that occupational stress is not synonymous with a feeling of just being under pressure, but that the syndrome may be insidious, and that occupational stress may only be found to be attributable after an injury or illness.

Phillips (1994) cites no fewer than six clear and distinctive causes of Occupational Stress.

- a) factors intrinsic to the job: including shift work, overload, and general poor working conditions;
- b) role in the organisation: role ambiguity and cross boundary working;

- c) career development: this refers to thwarted ambition, under-achievement, and lack of training;
- d) relationships at work: this includes varying quality of support from subordinate staff, bosses, and colleagues;
- e) environmental factors: such as heat, cold, noise, visual display units, poor ventilation, hazardous materials;
- f) organisational factors: this may include 'office politics,' lack of consultation, and flawed management structures.

A factor that could be added to this list is that of an individual who has been placed in a position that he or she simply cannot manage or is not trained for, and is generally mismatched to the post. The individual then may be expected to perform at a level and pace which they cannot sustain or are not competent to do, with stress being the consequence.

CHAPTER THREE

Burnout, What is it ?

Much of the work on Professional Burnout, when first defined in the early 1970s, has come from the USA following research by Freudenberger, Pines, Maslach, and Cherniss, (Paine 1982).

Burnout, in the professional or occupational sense, is not stress but a consequence of stress, and can be evoked by industrial circumstances. Edelwich and Bronsky (1980) state that the term can:

refer to a progressive loss of idealism, energy, and purpose, experienced by people in the helping professions as a result of their conditions of work.
(page 14).

These conditions include: no supervision, client overload, poor training and support, and bureaucratic restraints. Burnout is a chronic occupational discontentment, and is caused by prolonged exposure to stress, pressure, and frustration, and may manifest itself at work, even if the stress and pressure generated is from family or environmental factors. (Carroll and White 1982).

Freudenberger and Richelson (1980) state that burnout occurs when someone:

is in a state of fatigue or frustration brought about by a devotion to a cause, way of life or relationship that failed to produce the expected reward.”
(page 13).

and that:

whenever the expectation level is dramatically opposed to the reality and the person persists in trying to reach that expectation, (page 13),

then consequences of burnout will only be negative ones, with a depletion of inner resources, lack of energy, and irritability. The literature consistently suggests that stress is likely to precede burnout.

Maslach (1982) presents a view that Professional Burnout is a syndrome of emotional exhaustion, and reduced self accomplishment that relates to work, whilst French *et al* (1973) argue that job stress and potential burnout occurs when the job either poses demands that the worker cannot meet, or the job fails to provide sufficient support that the worker may need.

Pines and Maslach (1978) discuss the consequence of burnout in health-care professionals, referring particularly to exhaustion, apathy, hopelessness, frequent sickness, detachment, boredom, and cynicism as being the main negative outcomes.

Burnout is considered to be especially common, and particularly severe amongst professionals who deliver direct 'hands on' services to clients in public institutions or other agencies. (Maslach 1976; Macinick and Macinick 1990).

There is an undeniable link, argues Craft (1993), between working environments and mental illness as well as mental health, and he feels that one of the major contributing factors is burnout.

Elliott-Binns *et al* (1992) discussing burnout in General Practice (medicine), describe it as: *a chronic inability to provide quality care for one's patients as a result of job related stress* (page 92). They further note that burnout can affect the quality of care a General Practitioner offers. Elliot-Binns (1992) further advises that the effects of burnout are produced only by the demands of the job and not by other stress related influences that may affect the doctor. This view is not supported by other researchers, who feel that various life events can reduce an individual's threshold to stress, especially in an industrial setting (Maslach 1976).

Burnout is further defined as a condition which develops when a person works too hard for too long in a high pressure environment (Kelly 1989).

O'Dowd (1987) lists three clear and distinct stages of burnout, and although his work particularly targets General Practitioners, the concept is relevant to most occupational settings.

Stage 1 is when an imbalance is created between the demands of work and the individual resources available to meet those demands. The burden of work will be clearly felt, and extra working time may be needed by the worker to meet the ever

increasing perceived demands. The fact that extra working hours are required to 'stand still' or 'keep up,' is in itself a stressor, and little personal 'quality time' will be available to the worker.

O'Dowd describes *Stage II* as when the worker can no longer accommodate emotionally the stress related work load. The imbalance created causes the worker to feel tired, drained, and the worker at this point may complain. The beginnings of loss of control may appear, and be accompanied by bad-temper. This behaviour may alienate colleagues, friends and family, and may remain a common feature in the individual's daily interaction with others.

O'Dowd's *Stage III* is when burnout is finally complete, manifested by chronic tiredness and irritability, difficulty with personal, working and family relationships, loss of sense of humour or fun, potential withdrawal and isolation. It is at this point when major psychological and physical symptoms may become evident.

Edelwich and Brodsky (1980) offer a similar theoretical model of burnout, as consequence of being undervalued, over-worked and under-paid. A mis-match in human resources of a personal nature and the demands focused on them is a recurrent theme.

Cooper and Marshall (1978) suggest that personality and behaviour, and family support, are particular variables and insulators regarding '*who is likely to burn out*' as a manager. They argue that the type A personality manager is more likely to suffer

from burnout and demonstrate similar symptoms to those which have been previously mentioned. The more stable family-orientated type of manager, however, who has a good structure of support, is more likely to be able to sustain pressure and stress and not become a burnout casualty. Jones and Chapman (1979) in their paper '*Stress out of Hours*' take the view that occupational stress and its damaging effects, can be a subsequent '*spill-over*' of domestic factors into work.

Newton (1995) asserts that certain individuals may be '*job fit*,' and as a result are likely to manage personal aspects of stress in an occupation. Shipley and Cook (1979) suggest the '*uncertainty factor*' as being the main influence in mis-fit variables found, with its inherent tendency to create subsequent occupational stress and burnout factors.

Cherniss (1982) indicates that professional work environments have changed in recent years, in keeping with social, political, economic, and also intellectual trends, and that these changes have combined and contributed towards chronic occupational stress and potential burnout.

CHAPTER FOUR

RESEARCH

Selection of Research Methodology.

There are two distinct views on research methodology, particularly within the behavioural and social sciences, which divide broadly into quantitative and qualitative approaches (Duffy 1987).

Duffy, a research analyst in the nursing field, notes that quantitative methods require measurable data, and that the researcher remains detached from the subject and facts in an attempt to prevent or deflect bias. Duffy, describes qualitative methodology as an interpretation of what is actually happening, as observed by researchers, who themselves may be key players as research participants. Reason and Rowan (1981) describe qualitative research as being part of 'New Paradigm' approach to research. They suggest that it is a flexible approach to social enquiry using whatever research techniques are available, appropriate and realistic. Reason and Rowan (1981) continue by suggesting that researchers themselves should be involved as one of the research tools, by enhancing the debate and by using the researcher's experience.

Guba (1990) attempts to clarify the mass of research paradigms by suggesting that qualitative methods are non-positivist, or new paradigm research, and highlighting the

central theme as being researcher led. What Guba terms as an 'indifference' is also shown towards statistical data.

Guba (1990) further outlines quantitative research as statistical data-led, and describes it as positivist, and outcome orientated. Duffy (1985) in a paper which acknowledged much of the work of Silverman (1972), and Schwartz and Jacobs (1979), discusses the merits of quantitative verses qualitative research in a nursing speciality. Whilst advocating that the truth is wherever it can be found, she encourages researchers to use quantitative and qualitative methods in concert, whenever they possibly can.

Corner (1991) contends that there is a major advantage to integrating both paradigms, as there is an implicit benefit in combining the reliability of quantitative research methodology, and the validity of qualitative research methodology. There are merits in both methodologies and whilst considering this 'either - or' methodology, this research draws on positive elements of both paradigms. This research dissertation therefore adopts a two-stage research design drawn from qualitative and qualitative paradigms. Mason (1994) describes a number of advantages with this type of research, especially if undertaken in the human sciences. She suggests that such a study will yield differing data relating to the subject studies, and that the two-stage research design will enhance the validity of the overall analysis.

Mason further suggests that research tools from both types of enquiry should be simple, 'user-friendly', and easily interpreted. Questions in qualitative interviews should be conducted in a confidential stress free environment, and where possible

open-ended dialogue should be used by the researcher to maximise the potential for freedom of response.

Research Background.

The researcher, as professional line manager to various groups of mental health practitioners, has been aware of an increasing psychological burden that staff groups associated with acute and community psychiatry have been subject to, especially over the past two years. For the purpose of this research, reference will be made to three distinct professional elements: staff who work on acute mental health admission wards, community psychiatric nurses, (CPNs) and day hospital therapy staff. Staff from these groups have a basic psychiatric nursing qualification (Registered Mental Nurse) and most of them have post-basic clinical qualifications, some to degree level. Part of the author's role is to provide clinical and managerial support and supervision, in one-to-one sessions on a monthly basis with some of these staff, and it has been during these sessions that staff have commented, often in 'no uncertain terms,' on the pressure and stress that they are experiencing as a direct result of dealing on a regular daily basis with a mentally disordered client group who may display depressive symptoms, suicidal ideas, psychosis, or have major anti-social personality disorders. Some of these clients / patients may be verbally abusive or even violent.

Over the past five years the NHS has undergone radical reforms that now require a more business-like market approach to care delivery from every speciality. The introduction of targets, patients' charters, and pressure from user groups, have all

brought extra work and pressures for staff, with little or no extra resources to help achieve the reforms' targets. The major changes are a consequence of the introduction of NHS legislation. There is now a strong emphasis on standards, both quantitative and qualitative, that have to be achieved in order to maintain health provider contracts, which in turn fund staff's salaries. If there is under-achievement, there is a threat to contracts and subsequently jobs. Staff understand that they have to perform at a very high level in a difficult area of care delivery just to maintain their posts. Various outcome measures are now available to assess staff performance. These measurement tools are often perceived by staff to be threatening, and ultimately stressful. Psychiatry is an unpredictable and variable science, with difficulties in evaluating its effectiveness. In psychiatry, any health gain is likely to be at best complicated, slow, or even static, yet there is a bureaucratic requirement to achieve. This causes real pressure and subsequent stress.

Further political initiatives that are causing psychiatric practitioners concern are the introduction of the Care Programme Approach, the Supervision Register, and amendments to the Mental Health Act (1983). These initiatives have required the community psychiatric worker in particular to be even more accountable for seriously mentally ill people in the community; this is regarded as quite a responsibility as there is much that can potentially go wrong with this client group. Staff involved also raise major concerns that the reforms have required extra documentation and statistics to be provided by them; this requirement reduces the time which would previously have been allocated to direct patient / client care and creating more pressure on clinical time.

There has always been stress and pressure associated with the work of these staff groups. It is known that one or two of these staff members have not just complained of stress over the years but have also been the subject of mental ill-health symptomatology. (Staff not necessarily associated with this research).

Other staff members have regularly complained of feeling tired, having little enthusiasm for work, and feeling irritable, all of which are indicators of professional burnout (Maslach 1976). Although not all the staff are stressed or burning out there are enough indicators to demonstrate that the issue requires a more scientific enquiry, rather than rely on anecdotal information. This research, therefore, is focused on investigating the perception that staff are more stressed, especially over the past year. The research was conducted using sample groups of staff to establish whether staff are professionally stressed, and if there is any evidence of professional burnout.

Ethical Considerations of Research

A) Access to Participants involved in Study

Permission was obtained from the Clinical Director of Mental Health Services at West Cheshire NHS Trust, Chester, to approach various individual staff members, of a nursing background, from Acute Psychiatric Admission Wards in a Hospital setting, and also Clinical Nursing Staff associated with Day Hospitals, and Community Mental Health Nursing Teams.

B) Guaranteed Rights of the Research Participants, and Issues of Confidentiality

All individuals involved in this study were approached to establish their willingness to be involved in this study. The nature of the study was carefully explained to each potential participant, and their unconditional right not to be involved, or withdraw from the study at any time was confirmed. The confidential aspect of the research was also verbally verified and all verbal guarantees offered were confirmed in writing directly to the participants (appendix iii). Participants were also informed that the research would be supervised. Further emphasis was placed on the fact that the research questionnaires which would be forwarded to participants would remain anonymous, that staff grouping would be coded for analytical purposes only, and that returned data would be destroyed on completion of the research. However, as a number of staff had asked for feedback from the questionnaire part of the research, a second letter was drafted, (appendix iv), which indicated that the opportunity for feedback was directly available from the research. Participants were also invited to take part in a second study which would include an interview either individually or in a group.

Quantitative Research Design.

In order to establish the levels of stress experienced by psychiatric nursing staff, two questionnaires, Are You Burning Out ? (Freudenberger 1980) (appendix i), and the Professional Life Scale (Fontana 1989) (appendix ii), were administered to a sample of nurses representative of:

- a) an Acute Psychiatric residential treatment ward.
- b) a Community Psychiatric Nursing Team (CPN).
- c) a Therapy Day Hospital.

Five staff from each of the three working areas agreed to participate in the Study (n=15). Two male and three female staff from each group were randomly selected.

All had been in post for at least five years.

A) Quantitative Enquiry - Burnout.

The instruments selected, which were originally recommended by a Clinical Psychologist, are simple data collection tools, with a limited set of variables. Whilst aware of the work of Christine Maslach, whose pioneering methodology in the subject of burnout is to be respected (Pines 1982), Maslach's methodology was reviewed by the researcher and found to be complicated and time consuming to implement, although her methods do reduce the number of potential variables that the researcher has to consider. A self report technique was therefore selected. The questionnaire was required to be 'user friendly' because of the limited time available to the participants. A balance was drawn between the need to avoid a complicated set of documents that might appear daunting, and a tool that offered an indicator about the more common type of burnout features, such as tiredness, energy levels, irritability, forgetfulness, cynicism, and somatisation (Maslach 1982; Farber 1983). The questionnaire selected was a burnout scale based on the work of Freudenberg, who is considered by most researchers to be the first individual in an occupational sense to coin the phrase

'burnout' in the 1970s. Freudenberger's enquiry offers fifteen questions and invites the participant to assign a value from 1 to 5 in response to each question, 1 representing no change, 5 representing a great deal of change. The questionnaire asks the participant to review the past six months when responding to a question, and also to respond to the question within 30 seconds. The researcher was aware that burnout factors associated with the research groups may have been present prior to the six month window that Freudenberger suggested, and was a variable that would be considered on analysis. The marking scale ranged in five bands, 0-25, indicating that the respondent is *'doing fine'* to a scale of over 65, which indicated that *'you are in a dangerous place, threatening to your physical and mental well-being'*.

The questionnaire, therefore, met the researcher's criteria, being quick, simple and 'user friendly'; it was also easy to analyse.

The Questionnaire was personally completed by the researcher and he concluded that the questionnaire achieved its aim of subjective assessment of personal burnout, and appeared to be a fair, accurate, estimate of professional burnout, and a reasonable tool to apply in this study.

B) Quantitative Enquiry - Professional Stress.

This questionnaire was designed by David Fontana. The source of Fontana's Professional Life Stress Scale can be found in his 1989 publication *'Managing Stress.'* There were 22 questions, with questions 1 and 2 being multi-faceted. Although the

questionnaire is longer than Freudenberg's it was simple to complete. The scoring grid was slightly complicated and needed care in processing, and gave a five band formula from 0-15 that indicated stress was not a problem in life, to 46-60 indicating that stress was a major problem. It is important to note that both enquiries were forwarded to participants without the scoring grid on the questionnaire. Fontana (1989) warns:

Scores on stress scales must be interpreted cautiously. There are many variables which lie outside the scope of these scales but which influence the way in which we perceive and handle stress (page 114).

Fontana concludes that the scale is a guide and indicator only, but nevertheless will give the user valuable information regarding their stress levels.

This questionnaire was also completed by the researcher who considered the result to be a realistic indicator of personal professional stress levels. However, the researcher reflected that the response might vary if the questionnaire was completed on a 'sunny Friday afternoon', compared with a 'rainy Monday morning' and concluded that there was likely to be a difference, as feelings, thoughts, energy levels, were just some of the variables that need to be taken into account (Fontana 1989). The researcher's score was 21, which fell into the lower end of the 16-30 category which indicated a moderate range of stress for a 'busy' professional person. This score-band also suggested that there may be a personal opportunity of looking at how stress levels could be reasonably reduced. The researcher concluded that the questionnaire was a reasonable and useful guide in indicating professional stress. It was noted that some of

the variables indicated in the two quantitative enquiries would need to be explored in the qualitative part of the research, and *integrated into the findings*.

Quantitative Research Outcomes.

A) Are You Burning Out ? (Freudenberger 1980).

Although Day Hospital staff indicated the lowest occupational stress levels, their response to Freudenberger's questionnaire suggested that they had a slightly higher burnout profile. The CPN group scored at a similar level, with the Acute Ward respondents scoring the lowest. The analysed data indicated the following:

The average Day Hospital score was 27. (18 > < 31).

The average CPN score was 26.6. (16 > < 39).

The average Acute Ward score was 21.2. (16 > < 27).

The Day Hospital and CPN mean scores were within half a point of each other and within Freudenberger's second lowest band indicator of burnout, 26 - 5 indicating *"There are things you should be watching"*

The Acute Ward Average score was within the lowest burnout indicator band of 0 - 25 which according to Freudenberger suggests *"You are doing fine"* and that occupational burnout is not a problem in the respondents' life. It is therefore concluded that the Acute Ward staff, on the evidence of Freudenberger's indicator, are

not occupationally burnt out, and that the Day Hospital and CPN staff groups are judged to have been only moderately burnt out.

It was not surprising that the acute wards' burnout profile was lower than the CPNs' and Day Hospitals,' as their locus of control is significantly different. They do not have the same relentless clinical appointments and travel factors to contend with, and they are probably able to take a breather, and pace their day more easily. Gross (1993), citing Rotter (1966), claims that individuals who have the ability to control their daily life events are less likely to become stressed.

B) Professional Life Stress Scale (Fontana 1989).

Analysis of Fontana's returned questionnaires from all three research groups did not suggest a major variance. CPNs were indicated as having the higher average stress levels, and Day Hospital staff having the lowest average stress level.

CPN average score was : 16 (10 > < 20).

Acute Wards: average score was : 11.4 (7 > < 14).

Day Hospitals: average score was : 10.5 (9 > < 14).

Both acute wards and Day Hospitals average score fell into Fontana's lowest stress indicator band score of 0 - 15 indicating:

“That stress is not a problem in your life at the moment. That does not mean that you are underachieving but rather that you have things in balance.”

The average CPN score fell into the lowest possible range of the second lowest band of 16 - 30 This suggested that:

“This is a moderate range of stress for a busy professional person. Nonetheless, you may wish to consider how it (stress) can be reduced.”

It is noted that the CPNs were the only group to have both moderate stress and burnout. The only total consistency in the returned data related to the Day Hospital respondents who all agreed they could usually find someone with whom they could discuss problems. Examination of data relating to Fontana’s second question which referred to 22 common features of stress, including physical symptoms, returned a response of only one individual indicating more than three common features of stress, and three respondents claiming that they had difficulty sleeping at night, with sleep patterns being disturbed by young families. These physical indicators of stress symptomatology were lower than anticipated, but consistent with the low sickness rates referred to in this enquiry, and the negligible reported stress related sickness for these staff groups. Fontana’s Professional Life Stress Scale questionnaire therefore does not indicate any significant professional stress in the three professional research groups. The evidence of both of the questionnaires fails to uphold the researcher’s assumption that the staff group represented in this enquiry are to any significant degree occupationally stressed or burnt out.

To conclude the review of the quantitative research data, It is worth noting several points. The sample group (n=15) was a relatively small one representing 10.8% of the workforce of the three clinical areas researched. However, Harper (1980), argues that

a sample of 10 - 15% should give a reliable outcome in a quantitative study. Fontana warns that his Professional Life Scale is an indicator only of occupational stress, and that non-occupational variables can influence responses; he further contends that frame of mind, mood, and current state of health at the time of the survey could all potentially flaw results. Freudenberger's survey had a major weakness as it elicited a response relevant to the past six months only; this survey does not therefore test for signs of burnout of earlier origin that may have been relevant.

Personal feedback from nine individual respondents revealed that eight respondents considered that both surveys confirmed a reasonable assessment of how occupationally stressed and burnt out they were. One respondent however, took the view that the Freudenberger's survey underestimated how burnt out she felt, but not significantly. The analysis of data confirms that both surveys are perceived as reasonably accurate tools for measuring occupational stress and professional burnout, and has failed to demonstrate major occupational stress or a significant element of burnout.

Qualitative Research Design.

Of the fifteen original participants who had contributed to the quantitative part of the research, nine indicated their willingness to participate in a qualitative interview that related to professional stress, and agreed to be interviewed individually; only one indicated a wish to participate in a group activity. This frustrated an earlier idea the researcher had planned of having several group sessions to engage the participants of the group in a major learning and research process, on the lines of new paradigm methodology as advocated by Reason and Rowan (1981) and others. This idea had

not been previously discussed with potential research participants. There was, therefore, no alternative other than to interview all nine independently. Whilst it was disappointing not to have the participants' approval and support for a co-operative enquiry group, constraints of time did not allow a review of why nine mature, experienced individuals did not wish to participate in a group activity, despite all of them having had experience in groups. On reflection, it seems reasonable to conclude that, for whatever reason, individuals may feel uncomfortable about disclosing information of a very sensitive and personal nature in a peer group setting. It was hoped that relevant disclosure by the participants would be afforded in a one-to-one session with the researcher.

In a review of the dynamics of qualitative interviews, Smith (1973) recommends that a researcher who conducts a qualitative interview should be trained in basic interview techniques. Management and clinical training processes, experience, and also counselling in a clinical field had equipped the researcher for this role. Smith (1973) also suggested a semi-structured interviewing technique. Mitchell and Jolley (1992) indicated that much can be gained in a qualitative interview, assuming the researcher uses opportunities to expand themes, reflect and develop ambiguous points; they also advocate an open-ended questioning technique. Taylor and Bogdan (1984) felt that results in a qualitative interview would have more validity if there was a good relationship between researcher and participant, and suggests that letting people talk, paying attention, and being sensitive are all extremely important factors in a researcher-interviewer setting in trying to achieve an accurate response from participants.

On critically evaluating this model, it is worth noting the significance and importance of the work of Heron (1989, 1990) in practitioner-client situations. He considers opportunities will exist for both client (research participant) and the practitioner (researcher) in developmental and learning processes. Thus, the qualitative interviews were conducted using the Rogerian concepts of unconditional positive regard, congruence and empathy (Rogers 1967). A maximum one hour interview framework was adopted, and a quiet venue with appropriate seating and spatial interview proximity of 4-6 feet as advocated by McKay *et al* (1983) was used. Permission was gained from the participants for the session to be recorded for analysis purposes, using a semi-open-ended format to acquire the minimum information that would be required for analysis. Patton (1986) advocates an interview guide for use by the interviewer to ensure that a basic check list is available. This is to guarantee that all topics are covered. The interview according to Patton, can then be directed in a conversational style, but with a focus on a pre-determined subject. Patton (1986) concludes that the interview should be flexible and take the opportunity to explore interesting themes when they arise. These are the principles and dynamics that underpinned the qualitative interviews.

Qualitative Interviews.

The interviews with the nine clinical staff were conducted independently. The main themes discussed in the interviews with the three clinical groups identified are as follows,

a) Ward Staff

Ward staff respondents indicated that they did not feel occupationally stressed or burnt out. They indicated that they were reasonably happy at work, and although two had negative perceptions regarding the lack of career opportunity, no one was able to articulate any long standing issues within the working perspective that weighed heavily on them. However, one respondent, interestingly, developed a point that frustrations in her working environment appeared only when the ward environment was clinically difficult. She noted that negative aspects of work which would normally be easily managed, became relevant during difficult clinical times. She stated that on occasions when she personally came under pressure, she could become cynical and 'blame the system'. She only became aware of these personal processes during a period of psychological reflection following a clinical course that she was undertaking.

All three ward respondents felt that a medical model of care was still much in existence in psychiatry, despite there being major initiatives to integrate a multi - disciplinary model. One respondent vigorously contended that some psychiatrists, who operate from a 'superior, autocratic' base, have given him occasional 'sleepless nights.' He also considered that he had encountered on occasions, a certain amount of clinical disagreement with multi-disciplinary groups. He balanced this view by stating the negative aspects he felt in inter-disciplinary encounters created only a modest degree of disquiet within him.

The importance of professional acceptance emerged during the interviews with the ward staff as being a major issue regarding a positive impact on morale. Generally, all three respondents felt that inter-professional working relationships were good, but occasionally, usually due to personality clashes, tensions would arise. Two respondents argued with vigour that the basis for good working ward teams was underpinned by a set clinical team. They felt that too many changes in personnel had an unsettling effect on team dynamics.

A major source of anxiety and stress for ward based staff appeared to come from various client groups. Clients with personality disorders and anti-social behaviour were particularly singled out because of their manipulative and destructive behaviour, and this in turn could create tensions and test the patience of this particular staff group. Two respondents cited individuals who were a danger to themselves, or others, as the main group of patients who are likely to create the majority of tension in staff. One respondent contended:

There is little doubt in my mind that when fellow male colleagues are thin on the ground and you have to deal with an aggressive male patient without adequate backup, that the risk of personal injury at the time is not my first thought, but there have been occasions when I have had to intervene without proper backup, and following my intervention, I have felt a little shaky and vulnerable. But in fairness this rarely happens.

Patient / client suicidal attempts appear to be an occupational stressor for staff of major significance. Two of the ward staff respondents have been involved in the same serious past incident. One respondent said she had got particularly stressed for several months after the event, and she thought that at one point she had a genuine

psychological problem that related to an anxiety state. She felt that this was a direct result of the incident, although she was psychologically debriefed after the incident and considered she had adequate support; symptoms persisted for some time, until professional help from a skilled counsellor was offered and the matter adequately dealt with. She concluded the discussion by suggesting that she had probably encountered a mild post traumatic stress episode.

On reflection of this account, post traumatic stress was probably evident, as her thoughts, feelings and emotions described were very powerful; her symptoms which included sleeplessness, loss of appetite, intrusive thoughts and feelings of unworthiness are all associated with post traumatic stress and also with clinical depression as described by the International Classification of Diseases 10, (1993). The respondent indicated that there were no residual personal mental health consequences following her involvement in the serious clinical incident, but suggested that there could have been without the prompt and adequate support she received.

Personal discussions with large numbers of staff (not just research respondents on psychiatric wards) over a number of years, have led the author to a belief that staff's involvement with para- suicidal behaviour by a patient / client is probably the most significant clinical stressor in psychiatry.

All three ward respondents confirmed that domestic issues affected their concentration levels in their working environment. One respondent half jokingly stated he had difficulty in dealing with patients with 'high expressed emotion' when his family were

displaying similar features. Family health was also noted as being a likely personal stressor in creating stress at work. Reflecting on positive issues, staff training and development were noted as being relevant in reducing burnout processes. One respondent suggested training kept her fresh and up to date. A good team spirit and staff mix were also considered to be essential factors in maintaining a healthy working environment. All three ward respondents had noticed an increase in staff morale that coincided with a reduction in sickness levels following the re-introduction of long day shift system. Staff felt that they appreciated an extra day off duty, and although they were all working longer hours, their working week was balanced, and they were able to appreciate the extra personal time. They argued that they were not as tired and looked forward to returning to work following breaks, as there were no longer any back-to-back late finishes and early starts (finishing duty at 10p.m. and recommencing at 7a.m. the next morning) which apparently were particularly unpopular. The introduction of the shift pattern (previously discarded four years ago) was considered by all three ward respondents as an appropriate management action after listening to the views of the workforce, with the benefits of increased morale and reduction in sickness.

b) Community Psychiatric Nurses(CPNs).

There were three CPN respondents from the Community Psychiatric Nursing Service. There are fundamental differences in the working environment between CPNs and ward based staff. Ward staff have the benefit of working as part of an eighteen person psychiatric nursing team that provides twenty four hour care for approximately twenty

three patients. The CPNs, although part of the nursing element of the multi-disciplinary team, are, in the main, lone workers and it has been estimated that they will spend approximately 90% of their working week professionally isolated. Each CPN is likely to have a client group of approximately 50 individuals, and they normally work a traditional Monday to Friday working week.

Large caseloads and the variable nature of the client group appeared to be an important source of stress for all three respondents. Two respondents also cited the newly introduced Department of Health's charter standards that required CPNs to respond to urgent referrals within four hours, and non-urgent referrals within two working days, as an impossible task, which was likely to cause stress in the long term. This is a comment that has been voiced locally and reported several times in professional journals. The standard is a very difficult one to meet for a professional group who have pre-booked weekly appointments for their varying client group of mixed symptomatology, and if the standard is not amended in some way is likely to create increasing burdens for community workers. The interviews with CPNs did not confirm the author's assumption which derived from comments raised on occasions by others that personal safety, which is often associated with lone psychiatric workers, was a particular stressor. Two respondents simply considered it was part and parcel of their role, and although they took simple automatic precautions about their personal safety, they were not unduly worried or felt that it caused occupational stress. Two CPN respondents also indicated that they used to worry about personal professional effectiveness when first appointed. Both respondents confirmed that experience and training had reduced this stressor within a year of appointment. All three respondents

suggested that there were times when they wished that they could have immediate access to supervision in order to deal with particularly 'live' or 'burning' issues. Although CPNs can avail themselves of clinical supervision on a booked sessional basis, they felt that they occasionally have to take psychological stresses home with them, or deal with them in other ways. One respondent suggested that she was feeling angry at that moment about the amount of paperwork, official forms, and reports that she had to deal with. She considered that they were not directly associated with her duties. This, she said, produced stress during busy clinical periods when paperwork mounted up and she considered that her clinical duties were her priority. She then indicated that she regularly took work home in order to keep abreast, and because this in turn caused some domestic conflict, she therefore felt resentment and stress in her place of work. Two respondents offered views on personal pressure they experience, to come to work when not feeling well. Both suggested that they encountered feelings of guilt on the odd occasion when they were unable to attend work. This is because they are aware of the burden that their absence would create for their colleagues, as there were no 'off-the-shelf' replacements to deal with their caseloads should they be ill; they argued that there was little spare capacity with other team members in order to cover their caseload. Guilt feelings as a personal response of staff who work on their own and who are sick, is an important psychological factor of which management groups should be aware (Clark 1975).

All three CPN respondents agreed that managerial, clinical and personal supervision was an extremely important factor in dealing with issues that create stress. All three

suggested that the current organisational system of clinical supervision had had an impact in reducing occupational stress. Scheduled supervision is now available, and the CPN staff group believed they had benefited from improvements to their working environments which was appreciated by the respondents. These improvements include extra secretarial services, mobile telephones and upgraded office accommodation. However, one respondent suggested, *“as you solve one issue, another problem seems to takes its place.”*

Simmonds and Brooker (1986), in work that relates specifically to CPNs' work overload, notes that role ambiguity, role conflict, general responsibility for people, and lack of career opportunity, change, and prioritising of work are all potential major stressors for CPNs; and whilst the respondents felt that role ambiguity and role conflict are not factors that would particularly worry them, they confirmed the view that work overload and responsibility for people, and the varying symptoms which are encountered when dealing with mentally ill individuals, are significant occupational stressors for CPNs. All three respondents, although in post for over five years, did not feel that they were burning out; two of them noted that the organisation's investment in their personal development with various training packages has kept them motivated.

They agreed that clinical confidence gained by keeping abreast of the latest developments in community nursing, is an essential factor in combating occupational stress.

c) Day Hospital

Again three respondents were interviewed. All three worked in the same Day Hospital, and although staff work autonomously in the same working environment, in either group therapy, or individual sessions with clients, a feeling of effective multi-disciplinary team work appeared to be a strong and common positive feature with all three respondents. All three staff members have been professionally qualified for over ten years, and are experienced in a number of clinical areas. Two respondents had significant post basic qualifications. During the course of the interviews with the respondents of this clinical group, it was notable that they had a high regard for each other, and the reputation of their team as a whole. Although all three individuals indicated that there were times when they were put under extreme clinical pressure by the burden of dealing with psychological issues, and transference processes of their client group, they were at the end of their clinical daily sessions, given the opportunity to share concerns with their team leader and peers. A similar session was available for staff at the commencement of a working day. Every team member also appeared to have a clear understanding of their client group and their requirements, and that supervision, personal, professional and clinical, was available from the team leader during the day if necessary. This, argued one respondent, is an absolutely vital component of the team dynamic; and without daily support she felt that she would be taking psychological burdens home with her. It was also apparent that this staff group were friends socially; two respondents suggested that this is one of the reasons why the team had a good working rapport and felt at ease with each other. Issues of domestic problems again appeared to be evident as a factor that has the potential of providing

stress at work. One respondent offered, *“I for one have problems in concentrating with a patient for any great length of time if I know I have got problems at home.”*

Family and personal health problems, relationship difficulties and financial worries were all cited as issues that can cause occupational stress by this particular clinical group.

Pressure on staff because of paperwork, recording mechanisms, and extensive care planning, were also considered to be major pressures. One staff member stated that she actually got respite through attending to paperwork; she claimed it was impossible to maintain concentration levels indefinitely, as her job required her to interact with individuals who are expressing negative emotions and disclosing the most intimate details of their lives.

As with the two other clinical groups, training and development appeared to be a significant factor in combating burnout. Additional qualifications, according to one respondent, helped to further her personal self-esteem and confidence and she subsequently felt better equipped and qualified to deal with clinical issues. The Team Leader (a research participant) for this department stated that it was important for management and other disciplines to listen to the considered view of nursing, and team staff, as when their views are not acknowledged this caused her to become angry, and possibly stressed. She felt it was important for the professional group to be recognised as independent clinical therapists with their own set of values; if these values were not acknowledged by others, this could have the potential to cause her professional disquiet. All three day hospital respondents consistently stressed the value

of supervised practice as being the single most significant factor in their being able to remain psychologically healthy, and that without the supervision that their team leader and others offered, they could not continue to deal adequately with the complicated set of therapy cases that they were required to see consistently. Positive team dynamics and the daily support appeared to be a vital and fundamental requirement in order for this staff team to remain healthy.

Staff Sickness Profile

The presented details relate to the organisation's staffing establishment, which is a relatively small NHS employing authority of 950 staff. They were retrieved from the organisation's manpower system. Management expects an approximate 5% - 7% average sickness and absence profile per annum. It employs a vigorous personnel policy for investigating and managing periods of staff sickness. A review of staff sickness spanned a twelve month retrospective period from March 1995 until February 1996. The Trust's average sickness for all staff during that period was 5.21%, which was well within the target. Combined Acute wards for the same period returned a sickness rate of 4.70%, two Day Hospitals a rate of 4.34% and three CPN teams, 2.09%. The CPN figure was remarkably low, and confirmed the view, which was also offered by the CPNs in the qualitative interviews, that lone workers are the professional group least likely to report sick, probably, according to Simmonds and Brooker (1986) because of the extra work that may be placed on colleagues, and associated feelings of guilt. Examination of records for reasons for recorded sickness for the same twelve month period revealed two separate worker episodes of sickness

that were confirmed as stress related, and a further three cases that may have been stress related. Care of course, must be taken regarding the reliability of sickness records as stress related symptoms may not have been reported honestly by staff, and other symptoms reported could have been attributed to stress.

Whilst stress related episodes of sickness for the Trust's psychiatric nursing staff appear to be low for the audited year, I am aware of several illnesses relating to these staff groups attributed to stress several years ago. Nevertheless, It was concluded, that for the audit period, statistically reported occupational sickness does not appear to be stress related.

Details of the Trust's sickness analysis profile are presented in appendix v.

CHAPTER FIVE

Conclusion

This study set out to examine and review stress, occupational stress, and burnout, and to research the potential effects of stress and possible occupational burnout in three separate groups of psychiatric nurses.

Review of relevant literature indicates that Mental Health Nurses are a professional group who carry a significant risk of suffering from occupational stress related syndromes. Simmonds and Brooker (1986) note that CPNs, in particular, will inevitably become stressed during their careers, especially if they are professionally isolated and unsupervised. Other non-psychiatric health care professionals who offer face to face services also carry similar risks (Roger and Nash 1995).

Whilst accepting that stress can effect people differently, and that pressures of work will vary, there appear to be particular personal qualities and variables in influencing a person's stress threshold. These variables include personality type, inner strength or resilience, which Newton (1995) describes as '*stress fitness*'. Health, domestic issues, negative major life events, and from an occupational point of view, experience, training, environment, and supervision are also significant.

These pressures, stressors and factors are all likely to affect individual ability to cope adequately with their professional role. If stress and worry are ignored, occupational

efficiency will be significantly at risk. Paine (1982) not only confirms this, but warns that the longer occupational stress is experienced and neglected, then the greater is the risk of professional burnout.

The author had an assumption, based on anecdote and personal interaction with staff, that stress, and potential burnout was a major problem. This assumption was reached in part because of the author's experience in staff group meetings, supervision, and other forums, where consistent negative comments were made which included cynicism, resistance to inevitable change, and comments criticising what was generally accepted by the majority to be improved working conditions. Whilst reflecting on some of these comments, the author concluded that it appeared to be the same small number of staff voicing these negative comments. Perhaps there is a tendency to being sensitive to the comments of the few, and projecting their view to the feelings of the majority. It is possible that general worries and grumbles were being misinterpreted by the author (and others) as significant indicators of occupational stress, poor morale, or burnout in staff.

Personal reflective processes were concluded by re-evaluating assumptions, and noting that certain individuals have a tendency to consistently exaggerate the negative, as this was probably part of their make up and personality. The researcher's personal view is supported by Ender and Edwards (1982).

An important factor and indicator in identifying occupational stress and burnout according to Handy (1991) is high worker sickness rates. The organisation's recently

audited sickness rate for 1995/1996 (financial year) was 5.5%, was apparently one of the lowest for a psychiatric unit in the North West of England.

The sickness profiles of the staff groups referred to in this study are even lower; the CPN group was exceptionally low, however, the CPN staff group quantitative enquiry suggested a relatively higher combined occupational stress and burnout indicator than the ward staff and day hospital groups. Handy (1991) further reports that low sickness rates are usually an indicator of high worker morale. Murphy (1988) also suggests that low sickness rates are not normally associated with a workforce that is stressed. Casual sickness did not appear to be a problem; examination of sickness records did not confirm or indicate that significant stress related symptomatology was evident.

Nolan (1995) identifies domestic conflicts as being an underpinning stressor of poor mental health in nurses, even outweighing the significance of client / patient related stressors. Family issues and difficulties featured regularly in the qualitative interviews as an external stressor that was most likely to negatively effect occupational performance. A suspicion that domestic issues were a contributing factor regarding occupational stress grew stronger throughout the course of the enquiry.

The low indicators of occupational stress and burnout in the sample group, confirmed in the quantitative enquiries, were consistent and compatible with the overall conclusion in the qualitative interviews. Interviewees on the whole considered that stress they encountered was likely to be reactive to isolated incidents rather than consistent. People however, will react differently to similar stressors, and literature appears to confirm that personality type is the most significant reason for this.

However, several staff in the past have had considerable periods of sickness that appeared to be stress related. This may be because of the major occupational pressures that NHS staff face; inevitably some staff will become stressed and may eventually display signs of burnout.

Supervision of quality and regularity has a significant prophylactic role to play.

Supervision may be personal, clinical, or managerial. Staff are, during this process, able to safely voice their fears, concerns, and explore issues with their supervisors.

Supervision may become therapeutic, with opportunities for catharsis. This process according to Heron (1990) has major potential benefits. The organisation has recently invested heavily in supervision for clinical staff, and there is evidence that the supervision process is beginning to play its part in contributing towards a more psychologically healthy work-force.

Review of staff turn-over over a five year period in the organisation has revealed extremely low leaver rates. Seccome and Buchan (1993) confirm that low personnel wastage usually indicates a satisfactory working environment.

In conclusion, the assumption that the work-force the researcher manages is significantly stressed, occupationally stressed, or burnt out has not been validated. The two questionnaires, and the series of interviews, did not reveal any noteworthy stress or burnout, and revealed that most stress encountered in the occupational sense was reactionary, short term and normal. This impression, together with data representative of low sickness and staff wastage rates, leads the author to concluded that this enquiry

has not been able to demonstrate that occupational stress, or burnout in the workforce is evident to any significant degree.

*I've got the burnout blues
Everything's is tense,
Feel too many Stressors
Beating on my sense.*

*This endless flow of clients
Drowns me in their needs,
Hope, compassion, love are gone
As ire wounds my deeds.*

*Policies, procedures
Weight my desk and life,
As bosses sit there screeching
Through me like a knife.*

*At home, a spouse is waiting
Amazing they're still here,
One more crisis with the job
And they'll be gone I fear.*

*Got the burnout blues
So I just sit an stare,
Feel too many stressors
And no one seems to care.*

Witton Stewart Paine.

APPENDIX I

ARE YOU BURNING OUT?

(Herbert Freudenberger 1980)

APPENDIX II

Professional Life Stress Scale

From D Fontana 1989

APPENDIX III



West Cheshire

NHS TRUST

If Telephoning please contact: Ken Sexton
Direct Dial:
Fax No.:

Our

15th January 1996

Dear Colleague

Further to my recent conversation with you, I am writing to thank you for agreeing to assist me with my research into occupational stress and 'burn-out'.

The purpose of the two enclosed questionnaires is for me to assimilate and interpret information provided by psychiatric health care professionals, which is part of an academic research protocol that I am currently involved in.

Please be assured that the information provided will be treated in strict confidence, and the information will be correlated into one of three staff groups, A) CPN, B) Day Hospitals, C) Wards, of which there are a number of staff from each specialist area participating. Processed documents will be destroyed.

Please do not identify yourself personally on your questionnaires, there will only be an identification code on the questionnaire that relates to your staff group.

Please let me know if you are not willing, for any reason to proceed with the questionnaire once you have received it, as this enquiry is on a voluntary basis.

Please find enclosed questionnaires (2) which have self explanatory instructions.

Continued

15th January 1996

I would be grateful if you could return them to me as soon as possible in the confidential envelope provided.

Once again, many thanks for your assistance.

Yours sincerely

~~Ken Sexton~~
CLINICAL MANAGER

Encs

APPENDIX IV



West Cheshire

NHS TRUST

If Telephoning please contact:

Direct Dial:

Ken Sexton

Fax No.:

21st February 1996

Dear Colleague

Thank you for your participation in my recent research project.

A number of research participants have asked for feed-back from the results of the questionnaire, and this I am arranging to do.

I now wish to extend the research project and, therefore, I would like to give you the opportunity to be involved in an interview or a group process to explore aspects of occupational stress and burnout.

If you are interested in participating in this part of my research project I would be grateful if you could indicate below and return to me as soon as possible.

Yours sincerely


K. J. Sexton
CLINICAL MANAGER

I would like to be involved in the Research Interview/Group Process
(highlight preference)

Name/Designation

Liverpool Road, Chester, CH2 1UL

Telephone: (01244) 365000

APPENDIX V.

SICKNESS PROFILE ANALYSIS

WTE = Whole time equivalent

%	MAR 95	APR 95	MAY 95	JUN 95	JUL 95	AUG 95	SEP 95	OCT 95	NOV 95	DEC 95	JAN 96	FEB 96	AVG %
Trust Average * Sickness N = 950 WTE Staff	5.70	5.04	4.54	4.20	5.06	5.51	4.73	5.57	5.03	5.41	6.12	5.70	5.21
Acute Psychiatric Ward Staff (wards) N = 68 WTE Staff	4.25	5.70	5.47	4.06	5.15	3.97	1.59	4.65	6.17	4.92	6.37	4.13	4.70
Day Hospital Staff (two day hospitals) N = 15 WTE Staff	6.21	10.08	7.14	0.75	9.91	3.76	0.00	3.30	1.88	4.80	1.91	2.45	4.34
Community Psychiatric Nurse (three teams) N = 28 WTE Staff	4.55	3.22	1.01	0.69	0.95	2.26	2.01	3.57	2.83	1.83	1.51	0.72	2.09

* Services include Elderly Mentally Ill, Adolescence Service, Learning Disabilities and a unit specialising in Elderly Rehabilitation and Support Services

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