Workplace stress in nursing: a literature review

Andrew McVicar BSc PhD
Reader, School of Health Care Practice, Anglia Polytechnic University, Chelmsford, Essex, UK

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Correspondence:
Andrew McVicar,
School of Health Care Practice,
Anglia Polytechnic University,
Chelmsford,
Essex CM1 1SQ,
UK.
E-mail: a.j.mcvicar@apu.ac.uk

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Background. Stress perception is highly subjective, and so the complexity of nursing practice may result in variation between nurses in their identification of sources of stress, especially when the workplace and roles of nurses are changing, as is currently occurring in the United Kingdom health service. This could have implications for measures being introduced to address problems of stress in nursing.

Aims. To identify nurses' perceptions of workplace stress, consider the potential effectiveness of initiatives to reduce distress, and identify directions for future research.

Method. A literature search from January 1985 to April 2003 was conducted using the key words nursing, stress, distress, stress management, job satisfaction, staff turnover and coping to identify research on sources of stress in adult and child care nursing. Recent (post-1997) United Kingdom Department of Health documents and literature about the views of practitioners was also consulted.

Findings. Workload, leadership/management style, professional conflict and emotional cost of caring have been the main sources of distress for nurses for many years, but there is disagreement as to the magnitude of their impact. Lack of reward and shiftworking may also now be displacing some of the other issues in order of ranking. Organizational interventions are targeted at most but not all of these sources, and their effectiveness is likely to be limited, at least in the short to medium term. Individuals must be supported better, but this is hindered by lack of understanding of how sources of stress vary between different practice areas, lack of predictive power of assessment tools, and a lack of understanding of how personal and workplace factors interact.

Conclusions. Stress intervention measures should focus on stress prevention for individuals as well as tackling organizational issues. Achieving this will require further comparative studies, and new tools to evaluate the intensity of individual distress.

Keywords: workplace stress, nursing recruitment and retention, stress management, organizational change

Background

Stress is usually defined from a 'demand-perception-response' perspective (see Bartlett 1998). Lazarus and Folkman (1984) integrated this view into a cognitive theory of stress that has become the most widely applied theory in the study of occupational stress and stress management (Lehrer & Woolfolk 1993, Rick & Perrewe 1995). The basic concept is that stress relates both to an individual's *perception* of the demands being made on them and to their *perception* of their capability to meet those demands. A mismatch will mean that an individual's stress threshold is exceeded, triggering a stress response (Clancy & McVicar 2002).

An individual's stress threshold, sometimes referred to as stress 'hardiness', is likely to be dependent upon their characteristics, experiences and coping mechanisms, and also on the circumstances under which demands are being made. A single event, therefore, may not necessarily constitute a source of stress (i.e. be a 'stressor') for all nurses, or for a particular individual at all times, and may have a variable impact depending upon the extent of the mismatch (Lees & Ellis 1990). Assessing stress is likely to be very difficult in an occupation as diverse and challenging as health care, yet the effectiveness of organizational interventions to reduce or eliminate sources of stress depends upon a sound understanding of the stress phenomenon for nurses. This paper reviews the implications of the subjective aspects of stress perception for nurses who, with teachers and managers, are a professional group most likely to report very high levels of workplace stress (Smith *et al.* 2000).

Assessment is further complicated because the term 'stress' is often used too simplistically. Negative connotations are usually ascribed to the term, yet some stress responses are of positive benefit (Bartlett 1998). 'Eustress' is a term commonly applied to these more positive responses, whilst the term 'distress' appropriately describes negative aspects. 'Stress', therefore, should be viewed as a continuum along which an individual may pass, from feelings of eustress to those of mild/moderate distress, to those of severe distress. Indicators of distress are recognized (Table 1), but those of mild/moderate distress may not be observed collectively, or may have differing degrees of severity, and so symptoms at this level of distress are likely to vary between individuals. In contrast, severe and prolonged distress culminates in more consistently observed symptoms of emotional 'burnout' and serious physiological disturbance.

Table 1 Psychological and physiological indicators of eustress and distress*

	Eustress	Distress	Severe distress
Psychological	Fear/excitement Increased level of arousal, and mental acuity	Unease Apprehension Sadness Depression Pessimism Listlessness Lack of self esteem Negative attitudes Short temper Fatigue Poor sleep Increased smoking/alcohol consumption	Burnout i.e. (a) emotional exhaustion (b) depersonalization and disengagement (c) decreased personal accomplishment
Physiological†	Autonomic arousal (a) Increased arterial blood pressure (b) Increased heart rate (c) Quicker reaction times Release of metabolic hormones especially cortisol (a) Increased metabolic rate (b) Mobilization of glucose, fatty acids, amino acids	Persistently elevated arterial blood pressure Indigestion Constipation or diarrhoea Weight gain or loss	Clinical hypertension Coronary heart disease Gastric disorders Menstrual problems in women Increased asthma attacks in sufferers
Impact on the individual	*Adaptive:* Increased alertness Attention focused on the situation Individual more responsive to changing situations Fear, fight, flight preparation for activity: 'Energised'.	Variable between individuals, but usually *maladaptive*	Variable between individuals but usually *severely maladaptive*, possibly life threatening‡

*The evidence that both cognitive and physiological responses occur simultaneously is debatable, except in extremely distressful situations, but it is convenient to consider cognitive and physical responses separately. See Sarafino (2002) for further information.
†Physiological responses based on the General Adaptation Syndrome (Selye 1976).
‡The health impact may be compounded in nurses by health-risk behaviours, for example excessive smoking and alcohol abuse (Plant *et al.* 1992).

It is the transition to severe distress that is likely to be most detrimental for nurses, and is closely linked to staff absenteeism, poor staff retention, and ill-health (Healy & McKay 1999, McGowan 2001, Shader *et al.* 2001). If severe distress is to be prevented, then it is important to understand what factors promote the transition. Nursing provides a wide range of potential workplace stressors as it is a profession that requires a high level of skill, teamworking in a variety of situations, provision of 24-hour delivery of care, and input of what is often referred to as 'emotional labour' (Phillips 1996). French *et al.* (2000) identified nine sub-scales of workplace stressors that might impact on nurses. In no particular order, these are:

- conflict with physicians,
- inadequate preparation,
- problems with peers,
- problems with supervisor,
- discrimination,
- workload,
- uncertainty concerning treatment,
- dealing with death, and dying patients,
- patients/their families.

As the transition from eustress to distress will depend upon an individual's stress perceptions, it follows that variability between people in the identification of workplace stressors within these sub-scales might be expected. Additionally, temporal changes in the sources of stress might also be anticipated, as working conditions are not static. Indeed, recent years have seen a number of changes in the structure of the United Kingdom (UK) National Health Service (NHS), in prioritizing of services, and in the roles of nurses, as detailed in policy documents published by the UK Department of Health (1998a, 1998b, 1998c, 1998d).

Review aims and research questions

The UK Government has recognized the need to address sources of stress in health care, and in particular to reverse the shortfall in nurse recruitment and retention, and to introduce a participative style of management (Department of Health 2002a, 2002b). In view of the subjectivity of stress perception, it would be useful to ascertain the potential of recent organizational interventions to meet the needs of nurses. This study is a integrative review that seeks to answer the following research questions:

- Is there commonality of sources of workplace stress for nurses?
- Are sources of workplace stress for nurses changing?
- Will recent organizational interventions introduced to reduce the sources of stress for nurses be effective?

A secondary question is:

- What should be the directions of further research on stress in nursing?

Methods

The CINAHL, MEDLINE and COCHRANE databases were accessed using the key words *nursing, stress, distress, stress management, job satisfaction, staff turnover, coping*. It soon became clear that some generic issues, such as workload, were identified by both mental health (psychiatric) and other nurses, but there were also some specific differences, particularly in relation to the more frequent need for mental health nurses to deal with aggression and violence (Carson *et al.* 1997). Accordingly, the search was restricted to adult and child care nursing.

Not all studies identified the practice areas from which the study sample was drawn. Where this was stated, the sample came from a wide range of practice settings, and sometimes an entire hospital. There was no consistency between studies in this respect, but medical, surgical and high dependency (for example, intensive care) units were prominent. No attempt was made in this review to establish comparisons between practice areas, although two empirical studies (Foxall *et al.* 1990, Tyler & Ellison 1994) did so. The findings from these are referred to later in this paper.

The search was completed in April 2003 and was restricted to papers published since 1985. It was supplemented by a manual search of current issues of periodicals, including major nursing and occupational health journals from the UK, United States of America, Australia and New Zealand, and manual follow-up of other cited material, where appropriate. In all, over 100 papers and texts were consulted, of which 21 were primary research studies that detailed the main sources of stress for nurses.

United Kingdom Department of Health documents from 1998–2003 were also accessed for information on policy directions in the context of the workplace for nurses, as were bulletins and reports from the UK Royal College of Nursing and the UK Health and Safety Executive. A resultant literature trail was followed that identified practitioner views of the likely impact of the policies.

Findings

Collating the evidence from the literature led to the identification of six main themes for the sources of workplace distress for nurses (Table 2). In line with findings of Williams *et al.* (1998), this review indicates that most sources of stress, that is workload, leadership/management issues, professional

Table 2 Major workplace stressors that impact on work satisfaction for staff nurses. Those stressors that relate to the same theme are collated, and presented pre- and post-1997, that is before and after recent policy changes in the workplace (Department of Health 1998a, 1998b, 1998c, 1998d). The stressors are *not* listed in order of importance

Stressor	References: 1985–1997	References: 1998–April 2003
Workload/inadequate staff cover/time pressure	Hipwell *et al.* (1989) Baglioni *et al.* (1990) Foxall *et al.* (1990) Lees and Ellis (1990) Tyler and Ellison (1994) Tyler and Cushway (1995) Hillhouse and Adler (1997)	Healy and McKay (1999) Demerouti *et al.* (2000) McGowan (2001) Stordeur *et al.* (2001)
Relationship with other clinical staff	Foxall *et al.* (1990) Lees and Ellis (1990) Tyler and Ellison (1994) Hillhouse and Adler (1997)	Hope *et al.* (1998) Healy and McKay (1999) Bratt *et al.* (2000) Stordeur *et al.* (2001)
Leadership and management style/poor locus of control/poor group cohesion/lack of adequate supervisory support	Constable and Russell (1986) Lucas *et al.* (1993) Tyler and Ellison (1994) Leveck and Jones (1996) Morrison *et al.* (1997)	Bratt *et al.* (2000) Demerouti *et al.* (2000) Schmitz *et al.* (2000) McGowan (2001) Shader *et al.* (2001) Stordeur *et al.* (2001)
Coping with emotional needs of patients and their families/ poor patient diagnosis/death and dying	Hare *et al.* (1988) Hipwell *et al.* (1989) Foxall *et al.* (1990) Lees and Ellis (1990) Tyler and Ellison (1994)	Bratt *et al.* (2000)
Shift working		Demerouti *et al.* (2000) Healy and McKay (2000)
Lack of reward		Demerouti *et al.* (2000) McGowan (2001)

conflict and emotional demands of caring, have been identified consistently by nurses for many years. Perhaps this should not be surprising, as they relate to the main generic characteristics of practice. Inexperienced nurses identified similar clinical sources of stress, but they also reported low levels of confidence in their clinical skills as a further source (Charnley 1999, Brown & Edelmann 2000).

Hillhouse and Adler (1997) suggest that it is the actual characteristics of the work environment, and workload, rather than any differences in practice requirements that are important in evaluating sources of stress for nurses. However, a small number of studies suggest that, whilst overall reported stress levels may be similar, their ranking may vary according to practice area. Foxall *et al.* (1990) found that nurses working in intensive care ranked coping with 'death and dying' more highly as a source of distress than did those in medical–surgical care, who ranked workload and staffing issues higher. Tyler and Ellison (1994) found that theatre nurses ranked emotional aspects lower than did those working in a liver unit, or in haematology or oncology. More such comparative studies are required, but from these few it appears to be important that the NHS should consider that nurses' needs could differ between practice areas.

Stordeur *et al.* (2001) attempted to rank stressors in order of severity of impact, the main ones being ranked as:

- high workload,
- conflict with other nurses/physicians,
- experiencing a lack of clarity about tasks/goals,
- a head nurse who closely monitors the performance of staff in order to detect mistakes and to take corrective action.

Healy and McKay (2000) also found workload to be most significantly correlated with mood disturbance. However, Payne (2001) did not find a significant relationship between workload and burnout, although levels of burnout in her study were lower than in related studies. The reasons for this variation are unclear, but seem likely to include differences of stress 'hardiness' (Simoni & Paterson 1997), of coping mechanisms (Payne 2001), of age and experience (McNeese-Smith 2000) or of the level of social support in the workplace (Ceslowitz 1989, Morano 1993, Healy & McKay 2000).

Inter- and intraprofessional conflict continues to be an important source of stress for nurses. Interprofessional conflict, particularly between nurses and physicians, appears to be more of a problem (Hillhouse & Adler 1997, Bratt *et al.* 2000, Ball *et al.* 2002). The impact of professional conflict as a source of distress is supported by findings that bullying is

prevalent (Kivimaki *et al.* 2000). The recent 'Working well' survey for the Royal College of Nursing (Ball *et al.* 2002) found that 30% of nurses on long-term sick leave reported harassment and intimidation arising from sex/gender, age, race, sexuality or personal clashes as the main cause of their absence.

Workplace stress is having a greater impact on today's workforce (McGowan 2001, Shader *et al.* 2001). This suggests that stress intensity from the most frequently recognised sources has increased, and/or additional sources are contributing to the cumulative effects. In this respect it is interesting that some recent studies (Demerouti *et al.* 2000, McGowan 2001) also identified lack of reward and shift working as major sources of distress, but these did not appear as significant stressors in earlier studies. These sources cannot be considered as 'new', but rather they appear to have increased in relative significance. Interprofessional conflict also appears to have increased in importance for many nurses during the last 10 years or so (Ball *et al.* 2002). In contrast, the emotional aspect of caring does not appear as frequently in the recent literature as a source of distress as it did in earlier studies. The emotional costs of providing care are unlikely to have reduced, and so it is possible that the increased significance of sources such as reward have assumed a greater significance for nurses. If this were so, then it would suggest that the problem is becoming one of growing dissatisfaction with the terms and conditions of employment, rather than nursing *per se*.

In addition to identifying sources of distress, Demerouti *et al.* (2000) sought to distinguish between the factors that were most likely to result in emotional exhaustion and (job) disengagement, the two main components of burnout arising as a consequence of severe distress (see Table 1). They found that job demands (viz. workload, time pressure, demanding contacts with patients) were most associated with emotional exhaustion, whereas job resources (viz. lack of participation in decision-making, lack of reward) were most associated with disengagement from work. These findings extend understanding by distinguishing between the type of impact that major stressors may have, but in terms of their general meaning are in broad agreement with those of Stordeur *et al.* (2001) noted above. However, data from these two studies also identify that there are limitations to such attempts to rank or categorize stressors. Thus, whilst Stordeur *et al.* (2001) identify 'workload' as the most frequently reported stressor, even this made a relatively low contribution (22%) to the variance in emotional exhaustion identified in that study. Likewise, although the impact of the combinations of stressors that contributed to exhaustion and disengagement was much higher at 55% and 66% respectively (Demerouti *et al.* 2000), the data still suggest that perceptions vary considerably even between nurses working in the same area.

It is, therefore, too simplistic to suggest that any one, two or even three sources of distress are the causal factors for all nurses, or to consider that the transition of an individual nurse from mild to severe distress can be predicted reliably at present. This is also supported by the work of Foxall *et al.* (1990), who found such variability between individuals that they could not recommend generalization of their findings that sources of distress were ranked differently between samples of nurses working in intensive care and medical/surgical care. Commonality of sources of distress, therefore, cannot be assumed even for nurses within the same practice area.

Discussion: implications for the impact of organizational interventions to reduce stress in nurses

This section considers the review findings in light of interventions that have been introduced to reduce stress in nurses. It is perhaps noteworthy that until recently there has been a scarcity of programmes to reduce work-related stress for nurses in the UK (Jones & Johnston 2000).

Workload, leadership/management, professional conflict, and 'emotional labour'

Workload, leadership/management, professional conflict, and 'emotional labour' have been the main collective sources of distress for nurses for many years.

Workload

The most obvious means of reducing the workload of practitioners is to ensure that staffing levels are adequate, including administrative staff who could reduce the paperwork burden on nurses (Finlayson *et al.* 2002). Recent funding increases introduced by the Government promise improvements in staff recruitment (Department of Health 2002a), and the Department of Health (2003) has noted that there has been 'excellent progress' in both recruitment and retention of nurses during the past 2 years, even exceeding their own forecasts. The document also looks forward to the 'largest substantial increase in funding (of the NHS) of any 5-year period in its history'. However, Deeming and Harrison (2002) and Finlayson *et al.* (2002) suggest that the rate of increased recruitment cannot be sustained, as statistics have been influenced by an initial large influx of employees from overseas and also by those returning to nursing after a break in employment. Finlayson *et al.* also argue that

year-on-year increases in newly-trained nurses seem unlikely, as universities struggle to fill their student places. It will also be some time before a new initiative for Junior Scholarships (Department of Health 2002c) to attract young people into nursing will make an impact. The Royal College of Nursing (RCN 2002) has identified that the NHS remains seriously understaffed, with an ageing staff profile, and so recruitment efforts perhaps should be seen as medium- to long-term measures that will produce little significant improvement in workload stress in the near future.

Leadership/management issues, and professional conflict

Introducing a participative strategy for management is at the heart of human resource proposals within the 'NHS Plan', a long-term strategy for the delivery of health care in the UK (Department of Health 2002a, 2002b). Ensuring an inclusive (i.e. 'transformational') leadership style would seem to be crucial to improving staff retention. This style engenders group cohesion and empowerment and has been found to be inversely correlated with burnout in nurses, but a 'transactional' leadership style that is interventionist and potentially critical was positively associated with it (Stordeur *et al.* 2001). The recent introduction of the Leading an Empowered Organization training programme (LEO; developed by the Centre for the Development of Nursing Policy and Practice, University of Leeds, UK) for senior NHS staff is welcomed, together with proposals to extend the programme to more junior nurses (RCN 2002).

Improved leadership/management styles could also go some way to reducing interprofessional and intraprofessional conflict. Conflict with other professionals is a group cohesion/management issue, and would seem to require a culture shift if the problem is to be eradicated. The Royal College of Nursing (RCN 2002) has urged that this issue be addressed quickly, as harassment from doctors, supervisors, managers and colleagues is an increasing cause of distress and absenteeism amongst nurses (Kivimaki *et al.* 2000, Ball *et al.* 2002). The NHS now requires a commitment from managers to remove harassment and discrimination (Department of Health 2002b). How and when moves towards a more inclusive style of management will produce the culture shift required in practice remains to be seen, but it may take some time before the situation is sufficiently improved to have a significant impact on stress reduction.

'Emotional labour'

Moves during the 1980s and 1990s to promote a more holistic approach to care have altered the dynamic between nurses and patients, from one in which nurses might distance themselves from the emotional needs of patients to one in which development of a nurse–patient relationship is considered essential (Williams 2001). Such 'emotional labour' places considerable demands on those delivering health care (Phillips 1996) and may reduce objectivity in caring (Williams 2001). Identification of the need to cope with sick patients and their families as a source of distress for nurses, therefore, is not surprising.

Smith and Gray (2001) suggest that new patterns in learning to care are required to enable nurses to cope better with the emotional demands of their work. Constructive clinical supervision, mentorship and praeceptorship, underpinned by an effective leadership style, will have a significant role to play here, especially for newly qualified nurses (Charnley 1999, Gerrish 2000). However, the introduction of preceptorship schemes in the UK has been patchy (Charnley 1999), and more effective mentorship is required to support nurses experiencing the emotional impacts of care (Smith & Gray 2001).

Pay and shiftworking

Pay and shift work schedules seem to be becoming more prominent as major sources of distress for nurses, to the extent that they are displacing other sources in importance. Lack of reward is an increasing source of frustration (Ball *et al.* 2002) and contributes to role disengagement, a component of burnout (Demerouti *et al.* 2000). There remains a disparity of pay for newly qualified nurses when compared with that for police officers and teachers, two professional groups traditionally compared with nurses (Duffin 2001, Holyoake *et al.* 2002), and nurses are especially aggrieved by governmental failure to address the issue of salaries (RCN 2002). Furthermore, proposals to remove clinical grades and to link pay to competency indicators through the 'Agenda for Change' programme (Department of Health 1999) have not helped to reduce anxieties over levels of pay (MacKenzie 2002). Deeming and Harrison (2002) and Duffin (2002) suggest that improving pay is the only long-term answer to the UK's nurse recruitment and retention difficulties. Improved funding of the NHS (Department of Health 2002a) may go some way to improving the situation, but it is questionable whether the anticipated pay awards will be sufficient recompense for the current level of workload (RCN 2002).

Shiftworking, particularly night shifts, traditionally attracts pay enhancements but can have a significant effect on personal and social life. Prolonged shiftwork, especially night shiftwork, also has a health risk as it produces symptoms that correspond closely to those of mild or moderate distress (Efinger *et al.* 1995). Long-term night shiftworking has even been suggested to increase the risk of cardiovascular disease,

although the data are inconclusive (Steenland 1996, Scott 2000).

There has to be equity in the allocation of shift schedules, and flexibility to reduce the social and personal impacts of shift working. A possible reason for the recent appearance of shiftwork scheduling as a source of distress is that staff shortages make it more difficult for nurses to choose when to work unsocial hours. This lack of choice runs contrary to NHS proposals (Department of Health 1998c). The situation will not be improved if prescriptive patterns of shiftworking for staff are introduced (Waters 2002). Indeed, the situation may worsen if current pay modernization plans lead to reduced payments for working unsocial hours (Buchan 2002). The scheduling of shifts seems likely to remain a source of distress until the problems, exacerbated by staff shortages, are resolved satisfactorily. Difficulties with internal shift rotation are common reasons for nurses leaving the profession (Learthart 2000). An alternative 12-hour shift pattern has been tried in some practice areas and in some studies has been found to be beneficial and popular, primarily because it can have social benefits (Reid *et al.* 1994, Gillespie & Curzio 1996, Bloodworth *et al.* 2001). However, other studies suggest that fatigue levels and stress may be higher with 12-hour shifts (Fountain *et al.* 1996), possibly depending upon the practitioner's age (Reid & Dawson 2001). Individual preferences appear to vary.

Individuality of stress perceptions

The preceding discussions suggest that organizational measures to reduce stress for nurses are likely to have limited impact, at least in the short-term. This is partly because of their limitations, but also because perceptions are not consistent. An important finding from the current review is that there is a lack of commonality between nurses' perceptions of sources of stress, even where the main sources seem to be identified strongly by a sample (Demerouti *et al.* 2000, Stordeur *et al.* 2001). Consequently, a collective evaluation of sources of distress for nurses in any given clinical area cannot be predictive of ensuing distress in an individual. In addition, there is some evidence that different clinical areas may influence perceptions of which sources are the most important (Foxall *et al.* 1990, Tyler & Ellison 1994). Measures introduced for the majority within a hospital, or even within a single practice area, are therefore unlikely to meet the needs of other staff. Variation between individuals in their perception of the workplace must be addressed.

The variation between individual perceptions is most likely to arise from differences in personal factors, as personal stress 'hardiness' influences ability to cope (Boyle *et al.* 1991, Simoni & Paterson 1997), as do the levels of companionship and social interaction at work (Ceslowitz 1989, Morano 1993, Healy & McKay 2000). There will also be contributions from sources outside the workplace. The study of Tyler and Ellison (1994) provides an illustration of this, as it identified that nurses living with a partner had fewer stress symptoms than those with no partner, and those with children experienced less stress from dealing with patients and relatives. The range of possible interactions between personal and workplace sources of distress is considerable, but under-researched (Schaefer & Moos 1993, Jones & Johnston 2000).

In view of the importance of personal factors in influencing the perception of stress, it is important for the NHS to consider just how individual nurses might be supported, enabling them to utilize the most effective coping strategies that work for them as individuals, supported by colleagues and senior staff. Two principal coping strategies have been proposed: emotion-focused coping and problem-focused coping (Folkman *et al.* 1986). Research indicates that problem-focused coping, such as problem-solving, is the more effective of the two at preventing burnout in nurses (Ceslowitz 1989, Tyler & Cushway 1995, Simoni & Paterson 1997, Healy & McKay 2000, Payne 2001). An issue here is the actual dimension that is employed (see Table 3). Thus, employing positive reappraisal or self-control (that is, positive emotion-focused dimensions) effectively decreases burnout (Ceslowitz 1989, Healy & McKay 2000, Payne 2001), and so a combination of problem-focused coping with the more positive emotion-focused dimensions ought to be most effective. Parkes (1986) refers to this combination as 'direct coping'. The demand for organizational support and personal

Table 3 Dimensions within problem-focused and emotion-focused coping strategies (derived from Folkman *et al.* 1986)*

Problem-focused coping	Emotion-focused coping
Confrontative coping	Attempts at self control
Seeking social support	Distancing†
Planful problem-solving	Positive reappraisal
	Accepting responsibility
	Escape/avoidance, including wishful thinking and short-term alleviating measures such as smoking, drinking alcohol†

*'Direct coping' strategies are also recognized (Parkes 1986), which utilize problem-focused dimensions with the more positive emotion-focused ones.

†These emotion-focused dimensions are typically viewed as being negative and unhelpful, and have been associated with burnout amongst nurses.

What is already known about this topic

- Stress is a subjective phenomenon based on individual perceptions, producing positive (eustress) and negative (distress) perspectives.
- The workplace for nurses provides a multiplicity of sources of stress.
- Recent organizational initiatives seek to reduce levels of distress in nursing, particularly by addressing staffing/workload, and leadership/management issues.

What this paper adds

- The pattern of reported sources of stress for nurses may be changing, with relatively greater emphasis on conditions of employment, such as pay and shiftwork scheduling, which are likely to add to rather than replace previously noted sources of stress.
- The effectiveness of organizational initiatives is likely to be limited in the short to medium term, and may not resolve the issues for many nurses.
- Perceptions of nurses may differ between practice areas but initiatives are not addressing this.
- Development of preventative strategies will be hindered until employers enable individualized coping strategies, and research enables understanding of personal and workplace interactions and provides a means of assessing the intensity of distress experienced by individuals.

training in stress management is clear: in a recent survey only 53% of nurses with significant signs of poor psychological health were receiving counselling or other supportive help (Ball *et al.* 2002). The need for the NHS to provide further stress management training is evident. However, there is evidence that the coping dimensions employed by nurses vary with experience (Lees & Ellis 1990), and so the workplace may have to be flexible in facilitating coping amongst nurses of different levels of experience.

Ensuring provision of professional, emotional and social support in the workplace as part of stress management should be seen as being preventative. One of the main problems in this respect is that assessment tools are not predictive (Rick *et al.* 2001). Until methods are improved, detection of distress in nurses is still only likely to identify clearly those who are already showing symptoms associated with severe distress, as these are consistent and extreme (see Table 1). This is too late. A means of accurately assessing an individual's position on the stress continuum is urgently required. Better psychological assessment tools are needed, but another possibility might be the development of biological stress tests based on evaluating changes in the secretion of biomarkers such as immunoglobulin-A in saliva (Ng *et al.* 1999).

Conclusions and directions for future research

Progression along the continuum from eustress to distress is subjective, depending upon the relationship between an individual and their environment. Thus, whilst there is recognition that workload, leadership style, professional relationships, and emotional demands are the most frequently reported major factors that cause workplace distress for staff, it is clear that their impact varies considerably. There are differences in the perceptions of nurses in different workplaces, and even between individuals in the same workplace. The workplace is also not static: lack of reward and complications of shiftworking have been identified recently as further significant sources of distress for nurses.

Initiatives introduced by the NHS to address the problem of stress in nursing have the potential to go some way towards improving the situation, although more comparative studies are required to clarify how interventions might be directed at specific clinical areas. Improvements are most likely in leadership/management styles and interprofessional conflict, but workload (i.e. staffing levels), emotional labour, pay and shiftwork are likely to remain problems, at least for the foreseeable future. Inadequate pay is increasingly a source of distress, exacerbated by high workload and falling levels of staffing. The UK Government and NHS are seeking to improve the situation but, whilst initiatives will help, it is questionable whether they will remove the problem.

Distress arising from the workplace, therefore, will not be addressed overnight. If interventions that are targeted at sources of distress for the majority of nurses do not succeed, then what seems to be required is more support for nurses as individuals. In order to identify how personal circumstances exacerbate workplace stress, and how they may be used to reduce stress, it is essential that personal/workplace interactions be researched. It is unreasonable to expect any individual to separate the workplace from their personal lives, and more research is needed to identify how personal circumstances exacerbate workplace stress, and how they may possibly be used to reduce stress.

Support services should be preventative, so that health problems for nurses can be averted. This requires more research into identifying the most effective way of detecting when individuals are experiencing early difficulties, and of improving their stress management techniques so as to prevent the transition to severe distress. Until the prediction of distress becomes possible, organizational initiatives to meet

the needs of the majority remain the best starting point, but should not be expected to provide the answer for all nurses.

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