BURNOUT, WORK ENVIRONMENT, AND COPING IN SURGICAL HOSPITAL NURSES

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ABSTRACT

This study examined the extent of burnout (as conceptualized by Maslach and Jackson (1981): emotional exhaustion, depersonalization and diminished personal accomplishment) being experienced by nurses in a South African state hospital, and its associations with a range of work environment variables and the ways in which nurses generally cope with their stress.

This exploratory study took the form of a cross-sectional, correlational field survey, in which both quantitative and qualitative data were collected from surgical hospital nurses by means of self-report questionnaires. Quantitative measures included were the Maslach Burnout Inventory (MBI; Maslach & Jackson, 1981), the Work Environment Scale (WES; Moos, 1986) and the Coping Orientations to Problems Experienced Scale (COPE; Carver, Scheier & Weintraub, 1989). Additional quantitative measures of personal control, support, sense of appreciation and job satisfaction were obtained from visual analogue rating scales. The qualitative data comprised a frequency analysis of themes evident in the content of subjects' written responses to four open-ended questions posed in the questionnaire.

On each of the three burnout subscales, respondents' scores were categorized into low, moderate or high levels of burnout. Apart from correlational and ANOVA analyses, performed in order to examine relationships between variables and differences in terms of demographics, nursing categories, and nursing specialities, discriminant analyses were performed in order to identify those variables which were experienced differently by nurses reporting different levels of burnout. A number of significant predictors of burnout were identified.

Of the work environment variables examined in the study, higher levels of work pressure, diminished physical comfort, and lack of peer cohesion predicted higher levels of emotional exhaustion. Lack of physical comfort and perceived lack of supervisor support were strongly associated with higher levels of depersonalization. Generally, lower levels of perceived autonomy and supervisor support were associated with a diminished sense of personal accomplishment.

Regarding coping, frequent use of the problem-focused strategy of planning was found to be associated with lower levels of emotional exhaustion and depersonalization. Frequent use of the emotion-focused strategies of positive reinterpretation, seeking emotional social support, and acceptance were related to higher levels of personal accomplishment, whereas increased use of the emotion-focused strategy of denial was strongly associated with diminished personal accomplishment. Regarding palliative/avoidant coping strategies, frequent behavioural disengagement was associated with higher levels of emotional exhaustion and depersonalization, and mental disengagement and focusing/venting of emotions were related to higher levels of emotional exhaustion.

Respondents who felt most appreciated for their work experienced the lowest levels of both emotional exhaustion and depersonalization. Enhanced job satisfaction was associated with lower experienced emotional exhaustion and depersonalization. Stronger informal support appears to have been related to higher levels of personal

accomplishment.

Qualitatively, whilst reward and enjoyment in nursing were evident, respondents identified poor remuneration, high levels of work pressure, lack of inclusion in decision-making regarding work shifts, lack of appreciation, staff shortages, lack of cohesion amongst staff, lack of autonomy, lack of recognition, abuse from patients and their families, lack of supervisor support, lack of opportunity to voice opinions and make suggestions, the need for career development, and a sense of devaluation as major concerns in their work.

As various social-ecological aspects of nurses work as well as personal coping resources were identified as being associated with burnout, the necessity of a transactional approach to the management and prevention of burnout, which includes both nurses themselves (amongst other things through training as part of the nursing curriculum) and the organizations for which they work, is emphasised.

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GLOSSARY AND LIST OF ABBREVIATIONS

Enrolled Nurse	nurse who has completed a two-year theoretical and practical training course which equips him or her to perform a wide variety of essential nursing duties, for example, the administration of medications and treatment of wounds. Enrolled nurses are generally responsible for the more direct patient care and answer to the professional nurses.
Enrolled Nursing Assistant	has completed a relatively short basic nursing skills training course and is trained to assist with the more primary aspects of patient care.
Professional Nurse	nurse who has obtained either a nursing diploma or degree in general nursing, midwifery and/or psychiatric nursing, usually over a period of four years. Professional nurses may be employed in a supervisory capacity (head nurses) or may be in senior positions of authority within their departments or wards, and may also be referred to in the text as supervisors. They are responsible for ward administration, patient care, staff control and the general organization of their wards or departments.
Surgical Pavilion	refers to the subdivision within the hospital which is concerned with surgery, surgical procedures, the management of trauma and emergency cases, resuscitations, and surgical nursing. The surgical pavilion in the hospital targeted for this study comprises the general surgical wards (including, for example, Neurosurgery, Ophthalmology, and Orthopaedics), the theatres and the trauma/emergency department.
Trained Nurse	nurse who has completed a specific course or undergone a specified period of training which equips him or her to perform nursing duties within the limits of such training.

COPE	Coping Orientations to Problems Experienced Scale
EN	Enrolled Nurse
ENA	Enrolled Nursing Assistant
ICU	Intensive Care Unit
M	Mean Score
MBI	Maslach Burnout Inventory
PN	Professional Nurse
WES	Work Environment Scale

INTRODUCTION

This study concerns hospital nurses, health professionals who probably have the most frequent, intimate, and continuous contact with people requiring medical treatment and care. Nursing is back-breaking work, heart-wrenching conflict between home and hospital, helplessness in the inevitability of death. However, it is also the awesome thrill of reversing a prognosis against all odds, the bittersweet triumph of helping a patient face death with dignity, and the satisfaction of easing pain. The rewards can be infinite. The blessing and the curse of nursing is that nurses are privileged to share these most intense moments of life with their patients, moments of birth, death, fear, anxiety, psychosis, sorrow, disability, healing, and joy. These moments are shared without the usual social barriers, so nurses are included in the most fundamental of humanity's experiences. However, these profoundly positive experiences take place mostly within a complex social environment already fraught with the pressures of workload, managerial control, responsibility, and accountability, in other words, stress.

South African hospital nurses, most of whom work for the state, are currently experiencing a number of stressors over and above those inherent in their kind of work. They often receive little recognition for their expertise and experience, both from the medical profession and from the general public. Conditions of service for state nurses also generally reflect the low status which they are afforded. Health services are currently being restructured locally, the new focus being on primary health care, as is fitting in a predominantly Third World country. Economic constraints have necessitated budget cuts and rationalization in many state medical specialities, resulting in career and financial insecurities amongst many healthcare workers. Not surprisingly, state hospitals in South Africa are now, more than ever, in crisis, faced with staff shortages, inadequate facilities and equipment, industrial action, and an ever-increasing patient load. Many of these patients are seriously ill and helpless, many are illiterate, and still others are abusive and unappreciative, and all require the same care and consideration. The work settings in which most South African nurses are working are, thus, generally replete with many and varied stressors.

In the current study stress (or stressors) are conceptualized as demands which arise in nurses' work, and strain is viewed as the effect of stress (or stressors).

It is reasonable to expect that many South African hospital nurses are experiencing strain, given the conditions under which they work, the burden of responsibility and accountability which they carry, and, above all, the fact that they are simply human beings.

Consequently, the objective of the present study is to examine the extent of strain being experienced by state hospital nurses (operationalized as burnout in this instance) and its associations with work environment variables and the ways in which nurses generally cope with their stress.

Concern for burnout is not just concern for nurses, but also concern for the quality of patient care, which is the primary consideration in the medical profession. Burned out nurses are simply not able to provide their patients with quality care.

CHAPTER ONE

LITERATURE REVIEW

1. BURNOUT

1.1 Background

The earliest research on burnout began as a result of work conducted on emotion, arousal, and the manner in which arousal is managed (Cordes & Dougherty, 1993). It took the form of interviews with healthcare professionals, the people considered, by virtue of the nature of their work and the settings in which this work takes place, most likely to experience burnout. Freudenberger first brought the concept of burnout to professional and public awareness in 1973 (Freudenberger, 1989), which was when this early research began. Much of the research comprised mostly authors' personal experiences, and reports based on case studies or specific programs, with the result that there were numerous similar conceptualizations of burnout, but no agreement on a common, precise means of measuring it. It was only in the late 1970s and early 1980s that the empirical research conducted by, for example, Maslach and Jackson (1981) and Iwanicki and Schwab (1981, in Cordes & Dougherty, 1993), resulted in a more widely acceptable definition of burnout and the development of the psychometrically sound Maslach Burnout Inventory in order to measure it.

1.2 The concept of burnout

The term burnout is used in the literature in two broad ways: as a convenient general label for a wide range of strain variables and as a composite label for the three component parts of Maslach and Jackson's (1981) definition of burnout (emotional exhaustion, depersonalization and feelings of low personal accomplishment).

There are many definitions of burnout which express a general focus. There are those who regard burnout as an occupational hazard and disease (e.g., Ianni & Reuss-Ianni, 1983, in Else,

1990), an expression of politico-social malaise (e.g., Sakharov & Faber, 1983, in Else, 1990), an exhaustion of physical and mental resources (e.g., Freudenberger, 1980, in Sullivan, 1989), spiritual collapse (e.g., Storlie, 1979, in Sullivan, 1989), loss of positive energy, flexibility and resourcefulness (e.g., Seiderman, 1978, in Sullivan, 1989), loss of touch with the meaning of work (e.g., Berkeley Planning Associates, 1977, in Sullivan, 1989), objectification of the skills of human interaction (e.g., Karger, 1981, in Sullivan, 1989), an explanatory term for decreased job performance by human service professionals (e.g., Carroll & White, 1982, in Else, 1990), and as a way of explaining ecological dysfunction where the environment is implicated in the development of burnout (e.g., Carroll, 1980, in Else, 1990). Burnout has also been defined as a state (e.g., Meier, 1982, 1983, 1984, in Else, 1990), a process (e.g., Cherniss, 1982, in Else, 1990), a continuum (e.g., Maslach & Jackson, 1981), the response-set of stress (e.g., Pines, 1983, in Else, 1990), a form of 'professional depression' (Firth, McKeown, McIntee & Britton, 1987; Glass, McKnight & Valdimarsdottir, 1993), and as a syndrome (e.g., Maslach & Jackson, 1981).

The definitive aspect of burnout is that the relationship between the human service professional and his or her recipient is disrupted (Cherniss, 1980a, 1980b, in Else, 1990). Muldary (1983, in Else, 1990) summarizes the multitude of conceptualizations of burnout, describing it as the process by which the once committed healthcare professional comes to be unable to cope effectively with the stress of the frequent emotional contacts with others of the helping context and then experiences exhaustion which results in withdrawal from patients, colleagues and the organization.

1.2.1 Burnout as a process

Researchers differ in their conceptualizations of the sequencing of the three components of burnout, that is, the process of burnout. Maslach (1982) suggests that emotional exhaustion appears first as the individual's emotional resources become drained due to excessive chronic work demands. Perhaps as a defensive coping mechanism, the person begins to limit his or her involvement with others and to distance the self psychologically. This depersonalization serves as an emotional buffer between the person and the job demands which are imposed upon him

or her. When the person finally recognizes the discrepancy between his or her original optimism about making a contribution to society and to the organization, and the current experience of depersonalization, he or she begins to feel inadequate about his or her ability to relate to people and to perform his or her work (Maslach, 1982). Depersonalization should, thus, be a predictor of level of sense of personal accomplishment. In other words, the presence of emotional exhaustion will only lead to a sense of diminished personal accomplishment if depersonalization develops as a mediating variable (Leiter & Maslach, 1988). According to Cordes and Dougherty (1993), there is research which provides support for this model (e.g., Leiter & Maslach, 1988) and other research (Lee & Ashforth, 1993, in Cordes & Dougherty, 1993) which provides partial support. Other researchers argue that there is no fixed sequencing of the burnout components (e.g., Schwab & Iwanicki, 1982a, in Cordes & Dougherty, 1993).

Other conceptualizations of burnout as a process are those of Golembiewski and Munzenrider (1981, 1984, in Cordes & Dougherty, 1993) and Golembiewski (1989, in Cordes & Dougherty, 1993), who hypothesize that significant depersonalization is necessary for feelings of personal accomplishment to diminish and that significant reductions in personal accomplishment are necessary for high levels of emotional exhaustion to develop. These researchers have developed an eight phase model of burnout, each phase characterized by some combination of the three burnout components, which were each measured as either high or low according to a median split. The effect of each component is said to depend on its position in the sequence. Each phase corresponds to a higher total burnout score than the preceding phase (Cordes & Dougherty, 1993).

1.2.2 Burnout as a type of stress

Whilst agreement around the concept of burnout continues to grow, the distinction between stress and burnout has not been clearly defined (Cordes & Dougherty, 1993). Schuler (1980, in Cordes & Dougherty, 1993), defined stress as a dynamic condition in which a person is confronted with an opportunity, a restraint or demand on being, having or doing what he or she desires. Resolving the situation involves uncertainty, but will lead to important outcomes. Shirom (1989, in Cordes & Dougherty, 1993) and Clark (1989) define burnout as a distinctive facet of stress by virtue of its having been defined and investigated primarily as a pattern of

responses to work stressors. Cordes and Dougherty (1993, p. 625) conclude that "burnout represents a particular kind of job stress, in which a pattern of emotional exhaustion, depersonalization, and diminished personal accomplishment (strains) result from a variety of work demands (stressors), especially those of an interpersonal nature. Moreover, the concepts of uncertainty and of the importance of outcomes should be as relevant to the experience of burnout as to other kinds of stress responses generated by various work demands and constraints." This three-component structure of burnout is a unique stress phenomenon, at the core of which is emotional exhaustion, a traditional stress variable (Cordes & Dougherty, 1993). Depersonalization, in relation to burnout specifically, is a relatively new construct which has not appeared in previous stress literature (Jackson, Schwab, & Schuler, 1986, in Cordes & Dougherty, 1993) and although feelings of personal accomplishment as a factor related to stress are familiar in the literature on stress, diminished levels of personal accomplishment may indicate that self-evaluations are a key component in the experience of job stress.

1.2.3 Burnout as a response-set of stress

In the same way that burnout can be conceived of as a type of stress, it can also be regarded as the end-product of the experience of job stress (Veninga & Spradley, 1981, in Else, 1990). Cordes and Dougherty (1993) and Harris (1989) concur, adding that burnout represents a set of responses to a high level of chronic work demands. Clarke (1989) and Pines (1983, in Else, 1990), for instance, define burnout as the physical, emotional and mental exhaustion which typically occurs as a result of long-term involvement with people in emotionally demanding situations like those in the human service professions. In other words, burnout may be seen as an occupational hazard of the helping professions (Ianni & Reuss-Ianni, 1983, in Else, 1990; Shinn et al., 1984, in Else, 1990). Pines and Aronson (1981, in Else, 1990) reflect this in their assertion that the non-reciprocal nature of the healthcare provider's work-related interactions with recipients and colleagues is a precursor to the development of burnout.

Muldary (1983, in Else, 1990) agrees that job-stress and burnout are intrinsically related, but does not consider them to be synonymous concepts, arguing that while job-stress is a precondition for the development of burnout, not all stressed people will experience burnout. Personal characteristics such as coping style, for instance, may prevent burnout occurring. Paine (1982, in Else, 1990) regards burnout as the manifestation of inadequate coping strategies

which the person employs to reduce stress. Withdrawal, which is implicit in most definitions of burnout, is regarded as a maladaptive coping mechanism. Where professional helpers develop intense and debilitating negative feelings, they may withdraw from the stress- or anxiety-provoking milieu (e.g., Cherniss, 1980a, 1980b, in Else, 1990). Cherniss (1980b, in Else, 1990), in fact, highlights the tendency for withdrawal behaviour to develop by defining burnout as a process of disengagement by the previously committed human service professional from his or her work as a response to job-stress and as a result of other less useful coping mechanisms.

1.2.4 Burnout as depression in the work setting

A number of authors have conceived of burnout as a form of 'professional depression'. Firth et al. (1987), hypothesizing that emotional exhaustion as a burnout response shows strong similarities to Oswin's (1978, in Firth et al., 1987) description of 'professional depression', found that depersonalization, emotional draining, avoidance of problems, and lack of accomplishment were experienced by the nurses in their study as being distinct from, although overlapping with, 'professional depression'. They thus concluded, as had Cherniss (1980, in Firth et al., 1987), that burnout had to be seen as a multi-faceted concept, and are supported in this view of there being an overlap between Maslach's (1982) concept of burnout and the concept of depression by, for example, Meier (1983, 1984, in Firth & Britton, 1989), Motowidlo, Packard and Manning (1986, in Firth & Britton, 1989), and Firth, Britton, McKeown and McIntee (1986a, 1986b, in Firth & Britton, 1989). In a more recent study, Glass et al. (1993, p. 153) replicated these earlier findings, concluding that, although depression accounted for a substantial proportion of the variance in burnout as measured by emotional exhaustion, burnout could be seen to have facets which were distinct from depression and that "burnout cannot be dismissed as little more than a career-related form of depression". Their factor analytic findings, in fact, provide support for the discriminant validity of the burnout components and depression, as well as for previous findings that indicated the orthogonality of the three burnout components (Glass et al., 1993).

1.2.5 The three-component definition of burnout

Currently, the most commonly accepted, influential, and widely used definition of burnout, which is also adopted for this study, is Maslach and Jackson's (1981) three-component conceptualization: a syndrome of emotional exhaustion, depersonalization and a sense of

diminished personal accomplishment (Shirom, 1989, in Else, 1990). There is considerable factor analytic support for these three aspects of burnout being separate, but related, components, with emotional exhaustion consistently proving to be the principal dimension associated with correlates and consequences of burnout (Else, 1990; Glass et al., 1993). The most agreed upon general features of burnout are that it occurs at an individual level, that it is an intrapsychic experience, and that it is experienced negatively (Maslach, 1982c, in Thornton, 1991).

The symptoms of burnout tend to appear largely among people in the human service professions, whose work entails intense, prolonged involvement with other people (Maslach & Jackson, 1981). Clark (1989) rates those health care providers who work in hospital settings with seriously ill patients as particularly vulnerable.

1.2.6 Components of the burnout syndrome

Emotional exhaustion is characterized by a low level of energy and the feeling that one's emotional resources have been expended. Cordes and Dougherty (1993, p. 623) maintain that this "compassion fatigue" possibly coexists with feelings of frustration and anxiety as workers become aware that they are unable to continue to give of themselves or take as much responsibility for patients as they had previously. Another common symptom is apprehension at the thought of another day at the workplace (Cordes & Dougherty, 1993).

Depersonalization is evident when workers treat clients as objects rather than as people, and display detachment and emotional callousness (Cordes & Dougherty, 1993). Workers may also be cynical towards colleagues, patients and the organization. Other symptoms of depersonalization include derogatory language, strict compartmentalization of professional life, withdrawal through longer breaks, and extensive use of jargon (Maslach & Pines, 1977, in Cordes & Dougherty, 1993). Daley (1979, in Cordes & Dougherty, 1993) employs, by way of illustration of depersonalization, the analogy of the petty bureaucrat who deals with clients strictly 'by the book' rather than taking the trouble of becoming personally involved enough to assist the client according to his or her individual needs.

Diminished personal accomplishment is characterized by an inclination towards evaluating oneself negatively (Cordes & Dougherty, 1993). Individuals feel less competent in the performance of their work and experience a decline in successful progress and achievement in their work and in interactions with people. Symptomatic of this component of burnout is the employee who regularly receives disciplinary citations from his or her supervisor (Cordes & Dougherty, 1993).

1.3 Antecedents of burnout

Central to Maslach's (1982) position on what causes burnout is the relationship between individual people and the situations in which they find themselves. Maslach (1982, p. 9) asserts that rather than focusing on "defective" people in attempting to understand burnout, attention should be given to the environments in which they function. Meier (1983, 1984, in Else, 1990) agrees with this, considering burnout to be a synthesis of environmental and individual factors, that is, a state which results from recurring negative work-related experiences. These correspond with Lazarus's (1971, in Bailey & Clarke, 1989) transactional model of stress: the concept of stress and emotion refers to relations between an organism and the environment rather than to either the organism or the environment alone. Similarly, Vachon and Stylianos (1991) described a cancer care setting as an interpersonal space, in which both stress and nourishment arise through social transactions with patients and co-workers, individuals shaping their work settings in part through personal and professional belief systems, preferred response styles and the quality of their relationships.

Important variables to consider are the reasons for and sorts of tasks workers are expected to do, the kinds of settings in which these activities take place, and the possible limitations or constraints which result from protocol, rules and standard operating procedures (Maslach, 1982). In so doing, one allows for the possibility that the nature of the job may be an antecedent to burnout and not just the nature of the person who performs it.

Maslach's (1982, p. 9) personal perspective, based on a synthesis of all her research, is thus "that burnout is best understood in terms of situational sources of job-related, interpersonal stress".

1.3.1 Job-related interaction with people

One of the most prominent features of burnout is the change in attitude towards other people which takes place as burnout develops. The caregiver who was once caring and positive becomes uncaring and negative, views others in more cynical and derogatory terms, and may begin to doubt his or her abilities and worth as a human being (Maslach, 1982). The negative view of people that develops is, ironically, promoted and maintained by the structure of the helping relationship. Maslach (1982) suggests that the four aspects of the helping relationship which are crucial to the development of burnout are the focus on problems, lack of positive feedback, the level of emotional stress, and the perception that change or improvement are not likely.

By definition, the recipients of care are people with problems. In time-pressured, people-filled jobs, the focus is limited to peoples' problems and flaws, and it is not surprising that carers might begin to become cynical and negative about human nature (Maslach, 1982).

Professional helpers, like all people, need positive feedback. Feedback for them is, however, either almost exclusively negative or nonexistent, and they are sometimes the targets for verbal and even physical abuse. They do not hear much appreciation when things go well, but are made well aware of failure when things do not go as well. This bias toward accentuating the negative and eliminating the positive results in unpleasant and unrewarding people contact, and over time the caregiver begins to view these ungrateful people just as negatively (Maslach, 1982). Bennett, Kelaher and Ross (1993) found, for instance, in a sample of healthcare workers working with HIV/AIDS patients (mostly nurses), that staff who felt rewarded and recognized for their work were less likely to experience burnout.

Regarding the level of emotional stress in the provider-recipient relationship, where the nature of the contact with recipients is especially upsetting, depressing or exacting, as is often the case with, for example, abusive patients, the provider may develop negative, even dehumanized perceptions of them (Maslach, 1982). Where there appears to be no possibility for change or improvement, for example with chronic schizophrenic patients, continuous problems become emotionally draining and have definite links to burnout (Maslach, 1982).

The nature of the helping relationship is also affected by the personal characteristics of the recipient, the fact that most professional helpers cannot choose whom they would like to help, and by the rules which govern the interaction (Maslach, 1982). The etiquette for helpers is that they are always warm, kind, understanding, patient and respectful of others. These constraints often lead to dissatisfaction with the relationship for both parties, and when caregivers suppress inappropriate or unprofessional emotions there is always the chance that this may lead to depersonalization (Maslach, 1982).

When a carer identifies with problems or situations experienced by a recipient and fear or anxiety arises, the countertransference may take the form of depersonalization as a means of protection. For health professionals, becoming too emotionally involved with clients may be especially stressful as the relationship will be terminated at some point, whether it be when the client becomes well or when treatment fails and he or she dies (Maslach, 1982). Lack of knowledge and understanding about transference and countertransference issues, particularly in young, inexperienced carers, are likely to have an influence on the interactions between providers and recipients.

Generally, thus, it appears that the close encounters between providers and recipients are implicated in the development of burnout.

1.3.2 The job setting

Frequently, the contact between providers and recipients takes place within the context of a formal institution such as a hospital or a school. Resources available to the caring professional, constraints placed on him or her, and the goals established are determined mostly by the institution and not by the individual provider. The structure of the job setting also shapes the relationships which exist between provider and recipient, between colleagues, and between staff and management. Maslach (1982, p. 37) asserts that "to the extent that job characteristics can either promote or reduce emotional stress, they become an important factor in the burnout syndrome".

Many burnout-prone work environments have one common denominator, overload or work pressure: too many people to attend to and not enough time to adequately serve their needs.

Jackson, Schwab and Schuler (1986, in Cordes & Dougherty, 1993) distinguish between quantitative caseload (frequency of contact, duration of contact, number of interactions, and amount of time spent with clients) and qualitative caseload (interpersonal distance and client characteristics, that is, intensity of client contact). As caseload and, hence, work pressure increases, demands on the provider's personal resources increases, rendering the provider vulnerable to burnout, particularly when these demands are continuous (Cordes & Dougherty, 1993). The emotional strain of having to deal with so many people can lead to carers developing quick and impersonal methods of dealing with them (Maslach, 1982).

Vachon and Stylianos (1991) equate having control over aspects of one's practice with problem-focused coping, which is known to be associated with decreased emotional strain. Burnout is prevalent when providers lack control over the care they provide. This lack of autonomy is often brought about and maintained by managerial rigidity, exclusion from job-related decision-making, being unable to escape stressful situations, or when carers are presented with more responsibility than they can cope with (Maslach, 1982). These stressors are prevalent in the work settings of nurses, particularly those working in hospitals where, according to Vredenburgh and Trinkhaus (1983, in Wolfgang, 1988), they also work under the operational control of doctors. Having minimal control over important issues in one's job not only adds to the strain of the helping relationship, but this helplessness also tends to promote frustration and feelings of failure and ineffectiveness (Maslach, 1982) and fear and anxiety (Meier, 1983, 1984, in Else, 1990). A number of studies have found that perceived control has a direct association with job stress (e.g., Revicki & May, 1985; Tetrick & LaRocco, 1987; McLaney & Hurrell, 1988). In a more recent study, Glass et al. (1993) found that perceived lack of job control was strongly associated with depression, emotional exhaustion and lack of personal accomplishment at work in a sample of 162 nurses.

Vachon and Stylianos (1991) emphasise the importance of the development and maintenance of a supportive, collaborative network within the working environment, stressing that caregivers need the support of their professional colleagues, both for technical support and because they share the social reality of the workplace. Marshall and Barnett (1992), provide evidence for this in the form of their findings that work-related support was positively associated with better mental and physical health in a large sample of nurses and social workers, regardless of the level

of job stress experienced. Relating to colleagues, supervisors, and administrators in the work setting, however, exacts emotional energy and resources (Maslach, 1982). Such team interactions can either be a source of great satisfaction or a major source of stress and pain. Peer conflict not only represents such an additional source of stress, but also contributes to the development of burnout by robbing individual workers of a valuable source of support. A lack of cohesion among co-workers can arise where there is competition, unacknowledged anger and frustration which is displaced onto peers, little opportunity for group interactions among staff, and when rivalry occurs between members of different helping professions working together in large institutions (Maslach, 1982). In situations where such peer conflict develops, individual workers may respond by isolating themselves from colleagues, and even recipients, in an attempt to minimize emotional stress (Maslach, 1982). Burnout has been correlated with a low degree of peer support (Maslach & Jackson, 1982; Burke, Shearer & Deszca, 1984; Duxbury, Armstrong, Drew & Henly, 1984, in Hare, Pratt & Andrews, 1988; Jackson, Schwab & Schuler, 1986, in Leiter & Maslach, 1988; Hare et al., 1988) and in some cases, interactions with co-workers have even been cited as being the most important sources of job stress and burnout (Gaines & Jermier, 1983, in Leiter & Maslach, 1988; Leiter & Maslach, 1988).

Relations with supervisors are another potential source of stress in the work setting, and when these are unsatisfactory, the ensuing friction and tension add to the emotional overload of the job (Maslach, 1982). The supervisor occupies a position of authority over the helper and has the power to shape and influence the nature of the relationship between helper and recipients (Maslach, 1982). Where supervisors and carers disagree over the evaluation of the care given, animosity and dissatisfaction on the part of the carer are likely to ensue. When helpers do not receive good, clear feedback from their supervisors, these feelings of dissatisfaction are heightened. Feedback from supervisors is particularly important, both from the point of view of providing commentary on the quality of care being offered, and as a means of expressing appreciation. A number of researchers have found that supervisor support is a strong negative predictor of burnout (e.g., Firth et al., 1987; Hare et al., 1988; Boyle, Grap, Younger & Thornby, 1991), and depression (Holahan & Moos, 1981). Unfortunately, negative feedback tends to predominate, whilst positive feedback is, at best, minimal, and even then may be tempered with additional critical comment (Maslach, 1982). Lack of trust in management also results in strained relationships with supervisors. An example of this is the perception among

many providers that management would not be supportive if a complaint were to be raised by the public. Without the support of supervisors, helpers lose another source of support against the onset of burnout (Maslach, 1982). Veninga (1982) cautions, however, that supervisory work itself is an acute stressor, and it seems reasonable to suggest that burned out supervisors might not be able to be supportive or appreciative by virtue of their own sense of depersonalization and emotional exhaustion.

On the subject of support, it might be worth emphasising at this point that another source of support which has proven to be of vital importance in protecting healthcare workers from psychological distress is informal support from family and/or friends (Holahan & Moos, 1981; Revicki & May, 1985; Hare et al., 1988; Wolpin, Burke & Greenglass, 1991, in Bennett et al., 1993; Boyle et al., 1991; Chappell & Novak, 1992; Bennett et al., 1993). Cohen (1988), in a review on the role of social support in the etiology of illness, expresses the generally held view that relatively higher levels of social support have been clearly linked to less negative affect. In summary, social support, defined in a variety of professional and personal ways has generally been shown to be related to lower levels of burnout (Cordes & Dougherty, 1993).

The goals, resources and operating policies of the service organization define and constrain the way in which helpers will interact with recipients. Institutional rules, such as time pressures and inflexibility with regard to where and with whom helpers have to work, can introduce and maintain emotional stress (Maslach, 1982). These rules and regulations can, however, also be used to *avoid* stress, for example, by providing a shield behind which helpers can hide in order not to become personally involved with recipients. Another source of frustration is the bureaucratic "red tape" and seemingly endless paperwork which often interferes with the provision of care and indeed often appears to have a higher priority within the institution. Maslach (1982) adds that poor organization, where there is no clarity about rules or staff roles and where there is a predominance of bureaucratic disputes, also contributes to burnout. Likewise, if communication between management and staff is unclear and non-supportive, helpers will find it difficult to provide good quality service to their recipients (Maslach, 1982).

It seems that work environments can defeat the best intentions of the professional carer who approaches his or her work with high ideals and a desire to be of service to others. The central

aspect of this kind of work context is the relationship between the provider and the recipient. This relationship takes place, however, within layers of the other interrelated contexts which make up the greater context of the organization, which, in turn, forms part of the context of the community. Where most of these contexts are supportive of the carer's role definition and sense of professional worth, some degree of disequilibrium can be endured. However, when many of these contexts are non-synchronized and are unacceptable to the helper, there is great risk for burnout (Maslach, 1982). "Thus it is the balance that exists between demands, supports, and constraints which determines the overall stressfulness of the environment" (Payne & Firth-Cozens, 1987, p. xvi).

1.3.3 Personal characteristics

It has become evident that virtually every aspect of the working environments in which professional helpers perform their work can, under certain circumstances, precipitate the development of burnout. Helpers bring with them a range of personal characteristics, however, which are just as crucial in the development or non-development of burnout. Maslach (1982) emphasises that the process of describing the burnout-prone person is not intended to impart blame, as is so often the case, but is rather an attempt to understand why this person has such a predisposition. Treatment and prevention (which should be the cornerstone of burnout research) are possible only when there is an understanding of the characteristics, motivations, needs, values, emotional expressiveness, and personal style of helpers.

1.3.3.1 Demographic variables

Based on findings from numerous studies, with a wide range of human services professionals as participants, Maslach (1982) has identified a number of basic demographic variables which have important implications for burnout.

With regard to gender, men and women are generally fairly similar in their experience of burnout, and the differences which do exist are usually small (Maslach, 1982). Women tend to experience more emotional exhaustion and to experience it more intensely than men, whereas men seem to be more likely to have depersonalized and callous feelings about those with whom they work. Maslach's (1982) speculations about the reasons for these differences are that they may be related to the traditional male and female sex role differences (women being expected

to be more nurturant and oriented toward people than men) or that they may be a function of the different occupations and levels of status characteristic of men and women (for example, men are more likely to be doctors whilst nurses are more likely to be women).

Ethnic background is another consideration in burnout research. Admitting that the vast majority of people workers whom she has studied have been American whites, Maslach (1982, p. 59) considers her description of burnout to be the "white experience of this phenomenon", which can be used as a standard against which to compare the experiences of ethnic minorities. Information obtained about burnout in minority groups is based on much smaller groups and should thus be interpreted with caution. Comparing the experiences of ethnic minorities with that of whites, Maslach (1982) has found that burnout among Asian-American helpers is very similar to that of whites, but the slight differences which do exist consistently point towards more burnout for Asian Americans. There are, however, dramatic differences in burnout between black and white caring professionals, with blacks experiencing much less emotional exhaustion and depersonalization than whites and, as is also the case with Asian Americans, less personal accomplishment. Maslach (1982) suggests that blacks may be less prone to burnout because of their stronger family and friendship networks and their emphasis on direct one-to-one relationships with others. Blacks are also more emotionally expressive, assertive, and spontaneous, and their interactions often comprise confrontation, conflict resolution and personal feedback. Consequently, they may be more experienced in dealing with people, even in emotionally charged situations. Furthermore, they may be more realistic about, and prepared to deal with, problems and pain because of problems experienced as a result of discrimination and poverty (Maslach, 1982).

Maslach (1982) reports a clear relationship between age and burnout. Burnout is greatest among young carers and is lower for those who are older. In a recent review, Cordes and Dougherty (1993) report considerable recent research which confirms higher levels of burnout among younger providers. One probable reason for the relationship of burnout to youth is that older providers are more experienced, stable and mature, and probably have a more balanced perspective on life, all of which serve to render them less prone to burnout (Maslach, 1982). Burnout typically develops within the first few years of a helper's career, and if people cannot deal with it effectively at this point, when they are younger, they may leave the profession

altogether. Those who survive burnout, or are less prone to it in the first place, and stay on to succeed in their careers are then the ones who are there to participate in research and it is not surprising that they often report less burnout than their younger colleagues (Maslach, 1982).

There is also a consistent relationship between burnout and marital status. Single providers experience the highest levels of burnout and married individuals the least (Maslach, 1982). Cordes and Dougherty (1993) cautiously confirm this assertion, suggesting that more evidence of this relationship needs to be obtained. Those who are divorced generally fall between these two groups. As with married carers, divorcees have lower scores on depersonalization and a greater sense of personal accomplishment. Divorced carers are, however, closer to singles with respect to elevated levels of emotional exhaustion (Maslach, 1982).

Being childless is also related to burnout. Professional helpers with children are less prone to burnout (Maslach, 1982; Maslach & Jackson, 1985, in Cordes & Dougherty, 1993), and there are various possible reasons for this. People with families are often older, more mature adults, and their involvement with spouse and children provides them with experience in dealing with emotional conflicts and personal problems. The family is also often a source of emotional support. Finally, people with families differ from singles in that those who support families possibly have a more realistic approach to job security, salaries, and benefits than the childless employee who is maybe more idealistic and certainly more free to leave intolerable job situations (Maslach, 1982). Families serve to provide affection and approval, and it is possible that practitioners who have families might have less reason than singles to seek personal gratification through emotional entanglements with recipients (Maslach, 1982).

With regard to education, professional helpers are generally a well-educated group, most having attended college and many may also have had postgraduate training. As with gender, the similarities in burnout between people with differing levels of education are more striking than are the differences (Maslach, 1982). The differences which are found are, however, fairly consistent and complex. The highest levels of burnout have been found amongst providers who have completed college training but have had no postgraduate training (Maslach, 1982). They tend to have the most depersonalization, the least personal accomplishment, and usually have more emotional exhaustion. Providers with postgraduate qualifications, interestingly, also have

high levels of emotional exhaustion, but their scores on the other burnout dimensions are lowest. Helpers who have less education, particularly those whose college education is incomplete, tend to be less burned out (Maslach, 1982). By way of explanation, Maslach (1982) suggests that people with different amounts of education enter different kinds of occupations, thus differences in burnout scores probably reflect largely the emotional demands of the work performed, rather than the level of education of the carer. This may also explain why the most highly trained providers tend to experience emotional exhaustion but not the other dimensions of burnout; their kind of work may cause emotional stress, but their training may have equipped them to cope with it more successfully. It is also true that more highly educated people may have higher expectations of what they wish to achieve in life and may be very idealistic. If not well prepared for the reality of the helper role, their ideals may clash with this reality and this could lead to disillusionment and burnout. Those who have less schooling may not have such high aspirations and there may thus be less of a gap between their goals and their actual achievements (Maslach, 1982).

1.3.3.2 Personality

The essential personality of a person also plays an important role in whether or not burnout develops. Aspects of personality which have special significance for burnout are interpersonal style, method of coping with problems, expression and control of emotions, and self-concept (Maslach, 1982). Maslach (1982, pp. 62-63) presents the following profile, based on research findings, of the person who is most likely to burn out:

> *"The burnout-prone individual is, first of all, someone who is weak and unassertive in dealing with people. Such a person is submissive, anxious, and fearful of involvement and has difficulty in setting limits within the helping relationship. This person is often unable to exert control over a situation and will passively yield to its demands rather than actively limiting them to his or her capacity to give. It is easy for this person to become overburdened emotionally, and so the risk of emotional exhaustion is high.*
>
> *The burnout-prone individual is also someone who is impatient and intolerant. Such a person will get easily angered and frustrated by any obstacles in his or her path and may have difficulty controlling any hostile impulses. He or she is likely to project these feelings onto clients and to treat them in more depersonalized and derogatory ways.*
>
> *Finally, the burnout-prone individual is someone who lacks self-confidence, has little ambition, and is more reserved and conventional. Such a person has neither a clearly defined set of goals nor the determination and self-assurance needed to achieve them. He or she acquiesces and adapts to the constraints of the situation, rather than confronting the challenges and being more forceful and enterprising. Faced with self-doubts this person tries to establish a sense of self-worth by winning the approval and acceptance of other people. In so doing the person may be so accommodating that he or she is overextended too often. This individual is more easily discouraged by difficulties and does not feel a sense of personal accomplishment and effectiveness in dealing with people."*

Maslach (1982) cautions that people who match the above profile are not the *only* ones at risk for burnout, neither should one assume that *every one* of these characteristics must needs be present before considering a person at risk, nor that everyone with them will necessarily burn out. Any one of these characteristics could render someone more susceptible to some aspect of burnout. To an extent, everyone is at risk for burnout under conditions of excessive emotional stress, however those with a certain personality make-up will be more vulnerable at any level of work stress (Maslach, 1982).

From the personality profile presented above, it is clear that self concept, one's sense and evaluation of who one is, is a key factor in the burnout syndrome. A helping relationship can place great demands on the helper and if one has little faith that one has the ability to meet these challenges, these demands may become overwhelming (Maslach, 1982).

Positive feedback and appreciation, as has already been mentioned, are seldom forthcoming in the helping professions, so those who rely on others for their sense of self-worth put themselves at great risk for burnout (Maslach, 1982; Cordes & Dougherty, 1993). Appreciation for what one does for others, even when one is doing one's duty, is a reasonable, justifiable expectation. Apart from wishing to know whether their assistance has been meaningful, useful, or satisfactory, people need to feel appreciated. Professional helpers are no exception. As Maslach (1982, p. 19) says, "they need the same reinforcing strokes as ordinary folk do". Van Yperen, Buunk and Schaufeli (1992, in Cordes & Dougherty, 1993) report evidence that nurses who believed that they invested more in their patients than they received in return (in the form of positive feedback, health improvements, appreciation, and gratitude) were found to have higher levels of emotional exhaustion, depersonalization, and reduced levels of personal accomplishment.

It is also important for a professional carer to have a clear understanding of his or her capabilities, limits, and strengths and weaknesses. Failure to recognize personal limits is particularly critical in helping professions, where recipients' lives are being dealt with, and it is all too easy for a helper to become emotionally overwhelmed by responsibility. The discrepancies between aspirations and actual accomplishments generally lead to feelings of failure (Maslach, 1982).

The strength of personal needs, which vary in significance for different people, also have important implications for burnout. The need for approval from others, which so often does not materialize in the healthcare workplace, is a crucial factor in the burnout syndrome and where this is not forthcoming, the needy carer will feel hurt and betrayed and will begin to dislike and disparage both recipients and colleagues (Maslach, 1982). Carers with a strong need for affection from others will also be extremely dependent on clients and colleagues for signs of appreciation (Maslach, 1982). Another universal necessity is the need to achieve, a personality factor which is especially crucial to the success of helping professionals. If goals are either vague or unrealistically high, however, the carer is likely to experience disappointment and failure, which, if experienced repeatedly, can be detrimental to his or her sense of competence and self-esteem (Maslach, 1982). Other personal needs which have important links with burnout are those of autonomy and personal control. According to Maslach (1982), the need to be independent and self-determining is a hallmark of personal growth and maturity. Autonomous people make choices, exercise initiative, and act decisively on their resolutions, and this is associated with enhanced confidence and self-esteem, and a greater sense of personal power and independence (Maslach, 1982). Payne and Firth-Cozens (1987) agree that a sense of autonomy is a crucial factor in decreasing the effects of work stressors, noting that low constraint, high support environments provide the individual with a high degree of control. When caregivers lack this sense of control over the care they are providing, the risk for burnout is high. Lack of control can stem from not being included in decision-making in matters relating to one's job, autocratic and rigid leadership, being given too much responsibility, or not having the opportunity to avoid a stressful situation (Maslach, 1982). This kind of helplessness leads to anger and frustration, and may serve to promote feelings of failure and incompetence (Maslach, 1982). Furthermore, a perceived lack of control over important outcomes in one's work adds to the emotional pressure of the helping relationship. People who feel helpless, constrained, and powerless in their work are bound to become burned out at some stage.

While burnout is certainly linked to the situational experience of lack of control, an excessive need *for* control is another personality trait with ties to this syndrome. A need to control people and situations and a refusal to share or delegate power is characteristic of the authoritarian personality type. Maslach (1982) quotes Freudenberger as saying that the authoritarian person is particularly prone to burnout due to his or her tendency to do everything, to take on too

much, and to overextend him- or herself. Also, authoritarians generally have a negative, power-based orientation towards others, which can easily feed into the callous cynicism so characteristic of burnout (Maslach, 1982).

The personal motivations of those who enter into a career of caregiving may also have links with burnout. Some helping occupations carry the traditional motivators of good salary, special benefits, and high prestige. Where these rewards are not forthcoming or almost nonexistent, intrinsic, personal motives become especially important predictors of whether or not burnout will develop. It is here that carers need to have a clear understanding of their reasons for giving and assisting. The 'selfish' reasons for helping others which may predispose helpers to burnout invariably involve gratification of personal needs such as those already mentioned, feelings of guilt for which they hope to make amends through good deeds, or viewing helping people as an expression of their identity (for example, as 'rescuers'), or as a way of working through, even avoiding, their own personal problems by focusing on the problems of others. Using the helping relationship in these ways is dangerous for both providers and recipients, carrying with it the potential for interference with the quality of care provided and serving as a potential source of immense emotional stress and eventual burnout. As has already been mentioned, clients cannot, and should not, be expected to provide for the caregiver's needs, and the frustration which may be experienced due to the non-provision of these needs can well be expressed in hostility towards recipients and may be accompanied by depression on the part of the carer (Maslach, 1982). It must be noted, however, that self-serving motives for pursuing a career as a helping professional are not *necessarily* bad ones. Helping relationships may serve as vehicles for personal growth, both for providers and recipients, and achieving satisfaction through one's work and feeling good about the self are perfectly reasonable rewards to expect (Maslach, 1982).

Personal expectations about the profession, personal efficacy, and the employer organization also play a role in employee burnout (Jackson & Schuler, 1983, in Cordes & Dougherty, 1993). These represent another source of 'job demands' placed on employees by themselves. Expectations which are both high and unmet can be a source of burnout. Health service professionals who idealise their work may well suffer burnout as a concomitant to the loss of, or their attempt to maintain, that ideal (Fischer, 1983, in Else, 1990). Shifts in expectations, for example, where older providers have become more realistic due to their experience, are also

linked to burnout (Cordes & Dougherty, 1993). As has already been mentioned, younger employees, who have perhaps not had enough working experience to be more realistic (that is, to shift their expectations), are more prone to burnout.

Career progress is also associated with burnout, with those who have had greater upward career development often experiencing less burnout (Cordes & Dougherty, 1993). Repeated promotion is usually accompanied by diminished client contact, and career advancement which exceeds that of peers may signify to employees that their contribution is worthwhile and appreciated. Employees who have made reasonable career progress may also perceive the organization's policies and procedures regarding promotions to be fair and equitable (Cordes & Dougherty, 1993).

Strong emotions are clearly a significant component of helping relationships. It follows that emotional control is another personality variable related to burnout. Due to difficulties frequently experienced in the process of providing care, frustrations, failures, anger, and irritation, are often more common than rare. Providers who cannot deal constructively with these emotions tend to vent their hostility on others in the search for someone to blame for these feelings. For those providers who have problems with self-concept, hostility expressed towards others may serve the function of boosting their self-esteem by depreciating others (Maslach, 1982). The ability to cope with fear, particularly fear of death and personal loss, is also extremely important for professional helpers, both from the point of view of working effectively and maintaining emotional health. Failure to come to terms with fears often results in avoidance, denial, and 'psychic numbing', which feeds into feelings of depersonalization and, consequently, burnout (Maslach, 1982). Another personality trait which can predispose a person to burnout is impatience. When a helper is impulsive, impatient, and intolerant, his or her tendency to burn out is enhanced, and feelings about people will probably become negative. Empathy has always been regarded as a critical personality characteristic in the helping professions. Maslach (1982) suggests that the distinction between emotional empathy (the vicarious experience of a person's emotional turmoil) and cognitive empathy (understanding someone's problems and seeing them from his or her point of view) may have important implications for burnout. While cognitive empathy should enhance the provider's ability to

provide good care, emotional empathy may well increase his or her susceptibility to emotional exhaustion and subsequent depersonalization. Maslach (1982) considers emotional empathy a weakness rather than a strength, and maintains that a helper who is less excitable and more psychologically detached will have less difficulty in dealing with emotionally stressful situations.

1.4 Individual and organizational consequences of burnout

Professionals who help others pay a heavy price for caring. A deterioration in physical and psychological well-being often accompanies the emotional exhaustion and cynicism of burnout. Relationships with others suffer. The burned-out provider is prone to loss of self-esteem and a growing dissatisfaction with his or her work. Burnout can, however, also hurt others. Recipients may receive unsatisfactory service and may be treated in a dehumanized manner. The caregiver's family may be adversely affected by the domestic strife and emotional withdrawal which is a frequent consequence of burnout. The institution for which the carer works, too, may be affected by burnout. It may receive less than optimal service from employees and may have to deal with the serious problems of absenteeism and high staff turnover. Maslach (1982) considers the costs of burnout for all society to be too high.

Cordes and Dougherty (1993), like Maslach (1982), claim that these negative side-effects are not unique to burnout, but that they illustrate how potentially costly and damaging burnout can be, and highlight the importance of improved management in dealing with a problem which is now generally considered to be more serious than had previously been thought.

Kahill's (1988, in Cordes & Dougherty, 1993) categorization of the consequences of burnout into physical, emotional, interpersonal, attitudinal, and behavioural consequences provides a useful framework within which to present empirical evidence of the effects of burnout.

Physical health problems associated with burnout include fatigue, insomnia, gastro-intestinal disturbances and ulcers, and headaches (Kahill, 1988, in Cordes & Dougherty, 1993). Maslach (1982) adds that chronic tension, poor eating habits, and tiredness (factors implicated in compromised immune-system functioning) may render carers vulnerable to illnesses, such as colds and influenza, which may linger. Psychosomatic complaints often associated with burnout include migraines, chest pains, and neck and back problems (Maslach, 1982).

Emotional consequences of burnout include decreased feelings of self-esteem, depression, irritability, anxiety and tension, and helplessness (Jackson & Maslach, 1982, in Cordes & Dougherty, 1993; Kahill, 1988, in Cordes & Dougherty, 1993). Maslach (1982) also includes suspicion and paranoia, which may develop out of the negative feelings about others associated with burnout, in the list of psychological consequences to burnout. She adds that some providers, in an attempt to stave off feelings of weakness, vulnerability, or failure, may even develop a sense of omnipotence, exposing themselves and others to risks, both on and off the job.

As research has begun to focus on the link between work and non-work domains, there has been a growing recognition of the deleterious effects of burnout on individuals' relationships with family and friends (e.g., Burke & Deszca, 1986, in Cordes & Dougherty, 1993). Burned out police officers have been found to withdraw from their friends, reduce their socializing, and treat their children impersonally (Jackson & Maslach, 1982, in Cordes & Dougherty, 1993), and to report a greater negative impact of their job demands on their personal, home, and family lives (Burke & Deszca, 1986, in Cordes & Dougherty, 1993). Interpersonal consequences of burnout also include changes in the nature or frequency of interactions with colleagues and recipients, for example, withdrawing from clients, taking extended lunchbreaks or poorer peer relations (e.g., Maslach & Jackson, 1985, in Cordes & Dougherty, 1993).

Attitudinal consequences of burnout include the development of negative attitudes towards recipients, the job itself, the organization, or the self (Kahill, 1988, in Cordes & Dougherty, 1993). Burned out employees reported higher levels of job dissatisfaction in studies of police workers and public contact workers (e.g., Jackson & Maslach, 1982, in Cordes & Dougherty, 1993) and nurses (Dolan, 1987). The components of burnout have also been linked to lower levels of organizational commitment in public service lawyers and nurses (Jackson, Turner & Brief, 1987, in Cordes & Dougherty, 1993; Leiter & Maslach, 1988).

Regarding behavioural consequences of burnout, organizational-related behaviours include turnover, absenteeism, and decreases in both the quality and quantity of job performance, and consumption behaviours include smoking and alcohol and drug abuse (Cordes & Dougherty,

1993). Police workers reporting higher levels of burnout were found to be more likely to have intentions of leaving their jobs and also reported using more drugs, alcohol and tobacco (e.g., Jackson & Maslach, 1982, in Cordes & Dougherty, 1993). Firth and Britton (1989), investigating the relationship between burnout and turnover, and burnout and absenteeism in a sample of qualified nursing staff, found that actual turnover was moderately associated with depersonalization and not significantly with either emotional exhaustion or feelings of diminished personal accomplishment. Absenteeism was reported to be higher amongst nurses who were experiencing higher levels of emotional exhaustion (Firth & Britton, 1989). Maslach and Jackson (1985, in Cordes & Dougherty, 1993) reported links between burnout components and both intention to leave a job and poorer job preparation among a sample of public contact employees.

As Maslach (1982) says, the person who burns out is not the only one affected, many others are also singed by its effects. She adds that "perhaps the most devastating legacy of burnout...[is]...a permanent hardening of the human heart" (Maslach, 1982, p. 85).

1.5 Summary

In summary, Maslach's (1982) position on what causes burnout has become clear: whilst personality is certainly instrumental in the development of burnout, situational sources of job-related, interpersonal stress offer the best explanation. To understand, modify, and prevent burnout, the job situation in which people find themselves, that is, the sorts of tasks which they are expected to do, the settings in which these tasks take place, and the limitations or constraints which exist because of rules and standard protocols, should be examined. Beuchler (1985, p. 181) agrees that "the key to burnout seems to lie in the work situation and the employee's perception of it". Leiter and Maslach (1988) recently re-emphasised the fact that the bulk of the burnout research to date suggests that environmental factors, in particular characteristics of the work setting, are more strongly related to burnout than personal factors such as demographic and personality variables.

2. THE WORK ENVIRONMENT

Burnout research consistently identifies the work environment as being of primary importance in the development or non-development of burnout. As has been mentioned, burnout occurs predominantly amongst human service professionals, with those professionals working in health care settings such as hospitals being at particular risk. DiMatteo and Friedman (1982, in Niven, 1989, p. 313) described hospitals as being largely inhospitable places which are "...one of the few places where people forfeit almost all control over their life ... Patients ... [and staff] ... must operate according to the schedule of the hospital and follow its rules, with little chance for individuality".

A growing concern about the quality of patient care being provided has resulted in a general increase in the attention being focused on healthcare work stressors and their effects on medical personnel (Moos & Schaefer, 1987). Work stress, demoralization, and frustration, which may lead to physical and emotional problems in health care providers, are common in the American health care industry, for example, and can have a negative impact on the quality of patient care provided (Moos & Schaefer, 1987). Already prevalent work strain is also likely to increase in South African hospitals, as the existing health services are restructured, cost containment efforts are increased, and the patient load continues to escalate.

One of the major contributions to health and organizational psychology has been the work of Moos (1976, 1979, in Niven, 1989), whose social-ecological perspective has provided a means of examining and assessing work environments and their influence on those who function within them. Based on previous organizational theories examining the relationship between employees and their work settings, this social-ecological framework considers a variety of physical and social aspects of work settings and their determinants and effects. It emphasizes how employees select and change work settings and also the effect of work on them. There is also a recognition of the influence which work has over other life contexts and of the fact that the job may have consequences for both employees and their families (Moos & Schaefer, 1987).

This social-ecological model comprises six interrelated systems which affect and are affected by each other. The environmental system consists of organizational and work-related factors, and

current stressors and social resources which originate in other life contexts, for example, family or neighbourhood. The personal system comprises sociodemographic factors, personal resources (such as self-esteem, values, and intellectual capability), and work-related factors such as type of job and work role. Two further systems are those of cognitive appraisal and coping responses. The final two systems relate to staff and patient outcomes. Staff outcomes include work morale and performance, while quality of care and treatment consequences constitute patient outcomes. The model proposes that its constituent processes are transactional and that reciprocal feedback between systems can occur at any level (Moos & Schaefer, 1987).

This social-ecological framework suggests that the link between the environmental system and employee work performance is influenced by the personal system as well as by cognitive appraisal and coping responses. Cognitive appraisal and coping come about through the interplay between the environmental and personal systems. More precisely, coping responses and their effectiveness (patient and staff outcomes) may be shaped by cognitive appraisal and the environmental and personal factors which foreshadow it (Moos & Schaefer, 1987). Ultimately, quality of care and patient outcomes are affected by staff morale and performance. Moos and Schaefer (1987) thus conclude that the organizational contexts of health care settings can have an effect on patient care and treatment outcomes through the type of work environments which they cultivate.

The social-ecological approach considers work from the individual employee's perspective, making it possible to integrate the literature on work stressors with knowledge from related areas such as stress and coping theory (Moos & Schaefer, 1987). In practical terms, it thus provides a means of assessing health care work settings and their determinants and effects.

As mentioned, the environmental system of Moos's (1976) social-ecological framework comprises in part the physical and architectural features, organizational structure and policy, suprapersonal factors (aggregate characteristics of individuals within a setting), in other words, social climate. Social climate factors may all affect healthcare employees, and serve to characterise healthcare work environments, making it possible to explore their impacts (Moos & Schaefer, 1987), burnout being the impact of relevance to this study. Moos's (1976) social climate perspective thus provides both an explanatory framework for understanding the

association between burnout and the working setting and a means of measuring the relationship between aspects of work environments and the development or non-development of burnout.

2.1 The social climate perspective

Every institution in society, whether a family, school, or hospital, attempts to set up social environments which will optimise personal growth and development in certain directions. According to the social climate perspective, social environments, like people, have unique 'personalities' and can be characterised in great detail and with great accuracy (Moos, 1976). Some social environments are more supportive than others, while others can be extremely inflexible, autocratic, and controlling. For example, where staff are supportive of each other or share personal matters, a work setting may be judged to be 'friendly' (Moos & Schaefer, 1987). In addition, social environments have overall programs which regulate and direct the behaviour of those who function within them (Moos, 1976). It is thus evident that social climates or environments may have a significant impact on those operating within them.

According to Moos and Schaefer (1987), people form global ideas about environments from their perceptions of the specific facets which make up these settings. The social climate or atmosphere is thus created by the conditions which exist within the setting. Perceptions of social climate are formed through the interplay between actual events and the characteristics of the organization (environmental system) and the values and beliefs of the individual (personal system) (Moos & Schaefer, 1987). Vachon and Stylianos (1991) aptly summarise such a transactional, person-centred, phenomenologic perspective on understanding the working environments of health professionals as follows: a health care setting can be viewed as an interpersonal space, in which both stress and nourishment arise through social transactions with patients and co-workers, individuals shaping their work settings in part through personal and professional belief systems, preferred response styles and the quality of their relationships.

The general consensus amongst burnout researchers is that any investigation into the antecedents of burnout amongst healthcare employees should include an analysis of the settings in which their work takes place (e.g., Maslach, 1982; Hisashige, 1991; Kandolin, 1993).

Potentially stressful aspects of working environments which have been mentioned most

frequently thusfar in the burnout literature are workload, peer relations, relations with supervisors or management, institutional control or restraints, lack of autonomy, lack of positive feedback, clarity about institutional goals and rules, and the nature of the relationships between providers and recipients (Maslach, 1982; Cordes & Dougherty, 1993).

Moos (1976, 1986) has developed a number of social climate scales which have proven accurate in characterizing social environments. One of these scales, which is of relevance to this study as it measures a number of the stressors purported to be strongly associated with burnout, is the Work Environment Scale (WES), which was developed through research in a variety of work settings (Moos & Schaefer, 1987).

Three underlying sets of dimensions of work settings are assessed by the WES: work relationship dimensions, personal growth dimensions, and system maintenance and system change dimensions (Moos & Schaefer, 1987). The work relationship dimensions include the extent to which employees are concerned about and committed to their jobs (involvement), the extent to which employees are friendly and supportive of each other (peer cohesion), and the extent to which management is supportive of employees and encourages them to be supportive of each other (supervisor support). The personal growth dimensions are autonomy (the extent to which employees are encouraged to be self-sufficient and to make their own decisions), task orientation (the degree of emphasis on good planning, completing tasks, and efficiency), and work pressure (the degree to which time urgency and the press of work dominate the job setting). System maintenance and system change dimensions include the extent to which employees know what to expect in their daily routine and how explicitly rules and policies are made known (clarity), the extent to which management uses rules and pressures to control employees (control), the degree of emphasis on variety, change, and new approaches (innovation), and physical comfort (the extent to which the physical surroundings contribute to a pleasant working environment) (Moos, 1986).

Administered to a large number of healthcare employees in a variety of healthcare settings, the WES has produced evidence of certain problems which are unique to health-care work (Moos & Schaefer, 1987). In comparison to a large group of employees in business settings, healthcare providers tend to report less job involvement, less peer cohesion, and less supervisor support.

Healthcare settings have also proved to be lacking in autonomy and clarity, and are less physically comfortable. Greater emphasis is also placed on work pressure and supervisor control in these settings (Moos & Schaefer, 1987). Moos and Schaefer (1987) suggest that these differences probably reflect both the inherent stresses and emotionally difficult nature of this kind of work, and the problems related to working in large, extremely structured organizations.

Regarding differences in perceptions of work environments, Moos (1986) reports that, when variations among work roles are controlled, men and women's perceptions across work environments are not generally different. Those in managerial or supervisory positions tend to perceive their work environments somewhat more positively than employees do on each of the subscales, with the exception of work pressure and physical comfort (Moos, 1986). Interestingly, administrative and supervisory hospital personnel appear sometimes to experience their work settings more negatively than other hospital employees (Moos, 1986). In general, healthcare workers involved in direct patient care (for example, doctors and nurses) have been found to experience their work settings more negatively than those whose patient contact is more restricted (for example, dieticians and laundry workers) (Moos, 1986).

Moos (1986), in support of the usefulness of the WES, reports some general findings from studies which linked work climate characteristics to burnout in mental health workers. Savicki and Cooley (in press, in Moos, 1986) found that high work pressure, lack of autonomy, and lack of involvement were related to emotional exhaustion, while low task orientation and high control were associated with depersonalization. Peer cohesion and physical comfort were found to be positively related to personal accomplishment (Savicki and Cooley, in press, in Moos, 1986).

In a large group of community mental health centre employees, Hunnicutt (1983, in Moos, 1986) found that those who perceived their work environments to be higher in involvement, supervisor support, autonomy, task orientation, and clarity tended to feel that they were accomplishing more at work and to report lower levels of emotional exhaustion and depersonalization. High work pressure was found to be related to emotional exhaustion (Hunnicutt, 1983, in Moos, 1986).

Similar findings were reported in a study of child abuse and neglect demonstration programs, where employee morale was found to be higher in settings which were higher in peer cohesion, supervisor support and clarity, and which emphasized task orientation and autonomy (Berkeley Planning Associates, 1977, in Moos, 1986). High work pressure was associated with lower employee morale (Berkeley Planning Associates, 1977, in Moos, 1986).

2.2 Review of recent research on burnout and the work environment

A significant number of researchers have identified work overload as the work stressor most strongly and consistently associated with experienced stress and burnout, particularly emotional exhaustion (e.g., Caldwell & Weiner, 1981; Bailey, 1985; Parkes, 1985, in Nash, 1989; Constable & Russell, 1986, in Boyle et al., 1991; Hingley & Harris, 1986, in Kunkler & Whittick, 1991; McCranie, Lambert & Lambert, 1987; Hawkins, 1987; Dewe, 1987, 1988; Hipwell, Tyler & Wilson, 1989; Lees & Ellis, 1990; Hisashige, 1991; Robinson, Roth, Keim, Levenson, Flentje & Bashor, 1991; Chappell & Novak, 1992; Kandolin, 1993). Foxall, Zimmerman, Standley and Bene (1990) reported that medical-surgical nurses experienced significantly higher levels of workload stress than intensive-care and hospice workers. Closer to home, Wagenaar (1990) reported a significant positive relationship between elevated work pressure and higher levels of burnout in a sample of South African nurses.

Staff shortage, usually linked to higher workload, is also considered to be strongly implicated in the development of burnout (e.g., Caldwell & Weiner, 1981; Parkes, 1985, in Nash, 1989; Hawkins, 1987).

Interpersonal relationships between nursing staff in general are frequently cited in the literature as being a highly pertinent source of stress (e.g., Caldwell & Weiner, 1981; Bailey, 1985; Hawkins, 1987; Dewe, 1987, 1988; Hipwell et al., 1989; Lees & Ellis, 1990; Cull, 1991; Donat, Neal & Addleton, 1991; Kunkler & Whittick, 1991; Corrigan, 1993). Greater perceived support from colleagues and supervisors is related to lower reported levels of the burnout dimensions (e.g., Constable & Russell, 1986, in Boyle et al., 1991; Hare et al., 1988; Beehr, King & King, 1990; Leiter, 1991, in Cordes & Dougherty, 1993; Albrecht & Halsey, 1992; Cordes & Dougherty, 1993). Janzing (1991) goes as far as to say that working with one's colleagues may often be more exhausting than working with patients.

Regarding supervisor support specifically, the general consensus in existing research is that lack of supervisor support is associated with higher levels of burnout (e.g., Parkes, 1985, in Nash, 1989; Constable & Russell, 1986, in Boyle et al., 1991; Leiter & Maslach, 1988; Wagenaar, 1990; Boyle et al., 1991; Robinson et al., 1991). Supportive supervisor behaviour has also been found to enhance job satisfaction and performance by reducing role ambiguity (Valenzi & Dressler, 1978, in Revicki & May, 1989).

Lack of peer cohesion and support have also been found to be related to higher levels of burnout (e.g., Moos & Schaefer, 1987; Leiter & Maslach, 1988; Wagenaar, 1990; Revicki, Whitley & Gallery, 1993).

Anther professional relationship which is often cited as a source of stress in the health care setting is the nurse-doctor relationship (Caldwell & Weiner, 1981; Bailey, 1985; Jenkins, 1985, in Pot-Mees, 1987; Leatt & Schneck, 1985; Dewe, 1987, 1988; McGrath, Reid & Boore, 1989; Lees & Ellis, 1990; Donat et al., 1991). Beuchler (1985) claims that lack of appreciation from doctors is consistently cited by nurses as being a reason for leaving the profession.

Reviewing the literature on the role of interpersonal relations in the development of burnout, Cordes and Dougherty (1993) attest to the impact which client stance may have on providers of service. Recipients may be aggressive, passive-dependent, or defensive (Maslach & Jackson, 1984, in Cordes & Dougherty, 1993), often contributing to the stress inherent in helping work. Kandolin (1993) found evidence of a relationship between burnout and Finnish nurses' experience of violence and aggressiveness in their contacts with psychiatric patients, particularly for female nurses. Dewe (1987, 1988) reports that dealing with difficult or helplessly ill patients emerged as a pertinent stressor in his examination of the frequency of stressors experienced by a sample of 1081 New Zealand nurses. Stress that results from day-to-day interactions with patients also emerged as a pertinent factor in Corrigan's (1993) recent study on staff (including nurses) stressors at a state hospital/developmental centre. Beuchler (1985) cites lack of appreciation from patients as being a major reason for nurses leaving their profession.

Generally, lack of involvement in decision-making has emerged as one of the major organizational stressors in nursing (Leatt & Schneck, 1985; Hawkins, 1987; Hipwell et al.,

1989; Donat et al., 1991; Mgoduso & Butchart, 1992; Corrigan, 1993). McGrath et al. (1989) also cited lack of autonomy or decision-making latitude as a major factor in occupational stress and burnout, reporting findings that the majority of the burned out nurses in their study felt unable to make decisions at times, and powerless to change unsatisfactory conditions. This echoes Moos and Schaefer's (1987) findings that nurses reporting high job autonomy experienced less burnout. Similarly, Pretorius (1993) reported finding a direct positive relationship between inclusion in decision-making and personal accomplishment in a sample of South African university educators. Landsbergis (1988) reported findings that burnout was significantly higher in high workload jobs with low decision-making latitude. Chiriboga and Bailey (1986) also found an association between low involvement in decision-making and burnout in their sample of nurses, as did Wagenaar (1990) in a group of South African nurses.

Another of the most frequently cited stressors in the nurse's working life is dealing with death and dying (Caldwell & Weiner, 1981; Hingley & Harris, 1986, in Kunkler & Whittick, 1991; Hipwell et al., 1989; Nash, 1989; Lees & Ellis, 1990). Foxall et al. (1990) identified death and dying as a major stressor in their comparison of the frequency and sources of nursing job stress amongst different nursing specialities, with situations involving death and dying considered significantly more stressful for intensive-care and hospice nurses than for medical-surgical nurses. Dewe (1987, 1988) reports that the difficulties involved in nursing the critically ill emerged as a frequent occupational stressor in his large sample of nurses.

Bureaucratic-political constraints within the service organization are also strongly implicated in the experience of stress by healthcare providers (Bailey, 1985) and oncology nurses (Jenkins, 1985, in Pot-Mees, 1987).

Changing shifts has also been mentioned as a significant source of nursing stress. The few earlier studies on shiftwork amongst nurses provide evidence that rotating shift work is associated with significantly more physical and psychological problems (Tasto, Colligan, Skjei & Polly, 1978, in Milne & Watkins, 1986), increased sick leave and frequency of worksite clinic visits (Colligan, Frockt & Tasto, 1979, in Milne & Watkins, 1986), and detrimental effects on work performance and health (Jamal & Jamal, 1982, in Milne & Watkins, 1986). Two further studies concerned with the relationship between shift work and job-related stress

identified the shift schedule system as being one of the major factors causing stress and nurse burnout (Shubin, 1978, in Coffey, Skipper & Jung, 1988; Storlie, 1979, in Coffey et al., 1988). Also emphasising the importance of shift rotation as a stressor for nurses, Milne and Watkins (1986) reported that their sample of paediatric nurses only perceived their shift rotation to be mildly stressful, and attributed the reduction in their experienced strain to an increase in use of certain more active coping strategies. Coffrey et al. (1988), however, reported increased job-related stress among nurses on rotating shifts. More recently, Foxall et al. (1990) found that changing shifts (or 'floating') was found to be a powerful source of stress for intensive-care and medical-surgical nurses.

With regard to task orientation, Wagenaar (1990) reported that in her sample of nurses, those in the low burnout group were more task-oriented. This accords with Moos and Schaefer's (1987) findings that nurses reporting high levels of task orientation experience less emotional exhaustion and alienation.

Role conflict (which occurs when an employee's role expectations are incompatible with those of his or her role sender) and role ambiguity (when role information is restricted or not clearly defined and explained) have also received attention in the burnout literature (Cordes & Dougherty, 1993). According to Cordes and Dougherty (1993), the findings that these two variables are largely significantly associated with burnout are consistent across various studies amongst teachers, human service professionals, nurses, and public service lawyers (e.g., Schwab & Iwanicki, 1982a, in Cordes & Dougherty, 1993; Jackson, Turner & Brief, 1987, in Cordes & Dougherty, 1993). Similar findings were reported by Leiter and Maslach (1988) and Wagenaar (1990). Revicki and May (1989) report that the level of stress experienced by hospital nurses in their study was directly related to their perceived role ambiguity. In a later study, Revicki et al. (1993) found role ambiguity to be a significant factor, both as an influence on work-related stress and as a direct contributor to psychological distress amongst emergency medical residents.

Concerning job commitment or involvement, Leiter and Maslach (1988) report that burned-out healthcare workers (including nurses) in their study were less committed to their jobs, due to the lack of enthusiasm brought about by feelings of emotional exhaustion, depersonalization, and

diminished personal accomplishment. Further support for the association between commitment and burnout is provided by Pretorius (1993), who found that depersonalization was negatively correlated with commitment in a sample of university lecturers. Topf (1989) also reported a convincing link between greater burnout and less commitment to work in a sample of nurses. Using a total burnout score, Chiriboga and Bailey (1986) obtained a significant negative relationship between involvement and burnout in their sample of nurses, and concluded that those nurses who felt a low sense of involvement in their work were most at risk for burnout. Likewise, in a recent South African study, Wagenaar (1990) found that nurses categorized as experiencing high levels of burnout were significantly less involved in their work.

With regard to innovation, the extent to which variety, change and new approaches dominates the work environment, Wagenaar (1990) found a significant association between high levels of burnout in a group of nurses and perceptions of low innovation in the workplace. This accords with Moos and Schaefer's (1987) opinion that nurses who perceive their work setting to be innovative develop an enhanced sense of personal accomplishment.

As regards physical comfort, Wagenaar (1990) reports that the nurses in her study who experienced high levels of burnout perceived their working environments to be less pleasant and comfortable. Very few studies either investigated or reported findings of an association between physical comfort and burnout.

It is well known that nurses are generally underpaid for the work which they do, despite the fact that nursing has become increasingly more specialized, requires longer training, and increasingly involves degree level courses. In the literature reviewed for this study, very few studies specifically investigated salary as a stressor in nursing. In one study, in which nurses were asked to identify occupational factors which would alleviate their stress, salary was cited by 52% of the nurses as being the most important factor which required attention (McGrath et al., 1989). Hisashige (1991) reports that the extremely high levels of burnout found in a sample of Japanese hospital nurses, due to severe workloads and poor working conditions, was compounded by frustration with low salaries in comparison with those earned by other professionals and even non-skilled workers. Jick (1989), however, fears that budget cuts and rationalization of services, the challenge to the medical profession which has emerged as a pertinent stressor in recent

times, will serve to worsen this problem. As the number of nurses in many hospitals continues to drop in order to save funds, the workload for remaining nurses will rise commensurately, as will the demand stress (Jick, 1989).

2.3 Summary

Clearly, the working environments of nurses, particularly those nurses working within large organizations such as hospitals, abound with potential stressors. Bailey (1985) emphasises, though, that many of the sources of stress mentioned can also be sources of satisfaction for nurses (e.g., Claus & Bailey, 1980, in Bailey, 1985). For instance, a lower workload with improved staff ratios, the recovery of patients, colleague support organizations and backing, and working within desired disciplines of nursing all provide satisfiers for nurses. Bailey (1985) explains this as being in line with the view that stress or its absence originates in the way nurses and other health professionals construe or appraise the demands of caring and the meaning it has for them within their present repertoire of coping.

This accords with the social-ecological perspective, which claims that the link between social climate and employee work performance and outcomes, in this case burnout, is influenced by personal factors as well as by cognitive appraisal and coping responses. Coping responses and their effectiveness (patient and staff outcomes) are in turn shaped by cognitive appraisal and the environmental and personal factors which foreshadow them (Moos & Schaefer, 1987).

3. COPING

3.1 Concept and theory of coping

The concept and theory of coping have been shaped by the early animal experimentation approach and by psychoanalytic theory (Lazarus & Folkman, 1984, in Kelly, 1991), which have been criticised for being too simplistic and incomplete as cognitive-emotional factors are not included (e.g., Billings & Moos, 1981; Lazarus & Folkman, 1984, in Kelly, 1991), and because coping is viewed structurally as a style and not as a dynamic process (Lazarus & Folkman, 1984, in Kelly, 1991), respectively.

The complexity of the coping domain is reflected in a diversity of existing approaches to conceptualization and assessment (Billings & Moos, 1984). A predominant contemporary approach to coping is, however, the approach that views coping as a process (e.g., Lazarus & Folkman, 1984, in Kelly, 1991; Bailey & Clarke, 1989; Carver, Scheier & Weintraub, 1989; Vachon and Stylianos, 1991).

Building on the work of Richard Lazarus, Bailey and Clarke (1989) developed a comprehensive view of stress and coping, a cognitive-phenomenological-transactional perspective. This model is cognitive because it holds the assumption that whether or not stress and coping occurs (in whatever form) depends on the individual's appraisal of his or her relationship to environmental events. This appraisal is a function of the thinking, memory, and past experience of the person. The approach is phenomenological because it is the person's own unique and often idiosyncratic appraisal which is seen as the crucial factor in his or her response. The individual's response to a particular circumstance might also not be the same every time he or she is confronted by it. The transactional facet of this model emphasises the interaction between individuals' appraisals and the environments in which they find themselves (Bailey & Clarke, 1989).

Appraisal leads to an evaluation of the degree of threat, harm, loss, or challenge perceived as actually occurring or expected to occur. Whether a potential stressor is perceived to be threatening or not depends on whether the individual appraises him- or herself as being capable of coping with it. Lazarus (1966, in Bailey & Clarke, 1989) conceptualized three levels of appraisal. Primary appraisal refers to the individual's assessment of the challenge or demand

evident in the situation. Secondary appraisal is the individual's estimation of whether or not he or she can cope with the demands, and reappraisal constitutes an evaluation of the effectiveness of the coping behaviour employed to reduce or remove the source of threat (Bailey & Clarke, 1989). Lazarus (1966, in Carver et al., 1989) cautions that these processes of appraisal, although most easily described in such linear fashion, do not occur in an unbroken stream. An outcome of one process may necessitate the repetition of a preceding process, the entire set of processes potentially able to cycle repeatedly in a stressful transaction (Carver et al., 1989).

Lazarus's (1971, in Bailey & Clarke, 1989) fundamental assumption regarding stress is that it refers to the relations between an organism and the environment, rather than to the organism or the environment alone. In this transactional view, therefore, stress can only be understood in terms of the individual and his or her surroundings, an assertion shared by Maslach (1982) with respect to burnout, as previously mentioned. Far from being at the mercy of stressful situations, the person is seen as a dynamic system attempting to control levels of threat, challenge or demand by effective coping (Bailey & Clarke, 1989). Indeed, Moos (1976) has pointed out that individuals' behaviour cannot be understood solely in terms of stimuli presented to them, as these stimuli are largely created by the individuals themselves. These stimuli are responses to their own behaviours - the events they have played a role in bringing about - not occurrences which are independent of who individuals are and over which they have no control (Moos, 1976).

Bailey and Clarke (1989), like Moos (1976), Maslach (1982) and Moos and Schaefer (1987), thus conceptualize coping, the means by which attempts are made to control perceived levels of demand or threat, as one component of individuals' transactions with their internal and external environments. This conception includes all attempts to reduce the impact of threat or demand, whether or not these attempts are successful.

Bailey and Clarke (1989) view coping behaviour as variable. Individuals sometimes cope actively, and at other times they may not act upon demands, but may wait for a more opportune time in which to take action. Coping may also take the form of adjusting perceptions of threat or demand. Methods of psychological or physiological relaxation may be useful where active coping is unrealistic. Yet other individuals may find a more palliative coping strategy, which

permits putting aside a threat or demand for the time being without changing it, more useful (Bailey & Clarke, 1989).

Carver et al. (1989) continue this delineation of the processes by which people cope, defining coping as the manner in which the potential responses to threat brought to mind during secondary appraisal are executed.

The dramatic increase in interest in the coping behaviour of people since the late 1970's resulted in the development of measures by which to study coping, one of the most influential and widely used being the Ways of Coping scale devised by Folkman and Lazarus (1980, 1985, in Carver et al., 1989). This measure distinguishes between two general types of coping: problem-focused coping (problem-solving or doing something to alter the source of the stress) and emotion-focused coping (reducing or managing the emotional distress related to or brought about by the stressful situation). Although most stressors elicit both kinds of coping, the assumption is that problem-focused coping tends to predominate when individuals perceive themselves capable of doing something constructive, whereas those who believe that a stressor must be endured tend to make use of emotion-focused coping (Folkman & Lazarus, 1980, in Carver et al., 1989).

Cautioning that how a particular person copes with a specific situation is determined by various factors, Carver et al. (1989) dispute the simple division of coping strategies into only these two general types and quote empirical support for their view (e.g., Aldwin & Revenson, 1987, in Carver et al., 1989). Folkman, Lazarus, Gruen and De Longis (1986, in Dewe, 1993) had also pointed out that the simple division of coping behaviours into problem- and emotion-focused categories did not offer a precise distinction between sets of strategies. There is general consensus among researchers that various conceptually distinct, even inversely correlated, coping strategies constitute both emotion- and problem-focused coping and that these should be studied and measured separately, based on a theoretical approach rather than the more frequently used empirical method of deriving scales (Carver et al., 1989). Cooper and Baglioni (1988) echo this need for a more detailed knowledge of *particular* coping skills. Billings and Moos (1981) admit, however, that acknowledging all possible types of coping behaviours that people use to manage the demands of everyday life is a formidable task. Other researchers (e.g., Dewe & Guest,

1990; Dunkel-Schetter, Feinstein, Taylor & Falke, 1992;) have suggested that, whilst coping research has increasingly assumed a more central role in attempts to understand the stress process, various facets of coping research remain unclear. Dewe and Guest (1990) argue that coping is still a poorly defined concept, that current methods of measuring coping are inadequate (e.g., Folkman & Lazarus, 1980, in Dewe & Guest, 1990), that we do not know much about the specific coping strategies which people use (e.g., Moos & Billings, 1982, in Dewe & Guest, 1990), and that there is insufficient empirical evidence about the effects of coping in general and in work settings in particular (e.g., Parasuraman & Cleek, 1984, in Dewe & Guest, 1990).

Carver et al. (1989) subsequently developed, based mostly on specific theoretical arguments, a coping inventory comprised of conceptually distinct scales which measure thirteen coping tendencies, some considered functional and others, arguably, less functional. This relatively comprehensive representation of the major types of coping skills identified to date, which are used either singly or in various combinations, corresponds largely with that of Moos (1986) and Bailey and Clarke (1989), and represents an attempt to address some of the shortcomings mentioned above.

Distinct coping strategies which form part of the overall category of problem-focused (or direct) coping include active coping (initiating direct action and increasing one's efforts), planning (thinking about how to manage a stressor), suppression of competing activities (side-lining other projects, avoiding distraction by other events, and even letting other details slide), restraint coping (waiting for a more appropriate time to act, holding the self back, and not acting prematurely), and seeking social support for instrumental reasons (seeking advice, information or assistance). Restraint coping can be seen as passive coping in the sense of not acting, but it is also an often necessary and functional active coping strategy in the sense that the individual focuses attention on dealing actively with a stressor (Carver et al., 1989).

Distinct aspects of the category of emotion-focused (or indirect) coping include seeking social support for emotional reasons (getting moral support, sympathy, or understanding), positive reinterpretation and growth (managing distress emotions rather than dealing with the actual stressor), acceptance (accepting the reality of a situation), denial (denying the reality of a situation), and turning to religion (general tendency to turn to religion in times of stress) (Carver

et al., 1989). Carver et al. (1989) express a number of caveats in relation to the understanding of emotion-focused coping. These include the warnings that seeking social support for emotional reasons may take the form of venting emotions (which may be maladaptive), that positive reinterpretation of a stressful situation may lead to problem-focused coping, that denial may be both an adaptive and a maladaptive mechanism, and that acceptance of the inability to cope with a stressor would also be important if there was a necessity to accommodate the stressor as opposed to being able to change the stressful situation (Carver et al., 1989).

Three further coping strategies (also often referred to as palliative or avoidant strategies) which are, arguably, less useful, are focusing on and venting emotions (focusing on the current upset and ventilating those feelings), behavioural disengagement (reducing efforts to deal with the stressor and giving up the attempts to achieve goals which the stressor is impeding), and mental disengagement (activities which serve to distract the person from contemplating the goal which is being impeded by the stressor, for example, daydreaming or watching television) (Carver et al., 1989). The authors emphasise the fact that a given coping strategy may not be inherently maladaptive, but may become dysfunctional if adhered to over an extended period of time. Although, for instance, focusing on and venting emotions may be functional in certain circumstances (for example, accommodation to the loss of a loved one through a period of mourning), this strategy may exacerbate stress and impede active coping efforts if relied upon for long periods. Likewise, behavioural disengagement (related to helplessness) and mental disengagement may also be highly adaptive responses, but may be dysfunctional if relied upon for prolonged periods (Carver et al., 1989). Alcohol and drug disengagement, which does not appear to be a component of mental disengagment as originally postulated, is also identified as a distinct coping strategy which warrants further investigation (Carver et al., 1989).

3.2 Review of recent research on coping and burnout

The study of coping is a comparatively new area of research, as is the study of burnout. To date, the relatively few empirical studies designed to investigate the associations between coping efforts and burnout in nurses have identified a fairly consistent pattern of associations, given that measurement of coping has not occurred in a uniform way and that there are inconsistencies in the definitions and categorizations of coping strategies used by researchers.

Adding weight to the view that people generally make use of a variety of coping strategies (e.g., Billings & Moos, 1981), depending on their appraisal of the stressful situation and the coping responses and resources available to them, are a number of recent studies (e.g., Cooper & Baglioni, 1988; Rosenthal, Schmid & Black, 1989; Dewe, 1993). Certain authors have also maintained that problem-focused-coping strategies are used most often (e.g., Rosenthal, et al., 1989).

Various researchers have reported that active, problem-focused ways of coping are associated with lower levels of strain and burnout (e.g., Caldwell & Weiner, 1981; Billings & Moos, 1984; Parasuraman & Hansen, 1987; Hare et al., 1988; Ceslowitz, 1989; Boyle et al., 1991; Ogus, 1992; Bennett et al., 1993; Kandolin, 1993; Sullivan, 1993).

A number of studies have provided evidence for an association between emotion-focused coping and higher levels of emotional distress and burnout (e.g., Parasuraman & Hansen, 1987; Boyle et al., 1991; Bennett et al., 1993; Dewe, 1993; Sullivan, 1993). (Dunkel-Schetter, Feinstein, Taylor and Falke (1992), in contrast, reported an association between decreased emotional stress and more frequent use of emotion-focused coping techniques such as seeking social support, focusing on the positive, and distancing, although participants in their study were a large sample of cancer patients.)

There is also evidence that frequent use of avoidant or palliative methods of coping (such as mental and behavioural disengagement) are linked to higher levels of experienced burnout (e.g., Billings & Moos, 1981, 1984; Milne & Watkins, 1986; Aldwin & Revenson, 1987, in Carver et al., 1989; Cooper & Baglioni, 1988; Hare et al., 1988; Ceslowitz, 1989; Rosenthal et al., 1989; Thornton, 1991; Ogus, 1992; Bennett et al., 1993; Kandolin, 1993). (Dunkel-Schetter et al. (1992) also found an association between the use of cognitive and behavioural escape-avoidance coping strategies and increased emotional distress in their sample of cancer patients.)

3.3 Summary

In summary, the literature on nursing coping research, as related to burnout, consistently points to the usefulness of the more problem-focused methods of coping. Emotion-focused and palliative coping strategies generally appear to be associated with higher levels of experienced

burnout. Dewe (1989), however, like Carver et al. (1989), cautions against overlooking emotion-focused or palliative coping, or regarding these methods as being second rate or ineffective, making the point that dealing with the emotional discomfort of demanding situations is a legitimate part of the coping process, and that very often nurses find themselves in situations where little can be done (for example, when patients are critically ill or dying) or when problem-solving strategies are not available to them. Coping with emotional discomfort thus becomes a necessary part of the stress transaction (Dewe, 1989).

4. REVIEW CONCLUSIONS

Nursing clearly takes place within a social climate replete with potential stressors, whether these be interpersonal (for example, work relationships, nurse-patient relations, or informal supports) or situational (such as work setting variables or personal demographics). The potential for burnout thus appears to be everpresent. Bailey (1985, p.45) adds that "stress and coping are irrevocably connected with environmental demands. Those in the helping professions have daily commerce with demands which they have to cope with more or less effectively. So burn-out symptoms should be seen as just one part of a relationship schema of environmental demands, appraisal, stress, and coping".

Clear indications emerge from the literature that various aspects of the work environment of nurses are strongly implicated in the development of burnout (for example, workload, interstaff relations, and inclusion in decision-making, to name a few). The severity of experienced burnout also appears to be associated with the manner in which nurses cope with it. Other factors which have been emphasised consistently in the literature as being related to burnout are sense of control, perceptions of support, job satisfaction, and sense of being appreciated for work done.

A number of authors emphasise the importance of identifying work-related stressors as predictors of burnout and as a first step in improving the working environments of nurses (e.g., Buechler, 1985; Chiriboga & Bailey, 1986; Revicki & May, 1989; Chappell & Novak, 1992; Corrigan, 1993).

Concerning coping research, various authors have suggested that, whilst it has increasingly assumed a more central role in attempts to understand the stress process, various facets of coping research remain unclear (e.g., Dewe & Guest, 1990; Dunkel-Schetter et al., 1992). It is argued that current methods of measuring coping are inadequate (Folkman & Lazarus, 1980, in Carver, et al., 1989; Cohen, 1987), and that there is a need for a more detailed knowledge of *particular* coping skills (e.g., Moos & Billings, 1982; Folkman, Lazarus, Gruen & De Longis, 1986, in Dewe, 1993; Aldwin & Revenson, 1987, in Carver et al., 1989; Cooper & Baglioni, 1988; Carver et al., 1989). Other researchers have added that there is also insufficient

empirical evidence about the effects of coping in work settings (e.g., Parasuraman & Cleek, 1984, in Dewe & Guest, 1990; Shinn, Rosario, Morch & Chestnut, 1984, in Dewe & Guest, 1990). This study attempts to make a contribution to addressing these deficits in coping research, both by using a coping inventory which measures a wider range of coping skills, and by examining the association between these various coping strategies and burnout within the nurse's work setting.

The circumstances under which South African nurses are currently working, particularly those within provincial hospitals, appear to be particularly stressful, and it is reasonable to expect that burnout is being experienced. This study examined how hospital nurses were experiencing their work environments and how they coped with their stress. Other salient factors which appear to warrant examination and were included in the study were perceptions of personal control, support, job satisfaction, and sense of being appreciated for work done. The overall purpose of the study was to ascertain which of the abovementioned variables were significant predictors of the three components of burnout (emotional exhaustion, depersonalization and diminished personal accomplishment).

During computerized and manual accumulation of the literature for review in this dissertation, it became evident that there is a relative paucity of published research on South African nurses' experience of burnout in relation to their work settings and the coping strategies which they employ. This primarily descriptive study represents a contribution towards addressing this deficiency, the rationale being that only through research and the subsequent assimilation of findings into prevention and training programs can the situation for nurses, and ultimately the adequate treatment of their patients, be improved.

CHAPTER TWO

METHODOLOGY

CHAPTER TWO

METHODOLOGY

1. RESEARCH DESIGN

This descriptive, exploratory study took the form of a cross-sectional, correlational field survey, in which data was collected retrospectively by means of self-report questionnaires. This design was considered appropriate for examining the associations between, primarily, work environment variables, coping strategies, and burnout, as it has the ability to provide the basis for a preliminary, exploratory examination of the relationships between these variables, given that the study of both coping and burnout are relatively new areas of research.

2. THE RESEARCH INSTRUMENT

2.1 Procedure

A survey questionnaire was developed in order to collect demographic information and data concerning burnout, perceptions of working environment, coping strategies, and perceptions of support, personal control, job satisfaction, and sense of appreciation. Qualitative information was also collected in the form of responses to four open-ended questions posed in the research instrument. An example of the research questionnaire is provided in Appendix A.

The researcher made a written application to the Deputy Director of Nursing of the target hospital, requesting permission to conduct the study amongst nurses in her employ. Once permission had been granted for the study to be conducted and a decision made as to which nurses would be requested to participate, arrangements were made for distribution of the questionnaires.

In consultation with senior nursing personnel from the hospital pavilion selected for inclusion in this study, it was decided that the head nurses from each ward or department concerned would distribute the research questionnaires within their departments to every trained nurse, on both day and night duty. A meeting was held with the head nurses, at which time the researcher introduced herself, discussed the research project, stressed the importance of anonymity and answered questions related to the project. Head nurses were requested to distribute the questionnaires, thanked for their cooperation, and supplied with the requisite number of questionnaires for the nursing complements within their departments. Each anonymous questionnaire, together with an explanatory covering letter and a stamped envelope addressed to the researcher, was presented sealed in an unmarked manilla envelope.

The research questionnaire was presented in English and the researcher was prepared to arrange for translation, should that have been considered necessary. The instrument was scrutinized by nursing management, who suggested that more appropriate local terminology be substituted for five words or sentences in the standardized questionnaires (four in the WES and one in the MBI). Four of these minor modifications were made, and the researcher was assured by nursing management that translation of the questionnaire was unwarranted as the hospital concerned is largely comprised of English-speaking personnel. The nursing college and university affiliated to the hospital are also English-medium training institutions. The researcher, nevertheless, furnished her telephone number in the questionnaire covering letter, assuring respondents that they were welcome to approach her with any problems experienced in completing the questionnaire. No participants required such assistance.

The questionnaires were distributed to the nurses within a week of the meeting with head nurses, and nurses were requested by their head nurses to complete the questionnaires and mail them to the researcher within two weeks of receiving them.

Considerable interest was expressed in the project, and the researcher undertook to present a technical report of the research findings to the Deputy Director of Nursing.

2.2 Instructions to respondents

Apart from the specific instructions which accompanied each section of the questionnaire, each instrument was distributed together with a personal letter from the researcher. The letter, printed on a university letterhead and signed personally by the researcher, informed respondents of the broad purpose of the study. It emphasised the importance of obtaining the necessary information from nurses themselves and the value of their input was highlighted. Respondents were assured that there were no right or wrong responses to any of the questions or statements posed in the questionnaire, and that their own honest responses were required.

Regarding confidentiality and anonymity, it was emphasised that participants were not required to identify themselves in any way and that all information obtained through their participation in the study would remain confidential.

The researcher's name and telephone number were provided in the letter so that respondents could request assistance should the need for clarification and translation have arisen.

Finally, respondents were thanked for their participation and requested to return by mail the completed questionnaires in the stamped, addressed envelopes provided.

An example of the abovementioned covering letter is furnished in Appendix B.

2.3 Demographic details

Respondents were requested to provide the following demographic information: age, gender, home language, marital status, whether or not they had children, ages of children, educational status, current nursing status, how long they had been nursing, whether they were on day or night duty, when last they had had a vacation, the length of the previous vacation, and the ward/department in which they were working.

With regard to the coding of the demographic data obtained, gender, day/night duty data, and whether or not respondents had children were coded as dichotomous character variables. Data regarding home language, marital status, ages of children, educational status, nursing status, and ward/department data were categorized and assigned nominal numerical or character values.

Age and years of nursing experience were recorded in years (rounded off to the nearest year) and constituted continuous numerical variables, as did length of time since previous vacation (in weeks) and length of vacation (in days).

A demographic code-sheet is presented in Appendix C.

2.4 Standardised measuring instruments

The research instrument largely comprised three standardised measuring instruments. Burnout was measured by means of the Maslach Burnout Inventory (Maslach & Jackson, 1981). The Work Environment Scale (Moos, 1986) was used to measure respondents' perceptions of their working environments, and respondents' coping styles were investigated by means of the Coping Orientations to Problems Experienced questionnaire (Carver, Scheier, & Weintraub, 1989).

2.4.1 Maslach Burnout Inventory (MBI)

The Maslach Burnout Inventory (MBI; Maslach & Jackson, 1981) is a 22-item scale designed to measure the three components of burnout, namely, emotional exhaustion, depersonalization and lack of personal accomplishment. Each component is measured on a separate subscale and each item within each subscale is rated by respondents on two dimensions: frequency (how often people have these feelings: score range 0 for "never" to 6 for "every day") and intensity (the strength of these feelings: score range 0 for "never" to 7 for "very strong").

The emotional exhaustion subscale measures feelings of being emotionally overextended and exhausted by the work one does. The depersonalization subscale assesses the extent of unfeeling and impersonal responses towards recipients of one's care. The personal accomplishment subscale measures feelings of competence and successful achievements in one's work with people (Maslach & Jackson, 1981).

Burnout is conceptualized as a continuous variable, ranging from low to moderate to high levels of experienced feeling. It is not viewed as a dichotomous variable which is either present or absent. A high degree of burnout is reflected in high scores on emotional exhaustion and depersonalization and a low score on personal accomplishment. Moderate scores on all three subscales are indicative of a moderate degree of burnout. A low degree of burnout is indicated

by low scores on emotional exhaustion and depersonalization and a high score on the personal accomplishment subscale. Scores for each subscale are considered separately, as are the frequency and intensity scores. Six scores are thus computed for each respondent: emotional exhaustion-frequency and -intensity, depersonalization-frequency and -intensity, and personal accomplishment-frequency and -intensity (Maslach & Jackson, 1981).

Recent burnout studies have revealed relatively high correlations between the frequency and intensity subscales of the MBI suggesting a fairly strong relationship between them. Numerous researchers (e.g., Chiriboga & Bailey, 1986; Firth, McIntee, McKeown & Britton, 1986; Leiter & Maslach, 1988; Hisashige, 1991; Glass et al., 1993; Kandolin, 1993) have used only the frequency subscale on each of the three burnout components in recent years, while others such as Bennett, Michie and Kippax (1991) have used both subscales. Maslach and Jackson (1986, in Glass et al., 1993) currently recommend the use of the frequency subscale only. In the present study, scores were obtained on both subscales in order to ascertain whether this high correlation would be replicated. This was indeed the case; correlations of 0.82 for emotional exhaustion, 0.72 for depersonalization and 0.78 for personal accomplishment (each significant at $P=0.001$) between the two subscales were obtained, suggesting that these two kinds of ratings were measuring more or less the same concept. It was thus decided to follow Maslach and Jackson's (1986, in Glass et al., 1993) more recent recommendations and to use only the frequency scores on the burnout subscales for the analyses in this study. Normative MBI data, based on a sample of 1104 healthcare workers (including nurses) is presented in Table 1.

Table 1. MBI normative data for the frequency subscale (Maslach & Jackson, 1986)

Subscales	M[b]	SD
Emotional Exhaustion (EE)	22.19	9.53
Depersonalization (DEP)	7.12	5.22
Personal Accomplishment (PA)	36.53	7.34

Note. [a]Sample included nurses (Maslach & Jackson, 1986).
[b]Range of possible values on EE is 0-54, on DEP is 0-30, and on PA is 0-48.

With respect to reliability, internal consistencies (Chronbach's alpha) for each of the three MBI subscales are all in an acceptable range, as is evident from Table 2. Two-to-four week test-retest reliabilities were also found to be within an acceptable range, and although these coefficients range from moderate to relatively high, all are significant beyond the 0.001 level. These statistics are also presented in Table 2.

Table 2. Internal consistencies (Chronbach's alpha) and test-retest reliabilities for the frequency subscale of the MBI (Maslach & Jackson, 1981)

Subscales	Internal Consistency (N=1316)	2-4 Week Test-retest Reliability (N=53)
Emotional Exhaustion	0.90	0.82
Depersonalization	0.79	0.60
Personal Accomplishment	0.71	0.80

Regarding validity, convergent validity has been demonstrated through correlation of MBI scores with peer ratings, job dimensions associated with burnout, and stress outcomes (Maslach & Jackson, 1981). Discriminant validity of the MBI has also been provided through distinguishing it from other psychological constructs that might be presumed to be confounded with burnout. For example, burnout was found not to be simply a synonym for job dissatisfaction, nor were any of the burnout subscales found to be significantly correlated with social desirability in studies conducted by Maslach and Jackson (1981). In general, promising results concerning the MBI's concurrent and predictive validity have been reported in a number of studies (e.g., Rafferty, Lemkau, Purdy & Rudisill, 1986, in Green & Walkey, 1988). Positive indications have also been found for the cross-cultural validity of the MBI (Schaufeli & Van Dierendonck, 1993).

The Human Sciences Research Council of South Africa have no record of published normative MBI data for South African healthcare workers to date.

With respect to administration of the MBI in this study, the questionnaire format was modified for reasons of convenience and practicality (see Appendix A). In accordance with Maslach and Jackson's (1981) stipulation that the word 'burnout' should not appear in the inventory (in order to avoid sensitization and possible response bias) the MBI was presented as *a questionnaire comprising a list of statements about job-related attitudes* in the research instrument (see Appendix A, page 4).

As mentioned previously, nursing management at the hospital in which the study was carried out suggested one change to a word in the MBI which might prove unfamiliar or unclear and, hence, confusing to participants. The statement in question was: "I've become more callous toward people since I took this job" (question 10) and the word 'callous' was considered problematic. Consequently, the word 'unfeeling' (Fowler & Fowler, 1969) was inserted in parentheses after the word 'callous' for the purposes of this study.

Recent research generally confirms that the MBI is a reliable, brief, readily interpretable, and adequate measure that can be employed to assess the level of burnout in professionals who do 'people work' of some sort (Green & Walkey, 1988; Schaufeli & Van Dierendonck, 1993). The replicable, three-factor structure of burnout conceptualized by Maslach (1982) has been confirmed in most studies (e.g., Green & Walkey, 1988; Glass et al., 1993; Schaufeli & Van Dierendonck, 1993).

2.4.2 Work Environment Scale (WES)

The Work Environment Scale (WES; Moos, 1986) is a 90-item self-administered scale developed to measure the social climates of working environments. It comprises 10 subscales (each containing nine 'true/false' items) which measure different facets of the social climates of work settings. The subscales assess three underlying domains or sets of dimensions: the work relationship dimensions, the personal growth dimensions, and the system maintenance and system change dimensions. The WES subscales and dimension descriptions are presented in Table 3.

Table 3. WES Subscales and dimension descriptions (Moos, 1986)

Subscales	Dimension Descriptions
	Work Relationship Dimensions
1. Involvement	the extent to which employees are concerned about and committed to their jobs
2. Peer Cohesion	the extent to which employees are friendly and supportive of each other
3. Supervisor Support	the extent to which management is supportive of employees and encourages them to be supportive of each other
	Personal Growth Dimensions
4. Autonomy	the extent to which employees are encouraged to be self-sufficient and to make their own decisions
5. Task Orientation	the degree of emphasis on good planning, efficiency, and getting the job done
6. Work Pressure	the degree to which the press of work and time urgency dominate the job setting
	System Maintenance and System Change Dimensions
7. Clarity	the extent to which employees know what to expect in their daily routine and how explicitly rules and policies are communicated
8. Control	the extent to which management uses rules and pressures to keep employees under control
9. Innovation	the degree of emphasis on variety, change, and new approaches
10. Physical Comfort	the extent to which the physical surroundings contribute to a pleasant work environment

The WES has three forms: the Real Form (Form R). the Ideal form (Form I), and the Expectations Form (Form E). For this study, Form R, which measures perceptions of existing work settings, was used.

With regard to the psychometric properties of Form R of the WES, normative data was collected from 1442 employees in general work settings and from 1607 employees in a variety of healthcare work environments (Moos, 1986). Subscale means and standard deviations for the sample of health care workers, of relevance to this study, are presented in Table 4.

Table 4. WES Form R normative data for healthcare employees (Moos, 1986)

	Health Care Employees (N=1607)	
Subscales	M[a]	SD
Involvement	5.56	1.54
Peer Cohesion	5.22	1.40
Supervisor Support	4.99	1.40
Autonomy	4.98	1.46
Task Orientation	5.63	1.31
Work Pressure	4.87	1.57
Clarity	4.44	1.41
Control	5.43	1.42
Innovation	4.37	1.82
Physical Comfort	3.72	1.28

Note. [a]Range of possible values is 0-9.

Internal consistencies (Chronbach's alpha) for each of the ten subscales of the WES are all in an acceptable range, as is evident from Table 5. One-month test-retest reliabilities were also found to be within an acceptable range, and test-retest reliability coefficients calculated for respondents who had worked in the same work settings for twelve months were found to be moderately high for this time interval (Moos, 1986). These statistics are also presented in Table 5.

Table 5. WES Form R internal consistencies (Chronbach's alpha), test-retest reliabilities, and stabilities (Moos, 1986)

Subscales	Internal Consistency (N=1045)	1-Month Test-Retest Reliability (N=75)	12-Month Subscale Stability (N=254)
Involvement	0.84	0.83	0.62
Peer Cohesion	0.69	0.71	0.58
Supervisor Support	0.77	0.82	0.51
Autonomy	0.73	0.77	0.52
Task Orientation	0.76	0.73	0.52
Work Pressure	0.80	0.76	0.63
Clarity	0.79	0.69	0.59
Control	0.76	0.79	0.60
Innovation	0.86	0.75	0.54
Physical Comfort	0.81	0.78	0.61

The Form R profiles were also found to be moderately stable over time (Moos, 1986). Regarding subscale intercorrelations for Form R, Moos (1986) confirms that the subscales measure distinct, though somewhat related, aspects of work environments. The work relationship subscales are positively correlated with one another and to the autonomy and task orientation subscales. These subscales are also moderately positively correlated with the innovation and clarity subscales. There are negative correlations between these dimensions and the control and work pressure subscales. On average, the intercorrelations account for less than 10% of the subscale variance (Moos, 1986).

With respect to cross-cultural applicability, the WES has been adapted for use in a number of countries other than that in which it was developed (The United States of America). It has been translated into Dutch, French, German, Hebrew, Japanese, Portuguese, Spanish, and Vietnamese. Fisher and Fraser (1983, in Moos, 1986) applied the WES to a group of Australian teachers and reported the psychometric characteristics of the subscales as being similar to those of the original WES normative sample. With the exception of the clarity subscale, the psychometric characteristics of a Dutch version of the WES were generally similar to those of the English version (Lange, 1978a, 1978b, in Moos, 1986). A German study, in which the WES and a scale measuring feelings of work pressure and dissatisfaction was administered to

teachers, revealed that the two scales discriminated reliably between subgroups of teachers (Weyer & Hodapp, 1978, in Moos, 1986). These researchers concluded that their findings provided a measure of evidence of construct validity for the two scales.

The Human Sciences Research Council of South Africa reports that there are as yet no published South African norms for the WES, although the WES has been used in the country to date (e.g., Wagenaar, 1990; Pretorius, 1993).

The WES comprises 90 statements which respondents are required to indicate as being either true or false with regard to their work settings. The questionnaire is not difficult to complete and full instructions are provided (see Appendix A). The instructions were modified slightly in this study to include the designations 'matron' and 'senior sister' under the heading of 'supervisor'. The questionnaire format was also modified for reasons of convenience and practicality. With regard to scoring (a simple task of counting the number of responses showing through a standard scoring template), participants' responses were transcribed from the research questionnaires onto the standard WES answer sheets and subscale scores were then obtained.

As mentioned previously, nursing management at the hospital in which the study was carried out suggested changes to four statements which might have proved unfamiliar or unclear and, hence, confusing to participants. These were: "Few employees have any important responsibilities" (question 4), "It sometimes gets too hot" (question 10), "Employees generally feel free to ask for a raise" (question 53), and "It is rather drafty at times" (question 70). The researcher agreed with the suggestions made and these statements were duly amended. The revised versions can be found on pages 2 and 3 of Appendix A.

The WES has various clinical and consulting applications such as work-setting profile assessment, interpretation, and comparisons, in both real and ideal work environments. Practical applications include the provision of feedback and promotion of improvement, the monitoring of the impact of change in work climates, the formulation of clinical case descriptions, measurement of the impact of work climates, and assessing individual adaptation (Moos, 1986).

As the WES appears to be a psychometrically sound instrument for measuring a comprehensive range of job dimensions, it was considered to be an appropriate means of both determining the profiles of the work environments under investigation in this study, and of assessing the impacts of those settings as far as burnout is concerned.

2.4.3 Coping Orientations to Problems Experienced (COPE)

The Coping Orientations to Problems Experienced scale (COPE; Carver, Scheier & Weintraub, 1989) is a 53-item self-administered multidimensional coping inventory developed to assess the different ways in which people respond to stress. Five subscales measure conceptually distinct aspects of problem-focused coping. A further five subscales measure aspects of emotion-focused coping. Four subscales measure coping responses which are, arguably, less effective. The final subscale, alcohol and drug disengagement, was found not to be sufficiently loaded on the factor, mental disengagement, during scale development, and has thus been retained separately, for exploratory purposes (Carver et al., 1989). Response choices were "I usually don't do this at all", "I don't usually do this except every now and again", "I often do this, but not all the time", and "I almost always do this" (scored from 1 to 4). The COPE subscales, and descriptions thereof, are presented in Table 6.

Table 6. COPE subscales and descriptions (Carver, Scheier & Weintraub, 1989)

Subscales	Descriptions
	Problem-focused Coping
1. Active coping	taking active steps to remove, circumvent or ameliorate the effects of a stressor
2. Planning	thinking about how to cope with a stressor
3. Suppression	putting other projects aside, trying to avoid becoming distracted by other events, even letting other things slide if necessary in order to deal with the stressor
4. Restraint Coping	waiting until an appropriate chance to act presents itself, holding oneself back and not acting prematurely
5. Seeking Instrumental Social Support	seeking advice, assistance or information
	Emotion-focused Coping
6. Seeking Emotional Social Support	getting moral support, sympathy or understanding
7. Positive Reinterpretation	managing distress emotions rather than dealing with the stressor per se
8. Acceptance	acceptance of the reality of the stressor
9. Denial	refusal to believe that the stressor exists or trying to act as if the stressor is not real
10. Turning to Religion	tendency to turn to religion in times of stress
	Less Effective Coping Mechanisms
11. Focus on and Venting of Emotions	tendency to focus on whatever distress one is experiencing and to ventilate those feelings
12. Behavioural Disengagement	reducing one's efforts to deal with the stressor and even giving up the attempt to achieve goals with which the stressor is interfering
13. Mental Disengagment	activities that serve to distract one from thinking about the behaviour or goal with which the stressor is interfering, for example,escapism through sleep or television, or daydreaming
14. Alcohol and Drug Disengagement	the use of alcohol or drugs in an effort to avoid a stressor

The inventory may be used to assess both situational and dispositional strategies of coping. For the purposes of this study, a dispositional version of the scale was used, in which items were framed in terms of what respondents *usually* did when under stress. Normative data for the dispositional version of the COPE are presented in Table 7.

Table 7. COPE normative data, dispositional version (Carver, Scheier & Weintraub, 1989)

Subscales	Normative Data (N=1030)	
	M[a]	SD
Active Coping	11.89	2.26
Planning	12.58	2.66
Suppression	9.92	2.42
Restraint Coping	10.28	2.53
Social Support-Instrumental	11.50	2.88
Social Support-Emotional	11.01	3.46
Positive Reinterpretation	12.40	2.42
Acceptance	11.84	2.56
Turning to Religion	8.82	4.10
Focus/Venting Emotions	10.17	3.08
Denial	6.07	2.37
Behavioural Disengagement	6.11	2.07
Mental Disengagment	9.66	2.46
Alcohol/Drug Disengagement	1.38	0.75

Note. [a]Range of possible scores is 4-16, except for alcohol/drug disengagement, which is 1-4.

Regarding the internal consistency of the COPE subscales, Chronbach's alpha reliability coefficients, as is evident from Table 8, are generally in an acceptable range. Test-retest reliabilities, also presented in Table 8, suggest that the self-reports of coping tendencies assessed by the COPE are relatively stable (Carver et al., 1989).

Table 8. Chronbach's alpha reliabilities and test-retest reliabilities in two samples of college students - dispositional COPE subscales (Carver, Scheier & Weintraub, 1989)

COPE Scales	Alpha Reliabilities (N=978)	Test-retest[a] Reliabilities (N=89)	Test-retest[b] Reliabilities (N=116)
Active Coping	0.62	0.56	0.69
Planning	0.80	0.63	0.69
Suppression	0.68	0.46	0.64
Restraint Coping	0.72	0.51	
Social Support - Instr.	0.75	0.64	0.76
Social Support - Emot.	0.85	0.77	0.72
Reinterpretation	0.68	0.48	0.63
Acceptance	0.65	0.63	0.61
Turning to Religion	0.92	0.86	0.89
Focus/Venting	0.77	0.69	
Denial	0.71	0.54	
Disengagement - Behav.	0.63	0.66	0.42
Disengagement - Mental	0.45	0.58	0.56
Disengagement - Subst.		0.57	0.61

Note. [a] Interval = 8 weeks. [b] Interval = 6 weeks. There is no alpha reliability for alcohol/drug (subst.) disengagment as this subscale comprises only 1 item. Test-retest reliabilities for the second sample (N=116) were not all provided.

Regarding correlations among the COPE subscales, apart from two exceptions (a correlation of 0.67 between active coping and planning, and a correlation of 0.69 between seeking instrumental social support and emotional social support), the scales are not strongly intercorrelated.

Carver et al. (1989) also provide evidence of both convergent and discriminant validity of the COPE. For example, coping strategies postulated to be effective (active coping and planning) were found to be linked to personality qualities which are considered beneficial (optimism, self-esteem, hardiness, and Type A). Similarly, coping strategies considered less useful (denial and behavioural disengagement, for example) were found to be inversely correlated with desirable personality characteristics, in this case, optimism, self-esteem, and hardiness (Carver et al., 1989). Discriminant validity was demonstrated in three ways: (a) although certain personality variables correlated with the coping strategies in accordance with theoretical postulations, the correlations were not very strong, (b) the COPE scales were not strongly associated with social desirability, and (c) the COPE scales were relatively unrelated to two other measures of coping

style (monitoring and blunting) included in a further study (Carver et al., 1989).

The COPE was considered to be a relatively reliable, valid, and comprehensive measure of the various coping strategies which people employ when dealing with stress, and was therefore chosen for this study. The full inventory was presented to respondents in accordance with the instructions given by Carver et al. (1989) and may be examined on pages 5 and 6 of Appendix A.

2.5 Rating scales

Six visual analogue rating scales (on which subjects were requested to rate their responses on a scale of 0 to 10) were included in the research questionnaire. Two of these scales provided a measure of how much personal control respondents perceived themselves to have, both in their professional capacities as nurses and over their lives in general. Nurses were also required to rate their level of job satisfaction. Two scales requested ratings of social support: how well supported participants perceived themselves to be by nursing colleagues, and by friends or family. A final rating scale requested an indication of the extent to which respondents felt appreciated for their work.

Participants were requested to circle their ratings on each scale. The rating scales are to be found on pages 7 and 8 of Appendix A.

2.6 Qualitative data

Four open-ended questions or statements were included in the research instrument, to which respondents were requested to reply in the space provided. Participants' replies to this section of the questionnaire will be referred to as the qualitative data throughout the dissertation.

With respect to personal control, respondents were requested to mention any job areas in which they might like to have had more control. Respondents were also requested to mention what, if anything, would make their jobs more fulfilling and satisfying. Participants were asked to indicate which job areas they found particularly stressful. The final section of the questionnaire provided opportunity for participants to express any further opinions or feelings.

This qualitative portion of the research questionnaire may be found on pages 7 and 8 of Appendix A.

2.7 Pilot study

In order to obtain commentary on the clarity of the questionnaire, the level of 'user-friendliness', and time requirements, a small pilot study (N=6) was undertaken.

Subjects included one male and five females, whose ages ranged from 25 years to 62 years (average age of 40.2 years). This small sample included one optometrist, one student, one secretary, one enrolled nurse, one housewife, and one credit-controller.

With regard to clarity, one respondent found two of the COPE statements confusing, and this same person reported being unfamiliar with rating scales. Another subject found the completion of the frequency and intensity subscales on the MBI confusing. Three subjects pointed out the need to obtain separate ratings for support from nursing colleagues and family and friends. Generally, subjects found the format, instructions and language acceptable and did not report experiencing any major problems completing the questionnaire.

The average time taken to complete the questionnaire was 28.3 minutes.

In response to the commentary received, the instructions for the rating scales were further clarified, and the relevant changes were made to the support rating scale.

3. PARTICIPANTS

3.1 Participants

Participants in this study were different levels of trained nurses, working within the wards and departments of the surgical pavilion of a provincial training hospital in the Western Cape Province of South Africa.

Trained nurses were chosen as participants as they tend to be placed in particular wards or departments for extended periods of time. As one of the primary aims of this study was to obtain an understanding of burnout as a function of the working environments of nurses, it was thought that trained nurses' responses would present a relatively reliable picture of how these environments were being experienced. Student nurses, due to the nature of their training, tend to rotate through departments within the hospital with greater frequency, and are also subject to additional specific sources of stress, such as coursework, examinations, and academic projects. For these reasons they were excluded from the study.

During the process of sample selection, it was decided that a comprehensive investigation would be conducted into the incidence of burnout among trained nurses within one particular subdivision of the hospital. In other words, *all* trained nurses within that pavilion would be requested to participate in the study. As the largest complement of nurses is placed within the surgical pavilion of the hospital in question, this pavilion was targeted for the project.

3.2 Categorization of the sample of trained nurses

As has been mentioned, the sample of nurses in this study has been categorized primarily according to nursing status (professional nurses, enrolled nurses, and enrolled nursing assistants) and nursing speciality (surgical wards or trauma/emergency). The operating theatres also form part of the surgical pavilion of the hospital, however the questionnaire return rates received from operating theatre nursing staff were small (8%) overall: 9% for professional nurses, 8% for enrolled nurses, and 7% for enrolled nursing assistants), as can be seen in Table 10. It was decided, after consultation with nursing research personnel, to incorporate the operating theatres into the trauma/emergency category for the purposes of this study, as the trauma/emergency department contains minor theatres and the nursing staff working there assist with and perform

minor surgical procedures. The two final categories of working environments investigated in this study were, therefore, the surgical wards and trauma/emergency, and are referred to as such throughout.

3.3 Questionnaire response rate

Of the 617 questionnaires distributed, 177 questionnaires were returned to the researcher by mail, representing an overall response rate of 28.7%. Of the questionnaires returned, 153 (24.8%) contained sufficient response data to warrant inclusion in the subsequent analyses. As Glass et al. (1993) point out, such a low response rate is probably to be expected for institutional surveys which offer anonymity but no incentives.

Staff allocations for all trained nurses in the different departments within the surgical pavilion in the hospital at the time of distribution of the questionnaires are presented in Table 9.

Table 9. Allocation of all trained surgical nursing staff (N=617) at time of study

Department	PN	EN	ENA	Totals
Surgical Wards	103	133	91	327
Operating Theatres	64	25	43	132
Trauma/Emergency	64	43	51	158
Totals	231	201	185	617

Table 10 comprises the frequencies and response rates of suitable questionnaires returned by respondents from all departments within the surgical pavilion.

Table 10. Frequencies of responses and response rates from surgical nursing staff (N=153)

Department	PN	EN	ENA	Totals
Surgical Wards	36 (35%)	33 (25%)	18 (20%)	87 (27%)
Operating Theatres	6 (9%)	2 (8%)	3 (7%)	11 (8%)
Trauma/Emergency	27 (42%)	15 (35%)	13 (26%)	55 (35%)
Totals	69 (30%)	50 (25%)	34 (18%)	153 (25%)

Table 11 presents the final categorization of respondents (by nursing status and department) and the response frequencies and rates from the nurses within these categories. It is evident that the number of participants in each professional nursing category reflects the general trend in the distribution of trained nurses within the surgical pavilion of the hospital and could therefore be considered a representative sample of the population of trained surgical nurses within the hospital.

Table 11. Frequencies and rates of responses from nursing staff from the surgical wards and trauma/emergency (N=153)

Department	PN	EN	ENA	Totals
Surgical Wards	36 (35%)	33 (25%)	18 (20%)	87 (27%)
Trauma/Emergency	33 (26%)	17 (25%)	16 (17%)	66 (23%)
Totals	69 (30%)	50 (25%)	34 (18%)	153 (25%)

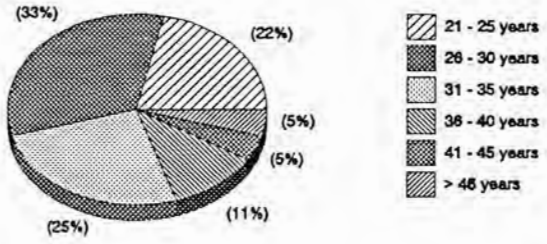
Returned questionnaires excluded from the study were two completely blank questionnaires, two questionnaires completed by nurses not working within the surgical pavilion, one completed by a student nurse, six questionnaires in which nurses had not indicated clearly the ward or department in they were working at the time of the study, a questionnaire in which a nurse had not stipulated her nursing status, and twelve questionnaires containing insufficient data.

3.4 Biographical characteristics

3.4.1 Age

The average age of the participants in the study was 31 years. Ages ranged from 21 years to 61 years. Figure 1 presents the age distribution of the sample.

Figure 1. Age distribution (N=153)



3.4.2 Gender

In this sample of 153 nurses, 140 were female and 10 were male. Three respondents failed to indicate gender on their questionnaires. Table 12 constitutes a representation of the distribution of male and female nurses according to the primary sample categorizations of ward/department and nursing status.

Table 12. Distribution of respondents according to gender, ward/department and nursing status (N=150)

	Surgical Wards			Trauma/Emergency		
Gender	PN	EN	ENA	PN	EN	ENA
Males	2	0	1	0	5	2
Females	34	31	17	33	11	14

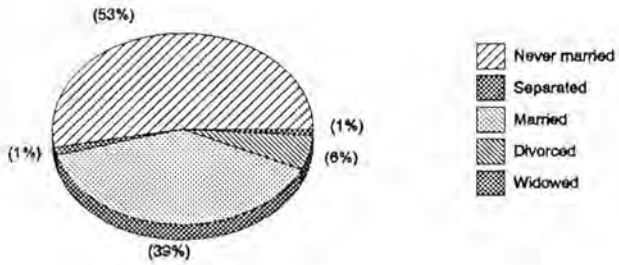
3.4.3 Home language

With regard to home language, 72 participants were Afrikaans-speaking, 53 were English-speaking, while a further 14 nurses indicated that they were both Afrikaans- and English-speaking. A further 11 respondents were Xhosa-speaking and 3 nurses had languages other than Afrikaans, English or Xhosa as their home language.

3.4.4 Marital status

Eighty-one nurses (52.9%) in this sample had never been married, while 59 (38.6%) were married. Nine (5.9%) respondents indicated that they were divorced, 2 (1.3%) that they were separated, and a further 2 (1.3%) nurses had been widowed. Figure 2 presents these statistics graphically.

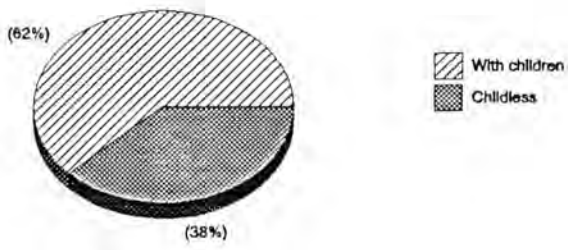
Figure 2. Marital status (N=153)



3.4.5 Children

Ninety-five (62.1%) of the participants indicated that they had children of their own. Fifty-eight (37.9%) nurses were childless. These figures are presented graphically in Figure 3.

Figure 3. Family status (N=153)



3.4.6 Children's ages

Three respondents failed to indicate the ages of their children. Of the respondents who were parents, most nurses (48%) had a child or children below the age of 6 years. Overall, most nurses (76%) had children who were 12 years or younger in age. This is probably to be expected as the mean age of nurses in this sample was a relatively young 31 years of age.

3.4.7 Educational status

One participant (0.7%) failed to give an indication of his or her educational status, but of those who did provide this information, 62 (40.5%) had obtained a qualification as a professional nurse, 49 (32%) were enrolled nurses, 5 (3.3%) were enrolled nursing assistants who had matriculated, and a further 29 (19%) were enrolled nursing assistants with less schooling than matriculation. Seven professional nurses (4.6%) reported having obtained postgraduate qualifications.

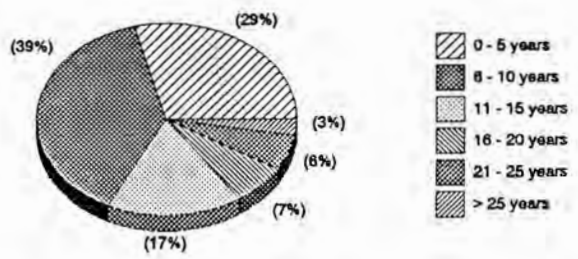
3.4.8 Nursing status

Of the 153 respondents included in this study, 69 (45.1%) were professional nurses, 50 (32.7%) were enrolled nurses, and 34 (22.2%) were enrolled nursing assistants.

3.4.9 Nursing experience

Four participants failed to indicate how long they had been nursing. For the nurses who provided this information, the average extent of nursing experience was 9.6 years, ranging from 1 to 30 years of experience. Figure 4 is a graphic representation of the frequencies of nurses in each category of nursing experience.

Figure 4. Nursing experience (N=139)



3.4.10 Day or night duty

Of the 152 respondents who indicated whether they had been on day or night duty at the time of study, 108 (70.6%) were on day duty and 44 (28.8%) on night duty. Sixty nurses worked day duty and 27 night duty on the surgical wards, and in trauma/emergency 48 nurses were on day duty and 17 on night duty.

3.4.11 Last vacation

With regard to when last respondents had been on vacation, the average length of time which had lapsed since the previous vacation was 19.8 weeks (approximately 5 months). This figure is based on responses from 139 nurses; 14 respondents did not provide this information.

3.4.12 Length of vacation

One hundred and forty-nine nurses provided an indication of the length of their last vacation, the average of which was 39.4 days.

3.4.13 Ward or department

As has already been indicated, 87 respondents were working in the surgical wards of the hospital and 66 were based in the trauma/emergency department.

4. DATA ANALYSIS

4.1 Quantitative data

As has already been mentioned, the primary aim of the study was to investigate burnout as a function of work environment variables and coping strategies employed in this sample of nurses. The ratings obtained on perceived control, support, job satisfaction and appreciation for work done were also included in the analyses.

Maslach's (1982) three-component conceptualization of burnout was adopted for the study and the three burnout components were thus examined and reported separately throughout. As already mentioned, only the frequency dimension of each burnout subscale was included in analyses in the present study.

Maslach and Jackson (1981) conceptualize burnout as a continuous variable, ranging from low to moderate to high levels of experienced feeling, not as a dichotomous variable either absent or present. Following Maslach and Jackson's (1981) categorization of MBI scores, the scores obtained on each subscale in the present study were categorized as being low, moderate or high in burnout according to a tertile split, resulting in roughly equal sized groups. The categorization of MBI frequency scores for this sample of nurses is presented in Table 13.

Table 13. Categorization of MBI frequency scores (N=153)

	Range of Experienced Burnout		
	Low	Moderate	High
MBI Subscale	(lower third)	(middle third)	(upper third)
EE	≤ 20	20.3 - 31	≥ 31.5
DEP	≤ 3	4.0 - 10	≥ 11.0
PA	≥ 38	37.5 - 31	≤ 30.9

Each burnout subscale could thus be seen as a classificatory variable, with a particular individual belonging to only one of the three possible classes (low, moderate or high) of burnout on each. Discriminant analysis techniques were employed in order to identify the independent variables, or predictors, (in this study, a range of work environment and coping variables as well as the ratings obtained) which contributed to making the classification between low, moderate and high levels of emotional exhaustion, depersonalization and personal accomplishment.

4.1.1 Discriminant analysis

Initially, stepwise discriminant analyses were performed in order to determine which of the predictors differentiated between the three classes of burnout on each burnout component. Each stepwise procedure selects the subset of predictors which produces the best discrimination model. The set of variables which makes up each class is assumed to be multivariate normal with a common covariance matrix. With regard to these assumptions, the researcher ascertained, in consultation with university statisticians, that the variables included in the study were satisfactorily distributed, with the exception of one COPE subscale, alcohol/drug disengagement, which was subsequently excluded from all further analyses. Tests of homogeneity of within class covariance matrices confirmed that the within-groups covariance matrices were in fact equal (emotional exhaustion: $X^2_{90}=87.06$, $p=0.57$: depersonalization: $X^2_{42}=37.60$, $p=0.66$; personal accomplishment: $X^2_{72}=74.15$, $p=0.41$).

Another assumption which underlies correlational, regressional statistical techniques is that there must be an absence of high multicollinearity, that is, that the independent variables should not be too highly correlated ($r < 0.80$; Pedhazur, 1982, in Kelly, 1991). In the present study, Pearson's product moment correlations between the independent variables ranged from $r = -0.39$ to $r = 0.57$. Multicollinearity was thus not considered problematic.

Stepwise selection begins with no variables in the model. At each step the model is examined and only one variable can be entered. If the variable in the model that contributes least to the discriminatory power of the model, as measured by Wilks' lambda, fails to meet the criterion to stay, then the variable is removed. Otherwise, the variable not in the model that contributes most to the discriminatory power of the model is entered. When all variables in the model meet the criterion to stay and none of the other variables meets the criterion to enter, the stepwise

selection process stops. In most applications, all variables considered have some discriminatory power, however small. To choose the model that provides the best discrimination using the sample estimates, a moderate significance level in the range of 10% to 25% for variables entering or staying in the model is considered appropriate (Constanza & Afifi, 1979, in SAS Institute Inc., 1989), although Afifi and Clark (1990) add that even a 30% significance level to stay may be appropriate. The default significance level of the statistical program used in this study was 15%, which was considered reasonable and was adhered to throughout this analysis.

Once sets of variables had been identified which had contributed towards making classifications on each burnout subscale, they were entered into discriminant analyses in order to obtain sets of linear combinations (discriminant functions) of the quantitative variables that best revealed the differences among the classes.

The performance of the discriminant functions obtained was evaluated by cross-validation, achieved by randomly splitting the original sample on each MBI subscale into two subsamples and comparing the total percentage correct classifications in each subsample with those obtained in the total sample. Prior probabilities of correct classification were set at 0.33 for each class on each MBI subscale. The final classification tables are presented with the discriminant analysis summary tables in the results section of the dissertation.

4.1.2 Other statistical analyses

Other statistical analyses performed on the data accumulated in this study include frequency analyses, Student's t-tests (two-tailed throughout), Pearson's product moment correlations, calculation of Chronbach's alpha coefficients on scores obtained on the standardised questionnaires included in the research questionnaire, and 1-way ANOVA procedures (using the Scheffe post hoc test to identify any significant differences between groups).

4.1.3 Primary categorization of data

The two primary categorizations by which the data was analyzed were nursing status (professional nurses (PN), enrolled nurse (EN), or enrolled nursing assistant (ENA)), and ward or department (surgical wards and trauma/emergency).

4.1.4 Computerised statistical program utilized in the study

Programs of the Statistical Analysis System (SAS®) computer program were used for all analyses in this study.

4.2 Qualitative data

The qualitative data obtained in the study comprised nurses' responses to the four open-ended questions posed in the research questionnaire. (Verbatim transcripts are provided in Appendix D.) A simple analysis of the content of these responses was performed and reported in the form of frequencies of recurring themes.

During examination of the qualitative material, a number of recurring themes, mostly phrases or sentences, were identified and the data has been analyzed and reported as frequencies of reference to these themes, per question, and per category of nurse. Every viewpoint, suggestion or complaint mentioned more than once was considered a theme. Any responses not consistent with any of the themes, are reported separately in conjunction with the frequency analysis for each open-ended question. Apart from a question-by-question analysis of the responses received from participants, an overall representation of the sentiments expressed by the nurses who participated in this study is provided.

CHAPTER THREE

RESULTS

CHAPTER THREE

RESULTS

The final sample in this study consisted of 153 nurses, some of whom returned partially completed questionnaires. The SAS® statistical program excludes observations which contain missing data. Consequently, sample sizes included in some of the analyses were smaller than 153.

1. RESULTS OF QUANTITATIVE ANALYSES

1.1 Burnout

The mean scores obtained on the three components of burnout in the present study, using the MBI, are presented in Table 14. The nurses included in this study reported significantly higher scores on both emotional exhaustion (EE; $t = 5.1556, p = 0.001$) and depersonalization (DEP; $t = 2.6867, p = 0.01$) than those in Maslach and Jackson's (1986) normative sample, as well as significantly lower scores on personal accomplishment (PA; $t = -4.5292, p = 0.001$). The present average scores on the three burnout subscales are also higher in the case of emotional exhaustion and depersonalization, and lower with respect to a sense of personal accomplishment than those reported in a number of recent burnout studies with nurses as subjects. For example, Dolan (1987), Leiter and Maslach (1988), Ceslowitz (1989), Robinson et al. (1991), and Glass et al. (1993) report mean scores of 15.21, 21.63, 20.40, 22.66, and 20.00, respectively, with regard to emotional exhaustion. The same authors report average scores of 7.62, 7.52, 6.37, 6.56, and 5.71, respectively, on the depersonalization subscale. Mean scores of 36.14, 41.32, 35.30, 35.99, and 37.00, respectively, were obtained by the same authors on the personal accomplishment subscale of the MBI.

Table 14. Comparison of present MBI subscale scores with normative data

Sample	EE	DEP	PA
Present (N=153)			
M	26.58	8.39	33.62
SD	12.06	7.08	8.19
Maslach & Jackson (1986) (N=1104)[a]			
M	22.19	7.12	36.53
SD	9.53	5.22	7.34

Note. [a]Sample included nurses (Maslach & Jackson, 1986).

Estimates of internal consistency (Chronbach's alpha), which were moderate to high, and intercorrelations between the MBI subscales are presented in Table 15.

Table 15. MBI Subscale intercorrelations and Chronbach's alpha coefficients (N=153)

Subscales	1	2	3	Alpha
1. EE		0.57···	-0.01	0.88
2. DEP			0.02	0.77
3. PA				0.68

Note. ···$p < 0.001$

The three MBI subscales were related to each other in a manner largely consistent with Maslach and Jackson's (1981) theory of burnout, apart from personal accomplishment, which was unrelated to emotional exhaustion and depersonalization.

1.1.1 Burnout and demographic factors

With regard to the relationship between age and burnout, no correlation was found between age and emotional exhaustion and age and personal accomplishment in this study. A relatively weak, yet significant, negative correlation (r = -0.18, p = 0.02) was found between age and depersonalization, however. Subsequent 1-way ANOVA analyses revealed no significant differences between any of the age groups on the three burnout subscales.

Student's t-test analyses on gender revealed that male and female nurses differed significantly on the emotional exhaustion subscale (t = 3.93, p < 0.01), with males reporting much lower levels of emotional exhaustion (M = 15.20) than females (M = 27.59). Male and female respondents' mean scores on depersonalization and personal accomplishment were not significantly different. Due to the large difference in numbers of male and female nurses in this sample (10 males and 140 females among those who indicated their gender), and the fact that the nurses differed only on one of the burnout subscales, gender was not included as a further classification in subsequent analyses.

On all three components of burnout, there were no significant differences between respondents with respect to home language.

Marital status also did not appear to have any significant association with burnout in this sample of nurses.

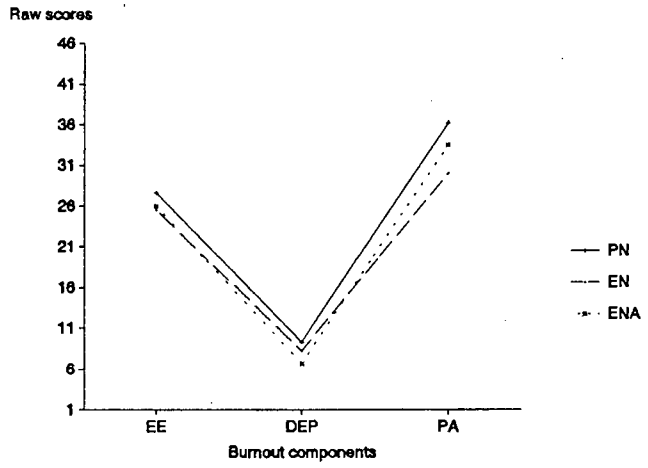
With regard to whether or not respondents had children of their own, there was a significant difference on the personal accomplishment subscale between those with children and those who were childless (t = 2.86, p < 0.01), those with children obtaining lower mean scores (M = 32.25) than those who were childless (M = 35.86). No significant differences were found on either the emotional exhaustion or depersonalization subscales.

One-way ANOVA analyses of burnout scores in relation to the age groups to which respondents' children belonged did not indicate any significant association between burnout and the ages of their children.

As regards educational status, there were no significant differences between the different status groups on the emotional exhaustion and depersonalization burnout subscales. In the case of personal accomplishment, however, ANOVA analysis revealed significant differences between nurses with a highest educational status of matriculation (mostly ENAs) ($M = 43.22$) and trained ENs ($M = 29.89$), as well as between ENs ($M = 29.89$) and PNs ($M = 36.19$) ($F_{4,144} = 7.39$, $p < 0.0001$).

Regarding nursing status, ANOVA analysis revealed a significant difference between ENs ($M = 30.01$) and PNs ($M = 36.28$) on personal accomplishment ($F_{2,147} = 9.27, p < 0.0002$). No noteworthy differences were found between the different categories of nurses on the other two burnout subscales, as can be seen in Figure 5.

Figure 5. Mean burnout scores by nursing status (N=153)



No notable association between years of nursing experience and burnout was found in this sample of nurses.

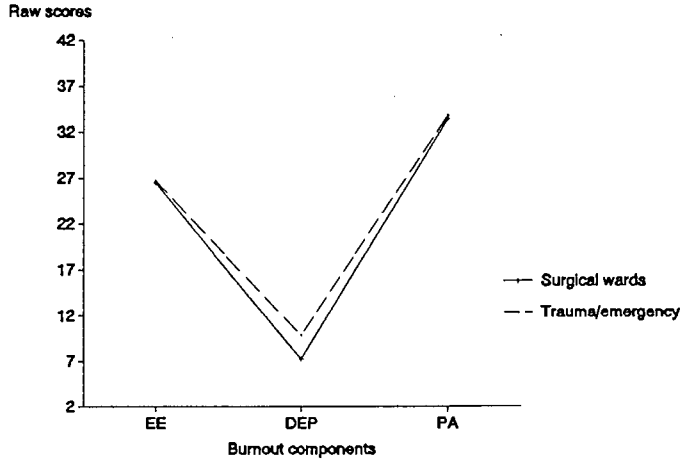
Whether nurses worked on day duty or night duty did not appear to make any difference to burnout scores in this sample of nurses.

Time since last vacation also proved to have no significant association with emotional exhaustion, depersonalization, or personal accomplishment.

With regard to length of vacation, the only significant correlation found was a moderate negative relationship with personal accomplishment (r = -0.22, p < 0.01).

With respect to whether nursing speciality made any difference to their experience of burnout, nurses working in trauma/emergency reported significantly higher levels of depersonalization (M = 9.90) than those who worked in the surgical wards (M = 7.23) (t = -2.24, p = 0.03). Respondents from the different departments did not differ significantly in their scores on the other two burnout subscales, as is evident from Figure 6.

Figure 6. Mean burnout scores by nursing speciality



1.2 Work environment

Table 16 contains normative data, descriptive statistics, and estimates of internal consistency (Chronbach's alpha) obtained on the WES subscales in this study.

Table 16. WES normative data, descriptive statistics and Chronbach's alpha coefficients

Subscales	Health workers (N=1607)[a]		Present Sample (N=153)		Alpha
	M	SD	M	SD	
Involvement	5.56	1.54	5.29	2.00	0.63
Peer Cohesion	5.22	1.40	4.19	1.85	0.46
Supervisor Support	4.99	1.40	3.00	2.27	0.70
Autonomy	4.98	1.46	4.56	1.84	0.47
Task Orientation	5.63	1.31	6.18	1.68	0.49
Work Pressure	4.87	1.57	6.43	2.04	0.69
Clarity	4.44	1.41	4.15	1.73	0.45
Control	5.43	1.42	6.94	1.61	0.48
Innovation	4.37	1.82	3.84	2.06	0.60
Physical Comfort	3.72	1.28	4.34	2.11	0.65

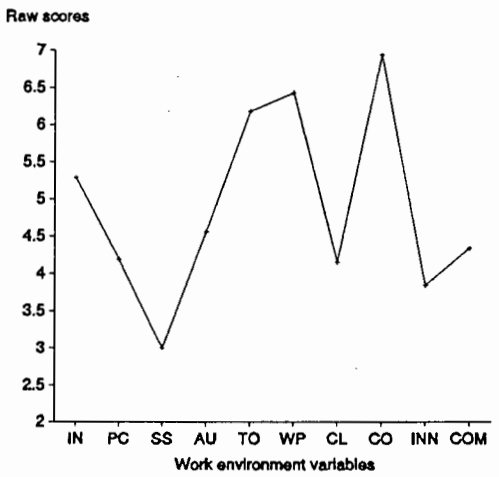
Note. [a]Normative data for health-care work group (Moos, 1986).

The discrepancies between Moos's (1986) normative mean scores on each of the WES subscales and those obtained in this study are, with the exception of involvement and clarity (which are significant at $p = 0.05$), all significant at $p = 0.001$.

The estimates of internal consistency obtained in this study were generally modest, ranging from 0.45 for clarity to 0.70 for supervisor support, as can be seen in Table 16.

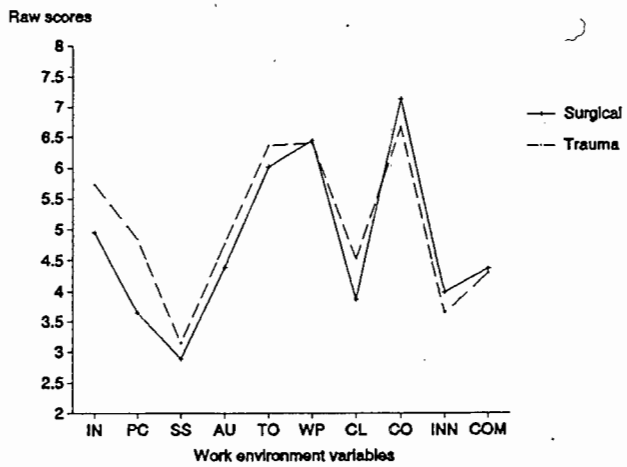
Bearing in mind that the mean score on each WES subscale is 4.50, it is evident from Table 16 that, overall, this sample of nurses reported above average levels of control (CO), work pressure (WP), task orientation (TO), and involvement (IN) in their working environment. Below average scores were obtained on the autonomy (AU), physical comfort (COM), peer cohesion (PC), and clarity (CL) subscales, with particularly low average scores on innovation (INN) and supervisor support (SS), as is evident from Figure 7.

Figure 7. Perceptions of work climate (N=153)



One-way ANOVA analyses identified no significant differences between the different categories of nurses with respect to their scores on the WES. Similar ANOVA analyses, performed in order to ascertain whether nurses in the different departments within the hospital experienced their working environments differently in any way, revealed that nurses working in trauma/emergency scored significantly higher on involvement (IN; $M = 5.73$) than those working in the surgical wards ($M = 4.95$) ($F_{3,139} = 5.44$, $p < 0.05$). Nurses working in the trauma/emergency department also obtained significantly higher scores for peer cohesion (PC; $M = 4.84$) than those who worked in the surgical wards ($M = 3.65$) ($F_{3,136} = 15.14$, $p < 0.001$). Significant differences ($F_{3,137} = 4.96$, $p < 0.05$) were also found on the clarity subscale (CL), with trauma/emergency nurses reporting higher average scores ($M = 4.53$) than their colleagues on the surgical wards ($M = 3.88$). These differences in perceptions of work climate are evident in Figure 8.

Figure 8. Perceptions of work climate by nursing speciality (N=153)



1.2.1 Work environment and burnout

Regarding correlations between the WES and MBI subscales in this study in general, Table 17 reveals that, with the exception of control, all WES variables were significantly correlated with emotional exhaustion, particularly work pressure ($r = 0.48, p < 0.001$). The physical comfort, supervisor support, innovation, involvement, task orientation, autonomy, peer cohesion, and clarity subscales showed modest negative correlations with emotional exhaustion (r = -0.22 to r = -0.46). Physical comfort, innovation, and supervisor support were also moderately negatively correlated with depersonalization (r = -0.21 to -0.38). No notable associations were found between personal accomplishment and any of the work environment variables. Overall, it appears that the work environment variables included in this study had the strongest links with emotional exhaustion for this sample of nurses, and that supervisor support, innovation, and physical comfort were also significantly associated with depersonalization.

Table 17. Correlations between WES and MBI scores (N=153)

WES Subscales	EE	DEP	PA
Involvement	-0.32•••	-0.16	0.01
Peer Cohesion	-0.26•	-0.13	0.03
Supervisor Support	-0.39•••	-0.21•	0.11
Autonomy	-0.23••	-0.09	0.00
Task Orientation	-0.22••	-0.07	0.04
Work Pressure	0.48•••	0.13	0.04
Clarity	-0.30•••	-0.08	0.09
Control	0.06	0.06	0.02
Innovation	-0.36•••	-0.30•••	0.07
Physical Comfort	-0.46•••	-0.38•••	0.06

Note. •p < 0.05; ••p < 0.01; •••p < 0.001

1.3 Coping

Table 18 contains normative data, descriptive statistics, and estimates of internal consistency (Chronbach's alpha coefficients) obtained on the COPE subscales in this study.

Table 18. COPE normative data, descriptive statistics and Chronbach's alpha coefficients (N=153)

Subscales	Normative Data (N=1030)[a]		Present Sample (N=153)		Alpha
	M	SD	M	SD	
Active Coping	11.89	2.26	11.80	2.24	0.53
Planning	12.58	2.66	12.86	2.18	0.63
Suppression	9.92	2.42	10.44	2.19	0.41
Restraint Coping	10.28	2.53	11.39	2.32	0.52
Social Support-Instrumental	11.50	2.88	11.58	2.56	0.63
Social Support-Emotional	11.01	3.46	11.61	2.66	0.71
Reinterpretation	12.40	2.42	13.37	1.92	0.60
Acceptance	11.84	2.56	12.14	2.32	0.48
Turning to Religion	8.82	4.10	12.81	3.30	0.89
Focus/Venting Emotions	10.17	3.08	10.96	2.89	0.72
Denial	6.07	2.37	8.01	3.10	0.76
Behav. Disengagement	6.11	2.07	8.92	2.45	0.54
Mental Disengagement	9.66	2.46	10.58	2.49	0.45
Alcohol/Drug Disengagement	1.38	0.75	1.14	0.49	

Note. [a]Normative data for dispositional COPE scale (Carver, Scheier & Weintraub, 1989).

Regarding differences between the COPE normative data and mean scores obtained on each subscale in the present sample, average scores on active coping, planning, seeking instrumental social support, and acceptance did not differ significantly. Scores on suppression of competing activities and seeking emotional social support were significantly higher at $p = 0.05$, while scores on focus on and venting of emotions were significantly higher at $p = 0.01$. At $p = 0.001$, restraint coping, positive reinterpretation, turning to religion, denial, behavioural disengagement, and mental disengagement were used more frequently by the present sample of nurses than participants in the normative sample, while alcohol/drug disengagement was used significantly less frequently.

The estimates of internal consistency obtained in this study were generally moderate to high, ranging from 0.41 for suppression of competing activities to 0.89 for turning to religion, as can be seen in Table 18.

From Table 18 it is also evident that respondents in this study made use of all the different coping strategies included in the inventory, most frequently positive reinterpretation, planning, turning to religion, and acceptance. Relatively frequent use was also made of coping strategies such as active coping, seeking emotional social support, seeking instrumental social support, restraint coping, focus on and venting of emotions, mental disengagement, and suppression of competing activities. Whilst employed less frequently, denial and behavioural disengagement appear to have featured more strongly in this sample of nurses than in the normative sample. Alcohol/drug disengagement did not appear to have featured strongly in this sample.

With respect to the existing problem- versus emotion-focused coping findings, respondents in this sample appear to have made equally frequent use of both general kinds of coping. Coping strategies considered to be less useful (focus on and venting of emotions, behavioural disengagement, and mental disengagement) appear to have been employed less frequently than the other strategies at face value.

ANOVA analysis of COPE scores by nursing status identified significant differences between the categories of nurses on three of the COPE subscales. In the case of turning to religion, ENAs scored higher ($M = 13.92$) than PNs ($M = 12.11$) ($F_{2,152} = 3.66, p = 0.028$). Both ENs ($M = 9.17$) and ENAs ($M = 9.21$) reported making more frequent use of denial as a coping mechanism than PNs ($M = 6.58$) ($F_{2,150} = 16.07, p = 0.0001$). Similarly, ENs ($M = 9.56$) and ENAs ($M = 9.63$) scored significantly higher on the behavioural disengagement subscale than PNs ($M = 8.11$) ($F_{2,150} = 7.47, p = 0.0008$).

ANOVA analyses conducted to ascertain whether nurses working in the two different departments coped differently, revealed no significant differences in the mean frequencies with which surgical ward and trauma/emergency nurses made use of the range of coping techniques examined.

1.3.1 Coping and burnout

Regarding correlations between the COPE and MBI subscales in this study in general, Table 19 reveals a relatively small, yet significant, negative correlation between planning and emotional exhaustion (r = -0.17, p = 0.05), and relatively moderate positive correlations between emotional exhaustion and denial, behavioural disengagement, and mental disengagement (r = 0.19 to r = 0.27). Denial and behavioural disengagement were also moderately positively related to depersonalization (r = 0.19 to r = 0.20). Significant moderate positive correlations were found between personal accomplishment and planning, seeking both instrumental and emotional social support, and positive reinterpretation (r = 0.25 to r = 0.29). Denial was relatively strongly negatively correlated with personal accomplishment (r = -0.37, p = 0.001), and there was also a small negative correlation between behavioural disengagement and personal accomplishment (r = -0.18, p = 0.05). In general, coping strategies such as planning, denial, and behavioural disengagement exhibit a rather consistent pattern of associations with the three components of burnout.

Table 19. Correlations between COPE and MBI scores (N=153)

COPE Subscales	EE	DEP	PA
Active Coping	-0.06	-0.11	0.12
Planning	-0.17·	-0.13	0.29···
Suppression	0.06	0.04	0.01
Restraint Coping	-0.01	-0.04	0.08
Social Support - Instrumental	-0.07	-0.07	0.25··
Social Support - Emotional	0.01	0.00	0.22··
Positive Reinterpretation	-0.12	-0.08	0.28···
Acceptance	-0.05	0.04	0.12
Turning to Religion	-0.03	-0.06	-0.01
Focusing/Venting of Emotions	0.14	0.11	-0.03
Denial	0.19·	0.19·	-0.37···
Behavioural Disengagement	0.22··	0.20·	-0.18·
Mental Disengagement	0.27···	0.13	0.00

Note. ·p < 0.05; ··p < 0.01; ···p < 0.001

1.4 Control, support, job satisfaction, and appreciation

Average scores obtained by respondents on the variables evaluated by means of rating scales in the study are presented in Table 20.

Table 20. Descriptive statistics - control, support, job satisfaction, and appreciation (N=153)

Rating Scale	M[a]	SD
Control at Work	6.15	2.39
Control in General	7.57	2.10
Job Satisfaction	6.32	2.11
Support from Nursing Colleagues	5.26	2.57
Support from Friends and Family	6.53	2.42
Appreciation for Work Done	4.87	2.78

Note. [a]Range of possible values on each scale is 0-10.

With regard to control, although perceiving themselves to have above average levels of control, the nurses perceived themselves to have significantly less control in their work than in their lives in general (t = -5.52, p = 0.001). ANOVA analysis of control at work in terms of nursing status reveals a significant difference ($F_{2,146}$ = 4.23, $p < 0.05$) between PNs (M = 6.78) and ENs (M = 5.67), PNs considering themselves (as is realistic) to have more control than ENs in their work. A similar analysis of control in general revealed no significant differences between the different categories of nurses on this variable. ANOVA analyses, performed in order to ascertain whether nurses working in the surgical wards differed significantly from their colleagues in trauma/emergency with respect to control at work and in general, revealed no noteworthy differences.

With regard to job satisfaction, the nurses in this study reported an above-average level of satisfaction (M = 6.32) and ANOVA analysis confirmed that there were no significant differences between the three categories of nurses on this variable. There was also no significant difference in job satisfaction between nurses working in trauma/emergency and those working in the surgical wards.

In the case of support, respondents reported experiencing significantly less support from their nursing colleagues than from friends and family (t = -4.4483, p = 0.001). ANOVA analyses revealed that surgical ward nurses (M = 4.76) felt significantly less supported by their nursing colleagues than did those in trauma/emergency (M = 5.77) ($F_{1,150}$ = 4.68, p > 0.03). There were no significant differences between the different categories of nurses on either of the two support variables.

With regard to a sense of appreciation for their work, Table 20 shows that respondents generally felt that the level of appreciation for their work was below average (M = 4.87). Analysis of average scores according to category of nurse showed that PNs felt significantly less appreciated (M = 4.37; t = -2.9786, p = 0.01), than ENs (M = 5.26), who obtained only slightly higher than average scores on this variable.

A relatively strong significant correlation between job satisfaction and appreciation for work was also found (r = 0.48, p = 0.0001).

1.4.1 Control, support, job satisfaction, appreciation and burnout

Regarding the associations between the rating scores and MBI subscales in general, it is evident from Table 21 that job satisfaction and perceived appreciation for work had modest significant negative correlations with both emotional exhaustion and depersonalization (cor*relations ranging from* r = -0.30 to r = -0.48). Control, both at work and in general, and support from nurses also showed smaller, yet significant, negative associations with emotional exhaustion (correlations ranging from r = -0.22 to r = -0.23). General control was also significantly correlated with personal accomplishment, although this association was relatively small (r = 0.16, p = 0.05).

Table 21. Correlations between ratings and MBI scores (N=153)

Rating Scale	EE	DEP	PA
Control at Work	-0.23••	-0.13	0.01
Control in General	-0.22•	-0.13	0.16•
Job Satisfaction	-0.48•••	-0.30•••	0.00
Support from Nurses	-0.22••	-0.09	0.03
Support from Family/Friends	-0.15	-0.02	0.15
Appreciation for Work	-0.34•••	-0.35•••	-0.07

Note. •$p < 0.05$; ••$p < 0.01$; •••$p < 0.001$

1.5 Discriminant analyses on emotional exhaustion, depersonalization and personal accomplishment

1.5.1 Stepwise discriminant analyses

1.5.1.1 Emotional exhaustion

Stepwise discriminant analyses with WES, COPE and rating scores identified sets of variables which were experienced differently by the three groups of nurses: those categorised as having low, moderate, or high levels of emotional exhaustion. Table 22 summarises these results, the relative importance of the predictors indicated by the partial R^2 obtained for each.

Table 22. Summary of stepwise discriminant analysis results and relevant group means for group division: emotional exhaustion

Variable	Low B/O Mean	Mod B/O Mean	High B/O Mean	Partial R^2	F	Prob > F	Wilks' Lambda	Prob < Lambda
Work Environment Set (N=101)								
Work Pressure	5.03	6.90	7.29	0.24	15.80	0.00	0.76	0.00
Physical Comfort	5.62	3.97	3.46	0.12	6.39	0.00	0.67	0.00
Peer Cohesion	4.51	4.90	3.74	0.06	2.92	0.06	0.63	0.00
Coping Strategies Set (N=151)								
Mental Disengagement	9.71	10.96	11.14	0.07	5.28	0.01	0.93	0.01
Behavioural Disengagement	8.61	8.50	9.66	0.04	2.79	0.07	0.90	0.00
Focus/Venting Emotions	10.15	11.12	11.72	0.03	2.39	0.10	0.87	0.00
Planning	13.23	12.74	12.57	0.05	3.97	0.02	0.83	0.00
Ratings Set (N=143)								
Job Satisfaction	7.21	6.68	5.13	0.18	15.18	0.00	0.83	0.00
Appreciation for Work	5.54	5.51	3.60	0.03	2.10	0.13	0.80	0.00

Note. Significance level for variables to enter and stay in the equation in this study: $p < 0.15$. B/O - abbreviation for burnout.

1.5.1.2 Depersonalization

Stepwise discriminant analyses with WES, COPE and rating scores identified sets of predictors which differentiated between respondents experiencing low, moderate, or high levels of depersonalization. Table 23 represents a summary of these results.

Table 23. Summary of stepwise discriminant analysis results and relevant group means for group division: depersonalization

Variable	Low B/O Mean	Mod B/O Mean	High B/O Mean	Partial R^2	F	Prob > F	Wilks' Lambda	Prob < Lambda
Work Environment Set (N=100)								
Physical Comfort	5.38	4.39	3.57	0.13	7.31	0.00	0.87	0.00
Supervisor Support	3.91	2.32	3.09	0.06	3.12	0.05	0.82	0.00
Coping Strategies Set (N=150)								
Behavioural Disengagement	8.22	9.04	9.56	0.05	3.80	0.03	0.95	0.03
Planning	13.28	13.03	12.22	0.04	2.63	0.08	0.92	0.01
Ratings Set (N=142)								
Appreciation for Work	6.46	4.49	3.82	0.16	12.96	0.00	0.84	0.00
Job Satisfaction	7.27	6.27	5.51	0.04	2.60	0.08	0.81	0.00

Note. Significance level for variables to enter and stay in the equation in this study: $p < 0.15$. B/O - abbreviation for B/O.

1.5.1.3 Personal accomplishment

Stepwise discriminant analyses with WES, COPE and rating scores, likewise, identified sets of variables which were experienced differently by nurses from each classification group: those with low, moderate, or high levels of personal accomplishment. Table 24 summarises these results.

Table 24. Summary of stepwise discriminant analysis results and relevant group means for group division: personal accomplishment

Variable	Low B/O Mean	Mod B/O Mean	High B/0 Mean	Partial R^2	F	Prob > F	Wilks' Lambda	Prob < Lambda
Work Environment Set (N=100)								
Autonomy	4.93	4.06	4.92	0.05	2.38	0.10	0.95	0.10
Supervisor Support	3.61	2.94	2.64	0.05	2.48	0.09	0.91	0.05
Coping Strategies Set (N=150)								
Denial	6.90	7.57	9.63	0.14	11.66	0.00	0.86	0.00
Positive Reinterpretation	13.98	13.13	12.90	0.06	4.95	0.01	0.81	0.00
Emotional Social Support	12.11	11.90	10.73	0.04	3.16	0.05	0.77	0.00
Acceptance	12.72	11.44	12.24	0.04	2.86	0.06	0.74	0.00
Ratings Set (N=150)								
Appreciation for Work	4.94	4.11	5.59	0.05	3.32	0.04	0.95	0.04
Support from Family/Friends	6.86	6.68	6.18	0.03	2.09	0.13	0.93	0.03

Note. Significance level for variables to enter and stay in the equation in this study: $p < 0.15$. B/O - abbreviation for burnout.

1.5.2 Discriminant analyses

The sets of predictors which were identified in the stepwise procedures were entered into separate discriminant analyses, one for each burnout component. Summaries of these results are now presented. The relative importance of each predictor is shown by the R^2 obtained for each.

1.5.2.1 Emotional exhaustion

Table 25. Summary of discriminant analysis results and relevant group means for group division: emotional exhaustion (N=122)

Variable	Low B/O Mean	Low B/O Var	Mod B/O Mean	Mod B/O Var	High B/O Mean	High B/O Var	R^2	F	Prob > F
Work Pressure	4.89	4.15	6.86	3.38	7.29	2.31	0.26	21.30	0.00
Physical Comfort	5.57	3.69	3.97	3.97	3.43	2.84	0.20	15.24	0.00
Peer Cohesion	4.36	3.31	4.94	2.74	3.48	2.99	0.11	7.10	0.00
Mental Disengagement	9.70	5.31	11.01	4.61	11.06	8.08	0.07	4.10	0.02
Behavioural Disengagemnt	8.31	6.48	8.39	5.10	9.73	6.67	0.07	4.29	0.02
Focus/Venting Emotions	10.05	7.95	11.53	7.11	11.84	7.47	0.08	5.21	0.01
Planning	13.16	3.95	12.63	3.86	12.60	5.81	0.02	0.93	0.40
Job Satisfaction	6.94	4.27	6.71	3.26	5.08	5.07	0.15	10.10	0.00
Appreciation for Work	5.38	8.32	5.68	5.85	3.62	7.64	0.10	6.84	0.00

Note. B/O - abbreviation for burnout.

Although, as is evident from Table 25, respondents' mean scores in each of the three burnout groups on the coping variable, planning, were not significantly different in this discriminant analysis ($F = 0.93$, $p = 0.40$), the variable was not removed from this analysis because of it having been entered and retained in the stepwise discriminant procedure.

Table 26 provides an indication of the measure of success with which respondents were classified as belonging to one of the three burnout groups. The battery of predictors correctly classified 67% of the sample.

Table 26. Classification of respondents as low, moderate or high in burnout: emotional exhaustion (N=122)

	Classified As			
Actual Status	Low	Mod	High	% Correct
Low EE (N=44)	31	6	7	70.45
Moderate EE (N=36)	4	23	9	63.89
High EE (N=42)	4	10	28	66.67
Total N=122	39	39	44	67.00

The obtained measure of goodness of the classification procedure for emotional exhaustion was cross-validated through the process of randomly splitting the study sample into two subsamples, which revealed that the total percentage correct classifications were similar to the moderately high 67% reported in Table 26 (cross-validation subsample 1 = 65%; subsample 2 = 69%). It is evident from Table 26 that the classification of respondents into the moderate group was less accurate than for the other two groups.

1.5.2.2 Depersonalization

Table 27. Summary of discriminant analysis results and relevant group means for group division: depersonalization (N=121)

Variable	Low B/O Mean	Low B/O Var	Mod B/O Mean	Mod B/O Var	High B/O Mean	High B/O Var	R^2	F	Prob > F
Physical Comfort	5.36	3.71	4.61	3.94	3.41	4.00	0.14	9.93	0.00
Supervisor Support	3.72	6.42	2.68	3.72	2.85	5.68	0.04	2.33	0.10
Behavioural Disengagemnt	7.90	6.07	9.23	4.86	9.61	7.19	0.08	5.32	0.01
Planning	13.38	2.66	13.09	4.11	12.31	5.72	0.05	2.92	0.06
Appreciation for Work	6.37	6.76	4.43	10.07	4.16	5.86	0.13	7.64	0.00
Job Satisfaction	7.05	4.38	6.22	5.45	5.61	4.22	0.08	4.45	0.01

Note. B/O - abbreviation for burnout.

The battery of predictors correctly classified 59.24% of the sample. With regard to the measure of goodness of the classification procedure for depersonalization, cross-validation after random splitting of the sample into two subsamples revealed that the total percentage correct classifications were similar, albeit slightly higher, than the moderate 53% reported in Table 28 (cross-validation subsample 1 = 55%; subsample 2 = 58%). Again, classification of respondents into the moderate group was less accurate than for the other two groups.

Table 28. Classification of respondents as low, moderate or high in burnout: depersonalization (N=121)

Actual Status	Classified As Low	Mod	High	% Correct
Low DEP (N=39)	25	10	4	64.10
Moderate DEP (N=41)	12	16	13	39.02
High DEP (N=41)	7	11	23	56.10
Total N=121	44	37	40	53.07

1.5.2.3 Personal accomplishment

Table 29. Summary of discriminant analysis results and relevant group means for group division: personal accomplishment (N=132)

Variable	Low B/O Mean	Low B/O Var	Mod B/O Mean	Mod B/O Var	High B/O Mean	High B/O Var	R^2	F	Prob > F
Autonomy	4.92	2.89	4.04	3.09	5.00	3.74	0.06	3.85	0.02
Supervisor Support	3.33	7.08	2.80	4.03	2.85	4.45	0.01	0.76	0.47
Denial	6.80	8.13	7.42	7.94	9.74	10.04	0.15	11.61	0.00
Positive Reinterpretation	14.08	2.25	13.13	3.03	13.00	5.11	0.07	4.72	0.01
Emotional Social Support	12.10	7.07	11.95	7.00	10.79	6.68	0.05	3.07	0.05
Acceptance	12.77	5.46	11.58	4.20	12.11	6.47	0.05	3.12	0.05
Appreciation for Work	4.96	8.74	4.17	7.03	5.65	7.66	0.05	2.97	0.06
Support from Fam/Friends	6.94	7.59	6.36	6.26	6.08	5.10	0.02	1.33	0.27

Note. B/O - abbreviation for burnout.

With regard to personal accomplishment, the mean scores on four of the variables (autonomy, supervisor support, acceptance, and appreciation) are less readily interpretable. In the case of autonomy, mean scores for both the low and the high burnout groups differed significantly from the lower score of the moderate burnout group. In this sample, respondents from the low and high burnout groups appeared to have been experiencing similar levels of autonomy (internal consistency coefficient: $r = 0.47$). Lower levels of supervisor support were generally associated with higher levels of burnout (mean scores of the groups not significant different), and interestingly, a higher score on supervisor support appears to have been associated with higher burnout. The general trend with acceptance (internal consistency coefficient: $r = 0.48$) appears to have been that lower levels of burnout were associated with more frequent use of this coping strategy. As regards appreciation, contrary to expectation, the higher score appears to have been associated higher levels of burnout. These findings should perhaps be interpreted in the light of the moderate internal consistency coefficient obtained for scores on this MBI subscale ($r = 0.68$) and the fact that cross-validation of the goodness of the classification procedure on personal accomplishment revealed a rather large discrepancy between the overall percentage correct classifications obtained in the two cross-validation subsamples, suggesting a questionable reliability of responses on this subscale.

The battery of predictors correctly classified 59.24% of the sample. With respect to the measure of goodness of the classification procedure for personal accomplishment, cross-validation after random splitting of the sample into two subsamples revealed that only the total percentage correct classification for subsample 2 was similar to the 59% reported in Table 30 (63%), while the total percentage correct classifications for subsample 1 was a notably high 85%. Again, classification of subjects into the moderate group was less accurate than for the low and high groups (see Table 30).

Table 30. Classification of respondents as low, moderate or high in burnout: personal accomplishment (N=132)

	Classified As			
Actual Status	Low	Mod	High	% Correct
Low PA (N=48)	30	13	5	62.50
Moderate PA (N=45)	10	23	12	51.11
High PA (N=39)	7	7	25	64.10
Total N=132	47	43	42	59.24

1.6 Summary of discriminant analysis results

In summary, those nurses classified as being low in burnout on all three burnout subscales obtained higher scores on the physical comfort, peer cohesion, supervisor support, and autonomy work environment subscales. More frequent use of the coping strategies planning, positive reinterpretation, acceptance, and seeking emotional social support, also appeared to be associated with low levels of burnout in this sample. Higher levels of job satisfaction, appreciation, and support from family and friends were also related to lower burnout.

Moderate to high levels of burnout appear to have been associated with elevated scores on the work pressure subscale of the WES, and with more frequent use of palliative coping strategies such as mental disengagement, behavioural disengagement, focusing on and venting of emotions, and one of the emotion-focused strategies, denial.

2. RESULTS OF QUALITATIVE ANALYSIS

As mentioned previously, the qualitative data obtained in the study has been analyzed, and is herewith reported, in terms of the number of references to themes identified in respondents' written responses to the open-ended questions posed in the research questionnaire.

2.1 Themes identified in respondents' qualitative responses

The themes according to which the data have been analyzed are listed, defined, and presented in Table 31.

Table 31. Themes identified in nurses' responses to the open-ended questions posed in the research questionnaire

Theme	Definition
Abuse	Reports of physical and verbal abuse from patients, their escorts, and relatives.
Allowances	Requests for compensation for ICU nursing, for nursing over weekends and on public holidays, and for "danger pay".
Appreciation (lack of)	Reports of lack of appreciation from supervisors and patients.
Autonomy (lack of)	Frustration at being excluded from decision-making with regard to, for example, patient care, sorting and attending to minor ailments, ward management, stock and equipment control and staff placements.
Career Development	Need for and willingness to obtain further education and training.
Cohesion (lack of)	Reports of lack of team spirit and peer support.
Control	Experience of being kept under control by management through rules and pressures.
Devaluation	Reports of being considered inferior, incompetent, dispensable, and generally not being respected by supervisors and patients.
Equipment/Stock	Reference to shortage and abuse of stock and equipment.
Frustration	Experienced frustration, insecurity, despair, thoughts of leaving the profession.
Night Duty	Reports that night duty is stressful.
Non-nursing Tasks	Frustration at having to perform a variety of non-nursing work tasks due to, for example, general staff shortages and incompetence, and strike action.
Nursing Management	Disillusionment with nursing management and suggestions that seniors become more familiar with nursing conditions by visiting the wards and units.
Opinions/Suggestions	Desire for the opportunity of voicing opinions and making suggestions without fear of criticism and devaluation.
Organizational Issues	Need for organizational changes in the hospital and frustration with bureaucracy.
Patient Care	Concern about the quality of nursing care being provided and desire to enhance it.
Personal Development	Need for personal growth and development in, for example, assertiveness, and effective democratic leadership qualities.
Poor Communication	Need for improved communication and enhanced rapport between nurses, management, and patients.
Problems with Doctors	Dissatisfaction with perceived lack of respect and appreciation from doctors and tendency for doctors to use nurses as servants.
Problems with Nurses	Concern about perceived lack of respect, depersonalisation, absenteeism, and lack of both commitment and cooperation amongst nurses.
Lack of Recognition	Desire for recognition and respect for training, ability, and work well done.
Reward	Reward and enjoyment experienced in nursing duties and abilities, and patient contact and recovery.
Safety (lack of)	Lack of safety in working environment.
Salaries	Dissatisfaction with inadequate salaries and salary increments.
Shifts/Rotations	Requests for inclusion in decision-making regarding duties, off duties, night duty, rotations, and a general call for shorter shifts.
Staff Shortage	Need for more nurses in order to relieve work pressure and provide quality nursing care.
Strike Action	Frustration at disruption, extra work pressure, and abuse of equipment as a result of strike action.
Supervisor Pressure	General pressure from supervisors.
Supervisor Support (lack)	Reports of lack of and need for support from supervisors.
Task Performance	Having to perform tasks not trained for and insecurity about ability.
Uniforms	Calls for more practical regulations regarding uniforms, particularly permission to wear sandals without pantihose in summer.
Vacation/Sick leave	Frustration at having to "beg" for and justify vacation and sick leave applications.
Visiting Hours	Need for better regulation of visitors and visiting hours.
Ward Administration	Frustration with report-writing and statements for trivial problems.
Work Pressure	Work pressure and time urgency due to staff shortages and increasing patient load.

2.2 Qualitative data response rates

Of the 153 participants in the study, 135 nurses provided qualitative data. Response details are provided in Table 32.

Table 32. Frequencies and percentages of the number of responses per open-ended question (N=135)

Question No.	PN (N=58)	EN (N=46)	ENA (N=31)	Total
1	32 (55%)	28 (61%)	17 (55%)	77
2	53 (91%)	37 (80%)	28 (90%)	118
3	55 (95%)	44 (96%)	29 (94%)	128
4	51 (88%)	34 (74%)	22 (71%)	107

2.3 Detailed analysis of response content

2.3.1 Analysis of responses to the first open-ended question

As is evident in Table 32, the response rate for question one was relatively low, with ENs providing more data than either PNs or ENAs. Six PNs, five ENs and five ENAs indicated that there were no job areas in which they wished to have more control, while one EN considered the question "not applicable" and one ENA responded: "nil comment".

Table 33. Frequencies of reference to themes identified in responses to the first open-ended question (N=77)

Theme	PN (N=32)	EN (N=28)	ENA (N=17)	Total (N=77)
Autonomy (lack of)	12	3	1	16
Shifts/Rotations	7	2	-	9
Opinions/Suggestions	1	4	2	7
Task Performance	-	3	1	4
Problems with Doctors	3	-	-	3
Abuse	1	1	1	3
Patient Care	1	2	-	3
Salaries	-	2	1	3
Work Pressure	1	1	-	2
Safety (lack of)	1	-	1	2
Career Development	-	2	-	2
Cohesion (lack of)	-	1	1	2
Devaluation	-	1	1	2
Recognition (lack of)	2	-	-	2
Poor Communication	-	-	2	2
Allowances	-	-	2	2
Equipment/Stock	1	-	-	1
Problems with Nurses	1	-	-	1
Personal Development	1	-	-	1
Uniforms	-	1	-	1
Visiting Hours	-	1	-	1
Vacation/Sick leave	-	1	-	1
Ward Administration	1	-	-	1

Note. The abovementioned frequencies of reference to themes were identified in responses to the question: "Are there any areas in your job in which you would like to have more control? If so, please mention them."

A number of nurses identified a variety of physical working areas within the hospital in which they would like to have more control. These ranged from surgical wards to paediatric neurosurgery, with trauma/emergency being mentioned most often.

From Table 33 it is clear that the main areas in which respondents, particularly PNs, would like to have more control are those of general decision-making (autonomy), and the regulation of shifts and ward rotations (shifts/rotations). Enrolled nurses seemed to be most concerned about having to perform duties for which they were not trained (task performance), and being afforded the opportunity to voice opinions and make suggestions (opinions/suggestions).

Other isolated areas in which increased control was deemed desirable included the increased gangster activity within the hospital, more autonomy for head nurses with regard to organizing staff duties and vacations within their own departments (suggested by an ENA), and a wish to arrange group activities for staff.

One EN remarked that she "wanted to feel the same as the day [she] started nursing".

2.3.2 Analysis of responses to the second open-ended question

A high response rate was obtained for the second question, as evidenced in Table 32. One EN indicated that it was "not applicable" to him/her.

Table 34. Frequencies of references to themes identified in responses to the second open-ended question (N=118)

Theme	PN (N=53)	EN (N=37)	ENA (N=28)	Total (N=118)
Salaries	18	9	10	37
Shifts/Rotations	10	8	5	23
Appreciation (lack of)	12	7	3	22
Staff Shortage	7	5	3	15
Recognition (lack of)	10	5	-	15
Cohesion (lack of)	1	6	6	13
Career Development	3	6	2	11
Autonomy (lack of)	9	-	-	9
Work Pressure	3	5	1	9
Devaluation	2	5	-	7
Control	3	2	1	6
Reward	1	3	2	6
Opinions/Suggestions	3	1	2	6
Supervisor Support (lack)	4	2	-	6
Allowances	3	2	1	6
Poor Communication	1	2	2	5
Problems with Nurses	3	-	1	4
Abuse	2	2	-	4
Problems with Doctors	1	1	1	3
Safety (lack of)	3	-	-	3
Nursing Management	1	2	-	3
Ward Administration	3	-	-	3
Task Performance	2	-	1	3
Supervisor Pressure	1	1	-	2
Equipment/Stock	2	-	-	2
Vacation/Sick leave	2	-	-	2
Personal Development	1	-	1	2
Non-nursing Tasks	1	-	1	2

Note. The abovementioned frequencies of reference to themes were identified in responses to the question: "What might possibly make your job more fulfilling and satisfying?"

From the analysis presented in Table 34, it is apparent that improvement in salaries, improved regulation of shifts/rotations, and more appreciation from both supervisors and patients were considered most likely to enhance job satisfaction. Attention to the problems of staff shortages, lack of team spirit and cohesion, and lack of recognition were also deemed important in improving working conditions. Enrolled nurses, particularly, emphasised the importance of opportunity for career development in enhancing job satisfaction. Professional nurses identified inclusion in decision-making (autonomy) as a further important factor in making their jobs more satisfying. Relief of work pressure was also considered desirable, as were a variety of other factors, including less devaluation and organizational control, the freedom to voice opinions and make suggestions, and increased supervisor support.

Other individual suggestions which were made by PNs in connection with enhancing job satisfaction and fulfilment included stress reduction methods, opportunity to conduct research in infection control, the need for community awareness campaigns, improvement in the working environment, improvement in the status of nurses, and the introduction of background music in trauma/emergency. Enrolled nurses made mention of improved fringe benefits (for married women, particularly), fairness in managing incidents between patients and nurses, improved working conditions, improvement in the porter situation within the hospital, and increased respect all round. Enrolled nursing assistants identified assistance from seniors with basic nursing tasks, respect, trust, and consideration as job enhancers.

2.3.3 Analysis of responses to the third open-ended question

As can be seen in Table 32, the third question, regarding the job areas which nurses found particularly stressful, received the highest response rate from each category of nurse. One PN, two ENs and one ENA indicated that no job area was particularly stressful for him or her.

Table 35. Frequencies of references to themes identified in responses to the third open-ended question (N=128)

Theme	PN (N=55)	EN (N=44)	ENA (N=29)	Total (N=128)
Work Pressure	11	8	4	23
Abuse	5	3	3	11
Staff Shortage	7	3	1	11
Problems with Doctors	6	3	1	10
Cohesion (lack of)	2	5	2	9
Supervisor Support (lack)	3	3	2	8
Problems with Nurses	6	1	-	7
Appreciation (lack of)	2	4	1	7
Task Performance	2	3	1	6
Non-nursing Tasks	4	-	1	5
Devaluation	3	1	1	5
Strike Action	4	-	1	5
Night Duty	3	1	1	5
Control	2	3	-	5
Patient Care	4	-	-	4
Shifts/Rotations	3	1	-	4
Recognition (lack of)	2	1	-	3
Ward Administration	2	-	-	2
Salaries	1	1	-	2
Equipment/Stock	2	-	-	2
Autonomy (lack of)	2	-	-	2
Vacation/Sick leave	1	-	1	2
Reward	1	-	-	1
Allowances	1	-	-	1
Safety (lack of)	1	-	-	1
Career Development	1	-	-	1
Visiting Hours	-	1	-	1
Opinions/Suggestions	-	1	-	1
Poor Communication	1	-	-	1
Frustration	-	-	1	1

Note. The abovementioned frequencies of reference to themes were identified in responses to the question: "Which areas of your job do you find particularly stressful?"

The data in Table 35 reveal that work pressure and abuse from patients and their escorts were cited as particularly stressful, mostly by PNs. Shortage of staff, problems with doctors and nursing staff, lack of team spirit (cohesion), lack of supervisor support, and lack of appreciation were also mentioned frequently. Enrolled nurses, in particular, found lack of cohesion and appreciation stressful. Other generally stressful factors in nursing which were mentioned fairly regularly included having to perform tasks they were untrained for (task performance), non-nursing work demands, sense of devaluation, strike action (relatively prevalent during the year in which the study was conducted), night duty, and sense of tight organizational control.

Nurses identified a number of working environments within the hospital as being particularly stressful in which to work. Some considered "everywhere" to be stress-inducing, but, again, the trauma/emergency area was considered to be by far the worst.

A number of kinds of patients were mentioned as being particularly stressful to work with, notably abusive patients, amputees, confused patients and those with neurological problems.

Other isolated job areas which were said to be particularly stressful included "being expected to know and have an answer for everything" (PNs and ENs), concern about perceived lack of counselling skills, effective coordination of the multidisciplinary health team, the dysfunctional support system within the hospital, comforting the relatives of deceased patients, increased gangster activity within the hospital, and administering medications (mentioned by an EN). One PN identified "the stupid reasons for some legal abortions" as being particularly stressful. Other ENs mentioned adjustment to new areas within the hospital, managing patients' and colleagues' personal problems, emergencies, and ward rounds as being particularly stressful. One EN remarked that "the pressure is sometimes so much that you don't want to go to work". Enrolled nursing assistants added having to "rush around" when tired, and working with gangsters to the list of stressors being experienced within the hospital.

2.3.4 Analysis of responses to the fourth open-ended question

Table 36. Frequencies of references to themes identified in responses to the fourth open-ended question (N=107)

Theme	PN (N=51)	EN (N=34)	ENA (N=22)	Total (N=107)
Reward	17	9	3	29
Salaries	15	5	4	24
Work Pressure	6	5	4	15
Appreciation (lack of)	11	3	-	14
Supervisor Support (lack)	8	3	1	12
Frustration	10	1	-	11
Abuse	7	1	2	10
Nursing Management	6	3	1	10
Staff Shortage	4	3	2	9
Cohesion (lack of)	3	2	4	9
Allowances	8	1	-	9
Opinions/Suggestions	5	1	3	9
Career Development	4	2	2	8
Devaluation	3	2	2	7
Shifts/Rotations	2	2	3	7
Recognition (lack of)	3	3	1	7
Control	2	1	2	5
Uniforms	2	2	1	5
Organizational Issues	3	1	-	4
Problems with Nurses	4	-	-	4
Autonomy (lack of)	1	2	1	4
Visiting Hours	-	3	1	4
Supervisor Pressure	3	-	-	3
Problems with Doctors	1	1	1	3
Safety (lack of)	-	1	2	3
Task Performance	2	-	1	3
Vacation/Sick leave	2	-	-	2
Equipment/Stock	2	-	-	2
Poor Communication	-	1	1	2
Patient Care	1	-	-	1
Strike Action	1	-	-	1
Non-nursing Tasks	1	-	-	1

Note. The abovementioned frequencies of reference to themes were identified in responses to the statement: "Please feel free to express any further opinions or feelings. For example, what you find most rewarding or frustrating about nursing or how you experience being part of a large organization like this hospital. You might even like to suggest changes which should be made within the profession."

As can be deduced from Table 36, the sentiment expressed most often in response to this question was, encouragingly, that of reward and enjoyment obtained from nursing, although frustration was also evident. Most of the other commentary provided in response to this question centred around the issues of inadequate salaries, elevated work pressure, lack of appreciation, and lack of supervisor support. Mention was also made of abuse from patients, problems with nursing management, staff shortages, lack of cohesion, the desire for various financial allowances, and the desire to be allowed to express opinions and make suggestions.

Regarding specific working environments within the hospital which were identified as being stressful in which to work, it was once again the trauma/emergency areas which were mentioned most frequently.

Other commentary, not related to any of the themes evident in the data, included specific practical suggestions concerning aspects of hospital management (for example, adjustments to old theatre gowns and improvement of ineffective air-conditioning in summer), emphasis on the need for support and possible government representation for nurses, and the suggestion that stress management programs and communication skills training be offered to nurses. One PN working in the operating theatre was adamant that promotion should automatically follow after fifteen to twenty years of experience. Another expressed frustration at the amount of money spent treating patients whose injuries resulted from alcohol and drug abuse. It was also suggested that the services of staff who did not pull their weight should be terminated. One PN considered the lack of follow-up on resuscitated patients problematic.

A PN described herself as being "emotionally exhausted" and said that she "live[s] for her off days". An EN remarked that she had "overheard one of [her] colleagues mentioning that she wants to go to sleep and wake up forgetting that she ever was a nurse". One ENA commented that "sometimes I feel that I work so hard and sometimes I really don't give a damn what I do while I'm working or I'll say to myself: Why do this or that?".

Enrolled nurses generally expressed dissatisfaction with unappreciative relatives of patients, being taken for granted, and unprofessional behaviour which goes unpenalized. Another point

which was made was that the dictum, "the patient is always right", was not always fair or acceptable to nurses. The sudden death of a patient was also considered particularly stressful, while one Xhosa-speaking EN reported problems with language during her training.

Commentary provided by ENAs included frustration at the lack of authority to make changes, preference for problems being solved without disciplinary action, and the need for improvements in food and medical support provided by the hospital. One ENA expressed concern over patients being treated impersonally by nurses and another suggested the possibility of taking patients out, for example, to the beach, over weekends.

2.3.5 Overall analysis of responses to the four open-ended questions

Table 37, a composite of all references to all themes, represents a summary analysis.

Table 37. Composite analysis of frequencies of all references to themes identified in responses to the open-ended questions posed in the research questionnaire (N=135)

	PN (N=58)	EN (N=46)	ENA (N=31)	Total (N=135)
Salaries	34	17	15	66
Work Pressure	21	19	9	49
Shifts/Rotations	22	13	8	43
Appreciation (lack of)	25	14	4	43
Reward	19	12	5	36
Staff Shortage	18	11	6	35
Cohesion (lack of)	6	14	13	33
Autonomy (lack of)	24	5	2	31
Abuse	15	7	6	28
Recognition (lack of)	17	9	1	27
Supervisor Support (lack)	15	8	3	26
Opinions/Suggestions	9	7	7	23
Career Development	8	10	4	22
Devaluation	8	9	4	21
Problems with Doctors	11	5	3	19
Allowances	12	3	3	18
Task Performance	6	6	4	16
Problems with Nurses	7	6	3	16
Control	7	6	3	16
Nursing Management	7	5	1	13
Frustration	10	1	1	12
Poor Communication	2	3	5	10
Safety (lack of)	5	1	3	9
Patient Care	6	2	-	8
Non-nursing Tasks	6	-	2	8
Vacation/Sick leave	5	1	1	7
Equipment/Stock	7	-	-	7
Ward Administration	6	-	-	6
Strike Action	6	-	-	6
Visiting Hours	-	5	1	6
Uniforms	2	3	1	6
Supervisor Pressure	4	1	-	5
Night Duty	3	1	1	5
Organizational Issues	3	1	-	4
Personal Development	2	-	1	3

In general, dissatisfaction with salaries was the sentiment most often expressed by the nurses. Relatively frequent reference was also made to elevated work pressure, desire for inclusion in decision-making regarding shifts/rotations, perceived lack of appreciation, the problem of staff shortage, abuse from patients and their escorts, and lack of cohesion and autonomy amongst nursing staff. There is evidence that reward was being experienced by respondents. Other themes cited relatively often include lack of recognition and supervisor support, the desire to be able to express opinions and make suggestions, feelings of devaluation, the need for career development, problems with doctors, and requests for allowances for intensive-care work, after-hours work, and dangerous working conditions.

Whilst the frequencies of reference to themes are generally proportional to the number of nurses who responded to the open-ended questionnaires, there are some notable exceptions. Enrolled nurses and ENAs, for example, make considerably more reference to lack of team spirit and cohesion than do PNs. Devaluation is also mentioned more often by ENs than by PNs, as is interest in career development and problems related to visiting hours. ENAs expressed a desire for improved communication between nurses and nursing management more often than both PNs and ENs.

For PNs, the issues most often referred to were those relating to salaries, lack of appreciation, lack of autonomy, abuse, shifts/rotations, work pressure, reward, staff shortage, lack of recognition, lack of supervisor support, problems with nurses, allowances, problems with doctors, and general frustration in nursing.

Themes most often cited by ENs included elevated work pressure, inadequate salaries, lack of appreciation, lack of cohesion, problems with shifts/rotations, reward, staff shortage, lack of recognition, a need for career development, and devaluation.

Similarly, the areas of greatest concern for ENAs were salaries, lack of cohesion, work pressure, shifts/rotations, opinions/suggestions, and the staff shortage.

CHAPTER FOUR

DISCUSSION

CHAPTER FOUR

DISCUSSION

1. BURNOUT

1.1 Burnout in general

Burnout scores reflect strain, and in this sample of nurses the average scores obtained on emotional exhaustion and depersonalization were significantly higher, and on personal accomplishment significantly lower, than Maslach and Jackson's (1986) normative scores and those obtained in a number recent studies (e.g., Dolan, 1987; Leiter & Maslach, 1988; Ceslowitz, 1989; Robinson et al, 1991; Glass et al., 1993), as already mentioned. Overall, it thus seems that this sample of nurses was exceptionally burned out. These findings appear to be corroborated by qualitative sentiments expressed by a number of respondents. A professional nurse, for instance, described herself as being "emotionally exhausted" and said that she "live[s] for her off days". An enrolled nurse remarked that she had "overheard one of [her] colleagues mentioning that she wants to go to sleep and wake up forgetting that she ever was a nurse". One enrolled nursing assistant commented that "sometimes I feel that I work so hard and sometimes I really don't give a damn what I do while I'm working or I'll say to myself: Why do this or that?".

The MBI subscales were related to each other in a manner generally consistent with Maslach and Jackson's (1981) theory of burnout, which suggests that emotional exhaustion should be a predictor of depersonalization, and should be unrelated to sense of personal accomplishment. In this study, however, depersonalization did not predict a decrease in sense of personal accomplishment, as expected, and personal accomplishment was not related emotional exhaustion or depersonalization in any way. The implication is that respondents were rendered less vulnerable, in some way, to a sense of diminished personal accomplishment, while experiencing

high levels of burnout on the other two burnout components. It could be speculated that the general association of personal accomplishment with a number of the coping strategies examined, the general lack of association between work setting stressors and personal accomplishment, and the respondents' relatively high reported sense of personal control in general may have contributed to preventing further decreases in their sense of personal accomplishment. Indeed, despite experiencing relatively high levels of emotional exhaustion and depersonalization and identifying a wide range of work stressors in their responses to the open-ended questions in the research questionnaire, this sample of nurses also expressed a relatively high level of reward and enjoyment in their work. One could also speculate that, although the nursing profession in South Africa is, as yet, generally afforded relatively low status, many South African women might consider a nursing qualification in itself an achievement and may experience an enhanced sense of personal accomplishment through their working achievements and individual status, despite the high levels of emotional exhaustion and depersonalization which accompany their work. The process of burnout, as proposed by Maslach and Jackson (1981), appears thus not to have progressed to the final stage, a finding consistent with that of Hisashige (1991) in a sample of Japanese hospital nurses, in which work stressors were also not significantly associated with personal accomplishment.

These findings that this sample of South African hospital nurses, in comparison with their colleagues in other countries, are experiencing higher overall rates of burnout are perhaps not surprising, given the current levels of overcrowding in provincial hospitals, nursing staff shortages, the resultant high levels of work pressure and stressors reported, and current career insecurity being experienced as a function of the restructuring and rationalization of health services presently taking place in the country. Also, as Hisashige (1991) says, how the nature of work is evaluated may be dependent on the socio-cultural backgrounds of different countries, and differences in burnout between countries need also to be examined from a cultural-anthropological perspective.

1.2 Burnout and demographic factors

The association between the general burnout findings and the demographic variables examined in this study yielded a number of interesting results.

In accordance with findings from a number of previous studies (e.g., Hare et al., 1988; Bennett et al., 1991; Robinson et al., 1991), depersonalization was found to be associated with age in this group of nurses. Contrary to the general expectation that younger nurses will experience higher overall levels of burnout (Maslach, 1982; Cordes & Dougherty, 1993), however, there were no significant differences in burnout, on any of the burnout components, between older and younger nurses in this sample. It must be emphasised, though, that, with a mean age of 31 years and only 9.2% of respondents being over 40 years of age, this entire sample of nurses is relatively young compared to samples in other studies reviewed, for example, Hare et al. (1988) and Robinson et al. (1991), who reported mean sample ages of 37 years and 39.9 years respectively. This sample may thus have been too homogenous in age for variance to be apparent.

Similarly, the finding in the present study that there appeared to be no correlation between extent of nursing experience and burnout may have been a function of the fact that 68% of the sample of nurses had been nursing for an average of less than 10 years. Hisashige (1991), in a sample of Japanese hospital nurses who exhibited very similar burnout trends to the current sample, found, for example, that high levels of emotional exhaustion peaked between five and nine years. The current sample may also have been too homogenous with respect to nursing experience for variance to be apparent.

In keeping with burnout theory, male and female respondents were generally fairly similar in their experience of burnout. Female nurses experienced significantly higher levels of emotional exhaustion than their male counterparts, which Maslach (1982) speculates may be related to traditional male and female sex role differences, women being expected to be more nurturant and oriented toward people than men. Male and female nurses did not differ in their experience of depersonalization and personal accomplishment.

In contrast with Maslach's (1982) findings on marital status, there were no differences in burnout between married, never married, divorced, separated, or widowed nurses in this study. The current findings add weight to Cordes and Dougherty's (1993) assertion that more evidence of the relationship between burnout and marital status needs to be obtained. A possible explanation for the findings in the present study is that a large number of the single (never

married) nurses in the sample had children of their own, and were probably not lacking in the family support which Maslach (1982) suggests is often less available to single people. It is also possible that due to socio-economic circumstances and still prevalent extended family support systems in South Africa, many single nurses may be living with families, partners or friends, who offer varying levels of support and affection.

A finding which contrasted somewhat with burnout theory (Maslach, 1982) was that there were no significant differences in burnout between those who had children and those who were childless, except with respect to personal accomplishment, which, interestingly, was lower in nurses with children. The ages of respondents' children were also not associated with burnout in any way.

In the case of educational and nursing status, enrolled nurses experienced considerably lower levels of personal accomplishment than enrolled nursing assistants (with respect to educational status) and professional nurses (with respect to educational and nursing status). In response to similar findings, Guppy and Gutteridge (1991) suggest that a possible explanation for this finding may well lie in the differing levels of responsibility between these groups. It is worthwhile to note here that, in the qualitative information collected in the study, enrolled nurses made the most frequent mention of a need for career development, of having to perform tasks they were not trained for and insecurity about ability, and of experiencing a sense of devaluation, sentiments which suggest feelings of negativity, diminished competence, and a lack of progress at work.

With respect to whether nurses experienced different levels of burnout depending on the ward or department in which they worked, nurses working in trauma/emergency reported significantly higher levels of depersonalization than surgical ward nurses. One could speculate that due to the nature of trauma/emergency work (high patient turnover, serious illness or injury, death, pain) nurses might resort to separating themselves from the painful aspects of their work in order to cope, albeit maladaptively. Qualitative responses obtained from respondents in this study provide anecdotal support for the overall stressfulness of, particularly, the trauma/emergency department. For instance, one nurse found it frustrating not having any follow-up contact with patients whom she had helped to resuscitate. The trauma/emergency department was also cited

most frequently as being the most stressful nursing speciality within the hospital concerned. A number of recent studies have investigated the differences in experienced stress and burnout in nurses across different nursing specialities, most identifying significant differences (e.g., Chiriboga & Bailey, 1986; Lyons, Hammer, Johnson & Silberman, 1987; Foxall et al., 1990), and few reporting that perceived stress was not significantly related to ward type (e.g., Hipwell et al., 1989). Bailey (1985) identifies intensive-care, mental handicap, rehabilitation, and medical-surgical nursing as the high stress nursing specialities. In the literature reviewed for this dissertation, only one study was found to have included accident/emergency nursing amongst specialities examined for levels of reported stress. It was found that on two stress factors, work resources and relations and dealing with death, the accident/emergency department was ranked third highest and second highest, respectively, in experienced stress amongst nine ward types (Guppy & Gutteridge, 1991). It seems that trauma/emergency work may well have unique stressors which need to be examined and reported separately in relation to strain.

2. THE WORK ENVIRONMENT

2.1 General findings on work environment

In general, the present sample of nurses' experience of their working environments was markedly different from the health workers on which the WES was standardised. With regard to the work relationship dimension examined (involvement, peer cohesion, and supervisor support), respondents were less concerned about and committed to their jobs, obtaining only a slightly above-average score on the involvement subscale. Peer cohesion and supervisor support were experienced as being particularly lacking, in comparison with the normative group. In all, this group of nurses did not feel well supported by their working colleagues, a finding which is supported by their independent rating on support at work. Nurses rated the amount of support received from their nursing colleagues as being average (52.6%), and significantly less than the support received from family and friends. The qualitative information obtained from participants reflected these sentiments, lack of cohesion amongst staff as well as inadequate supervisor support being mentioned relatively frequently as a source of stress.

Concerning the personal growth work environment variables examined, nurses reported experiencing low levels of autonomy, high levels of task orientation, and particularly high levels of work pressure, in comparison with Moos's (1986) sample of health care workers. These findings were, once again, supported by respondents' qualitative responses. Work pressure was the second most frequently mentioned stressor overall, and was identified as being the most stressful area of respondents' work. Lack of inclusion in decision-making was also identified frequently in the qualitative data as being particularly stressful.

In respect of the system maintenance and system change work factors examined, participants reported low levels of clarity, innovation, and physical comfort (although this group of nurses perceived their work settings to be more pleasant than Moos's (1986) normative group) and exceptionally high levels of managerial control. In the qualitative data, control was also mentioned relatively frequently as a source of stress.

This group of nurses thus generally experienced their work settings as being particularly high in work pressure, managerial control, and task orientation, and low on involvement, peer and

supervisor support, autonomy, clarity, innovation, and physical comfort. All three classes of nurses experienced their working environments in approximately the same way.

With regard to nursing speciality, however, some differences in perceptions of work environment across the two specialities examined in this study were evident. Nurses working in the trauma/emergency department appeared to have been more involved and committed to their jobs and to have experienced significantly more peer cohesion than the surgical ward nurses. The trauma/emergency department was also rated higher in organizational clarity. Whilst these aspects of the work environment are very important in any nursing speciality, it is perhaps in trauma/emergency, especially, that staff need to respond effectively, efficiently, and cooperatively in order to deal with the large number of emergencies and serious illness conditions encountered daily. Accomplishing this requires team work, clarity about procedures and rules, and a certain level of commitment. In respect of patient care in the trauma/emergency department, then, these findings are gratifying. Attention should, however, be directed towards improvement in these areas in the surgical wards of the hospital concerned.

2.2 Burnout and the work environment

Analysis of the correlations between the work environment and burnout variables lends support to previous research findings that emotional exhaustion appears to be the principal dimension associated with correlates of burnout (Else, 1990; Glass et al., 1993).

Perhaps not surprisingly, the strongest association was between emotional exhaustion and work pressure, a finding in keeping with contemporary burnout research. This finding was also well supported by respondents' qualitative responses. Work pressure was most often cited as being especially stressful, particularly by professional and enrolled nurses. With the exception of managerial control, which showed no association with emotional exhaustion, all other work environment variables included in the study were significantly negatively correlated with emotional exhaustion. These findings are consistent with previous research, which has consistently emphasised that lack of supervisor support (e.g., Parkes, 1985, in Nash, 1989; Constable & Russell, 1986, in Boyle et al., 1991; Wagenaar, 1990; Boyle et al., 1991; Robinson et al, 1991), a low degree of innovation (e.g., Moos & Schaefer, 1987; Wagenaar, 1990), a less comfortable and pleasant work setting (Wagenaar, 1990), a lack of job involvement (e.g.,

Chiriboga & Bailey, 1986; Leiter & Maslach, 1988; Topf, 1989; Wagenaar, 1990; Pretorius, 1993), a lack of job clarity (e.g., Leiter & Maslach, 1988; Revicki & May, 1989; Wagenaar, 1990; Cordes & Dougherty, 1993; Revicki et al., 1993), diminished peer cohesion and team work (e.g., Moos & Schaefer, 1987; Leiter & Maslach, 1988; Wagenaar, 1990; Revicki et al., 1993), lower perceived autonomy (e.g., Leatt & Schneck, 1985; Chiriboga & Bailey, 1986; Hawkins, 1987; Hipwell et al., 1989; Wagenaar, 1990; Donat et al., 1991; Corrigan, 1993; Pretorius, 1993), and a relatively low emphasis on task orientation (e.g., Moos & Schaefer, 1987; Wagenaar, 1990), are associated with higher levels of burnout, particularly emotional exhaustion.

The only work environment stressors which were significantly associated with depersonalization were lack of physical comfort, innovation, and supervisor support. These correlations were all negative, with lack of physical comfort being the strongest predictor of an enhanced sense of depersonalization.

There were no noteworthy correlations between personal accomplishment and any of the work environment predictors. As mentioned previously, whilst the overall average score on personal accomplishment for this sample of nurses was significantly lower than previously reported research findings (e.g., Maslach & Jackson, 1981; Maslach & Jackson, 1986, in Glass et al., 1993), the exceptionally high levels of emotional exhaustion and depersonalization experienced did not appear to predict significantly lower levels of personal accomplishment. One could speculate that this apparent lack of association between work environment stressors and personal accomplishment may have played a role in the relations between the three burnout variables.

The discriminant analyses performed in order to identify those work variables which were experienced differently by respondents in each of the three burnout groups, revealed that work pressure, physical comfort and peer cohesion were significant predictors of the level of burnout which would be experienced by the nurses on the emotional exhaustion subscale. Nurses experiencing higher levels of work pressure were significantly more burned out. This finding is consistent with the existing burnout literature (e.g., Hunnicutt, 1983, in Moos, 1986; Caldwell & Weiner, 1981; Bailey, 1985; McCranie, Lambert & Lambert, 1987; Hawkins, 1987; Dewe, 1987, 1988; Hipwell et al., 1989; Lees & Ellis, 1990; Hisashige, 1991; Robinson et al., 1991;

Chappell & Novak, 1992; Kandolin, 1993). Physical comfort also explained a large proportion of the variance on emotional exhaustion, with nurses in the moderate and high burnout groups obtaining significantly lower scores than those in the low burnout group, a finding which echoes that of Wagenaar (1990) in a previous sample of South African nurses. In keeping with existing research (e.g., Moos & Schaefer, 1987; Leiter & Maslach, 1988; Wagenaar, 1990; Revicki et al., 1993), peer cohesion was experienced as being particularly lacking amongst nurses in the higher burnout groups.

With respect to depersonalization, discriminant analysis identified physical comfort and supervisor support as salient predictors of differing levels of burnout. Nurses in the moderate to high burnout groups experienced their work settings as being significantly less comfortable than those who reported low levels of burnout. Nurses in the higher burnout groups also felt significantly less supported by their supervisors than those in the low burnout group. This finding accords with previous findings on the role of diminished supervisor support in the development of burnout (e.g., Parkes, 1985, in Nash, 1989; Constable & Russell, 1986, in Boyle et al., 1991; Wagenaar, 1990; Boyle et al., 1991; Robinson et al, 1991).

With regard to personal accomplishment, the only work environment variable which differentiated significantly between the three burnout groups was autonomy. Here the group of nurses experiencing moderate levels of burnout considered themselves to have less autonomy than those in the low burnout group. The finding that nurses in the high burnout group also reported having more autonomy than those in both the low and moderate groups is probably best explained as a function of the relative lack of reliability of response to this subscale (Chronbach's alpha coefficient: $r = 0.47$). Aside from this particular finding, there is the suggestion in the current findings that higher levels of perceived autonomy are associated with lower levels of burnout, as has been found in earlier studies (e.g., Leatt & Schneck, 1985; Chiriboga & Bailey, 1986; Hawkins, 1987; Hipwell et al., 1989; Wagenaar, 1990; Donat et al., 1991; Corrigan, 1993; Pretorius, 1993). Whilst supervisor support did not remain a significant predictor in the final discriminant analysis on personal accomplishment, the more burned out nurses generally perceived themselves as being less supported by their supervisors.

The fact that lower levels of physical comfort were convincingly linked with greater burnout in

this sample of nurses is noteworthy. Of the studies reviewed for this dissertation, only one study examined the association between burnout and physical comfort. This was, interestingly, also a South African study (Wagenaar, 1990), and the findings were similar to the current study. An indication of the importance attached to physical comfort can be found in the qualitative information provided by respondents in the current study. For instance, respondents repeatedly expressed the desire to be permitted to wear sandals in summer, and mention was also made of the need to make improvements in the hospital air-conditioning system in summer. One nurse suggested that general improvements in the working environment were necessary. Another suggested that the introduction of background music in the trauma/emergency department would enhance job satisfaction. As these South African findings on physical comfort may well be further evidence of a possible socio-cultural dimension to nursing stress, future research on work environment stressors and burnout should further examine this association.

This study has also highlighted the importance of work relationships in relation to burnout. Lack of peer cohesion and supervisor support were associated with higher levels of emotional exhaustion and depersonalization, respectively. These results are consistent with other studies which have suggested that lack of support at work enhances nurses' vulnerability to burnout (e.g., Hare et al., 1988; Beehr et al., 1990; Boyle et al., 1991; Albrecht & Halsey, 1992). As a result of the cross-sectional nature of the current study, it is not possible to determine the exact direction of the relationship between burnout and work relationships. It is possible that while poor work relationships may contribute to burnout, burnout may also further reduce the quality of work relationships (Maslach, 1982). Participants in this study appear to have been experiencing high levels of emotional exhaustion and depersonalization, which may well have contributed to the work relationships being less supportive. It seems that work environment and burnout may reciprocally influence one another.

2.3 Summary

In summary, it seems that this sample of South African surgical nurses generally experienced their work settings as being high on control, task orientation and, in particular, work pressure. Relatively low levels of involvement, peer cohesion, autonomy, clarity, innovation, physical comfort, and, especially, supervisor support were experienced. These findings are consistent with Moos and Schaefer's (1987) characterization of healthcare work settings, which are

generally experienced negatively, due both to the inherent stresses and emotionally difficult nature of the work and the problems associated with working in large, rigidly structured organizations.

Associating these findings with respondents' levels of experienced burnout revealed that work pressure, physical comfort, and peer cohesion (with respect to emotional exhaustion), and physical comfort and supervisor support (as regards depersonalization), and autonomy (in the case of personal accomplishment) were the work environment variables which differentiated between the three burnout groups. Nurses experiencing higher levels of burnout perceived their work settings to be less comfortable, reported lower autonomy, and perceived their work relationships to be less supportive than nurses in the low burnout group. Nurses identified as having higher levels of burnout generally reported experiencing higher levels of work pressure.

All three categories of nurses were similar in their experiences of their working environments. With respect to nursing speciality, however, surgical ward nurses reported lower degrees of organizational clarity, job involvement, and peer cohesion.

3. COPING

3.1 General findings on coping

The general findings on respondents' coping dispositions were that this sample of nurses tended to make significantly more use of strategies such as suppression of competing activities, restraint coping, seeking emotional support, focusing on and venting of emotions, denial, behavioural disengagement, mental disengagement, and, in particular, positive reinterpretation and turning to religion than the normative group. Participants also reported making use of the full range of coping mechanisms examined in the study, a finding in keeping with existing research (e.g., Cooper & Baglioni, 1988; Rosenthal et al., 1989; Dewe, 1993). The nurses appeared to have used the problem- and emotion-focused coping mechanisms to a similar degree, which contrasts with a finding by Rosenthal et al. (1989) that problem-focused techniques were used most frequently. Avoidance and palliative coping strategies such as denial, focusing on and venting emotions, and behavioural and mental disengagement were generally used less frequently than the other strategies examined, although, as will be discussed, those nurses who used them most frequently were significantly more burned out than those using them less.

Evidence of a possible relationship between level of education or training and the extent to which certain coping strategies are employed, was suggested by the findings that the different classes of nurses differed significantly in the frequency with which they made use of three of the strategies included in the study. In the case of turning to religion as a means of coping, professional nurses made significantly less use of this strategy than enrolled nursing assistants. Professional nurses also were markedly less inclined to use denial and behavioural disengagement as coping mechanisms than were both enrolled nurses and enrolled nursing assistants. As mentioned previously, nursing and educational status were also implicated in the levels of burnout experienced, with enrolled nurses generally experiencing considerably lower levels of personal accomplishment than enrolled nursing assistants and professional nurses. It is possible that the increased use of these two emotion-focused coping strategies (turning to religion and denial) and the avoidant/palliative mechanism of behavioural disengagement may be associated with the higher level of burnout (in terms of decreased personal accomplishment) experienced by the enrolled nurses. These findings are consistent with existing research in which Billings and Moos (1981, 1984) report that people with less education may tend to use

fewer active and preparatory coping strategies and to make more frequent use of fatalistic or avoidance coping responses than those with more education. Similarly, in a large sample of New Zealand nurses, Dewe (1989) found that professional nurses tended to make more frequent use of problem-oriented coping behaviours than those with less training, while enrolled nurses and assistants made more frequent use of emotion-focused and palliative strategies.

3.2 Burnout and coping

Examination of the correlations between the three burnout components and the COPE scores showed consistent significant associations between burnout and strategies such as planning, denial, and behavioural disengagement. Planning (a problem-focused strategy) was negatively correlated with emotional exhaustion and depersonalization (although this correlation was not significant) and relatively strongly positively associated with personal accomplishment. Denial and behavioural disengagement were positively related to both emotional exhaustion and depersonalization and relatively strongly negatively associated with personal accomplishment. Of the other coping strategies examined, the only significant associations were a moderately strong positive correlation between mental disengagement and emotional exhaustion, and correlations of similar magnitude between personal accomplishment and the use of instrumental and social support and positive reinterpretation. The increased use of the palliative/avoidance strategies of denial, mental disengagment and behavioural disengagement thus show consistent associations with burnout, while more frequent use of the more problem-focused (planning and seeking instrumental social support) and emotion-focused (seeking emotional social support and positive reinterpretation) forms of coping, appeared to have been related to decreased levels of burnout.

These findings were supported by the results of the discriminant analyses, from which it was clear that, with regard to emotional exhaustion, more frequent use of mental and behavioural disengagement, and focusing on and venting of emotions as coping strategies were associated with higher levels of burnout. This finding accords with Carver et al's. (1989) suggestion that these are less useful strategies. The problem-focused strategy of planning, which only approached significance in the final discriminant analysis, appeared to have been used most frequently by nurses in the low burnout group.

With regard to depersonalization, the use of behavioural disengagement as a coping mechanism again featured as a predictor of different levels of burnout, nurses in the high burnout group making most frequent use this strategy. Planning was also identified as having been used significantly more frequently by respondents who were less burned out.

With respect to personal accomplishment, three emotion-focused coping techniques appear to have been associated with lower levels of burnout. Nurses who made more frequent use of positive reinterpretation, emotional social support, and acceptance were less burned out. Frequent use of denial was identified as being related to significantly higher levels of burnout.

It is clear that, with respect to their levels of experienced burnout, this group of nurses mostly coped by managing the emotional distress associated with their stress (mostly to good effect) and by avoidance or palliation. Aside from planning, there was very little evidence of problem-solving or doing something to alter the source of the stress amongst those experiencing higher levels of burnout. Although stressors mostly elicit all kinds of coping, problem-focused coping tends to predominate when people feel that something constructive can be done (Carver et al., 1989). Whilst respondents' choice of coping strategies may well have been influenced by personal choice, previous learning, or culture, one could speculate that, given the generally low levels of autonomy and high degree of work pressure and organizational control which dominated their work settings, they may not have had the opportunity, resources or emotional energy to have coped more actively, or may simply not believe that they can do anything to change the sources of their stress in their workplace.

3.3 Summary

In summary, this sample of nurses made use of a variety of coping mechanisms, a finding in keeping with existing coping research (e.g., Billings & Moos, 1981; Rosenthal et al., 1989; Dewe, 1993). Nurses in the low burnout group appear to have made more frequent use of emotion-focused coping strategies such as positive reinterpretation, seeking emotional social support, and acceptance, a finding which contrasts with the general reports that emotion-focused strategies are associated with higher levels of burnout (e.g., Parasuraman & Hansen, 1987; Boyle et al., 1991; Bennett et al., 1993), and is in accordance with Dunkel-Schetter's et al. (1992) finding of an association between decreased emotional stress and more frequent use of

emotion-focused coping. It would thus seem that coping efforts are best examined and assessed separately, as in the present study, as composite scores obtained for emotion-focused coping may preclude the identification, and possible evidence of the usefulness, of certain of these strategies.

The only problem-focused coping strategy to have differentiated significantly between the burnout groups in this study was planning, which was associated with lower levels of burnout. This is in keeping with the existing view that problem-focused coping is related to lower experienced burnout (e.g., Bennett et al., 1993; Kandolin, 1993; Sullivan, 1993).

Palliative/avoidant coping strategies such as mental disengagement, behavioural disengagement, and focusing on and venting emotions, and denial (conceptualized as an emotion-focused strategy in the present study), whilst used less frequently than the other coping mechanisms examined, appear to have been associated with higher levels of experienced burnout, findings very much in keeping with existing research (e.g., Billings & Moos, 1981; Parasuraman & Hansen, 1987; Cooper & Baglioni, 1988; Hare et al., 1988; Thornton, 1991; Dunkel-Schetter et al., 1992; Bennett et al., 1993).

The findings of the present study thus provide support for the contentions of those researchers, mentioned previously, who dispute the simple division of coping strategies into problem- and emotion-focused strategies, asserting that the various conceptually distinct coping strategies which constitute both emotion- and problem-focused coping should be studied and measured separately (e.g., Folkman, Lazarus, Gruen & De Longis, 1986, in Dewe, 1993; Aldwin & Revenson, 1987, in Kelly, 1991; Cooper & Baglioni, 1988; Carver et al., 1989), and constitute further empirical evidence about the effects of coping in work settings, as considered necessary by other previously mentioned authors (e.g., Parasuraman & Cleek, 1984, in Dewe & Guest, 1990; Shinn, Rosario, Morch & Chestnut, 1984, in Dewe & Guest, 1990).

4. CONTROL, SUPPORT, APPRECIATION AND JOB SATISFACTION

4.1 General findings on control, support, appreciation and job satisfaction

The discussion now turns to the findings obtained by means of the four visual analogue rating scales included in the research questionnaire.

With regard to control, this sample of nurses perceived themselves to have significantly less control in their work than in their lives in general, a finding which corroborates the low average scores obtained on the autonomy subscale of the WES, and respondents' frequent identification of a desire for inclusion in decision-making in their work as being the most important job area in which they would like to have more control. Enrolled nurses perceived themselves to have significantly less control in their work than professional nurses, a realistic reflection of their status in relation to professional nurses.

There were no differences in experienced job satisfaction across nursing specialities or classes. Despite the relatively unfavourable conditions under which the nurses were working and the levels of emotional exhaustion and depersonalization being experienced, this group of nurses reported an above-average level of job satisfaction, a finding consistent with previous research (e.g., Joiner, Johnson, Brad Chapman, & Corhean, 1982, in Landeweerd & Boumans, 1988; Wallis, 1987, in Landeweerd & Boumans, 1988; Landeweerd & Boumans, 1988). Further support for this finding may be deduced from the qualitative material obtained from present participants, in which experienced reward and enjoyment in their work was expressed relatively frequently.

Concerning support, respondents reported experiencing significantly less support from their nursing colleagues than from friends and family. This finding is supported by the general perception of low peer cohesion and supervisor support reflected in the WES scores, as well as respondents' relatively frequent mention of lack of team spirit and supervisor support in the qualitative material.

With respect to a sense of being appreciated for their work, this group of nurses generally felt unappreciated, particularly professional nurses. Supportive evidence for this finding was found

in the qualitative information, in which nurses repeatedly made reference to feelings of not being appreciated for their efforts.

4.2 Burnout and control, support, appreciation, and job satisfaction

Examination of the correlations between perceptions of control, job satisfaction, support, and appreciation, and the three components of burnout, revealed that job satisfaction and appreciation were relatively strongly negatively related to both emotional exhaustion and depersonalization. Similarly, control, both at work and in general, and support from nursing colleagues were negative predictors of emotional exhaustion, although these associations were relatively less strong. Control in general was positively related to personal accomplishment. Control, both at work and in life in general, did not, however, enter the multivariate discriminant analyses as a predictor which differentiated between the burnout groups. Given the emphasis placed on the importance of a personal control in relation to the development or non-development of burnout and strain (e.g., Maslach. 1982; Vachon & Stylianos, 1991), one might have expected control, particularly at work, to have been identified as a predictor of burnout in the current study, given that respondents rated themselves as having above-average levels of personal control. These ratings, however, contrasted with both the quantitative WES data, which showed that respondents experienced generally low levels of autonomy, and the qualitative data, in which respondents made frequent reference to feelings of lack of decision-making latitude in their work. Problems of measurement and personal definitions of control may have resulted in this finding, with a 1-item rating perhaps eliciting a more optimistic rating than might have been the case had a standardized multiple-item scale measuring different dimensions of personal control been employed.

Job satisfaction was also relatively strongly correlated with sense of appreciation. Davidson (1985, in Vachon & Stylianos, 1991) suggests a similar link between appreciation and job satisfaction, reporting that patient appreciation was a critical factor in a group of social workers' experiencing job satisfaction.

Relating perceptions of control, job satisfaction, support, and appreciation to experienced burnout in the discriminant analyses revealed that, on all three burnout components, perceptions of appreciation consistently differentiated between the three levels of burnout. The lower the

sense of being appreciated for their work, the higher the level of burnout experienced, as has been found in previous studies (e.g., Maslach, 1982; Clark, 1989; Bennett et al., 1993).

Job satisfaction was also experienced differently in the three burnout groups, on both the emotional exhaustion and depersonalization burnout components. Nurses in the low burnout group were very much more satisfied with their jobs than those in the high burnout group. This accords with Dolan's (1987) reports of there being an inverse relationship between job satisfaction and burnout. Other studies reviewed for this dissertation, however, did not suggest a clear association between these two variables (e.g., Veninga, 1982; Tetrick & LaRocco, 1987; Landeweerd & Boumans, 1988; Ehrenfeld, 1991).

Whilst not significant on the personal accomplishment subscale, support from family and friends generally appears to have been higher amongst nurses experiencing lower levels of burnout and psychological well-being, a finding in keeping with existing research (e.g., Cronin-Stubbs & Rooks, 1985, in Hare et al., 1988; Revicki & May, 1985; Hare et al., 1988; Marshall & Barnett, 1992; Bennett et al., 1993). Boyle et al. (1991) also found that informal support was not as strongly associated with burnout as was work-related support, suggesting that social support is situation specific.

4.3 Summary

In summary, a sense of being appreciated for their work and of job satisfaction were consistent predictors of burnout in this sample of nurses. It appears, too, that informal support was generally, if not significantly, associated with lower levels of burnout in terms of personal accomplishment.

5. QUALITATIVE FINDINGS

Despite the high levels of emotional exhaustion and depersonalization experienced by many participants in the study, the nurses responded particularly well to the open-ended questions posed in the research questionnaire, suggesting both a willingness and a need to voice opinions and make suggestions. Some respondents found the chance to express their feelings about their work beneficial and were grateful for the opportunity for this afforded by the study. Verbatim commentary on the experience of having completed the questionnaire is provided in Appendix E. During analysis of the content of respondents' responses a number of recurrent themes were identified and enumerated.

With regard to the job areas in which this sample of surgical hospital nurses would like to have more control, a desire for inclusion in decision-making (autonomy) was most frequently mentioned, particularly by professional nurses. Respondents wanted to be included in decision-making with respect to, for example, patient care, sorting and attending to minor ailments, ward management, stock control, and staff placements. Another area where more control was required was related to shiftwork, where the nurses wanted to be included in the decision-making regarding duties, off duties, night duty, rotations, and made a general call for shorter shifts. Existing research suggests an association between shiftwork, rotations and increased strain (e.g., Milne & Watkins, 1986; Coffrey et al., 1988; Foxall et al., 1990). Enrolled nurses, particularly, expressed a desire for the opportunity of voicing opinions and making suggestions without fear of criticism and devaluation. Enrolled nurses, chiefly, also expressed a lack of control when having to perform tasks they were not trained for and reported some insecurity about ability. Other job areas in which participants felt that more control was necessary ranged from their interactions with doctors, interactions with abusive patients, patient care, and salaries, to issues such as vacations and sick leave and ward administration. The physical working area mentioned most often as being one in which nurses would like to have had more control was the trauma/emergency department.

In response to the enquiry as to what might make their work more fulfilling and satisfying, nurses mentioned improvements in salaries, inclusion in decisions regarding shiftwork and duties, more appreciation for their work, attention to the problem of shortage of staff, more

recognition for their training and efforts, increased cohesion amongst staff, opportunity for career development, more autonomy (mostly professional nurses), and decreased work pressure. Cohesion amongst staff was cited most often by enrolled nurses and enrolled nursing assistants, and enrolled nurses most frequently expressed a desire for career development opportunities in response to this question. Other less frequently mentioned suggestions as to what might improve job satisfaction ranged from decreased devaluation (of enrolled nurses in particular), increased supervisor support, and less managerial control to increased opportunities for personal development and less non-nursing work demands. Various other individual suggestions were made, the general impression given being a desire for respect, care, and fairness and improved general working conditions.

The most frequently mentioned job areas which the nurses found particularly stressful were the extremely high levels of work pressure, physical and verbal abuse from patients, their escorts, and relatives, staff shortages, problems with doctors, lack of cohesion amongst the nursing staff, lack of supervisor support, problems with nursing staff, lack of appreciation for their work, and having to perform tasks not trained for or capable of. The list of stressors mentioned less frequently included, for example, non-nursing work demands, devaluation, strike action (relatively prevalent during the year in which the study took place), and general frustration. The trauma/emergency department was cited as being the most stressful work setting in which to work. Respondents also identified specific kinds of patients who were difficult to work with, the most frequently mentioned being abusive patients, amputees, confused patients, and those with neurological problems. Conspicuous by its relative absence, was mention of death and dying and working with very ill or helpless patients as a particularly stressful facet of respondents' work. Only one nurse reported finding the sudden death of a patient particularly stressful. This finding contrasts sharply with general nursing stress research, which consistently identifies dealing with death and dying as being a major stressor (e.g., Caldwell & Weiner, 1981; Hingley & Harris, 1986, in Kunkler & Whittick, 1991; Hipwell et al., 1989; Nash, 1989; Lees & Ellis, 1990; Foxall et al., 1990). One could speculate that this apparent lack of concern with death and dying may lie in the high levels of depersonalization experienced by this group of nurses in general, or in the fact that relatively frequent use was made of coping strategies such as turning to religion (which may serve to lessen the threat of death), denial, behavioural disengagement, and mental disengagement.

The most frequently mentioned theme in response to the question which provided for any further commentary from respondents was, encouragingly, that of reward and enjoyment in their work. Concerns highlighted frequently were inadequate salaries, high levels of work pressure, a lack of supervisor support, lack of appreciation, general frustration with their work, abuse from patients, their families and escorts, and frustration with nursing management. Other less mentioned concerns ranged from the problems of staff shortages and lack of team spirit amongst staff to frustrations with strike action and having to perform a variety of non-nursing work tasks.

5.1 Summary

In summary, the qualitative information obtained in this study provides support for the quantitative findings that this sample of surgical hospital nurses, whilst generally experiencing some reward and enjoyment in their work (a finding supported by the respondents' relatively high ratings of job satisfaction), found many aspects of their work stressful. Most of the major themes identified in the responses to the open-ended questions posed, namely, extremely high levels of work pressure and reports of staff shortages, non-supportive work relationships (in terms of supervisors, peers, doctors, and nursing management), a general lack of autonomy (regarding patient care, ward administration, shifts and duties, and being free to voice opinions and make suggestions), and a perceived lack of appreciation, respect and recognition were found to be associated with burnout in the quantitative analysis.

Three major themes not examined quantitatively, namely, inadequate remuneration for their work (including allowances for specialised or after-hours work), frequent emotional and verbal abuse from patients, their families and escorts, and concern over nursing abilities and the need for career development emerged as pertinent work stressors for these respondents. Evidence of the negative impact which these particular factors have on nurses' strain and job satisfaction is provided in existing research. McGrath et al. (1989), Hisashige (1991) and Ehrenfeld (1991) report that a serious grievance amongst nurses studied was financial. With regard to client stance, Maslach (1978, 1982) has emphasised that client feedback, so often negative, has the potential to be a major source of dissatisfaction, disillusionment and psychological pain. Kandolin (1993) reported a connection between physical violence from patients and burnout in a sample of mental health nurses. Donat et al. (1991) and Sullivan (1993) also identified dealing with difficult psychiatric patients as a pertinent nursing stressor. Whilst the last three studies

report findings on specifically psychiatric patients, they nevertheless exemplify the relationship between client stance and strain. A number of studies have also identified concern over nursing abilities as a major stressor in nursing (e.g., Dewe, 1987, 1988; Corrigan, 1993).

It was also apparent that there were some concerns unique to the each class of nurse. Professional nurses expressed concern about absenteeism, depersonalisation, perceived lack of respect, and lack a of both commitment and cooperation amongst some nurses. Enrolled nurses and enrolled nursing assistants were particularly concerned about lack of cohesion amongst nursing staff, whilst enrolled nurses expressed a desire for career development most frequently.

6. SUMMARY AND CONCLUSIONS

The purpose of this study was to examine the extent of strain (operationalized as burnout) being experienced by nurses in a South African state hospital, and its associations with a range of work environment and respondents' coping strategies.

Participants in this study were found to be experiencing high levels of emotional exhaustion and depersonalization and low levels of personal accomplishment.

Of the work environment variables included in the study, higher levels of work pressure, diminished physical comfort in the work setting, and lack of peer cohesion predicted higher levels of emotional exhaustion. Lack of physical comfort and lack of supervisor support were strongly associated with higher levels of depersonalization. Generally, lower levels of perceived autonomy and supervisor support were associated with a diminished sense of personal accomplishment.

Regarding coping, whilst respondents generally made use of a wide range of coping strategies, frequent use of the problem-focused strategy of planning was found to be related to lower levels of emotional exhaustion and depersonalization. Frequent use of emotion-focused strategies such as positive reinterpretation, seeking emotional social support, and acceptance were associated with a sense of enhanced personal accomplishment, whereas increased use of the emotion-focused coping strategy of denial was strongly associated with a diminished sense of personal accomplishment. Regarding palliative/avoidant coping techniques, frequent behavioural disengagement was associated with higher levels of emotional exhaustion and depersonalization, and mental disengagement and focusing/venting of emotions were related to higher levels of emotional exhaustion.

Those respondents who felt most appreciated for their work experienced the lowest levels of both emotional exhaustion and depersonalization. Enhanced job satisfaction was found to be related to lower levels of emotional exhaustion and depersonalization. Stronger informal support from family and friends appears to have been related to a sense of enhanced personal accomplishment.

Qualitatively, whilst nursing was found to be rewarding, participants identified poor remuneration, high levels of work pressure, lack of inclusion in decision-making regarding work shifts, lack of appreciation, staff shortages, lack of staff cohesion, lack of autonomy, lack of recognition, abuse from patients and their families or escorts, lack of supervisor support, lack of opportunity to voice opinions and make suggestions, the need for career development, and a sense of devaluation as major concerns in their work. These findings largely corroborated the quantitative results, and highlighted the importance for this group of nurses of the issues of inadequate remuneration and abuse from patients and their families, and the need for career development, which were not examined in the quantitative analyses.

Whilst identifying pertinent organizational stressors such as work pressure and lack of physical comfort, the results of this study also strongly emphasise the importance of the social-environmental context in determining burnout in nurses. It seems that the interpersonal ability of the nurse to use coping strategies effectively and the social characteristics of the work environment are of special salience in nursing burnout. Nurses included in the study generally felt unsupported by their colleagues, supervisors, and nursing management, and perceived themselves to have little autonomy and decision-making latitude over many aspects of their own work. They tended to feel that their work, training, and experience were not appreciated or recognized by their colleagues, by medical personnel, and by their patients and their families. These overall feelings of lack of autonomy and the perceptions of high organizational control may have precluded more problem-oriented attempts at coping with work stressors which they were experiencing, and may have had a part to play in respondents making use of the avoidant strategies which were associated with higher levels of burnout.

Whilst remuneration and working conditions need to be improved and are extremely important, it seems that nurses want very much to be respected, recognized, and appreciated for their work, and given the freedom to practice to the limits of their talent and knowledge without institutional or interprofessional interference, as was previously argued by Diers (1982). In order to be able to help others to improve physically, emotionally, and spiritually in this way demands a certain level of individuality, humanness, and psychological health. According to Maslow (1970, in Hjelle & Ziegler, 1981), such self-actualization is generally contingent upon some degree of gratification of needs of lesser potency, that is, physiological needs, safety needs, belongingness

and love needs, and self-esteem needs. The findings of the present study have indicated that, within the nurse's work setting, some of these needs are possibly not being met adequately. Inadequate remuneration may restrict the fulfilment of physiological needs (simply making ends meet) and safety needs (in the form of job uncertainty and inadequate financial security), whilst a rigid, restrictive, non-supportive work atmosphere in which there is a lack of recognition and appreciation may well interfere with gratification of the needs for belongingness, acceptance, and self-esteem. It is clearly in the interests of satisfactory patient care that the conditions under which nurses work be evaluated and improved.

Nursing is an essential service. The nursing profession cannot afford to lose those it spends so much time and money training, neither do nurses generally wish to leave. Burnout, which is one of the major factors in nursing attrition rates, must be dealt with and, in particular, prevented. In transactional terms, it follows that if burnout is a product of both the individual and the social-ecological setting, then this can only occur if management and prevention is undertaken co-operatively by both nurses (through training and the acquisition of effective interpersonal and coping skills) and the organizations for which they work. McGrath et al. (1989) agree that it is indeed time to care for staff, if caring for patients is to be a continuing possibility. Yarborough (1989, p. 113) says, "you can't take care of someone else unless you also take very good care of yourself." The researcher emphasises that nurses need the assistance of their organizations in taking care of themselves. Only then can they care truly adequately for those who entrust them with their well-being.

7. LIMITATIONS OF THE PRESENT STUDY

A number of general limitations, which may have influenced the findings in this study, can be identified, and will be discussed in terms of internal consistencies obtained on subscales of the standardised questionnaires, sample, research design, measurement, and possible theoretical criticisms.

It is emphasised that the findings of this study must be interpreted in the light of the modest Chronbach's alpha reliabilities obtained on responses to a number of the subscales of both the WES and the COPE inventories, and on the personal accomplishment subscale of the MBI.

With regard to sample size, although a total of 617 questionnaires were distributed, the final total of 153 participants, whilst statistically a valid sample, does restrict the generalizability and applicability of the findings. As questionnaires were distributed to all trained nursing staff within the surgical pavilion of the hospital in question, the study sample cannot be regarded as a random sample of all nurses. It could be argued that the most burned out nurses may not have responded to the questionnaire. However, given the high burnout scores evident in this sample, this seems less likely.

So far as research design is concerned, the cross-sectional, correlational design adopted for the study does not permit inferences about causal relationships as results may support opposing hypotheses with reverse paths of causality (Beutell & Greenhaus, 1983, in Kelly, 1991). For example, it is possible that while poorer work relationships may contribute to burnout, burnout may well further reduce the quality of work relationships (Hare et al., 1988). It is thus recognized that, whilst the paths of association are generally discussed as being unidirectional in the present study, relationships between work environment stressors, coping, and burnout may be reciprocal. The designation of the study variables to the role of 'dependent' and 'independent' in the current study design is, however, consistent with previous research in the area (e.g., Boyle, et al., 1991; Ceslowitz, 1989; Hare et al., 1988). Another design limitation of the present study is that it took place at a single point in time.

Limitations of measurement are concerned with criticism of the instruments used and the method of data collection. One possible criticism of the measuring instrument used was that all scales were in English. Given that 47% of the respondents' home language was Afrikaans, and a further 7% spoke Xhosa as a first language, the possibility exists that some participants may have misunderstood the questionnaires. Indeed, some participants completed the open-ended sections of their questionnaires in Afrikaans. However, as the hospital in which the study took place was an English-medium institution, it was considered appropriate to administer the questionnaires in their original form, apart from five minor clarifications. With respect to the method of data collection, only one source of information was obtained, namely, self-report paper-and-pencil responses. Although the instruments included in this study were psychometrically acceptable, there are certain problems with self-report. Folkman and Lazarus (1984, in Kelly, 1991) cite truthfulness, problems with memory, social desirability, language ambiguity, and the use of defence tactics as possible problems. Although the anonymity of the questionnaire provided some form of precaution against such artifacts, the data may have been vulnerable to such inaccuracies.

The research strategy employed in the study may also be criticized for its individual focus as sole source of data, as opposed to the administration of objective measures such as physiological indicators, for example, in conjunction with individual assessment. In defence of the individual focus, however, the study of burnout, work environment and coping *is* dependent on the person's perceptions of events (i.e. cognitive appraisal) and how they will manage this (i.e. coping), and, furthermore, until the findings on burnout and coping, in particular, are clear, the preferred solution is to persist with individual analysis and especially self-report, in order to identify meaningful relationships and rules about the conditions under which they occur. Only then can the use of more costly behavioural and physiological methods of data collection be justified.

A possible theoretical criticism of the current study could be that a dispositional version of the COPE inventory was used, as opposed to relating nurses' coping to specific situations. It is argued, though, that while such an examination would be equally valuable, the number of nursing coping situations which would need to be explored is vast and beyond the scope of this study, and a possible problem with such an approach concerns varying individual perceptions

of the extent of stressfulness of any given situation.

8. STRENGTHS OF THE PRESENT STUDY

The strengths of this study relate to issues of data analysis, theoretical contributions, and to the contribution it offers to nursing research in South Africa.

Regarding data analysis, one strength was the use of multivariate analysis to identify those work environment and coping variables which were associated with the different levels of burnout. These variables were also measured by means of standardized questionnaires which are considered reliable and valid. Another strength was that the study included an analysis of respondents' qualitative reports regarding their experience of their work environment, which served both to corroborate the quantitative findings and to highlight additional issues of importance.

The findings in this study had implications for both burnout and coping theory.

The need to examine burnout, the working environment, and coping across nursing specialities and levels of nursing training, as emphasized by, for example, Dewe (1988), was also addressed in the present study.

This study also makes a contribution to nursing research amongst South African nurses, which is both relatively limited and much needed.

9. IMPLICATIONS OF THE RESEARCH FINDINGS

The findings and limitations of this study have a number of theoretical and practical implications, as well as implications for future research.

9.1 Theoretical implications

With respect to burnout, the finding that personal accomplishment was not related to emotional exhaustion and depersonalization in any way adds weight to Cordes and Dougherty's (1993) suggestion that more attention be directed towards the process of burnout. The present findings suggest that personal accomplishment may either be independent of the other two burnout components or may be related in some other very complex way.

As regards coping, because the present study made use of an inventory which assessed a wide range of coping strategies, it was found that a number of emotion-focused techniques were used to good effect (contrary to previous findings). These findings emphasise the importance of assessing the effects of distinct coping strategies in coping research. As Dewe (1989) has cautioned, emotion-focused coping strategies cannot be overlooked as being second rate or ineffective, and are often the only, or the most necessary, part of the stress transaction. It seems that the various conceptually distinct coping strategies which constitute both emotion- and problem-focused coping should be studied and measured separately. Secondly, this study has offered some empirical evidence of the associations between a range of coping strategies and the effects of work setting stress, in this case burnout, as experienced by a group of South African hospital nurses.

9.2 Practical implications

From a practical perspective, it is important to consider how nurses can manage work stressors. The three strategies which have been used previously to manage stress are (a) to change working conditions, (b) to develop and initiate stress management programs, and (c) to develop interventions based on the relationship between the individual and the environment (Lazarus, 1991, in Dewe, 1993). There are, however, problems with the first two strategies, namely, that changing work conditions may not help all employees, and that stress management programs, which primarily focus and place responsibility on the individual, do not guarantee the resolution

of organizational difficulties. Latack and Havlovic (1992, in Dewe, 1993) emphasise the importance of moving from stress management programmes aimed at individual dysfunction to programs which encourage individual control over working conditions. As it is transactional, with an emphasis on person-environment fit, the third strategy mentioned by Lazarus (1991, in Dewe, 1993) provides that opportunity.

The results from this study highlight how such a program could work for nurses. The primary issues would be (a) to enhance the quality of peer and supervisor interaction and support, (b) to recognize nurses' need for autonomy and the fact that their coping resources will become depleted and will need renewal, (c) to extend the range of coping strategies found to be useful in preventing strain and to make these available to nurses, (d) to change those aspects of the work setting which can be changed, (e) to minimize the impact of work stressors which are less amenable to change, (f) to identify the organizational conditions which can help nurses to express and resolve their difficulties in a constructive way, and, importantly, (g) to enhance nurses' self-esteem by offering recognition and appreciation where it is due. The researcher submits that this type of intervention should be included in the nursing curriculum, together with burnout awareness, life-skills, and interpersonal skills training, so that prevention becomes the predominant way of managing burnout, as opposed to crisis management.

Healthcare organizations need to provide positive, supportive structures through which nurses can grow and develop, rather than simply teaching self-control and coping techniques, or just universally changing aspects of the job. Any initiatives also need to take into account nursing status and nursing speciality, which each have unique features and concerns.

9.3 Implications for future research

This study provided insights into the way in which surgical ward and trauma/emergency hospital nurses experienced their work settings. These findings offer a basis for initiatives to reduce and prevent burnout in these nursing specialities. Similar studies, conducted amongst other nursing specialities could prove equally useful, as could investigations across different types of medical facilities.

Future research on coping and burnout should continue to delineate the associations between

conceptually distinct coping strategies and burnout.

The richer description of contextual factors obtained in this study by not relying exclusively on standardised questionnaires, and the extent to which it corroborated the quantitative findings, emphasizes the potential value of qualitative research in the study of burnout. Cordes and Dougherty (1993) agree that qualitative research could be valuable in future studies on burnout.

Future experimental or quasi-experimental investigations, in which intervention strategies and training programs are devised, implemented, and evaluated over time are necessary, both in terms of ameliorating and preventing burnout.

The findings that the different classes of nurses had unique perceptions and concerns over and above those which they had in common, emphasises the necessity of incorporating nursing status in nursing research.

10. A FINAL REMARK

Burnout is probably the major culprit in dehumanized healthcare provision. It happens frequently, it looks terrible and feels even worse. In order to provide patients with excellent care, burnout must be beaten. It *is* possible.

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APPENDIX A

DATE: _____ 19_____

AGE: _____ Years

GENDER: ☐ Female ☐ Male

HOME LANGUAGE: ☐ Afrikaans ☐ English ☐ Xhosa ☐ Other: _____

MARITAL STATUS: ☐ Never married ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

CHILDREN: ☐ Yes ☐ No AGES: _____

HIGHEST QUALIFICATION: School: _____ Other: _____

CURRENT NURSING STATUS: ☐ Professional nurse
☐ Enrolled nurse
☐ Enrolled assistant nurse

HOW LONG HAVE YOU HAVE BEEN NURSING? _____ Years _____ Months

ARE YOU CURRENTLY ON DAY DUTY OR NIGHT DUTY? ☐ Day duty ☐ Night Duty

WHEN LAST DID YOU HAVE LEAVE? _____ FOR HOW LONG? _____

WARD/DEPARTMENT IN WHICH YOU CURRENTLY WORK: ☐ Surgical Wards
☐ Theatre
☐ Trauma/Emergency
☐ Orthopaedics
☐ ENT
Other: _____

Your opinion is sought in this questionnaire, therefore there are no right or wrong responses to any of the statements or questions. Please read each statement carefully and try to answer *every* item.

Below are a number of statements about the place in which you work. The statements are intended to apply to all work environments, but some words may not be quite suitable for your particular place of work, for example, the term supervisor is meant to refer to the head nurse, matron or any person/s to whom you report. Please read each statement carefully and be sure to answer *every* statement.

Circle either the *T* (for *true, or mostly true*) or the *F* (for *false, or mostly false*), depending on whether or not it describes your own working environment.

---

1. The work is really challenging. T F
2. People go out of their way to help a new employee feel comfortable. T F
3. Supervisors tend to talk down to employees. T F
4. Not many employees have any important responsibilities. T F
5. People pay a lot of attention to getting work done. T F
6. There is constant pressure to keep working. T F
7. Things are sometimes pretty disorganised. T F
8. There's a strict emphasis on following policies and regulations. T F
9. Doing things in a different way is valued. T F
10. Sometimes it gets too hot here. T F
11. There's not much group spirit. T F
12. The atmosphere is a bit impersonal. T F
13. Supervisors usually compliment an employee who does something well. T F
14. Employees have a great deal of freedom to do as they like. T F
15. There's a lot of time wasted because of inefficiencies. T F
16. There always seems to be an urgency about everything. T F
17. Activities are well-planned. T F
18. They are not very strict about what you wear in this place. T F
19. New and different ideas are always being tried out. T F
20. The lighting is extremely good. T F
21. A lot of people seem to be just putting in time. T F
22. People take a personal interest in each other. T F
23. Supervisors tend to discourage criticisms from employees. T F
24. Employees are encouraged to make their own decisions. T F
25. Things rarely get "put off until tomorrow". T F
26. People cannot afford to relax. T F
27. Rules and regulations are somewhat vague and ambiguous. T F
28. People are expected to follow set rules in doing their work. T F
29. This place would be one of the first to try out a new idea. T F
30. Work space is awfully crowded. T F
31. People seem to take pride in the organisation. T F
32. Employees rarely do things together after work. T F
33. Supervisors usually give full credit to ideas contributed by employees. T F
34. People can use their own initiative to do things. T F
35. This is a highly efficient, work-oriented place. T F
36. Nobody works too hard. T F
37. The responsibilities of supervisors are clearly defined. T F
38. Supervisors keep a rather close watch on employees. T F
39. Variety and change are not particularly important. T F
40. This place has a stylish and modern appearance. T F
41. People put quite a lot of effort into what they do. T F
42. People are generally frank about how they feel. T F
43. Supervisors often criticize employees over minor things. T F

44. Supervisors encourage employees to rely on themselves when a problem arises. T F

45. Getting a lot of work done is important to people. T F

46. There is no time pressure. T F

47. The details of assigned jobs are generally explained to employees. T F

48. Rules and regulations are pretty well enforced. T F

49. The same methods have been used for quite a long time. T F

50. The place could stand some new interior decorations. T F

51. Few people ever volunteer. T F

52. Employees often eat lunch together. T F

53. Employees generally feel free to ask for a salary increase. T F

54. Employees generally do not try to be unique and different. T F

55. There's an emphasis on "work before play". T F

56. It is very hard to keep up with your work load. T F

57. Employees are often confused about exactly what they are supposed to do. T F

58. Supervisors are always checking on employees and supervise them very closely. T F

59. New approaches to things are rarely tried. T F

60. The colours and decorations make the place warm and cheerful to work in. T F

61. It is quite a lively place. T F

62. Employees who differ greatly from the others in the organisation don't get on well. T F

63. Supervisors expect far too much from employees. T F

64. Employees are encouraged to learn things even if they are not directly related to the job. T F

65. Employees work very hard. T F

66. You can take it easy and still get your work done. T F

67. Fringe benefits are fully explained to employees. T F

68. Supervisors do not often give in to employee pressure. T F

69. Things tend to stay just about the same. T F

70. It is rather draughty at times. T F

71. It's hard to get people to do any extra work. T F

72. Employees often talk to each other about their personal problems. T F

73. Employees discuss their personal problems with supervisors. T F

74. Employees function fairly independently of supervisors. T F

75. People seem to be quite inefficient. T F

76. There are always deadlines to be met. T F

77. Rules and policies are constantly changing. T F

78. Employees are expected to conform rather strictly to the rules and customs. T F

79. There is a fresh, unique atmosphere about the place. T F

80. The furniture is usually well-arranged. T F

81. The work is usually very interesting. T F

82. Often people make trouble by talking behind others' backs. T F

83. Supervisors really stand up for their people. T F

84. Supervisors meet with employees regularly to discuss their future work goals. T F

85. There's a tendency for people to come to work late. T F

86. People often have to work overtime to get their work done. T F

87. Supervisors encourage employees to be neat and orderly. T F

88. If an employee comes in late, s/he can make it up by staying late. T F

89. Things always seem to be changing. T F

90. The rooms are well ventilated. T F

This section of the questionnaire comprises a list of statements about various job-related attitudes that people may have. You are required to read each statement carefully and then indicate, by circling the number which corresponds with HOW OFTEN *and* HOW STRONGLY each applies to you.

Be sure to answer *all* of the items - you should circle *two* numbers for each item.

	HOW OFTEN Never = 0 A few times a year or less = 1 Once a month or less = 2 A few times a month = 3 Once a week = 4 A few times a week = 5 Every day = 6	HOW STRONG 0 = Never 1 = Very mild 2 3 4 = Moderate 5 6 7 = Very strong
1. I feel emotionally drained from my work.	0 1 2 3 4 5 6	0 1 2 3 4 5 6 7
2. I feel used up at the end of the work day.	0 1 2 3 4 5 6	0 1 2 3 4 5 6 7
3. I feel fatigued when I get up in the morning.	0 1 2 3 4 5 6	0 1 2 3 4 5 6 7
4. I can easily understand how my patients feel about things.	0 1 2 3 4 5 6	0 1 2 3 4 5 6 7
5. I feel I treat some patients as if they were impersonal objects.	0 1 2 3 4 5 6	0 1 2 3 4 5 6 7
6. Working with people all day is really a strain for me.	0 1 2 3 4 5 6	0 1 2 3 4 5 6 7
7. I deal very effectively with the problems of my patients.	0 1 2 3 4 5 6	0 1 2 3 4 5 6 7
8. I feel burned out from my work.	0 1 2 3 4 5 6	0 1 2 3 4 5 6 7
9. I feel I'm positively influencing other people's lives through my work.	0 1 2 3 4 5 6	0 1 2 3 4 5 6 7
10. I've become more callous (unfeeling) toward people since I took this job.	0 1 2 3 4 5 6	0 1 2 3 4 5 6 7
11. I worry that this job is hardening me emotionally.	0 1 2 3 4 5 6	0 1 2 3 4 5 6 7
12. I feel very energetic.	0 1 2 3 4 5 6	0 1 2 3 4 5 6 7
13. I feel frustrated by my job.	0 1 2 3 4 5 6	0 1 2 3 4 5 6 7
14. I feel I'm working too hard on my job.	0 1 2 3 4 5 6	0 1 2 3 4 5 6 7
15. I don't really care what happens to some patients.	0 1 2 3 4 5 6	0 1 2 3 4 5 6 7
16. Working with people directly puts too much stress on me.	0 1 2 3 4 5 6	0 1 2 3 4 5 6 7
17. I can easily create a relaxed atmosphere with my patients.	0 1 2 3 4 5 6	0 1 2 3 4 5 6 7
18. I feel exhilarated after working closely with my patients.	0 1 2 3 4 5 6	0 1 2 3 4 5 6 7
19. I have accomplished many worthwhile things on this job.	0 1 2 3 4 5 6	0 1 2 3 4 5 6 7
20. I feel like I'm at the end of my rope.	0 1 2 3 4 5 6	0 1 2 3 4 5 6 7
21. In my work, I deal with emotional problems very calmly.	0 1 2 3 4 5 6	0 1 2 3 4 5 6 7
22. I feel that patients blame me for some of their problems.	0 1 2 3 4 5 6	0 1 2 3 4 5 6 7

There are many ways in which people respond when confronted with difficult or stressful events in their lives. This section of the questionnaire asks you to indicate what *you* generally do and feel when *you* experience stressful events. Obviously different events bring about somewhat different responses, but think about what you *usually* do when you are under a lot of stress.

Please circle the number which corresponds with how often the statement applies to you when you deal with different stressful events.

1 = Not at all.....	*I usually don't do this at all*
2 = Not often.....	*I don't usually do this except every now and again*
3 = Often.....	*I often do this, but not all the time*
4 = Most of the time...	*I almost always do this*

GENERALLY, WHEN I EXPERIENCE A DIFFICULT OR STRESSFUL SITUATION...

1. I talk to someone about how I feel.
   1 2 3 4

2. I make a plan of action.
   1 2 3 4

3. I talk to someone who could do something concrete about the problem.
   1 2 3 4

4. I turn to work or other substitute activities to take my mind off things.
   1 2 3 4

5. I just give up trying to reach my goal.
   1 2 3 4

6. I go to movies or watch TV, to think about it less.
   1 2 3 4

7. I drink alcohol or take drugs, in order to think about it less.
   1 2 3 4

8. I keep myself from getting distracted by other thoughts or activities.
   1 2 3 4

9. I think about how I might best handle the problem.
   1 2 3 4

10. I accept the reality of the fact that it happened.
    1 2 3 4

11. I force myself to wait for the right time to do something.
    1 2 3 4

12. I admit to myself that I can't deal with it, and quit trying.
    1 2 3 4

13. I look for something good in what is happening.
    1 2 3 4

14. I pretend that it hasn't really happened.
    1 2 3 4

15. I hold off doing anything about it until the situation permits.
    1 2 3 4

16. I try hard to prevent other things from interfering with my efforts at dealing with this.
    1 2 3 4

17. I think hard about what steps to take.
    1 2 3 4

18. I refuse to believe that it has happened.
    1 2 3 4

19. I get upset and let my emotions out.
    1 2 3 4

20. I take additional action to try to get rid of the problem.
    1 2 3 4

21. I learn to live with it.
    1 2 3 4

22. I restrain myself from doing anything too quickly.
    1 2 3 4

23. I get upset, and am really aware of it.
    1 2 3 4

24. I try to get emotional support from friends and relatives.
    1 2 3 4

25. I ask people who have had similar experiences what they did.
    1 2 3 4

26. I do what has to be done, one step at a time.
    1 2 3 4

27. I learn something from the experience.
    1 2 3 4

28. I try to come up with a strategy about what to do.
    1 2 3 4

29. I act as though it hasn't even happened.
    1 2 3 4

30. I try to find comfort in my religion.
    1 2 3 4

31. I take direct action to get around the problem.
    1 2 3 4

32. I focus on dealing with this problem, and if necessary let other things slide a little.
1 2 3 4

33. I make sure not to make matters worse by acting too soon.
1 2 3 4

34. I seek God's help.
1 2 3 4

35. I get sympathy and understanding from someone.
1 2 3 4

36. I say to myself "this isn't real".
1 2 3 4

37. I accept that this has happened and that it can't be changed.
1 2 3 4

38. I pray more than usual.
1 2 3 4

39. I let my feelings out.
1 2 3 4

40. I sleep more than usual.
1 2 3 4

41. I try to get advice from someone about what to do.
1 2 3 4

42. I try to see it in a different light, to make it seem more positive.
1 2 3 4

43. I reduce the amount of effort I'm putting into solving the problem.
1 2 3 4

44. I feel a lot of emotional distress and I find myself expressing those feelings a lot.
1 2 3 4

45. I daydream about things other than this.
1 2 3 4

46. I talk to someone to find out more about the situation.
1 2 3 4

47. I put my trust in God.
1 2 3 4

48. I put aside other activities in order to concentrate on this.
1 2 3 4

49. I give up the attempt to get what I want.
1 2 3 4

50. I discuss my feelings with someone.
1 2 3 4

51. I concentrate my efforts on doing something about it.
1 2 3 4

52. I try to grow as a person as a result of the experience.
1 2 3 4

53. I get used to the idea that it happened.
1 2 3 4

In your *professional capacity* as a nurse, how much control do you generally feel that you have in your *job*? Please circle the estimated amount on the following scale:

0	1	2	3	4	5	6	7	8	9	10
None	hardly		not much		average		fair amount		considerable	

How much control do you feel you have over your *life in general*? Please circle the estimated amount on the following scale:

0	1	2	3	4	5	6	7	8	9	10
None	hardly		not much		average		fair amount		considerable	

Are there any areas in your job in which you would like to have more control? If so, please mention them.

_____

_____

_____

_____

How satisfied are you with your job?

0	1	2	3	4	5	6	7	8	9	10
Not at all		not very			average		fairly		totally	

What might possibly make your job more fulfilling and satisfying?

_____

_____

_____

_____

_____

_____

How well supported do you feel by *nursing colleagues* when you're under stress at *work*?

0	1	2	3	4	5	6	7	8	9	10
Not at all		not very			average		fairly		totally	

How well supported do you feel by *friends or family* when you're under stress at *work*?

0	1	2	3	4	5	6	7	8	9	10
Not at all			not very		average		fairly		totally	

Do you feel appreciated for the work you do?

0	1	2	3	4	5	6	7	8	9	10
Not at all			not very		average		fairly		totally	

Which areas of your job do you find particularly stressful?

Please feel free to express any further opinions or feelings. For example, what you find most rewarding or frustrating about nursing or how you experience being part of a large organisation like Groote Schuur. You might even like to suggest changes which should be made within the profession.

THANK YOU VERY MUCH FOR YOUR PARTICIPATION IN MY STUDY! I APPRECIATE THE TIME DEVOTED AND TRUST THAT, BY HIGHLIGHTING POSSIBLE STRESSES IN YOUR WORKING LIFE AND THE WAYS IN WHICH YOU HANDLE THESE, THE EXPERIENCE WILL HAVE BEEN MEANINGFUL FOR YOU.

APPENDIX B

UNIVERSITY OF CAPE TOWN

Department of Psychology

University of Cape Town · Rondebosch 7700 · South Africa
Telephone: (021) 650-9111
Fax No: (021) 650-3726

16 January 1995

Dear Nursing Professional

I am currently completing an internship in health psychology. Research of an academic nature, which also has a strong practical application, forms part of the requirements for this Master's degree. My work is supervised by Dr Richard Oxtoby.

During my own nursing career I became aware of the stresses which are often experienced in the hospital setting. With this study, I hope to be able to obtain more information about specific causes of such stresses and how nurses generally deal with these. I would like to use this information in an effort to contribute towards finding ways of lessening the effects of stress in nursing, should this be through fostering awareness, education, development of stress management skills and/or the establishment of sources of support.

For any such program to be effective, it is vitally important to obtain the relevant information from the people within the profession. I would thus be sincerely grateful if you would assist me by completing the enclosed questionnaire and returning it to me in the stamped, self-addressed envelope provided, as soon as you can manage. Should you have any queries, you are welcome to contact me on 96-8033.

As you are not required to furnish your name on the questionnaire, please be assured that you will remain absolutely anonymous. Please be free, thus, to be completely open in your responses. Your opinion is sought, therefore there are no right or wrong responses to any of the statements or questions. Please read each statement carefully and try to answer every item.

Thank you for your time and effort in sharing your insight and experience!

Yours sincerely

Signed by candidate

Signature removed

MISS M NIXON

APPENDIX C

DEMOGRAPHIC CODE SHEET

Respondent number: ____

Age:
1 = 20 - 25 years
2 = 26 - 30 years
3 = 31 - 35 years
4 = 36 - 40 years
5 = 41 - 45 years
6 = > 46 years

Gender: Female = F Male = M

Home language:
A = Afrikaans
E = English
A/E = Afrikaans & English
X = Xhosa
O = Other

Marital Status:
NM = Never Married
M = Married
D = Divorced
W = Widowed
S = Separated

Children?: Y = Yes N = No

Children's Ages:
1 = 0 - 6 years
2 = 7 - 12 years
3 = 0 - 12 years
4 = 13 - 18 years
5 = 0 - 18 years
6 = > 18 years

Educational Status:
1 = Below Matriculation
2 = Matriculation Certificate
3 = Nursing Qualification - Enrolled Nurse
4 = Nursing Qualification - Professional Nurse
5 = Postgraduate Qualifications

Nursing Status:
PN = Professional Nurse
EN = Enrolled Nurse
ENA = Enrolled Nursing Assistant

Years of Nursing Experience (rounded to the nearest year):
1 = 0 - 5 years
2 = 6 - 10 years
3 = 11 - 15 years
4 = 16 - 20 years
5 = 21 - 25 years
6 = > 25 years

Day/Night Duty: D = Day Duty N = Night Duty

Time Since Last Vacation: Expressed in weeks

Length of vacation: Expressed in days

Current Ward/Department: S = Surgical Wards T = Trauma/Emergency

APPENDIX D

VERBATIM RESPONSES TO OPEN-ENDED QUESTIONS POSED IN THE RESEARCH QUESTIONNAIRE

PROFESSIONAL NURSES (PNs)

Q1 "Are there any areas in your job in which you would like to have more control? If so, please mention them."

- None x 5.

- N/A.

- Where I work...[Trauma/Emergency].

- More control in organization of stock/equipment. More control re status of professional nurse, e.g., given more responsibility in sorting and seeing to minor ailments.

- Choice of ENAs who work in my department...[Theatre]. Choice of PNs who work in my department...[Theatre]. Frequency control on rotation of staff. Report writing.

- I would like to have control of whom I want working in my department...[Theatre].

- The area in which one works must be decided on by the individual and not the system, i.e., management/supervisors.

- Staffing: amount of staff; allocation, eg., departmental leave roster, night duty allocation. Decision-making: not everything should have to be approved by top management; let the staff in the ward make the decision and be responsible for it.

- In Trauma Unit staff sometimes end up working 5-6 months of night duty and this is extremely disruptive on one's personal life. I feel we shouldn't be forced to work nights for so long.

- Solving problems in the ward without having to notify the Nursing Service Manager. She intends to be too autocratic because of her position. I abhor this kind of attitude. She intends also to be more holier than thou.

- In dealing more effectively with staff who has emotional/domestic problems that insists on (acc. vac.) leave when you can't give to them. Personal growth of staff as well as my own. Medical staff who thinks they are superior to the rest of the team.

- Not at present - doing part-time study, so time for me is limited and less responsibility is better now.

- I try to be as democratic as possible towards my colleagues. But this seem get out of hand at

times because the nurse takes advantage of the situation. More control over the nurses but not with an iron fist.

- Probably in a delegating capacity. I sometimes feel I lack good leadership qualities.

- I would like it if I received more respect from nursing staff and general assistants. I am not taken seriously. Would be great to have a bigger influence over days off, especially as my social life has gone to the dogs - thanks to work!

- Off duties - I would just like to have fair off duties.

- Hours of work - 12 hrs/3 times a week for a family person can really drain you. Influx of patients - if 2 neurosurgical wards with reduced amount of patients - less stressful. Surgical interventions on patients: the frail and elderly should not be forced/pressurised to accept surgery.

- All paramedics should be included in planning of the patient's management - I think so far it's only doctors. Even in management some issues must be discussed with us before they are put in action, e.g., getting paid on the 15th of each month, which was not discuss.

- Areas like the Triage, nursing staff have limited control over sorting patients coming in the Emergency Unit. Whereas the doctors who work there are housemen and are inexperienced and make mistakes most of the times which we as nursing staff have to cover up.

- Yes. Some of the decisions concerning the patients which is made by doctors.

- Making reasonable decisions without fear of disciplinary thus having to consult the matron as if you're no mature grown up.

- More control in my interaction with doctors and their attitude of being better and often disregarding views or observations of the nurse.

- I would like that the image of the nurse to be uplifting from a doctor's handmaiden to a independent nurse practitioner.

- Decision making - on how to help with cutting costs.

- Yes. In our Triage area (sorting). To deal and educate our people to see how urgent it is for them to come to hospital instead of DHO...[Day Hospitals Organization].

- Try have control over aggressive "gangster" patients. Have minimal control thusfar.

- Safety. Off duties.

- Being able to express my feelings, i.e., being a true advocate for my patients and staff. Being more assertive sometimes.

Q2: "What might possibly make your job more fulfilling and satisfying?"

- If I would not have pressure from my superiors and if I can earn a living wage considering that nursing is the or one of the most important jobs or professions because nurses care for human life.

- Less interference. To be able to have more say in decision making. Being afforded the respect that you should get, even if their status is higher. The Nursing Service Manager must try to be fair, which she is not always. Also to be more understanding.

- More inservice training, eg., lectures/talks/videos relating to our area (Emergency Unit). More responsibility in assessing patients and taking a history. The supervisor is not very dynamic with the result unit is disorganized in terms of stock/equipment. Having a more dynamic person would make it more interesting and organized, easier place to work.

- More inservice training and education.

- Go on with my studies as at present and be better qualified so I can get out of being moved from dept. to the next without much consultation of any at all.

- The opportunity to have more time and assistance to do research much needed in the field of infection control nursing.

- More control over operating lists. Above 4* points. Own control over stock and equipment. Sole responsibility of stock counting.

- To be allowed to use my initiative more often. An increase in salary.

- Having autonomy to make decisions on my own. Doctors need not to make decisions for me as professional nurse.

- If the management will allow people to make decisions themselves and allow them to sort out their interdepartmental problems themselves.

- To be able to have more say in the management or the everyday function of the ward as to how better to accommodate the patient in this very difficult and expensive times and to be able to cut down on red tape.

- If a supervisor could adopt democratic leadership style so that every one can participate in decision making. If the supervisors could be not more conscious about regulations or writing statement or disciplinary measures on small matters. If we can have other activities at work, eg., going out, dance, or choral choirs. This will help us to relieve stress at work. As our homes are sometimes stressful.

- Having more support from supervisors. Not having them on your case at times when you do make a mistake. Appreciation from them when you do your best. Having a change in attitude of patients and families towards you (they do not have that respect for nurses anymore).

- For the authorities to be less rigid about certain things. To acknowledge more positively how

hard we are really working. Also to be able to ask for a holiday when you want it and not when there is a space available. To not always feel as though you are taking sick leave when it is not convenient, i.e., you are hardly ever off sick but are made to feel it is a crime.

- If your authorities would be more open to their employees' point of view. Actually my main problem lies with my supervisor who always treat you like a child. They always want to show you who the boss really is - very disappointing.

- Being able to reach out to the community (by awareness campaigns). Being recognized for what you do for patients. By encouraging more professional people to be actively involved in self-motivation (growth).

- I enjoy nursing very much, but I only think my salary of R1500.00 p.m. is ridiculous for four years training, and that makes me very frustrated.

- By reviewing all our salaries as nurses because the cost of living is too high and I find out that I can't make ends meet.

- Music in the background while we work...[Trauma/Emergency]. Appreciation from the patients for the help I give them.

- To be more appreciated by patients and employer. To be listen to if you have a problem. To be better paid for work done.

- Recognition - re work performance. Better salary. Better working hours.

- If everybody could just recognize my good deeds once.

- Recognition for working in this highly stressful area...[Trauma/Emergency]...by means of danger allowance as we nurses are often abused verbally and physically by patients and relatives. To be able to work in a more safe environment, eg., security step-up inside the Emergency Unit. To have leave at least every 6 months.

- Senior people to give you the credit of the days work that are done. More compliments. Appreciate what we nurses (juniors) are doing.

- If your supervisors listen to your problems. If your supervisor gives you credit if you achieved a goal in your unit. If they praise you if you work short staff and very hard. If you have more staff.

- More appreciation from my patients and more consideration from my employer. Our employer does not seem to realize under how much stress we are working and that working with a skeleton staff makes matters even worse. Most of the time I just look to get paid at the end of the month and that is not even worth looking forward to.

- Sincereness and appreciation from everybody.

- Receiving recognition for the extra work that one puts in. Allowing people/employees to voice

their opinions without fear of incrimination.

- I might feel more satisfied and fulfilled if we were actually paid better after 4 years of studying for a diploma or a degree - the yearly increments do not even get seen in your nett salary and we haven't had an increase for ages. Also, I feel we should be paid extra for working public holidays and weekends - as in the private sector.

- Increased remuneration. Better rapport with supervisors.

- A higher salary. Recognition for what I'm doing.

- To be better paid. That top management be aware what is happening on ward level.

- Better pay. More leave. Better working conditions, i.e., equipment that works, spacious facilities, etc.. Supervisors who stand by their workers and have the workers' interests at heart.

- More money. More respect from higher authority (matrons and doctors).

- More money. Study for 4 years and earn peanuts. Uplift the status of a nurse. Your safety on duty, eg., gangsters. Supervisors must look to the benefits of married women.

- If we were given money for stress compensation my job will be more fulfilling and satisfying and when patients lay charge on nurses hearing must be done on both.

- Being able to work in the areas you feel you would like to work. Being able to go to your supervisor freely with personal problems and getting them solved/supervisor showing some sensitivity to your situation. Not just being thrown into the deep end and expected to function optimally. Recognition from Government level toward nursing in general. Fringe benefits improved, eg., housing subsidies to all, transport facilities.

- To rotate on at least a 6-monthly basis and NOT to stagnate in one area for longer than 1 year.

- If there was enough time to get routine work done, and have spare time to interact with the patients. If documentation could be more simplified (nursing process and care plans are a total waste of time - no one reads it and it does not improve patient care). If I did not have to work every second week-end and most public holidays and 3 months night duty I could get closer to friend and family support (as is - one tends to be isolated, as you are too tired to socialize after a 7-7).

- Emergency Unit is the best place to work in but you get treated like dirt by the doctors, patients and impatient escorts. If this could be changed we, as nursing staff, will never have a better time in this area.

- If the public were not so rude and demanding. If the superiors would consider as human beings that also needs basic things like a house, good salary and protection as well as recognition. There is no protection but we are exposed to a lot of danger...[Surgical wards].

- A solution to the 'sardine tin' situation in the Holding Area...[Trauma/Emergency]. Adequate

staff/per patient ratio. Not having to search for equipment/drugs. Further improvement in the porter situation. A chance to stay 'put' in this area and really get to know it well.

- To work with the amount that you can cope with - not to do work that you are not trained for. To have more staff when you must take and nurse a patient that is not for your area.

- To be given enough staff to give excellent nursing care and also to find time to teach, which is neglected at the moment. Not to have to do so many non-nursing duties, eg., answering phone, fetching things from stores, ward clerk duties because ward clerks who have resigned do not get replaced. Getting real acknowledgement when we do all the extra work. eg., when strikes take place, and not just a "message of thanks".

- More staff to cope with patients. More money.

- Add more staff and reduce hours.

- More staff. More money, e.g., DANGER MONEY. Co-operation of escorts of patients and patients. Less writing of statements for small (nonsense) problems. Less working hours (12 hours too much), eg., mothers must still go see to housework, food, paying bills, childrens' schoolwork, etc..

- If we could do away with old fashion matrons who are still governed by old policies, like you must stand up for them. Some matrons they still treat you like a child or criminal if you have been off sick as if you stayed away purposely. More money can also make my job more fulfilling, imagine you train for four years and you end getting paid same wages as one who is in factory with no training.

- If all professional staff could pull their weight, be little more efficient and together can achieve greater goals through teamwork.

- Total commitment.

- If employees can just commit themselves more.

- That I may work nearer to my home to cut out getting up at 04:30 in the morning and get home at night at 20:30. It tires me and makes me feel irritated with travelling.

- I hate administrative work and it would make me very happy and satisfied if I could stay in a clinical field.

Q3 "Which areas of your job do you find particularly stressful?"

- None.

- There's some degree of stress in every area.

- Theatre days - one sister on duty...[Surgical wards].

- Oncology x 3; Neurosurgery; Medical wards; Trauma/Emergency areas; Theatre;

- Medical wards. Those wards are busiest wards in this hospital.

- In Casualty and some surgical wards where neuro patients are nursed and in the wards where most patients have amputation of limbs.

- Working in a vascular ward with 3/4 of the ward pt. have amputations and they are not properly counselled. Nurse must deal with problems, because patients projecting their feelings into us.

- The whole Unit...[Trauma/Emergency]... - management, administration, patient care, workload.

- All areas in Emergency Unit are stressful. One has to contend with the demands of patients, their relatives and doctors who never can find anything on their own. One has to play receptionist, porter, clerk, doctor's assistant, psychologist, domestic, etc., etc.....then go home and play mommy and wife.

- I love working in the Emergency Unit. But I always feel so run down at the end of the day. Trying to do everything for the patient, getting the work done and generally just coping with the load of patients seen in proportion to the staff. I feel the patients are being short-changed sometimes in their medical and nursing care, not for any other reason but lack of staff.

- Holding area...[Emergency]...Because doctors/sisters just dump patients in Holding area and you must find solutions to patients' problems. Lots of social cases is left to be sorted out by you as sister. In Holding area the sister and nurse must run around getting results of patients and showing it to the doctors. Patients and escorts often abuse the staff, e.g., using bad language.

- Dealing with escort of patients especially in Emergency Unit who are rude and abusive. Also patients who are rude and drunk in Trauma Unit. Going to ask for an acc. vac....[accumulated vacation]... from the matron you feel as if you are climbing Table Mountain.

- Working with abusive members of public who do not want to understand your position in the hierarchy.

- Having to deal with escorts of patients. Also very stressful when, for e.g., four very sick patients comes into the...[Trauma/Emergency]...Unit all at once, especially in Emergency Unit, you have to deal with +/- up to 90 patients a day.

- Dealing with escorts of patients. Shortage of staff. Salary - little money, eg., in Emergency Unit we get no DANGER money. Some people taking you for a servant more than a nurse.

- In dealing with the increase gangster activity in the trauma unit and ward.

- Having to deal with drunk and aggressive patients and even their relatives makes it difficult for me to show empathy towards them. Also having to resuscitate patients who have murdered others or are gangsters - I feel what is it all for? Just to get them back on the streets to commit crime again. I also feel emotionally drained when we get innocent victims of trauma for resuscitation and they die, eg., 14 year-old girl dying from a car accident.

- Dealing with violent patients in...[Emergency]...Unit with minimum protection. Having to put up with verbal abuse from patients and the public, i.e., relatives escorting patients. Daily workload of the Unit - seeing a minimum of 70-80 patients per day - very ill patients with limited staff on duty.

- When I work from 7am to 7pm.

- We receive out patients mostly from Trauma Unit (70%) and 30% cold cases. Trauma staff tends to be inconsiderate when transferring patients. At times as much as 3 at a time. I know they very busy but consider the ward situation...[Orthopaedics]...where cold cases is concern. The doctors does not care where we put halve of the patients and how much nurses we have on duty to see to all their needs.

- Night duty.

- Night duty and not having the time to give really adequate patient care. Working in an area...[Trauma/Emergency]... where 'some people' just don't seem to care - broken equipment - a messy environment.

- The long unsociable hours. Particularly being on call and working day and night.

- Time management - too much happening at once, i.e., 5 porters in the ward at once, all wanting your attention. No one else seems to be around when the ward is busy. Having high absentee rates - increases the workload for those left - burning them out. Prioritizing orders - many tasks to get doen in a short time.

- Working in Trauma Unit with under staff especially holdings and night duty.

- Shortage of staff. Being treated like a naughty child when reprimanded for a trivial offence.

- Shortage of staff. Patient turnover. Sick and absentee rate. "Strikes".

- Having to cope or trying to cope with insufficient staff to provide the necessary nursing care. That the nursing staff has to fill in whenever there is a , eg., strike, go-slow or absenteeism of domestics, clerks, porters, etc.; has to do the extra work and still is expected to cope with the nursing care and mustn't slip up, eg., forget something! That one hears so often "we will just have to cope" and "it's probably not going to get better", eg., staffing. Having to sort out every

problem - from doctors to cleaners, porters, clerks - it's always the sister's responsibility to find a solution, to control them, eg., cleaners.

- The fact that I am supposed to know everything and must have a answer for everything in the ward.

- Amount of work load, in addition there is no clerk in the unit...[Trauma/Emergency]...to handle enquiries, fetch folders from reception. A great deal of time is spent looking to see where patients have gone, etc.. Amount of enquiries is considerable.

- Assisting with an outbreak...[Infection control]... - overtime is often necessary when needing to perform extra surveillance methods needed to detect the source of the problem. Dealing with labour related problems in a strike situation, i.e., abuse of equipment, protective clothing and disrupted environmental hygiene services.

- Constant changing of staff. Constant changing of operating lists. Staff allocated to Theatre who are COMPLETELY NOT SUITED to Theatre. Constant interference from 'Middle Management'.

- Co-ordinating the different members of the multidisciplinary team to provide total patient care especially when members, i.e., social worker or data is not available for immediate action required. Being responsible for everyone even if the work is not in my scope of practice.

- I feel that my job could be less stressful if the communication between all team members was effective and if the nurses would work together for the benefit of the patient and their colleagues.

When people can't work together then it feels there are more pressure on one person. When there is less team spirit. When you are fighting for a person's life. Resus. A. Trauma Unit.

- Having to answer everybody's questions from all categories of staff, i.e., nurses, domestics, doctors, pharmacist, social worker, porters, etc..

- Medical staff that expects you to answer to their beck and call and taking for granted that the nursing will do what is expected. During strike periods when patient need diagnostic tests and the nursing staff have to fetch, take and escort patients when you have minimum staff available. Management is never prepared when strikes happen. Patients need to be cancelled.

- Medical staff. Extra services, eg., portering, computer not working, general assistance, strikes, clerical staff; accidentally most of the support system in This hospital are not functioning and it is the nurses' responsibility to ensure that everything is done because she is legally answerable to her patients' needs.

- In dealing with new doctors who have a very high opinion about themselves and then say I am the doctor and you are only a nurse. Sometimes we have to resort to drastic steps by reporting them to the Head of Department before they, the doctor, listen to us.

- After hours the doctors all fight to have their emergencies done with a minimum amount of

staff...[Theatre]. You as the nurse don't have the right to decide whose cases are more important and the doctors try to involve the sisters in their fights.

- When dealing with a severely injured patient or trying to comfort relatives of a deceased patient especially if death was unexpected.

- Counselling patients especially if drug addicts. Theatre nights. Intake (double lot) on weekends with gangsters who often stabbed/gunshot victim who are abusive, aggressive toward multidisciplinary team.

- When people make decisions which involves you and not bothered to discuss it with you. People going back on their promises. Makes you feel very junior and sometimes it appears that they are not aware of your existence unless there are serious matters involved - to write statements.

- The fact that I am not being given credit for my experience and qualifications.

- When you put in all your effort and nobody takes notice. Should there be a mistake, everyone makes a loud noise.

- Not knowing enough.

- Working with nurses that does not give their co-operation. Working sometimes with limited equipment and night workload and getting no "thank you" for your input and effort.

- To have to beg for what you want done by some employees.

- Heavy workload especially over weekends. Very badly injured patients and many patients arriving at Trauma at the same time. Verbal and physical abuse from patients when you try to help them.

- The stupid reasons for some legal abortions.

- Being thrown in an area, on night duty where I've never worked as a registered nurse. Having all the responsibilities of a 32 bed ward, high care of 6 beds included placed on me solely. When I approached my supervisor to tell her I don't feel capable, her reply was: "It's only a bit of hard work". Mixing IV infusions over weekends - sometimes close to 40 per night. Confused patients pulling out drips, tubes and catheters several times during the night - being restrained.

- When your supervisor promises you one thing, but exactly the opposite is being done.

Q4 "Please feel free to express any further opinions or feelings."

- Nurses don't work for charity anymore. Florence is dead. Pay us more - it is a job - you studied for it. Do away with the old militant matrons. Get one category for nurses (anyway nursing is cheap labour). All categories are doing the same duties - it is a fact that management **must** accept, eg., why not just professional nurses or just assistant nurses. I'm saying this many times enrolled nurses and enrolled nurse assistants must do sisters' work because there are not enough sisters.

- Change the uniform policy and allow us to wear sandals and no pantyhose - it's unhygienic. I often just feel like a number - people in higher echelons don't really listen to your problems at ward level. One complains, one tells about shortages - and gets told we can do nothing about it. Improve the salaries - for the hard work and big responsibility - our salaries don't reflect that. And people who don't work - fire them, there are enough unemployed people out there who want to work. Provide decent airconditioning for the wards - it's boiling in summer!

- Nursing is strenuous, demanding, we are practising under rules and regulations and small matters are serious in a way that you can find yourself answering in disciplinary committee. In other wards you will find that supervisors (head nurses) are applying pressure on the staff. What is rewarding in nursing is non except we try to use all our efforts in maintain the patients' health. We give a comprehensive care to our patients therefore there is no reward. What we do is for the benefit of our patients.

- The whole system of this hospital needs to be revised. I feel almost sorry for the patients at how long they have to wait to be tended to some times. We need more medical and nursing staff to satisfy completely the patients' hierarchy of needs. I find that This hospital in the whole seems to be on the decline. In the nursing profession and increase in salary would be great, then more scope for further studies. Nobody wants to stagnate and that seems to be happening more.

- Difficult pts., e.g., gangsters, abusive language. Daily attendance sick and absent. Increase in pt. turnover. Working hours. "Strikes". Uniforms. Increase in staff social and emotional problems. Staff more money-orientated instead of pt.-orientated. Salaries.

- At this hospital a nurse learns more and gets experience of everything as you are free to rotate each and every ward and get experience of all. Working with different types of patients and experiencing different behaviours. There is more nurse patient relationship and teamwork. The superiors (matrons, doctors) are willing to help and teach.

- In Trauma Unit I find the work challenging and interesting but not rewarding. There is no follow up with the resus..[resuscitation]...cases and often the 'walking wounded' just return a week or two later after another drunken brawl. I feel frustrated when I 'see' the amount of money being poured into patients (non-paying) when their injuries are due to alcohol/drug abuse, etc.. I enjoy working at this hospital as I find it academically challenging and intend studying further but it is not where I see myself in ten years time.

- When I first started as a professional nurse in Emergency/Trauma Unit, it was indeed very rewarding, I enjoyed it especially the team spirit, we were like a family. Then things started

to change. Staff became unhappy about certain changes in which they were not consulted in and started to leave the departments. New staff, frozen posts, increase in the amount of patients seen by the Units, verbal abuse by patients and escorts makes the Units not pleasant to work in anymore. I tried my best to put joy into a working day, but still every morning, it is an effort to get up and to face the working day.

- Working in Theatre we are always the last to know what our benefits are, e.g., Christmas shopping hours. We always hear from our friends and when we enquire we are always told that they have not yet been informed.

- The hospital are so specialized that department are not supportive of each other thus a very impersonal atmosphere and different people all just looking at seeing to their own needs. And nursing staff of different area not being supportive of each other.

- I feel proud to be a nurse. There is always that one "thank you nurse" patient (that appreciate me) that keeps me in my job (1:1000). Some of my colleague work well with each other. Worse frustration in Emergency Unit: RUDE IMPATIENT VISITORS. You know most of us is quiet nice girls. But don't this people know that every organization, factory, church even a hospital got rules. Why do they want to tell us what to do? Why don't they want to obey our rules!! Why tell us every time we are being paid to work!!

- I think that generally nothing could ever be done to overcome problems with authority. Maybe I don't have insight into the work they do, but God knows, I'm sure I would handle certain problems differently, or at least try to. Apart from the problem with the RED TAPE, I think I am reasonably happy, but in the end I think its the RED TAPE that will cause me to leave this hospital.

- The most frustrating aspect about my job is that either nursing staff nor patients appreciate what you do for them. They take things for granted. People greet you when they feel like it. In this profession they don't see you as a human being that get sick also. You must look after sick people but you not supposed to get sick. Even you colleagues.

- Being part of such a large organization has actually made or created rather and uncaring atmosphere more inhuman in that there no 'get together type' of facilities where the nurses are made to feel that they belong to the hospital. There are small groups formed departmentally and most depts. have nothing at all. Recently it was advertised in the 'Woman's Value' that This hospital was/is running workshops on how to care for stress. Why not free its employees of stress before going to the community? There's lots more that needs to be taken care of within the hospital. Don't even mention Human Resources Dept. because all the problems referred to them become hospital staff break time news! Have you heard type of thing? How it gets out there, you can think yourself. Disgusting. I am very much aware that it is very difficult trying to unite big crowds of people, but then this hospital has been known for its "apartheid type of admin.". There is lots of segregation among staff, it would take ages trying to overcome that. Most of the staff is very negative including myself.

- The top management usually puts more pressure on the nursing staff that's working in the wards/units and they really don't have the experience of what are really going on in the wards. Fairness should be one of the main priorities of this place.

- It's frustrating not being able to pursue my sporting activities on a regular weekly basis. As soon as money permits, the old Theatre gowns now being used to supplement the 'blue supply' should have their arms cut off. 'Workshops' where staff learn about how they 'come across' to patients should be ongoing. 'Danger pay' for Emergency/Trauma staff.

- Being in Theatre patient contact is at a minimum. But I get such fulfilment from giving the patients my undivided attention for those brief moments before they go to sleep. Frustration lies in how a large number of nurses and sisters just find nursing a job and they don't seem to see the patient as someone's loved one. But just a case or a job to be done. Discipline also seems a thing of the past. If this could be encouraged more respect would evolve and working condition could be made more pleasant. Nursing may be a happier profession.

- I like very much to be part of this hospital, the only thing which frustrates me is the supervisors. They don't have manner of approach they gossip instead of coming to you and tell you straight about how they feel about you and when you are an open mind character they regard you as the rude person.

- You work so hard in the ward with limited staff and one complained letter cause unnecessary unhappiness. Pressurized by top management. Everybody must write statements. It look like they don't want to look from the nursing side. Patients are always right.

- I feel that a change of top management, e.g., matron. Nursing Service Managers should get toppled from their perch. The D.D.N's. should visit the wards more regularly to hear the difference of opinions of the nursing staff. The top brass stick together, no matter what, they are inclined to be very bitchy because of their status. They will never admit when they are wrong, you are always wrong. They think they are perfect. They should get toppled immediately.

- Very seldom a word of gratitude is expressed to or written to nursing staff. We are being taken for granted. You got to do the job. Supervisors asking for incidents rather than a word of thanks for a job well done. We stabilize patients in the...[Emergency]...Unit before they can be moved to the ICU. Not getting any remuneration or recognition instead the ICU nursing staff gets an allowance. We are always on the run in order to attend to patients' needs. We are expected to do the impossible having to cope with so many patients on a daily basis. Most of the time we forget to smile.

- As a Headnurse...[Theatre]..., I feel that Headnurses should have a say as to whom they want working in their departments. They should also have the authority to change shifts so as to suit their own departments.

- I'm feeling proud to be a nurse at this hospital. What I'm feeling frustrating about is the less money you earn.

- I always wanted to be a nurse so I feel good working with the patients and if they appreciate what I do it really makes my day. What is so frustrating is the fact that the superiors expect too much of us and they give so little in return. What's driving me crazy is that the public always say: "You get paid by my tax". They don't know how much that hurts as I feel I had to pass matric and still study to get where I am and also that we pay more tax than most of them. I'd

like to suggest that we also have benefits like the police or even the busdrivers - they are being cared for by their employers.

- Most rewarding - when my patients are happy and their family are grateful. Most frustrating is when at end of month looking at my little earnings (salary) for such a high quality of work.

- Frustrating part is that I feel my 'employers' (matrons and other management staff) don't appreciate the work I do. Rewarding - a smile and a thank you from my patients and doctors. The knowledge that I contribute to somebody's good health.

- The most senior personnel is sometimes very unthankful. Express disgust when late but never give recognition when working voluntary overtime or due to overload of work and very sick patients. This questionnaire is also stressful most questions sound the same, it took a lot of time to complete.

- What I find rewarding is just a thank you for a job well done.

- What frustrates me the most is that one does not get credit for your new ideas - as it is mostly frowned upon. The frustration of wanting to discuss problems - with a personnel matron, but refraining from doing so to prevent everyone from finding out that you are experiencing a problem/s. NO PRIVACY OR CONFIDENTIALITY.

- Frustrations - nursing management too autocratic and staid, i.e., expecting nurses to be the same as Florence Nightingale era and not allowing them to speak for themselves. Being made to feel that one is expendable, i.e., only good when one is needed and thereafter moved around when someone of higher hierarchy available to perform the duty that one was busy with. Rewards - having certain people to go to for advice and moral support, i.e., Human Resource Department, Personnel Matron. Changes - nurses must be less passive and more active in decisions regarding the profession - own representatives/Minister in Parliament to deal to problems related to nurses only!

- It is really exciting being part of the multidisciplinary team at this hospital although I feel the tremendous amount of work nurses do aren't always appreciated.

- One of the disadvantages of this hospital is that it is too big and we have no or very little contact with top management, there are meetings but top management does not come down to the units and see how things are being run and to give encouragement to the lower ranks. Our jobs would be less stressful if we were given better remuneration. Particularly more money for public holidays/weekends. In Emergency Unit danger money would be in order.

- What I find frustrating is the fact that when a nurse is involved in a mishap, instead of her colleagues supporting her, they start gossiping about her, forget that we all human, we are liable to make mistakes. One other thing, doctors think nurses are their maids or they are working for them. They expect nurses to do everything for them as if they are employed by them.

- I feel that when I did something not in my capacity, for example, nursing a patient that should have been in the ICU, people can at least thank you, and I feel that Trauma staff need a allowance - we are doing more that what we should do in Trauma and C12.

- I find it rewarding to save a patient's life. What I find frustrating about nursing is the fact that nurses are always not heard when they speak. It seems to me that the top management does not see the problems or frustrations we encounter especially when it comes to salaries. Nobody can be satisfied in a job if it is not paying well. When we complain, no one listens, when we strike even the community blames us but never help us to find solutions to our grievances. We work night duty, public holidays, weekends, with no extra pay on public holidays and weekends, even night duty allowance is highly taxed.

- The nursing staff at this hospital attitudes have changed quite a lot over the years. They have no respect for the employees feelings. We get no support from our employers, our seniors. The patients and escorts have also gone very rude and obstinate which makes our work sometimes virtually impossible. There is very little which can be changed to make this better because everything we tried never worked.

- There are too many patients for the number of beds. Admissions have to wait all day, and discharges are kicked out early and sit in chairs (embarrassing for the nurses). Pharmacy can take all day with medications - so the prescription charts are away too long and treatment is missed (nurses blamed). The registered nurse has to take responsibility for all other health care members' downfalls. The nurses are expected to do other peoples' work, eg., domestics - cleaning beds and lockers. The domestics sit and watch TV or sleep!! The patients are demanding and ungrateful. A lot of them are gangsters.

- Too many 'chiefs and not enough Indians' to do the work. I think if they cut down on half of the management staff and put them to work in the wards.

- First of all our salary needs an improvement, and that will decrease a lot of stressors. Feedback from our supervisors not only when you did something "wrong", but also when you gave some extra input, to show appreciation. Supervisors that will stand up and will go till the end with our grievances, and not leave it at a dead end.

- I have always experienced security in my job, but lately, as a result of political changes, new dispensation, early retirement packages and friends leaving, I feel anxious about my job security and a low income for all my qualifications...[postgraduate]...and experience...[30 years]..., compared to others (other jobs) of my age. I just take one day at a time. However, I love my work and get reward from helping people.

- Most frustrating is the fact that nurses don't have respect for their senior staff. Frustration at professional jealousy of some professional nurses who does not make an effort to improve themselves but expect other to give feedback, when they have attended seminars. Suggest: continuous education for professional nurses in other fields of nursing, eg., new developments in medicine, surgery, etc., not just in your own field of speciality. Most rewarding: opportunity is given to junior staff for professional growth now more than in the past.

- Rewarding: That I am a good teacher. That I run an excellently organized and clean Theatre and it is well known. That I sometimes achieve a difficult goal. There are few things in my job at present that are rewarding. Frustrating: Having to attend countless fruitless meetings. No REAL support from direct supervisors or management. Pathetic salary increases. UNAVAILABILITY of CPN...[Chief Professional Nurse]...posts for Theatre staff. No stress

or overtime pay. No visible recognition for endless years...[27 years]...of dedication. CPN posts should be "Ranks Promotable" after 15-20 years of service!!

- I feel that there is a need for career planning and development programme which should be aimed at systematic guiding and developing subordinates. This would enhance personal feelings of achievement and recognition.

- I enjoy vocation to fullest. Often becomes stressful, but coping. Frustrated at way everyone feels their equipment are given from their 'pocket' instead of CPA...[Cape Provincial Administration].

- Head nurses or matron they don't stand by us if there is any incidents they become judges. If the government can give us more money maybe we wouldn't so frustrated with our work. Also the public if they can be educated about our job - maybe more project on TV about our job - maybe they will be more understanding and they won't be rude.

- People who have specialized in an area/done courses specified to that area should not be taken out all at once so that others don't find themselves thrown in the deep end. Supervisors should be more approachable and understanding toward employees and their feelings/problems. The Government should be made more aware of the financial and staffing problems of training hospitals. Employees should be encouraged more for further development in extra courses instead of reducing this facility. At the moment I don't find any part of my work rewarding. I have reached a stage where I just feel like resigning to become a housewife and put all my efforts toward my family. Thank you for giving me the opportunity to at least put my feelings on paper - it makes a great difference!!

- Emergency Unit is a stressful place, eg., seeing psychotic patients that must be sedated. Nurses often has to tolerate escorts' nonsense as well as patients' nonsense. Once I've been assaulted by a patient and nobody sympathised with you, eg., didn't go off sick although I had pain. I feel you work the hardest and gets most work done in the whole hospital. I just feel my supervisor don't care about her staff, eg., not listening to what you have to say, they just like to look down on you. Even your sick leave is a query.

- Rewarding: When you open the thank you letters form patients and notice that some people really appreciate what you do for them. Frustrating: When you really cope well under major stress circumstances, eg., strikes, and your supervisors just say thank you without giving you something constructive to show their appreciation, e.g., a extra day off.

- Working with people is very rewarding - but not under the circumstances that we are forced to work under, i.e., we are short-staffed, equipment is either broken or unavailable, facilities are cramped AND WE ARE DEFINITELY UNDERPAID!!! We work in a high stress area...[Trauma/Emergency]...with abusive and sometimes dangerous patients. Many staff members have sustained injuries from assaults by patients but we don't get danger pay. ICU staff get an allowance but we don't, which is unfair because we stabilize the patient BEFORE the patient reaches ICU. Sometimes I feel that this hospital has not heard that there is a new South Africa out there, because the same "verkrampte" people are still in supervisory positions and nothing much has changed for the better. People are still too scared to voice their opinions and the few who do are black-listed - find themselves transferred out of the department. Under

such conditions - if I had the choice, I'd rather be a HAUSFRAU!!

- For the work we do we do not get job satisfaction. Very underpaid. Cannot, cannot cope with the salaries we receive. Live for my off days. Emotionally exhausted. More attention and solving of problems - socially and financially. To be more sensitive to the needs of nurses. As a registered nurse you have to listen to everybody else's problems and who listens to ours? Being victimized by patients and visitors.

- The knowledge I gained in the orthopaedic department is very valuable and rewarding to me. A patient with multiple fractures being discharged is rewarding to me. All the appreciation from my patients and fellow colleagues warm my heart. Because this hospital is such a large organization you meet a new person every day and that can be very pleasant. I hope the serious under staff situation will change. We need more hands desperately. So many finish their training and leave for greener pastures. I wish that can be change. This questionnaire has been thoroughly enjoyed. Thank you Miss Nixon. I wish you well in this study and for the future.

ENROLLED NURSES (ENs)

Q1 "Are there any areas in your job in which you would like to have more control? If so, please mention them."

- The amount of control in my areas are fair enough.

- Initiating any particular duty - and being able to allocate to more people other than taking on the job myself.

- For example in doing dressing. To see in that matter to let the patient get better cured sooner as usually. So that they don't have to stay in hospital so long.

- Deciding in dealing with problems from patients and patient care - and also to have more control/insight in my salary.

- Salaries and education to study further.

- I would like to be free to use my own ideas and initiative relating to my job.

- To make suggestions without feeling inferior.

- Decide on which uniform to wear, sandals in summer and without pantyhose.

- To be able to choose whatever courses one feels he/her is capable in taking up.

- I would like to be able to speak up when I feel something is wrong and not be criticized about it.

- Yes, the freedom to say if you are unhappy about something.

- To have more courage to talk about problems between colleagues about work situation.

- No I don't want more control in the area where I work, all what we want is team spirit because there is to much to do.

- Not yet.

- No x 2.

- Not applicable.

- Group activities. Job organizing, etc..

- Duty times - starting and finishing.

- Trauma x 2; medical ward x 2; casualty; surgical wards; special wards; except trauma unit;

- In trauma ward and trauma unit where we work with gangsters and strict security.

- Visiting hours: for example, visitors do not obey rules, etc., 3 visitors per patient at bedside.

- Trying to deal with demanding patients and relatives.

- I would like to have more control over the fact that I can take a day/night off without being cross-questioned about how I felt when I took off, was I really sick or.....?

- As a enrolled nurse you feel sometimes people misjudge your experiences and your work goes down the drain.

- I want to be in control of my life and work. I also want to feel the same as the day I started nursing. You gave everything you had in you to give. Rules and regulations change so much that sometimes you don't even know what your duties are because there's so much other things that you have to do that's not in your scope of practice.

- Being an enrolled nurse [male] my job description has certain limitations which only registration can overcome, yet with relevant experience I find that I have to teach a registered nurse procedures which under certain situations are not in my job description.

Q2: "What might possibly make your job more fulfilling and satisfying?"

- If we getting a higher salary at least for what we worth doing in the nursing profession.

- To get more money to fulfil my problems. To get overtime anytime and anywhere I want especially in casualty or other wards. Less hours because twelve hours is too strenuous. To work only two-three months night duty a year. No taxation on my salary and bonus. An hour tea and 2 hours lunch if still working these hours, or hours to be reduced.

- Salary adjustments - treat everybody the same. Subsidies for married women. Less tax deductions. Better working conditions - less working hours. More nurses in wards. Less salaries for Matrons - too many of them doing nothing about nursing problems. They can work in the wards to see what is happening in the wards.

- More money, danger pay which we work in areas where patient very rude... [trauma/emergency].

- By getting more money and not let the relatives to be rude to the nurses.

- If the pay is to our satisfaction and enough for the hard work. Increase is needed on our wages and that would make our job fulfilling.

- More money.

- Better hours.

- Less working hours. More money. Teamwork. Recognition for good work done. Less pressure and stressful work. More support from superiors.

- The long hours in which we work must be reduced. The atmosphere in which we work must be warm and loving. The supervisors must stop treating us as kids, because the moment you work you are not a kid anymore. Kids are at school and creche.

- If some wards would make out off duties to suit and cover the ward as well as the staff.

- To work in an area that stress free, and where patient appreciate what you do for them.

- Less pressure from my supervisors. To make the nurses feel like they worth something. To say thank you once in a while for a job well done (not to me alone but the whole team who worked hard that specific day). If patients give something, eg., cake for the staff then it is always eaten or taken home by the sisters.

- To work more freely and not under pressure. To further your studies whenever you want without any control.

- I need to know more - Bridging Course. Being able to communicate better with all staff concerned.

- In studying further, specially in your own time.

- Change of category - doing of Bridging Course. Changing of areas to get more experience.

- By having the opportunity to study further and be in control.

- To study further as a trained sister.

- More team work. More support from seniors. Getting praises for things well done. Being treated as a human being not a slave.

- Team spirit. Recognising after job was well done. To get the nursing staff to respect Etic [?ethics]. Respect for another's feelings.

- More staff in specializing wards and team spirit are important. One sister can also hand out medicine. The top people - managing - must work in a ward for one month. They will also experience the pressure and stress, rudeness of people and at the end of the day they'll also feel so used up and tired. They should appreciate us and all thank us now and again for our hard work. We can have a stress test taken or even have monthly meetings about stress.

- More nurses to help in your working area when it is very busy.

- I think more staff, more money, and team work will fulfil and satisfy my job.

- If as an enrolled nurse, I can be recognized for my experience and expertise in my specialised area of work... [trauma]... and not only as an enrolled nurse who "should not and must not", and rather be appreciated in my capacity.

- To be appreciated for what I do.

- Patients appreciating staff. Staff appreciating one another. Team effort. Give credit where credit is due. Educating the patients that all nurses are just as human as they are - nurses have rights.

- If some of the supervisors can says thanks for all the hard work what the nurse done.

- That nurses' place in the society be appreciated and uplifted more. That nurses get credit when doing something well/with good effort.

- Supervisors to communicate with employees. Less stress at work. More nurses in a ward. Doctors to be less demanding.

- That those people up in management stop counting you as a number and sees me for the person I am and when I approach them with my problems, that are very real, they will understand and not just tell me their stories, about what they did when they had problems.

- If we had the choice to voice our grievances.

- When everything is done what I'm supposed to do.

- Being nursing my patient.

- To work with people that is in need for help and that I can help them in my capacity as a nurse.

- It is a new approach every day and you learn a lot. Depending on individual itself.

- Not applicable.

Q3 "Which areas of your job do you find particularly stressful?"

- Nil.

- Nowhere particularly.

- Every area x 2.

- I find everything stressful. Workload is a lot and the pressure too much. You are expected

to do your own work and you can't forget to do anything. The pressure is sometimes so much that you don't want to go to work.

- Having to do the work of four people. Doing the work of the sister. Tolerating the rudeness of the doctors.

- When working for 12 hours and it seems that no one even appreciate what you've done.

- When organizing pre-meds before theatre. On a handover - patients needs to be met all at once.

- Given out medication.

- To work in the medical areas. I think that everyone should at least 3 months in a department and not for years.

- Adjusting to new areas within the work-place, emergency situations, nagging supervisors, short-staff situations.

- Working in areas which are short-staffed and not even getting credit for it or a "Thank you" from supervisors (matrons etc.). Working (night shift especially - without taking tea/lunch) and feeling drained the next day.

- When I am overworked with short staff. And incompetent doctors.

- When there's alot of work and not alot of co-operation from the nurses.

- When you have to approach a new technique and have no-one to help and support you.

- Casualty; trauma x 2; C17; oncology ward (F7) - radiotherapy x 2; medical ward x 2; surgical ward x 2; emergency;

- In trauma unit and trauma ward where work with gangsters around.

- Trauma and emergency units.

- Trauma unit.

- Resuscitation.

- Especially the C5 floor, i.e., trauma casualty, C5 admissions.

- Working with neurosurgical patients and not getting the recognition for doing your work to the best of your ability. White nurses and sisters that can refuse to work in this ward...[neurosurgery]... Doctors treating the nursing staff like dirt.

- As an enrolled nurse everybody comes to you to ask about blue boards, meds not given, dosages being changed, the list goes on forever. The supervisors to have a more 'friendly

attitude' towards employees (not being over friendly).

- Handling ward rounds (doctors' rounds). Tending to patients' individual needs when you're the only nurse around. When hearing sarcastic comments, especially from not-so-ill comments.

- Visiting hours - especially on night duty. People do not leave wards on time etc. (7-8 visiting hours). People get rude when they are told to leave the wards.

- Rude patients who make life difficult and who think that they are the only ones on the ward. No support from day sisters they are always looking for problems in the work that we do at night they don't understand that we get really busy with confused patients...[orthopaedic ward].

- Dealing with demanding patients/impossible patients.

- The most stressful area of the job is the kind of pt. we seen...[Trauma]..., the majority is drunk and extremely vulgar and disrespectful to everybody including themselves and the fact that we have to treat these pts. holistically.

- Trauma unit is the place where I work at present. Most of them who come in are drunk people, then I rather feel I can nurse very sick people, who really need a nurse.

- Handling of patients and colleagues personal problems. Patients not appreciating what you're doing for them. People looking over your shoulder every time. Workload in general.

- When you try to best to do something for a patient and is still unhappy. And team spirit in ward not much.

- The ungrateful patients, and the unempathetic government for not giving us a salary for the amount of work we produce.

- Working with some pancreatitis patients who demands analgesia whenever they feel they have pain even if they not due for any.

- When you have work on patients that can go straight to their own wards, eg., patients that come from theatre orthopaedic cases and we must still admit patients over the weekends. To nurse ventilator patients, and we are not trained ICU experience.

- When the ward is on intake of patients and the same day is theatre days as well as discharges. As soon as the ward discharge patients, it admissions are full. All in one day, at the same time and minute.

- Educational area. Where the supervisors (sisters) expect from you to know more as what you got from college.

- Patients - very confused. Few nurses - 4 nurses for 32 patients. Supervisors not helping at all, but expect work to be done. No teamwork between nurses.

- Being in a situation where patient ask your opinion about something, along comes the

supervisor and reminds you that you cannot decide or think for that matter.

- Resus...[resuscitation}... areas is exciting but can be very stressful if everybody involved is not working together.

- If all the staff doesn't work together as a team.

Q4 "Please feel free to express any further opinions or feelings."

- Not applicable.

- I personally feel that nursing at this hospital needs some changes to be made. The This hospital organization are too big, and therefore they cannot given attention to all their problems and complains. There's a lack of communication between the staff.

- The hierarchy should be dealt with - there is too much emphasis on "who's who" in the hospital disregarding the person. Uniform should be allowed by all staff, eg., navy blue skirts - as long as a code is expected - neatness and style will be there. There is even hierarchy in uniform.

- The most frustrating part of nursing in my view is visiting hours. Most of the patients' relatives doesn't appreciate what we are doing. They usually criticized our work, and usually expect answer from us which we are not allowed to answer.

- Visiting hours are not controlled at the hospital. I suggest if they can work out a system like private hospitals that relatives/friends get via the security guard first, where the security phoned the ward first to find out, whether the patient has got visitors and how many, and if there are say three visitors at bed, tell the relatives/friends there are visitors, and then they must come down first before the others can get to the patient. (NB! It's only a suggestion.)

- I feel frustrated about the general feeling of the community that a nurse should perform wonders to the sick while in hospital. I also feel frustrated of the in and out flowing of uncontrolled visitors to the sick. It should be monitored and controlled by our supervisors and managers of the hospital. I've overheard one of my colleagues mentioning that she "wants to go to sleep and wake up forgetting that she ever was a nurse".

- Nursing is extremely strenuous, 12 hours is too much. Not enough rest at work even at home. We can't express our feelings because we are not aloud to strike. We can't even fulfil our financial problem because there is no money at all especially if you have subsidy. No overtime in casualty. Suggestion: Short working hours. Overtime in casualty. Extra money for trauma, casualty and C17. Only 2-3 months night duty. No taxation especially in bonus and to those who have subsidy. More time on teas and lunches. To be kept in a place for 3 months, eg., triage, holding area, trauma/emergency or C22, etc.. No half day especially casualty, only long weekends.

- I don't find anything rewarding at this hospital and what is frustrating is that you as person

who did not have this hospital training you feel out of place but everywhere where you came they ask you where did you have your training or you are not a this hospital nursing. Never mind where I have the training, If I can do nursing and do it well, it is fine. I am all my life since I at this hospital on night duty, because of problem. But I will try to go on day. That the people will known me better. I don't want to be known, I just want to be a nurse at this hospital.

- Trauma unit is the worse frustrating unit you find small children being stabbed by boyfriend or husband by wife.

- I can just wish that all of us can get treated equally. I don't want people to look at my epaulettes and judge me, but rather learn to know me as a person and for who I am.

- Top management making decisions we nurses had to accept whatever they're coming up with.

- The nurse must be given a chance to make changes in the ward. The reason is that the sisters hardly work in the ward, but only the nurse so they know what is best for the ward.

- Further your studies, it is very difficult because you have to wait for years and ended up you loose interest of the course you have been waiting for - especially bridging course. What is more frustrating is about language problem (Xhosa). What I mean at home we talking our language, I don't think we will be hundred percent with other languages, but most of the classes we passed without any complain of language, only this hospital complain about it.

- They must just fulfil the category of nursing education that many staff and assistant nurses can study further in the bridging course or to get better rank promotions for the good work we put in for such little salary we getting from the government. They don't appreciate nursing.

- It is the best hospital in South Africa. Not enough is being done for nursing as a profession and the nurse. More understanding from the supervisors is needed for the nurse as an individual.

- Ek voel somtyds baie teleurgesteld in my seniors wanneer verpleegkundiges onprofessioneel optree of dinge in haar teenwoordigheid doen wat die beeld van die professie kan skend, en hy/sy niks daaromtrent doen nie. Ek voel ook somtyds baie gefrustreerd wanneer een verpleegkundige die "workload" op haar alleen moet neem, terwyl andere ledig rondloop of sit.

- Most frustrating thing is to booked leave for one of the popular months. Waiting up to a year and than to be told sorry unsuccessful not that you don't have any leave.

- To see my patients happy and restored to health makes me very happy and encourages me in continuing to do my daily work. What really frustrates me is the fact that we as junior nurses are always looked down at and put down by our superiors and don't get any recognition for jobs well done.

- It's rewarding to see a very sick patient gets better and walks out of the ward when discharge. When patients appreciate what you do for them.

- This job is very rewarding for me because this is what I wanted to do since I can remember, but too little emphasis is placed about this profession at school level. If details about which courses are available at colleges and hospitals are made clear, then more people who are meant to be nurses will arise and less people who are not meant for the profession will enter and get frustrated because they did not know what it entails.

- What I find most rewarding about nursing is when patients say "Thank you!" - and when they eventually get well and can be discharged home (wonderful feeling). Frustrating - when doctors or staff of other departments take advantage of nurses (by for instance having them relieve in busy areas when they (nurses) already have had a hectic time in their own ward) - and their supervisors cannot stand up for them (nurses).

- The most rewarding part is to nurse my patient well so that they can left the hospital. The most frustrating part is that the patient word comes first even when the patient is wrong. I like being part of this hospital it's a nice experience.

- The rewarding part is when they save a person's life, or when you feel that your work is appreciated. The frustrating part is when a patient suddenly passed away.

- What I find rewarding is the knowledge you get and you learn very easily. It's also very interesting at This hospital. New diagnoses and new ways to prevent and help for patients, physically and emotionally. What is frustrating is the overload of work and the skeleton staff at this hospital. The workload here is tough and lots of pressure, but learn to grow and live with it!!!

- What frustrates me most is the fact that in some busy areas there's always a few nurses and you as the nurse are put under alot of stress to get the work done. The most rewarding thing is when your supervisor appreciates what you do and compliments you on that. Changes I'd like is that the working hours should be less.

- In theatre the professional nurses and enrolled nurses do the same job description, but at the end the professional nurse gets first privilege in many things, e.g., promotions and support. Something should be done on improvement on that issue.

- About nursing in general - the amount of time spent at hospital and still not being paid fairly. To stop abusing us as nurses.

- The work that we deliver in hospital is very good, so we expect more money. To see patients get better and out of hospital as normal persons (neurosurgical ward). It feels good to know that you helped them.

- Why can't we wear sandals in summer. Working in a specialised ward there should be more nursing staff. In a large hospital there should be team work and sisters must also help in this, eg., handing out medicine. The people in the top managing must also just come work in a ward for one month and then they'll see how hard we work and all the stress we have to deal with. Doctors must also write letters to the top managing to tell them how hard people work and they must also write letters and give statistics to show them.

- The reward in the profession is seeing a pt. well and especially resuscitation/critical patients, and knowing full well that I was part of a team, instrumental in that person's life. The frustrations would have to be the physical and emotional abuse a person has to tolerate not only from pts. but escorts and family as well...[trauma unit]. Rotate management on a routine basis to the physical side of the nursing profession, e.g., place in a ward situation and in render of physical pt. care more often. Thank you. PS: I hope that the input given would be put to valid use!!

- The supervisor should be able to understand the problems the staff are having. They should be helpful and motherly to they staff. They should not have favours. People should be treated all alike. Also, should learn to understand and prepare to listen to works (nurses) problems and feeling.

- What make me more frustrating is, I think is, we under staff, underpaid, and then we still have to nurse people who do not appreciate you as a nurse. We in trauma unit we get involve with (skollies) most of the time we scared for them.

- I feel that we as nurses have cried such a lot. I don't think that there is any more tears. What is the use of complaining to you?

- This thing is slightly confusing and you must state your question more to the point.

ENROLLED NURSING ASSISTANTS (ENAs)

Q1 "Are there any areas in your job in which you would like to have more control? If so, please mention them."

- Nil comment.

- No x 4.

- No, there are no areas in which I can have control as I feel it is not in my scope of practice.

- In the nursing profession no control you can make in any area more especially when working as a junior nurse. The only thing you can do are the changes or restructuring as a group because you must always work as a team not as an individual.

- Yes, there is. In the communication between different categories of staff and with patients. Here I know I could help alot.

- Trauma unit; ICU; ophthalmology; ENT; Paediatric neurosurgery;

- In trauma unit and trauma ward, where employees lives are in danger with the gangsters around; more strict security. Definitely more money for the type of work we do, eg., danger money, ICU allowance.

- Triage sometimes got no control of patients and escorts. Holding area about patient lying, waiting for transport and psy patients.

- I personally feel that the Head Nurse should manage when the nurses in her ward will go on leave, night duty, etc.. and that decision does not come from personnel matrons for eg. if you do not book leave in advance, you don't get leave for that year until the next year, because it's fully booked.

- The meetings attended by the supervisor or head nurse should have more representative from other categories so that one does not feel the meeting are for them only. The report backs should be for everyone to hear so to enlighten one as to the going on in the hospital as a whole.

- We would like to have more grievance meetings so that we can make the environment that we working in a better place of happiness, understanding and good relationship amongst each other.

- Some of the qualified nurses way of thinking about the unqualified staff.

- The gangsters are putting a lot of stress on me. They abuse us verbally. I would like to be honest about my feelings.

Q2: "What might possibly make your job more fulfilling and satisfying?"

- No comment.

- Team spirit, the personal relationship between the nursing staff.

- Team work. Consideration for your colleagues.

- Team work. Supervisors or sisters must help and not give orders from the nurses station.

- If professional nurses would help more with urinal pans and go less to meetings and sitting in nurses stations answering phones.

- Samewerking. Working as a team.

- If there's more team spirit, more cheerful moments and less hours to work, the job will be much more fulfilling and satisfying.

- More interpersonal relationships with colleagues. Better working conditions. Open channels in which you can discuss your working problems and conditions. More money. Better communication between employers and employees.

- Understanding, respect, consider other, fairness.

- Respect, honesty, loyalty irrespective who or what you are.

- More self confidence and other people trusting me more.

- A better inter-management nurse relationship will be more fulfilling. Being more appreciated as a nurse and not being taken for granted by the doctors, management and visitors. A better salary, so that the pressures of strikes can come to a stop. Better working conditions and a head nurse that will look at the needs of the nurses first.

- Conducive atmosphere. The improvement of salary. Nurse's salary very inadequate even the increment is always far behind the rate of inflation.

- To be appreciated by the public. To earn a living wage.

- A good living wage, especially for those with subsidies.

- Less hours and more money.

- Better hours and more money would make my job more fulfilling and satisfying.

- Working less hours. Getting more paid.

- If I could have more leave a year. The hours are too long.

- Shortening of hours, public holidays off - paid.

- More nurse and more money.

- Let there be more nurses in the area. Money is the most important aspect. Let we as nurses say what is right and wrong. Listen to what we say. Let us be more flexible. Special clothes wear. Listen to the nursing opinions.

- To be provided with sufficient staff and also nurses who would truly like to nurse in its true meaning. To be surrounded with more people who would observe rules and regulation attaining to the hospital. To have people take care of their surroundings and also observe time saving when necessary and not to waste your time trying to impress people at others expense.

- To help the sick people.

- To study further (Std 10) become a staff nurse or sister.

- Well if there were more challenges, but I suppose that would be up to me by educating myself more and proving myself in whatever I do.

- When I can do more for the patient, as a assistant nurse I can't do more.

- You deal with new problems and sickness of the people. You study how the people are living from outside on their destinations. You grown your mind by dealing with people.

Q3 "Which areas of your job do you find particularly stressful?"

- Nowhere.

- Theatre; ICU; neurosurgical wards x 2; psychiatric wards; trauma unit x 2; orthopaedics; emergency unit; the holding area; oncology; medical; orthopaedic; trauma;

- Trauma unit and the ward at times.

- Triage and holding area. The escorts, the professional people must do something about, they are rude, expect the nursing staff must jump for them. Those days are pass. We as nurses are for the patient not the escorts. They swore to us, sometimes they want to smack you. I had that experience once. That's why I feel to pack up and go.

- The triage and holding area is most stressful because you do your best to do things on time and as it should be then the seniors will come around and shout at you or insult you in front of patients and escorts and you must pretend as if nothing has happened.

- Neurosurgery department is stressful because you are dealing with unco-operative patients, repeat one thing more than ten times.

- Dealing with gangsters in trauma.

- Working with difficult people (gangsters).

- Everywhere you go an work is sometimes stressful.

- I feel rushing around stressful when I come to work tired.

- I find that the nightshift is very stressful because there are more to do on nightshift.

- Working under pressure. Supervisors not listening to your problems. Supervisors not appreciating your work.

- When at times we short staffed and you expected to do more than your own work, eg., doing the work of 2 or three persons.

- Having to see your supervisor dictate to you your nursing duties which she could have carried out herself, whilst you are busy, so that you should leave your present duty to carry out her orders. I believe nursing should be our first priority and not the clerical work which could be done by the secretaries provided.

- When there is no co-operation between us employees. When someone above you force you to do things without considering your customs and traditions.

- When there is no team spirit. When there's a crisis or inter-hospital strike.

- To go to the matron in casualty when you for some reason off sick or having problems at home and did not went to work.

- Sometimes working with the patient itself can be very stressful, as the patients are confused, difficult to nurse and becomes aggressive at times. The doctor's give orders and do not understand that sometimes it's a bit difficult for the nurse to carry out that order. So basically all aspects of my job as nurse can be stressful.

- The area which I feel most stressful is to work with patients who had amputations or abortions.

- The fact that I as unqualified staff can only do the most easy jobs, such as observations, intake-output and bed baths (as examples).

- Ratio 1-10.

Q4 "Please feel free to express any further opinions or feelings."

- What I find most rewarding about nursing is that the people remember you for your good deeds and always will say that it is a very noble and rewarding job. What makes me very

frustrated at times, is the fact that there is sometimes maldicimal lack of staff and little team spirit on busy days. I like being part of a large organization like This hospital, because is well-known overseas and it's a teaching hospital and every year , nursing staff update themselves. It's unlikley for me to make changes in my profession as it's not in my scope of practice, that's why the SANC and SANA are there to take full control.

- What's the most frustrating is the fact that you must just keep your mouth while the patients tells you shit.

- For the past 5 years at Casualty I enjoy my nursing very much. I learn so much from my colleagues an doctors and feel part of the department. There are all the ups and downs but I come over it. I just want to be feel worthwhile in the community.

- I feel that we must be flexible. I feel that the people must have more time with the lower class of nursing, encourage us to do the things the easy way to benefit the patient. We as nurses feel sometimes things getting to hard for us. Special when you had some problems. Let the St.8 people had that authority to study for staff nursing, special the old assistant nurses.

- Salary increase.

- One of the problems is the salary problem. We work to hard here in Trauma/Emergency dealing with people we don't know their diagnosis but we must work it out. Sometimes we feel in a danger especial in Trauma because fight appears there from gangsters and we can easily get diseases from squirting blood. There is that lot of discrimination between us as races so that always feels you that you are separated from other people.

- I personally feel that working in a ward such as D9 you need to express yourself not only to those nurses working with you, but to the doctors as well, so I think a session group will be very good. I feel that we are 12 hours a day on our feet and that they should allow us to wear sandals in summer, etc.. I also feel that pantyhose should be the choice of the nurse as pantyhose is a waste of money, i.e., buy today, broken tomorrow. I also feel that they should look at the workload of a ward before allocating staff, e.g., in a quiet ward of 32 patients you will find 6 nurses but in a busy place as D9 you find 7 nurses of which two must cover the trachi unit. Doctors should also first assess the ward and its workload before admitting patients, eg., 32 beds of which all is full, but still admitting more people.

- What I would like the most is that the higher authorities must also ask our nursing staff opinions when they decide in making new rules, because we are the people who's doing all the work, and we must just fall in on whatever they decide.

- I would like team work, more nurses on the ward.

- Being part of a large organization like this hospital feel great, but the frustration of working hard and earning little money by the end of each month must really be look at. If they see to our needs we all will be like a happy family.

- I personally feel that we must be promoted for what we are doing and not according to a certificate. Sometimes we does the work of a senior person, but is not recognize in general.

When everybody does strike, the nurses have to do their jobs? Can't we be verified for it that time!!!

- Why not leave nurse we they happy. Not by changing them to other department. Leave nurse who loves night duty on nights. Don't force people to do night duty if it don't suit them.

- What frustrates me many a' times is when nurses treat the patients like things and not as an individual with feelings and now many nurses just don't give that tender loving care. Also when nurses don't support and work together. Many a times too the way doctors and nurses treat us like garbage. Emphasis should genuinely be placed on communication skills throughout this hospital. Regular meetings where every grievance can be spoken about without taking it personally and doing something concrete about the situation.

- Employees should be more honest about their feelings. The higher authority should try and solve problems on your level before taking further steps such as DISCIPLINARY!

- Nursing now has been totally changed because now you as a nurse you cannot say nothing about the rudeness of the patient to the nurses and even visitors they are also problem because during visiting time they expecting nurses to be busy with the patients and they demanding a lot.

- The nursing sisters are not treated as professionals they are treated as immature children, having their own skill with a four years diploma, no restructuring they can make. Even in the meeting no input instead they take everything from their deputy director without expressing their feelings and take the matter down to the nurses. When you ask questions they feel embarrassed as if you are undermining them. All in all the nursing profession is quite interesting and you learn something new everyday. People who spoils the nursing profession are the authorities.

- The nursing staff at this hospital is under a fairly great area of stress to the Cape at large. One has seriously to take into account the safety of one employee and also to take into account the duties of the security which are presently employed. What are really their duties? The food provided by the hospital should also be carefully monitored and a better variety supplied. The facilities to staff as far a medical care - one should provide, and not take the staff medical aid facilities into account. When on duty or over weekends one is placed in unfortunate circumstances as to medical doctors. Medical aid members should be able to get attended on premises. One should not have to leave the hospital to be attended to by your own general practitioner.

- Sometimes I feel that I work so hard and sometimes I really don't give a damn what I do while I'm working or I'll say to myself: "Why do this or that?". We get so little pay. If only they can pay us a little more to live on; I really wouldn't mind going out of my way for some patients. The end of the month I'm more frustrated after I've been subsidized.

- Change the theatre permanent staff a few times (too) because they don't know about the rest of the hospital.

- I would very much like the authorities of Health Department to shorten the long nursing hours. Please? Please? Please? Thank you.

- As a nurse you try your best for the sake of your patient, but when you really in trouble your must think twice before you go seek for comfort by the seniors. They are not always sympathetic and sometimes treat you as if your feelings don't count. When it come to work you work hard and when the place is quiet you not free to sit. Because you as a nurse don't get tired you must be on your feet all the time. The seniors do as they please and yet they get the credit.

- It makes my day when patients or especially the supervisor has a "thank you" when the day is over. Over weekends taking patients out for a picnic, beach, etc..

APPENDIX E

COMMENTARY ON THE RESEARCH QUESTIONNAIRE

This questionnaire is also stressful most questions sound the same, it took a lot of time to complete.

Thank you for giving me the opportunity to at least put my feelings on paper - it makes a great difference!!

This questionnaire has been thoroughly enjoyed. Thank you Miss Nixon. I wish you well in this study and for the future.

Thank you. PS: I hope that the input given will be put to valid use!!

I feel that we as nurses have cried such a lot. I don't think that there is any more tears. What is the use of complaining to you?

This thing is slightly confusing and you must state your question more to the point.

Thank you for allowing me to be part of your survey. May God richly bless you in your ministry.