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The design of a stress-management programme for nursing personnel

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The design of a stress-management programme for nursing personnel

This study identifies the stressors and coping strategies of nursing staff (students, trained staff and those who had left the profession before qualification) in a variety of ward specialisms The research instruments included an open-ended interview concerning pre-nursing experience, perceived stressors and satisfactions, and ways of coping, and psychometric tests of self-esteem, assertion, ways of coping and personality The five most frequently cited stressors were understaffing, conflict with nurses, dealing with death and dying, overwork and conflict with doctors Experience of stressors was related to role and seniority of respondents, with different aspects of the same stressor differentially affecting nurses at different levels of experience Coping strategies also depended on experience Trained staff showed more use of problem-focused ways of coping, whilst students and leavers relied more on emotion-focused strategies to deal with stressful situations These differences were related to personality characteristics of respondents and to self-esteem as well as to situational characteristics of the stressful episode Social support was important in times of work-related stress, with students in particular making good use of peer group support Respondents were generally lacking in assertiveness and high in anxiety. Although self-esteem was generally high, leavers scored markedly less than other subject groups in the areas of personal and social self-esteem Leavers had little prior knowledge or experience of nursing before entering training and knew few nurses or doctors consequently, nursing failed to meet their expectations. Stress was identified as the major cause of attrition and the sources of stress are identified This study informed a major programme of stress-management training for student nurses which began in 1988 at the North Wales School of Nursing and which is currently under evaluation. It includes relaxation therapy, assertiveness training, and on-going group discussions which foster peer-group support and which explore the stressors and coping strategies relevant to different stages of training and ward specialisms.

INTRODUCTION

The attrition rate amongst student and pupil nurses is between 15 and 30% Thirty thousand trained nurses leave the profession annually according to *Project 2000* (UKCC 1986) Not only is this a terrible waste of resources, but the forecasted fall in the number of 18-year-olds available for nurse training makes it essential that this leakage be stayed

Stress in nurse training is an important cause of attrition Birch (1979) showed that 66% of his sample of nurse drop-outs said that they left because they could not cope with the stress of nursing, and stress was a key factor in six out of 30 students at one of the top teaching hospitals who never reach their final year (Beck 1984) Other ill effects of stress in nursing populations include chronic tiredness (Albrecht 1982, Stewart *et al* 1982), high rates of absenteeism (Campbell 1985, Menzies 1960, Price 1985) and increased use of smoking (Elkind 1988, Price 1985) Whilst we should appreciate the potentially beneficial effects of moderate amounts of demand in our lives, the damaging psychological effects of certain types and levels of stressor cannot be ignored Anxiety levels indicative of psychological morbidity have been found in student nurse populations (Birch 1979)

Selye (1956, 1975) defines stress as the 'nonspecific response of the body to any demand made upon it' (Seyle 1975) and describes an organism's response to the stressor in terms of a General Adaptation Syndrome comprising three stages an alarm reaction, the organism's initial response to the stressful stimuli, the stage of resistance, the organism's full adaptation to the stressor with consequent improvement or disappearance of alarm reaction symptoms, and the stage of exhaustion which occurs if the stressful stimulus continues and is severe or prolonged This final stage has also been termed 'burnout', 'a very specific and distinctive kind of emotional exhaustion, the helping professional's losing positive feelings, sympathy and respect for their clients or patients' (Maslach 1982)

However, individuals differ in their perception and response to stressful stimuli (Cox 1978) What is perceived by some individuals as stressful is for other challenging and exciting The judgement that a particular person–environment relationship is stressful hangs not only on the stimulus characteristics of the situation but also on the individual's appraisal of it (Folkman & Lazarus 1980) Thus we must take an interactionist view of stress and view the stress response as 'part of a complex and dynamic system of transaction between the person and his environment' (Cox 1978)

In the occupational setting, stress can be seen as developing most frequently in those occupations with low autonomy and high physical or psychological demand, and the nursing profession is paradigmatic of such. Stressors within the nursing profession are many and varied. In a comprehensive study of stress in nurse managers, Hingley & Cooper (1986) identified nine main categories from which potential stressors emerge workload (both overload and underload), relationships with superiors (e g lack of involvement in decision making), role conflict and ambiguity, dealing with death and dying, home–work conflict (both home-life intruding on work performance and work problems being taken home), career (development blockages, responsibility without authority), interpersonal relationships (with patients, relatives, colleagues), physical resources (shortages of essential resources and poor physical conditions) and change (keeping up with professional developments and new technology)

Student nurses

Many of these factors are also relevant to the stressors facing a student nurse Dealing with death and dying is frequently cited as a stressor for nursing students (Parkes 1984, 1985, Birch 1979) as are relationships with patients and other nurses (Parkes 1980, 1985, Llewelyn & Fielding 1983), work overload (Parkes 1985), lack of confidence and worries about incompetence (Parkes 1985, Beck 1984), performing tasks before an 'audience', e g a tutor (Kushnir 1986), change, such as changing wards (Birch 1979, Price 1985), and the lack of fit between service and educational aspects of the student nurses' training, for example being taught a procedure in one way in nursing school only to be requested to perform it differently in the ward situation (Jones 1978, Melia 1984)

Within nursing, some wards or units have been identified as having a more stressful environment than others Such areas tend to have an unpredictable workload, use of high-technology equipment, high levels of environmental stimuli (excessive heat, light, noise), the continual possibility of a crisis occurring, and the frequent need for immediate assessment of priorities Such areas include the accident and emergency department (A/E) (Brunt 1984, Thompson 1983), special care baby unit (Thornton 1984), spinal injuries unit (Hobbs 1985) and intensive care unit (Bishop 1981, Anderson & Basteyns 1981, Bailey *et al* 1980, Hay & Oken 1972) In addition, Parkes found higher levels of anxiety for student nurses working in medical wards compared to surgical wards (1980a), and male wards compared to female wards (1980b)

What then can the nurse do when under stress at work? It appears there are three main paths she may follow she may learn to cope, with or without external support, and function well, she may remain in the working environment coping poorly and eventually become exhausted and suffer burnout, or she may leave the profession altogether

Given the wide literature on causes of stress in the nursing profession, reports of formal stress-alleviation programmes are surprisingly scarce Although mainly short-term, those that have been carried out have been encouragingly successful Success has been achieved in reducing trait anxiety in nurse subjects in various short-term therapy programmes, notably by the use of progressive muscle relaxation (Wernick 1984, Charlesworth *et al* 1981, Murphy 1983), in combination with other methods such as systematic desensitization

In some cases, nurses seem unable to seek support from either personal sources or from a formal programme Thus, for example, Jones (1978) found that 25% of his sample of 50 nurse trainees said they would not know who to turn to when in need of counselling and guidance For nurses in this position, burnout becomes a real possibility, and this lack of support underpins the success of group and individual counselling programmes in reducing reported stress and staff turnover (e g Gray-Toft & Anderson 1983) and their recommended adoption as methods of helping student nurses cope with stress (Lampkin *et al* 1985, Jones 1978, Castledine 1985)

Subjective nature of response

Whilst accepting that many stressors within nursing are universal, the subjective nature of stress response must be considered when planning stress management Personality differences have been found to affect the nurse's ability to cope, either by dealing directly with the stressor or with its effect on herself Karson (1963) found successful student nurses to be higher on intelligence and lower on sobriety than their unsuccessful counterparts McCranie *et al.* (1987) discovered nurses low on hardiness to experience higher levels of burnout, and Freudenberger (1975) describes the burnout-prone individual as someone over-dedicated to work, believing she is the only one to do the job, with few outside work interests Parkes (1985) found that while the nature of the work environment had the most effect on the variance in coping scores of her student nurses, extroversion was significantly related to use of direct coping (as compared to indirect coping and suppression), and high neuroticism to consistently low levels of direct coping Furthermore, student nurses showing internal locus of control exhibited patterns of coping with stressful episodes that were potentially more adaptive in relation to types of appraisal than those of externals (Parkes 1984).

This study aimed to provide information which would assist in the design of a stress-management programme for student nurses, which would include general relaxation and assertiveness techniques, and which additionally would be tailored to meet the needs of students at different stages of training The stages of the study were thus (1) to explore the different stressors arising in different ward environments and study their effects on nursing staff at different levels of professional development (sisters/charge nurses, staff nurses, first, second and third year student nurses and those who had left the profession before completing nurse training), (2) to examine the detailed reasons underlying student nurse attrition, and (3) to identify individual differences in personality, assertiveness and self-esteem and relate these to ways of coping, reaction to stressors and susceptibility to leaving the profession

METHOD

Subjects

Fifty-three respondents were drawn from two general hospitals, one in North Wales, one in Birmingham There were 20 trained staff (North Wales) who were all RGN qualified (10 sister/charge nurses, 10 staff nurses, mean age 34 years, 19 females, one male), 20 students who were all drawn from modular training programmes leading to RGN qualification in North Wales (six first years, five second years, nine third years, mean age 23 years, 16 females, four males), and 13 ex-student nurses who had left the training programmes in either North Wales or Birmingham (mean age 28 years, 12 females, one male) The gender ratio of these nursing students is representative of the intake of the North Wales School of Nursing

Four ward specialities were chosen as the focus for the study accident and emergency, medical, surgical and paediatrics All trained and student staff working on these units between May and October 1988 were sent letters which briefly explained the nature of the research, assured confidentiality and requested their participation The respondents, five trained staff and five students from each of the four selected units, were randomly selected from the positive replies received Student nurse leavers who had left nursing, for whatever reason, during the last 3 years, who had been on the course leading to a single qualification as a registered general nurse and who had completed at least one ward allocation, were sent a similar letter All who responded positively were interviewed

MEASURES

Open-ended interview

The interviews took place whenever possible away from the work environment All interviews were taped, and took an average of 25 minutes

Trained staff and students were asked the same sequence of questions concerning their pre-nursing experience, early

experience of nursing, present stressors and work satisfactions, and their ways of coping in times of stress (Appendix) Student nurse leavers were also asked their reasons for leaving the profession Although the interviews were centred around specific questions, no attempt was made to direct the subjects' responses and they were encouraged to offer additional information

16PF Personality Questionnaire

The 16PF Personality Questionnaire (Cattell *et al* 1970) consists of 187 items concerning 16 personality dimensions designed to give information on an individual's primary personality characteristics reserved/outgoing, less/more intelligent, affected by feelings/emotionally stable, humble/assertive, sober/happy-go-lucky, expedient/conscientious, shy/venturesome, tough-minded/tender-minded, trusting/suspicious, practical/imaginative, forthright/astute, self-assured/apprehensive, conservative/experimenting, group-dependent/self-sufficient, undisciplined/controlled and relaxed/tense

In addition, the questionnaire covers eight 'derivative' or secondary personality factors extraversion, anxiety, dependency on feeling, independence, control, realism, fluid intelligence and super-ego strength

Assertion Inventory

The Gambrill & Richey (1975) Assertion Inventory comprises a 40-item Likert-scored questionnaire dealing with everyday interpersonal situations Eight assertive responses are sampled turning down requests, expressing personal limitations, initiating social contacts, expressing positive feelings, handling criticism, differing with others, assertion in service situations, giving negative feedback Scores indicate the degree of anxiety subjects would feel in the given situation, and the likelihood of them displaying the assertive behaviour described

From these measures, respondents are scored as being high or low assertive and fall into one of four assertion repertoires 'anxious performers' (high anxiety, high assertion), 'unassertive' (high anxiety, low assertion), 'doesn't care' (low anxiety, low assertion), 'assertive' (low anxiety, high assertion) Gambrill & Richey suggest that only the latter category is desirable, the rest falling into the 'dysfunctional assertion repertoire'

Revised Ways Of Coping Questionnaire

This 67-item questionnaire (Coyne *et al* 1981) was used to identify the thoughts and actions used to cope with a particular stressful encounter (in this case that one which the respondents chose to describe during their interview) The respondent indicated to what extent they used particular coping strategies Their answers were then scored for eight coping styles confrontive coping, distancing, self-controlling, seeking social support, accepting responsibility, escape–avoidance, planful problem-solving and positive reappraisal

Two scores were derived a raw score denoting the extent to which a particular type of coping was used by that subject in a given encounter, and a relative score, which describes the contribution of each coping scale relative to all of the scales combined

Culture-Free Self-Esteem Inventory

This inventory measured individuals' general, personal and social self-perception (Battle 1981) Three domains of self-esteem were assessed general, social and personal The inventory includes a lie scale

RESULTS

Attrition

Previous experience and expectations of nursing

Respondents were asked if they had known anything about nursing before commencing training, if they had known any nurses or doctors well, whether they had been strongly influenced by anyone to enter nursing, and what previous relevant nursing experience they had had on entering the profession

We expected that those respondents with little prior knowledge of nursing would be most likely to leave on the grounds that they would be most unprepared for the demands of nursing and most disappointed in terms of nursing meeting their prior expectations The responses tended to support this With regard to previous personal knowledge of nursing, 39% of leavers compared to 35% of trained staff and 20% of students said they had known nothing of nursing before commencing training this is consistent with the fact that 46% of leavers compared to 35% of trained staff and 20% of students had known no nurses or doctors well before commencing training, and hence leavers as a group had had less opportunity than the other two groups to learn about the nature of the work via professionals in the same or related occupations

The majority of leavers (92%) had not been influenced by anyone else to enter nursing, although this also held true for trained staff (80%) and students (85%) For those respondents who *were* influenced to enter nursing, such

influence came from two main sources parents/family (15% trained staff, 15% students) and partner (5% trained staff, 8% leavers)

Prior experience of nursing has been demonstrated to be negatively associated with attrition (Cross & Hall 1954, Cross 1968) and this is confirmed here only 38% of leavers had had relevant experience prior to commencing nurse training, compared to 65% of trained staff and 60% of students Relevant experience typically took the form of a college-based pre-nursing course, auxiliary nursing or work in a nursing home for handicapped or elderly patients When asked whether nursing had realised previous expectations, 54% of leavers said no compared to 45% of trained staff and 45% of students

Reasons for leaving

All student leaver respondents were asked about their reasons for leaving the nursing profession Stress was the main reason for attrition in the sample studied, with 54% of the leavers interviewed citing stress as the major factor contributing to their leaving nursing When probed further concerning the details of this stress, conflict with nurses was reported as the main contributor to stress-related attrition (23%), followed by overwork (15%) As one leaver put it, 'There's never a time when you don't know what to do next' Two leavers complained about the unsupportive attitudes of the school of nursing when they encountered work or home-related problems

The only personality characteristics (16PF) on which the leavers differed from those remaining in the profession concerned control, this being evident with both the primary factor where the leavers were less disciplined ($P<0.05$) and the secondary factor of control where the leavers tended to operate more at a mood than a cognitive level Thus leavers tend to 'feel rather than think' and such individuals are said to experience frustration and depression (Cattell *et al* 1970)

Point of leaving

The majority of leavers (69%) left during the first 12 months of their training, a further 23% between 13–24 months and 8% between 25–36 months These findings are consistent with those of Cross & Hall (1954) who found that the majority of the leavers they examined (68%) left during the first 12 months of training, especially during the first 6 months

When asked, 'Can you ever see yourself in nursing again?' the majority of leavers (69%) thought this was unlikely The present occupations of leavers at the time of interview were mixed 31% of leavers interviewed were in professional/managerial posts (e.g customs and excise officer, managing own retail business), 61% were in other non-manual posts and 8% (one leaver only) had embarked upon another training course and was undertaking teacher training at time of interview

Stressors

When our respondents were asked which situations or incidents in nursing caused them stress, a large variety of stressors emerged In total, 26 categories of stressor were identified and these are shown in Table 1 Many of the stressors, such as conflict with doctors and dealing with death and dying, featured in all subject groups However, some stressors were seen to affect some groups of respondents more than others, whilst some stressors were unique to one subject group only

For example, whilst understaffing, the most frequently-cited stressor overall, was seen by respondents in all groups as a stressor, it was cited significantly more by trained staff (75%), compared to the other two groups (25% and 23% $\chi^2=13.07$, $P<0.005$) Similarly, whilst conflict with doctors was cited by student nurses (15%) and leavers (8%) as a stressor, it was the trained staff who most frequently experienced this (40%)

Cardiac arrests were seen to affect student nurses most (30%), being less stress-inducing for trained staff and leavers (5% and 8% respectively) Responsibility and accountability, on the other hand, was a particular problem for trained staff (25%) and was reported somewhat less frequently by students and leavers less frequently, but no less dramatically, in the case of a student nurse leaver subject, who stated, 'I felt as if all the patients were time bombs, waiting to go off, and as if it was all my responsibility'

The stressors that affected one subject group exclusively are associated with the group's role Thus, dealing with porters or administrative staff, training junior nurses, juggling scanty resources and doing the off-duty are, as managerial duties, serving as stressors exclusively for the trained nurses This role-stressor relationship is confirmed by the higher frequency with which the trained staff cite stressors such as understaffing, conflict with doctors and responsibility

Stressors cited exclusively by student nurses include study/exams, being in a new situation for the first time together, and feeling inadequate to carry out certain procedures Students are obviously required to undertake more study than the majority of trained staff Similarly, being in a new situation for the first time with attendant feelings of inadequacy is indeed a situation to which the student nurse is more exposed, given the standard practice

Table 1 The stressors percentages of the subject groups and of the total 53 subjects citing this as a source of stress

Stressor	Trained	Student	Leaver	Total
Understaffing	75	25	23	43
Dealing with death and dying	25	55	46	41
Conflict with nurses	35	25	46	34
Overwork	25	30	15	25
Conflict with doctors	40	15	8	23
Hours	10	10	39	17
Cardiac arrests	5	30	8	15
Responsibility/accountability	25	5	8	13
Training junior staff	25	0	0	9
Dealing with relatives	15	5	8	9
Lack of resources (beds/equipment)	20	0	0	8
Aggressive patients	10	5	0	6
Study/exams	0	15	0	6
Carrying out certain nursing procedures	5	5	0	4
Feeling inadequate to carry out procedures	0	10	0	4
Seeing patients in distress	0	5	8	4
Staff rough to patients	0	0	15	4
Conflict with 'others' (porters/admin)	5	0	0	2
Child abuse	5	0	0	2
Dealing with overdose patients	5	0	0	2
Living in nurses home	0	0	8	2
Open visiting	5	0	0	2
Doing the off-duty	5	0	0	2
Disorganization of workload on the wards	0	0	8	2
Being in a new situation for the first time	0	5	0	2
Heat in hospital	0	0	8	2

of moving student nurses from ward to ward at 6–12 week intervals and their general lack of experience

The five most frequently cited stressors were understaffing, dealing with death and dying, conflict with nurses, overwork and conflict with doctors We have further analysed staff conflict and dealing with death and dying since there appeared to be many aspects to each of these stressors Table 2 shows these details

Dealing with death and dying

This was the second most-frequently cited stressor overall There were seven main reported aspects of this stressor These are, in order of importance caring for the dying person and seeing them deteriorate, having to tell the relatives that the patient is dead and dealing with the relatives' distress, the loss of a friend, seeing/handling the dead body, the suddenness and shock of death, a sense of failure at the death of a patient, and the deceit of keeping the patient's impending death from them.

However, these factors affected the groups in different ways, the differences being primarily role-related For the trained staff, telling the relatives was the most stressful aspect of dealing with death and dying In contrast, for the students and nurse leavers it was caring for the dying person, seeing and handling the dead body and losing a friend which proved to be more traumatic As one leaver put it, 'You have to face your family and the friends that you make around you dying, and I can't face that (patients dying) as well'

Conflict with nurses

Conflict arising from personality differences with members of the immediate ward team proved to be the most stressful aspect of nurse conflict and was cited by 13% of respondents overall Whilst to some respondents such incompatibilities are to be expected — 'You get the odd dragon but I suppose that's acceptable, isn't it?' (third year student) — to others they are the source of much frustration and anger 'I thought, if the nursing profession is full of people like that, I don't want to know, thank you very much' (leaver)

Again, there were group differences whilst feeling other ward members to be critical or contemptuous of one's

Table 2 Details of the stressors associated with dealing with death and dying and conflict with other staff numbers and percentages (in brackets) of the subject groups and all 53 subjects citing these sources of stress

	Trained	Student	Leaver	Total
Aspects of dealing with death and dying				
Caring for the dying person/seeing them deteriorate	1 (5)	2 (10)	3 (31)	13
Telling the relatives/dealing with their distress	5 (25)	0	1 (8)	11
The loss of a friend	0	3 (15)	1 (8)	8
Seeing/handling the dead body	0	3 (15)	0	6
Suddenness/shock of death	0	1 (5)	1 (8)	4
Sense of failure	0	1 (5)	0	4
'Deceipt' of keeping patient's impending death from them	0	2 (10)	0	2
Aspects of conflict with nurses				
Conflict/personality differences among members of immediate ward team	2 (10)	1 (5)	4 (31)	13
Lack of support/supervision from higher nursing management (e g nursing officers)	5 (25)	1 (5)	0	11
Feeling other ward members critical or contemptuous of own performance	0	3 (15)	2 (15)	9
Aspects of conflict with doctors				
Doctors do not listen to me or think I have a point of view	4 (20)	0	1 (8)	9
Doctors unavailable when needed	2 (10)	1 (5)	0	6
Doctors incompetent and this puts extra pressure on nurses	2 (10)	0	0	4
Doctors make me feel incompetent/intimidated	0	2 (10)	0	4

performance was a problem for the more junior staff, the worst stressor for trained staff arose from a perceived lack of support from higher nursing management, most frequently nursing officers These differences too are role-related It is the nurse in charge (in the most cases a trained nurse) who will have most contact with nursing officers and most need to approach them for help and support for example, to find an extra pair of hands if the ward gets busy or a member of the ward team does not report for duty

Conflict with doctors

Conflict with doctors fell into the main categories of doctors ignoring the nurse, being unavailable, incompetent or intimidating Although conflict with consultant medical staff was cited as a stressor by two members of trained staff, this accompanied complaints about more junior medical staff Hence each citing of conflict with medical staff was at least partly, and in most cases wholly, related to conflict with junior medical staff, house officers and senior house officers The medical staff were seen to ignore the advice of the nursing staff on how to treat patients in their care (both physically and emotionally), this despite the nurse's greater exposure to that patient and their family The frustration that can arise from this situation seems often compounded by the fears of some of the trained staff that doctors are in fact not always competent to make diagnoses or order treatment, thus making the nurse feel responsible for the medical as well as the nursing care of her patient

Inter-group differences in aspects of doctor conflict were again role- and status-related It is apparent from the results in Table 2 that as a nurse progresses in seniority, so her relationship with the medical staff changes Hence more junior nurses, represented here by students and student nurse leavers, seem to be in awe of the medical staff such that doctors have the ability to make them feel inadequate 'You feel they know so much more than you — they can be quite threatening, some of them' (third year student) They can feel intimidated by demands doctors make 'They expect me to know everything, they want everything there and then' (third year student) However, the situation changes noticeably when a nurse qualifies, takes on extra responsibility, and becomes more confident in her own judgement Then, quite the opposite from feeling intimidated by doctors, her complaints become those of a professional who cannot get the required help or recognition from a fellow professional Sometimes reactions to this are relatively mild 'I get a get annoyed when they don't listen to me' (sister) At other times they are the source of much

anger and resentment, as in the case of a staff nurse who correctly diagnosed a deep vein thrombosis in one of her patients She promptly called the medical officer on call, only to be told that he was having a bath and doubted her diagnosis On confirmation of the diagnosis on the consultant's ward-round the following day, the doctor concerned denied ever having been informed of the patient's condition

Main stressors

In addition to being asked to describe all incidents or situations that were stressful, respondents were asked to say which was the most stressful For the trained staff, the main stressors were understaffing (35% of trained staff sample) followed by conflict with doctors (25% of trained staff sample) For the student nurses and student nurse leavers, dealing with death and dying was the most frequently-cited main stressor (30% and 31% of the samples, respectively)

Coping

The respondents' coping behaviours were assessed from the Ways of Coping Questionnaire together with information on coping behaviours, support systems, and individual relaxation methods gathered during the open-ended interview

Ways of Coping Questionnaire

Trained staff used significantly more confrontive coping than the other two groups They showed the most use of all the groups of planned problem-solving and the least use of escape–avoidance as coping techniques Students made most use of all the groups of distancing, seeking social support, accepting responsibility, positive re-appraisal and escape–avoidance as ways of coping Using analysis of variance (Scheffé procedure), leavers used significantly more relative self control than the other groups ($P < 0\ 10$) and made the least use of all the groups of confrontive coping ($P < 0\ 10$)

These findings show the tendency of trained staff to make more use of problem-focused coping, and students and leavers to rely more on emotion-focused coping, and these strategies seem determined by the types of incident reported Thus trained staff tended to describe situations of managerial or organizational frustration (such as lack of resources or understaffing), requiring problem-solving or confrontation with senior nursing staff or administrative staff, whereas students and leavers typically described situations of cardiac arrests or patients they had become attached to dying, in which emotion-focused coping appears more appropriate

Social and emotional support

Most respondents reported having good friends outside nursing (89%), of whom 66% were considered supportive Friends within nursing were the most supportive group, 93% of the sample saying they had good friends within nursing, and 91% of these said their friends within nursing were supportive Of the 70% of respondents who had partners, 60% said their partners were supportive Where partners or friends were said not be supportive, it was usually that they were outside nursing and the medical professions and did not understand the pressures nurses were under, sometimes displaying an aversion to hearing things about hospital life, for instance, 'my husband hates anything to do with hospitals' (staff nurse)

Perhaps for these reasons, it was friends in nursing who were the people most consulted in times of stress (45% of trained staff, 50% of students and 39% of leavers) As one first-year student explained, 'Fellow students make for a fellow feeling' In some cases, support from friends in nursing is seen as bearing almost healing properties 'If we're upset about something, we usually make each other better' (second-year student)

Other nurses, not necessarily friends, provided the second most popular source in times of work-related stress 20% of trained staff and 10% of students said they would go to senior ward staff when needing to talk Few students chose to talk to their partners at such times (three students only), and even less to approach tutors (one leaver only) Not all respondents would approach someone in times of stress 15% of trained staff and 8% of leavers said they would not talk to anyone in times of work-related stress

Respondents were also asked if they thought the support they received, from whatever source, was adequate 62% of the sample said the support they received was adequate, 34% that it was not adequate, and 4% that it was adequate only sometimes Students were the group who appeared most satisfied with the support they received 75% of students said they were satisfied that the support they received was adequate, compared to 60% of trained staff and 46% of leavers

Methods of relaxation

The respondents used a wide range of relaxation methods, the most popular involving exercise (e g walking, badminton, squash, swimming) Relaxation time was often used for problem solving, thinking about things on one's own or talking about them with others as one student put it,

'Sometimes you think you couldn't carry on if you didn't have people to compare things with'

Differences in chosen methods of relaxation between groups were negligible, although 'going out for a drink' was cited as a relaxation method by more students (40%) than trained staff and leavers (20% and 23% respectively), whilst cookery/housework was a relaxant for trained staff only Leavers showed a tendency to relax by reading (62%), compared to trained staff and students (40% and 25% respectively)

Smoking and drinking as coping strategies

A significant difference was found between the groups concerning smoking habits ($\chi^2 = 6\,70$, $P < 0\,05$) 60% of trained staff were smokers compared to 20% of students and 39% of leavers At present, 34% of Welsh females aged 16–64 smoke (Welsh Heart Health Survey 1985) Furthermore, for those respondents who remained in the profession at time of interview, trained staff smokers smoked more cigarettes 50% of trained staff smokers smoked 1–10 cigarettes a day and 50% smoked 11–20 a day, compared to the student nurse smokers who all smoked 1–10 cigarettes a day

Ninety-four per cent of the sample drank alcohol, with no significant intergroup differences on consumption levels The reported amounts of alcohol drunk were small or moderate 76% of respondents drank 1–7 units of alcohol per week, with only one subject per group reporting drinking more than 15 units of alcohol a week.

How do different types of people cope?

Spearman correlation coefficients (rs) were calculated using the raw scores from the Ways of Coping Questionnaire to assess the relationship of styles of coping to the other personal characteristics measured in the study

1 Confrontive coping correlated with 16PF assertiveness (rs = 0 26, $P < 0{\cdot}05$), 16PF imagination (rs = 0 26, $P < 0\,05$), tough-mindedness (rs = 0 25, $P = 0\,05$) and high total self-esteem (rs = 0 31, $P < 0\,05$)
2 Planned problem-solving correlated positively with characteristics of being venturesome (rs = 0 25, $P < 0{\cdot}05$), self-assured (rs = 0 33, $P < 0\,05$), 16PF controlled (rs = 0 28, $P < 0{\cdot}05$) and high personal self-esteem (rs = 0 29, $P < 0\,05$), and negatively with 16PF anxiety (rs = −0 38, $P < 0\,01$)
3 Seeking social support correlated positively with being outgoing (rs = 0 40, $P < 0{\cdot}005$), venturesome (rs = 0·30, $P < 0{\cdot}05$), forthright (rs = 0 35, $P < 0{\cdot}01$), group-dependent (rs = 0 33, $P < 0{\cdot}05$) and 16PF extroversion (rs = 0 42, $P < 0\,01$), and with high general (rs = 0 32, $P < 0{\cdot}05$), social (rs = 0·44, $P < 0{\cdot}005$) and total (rs = 0 43, $P < 0\,005$) self-esteem
4 Distancing correlated positively with being 16PF intelligence (rs = 0 26, $P < 0\,05$)
5 Escape-avoidance correlated positively with being tense (rs = 0 52, $P < 0\,001$), happy-go-lucky (rs = 0 34, $P < 0\,05$) and 16PF imaginative (rs = 0 40, $P < 0{\cdot}005$) and anxious (Gambrill & Richey) (rs = 0 31, $P < 0\,05$), and negatively with assertiveness (Gambrill & Richey (rs = 0 26, $P < 0\,05$)
6 Positive reappraisal correlated positively with 16PF imagination (rs = 0 31, $P < 0\,05$)
7 Accepting responsibility correlated positively with being assertive (rs = 0 26, $P < 0\,05$) and 16PF imaginative (rs = 0 44, $P < 0\,005$)
8 Self control correlated negatively with personal self-esteem (rs = −0 33, $P < 0{\cdot}05$)

Whilst accepting the limitations of confining styles of coping to either being problem-focused or emotion-focused (Folkman & Lazarus 1981), it can be seen that in overall terms, problem-focused coping is associated with characteristics of being outgoing, venturesome and assertive, of high self-esteem and low anxiety, and it is these that are the characteristics of the trained staff

Assertion

The assertion inventory measured both the perceived anxiety and the degree of assertiveness associated with specific situations No significant differences were found between groups on either anxiety or assertiveness However, all groups showed high anxiety (students being the most anxious group), and low overall assertiveness

If we consider the distribution of the three groups of respondents as they fall into the three assertion repertoires as described by Gambrill & Richey (1975), we find no significant differences in pattern across the three groups Surprisingly, 75% of all respondents fall into assertion repertoires described by Gambrill & Richey as 'dysfunctional' Only 25% of respondents (26% of trained staff, 29% of students and 17% of leavers) are 'assertive' (high assertion with low anxiety) Most respondents (56%) overall fall into the 'unassertive' repertoire (low assertion with high anxiety), with students as the most unassertive group (65%)

Assertiveness as measured by the Gambrill & Richey Assertion Inventory correlated positively with being emotionally stable (rs = 0 36, $P < 0{\cdot}01$), expedient (rs = 0·31, $P < 0{\cdot}05$), venturesome (rs = 0 60, $P < 0\,01$), tough-minded (rs = 0·39, $P < 0{\cdot}01$), self-assured (rs = 0 50,

$P<0.01$), and 16PF extrovert ($rs=0.32$, $P<0.01$), and with high personal ($rs=0.48$, $P<0.01$), general ($rs=0.48$, $P<0.01$) and social ($rs=0.23$, $P<0.10$) self-esteem

FEATURES OF NURSING ENJOYED AND LEAST ENJOYED

There was little difference between the groups regarding the aspects of nursing they found enjoyable Caring for the patients (day-to-day nursing care and talking to patients) was rated the greatest source of satisfaction (mentioned by 87% of respondents) Other aspects of nursing commonly enjoyed were the demands of own speciality (e g bandaging in accident and emergency department) (23%), the excitement of nursing (11%) and seeing patients improve (11%) Only one subject, not surprisingly a leaver, stated that there was nothing she enjoyed about nursing

The aspects of nursing least enjoyed by respondents fell into nine main groups conflict with other people (including doctors, nurses, relatives), issues related to real/perceived status level, issues related to academic work, dealing with death and dying, looking after specific patient groups (e g overdose patients), issues related to specific ward/unit areas, nothing (i e there is nothing the subject does not enjoy about nursing)

Conflict with nurses caused the most overall dissatisfaction (21%), followed by understaffing (17%), and doing menial/monotonous tasks (e g taking a lot of patients' temperatures, filling in the fluid charts) (15%) These aspects are typically those which were reported earlier as being associated with stress

Role-related group differences were again apparent in these unenjoyable nursing situations Thus, for example, for trained staff paperwork is the aspect of nursing causing the most dissatisfaction (30% v 0% in the other groups), whilst for students, doing menial/monotonous tasks (35% v 0% for trained staff), followed by school work/study (25% v 0% for trained staff) cause the most dissatisfaction

DISCUSSION

Attrition

A picture emerges of the leaver who knew little about nursing before commencing training, who did not have social contact with nurses or doctors and who had little prior relevant experience, and who therefore found that nursing did not live up to her expectations More emphasis should thus be placed on a realistic knowledge of nursing in selection procedures and more should be done to educate sixth-formers about a career in nursing

The leavers explained that the primary reasons for going were that the stresses were too great, and the support inadequate Whilst accepting that some individuals are simply not suited to nursing — for example, the leaver who declared that there was absolutely nothing she enjoyed about nursing — attention must be focused on ways of increasing support and reducing stress in order to stem the costly flow of students from our schools of nursing There will soon be an unprecedented shortage of female school leavers who produce the bulk of student nurse staffing, and, as Dean (1987) states, 'It is not an overstatement to say that a crisis is imminent and can only be averted if action is taken by all concerned as a matter of urgency' Most of our respondents who left nursing did so within the first 12 months of training, and this emphasizes that intensive support must come early in training when so many students face new and threatening experiences In the remainder of this discussion we will analyse the stressors of nursing, the aspects peculiar to different stages and specialities of training, and the ways of coping or changing the environment that seem to alleviate these stresses This is the information that must inform the content of a stress management and support curriculum for trainee nurses

Stress

Twenty-six classifications of stressor emerged as a result of our open-ended interviews and many of these, such as dealing with death and dying, were universal across subject groups The five most frequently cited stressors for respondents overall were understaffing, conflict with nurses, dealing with death and dying, overwork, and conflict with doctors These have all been identified as major stressors by other researchers for both student and trained staff (Parkes 1985, Hingley & Cooper 1986, Price 1985, Birch 1979)

There also emerged a clear pattern of stressors related to subjects' role and seniority, some stressors being cited far more frequently by some subject groups than others (e g understaffing by trained staff), and some stressors being cited by one subject group exclusively (e g being in a new situation — students only) In addition, of those stressors that were universally cited across subject groups (e g dealing with death and dying, conflict with nurses and doctors) there emerged a clear distinction between different aspects of these stressors and these had differing impacts on the three respondent groups It is not surprising that stressors, and different aspects of the same stressor, should be role-related, since, for example, it is the trained staff who, acting in a managerial capacity, are largely responsible for allocating staff to patient care, for ensuring that adequate

resources are available on the ward, and for liaising with medical and paramedical staff and higher nursing management, whilst the less experienced student nurses are more likely to find themselves in new situations, with attendant feelings of inadequacy

Stress is present in the nursing profession at every level, but the perception of stressful situations changes according to position in the hierarchy This has important implications for stress management and counselling which must be tailored to meet the needs of the individual and the role they fulfil We will now consider the major stressors in turn and suggest some appropriate responses

Death

Student nurses require group or private discussion and counselling to help them face issues such as death and dying early on in their training Birch (1979) found that 'feelings of your own death' was one of the things that diminished in ability to cause stress as training progressed without intervention, but that with intervention these fears might be reduced even sooner Parkes (1985) recommended the use of role-play to improve communication skills of student nurses in order to help them interact with dying patients and their relatives With proper support and guidance, students will have their own level of stress reduced when dealing with death and will thus be more confident to support the dying patient at a time when he needs her most Student nurses cannot be totally protected against exposure to death or the dramatic circumstances, like cardiac arrest, in which people may die in hospitals The traumatic way in which patients actually died was a source of distress to some students, particularly if they had become attached to that patient (a situation which has become increasingly likely now that many of the 'defence systems' mentioned by Menzies (1960) — e g task allocation, and referring to patients as medical cases rather than individuals — have given way to the nursing process with its emphasis on total patient care) As one student said, 'It was horrible to see someone who loved life go like that' Student nurses provide the bulk of the 'hands on' patient care and this may explain why they feel the 'loss' of a friend more than the trained staff when the patient dies They are also more wary of the physical presence of the dead body, and more distressed than trained staff by the perceived 'deceit' of keeping the patient's impending death from him

Regardless of advances in medical science and technology, death in hospital settings is inevitable and for many student nurses it is their first exposure Thus great care must be given in their support Trained staff need to be made aware of the fears of the students (which they may have forgotten from their own student days), they need to give time to ward discussions following deaths of patients and introduce students gently to death The fact that trained staff also cited dealing with death and dying as stressful indicates that distress caused by caring for dying people is not something that disappears as the nurse continues on beyond her training, but the impact may be lessened or different aspects are more upsetting to nurses at different levels of experience Hence the trained staff, having become more accustomed to the painful loss of a friend aspect of death, are more traumatized by the particular duties (such as breaking the news to the relatives and comforting the bereaved) that their role demands of them

Conflict

Conflict with other members of staff, particularly nurses and doctors, also emerged as being very stressful and this has been identified elsewhere (Parkes 1985, Price 1985, Hingley 1984, Llewelyn & Fielding 1983, Anderson & Basteyns 1981) Although the aspects of conflict with both nurses and doctors change as student nurses qualify and take on a different role, it appears generally that student nurses would benefit from discussion of such conflicts and training in social skills in order to interact more profitably with health care professionals from their own and related professions Mapanga (1985) in a review of the relevant literature concludes 'proposals for more time in the curriculum to learn social skills is imperative' In the present study, some leavers and students also complained about being left unsupervised to carry out tasks, and appeared largely united in believing that trained staff had 'forgotten what it was like' to be a student Parkes (1985) found that a considerable part of student anxiety on moving wards stemmed from the perceived expectations of the trained staff Hence there should be opportunity for informal discussions between trained staff and students on the wards to discuss progress and expectations

From the trained staff's point of view, the majority of inter-nurse conflict arose from conflict with nursing officers, feeling them to be far removed from the difficulties and practicalities of managing a ward with inadequate equipment and staff In one case, a sister working at what she described as 'danger level' (grossly inadequate staffing levels), had to abdicate responsibility for the welfare of her patients before relief staff were provided

Conflict with doctors emerged as a large problem, accounting for the second major stressor for trained staff. It is sadly almost inevitable that when two different but

related professions work together, conflict arises The situation is compounded by the ever-extending image and role of the trained nurse, resulting in ambiguity of role and overlap of responsibilities once designated as strictly medical or nursing The increasing responsibility of nurses, whilst it has its advantages, also leaves them open to exploitation from unconscientious doctors Doctors in the present study were portrayed as being at times elusive, even at crucial moments Doctors are at liberty to move around freely whilst the nursing staff usually have to stay on the ward for the duration of their shift, and so difficulties arise when nurses try to contact doctors (Anderson & Basteyns 1981) Trained staff also expressed concern over the ability of doctors always to form competent diagnoses and prescribe correct treatments for patients, and that when the nurse is assertive enough to put forward her own point of view or worries quietly, she is placed under extra strain Since nurses are clearly no longer the 'handmaidens' of the medical profession, but knowledgeable professionals in their own right, such situations are clearly not acceptable

Dealing with death and dying, workload problems and conflict with other staff have been seen as particularly stressful since they are *externally* rather than *internally* controlled (Anderson & Basteyns 1981) The nurse is unable to control and sometimes even to anticipate crisis events or the death of a patient and hence feels helpless and increasingly stressed as a result

Overwork

Overwork and understaffing were complained about by all three groups of respondents, understaffing being the major stressor for trained staff

> If we're going to do the job properly, and be the caring people we're supposed to be, you've got to have a decent ratio of staff to patients
>
> (Staff nurse, qualified for 8 years)

> People say, 'why don't you just go off duty?', but you can't, because you'd be leaving things half done That gets you down
>
> (Staff nurse)

> You can't actually give what you're supposed to give to the patient, you have no choice
>
> (Night sister)

It is easy to see why, in the present climate of increased waiting lists, shorter hospital stays, advances in medicine and technology combined with dwindling human and technical resources, nurses feel increasingly pressurized and helpless

In order to cope with the wide range of stressors described, a correspondingly wide range of coping strategies were used Whilst trained staff showed more use of problem-focused coping, with particular emphasis on confrontive coping, students and leavers made more use of emotion-focused forms of coping In general, emotion-focused forms of coping are used when (1) there has been an appraisal that nothing can be done to change or modify harmful, threatening or challenging environmental conditions (Folkman & Lazarus 1980), or (2) when the subject's perceived level of stress rises too high The students and leavers often reported incidents in which a patient they had become close to had died, or suffered a cardiac arrest, as being at the forefront of their minds when describing a recent stressful incident, and it was this episode which was dealt with by emotion-focused coping Death of a patient is usually beyond the control of a student nurse, hence the feelings of grief, helplessness and powerlessness which result in the seeking of social support and escape–avoidance strategies Cardiac arrests, in addition to being largely out of the control of students and leavers, were also often described as very threatening situations in which they feel genuine fear and panic As Lazarus & Folkman (1984) state, 'The greater the threat, the more primitive, desperate or regressive emotion-focused forms of coping tend to be, and the more limited the range of problem-focused forms of coping' Death produces the same feelings of threat one student stated, when left alone with a dead patient, 'I was scared in case he jumped up'

The situations described by trained staff differed from those described by students and leavers in that they were predominantly concerned with stress arising from managerial or organizational frustration Situations in which staff shortages are evident could benefit from quick evaluation of nursing needs and planning the most effective allocation of nurses to patients, as well as requests for relief staff Similarly, lack of resources or equipment may be alleviated by assertive contact with nursing officers or administrative staff Hence problem-focused coping is appropriate in these situations in which the trained member of staff has some control

We should remember that both these forms of coping are valuable, but in different types of situation As Lazarus & Folkman (1984) state,

> Emphasizing problem-solving and mastery devalues other functions of coping that are concerned with managing emotions and maintaining self-esteem and a positive outlook,

especially in the face of irremediable situations Coping processes that are used to tolerate such difficulties, or to minimize, accept or ignore them, are just as important in the person's adaptational armamentarium as problem-solving strategies that aim to master the environment

However, it can be seen from the correlations of ways of coping with other individual characteristics that emotion-focused forms of coping generally correlated with characteristics of low assertiveness and high tension (escape–avoidance) and with low personal self-esteem (self control), the opposite being true of problem-focused coping (which correlated positively with being self-assured, controlled, of high self-esteem and low anxiety), and confrontive coping (which correlated with high assertiveness and self-esteem) Assertiveness training may therefore encourage the development of problem-focused coping strategies with attendant decreases in anxiety levels and increases in self-esteem, and we suggest such training be adopted for nurse trainees

Nurses as an occupational group have been described as being notoriously unassertive (Bush & Kjervik 1979) Gunning (1983) states that nurses are unable to assert the power that should be theirs (considering that they are the largest group of health care providers), because they, as women, have come to view power as typically masculine They act as mediators and hence have not learned to manage conflict constructively In the present study, in which 89% of respondents were female, only 25% of respondents were found to be assertive All other respondents fell into assertion repertoires described by Gambrill & Richey (1975) as being 'dysfunctional', the 'unassertive' repertoire having the highest representation of respondents, particularly of student nurses Such low levels of assertiveness in the respondents may go some way to explaining the potency of stressors such as nurse conflict and doctor conflict There appears a clear need for assertiveness training for these nurses, although training needs to be geared toward the particular assertion repertoire of the individual Gambrill & Richey (1975) state that for the 'anxious performer', increased relaxation and coverant control might be more useful in treatment than concentrating on the specific verbal and non-verbal components of assertion that would be the focus of treatment for the non-assertive individual A stress-management package that included both assertiveness training based on learning both verbal and non-verbal aspects of assertiveness as well as relaxation therapy would allow for meeting of such individual needs

Assertiveness

Assertiveness was found to be positively correlated with characteristics of emotional stability, expediency, tough-mindedness, extroversion, self-assuredness, and high personal, social and general self-esteem One might therefore expect such assertiveness training to be accompanied by a lessening of anxiety and overall rise in self-esteem in nurses

Leavers had lower general, social and personal self-esteem than the other groups This difference, although not reaching statistical significance, was most marked in the areas of personal and general self-esteem Whilst it is naive to assume that these characteristics are directly related to nursing experience, it is interesting to see that those nurses who have stayed in nursing longer and 'made a success of it' scored highest on personal self-esteem We cannot determine the causal directions here The failure experience of leaving nursing may have a detrimental effect on the leavers' self-esteem, or, conversely, the low self-esteem may have made them less confident or able to achieve valued goals

Avenues of support were also explored to examine their role in the coping process Students appeared to be the best supported group of respondents, most satisfied with the adequacy of the support they received (from whatever source), and always talking to someone in times of stress Finding support to be adequate was found to be associated with extroversion, the most extrovert individuals having less difficulty in seeking out and utilizing satisfactory support networks This points to the need for organized support groups among nurses so that opportunity for group discussions in which everyone can participate and share worries are not left to chance or personality factors

The student nurses in the group turned to friends in nursing more than the other two groups when in need of support regarding work-related stress This peer group cohesion, described by student nurses as a powerful source of emotional support, appears to break down as a nurse qualifies The fact that trained staff were least satisfied with support received and that 15% of trained staff did not speak to anyone about work-related stress suggests that trained staff may benefit from organized group discussions or counselling programmes which would help keep them in touch with each other

Tutors

Tutors were not seen as a good source of support by either students or leavers Whilst it may seem obvious that friends could provide much-needed emotional support, one might expect students to go elsewhere for practical help or information, perhaps to their tutors, but this was not the case in the sample interviewed Only one leaver stated that she would approach a tutor to discuss work-related problems

The general feeling was not that tutors were not approachable or sympathetic, but that tutors, who had been through the training experience successfully, would think the learners' worries 'pathetic' or trivial, and it is these tutors who are assessing the trainees' adequacy

Aspects of nursing most and least enjoyed by respondents were, like the stressors, many and varied Many of the issues which emerged as least enjoyable aspects (e g conflict with staff), were also reported as major stressors However, other issues, such as doing menial or monotonous tasks, whilst considered to be boring or dissatisfying, did not cause undue stress A certain amount of routine work is inevitable, even in as varied a profession as nursing However, the introduction of the nursing process ethos of primary nursing must ensure that allocation of such duties solely to junior student nurses is a thing of the past Little group difference was apparent in aspects of nursing most enjoyed, but aspects least enjoyed were, like stressors, role-related Paperwork was the most dissatisfying aspect of nursing for trained staff The introduction of the nursing process ethos also entailed much additional paperwork, such that some nurses went as far as to say that patients were being neglected in order to fill in forms

Satisfaction

Although this study has concentrated on the negative aspects of nursing, it remains to be said that many of the respondents expressed great satisfaction in their work, particularly relating to direct patient contact, and, despite the many pressures, nursing remains a challenging, varied and rewarding occupation These sentiments were summed up by a third-year student nurse who stated, 'I cannot think of a more worthwhile job at the end of the day'

CONCLUSION

This study provided the exploratory research to plan, execute and evaluate a major programme of stress-management training for student nurses This training, informed by the present findings and following their conclusions and recommendations, commenced in 1988 at the North Wales School of Nursing and is presently being evaluated using a true experimental design with alternative intakes to the modular training programme receiving either traditional (control) tuition or a programme which additionally includes the following

1 On-going discussions between groups of student nurses These have a dual purpose, namely (i) to help foster the peer-group support which has been shown to be so valuable during this exploratory study, and (ii) to explore and prepare the trainees better for those particular stressors relevant to the individual stages of training and idiosyncratic ward placements
2 Assertiveness training in order to help equip student nurses from the very onset to deal with the anxieties of nursing, and to provide them with the skills and knowledge to help them interact more profitably with other professionals and so help reduce stress related with interpersonal conflicts
3 Progressive muscle relaxation training which has proven physiological and psychological benefit and which could offer alternatives to the more harmful palliative strategies for relaxation (e g smoking and drinking) which the nurses are currently adopting

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APPENDIX: THE OPEN-ENDED INTERVIEW

1†	Did you know anything about nursing before you started?
2	Did you know any nurses or doctors well?
3	Were you strongly influenced by anyone to enter nursing?
4	Did you have any relevant experience before entering nursing?
5	What alternatives were there to entering nursing?
6	Is/was nursing what you expected it to be? If not, why not?
7	Do/did you have good friends outside of nursing? Are/were they supportive?
8	Do/did you have good friends within nursing? Are/were they supportive?
9	Do/did you have a partner/boyfriend? Is/was he supportive?
10	What aspects of nursing do/did you enjoy?
11	What aspects of nursing do/did you enjoy least?
12*	What would you say were the main factors contributing to your leaving nursing?
13†	What, if any, was the 'final straw'?
14†	What incidents or situations in nursing cause/caused you stress?
15	Which of these cause/caused you the most stress?
16	Can you describe a particular recent incident in nursing that has caused you stress?
17	Who do/did you talk to in times of work-related stress?
18	Do you believe that support is/was adequate?
19	Would you say you were quite good at coping with stress in your everyday life?
20	How do you relax/unwind?
21	Do you smoke? How many?
22	Do you drink? How much per week?
23	Going back to the stressful incident you described earlier, how did you cope with that at the time?
24*†	Can you ever see yourself in nursing again?
25*	What is your present occupation?

*Additional questions asked only of student nurse leaver subjects
†Questions also asked by Lindop (1988)