

**KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY
INSTITUTE OF DISTANCE LEARNING**

**OCCUPATIONAL STRESS IN HEALTH CAREWORKERS: THE CASE OF
THE GOASO GOVERNMENT HOSPITAL**

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BY

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DECLARATION

I hereby declare that this submission is my own work towards the CEMBA and that, to the best of my knowledge, it contains no material previously published by another person nor material which has been accepted for the award of any other degree of the University, except where due acknowledgment has been made in the text.

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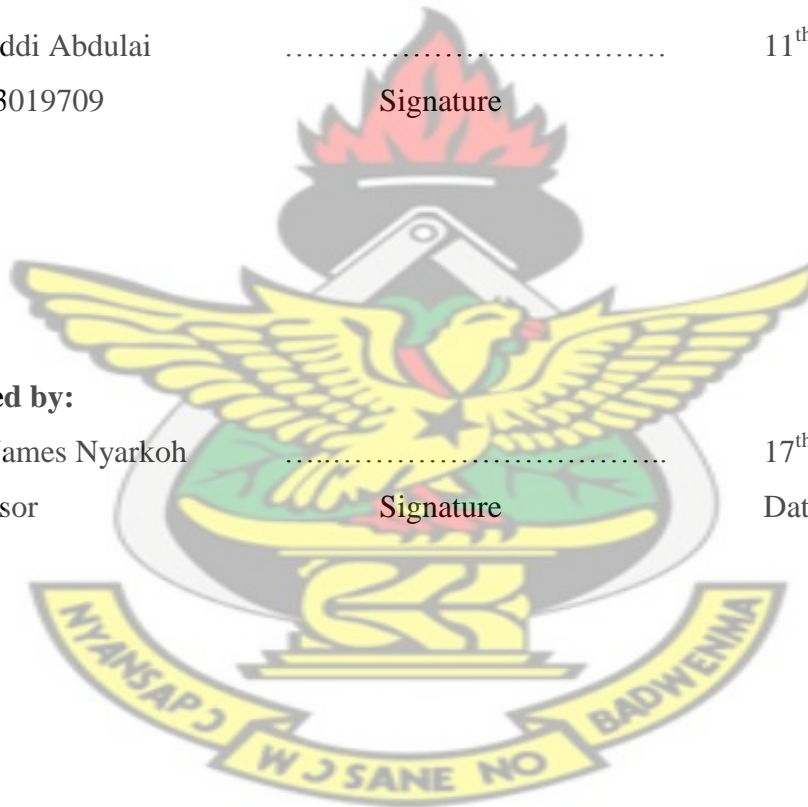
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ABSTRACT

Occupational stress is health hazard to the individual worker both physically and psychologically. It equally has deleterious effects on organizations and even nations in terms of productivity and financial losses. Whilst it is being given close attention in recent times in America and Western Europe as is evident from the growing number of wellness programs being developed for employees in these continents, it does not appear to evoke equal attention in developing countries. Occupational stress is common to all occupations but if it is unchecked in the healthcare sector, that could even be more disastrous for any nation. The issue is that, there are indications of above average occupational stress in some Ghanaian healthcare workers; but exactly how much of occupational stress is being experienced? Which stressors are the most common and what stress reduction strategies are commonly adopted by victims? This study set out to examine overall occupational stress, its causes, outcomes and possible solutions and, in particular, find out the level of occupational stress in workers of the Goaso Government Hospital in the Brong Ahafo Region of Ghana. Administering the Weiman Occupational Stress Scale to a sample of 68 workers drawn from the population of 136 established employees of the hospital, workers of the hospital were found to experience above average levels of occupational stress with nurses showing the highest levels. The study also found that the three most common stressors were workload, inadequate resources and conflicting demands whilst the three most common strategies the workers used for managing stress were briefing with peers or friends, seeking supervision and looking for the humor in the stressor.

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DEDICATION

This work is dedicated to my parents, Abdulai Dahaman Alhassan and Memunatu Fushein Yoruba for their parental care and guidance which enabled me to carry out this study.

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CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

In everyday life, we all experience feelings of pressure or annoyances placed on us by others or by events or incidents and we attempt to cope with, adapt or adjust to these pressures. Feelings of pressure at the workplace are commonly referred to as occupational stress. Steber (1998) defines occupational stress as the rising tension caused in us by any characteristic of the job environment, be it excessive demands or insufficient resources to meet a need, and whose intensity and enduring nature can have a detrimental effect on our ability to adjust and our physical health as well. Viewed in this sense, stress can be regarded as an occupational hazard. It is known to exist in all professions (Todd & Deery-Schmidt, 1996; Pelletier, Coutu & Lamonde, 1996; Pflanz & Sonnek, 2002; Dragano & Verde, 2005) with the healthcare profession being reported to be particularly stressful (Park, Wilson & Lee, 2004; French, 2005). In fact, occupational stress has been cited by many researchers as a significant health problem not only for the individual, but also the organization and the nation as a whole (Caplan, Cobb, French, et al., 1980; House, 1981; Pelletier, 1984; Bellani & Furlani, 1996)

One major hindrance to effectively managing the growing problem of occupational stress facing workers and their organizations is the complex nature of this type of stress.

Occupational stress as a construct has defied definition for several decades. Invariably, it is referred to as stress on the job (Braaten, 2000). But every worker goes to work with a certain level of predisposition towards stress (Greenberg, 1990) acquired from daily incidents and nuisances such as debts, rent, school fees, side effects of medicines, traffic congestion and pressure to get too many things done in less than enough time (Lazarus, Delongis, Folkman & Green, 1985).

Added to these daily hassles may be life-changing incidents such as marriage, childbirth, separation and divorce. At the workplace, the worker's individual characteristics join to further murky the nature of occupational stress. Individual differences put the individual at a lesser or greater risk of experiencing stress, occupational or otherwise. The level of a person's desire to succeed and achieve results, a person's ability to cope with his or her need for urgency, how much one feels able to influence and control events and the extent to which one plans ahead and manages his or her time to deal with problems are some of the individual differences (Greenberg, 1990) that predispose workers to corresponding lesser or greater risk from work stressors which according to (Steber, 1998) include such as the amount or difficulty of work one must deal with, how well one gets along with fellow workers, the extent to which the worker feels the need to have his or her achievements recognized and the day-to-day irritants and aggravations in the workplace.

Easily identified or not, occupational stress has occupied the attention of both industry and researchers alike, especially in developed countries, for more than four decades now

(Steber, 1998; Braaten, 2000; Dzirasah, 2005). It has been receiving increasing attention in recent times because both businesses and governments are genuinely beginning to accept that their well-being depends largely on that of the employee's physical and emotional well-being. This is evident in the growing number of companies and governments, especially in America and Western Europe that are developing employee wellness programs.

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However, it must be pointed that whilst in the developed countries occupational stress has long become a serious health issue both in terms of the individual's mental and physical well being and of the financial consequences to employers and governments, it does not appear to evoke equal attention in developing countries.

1.2 Statement of the Problem

In Ghana, it has been reported that between 60 and 70 per cent of hospital visits in 2005 were stress related. "Stress and lifestyle diseases are gradually becoming the main source of mortality among Ghanaians" (Dzirasah, 2005). As a developing country, the atmosphere in Ghana appears to be a breeding ground conducive enough for stressors. Inadequate resources and half-hearted interventions are some of the possible nutrients in this ground.

In the health sector, despite the institutional arrangements put in place to promote work and happiness, less than optimal working conditions and inadequate yet dwindling

numbers conspire with other factors to put most healthcare workers at risk from occupational stress. Occupational stress may account for some of the reasons why most hospitals are not responsive to patient needs and as a result significant health needs are left unmet.

At Goaso Government Hospital for instance, job design can be cited as a major cause of excessive workload, an occupational stressor. For instance, the Health Services Administrator (Hospital Administrator), in addition to being in charge of the day-to-day administration of the hospital, is also acting Environmental Officer, Transport Manager, Legal Officer, In-service Training Co-coordinator and sometimes acting as the Estate Officer. The Medical Superintendent (Medical Officer), in addition to work commonly associated with hospital administration, he is also in charge of treatment of patients as a core function. In such an instances where workload is the stressor and no job redesign is done, the workers find that they have to take time off to deal with the stress, only to return to work to find that the already unmanageable workload has substantially increased in their absence, thereby increasing the source of the stress and fuelling a vicious cycle which may ultimately lead to a complete breakdown in health.

Despite the fact that there are apparent indications of occupational stress in healthcare workers in Ghana, these indications are not well defined by evidence. In fact, no work on the subject as it relates to the Goaso Government Hospital has been sighted. The issue is that, there may be occupational stress in workers of the hospital; but just how much of it? Which stressors are the most common and what stress management or

reduction strategies are commonly adopted by victims? It is generally assumed that healthcare workers of the hospital experience above average levels of occupational stress and that nurses experience the highest levels of occupational stress whilst support staff of the hospital experience below average levels of occupational stress

In order to effectively fight any problem an awareness of its causes, outcomes and possible solutions is very important. This study examines overall occupational stress and in particular the level of occupational stress in healthcare workers at the Goaso Government Hospital.

1.3 Objectives of the Study

The main aim of the study is to examine overall occupational stress and explore its level, main causes and the most common techniques employed in coping with it among healthcare workers in Ghana. In specific terms, the study focuses on achieving the following objectives:

1. To examine the overall nature of occupational stress.
2. To examine the current level of occupational stress experienced by workers of Goaso Government Hospital.

3. To determine the most common occupational stressors among workers of the hospital.
4. To assess the most common strategies workers of the hospital use for managing or reducing occupational stress.

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1.4 Research Questions

In achieving the above objectives, the study hopes to find answers that throw light on the following questions and the issues engendered by them:

1. What is the overall nature of occupational stress?
2. What is the level of occupational stress among workers of Goaso Government Hospital?
3. What are the main causes of stress among workers of the Goaso Government Hospital?

4. What are the common strategies the workers employed to reduce or manage stress?

5 What are the common strategies used by management to mitigate stress?

1.5 Significance of the Study

This study is significant in a number of ways. It adds to existing knowledge and serves as a source of reference material on occupational stress among healthcare workers. The Ministry of Health (MOH) may find it useful and beneficial. Information on occupational stress among healthcare workers not only helps in assessing occupational stress in health facilities but also helps government to adopt a better and effective occupational stress management policy in public hospitals. Findings of the research broaden perceptions on occupational stress among healthcare worker thereby offering deeper insights for policymakers. It may inform health planners to enable them set up genuine planning schemes for health care services. Finally, the study will serve as a basis for further studies into occupational stress among health workers.

1.6 Scope and Limitations of the Study

This study covers only workers of Goaso Government Hospital and is basically exploratory in nature. Whilst it succeeds in establishing some baseline scores of

occupational stress for categories of workers at the hospital, convenience sampling obviously limits any meaningful generalization of its findings

1.7 Organization of the Study

The study has five chapters. Chapter one contains background information, statement of the problem, objectives of the study, research questions and the significance, scope and limitations of the study. The second chapter reviews literature on occupational stress whilst the third chapter describes the research methodology. Chapter Four analyzes and discusses findings made by the study and the final chapter is the conclusion and recommendations.



CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

In this chapter the literature on overall stress and that on occupational stress are reviewed. Evidence on the nature and effects of work stress is reviewed. The review helps to define the sources and effects of occupational stress. Evidence on occupational stress in the healthcare profession is examined. The intervening effects of gender, family and personality traits are clarified workers and evidence on the lessening of occupational stress in healthcare workers is also assessed. In addition, the roles of work relationships and management style are described. Finally possible methods employed in the management of stress arising from these stressors are explored.

In the physical or natural sciences such as physics, stress is a pressure (a “press”, a “push” or a “pull”) exerted on a body. Sources of physical stress are found in cement blocks crushing on the earth, in cars smashing one another, and in stretching rubber bands. Psychological stresses also “press,” “push,” and “pull” (Rathaus & Nevid, 1991). People can feel “crushed” by the need to make a life changing decision. They can feel “smashed” by a disaster, or “stretched” to the brink of “splitting” (Steber, 1998).

Ordinarily, most people talk about stress in terms of the pressure they are feeling from something happening around them or to them. Students may talk about being under stress from an impending deadline for a major paper. Parents may talk about the stress of raising their children and the financial burdens of running a household. Lecturers may talk about the pressure of maintaining professional currency while still managing to keep on top of duties connected with teaching. Lawyers, Doctors, Nurses and Therapists talk about meeting the endless demands of their patients and clients (Rice, 1992).

Regrettable events such as the death of a loved one or the loss of a job can be extremely stressful and overstretch our abilities to cope. However, stress is not naturally always harmful. Each individual's perceptions and interpretations give meaning to events and determine whether such events are threatening or positive (Lazarus & Folkman, 1984). Personality traits are therefore remarkable intervening variables in the stress equation because what may be overtaxing to one person may be exhilarating to another (French & Caplan, 1972).

Whilst positive events such as gaining admission to the university or starting a new job invariably require us to handle new responsibilities or adjust to a new environment, they can also be exciting, joyful or delightful. The birth of a child is often a source of great joy to its parents but may also raise the level of stress that the parents experience. The Canadian researcher, Seyle (1980) pointed out that small or mediocre amounts of stress can be good for us to keep us alert and occupied. Seyle referred to "good stress" as

eustress. However, intense, enduring stress can have a deleterious effect on our ability to adjust and our physical health as well.

There are many different sources of stress. Some are biological (e.g. toxins, heat, cold), some psychological (e.g. threats to self-esteem, depression), others sociological (e.g. unemployment, death of a loved one, birth of a child), and still others philosophical (e.g. use of time, purpose in life). Researchers have identified various sources of stress which include daily hassles, life-changes, physical pain and discomfort, frustration and conflict and natural and technological disasters. Regardless of the stressor, the human body always react (Greenberg, 1990).

2.2 Conceptual Framework

2.2.1 The Concept of Stress Thus, stress has been studied from many different perspectives. It has been classified as a stimulus, as a response, and as an interaction. Selye (1956) suggested a physiological approach that supports studying the stress by examining the association between it and illness. In his research, first published in his classic book *The Stress of Life*, Hans Selye, popularly called the Father of Stress, summarized reaction to stress as a three-phase process which he dubbed the general adaptation syndrome:

In Phase 1 which he refers to as the *Alarm Reaction*, the body shows changes characteristic of first exposure to the stressor and at the same time its resistance is diminished. If the stressor is sufficiently strong (such as severe burns, extremes of temperature, etc) death may result.

In Phase 2, the *Stage of Resistance*, resistance proceeds only if continued exposure to the stressor is compatible with adaptation. At this stage the bodily signs characteristic of the alarm reaction virtually disappears and resistance rises above normal.

Following prolonged exposure to the stressor, the body's adaptation energy is exhausted (Phase 3: *Stage of Exhaustion*). The signs of the alarm reaction reappear, but now they are irreversible, and the individual dies.

Contrary to the perspective proposed by Selye, Holmes and Rahe (1967) and later, Lazarus (1984, p. 19) advocated a psychological assessment in which they viewed stress as “a particular relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being.” From this psychological perspective, stressors most common to our lives involve our adaptation to life-changing incidents or our experience of daily hassles.

Thomas Holmes and Richard Rahe focused on life-changes as sources of stress. Life-changes by their nature are often isolated and infrequent happenings in our lives. Some could even be beneficial and enticing. Life-changing incidents such as marriage, childbirth, owning a house, going to university, etc are quite agreeable experiences. Others are very disagreeable such as separation, divorce, loss of a dear one, earthquakes, wars, etc. Since they conceptualized stress as adapting to change, Holmes and Rahe viewed more change as equivalent to more stress and consequently, more illness and disease. Thomas Holmes and Richard Rahe (1967) found that the more significant

changes a person had in his or her life, the greater the chance that he or she would contract some physical or psychological illness.

Lazarus and Folkman (1984) are of the view that the daily hassles a person experiences are more harmful to his or her health than are the significant life changes that concerned Holmes and Rahe. They believe that these daily events are more damaging to health because of their frequency of occurrence as compared to the major life-changing events that Holmes and Rahe researched, which are usually encountered only rarely.

Common daily hassles as a source of stress are an unavoidable part of our everyday life. They are the obvious daily nuisances and incidents that endanger people's well-being (Lazarus & Folkman, 1984). Lazarus, Delongis, Folkman & Green (1985) later classified daily hassles follows:

Household hassles – they described these as including making meals, shopping and keeping the home in order

Health hassles – were said to include physical sickness, concerns about medical care, and side-effects of medicine

Time Pressure hassles – these they found included having too many things to get done, too many obligations and not enough time to get it done

Inner concern hassles – were described as including feelings of loneliness, fears of social confrontations and concerns about the meaning of one's daily activities

Environmental hassles – these included air pollution, traffic congestion, traffic noise, neighborhood deterioration, and crime

Financial hassles – included concerns about debts, rent, and sending children to school

Work hassles – included dissatisfaction with the job, problems with one's supervisors and co-workers and not liking one's work duties

Future-security hassles – these included concerns about job security, property investments, and getting by in retirement

Lazarus and his colleagues (1985) found that the frequency of experiencing life hassles was strongly associated with negative outcomes such as nervousness, worrying, lack of energy, sadness, and feelings of isolation.

Be that as it may, not all of us react to daily hassles in the same manner. Some of us use active coping skills that minimize the effect of these petty annoyances. For instance, we may be able to focus not on the negative portion of traffic delays but instead use the time to plan other activities we may want to do that day (Steber, 1998).

It appears, however, obvious that daily hassles and disagreeable life-changes affect us psychologically by causing worry and dampening our moods. Apart from Holmes and Rahe (1967), other researchers have reported a link between non-work stress and physical illness. Some have found that marital disruption in the form of separation and divorce was linked to emotional problems and higher rates of a physical illness as such cancer (Ernster, Sacks, Selvin, & Petrakes, 1979). Life-changes have also been found to account for problems ranging from heart disease to accidents, school failures, and relapses among people with schizophrenia (Lloyd, Alexander, Rice, & Greenfield, 1980).

Stress is known to exist in all professions (Todd & Deery-Schmidt, 1996; Pelletier, Coutu & Lamonde, 1996; Pflanz & Sonnek, 2002; Dragano & Verde, 2005; etc.). The difficulty in measuring work stress lies in the fact that work life is not independent from family life; the two domains often conflict (Near, Rice & Hunt, 1980; Pearlin, 1983). In some cases, non-work stress may even be more at play at the workplace than work stress itself. For instance, non-work stress may be particularly salient to the female at work. Women continue to juggle multiple roles, including those roles related to the home and family, for which they always almost invariably have sole or major responsibility.

2.2.2 Occupational Stress

According to Rathaus and Nevid (1991), stress can be described as ‘a demand on an organism to adjust, to cope, to adapt’. From this perspective, occupational stress can

also be viewed as a workplace demand on the employee to cope, adjust or adapt. The American National Institute for Occupational Safety and Health (NIOSH) in its 1999 publication on stress at work defines it as the harmful physical and emotional responses of the worker when the requirements of the job do not match his or her capabilities, resources, or needs (NIOSH, 1999). However, the problem with this definition and most others is that, is the worker responding only to the job stressors or also to the stressors from outside the workplace and those from within himself or herself? Every worker goes to work with a certain level of predisposition towards stress (Greenberg, 1990).

For example, on a daily basis before going to the workplace, the individual already contends with incidents and nuisances that threaten his or her physical health and psychological sanity. These hassles may add to life-changing incidents such as marriage, childbirth, separation and divorce.

At the workplace, the worker's individual characteristics join to further murky the nature of occupational stress. Individual differences put the individual at a lesser or greater risk of experiencing occupational stress. The level of a person's desire to succeed and achieve results, a person's ability to cope with his or her need for urgency, how much one feels able to influence and control events and the extent to which one plans ahead and manages his or her time to deal with problems are some of the individual differences (Greenberg, 1990) that predispose workers to corresponding lesser or greater risk from work stressors.

According to Steber (1998), work stressors include such as the amount or difficulty of work one must deal with, how well one gets along with fellow workers, the extent to which the worker feels the need to have his or her achievements recognized and the day-to-day irritants and aggravations in the workplace.

Non-work stress, individual characteristics and work stressors may therefore be said to combine to induce in the worker the condition referred to as occupational stress.

Viewed in negative terms as the feelings of pressure placed on us by others or annoyances, occupational stress can be defined as the rising tension caused in us by any characteristic of the job environment, be it excessive demands or insufficient resources to meet a need, and whose intensity and enduring nature can have a detrimental effect on our ability to adjust and our physical health as well. This definition is corroborated by the simple definition offered by Rice (1992) that occupational stress results from job features that pose a threat to the individual and that threat may be due to either excessive job demands or insufficient supplies to meet employee's needs. When the job requires too much work in too short a time, job overload exists. Supply deficits concern the inadequacy or non-existence of things employees expect from their jobs such as salary, satisfaction, promotion and opportunity or growth on the job (Rice, 1992).

Freudenberger (1974) conceptualized a type of stress that is characteristic of occupations involving numerous direct interactions with people such as in the healthcare profession and termed this variant of occupational stress as "burnout". Burnout describes the worker's reaction to the chronic stress common in such occupations. It is

characterized by emotional exhaustion, depersonalization, and reduced personal accomplishment (Maslach & Jackson, 1982).

It has been defined by Reichel and Neumann (1993) as a state of physical, emotional and mental exhaustion followed by cynicism towards one's work which is created in the worker as he or she responds to chronic organizational stressors. In this state, the worker feels depressed, trapped and helpless. Everything including even family and friends becomes just one more demand on him or her in terms of time, patience and resilience to pressure (Reichel & Neumann, 1993).

2.2.3 Sources of Occupational Stress

Several culprits have been identified as sources of occupational stress. Cooper (1983) developed the following list of six sources:

(1) *Job Conditions* – these refer to those aspects of the job related to work overload, quantitative and/or qualitative, work decisions concerning people, physical dangers of the job to which the worker is exposed and stress induced by technology related to the job

(2) *Role Stress* – Role ambiguity, sex bias and sex-role stereotypes

(3) *Interpersonal Factors* – Poor work and social support systems, lack of management concern for the worker, political rivalry, jealousy, or anger

(4) *Career Development* – Under-promotion (or delayed promotion), over-promotion, job insecurity and frustrated ambitions

(5) *Organizational Structure* – Rigid and impersonal organizational structures, organizational politics, inadequate supervision or training and non-participation of workers in decision making

(6) *Home-work Interface* – Spillover of workplace into the home and vice versa, lack of support from spouse, marital conflict and dual career stress especially with regard to women

The organizational setting in terms of role and power structures may also be a source of job stress and burnout. In particular, conflicting, incompatible, or unclear expectations about one's professional role within an organization can cause job strain. In addition, healthcare workers for instance encounter a variety of stressors inherent in their occupations such as untreatable diseases, unobservable outcomes of their work and diminishing resources.

Combined with the inherent stressors, role stressors such as role conflict and role ambiguity in healthcare settings appear to have much greater impact on job strain than do role stressors in any other occupation. Hence, among many important antecedents of burnout, role stressors (role conflict or role ambiguity) have been selected as the major predictive variable of burnout (Um & Harrison, 1998).

Burnout has often been cited as a hazard of healthcare work with chronically ill children and adults, terminally ill patients, and patients requiring emergency or intensive care. Concern about the impact of sweeping changes that have occurred in the organization, financing, and delivery of health care over the past decade could also be culprits of job stress and burnout. The rapid expansion of for-profit health care, the need to develop income producing services, heavier caseloads and more complex and demanding cases, the pressure to discharge patients earlier, along with ethical dilemmas and value conflicts resulting from financial constraints have all been identified as potential sources of stress and burnout for healthcare workers (Siefert & Jayaratne, 1991).

2.2.4 Lessening Occupational Stress

Stress cannot be entirely eliminated from the individual's personal life or your professional life. Yet the individual does not necessarily have to be the victim of unbearable stress because he or she can recognize the nature of its effects and can make decisions about how to think, feel, and behave in respect of the situation. An awareness

of reactions that reinforce the stressful situation will cause the individual to abandon those reactions in favor of constructive ways of coping with it. In short, the worker can learn to manage and control stress rather than be controlled by it (Corey & Corey, 1993).

Matheny, Aycock, Pugh, Curlette, and Cannella (1986) define coping as any effort, healthy or unhealthy, conscious or unconscious, to prevent, eliminate, or weaken stressors, or to tolerate their effects in the least harmful manner. The definition captures both prevention and cure. To prevent, the individual may avoid stressors (such as physically removing oneself from the stressful situation), alter stress-inducing behavior patterns (such as decreasing "Type A" behaviors and self-destructive thinking) and/or develop coping resources (such as cognitive assets, social support and a sense of physical health).

To cure or combat stress, the individual monitors stressors and stress symptoms by for instance being aware of those situations which are stressful and reacting to them. He may also marshal his or her resources and develop effective plan of attack for the stressor. Lowering stressful arousal through relaxation and leisure for example can be most useful in coping with stress. Combating stress could also be by using problem-solving techniques such as assessing the problem, finding out relevant information, challenging limiting assumptions, and identifying alternative behaviors, and/or learning to tolerate those stressors that cannot be eliminated.

Lazarus and Folkman (1984) have differentiated between problem-focused coping and emotion-focused coping. Problem-focused coping is the use of activities specific to getting the task accomplished (such as researching and discussing the writing of a long essay), whereas emotion-focused coping is the use of activities to feel better about the task (such as joking about an assignment or discussing your feelings with a friend).

Other writers have proposed ways of reducing stress. Recognizing that perceptions of occupational stress are as important as the actual event precipitating that stress, it is necessary to intervene in these perceptions. Greenberg (1990) has suggested that the individual looks for the humor in the stressor encountered at work. He or she should try to see things for what they really are and what he or she may think they are. He or she should distinguish between need and desire by realizing for instance that "I must get this task completed" might be more truthfully stated as "I wish I could get this task completed." He or she should always separate his or her self-worth from the task because if you fail at a task, it does not mean you are a failure.

To help in preventing the onset of burnout, Greenberg (1990) further suggests the following:

1. The worker should list all the things that he or she gets out of the job, identify his or her motivations and examine the value and meaning of the job.
2. The worker should list all the activities he or she really wants to do, rank them in order of importance and then, note the last time he or she engaged in each.
3. The worker should also create s support group
4. The worker should start a psychological self-care program which may include relaxation, negotiation and time management.
5. He or she should start a physical self-care program which may include exercise, nutrition and the elimination of destructive habits.
6. Finally, the worker should something “silly” each day such as playing ‘ampe’, blowing bubbles, making a silly face, dancing and generally avoiding taking himself or herself too seriously.

2.3 Empirical Evidence

2.3.1 Evidence of Occupational Stress

There is occupational stress in all professions (Todd & Deery-Schmidt, 1996; Pelletier, Coutu & Lamonde, 1996; Pflanz & Sonnek, 2002; Dragano & Verde, 2005; etc.). Evidence also shows that occupational stress has since 1990s increasingly occupied the attention of both practitioners and researchers alike, especially in developed countries.

Using a self report questionnaire, Chaplain (1995) studied the sources of stress and job satisfaction amongst teachers in Northern and Eastern England. A sample of 267 teachers, drawn from primary schools in the Northern and Eastern regions of England scored the frequency and intensity of 18 items on a stress scale and using principal components analysis the researcher identified three sources of occupational stress – professional concerns, pupil behavior and attitude, and professional tasks. The strongest correlations were found between professional concerns and occupational stress. When specific aspects of job satisfaction were examined, teachers were most satisfied with their professional performance and least satisfied with teaching resources. Stress and job satisfaction were found to be negatively correlated. High reports of occupational stress were related to low levels of job satisfaction (Chaplain, 1995).

From the early 1990s, the topic of occupational stress hit the newsstands and television broadcasts in America and Western Europe almost on a daily basis (Steber, 1998; Braaten, 2000). In 1999 for instance, the National Institute for Occupational Safety and Health (NIOSH) of the USA reported that a quarter of all employees in the country saw their jobs as the main source of stress in their lives whilst three-quarters agreed that on-the-job stress of workers had considerably increased over what it was three decades before (NIOSH, 1999).

A study of 472 American Air Force personnel also illustrated high levels of work stress in 26 percent of the respondents, with 15 percent claiming work-related emotional distress and 8 percent noting work stress negatively affected their emotional health (Pflanz & Sonnek, 2002). Finally, in a sample of 25,559 male and female German workers, the combined effects of exposure to work stress and downsizing contributed to more symptoms than either experience alone (Dragano, Verde & Siegrist, 2005).

2.3.2 Effects of Occupational Stress

In a 3-year study of 14,337 middle-aged men in America, there was no strong evidence that job demands or job strain were predictors of coronary heart disease (De Bacquer, Pelfrene, Clays et al., 2005). However, their findings did confirm that a supportive work environment helped reduce coronary heart disease. The importance of work support was corroborated in a study of 1,786 lower-ranking American soldiers whereby support helped decrease psychological strain from job demands (Bliese & Castro, 2000).

Increasingly, stress at work has become a grave concern to both employee and employer in terms of health and financial well-being. In 215 organizations in the United States occupational stress was found to be largely responsible for poor work performance, employee burnout and acute and chronic health problems (Ivancevich, Matteson, Freedman & Phillips, 1990; Kohler & Kamp, 1992).

In 1996, the U.K. Health and Safety Executive estimated that at least half of the 360 million working days lost through sickness each year at an estimated cost of £8 billion (Sigman, 1992) were due to occupational stress (Steber, 1998). Lou and Shiau (1997) found that the United States economy loses an estimated 300 billion dollars annually to preventable workplace stress. In their study they estimated that the 5% of the total labor force which accounted for reduced productivity in the country suffered from preventable stress and that occupational stress caused 50% of all absenteeism and 40% of all turnovers.

2.3.3 Occupational Stress in Healthcare Workers

So far the review has studies identified focused on occupations other than healthcare. With regards to occupations in healthcare, numerous studies have explored occupational stress among healthcare workers in many countries. Among medical technicians by Blau, Tatum & Ward-Cook (2003), among radiation therapists by French (2005), among occupational therapists by Painter, Akroyd, Elliot et al. (2003), among physicians by

Carr, Gareis & Barnett (2003) and among collections of healthcare staff across disciplines by Park, Wilson & Lee (2004).

Donat and Neal (1991) conducted a study to identify situations that contained sources of occupational stress commonly experienced by psychiatric aides, mental health workers, and licensed practical nurses in a state hospital setting in the Commonwealth of Virginia. 100 participants were sampled from the day and evening shifts of direct care staff at a public residential psychiatric facility. Thirty-nine situations were found to have sources of high levels of anxiety, depression, and confusion.

In their factor analysis, eight factors accounted for 71% of the total variance. These factors were labeled as: staff conflict over decisions regarding duties and/or treatment, inability to control the behavior of residents, lack of control over treatment decisions, inconsistent and/or unfair work conditions, lack of respect from coworkers and/or the system, inadequate care by other staff members, lack of administrative support and having to work with uncooperative and/or incapable residents.

These findings imply that the effects of occupational stress or burnout may be inherent in institutional settings such as state hospitals. State hospitals often have exceptionally difficult-to-manage inpatients and typically low staff-patient ratios with relatively few licensed professionals involved in the provision of care. In such settings, workers with relatively low levels of education and compensation, such as attendants, orderlies and casuals are relatively more and experience more of the interpersonal interactions with

patients. The combination of a sick resident population, lack of adequate professional guidance and low pay can add to the stress and burnout experienced in such settings (Donat & Neal, 1991).

In another study, Prosser, Johnson, Kuipers, Szumukler et al, (1997), examined the sources of perceived occupational stress and job satisfaction among 121 mental health workers in the USA. Using factor analysis, Prosser and colleagues (1997) found that 5 factors which derived from questionnaire items on sources of work stress (i.e., role, poor support, clients, future, and overload) accounted for 70% of the total variance. In addition, 4 factors which originated from items related to sources of job satisfaction (i.e., career, working with people, management, and money), accounted for 68% of total variance. Stress from “overload” was associated with emotional exhaustion and with worsening mental health appeared to account for less “career” satisfaction.

In an investigation of the relationship between personal stress and clinical care in the USA, 225 physicians reported 76 incidents in which they believed patient care was adversely affected by their stress (Firth-Cozens & Greenhalgh, 1997).

Hoffman & Scott (2003) studied role stress and career satisfaction among Registered Nurses by work shift patterns in Michigan. In a random sample of Michigan nurses, Registered Nurses working 12-hour shifts (n = 105) reported significantly higher levels of stress than Registered Nurses working 8-hour shifts (n = 99). However, when differences in experience were controlled, stress was similar in both groups.

Conversely, a study from Poland published in 1996 illustrated that nurses working 12-hour shifts (n = 96) compared unfavorably in several aspects to nurses working 8-hour shifts (n = 30). Although the type of nursing personnel involved was unclear, the nurses on 12-hour shifts experienced significantly more chronic fatigue, cognitive anxiety, and emotional exhaustion (Iskra-Golec, Folkard, Marek et al., 1996).

Even though stress has been assumed to exist among workers in Ghana (Dzirasah, 2005), research evidence on its nature, levels and consequences is very hard to come by. This work is therefore intended to fill the yawning gap in the literature. Evidence of occupational stress in the healthcare profession is quite preponderant even though the literature appears silent with respect to empirical studies in the area in Ghana.

2.3.4 Occupational Stress, Gender and Family Obligations among Healthcare Workers

The effects of gender further illustrate the complexity of work stress. Marshall, Zahorodny and Passannate (1998) studied the prevalence of burnout in a convenience sample of hospital-based neonatologists (n = 86) and office-based pediatricians (n = 97) in the USA. Burnout was found to be more prevalent in female physicians (79 percent) than male physicians (62 percent). Also, in a study of female physicians, 51 working full-time and 47 working reduced hours, Carr, Gareis & Barnett (2003) found that

burnout was not related to number of hours worked per se. Rather, burnout was lower for female physicians working the number of hours they preferred ($r = -0.22$, $P = 0.03$).

In a 4-year investigation of medical technologists in America, 80 percent of who were female, Blau, Tatum & Ward-Cook (2003) found that work interfering with family had a direct relationship with work exhaustion. However, family interfering with work was not studied. In a related study of 101 female nurses Gottlieb, Kelloway & Martin-Mathews (1996) found that work interfered with family more than family interfered with work. The investigators noted, however, that most of the nurses, who were in their mid-40s, were torn between the demands of caring for children and caring for the elderly. This finding is consistent with findings from a study of 170 Australian nurses in which the principal determinant of stress was workload. It was revealed that nurses were unlikely to bring personal stress to work (Bryant, Fairbrother & Fenton, 2000). These studies may be of particular relevance to nursing because the profession is predominately female.

Finally, a study of family-work conflict identified personality as an important factor in whether individuals perceive situations as stressful (Birch, 2001).

2.3.5 Personality Traits, Work Relationships and Occupational Stress among Healthcare Workers

A number of investigations have also explored personality as an important variable in the occupational stress equation. Overall, the literature supports the assumption that perceptions of job stress and burnout are not just a product of work conditions because not all workers, exposed to the same conditions, develop burnout or perceive stress. However, the specific features of personality that affect the perception of stress or burnout remain unclear in the literature.

Allen and Mellor (2002) as well as Buhler and Land (2003) found neuroticism (the degree of a person's sensitivity to criticism for instance) to be associated with exhaustion. External locus of control has also demonstrated a moderating influence on burnout (Buhler & Land, 2003) and stress (French, 2005). Anxiety was equally found to reflect a link with stress and burnout (Decker, 1997; Smith, Ortiguera, Laskowski et al. 2001). Anxiety is seen to have two components—state anxiety, the temporary component which manifests when an individual perceives threatening demands or dangers, and trait anxiety, the more stable component, which may be regarded as a personality characteristic (Turnipseed, 1998). In a study of intensive care unit nurses, Smith et al. (2001) concluded that individuals high on state-anxiety were not only at risk for burnout, but also for making medical errors. In another study, higher trait-anxiety predicted psychological distress (Decker, 1997). The findings on hardiness (e.g. the belief in one's personal ability to handle difficult and new situations) are however mixed

(Rowe, 1997; DePew, Gordon, Yoder et al. 1999). In addition, relationships with other staff—coworkers, physicians, head nurses, other departments—were also predictors of psychological distress.

The exact linkages between interpersonal relationships and occupational stress in healthcare workers are not yet clearly understood. Problematic relationships among team members were shown to increase burnout (Demir, Ulusoy & Ulusoy, 2003). Verbal abuse from physicians has also been noted to be stressful for staff nurses (Manderino & Berkey, 1997). In a study of 260 Registered Nurses in America, conflict with physicians was found to be more psychologically damaging than conflict within the nursing profession (Hillhouse & Adler, 1997). However, in a related study exploring verbal abuse among 213 nursing personnel (95 percent Registered Nurses), Rowe & Sherlock (2005) found that the most frequent source of abuse was other nurses (27 percent). Families were the second most frequent source of abuse (25 percent), while physicians ranked third (22 percent).

2.3.6 Management Styles and Occupational stress among Healthcare Workers

Relationships between healthcare workers and healthcare managers are particularly important when examining occupational in healthcare settings. In a survey carried out in the USA, 1,780 Registered Nurses rated nurse managers as lowest with regards to supervisor support and quality of supervision (Fletcher, 2001). Handwritten comments

from 509 (28.6 percent) of the Registered Nurses clarified these ratings by noting the following problems: (a) inadequate unit leadership and the frequent turnover of nurse managers, (b) insufficient physical presence of the supervisor on the unit, (c) failure to address problems—too much sweeping them aside or not even being aware they exist, and (d) modest awareness of numerous staffing issues.

These ideas were corroborated in a study of 537 Registered Nurses from Canada. Using structural equation modeling, Laschinger, Wong, McMahon et al. (1999) substantiated the importance of manager behavior on employee experiences. Similarly, in a qualitative study of 50 nurses conducted in England, managers were identified as a direct cause of stress (Taylor, White & Muncer, 1999). Finally, responses from 611 Registered Nurses on 50 inpatient nursing units in four southeastern U.S. hospitals showed that group cohesion was higher and job stress lower when nurse managers used a more participative management style (Leveck & Jones 1996).

In addition to illustrating a likely connection between healthcare managers and healthcare worker stressors, these studies also reflected the demanding role of today's healthcare managers who are often responsible for multiple healthcare areas. Two studies were found in the literature in which burnout was examined in healthcare managers. One study, conducted in Canada, assessed burnout in a random sample of nurses in first-line ($n = 202$) and middle-management ($n = 84$) positions (Laschinger, Almost, Purdy et al., 2004). Nurses in both groups reported high levels of emotional exhaustion and average job satisfaction. The other study, conducted in the United

States, explored burnout among nurses (N = 78) from rural and urban hospitals in a southeastern State who held positions in middle-management and higher (Lee & Henderson, 1996). Almost half the respondents (49%) reported high levels of emotional exhaustion.

Various studies in Europe and America have attempted to evaluate ways of mitigating stress. Studies of social support and structural improvements such as the provision of opportunity, information, support, resources, power in the workplace are especially noteworthy. The importance of coworker support was found in a study by AbuAlRub (2004). In another study by Blau, Tatum and Ward-Cook (2003), “organizational support” exhibited the expected negative relationship with work exhaustion. Similarly, social support from supervisors or colleagues demonstrated a negative association with work stress in studies by Johnson, Hall, Ford et al. (1995), Muncer, Taylor, Green et al. (2001) and Joiner & Bartram (2004). Based on another study but stated differently, as nurses felt more stress, they relied more on social support (LeSergent & Haney, 2005). A cluster analysis by Hillhouse and Adler (1997) demonstrated that high social support was found only in the cluster with low burnout and low stress. Although these findings do not clarify the mechanism for social support, they do indicate that coworkers and supervisors at all levels would be wise to consider the importance of reciprocal interpersonal exchanges that enhance security, mutual respect, and positive feelings.

In other research, structural improvements of work and the workplace contributed to improved psychological empowerment of workers such as meaning, confidence,

autonomy and impact (Laschinger, Finegan & Shamian, 2001). These psychological benefits, in turn, had a strong positive effect on job satisfaction and a strong negative influence on job strain. Likewise, as perceptions of work improvements increased, staff nurses reported less emotional exhaustion and depersonalization along with a greater sense of personal accomplishment—the three components of burnout (Hatcher & Laschinger, 1996). Structural empowerment in the workplace was negatively associated with work stressors in the study by Joiner and Bartram (2004) as well. How work environments are structured has strong implications for the behaviors of healthcare managers and administrators.

2.4 Institutional Framework

The study was conducted in the Goaso Government Hospital, a public-funded health facility in the Asunafo North Municipality in the Brong-Ahafo Region of Ghana. The municipality is a cosmopolitan community. It shares boundaries with Asutifi District to the East, Dormaa District to the North, and Asunafo South District to the West. Asunafo in general (i.e. both North and South) has a double rainfall pattern with annual rainfall ranging between 125mm and 175mm. The peak season is between April and July and the minor season is in September-October. Goaso is the administrative capital. According to the 2000 Population Census the population of the municipality was projected to be 126,364 persons by 2010 based on an annual growth rate of 2.5%. This population growth has its own health-related problems and challenges.

The provision of health care in Goaso was first established as a dispensary in the early 1950s at the old education office. The then health personnel in-charge was Mr. Kwaku Owusu who later became the Chief for Mim (Mimhene). He was succeeded as health officer-in-charge by Nana Akwamoa Boateng. From the old education office the health facility was moved to its current location as a Health Centre in 1962 and headed by Mr. Osei who was affectionately called “Chief”. In 1987 the Health Centre was up-graded to a Hospital status. In line with that of the Ghana Health Service in general, the Hospital’s Vision is

‘To be an excellent first referral center in the provision of quality, accessible and client-focused health Care’ (GGH, 2010 Annual Report)

The Hospital operates for 24 hours everyday providing Medical, Surgical, Obstetric, Gynecological, Eye, Mental, Dental, Reproductive Health, Laboratory, Dispensary and X-Ray services. In terms of in-patient capacity, a total of 100 beds are shared among five wards – Emergency, Maternity, Children, Female and Male. The total workforce and personnel requirements of the hospital are as in the schedule below:

Table 2.1 Existing and Required Total Workforce of Goaso Government Hospital

Category	No. at post	No. Required	Shortfall
Doctors	4	4	0
Medical Assistants	4	4	0
Nurses	33	49	16
Midwives	12	15	3
Accounts Staff	6	16	10
Ward Assistants/Aides	17	21	4
Pharmacist	2	2	0
Dispensing Technician	5	14	9
Anesthetist	1	2	1
Administrator	1	2	1
Biostatisticians	3	10	7
Others	48	96	48
Total Established Staff	136	235	99

Existing and Required Total Workforce of Goaso Government Hospital

Source: Goaso Government Hospital Records, April 2011

Since 1987 till date, Goaso Government Hospital has not witnessed any notable structural or physical improvement even though utilization of its services by the people keeps growing. Attendance keeps increasing and even so after the entry of the mining giant, Newmont (GH) Limited.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter contains the research methodology of the study. It discusses the research design and shows the sources and search strategies used to obtain both secondary and primary data. It describes the subjects and the data collection instruments and procedures used in the research. It includes a description of the data analysis.

A descriptive cross-sectional design is used to establish the validity or otherwise of the propositions. This design is suitable for the study objectives, and appropriate for the time and setting. The study was conducted in the Goaso Government Hospital using a convenience sample 68 subjects. Survey data was obtained through a questionnaire, an adaptation of the Weiman Occupational Stress Scale, standardized instrument (Weiman, 1978), and a scaled list of stress management techniques. Data entry and analysis were done using SPSS-Version 17. Data were presented using descriptive statistics in the form of frequencies and percentages for qualitative variables, and ranges, means and standard deviations for quantitative variables.

3.2 Research Design

The study uses a descriptive survey design to collect data for portraying the characteristics of healthcares workers at the Goaso Government Hospitals with specific regard to occupational stress levels and coping strategies. This design was chosen because of its appropriateness for the purposes of the study. The descriptive survey design is suitable for describing the way things are. The data gathered are responses to predetermined questions asked of respondents to discover particular characteristics of workers of the hospital.

3.3 Method of Data Collection

3.3.1 Secondary data collection

Various libraries including the Ministry of Health (MOH) Research Library, the United Nations (UN) Library, the Institute for Social Science and Economic Research (ISSER) Library and the MOH Centre of Health Information Management (CHIM) were searched to locate literature on the topic for review. The respective librarians worked with the author to conduct the searches. Searches were also conducted on the Internet

by specifying the following search terms: psychological stress, occupational stress, work stress, occupational health, professional burnout, and healthcare workers.

After reviewing the prefaces of books and abstracts of articles and dissertations, a number of sources were eliminated from further consideration. For example, sources about instrument development and stress in specific populations such as children, adolescents, pregnant women and parents were dropped. Also excluded were materials that are not research based or are short reports lacking in essential details. Candidates for review included works on occupational stress in healthcare occupations and in occupations other than health care, dissertations, literature reviews, concept analyses, and physiologic and immunologic studies of stress in general. The researcher acquired and read a complete copy of each of these materials, where it is available.

Finally, secondary data were equally obtained from records of the hospital. In particular the main source of information were from minutes on durbars, meetings, reports on in-service training, clients-staff satisfaction surveys, a pile of excuse duties, staff duty roster, queries for absenteeism or lateness to work, submission of returns, suggestions and complaints in the information desk register and annual reports. Relevant information captured in these records was reviewed.

3. 3. 2 Primary data collection

Primary data collection was done using a structured self-administered questionnaire designed to measure occupational stress in workers of the hospital.

3.4 Population

The population under study comprises all established workers of Goaso Government Hospital. The total established workforce of the hospital stands at 136 employees. There are 48 others who consist of Health Extension Officers and casual workers. These were not considered for the study because they are not established staff of the hospital and may possess sufficient contextual backgrounds for studying stress in employees of the hospital. Extension Officers go and come whilst casuals are often engaged for not more than six months. This frequency in the change of work environment accounts for their exclusion from the population of study.

3.4.1 Sample size

A sample of 80 subjects was drawn from the population 136 employees and a survey instrument administered to them. 75 subjects returned their questionnaires and after a list-wise deletion of respondents with missing values on one or more variables, usable fully completed questionnaires were obtained from an eventual sample of 68 subjects resulting in a response rate of 85%.

The 68 subjects comprised of all 4 Medical Officers and 4 Medical Assistants (forming one category) and 30 nurses as another category (comprising nurses, midwives and ward assistants) and 30 support staff sampled from the remaining established workforce. The 30 support staff included the 5 Dispensing Technicians, 2 Pharmacists, 3

Biostatisticians, 1Anesthetist, 1 Administrators, 1 Supply Officer, 2 laundry staff, , 1 Health Information Officer, 3 records staff, 1 mortuary staff, 1 watchman, 1 driver, 1 labourer, the Catering Officer, 3 accounts officers, the Accountant , the Municipal Director of Health Services and his Disease Control Officer.

3.4.2 Sampling Technique

Due to the pilot nature of the research, purposive non-probability and systematic sampling techniques were used in selecting subjects for the study. Lists of workers were obtained from each department of the hospital and combined into one list with the most senior staff at the top. All Medical Doctors, Medical Assistants, Pharmacists, Anesthetists, Administrators, Biostatisticians, Dispensing Technicians, Nurses and Ward Assistants were purposively selected. Due to the fact that employees in each of these positions are either management or direct care givers it was convenient to purposively select them. From the remaining names on the list that were non-senior support staff, every third was systematically selected.

3.4.3 Instrument

A self-administered questionnaire was used for collecting data for this study. This instrument was developed based on pertinent literature. It consisted of three parts:

Part I: Occupational Stress Scale

The first part of the questionnaire comprises fifteen Likert-type questions that measure work-related stress. It is aimed at determining the level of occupational stress in workers of the hospital.

Answers on the Part I of the questionnaire range from 1-5 points, with 1 = never, 2 = seldom, 3 = sometimes, 4 = frequently, and 5 = nearly always. Respondents were asked to score questions on sources of stress and individual characteristics which may influence the level of stress experienced by the respondent. Questions on the following were scored:

Workload – the amount or difficulty of work one must deal with

Relationships – how well one gets along with the people around them, particularly those at work

Recognition – the extent to which people feel they need to have their achievements recognized

Organization Climate and resources – the resources available to the worker at work and the "feel" or "atmosphere" within the place of work

Personal Responsibility – taking responsibility for one's actions and decisions

Managerial Role – being responsible for managing and supervising other people

Home-Work Balance – “switching off” from the pressure of work when at home, and vice versa

Daily Hassles – the day-to-day irritants and aggravations in the workplace

Drive – the desire to succeed and achieve results

Patience-Impatience – a person's pace of life and ability to cope with his or her need for urgency

Personal Influence – the extent to which someone is able to exercise discretion in his or her job

Control – how much one feels able to influence and control events

Problem Focus – the extent to which one plans ahead and manages his or her time to deal with problems

Life-Work Balance – the extent to which a person is able to separate home from work and not let things get to him or her

Social Support – the help one gets by discussing problems or situations with other people

The Scale in this part of the questionnaire was developed based on the Weiman Occupational Stress Scale and other pertinent literature on occupational stress. It is scored by adding together the total number of points for the 15 questions and then dividing the sum by the number 15. The range that can be scored by a subject is a maximum of 75 and a minimum of 15. The greater the score, the more occupational stress is being reported. A similar instrument was used in similar research by William Steber in his study of frontline corrections officers of the Wittenberg Home Youth and Family Programs in Wisconsin in 1998. Dan Braaten also used the same design for gauging occupational stress in mental health counselors of both publicly and privately funded inpatient and outpatient mental health facilities in the state of Wisconsin (Braaten, 2000).

Part II: Stress Management or Reduction Strategies

The aim of this part was to determine the most common strategies used by workers of the hospital for the reduction of stress. Survey participants were asked to identify and rank order from a list provided to them the stress management techniques or methods that they use most frequently.

Part III: Socio-demographic Data

This part was concerned with the socio-demographic data of workers such as age, gender, marital status, experience and designation or department.

This instrument proved to be suitable for several reasons. The questions were simple for subjects to complete and it took very little time and instructions. Even though self-administered, the questionnaire took, on the average, approximately 15 to 30 minutes to complete. The survey instrument was thus easily administered and scored. In addition, it is the most economic and efficient method for collecting data. The subjects, who remained anonymous, were asked to complete the questionnaire and return it to the researcher or their departmental head. Responses were kept confidential.

3.5 Field work

Before any attempt to collect data, approval from the Medical Superintendent was obtained. Data collection was carried out in four months from January to April 2011. Each participant was notified about the right to refuse to participate in the study, before taking his or her verbal consent. Anonymity and confidentiality of the information gathered was ensured. Then, the designed questionnaire was distributed to them, with instructions about its filling. This was repeated in each department of the hospital. The questionnaire was largely self-administered even though the researcher was always readily available to clarify any ambiguity.

Each of the 80 respondents sampled were given a questionnaire. At the end of each day of fieldwork day, information gathered was assessed to ensure its reliability and relevance. Repetitions were discarded and gaps were filled. Where there was a doubt it was cross-checked at the source where applicable. The questionnaire instrument generated quantitative data for the analysis. 75 of the respondents were very cooperative and willing to contribute to the research process. Eventually however, 68 questionnaires were complete and useful for purposes of the study. The quantitative data collected was then processed and coded and presented for computer analysis.

Nonetheless, a number of problems were encountered during the research process. The main problem faced was that some records (e.g. data on excuse duties, queries, duty rosters and minutes) were not made available and where they were made available they were delayed arbitrarily. Under-reporting and inconsistencies were common problems encountered. Besides, proper records for 2009 at the records unit were not kept.

In some instances, files and vital statistics could not be accessed. Over and above this certain information being sought especially financial statements and personnel files were considered confidential and delving into such areas are considered intrusive. In view of this, a lot of apathy was encountered with some officers especially where personal files were involved. For such officers research of this nature would not only bring the secrecy of their offices into the public domain but it would also subject the personality and reputation of the officers to undue criticism and disrepute. On the whole, the absence of some vital information and inaccessibility of others made it difficult to cross-validate

responses and this in a way might have affected the reliability and relevance of the data collected.

3.6 Data Analysis

Data entry and analysis has been done using the Statistical Package for Social Science (SPSS) Version 17, a data analysis program. For qualitative variables, data are presented using descriptive statistics in the form of frequencies and percentages and for quantitative variables ranges, means and standard deviations. The scores obtained by the scale in Part I of the questionnaire for this study are compared to baseline scores achieved by Weiman and other researchers in their application of the Weiman Occupational Stress Scale (WOSS) to subjects from a variety of occupations. The reliability coefficient of the scale used in this study was found to be 0.82. Though this is not as excellent as the 0.90 achieved by Weiman, it is good enough to justify the relevance of comparing scores obtained in the study to baseline averages of the WOSS.

C. Weiman designed a standardized instrument in 1978 for measuring perceived occupational stress. The Weiman Scale is also scored by adding together the total number of points for the 15 questions and then dividing the sum by the number the number of test questions. The range that can be scored by a subject is a maximum of 75 and a minimum of 15. The greater the score, the more occupational stress is being reported. Applying the scale to a wide variety of occupations, Weiman and other researchers established a baseline mean score of 33.75 and individual average of 2.25.

Scores below this baseline are considered to indicate the absence of stress whereas those above indicate its presence in varying degrees.

In past administrations, the Weiman Occupational Stress Scale has yielded a .90 reliability coefficient and has also been shown to be a valid measure of occupational stress (Greenberg, 1990). The Weiman Occupational Stress Scale has also shown predictive validity in that high scores on this scale have been used as not only an indicator of the presence of stress in employees, but also of future stress associated with their positions if they do not proactively act to resolve their present situations (Steber, 1998).

Part I of the questionnaire was used to establish a baseline score for the participants in the study

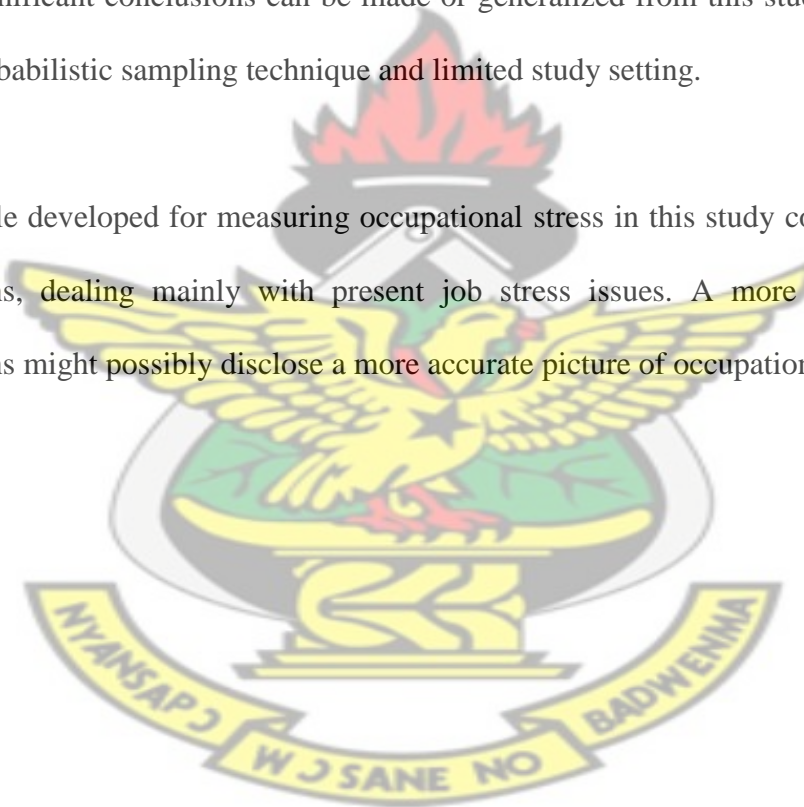
Using means, crosstabulations and bivariate analytical techniques, groups were compared to find out differences and variables analyzed to explore dominant characteristics. Medical Doctors and Medical Assistants constituted one group. Medical Assistants were classified along with Doctors as one group because they are very senior nurses who perform the same functions as doctors of the hospital to make up for the dearth of doctors. Nurses in general constituted a separate group and the third group consisted of the Support Staff who include all other staff except doctors and nurses.

To determine the most common stress reduction strategies, the mean score for each stress management technique or method was computed and compared.

3.7 Limitations

The results of this study cannot be generalized to workers of the entire healthcare sector. Few significant conclusions can be made or generalized from this study because of the non-probabilistic sampling technique and limited study setting.

The scale developed for measuring occupational stress in this study consists of only 15 questions, dealing mainly with present job stress issues. A more extensive set of questions might possibly disclose a more accurate picture of occupational stress.



CHAPTER FOUR

FINDINGS, ANALYSIS AND DISCUSSION

4.1 Introduction

This chapter contains a presentation of findings from the survey which in general include statistical data on respondents' demographic information, results of the occupational stress assessment, the three most common occupational stressors and stress management techniques, as well as any significant results that appeared within the study.

4.2 Presentation of Findings

4.2.1 Demographic Data

The survey instrument included items for demographic information such as gender and age of participants, marital status, job categories, number of years worked at the hospital, average hours worked per week, and total number of years experience as a healthcare worker.

Table 4.1 describes the socio-demographic characteristics and job categories of healthcare workers in the sample. As evidenced by the table, the highest percentage of

workers was in the age group of 25 to 30 years with mean age being 27(± 7.3 sd) years. The majority of healthcare workers were female and more than half the sample was married.

Table 4.1 Socio-demographic characteristics of sample (n = 68)

Demographic characteristics of Respondents	Frequency	Percentage
Gender		
Male	30	44
Female	38	56
Age (years)		
Less than 25	16	24
25 – 30	30	44
31 and above	22	32
Range	20-51	
Mean \pm sd	27 \pm 7.3	
Marital status		
Married	48	71
Not married	20	29

Source: Survey Data, 2011

As may be observed, the results show a sample relatively skewed in favor of female test subjects 56% with males being 44%. This may be explained by the fact the hospital's population of 136 established staff comprises of about 64% females. Proportionately however, the sample can be said to be gender-balanced and this ties in well with the study's purpose of investigating and determining occupational stress in workers of the hospital in general.

Table 4.2 Job Categories of Respondents (n = 68)

Job Category	Frequency	Percentage
Medical Doctors & Assistants	8	12
Nurses	30	44
Support Staff	30	44

Source: Survey Data, April 2011

The total population of medical doctors in the hospital is 4 and to this category the study has added medical assistants also with a total population of 4. Medical assistants are very senior nurses who perform the functions of a medical doctor to complement the number of doctors. The entire population of nurses who are established staff of the hospital and at post is 37 and in this category has been included mid-wives and ward assistants. The number of established support staff stands at 61. Support staff refers all other job designations besides doctors, medical assistants, nurses, mid-wives and ward assistants such as pharmacists, administrators, clerical staff, etc.

Responses to items on the survey instrument are invariably based on subjects' experiences and opinions relating to occupational stress. Number of years employed as a healthcare worker is therefore a useful variable for ensuring that respondents understand what is required of them. The typical subject in this survey had almost 7.5(± 2.8 sd) years of experience as a healthcare worker (Table 4.3).

Table 4.3 Experience of respondents in healthcare work (n = 68)

Number of years employed as a healthcare worker (years)	Frequency	Percentage
Less than 5	23	34
5 – 10	26	38
11 – 15	15	22
16 and above	4	6
Range	2.0 – 34	
Mean \pm sd	7.5 \pm 2.8	

Source: Survey Data, 2011

By job category, nurses had the most of experience followed by doctors and medical assistants. One doctor, who is Ghanaian, had four years of experience and the other four doctors, who are Cuban, had just 2.0 years of experience. The average of 7.63 was therefore as a result of long years of experience of the medical assistants who are very senior nurses with years of experience ranging from 7 to 23 years (Table 4.4).

Table 4.4 Av. Experience as a healthcare worker by Job Category (n = 68)

Respondents	Av # of Years	Range
Medical Doctors & Assistants	7.63	2.0 – 23
Nurses	10.78	4.0 – 34
Support Staff	4.27	2.0 – 6.0

Source: Survey Data, 2011

The average number of years spent by survey participants at their present place of work, i.e., Goaso Government Hospital, as well as the average number of hours done per week, is of equal relevance to this investigation. As may be seen from Table 4.5, the average number of years spent by participants at the Goaso Government Hospital is

4.4(± 1.7 sd) years. Also, even though a few had spent just 6 months before the survey, others have been working at the hospital for the past 11 years.

Table 4.5 Experience of respondents at their present job (n = 68)

No. of years at Goaso Government Hospital	Frequency	Percentage
Less than 1 yr	6	9
1 – 5 yrs	44	65
6 – 10 yrs	17	25
11yrs and above	1	1
Range	0.5-11	
Mean \pm sd	4.4 \pm 1.7	

Source: Survey Data, 2011

At the time of this survey, the doctors from Cuba had spent barely 10 months at the hospital. However, the medical assistants had spent between 7 and 11 years. The typical period the average nurse had spent at the hospital was 5.06 years even though a few had spent just 11 months and a few others close to 11 years (Table 4.6).

Table 4.6 Av. # of years at Goaso Government Hospital by Job Category (n = 68)

Respondents	Av # of Yrs	Range
Medical Doctors & Assistants	3.65	0.8 – 11
Nurses	5.06	0.9 – 10
Support Staff	4.07	0.5 – 5.3

Source: Survey Data, 2011

Also, for each worker surveyed, the average work week consisted of approximately 40.3(± 5.3 sd) hours. Each worker works for at least 35 hours a week and a few for as many as 56 hours (see Table 4.7).

Table 4.7 Number of hours respondents work per week (n = 68)

No. of hours worked per week	Frequency	Percentage
Less than 40hrs	30	44
40 – 55hrs	34	50
56hrs and above	4	6
Range	35-56	
Mean \pm sd	40.3 \pm 5.3	

Source: Survey Data, 2011

Almost all the support staff work for a minimum of 35 hours a week whilst all nurses work for a minimum of 42 hours a week (Table 4.8).

Table 4.8 No. of hours worked per week by Job Category (n = 68)

Respondents	Av # of Hrs	Range
Medical Doctors & Assistants	42 hrs	42 – 52 hrs
Nurses	42 hrs	42 – 52 hrs
Support Staff	35 hrs	35 – 40 hrs

Source: Survey Data, 2011

These demographic characteristics and job categorization provide a suitable context in subjects for investigating the presence or otherwise of occupational stress.

4.2 .2Occupational Stress Results

Reliability analysis done for the Occupational Stress Scale in Part I of the questionnaire yielded a Cronbach's Alpha coefficient of 0.82 indicating good internal consistency. Even though this coefficient is not as excellent as the 0.90 of the WOSS, it appears close enough for scores in this essay to be compared to the baselines established by the WOSS. The total score obtained in this survey for all 68 participants was 2,676 points. This computes into a mean score of 39.35 per participant which translates into an

individual average score of 2.62 on the five point scale (Table 4.9). Just what level of stress do 2.62 represent? Comparing it to the mean score of 33.75 and individual average of 2.25 established by the WOSS, helps answer this question.

Table 4.9 Occupational Stress Scores (n = 68)

Respondents	Av. Score	Individual Av.
Medical Doctors & Assistants	33.00	2.20
Nurses	50.40	3.36
Support Staff	30.00	2.00
Total	39.35	2.62

Source: Survey Data, 2011

The range of scores for all of the participants was from a low of 21 (1.4 on the 5 point scale) to a high score of 72 (4.80).

The mean score and individual average score of 39.35 and 2.62 respectively by survey participants is 17% higher than the established Weiman Occupational Stress Scale mean score of 33.75 and individual average of 2.25. Interpreting these results within the framework of the Weiman Occupational Stress Scale, there is a strong suggestion of occupational stress in workers of the hospital since with the WOSS instrument, the higher the score, the greater the stress in the subject. The average score of 39.35 is 17% above that of the WOSS baseline. Even though a small segment of the sample scored 21 which is below the WOSS average, the overall average supports the proposition that workers of the hospital experience above average levels of occupational stress. Another segment scored as high as 72 indicating the presence of a very significant level of stress.

It is significant to note that the average score for Doctors and Medical Assistants is 10% higher than that for the Support Staff and that for nurses 60% higher than that for the Support Staff. This finding also supports the proposition that support staff are the least stressed in the hospital.

It is equally revealing that the cumulative average mean test score for Doctors, Medical Assistants and Support Staff which computes to 31.50 is approximately 38% lower than the score recorded for Nurses. Also, the average mean of 50.40 scored by nurses of the hospital is nearly 17 points higher or 49 percentage points higher than that of the WOSS benchmark of 33.75. These results also support the proposition that nurses in the hospital experience the highest levels of occupational stress.

In addition, nurses employed at Goaso Government Hospital indicated a significantly higher average mean number of years working at the hospital, 7.6 years which is more than double the average (3.23) for the other two categories (Doctors and Medical Assistants and Support Staff). The nurses also score approximately 63% higher in average score, 50.40 versus an average of 31.50 for the other two categories. This suggests a positive correlation between number of years employed in their current position and level of occupational stress experienced.

The findings also supported the proposition that nurses are the highest stressed among workers at the Goaso Government Hospital. This could be explained by the fact that nurses are predominantly women and women experience several problems at work that may be highly related to stress. For instance, certain positions are male-dominated and women are often frustrated in their career development as they aspire to such positions.

Stress can occur from the effects of this glass ceiling syndrome whereby women can only rise to a certain point in an organizational hierarchy.

They are frequently exposed to sexual harassment at work. For instance, promotions could be withheld until sexual advances are accepted. Most often for women at the workplace it is 'do it or else.....' They are often also the objects of sexual jokes and innuendos. Sexual advances or harassment can actually make the working environment hostile, intimidating or offensive for the nurse resulting in higher levels of stress.

Another big stressor that may have accounted for the level of stress shown by nurses of the hospital is related to balancing work-life and home-life. For a woman, a lot of stress can arise from the conflicting demands of these two variables especially as there appears no long term tendency in Ghana for housework to be taken over by men. Culturally in Ghana, women have to work inside the home as well as outside. Men do not help enough with housework.

The female nurse often occupies several positions at home but ironically few at the workplace. At home, she is the housewife and even sometimes house husband (breadwinner) at the same time, homemaker, and domestic engineer – an overdose for stress. Therefore before going to the workplace, she may already be experiencing some level of stress from role overload, role insufficiency, role conflict and role ambiguity.

4.2.3 The Most Common Occupational Stressors

The specific characteristics of the jobs of workers of the hospital may be partly accountable for the stress level revealed by the results. This involves role ambiguity whereby the worker often feels unclear about just what the scope and responsibilities of his or her job are. The Medical Superintendent for example is unclear as to what exactly is the scope of administration he is responsible for. In addition to work commonly associated with hospital administration, he is also in charge of treatment patients, etc. Task-related stress at the hospital may have also arisen from work overload, inadequate resource support, conflicting task demands and poor communication, among others.

How often workers have to contend with too heavy a workload, one that could not possibly be finished with during an ordinary workday, how often they find themselves confronted with inadequacy of resources needed to carry out their jobs and how often they have to think about their inability to satisfy the conflicting demands of various people around them are the major contributors to occupational stress among workers of the hospital. Examining the scores obtained from the survey instrument questions related to work overload, inadequate resources and conflicting demands appear to be the most common sources of stress in workers of the hospital. These questions stand out from the others in that they received an item score means relatively higher than the overall average in the survey.

In order to explore which items may constitute the most common sources of stress to workers of the hospital, responses were summed up across all participants for each

question and, judging from the totals obtained, three items appeared to be the most common sources of stress because they had the highest total scores. Dividing their respective total scores by the total number of participants for the question resulted in above-average score means. These questions were as follows:

Question No. 4

How often do you feel that you have too heavy a work load, one that you could not possibly finish during an ordinary workday?

Total score = 126

No. of category responses = 3

Average score: 42 = or Individual score 2.80

2.80 is above Weiman's benchmark of 2.25 as well as the 2.62 established by this survey. One possible forebear to workload being a most common stressor at the hospital is staff shortages. The World Health Organization, in its 2006 Health Report estimated that 57 countries, including Ghana, have an absolute shortage of 2.3 million physicians, nurses and midwives.

The situation of dwindling numbers is aggravated by a disproportionate concentration of healthcare workers at the very urban areas in Ghana. The shortage condition has made it impossible for healthcare workers to avoid extra workload.

At Goaso Government Hospital the situation appears to be that of too much work and too few workers to carry it out. The hospital is experiencing a shortfall 99 workers. In this situation, even though jobs may be well-defined, roles are blurred because there are no personnel to take on tasks that are outside the ken of those jobs. Workers are thus compelled to overload their regular or normal workloads if those tasks are to be performed. For example, due to lack of qualified personnel, the Health Service Administrator super see duties of estate management and procurement.

The worker's skill set does not often include what is required for these additional tasks and as a result, the worker can only perform to his or her level of incompetence in those tasks.

In addition to the work overload, stress is thus further stimulated for the particular worker by these role demands which are external to the tasks associated with his or her regular or normal workload. The particular type of stress often results from the lack of clarity surrounding his or her work role and responsibility (Knotts, 1996). It typically develops as a result of flawed organizational structures, ineffective organizational development or the individual's inability to successfully pursue achievement goals within the organization (Knotts, 1996).

Question No. 10

How often do you find yourself unable to get resources needed to carry out your job?

Total score = 118

No. of category responses = 3

Average score: 39.33 or Individual score 2.62

For the question on how often workers of the hospital find themselves unable to get resources needed to carry out their jobs the item score average was 2.62 which for an individual item is relatively high compared to the summary item average mean of 2.62. Frequent lamentations at durbars and training seminars by workers about unavailability of resources to carry out their jobs corroborate the emergence of this variable as a common stressor among healthcare workers. Resources are inadequate right from hospital beds through equipment to drugs. Against their best judgments nurses often have to permit in-patients to sleep on blankets on the floor for lack of beds. Healthcare workers often have to experience the traumatic events of watching people they know die due to lack of equipment or requisite drugs to save them.

Question No. 5 (Is this question No. 5?)

How often do you think that you will not be able to satisfy the conflicting demands of various people around you?

Total score = 116

No. of category responses 3

Average score: 38.66 or Individual score 2.57

Conflicting demands as a common stressor scored an item mean of 2.57 which is also quite above Weiman's baseline item mean average of 2.25. Depending on management style and the manager's level of stress or predisposition to stress, having one boss could be bad enough for the subordinate; but having to report to several can result in conflicting expectancies. Healthcare workers in Ghana often have more than two bosses to report to. Nurses for example do not only have to report to doctors and other nurses but also departmental heads and administrators. Moreover, by the nature of the nursing profession, patients are like bosses to the nurse who is bound by ethics never to ignore demands of the patient for care. The resulting conflicting demands are a genuine source of stress.

Stress can occur when the nurse is uncertain about how her work is evaluated. In addition to this, these superiors are themselves often stressed and consequently irritable and manifest this in frequent anger. The resulting leadership style becomes a source of stress.

Apart from workload, inadequate resources, conflicting demands, time constraints, absence of support from organizational superiors, workers at the hospital are confronted

with several other sources of stress including physical workplace conditions such frequent power outages, non-competitive wage structures, organizational politics and ineffective organizational motivational strategies.

4.2.4 Individual characteristics

Researchers have suggested that a person's degree of vulnerability, extroversion, compulsiveness and belief in his or her ability to respond to novel or difficult situations and possible stressors might influence his or her level of stress (Torgersen, 1980). Questions in the survey instrument that investigated individual characteristics of respondents which researchers have suggested might influence stress levels scored as follows:

Question No. 3

How often would you agree that the following statement best describes your nature: "I am very sensitive to criticism."?

Total score = 129

No. of category responses = 3

Average score: 43 or Individual score 2.86

The characteristic investigated in this question is the individual's vulnerability to stress. A person who is innately impatient and unable to withstand bearable levels of criticism may be characterized as neurotic. Such a trait may increase disposition to stress. Seven participants did not score the question and the missing responses have been ignored in calculating the mean.

Question No. 12

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How often would you agree with the following statement about yourself: 'Many people consider me a lively person'?

The personality trait measured here is the respondent's degree of introversion or extroversion. An above-average score implies that workers are generally extroverts which could make them able to cope with stress better.

Total score = 120

No. of category responses = 3

Average score: 40 or Individual score 2.66

Only one missing case was observed for this variable.

Question No. 6

How often would you agree that the following statement best describes your nature?

'Everything I do must be precise and accurate.'

This question finds out the respondent's degree of obsession with his or her job. The level of compulsiveness in carrying out his or her job is a personality trait that can moderate or exacerbate the respondent's stress levels.

Total score = 121

No. of category responses = 3

Average score: 40.33 or Individual score 2.68

3 respondents did not answer this question.

Question No. 13

How often would you agree that you have the ability to respond to difficult situations?

This question is intended to measure respondent's self-efficacy or belief in his or her personal ability to handle difficult or novel situations. All 68 participants scored the question.

Total score = 130

No. of category responses = 3

Average score: $43.33 = 130 / 3$ or Individual score 2.88

In general, individual traits have been suggested as having an effect on stress levels. They may in part affect the frequency of exposure to stressors, but more importantly, may modify the severity of experience associated with the stressors (Bolger & Zuckerman, 1995; Parkes, 1994). A person's belief in his or her ability to handle novel and difficult situations (self-efficacy) and his or her sensitivity to criticism (neuroticism or vulnerability) for instance have been reported to be among the best dispositional predictors of job satisfaction and performance (Judge & Bono, 2001).

Individuals with high self-efficacy are hypothesized to deal more effectively with difficulties and persist in the face of failure (Gist, 1987), whereas highly neurotic persons are found to interpret more situations as threatening or damaging (Vollrath, 2001).

However, the effect of potentially important socio-demographic variables is not well understood (Sterud, Ekeberg & Hem, 2006). Being female for example may be a risk factor for higher levels of job stress among healthcare sector women. Older employees, on the other hand, are more experienced and may therefore experience potentially traumatic stressors as less severe.

Without inferring statistical significance, results suggest that both organizational variables and individual characteristics are related to the occupational stress experienced by workers of the hospital. Some individual characteristics appear to moderate the intensity of stressors whilst others appear to exacerbate stress. Among the individual traits, neuroticism with an average score of 2.86 may be related to the higher scores on occupational stress, whereas general self-efficacy with an average score of 2.88 may be related to lower levels. Being an extrovert may temper stress level whilst compulsiveness (2.68) could exaggerate it.

Test subjects claim they are all above average in their sensitivity to criticism (neuroticism) and at the same time they are typical lively persons (extroverts (2.66). They generally believe in their personal abilities to handle new or difficult situations (general self-efficacy, (2.88)) and at the same time each typically desires everything he or she does to be precise and accurate (compulsiveness (2.68)). General self-efficacy appears to overshadow the other traits and may be said to be helping workers get along with their apparently high levels of stress.

Caution must however be exercised in interpreting the results on personal traits such as extroversion, general self-efficacy and compulsiveness since they are qualities most people in Ghana may want to be seen as possessing. There is therefore the tendency for subjects to distort responses in a favorable (i.e. “fake good”) or unfavorable (i.e. “fake bad”) direction. The instrument used in this study did not have any built-in scale to test

for the honesty of subject's responses. The effects of individual traits in this study are therefore best ignored.

4.2 .5The Most Common Stress Management Techniques

In order to find out the most common techniques used by survey participants in coping with or reducing occupational stress, a Stress Management / Reduction Survey (SMRS) instrument was administered. Subjects were asked to rank in an order of 1-5 their most frequently used stress management techniques. The results of the top three stress management or stress reduction techniques among workers of the hospital are as follows:

Table 4.10 Stress Management Technique (n = 68)

Technique	Average Score	Rank Order
Talk about it with colleagues and friends	1.85	(1)
Ask for help or supervision	2.70	(2)
Look and go along with the funny side of it	3.43	(3)

Source: Survey Data, 2011

Left unattended, stress could grow to levels that are unbearable with consequent harmful effects on both individual and organization. Individuals adopt varied strategies to reduce their stress. Some may exercise, others may relax and others may just laugh it off. Workers of the hospital commonly adopt three strategies. In order of most common strategy:

1. They talk about their stressful condition with peers and friends
2. They seek help or supervision
3. They look for the humor side of it

Seeking colleague support is quite consistent with the finding that workers of the hospital are mainly extroverts. Another possible interpretation is that, although a formalized peer support system may or may not be essential at the hospital, it is nevertheless important to have co-workers or leaders to whom one can talk about stressful situations.

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4.2.6 Implications of stress at Goaso Government Hospital

The level of stress among workers of the Goaso Government Hospital uncovered by this research has several implications. Stress has been incriminated in the worsening of efficiency in both managers and subordinates (Gilberg, 1993). When performance suffers, the quality of the overall organizational environment and productivity deteriorates. A resultant deterioration in organizational communication ensues (Gilberg, 1993). A survey of 28,000 workers in 215 organizations in the United States linked stress at work to poor work performance, acute and chronic health problems, and employee burnout (Ivancevich, Matteson, Freedman, & Phillips, 1990; Kohler & Kamp, 1992).

The result of occupational stress has a tendency to vary widely. Staff may respond more actively by creating interpersonal and intra-organizational conflicts involving escalating levels of communication problems. Workers may also experience effects in their psychological and physical health such as anxiety, boredom, low self-esteem,

forgetfulness, depression, anger, apathy, or worry; headaches, diabetes, fatigue, hypertension, chest and back pain, ulcers, or even infectious diseases (Gilberg, 1993).

Studies show that 85% of all physical illness is stress-related (Randolfi, 1996). Workers may show behavioral deviations such as overeating, loss of appetite, smoking, alcohol abuse, sleeping disorders, emotional outbursts, or violence and aggression (Randolfi, 1996).

From the organizational aspect, stress has many outcomes. Ineffectiveness, low productivity, and poor communication are among some of the most incapacitating. Other results include absenteeism, low morale, job turnover, poor work relations, poor organizational climate, and accidents in the workplace (Randolfi, 1996).

Evidence gathered from contributions of staff at staff durbars, in-service training sessions and from a pile of excuse duties, staff arrangements for duty swaps, exchange their annual leave period for money by most of the technical staff, absenteeism (Goaso Government Hospital, 2010) as well as interviews with clients suggest that Goaso Government Hospital and its workers may be manifesting several of these outcomes. Workers have reported headaches, sleep dysfunctions, fatigue, anxiety, fear, and so on. These outcomes are a recipe for decreases in job satisfaction, increases turnover rate, and general deterioration in healthcare quality.

Bringing the discussion to a close, it is noteworthy that the level of occupational stress among workers of the Goaso Government Hospital is way above average especially in

nurses of the hospital. Nurses may be more at risk because of their gender and peculiarities surrounding it. As much as workers adopt strategies to reduce their stress levels, the occupational stress in the workers shows in outcomes that are negative for both the individual and the hospital.

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CHAPTER FIVE

SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.1 Summary of findings

One objective of this study was to examine overall occupational stress. A review of the literature found multiple sources identifying stress as common to all occupations. Literature was reviewed on the nature of occupational stress in terms of sources, individual characteristics (i.e. personality traits that predispose the worker to varying levels of stress) and outcomes.

Definitions of occupational stress from a couple of perspectives were encountered in the literature. The study drew heavily from the perspective in which occupational stress is viewed unfavorably. Viewed in negative terms as annoyances or the feelings of pressure placed on us by others, occupational stress was found to be the rising tension caused in us by any characteristic of the job environment, be it excessive demands or insufficient resources to meet a need, and whose intensity and enduring nature can have a detrimental effect on our ability to adjust and our physical health as well.

Since the mid-1950s, stress has been regarded as an occupational hazard (Kahn, Wolfe, Quinn, et al., 1964) though what is stressful to one person may be exhilarating to

another depending on the type of personality exposed to the stressor (French & Caplan, 1972). In fact, many researchers have cited occupational stress as a significant health problem (Caplan, Cobb, French, et al., 1980; House, 1981; Pelletier, 1984). Several sources also identified the healthcare profession as consisting of occupations which experience above average levels of job stress.

Several consequences of occupational stress have also been reported in the literature. The worker's motivation to go to work, do a good job while at work, or stay on the job diminishes drastically (Rice, 1992). According to Bellani and Furlani (1996), job stress can cause physical illnesses such as ulcers, heart conditions, elevated blood pressure, migraines, etc and psychological conditions such as emotional exhaustion, reduced personal accomplishments, lowered self-esteem, loss of positive attitude toward clients as well as the intention to quit.

Job stress also produces negative effects for the organization. It results in disorganization, disruption in normal operations, lowered productivity, and lower margins (Rice, 1992).

A more specific objective of the study was to determine the level of occupational stress experienced by workers of the Goaso Government Hospital through the use of a questionnaire developed along the lines of the Weiman Occupational Stress Scale. Using a cross-sectional design, the survey instrument was employed to measure the level of occupational stress in workers of the Goaso Government Hospital. The survey

instrument was administered to a sample of 80 subjects conveniently drawn from 136 established staff of the Goaso Government Hospital, a public hospital located in the Brong-Ahafo Region of Ghana. A return rate of 85% was achieved or 68 completed questionnaires turned out to be useful for the purpose of the study.

Workers of the Goaso Government Hospital were found to experience a level of occupational stress that is above the average standardized by the Weiman Occupational Stress Scale. Nurses were also found to experience the highest level of stress at the hospital. Though individual differences did not appear to influence levels of stress in any significant way, this propensity for higher stress levels among nurses of the hospital could be due to the effects of gender, a socio-demographic variable.

The study also aimed at determining the three most common occupational stressors and stress reduction strategies identified by this group of healthcare workers. The three most common stressors mentioned by workers of the hospital were workload, inadequate resources and conflicting demands. Workers also use varied coping strategies. The three most common stress management strategies reported were debriefing with peers or friends, seeking supervision and using humor. As much as workers adopt strategies to reduce their stress levels, the occupational stress in the workers shows in outcomes that are negative for both the individual and the hospital.

5.2 Conclusions

Findings from the study supported the proposition that workers of the Goaso Government Hospital experience above average work-related stress. The healthcare workers involved in completing the survey instrument scored an individual average of 2.62 on a five point scale. Past administrations of the Weiman Occupational Stress Scale by Weiman and many other researchers yielded a baseline score of 2.25. The healthcare workers in this study therefore scored on average 16% higher than the calculated WOSS baseline and with the Weiman Occupational Stress Scale, the higher the score, the higher the perceived stress.

One major corollary to this conclusion is that occupational stress and its attendant damaging effects may be quite high in institutional settings such as state hospitals. State hospitals in a developing country setting such as that of Ghana typically have low staff-patient ratios, limited professional resources and often take in patients that are habitually difficult to manage. The combination of sick people, low pay and lack of adequate guidance can add to the stress experienced in such settings.

In addition, survey results also supported the proposition that nurses experience the highest level of stress at the hospital. The average test score for participants in this category was approximately 17 points higher or 49 percentage points higher than that of the WOSS benchmark of 33.75. Also, the cumulative average mean test score for combined categories of Doctors and Medical Assistants and Support Staff which

computes to 31.50 is approximately 38% lower on the WOSS than the score recorded for Nurses.

Stress often associated with being female may explain the propensity of nurses for higher perceived stress. Women experience several problems at work that have been associated with stress. For instance, the glass ceiling effect whereby women can only rise to a certain point in an organizational hierarchy is a potential stressor. Sexual harassment at work whereby genuine rights are made conditional upon giving in to advances is another stressor peculiar to the female nurse. Such advances in addition to sexual jokes and innuendoes can create a hostile, intimidating or offensive working environment for the nurse resulting in higher levels of stress.

Depending on the cultural setting, balancing work-life and home-life can entail more stress for the woman than for the man. Ghana is such cultural environment where women have to work inside the home as well as outside. Men do not help enough with housework. The female is thus often overloaded from home before getting to work. At home, she is a housewife, probably house husband (breadwinner) as well, homemaker, etc. She may therefore already be experiencing some level of stress from role overload, role insufficiency, and role conflict and role ambiguity.

While computing the combined scores of the survey instrument, three questions appeared to stand out from the others. These items, recognized by the respondents in the

study, identified the three most common occupational stressors experienced at the hospital. These questions were as follows:

(4) How often do you feel that you have too heavy a work load, one that you could not possibly finish during an ordinary workday?

(10) How often do you find yourself unable to get resources needed to carry out your job?

(5) How often do you think that you will not be able to satisfy the conflicting demands of various people around you?

The implications in these three questions as the most common sources of stress are numerous. As noted in the literature reviewed earlier, healthcare and social work are all professions that deal with quality of life issues. In healthcare delivery for instance, customer service is often a major source of gratification, to the exclusion of the worker's needs. The world of a healthcare worker is an increasingly demanding and stressful one; in that, there is often a constant overwhelming need to continuously help the client (patients). In doing this the worker must equally answer to bosses such as doctors, managers, supervisors, administrators, etc. The worker is thus often afflicted with an inability to satisfy the conflicting demands of people around him or her. According to Winkoski (1998), this creates ethical dilemmas, a greater occurrence of compassion stress, and other negative effects on healthcare workers.

The changing demands of the healthcare industry, close interaction with traumatic and often difficult events, time pressures, dwindling resources, and increased workloads have led to increased stress in some healthcare workers. Many healthcare workers are under the stress of having to keep up a positive attitude towards clients amidst the diminishing resources to adequately address the needs of these people seeking their professional assistance.

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Changes occurring in the health service in Ghana engender further potential stress for workers. Previously, healthcare professionals in Ghana had been able to dictate the pace and sometimes shape of healthcare delivery. Health service positions were considered to be secured jobs because as long as they were adjudged professionals healthcare workers could always maintain their jobs irrespective of falling standards. However, this has been replaced by an ever-growing demand for increased quality characterized by arbitrary standards, and audits to determine performance and assess whether healthcare is achieving acceptable levels of quality.

Arbitrariness in particular may have led to stress and eventual dissatisfaction among many healthcare professionals in Ghana. For some healthcare workers who were previously dedicated and committed professionals, their jobs are now "just a job". Such withdrawal attitude is one of the effects of occupational stress from the pace of changes occurring in healthcare delivery in Ghana.

There is however some demonstration of resilience in healthcare workers. Workers of the Goaso Government Hospital surveyed in this study were asked to rank in order of most frequently used from 1-5 their stress management techniques or methods. The results of the top three stress management or stress reduction techniques were as follows:

- (1) Debrief with peers
- (2) Seek supervision
- (3) Look for humor

It is significant to note that in an absence formal peer support systems and adequate professional supervision and/or clinical guidance for occupational stress, healthcare workers of the hospital are forced to address their stress in isolation when it gets to unbearable levels. They have to seek out peers, both at work and in their individual communities, to debrief difficult issues related to their professional and personal lives. In doing so, workers may even have to pay for such services out of their own pockets.

It is equally noteworthy that workers of the hospital examine and monitor their individual stress arousal levels and when they become aware of situations potentially over-stressful, they alter their reactions to them. Identifying the humor within individual stressors at work is one such successful method for changing their reaction patterns.

Finally, conclusions from this study should be viewed with the caution necessary for its lack of methodological rigor. Even though a list of registered (established) workers of the hospital was available for use as the entire population, sampling was not randomly

done and this constrains the ability to generalize findings even to workers of the hospital much more those of the country. The significance of conclusions should therefore be assessed with the limited scope of the study and the convenience sampling technique in hindsight.

Also, the survey instrument developed for measuring perceived work stress at the hospital contains just 15 questions. A more extensive set of questions might be more reliable and may provide a lot more accuracy in portraying occupational stress. In addition, the instrument has no built-in scale to test for honesty or consistency. An instrument with a scale built in to allow researchers assess the tendency of respondents to distort their responses either positively or negatively could provide better data.

Nevertheless, this study offers some insight into overall occupational stress and its potential risks for healthcare workers in Ghana especially those at Goaso Government Hospital. Results of the study may help healthcare professionals and their institutions to become more sensitive and aware of the increased risks and difficulties they face in terms of occupational stress. Job stress produces negative effects for both the employee and the organization and it is important not to consider occupational stress as a mere private matter for the employee to deal with alone and in isolation.

5.3 Recommendations

A first step towards preventing occupational stress from escalating into unbearable proportions for any healthcare worker is to build awareness about it and how it relates to

the worker's profession. The worker should be educated to understand that healthcare-specific operational demands are an expected part of his or her job. He or she should be persuaded to accept that the challenge of the profession is one of the main reasons why he or she chose the healthcare occupation. Such education and guidance will make healthcare personnel consider operational demands specific to their jobs to be the most meaningful and the most motivating stressors.

However, high severity stressors may nevertheless continue to pose risks. These can then be handled through the institution of formalized peer support and clinical guidance systems within state hospitals. With such an intervention, workers can have co-workers and professionals or leaders to talk to about difficult topics or events or situations whose intensity could cause trauma or extreme stress and to which they have been exposed. Coworkers and supervisors at all levels should be encouraged to embrace reciprocal interpersonal exchanges that enhance security, mutual respect, and positive feelings.

To further mitigate stress at the hospital, the issue of workload should be tackled. The worker's role and responsibilities should be clearly defined and his or her workload should be brought in line with his or her capabilities and resources. Work schedules should be made compatible with demands and responsibilities outside the job. If one does not clearly know the requirements of the job (i.e. the criteria for success or for successful accomplishment of the job), stress may result. Redesigning work and work schedules will also lessen the feeling of too much to do and too little time in which to do it. Combining this with better education, improved skills and enhancing experience,

every worker will overall be conversant with how he or she can "play his or part" in things.

One very common intervention that needs to be recommended for reducing stress is a system of worker participatory methods which gives workers opportunities to participate in decisions and actions affecting their jobs. One cannot expect positive health when workers feel left out of decision-making processes of the organization. They should be consulted on their views about issues and involved in setting and managing the hospital's policies and rules.

If workers are given the opportunity to participate in decisions and actions affecting their jobs, uncertainty about career development and security may be reduced. This in turn may considerably lower psychological strain and role ambiguity in the workers. It may also engender a high utilization of skills and training, good working relationships, positive attitudes toward work and high productivity.

The hospital's work environment should be structured to provide staff with access to opportunity, information, resources, and power. This can empower the worker psychologically by improving his or her autonomy, increasing his or her confidence and impact, and generally helping him or her in efforts at giving meaning to his or her work. Such psychological empowerment, in turn, may result in job satisfaction, a greater sense of personal accomplishment (personal effectiveness and success) and less occupational stress.

With regards to further research, the first recommendation to proffer is that studies need to be conducted in Ghana on occupational stress. Whilst there is sufficient evidence in several other countries to believe that work stress is a factor among health care personnel, the literature is remarkably silent on Ghana. Studies are needed to enhance the understanding of stress in Ghana and its effect on patient outcomes in particular.

In addition, because administrators, supervisors and policymakers are largely responsible for creating the environment in which healthcare workers practice and patient care is given, it is important to explore interventions that will reduce the stress experienced by these categories. By reducing the stressful nature of the work of administrators, supervisors and policymakers, they could be more satisfied in their positions. This role satisfaction, in turn, could lead to enhancing those managerial behaviors that improve the work environment for healthcare staff.

Further research is also needed on the present study. In order to derive a better understanding of occupational stress in healthcare workers in Ghana, research with a wider scope is needed. The present study has been conducted using only one hospital. A more comprehensive scope and rigorous methodology should be used to explore the topic further.

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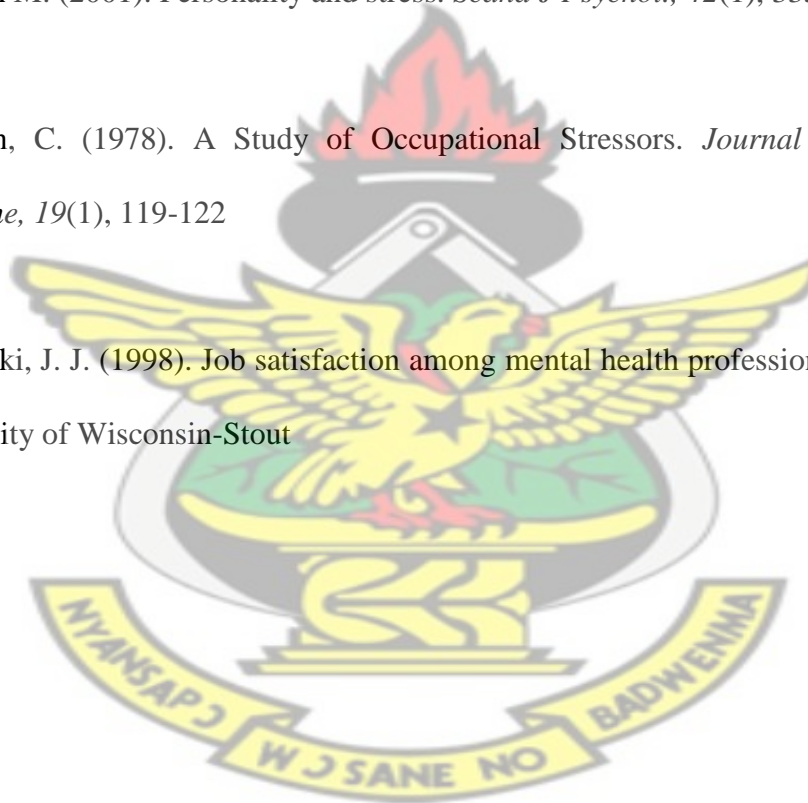
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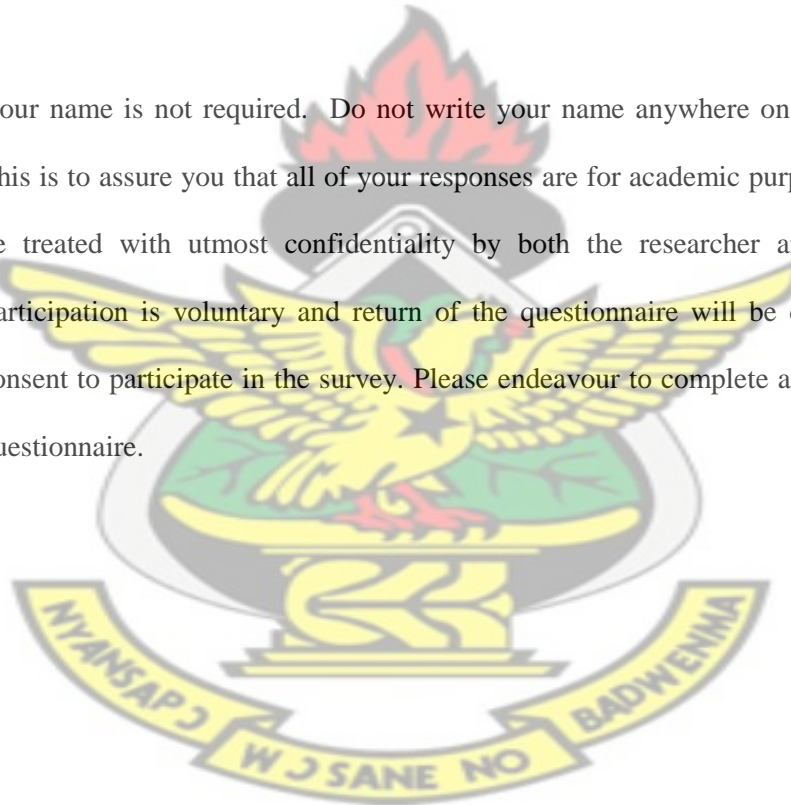
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1. Questionnaire

2. Introduction:

3. Dear Colleague, please complete this questionnaire. The questionnaire is designed to measure the level of job stress in workers of Goaso Government Hospital and identify how they manage or reduce such stress. Data from the questionnaire will be used for a thesis which is to be submitted to the School of Business of the Kwame Nkrumah University of Science and Technology in fulfilment of partial requirements for the award of a Master of Business Administration Degree.
4. Your name is not required. Do not write your name anywhere on this questionnaire. This is to assure you that all of your responses are for academic purposes only and will be treated with utmost confidentiality by both the researcher and the University. Participation is voluntary and return of the questionnaire will be considered as your consent to participate in the survey. Please endeavour to complete all three parts of the questionnaire.



5. Part I: Work pressure

6. We all encounter stress almost on a daily basis and at given times almost from any source. Also, as individuals, we feel such pressure differently. The statements below are all potential sources of pressure. You are required to rate them in terms of how much you feel the pressure each places on you. Please indicate this by writing beside each item the corresponding number from the scale below:

7. 1 = Never 2 = Seldom 3 = Sometimes 4 = Frequently 5 = Nearly always

8. Item	9. Answer
10. How often do you feel that you have too little authority to carry out your responsibilities at work?	11.
12. How often do you feel unclear about just what the scope and responsibilities of your job are?	13.
14. How often would you agree that the following statement best describes your nature: "I am very sensitive to criticism."?	15.
16. How often do you feel that you have too heavy a workload, one that you could not possibly finish during an ordinary workday?	17.
18. How often do you think that you will not be able to satisfy the conflicting demands of various people around you?	19.
20. How often would you agree that the following statement best describes your nature: 'Everything I do must be precise and accurate'?	21.
22. How often do you not know what your superior thinks of you? How he or she evaluates your performance?	23.
24. How often do you find yourself unable to get information needed to carry out your job?	25.
26. How often do you worry about the decisions that affect the lives of people that you know such as decisions affecting seriously injured and dying patients?	27.
28. How often do you find yourself unable to get resources needed to carry out your job?	29.
30. How do you worry about co-workers not doing their job?	31.
32. How often would you agree with the following statement about yourself: 'Many people consider me a lively person'?	33.
34. How often would you agree that you have the ability to respond to	35.

difficult situations?	
36. How often do you feel that you have to do things that are against your better judgment?	37.
38. How often do you feel that your job interferes with your family life?	39.

40. Part II: Stress management or reduction strategies

41. As individuals, we use a variety of ways to respond to work pressure and its effects, either consciously or unconsciously. Please rank in an order of 1-5 with **1 = most frequently; 2 = more frequently; 3 = frequently; 4 = sometimes and 5 = seldom** the techniques you use in managing or reducing pressure at work. Please indicate this by writing beside each item the number corresponding to the frequency shown on the scale:

42. Technique	43. Answer
44. I reorganize my work	45.
46. I seek support and advice	47.
48. I resort to my hobbies	49.
50. I try to deal with the situation objectively without emotions	51.
52. I effectively manage my time	53.
54. I just try not to let the stress show	55.
56. I talk about it with my colleagues and to understanding friends	57.
58. I keep myself occupied	59.
60. I plan ahead	61.
62. I concentrate on the specific problem	63.
64. I set priorities and deal with problems accordingly	65.
66. I use rules and regulations	67.
68. I delegate work and responsibility	69.
70. I simply try to avoid the situation	71.
72. I look for the funny side of the problem	73.

74. Part III: Demographic Information

75. Please indicate your

76. Designation:

.....

77. Department:

.....

78. Age bracket:

79. ☐ Less than 25 years ☐ 25 – 30 years ☐ 31 years and above

80. Sex: ☐ Male ☐ Female

81. Marital status: ☐ Married ☐ Not married

82. How many hours do you spend working in a week?

83. ☐ Less than 40 hours ☐ 40 – 55 hours ☐ 56 hours and above

84. How many years have you been working in the healthcare profession?

85. ☐ Less 5 years ☐ 5 – 10 years ☐ 11 – 15 years ☐ 16 years and above

86. How many years have you spent at Goaso Government Hospital?

87. ☐ Less than 1 year ☐ 1 – 5 years ☐ 6 – 10 years ☐ 11 years and above

