وزارة الصحة

كلية الصحة العامة

School of Public Health

القدس – فلسطين

جامعة القدس

The Effect of Stress on Work Motivation among Hospital Nurses in The Gaza Strip

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B.Sc.: Computer Information Systems El-Quds Open University

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A thesis Submitted in Partial fulfillment of requirements for the
Degree of Master of Community Mental Health

Al-Quds University- Palestine

وزارة الصحة

June 2006

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M.Sc Thesis

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بسم الله الرحمن الرحيم

« قَالُواْ سُبْحَانَكَ لاَ عِلْمَ لَنَا إِلاَّ مَا عَلَّمْتَنَا إِنَّكَ أَنتَ الْعَلِيمُ الْحَكِيمُ »

صدق الله العظيم

سورة البقرة

الآية (32)

Al-Quds University

Deanship of Graduate Studies

Community Mental Health

School of Public Health

The Effect of Stress on Work Motivation among Hospital Nurses in The Gaza Strip

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2. Dr Abd Alaziz Thabet Internal Examiner Signature ------------
3. Dr.Yousef El-Jaish External Examiner Signature ------------

Dedication

I dedicate this humble work to my country Palestine

To my colleague nurses,

To the spirits of my beloved Father and mother

To my dear brothers and sisters,

To my wife, to my sons and to my daughter,

To my friends and all those that I haven't mentioned and they are the closest to my heart.

Maher

Declaration

I certify that this thesis submitted for the degree of Master is the result of my own research, except where otherwise acknowledged, and that this thesis (or any part of the same) has not been submitted for a higher degree to any other university or institution.

Signed: …………………

Maher Wahba

14 /6 /2006

Acknowledgment

I would like to thank my promoter Dr.Samir Quta for his extraordinary supervision, guidance, patience, support, and encouragement. I would like to thank Dr.Suzanne Shasha'a for her guidance, support, and her valuable comments. I would also like to thank Dr. Abed El-Aziz Thabet and Dr. Yousef Al-Jeesh for accepting to read my thesis and their valuable comments. Without my family support I would never dare to think of standing where I am. My wife, thanks for dedicating your efforts, energy and time to support me during difficult times. Thanks for your encouragement, support, and extraordinary patience. Thanks for your prayers and blessings. I dedicate this thesis to the spirits of my beloved mother and father Huda, and Abed EL-Karim who were my meaning and reason for life, and left me before seeing their dreams come true. Thanks to my sisters, and my all brothers for their support. I extend many thanks to my friends who helped me in data collection encouraging and supporting me for their wise pieces of advice. Many thanks for Dr. Mahmoud El-Ostaz for his guidance and helping in statistical analysis and final layout.

Researcher

Maher Abed EL-Karim Wahba

IIAbstract

This study explored the sources of occupational stress and its effect on work motivation among hospital nurses who are working at ten governmental Gaza Strip hospitals; these hospitals include El-shifa hospital, Naser hospital, Al-Nasser Pediatric hospital, Al-Nasser Ophthalmic hospital, Al-Nasser Psychiatric hospital, Mohamed El-Dorah Pediatric hospital, Gaza European hospital, Abu Yousef Al-Najjar hospital, Shohda'a EL-Aqsa hospital, and kamal Odwan hospital. A sample of (125) nurses were randomly selected from a total target population of (1296) nurses using a descriptive cross sectional design. A self administered questionnaire was used with a likert scale from (0-4) showing the degree of effect for each given situation that might happ work setting to identify occupational stressors at work environment and Anc cale to identify work values or work motivators which is a self Administered questionnaire used to measure work values or work motivators asking subjects questions about eight different dimensions of work values and they had to choose whether to "agree, disagree, or I am not sure" about certain work values. The response rate was (83.3%) as (150) questionnaires were distributed and only (125) questionnaires were returned. Statistical tests were made to assure the reliability and the validity of the questionnaires. The study was applied in different departments of the mentioned ten hospitals. These departments include surgical, medical, obstetrics, oncology, burn units, intensive care units, emergency rooms, kidney units, chest units, operating rooms, and nursing administration offices. The study identified the most common work stressors and most common work values or motivators and tried to explore relationships between work stressors and work motivation. The study also tried to explore the relationship between work stressors and demographic variables such as age, sex, marital status, family size, Income, years of study, place of work, years of experience, job title, and work department. The study showed that: Firstly, the work environment dimension takes the first order of the occupational stressors dimensions with percentage of (76.3%) and, the least occupational stressor was the nurse interpersonal relations stressor with percentage of (58.02%). Secondly, strive for promotion dimension takes the first order of the motivational values dimensions with percentage of (63.19%) and, the least order of motivational values dimensions are for work preference dimension with percentage of (47.78%).The study also showed that there were significant differences between managerial stressors and family size in favor of large family size. There were significant differences between managerial stressors to income with favor to low salaries. There were significant differences between work environment stressor and the variable years of experience in favor to least years of experience . The study didn't find any significant differences with other socio-demographic variables. The study suggested many useful recommendations to control occupational stress which may increase the work motivation, productivity and quality of nursing care and decrease mistakes occurred due to occupational stress among hospital nurses in Gaza strip.

IIIملخص الدراسة

هدفت الدراسة إلى التعرف علي ضغوط العمل الشائعة وتأثيرها على الدافعية للعمل لدى ممرضي عشرة مستشفيات حكومية في قطاع غزة هذه المستشفيات هي مستشفى الشفاء ومستشفى ناصر ومستشفى النصر للأطفال ومستشفى النصر للعيون ومستشفى النصر للطب النفسي ومستشفى الشهيد محمد الدرة للأطفال ومستشفى غزة الأوروبي ومستشفى الشهيد أبو يوسف النجار ومستشفى شهداء الأقصى ومستشفى الشهيد كمال عدوان.

اشتملت عينة الدراسة علي 125 ممرض وممرضة من ممرضي تلك المستشفيات العشرة بواقع 84 ممرض و 41 ممرضة حيث استخدم الباحث المنهج الوصفي التحليلي لإظهار نتائج الدراسة كما تم استخدام مقياس قيم العمل:
(علام وزايد, 1992) و مقياس ضغوط العمل : The Stress Scale Questionnaire (Gary-Toft and Anderson, 1981)

نتائج الدراسة:

إن أكثر ضغوط العمل تأثيرا على عينة الدراسة هي الناتجة عن بيئة العمل بنسبة (76.3%) وأقلها تأثيرا هي الضغوط الناتجة عن العلاقات الشخصية بنسبة(58.02%) كما أن أكثر قيم العمل أو أكثر القيم دافعية هي قيمة السعي للترقي بنسبة (63.19%) واقلها دافعية هي قيمة أفضلية العمل بنسبة (47.78%). تبين وجود فروق ذات دلالة إحصائية بين الضغوط الإدارية تبعا لمتغير حجم العائلة. وجود فروق ذات دلالة إحصائية بين الضغوط الإدارية تبعا لمتغير الدخل الشهري. وجود فروق ذات دلالة إحصائية بين ضغوط بيئة العمل تبعا لمتغير عدد سنوات الخبرة. لم تجد الدراسة فروق ذات دلالة إحصائية مع باقي المتغيرات الاقتصادية الاجتماعية لعينة الدراسة. كما أظهرت الدراسة أنه يوجد علاقة عكسية ذات دلالة إحصائية بين الضغوط الإدارية وكل من قيمة أفضلية العمل والانتماء للعمل. كما بينت الدراسة وجود علاقة ذات دلالة إحصائية طردية بين العلاقات الشخصية لعينة الدراسة وقيمة الانتماء للعمل. بالإضافة لذلك أوضحت الدراسة أيضا وجود علاقة ذات دلالة إحصائية طردية بين ضغوط المعرفة والمهارة وقيمة الاندماج في العمل. كما أثبتت الدراسة أن هناك علاقة ذات دلالة إحصائية عكسية بين مجموع الضغوط و قيمة أفضلية العمل. لم تستطع

الدراسة إثبات أي علاقة بين مجموع الضغوط الخمسة ومجموع الدوافع الثمانية المستخدمة في الدراسة. أخيرا اقترحت الدراسة العديد من التوصيات الهامة عن كيفية التحكم في ضغوط العمل لدى ممرضي المستشفيات في قطاع غزة والتي من شانها رفع مستوى جودة الخدمة والدافعية للعمل وتقليل الأخطاء الناتجة عن ضغوط العمل التي يتعرض لها الممرضين والممرضات في مستشفيات قطاع غزة.

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st of Abbreviations

Abb.	The complete part
RNs	Registered Nurses
PN	Practical Nurses
ICU	Intensive Care Unit
DU	Dialysis Units
PDU	Peritoneal Dialysis Units
AAH	Ahli Arab Hospital
CMH	Community Mental Health
ED	Emergency Department
EGH	European Gaza Hospital
ER	Emergency Room
GNI	Gross National Income
GNP	Gross National Product
GS	Gaza Strip
IMT	International Management Team
MOH	Ministry of health
NCHS	National Health Center For Health Statistics
NGOs	Non-Governmental Organizations
NHS	National Health Services
NIS	New Israeli Shekels
OPD	Out Patient Department
OR	Operating Room
PCOH	Palestinian Council Relief Work Agency
PHC	Primary Health Care
PNA	Palestinian National Authority
PTS	Post –Traumatic Stress
PTSD	Post –Traumatic Stress Disorder
UNRWA	United Nations Relief and Works Agency For Palestinian Refugees

US$	United States Dollar
USA	United States of America
WB	West Bank
WHO	World Health Organization
ANOVA	Analysis of Variance
CCU	Coronary Care Unit
SPSS	Statistical Package for Social Sciences
Epi-Info	Epidemiological Package
CI	Confidence Interval
SSQ	Stress Scale Questionnaire
UK	United Kingdom
SDQ	Strength and Difficulties Questionnaire
TCSQ	Trait Coping Style Questionnaire
TSCC	The Trauma Symptoms Checklist for Children
WAYS	Ways of Coping Scale
WB	World Bank

Chapter 1

INTRODUCTION

Chapter 1
Introduction

No one can deny that our most powerful force, our strongest resource is people. The greatest asset of any organization is its people (Taggart, 1997). Theories through many researchers have proved that motivated employees have strong interest and support to their organization and work to their full potential in order to achieve its goals. Managers have to be fully aware of ways to motivate their subordinates. Actually, there is no simple formula to stimulate motivation. Motivation comes from within (Taggart, 1997). Three major components that affect the motivation are staff members, the organization, and the manager or the leader of the organization. First, the person joins an organization because there is something to gain from being there. Members of the organization have needs that have to be fulfilled through their organization. These needs give them the motivation to work. Managers have to understand these needs which will give them the clues to what motivate their employees most. Abraham Maslow (1954) developed a theory related to an individual needs showing the hierarchy of needs triangle. According to Maslow's hierarchy of needs, there are five basic needs that are found in the base of the triangle are the highest priority needs which are physical and security, so individual is motivated to fulfill a specific need, and as soon as it is fulfilled, it stopped to be a motivator and another need, according to Maslow, becomes the new motivator. (Taggart, 1997)

Within the modern workplace, individuals are being put under increasing pressure as they attempt to cope with heavier workloads, longer working hours, organizational restructure, intrinsic job insecurity and technological development. Nurses by nature are more vulnerable to occupational stress than other professions. Most nurses experience such stress as a result of morbidity and mortality process in every day basis. Simply stress can be defined as any force that moves a living system away from its point of equilibrium or

homeostasis (Arnold etal, 1989). Obviously, stress is universal and is intrinsic to life. The same definition of stress applies at all levels, ranging from molecular to cultural planes of complexity. Stress is just as important in growth, development and evolution of psychological and social functions as it is in those of genetic and biologic qualities. For example, without psychological stress, an individual would not develop his particular set of coping mechanisms that come to be known as the elements of his character. In that sense, stress promotes adaptability. On the other hand, the capacity to adapt is limited in all systems and, therefore, it is possible to have "too much" stress. Stress is neither good nor bad. Further, the amount of stress experienced as the result of an event does not depend on whether the event is in it self "good" or "bad". Therefore, stress is stress, whether it arises from joyous and welcome events or from those that are tragic and un-hoped for (Arnold etal, 1989).

The aim of this study is to describe the effect of stress on work motivation among hospital nurses in the Gaza strip and try to identify the most common work stressors and work motivators and to recommend many effective ways for nursing administrations and health policy makers to control stress and enhance work motivation and affect positively the quality of nursing care in Gaza strip hospitals.

1.1 Objectives

Aim of study

To understand the relationship between occupational stress and work motivation among hospital nurses in the Gaza strip.

Specific objectives

1. To identify types of occupational stressors among hospital's nurses in the Gaza strip.
2. To describe the most important factors that motivate hospital's nurses to work.

3. To discuss the most important factors those de-motivate hospital's nurses to work effectively.

4. To assess the relationship between the level of occupational stress and work motivation among hospital's nurses in the Gaza Strip.

1.2 Study Questions

1. What are the most common occupational stressors among hospital nurses?
2. Do occupational stressors differ regarding to age, sex, marital status, income, years of study in nursing, years of experience, job title, and work department?
3. What are the common work values (motivators) among hospital nurses?
4. Is there a significant relationship between occupational stressors and work values (motivators)?

1.3 Research Hypotheses

H1: There are various kinds of occupational stressors among hospital's nurses in the Gaza Strip.

H2: There is a significant relationship between level of occupational stress and work motivation among hospital's nurses in the Gaza Strip.

1.4 Justification of the Study

1. Nursing is considered one of the most important fields of health care system as it represents the majority group among healthcare professionals.
2. Negative stress costs us a lot; therefore, by lowering hospital's nurse's negative stress, we are lowering the cost by reducing nurse's mistakes and increasing the quality of nursing care.
3. Actually, 68% of nurses are employed by public sector in Gaza strip.
4. Nurses by nature are more vulnerable to occupational stress than other professions.

1.5 Background of the study

This study conducted in Gaza Strip. Therefore, here are some information about the geographical context, Palestinian population size, Palestinian economy, distribution of the refugees in Palestine, and health care system and services delivery in Palestine. Furthermore, it provides some information about nursing profession in Palestine. Finally, this study will give some information about hospitals in Palestine in general and Gaza Strip hospitals in particular.

1.5.1 Geographical context:

Palestinian National Authority territories comprise two areas separated geographically: West Bank (WB) and Gaza Strip (GS). WB lies within an area of 5,800 sq. Km2 west of the Jordanian river. It has been under Israeli Military Occupation, together with East Jerusalem since June 1967. West Bank is divided into four geographical regions. The Northern area includes the districts of Nablus, Jenin and Tulkarem; the Centre includes the districts of Ramallah and Jerusalem, where, The South is include Bethlehem, Al-Khaliel district, and the sparsely populated Jordan valley including Jericho. Many areas of West Bank have diversified communities. There are observable differences in life styles and living conditions not only among classes or socioeconomic levels and religious affiliations, but also among urban, rural and refugee camp communities with their respective subdivisions. Up to sixty percent of the population lives in approximately 400 villages and nineteen refugee camps, and the reminder in urban refugee camps and cities of which Nablus, East Jerusalem and Hebron are the most populous. GS is a narrow piece of land lying on the coast of the Mediterranean Sea. Its position on the crossroads from Africa to Asia made it a target for occupiers and conquerors over the centuries. The last of these was Israel who occupied the Gaza strip from Egyptians in 1967. GS is very crowded place with an area of 360 sq . Km2; the population is mainly concentrated in

the cities, small village, and eight refugee camps that contain two thirds of the population (MOH, 2003).

1.5.2 Population in Palestine:

The estimated number of Palestinian population all over the world by the mid of 2003 is 9,209,773 and they are distributed as follows:

In Palestinian territories: 3,464, 550 with a proportion of 37.6% of the total Palestinians are all over the world. In GS, the population size is estimated at 1,418,082 (36.4%) of total population in Palestine (13.7%) from the total Palestinian population. In WB, it is estimated at 2,202,641 million (63.6%) of total population in Palestine and (23.9%) from the total Palestinian population (MOH, 2005).

Population Density

Population density in GS is very high compared with the density in WB and the neighboring countries. Density rate is about 3,885 inhabitants per one square kilometer in GS, and 380 inhabitants per one square kilometer in WB(MOH, 2005).

1.5.3 Palestinian economy:

Using a poverty line of US$2 per day, the World Bank (WB) estimated that 21 percentage of Palestinian population were before the Intifada under the poverty line; this number increased to about 60 percent by December 2002. According to population growth, the numbers of the poor have tripled, from 637,000 to just less than 2 millions. The poor are also getting poorer. In 1998, the average daily consumption of a poor person was equivalent to US$ 1.47 per day. This number has now slipped to US$ 1.32. More than 75 percent of the populations of GS are now poor (MOH, 2003).

1.5.4 Distribution of the refugees in Palestine:

According to the United Nation Relief and works Agency (UNRWA) report in 2002, the total number of refugees is 1,532,589, where 893,141 are in GS, at percentage of 58%

and 639,448 residents at WB, at percentage of 42%. Refugees constituted a much larger percentage of the population in GS than WB. (MOH, 2003).

1.6 Health Care System in Palestine

In Palestine, health services are provided through four sectors: Ministry of Health (MOH), UNRWA, (The United Nations Relief and Works Agency), Non-Governmental Organizations (NGOs) and private sector (profit and nonprofit), with a developing governmental health insurance system. Remarkable improvements have been made in the last ten years since the Palestinian National Authority (PNA) assumed responsibility for the health sector. There are enhanced linkages between the MOH and related ministries such as the Ministry of Education, Social Affairs, Finance, Planning and International Cooperation, Supplies, Industry, Agriculture and Environment, which have improved the public health functions of the system (MOH, 2003). The most three prominent providers of health services are the ministry of health, UNRWA, and Non-Governmental Organizations (NGOs). Private for profit service provides (primarily involved in diagnostic services and individual or group specialized care) account for a relatively small proportion of services delivered. However, many physicians and nurses are working in more than on setting, including public and private clinics or NGO. The MOH is responsible for significant portion of both primary health care (PHC), secondary care and some tertiary care. Moreover, the MOH purchases tertiary services from other health providers, both locally and abroad. UNRWA plays an important role in health services delivery, providing free of charge PHC, and purchasing secondary and tertiary services for the 1,532,589 registered refugees. Additionally, UNRWA contacts for services with NGOs, primarily for secondary and tertiary care, and with some Israeli facilities for limited specialty specialized for tertiary care. A significant challenge for the Ministry of Health is to facilitate coordination among these services deliveries to ensure rational use

of scarce Palestinian recourses available for health sector. One aspect of the MOH efforts in this regard has been the initiation of a demonstration project involving the purchase of primary health care services by the MOH from NGOs. Further, increasing the numbers of injuries among Palestinians and resulting effect on the Ministry's of Health remain revenue used to provide free health services for those injured (MOH, 2003).

1.6.1 Nursing in Palestine:

The nursing profession has grown up significantly in the past recent years in Palestine. It has become an extremely important component in the health care system, taking the fact that nurses represent the majorities group among all health care professionals. Therefore, the increased awareness of the Palestinian nurses, together with the feasibility to promoting and developing the nursing profession, has seen in the latest years. The nursing population in Palestine is young. The majority (66.8%) was less than 37 years old. In WB, 73.8% of nursing personnel were females. While in GS, females constituted 44.8%. However, the overall male female ratio was 1:1.7 (PCOH, 1997).The total number of employed nurses in Palestine is 5910, out of which 2524 are working in MOH (42.7%), 1602 in NGOS (27.1%), 944 in UNRWA(16%) and 840 in military Medical Services (14.2%) (MOH, 2003). More nurses were employed by the public sector in GS (68%) than in the WB (40.3%). The local and international NGOS employed about 45.2% of the nursing population in the West Bank and 9.8% in GS. This can be attributed to the fact that NGOS Health Sector represents a larger constituency in the WB than GS. The UNRWA employed 6.8% of the West Bank nursing personnel and 16.9% of those in GS. This is related to the fact that there are more refugees residing in GS than in the WB (MOH, 2003).

In general, the majorities (59.9%) of nursing personnel were practicing in secondary health care services, 30,9% were in primary health care and 9.2% were in nursing

education. At least 62.7% of the WB nursing personnel were practicing in secondary health care and 26.9% in primary health care services, while GS, 55% were in secondary health care and 38% in primary health care. The tertiary services employed only a small portion (5. 8 %) of the total nursing population. This indicated that these services are limited in Palestine, thus minimizing job opportunities in that level of health care. The ratio of nurses per 5,000 populations was (1.3), this ratio is very low in Palestine compared with required ratio (2). The neighboring countries have higher ratios so; the nurse per 5,000-population ratio in Palestine should be increased (PCOH, 1997).

1.6.2 Hospitals in Palestine:

In Palestine, there are 78 hospitals. The population/hospital ratio is 47,922. The average bed capacity per hospital is 59.99 beds In GS, there are 24 hospitals making (30.77%). The population/ hospital ratio is 57,098. The average bed capacity per hospital is 79.88 beds in WB. Including Jerusalem, there are 54 hospitals making (69.23%). The ratio of population per hospital is 43,844. The average bed capacity per hospital is 79.88 beds in West Bank. Including Jerusalem, there are 54 hospitals making (69.23%). The ratio of population per hospital is 43,844. The average bed capacity per hospital is 51.15 beds (MOH, 2003).

1.7 Operational definitions

Occupational Stress: "it is the feeling that occurs within the modern workplace where individuals are being put under increasing pressure as they attempt to cope with heavier workloads, longer working hours, organizational restructure , intrinsic job insecurity and technological development".

Stressor: "is the stimulus which causes stress response".

Eustress: "**positive stress"**: some stress is good as it can motivate a person to do a task or challenge him to go the extra distance to achieve a goal".

Distress: "negative stress": too much stress can leave a person tired, angry, frustrated, and depressed ".

Motivation: is an internal state or condition (sometimes described as a need, desire, or want) that serves to activate or energize behavior and give it direction (Kleinginna and Kleinginna, 1981).

Burnout syndrome: "It is a physiological, psychological, and behavioral condition that presents in a professional whose job is aimed toward direct service to other people".

Practical Nurse: "The nurse who has a diploma in nursing science for 18 months from recognized school of nursing or college".

Staff Nurse: "The nurse who has a diploma in nursing science for at least 3 years from a recognized school of nursing or college".

intra-professional conflict:" conflict happens among persons having the same profession at the work setting(e.g. conflict among nurses".

inter-professional conflicts: "conflict happens among persons having different professions at the work setting (e.g. conflict among nurses and doctors)".

B.Sc. Nurse: "The nurse who has a bachelor certificate in nursing from a recognized college of nursing for at least 4 years**"**

CHAPTER 2

Literature Review

CHAPTER 2

Literature Review

The nursing profession is increasingly characterized by occupational stress, frequent job turnover, and job dissatisfaction (Cooper, 1986; Hawley, 1992). Nurses attend to the emotional needs of patients and their families, as well as undertake managerial responsibilities such as supervising junior staff. The demands of these roles make nurses vulnerable to stress and psychological ill health (Glass, McKnight & Valdimarsdottir, 1993).

2.1 Definition of stress

Stress: is abroad area of study in many branches of social and medical sciences. The definition of stress depends on which branch of science we are talking about. Therefore, the definition of stress is confused by the reference of many overlapping concepts.

Stress is normal. Everyone feels stress related to work, family, decisions, your future, and more. Stress is both physical and mental. It is caused by major life events such as illness, the death of a loved one, a change in responsibilities or expectations at work, and job promotions, loss, or changes. Smaller, daily events also cause stress. This stress is not as apparent to us, but the constant and cumulative impact of the small stressors adds up to big impact.

2.2 Physiological response to stress

In response to these daily stressors, your body automatically increases blood pressure, heart rate, respiration, metabolism, and blood flow to your muscles. This response is intended to help your body react quickly and effectively to any high-pressure situation. However, when you are constantly reacting to small or large stressful situations, without

making physical, mental, and emotional adjustments to counter their effect, you can experience stress that can hurt your health and well-being(Lin, 2001). It is essential that you understand both your external and internal stress-causing events, no matter how you perceive those events. During the past decade, providers of health care services have shifted their emphasis from treatment of illness to interventions aimed at promoting well-being(). The increasing emphasis on providing evidence-based health care has produced demands for greater knowledge of the evidence on which their practice is based( ). There are additional changes which influence the demands experienced by health care staff, including reductions in the average length of stay in hospital and growth in day surgery( ). Job insecurity has been managed by changed structures, the elimination in some cases of levels and categories of jobs, and modified contracts of employment(). This has led to concern among some health care professionals about the disappearance of traditional career structures and professional roles(). These fears are likely to be increased by proposals to merge roles, adjust boundaries and flatten structures(). Health services in developed countries also face problems with retaining skilled staff( ).

In the UK National Health Service (NHS), for example, levels of staff turnover and early retirement continue to increase, and these impacts on services in a number of ways(Secombe & Smith, 1997). The shortages of staff are a drain to resources, both human and financial, and lead to increased pressure on remaining staff who must deliver services with depleted numbers(). The high turnover means that there is a loss of skills and of the investment that has been made in training and developing staff(). Costs are also acquired in training new staff and in managing ongoing staff shortages(). Staff sickness and absence are other major costs to health care systems, with recent figures in the UK suggesting that sickness absence rates of 5% and more are costing the NHS more than £700 million a year (Williams, Michie & Pattani, 1999).

In summary, the context in which health care staff are working is constantly changing in ways that increase the level of work demands and, in many cases, reduce the support and job security available to staff. Both of these factors are known to contribute to ill health at work.

2.3 Ill health in health care staff

There is a large body of evidence that health care staff experience greater levels of both physical and psychological ill health than the population in general. For example, in the UK, 27% of health care staff report high levels of psychological disturbance in comparison to 18% of the population in general (Wall, Bolden & Borrill, 1997).

2.3.1 Nurses:

The aspects of work associated with ill health for nurses include high workload, workload pressures and their effect on personal life, unpredictable staffing and staff shortages and lack of time to provide emotional support to patients. Management style has also been shown to impact on both levels of ill health and absenteeism in nurses (Firth & Britton, 1989; Gray-Toft & Anderson, 1985).

2.3.2 Managers:

Stress among managers in health care is also high. A number of studies in the UK have demonstrated that stress in NHS managers is much higher than managers in other employment sectors, both public and private (Borrill et al., 1998). The major factors contributing to the stress of managers are levels of demand, levels of influence, role conflict, lack of feedback and lack of autonomy, support and control.It can be seen that stress is a significant feature of health care work associated with aspects of work and rates of staff ill health.

2.4 Personal characteristics

The examination of personal factors in the profession of nursing has been developed. Few studies dealt with personality variables; while many studies combined individual characteristics such, hardiness affinitive behavior with personality variables such as independence or dominance. The effect of stress depends on how individual's personality (Duck and Roithmayr, 2002; Cross and Fallon, 1985; Coffey 1999; Mlazzo 1988).

According to Collins (1996), nurse whom process higher levels of personality trait hardiness, most likely has less work stress and burnout. He suggested both staff development educators and administrators needed to be more aware of stressors that influence nurses as caregivers and hardiness training for staff development educator should facilitated.

McCraine et al (1987) agreed with Collins (1996) when concluded that nurse who exhibited less personality hardiness exported more burnout. They added that hardiness appeared to have beneficial main effects in reducing burnout but didn't seem to prevent high levels of work stress from leading to high levels of burnout.

In contrary with Rodney (2000) who found that hardiness is not related to nurse stress but aggression is significantly related to an increase in nursing stress. Martin and lefcour (1983) concluded that humor reduces the impact of Stress. In contrast, Healy and Mckay (2000) concluded that no evidence was found to indicate that the use of humor had moderated effect on stress mood relationship. There was support for the influence of the nurses coping and perception of stress also he added that there was significant positive relationship between nursing stress and mood disturbance and significant negative relationship between nursing stress and job satisfaction.

Baldwin (1999) in her project examined the health of young nurses in training and immediately post-qualification. There were four years follow up of two cohort studies of 147 nurses who qualified in 1994 and 212 nurses who began a project 2000 course in 1994. Data was collected by personal interview with two annual postal questionnaires when ill. A major methodological problem in stress literature is that the effects of stress are measured in many ways including job satisfaction, mental health, sickness absence, tension, tiredness, depression, burnout or post traumatic stress disorder. In addition, Parkes (1986) examined the individual differences, environmental factors and situational characteristics as of three self-report measure of coping. The data was collected from 135 female students through questionnaires. She concluded that individual and environmental differences and situational factors were significant predictors of the coping scores.

2.5 work environment

Great deals of the literature have been focused on the area of special care nurses. Sawatzky, (1996) described the experienced stressful place of work and the perception of stress in female critical care nurses. She concluded that patient care-related stressor considered the highest causes of stress; especially unnecessary prolongation of life was ranked as number one stressor such as apathetic, incompetent, nursing staff ranked among the top perceived threat stressor in two units from the four units in the study. The physical environment was reported as a significant stressor. Besides, insufficient or malfunction equipments was ranked highly for intensity in all four units. Inadequate knowledge and unfamiliar situation scored over all for perceived challenge. She added that inability to meet patient's needs; workload has been reported as primary source of stress for critical nurses, but the study didn’t support it. Cross and Fallon (1985) supported the previous study when they suggested common stressors, unnecessary

prolongation of life, inability to meet patient's needs, dealing with uncooperative patients and working with apathetic staff as a source of stress in critical care, surgical and medical units. In contrast to the previous study results, Nicholos et al (1981) concluded that high level of job satisfaction was registered with very few nurses indicating distress. Milazzo (1988) added intensive care nurse might not be as stressful as previous thought because of available balancing factors to decrease work related stress. She suggested that nurse's self-perception of the stress level in stress symptoms is more stressful than the actual stressors themselves. Nicholos et al, (1981) also mentioned the importance of psychological conditions which may foster distress in nurses. Some of the stressors, which described in the studies of critical care units, may be generalized to other nursing units in a stressor comparison study of four specialty areas (medical, surgical, obstetrics, and ICU).

Cross and Fallon, (1985) showed that stress levels were affected by four sets of variables: management of the ward, interpersonal relations, client care, and work environment. The three experienced variables from the four special groups (medical, surgical, obstetrics, and ICU) were management of the unit, client care, and work environment. The number of individual stressors belongs to nursing specialty, were interruption, paper work, inadequate staffing and dealing with uncooperative patient. Their study claims that obstetric nurse has the least personality distress.

Hipwell, Tyler and Wilson, (1989) studied four nursing units (renal, coronary care units, general medical units and acute geriatric unit). There were no difference in peer cohesion, supervisor's support, autonomy and clarity. They found that stress from workload and death were major problems for all nurses. Most aspects of work environment were found to differ significantly among the four types of nursing. For example, the stressor conflict

with medical nurses scores the highest but the renal unit nurses scores the lowest. They also added no specialized nurse was found to experience significant more stress from lack of support, work load, and their perception of environment. They suggested that the social climate is very important the drop out syndrome and further training after qualification appeared to diminish stress in situations of conflict with doctors of uncertainty over treatment. Types of training were found to be related to stress experienced from death and dying where nurses in managerial positions showing less stress. The dissatisfaction with the environment was found to be a predictor of occupational stress. Another study by Nichols et al. (1981) explored the sources of stress between four units (ICU, surgical, medical, and renal). They found that work load, level and adequacy of support and feed back by senior staff affect the four categories. Different categories of nurse complain from different sources of stress like psychiatric nurses. The community mental health nurse has been found to be a stressful occupation due to factors related to working with patients and organizational pressure (Coffey 1999; Fagin et al, 1995; Wong et al, 2001). Wong et al, (2001) mentioned that mental health nurse is found to be more susceptible to have mental health problems but, nurses with tertiary education and married tend to have better mental health.

2.6 Sources of stress in nursing

Edwards et al, (2000) mentioned that to maintain good quality service, poor resources, having too many interruptions when trying to work in offices and long waiting lists before the patient meet psychologist are the most stressful situations and the least stressful situation is feeling about support from colleagues, communication problems with colleagues and having to receive supervision that is not helpful. Fagin et al, (1995) supported Edwards et al, (2000) when they mentioned that nurses were more satisfied

with direct clinical care than with employment conditions. Another important area may be considered as a source of stress is related to patient workload. McGrath et al, (1989); Adey (1987); Harries (1989); Taylor et al, (1999); O'Donnell (1996). Taylor et al, (1999) identified workload, lack of control over own work and nature of nursing work as a major source of stress. They also added that the four highest related factors had a direct causal link to stress were: staffing levels, inadequate support, multiple roles, and patient suffering. O'Donnell (1996) mentioned that workload and time pressure are considered as the most stressful. He added that technical skills, job security and low pay as a source of stress for general nurses.

O'Donnell (1996) mentioned that the majority of stressors were perceived as being more extensive in mental health nursing than other nursing specialties. Therefore, it is considered as one of the stressful areas in nursing. In addition, she mentioned that nurses working in managerial positions scored the less stressful areas compared to the rest of the sample. However, the stressors generally were considered more extensive than they were by educational nurses. Moreover, she explained that the stressors which managers rated as more extensive than did the total sample were poor in communications, time pressure, long hours and role conflict. The four stressors rated as more problematic in community nurses were poor in communications, violence, time pressure, and conflicting demands of work and home. She concluded that shift working and violence perceived to be the least extensive pressure. Adey (1987) mentioned that the most nurses felt they could take problem to someone, usually colleagues in their ward. She suggested a need for local organized system of support. She added that, dealing with dying patient and his family is considered as a source of stress. She mentioned the importance of nonverbal communications when comforting a distressed patient or relative.

Triolo (1989) mentioned that occupational stressors in health care environment might be physical, biological, chemical or psychological. Physical stressors for nurses include environmental hazards such as poor ventilation, nose, heat and poor lighting. In the direct care nurses also subjected to rotating shifts, musculoskeletal injuries due to lifting, fatigue and work overload. The infectious diseases are biological occupational stress because nurses are in contact with their clients and their secretions. Psychological stressor includes physical and mental overload, job insecurity, role ambiguity, a client population with anxiety or fear and poorly designed work schedules.

Harris (1989) mentioned that a comparison of the result of three studies suggests four situations appear to be commonly perceived as stressful, difficult managing, the workload are identified as a major source of stress. For example, insufficient time to complete nursing tasks while having to deal with none nursing tasks such as clerical work, stress arising from conflict between staff, problems arising from inadequate preparation for role, dealing with death and dying. In a study on operating room nurses by Olsen (1977), he mentioned that some situations perceived to increase stress, for example, surgeon and other staff. He added that situations with low stress as the nurse moves down the hierarchy, the nurse becomes more familiar with the work and less stressful. Evans (2002) demonstrated that nurses are explained that the most stressful aspects of work for this group were: work overload, climate of change, nursing patients with complex patient's need, lack of team work with other departments, family responsibilities and under staffing. Not only have the nurses who contact with the patient complained of stress but also the manager nurses.

Leatt and Schenek (1980) concluded that there was an agreement among the head nurses about situations where stress is provoking for example, patient base stress, task ambiguity

stress, staff movement stress and physician base stress, task ambiguity stress, staff movement stress and physician base stress. He also added that head nurse's age and experience had no effect on their perception of stress. However, head nurses education seemed to affect some of the perceived stress factor. Finally, they explained that all the types of nursing specialties differ in the frequency of stress occurrence.

Severinsson and Kamaker (1999) concluded that role of clinical supervision affects nursing stress. They explained that the nurses who undergo systematic clinical supervision scored higher on the factor of stress. In contrast, they recommended that it is important to provide the nursing with clinical nursing supervision because it helps nurses to develop their personal qualities. In contrast, the role of leadership didn’t influence emotional exhaustion (Stordeur, 2001). Accordingly, to that Stordeur (2001) concluded that stress emanating from physical and social environment, role ambiguity management associated would increase levels of emotional exhaustion. Stordeur (2001) also added that having a high workload, being in conflict with physicians and other nurses, role ambiguities and having head nurse who closely monitors the performance of staff in order to detect mistakes are main factors associated with an increase in emotional exhaustion.

O'Donnell (1996) concluded that poor communications at all levels to increase stress through circumstances that reduce the individual's ability to perform. In addition, he added that poor working conditions, bullying and a desire for perfectionism could also contribute significantly to stress.

2.7 Effects and managing of stress

Harris, (2001) mentioned that stress can affect the stability of any organization, as it can cause significant harm. In addition, failure to recognize and address harm of stress effectively can lead to increase absenteeism, high turnover of staff, impaired productivity, lack of motivation, and unsafe behavior so; they increase accidents rates and mistakes. Jankins, (1997) concluded that if employers continue to ignore high levels of stress among their nurses, they might suffer financial consequences. Fagin et al, (1995) supported Jankins, (1997) when they explained that nurses under stress were more likely to have a higher number of days sick leave, lower self-esteem scores and feel unfulfilled in their work. Harris (2001) mentioned that the harmful level effects of stress on individuals might be physical like high blood pressure, suppression, anxiety, thyroid disorder and stomach and duodenal ulcers. Behavioral effects such as irritability, tendency to be excessive smokers, insomnia, loss of concentration, irritability to deal with daily tasks, deteriorating relationships at home and work and impairment of perception, memory, motivation and creativity. Bond (1996) supported the previous study and mentioned that the effects of stress may cause physical effects such as nausea, headache, increase blood pressure, sleeplessness, and stomach ulcers. In addition, she added that the effect of emotions such as anxiety, fear, feeling stupid and unwilling to do any thing, the effects of on thinking such as thought block, lack of concentration, amnesia, make mistakes and fear to think for him and effects on behavior as talking excessively, smoking, over eating, rejecting people, shouting at people and slowing reaction to danger. Sharp et al, (2002) concluded that stress effects include aggression, self-injures, disruptive and stereotyped behaviors.

In managing stress Sharp et al, (2002); Harries (2001); Dyck and Roithmayr (2002); suggested that supportive management structure can help to reduce occupational stress. They also suggested that three general approaches to manage stress. Theses approaches are life style management, relaxation, professional intervention, life style management is as having healthy diet and supportive network. Professional intervention is essential such as counseling or medication. Sharp et al, (2002) highlighted the importance of support in coping strategies. He suggested that managers should support staff team well by talking, supervising, and team meeting. They are considered forms of support that help coping with work related stress, but Cox, (1992) suggested that the application of the model of organizational health can make a contribution of both; the development of health care organization and the evaluation of health care provision. The model proposed that the capacity of the poor organizational health undermines it from achieving its goals. Walsh et al (1999) reached the conclusion that the most effective way of dealing with stress was to tackle the cause. Their study demonstrated that nurses do not fully understand stress and its management so; they suggested addressing stress to be a continuous topic for professional development. In addition, nurse perceived themselves as powerless to do any thing about the cause of stress and they see if they value this will help them to cope with stress. Finally McGowan (2001) concluded that job satisfaction negatively is affected by stress. The main source of stress was job variables such as shortage of resources, not enough time to complete tasks, dealing with aggressive people and initiating change, less sharing in decision making. He recommended empowerment of staff improve communications between different layers of the organization.

2.8 The meaning of motivation

Definition: The following definitions of motivation were gathered from a variety of psychology textbooks and reflect the general consensus that motivation is an internal state or condition (sometimes described as a need, desire, or want) that serves to activate or energize behavior and give it

- direction

- internal state or condition that activates behavior and gives it direction;
- desire or want that energizes and directs goal-oriented behavior;
- influence of needs and desires on the intensity and direction of behavior (Kleinginna & kleinginna, 1981).

Franken (1994) provides an additional component in his definition:

- the arousal, direction, and persistence of behavior.

While still not widespread in terms of introductory psychology textbooks, many researchers are now beginning to acknowledge that the factors that energize behavior are likely different from the factors that provide for its persistence.

2.9 Importance of motivation

Most motivation theorists assume that motivation is involved in the performance of all learned responses; that is, a learned behavior will not occur unless it is energized. The major question among psychologists, in general, is whether motivation is a primary or secondary influence on behavior. That is, are changes in behavior better explained by principles of environmental/ecological influences, perception, memory, cognitive

development, emotion, explanatory style, or personality or are concepts unique to motivation more relevant. For example, we know that people respond to increasingly complex or events (or stimuli) in the environment up to a point and then responses decrease. This inverted-U-shaped curve of behavior is well-known and widely acknowledged (Yerkes, Dodson. 1999).

2.10 The relationship of motivation and emotion

Emotion (an indefinite subjective sensation experienced as a state of arousal) is different from motivation in that there is not necessarily a goal orientation affiliated with it. Emotions occur as a result of an interaction between perception of environmental stimuli, neural/hormonal responses to these perceptions (often labeled feelings), and subjective cognitive labeling of these feelings (Kleinginna & Kleinginna, 1981). Evidence suggests there is a small core of core emotions (perhaps 6 or 8) that are uniquely associated with a specific facial expression (Izard, 1990). This implies that there are a small number of unique biological responses that are genetically hard-wired to specific facial expressions. A further implication is that the process works in reverse: if you want to change your feelings (i.e., your physiological functioning), you can do so by changing your facial expression. That is, if you are motivated to change how you feel and your feeling is associated with a specific facial expression, you can change that feeling by purposively changing your facial expression. Since most of us would rather feel happy than otherwise, the most appropriate facial expression would be a smile.

2.11 Studies review

In the United Kingdom, over twenty recent reports have consistently shown that between one quarter and one half of National Health Service (NHS) staff report significant personal distress (Weinberg & Creed 2000). There exists a substantial body of evidence to suggest that high levels of stress are endemic throughout the NHS (Anderson et al. 1996), and that many of these stressors may be unique to health care (Calboun & Calboun 1983; Payne & Firth-Cozens 1987).

Kanter (1979) asserts that "the true sign of power is accomplishment." Conditions in the work environment influence how much productive power is available to employees. According to Kanter, formal and informal systemic structures are the sources of workplace empowerment. Job discretion, recognition and relevance to organizational goals are important dimensions of formal power. High levels of job discretion ensure that work is non-routinized and permits flexibility, adaptation and creativity. Recognition reflects visibility of an employee's accomplishments among peers and supervisors. Finally, relevance of job responsibilities and accomplishments to the organization's strategic plan or current problems is also important. Another key systemic structure is informal power, which comes from the employee's network of interpersonal alliances or relationships within and outside an organization. Relationships with people at higher hierarchical levels confer approval, prestige and backing, whereas peer networks provide reputation and "grapevine" information.

Gray-Toft P& Anderson JG (1983) found that the literature indicates that nurses on special care units experience stress resulting from the role conflict and ambiguity to which they are exposed. Role theory predicts that such individuals will become dissatisfied with their work and will decrease their confidence in supervisors and co-

workers. Consequently, it was hypothesized that a staff support program designed to assist nurses to cope with role conflict and ambiguity would result in reduced stress; increased satisfaction with work, supervision, and co-workers; and decreased staff turnover. A nine week staff support program was implemented on a hospice unit in a large, private, general hospital. The program utilized an insight-oriented approach focused on specific sources of stress combined with structured exercises designed to facilitate nurses' ability to cope with stress resulting from a role conflict and ambiguity. Data were collected from two groups to hospice nurses using a Nursing Stress Scale developed for this study, the Job Description Index, and personnel records. A quasi-experimental research design was used to assess the validity and generalization of the results of the program. Data were analyzed in four stages: pre-program levels of stress and job satisfaction were analyzed using a multivariate profile analysis; correlated t-tests were used to test for significant differences between pre- and post-program levels of stress; a repeated measures ANOVA was used to examine the effect of the program on job satisfaction; turnover among the nursing staff on four other hospital units was compared to the hospice unit. Results of the evaluation indicated that the support program was effective in reducing nursing stress, increasing job satisfaction, and decreasing staff turnover. The implications of the study for the design and evaluation of hospital staff support programs are discussed.

Decker FH, (1985) showed the dominant explanation of nurses' affective experience in work is the conflict between the beliefs and expectations developed during the formal training process (education) and the role definitions in the hospital work setting. Specifically, it is generally proposed that baccalaureate trained nurses experience this person-role conflict more than the associate or diploma trained nurse because baccalaureate training instills more beliefs/expectations that conflict with the hospital

nursing role. However, research has not sufficiently compared the effect of 'socialization' variables like education with other variables found to affect the work experience. This study uses path analysis to explore the relative effects of education, length of experience and the measured interpersonal work environment across types of person-role conflicts, on overall job satisfaction and on propensity to leave. The results show that the interpersonal factors are the paramount determinants of the measured person-role conflicts and, as well, have a greater effect than education and experience on job satisfaction. Also, education and length of experience have greater direct than indirect effects on tendency to leave, indicating that their effects are not via causality of job-related stress. Implications for programs designed to improve the nurse's work experience and affects are discussed.

Cross, D.G., & Fallon, A. (1985) showed that stress levels were affected by four sets of variables: Management of the ward, interpersonal relations, client care, and work environment. The three experienced variables from the four special groups (critical care, surgical, obstetrics, and medical) were management of the unit, client care, and work environment. The number of the individual stressors, belong to all nursing specialty, were interruption, paper work, inadequate staffing and dealing with uncooperative patients. Their study also revealed that obstetric nurses have the least personality distress.

Hipwell, A. E, Tyler. P.A., & Wilson, C.M. (1989) studied four nursing departments (renal unit, coronary care units, general medical units and acute geriatric units). There were no differences in peer cohesion, supervisor support, autonomy and role clarity. They found that stress from work load and death were major problems for all nurses. Most aspects of the work environment were found to differ significantly among the four types of nursing departments. For example, the stressor from conflict with medical nurses

scored the highest where renal nurses scored the lowest score. They also added that no specialized nurse was found to experience significant more stress from lack of support, work load and in their perception of the work environment. They suggested that the social climate is very important in the drop out syndrome and further training after qualification appeared to diminish stress in situations of conflict with doctors or uncertainty over treatment. Types of training were found to be related to stress experienced from the death and dying where nurses in managerial positions found to be less stressful. The dissatisfaction with the environment was found to be a predictor to occupational stress.

Bai JY& Suh MJ, (1989) measured in a study the degree of work stress perceived by clinical nurses working in psychiatric ward, and to identify the factors influencing the difference of work stress. The survey method was used and the subjects of this study consisted of 135 psychiatric nurses from 7 university hospitals and 4 provincial general hospitals. The instrument used for this study was PNOSS (Psychiatric Nurse Occupational Stress Scale) which was developed by Bai (1989). The confidence verification of this instrument was computed and the Cronbach alpha was 0.94050. Data were analyzed by t-test and ANOVA on 5% significant level with SPSS program. The results of study were summarized as follow: first, the degree of perceived stress among psychiatric nurses was considerably high (4.32 out of 6.00). Second, among the stressors, inadequate staffing (5.04), hospital administration problems (4.7) and the conflict of nurse-patient relationship were identified as the stress factors with high rank of degree of stress. Third, there was significant relationship between the degree of stress and the demographic variables of nurses such as the marital status, educational level, and the motivation of working in psychiatric ward. Fourth, there was significant relationship between the job-related variables such as the working duration, the motivation of

working and nurse's attitude toward the psychiatric patients. Finally, the relationship between several stress factors and some of the demographic and the job-related variables were significantly identified.

Gottlieb BH et al, (1996) examined the contribution of demographic, job-related, social-support, and care giving variables to the prediction of work-family conflict, stress, and job satisfaction among a sample of 101 hospital-based nurses who had responsibility for the care of a child and/or an elderly relative. The results revealed that family support, perceived organizational support for family life, perceived workload size, and involvement in child care were mainly responsible for the outcomes studied. In addition, the study underscores the importance of separately measuring both the source and the direction of work-family conflict.

Michie S et al, (1996) investigated the factors that contribute to the stress reported by nurses and patients. Thirty-four nurses in a London teaching hospital completed the nurse stress index and the Spiel Berger state trait anxiety inventory, and attitudes towards the ward and nursing care were measured in 52 patients. Nurses in the sample reported significantly greater problems than the norm in dealing with stress (as measured by the nurse stress index). In particular, they expressed difficulty in dealing with patients and their relatives, with conflict between home and work, and with and pressure resulting from problems concerning confidence and competence in the role. Patients were generally satisfied with the health care they received. There was a positive relationship between the time that patients spent talking to nurses and the degree to which nurses were perceived as helpful. Results are discussed in terms of possibilities for further research and implications for the design of future intervention programs aimed at reducing job-related stress in hospitals.

Wiley C., (1997) explored past and present attitudes of employees concerning work-related motivational factors. Understanding the factors that employees consider motivating lends insight to the rewards to which they more positively respond. The researcher compares the results of four motivation surveys conducted in 1946, 1980, 1986 and 1992. The comparisons reveal that employees' motivational preferences vary over time. In addition, the results of the 1992 survey indicate that the factors that motivate today's workers are more extrinsic than they used to be. Although employees differ on how they rank these factors, they overwhelmingly selected "good wages" as the top motivator. A good wage is an extrinsic reward with intrinsic potency. On the surface "good wages" seem to be purely extrinsic. Yet, at a deeper level, monetary rewards communicate what the company values and affect employees' emotional and familial wellbeing.

Hillhouse JJ. & Adler CM. (1997) assessed work stress, burnout, affective, and physical symptomatology was conducted with 260 hospital nurses. As previous attempts to categorize nursing stress and burnout by ward type have yielded inconsistent results, an alternative method for grouping nursing stress effects was sought. Cluster analysis was chosen as it offers a statistically sound means of delineating natural groupings within data. Sets of questionnaires measuring burnout, work stressors, and physical and emotional symptomatology were sent to all staff nurses at a large university hospital. Of 709 nurses employed there, a total of 260 nurses returned completed questionnaire packets. These nurses were separated into two equal groups using random sampling procedures. Cluster analysis of this data revealed groupings which were based on nursing stressors (particularly workload and conflict with physicians), social support, and patient loads. These cluster-analytic findings were replicated on both samples, and validated using data not used in the original cluster analysis. Results suggest that the effects of

stress have more to do with the characteristics of the work environment and overall workload than with the degree of specialization on the unit. Results also suggest that intraprofessional conflict (i.e. with other nurses) is less psychologically damaging than is interprofessional conflict (i.e. conflict with physicians). Findings are discussed with respect to the burnout process and possible interventions.

Laschinger HK. & Havens DS, (1997) showed that occupational mental health has been linked to productivity and other desired organizational outcomes, such as commitment and satisfaction. Kanter's model of work empowerment was used to examine the relation between 62 staff nurses' perceptions of empowerment in their work settings and their occupational mental health. The authors discuss their findings and suggest organizational interventions that can be used by nurse administrators to ameliorate work stress and improve work effectiveness.

Laschinger and Havens (1997) found that lack of access to empowerment structures in downsized hospital settings resulted in frustration and job tension among nurses.

Cangelosi JD Jr et al, (1998) in his study showed that how to attract and retain hospital registered nurses (RNs) have become a recurring subject discussed by hospital boards, administrators and physicians in the U.S. This study seeks to provide current data on this situation. The exploratory research effort consisted of 13 depth interviews with physicians in a major metropolitan area in the southeastern U.S. and less formal discussions with six hospital nurse administrators. The formal research effort involved hand-delivering questionnaires to nurse administrators for distribution to nurses in six hospitals in the same region. The principle reasons nurses change jobs fall into four categories: salary or benefits, convenience, work schedule, and job-related stress. After one or more hospital moves the nurses become more satisfied. Hospital administrators

should institute motivational and hospital commitment programs to improve retention/reduce turnover, e.g., work schedule rotation, work responsibility rotation, team approaches to health care and award/recognition programs. Laschinger HK et al, (1999), tested a model linking specific leader-empowering behaviors to staff nurse perceptions of workplace empowerment, occupational stress, and work effectiveness in a recently-merged Canadian acute care hospital. Staff nurses (n = 537) were surveyed shortly after a merger of two large tertiary hospitals. Structural equation modeling techniques were used to test the proposed model. The study showed that leader-empowering behaviors significantly influenced employee's perceptions of formal and informal power and access to empowerment structures (information support, resources, and opportunity). Higher perceived access to empowerment structures predicted lower levels of job tension and increased work effectiveness. The amount of explained variance in the final model was 42%. The study reached the conclusion that the Support for the model tested in this study highlights the importance of nurse managers' leadership behaviors within current unstable healthcare organizations. Janssen PP, (1999) tested 156 Dutch general hospital nurses a theoretically derived model of specific relationships between work stressors and stress reactions. The model proposes four central domains of the work situation, namely work content, working conditions, social and labor relations, and conditions of employment. In addition, the model proposes three important stress reactions, namely a diminished intrinsic work motivation, occupational burnout and an inclination to leave the job. More specifically, it was hypothesized that intrinsic work motivation is primarily determined by work content variables, burnout is primarily determined by both work load and limited social support, and tendency to leave is primarily determined by conditions of employment. All these relationships were simultaneously tested using a structural equations modeling technique.

The results of a series of analyses indicate that the postulated model fits well to the data. The present study used conceptually integrated measures that cover the area of work stress and stress reactions, and provides directions for interventions aimed at preventing or reducing specific negative outcomes of work-related stress in general hospitals. Bolton SC, (2000) found that many commentators stress that nurses' 'emotional labor' is hard and productive work and should be valued in the same way as physical or technical labor. However, the term 'emotional labor' fails to conceptualize the many occasions when nurses not only work hard on their emotions in order to present the detached face of a professional career, but also to offer authentic caring behavior to patients in their care. Using qualitative data collected from a group of gynecology nurses in Trust hospital, this paper argues that nursing work is emotionally complex and may be better understood by utilizing a combination of concepts: emotion work as a 'gift' in addition to 'emotional labor'. The gynecology nurses in this study describe their work as 'emotionful' and therefore it could be said that this particular group of nurses represents a distinct example. Nevertheless, though it is impossible to generalize from limited data, the research presented in this paper does highlight the emotional complexity of the nursing labor process, expands the current conceptual analysis, and offers a path for future research. The examination further emphasizes the need to understand and value the motivations behind nurses' emotion work and their wish to maintain caring as a central value in professional nursing.

Payne, N., (2001) examined Stressors, coping and demographic variables as predictors of burnout in a sample of hospice nurses. The study aimed to investigate the level of burnout among hospice nurses; to ascertain which aspects of nursing work were positively or negatively related to burnout; to examine the relative contributions made by these different variables and to suggest individual and organizational interventions to reduce

levels of burnout. The results of this study were the level of burnout (characterized by high emotional exhaustion, high depersonalization of patients and low personal accomplishment) was found to be low. In multiple regression analyses, 'death and dying', "conflict with staff', 'accepting responsibility' and higher nursing grade contributed to emotional exhaustion.'Conflict with staff', 'inadequate preparation', 'escape' and reduced 'planful problem-solving' contributed to depersonalization. 'Inadequate preparation', 'escape', reduced 'positive reappraisal' and fewer professional qualifications contributed to lower levels of personal accomplishment. Overall, stressors made the greatest contribution to burnout and demographic factors contributed the least. As a result of this study we know the importance of not labeling individuals as good and bad was discussed, as the effectiveness of a strategy may depend on the situation. It was concluded that the investigation of problem-focused and emotion-focused coping in relation to burnout, was oversimplifying the coping-burnout relationship. Suggestions for stress management included staff training in counseling skills, monitoring staff conflict, implementing stress inoculation training to teach appropriate use of coping skills and finally, monitoring particularly vulnerable groups of hospice staff such as unqualified nursing assistants and qualified nurses in management positions. It was concluded that despite the difficult nature of hospice work, the hospice is a positive environment in which to work. Northcott (2000) found that having a co-worker laid off or bumped from the unit resulted in higher levels of depression and poor physical health.

Brokalaki H. et al, (2001) Described specific work-related factors that contribute to increased levels of stress experienced by nursing personnel, and to compare their impact on nurses and assistant nurses who work in Dialysis Units (DU) to those who work in Peritoneal Dialysis Units (PDU) in Greece. The sample of the study consisted of 682 members of nursing personnel working in DU and in PDU in Greek Hospitals. The

collection of data was done by means of a questionnaire. The latter included questions about the motivation of nursing personnel for having chosen to work in these units along with questions about the stress factors related to the patients and their care, the role of the nurse in the unit, and the working conditions. According to the results of the study, the percentage of nursing personnel working in DU or PDU by their own choice was 71% and 8.3% respectively, whereas the rest of the staff were placed there irrespective of their preferences, by the Administrators. Among nursing personnel who had chosen to work in DU, the reported motives that contributed to their decision were the absence of a night shift (27.8%), and working in a closed unit. The main motive that incited nursing personnel to work in PDU was the acquisition and the application of specialized knowledge. The percentage of nursing personnel working in DU that expected high levels of job satisfaction was 77%, whereas the corresponding percentage for nursing personnel working in PDU was 65%. However, only 44% and 37% of the nursing personnel working in DU and PDU reported high levels of job satisfaction. The most important stressors related: 1) to the patient: were the risk of contamination (79% DU, 84% PDU) and the death of a patient (77% DU, 80% PDU). 2) To the role of nursing personnel in the unit: were increased responsibilities (65% DU, 37% PDU), low involvement of the nursing personnel in decision making (58% DU, 54% PDU), and low professional status of nursing personnel. 3) To the working conditions: were the shortage of nursing personnel (74% DU, 99% PDU), limited material (74% DU, 57% PDU), the closed environment (75% DU, 64% PDU) and the daily work routine (78% DU, 61% PDU). In conclusion, we can say that working in DU and PDU provokes increased stress in nursing personnel, even though the implicated stress factors differ between these units.

Cartledge S, (2001) found that Access to the intensive care unit (ICU) is often tortuous as there is a high incidence of bed closure due to staff shortage, a problem exacerbated by a

high rate of turnover. It is proposed that the first step in addressing the problem is to explore the reasons why people leave, illuminating areas of policy and practice that would benefit from amendment. Given that the issues concerned are complex and contextual in nature, an open exploratory approach was adopted, whereby respondents were interviewed using open questions and given the freedom to shape their responses according to their perceptions of the problem. The transcripts of eleven interviews were analyzed, with four themes emerging which represent the most dominant factors influencing the respondents' decision to leave. These included stresses related to the work; inadequate opportunity for professional development; recognition and respect of others and the implications of shift-work. It was concluded that there needs to be a greater awareness of the potential for nurses to become excessively stressed in the ICU environment; that a decentralized management style may help maintain motivation; that roistering systems need to retain flexibility; and that there is a requirement for greater incentives to pursue a career in intensive care.

Wenderlein FU, (2003) assessed in this study the high level of absenteeism among nursing trainees compared with nursing staff. Unlike previous studies, the present study focused on work satisfaction and motivation. Specifically, combining satisfaction with absenteeism was a novel approach. The author used for assessing work satisfaction, a standardized form with 73 items in four areas was drafted and checked in a pre-test (n = 150). 861 nurses and 159 trainees were interviewed. The absenteeism data given by the nursing staff were compared with the 'missing' records of the personnel department. As a result, in all areas it was found that, in particular, problems of organization, personnel management and working atmosphere in the hospital were a burden on the employees. In detail, however, there were considerable differences between nurses and trainees in respect of appraisal. Work organization: Although trainees rated work organization

aspects lower than nurses, direct relationship to work satisfaction was less pronounced. For the trainees, improvements are imperative in respect of active self-responsibility. Leadership/co-operation: Trainees rated supervisor behavior and working atmosphere lower than their colleagues. There was a direct relation to satisfaction and absenteeism. Workload/stress: Although their responsibility was less, a larger proportion of the trainees felt stressed. This was directly related to work satisfaction and absenteeism. Fluctuation and turnover: 44% of the trainees would be prepared to work up to the age of retirement, but only 25% of the qualified staff. Nevertheless, three-quarters of the trainees and two-thirds of the nurses would choose the same profession again. Hence, unfavorable local (internal) circumstances led to the discontent and not the profession as such. The study reached the conclusion that the extremely high absenteeism of nursing trainees calls for action on the part of school and hospital management. There is a need for better information and care before and during professional training, because workload will be higher at the end of the training. The study indicates possibilities of increasing work satisfaction and decreasing absenteeism of trainees.

In a qualitative study of nurses' experiences of work in post-downsizing hospital settings, the most frequently identified sources of nurses' dissatisfaction with their work lives during this period were increased workload, uncertainty about the future, management's primary focus on the financial bottom line and a perceived lack of resources to provide high-quality patient care (Laschinger, Sabiston, Finegan and Shamian ,2001) Simmons BL, & Nelson DL, (2001) examined the relationship between eustress, the positive response to work demands, and health in 158 hospital nurses. The positive psychological states hope, positive affect, and meaningfulness were used as indicators of eustress, and the psychological state negative affect was used as an indicator of distress. Hope, the

belief that one has both the will and the way to accomplish one's goals, had a significant, positive relationship with the perception of health in this sample of hospital nurses.

Laposa JM, Alden LF, Fullerton LM, (2003) found that Work-related stress in the emergency department (ED) previously has been linked to depression and burnout; however, these findings have not been extended to the development of anxiety disorders, such as posttraumatic stress disorder (PTSD). Three sets of factors have been shown to contribute to stress in ED personnel: organizational characteristics, patient care, and the interpersonal environment. The current study addressed whether an association exists between sources of workplace stress and PTSD symptoms. They found that Interpersonal conflict was significantly associated with PTSD symptoms. The majority of respondents (67%) believed they had received inadequate support from hospital administrators following the traumatic incident and 20% considered changing jobs as a result of the trauma. Only 18% attended critical incident stress debriefing and none sought outside help for their distress. As a result, these findings underscore the need for hospital administrations to be aware of the extent of workplace stress and PTSD symptoms in their employees. Improving the interpersonal climate in the workplace may be useful in ameliorating PTSD symptoms.

Hoffman AJ & Scot LD. (2003) examined the variation in role stress and career satisfaction among hospital-based registered nurses (RNs) by shift length. Many hospitals have reorganized care delivery into 12-hour work shifts to improve RN recruitment, retention, and cost effectiveness. Yet little is known about the effects of 12-hour shifts on RN role stress and career satisfaction. As an unprecedented RN shortage approaches, factors that contribute to satisfying and healthy practice environments must be identified. This study used a descriptive cross-sectional research design. Five hundred RNs were randomly selected to receive a mailed questionnaire packet. Initial findings indicate RNs

working 12-hour shifts were younger, less experienced, and more stressed than colleagues working 8-hour shifts. When differences in nursing experience were controlled, similar RN stress levels were found. Although overall career satisfaction was comparable between groups, significant differences were found in the areas of salary and professional status. Pay, autonomy, and professional status were the most important determinants of career satisfaction for all RN participants. These findings suggest that RNs may experience greater professional fulfillment when strategies are implemented that promote autonomous practice environments, provide financial incentives, and recognize professional status. Proactive decision-making may avert RN disillusionment and avoid other negative consequences that impact quality of care. Trofino J. (2003) found that Power sharing with staff nurses is an essential strategy for organizational transformation. The current competitive health care environment requires a powerful team of participants, including staff at all levels, to provide health care in mutual partnership. The challenges of today's competitive and global environment call for collegial relationships among nurse executive leadership, middle nurse managers, and staff nurses. Research has demonstrated that middle nurse managers maintain primary responsibility for staff nurse retention. A higher retention rate was reported among nurses who were very satisfied with their nurse managers. Nurses considered favorably nurse managers who value staff contributions, promote information sharing, and exert influence for a stable work environment. Furthermore, as staff nurse satisfaction increased, effectiveness and extra effort also increased when staff nurses perceived transformational leadership strategies. Strategies for power sharing include serving as role models and mentors, energizing staff, resisting attitudes of staff ownership, reducing staff nurse stress of leader presence, and information sharing and commendations at meetings.

Dahi, A. (2003) in a similar study to my own the researcher assessed the occupational stressors among hospital nurses in south Gaza hospitals. The study explored the relationship between the stress, the demographics, and the organizational factors. It showed that there is significant relationship between the nurse's age and absence of doctors, supervisor's critique, heavy work, and decision taken under pressure and stress occurrence. In addition, Dahi's study showed that there is a significant relationship between gender and lack of time to give to the patient's psychological care, patient death, lack of nursing administration support and covering nurse's shortage in other sections and stress occurrence. Moreover, the study concluded that there is a significant relationship between the type of section, dealing with abusive patients, and patient death and stress occurrence. Besides, the study reached the conclusion that there is a significant relationship between number of working years in the section, exposure to hazards of health and safety and stress occurrence. Dahi's study also showed that significant relationship between the job title and the doctor ordering inappropriate treatment, absence of doctor in emergency cases, lack of control over work, not taking vacations and holidays, and nurse's shortage regarding stress occurrence. Finally Dahi's study showed that there are frequent causes of stress due to working in holidays, time pressure, and unpredictable schedule and uncertain about manager's abilities.

Dendaas N, (2004) observed that nursing research related to nurses' work environments in hospitals is often conceptualized around variables such as job satisfaction, professional practice environment, and job stress. Macro-level variables associated with political, economic, and social aspects of the work environment have received less attention. Philosophical issues are considered. Person-Environment Congruence Theory is proposed as a framework capable of addressing environmental incongruence in hospital nursing

work environments. Implications for theory and research using the framework are described.

Waters A., (2004) published the results of a special campaign survey undertaken by the Nursing Standard confirms that nurses are proud of what they do and the reason that they carry on is patients and a convincing 94 per cent of respondents say they are proud to be nurses. And 74 per cent say it is the patients who inspire or motivate them to stay in the profession. In addition, he surprisingly found that 76 per cent of the responding nurses still consider nursing to be a vocation. This may reflect the fact that 43 per cent feel that a characteristic most associated with nursing is that nurses are underpaid in spite of the high percentage (55%) who feel that nurses' work is highly regarded. Water also found that the five worst aspects of the job were considered to be under-staffing (74%), stressful work (50%), low resources (50%), inability to change the way things are done (31%) and rude or abusive patients (28%). The key attractions to the profession include job variety (60%), fellow workers (45%), job security (44%), the National Health Services NHS pension (33%), and on-going training (32%). He added that nurses may be one of the best recruitment tools to the profession as 58% of the respondents would recommend nursing as a career to children, relatives or friends. While 32% of the respondents felt that their working conditions were improving, 38% felt they had deteriorated and 29% reported no change.

Chapter 3

Theoretical Framework

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Theoretical Framework

Stress in nurses should be of great concern to any health organization. Nurses hold the majority of positions in most health care settings, and replacement of licensed personnel is costly and time consuming.

Stress is normal. You need some stress to perform your best. The key for management is to determine the right amount of stress that will give you energy, motivation, and enthusiasm versus the wrong amount which can harm your well-being.

3.1 Positive stress vs. negative stress

As long as we think of stress as negative, we will try to move it away from us, keep it at arm's length or try to prevent having stressed in the first place. In fact, stress is a life energy force in the body and is the key element in optimal performance. Positive stress is actually essential and beneficial, and can be our strongest assistant for leading stimulating healthy lives, filled with energy and resilience (Simmons &Nelson , 2001).

Have you ever thought of these words: creativity, passion, excitement, or motivation? These are stress words as well Positive stress words. Remember to watch your language! When you mean negative stress you have to say distress or negative stress. When you mean positive stress, you have to say eustress or positive stress. Avoid using the word stress for all things negative. Think about stress the way you think about blood pressure. High blood pressure or low blood pressure can be problematic, but you never want your blood pressure to go away completely. It is the same with stress. When unregulated, uncontrolled or ignored, stress can be harmful to your health and wellbeing; too little stress can lead to apathy, atrophy, fatigue and illness**.** A major step toward successful

stress management is to find and maintain a personal equilibrium, a balance that works for you at each stage of your life (Simmons & Nelson, 2001).

Before we can address the issues of stress and its affect on work motivation, we need to develop an understanding of what it is, and how it affects people both personally and in the workplace. It will then become very clear that it is not an issue that should be ignored either for personal good of an employee or for the good of the organization. The characteristics of nurses' tasks that are associated with psychological stress can be of great help in this respect. According to this model, it is not only the psychological demands of work that lead to stress and related illnesses, but a situation of high demand combined with low nurse control over the work process. Stress occurs when nurses are constrained from responding to the stressor on the basis of their own optimal psychological and physiological response pattern, because of external factors over which they have no control. In contrast, motivation can be achieved when the demands of the task are met according to a response pattern that is determined by the nurses.

The model seems to capture some important stressful job circumstances: the low-control, high-demand tasks, particularly in combination with low social support.

3.2 Stress in health care work

3.2.1 Psychological models:

Stress can be caused by a number of factors related to both the content and the context of the work. Models of stress provide a framework for assessing and intervening at an individual and organizational level to reduce work-related stress in health care settings. Two widely used models will be described.

3.2.2 The transactional model of stress:

The transactional model of stress (Lazarus & Folkman, 1984) emphasizes the importance of people's perceptions of not only the stress to which they are exposed but also of their own coping resources. The model proposes that the ability of people to prevent or reduce stress is determined by their appraisal of the threat within a situation (primary appraisal) and their coping skills to deal with that threat (secondary appraisal).

3.3 Theoretical concept of stress

Stress is abroad area of study in many different branches of social and medical sciences. The meaning of stress depends mainly on which branch of science we are talking. The definition of stress is complex sometimes as there are many overlapping concepts that may confuse most of us. For instance, topics such as emotions conflicts, defense reaction, fear, frustration, and anger have referred to stress in literature (Ricotta, 1984). Cox et al (2000) mentioned that there are essentially three different, but they are overlapped approaches to define the study of stress. The first approach conceptualizes occupational stress as destructive or harmful characteristics of work environment. This approach has been termed as the "engineering approach". The second approach defines stress in terms the common psychological effect of a wide range of harmful stimuli. It treats stress as a particular physiological response to a threatening or damaging environment. This has been termed as the "physiological approach". The third approach conceptualizes work stress in terms of the dynamic interaction between the person and his work environment. This final approach has been termed as the "psychological approach".

Two specific criticisms had been offered to the first two approaches, the first empirical and second conceptual. First, both engineering and physiological models are not

adequately accounted for existing data. For instance, they ignore the mediation of strong cognitive as well as situational factors in the overall stress process. The second criticism is that, the engineering and physiological models of stress are conceptually dated, and largely ignore individual differences of physiological nature and perceptual and cognitive processes that might underpin (Cox et al, 2000). These two approaches, therefore, treat the person as a passive vehicle for translating the stimulus characteristics of the environment into physiological response parameters. They largely ignore the interactions between the persons and their various environments, which are essential part of systems-based on approaches to biology, behavior and psychology. However, the third approach to the definition and study of stress pays special attention to the environmental factors and, in particular, to the psychological and organizational contexts of the work stress. Stress is either inferred from the existence of problematic person-environment interactions or measured in terms of the cognitive processes and emotional reactions, underpins those interactions. This has been termed as the "psychological approach" (Cox et al, 2000).

The development of psychological models, to some extent, attempts to overcome the criticisms leveled at the earlier approaches. There is now a consensus developing around this approach of the definition of stress. For example, psychological approaches of the definition of stress are largely consisted with the international Labor Organization's definition of psychological hazards and with the definition of well-being recommended by the World Health Organization (WHO, 1986).

Variants of psychological approach, contemporary, dominate stress theory and among them, the two distinct types are identified as the international and the transactional. The former focuses on the structural feature of the person's interaction with their work

environment, while the later is more concerned with the psychological mechanisms underpin that interaction. Transactional models are primarily concerned with the cognitive appraisal and coping. In a sense, they represent a development of interactional models, and largely consistent with them (Cox et al, 2000).

There is a growing consensus on the definition of stress as a negative psychological state with cognitive and emotional components, and its effects on the health of both individual employees and their organizations. In addition, there nowadays theories of stress that can be used to relate the experience and effects on work stress with exposure of work hazards and the harmful effects on health that such exposure might cause. Applying these theories on understanding of stress at work allows the approach of the management at work stress through the application of the control notion of the cycle. Like this approach has proved effective somewhere in health and safety. It offers a systematic problem-solving system for continuous improvement related to work stress. There are several distinct areas, which research is required; some relate to the individuals but others relate to the design and management of work and interventions to improve the work environment (Cox et al, 2000).

Finally, one of the earliest contributions to stress research was Water Cannon's(1932) description of fight or flight response. Cannon proposed that, when an organism perceives a threat, the body is rapidly aroused and motivated via the sympathetic nervous system and the endocrine system. This intensive physiological response mobilizes the organism to attack the threat or to flee; hence, it is called the fight or flight response.

Another important early contribution to the field of stress is Hans Selye's (1956, 1976) work on the general adaptation syndrome, Although Selye initially explored the effect of sex hormones on physiological functioning. Thus, whereas Cannon's work explored

adrenomedullary responses to stress specifically, catecholamine secretion. Selye's work more closely explored adrenocortical responses of stress. From these observations, Selye (1956) developed his concept of general adaptation syndrome. He argued that, when an organism confronts a stressor, it mobilizes itself for action. The response itself is nonspecific with respect to the stressor; that is, regardless of the cause of threat, the individual will respond with the same physiological pattern of reactions. Overtime, with repeated or prolonged exposure to stress, there will be wear and tear on the system. The general adaptation syndrome consists of three phases. In the first phase, alarm, the organism becomes mobilized to meet the threat. In the second phase, resistance, the organism makes efforts to cope with the threat, as through confrontation. The third phase, exhaustion, occurs if the organism fails to overcome the threat and depletes its physiological resources in in the process of trying. The substantial of Selye's model on the field of stress continues to be felt today. One reason is that it offers a general theory of time. As such, it provides a way of thinking about the interplay of physiological and environmental factors. Second, it posits a physiological mechanism for the stress-illness relationship. Specifically, Selye believed that repeated or prolonged exhaustion of resources, the third phase of the syndrome, is responsible groundwork for disease. In fact, prolonged or repeated stress has been implicated in disorders such as cardiovascular disease, arthritis, hypertension, and immune-related deficiencies.

3.4 Theories of motivation

3.4.1 Self-determination theory and work motivation:

Cognitive evaluation theory, which explains the effects of extrinsic motivators on intrinsic motivation, received some initial attention in the organizational literature. However, the simple dichotomy between intrinsic and extrinsic motivation made the theory difficult to apply to work settings. Differentiating extrinsic motivation into types that differ in their degree of autonomy led to self-determination theory, which has received widespread attention in the education, health care, and sport domains. The following paragraphs describe self-determination theory as a theory of work motivation and show its relevance to theories of organizational behavior.

Building on Vroom's (1964) expectancy–valence theory of motivation, Porter and Lawler (1968) proposed a model of intrinsic and extrinsic work motivation. Intrinsic motivation involves people doing an activity because they find it interesting and derive spontaneous satisfaction from the activity itself. Extrinsic motivation, in contrast, requires an instrumentality between the activity and some separable consequences such as tangible or verbal rewards, so satisfaction comes not from the activity itself but rather from the extrinsic consequences to which the activity leads. Porter and Lawler (1968) advocated structuring the work environment so that effective performance would lead to both intrinsic and extrinsic rewards, which would in turn produce total job satisfaction. This was to be accomplished by enlarging jobs to make them more interesting, and thus more intrinsically rewarding, and by making extrinsic rewards such as higher pay and promotions clearly dependent upon effective performance.

3.4.2 Cognitive evaluation theory:

Cognitive evaluation theory suggested first that external factors such as tangible rewards, deadlines observation and evaluations tend to diminish feelings of autonomy, prompt a

change in perceived locus of causality (PLOC) from internal to external and undermine intrinsic motivation (Heider, 1958). In contrast, some external factors such as providing choice about aspects of task engagement tend to enhance feelings of autonomy, prompt a shift in PLOC from external to internal, and increase intrinsic motivation (Zuckerman et al., 1978). CET further suggested that feelings of competence as well as feelings of autonomy are important for intrinsic motivation. Studies showed that optimally challenging activities were highly intrinsically motivating (Danner & Lonky, 1981) and that positive feedback (Deci, 1971) facilitated intrinsic motivation by promoting a sense of competence when people felt responsible for their successful performance (Fisher, 1978; Ryan, 1982). Further, negative feedback which decreased perceived competence was found to undermine both intrinsic and extrinsic motivation, leaving people a-motivated (Deci & Ryan, 1985). Underlying these CET propositions was the assumption that people need to feel autonomous and competent, so social-contextual factors that promote feelings of autonomy and competence enhance intrinsic motivation, whereas factors that diminish these feelings undermine intrinsic motivation, leaving people either controlled by contingencies or a-motivated.

3.4.3 Self-determination theory:

Central to SDT is the distinction between autonomous motivation and controlled motivation. Autonomy involves acting with a sense of volition and having the experience of choice. In the words of philosophers such as Dworkin (1988), autonomy means endorsing one's actions at the highest level of reflection. Intrinsic motivation is an example of autonomous motivation. When people engage an activity because they find it interesting, they are doing the activity wholly volitionally (e.g., I work because it is fun). In contrast, being controlled involves acting with a sense of pressure, a sense of having to engage in the actions. The use of extrinsic rewards in the early experiments was found to

induce controlled motivation (Deci, 1971). SDT postulates that autonomous and controlled motivations differ in terms of both their underlying regulatory processes and their accompanying experiences, and it further suggests that behaviors can be characterized in terms of the degree to which they are autonomous versus controlled. Autonomous motivation and controlled motivation are both intentional, and together they stand in contrast to a-motivation, which involves a lack of intention and motivation.

3.4.4 Goal-setting theory:

Locke and Latham's (1990) goal-setting theory has had a substantial impact in the field of work motivation. Integrating earlier work by Locke (1968) with aspects of self-efficacy theory (Bandura, 1986), Locke and Latham outlined a general goal-setting theory of motivation. They suggested that people's goal representations are the efficient causes of behavior and that people's performance will be maximized when (1) they set specific, difficult goals that have high valence and (2) they understand what behaviors will lead to the goals and feel competent to do those behaviors. This theory, which has received substantial empirical support, is an example of the theories that do not differentiate kinds of motivation. Thus, characteristics of goals (e.g., their difficulty) are used to predict work outcomes, but no attention is given to the fact that different goal contents and different types of regulation of goal pursuits lead to different qualities of performance (Sheldon & Elliot, 1999; Sheldon, Ryan, Deci, & Kasser, 2004). Furthermore, Locke and Latham do not differentiate the concept of performance in order to examine differences between the types of goals and regulations that predict algorithmic(a list of instructions which are carried out in a fixed order to get an answer or achieve a goal) versus heuristic performance. In contrast, SDT proposes that autonomous motivation and intrinsic goals are better predictors of effective performance on heuristic tasks (Vansteenkiste et al., 2004), whereas the two types of motivation do not differ in

predicting effective algorithmic performance, particularly over the long term (McGraw, 1978). Thus, SDT maintains that differentiating motivation and goals provides an integrated means of relating characteristics of tasks and interpersonal environments, as well as individual differences, to types of performance and well-being. There is a noteworthy point of convergence between the Locke and Latham approach and ours. Specifically, Deci et al. (1994) found that a 'meaningful rationale' is one of the important factors that facilitates integrated internalization, and Latham, Erez, and Locke (1988) found that it facilitates goal acceptance.

3.4.5 Action regulation theory:

For the past quarter century a number of scholars working primarily in Germany have used action theory to examine motivation in work organizations as well as other settings. Strongly influenced by the cybernetic approach, the theory uses the concept of goals and emphasizes the mechanisms that keep people effectively focused on goal-directed action (Frese & Sabini, 1991; Hacker, 1994). The theory includes the concept of decision latitude, which it equates with autonomy. It then suggests that maximal motivation and action result when there is considerable decision latitude, which allows workers to set their own goals. Hacker went so far as to say that greater decision latitude promotes greater intrinsic motivation, but the theory does not make differential predictions for intrinsic and extrinsic motivation. Working with this general approach, Frese (1989) suggested that control over one's behavior (i.e., decision latitude), combined with optimal complexity of the task and without undue complicatedness, leads to optimal performance and well-being. Subsequently, Frese (2001) outlined a model in which a variety of personality factors, skills, and environmental supports were theorized to lead to personal initiative, which is essentially a single motivation variable that is then used to predict work outcomes. In contrast, SDT explicitly uses the differentiated concepts of

autonomous and controlled types of motivation to make predictions about effective performance and psychological health. Furthermore, SDT views decision latitude to be just one factor that is important for supporting autonomy, with others such as the interpersonal style of managers also being extremely important. Kanfer's task-specific motivation Kanfer (1987; Kanfer & Ackerman, 1989, 2004) has outlined a theory of work motivation that falls in the same general cognitive tradition as action theory. It uses the interaction of motivation and individual differences in abilities as a primary basis for predicting work performance. Motivation is characterized in terms of two cognitive resource allocation processes, referred to as distal and proximal. Distal factors concern mechanisms such as the utility to the person of doing the task and the perceived instrumentality of expending effort for effective performance. When the target activities are relatively complex and require sustained effort, proximal factors such as self-monitoring and self-regulation are critical for performance and competence development. As with action theory, Kanfer's approach has a unitary conception of motivation that is affected by both distal and proximal factors. Further, it is heavily focused on the mechanisms that keep people focused on task performance and skill development. With the unitary conception of motivation and the focus on how goals are attained, Kanfer's theory is not well equipped to predict types of performance (algorithmic and heuristic) and does not give consideration to the affective or well-being outcomes that accompany different types of motivation and performance. In contrast, SDT is less concerned with the mechanisms that describe how a goal is achieved, but it does give central concern to predicting types of performance and it places great importance on the prediction of well-being outcomes as well as performance outcomes

3.4.6 Job characteristics theory:

Hackman and Oldham (1980) argued that the most effective means of motivating individuals is through the optimal design of jobs. Their theory of job characteristics focuses on facilitating high internal work motivation, which bears considerable relation to autonomous motivation, although the theory does not distinguish introjected forms of internal motivation from identified, integrated, and intrinsic forms, so it does not have the means for examining negative consequences that are associated with the introjected type of internal motivation. The authors proposed that the means for increasing internal work motivation is to design jobs so they will (1) provide variety, involve completion of a whole, and have a positive impact on the lives of others; (2) afford considerable freedom and discretion to the employee (what action theorists refer to as decision latitude); and (3) provide meaningful performance feedback. The authors further explain that individual differences in the strength of growth needs moderate the degree to which these job characteristics have a positive impact on job performance. Self-determination theory concurs that these job characteristics will tend to promote autonomous motivation, and research is consistent with this view (Gagne´, Sene´cal, & Koestner, 1997). However, SDT differs in three major ways from Hackman and Oldham's approach. First, SDT focuses not only on job characteristics such as choice and constructive feedback as one way to influence autonomous motivation, but it also suggests that the interpersonal style of supervisors and managers is important. Research by Deci, Connell, and Ryan (1989) found that when managers were trained to be more autonomy supportive—that is, to understand subordinates' perspectives, encourage their initiative, and provide feedback in an autonomy-supportive rather than controlling way—their subordinates became more trusting of the organization and displayed more positive work-related attitudes. Second, SDT does not focus on need strength as an individual difference but instead considers

causality orientations as the individual difference. This difference in type of individual differences is important because it suggests that everyone needs to satisfy the needs for competence, autonomy, and relatedness and will show positive consequences when they do. Third, because Hackman and Oldham focus only on one type of motivation (i.e., internal motivation), their approach does not consider issues such as the interplay and trade-offs between internal motivation and controlled motivation. Pertinent to this is the finding that jobs with high motivating potential scores were associated with enhanced psychological states and better outcomes only for workers who perceived that pay and promotion were not contingent on performance (Johns, Xie, & Fang, 1992).

3.4.7 Needs and motives: Maslow, Herzberg, and Alderfer:

The theories of Maslow (1954), Herzberg (1966), and Alderfer (1972) are considered classics in organizational behavior. In the work of Maslow and Alderfer there are five and three classes of needs, respectively, organized in a hierarchy from the basic, lower-order needs such as the physiological drives to higher-order needs for actualization or growth. In the work of Herzberg there are just two categories of motives, typically referred to either as satisfiers and motivators or extrinsic and intrinsic motives, with the motivators (i.e., intrinsic motives) being considered higher order. There are some aspects of these theories that are consistent with SDT. For example, like these previous theorists, we use a concept of psychological needs and we hypothesize that satisfaction of these needs will be associated with more effective performance and well-being, and we, like these previous theorists, tend to endorse participative approaches that allow people to experience satisfaction of their psychological needs. However, there are also important differences between SDT and these other theories. Whereas SDT posits basic psychological needs that must be satisfied for optimal functioning and well-being, it also elaborates regulatory processes that underlie the direction of behavior. Thus, whereas the

other theories focus primarily on the energizers of motivated action, SDT addresses both of the fundamental motivation questions, namely how behavior is energized and how it is directed. Furthermore, SDT differs from the others in the way it has evolved and is formulated. Specifically, it has evolved over three decades using an empirical approach in which each proposition has received empirical confirmation before being incorporated into the theory. In addition, many experimental paradigms and psychometric instruments have been developed along with the theory in order to allow for continued tests and elaborations. Thus, SDT is formulated in a way that suggests a wide range of researchable questions, and it provides methods for testing many of these questions. As such, although Miner (1990) criticized the 'humanistic' theories because of their lack of empirical support, SDT is one theory that would fall within Miner's definition of humanistic but has also received an enormous amount of empirical validation.

3.4.8 Kelman's theory of internalization and the concept of identification:

Kelman (1958) presented a differentiated theory of internalization or attitude change positing that a person's attitude-related behavior can either be compliant and short lived or can be enduringly influenced by others if (1) the person identifies with the others, or (2) the behavior is congruent with the person's values. In this theory, the focus of identification is with other people, and once a person has identified with others the person will be inclined to engage in all the behaviors exhibited or endorsed by those others. In contrast, in SDT, the focus of internalization is on values and behavioral regulations and on the degree to which they have been fully integrated with one's self. Thus, SDT would speak not so much of identifying with another but rather of identifying with values and behaviors that are endorsed by another. There is another important difference. Whereas Kelman's approach suggests that identifying with another person would lead people to

persistently engage in behaviors that are performed or endorsed by that other, we maintain that, were people to identify with another, the persisting behaviors that result could either be relatively controlled or relatively autonomous. In other words, although an identification or perceived connection with another could prompt a person's behavior, the behavioral regulation could be either (1) controlled (i.e., performed so the person would receive real or imagined approval from that other) or (2) autonomous (i.e., performed based on the individual's understanding and acceptance of the personal importance of the behavior for himself or herself). Thus, behavior that is said to be regulated by identification in Kelman's use of that term could correspond to regulation that results from either introjection or identification using SDT's definitions of the terms. It is worth noting that the concept of identification is central to a recent theory of work motivation presented by Ellemers, de Gilder, and Haslam (2004). These authors focused on identification with groups, suggesting that individuals' strong identification with a group facilitates their motivation in accord with the group's goals and in turn facilitates the group's performance. As with Kelman's (1958) concept of identifying with an individual, the Ellemers et al. conceptualization of identifying with a group does not address whether the group identification is autonomous or controlled (Ryan & Deci, 2002). As such, it is not able to make the differentiated predictions about performance and wellbeing that are central to SDT.

3.5 Summary

It is well established that use of salient extrinsic rewards to motivate work behavior can be deleterious to intrinsic motivation and can thus have negative consequences for psychological adjustment, performance on interesting and personally important activities, and citizenship behavior. However, research also clarifies ways in which tangible rewards can be used so as not to be detrimental to intrinsic motivation. Furthermore, self-determination theory has detailed the processes through which extrinsic motivation can become autonomous, and research suggests that intrinsic motivation (based in interest) and autonomous extrinsic motivation (based in importance) are both related to performance, satisfaction, trust, and well-being in the workplace. When the interaction of intrinsic and extrinsic motivation was first identified, cognitive evaluation theory provided an explanation for the phenomenon. However, many organizational psychologists and management theorists found the theory of limited use with respect to promoting performance and satisfaction in work organizations. Self-determination theory, which incorporates CET but is more comprehensive, particularly with respect to extrinsic motivation, provides a fuller and more useful approach to understanding the motivational bases for effective organizational behavior. Because much of the support for SDT has come from laboratory experiments and field studies in domains other than work organizations, we outlined a research agenda that will be important for supporting the use of SDT as a theory of work motivation.

Chapter 4

Methodology

Chapter 4
Methodology

4.1 Study design

This is a descriptive cross-sectional study, which will try to answer the study questions about assessing effect of stress on work motivation among hospital nurses in the Gaza strip.

4.2 Study population

The study population consists of all hospital nurses working in the Ministry of Health hospitals in Gaza Strip (1296 nurse) (MOH, 2004). Data collected from 10 governmental hospitals in Gaza strip (El-shifa Hospital, Naser Hospital, Al-Naser Paediatric Hospital, Al-Naser Ophthalmic Hospital, Al-Naser Psychiatric Hospital, Moh'd El-Dorah Paediatric Hospital, Gaza European Hospital, Abo Yousef El-najjar Hospital, Shohda'a EL- Aqsa Hospital, and Kamal Odwan Hospital).

All registered nurses (B.S nurses, Staff nurses, and practical nurses) working in these ten hospitals are included in this study from different nursing departments (ICU, CCU, ER, OPD, Medical and surgical wards, OR, Obstetric and Gynaecology departments, Neonatal intensive care units, Renal units and Oncology units) of the ten hospitals.

4.3 Period of the study

The study conducted by piloting a sample of hospital's nurses after receiving approval letter from the General Director of MOH hospitals Dr.Fasal Abu Shahla on 24th of October 2005. Reviewing of literature was a continuous process until the end of the study.

4.4 Sample size

After making statistical calculations using the epidemiological package (EPI-INFO) on sample size determination based on:

- Population size: 1296 Hospital nurses.

- Expected Frequency 10%.

-Worst acceptance value 5%.

-Confidence Level 95%.

- The calculated Sample size was (125) hospital nurses from the above target population.

4.5 Sampling process

In a systematic random sample, hospital nurses selected through manually prepared list from each hospital after comparing the actual number with list of nurses who work in each hospital. According to EPI-INFo Calculations (125 nurses) were chosen out of total population (1296 nurses) from the ten hospitals in order to achieve a representative sample.

4.6 Method of the study

This is a cross-sectional study, in which we used quantitative methods of data collection using questionnaires asking participants about:

1- **Socio-demographic variables** : Age, gender, social status, family size, salary in (NIS), academic qualifications, work place, years of experience, Job title, Working years in present job, and work department.

2- **The Stress Scale Questionnaire- based on Gray-Toft & Anderson scale (1981**) Translated to match the subject's language modified to match our culture, and judged by many experts in Methodology. SSQ (Stress Scale Questionnaire) includes expected stressful situations that may occur at Hospital environment and the subjects are asked to express their degree of effect on a lickert scale from (0-

4): {(0)=not stressful,(1)= mild stressful,(2)= moderate stressful, (3)=extremely stressful,&(4)= very extremely stressful}.

Note: the main sub-scales in (SSQ) were :(Managerial stressors, Nurse interpersonal relations stressors, Patient and Family stressors, Knowledge and skill stressors, and work environment stressors).

(Gray-Toft P& Anderson JG, 1983)

3- **The Work Values Scale:** By: Dr. Itimad Allam from Ein Shamas University & Dr. Ahmed Zaied from Cairo University, 1st Edition (1992).

The Work values scale gives the nurses statements regarding work values at work and they had to choose among the following answers (I agree, I am not sure, I don't agree)

Note: that main sub-scales of work values scale were:(pride in work, Merge in work, Work preference, Economical value of work, Social value of work, Strive for promotion, Motivation for achievement, and belonging to work) .(**Alam & Zaied , 1992)**

4.7 Ethical considerations and procedures

An official letter obtained from Helsinki committee in Ministry of Health to allow the researcher to carry out the study.

An official letters obtained from General Director of Ministry of Health and other directors of hospitals to facilitate data collection procedures. Each candidate read an informed letter about the study purpose and objectives added to each questionnaire. The names were anonymous and confidential.

4.8 Pilot study

The pilot sample of 21 hospital nurses conducted to examine clarity validity and suitability of the questions included in stress scale questionnaire before starting data

collection and to find the weakness areas in the questionnaire component. After the pilot study some questions were modified and some were totally removed. The pilot subjects were excluded from the study sample

4.9 Data collection

Many nurses' colleagues were trained by the researcher and volunteered to assist the researcher in data collection from all ten hospitals. The procedure of data collection was done after having consent from each nurse then participants were asked to answer the demographic and socio-economic questions first. After that instructions made clear in order to have accurate and full understanding about how to fill the degree of effect to each question without bias. The number of questionnaires distributed was 150 questionnaires; the collected questionnaires were 125 questionnaires with response rate of 100 % of the total sample.

4.10 Statistical analysis

4.10.1 The data entry:

The researcher entered the data after a continuous help and support from experts and statisticians using the SPSS (Statistical Package of social sciences). The data of about 125 questionnaires were entered for analysis.

4.10.2 Data analysis:

The researcher analyzed the data with the help and support of many experts and statisticians. They advised to use T-test and F-Test for analyzing the significant relations between stress and motivation.

4.10.3 Validity of the instrument:

The validity of the instrument means that the instrument measures what supposed to measure and what it is designed for.

4.10.4 Content Validity:

Content validity was conducted mainly to the Stress Scale Questionnaire which was translated to Arabic before the data collection. Many experts judged the questionnaire and according to their advises and modifications to add to the clarity and simplicity of understanding. About 10 questionnaires were sent to different experts and researchers and according to their valuable notes and comments some questions were modified and some were totally removed.

4.10.5 Reliability:

The reliability of the stress scale questionnaire which was translated to Arabic was estimated by using Chronback's Alpha and it was = 0.92.

4.11 Inclusion and exclusion criteria

4.11.1 Inclusion criteria

1. The sample included all hospital nurses actively working at hospitals at the time of the study.

4.11.2 Exclusion criteria

We excluded hospital nurses who were on leave at the time of the study.

4.12 Limitations of the study

1- This study don't include nurses from primary health care clinics in Gaza Strip.

2-There are no adequate studies relating the two variables of the study occupational stress and work motivation among nurses.

3-Nurses who were not interested in the study didn't complete answering the questions ,so the researcher canceled many uncompleted questionnaire which affected negatively the response rate.

4-The study don't include nurses from private and military hospitals.

Chapter 5

Results

Chapter 5
Results

In this chapter the researcher will try to introduce the results of the study; first, the occupational stress and Work Values (the motivators) dimensions using descriptive statistics such as frequencies, percentages, means, and standard deviation. Second, the researcher will present the socio-demographic variables showing whether Occupational Stress Differs with regard to age, sex, social status, family size, income, years of study in nursing, years of experience, job title, years of working in present job, and work department. Finally the researcher will show the correlation between Occupational Stress Dimensions and Work motivation dimensions using T-test and F-Test for analyzing the significant relations.

5.1 Characteristics of the study population

Figure 1: Distribution of the Sample regarding to Place of Work.

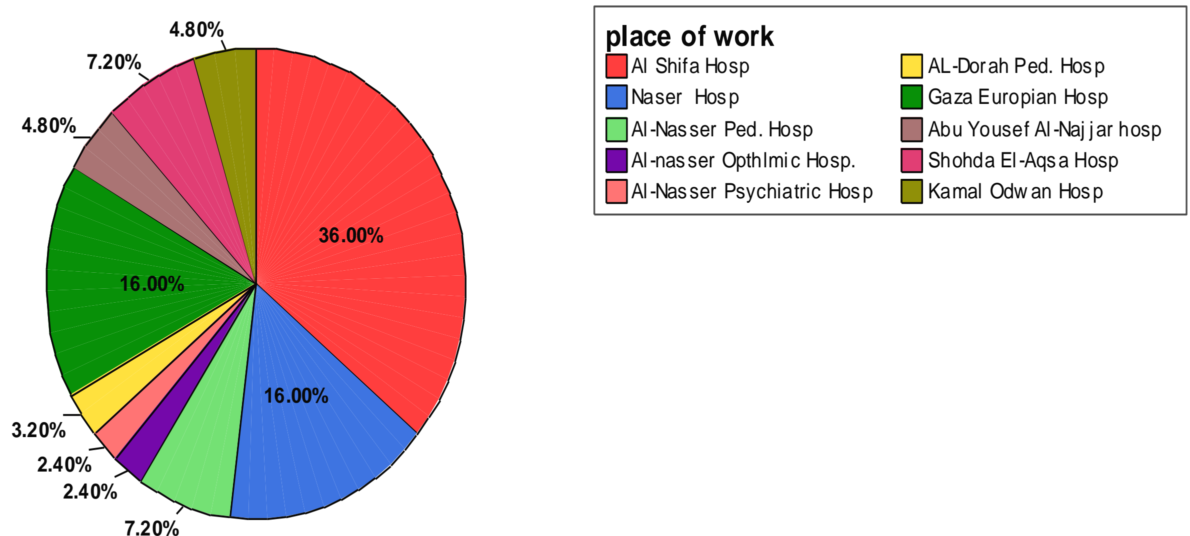

Figure 2: Distribution of the sample regarding to sex.

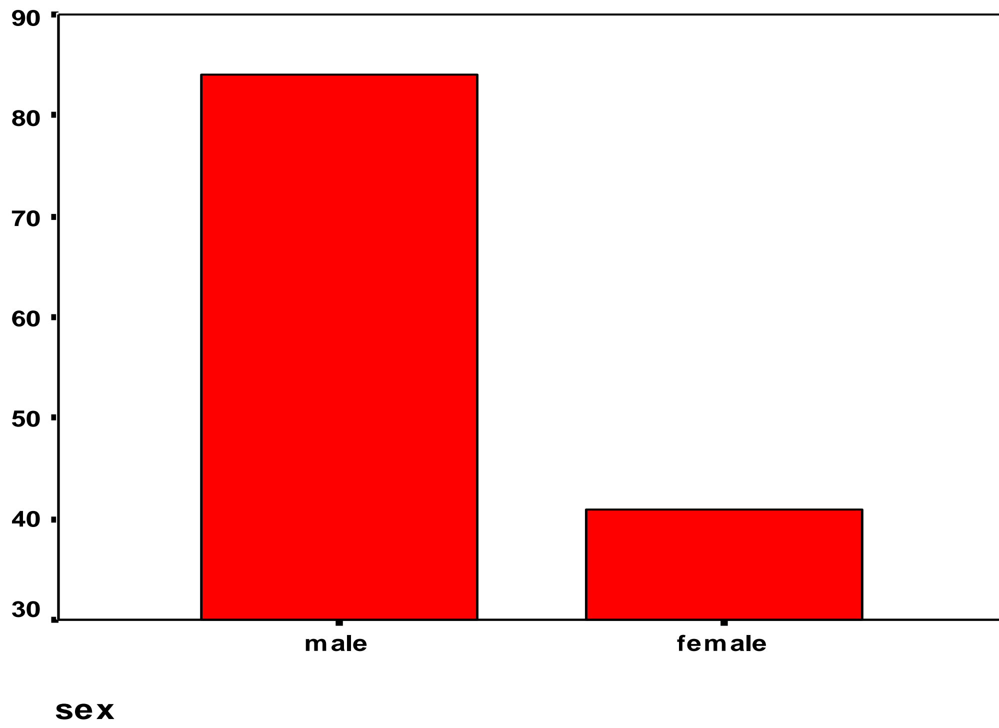

Figure 3: Distribution of the sample regarding to marital status.

5.2 Occupational stress Dimensions

Table 5.1: Occupational stress Dimensions

Dimension of Occupational Stress	No. of Items	Min.	Max	Mean	Standard Deviation	Relative weight (%)	%Order
Management	18	0	72	52.25	10.59	72.57	2nd
Nurse Personal Relation	14	0	56	32.49	7.84	58.02	5th
Patient &Family	15	0	60	36.06	8.75	60.10	4th
Knowledge &skills	19	0	76	48.62	10.40	63.97	3rd
Work Environment	5	0	20	15.26	4.15	76.3	1st
Sum.	71	0	284	184.68	33.66	65.03	

Table (5.1) shows that:

First, the work environment stressor takes the first order of the occupational stressor dimensions with percentage of (76.3%). Second, the managerial stressor takes the 2nd order with percentage of (72.57%). Third, the knowledge and skills stressor takes the 3rd order of the occupational stressor dimensions with percentage of (63.97%). Fourth, the patient and family stressor takes the 4th order of the occupational stressor dimensions with percentage of (60.1%). Finally, nurse personal relations stressor takes the 5th and the last order of the occupational stressor dimensions with percentage of (58.02%).

Table 5.2: Managerial Dimension

Management Related Stressors	Mean	Standard Deviation	Percentage%	%Order
Q3	2.27	1.27	4.34	18th
Q13	2.96	1.15	5.67	10th
Q21	2.35	1.36	4.50	17th
Q27	2.57	1.07	4.92	15th
Q31	2.98	1.08	5.70	9th
Q35	3.42	.89	6.55	2nd
Q36	2.46	1.05	4.71	16th
Q42	2.80	1.09	5.36	12th
Q43	3.15	.94	6.03	3rd
Q50	2.70	1.19	5.17	14th
Q51	2.77	1.20	5.30	13th
Q55	3.04	.90	5.82	6th
Q56	3.14	1.03	6.01	4th
Q58	3.02	1.13	5.78	7th
Q61	2.86	1.20	5.47	11th
Q64	3.64	3.74	6.97	1st
Q65	3.10	1.03	5.93	5th
Q67	3.00	1.09	5.74	8th
Sum.	52.25	10.59	100%	

Table (5.2) shows that the highest items are:

First, the 1st order is for item (64) which is "there are no enough nurses to cover the ward" with percentage of (6.97%). Second, the 2nd order is for the item (35) which is "there is no support from nursing administration" with percentage of (6.55%).

Third, the 3rd order is for the item (43) which is" Being responsible for things beyond your control" with percentage of (6.03%).

Finally, the last order goes to item (3) which is (Having differences with your direct supervisor) with percentage of (4.34%).

Table 5.3: Nurse Personal Relations Dimension

Nurse Personal Relations Stressors	Mean	Standard Deviation	Percentage%	% Order
Q5	2.68	1.20	8.25	3rd
Q6	2.13	1.14	6.56	11th
Q8	1.94	1.15	5.97	12th
Q10	2.15	1.16	6.62	10th
Q18	2.26	1.30	6.96	9th
Q19	1.69	1.12	5.20	13th
Q40	1.49	1.34	4.59	14th
Q45	2.47	1.46	7.60	5th
Q46	2.42	1.47	7.45	6th
Q47	2.77	1.33	8.53	2nd
Q54	3.18	.95	9.79	1st
Q57	2.34	1.17	7.20	7th
Q62	2.30	1.07	7.08	8th
Q63	2.66	1.10	8.19	4th
Sum.	32.49	7.84	100%	

Table (5.3) shows that the highest items are:

First, the first order is for item (54) which is "Working with lazy and dependant nurse" with percentage of (9.79%). Second, the 2nd order is for the item (47) which is" Experiencing discrimination based on the political position" with percentage of (8.53%).Third, the 3rd order is for the item (5) which is "Talking with a dying Patient" with percentage of (8.25%).Finally , the last order goes to the item (40) which is "Difficulty working with nurses from the opposite sex" with percentage of (4. 59%).

Table 5.4: Patient & Family Dimension

Patient & Family Stressors	Mean	Standard Deviation	Percentage%	%Order
Q4	2.96	1.04	8.21	3rd
Q7	2.78	1.16	7.71	6th
Q16	2.18	1.22	6.05	11th
Q26	3.27	.95	9.07	1st
Q28	2.31	1.29	6.41	9th
Q29	2.44	1.41	6.77	8th
Q30	2.85	1.08	7.90	5th
Q34	2.89	.96	8.01	4th
Q38	2.22	1.15	6.16	10th
Q39	1.93	1.12	5.35	12th
Q44	1.55	1.37	4.30	13th
Q48	1.50	1.18	4.16	14th
Q49	2.70	1.27	7.49	7th
Q60	3.05	1.02	8.46	2nd
Q70	1.45	1.32	4.02	15th
Sum.	36.06	8.75	100%	

Table (5.4) shows that the highest items are:

First, the 1st order is for the item (26) "death of young or a child patient" with percentage of (9.07%). Second, the 2nd order is for the item (60) which is "Experiencing discrimination between your profession and Doctor's profession" with percentage of (8.46%). Third, the 3rd order is for the item (4) which is "The patient having an emergency situation threatens his life" with percentage of (8.21%). Finally, the last order goes to the item (70) which is "feeling weakness because of lack of authority to your family" with percentage of (4.02%).

Table 5.5: Knowledge & Skill Dimension

Knowledge & Skill Dimension	Mean	Standard Deviation	Percentage%	% Order
Q1	1.93	1.10	3.97	19th
Q2	2.42	1.25	4.98	12th
Q9	2.31	1.26	4.75	15th
Q11	3.18	1.10	6.54	2nd
Q12	2.14	1.11	4.40	17th
Q15	2.40	1.06	4.94	13th
Q17	2.48	1.10	5.10	11th
Q20	2.87	1.11	5.90	4th
Q22	3.30	.94	6.79	1st
Q23	2.31	1.07	4.75	15th
Q24	2.50	1.01	5.14	10th
Q25	2.59	1.09	5.33	7th
Q32	2.14	1.29	4.40	17th
Q37	2.61	1.07	5.37	6th
Q59	2.83	.96	5.82	5th
Q66	3.17	1.03	6.52	3rd
Q68	2.51	1.08	5.16	9th
Q69	2.59	1.16	5.33	7th
Q71	2.34	1.25	4.81	14th
Sum.	48.62	10.40	100%	

Table (5.5) shows that the highest items are:

First, the 1st order is for item (22) which is "Lateness or absence of doctors during emergency sitautions" with percentage of (6.79%). Second, the 2nd order is for the item (11) which is "Doctors not being present when patient dies" with percentage of (6.54%). Third, the 3rd order is for the item (66) which is" not enough appreciation to your academic level "with percentage of (6.52%) . Finally, the last order goes to item (1) which is "Performing nursing procedures that patients feel as painful" with percentage of (3.97%).

Table 5.6: Work Environment Dimension

Work Environment Stressors	Mean	Standard Deviation	Percentage%	% order
Q14	3.03	1.00	19.86	3rd
Q33	3.14	1.04	20.58	1st
Q41	3.00	2.85	19.66	5th
Q52	3.02	.92	19.79	4th
Q53	3.06	.94	20.05	2nd
Sum.	15.26	4.15	100%	

Table (5.6) shows that the highest items are:

First, the 1st order is for item (33) which is "Being exposed to risk at work environment" with percentage of (20.58%). Second, the 2nd order is for the item (53) which is "Uncontrolled visiting hours" with percentage of (20.05%). Third, the 3rd order is for the item (14) which is" Lack of enough medical equipment while performing nursing tasks "with percentage of (19.86%). Fourth, the 4th order is for the item (52) which is "Quality of work setting regarding to hygiene and medical equipments" with percentage of (19.79%). Finally, the last order goes to item (41) which is “Forced to take decisions under pressure “with percentage of (19.66%).

5.3 Work Values Dimensions

Table 5.7: Work Values Dimensions

Work Motivations Dimensions	No. of Items	Min.	Max.	Mean	Standard Deviations	Relative Weight (%)	%Order
Pride in Work	9	0	27	14.42	2.20	53.41	7th
Merge to work	9	0	27	14.82	2.32	54.89	4th
Work Preference	9	0	27	12.90	2.47	47.78	8th
Economical Value of Work	9	0	27	15.86	2.34	58.74	3rd
Social Value of Work	9	0	27	14.69	2.08	54.40	5th
Strive for Promotion	9	0	27	17.06	2.57	63.19	1st
Motivation for Achievement	9	0	27	16.08	2.38	59.56	2nd
Belonging to work	9	0	27	14.56	1.97	53.93	6th
Sum.	72	0	216	120.39	9.85	55.74	

Table (5.7) shows that:

First, strive for promotion motivator takes the first order of the motivational values dimensions with percentage of (63.197%). Second, motivation for achievement dimension takes the 2nd order of the motivational values dimensions with percentage of (59.56%). Third, economical value of work motivator takes the 3rd order of the motivational values dimensions with percentage of (58.74%).

Finally, work preference motivator takes the last order of the motivational values dimensions with percentage of (47.78%).

Table 5.8: Pride in Work Dimension

Pride in Work	Mean	Standard Deviation	Percentage%	% order
M1	1.03	.22	7.14	9th
M9	1.27	.57	8.81	8th
M17	2.25	.85	15.60	2nd
M25	1.47	.72	10.19	5th
M33	1.99	.79	13.80	3rd
M41	1.99	.80	13.80	3rd
M49	1.28	.59	8.88	7th
M57	1.35	.62	9.36	6th
M65	2.26	.87	15.67	1st
Sum.	14.42	2.20	100%	

Table (5.8) shows that the highest items are:

First, the 1st order is for item (65) which is "Talking so much about my work with my friends beyond working hours" with percentage of (15.67%). Second, the 2nd order is for the item (17) which is "It's not necessarily for the person to be happy in life, he would be happy at work" with percentage of (15.60%). Third, the 3rd order is for the item (33) which is" Jobs that have special offices is more important than those sales jobs even though they have the same salaries" with percentage of (13.80%). Finally, the last order goes to item (1) which is "Good individual seeks for many means to improve what he is doing" with percentage of (7.14%).

Table 5.9: Merge to Work Dimension

Merge in Work	Mean	Standard Deviation	Percentage%	%Order
M2	1.07	.34	7.22	9th
M10	1.51	1.15	10.19	5th
M18	2.53	.68	17.07	1st
M26	1.35	.61	9.11	8th
M34	1.53	.75	10.32	4th
M42	1.84	.85	12.42	3rd
M50	2.13	.80	14.37	2nd
M58	1.49	.77	10.05	6th
M66	1.37	.68	9.24	7th
Sum.	14.82	2.32	100%	

Table (5.9) shows that the highest items are:

First, the 1st order is for item (18) which is "Interests of the Individual has to focus on the work he is doing regardless the rest of other activities in the institution he is working in" with percentage of (17.07%). Second, the 2nd order is for the item (50) which is "Individual may feel tired due to leaving for certain period of time; however, he may be more happy when his job needs hard working" with percentage of (14.37%). Third, the 3rd order is for the item (42) which is" It's necessary for the person to choose the job with highest income "with percentage of (12.42%). Finally, the last order goes to item (2) which is "each individual has to do his work out of love not out of fear or obligation" with percentage of (7.22%).

Table 5.10: Work Preference Dimension

work Preference	Mean	Standard Deviation	Percentage%	%Order
M3	1.09	.31	8.45	8th
M11	1.11	.41	8.60	7th
M19	1.26	.60	9.77	6th
M27	1.63	1.29	12.64	3rd
M35	1.33	.67	10.31	5th
M43	1.46	.69	11.32	4th
M51	2.11	.81	16.36	1st
M59	1.86	.85	14.42	2nd
M67	1.05	.21	8.14	9th
Sum.	12.90	2.47	100%	

Table (5.10) shows that the highest items are:

First, the 1st order is for item (51) which is "when the individual doesn't have a chance for promotion in the organization that he works in, He mostly makes mistakes in what he is doing" with percentage of (16.36%). Second, the 2nd order is for the item (59) which is "It's enough for the individual to have a satisfied work, and then he wouldn't leave that work even if he would have a promotion in another work" with percentage of (14.42%). Third, the 3rd order is for the item (27) which is" One of the causes for willing to work is to have the respect of my family" with percentage of (12.64%). Finally, the last order goes to item (67) which is "Each individual has to strive to improve his position in work" with percentage of (8.14%).

Table 5.11: Economical Value of the Work

Economical Value of the Work	Mean	Standard Deviation	Percentage%	% Order
M7	1.78	.79	11.22	4th
M15	1.68	.80	10.59	5th
M23	1.59	.76	10.03	6th
M31	1.38	.67	8.70	7th
M39	2.62	.74	16.52	1st
M47	1.24	.51	7.82	8th
M55	2.22	.71	14.00	3rd
M63	2.26	.80	14.25	2nd
M71	1.09	.31	6.87	9th
Sum.	15.86	2.34	100%	

Table (5.11) shows that the highest items are:

First, the 1st order is for item (39) which is "I feel no shame that the individual decreases his efforts at work if he has a plan to leave the work" with percentage of (16.52%). Second, the 2nd order is for the item (63) which is "I merge into work to a degree that I don't try to improve my position in it" with percentage of (14.25%). Third, the 3rd order is for the item (55) which is" Jobs with high salaries guarantee limited opportunities to promotion" with percentage of (14.00%). Finally, the last order goes to item (71) which is "Work helps the individual to gain more friends and be more wanted" with percentage of (6.87%).

Table 5.12: Social Value of the Work

Social Value of the work	Mean	Standard Deviation	Percentage%	% Order
M8	**1.14**	**.41**	**7.76**	**8th**
M16	**1.53**	**.69**	**10.42**	**5th**
M24	**1.99**	**.87**	**13.55**	**3rd**
M32	**1.32**	**.64**	**8.99**	**6th**
M40	**2.53**	**.74**	**17.22**	**1st**
M48	**1.29**	**.59**	**8.78**	**7th**
M56	**1.78**	**.82**	**12.12**	**4th**
M64	**2.02**	**.88**	**13.75**	**2nd**
M72	**1.09**	**.31**	**7.42**	**9th**
Sum.	**14.69**	**2.08**	**100%**	

Table (5.12) shows that the highest items are:

First, the 1st order is for item (40) which is "If it would be possible for the individual to leave his current job, he will try to decrease the effort expected by his superiors" with percentage of (17.22%). Second, the 2nd order is for the item (64) which is "I prefer to work in organizations that have fast promotions and better rises even though the nature of work is difficult and risky " with percentage of (13.75%). Third, the 3rd order is for the item (24) which is" I perform my work to a degree that sometimes makes me not to have time to speak with my friends or answer their personal questions" with percentage of (13.55%). Finally, the last order goes to item (72) which is " The individual has to feel proud with the work he is doing" with percentage of (7.42%).

Table 5.13: Strive for promotion Dimension

Strive for Promotion	Mean	Standard Deviation	Percentage%	%Order
Q4	1.30	.57	7.61	9th
Q12	1.48	.70	8.67	8th
Q20	1.50	.74	8.78	7th
Q28	1.98	.89	11.59	4th
Q36	2.45	.76	14.34	1st
Q44	1.91	.86	11.18	6th
Q52	1.98	.92	11.59	4th
Q60	2.06	.78	12.06	3rd
Q68	2.41	.81	14.11	2nd
Sum.	17.08	2.57	100%	

Table (5.13) shows that the highest items are:

First, the 1st order is for item (36) which is "The work that takes all the scheduled hours better than that work that have breaks in between" with percentage of (14.34%). Second, the 2nd order is for the item (68) which is "The individual has to accept the work with higher salary regardless his degree of acceptance or satisfaction to that work" with percentage of (14.11%). Third, the 3rd order is for the item (60) which is" The high quality work is the highest income" with percentage of (12.06%). Finally, the last order goes to item (4) which is "When the individual has a good idea to improve what he is doing, he has to reveal to the responsible persons in the organization" with percentage of (7.61%).

Table 5.14: Motivation for Achievement

Motivation for Achievement	Mean	Standard Deviation	Percentage%	%Order
Q6	1.17	.49	7.28	8th
Q14	1.99	.87	12.38	3rd
Q22	1.11	.36	6.90	9th
Q30	1.81	.88	11.26	4th
Q38	1.66	.67	10.32	7th
Q46	1.74	.71	10.82	6th
Q54	2.66	.65	16.54	1st
Q62	1.79	.82	11.13	5th
Q70	2.15	.85	13.37	2nd
Sum.	16.08	2.38	100%	

Table (5.14) shows that the highest items are:

First, the 1st order is for item (54) which is "I find difficulty to enjoy my vacation because I prefer to stay at work" with percentage of (16.54%).

Second, the 2nd order is for the item (70) which is "when a mistake made at work, it's for accuracy purposes that the person lets others to inform the responsible persons about that mistake" with percentage of (13.37%).

Third, the 3rd order is for the item (14) which is" I enjoy my work more than enjoying my free time" with percentage of (12.38%). Finally, the last order goes to item (22) which is "The individual has to comply with all the regulations in the organization that control that work" with percentage of (6.90%).

Table 5.15: Belonging to Work Dimension

Belonging to Work Dimension	Mean	Standard Deviation	Percentage%	% Order
Q5	2.44	.76	16.76	1st
Q13	1.73	.71	11.88	4th
Q21	2.27	.83	15.59	2nd
Q29	1.62	.78	11.13	5th
Q37	1.18	.46	8.10	8th
Q45	1.22	.54	8.38	6th
Q53	1.06	.23	7.28	9th
Q61	1.20	.52	8.24	7th
Q69	1.84	.88	12.64	3rd
Sum.	14.56	1.97	100%	

Table (5.15) shows that the highest items are:

First, the 1st order is for item (5) which is "I feel happy when I spend long hours at my work" with percentage of (16.76%). Second, the 2nd order is for the item (21) which is "I focus all my effort towards the work and I forget all commitments towards others while doing it" with percentage of (15.59%). Third, the 3rd order is for the item (69) which is" The individual has to prefer between two jobs and choose the higher income "with percentage of (12.64%). Finally, the last order goes to item (53) which is "one of the most important things at work is to love that work" with percentage of (7.28%).

5.4 Socio-demographic data

Table 5.16: One way ANOVA to occupational stress versus age

Dimension		Sum of Squares	df	Mean Squares	F	Sig.
Management	Between Groups	1035.364	4	258.841	2.415	.053
	Within Group	12861.948	120	107.183		
	Total	13897.312	124			
Nurse Personal Relations	Between Groups	226.651	4	56.663	.918	.456
	Within Group	7404.581	120	61.705		
	Total	7631.232	124			
Patient & Family	Between Groups	206.933	4	51.733	.668	.615
	Within Group	9286.555	120	77.388		
	Total	9493.488	124			
Knowledge & Skills	Between Groups	342.288	4	85.572	.785	.537
	Within Group	13073.040	120	108.942		
	Total	13415.328	124			
Work Environment	Between Groups	126.360	4	31.590	1.884	.118
	Within Group	2011.928	120	16.766		
	Total	2138.288	124			
Sum	Between Groups	3532.106	4	883.026	.774	.544
	Within Group	136976.73	120	1141.473		
	Total	140508.83	124			

***p<0.05** ****p<0.01** *****p<0.001**

Table (5.16) shows that all values of calculated **(F)** of the dimensions of the occupational stressors are less than tabulated **(F)** values which equal **(2.45)** at **(P<= .05)**, this indicates that that there are NO significant Statistical differences in the dimensions of occupational stressors regarding to **AGE**. So, the hypothesis of the study should be rejected.

Table 5.17: One way ANOVA to occupational stress versus sex

Dimension	Sex	N	Mean	Standard Deviation	Calculated T	Sig.
Management	Male	84	50.96	10.20	-1.94	.054
	Female	41	54.83	9.37		
Nurse Personal Relations	Male	84	32.19	8.20	-.605	.546
	Female	41	33.10	7.13		
Patient & Family	Male	84	35.42	9.56	-1.186	.238
	Female	41	37.39	6.70		
Knowledge & Skills	Male	84	47.93	10.31	-1.071	.286
	Female	41	50.05	10.57		
Work Environment	Male	84	15.04	4.67	-.879	.381
	Female	41	15.73	2.81		
Sum	Male	84	181.55	35.39	-1.500	.136
	Female	41	191.12	29.18		

***p<0.05** ****p<0.01** *****p<0.001**

Table (5.17) shows that all calculated **(**T**)** values are less than tabulated (T) values which equals **(**1.96) in all the dimensions of occupational stressors at (P<=.05)& Degree of Freedom(df**.**) 123. This indicates that there are no significant statistical differences in the dimensions of occupational stressors regarding to **sex**. So, the hypothesis of the study should be rejected.

Table 5.18: One way ANOVA to occupational stress versus social status

Dimension		Sum of Squares	df	Mean Squares	F	Sig.
Management	Between Groups	175.735	2	87.868	.781	.460
	Within Group	13721.577	122	112.472		
	Total	13897.312	124			
Nurse Personal Relations	Between Groups	77.208	2	38.604	.623	.538
	Within Group	7554.024	122	61.918		
	Total	7631.232	124			
Patient & Family	Between Groups	33.776	2	16.888	.218	.805
	Within Group	9459.712	122	77.539		
	Total	9493.488	124			
Knowledge & Skills	Between Groups	219.537	2	109.768	1.015	.365
	Within Group	13195.791	122	108.162		
	Total	13415.328	124			
Work Environment	Between Groups	31.103	2	15.551	.900	.409
	Within Group	2107.185	122	17.272		
	Total	2138.288	124			
Sum	Between Groups	1310.041	2	655.021	.574	.565
	Within Group	139198.79	122	1140.974		
	Total	140508.83	124			

***p<0.05 **p<0.01 ***p<0.001**

Table (5.18) shows that all values of calculated (F) of the dimensions of the occupational stressors are less than tabulated (F) values which equal (2.45) at (P<= .05), this indicates that that there are NO significant Statistical differences in the dimensions of occupational stressors regarding to social status**.** So, the hypothesis of the study should be rejected.

Table 5.19: One way ANOVA to occupational stress versus family size

Dimension		Sum of Squares	df	Mean Squares	F	Sig.
Management	Between Groups	1436.423	3	478.808	4.649	.004*
	Within Group	12460.889	121	102.983		
	Total	13897.312	124			
Nurse Personal Relations	Between Groups	76.069	3	25.356	.406	.749
	Within Group	7555.163	121	62.439		
	Total	7631.232	124			
Patient & Family	Between Groups	106.116	3	35.372	.456	.714
	Within Group	9387.372	121	77.582		
	Total	9493.488	124			
Knowledge & Skills	Between Groups	201.830	3	67.277	.616	.606
	Within Group	13213.498	121	109.202		
	Total	13415.328	124			
Work Environment	Between Groups	91.834	3	30.611	1.810	.149
	Within Group	2046.454	121	16.913		
	Total	2138.288	124			
Sum	Between Groups	3469.167	3	1156.389	1.021	.386
	Within Group	137039.67	121	1132.559		
	Total	140508.83	124			

***p<0.05** ****p<0.01** *****p<0.001**

Table (5.19) shows that all values of calculated (F) of the dimensions of the occupational stressors are less than tabulated (F) values except the family size vs. the managerial dimension Tabulated (F) value equals (2.45) at (P<= .05), this indicates that that there are no significant Statistical differences in the dimensions of occupational stressors regarding to Family size except the with the managerial dimension.
So, the hypothesis of the study should be rejected.

Table 5.20: One way ANOVA to occupational stress versus income

Dimension		Sum of Squares	df	Mean Squares	F	Sig.
Management	Between Groups	923.822	3	307.941	2.872	.039*
	Within Group	12937.490	121	107.219		
	Total	13897.312	124			
Nurse Personal Relations	Between Groups	80.452	3	26.817	.430	.732
	Within Group	7550.780	121	62.403		
	Total	7631.232	124			
Patient & Family	Between Groups	9.520	3	3.173	.040	.989
	Within Group	9483.968	121	78.380		
	Total	9483.488	124			
Knowledge & Skills	Between Groups	75.322	3	25.107	.228	.877
	Within Group	13340.006	121	110.248		
	Total	13415.328	124			
Work Environment	Between Groups	108.804	3	36.286	2.162	.096
	Within Group	2029.484	121	16.773		
	Total	2138.288	124			
Sum	Between Groups	2365.809	3	788.603	.691	.559
	Within Group	138143.02	121	1141.678		
	Total	140508.83	124			

$*p<0.05$ $**p<0.01$ $***p<0.001$

Table (5.20) shows that all values of calculated (F) of the dimensions of the occupational stressors are less than tabulated (F) values which equal (2.45) at (P<= .05) except with the managerial dimension , this indicates that that there are NO significant Statistical differences in the dimensions of occupational stressors regarding to Income except on managerial dimension**.** So, the hypothesis of the study should be rejected

Table 5.21: One way ANOVA to occupational stress versus years of Study in nursing:

Dimension		Sum of Squares	df	Mean Squares	F	Sig.
Management	Between Groups	62.568	3	20856	.182	.908
	Within Group	13834.744	121	114.337		
	Total	13897.312	124			
Nurse Personal Relations	Between Groups	407.022	3	135.674	2.272	.084
	Within Group	7224.210	121	59.704		
	Total	7631.232	124			
Patient & Family	Between Groups	148.904	3	49.635	.643	.589
	Within Group	9344.584	121	77.228		
	Total	9493.488	124			
Knowledge & Skills	Between Groups	398.402	3	132.801	1.234	.300
	Within Group	13016.926	121	107.578		
	Total	13415.328	124			
Work Environment	Between Groups	48.467	3	16.156	.935	.426
	Within Group	2089.821	121	17.271		
	Total	2138.288	124			
Sum	Between Groups	2882.439	3	960.813	.845	.472
	Within Group	137626.39	121	1137.408		
	Total	140508.83	124			

***p<0.05 **p<0.01 ***p<0.001**

Table (21) shows that all values of calculated (F) of the dimensions of the occupational stressors are less than tabulated (F) values which equal (2.45) at (P<= .05) , this indicates that that there are no significant Statistical differences in the dimensions of occupational stressors regarding to Years of studies in nursing **.** So, the hypothesis of the study should be rejected.

Table 5.22: One way ANOVA to occupational stress versus years of experience

Dimension		Sum of Squares	df	Mean Squares	F	Sig.
Management	Between Groups	450.164	2	225.082	2.042	.134
	Within Group	13447.148	122	110.223		
	Total	13897.312	124			
Nurse Personal Relations	Between Groups	22.006	2	11.003	.176	.838
	Within Group	7609.226	122	62.371		
	Total	7631.232	124			
Patient & Family	Between Groups	16.072	2	8.036	.103	.902
	Within Group	9477.416	122	77.684		
	Total	9492.488	124			
Knowledge & Skills	Between Groups	68.312	2	34.156	.312	.732
	Within Group	13347.016	122	109.402		
	Total	13415.328	124			
Work Environment	Between Groups	130.012	2	65.006	3.949	.022*
	Within Group	2008.276	122	16.461		
	Total	2138.288	124			
Sum	Between Groups	1180.572	2	590.286	.517	.598
	Within Group	139328.26	122	1142.035		
	Total	140508.83	124			

***p<0.05 **p<0.01 ***p<0.001**

Table (5.22) shows that all values of calculated (F) of the dimensions of the occupational stressors are less than tabulated (F) values which equal (2.45) at (P<= .05). this indicates that there are no significant Statistical differences in the dimensions of occupational stressors regarding to Years of experience except with work Environment stressor**.** So, the hypothesis of the study should be rejected.

Table 5.23: One way ANOVA to occupational stress versus job title

Dimension		Sum of Squares	df	Mean Squares	F	Sig.
Management	Between Groups	546.319	3	182.106	1.650	.181
	Within Group	13350.993	121	110.339		
	Total	13897.312	124			
Nurse Personal Relations	Between Groups	110.363	3	36.788	.592	.622
	Within Group	7520.869	121	62.156		
	Total	7631.232	124			
Patient & Family	Between Groups	527.657	3	175.886	2.374	.074
	Within Group	8965.831	121	74.098		
	Total	9493.488	124			
Knowledge & Skills	Between Groups	344.725	3	114.908	1.064	.367
	Within Group	13070.603	121	108.022		
	Total	13415.328	124			
Work Environment	Between Groups	129.817	3	43.272	2.607	.055
	Within Group	2008.471	121	16.599		
	Total	2138.288	124			
Sum	Between Groups	6905.960	3	2301.987	2.085	.106
	Within Group	133602.87	121	1104.156		
	Total	140508.83	124			

***p<0.05 **p<0.01 ***p<0.001**

Table (5.23) shows that all values of calculated (F) of the dimensions of the occupational stressors are less than tabulated (F) values which equal (2.45) at (P<= .05), this indicates that that there are no significant Statistical differences in the dimensions of occupational stressors regarding to job title**.** So, the hypothesis of the study should be rejected.

Table 5.24: One way ANOVA to occupational stress versus working years in present job

Dimension		Sum of Squares	df	Mean Squares	F	Sig.
Management	Between Groups	7.669	2	3.834	.034	.967
	Within Group	13889.643	122	113.850		
	Total	13897.312	124			
Nurse Personal Relations	Between Groups	72.868	2	36.434	.588	.557
	Within Group	7558.364	122	61.954		
	Total	7631.232	124			
Patient & Family	Between Groups	363.720	2	131.360	1.736	.181
	Within Group	9230.768	122	75.662		
	Total	9493.488	124			
Knowledge & Skills	Between Groups	157.384	2	78.692	.724	.487
	Within Group	13257.944	122	108.672		
	Total	13415.328	124			
Work Environment	Between Groups	54.137	2	27.068	1.585	.209
	Within Group	2084.151	122	17.083		
	Total	2138.288	124			
Sum	Between Groups	743.621	2	371.810	.325	.723
	Within Group	139765.21	122	1145.616		
	Total	140508.83	124			

***p<0.05 **p<0.01 ***p<0.001**

Table (5.24) shows that all values of calculated (F) of the dimensions of the occupational stressors are less than tabulated (F) values which equal (2.45) at (P<= .05), this indicates that that there are no significant Statistical differences in the dimensions of occupational stressors regarding to working years in present job **.** So, the hypothesis of the study should be rejected.

Table 5.25: One way ANOVA to occupational stress versus work department

Dimension		Sum of Squares	df	Mean Squares	F	Sig.
Management	Between Groups	674.793	6	112.465	1.004	.426
	Within Group	13222.519	118	112.055		
	Total	13897.312	124			
Nurse Personal Relations	Between Groups	440.453	6	73.409	1.205	.309
	Within Group	7190.779	118	60.939		
	Total	7631.232	124			
Patient & Family	Between Groups	577.507	6	96.254	1.274	.275
	Within Group	8915.961	118	75.559		
	Total	9493.488	124			
Knowledge & Skills	Between Groups	1121.955	6	186.992	1.795	.106
	Within Group	12293.373	118	104.181		
	Total	13415.328	124			
Work Environment	Between Groups	59.618	6	9.936	.564	.758
	Within Group	2078.670	118	17.616		
	Total	2138.288	124			
Sum	Between Groups	10493.472	6	1748.912	1.587	.157
	Within Group	130015.36	118	1101.825		
	Total	140508.83	124			

***p<0.05 **p<0.01 ***p<0.001**

Table (5.25) shows that all values of calculated (F) of the dimensions of the occupational stressors are less than tabulated (F) values which equal (2.45) at (P<= .05), this indicates that that there are no significant Statistical differences in the dimensions of occupational stressors regarding to work department **.**So, the hypothesis of the study should be rejected.

5.5 Occupational stress dimensions vs. work value dimensions

Table 5. 26: This table shows the correlation between Occupational Stress Dimensions and Work motivations dimensions:

Dimension	Management	Nurse Personal Relations	Patient Family	Knowledge &Skill	Work Environment	HSUM
Type of Correlation	Pearson Correlation	Pearson Correlation	Pearson Correlat ion	Pearson Correlatio n	Pearson Correlation	Pearson Correlati on
Pride in Work	.029*	.164	.166	.140	.062	.141
Merge to work	-.059	.024	-.097	.187*	-.005	.019
Work Preference	-.258**	-.167	-.141	-.083	-.164	-.203*
Economical Value of Work	.096	-.043	.003	.027	.074	.039
Social Value of Work	.021	-.100	.044	.076	.040	.023
Strive for Promotion	.022	-.073	-.038	.078	.093	.016
Motivation for Achieveme nt	-.039	−.080	−.010	−.037	.097	−.033
Belonging to work	-.221*	.319**	−.049	.026	-.100	-.161
SSUM	-.039	−.133	--.033	.094	.025	−.037

***p<0.05 **p<0.01 ***p<0.001**

Table (5.26) showed that there is a significant negative relationship between managerial stressors and work preference motivator. It also showed that there is negative significant relationship between managerial stressor and belonging to work motivator. Besides, there is positive significant relationship between nurse interpersonal relations and belonging to work motivator. In addition there is a positive significant relationship between knowledge and skills stressors and merge in work motivator. Moreover, there is a negative significant relationship between all dimensions of stressors and work preference motivator. Finally the table doesn't show any significant relationship between all dimensions of stressors and all work motivators.

Chapter 6

Implications and Recommendations

Chapter 6

Implications and Recommendations

This chapter will include the discussion of the results and recommendations of this study. Moreover, the hypotheses of study will be checked in order to know whether to accept or reject the alternative hypotheses.

6.0 The Main Results

6.1 Occupational Stressors Results

The first hypothesis of the study was:

H1: There are various kinds of occupational stressors among hospital's nurses in the Gaza strip.

This hypothesis was strongly supported by the study as the study showed that the most common stressor that faces the hospital nurses in the GS is according to the results of the study was the work environment stressor with percentage of (76.3%). The second stressful dimension was the managerial stressor with percentage of (72.57%). The third stressful dimension was the knowledge and skills Stressor with percentage of (63.97%). The fourth stressful stressor was the patient and family stressor with percentage of (60.1%). The last order was for the nurse personal relations stressor with percentage of (58.02%) (Table1). When we want to have a closer look to the questions of the managerial domain which had the second stressful dimension table (5.2) we notice that the question number 64 which was "there are no enough nurses to cover the ward" with percentage of (6.97%). This means that shortage in nursing is one of the most stressful issues that concern the nurses in GS hospitals in general. Thomas (1997) reports that work stress in nursing has been exacerbated of late by such factors as: Increasing workload, understaffing, job insecurity and continuous organisational change, an opinion shared by Buchan (1998). Second, the 2nd order is for the item (35) which is "there is no

support from nursing administration" with percentage of (6.55%).This is consistent with the findings of (Dahi A., 2003) that showed that there is a significant relationship between lack of nursing administration support and occupational stress. Third, the 3rd order is for the item (43) which is" Being responsible for things beyond your control" with percentage of (6.03%).This finding is supported by the study of (Dahi A., 2003) which showed that nurses are usually stressful when they are accountable for things beyond their control which will affect negatively their quality of nursing care given to their patients. This is consistent with the studies of (Baldwin, 1999, McGowan, 2001, Cross & Fallon, 1985, Taylor et al, 1999, and McGowan, 2001) findings. Actually, the nurse is responsible for things that are not mentioned in their job descriptions that they should do in the absence of doctors or other health personnel. Finally, the last order goes to item (3) which is (Having differences with your direct supervisor) with percentage of (4.34%). In fact, intra-professional and inter-professional conflicts are common in work settings especially in nursing. Nurses whom are exposed to extraordinary stressful situations during difficult hours offering a challenging bed side nursing care. This may leave a destructive negative impact regarding their ability to give as well to their patients. The study also showed that regarding to nurse interpersonal relations dimension, which had the last rank of the occupational stressors dimensions with percentage of (58.02). The first order is for item (54) which is "Working with lazy and dependant nurse" with percentage of (9.79%). I think, this is common in nursing to have a dependant lazy nurse which adds an extra work load that should be covered by an active motivated nurse that will leave those active nurses vulnerable to occupational stress, lack of concentration, and high possibility of doing mistakes. That’s why nursing managers and supervisors have to understand all these consequences and deal with it at once without delay to avoid fatal mistakes. This is supported by Olsen, 1977 and

Sawatzky, 1996) who found that working with apathetic incompetent nurse is considered as one of the highest stressors in clinical area. This result and opinion is supported by (Trofino J. 2003) who said in his study that today's challenge is that to call for collegial relationships among nurses in all levels. The 2nd order is for the item (47) which is" Experiencing discrimination based on the political position" with percentage of (8.53%). Our Palestinian society is identified as a political society because of Israeli occupation that makes each us to support a political party believing in its views and programs. Unfortunately, these differences in opinions affect in away or another interpersonal relations among health professions especially nurses and doctors. Ideally, that's shouldn't be the case, as they are the first line of treatment in clinical area and on their shoulders lie a heavy and crucial responsibilities since they are dealing with human beings who are in a bad need for their skills and experience. Therefore, they have to put aside their differences in political opinions and feel neutral dealing with other care providers and work as a team for the benefit of the patient who deserves a high quality of health care. The 3rd order is for the item (5) which is "Talking with a dying Patient" with percentage of (8.25%). Dealing with a dying patient is a very stressful part of the job of nurses as they have to use the skills, the knowledge and even the faith in God to let these moments to pass easily and peacefully protecting the dignity of their patients. This is consistent with the study done by Taylor (1999), and Mac rowan (2001) which reveals that death is a major problem for all nurses and causes moderate to extreme stress. Harris (1989) assures these findings and adds that this sad result which is death of the patient perceived by nurses and other caregivers as a failure to achieve positive results. Finally, the last order goes to the item (40) which is "Difficulty working with nurses from the opposite sex" with percentage of (4. 59%). Some nurses are affected negatively working with the opposite sex nurses since we are a conservative religious society considering cross

relations with opposite sex is illegal in work settings. That's why we have separate wards for females and males and female nurses working with female patients and male nurses working with male patients except in life threatening situations or when you are obligated to work where there is severe shortage in nurses and you have to work with opposite sex nurse especially in open wards in front of the public not in closed ones. Table (5.4) shows that first, the 1st order is for the item (26) "death of young or a child patient" with percentage of (9.07%). Dying is a sad and stressful event for all of us but health care providers are dealing with morbidity and mortality more frequent than others that makes them more vulnerable to occupational stress. Second, the 2nd order is for the item (60) which is "Experiencing discrimination between your profession and Doctor's profession" with percentage of (8.46%). Nurses and doctors professions are parallel to each other as they are dealing with the same human being who is suffering and eager to their skills and knowledge together working in an integration strategy and team spirit for the sake of their patients. This closed and parallel relationship between nurses and doctors sometimes grantees conflict in certain point about the proper and professional way of dealing with their patients. Therefore, this conflict leaves a negative impact on the quality of nursing care given to the patients. In addition to that nurses feel devaluated when people in our Palestinian society practice discrimination between the role of both professions despite the fact that we all know that nurses spend more time and effort to please and provide continuous bed side nursing care to their patients than doctors do but thanks always go first to the doctors then to nurses if there is any in a clear and unfair discrimination. (Hillhouse JJ. & Adler CM. (1997) found in their study that intra-professional conflict (i.e. conflict with other nurses) is less psychologically damaging than is the inter-professional conflict (i.e. conflict with doctors). Third, the 3rd order is for the item (4) which is "The patient having an emergency situation threatens his life" with percentage of

(8.21%).Nurses feel challenged when the patient has an emergency situation, but this challenge causes stress and sometimes this stress affects negatively their proper response to this emergency situation in a case of panic response that will affect their professional dealing with the situation. Finally, the last order goes to the item (70) which is "feeling weakness because of lack of authority to your family" with percentage of (4.02%). In fact, our society is a cumulative society and not an individualistic society. This mentality of dealing with things affects the feeling of being weak because you don't have a big family size for protection purposes. This is shouldn't be the case in my opinion but unfortunately we do have this way thinking as a cumulative society. Table (5.5) shows that, the 1st order is for item (22) which is "Lateness or absence of doctors during emergency situations" with percentage of (6.79%). Sometimes this happens, but not always, but when it happens, this leaves nurses with very stressful and challenging situation that they have to do something in the absence of the doctor to prevent disastrous consequences against the rules and regulations of the hospital. These rules and regulations don't permit most of the time the nurses to give any medication without doctor's order despite the fact that they know according to their long years of experience what is the proper medication that should be given, but most of the time they don't give any for fear of accountability if any thing wrong happens to the patient because they don't have legal coverage for their action and many patient may die because of that reason. Cross & Fallon, 1995 Milazzo, 1988 and Olsen, 1977) found that nurses may carry multiple conflicting roles at the same time and this finding supported by (McGrath et al, 1989) who concluded that nurses role is complex, and this obligates nurses sometimes to take decisions under pressure in emergency situations which may be subjected to mistakes. Second, the 2nd order is for the item (11) which is "Doctors not being present when patient dies" with percentage of (6.54%). This also may happen but

not always, but when it happens also it would be very stressful and challenging event as nurses have to manage the situation alone without the help and assistance of the assigned doctor. The nurse may be worried about the patient's family aggressive reaction especially when the death of the patient is unexpected (Dahi, A. 2003). Third, the 3rd order is for the item (66) which is" not enough appreciation to your academic level "with percentage of (6.52%). From personal observation as a nurse working in this field for so many years I can say that most nurses nowadays are seeking for more academic degrees than before. This new situation needs some time for others especially other health professionals to adapt with this new phenomena that so many nurses have BS, MA, or even PHD in nursing. As a matter of fact, having high qualifications doesn't mean that you have to ask for more appreciation to your profession and yourself but, others sooner or later they will have to confess the high academic standard of nowadays nurses than before. We as nurses understand that and sometimes nurses feel stressful when facing signs of lower appreciation from those dealing with them than other health professions. Finally, the last order goes to item (1) which is "Performing nursing procedures that patients feel as painful" with percentage of (3.97%). While doing their nursing tasks and procedures to the patient, sometimes patients consider as painful procedures especially invasive painful procedures (such as catheterization, NG-tube, IVs Insertions…etc.). This will add to their original stressful that they have already due to the nature of their job. Table (5.6) shows that First; the 1st order is for item (33) which is "Being exposed to risk at work environment" with percentage of (20.58%). The work environment that should be safe for both the patient and those caregivers who are in direct contact with the patient especially nurses who relatively spend more time than other health professions. Actually, the employers should make this work environment safe for all those in clinical area. Second, the 2nd order is for the item (53) which is "Uncontrolled visiting hours" with

percentage of (20.05%). Another problem that face nurses in general and Gaza hospitals in particular is uncontrolled visiting hours and all the bad consequences that may happen which leave it's negative impact on the nurses which will affect their quality of nursing care given to their patients. Third, the 3rd order is for the item (14) which is" Lack of enough medical equipment while performing nursing tasks "with percentage of (19.86%). Lack of enough medical equipment is also a stressful in clinical area or at work environment as this will double the negative affect on the quality of nursing care because nurses will feel stressful and don't give as well and from not having the proper equipments needed for giving proper nursing care. Fourth, the 4th order is for the item (52) which is "Quality of work setting regarding to hygiene and medical equipments" with percentage of (19.79%). Actually, this subject is so stressful especially nowadays as we have so many infectious diseases. Most nurses in the sample conceder this subject is so important because this related directly to their safety and well-being as well as the safety of patient udder their responsibility to prevent nosocomial infections. Finally, the last order goes to item (41) which is "Forced to take decisions under pressure" with percentage of (19.66%). Sometimes nurses are given responsibilities beyond their control and they should take decisions under pressure which will increase the possibility of making mistakes and making mistakes is very costly and disastrous and should be avoided.

6.2 Work values (work motivators) Results

While discussing these results, the second hypothesis will be checked which is:

H2: There are several factors that motivate hospital nurses to work to their full potential.

In this part of discussing the results we are going to show the results achieved concerning the work values or work motivators after discussing the occupational stressors in the first part of this chapter**.** First, "strive for promotion" takes the first order of the motivational values dimensions with percentage of (63.19%). Most nurses in Gaza hospitals according to the results of the study appreciate the strive to promotion as the highest motivator among all other motivators in the study. I think this is because nurses who work in direct contact with the patients strive always to be in managerial positions rather than being at bed side nursing care besides the economical and social benefits while moving to upper positions. Second, motivation for achievement dimension takes the 2nd order of the motivational values dimensions with percentage of (59.56%). As a matter of fact, nurses will feel more secured, like all other professions, when they achieve more, they will please both their superiors and their clients that's why they will put an end to the feeling of threat and being fired by more achievements and being always motivated and work to their full potential. Third, "economical value of work dimension" takes the 3rd order of the motivational values dimensions with percentage of (58.74%). Indeed, the economical value of the work is essential not only for hospital nurses in Gaza but also to all head families who have a challenging responsibilities regarding the crucial requirements of their families such as food, shelter, clothes, education and many other responsibilities. All this makes nurses motivated to do their work because they have an unsatisfied need to be fulfilled according to maslow's hierarchy of needs. Finally, work preference dimension takes the last order of the motivational values dimensions with percentage of

(47.78%).The work preference value comes at last according to the results obtained from hospital nurses sample and this related to the high percentage of unemployment in the Gaza strip which leaves not so many alternatives for nurses. This will make the result logical and consistent with the current situation that we have been living since the beginning of blessed Intifada. Table (5.8) shows the "pride at work dimension" and the 1st order is for item (65) which is "Talking so much about my work with my friends beyond working hours" with percentage of (15.67%). It seems that talking about your work with friends beyond working hours is an indicator of how much a person is proud in what he is doing. Second, the 2nd order is for the item (17) which is "It's not necessarily for the person to be happy in life, he would be happy at work" with percentage of (15.60%). I think it is not necessary for those who are happy in life to be happy at work because, in my opinion, daily life requirements are completely different than practical life requirements. Third, the 3rd order is for the item (33) which is" Jobs that have special offices is more important than those sales jobs even though they have the same salaries" with percentage of (13.80%). Actually, most managerial positions in nursing have special offices and I think this the main reason that makes hospital nurses to think that it would more important. Finally, the last order goes to item (1) which is "Good individual seeks for many means to improve what he is doing" with percentage of (7.14%). Nurses in Gaza hospitals, according to the results of the study, don’t have time to seek for improvement to their work because actually they are always under work overload and they don’t have time for creative extra work since they hardly can do the minimum of their tasks. Table (5.9) shows the value of merge at work and the 1st order is for item (18) which is "Interests of the Individual has to focus on the work he is doing regardless the rest of other activities in the institution he is working in" with percentage of (17.07%). Nurses have a need and a goal for going to work that make them merged completely in

what they are doing without giving any interest for other activities which may prevent or delay the achievement of that goa**l.** Second, the 2nd order is for the item (50) which is "Individual may feel tired due to leaving for certain period of time; however, he may be more happy when his job needs hard working" with percentage of (14.37%). I think that nurses in Gaza hospitals consider that any leave even for a short period of time is a threat to their practical life and being unproductive. Third, the 3rd order is for the item (42) which is" It's necessary for the person to choose the job with highest income "with percentage of (12.42%). I think this logical and consistent with difficult times and high rates of unemployment in GS. Finally, the last order goes to item (2) which is "each individual has to do his work out of love and not out of fear or obligation" with percentage of (7.22%). As I mentioned before, we as Palestinians don't have too many alternatives as even you don't like the job you are working with, you still have to work to fulfill the daily and important needs to your family. Table (5.10) shows the work preference dimension in which the 1st order is for item (51) which is "when the individual doesn't have a chance for promotion in the organization that he works in, he mostly makes mistakes in what he is doing" with percentage of (16.36%). I think that is related to the feeling of unfairness and inequity as nurses think that they deserve a promotion and this makes them vulnerable to do mistakes at work and affect their quality of nursing care. Second, the 2nd order is for the item (59) which is "It's enough for the individual to have a satisfied work, and then he wouldn't leave that work even if he would have a promotion in another work" with percentage of (14.42%). This is related to fear from change which is considered as a threat to nurses in Gaza hospitals,; therefore they prefer to be in their current job and don't try to make radical changes in their life. Third, the 3rd order is for the item (27) which is" One of the causes for willing to work is to have the respect of my family" with percentage of (12.64%).Work is important to every individual

and to us as Palestinians is even more important because of the uniqueness of our political, economical, and social circumstances. Therefore work to us is a social importance as you can make a good living relatively if you have a job. Finally, the last order goes to item (67) which is "Each individual has to strive to improve his position at work" with percentage of (8.14%). I think this normal to strive for improving your position at work and this is the nature of individuals not only Gaza hospital nurses but also all working individuals. Actually, what makes it crucial for nurses are that they want managerial positions in order to avoid direct contact with the patients.

Table (5.11) shows the economical value of the work dimension which reveals that the 1st order is for item (39) which is "I feel no shame that the individual decreases his efforts at work if he has a plan to leave the work" with percentage of (16.52%). I think if this is the case in Gaza hospital nurses, responsible persons have to watch carefully those nurses who intended to leave for high possibility of making mistakes as a result of decreasing their efforts in purpose. Second, the 2nd order is for the item (63) which is "I merge into work to a degree that I don’t try to improve my position in it" with percentage of (14.25%). In fact, if nurses are satisfied and merged in their work to a degree they don’t try to improve their positions; I think you have to start to get worried, since the nature of employees is to seek for promotion but if this stopped, you have to check your nurses for burnout (chronic stress). Third, the 3rd order is for the item (55) which is" Jobs with high salaries guarantee limited opportunities to promotion" with percentage of (14.00%). This is logical as jobs with high salaries are normally characterized with high managerial positions that make the possibility of promotion is limited. Finally, the last order goes to item (71) which is "Work helps the individual to gain more friends and be more wanted" with percentage of (6.87%). Again, this is consistent with the normal thinking. Those who are working have relatively high rate of meeting and recognizing more people each

working day than those who are at home without a job. Therefore, they are more susceptible of making friends and being socially wanted. Table (5.12) shows the social value of the work dimension that reveals the 1st order is for item (40) which is "If it would be possible for the individual to leave his current job, he will try to decrease the effort expected by his superiors" with percentage of (17.22%). This again immoral thing to do or even to think of since nursing is a humanitarian job and nurses are working under oath as they are not allowed to decrease their effort just because they are intended to leave. Second, the 2nd order is for the item (64) which is "I prefer to work at organizations that have fast promotions and better rises even though the nature of work is difficult and risky " with percentage of (13.75%). As we have reached to the conclusion out of this study that nurses have the right to seek for promotion and improve their quality of life through organizations with fast promotions and better raises despite the risky nature of the job. Third, the 3rd order is for the item (24) which is" I perform my work to a degree that sometimes makes me not to have time to speak with my friends or answer their personal questions" with percentage of (13.55%). This a high value that should be appreciated as this is the purpose of your existence in the organization is to work and do the tasks needed from you and leave social talks and issues at your break time. Finally, the last order goes to item (72) which is "The individual has to feel proud with the work he is doing" with percentage of (7.42%). Unfortunately, the social classification of nursing profession is low. I think this the main reason that just 7.42% of the sample answered that they are proud of what they are doing. Table (5.13) shows the" strive for promotion dimension". The 1st order is for item (36) which is "The work that takes all the scheduled hours better than that work that have breaks in
between" with percentage of (14.34%).

Nurses are professionals and they always pull to professionalize things and show their skills and they tend to use their time efficiently because timing is crucial regarding nursing tasks that should be done on time without delay. Second, the 2nd order is for the item (68) which is "The individual has to accept the work with higher salary regardless his degree of acceptance or satisfaction to that work" with percentage of (14.11%). Again the financial issue goes to the surface and become more important. I think this is because the high rates of unemployment in GS which make nurses value the financial aspect of work. Third, the 3rd order is for the item (60) which is" The high quality work is the highest income" with percentage of (12.06%). Theoretically this is may be correct, but actually nursing administrations today give great importance to two things first to decrease running costs and increase the benefits. Of course high quality nursing care is needed but with the lowest price possible. Finally, the last order goes to item (4) which is "When the individual has a good idea to improve what he is doing, he has to reveal to the responsible persons in the organization" with percentage of (7.61%). Nurses should share their superiors with any good idea that may come to their minds in order to share in improving work, but if they don't, we have to look for reasons why they are not doing so and investigate the problem and try to overcome it. Table (5.14) shows the "motivation for achievement" value. The 1st order is for item (54) which is "I find difficulty to enjoy my vacation because I prefer to stay at work" with percentage of (16.54%). Indeed, if nurses feel that they prefer being at work than being on vacation or at home that's may be due to difficult circumstances in GS that there is no so many places to have good vacation or may be due to high sense of belonging to that work which is nursing. Second, the 2nd order is for the item (70) which is "when a mistake made at work, it's for accuracy purposes that the person lets others to inform the responsible persons about that mistake" with percentage of (13.37%). If a mistake took place, nurses should have the courage to

do incident report and confess their mistake to avoid further disastrous consequences. So, they should do it themselves instead of letting others to tell about their own mistakes. Third, the 3rd order is for the item (14) which is" I enjoy my work more than enjoying my free time" with percentage of (12.38%). This is again may be due to high belonging to work or there is nothing to do in your social life that would be enjoyable. Finally, the last order goes to item (22) which is "The individual has to comply with all the regulations in the organization that control that work" with percentage of (6.90%).Of course, this is rule number one in all professions especially in nursing because nurses are dealing with human beings and they should comply fully with all rules and regulations to their organization. Table (5.15) shows the "belonging to work dimension". The 1st order is for the item (5) which is "I feel happy when I spend long hours at my work" with percentage of (16.76%). This is fully consistent to the logical explanation of belonging to work as the nurse feels happy when spending long hours at work. Second order is for the item (21) which is "I focus all my effort towards the work and I forget all commitments towards others while doing it" with percentage of (15.59%). In fact, this is also the real meaning of belonging when you concentrate in your job and forget all of the commitments towards others. Third order is for the item (69) which is" The individual has to prefer between two jobs and choose the higher income "with percentage of (12.64%). Actually, this is against the value of belonging since the cause of choosing the work is for financial reasons only. Finally, the last order goes to item (53) which is "one of the most important things at work is to love that works" with percentage of (7.28%). As a matter of fact, most nurses in Gaza don’t choose nursing because they love nursing, but most of them join nursing because they want to have a job regardless they love it or not.

6.3 The effect of demographic variables on occupational stress dimensions

H3: **There are several factors that de-motivate hospital's nurses to work effectively.**

Table (5.16) shows that all values of calculated (F) of the dimensions of the occupational stressors are less than tabulated (F) values which equal (2.45) at (P<= .05), this indicates that that there are no significant Statistical differences in the dimensions of occupational stressors regarding to age. So, the hypothesis of the study should be rejected. It seems that most nurses regardless their age are affected to an extent that the results couldn’t differentiate between age groups of nurses as they are all under the same stressful and demanding situations.

Table (5.17) shows that all calculated (T) values are less than tabulated (T) values which equals (1.96) in all the dimensions of occupational stressors at (P<=.05) & Degree of Freedom (df.) 123. This indicates that there are no significant statistical differences in the dimensions of occupational stressors regarding to sex. So, the hypothesis of the study should be rejected. Both male and female nurses are under the same stressful and demanding environment to a degree that there are no significant differences between them.

Table (5.18) shows that all values of calculated (F) of the dimensions of the occupational stressors are less than tabulated (F) values which equal (2.45) at (P<= .05), this indicates that that there are NO significant Statistical differences in the dimensions of occupational stressors regarding to social status. So, the hypothesis of the study should be rejected. I think that’s because most of the subjects in the sample are married which makes them almost as one homogenous group living in the same circumstances.

Table (5.19) shows that all values of calculated (F) of the dimensions of the occupational stressors are less than tabulated (F) values EXCEPT the family size vs. the managerial dimension Tabulated (F) value equals (2.45) at (P<= .05), this indicates that that there are

NO significant Statistical differences in the dimensions of occupational stressors regarding to Family size except with the managerial dimension. So, the hypothesis of the study should be rejected. Nurses with larger family size are more affected by managerial stressors than smaller family size. I think this related to the fact that those nurses with larger family size have more responsibilities to their dependants which adds more to their original stress already exists. Table (5.20) shows that all values of calculated (F) of the dimensions of the occupational stressors are less than tabulated (F) values which equal (2.45) at (P<= .05) except with the managerial dimension , this indicates that that there are NO significant Statistical differences in the dimensions of occupational stressors regarding to Income except on managerial dimension. So, the hypothesis of the study should be rejected. The managerial stressors and the hospital nurses income in GS have significant relationship because what concerns nurses most is the income which is subjected to continuous managerial cuts and violations. Table (5.21) shows that all values of calculated (F) of the dimensions of the occupational stressors are less than tabulated (F) values which equal (2.45)at(P<= .05) ,this indicates that that there are NO significant Statistical differences in the dimensions of occupational stressors regarding to Years of study in nursing. So, the hypothesis of the study should be rejected. Whatever the years of study are, nurses are under occupational stress so the majority of nurses are affected regardless their years of study in nursing . Table (5.22) shows that all values of calculated **(F)** of the dimensions of the occupational stressors are less than tabulated **(F)** values which equal (2.45) at (P<= .05), this indicates that that there are NO significant Statistical differences in the dimensions of occupational stressors regarding to Years of experience except with the work environment. So, the hypothesis of the study should be rejected. In fact, it’s normal to have significant statistical differences between years of experience and work environment as newly graduated nurses have normally higher occupational

stress than nurses with experience. This is consistent with the study done by Olsen (1977) in this regard. Table (5.23) shows that all values of calculated **(F)** of the dimensions of the occupational stressors are less than tabulated **(F)** values which equal (2.45) at (P<= .05), this indicates that that there are NO significant Statistical differences in the dimensions of occupational stressors regarding to job title**.** So, the hypothesis of the study should be rejected. Most nurses regardless to their job title have almost the same amount of stress to a degree you don't have significant statistical differences between all dimensions of occupational stress and job title.

Table (5.24) shows that all values of calculated **(F)** of the dimensions of the occupational stressors are less than tabulated **(F)** values which equal (2.45) at (P<= .05), this indicates that that there are NO significant Statistical differences in the dimensions of occupational stressors regarding to working years in present job**.** So, the hypothesis of the study should be rejected. Working in the same post for several years makes the biggest challenge for nursing administrators is like having a sword of two edges that whether to have highly motivated and productive nurses or to have a burned out nurses who are distressed and de-motivated. Table (5.25) shows that all values of calculated (F) of the dimensions of the occupational stressors are less than tabulated (F) values which equal **(**2.45) at (P<= .05), this indicates that that there are NO significant Statistical differences in the dimensions of occupational stressors regarding to work department So, the hypothesis of the study should be rejected.

6.4 The relationship between all occupational stress dimensions and all work values or motivators:

H4: **there is a significant relationship between level of occupational stress and work motivation among hospital's nurses in the Gaza strip.**

Table (26) showed that there is a significant negative relationship between managerial stressors and work preference motivator. It also showed that there is negative significant relationship between managerial stressor and belonging to work motivator. In fact, it's logical to have such relationship because the more the managerial stressors are the less the feeling of belonging to your organization. Besides, there is positive significant relationship between nurse interpersonal relations and belonging to work motivator. Also this is another logical finding that the more you have normal and strong interpersonal relationship, the more you have the feeling of belonging to your organization. In addition there is a positive significant relationship between knowledge and skills stressors and merge in work motivator. As long as you have the knowledge and the skill needed to perform your job effectively, the more you are merged to your work. Moreover, there is a negative significant relationship between all dimensions of stressors and work preference motivator. The work preference is a high value as persons prefer to work and be productive but having too many stressors at work will counteract that value and people think to vote by feet (quit) and leave the organization as a result of these stressors. Finally the table doesn't show any statistical significant relationship between all dimensions of occupational stressors and all dimensions of work values (motivators). In my opinion, the study couldn't find any statistical significant relationship between all occupational stressors and work values (motivators) is related to the nature of our profession as humanitarian job. Nurses dealing with human being not with machines

that’s why their ethics and values have always to be there regardless the amount of occupational stressors being put heavily on them.

6.5 Recommendations

1-To avoid role conflict between nurses themselves and between other health professions, clear and detailed job descriptions should be made in all health organizations especially hospitals.

2-It’s the responsibility of policy makers and nurse’s administrations to solve the problem of under staffing to decrease work load and occupational stress.

3-The nurse’s administrations have to highly value their team by sharing them in meeting concerning the problems they are facing at work in regular bases and listen carefully to their suggestions.

4-In order to equip nurses with up to date knowledge and skills, health organizations in Gaza have to establish an in-service education committee to arrange weekly lectures and practices for nurses.

5-The work environment should be safe to both nurses and their patients.

6-Improve the interpersonal relations by making parties and journeys; this will improve the spirit of a team work and the level of effective communications among nurses.

7-The nurses’ administrations should focus on work values at work to motivate their team especially the neglected value in literature which is the religious value of work which I think if it is used effectively, it would be of a great benefit for both the patient and the

organization. Faithful persons regardless their religion they will sacrifice themselves in true intentions to please not only their patients but also their lord.

8-Provide training opportunities for nurses in Gaza hospitals. Changes in an organization are predictable, particularly in the context of budgetary constraints and greater accountability in the use of resources. However, staff should be trained with knowledge and skills to meet the new challenges. Nowadays, nurses are given greater responsibility for the management of wards, department and hospital level. This implies that nurses, particularly those at the managerial level should be provided with more support in order to work efficiently and competently. Training on nursing leadership, interpersonal skills, financial and resources management skills should be conducted to equip ward managers with adequate knowledge and skills to cope with their demanding managerial role.

9-To prepare clinical nurses to take up the changing and expanding roles and responsibilities demanded by patient-centered care, training should emphasize providing for the emotional needs of patients and their families, and management as well as care delivery skills. Courses on psychosocial care of specific patient groups and on communication skills should be included in the nursing curriculum.

10- Organize stress management programs for nurses. The substantial number of nurses with occupational stress suggests then need for developing stress management strategies. A number of intervention models for stress management have been developed in the West, but stress management programs for nurses in Gaza are lacking. Since it has been documented that a cognitive-behavioral group approach to stress management is effective for other target groups this approach may be tried with nurses in Gaza Strip. Programs to assist nurses to examine and strengthen their positive cognitive coping skills may decrease occupational stress. Another way is to help nurses engage in positive

experiences in problem-solving. Assisting nurses to learn problem-solving skills can also increase positive coping and improve mental health outcomes**.**

6.6 Suggested further studies

1- The effect of religious values on work motivations among hospital nurses.

2-Safe Work settings and motivations among hospital nurses.

3-Effective measures to reduce occupational stress among hospital nurses.

4-Burnout syndrome (chronic occupational stress) and hospital nurses.

5-Mnagerial styles and work motivations among hospital nurses.

6- The effect of occupational stress on work motivation among primary health nurse.

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Appendices

Appendix(1)

بسم الله الرحمن الرحيم

Palestinian National Authority **Ministry of Health** **Helsinki Committee**		السلطة الوطنية الفلسطينية وزارة الصحة لجنة هلسنكي

Date: 6/3/2005	التاريخ: 2005/3/6
Mr./ Maher A. Wahba	السيد: ماهر عبد الكريم وهبة
I would like to inform you that the committee has discussed your application about:	نفيدكم علماً بأن اللجنة قد ناقشت مقترح دراستكم حول:-
The effect of stress on work motivation among hospital nurses in the Gaza strip.	تأثـــير الضغط النفسي على الدافعية للعمل لدى الممرضين في مستشفيات قطاع غزة.
In its meeting on march 2005 **and decided the Following:-** **To approve the above mention research study.**	و ذلك في جلستها المنعقدة لشهر مارس 2005 و قد قررت ما يلي:- الموافقة على البحث المذكور عاليه.

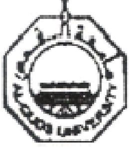
Signature
توقيع

Member	Member	Chairperson
عضو	عضو	

Conditions:-
- Valid for 2 years from the date of approval to start.
- It is necessary to notify the committee in any change in the admitted study protocol.
- The committee appreciate receiving one copy of your final research when it is completed.

Gaza Etwam – Telefax 972-7-2878166

Appendix (2)



جامعة القدس

وزارة الصحة

كليـــة الصحـــة العامـــة

School of Public Health

القدس - فلسطين

2005/10/24

الأخ/د. فيصل أبو شهلا حفظه الله

مدير عام المستشفيات

نائب مدير عام وزارة الصحة

تحية طيبة وبعد،،،

الموضوع: مساعدة الطالب ماهر وهبه

يقوم الطالب المذكور أعلاه بإجراء مشروع بحث بعنوان:

" Effect of Stress on work Motivation among Hospital Nurses in the Gaza Strip"

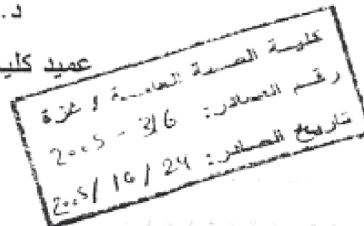
كمتطلب للحصول على درجة الماجستير في الصحة العامة-مسار الصحة النفسية المجتمعية علماً بأن الطالب قد حصل على موافقة لجنة هلسنكي لأخلاقيات البحوث و ستكون المعلومات متوفرة لدى الباحث فقط. و عليه نرجو التكرم للإيعاز لمن ترونه مناسب لتسهيل مهمة الطالب في جمع البيانات الخاصة من مستشفيات وزارة الصحة.

موافقتكم دعماً للمسيرة الأكاديمية

و تفضلوا بقبول فائق الاحترام ،،،

د. سوزان شعشاعه

عميد كلية الصحة العامة المساعد



نسخة: الملف

Appendix (3)

Arabic introduction of Questionnaire

بسم الله الرحمن الرحيم

نقدم فيما يلي استبيان يقيس أثر الضغوط التي يتعرض لها ممرضي/ممرضات مستشفيات قطاع غزة وتأثيرها على الدافعية للعمل.

عزيزي/تي الممرض/ة:

✷ هدف هذا الاستبيان هو دراسة أثر الضغوط التي يتعرض له الممرضون والممرضات في مستشفيات قطاع غزة وتأثيرها علي الدافعية للعمل حيث يحتوي هذا الاستبيان على مواقف قد تحدث في مكان العمل و التي قد تؤدي إلى هذه الضغوط .

✷ هذا الاستبيان هو جزء من دراسة علمية يقوم بها الطالب ضمن متطلبات حصوله على درجة الماجستير في الصحة النفسية المجتمعية بجامعة القدس ، وكذلك سوف تستخدم نتائج هذه الدراسة لتطوير مهنة التمريض بقطاع غزة ، هذا و سوف تكون الاستجابات سرية و لأغراض البحث العلمي ، و أستطيع أن أتعهد لك بذلك.

✷ إن المشاركة في هذا الاستبيان اختيارية و ليست إجبارية.

✷ الرجاء وضع علامة ☑ التي تحدد درجة تأثير كل موقف على حدا مع العلم أنه لا حاجة لكتابة اسمك على هذا الاستبيان.

الباحث
ماهر وهبه

Appendix (4)

I) المعلومات الشخصية (Personal Information) :

الرجاء تعبئة هذه الورقة إما بنص أو بعلامة ☑ من فضلك:-

1- العـــــمــــر : [ ] سنة

2- الـجـــنـــس : ☐ ذكر ☐ أنثى

3- الحالة الاجتماعية:

☐ أعزب/ة ☐ متزوج/ة ☐ مطلق/ة

☐ منفصل/ة ☐ أرمل/ة

4- عدد أفراد الأسرة : ____________

5- الـــدخل الشـهـري : ____________

6- عدد سنوات الدراسة في التمريض :

☐ دبلوم(تمريض سنتان) ☐ دبلوم تمريض(ثلاث سنوات)

☐ بكالوريوس تمريض ☐ ماجستير تمريض

7- مـكان العمـل:

☐ مجمع الشفاء الطبي ☐ م. ناصر ☐ م. النصر

☐ م. العيون ☐ م. الطب النفسي ☐ م. الدرة

☐ م. غزة الأوربي ☐ م. أبو يوسف النجار

☐ م. شهداء الأقصى ☐ م. كمال عدوان

8- سنـوات الخبرة في التمريض : [ ] سنة

9- المسمى الوظيفي :

☐ ممرض عملي ☐ حكيم ☐ رئيس قسم

☐ مشرف تمريض ☐ إدارة تمريض ☐ أخرى

10- عدد سنوات العمل بالوظيفة الحاليـــة : [ ] سنة

11- القـســـم الـــــذي تــعمل بـــــه : ________________

Appendix (5)

II) مقياس الضغوط (Stress Scale):

اقرأ العبارات التالية وضع علامة ☑ أمام الرقم المناسب الذي يدل على درجة التأثير لكل موقف من المواقف التالية التي قد تحدث في مكان العمل والتي من الممكن أن تؤدى إلي التوتر حيث أن:

(0) = لا تأثير (1) = تأثير خفيف (2) = تأثير متوسط
(3) = تأثير شديد ، (4) = تأثير شديد جدا

الرقم	العبـــــــــــــارة	0	1	2	3	4
1	أن تقوم بمهام تمريضية للمريض يعتبرها المريض بأنها مؤلمة له.					
2	الشعور بالعجز عند تدهور حالة المريض.					
3	الاختلاف مع مشرفك المباشر.					
4	تعرض المريض لحالة طارئة تهدد حياته.					
5	الحديث مع مريض في حالة نزاع.					
6	قلة فرص الحديث بشكل صريح وواضح مع طاقم العمل.					
7	موت المريض.					
8	الخلاف مع الطبيب.					
9	الخوف من ارتكاب أخطاء أثناء العناية بالمريض.					
10	قلة الفرص لمشاركة الآخرين لمشاعرك و خبراتك.					
11	عدم وجود الأطباء أثناء موت المريض.					
12	الاختلاف بخصوص طريقة علاج المريض.					
13	الجدولة والمناوبات الغير متوقعة.					
14	عدم وجود معدات طبية كافية عند أداء المهمات التمريضية.					

(0) = لا تأثير (1) = تأثير خفيف (2) = تأثير متوسط
(3) = تأثير شديد (4) = تأثير شديد جدا

الرقم	العبـــــــــــــارة	0	1	2	3	4
15	عندما يسألك المريض سؤالاً لا تملك له إجابة شافية.					
16	اضطرارك للعمل مع حالات خاصة على سبيل المثال(المريض العصبي أو سيء المزاج).					
17	شعورك بعدم جاهزيتك للتعامل مع الحاجات الفورية للمريض.					
18	النقد من قبل مشرفك المباشر.					
19	عدم توفر الفرصة للتعبير لزملائك في القسم عن مشاعرك السلبية تجاه المريض.					
20	عندما يأمرك الطبيب بإعطاء علاجا أنت تعتقد أنه غير مناسب للمريض.					
21	. عند وجود أعمال لا تندرج تحت مهنة التمريض مثل الأعمال المكتبية وغيرها.					
22	عدم وجود أو تأخر الطبيب عند حدوث حالة طارئة تستدعي وجوده.					
23	الشعور بعدم التأهل بالتعامل مع مشاعر أهل المريض و مساعدتهم.					
24	عدم المعرفة بما يجب أن تخبر المريض وعائلته عن حالته الصحية.					
25	نقص المعرفة بما يتعلق بالمعدات الطبية الحديثة.					
26	موت مريض صغير السن(طفل /ة أو شاب/ة).					
27	عدم وجود الوقت الكافي لإكمال كل المهام التمريضية.					
28	المرضى الذين يطلبون طلبات غير معقولة.					

(0) = لا تأثير (1) = تأثير خفيف (2) = تأثير متوسط
(3) = تأثير شديد (4) = تأثير شديد جدا

م	العبـــــــــــارة	0	1	2	3	4
29	مرافقي المرضى الذين يطلبون طلبات غير معقولة					
30	إلقاء اللوم عليك لأي خطأ أو أي أمر لا يسير كما يرام					
31	عدم وجود دعم من المشرف المباشر في العمل					
32	أن أكون الشخص المكلف بالتعامل مع أهل المريض					
33	أن تكون معرضاً للأخطار في بيئة العمل					
34	مشاهدتك لمريض يتألم					
35	عدم وجود دعم من إدارة التمريض					
36	عدم وجود الوقت الكافي للدعم المعنوي الذي يجب أن تقدمه للمريض					
37	عدم المعرفة الكافية للعمل وتشغيل الأجهزة المتخصصة					
38	اضطرارك للتعامل مع المرضى المضطهدين (أحد أنواع الاضطهاد)					
39	عدم وجود الوقت الكافي للاستجابة لاحتياجات عائلات المرضى					
40	صعوبة العمل مع الممرضين من الجنس الآخر					
41	اضطرارك لأخذ قرارات تحت الضغط					
42	اضطرارك للعمل خلال فترات الراحة					
43	تحملك المسئولية لأمور خارج نطاق سيطرتك					
44	علمك بأن المريض الذي تتعامل معه له سلطة قوية في المجتمع					
45	أن يتعامل الطبيب معك من خلال انتماءه السياسي أو التنظيمي					
46	أن يتعامل الطبيب معك من خلال انتماءه العائلي					
47	استخدام التمييز على أساس الموقف السياسي					
48	خروج مريض أقمت معه علاقة صداقة وكان تحت رعايتك لفترة ما					
49	الاختلاف مع عائلات مرضى أشرار					

(0) = لا تأثير **(1) = تأثير خفيف** **(2) = تأثير متوسط**

(3) = تأثير شديد **(4) = تأثير شديد جدا**

الرقم	العبـــــــــارة	0	1	2	3	4
50	نقص الثواب المعنوى.					
51	نقص الثواب المالي.					
52	جودة مكان العمل من ناحية النظافة و التجهيزات الطبية.					
53	عدم التحكم بساعات الزيارة					
54	العمل مع ممرض كسول أو ممرض معتمد عليك.					
55	وصف وظيفي غير واضح					
56	عدم تمكنك من أخذ إجازة نتيجة لنقص الممرضين.					
57	صعوبة العمل مع ممرض محدد أو ممرضين محددين في القسم الذي تعمل به					
58	العمل في الأجازات					
59	عدم التأكد من قدرة المسئول عنك للعمل					
60	ممارسة التمييز بين مهنة التمريض ومهنة الطبيب من قِبَلْ المجتمع .					
61	شعورك بأن الإدارة تستخدم العقاب القاسي.					
62	صعوبة التواصل والاتصال بين العاملين في المستشفي.					
63	قيامك بتوتيب عمل الطبيب .					
64	عدم وجود عدد كافي من الممرضين لتغطية القسم .					
65	انتظار زميلك المتأخر لاستلام القسم بدلا منك.					

(0) = لا تأثير **(1) = تأثير خفيف** **(2) = تأثير متوسط**
(3) = تأثير شديد **(4) = تأثير شديد جدا**

الرقم	العبـــــــــــارة	0	1	2	3	4
66	عدم وجود تقدير كافي لمستواك العلمي .					
67	اضطرارك أن تعمل عملا مرهق جسديا.					
68	عندما تضطر أن تتخذ قراراً بخصوص المريض الذي تتعامل معه في حالة غياب الطبيب.					
69	عدم وجود معلومات كافية من الطبيب بخصوص خطة العلاج والوضع الطبي للمريض.					
70	شعورك بالضعف بسبب قِلة سُلطة عائلتك في المجتمع .					
71	أن تكون مسئولا رغم خبرتك غير الكافية.					

Appendix (6)

III) مقياس قيم العمل(Work values scale):

فيما يلي مجموعة من العبارات و التي تتعلق بقيم العمل أرجو منك الإجابة عليها بصراحة علماً بأن الإجابات سوف تكون سرية و لأغراض الجزء العلمي .

يوجد ثلاث خيارات للإجابة : 1) موافق. 2) غير متأكد . 3) غير موافق
الرجاء تعبئة هذه الورقة بعلامة ☑ من فضلك و أن تقرأ كل عبارة و تقرر مدى موافقتك عليها ،،،

م	العبـــــــــــارة	موافق	غير متأكد	غير موافق
1	يسعى الفرد الجيد للبحث عن وسائل عديدة لتحسين ما يقوم به من عمل .			
2	يجب على الفرد أن يؤدى عمله حبا واختيارا لا خوفا وإجبار.			
3	يجب على الفرد أن يعتمد على عمله لتحقيق ذاته أكثر من اعتماده على أسرته.			
4	عندما يتوصل الفرد لفكرة جيدة لتحسين ما يقوم به من عمل، فعلبه أن يطلع المسئولين بالمؤسسة عليها			
5	أشعر بسعادة غامرة عندما أقضى ساعات طويلة في عملي.			
6	لا يجب أن يبخل الفرد في تقديم المشورة والمعاونة للزملاء في مجال العمل.			
7	إذا ما أتيح للفرد أن يختار بين أن يشارك زملائه بالمؤسسة التي يعمل بها في رحلات ترفيهية أو أن يبقى مع أسرته فانه يفضل البقاء مع أسرته.			
8	**إن أهم شيء في العمل هو حب الفرد لعمله.**			
9	ينبغي علي الفرد أن يؤدى عمله جيدا دون انتظار تقدير أو مقابل من قبل رؤسائه			
10	لا يمنع اشتغال الفرد بعمل في أدني المستويات الوظيفية في المؤسسة أن يتقدم في اقتراحات أو أفكار بناءة قد تؤثر على السياسة العامة للمؤسسة التي يعمل بها.			
11	أشعر بعدم السعادة إذا كان أدائي لعملي ليس على الوجه الأكمل.			
12	أهم ما يحققه لي عملي هو تحقيق ذاتي.			
13	غالبا ما يواظب الفرد المهتم بعمله على حضور الاجتماعات التي تعقدها المؤسسة.			
14	أستمتع بعملي أكثر من استمتاعي بوقت الفراغ.			
15	لم يعد اسم العائلة هو الذي يكسب الفرد سمعته ومكانته داخل المجتمع.			

يوجد ثلاث خيارات للإجابة : 1) موافق. 2) غير متأكد . 3) غير موافق

الرجاء تعبئة هذه الورقة بعلامة ☑ من فضلك و أن تقرأ كل عبارة و تقرر مدى موافقتك عليها ،،،

م	العبـــــــارة	موافق	غير متأكد	غير موافق
16	إن الأمور التي تخص زملائي في العمل تهمني مثل اهتمامي بأموري الشخصية.			
17	ليس من الضروري لكي يكون الفرد سعيدا في حياته أن يكون ناجحا في عمله.			
18	يجب أن تنصب اهتمامات الفرد علي ما يقوم به من عمل فقط دون أن يهتم بباقي الأنشطة الأخرى داخل المؤسسة التي يعمل بها.			
19	يجب أن يلتزم الفرد في أداء عمله بالوقت المحدد لهذا العمل.			
20	إن النجاح في العمل أفضل أنواع النجاح.			
21	أركز كل جهدي في العمل وأنسي التزاماتي حيال الأخريين أثناء أدائه.			
22	يجب أن يلتزم الفرد في أداء عمله بجميع القواعد المنظمة لهذا للعمل.			
23	لا يجب أن تقلل مشكلات العمل من مثابرة الفرد في الأداء.			
24	أمارس عملي باستغراق يجعلني أحيانا لا أملك وقتا للحديث مع أصدقائي أو الرد علي بعض أسئلتهم الخاصة.			
25	ينبغي أن يخالط الفرد في العمل الأشخاص اللذين يستطيعون مساعدته في بلوغ أهدافه.			
26	ينبغي أن يكرس الفرد قدرا كبيرا من طاقته لتحقيق أسهاما خلاقا في العمل.			
27	أحد أسباب رغبتي في العمل أن أكسب احترام أسرتي لي.			
28	إن الفرد لا يتحقق له كسب الاحترام لمجرد أنه يمارس عملا جيدا.			
29	إن العمل الذي يتصف بالمكانة الاجتماعية العالية لا يكون بالضرورة أفضل من الأعمال التي لا تتصف بتلك المكانة.			
30	لا تعتبر المكانة الاجتماعية العلية للعمل شرطا أساسيا لاختيار العمل الذي سوف يشغله الفرد.			
31	عندما يمارس الفرد عملا جيدا يكون أكثر احتراما بين جيرانه.			
32	عندما يحصل الفرد على العمل المرموق، فانه ينال تقدير أصدقائه وأسرته.			

يوجد ثلاث خيارات للإجابة : 1) موافق. 2) غير متأكد. 3) غير موافق

الرجاء تعبئة هذه الورقة بعلامة ☑ من فضلك و أن تقرأ كل عبارة و تقرر مدى موافقتك عليها ،،،

م	العبـــــــــــارة	موافق	غير متأكد	غير موافق
33	إن الأعمال التي تتم داخل مكاتب مخصصة لها، أكثر أهمية من أعمال المبيعات حتى لو كانت الرواتب متساوية لهما.			
34	إن العمل الذي أقوم به يسهم في تحقيق مستوي اجتماعي أفضل لاسرتي.			
35	ان الفرد الذي لا يتقن عمله، يجب أن يشعر بالخجل من نفسه لما يفعل.			
36	إن العمل الذي يستغرق من القائم به طوال ساعات العمل أفضل من العمل الذي يتخلله فترات توقف.			
37	حتى لو أتيح للفرد عمل جيد ليقوم به، فانه سوف يجاهد للحصول على عمل أفضل.			
38	ينبغي على الفرد أن يمارس عملا إضافيا كي يزيد من دخله.			
39	لا أرى عيبا في أن يقلل الفرد من جهده في العمل إذا كان في مخططه أن يترك هذا العمل.			
40	لو أمكن للفرد أن يترك عمله الحالي إلي فانه يحاول أن يقلل من معدل الأداء الذي يتوقعه منه الرؤساء.			
41	عند اختيار الفرد لعمل ما ، فان أول ما يهتم به فرص الترقي التي يتيحها له هذا العمل ثم يلي ذلك في الأهمية باقي الاعتبارات الأخرى المرتبطة بالعمل.			
42	من الضروري أن يختار الفرد العمل الذي يحقق له أكبر عائد مادي.			
43	ليس هناك أكثر إشباعا من تقديم أفضل أداء ممكن.			
44	إن أفضل الأعمال هي تلك التي تستنفذ قدرا ضئيلا من طاقة الفرد خلال ساعات العمل اليومية.			
45	يجب علي الفرد أن يفكر دوما في كيفية الترقي بنفسه داخل المجتمع.			
46	يجب أن يلتحق الفرد بالإعمال التي تتيح له ساعات عمل إضافية.			
47	إن الإنسان الذي لا يشعر بالفخر بعمله لا يشعر عادة بالسعادة.			
48	إن الفرد كثير التغيب عن العمل عادة ما يكون قليل القدرة علي العطاء.			

يوجد ثلاث خيارات للإجابة : 1) موافق. 2) غير متأكد. 3) غير موافق

الرجاء تعبئة هذه الورقة بعلامة ☑ من فضلك و أن تقرأ كل عبارة و تقرر مدى موافقتك عليها ،،،

م	العبــــــــــارة	موافق	غير متأكد	غير موافق
49	يجب على الفرد أن يبذل أقصي طاقته لضمان استمرار الترقي حتى يصل إلي أعلى المناصب.			
50	قد يشعر الفرد بالتعب بسبب توقف العمل الذي يؤديه لفترات معينة، كذلك قد يصبح الفرد أكثر سعادة كلما تطلب عمله جهدا شاقا.			
51	عندما لا يحظى الفرد بفرصة الترقي داخل المؤسسة التي يعمل بها، غالبا ما يرتكب أخطاء فيما يقوم به من عمل.			
52	إن أفضل أوقات العمل تلك التي يتم أثنائها استلام الراتب.			
53	من أهم الأمور في أداء العمل هو حب الفرد لعمله.			
54	أجد صعوبة في الاستمتاع بأجازاتي لأنني أفضل البقاء في العمل.			
55	إن الأعمال ذات الرواتب العالية تهيأ للفرد فرصا محدودة للترقي.			
56	عندما يبحث الفرد عن عمل فلا ينبغي عليه أن يضع العائد المالي في مقدمة الاعتبارات التي تهمه لشغل هذا المنصب.			
57	إن القيام بعمل يحبه الشخص أكثر أهمية من العائد المادي من عمل لا يحبه.			
58	يصعب علي الفرد الإصغاء لما يقوله الناس عندما يكون مشغولا بعمله.			
59	يكفي أن يكون العمل مرضيا للفرد الذي يقوم به، من ثم فانه لا يترك هذا العمل حتى لو انتقل بترقية إلي عمل آخر.			
60	إن العمل عالي الجودة هو الأكثر دخلا.			
61	أشعر بالفخر عندما أبذل أقصى طاقة لإنجاز عملي علي أكمل وجه.			
62	من السهل أن أتناسي ما يتعلق بعملي عندما أكون في إجازة.			
63	أنغمس في عملي إلى درجة لا أحاول عندها تحسين وضعي فيه.			
64	أفضل العمل بالمؤسسات التي بها ترقية أسرع وعلاوات أفضل ولو كانت طبيعة العمل بها صعبة وخطرة.			
65	إنني أتكلم كثيرا عن عملي مع أصدقائي خارج ساعات العمل.			

يوجد ثلاث خيارات للإجابة : 1) موافق. 2) غير متأكد. 3) غير موافق

الرجاء تعبئة هذه الورقة بعلامة ☑ من فضلك و أن تقرأ كل عبارة و تقرر مدى موافقتك عليها ،،،

م	العبـــــــــــــارة	موافق	غير متأكد	غير موافق
66	لو أتيح للفرد حرية الاختيار بين الأعمال التي تمنح نفس الراتب فانه يختار العمل الذي يتطلب أقل قدر ممكن من الجهد.			
67	ينبغي على الفرد أن يسعى لتحسين وضعه في العمل.			
68	يجب أن يقبل الفرد العمل ذا الدخل العالي بصرف النظر عن تقبله لهذا العمل أو رضائه عنه.			
69	يجب أن يفاضل الفرد بين عمل وآخر بحيث يختار أعلاهم دخلا.			
70	عندما يقع خطأ ما في مجال العمل، فمن دواعي الحرص أن يدع الفرد لغيره إبلاغ المسئولين عن هذا لخطأ.			
71	إن العمل يساعد الفرد على كسب مزيد من الأصدقاء، ويجعله محبوبا.			
72	يجب على الفرد أن يشعر بالفخر بالعمل الذي يمارسه.			

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