A MULTI-METHOD INVESTIGATION OF THE PSYCHOSOCIAL WORK ENVIRONMENT AND NATURE OF WORK-RELATED STRESS OF NHS PHYSIOTHERAPISTS AND OCCUPATIONAL THERAPISTS.

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CHAPTER FOUR: Physiotherapy and Occupational Therapy Line-managers' Understanding of Workplace Stress.

Abstract

Background: Line managers play an important intermediary role between individual staff members and the organisation and can therefore play a significant role in how well the organisation facilitates the management of stress in its employees. However; little attempt has been made to find out what managers understand by stress and the extent to which they think them, or their organisation, has a responsibility to address stress related problems. **Aim:** This research study aims to bridge the gap in the research literature by exploring what physiotherapy and occupational therapy mangers understand by work-related stress. The research questions guiding this study were: what do physiotherapy and occupational therapy managers understand by work-related stress, and what are their views about stress interventions and who should be responsible for addressing work-related stress within the work environment? **Methods:** this study will use a (pre-tested and piloted) self report questionnaire survey. **Analysis:** descriptive statistics and frequency analysis i.e. frequency distributions and bar charts. **Results:** This study found that of those surveyed, many line-managers have some or most of the knowledge required to identify, prevent and tackle stress at work. Importantly, they report an understanding of the critical role of line managers in tackling stress and appropriate line manager behaviours for minimising and managing employee stress. Furthermore, results show that even though managers believe ultimate responsibility for stress management rests with them and the trust jointly, they conversely report that the most effective stress management strategies are those that concentrate on changing the individual's performance or ability to cope rather than making changes to the work environment, thereby lessening any responsibility that may have adopted by the Trust(s). **Conclusion:** This study provides insight into the self-reported knowledge of work-related stress and self reported stress management practice patterns of therapy line-managers.

4.1 Introduction

Results from the earlier COPSOQ study (chapter 2) and findings from the previous in-depth interview study (chapter 3) reveal differences in perceptions and reporting of supportive line management. The results from COPSOQ study indicate that therapists' self-report high level of supportive line management, albeit unrelated to their self reports of work-related stress. Whilst the in-depth interviews with the smaller subset of therapists exposed a lack of straightforward, regular, accessible instrumental and emotional line management support. Interestingly, without exception interviewees' perception of their supervision emerged as having the potential of being detrimental to professional effectiveness and competence, and to therapists' wellbeing.

Clearly the results and findings of these two studies are contradictory, whether this reflects an unintentional selection of interview respondents with a very specific negative perception and/or experience of their line-management, is unknown. However, as the interviewees were selected from multiple sites across trusts, this happenstance is unlikely. Or perhaps, the questions asked by the COPSOQ do not capture the failings of line management reported during the interviews, which on examination of the questions is to some extent an accurate explanation. Irrespective, this contradiction highlights an ambiguous attitude to the role of line management in work-related stress.

Indeed very little research has been undertaken to examine the role the manager as an intervention in their own right or the role they play in facilitating other interventions. Moreover, managers' skills at perceiving employee stress are unknown. Examination of referral patterns in employee assistance programs (EAPs) indicate that line-manager (supervisory) referrals account for only 5% of EAP usage, with the remaining help seekers being self-referred (Cagney, 2006). Whether this reflects a lack of line-manager awareness, inaction, or more subtle

supervisor suggestions resulting in self-referrals is unclear. One reason given for this is that little attempt has been made to find out what managers understand by stress and the extent to which they think them, or their organisation, has a responsibility to address stress related problems (Dewe and O'Driscoll, 2002).

Of the research conducted (Dewe and O'Driscoll 2002; Lowe, 2005) findings draw attention to a number of issues. Firstly there is a role for the manager in identifying and managing stress, which is both direct in terms of being able to identify stressors and initiate action to remove or reduce the impact of a stressor, and indirect, in terms of the culture engendered in order to encourage open discussion and reporting the stress experience. Secondly, it is clear that without a proper understanding of he stress process and the particular context within which it is to be managed, the manager's ability to identify and act can be limited.

The purpose of this research study therefore, is to explore manager's perceptions of stress and their role in its management.

4.1.2 Stress Management Interventions (SMI's)

Research over the past decade demonstrates that work-related stress is potentially a serious problem with implications for both the individual, in terms of ill-health, and for the organisation, in terms of productivity. For example, numerous reports have shown that between one quarter and one half of the UK's NHS employees report significant personal distress as a consequence of work-related stress (Weinberg & Creed, 2000); and the NHS Health and Well-being Review interim report (2009) of NHS staff, found that absentee and sickness rates were significantly higher than for other sectors. NHS staff are on average absent for 10.7 days a year, compared with 9.7 in the public and 6.4 in the private

sector. This concern has lead to a great deal of research about stress, in particular how it can be managed.

Researchers have attempted to classify different types of stress management interventions (SMI's), which is useful in helping to understand the broad context of stress management and what the organisation is aiming to achieve by implementing SMI's. The classifications distinguish between the focus and the aim of the intervention. The focus tends to be either individual or organisational. Individual focused interventions typically include stress management training and counselling. Organisational level interventions are generally concerned with workload, job design and reducing role ambiguity. The aim of the intervention is usually either to prevent stress or treat the effects of stress (Lowe, 2005).

SMI's are commonly classified as either primary, secondary or tertiary approaches (Kendall et al, 2000) and workplace strategies to combat stress are identified at each of these levels (Quick et al, 1998). Within this framework, primary preventions are regarded as proactive approaches and are designed to reduce workplace stressors through the implementation of strategies such as workload reduction or job redesign. Secondary interventions as regarded as being both proactive and reactive, and are generally aimed toward assisting employers to develop more effective coping behaviours typically through stress management training programmes. Tertiary interventions are regarded as being mainly reactive (Dewe, 1994), focusing on the rehabilitation of employees who have already experienced workplace stress and its consequences; through for example employee assisted programmes (EAP's).

There is research to show that each level of intervention produces a range of practises that promote individual development and well-being, however, there exists as yet, no concrete evidence to show that stress management interventions are effective (Dewe & O'Driscoll, 2001;

Mimura and Griffiths, 2003). Lowe (2005) suggests that single most important reason as to why interventions appear limited is that they are not underpinned by a clear definition or explanatory definition of stress. She states that what is meant by stress and how the effect on employees is explained, has an effect on the identification of stress in the first place and the design and implementation of an intervention in response. Without understanding what the problem is, there is the potential for managers to resort to implementing non-specific interventions with the result that stress problems are likely to remain unresolved. Continuing this argument Dewe & O'Driscoll (2001) argue that one reason existing interventions may be inadequate is that very little effort has been made to determine what managers understand by stress and the extent to which managers think that their organisation has a responsibility to address stress related problems.

The importance of interventions and strategies to combat stress suffered by employees in the workplace should not be underestimated. Concern has been expressed however; that many UK employers are failing to address the issue (Employee Risk @ Work Survey, 2004; 'Workplace Stress in the NHS' report, 2005). According to Aon Consulting's[22] latest 'Employee Risk @ Work' study (2004) which surveyed 1500 employees across the UK about their workplace, almost half of their sample felt that their organisations were not doing enough to create a work environment that is stress free. They report that as many as one in five stressed employees attributed the cause of their stress to lack of management support.

4.1.3 Role of the Manager in Stress Management

Under UK law, the NHS has a legal duty of care to ensure its employees do not suffer adverse effects of work-related stress. They

[22] Aon Consulting is a division of Aon: insurance broker and provider of risk management services. They advice on advise on all aspects of employment including human resource strategy planning; job design and change management

also have a duty to assess the risk arising from hazards at work, including stress. To help organisations such as the NHS meet these duties and respond to the problem presented by work-related stress, the HSE established "Management Standards" for stress that are designed to help employees tackle the sources of work related stress risk. Published in 2004, these represent a series of conditions that reflect high levels of health, well-being and organisational performance. They cover six key areas that if not managed well, put employees at risk of stress related problems. They are demands, control, relationships, role and change (www.hse.gov.uk/stress)

While human resource departments are responsible for ensuring that an organisation has in place the required policies and procedures, line managers are responsible for implementing people management practises on a day-to-day basis. Line managers are also the main intermediaries between the employee and the organisation. Therefore, line managers can be a significant determinant on how well and organisation manages employee stress. Managers can impact on workplace stress of employees in a number of ways (Donaldson-Feilder et al, 2008):

- Managers can cause (or prevent) stress by the way they behave towards their employees.
- Managers can act as the "gatekeepers" to the presence or absence of hazardous working conditions for employees, for instance, preventing an unfair workload being placed on an individual or ensuring that organizational change is well communicated.
- Managers can help ensure that stress is identified early if it occurs in their team.
- If an individual suffers from stress, the manager needs to be involved in the solution.

- Managers "hold the key" to the success of work development or change initiatives.
- Managers are responsible for the uptake and rollout of risk assessments for work stress within their team/department.

It would appear important therefore; for managers to have the necessary knowledge and skills for dealing with employees who may be experiencing stress. This should include an understanding of stress and its potential causes, effects and solutions, as well as personal skills such as the ability to listen and empathise. The absence of such skills is likely to exacerbate the problem rather than manage it (Welsh, 2003).

The research evidence to support managers in this area has, until recently, been sparse, however new research designed to clarify the key behaviours relating to what a manager should (and should not) be doing to prevent and reduce workplace stress is beginning to emerging. For example, Donaldson-Feilder et al (2008) identified what they believe are a universally applicable set of management competencies that support managers in preventing and reducing stress at work, which they state can be easily incorporated into managers' management approach and into human resource practises such as training, selection and appraisal of managers. Alongside research, the HSE has developed a number of useful aids to support managers, including a tool that line managers can use to assess their stress management competencies (http://www.hse.gov.uk/stress/mcit.htm).

Dewe and O'Driscoll (2002) suggest however, that trying to establish what managers do about workplace stress is a meaningless endeavour without first establishing the extent of managers' knowledge of stress.

4.1.4 Managers' Perceptions of Work-Related Stress

Dewe and O'Driscoll (2002) write that they have no doubt that each level of stress management intervention can provide a range of

practices that offer employees the opportunity for individual development and improved well-being. They argue however, that many interventions are found to be inadequate by research because little effort is made by researchers in the public and private sectors, to investigate how managers understand the concept of stress and to what extent they believe that their organisations are responsible for addressing work-related stress and associated problems. This is potentially a problematic omission; as managers of all levels are generally the first contact for stressed employees and often have both operational and personnel management responsibilities which involve the implementation of workplace interventions, particularly in the form of non-specialist assistance, or referral and access to specialist interventions.

4.2 Literature Review

The following section reviews UK and international literature published over the last two decades (1990 to 2009) relating to the role of the manager in stress management interventions.

Databases searched included: Web of Science, Social Sciences Citation Index, Medline, PsycARTICLES, PsychINFO, CINAHL, AMED, EBSCO, PubMed, and ASSIA. Search terms for this study included: manager(s), management, line-manager(s), supervisor(s), stress management interventions (SMI's), stress, stressors, work-stress and occupational stress, and searched as 'and' / 'or'. The database searches involved setting limiters to include the following: publications between 1990 and 2009, human respondents, English language and searching by all text and key words. Manual searches of reference lists of relevant articles were also conducted and articles obtained were searched for further relevant studies.

In a survey of management perceptions of stress in Northern Ireland, McHugh and Bryson (1992) found that over 70% of the managers interviewed reported a belief that work-related stress was a problem for employees in their organisations. In addition over 84% of these managers acknowledged that workplace stress represented a problem at both the organisational and individual level. Interestingly however, less than 7% of the sample reported that their organisation had any stress management policies or procedures in place and less than 5% reported that their organisation employed stress management interventions.

In a study to investigate managers' understanding of stress, Dewe and O'Driscoll (2002) conducted a survey amongst a random sample of private sector managers in New Zealand. They found that managers largely understood stress as response-based behaviours and actions, and believed that considerable responsibility ought to be assumed by the individual employee for stress management, with the organisation accepting some responsibility but to a more limited degree. The study additionally found that secondary and tertiary level strategies (in the form of 'non-specialist' assistance made available by managers along with 'specialist' assistance in the form of EAPs and stress management programmes) were the most common form of intervention strategies utilised by the organisations, despite managers rating the less utilised primary intervention strategies (such as reducing the workload and re-structuring the physical and social work environment) to be the most proactive strategies.

In a similar study, Lowe (2005) investigated the role of the manager in stress management. Data were collected from Network Rail signaller managers using a mixed methodology (interviews and questionnaire). Research suggested that signaller mangers tended to have a simplified and in some cases incomplete understanding of the concept of stress. The majority defined it in simple stimulus-response terms, although some were able to recognise that it could depend on the individual and

there could be some mediating variable. For example, not having enough to do is only a source of stress if it leads to feelings of boredom and an uncomfortable work environment is a source of stress because it leaves signallers feeling undervalued. Furthermore the results indicated a consistent sceptical view about stress. It was mentioned that managers believed that stress was used as an excuse when mistakes were made by employees and that others 'jump on the bandwagon'. The author suggests that such comments are an example of why having a broad definition of and no underpinning theoretical model is so limiting. Findings also revealed that managers had an incomplete understanding of stress, for example, only 33 per cent of managers indicated that ill health was sign of stress.

Rodham and Bell (2002) in a qualitative in-depth exploration of the practises and perceptions of six female junior healthcare managers, found that in general the participants showed a lack of awareness of work-related stress. It was found that all of the managers experienced difficulties in articulating their understanding of the concept of stress and were unaware of the potential stressors within their own environment. Furthermore, none of the managers reported any attempts to alleviate or lessen stress within the workplace, but were aware of secondary level strategies aimed at developing and improving ways of coping in the individual employee. Although all of the managers acknowledged stress to be a trust wide problem, only a third accepted any responsibility for managing stress and none felt that the trust should take responsibility for its management. As a qualitative study no wider generalisations can be made from the Rodham and Bell findings, however as an in-depth exploratory investigation of managers' understanding and perceptions of stress, these findings are extremely insightful. Of particular interest is that despite all of the managers having operational and personnel management responsibilities, none showed any organisationally focused perceptions or awareness of workplace stress determinants or management.

The Dewe and O'Driscoll (2002), Lowe (2005) and McHugh and Bryson (1992) studies suggest that to some degree, managers understand that work-related stress is a potential problem at both the organisational level and individual level. Managers also appear to be knowledgeable of at least some of the causes, effects and strategies to manage workplace stress. Yet according to Daniels (1996) managers are not in fact 'managing' the problem. He argues that they appear to be uninterested in both workplace stress management and with the concerns relating to the risks of work-related stress to employee well-being and job performance. Finally, Daniels argues that it is managers' perceptions of stress that lead to lack of action in managing and preventing its occurrence.

In a similar vein, Cox and Cox (1992) argue that lack of stress management interventions is in part due to managers' beliefs that any change involved in the adoption of less stressful working practises, will cause more organisational problems in the long run, than already encountered as a consequence of stress from current working arrangements. Cox and Cox (1992) conclude that managers perceive stress to be something that organisations can do little about. Dewe and O'Driscoll (2002) on the other hand, suggest that the issue is not about whether managers are interested or uninterested in stress management interventions, but is instead about them being unsure of how to address the problem. This suggestion receives support from the Rodham and Bell (2002) study which found that the participating junior managers had limited knowledge of organisational, local or national initiatives in the area of work-related stress.

Briner (1996b) adds to the proposition that managers lack informed knowledge of stress and of how it can be managed, by arguing that even when managers implement stress management interventions, they do so mainly because "everyone else is doing something about stress" (pp:3-4) rather than from understanding stress and its potential consequences.

A yet further reason as to why managers can appear uninterested in stress management is proposed by Daniels (1996), who argues that it is due to how they perceive risk. He suggests that managers perceive stress to be a low workplace risk and therefore a problem that requires little or no intervention. Daniels also suggests that managers ignore work-place stress because it is perceived as a "risk with which individuals should cope rather than one that organisations should manage" (p. 353). This suggestion is supported by the work conducted by Dewe and O'Driscoll (2002) which found that when it came to apportioning responsibility for stress management, over half of their sample indicated that the individual had either 'quite a lot' or 'total responsibility' for attending to stress related problems. Daniels (1996) concludes that the individualistic approach to stress management is dominant within the professional culture of management and has allowed stress inducing organisational practises to continue.

4.3 Rationale and Research Question

The Institute of Healthcare Management (April, 2006) has highlighted the importance for managers at all levels of an organisation, to be equipped with the skills to enable them to prevent the occurrence of work-related stress amongst their employees, and to manage it if it does occur. Managers' skills and knowledge, amongst other factors ought therefore, to include a clear and accurate understanding of the issues of workplace stress and of strategies for dealing with it. Furthermore, they ought to be able to recognise that it is their role and that of their NHS employers to be responsible for the health and safety of their staff and be able to provide information and guidance about in-house support and external services. As mentioned earlier, Dewe and O'Driscoll (2002) suggest however, that trying to establish what managers do about workplace stress is a meaningless endeavour without first establishing the extent of managers' knowledge of stress.

For this reason this study's primary **research question** is: What do physiotherapy and occupational therapy managers understand by work-related stress and what are their views about stress interventions and who should be responsible for addressing work-related stress?

4.4 Research Aims

In order to answer the research question this study aims to establish the following:

1. What do managers understand by stress?
2. Who do managers believe should assume responsibility for managing stress?
3. What action(s) the trust actually takes in managing or preventing workplace stress and how effective the manager believe these actions to be?

4.5 Research Design

This study is a multi-site quantitative design. Data were collected through a self-report questionnaire survey (appendix) to be completed by a sample of physiotherapy and occupational therapy line-managers.

4.5.1 Measurement Instrument - Managers' Questionnaire

Decisions about how to collect information from therapy managers were based on the key requirement of how to access managers' own views and knowledge of work-related stress in a straightforward and quantifiable way. Based on this requirement a self-completion questionnaire survey was selected as the most useful way to elicit this kind of information.

The questionnaire is composed of 18 questions formulated to establish what managers understand by stress; the extent to which they believe the individual, the manager and the organisation have a responsibility to

address stress related problems; what actions the organisation employ in dealing with work-related stress; how effective the manager believes these actions to be; and actions managers would employ if they were responsible for stress management interventions within their department.

The questionnaire is designed to utilise closed-ended response formats giving respondents a dichotomous choice (yes or no) or requiring them to tick a box to indicate their choice of answer from multiple-choice response options, or circle a category in order to indicate their answer on Likert item scales. All items that compose the multiple-choice answers are correct answers (no incorrect or false items are used). If responders agree with each item as an answer they are given the option to tick the corresponding box or boxes.

Also included in the questionnaire were 11 questions concerning demographic, biographical and job related information on age and gender; professional title and grade; professional qualifications held and length of time qualified; in which department they work; full-time or part-time working, length in current profession, position and length of time employed by the Trust in total; and whether they have clinical responsibilities.

4.5.2 Pre-testing – questionnaire

The questionnaire was developed and pretested during the 2004. All questions were carefully formulated from the existing literature and were pre-tested to ascertain usability with a convenience sample (n=8) of Lecturer/Practitioners; all of whom worked at the University of Nottingham and who were excluded from the pilot and main stages of data collection. Pretesting was conducted in the following manner: drafts were distributed to the lecturer/practitioners by the researcher (FGN). These responses were appraised during one-on-one interviews with pre-test respondents, and afterward by the researcher. The

questionnaire was appraised with the intention of making sure that the questionnaire was organised and worded to encourage respondents to provide accurate, unbiased and complete information. Pre-testing was used to detect obvious flaws or awkward wording of questionnaires, and the level of knowledge needed to answer the questions. In some cases, academic terminology was replaced with words and phrases that provided subjects with the intended meaning but with a minimal amount of added wording and definitions.

4.6 Pilot Study

The pilot study was the first step in defining the methodology and research design for this study. The purpose of the pilot study was to test the study design and to identify any methodological related problems.

4.6.1 Pilot Study Sample

A questionnaire was sent to a convenience sample of 10 physiotherapy (n=5) and occupational therapy managers (n=5) at one NHS Trust hospital (local to the researcher). All pilot participants were excluded from the main stages of data collection. 10 questionnaires were returned.

4.6.2 Pilot Research Procedure

Following approval from a Multi-site Research Ethics Committee[23] (MREC), a non-personalised invitation (via letter); inviting the recipient to participate by completing the accompanying questionnaire, was extended to physiotherapists and occupational line-managers at their place of work along with a questionnaire pack. The questionnaire pack contained a covering letter; a copy of the questionnaire; and a sealable envelope in which to enclose the completed materials.

[23] MREC Reference number: 04/Q2604/87. Dated: 26.01.05

Managers were given a completion period of three weeks from the initial delivery date. Completed questionnaires were to be returned in the sealed envelopes to the various department reception desks and subsequently collected by the researcher. At this time a generalised non personalised letter was sent (via the hospital internal mailing system) to inform all managers that if they have not already done so, they were still able to complete a questionnaire which will be collected by the researcher in a further week's time.

4.6.3 Outcome of Pilot Study

As stated previously, the principal aim of this pilot study was to test the study design with potential respondents and to identify any methodological related problems. Methodologically the pilot study proved to be sound hence; it was decided that no changes were made to either the questionnaire of the research procedure (However; the research procedure employed in the main study did vary to that of the pilot due to a previously unforeseen problem with access to therapy employees for the purpose of recruitment).

4.7 Main Study

4.7.1 Research procedure

Permission to contact individual therapy staff was denied. Therefore the questionnaire packs were disseminated independently and voluntarily by the participating trusts, there was no control over the sampling frame. The response rate cannot be calculated for this reason also, since the number of employees who received this survey in totality is unknown.

Questionnaires packs (as per pilot study) were delivered by the researcher to the human resource departments (at each hospital) for distribution. Line-managers were given a completion period of three weeks from the initial delivery date. The survey questionnaires (sealed

within return envelopes to ensure confidentiality) were collected at the close of this date by the researcher from the human resource department. One week from the initial collection a generalised follow-up reminder was sent to managers via the human resource departments. This follow-up included a new cover letter that did not specify a target due-date, but instead stressed the importance of responding. Another copy of the questionnaire was offered at this time.

4.7.2 Sample

60 Questionnaire packs (as per pilot study) were sent to clinical line-managers (n=30 to physiotherapy departments and n=30 to occupational therapy departments. The number of questionnaire packs issued was determined by the Trusts) working at four UK NHS Trusts (Six NHS hospitals across the Trusts participated). Participating NHS trusts were located within the Midlands and North West England and were chosen for their geographical location; ease of access for the researcher.

4.7.3 Measurement instrument

The managers' questionnaire (as per pilot study) was used as the research questionnaire in this study.

4.7.4 Analysis

Questionnaires were coded and the numerical data entered into SPSS in order to produce descriptive statistics and frequency analysis i.e. frequency distributions and bar charts.

4.8 Results

4.8.1 Sample Demographics

49 usable questionnaires were returned. As mentioned previously, the response rate cannot be calculated. Table 4.1 shows demographic and descriptive data for the sample.

Table 4.1: Sample Demographics

	Mean	Range
Age	44 yrs	33 yrs to 57 yrs
Time spent working in:		
Current position	5yrs	2 months to 18 years
Profession	21yrs	9 years to 35 years
NHS Trust	16 yrs	2 months to 31 years
	N	**%**
Gender		
Female	49	100
Male	0	0
Profession		
Physiotherapy	23	47
Occupational therapy	26	53
Qualifications		
Higher degree	2	4
Undergraduate degree	32	65
Professional diploma	15	31

The results of this study are summarised under the headings corresponding to the research aims and are as follows:

4.8.2 Research question 1: What do managers understand by stress?

Figure 4.1 illustrates that none of the respondents believe that the experience of work-related stress is as a negative consequence of the work environment, whilst they are evenly split between the beliefs that stress is a physical response to a threatening or damaging environment (47.8% n=23[24]) or stress is an outcome of the interactions between the person and their environment (52.2% n=26).

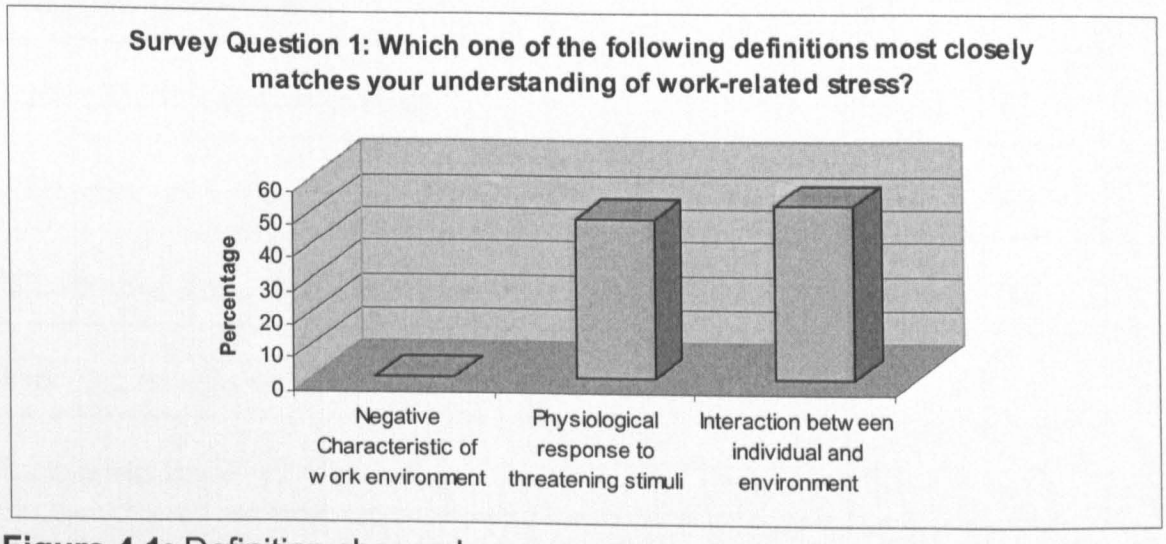

Figure 4.1: Definition chosen by managers as most closely matching their own definition.

Regarding the managers' ability to identify signs of employee work-related stress, table 4.2 shows the number of respondents who correctly identified each of the symptoms listed. Percentages are shown. The maximum number of signs (response items) that a respondent could select was 14 and the median number of signs correctly identified was 10.

[24] n = the number of respondents who selected the response item

Table 4.2 Symptoms chosen by managers as signs of employee stress.

Emotional or erratic behaviour	91	44
Changes in work performance	91	44
Increased impatience	91	44
Changes in relationships - staff	91	44
Absenteeism	87	43
Changes in motivation	87	43
Reduction in self confidence	87	43
Reduction in self esteem	87	43
Withdrawal from social contacts	78	38
Working excessive hours	67	33
Increased smoking/drinking	56	27
Increased lateness	52	25
Leave work early	35	17
Insubordination	35	17

Table 4.2 demonstrates that most responders identified the signs of emotional or erratic behaviour, changes in work performance; increased impatience or irritability and changes in relationships with other staff members as signs of work-related stress. Conversely, insubordination and leaving work early were the least identified signs.

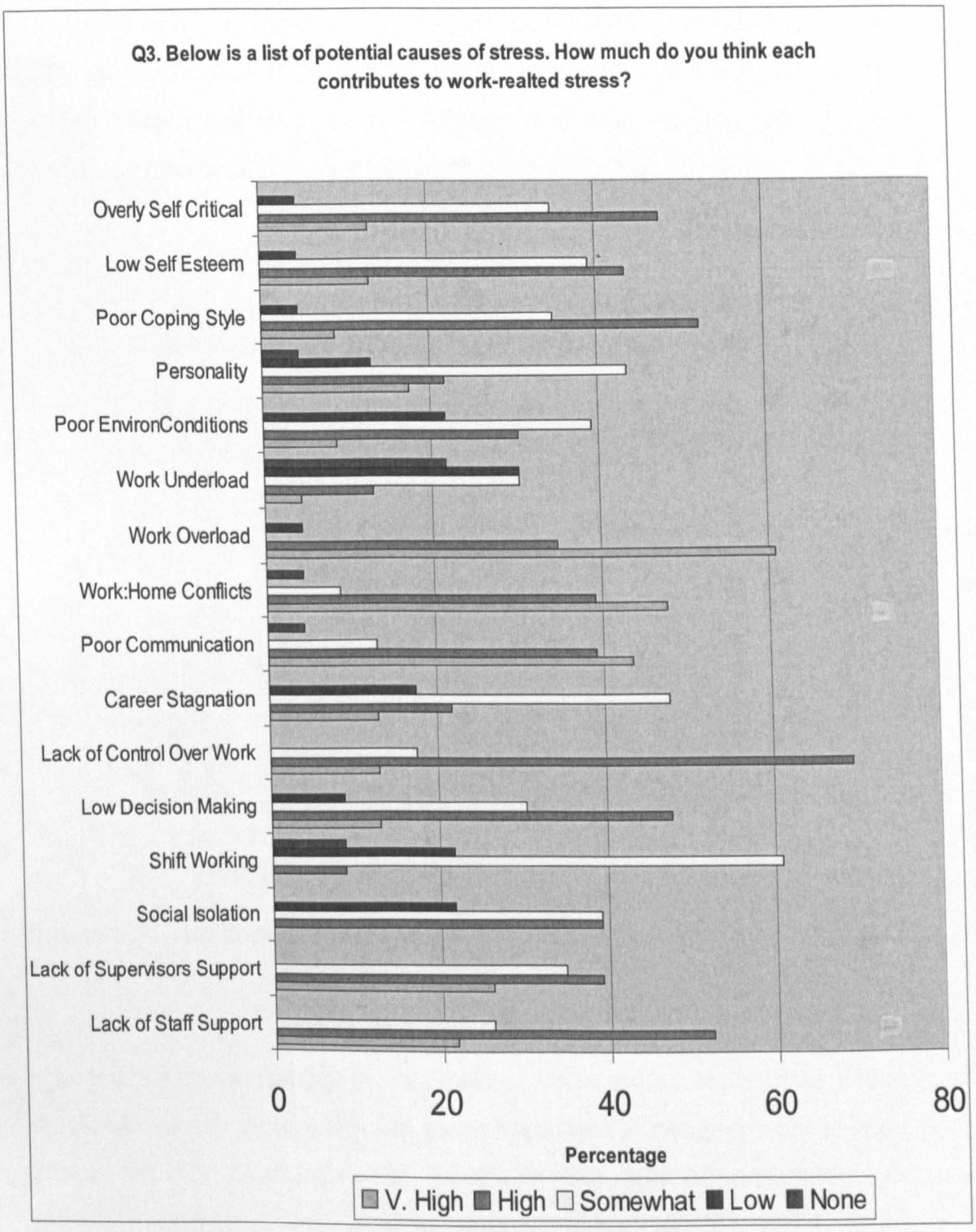

Figure 4.2: Potential causes of stress and the degree to which managers report them as causal determinants of stress.

Figure 4.2 shows that responders report that work overload (60.9% n=30), imbalance between home and work (47.8% n=23) and poor communication (43.5% n=21), are most liable to contribute to work-related stress to a very high degree. Furthermore, lack of control over work (69.6% n=34), poor coping style (52.2% n=26), lack of support form other staff members (52.2% n=26), being overly self critical (47.8%

n=23) and low participation in the decision making process (47.8% n=23) contribute to a high degree. Work underload (30.4% n=15); poor environmental conditions, social isolation and shift working (all 21.7% n=11) were considered to contribute to a low degree.

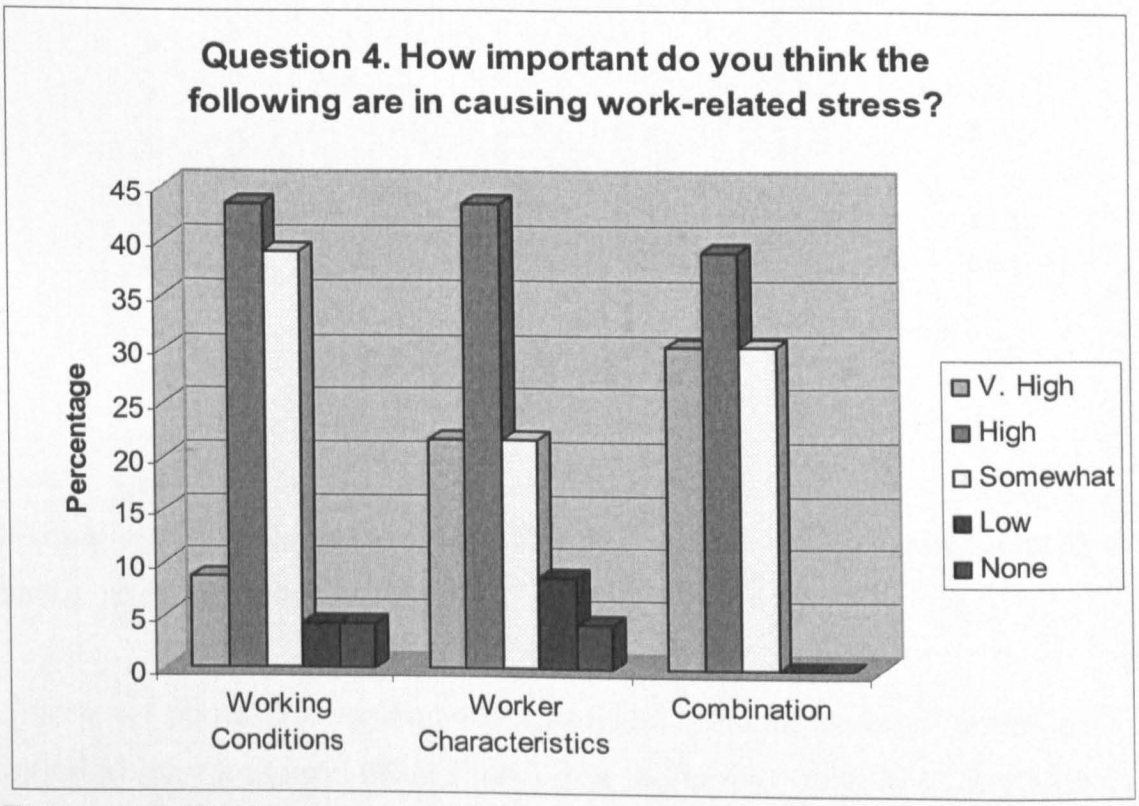

Figure 4.3: The importance of causal conditions as chosen by managers

Figure 4.3 shows managers' responses when asked to indicate which conditions or characteristics are more important in causing work-related stress. Worker characteristics (65.4% n=32) and a combination of 'working conditions and worker characteristics' (69.5% n=34) were viewed as contributing to a 'high or very high' degree.

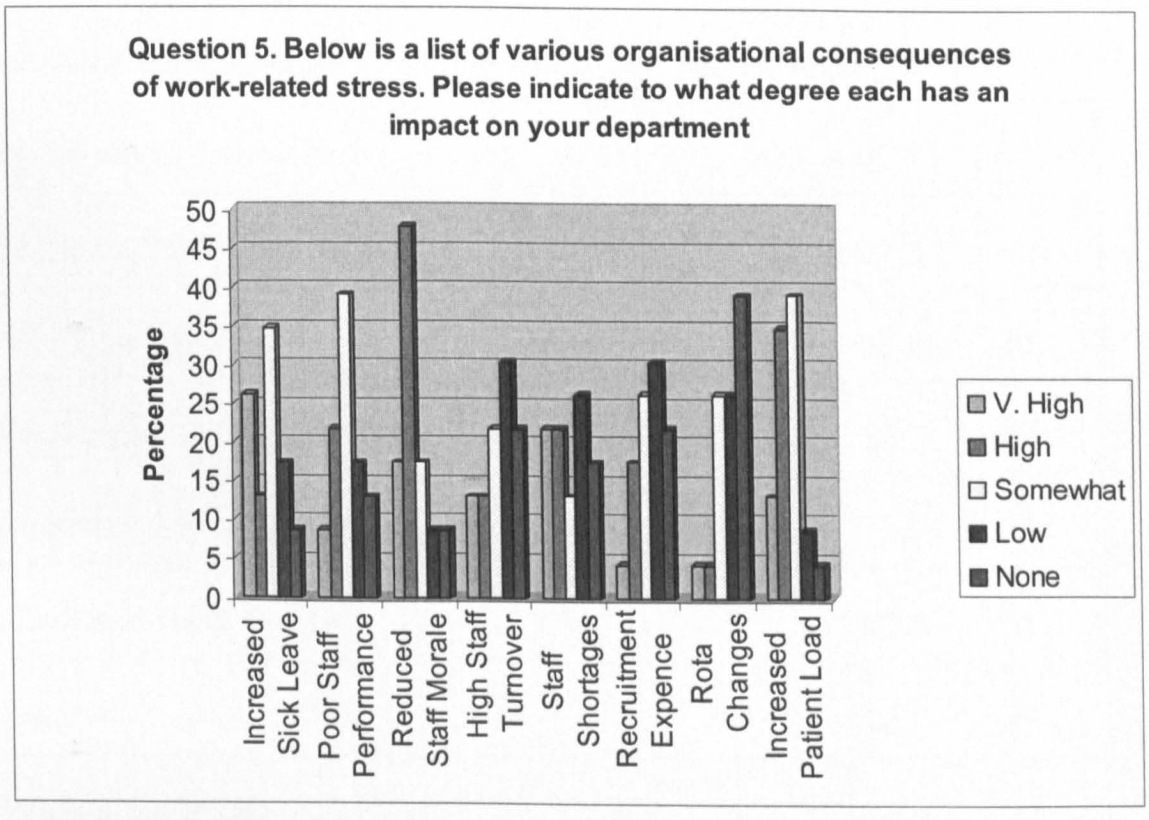

Figure 4.4: The various organisational consequences of work-related stress as reported by managers.

Figure 4.4 shows the various organisational consequences of stress as reported by managers. 65.2% (n=32) of managers (high and very high response categories combined), reported that the most dramatic impact work-related stress has upon the organisation was a reduction on staff morale whilst they reported the lowest impact (low and none response categories combined) on rota changes (65.2% n=32), expense of recruitment (52.1% n=26) and a high staff turnover (52.1% n=26).

Table 4.3 shows what the managers consider to be possible health consequences of a person experiencing work-related stress. The highest response was for mental health problems (95.7% n=47), whilst the least identified health consequence was cancer (21.7% n=11). The maximum number response items that a respondent could select was 10 and the median number of signs correctly identify was 6 (range of 4 to 8).

Table 4.3: The consequence of stress as chosen by managers

Mental health problems	95.7	47
Musculoskeletal disorders	82.6	40
High blood pressure	82.6	40
Gastrointestinal illness	82.6	40
Impaired immune function	73.9	36
Cardiovascular disease	62.5	31
Suicide	56.5	28
Work-place injury	56.5	28
Cancer	21.7	11
No consequence	0	0

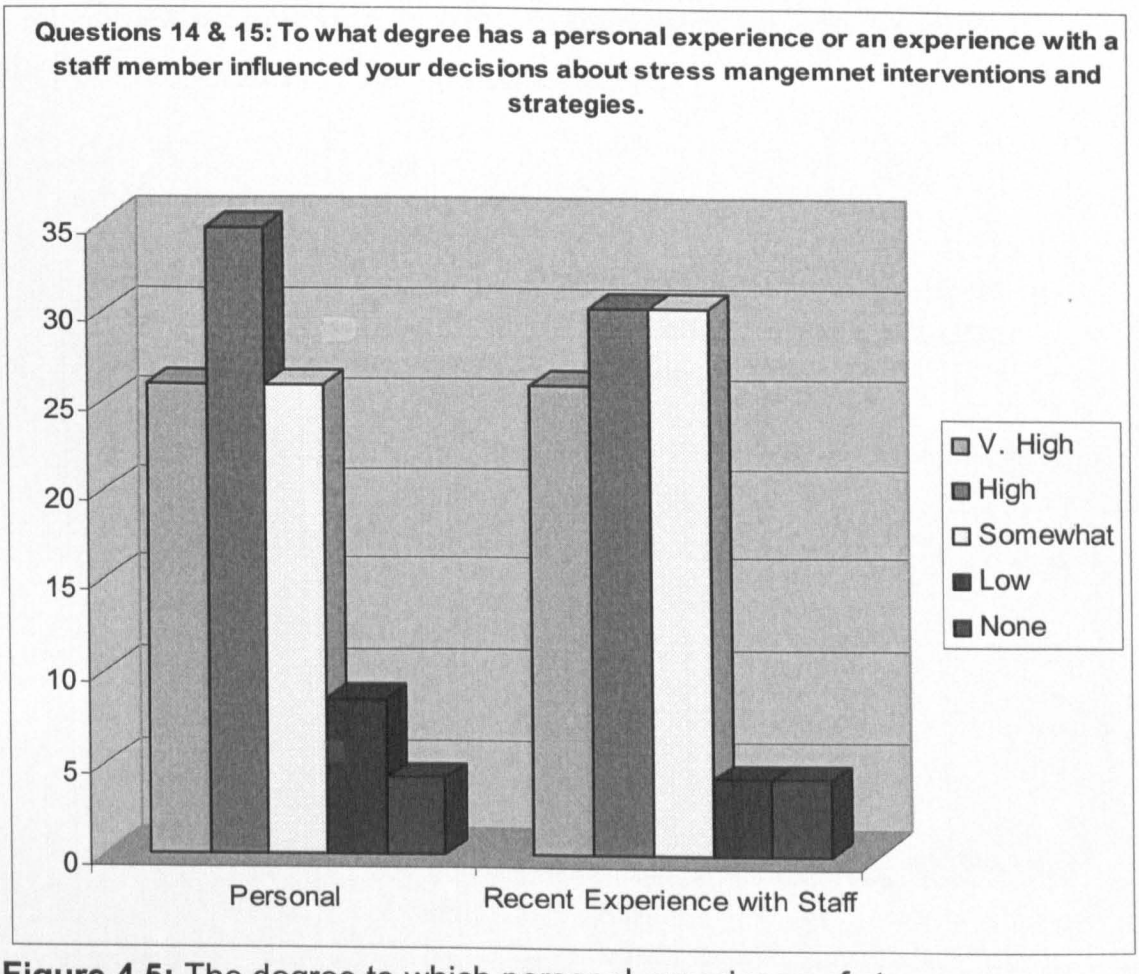

Figure 4.5: The degree to which personal experience of stress or recent experiences of stressed staff influence manager's decisions about stress management

Figure 4.5 shows that both personal (60.9% n=30) and recent experience with a member of staff (56.5% n=28) influence managers decisions about stress management to a 'high or very high degree'.

4.8.3 Research question 2: Who do managers believe should assume responsibility for managing stress?

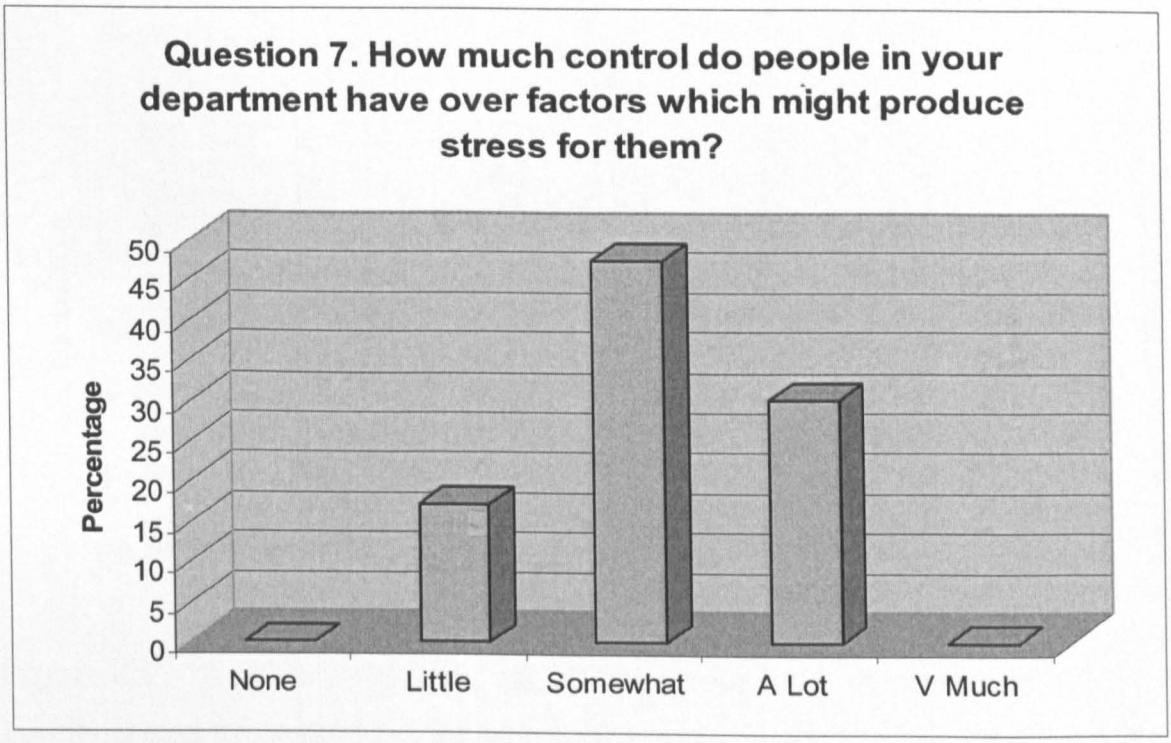

Figure 4.6: The degree of control employees have over stress determinants as reported by managers.

Figure 4.6 shows that 65.2% (n=32) responders believe that people have 'little or some' control over their experiences of work-related stress, whilst only 30.4% (n=15) suggested that people have a lot of control over their experiences.

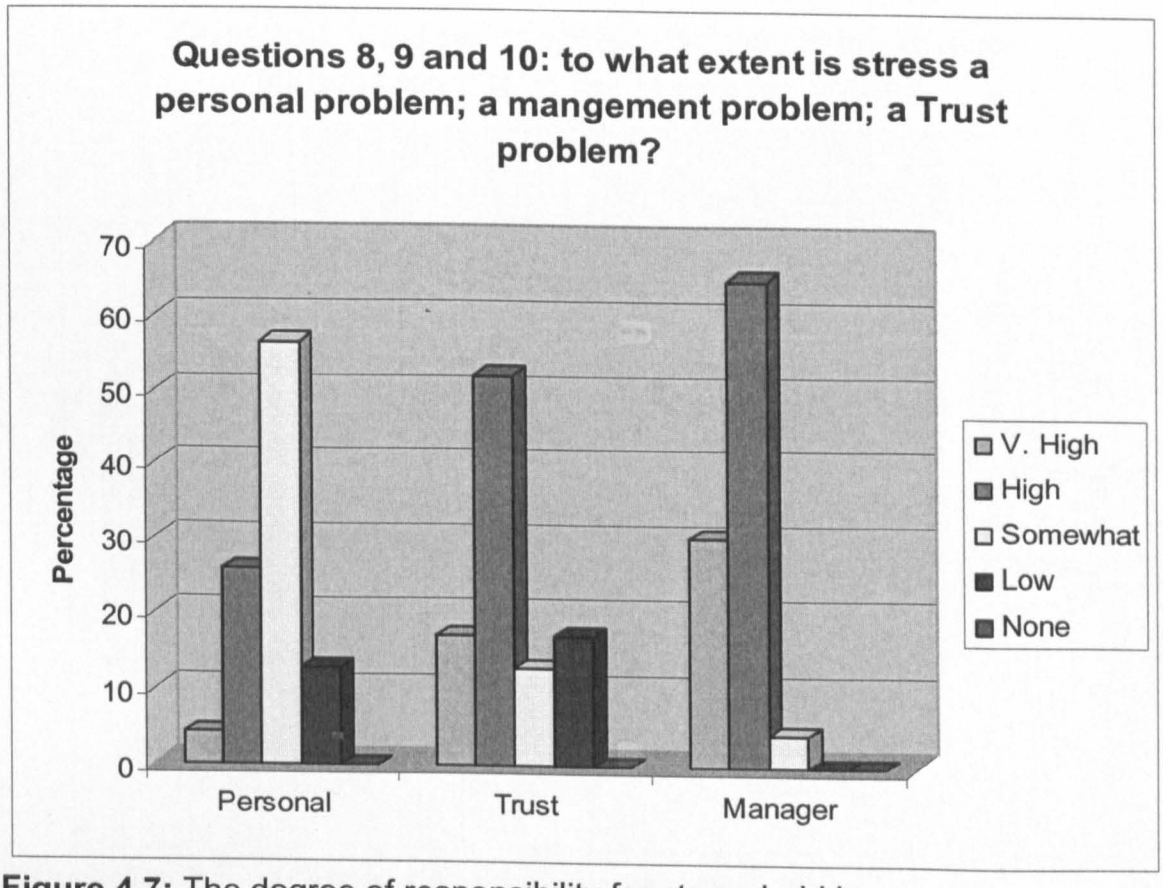

Figure 4.7: The degree of responsibility for stress held by managers, the Trust and the individual, as reported by managers.

Figure 4.7 shows that 95.3% (n=47) of responders have stated that managers have a 'high to very high' degree of responsibility to address the problems of work-related stress. The trust is reported by 69.3% (n=43) of managers has having a 'high to very high' degree of responsibility, whilst only 30.3% (n=15) of managers report the individual experiencing stress to have a 'high to very high' degree of responsibility.

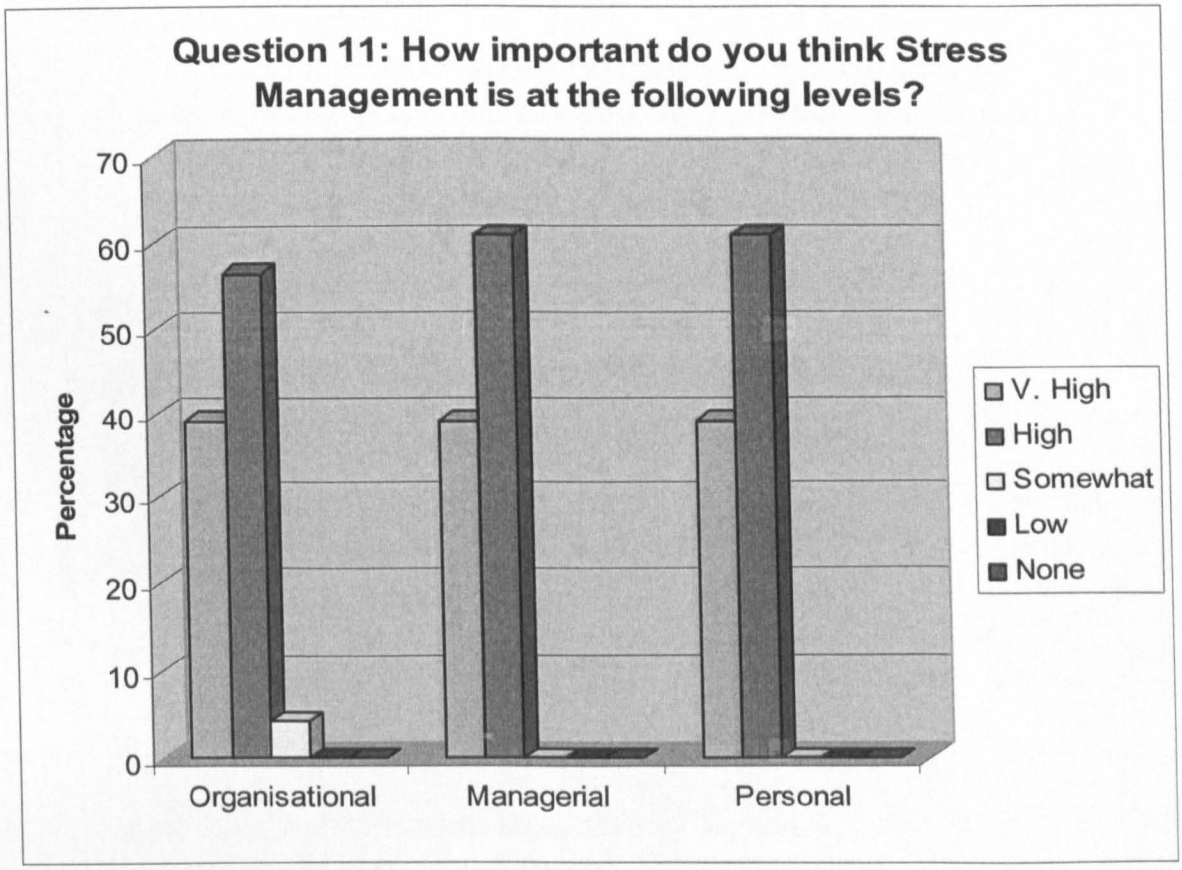

Figure 4.8: The importance of stress management at the organisational, managerial and individual level, as reported by managers.

Figure 4.8 shows the importance of stress management at organisational, management and individual level as reported by the responders. 99.1% (n=48) of managers report that stress management is important at the personal and managerial level to a 'high or very high' degree, whilst 95.6% (n=47) report that stress management is important at the organisation level to a 'high or very high degree'.

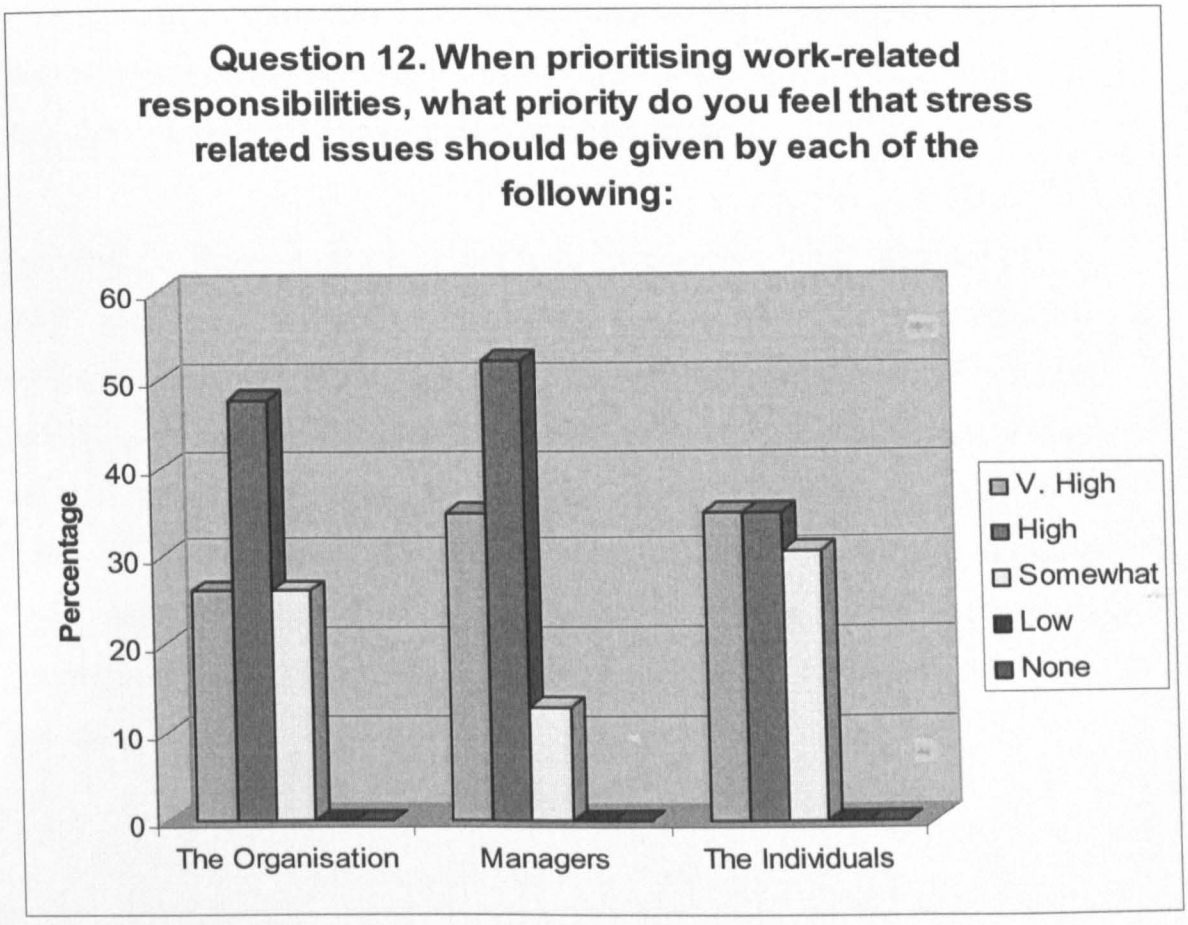

Figure 4.9: The level of priority that ought to be given by the Trust, the manager, and the individual to stress related issues, as reported by managers.

Figure 4.9 shows the level of priority that ought to be given at the organisational, management and individual level to stress related issues as reported by the responders. 86.5% (n=42) report that a 'high or very high' level of priority should to be given by managers. 73.9% (n=36) report that a 'high or very high' level of priority should be given by the Trust, and 69.6% (n=34) report that the individual should be giving a 'high or very high degree' of priority to stress related issues.

4.8.4 Research question 3: What actions do the trusts actually take in managing or preventing workplace stress and how effective does the manager believe these actions to be?

Figure 4.10 shows that the majority of responders stated that all of the listed strategies to assist people experiencing work-related stress are being implemented within their trust, with the exception of the Employer Assisted Programmes (EAPS) where 34.8% (n=17) stated that it was not part of the trust response (figure 4.10). Performance evaluation and feedback was determined to be the most effective action in tackling work-related stress (100% n=49), whilst workplace health and fitness programmes (78.3% n=38) and disciplinary action (73.9% n=36) were the least effective.

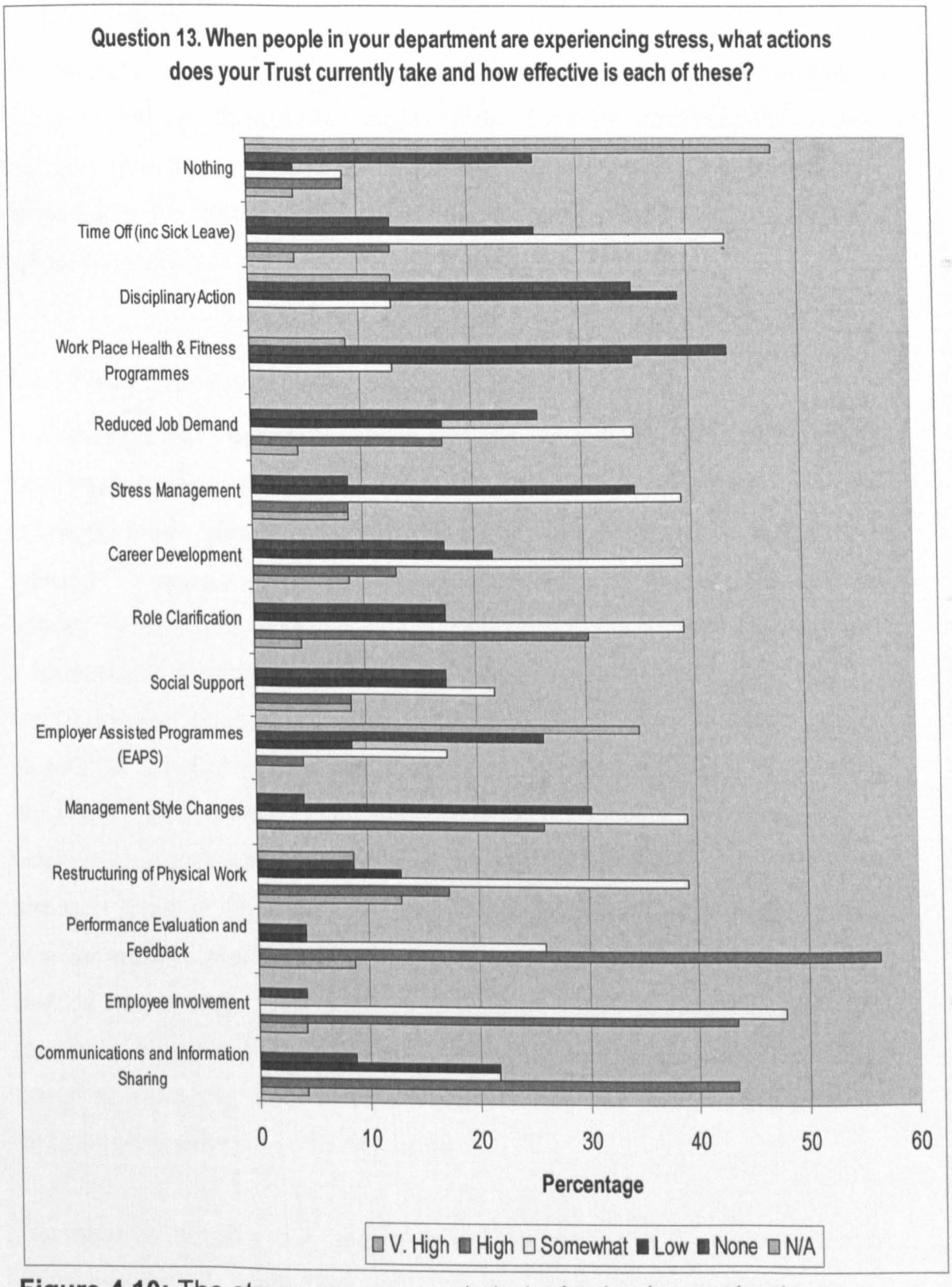

Figure 4.10: The stress management strategies implement by the trusts and the degree to which managers report them as effective.

4.9 Discussion

The research questions guiding this study were: what do physiotherapy and occupational therapy managers understand by work-related stress and what are their views about stress interventions and who should be responsible for addressing work-related stress? The following section will discuss each of these questions in turn.

4.9.1 What managers understand by stress?

The findings from this study show that the majority of managers chose the psychological-based definition of work-related stress as the definition most closely matching their own. In choosing this definition, therapy managers reflect a contemporary perspective that conceptualises stress as a result of on-going dynamic interactions and transactions among personal and environmental factors (Lazarus, 1991). Having chosen a psychological-based definition of work-related stress, a small majority of therapy managers continue to remain consistent and report an interaction between working conditions and worker characteristics, to be the major determinant of work-place stress. This is important as any intervention strategy designed to resolve work-related stress will be based on prevailing perception of the factors responsible for the stress-related problem. Recognising the full range of possible stress determinants is therefore, a crucial issue in enabling a line-manager to take a more supportive position of staff with stress and resultant health problems.

However, a smaller but almost equal number of managers chose a response-based definition of stress; which corresponds to a physiological approach to stress. Similarly, a large minority of managers identified 'worker characteristics' to be the most important determinant of work-related stress. This belief reflects the traditional, and according to Lazarus (1991) outdated, perspective that regards stress to be something that resides solely in the individual. The traditional perspective is a person-centred problem definition, which in practise

translates into work-place stress management strategies concerned with bringing about change within the individual (such as improving their ability to cope) and in which the role played by organisations in relation to the experience of employee stress is downplayed (Ivancevich et al., 1990) .While these strategies have been shown to have positive outcomes in stress reduction, Dewe and O'Driscoll (2001) argue that they may represent a too simplistic representation of work-related stress. Managers may realise more benefit in adopting a preventative view and promoting organisational interventions designed to change the system producing the stress before the stress occurs.

This non-consensus in managers understanding of work-related stress is reflected in the research literature. In a study to investigate managers' understanding of stress, Dewe and O'Driscoll (2002) found that managers largely understood stress as response-based behaviours and actions. Whereas, Lowe (2005) found the majority defined it in simple stimulus-response terms, although some were able to recognise that it could depend on the individual and there could be some mediating variable.

Within this present study managers were able to identify all of the psychosocial determinants of work-related stress (i.e., jobs demands, lack of social support and poor quality leadership, and lack of employee control) and understood that exposure to stressors may affect employee psychological as well as physical health. Managers also demonstrated an awareness of common and/or chronic health conditions as a consequence of work-related stress. On the whole, managers demonstrated a good comprehension of work-related stress. This finding is in contrast to Rodham and Bell (2002) which study found that in general the participants showed a lack of awareness of work-related stress; and Lowe (2005) who revealed that managers had an incomplete understanding of stress, for example, only 33 per cent of managers indicated that ill health was sign of stress.

It is interesting to note that the most selected health consequence of stress was 'mental health problems'. This may be explained by the growing recognition among employers and many employees, that the effects of work-related stress experienced by many may well constitute a mental or psychological disorder. This belief is justifiable, as the incidence of new cases of work-related mental health problems in Britain in 2005, was estimated to be approximately 6,400 per year (Surveillance of Occupational Stress and Mental Illness (SOSMI) and Occupational Physicians Reporting Activity (OPRA). Moreover, the HSE states that this almost certainly underestimates the true incidence of these conditions in the British workforce.

This research study asked managers to identify various organisational consequences of work-related stress and to indicate the degree to which these consequences have an impact on their department. The consequences identified (chosen from a comprehensive pre-determined list) vary from loss of individual productivity to increased absenteeism, to a rise in employee attrition; representing managers' belief that work-related stress has a wide ranging impact within an NHS context. On the other hand, the negative impacts of these various consequences were reported by managers to be only small to moderate, indicating a belief that there is a low risk of organisational problems associated with employee stress. The only organisational consequences identified as 'highly' adversely affecting the departments was team morale. Team morale however, is not to be dismissed as a peripheral problem for the NHS. Costs to an organisation in terms of low morale can be high in that work cultures characterised by low morale are normally co-characterised by employees who are unmotivated, disengaged, all of which result in inefficiencies, lowered staff competence and high staff turnover (Harbeke, 2007).

Stress amongst NHS employees is not merely an individual burden but threatens both the maintenance and viability of an effective team and their capacity to provide quality healthcare. Not only has patient

satisfaction and safety has been shown to deteriorate as healthcare staff experience consequences of stress such as, emotional exhaustion and depersonalisation (Douglas & Sibthorpe, 1998) but that work-related stress is also related to intention to leave and turnover for hospital-based workers (Coomber & Barriball, 2007).

Managers' responses to the survey questions indicate that they are aware that poor environmental conditions contribute to stress. For example, when asked to rate the importance of working conditions, compared to worker characteristics or an interaction between both, although rated as a lesser determinant than the other two options, working conditions were rated as a 'high to very high' causal factor by over half of the respondents.

4.9.2 Who do managers believe should assume responsibility for managing stress?

The majority of managers within this study appear to be cognizant of stress determinants that tend to fall within the sphere of the responsibility of the manager and organisation. The implicit assumption is that the responsibility for the problem does not lie solely with the individual employee, but rather with the individual, manager and organisation in combination.

The data presented in figure 4.7 reveal that managers perceive that they, the organisation and the individual all have responsibility for managing stress. On the face of it this seems to be very positive. This supports the 'dual responsibility' findings of Dewe and O'Driscoll's (2002) study but presents something of a paradox. On the one hand managers recognise they have responsibly, but on the other they are suggesting that it is the individual's responsibility to come forward and report they are experiencing stress or to manage the stress themselves.

This present study asked managers to indicate at what level within their organisation they believe the responsibly for stress management should

be adopted. The results illustrate a consensus, in that all respondents believed that stress management is an important issue that should be addressed by the Trust, managers and the individual employee themselves, all of whom should give a high degree of priority to stress related issues. However, whilst managers believed that the trust and the individual have a 'high degree' of responsibility for stress management, they hold them less accountable than managers. This finding contradicts to a large degree what has been found in previous research (Daniels; 1996; Dewe and O'Driscoll, 2002; McHugh and Bryson, 1992) which suggests that managers apportion the responsibility for stress in the workplace to the individual employee more so than the organisation or managers. Collins (2006) argues that the responsibility for instigating work-related stress management strategies falls within the remit of managers. He writes that because stress has not until recently been identified as a priority in primary care organisations, managers have been reticent in reacting to the debilitating effects of workplace stress. This doctoral work concludes however, that in light of HSE (2004) legislation, managers within the Trusts are now publicly held accountable for employee wellbeing, and as a consequence managers are by necessity more conversant with their obligations to create and maintain health and stress free work environments.

4.9.3 What action(s) are the trusts' implementing in managing or preventing work-related stress? And are these strategies reflected in the practises employed in the therapy departments?

As an employer the NHS has duties under health and safety law to assess and take measures to control risks from work-related stress. Accordingly all participating NHS Trusts' have work stress documents, and all promote stress prevention and stress management measures as part of their respective work-stress policies. These Trusts employ a participative approach to work-place stress management involving managers, workers and other relevant parties. Alongside outlining the

line manager's role in relation to workplace stress management, the Trusts' work-related policies communicate clear guidelines for stress prevention and intervention, which would function to enable line managers to implement their responsibilities.

The final aim of this study was to determine whether stress management measures actually used by line-managers, reflect the strategies and guidance promoted by the trust. The results found that the measures reported by managers as being employed by the participating therapy departments, incorporate multiple strategies at both primary (management style changes and restructuring of physical work) and secondary (stress management programmes) intervention levels all of which are indeed promoted as good practice within Trust policy.

With regards to the effectiveness of these practices, managers report measures that focus on the individual utilising person-centred techniques (such as performance evaluation, communication and information sharing) to be the most effective. This is somewhat in contradiction to managers' demonstrated awareness of the potential benefits of proactive workplace measures, such as reducing the workload and re-structuring the physical and social work environment. Proactive workplace measures were in fact amongst the least mentioned of the actions taken by managers to tackle work-related stress.

This result in combination with the previously mentioned indicates that that there exists a level of dissonance between manager's beliefs about the causes of stress and their decision-making with regard to reducing the incidence of stress experienced by employees. Cox and Cox (1992) suggest that although managers are aware that work-related stress is problematic for both the individual and the organisation, they also believe that change-related actions (i.e. restructuring work environment) to reduce work-related stress will cause more problems than those already encountered as a consequence of stress from current working

arrangements. This work argues therefore, that the belief held by respondent managers that stress is not having 'too high' a detrimental impact on the running of the therapy departments, is in fact a way of reducing the importance of their dissonant beliefs by focusing on implementing strategies to bolster employees' strengths (such as facilitating their ability to cope with work-related stress), managers are adding more consonant beliefs.

The findings from this study raise one further important issue. Managers report that Employee Assistance Programs (EAP) are either unavailable to employees, or when available are rated as being alongside 'taking no action' as the least effective strategy employed by a trust. However, the Trust policy documents indicate that all have Employee Assistance Programmes (EAP) free of charge to all their employees. Managers' unawareness of the availability of EAP's to them and their staff brings into question managers' familiarity with trust policy and highlights a potential operational deficiency. This raises yet a further question of whether many of the interventions reported as being in use by managers within their departments, are in fact nothing more than good human resource practice, rather than specific implementation of trust policy. This last implication receives support from Rodham and Bell (2002) who found that managers had limited knowledge of organisational, local or national initiatives in the area of work-related stress. This doctoral work recommended that further research is undertaken by the Trusts or by academic researchers to establish managers' familiarity with Trust work-related stress management policy, particularly as managers may be required in the near future to demonstrate their knowledge of policy and procedure to HSE inspectors.

In summary of this discussion section, this study has found that of those surveyed, many managers have some or most of the knowledge required to identify, prevent and tackle stress at work. They report an awareness of the nature of stress in their workplace and of how the

experience can negatively affect an individual employee and the wider working environment; although at present do not regard risk to the work environment to be too high. Importantly, they report an understanding of the critical role of line managers in tackling stress and appropriate line manager behaviours for minimising and managing employee stress. Moreover, managers indicate that even though they believe ultimate responsibility for stress rests with the manager, they have adopted the view that the individual employee, the manager and the trust are jointly responsible for managing work-related stress. Conversely they go on to report that in their opinion, the most effective stress management strategies actually in use, are those that concentrate on changing the individual's performance or ability to cope rather than making changes to the work environment, thereby lessening any responsibility that may have adopted by the Trust(s).

4.10 Strengths and limitations of this study

This study had one main limitation. Because we relied on self-reported data from employees participating in a large voluntary survey disseminated independently and voluntarily by their Trust, there was no control over the sampling frame, therefore the results may have been subject to recall or selection bias. The response rate cannot be calculated for this reason also, since we do not know the number of employees who received this survey in totality.

The data are self-reported and even though self report surveys are a recognised tool for examining attitudes and behaviour in health-care settings, there may be discrepancies between what respondents self-report about their practice patterns and their actual behaviour. Where closed questions are used the respondent is restricted to answer using categories provided by the researcher. Similarly the questions asked are those considered important by the researcher. In retrospect, although not an original intention and despite the questionnaire being 'fit for purpose', this study may have been strengthened with the addition

of open questions to the questionnaire (requiring a respondent to explain their reasons for believing or implementing something) in order to elicit complex information about actual practice patterns.

Moreover, because they don't explore questions in any depth or detail, self report questionnaires are generally regarded as having low validity. However the fact that the questionnaires were anonymous means that respondents may be encouraged to answer questions truthfully in the knowledge that they cannot be identified. This may increase the validity of their responses.

Although multi-site in design, this work may be criticised for its small sample size and geographic representation, as it may be argued that four NHS trusts (6 hospitals in total) is a small portion of the wider NHS. Nevertheless, even with limited geographic representation, the findings documented here have generated very significant questions to the way stress is addressed by managers within the therapy professions within the NHS and as such has resonance for other settings.

4.11 Future work

With the current emphasis placed on work-related stress within the NHS, it is legitimate to ask why managers express a preference for utilising person-centred techniques which are not always designed to deal with the cause of the stress experienced. Further work however, should look at how managers define effectiveness; what priority managers give to dealing with work-related stress in relation to their other responsibilities; at the impact of managers' own experiences of work-related stress on their stress management practices.

4.12 Conclusion

This study provides previously unknown insight into the self-reported knowledge of work-related stress and self reported stress management

practice patterns of physiotherapy and occupational therapy line-managers.

Line-managers possess knowledge enough to prevent and reduce stress amongst their staff. Moreover they report that responsibility for the stress management lies with the individual employee, the individual, and organisation in combination. This is encouraging, however paradoxically; results also indicate that managers believe it is the individual's responsibility to manage the stress themselves by adopting stress management approaches that modify individual stress appraisal and coping strategies. This finding is perhaps one corollary of the lack of clarity surrounding work-related stress. Managers are likely to be guided by their own perceptions of the nature and determinants of stress. The apparent contradictory views amongst managers within this study; demonstrated by the almost equal split amongst them, as to the definition of work-related stress, is symptomatic of this lack of clarity.

Moreover, the lack of clarity in the field of work-related stress provides managers with the authority to emphasise certain factors which they might feel are linked to stress, whilst at the same time minimising the potential effects of other factors. It is noteworthy however, that participating managers chose to identify determinants of stress that reflect an awareness that the problem of stress does not lie solely with the individual employees, but rather the interaction between an employee and the environment within which the employee is working.

In conclusion, this chapter is concerned with what managers understand and do about work-related stress. It has drawn attention to a number of issues that flow from exploring managers views on stress and stress management. The importance of these issues to the overall aim of this doctoral programme of work relates to the 'management culture' of the psychosocial environment in which therapists work.

CHAPTER FIVE: Overall Discussion and Conclusion.

5.1 Introduction

The objective of this body of research was to investigate the psychosocial work environment and nature of work-related stress of NHS physiotherapists and occupational therapists. And in doing so establish: a) how work-related stress is experienced by physiotherapy and occupational therapy employees in the NHS, and b) how we understand the determinants of stress and structural and social resources that counteract stress, and c) the implications of these for therapists' health. In order to do so three independent parallel studies were conducted; each designed in part to contribute to the overall research objective. Findings from these studies will be conceptually integrated and discussed in this final chapter.

5.2 The psychosocial work environment and nature of work-related stress of NHS physiotherapists and occupational therapists.

The psychosocial work environment of therapists can be seen as a combination of work content (e.g. workload, opportunities for involvement, level of responsibility) and factors in connection with how the working community functions (leadership, work organisation, cooperation). These were found to be often interconnected. Therapists psychosocial work environment therefore has to be seen as a whole, embracing both work content and the functioning of the working community, since these factors are cumulative and mutually influential.

Chapter 2 presented a quantitative questionnaire survey that resulted in the conclusion that core psychosocial stressors and structural and social resources to counteract stress (as identified by accumulated evidence in occupational stress literature and by consensus amongst the theoretical literature) are potential determining factors for NHS therapists' self-reported experience of work-related stress. Although, the relationships between these factors and the outcome of stress were

low to moderate, most probably as a consequence of the low stress levels reported. Chapter 2 concluded that the psychosocial working environment of therapists was not, at the time of the survey, experienced by respondents as stressful.

The depth and quality of the data gained as a result of the qualitative interview study presented in chapter 3 enabled a close description of physiotherapists' and occupational therapists' experiences of the physical and psychosocial work environment and personal meanings prescribed to the experience of work-related stress. This study concluded that despite the results from the survey study, interviewed therapists were in-fact experiencing stress as a consequence of their psychosocial environment. However, an important discovery pertaining to the psychosocial working environment is that interviewed therapists consistently dichotomised their working environment into two contradictory parts: these being the clinical environment and organisational environment. Although in reality not mutually exclusive, descriptions and perceptions of each environment and their related conditions, were frequently presented as if in isolation from one another. These two environments will now be described.

5.2.1 The Clinical Environment

The COPSOQ survey (chapter 2) questioned therapists about their work as clinical practitioners. Results indicate that for this sample, work as a 'clinical practitioner' in the NHS setting is conducted within a favourable psychosocial work environment. This finding was supported by emergent findings from the in-depth interviews.

Both the questionnaire survey and the in-depth interviews suggest that the clinical psychosocial environment is characterised by positive inter-professional relationships. The interviews revealed that therapist feel integrated with their professional group and immediate therapist colleagues. Indeed the relationship between therapists emerged to be

especially important and was experienced positively with a notable emergent theme of group cohesion and solidarity. Much of the benefit of teamwork comes from a "working alliance" which permits access to shared experience, knowledge transfer and the formation of close working relationships.

Findings from this qualitative work, strongly suggest that therapists professional identity developed through interaction with other therapists and subsequent internalisation of the knowledge, skills, norms, values and culture of the therapy professions. Professional identity is viewed as an integral part of the therapists' personal identity. It is described as having the feeling of being a person who can conduct clinical practise with skill and responsibility. Taken as a whole, Therapists clearly believe in themselves and their abilities; competence, confidence, and commitment are referred to as the most significant attributes corresponding to the image of the professional therapist.

Moreover, the clinical practitioner role was perceived as the driving force of their work motivation and as being their work-related source of self-esteem; which in turn fostered feelings of competence, particularly when therapeutic goals were attained. Working independently, application of skills and knowledge were aspects of the clinical practitioner role perceived by therapists to be contributing to their satisfaction with work.

The generic existing literature is in support of these findings. For example, a positive relationship between work mastery at work, autonomy and job satisfaction has been documented for a number of years. For instance, the Job Characteristics Model (JCM: Hackman and Oldham, 1976) hypothesises that if employees feel they are able to make use of skill variety in their work; if they believe that work positively affects many people to a great extent; and they are allowed to complete the task once begun, it is likely they will perceive their job as meaningful, leading to high job performance and/or high intrinsic

motivation. The model furthermore predicts that the presence of autonomy in the workforce leads to the emotional state of felt responsibility for outcomes, resulting in high job satisfaction. These JCM predictions mirror closely the findings from this doctoral work with NHS therapists.

In summary, in-depth interviews with therapists, established that the concepts of occupational identity, self-esteem, self-image and role of the therapist are closely related to the concept of professional identity of the therapist. When given the opportunity to talk about the psychosocial experience of being a therapist, participants were unambiguous in that they experience fulfilment from the type of work that they do and the variety inherent in their work; the sense of achievement they feel from helping clients, and clinical autonomy.

The clinical psychosocial environment of participating NHS therapists is one characterised as being composed of psychosocial factors that are positively experienced and as such, these typifying psychosocial factors are determinants of something other than stress.

5.2.2 The Organisational Environment

The organisational psychosocial environment is described as being distinct from the clinical. Findings from the in-depth interviews indicate that turbulence and hostility characterises the organisational psychosocial environment of therapists. Prevailing rapid and ongoing change, intense competitive pressure together with demands for heightened effectiveness and stringent cuts in spending, all emerged as predominant features of the organisational work environment of NHS therapists.

The rate of change is accelerating, and is alleged by therapists as being inflicted upon them. The constant change and threat of future change has resulted in feelings of instability, agitation and frustration. The NHS

is perceived as an antagonist that employs autocratic and authoritarian leadership. Therapists are feeling disempowered by an organisational culture that they believe has been enforced upon them and fails to support their needs, an example cited is the agenda for change (AfC). Although promoted by the NHS as being implemented for the benefit of it's employee, the AfC is believe by therapists to be an agenda implemented to bring about the NHS's rationalisation plans and one which is cited as 'most likely' resulting in a reduction in wages and a further devaluation of their professional status.

Moreover, interviewee participants (chapter 3) perceive the NHS to be the main decision maker and themselves to be passive recipients of change. Decisions 'enforced' upon them by the Trust and wider NHS organisation were not deemed to contain a significant degree of foresight. Moreover, although not explicitly discussed, it appeared that therapists were not able to recognise any strategic overview and it was felt that decision made by the Trust and organisations were at times uninformed. For example: targets being set against clinical work that cannot be broken down into measurable components and therefore not easy to match against objective 'targets'.

Unmistakably therapists feel neglected from the planning and implementation of organisational change and believe they are expected to adapt without complaint. The NHS is accused of looking at the needs of the organisation whilst overlooking the needs of the employees. Paramount in these findings is the issue of how change and new policy is communicated. This work has found that organisation level communication in the participating trusts is poor, which is in support of previous findings that have shown communication within the NHS to be consistently poor (Audit Commission, 1994; Lloyd, 1994; Tourish and Hargie, 1998). If change is to be managed effectively the process needs to be become a 'collaborative' process between the NHS organisation and employees (Collins, 2006); effective two-way communication is crucial to this relationship being established and maintained. Therefore

the importance of communication cannot be underestimated and additional work is needed to formulate appropriate processes for collaborative interaction and consultation between the NHS and therapists.

The significance of this current body of work is that for the first time, findings have been generated that indicate the degree to which change is affecting therapists' experience of stress and subsequently their physical and emotional health. Therapist's in this study are not being given time to adjust between changes and are not experiencing any periods of stabilisation. Insecurity and uncertainty emerge as the feelings most attributable to the experience of ongoing change; brought about by not knowing probable outcomes for example: agenda for change; whether or not they will loose more of their resources and what future changes to working practice will be implemented. These feeling of insecurity and uncertainty alongside being determinants of stress are strongly linked to decreased levels of organisational identity.

It is interesting to note that managers (chapter 4) clearly report beliefs that would suggest the 'management culture' of the psychosocial environment is in-fact attuned to the needs of the individual employee. For example, managers report that ultimately the foremost responsibility for the management of work stress rests with managers, thereby lessening the accountability of the individual employee and the NHS. Intriguingly, this is in contradiction to therapists perceptions of their psychosocial environment. Findings however, from the interviews (chapter 3) indicate that despite managers recognition of their responsibility, there is a definite lack of regular and supportive supervision for therapists. This creates a paradox, as one the one hand managers acknowledge their responsibly regarding their role and obligations to employees in relation to stress management, whereas and on the other they are not performing their responsibilities and obligations.

Interestingly, the paradox is continued with over half of the managers surveyed reporting their belief that lack of supervisor support is not a potential source of stress for employees. This is a significant finding in consideration of the apparent dearth of supervision. It may be concluded that although managers acknowledge their responsibility for work-place stress and it may reasonably argue that management level support would normally be regarded as a prerequisite for meeting this responsibility; managers participating in this work however, believe that management support would not be decisive in any outcome of stress reduction or management, and therefore regular supervision is not imperative. Future work needs to be undertaken to further explore the disparity between managers' awareness of their responsibility and their actions in deploying that responsibility. Coupled with this, is the need for assessment of the effectiveness of supervision to management of work-stress for therapists.

Interviewees believe the NHS work environment is characterised by a lack of support for, if not outright hostility towards the therapy professions and therapists convey themselves as a professional group nested within, rather than part of, the wider NHS. This doctoral body of work argues that this secularism is a defensive strategy of therapists' in response to perceived professional powerlessness and exclusion. The secularism of the therapy professions means that opinions are passed on from one to another, including those involving hostile estimations of other professions such as nurses, and of therapists' poor professional image. In effect the culture of therapists tends to perpetuate itself, and is negatively reinforced by behaviours such as demonstrating negativity toward other professions will inevitably invites negativity and hostility in return.

An additional consequence of the secularism appears to be a strong sense of professional and personal self-reliance. Therapists' perception that the organisation does not value their professional contributions nor does it care about their well-being, might lead them to believe that

supervisors, as agents of the NHS, by withholding supervision are being unfavourably inclined toward them. However, therapists profess (chapter 3) to being not unduly concerned about the lack of supervision. This is not because therapists are not affected by the lack of support, in fact participants readily highlight a variety of concerns about managers for example, managers not listening to therapists' issues, not being physically available for supervision and not being emotionally available due to their own pressures of work. This doctoral work instead argues that the self-imposed secularism has resulted in therapists, as a profession, turning away from reliance on outside organisational assistance for resolution of problems. Instead therapists rely either upon themselves or others from the therapy professions, as discussed earlier; therapists have a strong sense of professional identity coupled with strong group solidarity, they believe themselves to have professional autonomy.

Interestingly and in support of this argument, when talking about managing work-related stress therapists did not talk about using any other strategies than those implemented by them. Research conducted by Steinhardt (2003) explored job stress and satisfaction in relation to employee hardiness, supervisor support and group cohesion. Steinhardt found that irrespective of 'hardiness' supportive supervisors contributed to the employee's resources in tackling work-related stress. The findings from this doctoral body of work raise a critical question about the duty of care the NHS has to therapists. The danger is that without an effective working relationship between the NHS and the therapy professions, therapists' needs will become more marginalised and therapists less likely to own up to their own stress. As a consequence Trust responsibility to therapists will have to mean more than just having written policy; indeed meeting the needs of therapists will require an active process of communication and needs analysis implemented by the Trust.

In summary therefore, the psychosocial working environment of NHS physiotherapists and occupational therapists is dichotomised into contradictory parts. In one they have a positive self-image, as a reflection of their professional identity and they perceive their work as a valuable and creative activity. In the other they are still striving for acceptance and recognition as a profession and believe themselves to be marginalised by the NHS. More than anything, it is a climate of constant change perceived as disruptive, intrusive and undermining morale, which characterises this organisational psychosocial working environment of therapists.

5.3 Determinants of stress and structural and social resources that counteract stress

The COPSOQ survey (chapter 2) confirmed that the core psychosocial factors, such as work-related demands, are potential but not immediate determinants of stress for respondent therapists. When given the opportunity to talk about their experience of work-related stress, therapist were able to clarify that they did in-fact believe themselves to be experiencing high levels of stress. Although not from their profession-specific practitioner work, but instead from their role as NHS employees; which they conceptualise as being distinct from their role as therapists. For example, it emerged from the in-depth interviews that therapists were experiencing role conflict however; not from profession specific determinants, but instead as a consequence of incompatible role demands from the dichotomised and often contradictory work environments they perceive themselves to be working within. Role conflict for the participating therapists was therefore a consequence of conflicting requirements or expectations of the two or more roles, located in each one of the environments, they perceive themselves to occupy.

An interesting conclusion from both the COPSOQ survey (chapter 2) and the in-depth interviews (chapter 3), is the suggestion that the 'organisation' is the predominant determinant of stress. Taken together, the results and findings from these two studies suggest that predominant determinants of stress for therapists are clustered around the current climate of change that is occurring in accordance with the NHS modernisation and rationalisation agenda. This work has for the first time established that the pressures associated with the current climate of rapid and ongoing change along with intense target orientated pressure, allied to the uncertainty about cuts in spending and the ensuing limited availability of resources, are all key determinants of stress for therapists. Moreover, it emerged from the in-depth interviews (chapter 3) that such pressures and uncertainty are brought about by lack of employee participation in decision making; lack of effective employee consultation; and poor organisational communication strategies.

There are numerous documents in circulation that inform healthcare managers and professionals how to manage change in the NHS (Lles & Sutherland, 2001). However, Cortvriend (2002) used the fact that there is a lack of literature focusing on the 'impact' of organisational change on NHS employees as the rationale for her study. She found that change in the NHS leads to feelings of uncertainty and de-motivation and she likens the experience to an 'emotional rollercoaster' (p vii). This doctoral research adds to the existing literature by finding that organisational change impacts negatively on NHS therapists and is a major potential determinant of stress.

In answer therefore, to the question of which psychosocial factors in the work environment play a role in the development of work-related stress, this current body work has established that instability within the NHS as a result of organisational change and the ensuing organisational climate, are the primary determinants of workplace stress for participating therapists, rather than any profession specific factors. Not

forgetting however, that core psychosocial factors, such as profession specific quantitative demands, are related to work-related stress.

Much has been written in the last two decades (i.e. Landsberg et al, 1992; Johnson and Hall, 1988) about the ability of social support and interpersonal relationships to moderate the impact of psychosocial determinants on the outcome of stress. This pre-existing body of work predicted that the negative effects of psychosocial stressors may be lessened in the presence of social support. Results from the COPSOQ (chapter 2) suggest that interpersonal relationships (operationalised by social support and quality of supervision) functioned to mitigate the relationship between work-related psychosocial factors and stress. In further support of this finding, therapists' during the in-depth interviews cited good interpersonal relationships with colleagues to be a determinant of satisfaction at work which they reported as lessening the experience of stress.

An additional prediction of previously published work was that problem-focused coping would also mitigate the outcome of stress. This prediction was supported by results and findings from both the COPSOQ survey (study 1; chapter 2) and the in-depth interviews (study 2; chapter 3). In the context of this current body of work, problem-focused coping was cited by therapists as being all activities (cognitive and behavioural) performed to control a situation. It is a coping strategy that enables them to retain control and tackle the problem 'head on'. For example therapists talked about effectively coping with work stress by re-scheduling work tasks.

In addition, findings from the in-depth interviews may be linked to another classification of coping: termed preventive coping. Wong and Reker (1984) suggest that a preventive coping style is aimed at promoting well-being and reducing the likelihood of future stress. Preventive coping was an approach utilised often by interviewees. For example, participants talked about activities as such as planning, time

management and social support skills as being things they put in place not only as a problem focused reaction to stress but also as a prevention to stress. This 'preventative' approach was believed to be positive coping strategy and was thought to lead to a reduction in the levels of stress experienced.

In summary, this present body of research has shown that interpersonal relationships and proactive strategies: problem focused and perhaps preventative coping, are strategies implemented by the therapists that function to make them more resilient to stress. In conclusion interpersonal relationships and problem-solving coping strategies have been found to moderate the relationship between psychosocial work-related factors and of the outcome of stress.

5.4 The implications of work-related stress on therapists' overall health.

Previously published research supports an assumption that individuals who experience work-related stress were also likely to experience lower levels of health. This assumption was supported as the COPSOQ survey, (chapter 2) the results of which confirmed the prediction that stress has a negative relationship with therapists overall health (operationalised by physical, mental and emotional health). The in-depth interviews gave therapists the opportunity to talk about how they experienced the relationship between stress and ill-health. It emerged that relatively low levels of temporary stress were not generally perceived to be having a serious long-term impact on health. For example, participants spoke of suffering from anxiety, anxiousness and a lack of concentration. But overall, the signs and symptoms of short-term stress were not severe. Therapists who reported experiencing long-term stress (subjectively) reported more severe negative impact(s) on their health. For example psychological symptoms attributed to the experience of long-term stress include affective disorders such as: anxiety, depression and anger; somatic symptoms such as: headaches

and dizziness; and cognitive effects such as the inability to concentrate. The most frequently reported physical symptoms of long-term stress, included stomach upsets and muscle tension.

5.5 Strengths and limitations

The strengths and limitation of each study have been presented in the corresponding chapters.

The three studies have been designed and conducted true to the assumptions of the respective paradigms, therefore maintaining the integrity and unique contribution of the methods of inquiry. Qualitative and quantitative results are presented independently (therefore alleviating concerns about combining mixed data sets). Integration of findings occurred at a conceptual level and only in the discussion chapter (chapter 5) of this thesis.

This overall body of work has several strengths. To date only a limited number of studies have (in any way) investigated the psychosocial environment and nature of work-related stress of NHS physiotherapists and occupational therapists. Former investigations have been either qualitative or quantitative therefore; this work represents the first of its design. Moreover, for the first time this present work, builds upon the value of each method and integrates salient findings at a conceptual level to present a holistic representation of the psychosocial environment and nature of work-related stress of NHS therapists'.

Alongside the strengths of this work there are limitations. The main one being that the generalisability of this work is limited. However, the findings documented here have resonance for other settings and it is for the reader to decide upon the transferability of these findings. Certainly the nature of work-related stress and psychosocial conditions described in this programme of research could be applied to other NHS therapy setting and contexts.

5.6 Conclusion

The objective of this body of research was to investigate the psychosocial work environment and nature of work-related stress of NHS physiotherapists and occupational therapists. The objective was achieved and this multi-method work has enabled the construction of an emergent picture of the psychosocial work environment(s) of NHS therapists and of the factors that are potential determinants and/or alleviators of stress in therapists' work environment.

The most salient outcome of this research has been the finding that although, work-related factors such as high quantitative work-related demands were found to be related to stress, the clinical psychosocial work environment of therapists was positively experienced. This body of work does not indicate that the nature of the profession specific (clinical) psychosocial work environment among NHS physiotherapists and occupational therapists was at the time the research was conducted, a source of work-related stress. However, this finding did not mean that therapists were not experiencing stress as a consequence of their work in the NHS. It was instead found to be as a consequence of the organisational work environment. In-depth exploration of therapists experiences, revealed that rapid and ongoing organisational change, lack of effective top-down communication, together with issues relating to demands for heightened effectiveness were determinants of stress for NHS therapists. Finally, in light of the increasing challenge of achieving a stress free work environment, it was interesting to examine more closely the role of the manager (from their own perspective) in stress management, reduction and prevention. Line-managers were found to have some or most of the knowledge required to identify, prevent and tackle stress at work. Importantly, they reported an understanding of the critical role of line managers in tackling stress and appropriate line manager behaviours for minimising and managing employee stress.

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Appendices

Chapter 2

Appendix 1: Therapists Questionnaire

Therapists Questionnaire

ABOUT YOU...

What age are you? ..... Years

What gender are you? Male ☐ Female ☐

What length of time have you spent working...

- In your current position? ..... Years ..... Months
- In your current profession? ..... Years ..... Months
- For your current trust? ..... Years ..... Months

In which department do you work?

.....

Is this department of your Choosing? Yes ☐ No ☐

Is this department a rotation? Yes ☐ No ☐

What is your professional title and grade?

Title: ..... Grade: .....

Example: Title: Physiotherapist
Grade: Basic

What hours do you work?

Full-time ☐ Part-time ☐

Please list your professional qualifications and year gained.

..... Year gained .....

..... Year gained .....

Have you attended any sort of stress management training?

Yes ☐ No ☐

If you answer yes to the above question...

- Was this training provided by your trust?

  Yes ☐ No ☐

- Did you find this training helpful?

  Yes ☐ No ☐

Have you received a copy of the Health and Safety Executive leaflet (HSE) "Tackling work-related stress: a guide for employees (DNG341)

Yes ☐ No ☐

If YES, has this booklet positively influenced your understanding of work-related stress?

Yes ☐ No ☐

	Excellent	Very good	Good	Fair	Poor
In general, would you say your health is...	☐	☐	☐	☐	☐

Please tick only one answer for each of the following questions:

	Always	Often	Sometimes	Seldom	Never
Do you have to work very fast?	☐	☐	☐	☐	☐
Is your workload unevenly distributed so it piles up?	☐	☐	☐	☐	☐
How often do you not have time to complete all your work tasks?	☐	☐	☐	☐	☐
Does your work require that you do not state your opinion?	☐	☐	☐	☐	☐
Does your work require that you hide your feelings?	☐	☐	☐	☐	☐
Does your work put you in emotionally disturbing situations?	☐	☐	☐	☐	☐
Is your work emotionally demanding?	☐	☐	☐	☐	☐
Do you get emotionally involved in your work?	☐	☐	☐	☐	☐

How TRUE or FALSE is <u>each</u> of the following statements for you?

	Definitely true	True	Mostly true	Don't know	Definitely false
I seem to get sick a little easier than other people.	☐	☐	☐	☐	☐
I am as healthy as anybody I know.	☐	☐	☐	☐	☐
I expect my health to get worse.	☐	☐	☐	☐	☐
My health is excellent.	☐	☐	☐	☐	☐

These questions are about how you feel and how things have been with you <u>during the last 4 weeks.</u> For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the <u>Past 4 weeks</u> –

	All of the time	Often	Sometimes	Seldom	Never
Have you been a very nervous person?	☐	☐	☐	☐	☐
Have you felt so down in the dumps that nothing could cheer you up?	☐	☐	☐	☐	☐
Have you felt calm and peaceful?	☐	☐	☐	☐	☐
Have you felt downhearted and blue?	☐	☐	☐	☐	☐
Have you been a happy person?	☐	☐	☐	☐	☐
Have you had a lot of energy?	☐	☐	☐	☐	☐

Have you felt worn out?	☐	☐	☐	☐	☐
Have you felt tired?	☐	☐	☐	☐	☐

Please tick only one answer for each of the following questions:

	Always	Often	Sometimes	Seldom	Never
Does your work require you to make difficult decisions?	☐	☐	☐	☐	☐
Does your work require a wide knowledge?	☐	☐	☐	☐	☐
Does your work demand that you are good at coming up with new ideas?	☐	☐	☐	☐	☐

	Always	Often	Sometimes	Seldom	Never
Does your work require that you have very clear and precise eyesight?	☐	☐	☐	☐	☐
Does your work require that you have to control your movements, e.g. your arms and hands consciously?	☐	☐	☐	☐	☐
Does your work demand your constant attention?	☐	☐	☐	☐	☐
Does your work require a high level of precision?	☐	☐	☐	☐	☐

To what extent would you say that your immediate superiors...

	Always	Often	Sometimes	Seldom	Never
Make sure that the individual member of the staff has good development opportunities?	☐	☐	☐	☐	☐
Give high priority to job satisfaction?	☐	☐	☐	☐	☐
Are good at work planning?	☐	☐	☐	☐	☐
Are good at solving conflicts?	☐	☐	☐	☐	☐

Please tick only one answer for each of the following questions:

	Always	Often	Sometimes	Seldom	Never
Do you have a large degree of influence concerning your work?	☐	☐	☐	☐	☐
Could it injure other people if you make mistakes in your work?	☐	☐	☐	☐	☐
Could it cause financial losses if you make mistakes in your work?	☐	☐	☐	☐	☐
Does your work affect the well being of others?	☐	☐	☐	☐	☐

	Always	Often	Sometimes	Seldom	Never
Can you influence the amount of work	☐	☐	☐	☐	☐

assigned to you?

Do you have any influence on WHAT you do at work?	☐	☐	☐	☐	☐
Do you have a say in choosing who you work with?	☐	☐	☐	☐	☐
Is your work varied?	☐	☐	☐	☐	☐
Does your work require you to take the initiative?	☐	☐	☐	☐	☐
Do you have the possibility of learning new things through your work?	☐	☐	☐	☐	☐
Can you use your skills or expertise in your work?	☐	☐	☐	☐	☐

Are you worried about ...	Always	Often	Sometimes	Seldom	Never
-becoming unemployed? ...	☐	☐	☐	☐	☐
-new technology making you redundant? ...	☐	☐	☐	☐	☐
-it being difficult for you to find another job if you became unemployed? ...	☐	☐	☐	☐	☐
-being transferred to another job against your will? ...	☐	☐	☐	☐	☐

Please tick only one answer for each of the following questions:

	Always	Often	Sometimes	Seldom	Never
Can you decide when to take a break?	☐	☐	☐	☐	☐
Can you take holidays more or less when you wish?	☐	☐	☐	☐	☐

	Always	Often	Sometimes	Seldom	Never
If you have some private business, is it possible for you to leave your place of work for half an hour without special permission?	☐	☐	☐	☐	☐
Is your work meaningful?	☐	☐	☐	☐	☐
Do you feel that the work you do is important?	☐	☐	☐	☐	☐
Do you feel motivated and involved in your work?	☐	☐	☐	☐	☐
Would you like to stay at your current place of work for the rest of your working life?	☐	☐	☐	☐	☐
Do you enjoy telling others about your place pf work?	☐	☐	☐	☐	☐
Do you feel that the problems at your place of work are yours too?	☐	☐	☐	☐	☐
Do you feel that your place of work is of great personal importance to you?	☐	☐	☐	☐	☐

At your place of work, are you informed well in advance concerning for example important decisions, changes, or plans for the future?	☐	☐	☐	☐	☐
Do you receive all the information you need in order to do your work well?	☐	☐	☐	☐	☐
Do you know exactly how much say you have at work?	☐	☐	☐	☐	☐
Does your work have clear objectives?	☐	☐	☐	☐	☐
Do you know exactly which areas are your responsibilities?	☐	☐	☐	☐	☐

	Always	Often	Sometimes	Seldom	Never
Are contradictory demands placed on you at work?	☐	☐	☐	☐	☐
Do you sometimes have to do things, which ought to have been done in a different way?	☐	☐	☐	☐	☐
Do you sometimes have to do things, which seem to you to be unnecessary?	☐	☐	☐	☐	☐
Do you do things at work, which are accepted by some people but not others?	☐	☐	☐	☐	☐

How often are your colleagues willing to listen to your work related problems?	☐	☐	☐	☐	☐
How often do you get help and support from your immediate superior?	☐	☐	☐	☐	☐
How often is your immediate superior willing to listen to your work related problems?	☐	☐	☐	☐	☐
How often do you get help and support from your colleagues?	☐	☐	☐	☐	☐
How often do you talk with your superior about how well you carry out your work?	☐	☐	☐	☐	☐
How often do you talk with your colleagues about how well you carry out your work?	☐	☐	☐	☐	☐

Please tick only one answer for each of the following questions:

	Always	Often	Sometimes	Seldom	Never
Do you work isolated from your colleagues?	☐	☐	☐	☐	☐

	Always	Often	Sometimes	Seldom	Never
Is there a good atmosphere between you and your colleagues?	☐	☐	☐	☐	☐
Is there good co-operation between you and your colleagues at	☐	☐	☐	☐	☐

work?

Do you feel part of a community at your place of work?	☐	☐	☐	☐	☐

Regarding your work in general. How pleased are you with...

	Very satisfied	Satisfied	Unsatisfied	Very unsatisfied	Not relevant
Your work prospects?	☐	☐	☐	☐	☐
The physical working conditions?	☐	☐	☐	☐	☐
The way your abilities are used?	☐	☐	☐	☐	☐
Your job as a whole, everything taken into consideration?	☐	☐	☐	☐	☐

Please consider each of the following statements and indicate how well the descriptions fit your situation <u>during the past 4 weeks!</u>

	Correct	Almost correct	Somewhat correct	Only slightly correct	Incorrect
I have not been able to stand dealing with other people.	☐	☐	☐	☐	☐
I have not had time to relax or enjoy myself.	☐	☐	☐	☐	☐

I have been a bit touchy.	☐	☐	☐	☐	☐
I have lacked initiative.	☐	☐	☐	☐	☐

How much of the time <u>during the past 4 weeks have you</u> –

	Always	Often	Sometimes	Seldom	Never
Had stomach ache or stomach problems?	☐	☐	☐	☐	☐
Had a tight chest or chest pains?	☐	☐	☐	☐	☐
Been dizzy?	☐	☐	☐	☐	☐
Had tension in various muscles?	☐	☐	☐	☐	☐
Had difficulty in making decisions?	☐	☐	☐	☐	☐
Had difficulty remembering?	☐	☐	☐	☐	☐
Found it difficult to think clearly?	☐	☐	☐	☐	☐

What do you do when problems arise at work?

	Always	Often	Sometimes	Seldom	Never
Do you try to find out what you can do to solve the problem?	☐	☐	☐	☐	☐
Do you try to think of something else or do something you like?	☐	☐	☐	☐	☐
Do you concentrate on aspects of your work where there are no problems?	☐	☐	☐	☐	☐

Do you accept the situation because there is nothing to do about it anyway?	☐	☐	☐	☐	☐
Do you carry on working and pretend the problem doesn't exist?	☐	☐	☐	☐	☐

Thank you for completing this questionnaire – your time and effort are greatly appreciated.

Appendix 2: Participant Information Sheet

REC ref: 04/Q2403/132.
Date: 21/10/04.
Version 2.

A Study of Work-related Stress among Physiotherapists and Occupational Therapists.

Name of Investigators:
Faye Griffith-Noble

Participant Information Sheet

Invitation paragraph

You have been invited to take part in a research study. Before you decide whether to take part it is important for you to understand why the research is being done and what it will involve. Please contact us if there is anything that is not clear or if you would like more information.

Background

Previously published evidence indicates that the experience of work related stress has detrimental effects upon an individual's quality of life and work performance. Furthermore, it suggests that health professionals by nature of their work are particularly vulnerable to occupational stress. However, despite the already substantial volume of research examining these aspects among health care professionals, little of this research addresses physiotherapists and occupational therapists.

What does the study involve?

This survey consists of a questionnaire that should take approximately 25 minutes to complete. The sections of the questionnaire consist of demographics, and tick box questions dealing with the issues of stress, burnout and coping. You will be provided with a period of two weeks to complete the questionnaire.

Why have you been invited to participate?

You have been invited to participate in the survey as you are currently working as a Physiotherapist or Occupational Therapist.

Do you have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason.

What do I have to do?

If you consent to the study, all you need to do is complete the questionnaire.

What will happen if I score highly on the measures of stress?

The scales within the questionnaire that measure a respondent's level of stress are brief and are not designed to be diagnostic measures of stress. The results will however, give the researcher an indication of your level of stress.

If you score highly on the measures of stress and you have indicated on completion of the questionnaire that you are happy to be informed of your scores, the researcher will contact you by letter and informed you of such along with contact names for advise and/or support with work-place stress should you feel you need it.

Will my taking part in this study be kept confidential?

All information which is collected about you during the course of the research will be kept on a password protected database and is strictly confidential.

What will happen to the results of the research study?

Results from this study will be presented to a learned society and submitted for publication in an appropriate peer-reviewed journal to assist the dissemination of the findings to clinical practice.

Who has reviewed the study?

This study has been reviewed and approved by the Nottingham University Ethics Committee.

Contact for Further Information

If you have any questions or need clarification you can contact me at Nottingham University - Division of Physiotherapy Education:

Thank you for taking the time to read this information sheet.

Appendix 3: Invitation letter to accompany Questionnaires

REC ref: 04/Q2403/132.
Date: 21/10/04.
Version 2.

Physiotherapeutic Research Group,
Division of Physiotherapy Education,
University Of Nottingham,
Clinical Sciences Building,
Nottingham City Hospital,
Hucknall Road,
Nottingham,
NG5 1PB

To Whom It May Concern:

Re: **A study of Psychosocial Working Conditions, Stress, Health and Burnout among Professions Allied to Medicine.**

The Physiotherapeutic Research Group (PRG) at the University of Nottingham is conducting a questionnaire survey of the Professions Allied to Medicine experiences of work-related stress, burnout and coping. This survey has been reviewed and approved by the Central Office for Research Ethics Committees: Nottingham (1) Ethics Committee.

You are being invited to participate in this survey because of your role as a Professional Allied to Medicine.

Therefore, please find enclosed a questionnaire that should take no more than 25 minutes to complete. Please note that all answers are confidential/anonymous and responses will be held under the terms of the Data Protection Act, 1984. Additionally you are reminded that you are under no obligation to complete the questionnaire and by filling in the questionnaire you are giving your consent to participate in the survey.

The physiotherapeutic research group plan to disseminate the findings from this study through relevant journals and conferences. However, because of the

importance of this research and its potential for informing working practice, we will be making a summary of the results available to all who participate. Please contact me on completion of the questionnaire if you wish to receive a summary of our findings.

Please do not hesitate to contact me at the address above if you require further information regarding the survey.

Thank you for your time and co-operation.

Yours sincerely,
Faye Griffith-Noble

Appendix 4: Procedure for referral to relevant counselling organisations

REC ref: 04/Q2403/132.
Date: 21/10/04.
Version 2.

Full Title of the study:
A study of Psychosocial Working Conditions, Stress, Health and Burnout among Professions Allied to Medicine.

This document is submitted in response to Point 10 of the further information and clarification required, stated in the letter dated 13th October 2004 regarding the committee's provisional decision about the above ethics application.

Procedure for referral to relevant counselling organisations

1. Responding to feelings and distress that may arise

The wellbeing of the person should always take precedence over the study itself. Completing the questionnaire may arouse feelings that need to be acknowledged and responded to sensitively. If a respondent becomes distressed and contacts the researcher it may be necessary for the researcher to provide appropriate contact names and telephone numbers of counselling services so that the individual can seek further support if they wish (See details below of counselling services).

2. Identification of stressed respondents

The scales within the questionnaire that measure a respondent's level of stress and burnout are brief and are not designed to be diagnostic measures of stress. The results will however, give the researcher an indication of a respondent(s) level of stress and/or burnout.

A paragraph will be added to the information sheet to state that if a respondent is found to have scored highly on the measures of stress and burnout they will be contacted via letter by the researcher and informed of such findings, unless they have indicated on completion of the questionnaire that such contact is unwanted. Hence, a further question will be added at the conclusion of the questionnaire asking the respondent if they agree or disagree to be contacted if they are found have scored highly on measures of stress and burnout.

The contact letter will provide appropriate contact names and telephone numbers of counselling services so that the individual can seek further support if they wish (See details below of counselling services).

Should a questionnaire respondent decide to access a counselling service the decision about which service or organisation will be theirs to make. If requested the researcher will offer structured and informed advice about services available.

3. Health and Safety Leaflet

Every respondent, after the survey will be given a copy of the HSE leaflet 'Tackling work-related stress: A guide for employees' (HSE Leaflet INDG341).

CONTACT NAMES:

Internal Counselling Services / Advice Points

Occupational Health

Confidential counselling is provided as well as counselling sessions being provided with a qualified staff counsellor. Frequency and number of sessions will be agreed with the individual counsellor. Occupational health services also have contact with specialist agencies if this is required.

Chaplaincy Departments

Chaplaincies provide formal staff counselling which is normally operated on a short/medium term basis. They are able to refer people for longer term/specialist counselling if necessary.

Staff Health Promotion

The Staff Health Promotion services hold databases of all counselling services available both locally and nationally. Information is also held regarding B.A.C registered and accredited counsellors.

External Counselling Services

There are many external sources of counselling. The following outline some of those on offer.

- N.H.S Direct
  0845 46 47

- British Association for Counselling and Psychotherapy (BACP) - www.bacp.co.uk

  The BACP list contact details (nationally) of all accredited and qualified private counsellors.

- Trade Unions/Professional Associations

  Many trade unions and professional associations do have information and advice they can offer on stress issues. Some provide their own telephone counselling service.

Appendix 5: Letter to be issued to participants who are found to have high levels of stress.

REC ref: 04/Q2403/132.

Date: 21/10/04.

Version 2.

Physiotherapeutic Research Group,
Division of Physiotherapy Education,
University Of Nottingham,
Clinical Sciences Building,
Nottingham City Hospital,
Hucknall Road,
Nottingham,
NG5 1PB

To Whom It May Concern:

Re: A study of Psychosocial Working Conditions, Stress, Health and Burnout among Professions Allied to Medicine.

The questionnaire survey of psychosocial working conditions, stress, health and burnout among professions allied to medicine is now finished.

You indicated on completion of the questionnaire that you would like to be informed if you scored highly on the measures of work-place stress and/or burnout.

I would like to reiterate that the scales within the questionnaire that measure a respondent's level of stress and burnout are brief and are not designed to be diagnostic measures of stress. The results have however, given the researcher an indication that your level of work-related stress/burnout is high.

I have enclosed a leaflet you may find informative published by the Health and Safety Executive entitled: 'Tackling work-related stress: A guide for employees' (HSE Leaflet INDG341).

If you feel that your work-related stress is of concern to you, you may wish to speak to one of the organisations or counselling services detailed on the information sheet enclosed with this letter.

If you have questions or need clarification, please do not hesitate to contact me at the above address.

Yours sincerely,

Faye Griffith-Noble
Postgraduate Student,
Physiotherapeutic Research Group.

INFORMATION SHEET: CONTACT NAMES:

Internal Counselling Services / Advice Points

Occupational Health
Confidential counselling is provided as well as counselling sessions being provided with a qualified staff counsellor. Frequency and number of sessions will be agreed with the individual counsellor. Occupational health services also have contact with specialist agencies if this is required.

Chaplaincy Departments
Chaplaincies provide formal staff counselling which is normally operated on a short/medium term basis. They are able to refer people for longer term/specialist counselling if necessary.

Staff Health Promotion
The Staff Health Promotion services hold databases of all counselling services available both locally and nationally. Information is also held regarding B.A.C registered and accredited counsellors.

External Counselling Services

There are many external sources of counselling. The following outline some of those on offer.

- N.H.S Direct
  0845 46 47

- British Association for Counselling and Psychotherapy (BACP) - www.bacp.co.uk

  The BACP list contact details (nationally) of all accredited and qualified private counsellors.

- Trade Unions/Professional Associations

  Many trade unions and professional associations do have information and advice they can offer on stress issues. Some provide their own telephone counselling service.

Chapter 3.

Appendix 1: Participant Information Sheet

Version 2.

MREC Ref No: 04/Q2404/102
Date 19/10/04

University of Nottingham
Physiotherapeutic Research Group
Division of Physiotherapy Education
Clinical Sciences Building
City Hospital
Hucknall Road
Nottingham
NG5 1PB

A Study of Physiotherapists and Occupational Therapists Experiences of Work-Related Stress.

Name of Investigators:
Mrs Faye Griffith-Noble

Healthy Volunteer's Information Sheet

Invitation paragraph

You have been invited to take part in a research study. Before you decide whether to take part it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with friends and relatives if you wish to. Ask us if there is anything that is not clear or if you would like more information.

Background

Previously published evidence indicates that the experience of work-related stress has detrimental effects upon an individual's quality of life

and work performance. Furthermore, it suggests that health professionals by nature of their work are particularly vulnerable to occupational stress and burnout syndrome. However, despite the already substantial volume of research examining these aspects *among* health care professionals, little of this addresses professional allied to medicine.

What does the study involve?

This study focuses on members of the professions allied to medicine experiences of work-place stress. The study is to be conducted through interviews during which interviewees will be given the opportunity to talk about their experiences of stress as a consequence of their job.

Why have you been chosen?

You have been chosen to participate in the survey as you are a member of the professions allied to medicine.

Do you have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason.

What do I have to do?

If you consent to the interview, you will be asked some questions by a researcher about your experiences of work-place stress. The interview will take approx 45 minutes to complete and will be conducted at a time to suit your convenience, if the interview is to conducted during work hours the consent of your manager will be required. You will be interviewed within the hospital building in which you work, but away from your department in private room being used solely for the purpose of the interviews. The interview will be entirely voluntary and even after the interview begins you can refuse to answer any specific questions and can terminate the interview at any point. You may be contacted after the interview by the researcher to confirm details of the interview and/or for further information.

Will my taking part in this study be kept confidential?

All information which is collected about you during the course of the research will be kept on a password protected database and is strictly confidential.

What will happen to the results of the research study?

Results from this study will be presented to a learned society and submitted for publication in an appropriate peer-reviewed journal to assist the dissemination of the findings to clinical practice.

Who is organising and funding the research?

This research study is being organised and funded by the Physiotherapeutic Research Group within the Division of Physiotherapy Education at the University of Nottingham.

Who has reviewed the study?

This study has been reviewed and approved by the Nottingham Local Research Ethics Committee.

Contact for Further Information

If you have any questions or need clarification you can contact me the Division of Physiotherapy Education:

Mrs Faye Griffith-Noble (Postgraduate Student)
Physiotherapeutic Research Group
Division of Physiotherapy Education
Clinical Sciences Building
City Hospital
Hucknall Road
Nottingham
NG5 1PB

Tel: 01782 722412
Email: mcxfg@nottingham.ac.uk

Thank you for taking the time to read this information sheet.

Appendix 2: LETTER OF INVITATION

REVISED DOCUMENT.
Version 2.
Ref No: 04/Q2404/102
Date:19/10/04

Physiotherapeutic Research Group,
Division of Physiotherapy Education,
University Of Nottingham,
Clinical Sciences Building,
Nottingham City Hospital,
Hucknall Road,
Nottingham,
NG5 1PB

To Whom It May Concern:

Re: A Study of Professionals Allied to Medicine Experiences of Work-Related Stress.

The Physiotherapeutic research group at the University of Nottingham are conducting a series of interviews with members of the Professions Allied to Medicine during which interviewees will be given the opportunity to talk about their experiences of stress as a consequence of their job.

Please find enclosed an information sheet that describes the study and explains what would be required of you should you choose to participate.

Having read the information sheet, if you would like to volunteer or request further information please contact me at the above address.

Thank you for taking the time to read this.

Yours sincerely,

Faye Griffith-Noble

Appendix 3: Consent form.

CONSENT FORM

Title of Project:

A Study of Professionals Allied to Medicine Experiences of Work-Related Stress

Name of Researcher: Faye Griffith-Noble

Please initial box

I confirm that I have read and understand the information sheet ☐ dated 19/10/04 (version 2) for the above study and have had the opportunity to ask questions.

I understand that my participation is voluntary and that I am free ☐ to withdraw at any time, without giving any reason, without my legal rights being affected.

I agree to take part in the above study. ☐

Name of Participant	Date	Signature
Name of Person taking consent (if different from researcher)	Date	Signature
Researcher	Date	Signature

Appendix 4: Procedure for dealing with participant distress

REC Reference number: 04/Q2404/102
Protocol number: 2
Date: 19/10/04

Full Title of the study:
A study of Professionals Allied to Medicine Experiences of Work-Related Stress.

This document is submitted in response to Point 5 of the further information and clarification required in the letter dated 5th October 2004 regarding the committee's provisional decision about the above ethics application.

Responding to feelings and distress that may arise

The wellbeing of the person being interviewed should always take precedence over the interview itself. Telling their story may arouse feelings that need to be acknowledged and responded to sensitively. If the participant becomes too distressed, it may be necessary to finish the interview. The interviewer will provide appropriate contact names and telephone numbers of counselling services so that the participant can seek further support if they wish (See details below of counselling services).

Follow-up phone call

A follow-up phone call will be made, one week after the interview, to ask whether the interviewee is still concerned about any issues mentioned during the interview. The phone call is an opportunity to reiterate advice about counselling services.

Health and Safety Leaflet

Every interview participant will be given a copy of the HSE leaflet 'Tackling work-related stress: A guide for employees' (HSE Leaflet INDG341).
Should an interview participant decide to access a counselling service the decision about which service or organisation will be theirs to make. The researcher will offer structured and informed advice.

CONTACT NAMES:

Internal Counselling Services / Advice Points

Occupational Health
Confidential counselling is provided as well as counselling sessions being provided with a qualified staff counsellor. Frequency and number of sessions will be agreed with the individual counsellor. Occupational health services also have contact with specialist agencies if this is required.

Chaplaincy Departments
Chaplaincies provide formal staff counselling which is normally operated on a short/medium term basis. They are able to refer people for longer term/specialist counselling if necessary.

Staff Health Promotion
The Staff Health Promotion services hold databases of all counselling services available both locally and nationally. Information is also held regarding B.A.C registered and accredited counsellors.

External Counselling Services

There are many external sources of counselling. The following outline some of those on offer.

- N.H.S Direct
  0845 46 47

- British Association for Counselling and Psychotherapy (BACP) - www.bacp.co.uk

  The BACP list contact details (nationally) of all accredited and qualified private counsellors.

- Trade Unions/Professional Associations

  Many trade unions and professional associations do have information and advice they can offer on stress issues. Some provide their own telephone counselling service.

Appendix 5: Pilot Interview Schedule

PILOT INTERVIEW

This interview is with participant no.1 at Cannock chase hospital on the .....

To begin the interview I have a few questions to ask about you then I will move on to questions about work-related stress and your experiences.

1) What age are you?
2) What is your present job and grade?
3) What length of time have you spent working in your:
   a. Current position?
   b. Profession?
4) Have you attended any sort of stress management training?

   If yes; who provided by and did you find it useful?

5) Can you describe your job for me?
6) On a typical day what is it that you actually do?
7) How much time daily, perhaps as a percentage do you spend:
   - Patient contact
   - Administration
   - Other tasks
8) Do you have any influence over the type and amount of patients that you see?

9) In terms of patient load; what would the most common clinical condition you deal with?

- Do you find this work interesting

10) What are your working conditions like, for example are you happy with the equipment available to you; the rooms available etc.

11) Do you find your work emotionally demanding?

12) Do you find your stimulating?

13) Do you find your job frustrating?

14) What is it about your job that you like?

15) What is it about your job that you dislike?

16) Would you say that you are satisfied with your job?

17) How often do you receive supervision?

- Is this enough?
- Are you happy with your supervision?
- Is your supervisor willing to listen?

Theme: Conceptualisation

1) What do you think the term work stress means?

2) If someone is experiencing stress at work what do you think the signs and symptoms would be?

3) Do you feel that you experiencing any of these symptoms?

Theme: Personal experiences

1) Are you experiencing stress at work at the moment?

2) What is it about your work or working environment that is causing you to feel stressed, i.e.

- Patient load
- Administration
- Working conditions
- Level of responsibility
- management

3) Can think of the most stressful event you have experienced recently,

- can you describe it
- how you felt
- how you coped with it – what you did
- Who you discussed it with

Theme: Personal effects of stress

1) What effect, such as on your physical or psychological health do you feel that stress is having/ has had on you?

Theme: Coping

1) How do you cope with stress at work, for example, if you are feeling particularly stressed during the day what do you do?

- Do you try to find out what you can do to solve the problem? Or perhaps,
- Pretend that the problem does not exist?

2) Are you able to talk about your experiences of stress with your colleagues and if so, does this help?

3) Is there a good atmosphere between yourself and your colleagues?

4) What support have you received from your manager?

a. How willing to listen
b. How accessible is your manager / supervisor?

Overall

1) What do you believe could be altered about your job, for example your: working environment; job description; supervision, etc, to **decrease** the amount of stress that you experience at work?

Managers Survey

ABOUT YOU...

What age are you? ..... Years

Male ☐ Female ☐

What gender are you?

What length of time have you spent working...

- In your current position? ..... Years ..... Months
- In your current profession? ..... Years ..... Months
- For your current trust? ..... Years ..... Months

In which department do you work?

.....

Do you have clinical responsibilities? Yes ☐ No ☐

What is your professional title and grade?

Title: ..... Grade: .....

(Example: Title: Clinical Manager
Grade: Superintendent)

What hours do you work?

Full-time ☐ Part-time ☐

Please list your professional qualifications and year gained.

..... Year gained .....

..... Year gained .....

..... Year gained .....

Have you attended any sort of stress management training?

Yes ☐ No ☐

If you answer yes to the above question...

- Was this training provided by your trust? Yes ☐ No ☐
- Did you find this training helpful? Yes ☐ No ☐

Have you received a copy of the Health and Safety Executive booklet (HSE) "Tackling work-related stress: a managers' guide to improving and maintaining employee health and wellbeing?

Yes ☐ No ☐

If YES, has this booklet positively influenced your understanding of work-related stress?

Yes ☐ No ☐

Which one of the following definitions most closely matches your understanding of work-related stress? Please tick only one answer.

☐ – Stress is a negative characteristic of the work environment.

☐ – Stress is a physiological response to a threatening or damaging environment.

☐ – Stress is a consequence of an interaction between the person and their environment.

What do you think are the signs that people in your department are under stress? Tick as many as you think are applicable.

☐ Emotional or erratic behaviour

☐ Changes in motivation

☐ Insubordination

☐ Changes in work performance

☐ Absenteeism

☐ Working excessive hours

☐ Increased smoking and / or drinking

☐ Reduction in self confidence

☐ Increased lateness

☐ Withdrawal from social contacts

☐ Leaving work early

☐ Irritability or increased impatience

☐ Reduction in self esteem

☐ Changes in relationships with other staff members

Below is a list of potential causes of stress. How much do you think each contributes to work-related stress? Please tick one answer for each.

	To a very high degree	To a high degree	Somewhat	To a low degree	None
Lack of support form other staff members.	☐	☐	☐	☐	☐
Lack of support from supervisors.	☐	☐	☐	☐	☐

	To a very high degree	To a high degree	Somewhat	To a low degree	None
Social isolation.	☐	☐	☐	☐	☐
Shift working.	☐	☐	☐	☐	☐
Low participation in decision-making.	☐	☐	☐	☐	☐
Lack of control over work.	☐	☐	☐	☐	☐
Career stagnation.	☐	☐	☐	☐	☐
Poor communication.	☐	☐	☐	☐	☐
Conflicting demands of work and home.	☐	☐	☐	☐	☐
Work overload.	☐	☐	☐	☐	☐
Work underload.	☐	☐	☐	☐	☐
Poor environmental conditions.	☐	☐	☐	☐	☐
Personality.	☐	☐	☐	☐	☐
Poor coping style.	☐	☐	☐	☐	☐

Low self esteem.	☐	☐	☐	☐	☐
Overly self critical	☐	☐	☐	☐	☐

How important do you think the following are in causing work-related stress? Please tick one answer for each.

	To a very high degree	To a high degree	Somewhat	To a low degree	None at all
A) Working conditions.	☐	☐	☐	☐	☐
B) Worker characteristics.	☐	☐	☐	☐	☐
C) Combination of A and B.	☐	☐	☐	☐	☐

Below is a list of various organisational consequences of work-related stress. Please indicate to what degree each has an impact on your department. Please tick an answer for each.

	To a very high degree	To a high degree	Somewhat	To a low degree	None
Increase in sickness absence.	☐	☐	☐	☐	☐
Poor staff performance.	☐	☐	☐	☐	☐
Reduction on staff morale.	☐	☐	☐	☐	☐
High staff turnover.	☐	☐	☐	☐	☐
Staff shortages.	☐	☐	☐	☐	☐
Expense of recruitment.	☐	☐	☐	☐	☐
Rota changes.	☐	☐	☐	☐	☐
Increase in patient load for other staff members.	☐	☐	☐	☐	☐

What do you think are the possible health consequences of work-related stress? Tick as many as you think are applicable.

- ☐ Cardiovascular disease
- ☐ Mental health problems
- ☐ Suicide
- ☐ High blood pressure
- ☐ Impaired immune function
- ☐ Musculoskeletal disorders
- ☐ Work – place injury
- ☐ Cancer
- ☐ Gastrointestinal illness
- ☐ No consequence

Please circle ONE answer for each of the following questions:

How much control do people in your department have over factors which might produce stress for them?

None at all	*Little control*	*Somewhat*	*A lot of control*	*Very much control*

If a person in your department is showing signs of stress, to what extent is it their own responsibility to do something about the stress?

A very high degree	*A high degree*	*Somewhat*	*A low degree*	None at all

To what extent does the trust itself have a responsibility to address problems of stress within your department? Please circle you answer.

A very high degree	*A high degree*	*Somewhat*	*A low degree*	None at all

To what extent does the department manager have a responsibility to address problems of stress within your department?

A very high degree	*A high degree*	*Somewhat*	*A low degree*	None at all

How important do you think Stress Management is at the following levels?

	To a very high degree	To a high degree	Somewhat	To a low degree	None at all
A) Organisational level	☐	☐	☐	☐	☐
B) Managerial level	☐	☐	☐	☐	☐
C) Personal level	☐	☐	☐	☐	☐

When prioritising work-related responsibilities, what priority do you feel that stress related issues should be given by each of the following:

	To a very high degree	To a high degree	Somewhat	To a low degree	None at all
A) The organisation	☐	☐	☐	☐	☐
B) Managers	☐	☐	☐	☐	☐
C) Individuals themselves	☐	☐	☐	☐	☐

When people in your department are experiencing stress, what actions does your trust currently take and how effective is each of these?

	To a very high degree	To a high degree	Somewhat	To a low degree	Not at all	Not applicable
Communication and information sharing.	☐	☐	☐	☐	☐	☐
Employee involvement.	☐	☐	☐	☐	☐	☐
Performance evaluation and feedback.	☐	☐	☐	☐	☐	☐
Restructuring of physical work.	☐	☐	☐	☐	☐	☐
Management style changes.	☐	☐	☐	☐	☐	☐
Employer assisted programmes (EAPS).	☐	☐	☐	☐	☐	☐
Socials support.	☐	☐	☐	☐	☐	☐
Role clarification.	☐	☐	☐	☐	☐	☐

	To a very high degree	To a high degree	Somewhat	To a low degree	Not at all	Not applicable
Career development.	☐	☐	☐	☐	☐	☐
Stress management.	☐	☐	☐	☐	☐	☐
Reduced job demand.	☐	☐	☐	☐	☐	☐
Work place health and fitness programmes.	☐	☐	☐	☐	☐	☐

Disciplinary action.	☐	☐	☐	☐	☐	☐
Time off (including sick leave).	☐	☐	☐	☐	☐	☐
Nothing	☐	☐	☐	☐	☐	☐

To what degree has a personal experience with stress influenced your decisions about stress management interventions and strategies?

Please circle your answer.

A very high degree	*A high degree*	*Somewhat*	*A low degree*	None at all

To what degree has a recent experience with a staff member exhibiting signs of stress influenced your decisions about stress management interventions and strategies? Please circle your answer.

A very high degree	*A high degree*	*Somewhat*	*A low degree*	None at all

Thank you for completing this questionnaire – your time and effort are greatly appreciated.

Appendix 2: Consent Form

CONSENT FORM

Title of study:

A study of Clinical Managers Knowledge of Psychosocially Mediated Work-Related Stress Amongst Professions Allied to Medicine and Current Workplace Stress Management Techniques.

Name of Researcher: Faye Griffith-Noble

Please initial box

I confirm that I have read and understand the information sheet ☐ dated 19/10/04 (version 2) for the above study and have had the opportunity to ask questions.

I understand that my participation is voluntary and that I am free ☐ to withdraw at any time, without giving any reason, without my legal rights being affected.

I agree to take part in the above study. ☐

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	
Name of Person taking consent (if different from researcher)	Date	Signature

_____	_____	
Researcher	Date	Signature

1 for patient; 1 for researcher; 1 to be kept with hospital notes

Appendix 3: Participants Information Sheet

COREC REF No: 04/Q2604/87. Date 09/09/2004

A study of Managers Knowledge of Psychosocially Mediated Work-Related Stress Amongst Professions Allied to Medicine and Current Workplace Stress Management Techniques.

Name of Investigators:
Faye Griffith-Noble

Research Participant Information Sheet

Invitation paragraph

You have been invited to take part in a research study. Before you decide whether to take part it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Please contact me if there is anything that is not clear or if you would like more information.

Background

Interventions aimed at the psychosocial issues within the workplace frequently distinguish between the individual and organizational level. There is evidence to support the proposal that each level of intervention produces a range of practices that offer opportunities for individual development and well-being. However, research further suggests that many interventions are inadequate because they provide only a partial solution.

One reason that existing interventions may be failing is that, little effort has been made in determining what managers understand by stress and the extent to which they think that their organisation has a responsibility to address stress related problems. Furthermore, not enough information is ascertained about what actions (if any) organisations actually employ; how effective they are believed to be, and what actions managers would take (if they were responsible for stress management intervention) within their organisation.

What does the study involve?

This survey consists of a questionnaire that should take approximately 20 minutes to complete. The questionnaire asks questions that relate to your knowledge of work-place stress for the people you manage and of your departments current stress management practises. You will be provided with a period of two weeks to complete the questionnaire.

Why have you been chosen?

You have been invited to participate in the survey as you are currently working as a Manager within the professions of Physiotherapy or Occupational Therapy.

Do you have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep

What do I have to do?

If you consent to the study, all you need to do is complete the questionnaire.

Will my taking part in this study be kept confidential?

All information which is collected about you during the course of the research will be kept in accordance with the Data protection Act 1998 and as such on a password protected database and is strictly confidential. Confidentiality will also be guaranteed with respect to all publications, presentations and any other method of disseminating findings from this study.

What will happen to the results of the research study?

Results from this study will be presented to a learned society and submitted for publication in an appropriate peer-reviewed journal to assist the dissemination of the findings to clinical practice.

Who has reviewed the study?

This study has been reviewed and approved by the Nottingham University Research ethics Committee.

Contact for Further Information

If you have any questions or need clarification you can contact me the Division of Physiotherapy Education at Nottingham University.

Thank you for taking the time to read this information sheet.

Appendix 4:

COREC REF No: 04/Q2604/87. Date 09/09/2004

Invitation letter to accompany Questionnaires

Physiotherapeutic Research Group,
Division of Physiotherapy Education,
University Of Nottingham,
Clinical Sciences Building,
Nottingham City Hospital,
Hucknall Road,
Nottingham,
NG5 1PB

To Whom It May Concern:

Re: Survey of Professions Allied to Medicine Managers knowledge of work-place stress and attitudes toward stress management interventions.

The Physiotherapeutic research group at the University of Nottingham are conducting a questionnaire survey of managers' knowledge of work-place stress and attitudes toward stress management interventions. This survey has been reviewed and approved by the Central Office for Research Ethics Committees.

You have been chosen to participate in the survey as you are currently working as a manager within one of the Professions Allied to Medicine.

Therefore, please find enclosed a questionnaire that should take no more than 20 minutes to complete. Please note that all answers are confidential/anonymous and responses will be held under the terms of the Data Protection Act, 1984. Additionally you are reminded that you are under no obligation to complete the questionnaire and by filling in the questionnaire you are giving your consent to participate in the survey.

The physiotherapeutic research group plan to disseminate the findings from this study through relevant journals and conferences. However, because of the importance of this research and its potential for informing working practice, we will be making a summary of the results available to all who participate.

Please do not hesitate to contact me at the address above if you require further information regarding the survey.

Thank you for your time and co-operation.

Yours sincerely,
Faye Griffith-Noble