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Experience of stress in psychiatric nursing students in Ireland

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Abstract

Aim The aim of this study was to explore the experience of stress among psychiatric nursing students undertaking their 'internship' or final year of a four-year degree course.

Method A questionnaire was administered to all 28 students in the intern year in conjunction with the 28-item version of the General Health Questionnaire. Semi-structured interviews were subsequently undertaken with four volunteers from a range of clinical locations.

Findings Approximately 48% of respondents reported levels of stress above the threshold score as described by Goldberg (1978), indicating levels of distress unlikely to remit without intervention. Interview data suggested that the main sources of stress during the intern year were associated with relationships in the clinical environment; clinical workload; matching competence and responsibility; and simultaneous clinical and academic demands.

Conclusion The findings should be interpreted with caution and understood within the context of the dynamic nature of nurse education in Ireland. However, the issues raised demand further enquiry to examine the structure of educational programmes, the nature of the work and the organisational culture in which the work is carried out.

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Keywords

Clinical placements; Mental health nursing; Nursing students; Stress

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IDENTIFICATION OF STRESS levels and sources of stress in nursing have received significant attention in the literature. There is much evidence to suggest that nursing as a profession is associated with high levels of occupational stress (Tully 2004). One review of the literature led Cottrell (2000) to conclude that the levels of occupational stress experienced by psychiatric nurses were 'unusually and especially high'. Lambert and Lambert (2001) found more than 100 studies that investigated stress in the nursing profession. Factors such as workload, hard work, shift work, understaffing and organisational change (Lindop 1999, Cottrell 2000), along with nursing shortages, an increasing average age profile, lack of experience in newly qualified nurses and violence (Chang *et al* 2005) have been identified as contributing to occupational stress in nurses. Jenkins and Elliott (2004) identified inadequate staffing levels and a lack of resources as the major stressors for nursing staff working in acute mental health units. Cottrell (2000) found significant levels of stress in hospital-based nurses and the stressors identified were similar to those for community-based nurses: workload, interpersonal relationships, managerial role and home/work balance (Hopkinson *et al* 1998).

Little research into stress in psychiatric nursing in the Irish context has been undertaken, with the exception of one study by Ryan and Quayle (1999), which identified lower than expected levels of stress among psychiatric nurses in all work locations and that organisational issues are the major source of stress. Mann and Cowburn (2005) found that organisational expectations of psychiatric nurses to respond to emotionally charged situations in a manner considered to be professionally appropriate were a significant factor in the development of occupational stress.

They further suggested that the level of stress among nurses had implications for the design of psychiatric nurse education programmes.

Much of the contemporary research into the experience of stress among nursing students is concerned with the recent move to third level education (courses offered by universities or higher institutes of education at degree level) in nursing education programmes. Jones and Johnston (1997) examined levels of stress in first-year nursing students shortly after their first clinical placement and reported significant levels of stress and distress in diploma nursing students around the time of their initial clinical placement. They suggested that there was an enduring problem with distress among nursing students in the early stages of nurse training.

Oermann and Sperling (1999) compared stress associated with the psychiatric clinical component of nurse training with placements in other specialty areas and found lower levels of stress in students on psychiatric placements compared with those on paediatric or surgical placements. Notably the stress levels were examined at the end of the training programme and the authors suggest that the students may have developed knowledge and skills as well as coping strategies to deal with the stressors associated with their role. Nursing students should adjust to a new setting with each change of placement, and have to contend with clinically based as well as academically based assessments.

In the Irish context, students should function as full-time employees during the final year of the nurse education programme. Jones and Johnston (1997) found major stressors for nursing students included fear of failure in the course, examinations, the amount of class work and financial concerns. These findings were supported by Lindop (1999) in a comparative study of stress in pre- and post-Project 2000 diploma nursing students. His study found that educational factors were a more significant stressor for Project 2000 diploma nursing students than for students undertaking the traditional apprenticeship model of training. However, Lindop (1999) identified that the groups rated the same clinical factors as stressful.

Many of the factors identified by Lindop (1999) resonate with the stressors identified by qualified nurses, for example hard work, shift work, understaffing, workload pressures and organisational change (Cottrell 2000), along with nursing shortages, an increasing average age profile, newly qualified nurses' lack of experience

and violence against staff or in the work environment (Wells and Ryan 2000, Wells *et al* 2000, Chang *et al* 2005). In addition, stressors specific to nursing students were identified, such as too much course work, feeling useless and unable to contribute in a meaningful way to the team, perceived negative attitudes towards patients and conflicts between theory and practice. Lindop (1999) also revealed that students experienced the stress associated with the clinical component of the course more intensely in their final year than those in the first or second year of the programme. Higher levels of stress in the latter part of the course were confirmed in the Irish context by Tully (2004), who proposed a number of possible explanations. Increased professional demands on more experienced students, students having higher expectations of themselves as they progress and students having greater insight into the patient's situation may all be contributory factors.

There are difficulties in drawing comparisons between international findings. Significant differences exist internationally in the structure of nurse education programmes and in terms of the clinical components of those programmes. The move from a diploma-level nursing programme to an undergraduate degree programme has brought Ireland into line with countries such as Australia and the United States where undergraduate nursing degree programmes are well established. Given the differences in organisational structures and culture internationally, however, caution should be exercised in drawing any comparisons between the experiences of students internationally and in Ireland.

There is limited research on the stress experienced by students undertaking undergraduate diploma nursing programmes, with most research focusing on general nursing programmes. Only one study relating to stress in undergraduate diploma psychiatric nursing students in Ireland was identified in the literature (Tully 2004) and none were found that related specifically to undergraduate degree programmes in Ireland, where direct entry programmes to general nursing, intellectual disability and psychiatric/mental health nursing are the norm, unlike in most countries. Nurse education programmes in Ireland are four-year degree programmes. Students have graded exposure to clinical practice culminating in a full year 'internship' in their final year of study.

Aim

The aim of this study was to explore the experience of stress among psychiatric nursing students during the internship year of their nurse education programme.

Methods

A mixed methods or triangulation design was used for this study employing qualitative and quantitative data collection methods.

Triangulation approaches in research have been viewed as a means of providing confirmation or convergent validity (Fielding and Fielding 1986). However, while this is one clear function of triangulation, it is equally accurate to presume that multiple methods, especially ones drawing on differing research paradigms, either add to or reveal additional dimensions of phenomena being investigated to provide completeness (Shih 1998). The mixed method approach in this study was chosen primarily for this reason.

A self-administered quantitative questionnaire was distributed to intern year psychiatric nursing students undertaking placement within the Irish Health Service Executive, Midwest Region ($n = 28$) to establish the levels of stress in this cohort of students. A total population sample was deemed appropriate given the small number of students involved.

Survey packs comprising two questionnaires, an explanatory letter and a letter inviting expression of interest in participation in a subsequent interview were distributed to students through the internal postal system. A pre-addressed envelope for return of the questionnaires was also included. A deadline of two weeks was set for return of the completed questionnaires. To maximise the response rate, clinical placement co-ordinators agreed to remind students to return completed questionnaires and assisted this process by collecting completed questionnaires and returning them to the researcher. This helped to ensure that the impact of loss or late submission of questionnaires on response rates was minimised. The original date was, however, extended by one week to enable nursing students who were absent due to illness at the time the questionnaires were distributed, to return them. This resulted in the collection of four additional questionnaires.

Subsequently a series of semi-structured interviews was conducted with students to explore sources of stress experienced during the intern year. Semi-structured interviews have the advantage of allowing the interviewer to ensure that similar types of data are collected from each respondent while allowing flexibility in the interview to capture the experience and perspective of the respondent (Holloway and Wheeler 2002).

Following the return of expression of interest letters, a purposive sample of students was selected to ensure that students on different types of clinical placement, for example acute care, care

of the older person and continuing care in the community, were represented. The names of students who had expressed an interest in participating were grouped by clinical placement and selected purposely from this group to represent each clinical placement. A written explanation of the process was given to each student who expressed a desire to participate and a consent form was signed by the student. Fourteen respondents volunteered for interview and three respondents were selected. One further respondent was subsequently included to ensure that saturation of data had been achieved.

The survey used two instruments. The first questionnaire consisted of eight questions to facilitate a descriptive analysis of independent variables including age, gender, living arrangements, previous experience as a carer, and level of academic and clinical assessment attainment.

The second questionnaire was the General Health Questionnaire (GHQ) 28 (Goldberg 1978). The GHQ 28 is a 28-item version of the GHQ (Goldberg and Hillier 1979). Each item has four response options, ranging from 'Not at all' to 'Much more than usual'. The questionnaire is divided into four scales measuring anxiety, depression and somatic symptoms as well as social functioning. The questionnaire is most commonly scored by assigning a dichotomous (0-0-1-1) value to the responses. This means that those who indicate 'Not at all' or 'Sometimes' are assigned a score of '0', while those indicating either 'More than usual' or 'Much more than usual' are both given a score of '1'. In this way the possible scoring range is 0-28. A threshold score is attributed as an indication of psychological distress. Many studies use a threshold score of 5 (McPherson *et al* 2003). However, the threshold scores where 'no distress' is indicated by a score of 3 or less, 'mild distress' by scores from 4 to 6, and 'severe distress' is indicated by scores greater than 6 (Goldberg and Williams 1991, Goldberg *et al* 1997) provide greater refinement. The World Health Organization independently suggested the use of a score of 6 or higher to indicate 'caseness' (Goldberg *et al* 1997). Psychiatric caseness refers to a level of psychological disturbance that is unlikely to remit without intervention (Goldberg and Williams 1991, Goldberg *et al* 1997). In this study, the 'banded scores' are presented for descriptive purposes, but the more conservative threshold score of 6 or higher is used to indicate 'problematic stress', while lower scores are interpreted as being non-problematic, in that they are likely to remit without intervention.

The GHQ 28 has been used extensively and validated in health care as well as in specific

studies to identify stress levels in nursing students (Jones and Johnston 1997, 2000, Deary *et al* 2003, Nicholl and Timmins 2004) and in studies measuring stress levels in qualified psychiatric/mental health nurses (Ryan and Quayle 1999, Edwards *et al* 2000, 2001).

Four respondents were interviewed. The interviews ranged in duration from ten minutes to 20 minutes. Interviews were carried out on week 34 and 35 of the intern year. All interviews took place by appointment in the student's place of work. Interviews were recorded and transcribed verbatim to facilitate analysis. The researcher used an introductory statement to introduce the student to the interview session and to focus students on the sources of stress during the internship year. Active listening skills were used to encourage students to talk about their experiences and to explore and clarify issues or sources of stress raised by students.

Data were analysed using the Statistical Package for the Social Sciences (SPSS) 13.0 programme for Microsoft® Windows®. Data from the questionnaires were subjected to a frequency count and descriptive analysis. GHQ total scores were recorded to allow cross-tabulation of scores indicating problematic stress levels with gender, age, living arrangements and previous experience as a carer. Quality Credit Average (QCA) scores were recorded to allow cross-tabulation between GHQ scores indicating problematic and academic achievement. Mean scores were calculated as

appropriate. QCA scores represent a weighted average score based on the quality of a student's performance across all modules taken to date (University of Limerick 2005). A QCA score of 3.40 or higher equates with a first-class honours standard. A QCA score of 3.00 to 3.39 equates with a second-class honours (level 1) standard. A QCA score of 2.40 to 2.99 equates to a second-class honours (level 2) standard, while the minimum QCA score of 2.00 to 2.39 equates to a third-class honours standard.

The interview transcripts were analysed initially by the interviewer and then independently as suggested by Benton (2000) to maximise reliability in identification of the broad categories contained in the data. The transcripts were analysed using a bottom-up approach to content analysis. Wilkinson (2003) describes this approach as coding respondents' talk into closed categories to summarise and systemise the data in a way that allows categories to be generated inductively rather than according to a preconceived theoretical framework. Initial analysis involved reading the transcripts to identify and code individual words or phrases. These codes enabled the identification of words or phrases, contributing to the understanding of the underlying concepts (Benton 2000). They were subsequently sorted into categories.

Following initial data coding, a further meeting was arranged with each interviewee to ensure that the coding reflected the social reality of the respondent. The data were reread to explore the emerging categories in more depth and to identify previously discrete links between categories. In this phase of analysis, some categories were subsumed within others. The final part of the transcript analysis involved rechecking the categories to ensure that they reflected the data accurately.

Ethical issues Permission to conduct the study was sought from the director of nursing of the mental health services where the study was undertaken. Approval for the study was granted by the regional ethics committee. Arrangements were made with the occupational health department to provide any support to individual respondents should that become necessary. The cover letter provided to respondents included details of this support as well as information on confidentiality, anonymity and the right to withdraw. Before each interview, aspects of confidentiality as well as the purpose of the study were explored with the respondent. These details were also outlined in a consent form which was signed by the respondent and interviewer before the interview commenced. The study was conducted in 2006.

TABLE 1

Profiles of respondents' characteristics and circumstances (n = 23)

Variable	No. (%)
Age	
24 years or under	14 (61)
25-30 years	6 (26)
31 years or over	3 (13)
Gender	
Male	7 (30)
Female	16 (70)
Living arrangements	
With partner	4 (17)
Single	19 (83)
Dependent children	
Yes	3 (13)
No	20 (87)
Living away from home	
Yes	14 (61)
No	9 (39)

Results

Of the total number of questionnaires distributed ($n = 28$), 23 were returned. This represented a response rate of 82%. The majority of respondents were aged 24 years or under (14, 61%) and seven respondents (30%) were male. Four respondents (17%) were married or lived with a partner, with only three (13%) reporting dependent children. Fourteen respondents (61%) lived away from home (Table 1).

Table 2 outlines the mean scores and the standard deviation for each of the subscales and the total score of the GHQ. The minimum and maximum scores are also outlined for each subscale.

The mean total score for the GHQ 28 was 7.48. The highest mean score in relation to the manifestation of stress was for somatic symptoms, such as sleep disturbance or physical symptoms of illness (2.91; SD 2.341), followed by anxiety symptoms (2.52; SD 2.538). The lowest mean score was reported for depression (0.48; SD 1.310). The scoring range for each subscale was 0-7, with an overall scoring range of 0-28 for the GHQ total score.

The GHQ 28 scores may be divided into three bands (Goldberg 1978, Goldberg and Williams 1991). The bands indicate levels of stress described as no stress, mild stress and severe stress. Scores of 3 or less indicate no stress, scores of 4 to 6 indicate mild stress (stress that is likely to resolve without intervention). Scores of greater than 6 indicate severe stress (stress levels that are unlikely to resolve without intervention). Table 3 illustrates the distribution of scores in each stress band.

Thirty per cent of respondents scored within the no stress band. A further 22% scored in the mild stress band and 48% scored in the severe stress band. When considered in terms of levels of stress likely to remit without intervention and those unlikely to remit without intervention, the sample was almost equally divided in terms of non-problematic stress (52%) and problematic stress (48%).

The GHQ total scores were cross-tabulated against gender, age, living arrangements, dependent children and previous experience as a career. Levels of academic achievement were considered in terms of the QCA scores as described previously and were also cross-tabulated against the GHQ total scores (Table 4).

All respondents in the 31 years or older age bracket ($n = 3$) reported problematic levels of stress while respondents aged 25-30 years ($n = 6$) were equally divided between the problematic and non-problematic brackets. Of those who were 24 years or less ($n = 14$) 64% reported problematic levels of stress.

TABLE 2

Subscale	No.	Range	Min.	Max.	Mean	Standard deviation (SD)
Somatic symptoms	23	0-7	0	7	2.91	2.341
Anxiety symptoms	23	0-7	0	7	2.52	2.538
Social functioning	23	0-7	0	7	1.57	2.107
Depression	23	0-7	0	6	0.48	1.310
GHQ total	23	0-28	0	27	7.48	8.296

TABLE 3

Stress band	No. (%)
No stress (scores ≤ 3)	7 (30)
Mild stress (scores 4-6)	5 (22)
Severe stress (scores > 6)	11 (48)

Male respondents were fairly equally divided with 43% reporting problematic stress, while 75% of female respondents reported problematic stress levels. Of those living with a partner 50% ($n = 4$) reported problematic stress, as did 68% of the single respondents ($n = 19$).

In relation to respondents' academic achievements, of those with higher achievement 100% ($n = 2$) reported problematic stress levels, while 13 (79%) of those identified to be in the middle bracket reported problematic stress levels and four (75%) of the lower achieving respondents reported high stress levels. Notably, four respondents (17%) did not answer the QCA question and of these 75% reported high stress levels.

Interviews The areas that respondents considered to be related to stress during the internship year were categorised as:

- ▶ Relationships in the clinical environment.
- ▶ Matching competence and responsibility.
- ▶ Workload.
- ▶ Simultaneous clinical and academic demands.

Some of the areas identified had positive effects on stress levels as well as being considered potential sources of stress, depending on particular factors.

Relationships in the clinical environment The relationships that respondents had with clinical staff had a considerable impact on stress. Good relationships with staff nurses in clinical placements had the effect of relieving stress:

'Well initially it wasn't that stressful because staff were, how do I say it, kind of still minding us in a way' (Respondent A) and 'I had no worries

that way, I always had support and was never left alone with anything' (Respondent B).

Conversely, lack of support from staff nurses emerged as being a source of significant stress: '... when you are new in a place and you feel so inadequate and you don't know what to do and they are telling you, "come on, do this, no that's not the way we do it here, that's not what she wears" and you just feel lower and lower' (Respondent B). Another respondent commented: 'If you get someone who's not helpful it's much more stressful' (Respondent C).

For some students this lack of support was coupled with a lack of clear guidance as to their role:

'... small things like making beds and walking along the corridors and see[ing] nurses come along and fix them after you. You know, if they would just tell us what to do and when we are not doing them properly, you would be half afraid to do something in case you do something wrong' (Respondent B).

Not fitting into the team was identified as a source of stress for one respondent:

'... you kind of still feel that you are outsiders when you come in' (Respondent B), and feeling unwanted within the team was identified as a source of stress for another:

'I suppose the feeling of not feeling wanted is stressful' (Respondent A).

There was a suggestion that there may be prejudice among some staff members towards nursing students undertaking the BSc degree programme:

"Oh here's the new degree students" and "our way [of training] was better" and "you won't be good enough 'cause you spent too much time in college" and you felt stressed by that' (Respondent B).

Matching competence and responsibility

Respondents described an awareness of increasing levels of responsibility and accountability while on rostered placement:

'In the acute area you'd have a lot of responsibilities, you would have your own caseload and that, and that was stressful definitely' (Respondent B).

The expectations that staff members had of students were identified as a source of stress:

'... the level [of knowledge] that is expected of the degree [students] is high and that causes stress' (Respondent A).

The stress was compounded by students' lack of confidence in their ability to deal competently with situations that may arise:

'... how you are going to deal with it and are you going to do it the right way' (Respondent C).

This was particularly the case when students were faced with new experiences:

'... it would be stressful if you saw someone die for the first time, that could be very hard' (Respondent B), and 'You are thinking, did I do everything right, you know, could I do more, then obviously you're afraid in case you get very upset in front of their family' (Respondent B).

Interestingly, although respondents identified lack of confidence in their competence to deal with situations, competence assessments, which are designed to measure students' competence across a range of domains, were identified as a source of stress only in terms of meeting deadlines for submission of completed documentation:

'I'm glad I have them done, because if I had them hanging over me I'd be thinking, oh my god ... because, you know, December deadline they have to be done' (Respondent D).

Workload Factors related to workload also emerged as a source of stress. Respondents described being tired as a source of stress:

'... when you are working 12-hour shifts all the time and you are just wrecked when you get

TABLE 4

Distribution of stress levels by personal characteristics			
Variable	No.	Non-problematic stress No. (%)	Problematic stress No. (%)
Age			
24 years or under	14	4 (29)	10 (71)
25-30 years	6	3 (50)	3 (50)
31 years or over	3	0 (0)	3 (100)
Gender			
Male	7	4 (57)	3 (43)
Female	16	4 (25)	12 (75)
Living arrangements			
With partner	4	2 (50)	2 (50)
Single	19	7 (37)	12 (63)
Dependent children			
Yes	3	1 (33)	2 (67)
No	20	7 (35)	13 (65)
Previous experience as a carer			
Yes	9	1 (11)	8 (89)
No	14	7 (50)	7 (50)
Quality Credit Average scores			
Third class honours	4	1 (25)	3 (75)
Second class honours (Level 2)	13	2 (15)	11 (85)
Second class honours (Level 1)	2	0 (0)	2 (100)
Unanswered	4	1 (25)	3 (75)

home ... just tired ... everybody is stressed over that' (Respondent C).

Interestingly, if the respondent felt the workload was manageable it was viewed more positively:

'... other times that [workload] can be good because you work even harder and you are more alert because you have to, then if it goes beyond your limit you feel stressed' (Respondent A).

The role played by nursing colleagues in relation to workload was identified as contributing to the students' stress:

'... then again there might be this nurse saying "do this, do that", as well as doing your own work and you are trying to get everything done' (Respondent D).

Related to this was the issue of lack of control over their workload:

'You had your workload and like that the staff would add to it and with staff you didn't like to say no' (Respondent B).

The traditional role of the nursing student was considered as being vulnerable to work overload:

'I felt that as a student [I] was an easy target' (Respondent A) and another student commented: 'You would have your patients, and tasks like obs, and someone would come along, and recognising that you are a student and knowing you can't say no, would give you a job' (Respondent D).

There was a view that staff saw students as beneath them in the ward hierarchy and that until they had qualified students would have little control over their workload:

'...they let you know that you were a student and until you had your navy pants that's what you were going to be treated like, you know getting all the crappy jobs' (Respondent D).

The theme of fulfilling professional expectations coupled with the heavy workload emerged as a source of stress:

'Finding time to get to all of them [patients] to make sure they all got the time they needed' (Respondent B).

Simultaneous clinical and academic demands

All four respondents interviewed identified the requirement to work full time along with the need to meet academic requirements as a source of stress. The stress associated with the academic element of the intern year was reported to be greater than any previous year in the programme:

'... more [stressful] than the last four years anyway' (Respondent C).

This increased stress in relation to academic achievement in the intern year echoes the findings in relation to workload in that it was reported to be related to the fact that the students were tired on days off and finding it difficult to find time to work on their final year project (FYP), which comprised a 10,000 word research proposal:

'... finding time to do the FYP then, as well, it's hard on your days off; I'm wrecked all the time, constantly, always' (Respondent B), and 'You are thinking about it all the time, you'd be stressed out' (Respondent D).

The fact that the FYP was regularly discussed among the students appeared to contribute to their stress:

'That's all that everybody talks about' (Respondent C).

Peer comparison of progress in relation to this project was a source of stress:

'When you hear that so and so has so much done and you're like, oh my god, and you're trying to keep up' (Respondent C).

Stress in relation to academic work was increasing as the deadlines for submission approached:

'... as it's coming to the end now, I think, you're beginning to panic and getting stressed out by everything' (Respondent C).

Discussion

This was the first cohort of students to undertake the intern year and the overall number of students was small, so the results cannot be generalised.

The response rate of 82% to the survey element of the study was high. It was satisfying that 14 students were willing to participate in interviews. A number of factors may have influenced the high response rate. Questionnaires were distributed to the students at their place of work and students were able to return the forms through the internal postal system. Clinical placement co-ordinators also reminded students about questionnaires and offered to return completed questionnaires. This, coupled with the fact that the GHQ 28 can be completed in a relatively short time, meant that many students returned the questionnaire by return of post. Furthermore, the extension of the closing date by one week for return of questionnaires to facilitate students who were absent due to illness, resulted in the collection of questionnaires that would otherwise not have been included in the study.

The GHQ 28 is used to measure stress levels. It is a reliable, well-validated instrument and has been used widely to measure stress levels in psychiatric nursing populations (Ryan and Quayle 1999, Edwards *et al* 2000, 2001) as well as among nursing students (Jones and Johnston 1997, 2000, Lo 2002, Deary *et al* 2003, Nicholl and Timmins 2004). In similar studies, Jones and Johnston (1997), using the 30-item version of the GHQ, found that approximately 50% of one cohort of students and 68% of a second cohort reported levels of distress above the threshold score for 'caseness'. In the only similar Irish study, Tully (2004) reported that all respondents

in her sample of diploma students were over the threshold score. In contrast a study by Ryan and Quayle (1999) found levels of problematic stress among psychiatric nurses in Ireland to be 7%, which is significantly lower than international studies. While the results of the survey element of this study of student stress are lower than the studies referred to, there is no room for complacency.

Irish nurse education programmes are designed to provide students with graded levels of clinical exposure, supported protected reflection time and a myriad of support structures including the assignment of students to preceptors in clinical areas, the support of clinical placement co-ordinators while on practice assignments and the support of members of faculty. Therefore, there is little comfort in the fact that nearly half the students in the final stages of their programme reported levels of distress that were unlikely to resolve without intervention. While this sample reported lower levels of distress than in Tully's (2004) study of diploma students, it is clearly an area that warrants further research.

The fact that this cohort of students was also the first to engage in this system of placement assignment also makes valid comparison with

international studies problematic. The interviews offered a useful opportunity to explore the sources of stress in the intern year for these students. The sources of stress identified were organised into four main categories: relationships in the clinical environment; matching competence and responsibility; workload; and simultaneous clinical and academic demands.

These specific stressors are consistent with stressors identified by others in the literature, but the configuration is somewhat different. For example, Hamill (1999) reported difficulty in fitting into peer groups and being competent in clinical skills as stressors among Project 2000 nursing students. Lindop (1999) identified physical work, lack of interest in teaching by staff and pressure of time relating to work as stressors among Project 2000 nursing students. Some of the differences may relate to the distinctive structure of the internship component of Irish nurse education. In the Irish context, the findings of this study support Tully's (2004) findings. She found that peer competition, staff relations and too much responsibility were key stressors among diploma students. The category of combining simultaneous clinical and academic demands was not identified as a stressor in these studies and appears to be a new stressor, which may also relate to changes in the structure of nurse education programmes in Ireland.

In that regard, the movement to third level education has placed pressure on all stakeholders

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within the system. For example, a key element of the support structures proposed for nursing students during clinical placements was a shared support structure of dedicated clinical placement co-ordinators and academic support from members of faculty. It should be remembered that the clinical placement co-ordinator structure is relatively new and the transition to third level for former nurse tutors has placed extra demands on them. For example, the traditional focus of nurse tutors in Ireland related to teaching and dissemination of knowledge. Within the third level structure, the requirement to generate and test knowledge through research and publishing places time demands on the faculty that may detract from their supportive roles in clinical practice. Higgins and Farrelly (2007) reported on the increase in publications from mental health nurses from Ireland which reflects this position.

Conclusion

The results of this study should be understood within the context of the changing and dynamic nature of nurse education in Ireland (Evans *et al* 2007).

It is clear that the high stress levels experienced by this cohort of students arose from a number of sources which have implications for the structure of the programme, the nature of the work and the organisational culture in which the work is carried out. These issues demand

consideration by those who design and deliver nurse education programmes and those offering a supportive role to nursing students in their intern year. While the limitations of this study are recognised, it would seem that current support structures need to be monitored. The fact that the stressors are consistent with international findings suggests that lessons from the Irish context can be shared with international colleagues and despite the differences in educational structures, opportunities to achieve valid comparative analysis internationally should be sought as an area for further study. Peer support groups should be established to provide structures for sharing and comparing experiences. It is also suggested that greater consistency between matching levels of competence and responsibility be achieved. Likewise academic assignments have to be balanced with practice-based requirements and working a 39-hour week **NS**

IMPLICATIONS FOR PRACTICE

- ▶ Current support structures for students undertaking practice-based learning on nursing programmes need to be reviewed.
- ▶ Structures should be established to facilitate peer support for those undertaking experiential learning in clinical placements.
- ▶ Educational programme providers should be aware of the need to achieve an appropriate balance between academic assignments and the fulfilment of clinical practice requirements, so that nursing students are not burdened in their learning.

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