CHAPTER II

THEORETICAL ORIENTATION

The present study is an attempt to understand the need profile and need gratification of nursing personnel and the relationship of these with job satisfaction and anxiety level of these personnel. To do full justice with this study, it is imperative to have a critical look at the various concepts involved in this study, such as nursing, needs, anxiety, and job satisfaction. These concepts have been discussed in the above-given order in this chapter.

This theoretical orientation is based upon the views of authorities in the field. In order to meet the objectives of the study, the theoretical review has been limited to concepts which are directly
involved in this study.

The conceptual framework of this study implies that all human behaviour is need-based. Needs create tension. Need gratification leads to tension reduction and a feeling of satisfaction. Non-gratification of needs produce psychological disequilibrium and anxiety. The vocation a person chooses is supposed to provide opportunities for the gratification of the needs of the person. This conceptual framework has been applied to two important categories of personnel of the nursing profession, that is, Ward-sisters and Staff-nurses.

The theoretical concepts and their relevant significance have been continuously and consistently kept in mind throughout this study. Not to get tangled in the theoretical mesh, an effort has been made to remain succinct, concise, and to-the-point, without sacrificing the details, wherever necessary.

NURSING

Nursing literature of the last twenty years has produced a plethora of expository pronouncements on the nature, philosophy, and science of nursing. Brunner et al (1964) have described nursing in the following words:

"Nursing is a service devoted to the prevention and the relief of physical suffering. Inherent
in nursing is the control of disease, the care and rehabilitation of the sick and the promotion of health through teaching and counseling. The nurse, applying her technical knowledge, experience and skill, combats the physical disabilities of her patients; and through the contribution of her wisdom and insight, she assists them to overcome their emotional difficulties."

The relatively stable essence of nursing is captured in one of the most widely quoted definitions of nursing, by Henderson (1964):

"The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge. And to do this in such a way as to help him gain independence as rapidly as possible ..... In addition, she helps the patient to carry out the therapeutic plan as initiated by the physician."

From its earliest inception, nursing has had a nurturing quality, and today this quality is incorporated in practices which are designed to assist patients physically, psychologically, and sociologically. Knutson (1965) opined:

"Nursing is a helping art in which the nurse helps a person to meet certain of the physical, psychological or sociological needs he has at a particular time."

In brief, nursing is a service in which people are helped to meet needs related to their general health. In health, people can generally meet their own physical, psychological, and sociological needs; but at a time of illness,
a person may require assistance in one or more of these areas.

For the purposes of the present study, nursing has been defined as a process of action, reaction, interaction, and transaction whereby nurses assist individuals of any age-group to meet their basic human needs in coping with their health status at some particular point in their life cycle.

The Changing Concept of Nursing:

The origins of nursing are rooted in the hoary past (Osler, 1932; Austin, 1957; Steward & Austin, 1962; Bullough & Bullough, 1969). The history of nursing clearly depicts how nursing as a 'family affair' became a religious obligation, how nursing as a 'service to the sick' developed into a noble profession. The review of nursing history graphically depicts the forces that have radically changed the image of nursing through the ages and have placed nursing on the professional pedestal in the modern times.

Florence Nightingale has been universally acclaimed as the founder of nursing profession (Seymer, 1950; Woodham-Smith, 1951; Levine, 1963; Thompson, 1980). But nursing as a profession has progressed unevenly. The steady
push toward professionalism has sharply accelerated since the early 1950's (Darley, 1952), and the rate of change in levels of nursing education and practice along with the change in attitudes of nurses towards themselves, has amounted to a small revolution.

The ferment in nursing has not gone unnoticed by members of the medical profession, the administrators, and the patients and their families. The individual nurse, whether leaning toward right, left, or middle of the professional dialogue or battle, becomes engulfed in conflicts arising from these differences in nursing role and nursing practice (Benne & Bennis, 1959; Kahn et al., 1964; Davis, 1966; Woodridge, 1968; King, 1968; Mereness, 1970).

Whether one supports or opposes these recent changes in the nurse's role, functions, and attitudes, one must admit that changes have occurred (Meyer, 1959 and 1960; Simmons, 1962; Thomas, 1971). The role of the nurse has evolved from that of hand-maiden to the physician to that of colleague and collaborator; from being a procedure-oriented, trained hospital employee to becoming a scientifically educated, problem-solving health care personnel, and from functioning as a bed-maker and bed-pan carrier to being a team-leader who assumes responsibility for planning and expediting comprehensive
hensive patient care, delegating duties and supervising members of the nursing team. In the words of Peplau (1975), "Nurses have shifted their focus from 'aiding the physician in his work' to aiding the patient in his work; this involves recognition and coping with reactions to health problems." However, modern nursing is emphasising the importance of psychological factors as well as physiological factors which affect the behaviour of the patient. It is no longer enough to know aseptic routines or to be able to follow doctor's orders to be a good nurse; it is equally important to identify and minister to the emotional and social needs of patients while serving their physical needs.

With the growth of huge hospital complexes and their expansion into specialised areas of health care with increased technology and mechanisation (Brackett, 1960; Hagen & Wolff, 1961; Barnes, 1961; Masur, 1961; McGibony, 1969; Alexander, 1972; Fagerhaugh, 1980), and with the introduction of technologists to handle machines (Payne, 1965; Givens & Gwen, 1969; Drucher, 1970), ward managers to handle non-nursing jobs (Hershey, 1962; Mauksch, 1965; Mooth & Rivto, 1966; Fagin, 1967; Rogers, 1970; Springall, 1971; Donovan, 1971; Carruthers, 1977; Jones, 1977; England, 1980; Kimbro, 1980), and clinical specialists to teach and supervise nursing management of complex patients...
care problems (Simmons, 1965; Scully, 1965; Erickson, 1965; Reiter, 1966; Anderson, 1966; Little, 1967; Ramey, 1969; Driscoll, 1972; Congalton, 1977; Curtin, 1980), the appropriateness of nurse's behaviours becomes a crucial issue in inter-personal and inter-professional relationships with peers, patients, families, supervisors, doctors, technicians, and administrators (Fields, 1953; Rapaport, 1957; Abdellah & Levine, 1958; Whiting, 1959; Hays & Larson, 1963; Wiedenbach, 1964; Peplau, 1965; Skipper & Leonard, 1965; Henderson, 1966; International Council of Nurses, 1977; Billings, 1980; Brown, 1980; Garant, 1980; Jacobs, 1980; Little, 1980). All this is further complicated by local and regional customs, prejudices, religious restrictions, politics and personal and public values related to health care, which create further issues which the nurse must cope with in her efforts to do her primary job, that is patient care, well (Mead, 1956; Mariam & Martin, 1958; Robwedder & Hart, 1960; Malone, 1964; Smith, 1964; Duff & Hollingshead, 1968; Bermsok & Corsini, 1973; Schrock, 1977; Aroskar, 1980; Bayles, 1980; Johnston, 1980).

The nurse's professional life is a difficult one. The scope of her responsibilities includes helping people stay well by preventing or

She seldom does this alone. Her behaviours are highly visible to patients, families, members of the health team, and the community. She must adapt her language and approach to accommodate the patient's vocabulary and expressed need. She must deal with an irritating minor personnel problem one minute and respond to life-threatening problem a few minutes later. These events are rarely scheduled; they may be anticipated but are seldom predicted. The nurse is expected to react to each situation in a calm, rational, non-threatening, non-critical, knowledgeable
and understanding manner. She is expected by herself and by others to be super-human in her abilities, endurance, and frustration tolerance. In the past, she has seldom been rewarded for a good performance, but usually is criticised for a poor one. Although the nurse's primary activities may be with the consumer of nursing services, the patient, who responds favourably to her case, her own peers, supervisors, doctors and administrators sit in judgment and readily find fault or criticise her decisions and behaviour as each sees it.

In India, there is social stigma and psychological rejection attached to the nursing profession. The problems faced by the nurse in the world are covering the nurse's acceptance of herself as a person. These problems can be stated in terms of human and social rights, loyalty, privilege, obligation, power, philosophy, communication, authority, legality, confidentiality, responsibility, and conscience (National Manpower Council, 1957; Smuts, 1959; Friedan, 1963; Farber & Wilson, 1963; Fletcher, 1967; Kubler-Ross, 1969; Tart, 1969; Scheinman & Farberow, 1970; Murchison & Nicholas, 1970; Schoenberg et al, 1972; Bermosk & Corsini, 1973; Krueger, 1980).

Preparation for Nursing:

In the past, the nurse received most
of her instruction at the bed-side of the patient under the strict discipline of superiors who concentrated on the mastery of technique. The emphasis was on the maintenance of a clean environment and the development of basic skills in patient comfort.

But today, the nurse is given a broad background of scientific principles which can be applied in a variety of circumstances. Skipper & Leonard (1965) hold:

"As a professional person, she develops technical skills for the performance of her duties. She must have scientific background in order to apply problem-solving techniques. She needs a clear understanding of her own role and her place in the health team. She must be aware of the forces motivating human behaviour. She must be able to apply basic principles from social sciences in helping the patient to accept the limitations imposed by his illness. She must understand and grasp the forces that motivate the patient for rehabilitation."

In nutshell, the preparation of a nurse should include a basic understanding of the physical and biological sciences, the social sciences, the medical sciences, the nursing arts, and the philosophy of life and living. Today, educational experiences are provided which offer the nursing student an opportunity to gain the necessary scientific knowledge, to acquire basic skills in technique, observation and communication, and to apply this knowledge and skill in a guided clinical situation.
Code of Professional Ethics:
The International Council of Nurses (1953) has recommended the following Code of Ethics:

1. The fundamental responsibility of a nurse is three-fold: to conserve life, to alleviate suffering, and to promote health.
2. The nurse must maintain at all times the highest standards of nursing care and of professional conduct.
3. The nurse must not only be well-prepared to practice, but must maintain her knowledge and skill at a consistently high level.
4. The religious beliefs of a patient must be respected.
5. Nurses hold in confidence all personal information entrusted to them.
6. A nurse recognises not only the responsibilities but the limitations of her or his professional functions; recommends or gives medical treatment without medical orders only in emergencies and reports such action to a physician at the earliest possible moment.
7. The nurse is under an obligation to carry out the physician's orders intelligently and loyally and to refuse to participate in unethical procedures.
8. The nurse sustains confidence in the physician and other members of the health team; incompetence or unethical conduct of associates should be exposed but only to the proper authority.
9. A nurse is entitled to just renumeration and accepts only such compensation as the contract, actual or implied, provides.
10. Nurses do not permit their names to be used in connection with advertisement of products or with any other forms of self-advertisement.
11. The nurse cooperates with and maintains harmonious relationships with members of other professions and with her or his nursing colleagues.
12. The nurse in private life adheres to standards of personal ethics which reflect credit upon the profession.
13. In personal conduct nurses should not knowingly disregard the accepted patterns of behaviour of the community in which they live and work.
14. A nurse should participate and share responsibility in promoting efforts to meet the health needs of the public — local, state, national, and international.
Development of Nursing in India:
The history of nursing in India goes back through centuries to about 1500 BC. The beginnings are shrouded in the mist of ancient myths recorded in Hindu Scriptures. Diseases were attributed to demons; treatment of choice was charms and spells.

Between 700 - 600 B.C., Ayurveda, the Hindu system of medicine, flourished. 'Halls of Healing' were founded. The nurses, all of whom were men, staffed these hospitals. According to Kelly (1968), Charak Samhita prescribed the following qualifications for a nurse:

"..... there should be secured a body of attendants of good behaviour, distinguished for purity or cleanliness of habits, attached to the person for whose services they are engaged, possessed of cleverness and skill, endued with kindness, skilled in every kind of service that a patient may require ..... clever in bathing or washing a patient ..... well skilled in making or cleaning beds ..... and skilled in waiting upon one that is ailing, and never unwilling to do any act that they be recommended to do....."

The period 500 BC to AD 300 saw the rise and development of Buddhism. Compassion for all living creatures, which was an essential part of Buddhism, showed itself in ministrations to all sufferers. In the rule of life of a Buddhist monk, assistance to the sick was a part. The famous Buddhist king, Ashoka, established a large number of hospitals, not only for men but also for animals. Under the influence of Buddhistic laws of mercy and compassion, hostels were built for housing the sick, blind and deformed.
With the decline of Buddhism, Hindu caste system became more rigid. On religious grounds, any kind of physical contact which involved 'pollution', was strictly avoided. This seriously affected the profession of medicine and practice of nursing.

The Mohammedan invasions leading to the conquest of India about AD 1200, accelerated the process of decline in medicine and nursing. Finally public hospitals disappeared, and the next mention of such institutions is in connection with the British Army.

The Crimean War of 1854 brought Nightingale into limelight. She proved instrumental in bringing about sweeping changes and reforms in the British Army Nursing Service. The Royal Sanitary Commission on the Health of Army in India was appointed in 1859. Through a 'Circular of Enquiry', Nightingale collected detailed information about the health of troops in every Indian station. This Commission instituted many reforms.

In 1888, the first Army Nursing Sisters arrived. They trained nursing orderlies and ward servants in order to efficiently run the nursing services.

The First World War gave impetus to the formation of the Indian Military Nursing Service (I.M.N.S.). It was composed of 12 matrons, 18 ward-sisters and 25 staff-nurses, a total of 55. During the Second World War, the I.M.N.S. was gradually
expanded. The Preliminary Training Schools were established under the charge of fully trained nursing Tutors. After completing the P T S course, student nurses went to 3 years General Nursing training organised in selected Military Hospitals.

On the civil side, government and municipal hospitals gave nursing training only to Anglo-Indian and Europeans for many years. It were the Mission Hospitals which gave training to Indians. However, the deep-seated inhibitions of caste among Hindus and the pudah system among Muslims proved a hurdle for Indians to go in for nursing training. It was in 1895 that 3 years General Nursing course was instituted. During 1907-1909, the North India United Board of Examiners for Mission Hospitals was established for the training and examination of nursing education as such. Other parts of the country set up similar boards. Mission Hospitals with nursing training schools spread all over India very quickly (Wilkinson, 1958).

After independence, the central and state governments gave priority to health care delivery systems in the country. Bhore Committee (1946), Mudaliar Committee (1962), Chadhwa Committee (1963), Mukerji Committee (1965), Jungalwala Committee (1967), Kartar Singh Committee (1973), and Srivastava Group (1975), assessed the health needs and the medical-nursing manpower required to meet these needs of the
country. Today, in every district, there are hospitals, dispensaries, and primary health centres to deliver health care to the people. With the proliferation of hospitals and health care services, nursing has also developed and expanded (Goel, 1981).

**Categories of Nursing Personnel in India:**

There are a large number of categories of nursing personnel in the country. Nursing personnel can be categorised according to (1) the position one holds, and (2) the level of professional education/training attained.

Nursing profession is traditionally sub-divided into (A) Nursing Service, (B) Nursing Education, and (C) Nursing Administration. For convenience, nursing personnel have been categorised under these three headings, as follows:

(A) Nursing Service: Nursing personnel can be categorised under hospital-based services and community-based services.

In the hospital-based services, the categories are:
- Staff-nurse,
- Ward-sister,
- Clinical Supervisor,
- Assist. Matron,
- Deputy Matron,
- and Matron/Nursing Superintendent.

In the community-based services, the categories are:
- Auxiliary Nurse-Midwife (ANM)/Multi-purpose Worker (Female),
- Lady Health Visitor (LHV),
- Public Health Nurse,
- and District Nursing Officer (at some places).
(B) Nursing Education: Nursing personnel can be categorised under hospital-linked schools and university-affiliated colleges.

In the hospital-linked schools, the categories are:
- Public Health Nurse
- Sistor Tutor
- Principal Tutor

In the university-affiliated colleges, the categories are:
- Clinical Instructor
- Lecturer
- Assist. Prof.
- Assoc. Prof./Reader
- Professor
- Principal

(C) Nursing Administration: Nursing personnel can be categorised under State-level positions and Central-level positions.

In the State-level positions, the categories are:
- State Nursing Superintendent
- Assist. Director (Nursing)
- Deputy Director (Nursing)

In the Central-level positions, the categories are:
- Nursing Officer
- Nursing Advisor

Indian Nursing Council had issued the following census of nursing personnel available in the country, compiled up to December, 1979:

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;A&quot; Grade Nurses (Men)</td>
<td>5359</td>
</tr>
<tr>
<td>&quot;A&quot; Grade Nurses (Women)</td>
<td>127287</td>
</tr>
<tr>
<td>Midwives (A Grade)</td>
<td>124066</td>
</tr>
<tr>
<td>Midwives (B Grade)</td>
<td>10707</td>
</tr>
<tr>
<td>Auxiliary Nurse Midwives</td>
<td>66158</td>
</tr>
<tr>
<td>Lady Health Visitors</td>
<td>8976</td>
</tr>
</tbody>
</table>
Present Status of Nursing Education in India:

Nursing education began as a learning-through-service training. Then schools of nursing were developed. These schools were not autonomous institutions, but were just departments of hospitals. The education offered was largely of the apprenticeship type; there was some theory and formal classroom work, but for the most part, students learnt by doing, providing the major part of the nursing care for the hospital's patients in the process. That is why the hospitals welcomed the idea of 'training schools'. The hospital-based training schools offered Diploma in Nursing.

The Indian Nursing Council (INC) was constituted in 1947, to standardise nursing education. The INC prescribed the basic curricula for the various nursing courses and laid down standards of nursing education and practice. Public Health Nursing was integrated with General Nursing programme. This step proved instrumental in spreading nursing from the confines of hospitals and care of the sick to the prevention of sickness and promotion/maintenance of community health. The addition of elementary physics/chemistry, biological sciences and social sciences to nursing skills, made the General Nursing syllabus rich, catholic and broad-based.

Along with the hospital-linked nursing schools, the university-affiliated colleges of nursing
have flourished. In 1946, there were only 2 institutions duly affiliated to recognised universities, offering degree courses. In 1966, there were 11 colleges offering B. Sc. Nursing degree courses. Today, there are as many as 19 colleges (TNAI, 1980).

Indian Nursing Council (1979) has published the number of recognised training centers for different courses. These are:

<table>
<thead>
<tr>
<th>Course</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;A&quot; Grade General Nursing (men)</td>
<td>25</td>
</tr>
<tr>
<td>&quot;A&quot; Grade General Nursing (women)</td>
<td>275</td>
</tr>
<tr>
<td>Midwifery (A Grade)</td>
<td>266</td>
</tr>
<tr>
<td>Auxiliary Nurse-midwife</td>
<td>325</td>
</tr>
<tr>
<td>Lady Health Visitor</td>
<td>21</td>
</tr>
</tbody>
</table>

The Trained Nurses Association of India (1982) compiled information about nursing education institutions, offering post-graduate, graduate, diploma and post-certificate courses, as given below. This information was compiled up to December, 1980.

<table>
<thead>
<tr>
<th>Course</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>M. Sc. Nursing</td>
<td>4</td>
</tr>
<tr>
<td>B. Sc. Nursing</td>
<td>12</td>
</tr>
<tr>
<td>B. Sc. Nursing (Post-certificate)</td>
<td>9</td>
</tr>
<tr>
<td>Ward Administration Certificate</td>
<td>10</td>
</tr>
<tr>
<td>General Tutors Certificate</td>
<td>6</td>
</tr>
<tr>
<td>Midwifery Tutor's Certificate</td>
<td>1</td>
</tr>
<tr>
<td>Nursing Administration Certificate</td>
<td>5</td>
</tr>
<tr>
<td>Orthopedic Nursing Certificate</td>
<td>3</td>
</tr>
<tr>
<td>Operation-theatre Training Certificate</td>
<td>3</td>
</tr>
<tr>
<td>Community Health and Family Planning Certificate</td>
<td>1</td>
</tr>
<tr>
<td>Ophthalmic Nursing Certificate</td>
<td>2</td>
</tr>
<tr>
<td>Paediatric Nursing Certificate</td>
<td>1</td>
</tr>
<tr>
<td>Psychiatric Nursing Certificate</td>
<td>1</td>
</tr>
<tr>
<td>Public Health Nursing Certificate</td>
<td>6</td>
</tr>
<tr>
<td>Public Health Nursing Certificate (for LHV)</td>
<td>1</td>
</tr>
</tbody>
</table>
NEEDS

The terms need, motive and drive, have often been used synonymously and interchangeably in literature. However they have been differentiated from each other, as given below:

Needs are presumed to derive from deficits. They are relatively permanent tendencies which seek their satisfaction in achieving certain specific goals. When these goals are achieved, needs no more exist for the time being. Needs can be classified into biological, psychological and social needs.

Motive is a condition --- physiological and psychological --- within the individual that disposes him to act in certain ways. It initiates and sustains activity.

Drive is an original source of energy that activates the organism. It is an intra-organic activity or condition of tissue supplying stimulation for a particular type of behaviour. Drives become active when there is some felt need. If there is no need, there is no drive. The drive directs the behaviour in a definite direction according to the needs. Drives are classified into primary and secondary drives. Primary drives are unlearnt, physiological imbalances, whereas secondary drives are learnt.

Definition of Need:

Murray (1938) defined a need as a construct ... "which stands for a force (the Physico-chemical nature of which is unknown) in the brain region, a force which organises perception, apperception, intellection, conation, and action in such a way as to transform in a certain direction an existing, unsatisfying situation. A need is sometimes provoked directly by internal processes of a certain kind (Viscerogenic, endocrinogenic, thelamicigenic)"
arising in the course of vital sequences, but, more frequently (when in a state of readiness) by the occurrence of a few commonly affective presses (or by anticipatory images of such presses). Thus, it manifests itself by leading the organism to search for or to avoid encountering or, when encountered, to attend and respond to certain kinds of press."

Cameron (1963) defined need as follows:

"By need we mean a state of unstable or disturbed equilibrium, appearing typically in the organism as increased tension, in relation to some more or less specific source of potential satisfaction."

Atkinson (1966) stated that

"A motive or need, is a disposition to strive for a particular kind of goal-state or aim, e.g., achievement, affiliation, power. The aim of a particular motive is a particular kind of effect to be brought about through some kind of action. The aim of a motive defines the kind of satisfaction that is sought, e.g., pride in accomplishment, a positive affective relationship with another person or a sense of being in control of the means of influencing the behaviour of other persons. The attainment of a goal-state is accompanied by feelings of satisfaction; disruption of goal-directed activity, or non-attainment of a desired goal-state, is accompanied by feelings of dissatisfaction."

Morgan, King and Robinson (1979) have stated:

"Motivation has three aspects: (1) a driving state within the organism that is set in motion by bodily needs, environmental stimuli, or mental events such as thoughts and memories; (2) the behaviour aroused and directed by this state; and (3) the goal toward which the behaviour is directed. Motives thus arouse behaviour and direct it toward an appropriate goal."
Munn et al (1972) have observed:

"As human beings grow, they acquire interests, aspirations, and life goals, and they persistently pursue some of these goals inspite of distractions and frustrations which sometimes seem insurmountable. Indeed, persistence in a life-long task is one of the clearest signs of motivated behaviour."

Motives, in the broadest sense of the word, include needs, basic drives, interests, likes and dislikes, and attitudes, because all these move us to some action.

Theories of Motivation:

There are mainly four kinds of theories of motivation put forth by various psychologists. These are:

1. Stimulus-Response Theory of Motivation: It is also known as behaviouristic theory of motivation. In this theory, the concepts of motivation are largely governed by the principles of reinforcement.

This theory pre-supposes that drive arises directly from need states within the organism. This theory employs different theoretical concepts to deal with the emerging aspects and the directive aspects of motivation. Walia (1977) has summarised the behaviouristic theory of motivation with the following tenets:

a. All behaviour is motivated in the sense that all behaviour is based on needs and drives.
b. All learning involves reward, in the sense that only those responses that reduce need or drive, are stamped in.
c. Needs may be biological or psychological, primary or secondary.
2. Physiological Theory of Motivation: According to this theory, human body has to face a number of changes, which force a number of reactions in the physiological domain. These physiological reactions act as motivating force. This theory seeks to determine the ways in which needs, desires, interests and attitudes vary with the different physiological states, and with the different types of body-built. In other words, the physiological state of the human body determines and controls the behaviour patterns of an individual. When the physiological needs are satisfied, the organism achieves homeostasis or equilibrium.

3. Psycho-analytic Theory of Motivation: According to this theory, human behaviour is motivated and governed by semi-conscious and unconscious will of the individual. Human behaviour is explained in terms of the pleasure principle, the death instinct, the libido and the concepts of id, ego and super-ego. Freud placed more importance on sex or libido which was considered by him as a primary driving force in behaviour.

4. Cognitive Theory of Motivation: According to this theory, understanding and anticipation of events by means of perception, thought and judgment, govern human behaviour. All our beliefs, opinions,
and expectations are regulators or motivators for our goal-seeking behaviour. The individual chooses between alternatives which involve uncertain outcomes. Cognitive theory of motivation states that the choice an individual makes among the alternative courses of action depends upon the relative state of knowledge the individual possesses. This relative state of knowledge governs all forces acting on the individual.

**Classification of Needs:**

Needs may be classified in a number of ways. They may be divided into primary (Viscergenic) and secondary (Psychogenic) types. Boring, Langfeld and Weld (1968) classified needs into two types:

- (a) primary, vital, physiological and biological needs, and
- (b) secondary, non-vital, psychological and social needs.

The instinct theorists have hypothesised a catalogue of innate motives. Cattell (1950) has used the term 'erg' instead of instincts to identify these inborn tendencies. The exact number of human ergs is not precisely specified by Cattell, but he has offered a listing of 14 ergs, as given below, in the order of relative strength: Mating, Self-assertion, Pugnacity, Repugnance, Appeal, Hunting, Laughter, Self-abasement, Construction, Flight, Curiosity, Protection, Gregariousness and Acquisition.

Some theorists have emphasised goals
rather than inborn tendencies. They look for the external objects or situation sought, instead of postulating an inner need. Among these, Thomas (1923) has espoused a list of four "Wishes": the wish for security, the wish for recognition, the wish for intimate response, and the wish for new experience. Although these wishes do not cover substantial areas of goal seeking, they represent a major segment of our motivational life.

Other writers have tried to draw all goal-seeking into a single category, by seeking some common denominator. Adler (1924) used the phrase "will to power" to identify what he considered the essential component of all goal-seeking. The individual seeks power over his environment, over objects and over people.

Another monistic formulation is that of Snygg and Combs (1949) who have asserted that the "basic human need" should be defined as "the preservation and enhancement of the phenomenal self". Adler's "will-to-power" differs very little from the conception offered by Snygg and Combs.

Murray (1938) compiled a comprehensive list of all categories of goals important to human beings. He tried to penetrate the observable human behaviour and find out in what classes of situations, and for what purposes, adult humans mobilise energy. He
lists some twenty different "needs", as follows:

- Dominance
- Achievement
- Exhibition
- Autonomy
- Counteraction
- Aggression
- Deference
- Order
- Sentience
- Play
- Affiliation
- Nurturance
- Succorance
- Dependence
- Harm-avoidance
- Rejection
- Abasement
- Infavoidance
- Hetero-sexuality
- Understanding

The word 'need' here implies only that the individual will exert efforts on behalf of the kind of goal implied by the name of the need. What Murray has offered is a set of classes of goal objects and goal relationships which should be useful in comparing individuals.

Smeltzer (1965) postulated three basic psychological needs of every person. These are (1) the desire of every person to experience a feeling of self-worth, (2) the necessity of being intensely loved by someone, and (3) the craving to experience progress of some type.

Stallwood (1975) offered a conceptual model of the nature of man. The model illustrates the composite nature of the whole person. As a unity, man has three components: I. The biological component, which provides consciousness of our world or external environment via the sensory apparatus; II. The psychological component which provides self-consciousness via the intellect, emotion, will and moral sense. This component expresses individuality, self-identity,
and personality. The intellect reveals the thought processes out of which arise wisdom, knowledge, and reasoning. The emotional area reveals likes and dislikes. It is an instrument expressing love or hate, joy, anger, sadness, loneliness, happiness, desires and aspirations. The will is an instrument revealing power to choose — the 'decision-maker'. Without it, a person would be an automaton. The moral sense (conscience) is an instrument that distinguishes right from wrong. If a person violates its dictates, self-accusation resulting in guilt is experienced. There is interaction and inter-dependence among the intellect, emotions, will, and moral sense. III. The spirit component which provides God-consciousness. It is indefinable scientifically. Maslow (1954) contends that "spiritual problems fall within the realm of nature and should be considered part of science, not as an opposing realm."

Bayly (1969) suggests that the spirit "is the real person, the part of us nobody can see, the part that does not die ... it is the inside you ..." Nee (1968) states the functions of the spirit are intuition and communion. He defines intuition as the "sensing organ of the human spirit". It is independent of assistance from the intellect, emotion or will. "We know through our intuition; our mind helps us to understand". Communion is defined as worship of and communication with God.
The needs of an individual are determined by the three components of man, as discussed above. Maslow (1954) has developed a hierarchy of needs which cuts across the various frames of reference. He suggested that the average individual reveals a series of needs; those at the top of the hierarchy, will dominate behaviour until they are relieved, after which less demanding needs may achieve expression. His hierarchy looks like this:

- Physiological needs
- Safety needs
- Belongingness and love needs
- Esteem needs
- Self-actualisation needs

According to Maslow's view, when any situation involves the physiological needs, it will tend to make objects in that group especially attractive, until the disturbance is removed. After these are satisfied, the safety needs predominate, and objects of protection and defence look very attractive. When these are taken care of, the desire to be loved and to belong to a friendly group, will dominate the phenomenal field; and so on through the list. This theory states that objects will be perceived as more attractive, if they appeal to an unsatisfied need. According to this analysis, individual personalities will differ in two respects: (a) Within a given need category, the kind of object considered
most attractive will vary; (b) Across need categories, this system of dominance of values will vary. These frames of reference become the basis for traits of temperament and for systems of attitudes and values.

To conclude, it is now clear that the various attempts at classification of human needs, are not enough to justify any universally accepted classification. However, a basic trend is visible:

All human behaviour is need-based and goal-oriented. When immediate needs are gratified, other needs arise. Needs create tension. All behaviour aims to reduce this tension, arising from needs. When a strong need is upper-most, all behaviour is directed toward it and other needs may be unrecognised. Most actions involve a fusion of several needs. Needs have been given the hierarchy of physiological, psychological, social and spiritual needs. Some needs have been regarded as more potent than other needs. Gratification of lower-level needs is a pre-requisite for the gratification of higher-level needs. Finally, man is an organism that lives in an unstable equilibrium, and life is the process of striving in the direction of some stable equilibrium.

The theoretical framework of needs presented here will assist in understanding the implications and importance of need profile and need hierarchy of the nursing personnel.

For the purposes of this study, the 15 needs of Tripathi Personal Preference Schedule (1973) have been accepted and adopted to understand the need profile and need hierarchy of the nursing personnel. TPPS is a standardised adaptation of Edwards Personal Preference Schedule (1959), which in turn was based on the theory of needs as propounded by Murray (1938). The comprehensive description of the 15 needs as given
Description of the 15 TPPS Needs:

1. **Ach**: **Achievement**: To do one's best; to be successful; to accomplish tasks requiring skill and effort; to be a recognised authority; to accomplish something of great significance; to do a difficult job well; to solve difficult problems and puzzles; to be able to do things better than others; to write a great novel or play.

2. **Def**: **Deference**: To get suggestions from others; to find out what others think; to follow instructions and do what is accepted; to praise others; to tell others that they have done a good job; to accept the leadership of others; to read about great men; to conform to custom and avoid the unconventional; to let others make decisions.

3. **Ord**: **Order**: To have written work neat and organised; to make plans before starting on a difficult task; to have things organised; to keep things neat and orderly; to make advance plans when taking a trip; to organise details of work; to keep letters and files according to some system; to have meals organised and a definite time for eating; to have things arranged so that they run smoothly without change.

4. **Exh**: **Exhibition**: To say witty and clever things; to tell amusing jokes and stories; to talk about personal adventures and experiences; to have others notice and comment upon one's appearance; to say things just to see what effect it will have on others; to talk about personal achievements; to be the center of attention; to use words that others do not know the meaning of; to ask questions others can not answer.
5. **Aut : Autonomy**: To be able to come and go as desired; to say what one thinks about things; to be independent of others in making decisions; to feel free to do what one wants; to do things that are unconventional; to avoid situations where one is expected to conform; to do things without regard to what others may think; to criticise those in positions of authority; to avoid responsibilities and obligations.

6. **Aff : Affiliation**: To be loyal to friends; to participate in friendly groups; to do things for friends; to form new friendships; to make as many friends as possible; to share things with friends; to do things with friends rather than alone; to form strong attachments; to write letters to friends.

7. **Int : Intracception**: To analyse one's motives and feelings; to observe others; to understand how others feel about problems; to put one's self in another's place; to judge people by why they do things rather than by what they do; to analyse the behaviour of others; to analyse the motives of others; to predict how others will act.

8. **Suc : Succorance**: To have others provide help when in trouble; to seek encouragement from others; to have others be kindly; to have others be sympathetic and understanding about personal problems; to receive a great deal of affection from others; to have others do favours cheerfully; to be helped by others when depressed; to have others feel sorry when one is sick; to have a fuss made over one when hurt.
9. **Dom : Dominance :** To argue for one's point of view; to be a leader in groups to which one belongs; to be regarded by others as a leader; to be elected or appointed chairman of committees; to make group decisions; to settle arguments and disputes between others; to persuade and influence others to do what one wants; to supervise and direct the actions of others; to tell others how to do their jobs.

10. **Aba : Abasement :** To feel guilty when one does something wrong; to accept blame when things do not go right; to feel that personal pain and misery suffered does more good than harm; to feel the need for punishment for wrong doing; to feel better when giving in and avoiding a fight than when having one's own way; to feel the need for confession of errors; to feel depressed by inability to handle situations; to feel timid in the presence of superiors; to feel inferior to others in most respects.

11. **Nurturance : Nur :** To help friends when they are in trouble; to assist others less fortunate; to treat others with kindness and sympathy; to forgive others; to do small favours for others; to be generous with others; to sympathise with others who are hurt or sick; to show a great deal of affection toward others; to have others confide in one about personal problems.

12. **Cha : Change :** To do new and different things; to travel; to meet new people; to experience novelty and change in daily routine; to experiment and try new things; to eat in new and different places; to try new and different jobs; to move about the country and live in different places; to participate in new fads and fashions.
13. **End : Endurance** : To keep at a job until it is finished; to complete any job undertaken; to work hard at a task; to keep at a puzzle or problem until it is solved; to work at a single job before taking on others; to stay up late working in order to get a job done; to put in long hours of work without distraction; to stick at a problem even though it may seem as if no progress is being made; to avoid being interrupted while at work.

14. **Het : Hetero-sexual** : To go out with members of the opposite sex; to become sexually excited; to be regarded as physically attractive by those of the opposite sex; to read books and plays involving sex; to participate in discussions about sex; to engage in social activities with the opposite sex; to kiss those of the opposite sex; to be in love with someone of the opposite sex; to listen to or to tell jokes involving sex.

15. **Agg : Aggression** : To attack contrary point of view; to tell others what one thinks about them; to criticise others publically to make fun of others; to tell others off when disagreeing with others; to get revenge for insults; to become angry; to blame others when things go wrong; to read newspaper accounts of violence.
The importance of anxiety as powerful influence in contemporary life is increasingly recognised. Anxiety is found as a central explanatory concept in almost all contemporary theories of personality. It is regarded as a principle causative factor for such diverse behavioural consequences as insomnia, immoral and sinful acts, instances of creative self-expression, debilitating psychological and psychosomatic symptoms, idiosyncratic mannerisms of endless variety, student agitations, and industrial unrest.

Non-gratification of human needs results in psychological imbalance, always accompanied by an unpleasant emotional state, tension and anxiety. Thus, the level of anxiety can serve as an index of need gratification.

It is presumed that job satisfaction and anxiety are correlated with each other. A lower level of anxiety in the job situation may be indicative of higher job satisfaction. Conversely, a lower level of job satisfaction may serve as an index of a higher level of anxiety.

Definition of Anxiety:

Anxiety has been defined in various ways by theorists and researchers in the professional field. Mostly, such definitions are based on (a) clinical impressions and observations (b) introspective reports by subjects and/or patients, and
(c) physiological or behavioural changes noted during the experimental situations. Some other definitions have only conceptual basis. Martin (1971) has distinguished between 'stimulus-oriented' and 'response-oriented' definitions of anxiety.

According to Grinker (1961):

"Anxiety is a universal human emotion of an indescribable foreboding or dread of personal doom".

Meyer-Gross (1969) has stated:

"Anxiety reactions carry an unpleasant emotional tone, which may perhaps have survival value in predisposing the individual to avoid circumstances which evoke the reaction".

Izard (1972) has opined:

"Anxiety is a pattern of emotions; a complex emotional reaction that includes fear as well as other fundamental emotions, like anger and shame. Anxiety is thus always a complex of fundamental emotions and their interactions and it cannot be adequately conceptualised and understood or effectively assessed and treated when considered as a unitary concept".

Most of the definitions have either emphasised the psychological concomitants or the physiological accompaniments of anxiety. For the purposes of the present investigation, anxiety has been operationally defined as an unpleasant emotional state which is accompanied by feeling of apprehension and restlessness, fear, and general bodily tension.

**Types of Anxiety**:

Psychologists, psychiatrists and psycho-analysts label anxiety in different ways.
A psychologist would label anxiety as trait or/and state anxiety.

A psychiatrist would label anxiety as free-floating and bound anxiety; acute and chronic anxiety.

A psycho-analyst would label anxiety as conscious and/or unconscious anxiety.

These types are not the real, distinct entities. However, it seems as if the typing of anxiety is done to facilitate the clinical syndrome or to emphasise one aspect of anxiety over another. Cattell and Scheier (1961) have rightly refused to believe that there are different types of anxiety, saying that "it is justifiable to develop the popular habit of using the term anxiety for anxiety".

Theories of Anxiety:

Man can hardly escape experiencing anxiety while facing novelty and trauma. Evidences abound from the recorded history of mankind for its attempts at understanding of the nature, the meaning and the process of anxiety. The developments that followed in theorising about anxiety are generally grouped under three major approaches: (1) Conditioned response approach, (2) Psycho-analytic approach, and (3) Existential approach.

1. Conditioned response approach:

The conditioning model states that a previously natural event when paired with an unconditioned stimulus that produces a noxious state such as pain, will elicit a conditioned response after a sufficient number of pairings. This conditioned response is fear. Fear or
anxiety is viewed as a secondary or acquired drive, when fear acts as a drive, new responses are reinforced by the reduction of the drive. Further, it has also been recognised that the conditioned emotional responses in a variety of situations interfere with or suppress ongoing behaviour. In this respect, it is similar to psycho-analytic position. Mowrer (1960) comes close to psycho-analytic position when he expresses agreement with the position that fear is a psychological warning of impending discomfort. However, work with experimental animals has failed to establish clearly that fear can be conditioned upon the onset of discomforting primary drives other than those associated with painful stimuli.

According to this approach, anxiety is an acquired drive.

2. Psycho-analytic approach:

Freud's contribution to the understanding of the concept of anxiety is by far the most significant. He developed his theory of anxiety in two stages. In the early stage, Freud (1926) has stated that whenever the organism is prevented from carrying out an instinctually motivated act, whether through repression or through some prevention of gratification, anxiety will ensue. Such anxiety may of course serve as a motive for a symptom that in turn functions to terminate or completely prevent the subsequent occurrence of anxiety.
In the second stage, Freud (1938) stated that repression was suggested to occur because of the experience of anxiety. It means that whenever real or potential danger is detected by the ego, this perception gives rise to anxiety which in turn mobilises the defenses including repression.

Freud derives the origin of anxiety from the prototype of over-stimulation due to the birth-trauma and the immediate period thereafter, emphasising the helpless nature of the infant in contrast to Rank (1924) who relies solely on the birth-trauma as the source of anxiety.

For Freud, the experience of anxiety has three aspects: (1) a specific feeling of unpleasantness, (2) efferent or discharge phenomena, and (3) the organism's perception of this.

Horney (1945) supplements by adding the concept of basic anxiety which is "the feeling a child has of being isolated and helpless in a potentially hostile world". For Horney, primary anxiety is related to disturbances in inter-personal relations between the child and the significant adults.

Sullivan (1953) relates parental disapproval to the development of anxiety.

To sum up, the psycho-analytic approach not only treats anxiety as an important tool for the handling of a realistically threatening environment.
but it also relates anxiety to the development of neurotic behaviour.

3. Existential approach:

Anxiety is elicited by threats to one's being---to living as fully as possible, to self-definition and actualisation. Such threats to existence may stem from outer or inner sources.

Existential philosophers are very concerned about the social predicament of modern man. They emphasise the break-down of traditional faith, the depersonalisation of man in our mass culture, and the loss of meaning in human existence. They view modern man as alienated and estranged---as a stranger to God, to himself, and to other men. Thus they see the social context of contemporary life as one which leads to existential anxiety. Anxiety is also seen as stemming from inner conflicts between being and non-being. For example, the individual may be confronted with the anxiety-arousing choice of maintaining his present life pattern with the security it offers or exploring a new possibility which appears to offer greater self-fulfilment but also involves greater uncertainty (Coleman, 1969).

Sartre's (1943) position about the problem of anxiety is not very much different from Kirkegaard's (1844). The concepts of Kirkegaard on human development and human maturity are closely linked with his notion of freedom. Freedom implies the
existence and awareness of possibility. The term possibility is used to refer to that which is created and developed by man.

Anxiety is closely linked to the existence of this possibility and potential of freedom. Whenever an individual attempts to carry any possibility into action, anxiety is a necessary accompaniment. In other words, any choice situation involves the experience of anxiety.

Kirkegaard endows even the new-born child with an unavoidable and necessary prototypical state of anxiety. Anxiety appears at each point of development of the child. Kirkegaard suggests that not only anxiety is inevitable but is actually sought out. It is suggested that only by facing the experience of anxiety during the developmental stages, one can truly become an actualised person and will be in a position to face reality. Kirkegaard also distinguishes between fear and anxiety by saying that fear involves a specific object that is feared and avoided, whereas anxiety is independent of the object and follows all choice and possibility.

To sum up, existential approach upholds the inevitability of anxiety in life and its naturally occurring initial state at birth of the organism.

Measurement of Anxiety:

There have been different approaches
for the measurement of anxiety. These can be broadly classified into (a) Physiological/Bio-chemical measurements, (b) Observational behavioural indices, and (c) Objective/Projective psychological tests.

(a) Physiological/Bio-chemical measurements:

Among the physiological and bio-chemical measurements, blood pressure, palpitation rate, respiration rate, GSR, thyroid activity, amino acids, blood urea, cholesterol levels, various secretions etc. are recorded. Though these variables tap anxiety through physiological and body chemistry studies, yet their measurement is not stable. These get changed even after minor changes in the environment. That is why these studies do not form a part of psychological parameters. In psychology, enduring and reliable measurements are much more appreciated rather than non-static measurements. Moreover, they need a lot of time of the technician who makes the readings. Further, many a patient resent to undergo such rigorous, unpleasant testing. It is this reason that most of the researches on anxiety are conducted through objective or projective psychological tests.

(b) Observational behavioural indices:

Behavioural indices require the acumen of the observer to note down the various percepto-motor activities of the subject, such as speech, posture, gestures, sleep pattern, activity level, facial expression, etc. The rating of these indices has
never been objective because, after all, the observer is a human being. His observations are likely to be coloured by one or other behaviour index and thus may bias the observation. Secondly, observers are generally not so accurate to detect minor changes in the behaviour. On ethical grounds, if the individual who is being observed does not complain of discomfort, what right the observer has to label him as uncomfortable. The subject's internal state of psyche can not be observed by the observer. It is only the subjective report which can be considered as the correct measurement of internal psychic processes of an individual.

(c) Objective/Projective psychological tests:

Psychological tests are the best instruments to measure the level of anxiety. The techniques of psychological measurements have been emphasised from 1950. A large number of paper-pencil tests have been developed. To name a few, for example, Taylor's Manifest Anxiety Scale (1953), IPAT Anxiety Scale (1961), Spielberger's Anxiety Scale (1970), May's Anxiety Scale (1950), Sarason's General Anxiety Scale (1960), and Sinha's Anxiety Scale (1961).

In India, most of the psychological tests are developed without caring for their objectivity, reliability, validity and usability. Krishnan (1972) wrote in his report "Trends in Clinical Psychology", that most of the tests adapted, translated or developed, were not upto the mark.
Pareek and Rao (1974) have commented:

"There are in all 10 instruments located that measure anxiety. Five of these are adaptations and the rest originals. However, even the few originals seem to take quite a bit from foreign instruments. ..... There is less of duplication as different scales of anxiety find place in adaptations. Much information on the standardisation of these adaptations is not available."

**JOB SATISFACTION**

Man is a working animal. He spends at least one-third of his lifetime either doing some job or making preparations for doing some job. Work provides to man opportunities to actualise his creative potential as well as to satisfy his needs. Work also provides to man his economic security. But man does not live by bread alone. Along with the satisfaction of his economic needs, man wants satisfaction of his other needs, such as psychological needs, social needs, and spiritual needs. This fact is applicable to all kinds of work-situations, jobs, and professions, including the nursing profession.
Shanks and Kennedy (1965) have emphasised:

"The fundamental goal of nursing profession is to provide patients with the best possible nursing care. Throughout the history of their profession, nurses have strived to attain this goal while confronted by vast technological, economic, and sociological changes that have exerted a challenging impact on the nature of the health services provided. Nursing has responded to the demands imposed by these changes and will continue to respond in order to accomplish the goals of the profession. As health services increase, the need for nursing services increases, and more and more persons become involved in providing these services."

A person who joins nursing profession must reconcile with the objectives of the profession, along with the gratification of her personal needs in the profession. These needs may be material needs, social needs or psychological needs. If her objectives reconcile with the objectives of the organisation in which she works, then she is likely to satisfy her needs and thereby derive satisfaction at her job. If the individual finds that her job satisfies her needs, then she will continue to stick to her job and she will do it whole-heartedly.

Job satisfaction is a complex phenomenon. Since no two human beings are alike, their needs also differ from each other. Therefore, they also differ in the attainment of various levels of job satisfaction. Not only this, the same individual derives different levels of job satisfaction at different times. Further, the same individual may have different levels of job
Job satisfaction refers to a person's feeling of satisfaction on the job, which acts as a motivation to work. It must be remembered here that it is not satisfaction, happiness or contentment per se, but it is always related to the job. The satisfaction is necessarily on the job.

Although this is generally accepted by most of the research workers, some workers have expressed a little different opinion also on the subject. Blum (1966) relates job satisfaction with the general satisfaction and feels that job satisfaction, in part, may be a function of a general satisfaction or attitude towards life.

Before defining job satisfaction, it is desirable to be clear about the connotation of such words as work, job, occupation, and satisfaction.

Work is a form of activity that has social approval and satisfies a real need of the individual to be active. (Blum & Naylor, 1968)

Job is an activity which is performed under contractual agreement and for which one gets paid. (Srivastava, 1974)

Occupation is a source of need satisfaction. (Ann Roe, 1956)

Satisfaction means the simple feeling state accompanying the attainment of any goal; the end state in feeling accompanying the attainment by an impulse of its objective. (Wallerstein, 1974)

Blum (1951) held that job satisfaction differed from "attitude" and "morale" in the following manner:
"Job satisfaction is an individual phenomenon and is measured by ascertaining certain attitudes. In other words, these attitudes result from summation of many likes and dislikes in connection with the job. Attitude of an employee can be considered as a readiness to act in one way rather than another in connection with specific factors related to the job.

Though attitude is not job satisfaction, job satisfaction is comprised of a number of attitudes.

Similarly, job satisfaction is not the same as morale, although it contributes to morale. Morale is a by-product of the group and is generated by the group.

The significance of the term 'job satisfaction' has been highlighted by Strauss and Sayles (1971) in the following words:

1. People want self-actualisation.
2. Those who do not obtain job satisfaction, never reach psychological maturity.
3. Those who fail to obtain job satisfaction, become frustrated.
4. The job is central to man's life.
5. Those without work are unhappy. People want to work even when they do not have to.
6. Lack of challenging work leads to poor mental health.
7. Work-and-leisure patterns spill into each other. Those with uncreative jobs engage in uncreative recreation.
8. Lack of job satisfaction and alienation from work lead to lower morale, lower productivity and unhealthy society.

Srivastava (1974) defined job satisfaction as "the attitudes people hold towards their job: positive attitudes toward the job connote satisfaction with it, and negative attitudes toward the job connote dissatisfaction with it."

The above definition of job satisfaction has been accepted and adopted for the present study. However, various theories have been
propounded in the past concerning job satisfaction. A brief critical account of these theories has been attempted here for better understanding of this concept in its historical perspective.

**Theoretical Background:**

The intent of job satisfaction studies has changed greatly since the early experiments of Frank Taylor (1911) who assumed that job satisfaction was related completely to the amount of money earned, i.e., tied to rewards. Workers at this time were regarded as part of the machinery to be managed in the most efficient way possible. Industrial studies that considered the worker as a human being with complex needs and feelings first appeared in the 1930s. Hoppock (1935) interviewed a cross-section of workers and concluded that work satisfaction was only a part of general satisfaction with life and was related to the individual's ability to adapt to situations, ability to relate to others, relative status in the socio-economic group with which one identified, and the nature of the work in relation to abilities, interests and preparation for the job.

Elton Mayo (1945), experimenting on the working conditions of a chosen group of factory employees (the Hawthorne studies), concluded that the most important determinant of job satisfaction was group inter-action; morale increased within the experimental group at every change in conditions,
whether better or worse; although his findings stressed the importance of group interaction over any of the other needs being met by the work situation (security, esteem, affiliation, intrinsic interest in the job, or achievement) his was the first industrial study to consider the worker from a psychological perspective, and it provided the basic approach for later job satisfaction studies.

Another important influence on job satisfaction studies, has been the theories of motivation developed by the humanistic psychologists. Maslow (1954) developed an influential and useful hierarchy of human needs, placing at the lower end needs which are vital to survival, but which can be attained and satisfied, and at the upper end needs which allow a person to develop his potential and whose partial attainment spur greater need. Maslow's need hierarchy from lowest to highest includes physiological needs, safety, affiliation, esteem of oneself and by others and self-actualisation (realisation of one's potential). These needs have been the basis of job satisfaction studies either used alone or in combination with the expectancy theory, which relates motivation to the expectations of achieving a reward, the value of the reward, and the effort required to achieve it (Lawler, 1973).

Herzberg et al (1959) developed a
theory of job satisfaction based on Maslow's hierarchy, but they concluded that not all factors increase satisfaction. Certain factors --- corresponding roughly to Maslow's lower level needs --- add to dissatisfaction if not met, but cannot increase satisfaction; while other factors --- the higher level needs --- add to satisfaction by their attainment. The dissatisfiers include company policy and administration, supervision, and working conditions; the satisfiers include achievement, recognition, work itself, personal relations, factors in personal life, job security and status, with pay over-lapping both categories.

Maslow's need hierarchy has been criticised as representing the value system of the upwardly mobile members of society while not considering other groups whose values may deviate from this standard. Herzberg has been similarly criticised for presenting a division of needs which cannot possibly apply to all job situations. Both theories have been valuable, however, in the comprehensiveness of needs they include. They have also suggested that to motivate a worker successfully, rewards must be linked to needs which are most desired and least attainable.

One weakness of job satisfaction studies is that they have failed to pin point needs which would predict satisfaction in all jobs, and, as a result, there has been empirical data concerning specific studies, but little which can be generalised.
to improve theories. Often job satisfaction studies have focussed on those areas easiest to measure and easiest for management to change, such as physical conditions, hours, wages, promotion, fringe benefits, supervisory training, organisational structure, job enrichment, auto-mation, pension plans or amount of interaction with other workers. In failing to measure all the needs in Maslow's hierarchy, specifically the upper level needs, the surveys miss the basic areas of satisfaction.

In addition, the normal focus of a study is the group rather than the individual, as it is often impractical to seek solutions for the individual. Thus, management's focus on areas which it can change may ignore the needs most important to the worker and in attempting to discover solutions for an entire work group, may obscure the needs of the individual. Vroom (1964) suggested that the variation among individuals may be greater than that accounted for by any factors thus far associated with job satisfaction, and that studies of individual workers might yield better theories of job satisfaction than those so far developed.

Another short-coming of job satisfaction studies is that while they have demonstrated the relationship between dissatisfaction and turn over, absenteeism and possibly accidents, there has been
little proof that satisfaction correlates with other variables such as productivity or quality, two outcomes management originally hoped to promote by increasing worker satisfaction (Vroom, 1964).

Measurement of Job Satisfaction:

There are normally two approaches to measure job satisfaction. These approaches may be termed as the "global" approach and the "summation" approach. The global approach is concerned with eliciting generalised, undifferentiated evaluations of the job or vocation, whereas the summation approach elicits the reactions or attitudes of the individual to specific aspects of the work situation, which are then summated to obtain an overall index of liking or disliking.

The present study has adopted the global approach in measuring job satisfaction of the nursing personnel. This approach was preferred on the following grounds:

1. It can be logically argued that job satisfaction is simply not the summation of likes and dislikes, of specific aspects in the work situation. One may be dissatisfied with many aspects of the work situation and yet be satisfied with the job and vice versa.

2. The global approach to the measurement of satisfaction seems to be more rational. It measures the attitudes of the individual towards his job as a whole. It forces the individual to give his reactions...
to the job in its totality.

In order to understand their need for gratification, it is imperative to understand the level of job satisfaction of nursing personnel.

Rider (1950) has very well emphasised the importance of the job satisfaction of nurses in the following words:

"Unless the nurse's human needs are met in her work, she will be unable to satisfy the human needs of her patients."