CHAPTER - TWO
ADJUSTMENT PROBLEMS VIS-À-VIS HOSPITAL SETTING

2.1. What is adjustment

Adjustment means many things, such as need gratification, skill in dealing with frustrations and conflicts, peace of mind, or even the formation of symptoms. It means learning how to get along successfully with other people and how to meet the demands of the job. Adjustment as a process, involving both mental and behavioral responses, by which an individual strives to cope with inner needs, tensions, frustrations and conflicts and to bring harmony between these inner demands and those imposed upon him by the world in which he/she lives (Wylie, 1961). People strive to be comfortable in their surroundings and to have their psychological needs (such as love or affirmation) met through the social networks they inhabit. When needs arise, especially in new or changed surroundings, they impel interpersonal activity meant to satisfy those needs. In this way, people increase their familiarity and comfort with their environments, and they come to expect that their needs will be met in the future through their social networks.

Adjustment mechanism is almost used by all people. They are ideas which are inferred from the behavior of the individuals. All mechanisms are used to protect or enhance the persons self esteemed against dangers. They increase satisfaction and help in the process of adjustment if used within limit. The overall effect of adjustment mechanism is to cripple the individual's functioning and development through falsifying some aspects of individual’s impulses so that an individual is deprived of accurate self knowledge as a basis for action.
2.2. Studies on adjustment

In non-psychiatric health care settings, it does not show a significant relations between higher level of anxiety in nurse and staff and violence showed by the patient, it is not detrimental to the work performance in the work setting and also not detrimental to adjustment patterns, because the notion of adjustment as self-maintenance or survival is applicable to physical well-being and psychological well-being (Crotty, 1998). Research findings showed that the staff and nurses had higher level of state anxiety after being assaulted by the patient and that emphasized that some of them are able to plan and to organize personal responses in such a way that arise conflicts, difficulties and frustrations which leads to the ability to cope with reality in an adequate and healthy manner and to manipulate the environment of people and events in a way that leads to adjustment (Elias and Merriam 2005). Emotional response of nurse and staff was studied and the findings revealed that the levels of distress were largely within the normal range and few individuals reported any distress that reached clinical significance that may create feelings of worthlessness, failure or despair which are contrary to personal adjustment (Lindop, 1989). Several researchers have noted that nurses working in non-psychiatric hospitals have a tendency to minimize and deny the effects of assault, showing the less anxiety associated with stress and emotional disturbances while working with the assaultive patient and in that case it is not that much difficult to adjust well to the demands of work that gradually helps to minimizes tension, boredom and unhappiness lead to healthy adjustment (Merriam and Simpson 2000). Another study proposed that the expression of non-pathological anxiety as well as features of diagnosable state anxiety conditions in nursing staff is not detrimental to mental health as well as adjustment that related to personal integrity (Sogunro, 1998). Several studies indicated that stress
increased the level of anxiety, depression and tension which may affect the further area of work performance and the individual’s experience interferes with efficient concentration often disturbs emotional stability, develops mental conflict or anxiety cause poor adjustment and conflicts in every aspects of life or misbehavior (Booyens, 1998). In the hospital situation the direct impact on the nurse of physical illness was intensified by having to meet and deal with the psychological stress in other people including colleagues. The degree of stress found in the nurses was developed due to the direct contact to the patient’s and relative’s distress which increases anxiety and difficulty in handling it. Feelings of personal inadequacy, helplessness, inferiority or insecurity or worthlessness undermine the adjustment patterns of nurse and staff in hospital setting (Zerwekh and Claborn, 2003). Actually the emotionally disruptive conflicts sometimes disturb the nursing staff. Striving for maintaining balance in conduct, thoughts, feelings and impulses that make possible to resolve conflict and frustrations with the necessity of developing defense mechanisms or symptomatic behavior (Cordes and Dougherty, 1993). Rafferty et al. (2001) found that nurses who report a higher level of stress were more dissatisfied with their jobs, planned to leave their job and were likely to have a higher burnout score. They also reported low level of social support during times of difficulty or stress and perceived that there was less cooperation in the department than those not working in the department. This led to more negative work attitudes and lesser propensity to co-operate with others. They are disturbed, unhappy or neurotic, confused and isolated detrimental to the healthy adjustment patterns. Adjustment processes occur at several different levels that the reaction to a conflict, frustration or problem may be on a distinctly mental level, the nursing staffs may take projection, egocentrism and rationalization when they develop the form of psychosomatic symptoms like anxiety, depression, feeling of inferiority, concentration difficulty, high level of neuroticism and lie factor, all are
detrimental to the adjustment to the surrounding situations (Burns and Grove 2001). High level of state anxiety adds failure to adjust is often determined by the relation between the adjustment capacity of people and the nature of the demands made on them (Firth, 1986). Fischer (1988) found that nurse and staff who is the \textit{neurotic} person is characteristically inefficient and never manages to complete tasks and badly inefficient in completing assignments would experience more symptoms of depression and anxiousness than nurse and staff who had not experienced an assault. Research findings also indicates that violence in hospital settings is a frequent and serious problem and may compromise emotional well-being of nursing staff as well as job satisfaction (Greenberg, 2004). Besides this, assaulted staff would report higher levels of psychological distress, specifically state anxiety and depression than non-assaulted staff. However, the results of this study indicated that emotional distress appeared linked to anxiety. Assaulted staff reported higher state anxiety and somatic concerns than that of the non-assaulted staff. They lack insight and tend to find fault with others to rationalize inadequate behavior or to develop defensive mechanisms-all of which are inimical to good adjustment (Hood and Leddy, 2003). Studies of nursing staff assault have also noted persistent state anxiety and/or an increased sense of vulnerability among assaulted nursing staff. Related to this findings, integration for the neurotic or for the normal person requires self objectification, but this objectivity are direct opposites of the subjectivity that is so characteristic of disturbed or maladjusted persons. Personal limitations, feelings of inferiority and similar handicaps are present in the nurse and staff detrimental to the adjustment patterns (Krlichtbaum, 1994). Work in the general medicine department provides formidable stresses for nursing personnel. A major problem is the exposure to death and dying, posing threats of object loss and personal failure. The impossible work overload and lack of gratification from obtunded patients add to the problems of maintaining self-
esteem. Lack of support from these crucial groups (physicians, relatives, hospital administration) added stress in the nurse and staff that associated with anxiety may lead to emotional instability and mental inefficiency that are the causes of maladjustment (Schmeiser and Yehle, 2001). The hospital situations likely to evoke stress in nurses are familiar. Nursing patients with incurable diseases is a distressing task. The work arouses strong and conflicting feelings like guilt and anxiety, the intensity and complexities in nurse’s anxieties are to be attributed to the accompanying emotions and having impact on their work performance and their personal life that negative feelings can act to disrupt or even to destroy mental stability leads to maladjustment (Timmins and Kaliszer, 2002).

Nurses worried about performing their work correctly. The worry, tensions, anxiety sometimes make them disbalanced with certain behavior and traits that unable them to cope effectively with those tension, conflict and frustration where the determinants of adjustment exert a damaging influence, maladjustment is a likely result (Santos and Guirardello, 2007). In another study, patients and relatives had complicated feelings towards nurse and staff that often puzzled and distressed them. In a more subtle way, both patients and relatives made psychological demands on nursing staff increased their experience of stress contributed to the development of anxiety, the sufferer is hypersensitive, resentful in stressful hospital situations may cause maladjustment in the nurse and staff (Bennett and Lando, 1999). Nurses were uncertain of their ability to perform skills on patients during their interaction with violent or aggressive patients that make them vulnerable to develop mental health problems and adjustment problems (Hallberg and Norberg, 1993). It was hypothesized that the levels of anxiety, depression of staff nurses working in general medicine ward is higher when staffing is inadequate than when staffing is adequate that are presumed to be
neurotic (Walsh et al., 2000). The analysis of the data showed that the behavior is supposed to be unsatisfactory and not wholesome. This may cause maladjustment which may be damaging to personality or to person's interpersonal relations (Zerwekh and Claborn, 2003). Some nurses experience high levels of stress in the clinical setting (Athanassios et al., 2001) more than the other situation. General anxiety and depression has been found to be one of the four major obstacles to performance and perceived the surrounding as a threatening in the clinical setting (Barling, 2001). Lacking such insight, people tend to find fault with others, to rationalize inadequate behavior or to develop defensive mechanisms, all of which are detrimental to adjustment. Personal limitations, feelings of inferiority and similar handicaps may be causes of maladjustment (Callaghan et al., 2000). The result of the study indicated that experienced nurses showed lower levels of depression and anxiety in the clinical setting than the newly joined nurses. The researcher showed that the higher level of depression, anxiety and stress are found among the newly joined nursing staff due to their frequent exposure to the patient, leads to adjustment problems (Cole, 2001). The research findings also reveal that newly joined nurses in all levels of nursing care, experience stress and that cause depression and anxiety. Tensions of nurse and staff are aroused by the situation lead to frustrations that are ineffective and even damaging to adjustment (Blomqvist, 2001). Campbell et al (2010) shows that good nursing care leads to a more responsive and patient sensitive service and more clinically effective and/or cost effective service in the psychiatric department. More satisfying roles for team's members is to increase job satisfaction by reducing perceived alienation, anxiety, depression or other mental health problems. Borill et al (2001) found that those working in disturbed environment reported much higher levels of stress and were more likely to leave their profession. Cox et al (2000) described the stress response as being a mismatch between the perceived demands and the ability of
the individual to cope with these demands. Mental healthcare workers have been recognized as experiencing occupational stress. The study finds the perceived causes of stress in the physical, psychological and social environment specific to nursing. It postulates that when psychological demands in the workplace are high and the control of the worker is low, then psychological stress or strain occurs that disturbs mental hygiene and personal adjustment (Brody, 2002). Another study concluded that female nurses of psychiatric ward are correlated with levels of anxiety. Sometimes, higher level of anxiety in nurses of psychiatric department causes psychological and physical illnesses and insecurity, emotional instability that are indispensable to understanding human adjustment and mental health (Sakauye, 1996). Research findings also revealed that stressful relationships between nurses and mentally ill patients caused high levels of depression and anxiety was one of the primary reasons for nursing staff to leave nursing profession (Satcher, 1999). Stressful relationships resulted when nurses were demeaned, belittled, and humiliated by psychiatric patients that interferes with efficient concentration, often disturbs emotional stability and may contribute to failures, cause mental conflict or anxiety influence mental and physical functioning which cause maladjustment (Simon and Rosenbaum, 2003). The researcher suggested that the psychiatric patient may have posed a threat to staff nurses because of their unpredictable adverse mental condition. This threat may have resulted in unfavorable attitudes of staff nurses toward their patients because nursing staff developed higher level of anxiety, it can seriously interfere with efficient mental functioning that interferes the adjustment processes in family, health, occupational, social aspects of life of nursing staff of psychiatric department (Streim, 2002). In a study, nurses felt that they were being mistreated and assaulted by mentally ill patients that caused lack of confidence, increased anxiety, restlessness and other psychological and physical illnesses (Irving and
Some nurses and staffs felt that the psychiatric patients simply did not like nurse and staff because of the unfavorable relationships they experience with psychiatric patients develop increased level of anxiety, neuroticism/psychoticism and perceived environment as a barrier of needs and motivations in nursing staff that lead them to difficulties in maintaining proper adjustment in their department (Petersen and Alexander, 2001). Nurses from the psychiatric department experience anxiety and other mental blockages when providing patient care, this frustration can lead to real personal difficulties or the deep conviction of failure that they experience when their best efforts prove inadequate can give rise to deep feelings of inferiority or worthlessness that fosters the development of unhealthy attitudes toward self and toward others (Polit and Beck, 2008). Nurses experienced higher levels of anxiety and depression cause deprivation on emotional stability that contributes to inadequate adjustment (Baba et al, 1999). Some female nurses experienced stress and becomes anxious (increased anxiety, depression and neuroticism) when providing care to patients who were male and hospitalized on psychiatric wards (Romanov, 1996). Maladjustment that damaging social experience, interferes the interpersonal relationships block the natural expression of communication among nursing staff in the department (Mills, 1998). Nurses from psychiatric ward felt that they lacked clinical knowledge and questioned their ability to perform nursing procedures (Burke, 2000). What is quite troubling is that seniors questioned about their ability to perform in the clinical setting (Prosser, 1997). Initial clinical experiences were found to be a significant source of mental health problems. Providing patient care was an initial clinical experience that caused most anxiety, depression and neuroticism for some nurses. In that case, social disapproval can have a damaging effect on the self-concept, on feelings of adequacy, achievement and personal worth lead to serious social maladjustment (Spurgeon, 1997). Some studies
explore that the psychiatric nurses' anxiety, frustrations and conflicts, modes of
adjustment and all of the details of daily conduct follow certain fundamental
motivating forces within them which may resolve their turmoils (Huynh et al.,
2008). The nursing staffs said that they were nervous and getting anxious the first
time when reviewing the mentally ill patient. The nursing staffs said that the more
often they deal with the patient, the less anxious they felt. They experienced low
level of anxiety when there was a lapse of time from when they last performed a
skill, but once they began to perform the skill they felt better and try to cope with
the demands of the respective department (Kalisch, 2006). Similarly, the results of
other research found that nurses of psychiatric ward felt they lacked clinical
knowledge to accomplish patient care (Davidson, 2000). Data from several studies
indicated that nurse and staff felt that they were adequately prepared for getting
clinical experience and this was the way of resolving stress and anxiety, they are
being able to cope adequately with problems and conflicts under stressful
conditions (Mahat, 1998). Nurses in another research study said they were quite
worried about causing paralysis to a patient if they provide incorrect medications
(Gillette, 1996).

2.3. About state anxiety

Anxiety is a psychological and physiological state characterized by somatic,
emotional, cognitive and behavioral component. It is the displeasing feeling of
fear and concern. Anxiety is a generalized mood that can occur without an
identifiable triggering stimulus, a future-oriented mood state in which one is ready
or prepared to attempt to cope with upcoming negative events. Anxiety is the
sense of uneasiness that is experienced in the individual’s relationships with other
people and in his/her relationship to their own conscience (Speilberger et al.,
1972). State anxiety manifests itself as an interruption of an individual’s
emotional state, leading to a sudden subversion of one’s emotional equilibrium. A person experiencing ‘state’ anxiety will feel tension or worry or might enter a state of restlessness. In such moments, the individual may feel very tense and easily react or over-react to external stimuli. State anxiety involves activation of the autonomous nervous system and the consequent triggering of a series of physiological reactions and conditions. High levels of state anxiety are particularly unpleasant, disturbing and can even be painful to the point of inducing the person to engage in adaptive behaviour aimed at ending these sensations. However, these adaptive reactions may not be successful in attaining their goal and other behaviour patterns may become manifest - this time of the maladaptive type - which can result in the opposite effect: a further increase of anxiety, which can trigger a pathological vicious circle.

2.4. Few studies on State anxiety
Research study shows a significant relationship between higher levels of state anxiety and violence showed by the nursing staff which is detrimental to the work performance in the work setting (Kelsall, 1995). Ryan and colleagues (2004) found that the staff who had experienced physical assault by a patient severe enough to produce an injury would experience more symptoms of depression and anxiousness than staff who had not experienced an assault. Carmel and Hunter (1989) have noted that those staff who are tasked with the responsibility of setting limits, making requests or demands, denying a request and assisting ill patients in the activities of daily living are most at risk for developing stress or anxiety. In addition, frequently assaulted nurse and staff is showing such as attitudinal problems, or displaying behavior, but may reflect anxiety or any other psychological problems perceived by others as provocative (Lanza et al., 1991). The finding that assaulted staff (in comparison to non-assaulted staff) reported a
higher level of generalized impairment at work and considered terminating employment (Wykes et al., 1998). The experienced nurse develops a subtle adaptive compromise, but stimulating state anxiety about one's own vulnerability. The nurse simply must protect herself from grief, anxiety, guilt, rage (Matlakala, 2003). Work in the non-psychiatric setting provides formidable stresses for nursing personnel. The impossible work overload and lack of gratification from obtunded patients add to the problems of maintaining self-esteem associated with state anxiety (Hunter et al., 2010). The degree of stress found in the nurses was developed due to the direct contact to the patient’s and relative’s distress which increases the personal state anxiety and difficulty in handling it (LoBiondo, 2002). In a more subtle way, both patients and relatives made psychological demands on nursing staff increased their experience of stress contributed to the development of anxiety (Streubert, 2007). The nurse’s own deep anxieties were psychically hampering their mental status and job performance (Klein, 2009). The study found increased state anxiety leads to perceived lack of support from the surroundings (Meisenhelder, 1987). Dealing with patient’s physical illnesses, nursing staffs have faced problems that create anxiety in them (Fischer, 1988). In a medical condition, nurses experience state and trait anxiety in the clinical setting on a daily basis (Gorham, 1963). When nurse and staff experiences state anxiety they may sense a threat to physical life, a threat to psychological life, which could be loss of freedom or a threat to some value that the person holds in esteem and views as an essential part of their existence (May, 1996). Gwele and Uys (1998) studied that experienced nurses showed lower levels of state anxiety in the clinical setting than those the newly joined nurses. The researchers contributed the higher state anxiety and stress levels of younger nurse and staff due to the exposure to the patient. Similarly, Kim (2003) found nurses experienced anxiety during clinical experiences. The results of one study showed that some nurses experienced an
increase in neuroticism and psychological distress during their nursing experience. The researchers found that high level of neuroticism could be a negative consequence of the stressful experience of student nurses in the nursing program (Deary et al., 2003). The results of several studies show that relationships between newly joined nurses and experienced staff nurses are stressful. Older nurse and staff had already their clinical experiences than the others. The research reveals that young nurse and staff experiences state anxiety, stress and strain in maintaining the relationships with the experienced and older staff nurses (Timmins and Kaliszer., 2002). Nurses felt sometimes they were being mistreated and assaulted by mentally ill patients that caused lack of confidence, state anxiety, restlessness and other psychological and physical illnesses (Shipton, 2002). Some nurses felt that the psychiatric patients simply did not like nursing staff and others felt slighted when staff nurses would not maintain healthy relations with their patients. Because of the unfavorable relationships they experience with psychiatric patients, develop increased level of state anxiety in nursing staff (Seel, 2001). Nurses from the psychiatric department experience anxiety and mental blockage when providing patient care (Evans and Kelly, 2004). Providing total patient care which involved meeting the physical and emotional needs of assigned patients was found to be particularly stressful, increases levels of state anxiety for nurses (Sellek, 1982). Nurses experience higher levels of anxiety when personal contact was required to provide patient care (Dye, 1974). Some female nurses experienced stress and becomes anxious (increased state anxiety) when providing care to patients who were male and hospitalized on psychiatric wards (Parkes, 1982). Some nurses felt they lacked clinical knowledge and were uncertain in their ability to perform nursing procedures is another source of anxiety. A significant source of stress for some nurse was the ability to transfer theoretical knowledge to the clinical setting when providing care for patients (Brown and Edleman, 2000).
One example in which a nurse of the psychiatric ward felt she lacked clinical knowledge, was being unable to respond and react appropriately in an emergent situation (Kim, 2003). Nurses of the psychiatric unit found initial clinical experiences is stressful (Mahat, 1998). Interestingly, nurses found initial clinical experiences on a unit that was unfamiliar to them to be a source of stressful situation causes anxiety (Beck and Srivastava, 1991). Nurses reported that stress is related to initial clinical experiences on a new unit is due to “…fear of the unknown,” and that it can be frightening until one becomes more comfortable in the environment, Clinical experiences in specialty rotations such as psychiatric nursing, was stressful (Shipton, 2002). Experiences in psychiatric nursing were stressful because nurses were unsure of their role in these areas. In psychiatric nursing, nurses were uncertain about their role because they found it difficult that their clinical experiences involved only talking to patients without having to perform nursing procedures that developed anxiety (Elfert, 1976). Nurses’ anxiety about differing clinical experiences in regard to the evaluation of the patient and their learning in the clinical setting. The nurses in this current study felt that nurse and staff in other clinical setting facing less challenges and are less vulnerable to develop anxiety and stress (Oermann, 1998). The nurses said their peers were getting better experiences on other units and at other hospitals and even said their peers within their own clinical group were getting better experiences than they. When the nurses sensed these differences it led not only to anxiety, but also tension, jealousy, and anger within the nurse’s clinical group and between other clinical groups. This made difficult to focus on patient care, this is a new finding in relation to anxiety in nurses in the clinical setting (Oermann, 2006). The results of other research found that nurses of psychiatric ward felt they lacked clinical knowledge to accomplish patient care (Mahat, 1998). The nurses in the research study were anxious about causing pain to the mentally ill patient when dealing
with them. They worried about their assessment skills, in particular doing them properly and knowing which assessments to perform in order to accurately monitor the patient’s clinical condition. They were anxious about administering medications in psychiatric patients. This increases nurse’s general anxiety level which affects their performance (Wykes, 1998).

2.5. About trait anxiety

Trait anxiety denotes relatively stable individual differences in anxiety proneness and refers to a general tendency to respond with anxiety to perceived threats in the environment. Trait anxiety is the preset level of anxiety experienced by an individual who has a tendency to be more anxious, to react less appropriately to anxiety provoking stimuli. Trait anxiety refers to a general level of stress that is characteristic of an individual, that is, a trait related to personality. Trait anxiety varies according to how individuals have conditioned themselves to respond to and manage the stress. What may cause anxiety and stress in one person may not generate any emotion in another. People with high levels of trait anxiety are often quite easily stressed and anxious. Those who show a more developed trait anxiety is much more prone to reacting to a large number of stimuli and will tend to worry also in situations which for most individuals would not represent a source of threat. These individuals are more likely to present state anxiety in circumstances with low anxiety-generating potential, such as normal day-to-day activities, and will probably experience higher levels of state anxiety in the presence of anxiety-generating stimuli.
2.6. Few studies on Trait anxiety

Nurse and staff are under increased stress because of excessive workloads and hospitals' restructuring which is affecting their work tasks. But, trait anxiety could not affect their mental health. The results revealed both the stress-release and cognitive relaxation training enhanced mental health in nurse and staff of general medicine department (Yung et al., 1991). Studies have shown that the reported mental health symptoms of anxiety for nurse and nurse executives of general medicine department are greater than the published norm and high job demands affected self-rated health and resulted in emotional exhaustion (Lindencrona, 2001). Personality traits also influence the level of trait anxiety because what may be overtaxing to one person may be exhilarating to another (Neff, 2007). The nurse's role has long been regarded as stress-filled based upon the physical labor, human suffering, work hours, staffing and interpersonal relationships that are central to the work nurses do (Awaritese and Kadiri, 1982) However, nurses' work stress may be escalating due to the increasing use of technology, continuing rises in health care costs and turbulence within the work environment. The effects of both work and non-work anxiety among nurses have been studied infrequently. And yet, non-work anxiety may be particularly salient to nursing, a predominantly female profession. Women continue to juggle multiple roles, including those roles related to the home and family, for which the women may have sole or major responsibility (Elliott, 1994).

Work stress and burnout remain significant concerns in nursing, affecting both individuals and organizations. For the individual nurse, regardless of whether stress is perceived positively or negatively ultimately lead to increased trait anxiety that contributes to illness. In the health care organization, work stress and anxiety may contribute to absenteeism and turnover, both of which detract from
the quality of care (Sreevani, 2006). Hospitals in particular are facing a workforce crisis. The demand for acute care services is increasing concurrently with changing career expectations among potential health care workers and growing dissatisfaction among existing hospital staff. By turning toxic work environments into healthy workplaces, researchers and nurse leaders believe that improvements can be realized in recruitment and retention of nurses, job satisfaction for all health care staff and patient outcomes—particularly those related patient safety (Elliot and Timothy, 1996). The investigation considered the effect of increased trait anxiety and burnout among nurses on patient outcomes (Snellgrove, 1998). These studies examined trait anxiety in relation to increased mortality, failure to rescue, and patient dissatisfaction (Trummers et al., 2001). Similarly, in an investigation of the relationship between personal stress, anxiety and clinical care, 225 physicians reported 76 incidents in which they believed patient care was adversely affected by their stress (Browner et al., 1987). Despite increased recognition of the trait anxiety experienced by hospital nursing staffs and its effects on burnout, job satisfaction, turnover, and patient care. Research findings reveal that the situations that have been identified as causing trait anxiety for nurses in the performance of their duties. Stress, job satisfaction, and nursing turnover hypothesized to be related to level of trait anxiety. In addition, the nurses known to experience high levels of trait anxiety resulting in staff turnover was found (Powell and Enright, 1993). Increases in emotional exhaustion due to increased level of trait anxiety lead directly to an increase in depersonalization as a coping mechanism, which subsequently manifests as a negative behavioural change toward patients, thus rendering staff more vulnerable to further aggression (Sveindottir et al., 2006). The study gives clear direction for the areas that could be included in nursing training to better prepare nurses for dealing with their attitudes toward death and the trait anxiety produced when working with dying
patients (Andrews 1991). The majority of attitudes and beliefs held by health professionals seem to be based on personal rather than work experiences, and most nurses stated that they felt inadequately trained to deal with the issues surrounding death, especially the death of a child. Another area of concern noted in this brief review was the challenge of resolving conflicts between nursing staff and patients with opposing attitudes and the anxiety these situations produce. What is lacking is a clearly stated connection between those attitudes and the level of trait anxiety. It is possible that a more positive attitude might help to decrease the level of trait anxiety (Descamp and Thomas 1993). The purpose of this study was to identify the clinical experiences of nurses that were anxiety provoking and examine the relationship between the level of trait anxiety and the clinical experience that produced anxiety in nurse and staff. A significantly positive relationship was found between the trait anxiety and clinical experience that was anxiety producing. A higher level of perceived anxiety accompanied the clinical experiences. The most anxiety producing clinical experiences in nursing before patients are evaluated with descriptive data (Carson and Kuipers 1998). Another study reports the results of a questionnaire survey among 212 health care workers at a hospital. Measures included burnout, trait anxiety, various job demands and supports, and work attitudes (job satisfaction and organizational commitment). The influence of trait anxiety on work attitudes was mediated through emotional exhaustion due to handling the ill patients. Both job demands and organizational supports had direct effects on work attitudes (Harris, 2001). In the study, staff assaulted by patients in the past six months were compared with those who had not been assaulted. Assaulted staff was more likely to report higher trait anxiety, more somatic concerns, greater vulnerability and lack of control, and higher levels of impairment at work and were more likely to consider terminating employment than were non-assaulted staff (Cozens and Payne, 1999). Research findings also
reveal that the emotional sequelae of staff who experience or witness an assault by a child or adolescent patient suffered from burnout and higher level of trait anxiety (Calnan et al., 2001). Both an increased workload for nursing staff with jobs and feelings of job insecurity that not always increases level of trait anxiety, but, sometimes increases state anxiety and stress. Other studies revealed that health care nurses suffered a high degree of burnout because of increased stress, sometimes leading to leaving their jobs (Edward and Burnard, 2003). In a random sample of nurses, some working 12-hour shifts reported significantly higher levels of stress, not reported any kind of anxiety or depression than some working 8-hour shifts (Numeroff, 1983). A study of 101 female nurses found that work interfered with family more than family interfered with work create increased trait anxiety (Dawis, 1994). The finding is consistent with findings from a study of 170 nurses perceive situations as stressful and becomes anxious (Glass, 1993). In another study, higher trait-anxiety predicted psychological distress, but that not usually manifested. In addition, relationships with other staff—coworkers, physicians, head nurses, other departments—were also predictors of psychological distress (Greenglass et al., 1996). In addition to illustrating a likely connection between nurse managers and staff nurse, nurses in both groups reported high levels of emotional exhaustion and average job satisfaction, not postulated any symptoms of trait anxiety. In another study, the investigators explored trait anxiety among nurses (N = 78) from rural and urban hospitals who held positions in middle-management is lower. Almost half the respondents (49%) reported low level of trait anxiety, but, high level of emotional exhaustion (Shinn et al., 1984). Stated differently, based on another study, as nurses felt less anxious (level of trait anxiety) they relied more on social support. There was a direct and beneficial effect of social support on nurse's psychological wellbeing and hospital productivity. The study showed that they do indicate that staff nurses and
supervisors at all levels would be wise to consider the importance of reciprocal interpersonal exchanges that enhance security, mutual respect, and positive feelings by lowering down the level of trait anxiety (Ross, 1989). Likewise, as perceptions of empowerment increased, staff nurses reported less emotional exhaustion and depersonalization along with a greater sense of personal accomplishment—the three components of less burnout and vice versa: positive perception of patient and surrounding environment creates lower level of trait anxiety (Hillhouse, 1997). The findings related to social support indicated that interpersonal exchanges with coworkers and supervisors may enhance security, mutual respect, and positive feelings—which helped to reduce trait anxiety level. Given the current emphasis on improving the work environment, there is an imperative to carefully investigate both aspects of the nurse administrator in relation to stress and burnout (Golubic et al., 2009). Feelings of anxiety and negative attitudes may cause physicians and nurses to react by pulling away both emotionally and physically, but that not reported the symptoms of trait anxiety. Helping nurses while in training to recognize and consider the affects of these emotions through self-reflection would increase professional satisfaction and quality of the relationship with the patient and their family (Aakster, 1990). Poster (1996) argued that experiencing aggression or violence from patients is an expected occupational hazard of multinational psychiatric nursing staff members. It is natural for psychiatric nurses to manage aggressive behaviors and the lack of safety may be the key source to their trait anxiety. In addition, role conflict and decision dilemma adds to increased level of trait anxiety during the management process that should be considered (Dawson et al., 1988). According to Beck (1985) the degree of behavioral arousal and subjective anxiety is proportional to a person’s subjective estimate of danger. An individual with a high anxious trait evaluates a relatively innocuous stimulus as having a higher subjective threat
compared with one who has a low anxious trait (Mogg and Bradley, 1998). A sample of staff members working at a psychiatric hospital responded to a survey, results indicated an associative relationship among a more external locus of control, high trait anxiety and employees' experience of work-related injuries. The findings provide important information that suggests that locus of control, authoritarianism and trait anxiety on the part of staff members are connected with patient assaults and injuries (Chen, 2005). Results showed increased threat of cognitive appraisal of aggression, increased trait anxiety, and decreased positive attitudes toward aggression predicted higher levels of state anxiety. There were significantly higher levels of state and trait anxiety among psychiatric nurses when patients exhibited verbal and physical aggression rather than just physical aggression (Rout, 2000).

Berg and Hallberg (2000) found that caring for people with mental illness demands an intensified presence. The daily work demand requires psychiatric/mental health nurses have the capacity to handle continually new and unpredictable experiences which may develop trait anxiety, insecurity in managing the mental illness of a patient (Berg, 2000). This endeavour is made more difficult because in some situations psychiatric/mental health nurses are faced with the paradox of providing therapeutic care in conjunction with involuntary treatment and detainment (Rask and Brunt, 2006) that results emotinal exhaustion due to increased level dispositional anxiety. International concern has been expressed about a perceived rise in occupational violence as a major worldwide public health problem, including aggression toward nurses, develops higher level of trait anxiety (Farrell et al., 2006). Love and Morrison (2003) concluded that nurses who sustain injuries from patient assault not only lose time from work and experience financial constraint, but also suffer from psychological
trauma such as post-traumatic stress disorder and increased level of trait anxiety. Results revealed that trait anxiety was primarily controlling “mental health” status (Rask, 2006). Nurses in hospital settings often provide care for patients and families who are suffering. But sometimes they felt anxious (increased level of trait anxiety), stressed and dissatisfied with the job and surrounding environment (Scanlon 2006). This descriptive, cross-sectional, correlational study was performed with the objective to evaluate anxiety and depression among nursing professionals working in psychiatric units. A statistically significant difference was found between general anxiety and depression for cases of psychiatric nurses in case of dealing with the psychiatric patients (Hem and Heggen, 2003). In the current way of life, depression and anxiety are very common disorders that strongly affect mental health’s wellbeing and daily activities. In nursing, some studies have examined these disorders among mental health professionals (Lisspers, 1997). In a study, the findings indicate that, dealing with the psychiatric patients, mental health professionals are more prone to develop trait anxiety and other adjustment problems (Payne, 2001). Nursing profession is linked with anxiety and of course the hospital unit where the nurses work either amplifies or keeps under manageable control their anxiety level and manifestations (Aguocha, 2011). Workload was often identified in the research as being one of the most important sources of stress, trait anxiety, job dissatisfaction, and other negative outcomes. The most obvious source of excessive workload is nursing staff shortages (Aiken et al., 2001). In a survey, the mental health outcome of psychological distress was strongly related to the personality trait of being prone to have anxiety, lower social integration and poor relations with the head nurse and physicians, lower position in the job hierarchy and less experience. Nurses expressed significantly less job satisfaction relating to achievement, feeling devalued and they felt their job was not rewarding (Rees and Cooper, 1992).
Occupational burnout is associated with increased work experience, increased workload and increased level of trait anxiety (Maslach and Florian, 1988), absences and time missed from work, impaired empathy and cynical attitudes toward client and with thoughts about leaving and actual job termination. Distressed people may simply have habitual ways of coping, generally having higher level of trait anxiety, emotional exhaustion and stress (Coyne et al., 1981). Relationship between trait and state anxiety experienced by nursing staff during dealing with the psychiatric patient has been measured. The findings revealed low correlations between trait anxiety and job performance, but high between state anxiety and job performance. The findings suggest that mental health professionals confronted with constraints while interacting with the psychiatric patients to deal with their uncertain behaviors that may influence emotional stability may lead to state anxiety (Moyle, 2003). In psychiatric ward, nurse and staff of psychiatric department experienced stress and state anxiety (not trait anxiety) due to patients' demands, interruptions, practice administration, and job demands (Rout and Rout, 1997). Nursing stress correlated with job satisfaction and state anxiety. Overall results indicate the importance of nursing specialty as a major factor influencing nursing stress (O'Brien, 2000). A study among nursing professionals revealed that situations in the work environment can provoke state anxiety, particularly, among countless circumstances, the instability or aggravation of mentally ill patients' health condition, lack of material, equipment and staff, relation with patients' relatives, as well as nursing care systemization difficulties and high-complexity procedures (Flannery et al., 1991). Research finding shows that some triggering factors can be related with internal factors in the environment and work process, such as: professional activity sectors, shift, interpersonal relation, work overload, work schedule problems, task accomplishment autonomy, client care, exhaustion, social support, insecurity,
conflict of interests and developed coping strategies and some factors are external to work, such as: gender, age, domestic work load, family support and income, workers' general health condition and individual characteristics (Hansen, 1996). Regardless of sex and occupation, the incidence of stress from high level of authority those are making decisions, psychological/physical demands and social support work stress appears to decline with increasing age (Kajiwara, 2002). Analysis of the data relating to shift work and health outcomes suggests that shift work has little or no impact on the incidence of chronic conditions or psychological distress once socio-economic characteristics and reported work stress levels are taken into account. Rotating shifts seem to have the most consistent relationship with negative results across work stress dimensions and high job insecurity is more evident among all shift workers compared with regular daytime workers (Shields, 2002). He suggested that the lack of cross-sectional relationship between shift work and health outcomes may be due to workers “self-selecting” for the ability to tolerate shift work with fewer ill effects. It is indicative of proneness among psychiatric nursing staffs in developing stress, trait anxiety, depression and emotional exhaustion.

2.7. A few words about depression

Depression is a state of low mood and aversion to activity that can affect a person's thoughts, behavior, feelings and physical well-being. These problems can become chronic or recurrent and lead to substantial impairments in an individual's ability to take care of his/her everyday responsibilities. Depression occurs in persons of all genders, ages and backgrounds (Beck et al., 1996). In the fields of psychology and psychiatry, the terms depression or depressed refer to both expected and pathologically chronic or severe levels of sadness, perceived helplessness, loss of interest or pleasure, and other related emotions and
behaviours. The Diagnostic and Statistical Manual of Mental Disorders (DSM) states that a depressed mood is often reported as feeling depressed, sad, helpless, and hopeless. In traditional colloquy, "depressed" is often synonymous with "sad," but both clinical and non-clinical depression can also refer to a conglomeration of more than one feeling. Depression is one of the most common mental illnesses existing today, so much so that it has been dubbed the "common cold of mental disorders." Although the term is often used to describe normal emotional reactions, depression is a whole body illness, affecting feelings, thoughts, behavior as well as physiological functioning. It is not a transient state that quickly passes by or some sort of emotional trance that you can just "snap out of".

2.8. Studies related to depression

The prevalence of depressive disorders among nursing staffs is high; depression recognition is also high, with only 37%-45% of cases diagnosed by psychiatrists recognized as depressed by nursing staff due to consistently dealing with the chronically ill patients, surrounding environment (Henry and Blanchard, 2003). Tolabi and Javadi (2000) showed significant depression by nurse and staff in nursing profession. Saberian et al (2005) reported significant relationship between depression and type of accommodation. Significant relationship was found between the rate of depression and impact of exposed to patients on nursing staffs. Amani (2004) showed significant relationship between depression and vulnerability of individual nursing staffs. Depression develops in the healthcare professionals of non-psychiatric ward due to stressful duty with the patients leads to psychological and poorer physical health (Greenberg et al., 2003). But, on contrary, the current health status of psychiatric nursing staff with depression is worse than those nursing staffs who are working in the general medical department. The nursing staff of general medicine unit with depression (Sartorius,
Rickerson et al (2005) conducted a quantitative study surveying nursing staff working in non-psychiatric ward. This research found that staff experiencing the most grief related symptoms were those who had worked longest in institutions and had closer and longer relationships with the patients. The symptoms investigated in this research were physical, emotional relationships with family and co-workers and effects on work performance. The most common reported effects were feeling sad, seriously depressed, crying and thinking about death of their patient(s) and the negative impact of the death had on their relationships and performance both at home and at work. Kubler-Ross (1973) surveyed Nurses and staffs reported pain and felt depressed as a difficult issue for them and they identified this as being outside their area of expertise, knowledge and their professional role. Feldstein and Gemma (1995) studied whether nurses who left medicine wards to work in other areas had a higher level of depression and grief experiences than those who stayed in other specialities. The findings from nurses and staffs who responded showed both those who stayed and those who left this area of nursing experienced social isolation, somatisation and despair as a result of caring for ill patients who is suffering and/or those who died. Anderson and Gaugler (2006) found that nursing professionals those working in non-psychiatric wards, some staff perceived their depression and grief to be disenfranchised whereas others felt more able to openly express their emotions around death and as a result reported less prolonged grief related symptoms. Katz and Johnson (2006) claim that many nurses choose to work in end of life care because of their own experiences of death, trauma, depression and loss in their lives. Having had a personal experience of the suffering, death of someone close to them is seen as creating a personal-professional interface for the nurse between their own life events and professional interactions (Genevay and Katz, 1990). Jolivet et al
(2010) surveyed nurses and nursing assistants working at general ward in hospitals to determine the association between work environment and depressive symptoms. The study sample was made up of registered nurses (RNs) and nursing assistants. Poor relations between workers and low levels of communication were found to be associated with higher depressive symptom scores. Welsh (2009) conducted a study of nurses employed on general medicine wards. Depressive symptoms were correlated with having somatic complaints, major life events, and occupational stress. The review of the literature demonstrates that nurses may have high rates of depression that may have an impact on quality of care. Thus, more research is needed on specific variables that may contribute to depression in hospital-employed nurses and the effect on patient care quality and safety (Zerwekh and Claborn, 2003). Working in a profession where the focus is on healing, death of ill patients can seem like a failure. Nurses often experience sadness and grief when dealing with the deaths of patients, and without any support, can suffer distress (Hanna and Romana, 2007). When nurses are not given the opportunity to process and assimilate their distressful experiences, symptoms including depression, anxiety, depersonalization and dissociation can develop (Irving and Long, 2001). Nurses must recognize and confront their own feelings toward sufferings and death so that they can assist patients and families in end of life issues (Dickinson, 2007). It may be helpful to nurses if they had the opportunity to explore their emotions in a debriefing session after a patient dies. However, most nurses have received little support in coping with end-of-life issues (Ferrell et al., 2007). Nurses have lacked a formal support structure in which to deal with their reactions to distressing experiences. Informal discussion with peers at meal breaks or social gatherings has shown to be inefficient and ultimately harmful in its approach (Laws, 1995). Comments and comparisons of peers can be judgmental and unhelpful in resolving emotional distress. The need
to find meaning is a profound motivational force that may decrease distress in nurses following a physically ill patient’s suffering and death (Desbeins and Fillion, 2007). Emotional coping strategies of hospital’s general unit, nurses include venting of emotions, emotional processing and emotional expression. Hospice nurses with evolved coping strategies exhibit a positive response to the stress associated in caring for the dying. At a very human level, these emotionally-intense situations can lead to nurses experiencing distress. Traditionally, nurses have not had an appropriate emotional outlet for this distress. Stress debriefing may help nurses deal with their emotions after a patient has died (Desbeiens and Fillion, 2007). Distress in nurses of non-psychiatric ward is associated with emotional burnout, depression, frustration, and resignations (Zuzelo, 2007). Stress responses to an event, like a patient death, may be a severe and debilitating enough to impair daily functioning. Nurses exposed to ill patients need to be familiar with stress response symptoms and know that their jobs increase the likelihood that they may experience symptoms of distress and/or depression (Berman and Berman, 2005). One situation considered as traumatic by health care professionals, particularly for nurses in hospitals setting, is the aggression or violence experienced from mentally ill patients (Lam et al., 1999). In an extensive literature review by Rippon (2000), the magnitude of aggression and violence towards health care professionals is described. Depression which may be a sequelae of such exposure on the mental health of health professionals is common. The working environment creates greater workload that commonly occur in a context of high job insecurity. The implications of work-related stress include the effects on healthcare worker satisfaction and productivity, their mental and physical health, absenteeism and its economic cost, the wider impact on family function and finally, the potential for employer liability. The review assesses the stressor findings by different occupational groups because they may embrace
different qualities of stress which furthermore may be a major factor contributing to psychological morbidity in these groups (Gaberson and Oermann, 1999). Nurses of psychiatric unit expressed a lack of enjoyment in caring for patients with eating disorders, schizophrenia and those who committed deliberate self-harm as the result of a mental health problem (Fleming and Szmukler, 1992). A study of emergency nurses suggests they were not clear whether their role should include care for patients with mental health problems (Gillette et al., 1996). Consequently, nurses have come to avoid patients experiencing mental health problems because of feelings of fear and powerlessness, depressive and making them more anxious and the acknowledgement that attending to these patients is more time consuming (Gillette et al., 1996). Negative labelling is more likely to occur in hospital settings, as patients with mental illness often exhibit behaviour inconsistent with the traditional ‘sick role’ (Sharrock and Happell., 2000). The nursing staffs of psychiatric unit frequently exposed to mentally ill patients creates emotional disturbances like:- depression, anxiety, fear, restlessness etc. This may be partly due to a lack of understanding of the extent to which mental illness contributes to precipitating, aggravating and prolonging physical disability and illness, the psychological and psychiatric disturbances of nursing staffs (Armstrong, 2000). Currently, psychiatric nursing is the primary formal avenue to increased nurse expertise in caring for people experiencing a mental illness (Sharrock and Happell., 2000). Improving psychological and psychiatric care for patients on a large scale will require increased training in mental health education as part of comprehensive nursing education (Prebble, 2001). Mental health care skills were noted to diminish distress for nurses those are caring for patients with mental illness following an attitude change intervention (Hallberg and Norberg, 1993). It is not uncommon for physical and psychological problems to occur in general hospital patients. Symptoms of depression may be confounded with
physical illness symptoms in nursing staff (Parker et al., 2001). The prevalence rate of psychiatric disorders is higher in the nurse and staff of psychiatric unit (Clarke, 1998). Nursing staffs have particularly high rates of psychiatric illness, due to the closure of long-term care services of mentally ill patients (Snowdon, 2001). Davidson et al (2000) strongly suggest that mental illness is associated with significantly poorer health in cases of nurse and staff of psychiatric ward. A representative study found that nurses with depression reported a diminished level of physical functioning, including physical illness and difficulties with independent living (Goldney et al., 2000). Nurses can play a central role in lowering prevalence and burden of mental disorders by broadening the scope of care, reducing the levels of stigma and discrimination in the hospital setting and engaging in simultaneous assessment to increase detection rates. Most importantly evidenced that the nurse and staff of psychiatric department are more vulnerable to develop depression, trauma, lack of security for taking care of such mentally ill patients on the regular basis (Bagley and Cordingley, 2007). Inadequate staffing, work overload, dealing with difficult mental patients, interpersonal conflicts, awareness of tremendous responsibility for patients and other organisational constraints inherent in the hospital system are work stressors frequently encountered by nurses. These work stressors are believed to affect the mental health status of the nurses, which may lead to high levels of anxiety and depression (Abraham et al., 1994). Results of the study suggested that meeting with family demands was most detrimental to nurses’ of psychiatric ward emotional stability and sense of adequacy. Relevant to this finding, it may be recalled that a great majority of subjects were females. Women are still the primary persons to attend to household and children’s needs. On the other hand, women’s tendency to attach much significance to the marriage and home-related activities also made them susceptible to guilt and distress if they perceived that
work commitments prevented them from meeting family demands. In such situations, it is understandable that stress associated with meeting family demands would affect negatively a person's psychological well-being develops depression (Badger et al., 1996). The findings suggested that psychiatric nurses could be emotionally upset in stressful situations, but their sense of adequacy was less seriously affected. The study considers that nurses of psychiatric ward who were more anxious and depressed tended to perceive a higher level of work stress. It ventures that those in the nursing profession were in the first place mentally unhealthy and therefore experienced greater work stress (Kroenke, 2001). Psychiatric nurses with depression are not only likely to suffer themselves, but their illness may have an impact on their coworkers and potentially the quality of care they provide. Hospital-employed nurses have higher rates of depressive symptoms than national norms. (Willet and Leff, 2003). Peterson (2005) and colleagues surveyed the point to depression leading to burnout as well as burnout creating depression. Virtanen and colleagues (2002) conducted a study on psychiatric nurse and staff that showed high workloads may be associated with higher depression rates. Tyler and Cushway (1998) surveyed nurses employed in a psychiatric hospital to determine the association between job stress, coping, social support and depression. Job stress and affective-oriented coping were positively correlated with depression scores. Social support was also significantly correlated with depression, but did moderate the relationship between job stress and depression. Gartner et al (2010) conducted a systematic review of the literature on the impact of common mental disorders on the work functioning of nurses and allied health professionals. The researchers concluded that evidence exists between common mental disorders in nurses and staff of psychiatric ward and higher rates of general and medication errors and decreased patient safety and patient satisfaction rates. Poor work conditions can impair the mental health of
employees and mental health problems can negatively impact work outcomes. Nurses of psychiatric ward may also experience depressive symptoms, especially at a rate twice as high as the nurses of general ward. Depression in hospital nurses of psychiatric ward can be assumed to impact not only the nurse and his/her colleagues, but also potentially his/her quality of care. Because of the stigma attached to mental illness, nurses, like the general population, may be reluctant to get screening and treatment. (Lambert et al., 2004). The study indicates that nursing staff of psychiatric unit with depression contributed to dimensions of burnout. A significant difference was found in the three dimensions of burnout (emotional exhaustion, depersonalization, and personal accomplishment) for mental health caregivers. (Kirkcaldy and Martin, 2000). Psychiatric-mental health nursing is undergoing significant difficulty in recruiting and retaining nurses in the profession due to many obstacles created by current conditions in psychiatric hospitals. Many nurses entering the specialty have limited experience and educational background in psychiatric nursing, creating a lack of confidence in their ability to form one-to-one therapeutic relationships with patients (Karasek and Theorell, 1990).

2.9. Personality – what it is
A person's vulnerability to develop psychological disturbances under environmental pressures absolutely depends upon individual personality structure. Personality can be defined as a dynamic and organized set of characteristics possessed by a person that uniquely influences his or her cognitions, emotions, motivations, and behaviors in various situations. Personality can be defined as a dynamic and organized set of characteristics possessed by a person that uniquely influences his or her cognitions, emotions, interpersonal orientations motivations, and behaviors in various situations. An individual's pattern of psychological
processes arising from motives, feelings, thoughts, and other major areas of psychological function. Personality is expressed through its influences on the body, in conscious mental life, and through the individual's social behavior (Mayer, 2005). Personality embraces a person's moods, attitudes, opinions, motivations, and style of thinking, perceiving, speaking, and acting. It is part of what makes each individual distinct.

2.10. Studies in connection with personality dimensions

The hospital staff in a general medicine department participated in a study on the associations between personality traits and dealing with the patients. Results showed moderate, though highly significant correlations between personality traits and dealing with the patients. There was a general trend for nursing staff to be more closely related to these personality traits (neuroticism, psychoticism, extraversion, lie factor). Main conclusion from the present study is that neuroticism, trait anxiety and Type A behaviour is detrimental to their job performance, but that the mediating effects of the personality traits are influenced by occupational demand characteristics (emotional vs physical load) (Bru et al., 2002). Research studies revealed that higher level of neuroticism and lower level of extraversion were significantly related to develop depression and anxiety that may hamper normal work performance and unable to meet the standards (Quigley et al., 1990). There are several characteristics of nursing staff which are mainly: tendency to achieve more and having higher well being, having high level of motivation, more likely to achieve highly and obtain higher well being. Personality traits (extraversion, neuroticism, psychoticism, and lie factor) has been shown to be the most useful factor in personnel selection for all jobs (Aiken, 2001). Personality is a possible trait oriented motivation variable and correlated with job performance (Leiter, 1998). Personality trait is an actual situated
behavior that is what is actually done in the real life and what is actually carried out by nurses of general medicine ward in their clinical practice (Laschinger and Leiter, 2006). In nursing, there is positive correlation between personality traits and job performance. The nurses who are high in neuroticism and extraversion to be responsible, dependable persistent and achievement oriented. They are likely to accomplish their performance or try to accomplish what is expected from them. But, dealing with the patients, the nurses develop increased level of neuroticism, extraversion and sometimes increased level of psychoticism may hamper the job performances, affect the mental condition of the nursing staff (Shaw, 1999). As regard to the overall total dimensions of personality traits, the majority of staff nurses of psychiatric department had higher scores in neuroticism, extraversion, psychoticism and lie factor (Borritz et al., 2006). Nurses who have been selected for the study are often reluctant to opt for withdrawal even in the face of increasing stress or mal-adaptation (Rovinski, 1990). A study by Gulack of nearly 3,000 registered nurses revealed the complicating factor that 58% of those working were the sole support of themselves or their families (Gulack, 1983). The nursing staffs whose personality traits are not suitable for the job find themselves in a potentially disastrous situation. Attempts to alleviate stress often involve alcohol and drugs. Most nurses who abuse alcohol and drugs are the high achievers, the so-called super nurse (Cross, 1985). If nursing staffs do not enjoy working in their chosen field, the stress of the job and the resulting dissatisfaction may well could lead to use of alcohol and drugs. Kanter (1993) maintains that situational conditions can constrain nurse’s optimal job performance, regardless of positive personal tendencies or predispositions, also leads to lower work productivity. When strong relationships among superiors, peers, and subordinates are encouraged within the work setting that may be due to the personality traits, dealing with the patients. Neuroticism, extraversion, psychoticism and lie factor
may vary with the situational demands (Buhler and Land, 2003). Human service professionals are generally at relatively high risk for burnout that are related to high level of psychoticism and neuroticism (Schaufeli, 2003). Extraversion is generally associated with a tendency to be optimistic and a tendency to reappraise problems positively, it may lead them to focus on the good and positive side of their experiences. In addition, extroversion tends to be associated with the use of rational, problem-solving coping strategies and with social-support seeking and positive reappraisal (Watson and Hubbard, 1996). More specifically, Vries and Heck (2004) have found that extraversion is positively associated with emotional exhaustion. Zellars et al (2000) found that of the personality traits, neuroticism significantly predicted emotional exhaustion in a sample of nurses working in a hospital. Hickey (2009) has also found a association between extraversion and depersonalization in the nursing staff. Buhler and Land (2003) observed a positive relationship between extraversion and two burnout variables (emotional exhaustion and depersonalization) existed in a sample of nursing staff. Deary et al. (1996) have consistently found a positive association between extraversion and personal accomplishment in the burnout literature. In addition, Eastburg and his colleagues (2007) found that extraverted nurses required more work-related peer support than did introverted ones to avoid emotional exhaustion. The tendency of extraverts to seek interactions with other people may also counteract processes of depersonalization. Piedmont (1993) showed that agreeableness correlates negatively with emotional exhaustion and positively with personal accomplishment. Subjective stressors in nursing work in psychiatric department, coping behavior, as well as burnout are different in relation to personality characteristics. The nursing staff of psychiatric ward with high neuroticism and low extraversion reported high scores of stressors and showed more burnout. Quantitative workload and qualitative workload are likely to stimulate client-
related burnout through elevating the nurses' association with conflict with patients, thus paying special attention to the volume and nature of the job are necessary (Shimazu et al., 2005). The sample of the study included nursing staff providing direct care to patients. Nurses with high and low job performance skills were distinguished by the cluster of traits (neuroticism, extraversion, psychoticism and lie factor) associated with teamwork skills. (Shimazu et al., 2005). Burnout of nurses at hospitals was analyzed in relation to their personality characteristics and coping behaviors. Multiple regression analysis showed that neuroticism was more closely related to personal, work-related, and client-related burnout than extraversion. Covariate structure analysis revealed that among the nurses who are dealing with the mentally ill patients with high neuroticism and low extraversion, client-related burnout was found to be correlated with stressors in relation to conflict with patients and with positive coping behaviors. Among the nurses with low neuroticism and high extroversion, client-related burnout correlated with the coping behavior of behavioral disengagement and conflict with patients (Maslach et al., 2001). An increase in quantitative workload was associated with a higher score for stressors arising from conflict with patients, leading to client-related burnout. These results suggest that acquisition of skills to cultivate appropriate coping behaviors might be useful for reducing client-related burnout in relation to nurses' personality characteristics. These findings need to be further endorsed by intervention studies (Laschinger and Leiter, 2006). Research findings also revealed that burnout in nurses, among established personality traits such as neuroticism, extraversion, openness, agreeableness or conscientiousness, neuroticism and extraversion were especially relevant to stress-related outcomes (Baldursdottir and Jonsdottir, 2002). Multiple regression analysis revealed that neuroticism was relatively strongly associated with all scales for burnout, namely, personal burnout, work-related burnout, and client-related burnout (Tyler and
Cushway, 1998). Besides this, research findings also revealed that higher neuroticism was reported to be associated with increased reactions to stress, while high extraversion reduced reactions to stress. Multiple regression analysis revealed that client-related burnout was most closely associated with “conflict with patients” compared with personal and work-related burnout. This implies that client-related burnout is likely to occur if the nurse of psychiatric ward faces stress in her/his relationship with patients. (Penley et al., 2002). It was also noted that “personal relationships at the workplace” such as conflict with nursing staff or conflicts with supervisors correlated closely with “conflict with patients”, and that both of these factors affected client-related burnout, suggesting that an increase in the score for either “personal relationships at the workplace” or “conflict with patients” elevates the score for the personality traits, resulting in an increase in client-related burnout. This means if conflicts arise in the relationship between nursing staff and coworkers of psychiatric department in the hospital, this may disturb subjects’ relationship with patients or influence their attitude toward patients and possibly leads to burnout (Witt et al., 2004). It was revealed that burnout-related coping styles differ by the subjects’ personality characteristics suggesting that the nursing staff of psychiatric ward with high neuroticism and low extraversion was more likely to show client-related burnout due to subjective burden with “personal relationships at the workplace” (LePine et al., 2004). According to Green and McManus (2001) the nursing staff of psychiatric unit may have preferred ways of coping based on personality. The study suggests that an increase in conflict with patients or adopting the coping behavior of behavioral disengagement serves as a strong factor stimulating client-related burnout. An association was noted between the lack of “positive coping behavior” and the selection of “behavioral disengagement” as a coping behavior, resulting in a higher likelihood of client-related burnout (Mark and Smith, 2008). On the basis
of the finding, the study shows that among the nursing staff of psychiatric ward with high neuroticism and low extraversion, positive coping behavior is useful for preventing burnout and that in the nursing staff with low neuroticism and high extraversion, quantitative workload and qualitative workload are likely to stimulate burnout through elevating the nurses' association with conflict with patients, thus indicating the importance of paying special attention to the volume and nature of the job (Kirkcaldy and Martin, 2000). This study provides information that should be considered by nursing staff of the psychiatric ward in hospital setting. This study suggest that the importance of personality traits consistently with the competencies of the nursing staffs, a high level of importance on the personality trait of endurance, it is commendable that nurses are willing to work long hours, even in the face of great difficulty, it may consider the relationship of working long hours to job related stress and burn out. One of the primary responsibilities of nurses is the safety of their patients. The different type of personality trait in the nursing staff of psychiatric ward protect mentally ill patients from nursing errors as well as to help decrease the loss of nurses due to job related stress and burn out (Mechanic, 2007). Working in the hospital setting and caring for groups of mentally ill patients requires a nurse to be well organized. The nursing staff need to provide consistency in their expectations of the patients to communicate more effectively concerning the importance of personality traits like neuroticism and extraversion with respect to the competencies to deal with the patient's suffering (Lavoie, 2005).
2.11. About environmental setting
A person's environment consists of the sum total of the stimulation which he receives from his conception until his death. The term environment is used to describe, in the aggregate, all the external forces, influences and conditions, which affect the life, nature, behavior and the growth, development and maturity of living organisms. People tend to seek out places where they feel competent and confident, places where they can make sense of the environment while also being engaged with it. Research has expanded the notion of preference to include coherence (a sense that things in the environment hang together) and legibility (the inference that one can explore an environment without becoming lost) as contributors to environmental comprehension. Being involved and wanting to explore an environment requires that it have complexity (containing enough variety to make it worth learning about) and mystery (the prospect of gaining more information about an environment). Preserving, restoring and creating a preferred environment is thought to increase sense of well being and behavioral effectiveness in humans.

2.12. Studies on environment of the hospital setting
The physical environment along with social support, organizational culture, and technology can play an important role in improving health, safety, effectiveness and satisfaction of the healthcare team (Hayes et al., 2006). A growing body of evidence demonstrates that healthcare work happens most effectively when practitioners work highly interdependently in well-functioning teams with active participation by patients and families (McCarthy and Blumenthal, 2006). According to the Peter D. Hart Research Associates' (2001) survey of registered nurses, the primary reason why nurses leave healthcare—other than for retirement—is to find a job that is less stressful and physically demanding. In a survey of
nurses conducted by the American Nurses Association (2001), 76 percent of the nurses stated that unsafe working conditions interfered with their ability to provide quality care, it is necessary to consider the healthcare workplace as an interdependent system comprised of the physical environment, work processes, organizational culture (formal and informal values, norms, expectations, and policies etc.), workforce demographics and information technology (Becker, 2006). The three sections in the paper examine how the physical environment, along with other factors such as culture and social support create impact on (a) the health and safety of the care team, (b) effectiveness of the healthcare team in providing care and preventing medical errors and (c) patient and practitioner satisfaction with the experience of giving and receiving care (Zimmerman et al., 2002). Environmental stressors such as high noise levels, inadequate light and poorly designed workspaces impact on staff health and safety. Proper design of healthcare settings along with a culture that prioritizes the health and safety of the care team through its policies and values, can reduce the risk of disease and injury to hospital staff and provide the necessary support needed to perform critical tasks (Benson, 2002). Nurses from units with low staffing and poor organizational climates were generally twice as likely as nurses on well-staffed and better-organized units to report risk factors, needle-stick injuries, and near misses (Clarke and Aiken, 2002). It is plausible that injury rates are higher in chaotic environments as compared to more organized environments (Shamian, 2001). Studies have shown that increased nursing time per patient results in better patient outcomes (Institute for Healthcare Improvement, 2004). Nurses spend a lot of their time searching for other staff, materials, missing meds, and supplies and also are frequently interrupted during their work to address these problems (Tucker and Spear, 2006). It is becoming increasingly clear that poorly designed physical environments, along with other factors such as lack of social support and an
unsupportive work culture reduces the effectiveness of staff in providing care and potentially leads to medical errors (Reiling et al., 2004). Besides this, research study describes some of the inefficiencies and breakdowns that typically undermine staff effectiveness in healthcare settings and the role the physical environment can potentially play in conjunction with a supportive work culture and technology infrastructure in increasing staff effectiveness and reducing errors (Pallas, 1997). According to Reiling et al (2004) some errors (active failures) occur at the point of service (for example, a nurse administering the wrong drug), most occur due to flaws in the healthcare system or facility design—such as due to high noise levels or inadequate communication systems. Inadequate lighting and a disorganized chaotic environment are likely to compound the burden of stress for nurses and lead to errors. There is evidence that a supportive physical work environment along with other factors such as high autonomy, low work pressure, and supervisor support, positively impacts job satisfaction and burnout among nurses (Tyson et al., 2002). Further, studies show that environments (i.e. physical environment, culture, and work processes) that include patients and families as active participants in the care process (as opposed to passive recipients of care) result in higher levels of satisfaction among patients and families (Sallstrom, 1987). The environment was perceived very positively by patients and families who felt empowered by being part of the care team and comforted by the fact that the team members were all talking to each other (McCarthy and Blumenthal., 2006). Judge (1993) found that the more positive the disposition of the individual, the stronger the relationship between job dissatisfaction and turnover. Individuals dissatisfied with their jobs, were the most likely to quit. Cameron et al (1994) found that nursing staffs were moderately satisfied with jobs. Nurses with more years of experience had highest job satisfaction, lowest burnout and were less likely to leave the job. Leveck and Jones (1996) found that management style,
group cohesion, job stress, organizational and professional job satisfaction influenced staff nurse retention and quality of care. In support of previous studies it can be said that reward-based climates, high levels of communication openness and accuracy explained lower turnover in nursing homes (Anderson et al., 2004). Laschinger et al. (2001) whose survey of hospital staff nurses suggested that perceived autonomy, control and physician relationships influence the trust, job satisfaction and perceived quality of patient care. Some studies refer to a participative management style as enhancing job satisfaction. Boyle et al (1999) examined the effects of nurse managers’ characteristics of power, influence and leadership style, finding managers’ position power and influence over work coordination to have a direct link to intent to stay in employment. Instrumental communication, autonomy and group cohesion decreased job stress and increased job satisfaction, which in turn, were directly linked with intent to stay. Management practices identified as critical to patient safety included balancing productivity and reliability, developing and maintaining organizational trust, actively managing change, inclusion of employees in the decision making process, and encouraging a learning environment (Page, 2004). These practices also have been shown to have a positive correlation with nursing job satisfaction (Houser, 2003). Nursing studies conducted on psychiatric ward, pertinent outcomes were found out such as autonomy, inclusion in organizational decisions, decreased levels of job burnout, and ultimately, job satisfaction (Wilk, 2001). Hospital work environment attributes that have been associated with negative nursing outcomes (and patient outcomes) include (a) patient to nurse ratios, (b) educational composition of nursing staff, (c) nurse-physician working relationships, (d) responsiveness of management to nursing concerns, (e) organizational support of nursing, and (f) an overall culture of retention (Aiken, 2003). He reported three major sources of job dissatisfaction that intuitively have an adverse affect on
perceived work pressure, increased patient assignments, too few registered nurses for quality care and inadequate support services. Further investigation into these factors may lead to interventions that offer an improvement in this dimension of the work environment. The study implies that nursing staff of psychiatric ward was dissatisfied with the level of managerial control. Findings suggest that the managers on these units have found an imbalance between their leadership style and that desired by their nursing staff of psychiatric ward. This study implies that these nurses have a low level of concern about and commitment to their jobs, because of their own distress due to dealing with the mentally ill patients. Job commitment clearly is a positive step in retaining valuable nursing staff. Also, there may be areas that a unit determines are not priorities, or for which administrative or financial constraints preclude immediate intervention or modification. Thus, each unit must evaluate their results in light of their goals, values, needs, and desire for change (Williams et al., 2005). Nursing managers in psychiatric ward is directed to focus more on coordination, integration, and facilitation of their nursing staff's work and less on control (Laschinger et al., 2003). On the study units, significant difference between staff's real and ideal perceptions of their manager's level of control speaks highly to the quality of leadership within the organization. Although the nurses in this study portrayed a work environment that was highly negative, these data suggest that nurses of psychiatric ward lacking in aspire to improve their work environment. Statistically significant result may help target intervention strategies for the specific units. Lyon (2000) suggests that stress is shaped by the balance of perceived demands that the mentally ill patients is facing, and the resources perceived as being necessary to meet those demands, and when the individual’s available resources are perceived as being insufficient for meeting the demands, the individual experiences stress may lead to depression (Karasek and Theorell, 1990).
phenomenon of the psychosocial work environment generally includes a multitude of factors such as organizational climate and culture, work demands, work control, and leadership and co-worker support. Stress and different health problems may be the result of high levels of psychological demands or pressure combined with a low level of control or decision latitude (Karasek and Theorell, 1990). The work environment in psychiatric care has been found to differ from that of other general care settings (Roche and Duffield, 2010). Working in psychiatric care has also been found to be associated with a higher risk for sickness, absence and in interview studies, the psychiatric work environment has been described as complex and characterized by high pressure levels (Currid, 2009). For many mental health professionals, frequent exposure to various traumatic situations is part of their daily work. The effects of trauma exposure on some mental health professionals, in particular, emergency personnel such as dealing with the mentally ill patients’ sudden aggression, violence has long been recognized (Ward and Cowman, 2007). Over the last 10 to 15 years, it has been ascertained that nursing staff of psychiatric unit are affected by their work in both long and short-term (Follette et al., 1994). Negative effects have been observed in terms of lowered performance, deteriorated physical and mental health, resulting in alcoholism and even suicide (Lam et al., 1999). One situation considered as traumatic by mental health professionals, particularly for nurses in hospitals setting, is the aggression or violence experienced from patients (Lam et al., 1999). The study investigates the impact of work and physical environment on nurses of psychiatric commitment. Using an adapted questionnaire as a research tool the author investigates the impact of work environment (supervisor support, communication openness and teamwork) and physical environment (quality of patient areas, safety and quality of work spaces) and observed that the variables have negative and strong correlation with hospital nurses of psychiatric ward
commitment. This study can give insights to the executives and the facility designers to build and design the hospital facility in a way that it provides comfort, safety and quality in patient caring. Moreover hospital management can consider this study as an asset to manage and enhance their nursing staff commitment towards their job (Relf, 1995). Hospitals are on the verge of great competition, they are strictly challenged by external and internal environments and nurses of psychiatric ward are considered to be the largest group of professionals who play a vital role in determining the quality and cost of healthcare. There is an argument that they have the potential to answer the key problems in the healthcare (Tonges et al., 1998). Nurses' of psychiatric ward commitment towards job is of profound importance for administrators and mangers in healthcare organizations due to the pivotal role they play in their organizational performance. Work environment of nurses has been elaborated as a preference for health care organization (Jaradali et al., 2009). Quality of work environment in psychiatric ward is critical in the context of global paucity of qualified nurses (Aiken et al., 2004). A hospital can be a toxic work environment with unsafe working conditions, emotional exhaustion, long hours and mandatory overtime (Bolch 2008). As stated by Dawley, et al. (2008), perceptions of work environment are main issues in many researches. Behavior of nursing staff of psychiatric ward is generally understood by the influence of working climate in the hospital setting. Work environment with negative perceptions should produce unfavorable responses among nursing staff of psychiatric ward. Social exchange theory identifies that when an organization gives value and support its employees in return feel obligated and exchange pure, honest and true spirits and values with the organization. Thus, overall work environment takes an important role in connection with both negative and positive attitude towards the existing condition of the hospital setting.