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RESEARCH

Predictors and Outcomes of Nurse Leader Job Stress Experienced by AWHONN Members

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ABSTRACT

Objective: To measure the relationships among stressors (personal factors, job/role factors, hospital factors), job stress, and outcomes experienced by nurse leaders and examine moderation of autonomy and leadership style on outcomes of job stress.

Design: A cross-sectional, quantitative design.

Setting: Acute and nonacute care settings throughout North America.

Participants: A nonprobability convenience sample of 392 was drawn from a population of nurse leaders across the United States and Canada who were members of the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN).

Methods: A mailing list was obtained from AWHONN, and a total of 3,986 recruitment and follow-up postcards were sent to nurse leaders. Participants were asked to complete the survey online or request a hard copy to return by mail. Study variables were measured using previously published scales with demonstrated psychometric properties.

Results: Nurse leaders reported stress averages above the midpoint of the scales. Personal factors did not significantly predict stress, but role overload, organizational constraints, and role ambiguity were found to be the best predictors of stress. Job satisfaction, intent to quit, and mental health symptoms were the most significant outcomes of stress. Autonomy moderated relationships between perceptions of stress and outcomes with low autonomy showing greater negative outcomes when levels of stress are higher.

Conclusion: Nurse leaders experience significant job stress that may suggest a need to design and implement evidence-based interventions to reduce stress among this group.

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As the direct interface between the clinical workforce and healthcare executives, nurse leaders have a direct influence on professional practice, staff experience/attitudes/retention, and unit culture and climate (McNeese-Smith, 1997). Shirey (2006) reported that the stress of nurse leaders has been directly affected by the reengineering efforts of many hospitals and health systems in the mid-1990s. Increased span of control, scope of responsibilities, and financial and operational performance demands have seriously challenged nurse leaders. Performance expectations and the need for staff resources create pressure as nurse leaders deal with the demands of competing priorities.

In the face of intense job-related demands, many nurse leaders report symptoms of burnout (Adams, 1991; Sherman, 2005; Shirey, 2006), and some transition to less-demanding positions. With an increase in experienced nurse leaders nearing retirement age, attrition of nurse leaders for less demanding roles, and fewer nurses electing to attend graduate school (preparing them for leadership roles), a serious leadership void is anticipated that could adversely affect nursing care quality and patient outcomes (Institute of Medicine, 2004). Although job stress experienced by clinical/bedside nurses has been studied extensively, there is a serious need to study stressors experienced by nurse leaders that lead to job stress and to identify effective stress moderators that will minimize negative outcomes from nurse leader job stress.

Review of the Literature

To guide the development of the conceptual model, a literature search was conducted in

organizational psychology and nursing using CINHAL, PubMed, and PsycINFO using keywords such as *nurse leader stress, job stress, organizational stress, role stressor, autonomy, empowerment, nurse leadership, nurse satisfaction,* and *turnover*.

It has long been acknowledged that the role of a manager/leader is inherently stressful (Rafferty & Griffin, 2006; Rodham & Bell, 2002; Shirey, 2006; Shirey, McDaniel, Ebright, Fisher, & Doebbeling, 2010). Middle managers in health care reported significant workload and job stress due to top-down changes recommended from administration and bottom-up changes requested by subordinates (Conway & Monks, 2011). Different than most business managers, nurse leaders are required to have clinical expertise as well as knowledge of business management (Omoike, Stratton, Brooks, Ohlson, & Storfjell, 2011). Additionally, implementation of organizational change has been noted as a stressor for many managers (Rafferty & Griffin; Sparks, Faragher, & Cooper, 2001). Nurse leaders often chart the course for organizational change (Maragh, 2011), which is ever present in health care. They also prepare for stressful regulatory and accrediting site visits (Elkins et al., 2010). Despite research that supports the notion that management positions are inherently stressful, to the best of our knowledge, no one has quantitatively examined the nurse leaders' perceived job stress across multiple organizations.

Personal Factors and Job Stress

The job demands-resources (JD-R) model (Bakker & Demerouti, 2007) posits that employees can call upon a number of personal and job resources to help manage the job demands placed upon them. From the perspective of the JD-R model, age, education, and experience (as represented in this study by tenure as a registered nurse [RN] and tenure in nursing management) could serve as important personal resources that could lead to reduced nurse leader stress (Carstensen, Fung, & Charles, 2003; Judkins, Massey, & Huff, 2006; Schmied & Lawler, 1986). Because these personal factors have not been studied in a sample of nurse leaders, it is important to examine how personal factors may be related to nurse leader stress.

Job/Role Factors and Job Stress

Role stress theory (Beehr & Glazer, 2005) posits that employees typically have several roles. For example, nurse leaders have a role in supporting patient outcomes or staff satisfaction and another role in managing budgets. According to Beehr and Glazer, when these roles are not well defined (role ambiguity), are too demanding (role overload), or create incompatible demands (role conflict), employees are likely to feel stressed. A large number of direct reports could lead to increased role overload, and higher organizational level could lead to increased role ambiguity. Role stressors are frequently reported by nurse leaders as they manage multiple competing priorities for their time (role conflict), work with unclear perceptions of responsibilities and the range of their authority to make decisions autonomously (role ambiguity), and manage the role overload associated with a large span of control and responsibilities (Cathcart et al., 2004; Kleinman, 2003; Shirey, 2006).

Nurse leaders often feel the stress of responding to competing priorities.

Spector and Jex (1998) conceptually defined *organizational constraints* as situational barriers to performance and interpersonal conflict as experiences of hostility or rudeness from others at work, both of which are job demands associated with job stress. The nurse manager role is often characterized by organizational constraints such as limited human and financial resources, hostility from physicians, or angry staff during work process changes. Nurse leaders in unionized hospitals report more stress related to union activities because of the complexity of the interdependent hospital and union structures (New, 2009).

Because one of the benefits of the Magnet initiative is to improve the work environment, it would seem that nurse leaders in Magnet-designated hospitals would report less stress and increased job satisfaction, although there is no documented evidence to support this assumption for nurse leaders (Upenieks, 2003). There is also a dearth of evidence that might indicate if hospital types (e.g., university, community tertiary) or community type (rural, suburban, or urban) might contribute to nurse leader stress.

The Relationships between Job Stress and Outcomes (Strains)

The organizational psychology and nursing literature is full of studies of the negative effects of job stress (Milliken, Clements, & Tillman, 2007; Örtqvist & Wincent, 2006; Shirey et al. 2010; Thorpe & Loo, 2003), but there is little reported

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