Stress Overload: A New Diagnosis

Margaret Lunney, PhD, RN

PURPOSE. To describe the phenomenon of stress overload as a nursing diagnosis.

METHODS. A qualitative study using case study method was conducted with nine adults experiencing stress overload to fully describe the experience and identify possible defining characteristics. Current literature sources on stress and its related factors were examined to support stress overload as a nursing diagnosis for inclusion in the NANDA International classification.

FINDINGS. Stress overload, defined as excessive amounts and types of demands that require action, is a human response that is experienced as a problem and contributes to the development of other problems. The proposed defining characteristics are perceives situational stress as excessive, expresses a feeling of tension or pressure, expresses difficulty in functioning as usual, expresses problems with decision-making, demonstrates increased feelings of anger and impatience, and reports negative effects from stress such as physical symptoms or psychological distress.

PRACTICE IMPLICATIONS. Nursing interventions such as active listening and decision-making support are needed to help people reduce stress levels. Studies are needed to further validate the defining characteristics and related factors of this new diagnosis.

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Stress Overload: A New Diagnosis

the experience of stress in the NANDA classification, nurses may use the diagnosis of ineffective coping in clinical situations when stress overload is a more accurate interpretation. When this occurs, it is akin to “blaming the victim.” The purpose of this article is to describe a qualitative study to validate the diagnosis of stress overload, previously reported in an abstract (Lunney & Myszak, 1997), and to use the findings from this study and recent research and theoretical analyses to propose a new nursing diagnosis for inclusion in the NANDA International Diagnostic Classification (2005).

Background

Stress overload is defined as excessive amounts and types of demands that require action (Lunney & Myszak, 1997) that are experienced as a problem and contribute to the development of other problems. The classic work of Holmes and Rahe (1967) in which amounts and types of stressors are measured by adding numbers assigned to stressors, such as divorce and changing jobs, demonstrated that the numbers and types of stressors that exist in people’s lives are predictive of future illness, both psychological and physical.

The impetus for development of this new diagnosis is (a) stress overload is a human response that differs from all other diagnoses in the NANDA I taxonomy, and (b) accuracy of nurses’ diagnoses of human responses requires use of this concept. The concept of stress overload had not been formally named before this and is believed to be intuitively understandable. In many literature sources on stress, stress overload is implied, for example, terms like “stressed out” or “high stress” are used (e.g., Boardman, 2004; Lim, Williams, & Hagan, 2005; Nielsen et al., 2005). After a paper presentation on stress overload at a NANDA conference (Lunney & Myszak, 1997), the diagnosis was used by a researcher to partly describe the experience of women in the postacute phase of battering (Carlson-Catalano, 1998).

Inaccurate interpretations of the stress experience contribute to harm to healthcare consumers, just as low accuracy interpretations of other phenomena were shown to be harmful (Lunney & Paradiso, 1995; Ryan, 2001). If nurses focus on other overlapping diagnoses, such as ineffective coping or powerlessness, the interventions may not be appropriate for stress overload. Interventions for stress overload are specific to helping consumers reduce the burden of stressors. Since nursing diagnosis labels guide the selection of interventions, it is important that nurses recognize and identify stress overload when it occurs. Using other diagnoses when stress overload is the most accurate diagnosis probably leads to inappropriate choices of nursing interventions and subsequent failure to produce positive outcomes.

In order to advance knowledge of this diagnosis and possible interventions, a qualitative study was conducted to describe this experience from the perspective of people who were experiencing stress overload and an in-depth literature search was conducted to support and expand knowledge of this diagnosis.

Study Methods

Design

The qualitative case study method described by Mariano (1993) was used for this study. Structured interviews were conducted using 10 questions to obtain a description of the stress experience (Table 1). The interviews took from 30 to 60 min and were audi-taped and transcribed verbatim for a written record. The methods described by Miles and Huberman (1984) were incorporated in the study, including identification of themes or data reduction, data display, and conclusion drawing and verification of the data. The study was approved by the Hunter College Institutional Review Board. Each participant signed an informed consent to participate.

Sample

The sample was nine persons who answered “Yes” to the question, “Are you experiencing stress overload
at this time?” and who, during the interview, rated their stress level as at least 7 on a scale of 1–10. Four persons lived in the community and had no identified psychiatric illnesses and five persons were from a psychiatric day care center with identified psychiatric problems. The two different populations were selected because stress overload may be expressed differently in these populations. The nonpsychiatric community population consisted of two men and two women, all white, and were 30–45 years of age (mean = 38 years). Of the five psychiatric patients, there are three women and two men, four white, and one Hispanic, 25–61 years of age (mean = 37.5 years).

Procedures

The procedure for obtaining persons in the community without identified psychiatric illness was to ask nurses in the community for referrals to persons who they believed were experiencing stress overload. Some persons who were referred to the investigators were not interviewed because they were not experiencing stress overload at the time of the study. Interviews were conducted in a quiet, private place where interruptions would not be likely (e.g., in a participant’s kitchen with no one else at home).

For the participants who were psychiatric patients in a hospital day treatment center, only those patients who were not primary patients of the co-investigator, a clinical nurse specialist (CNS) in psychiatric nursing, were asked to participate. This was done to avoid bias by the CNS and to avoid putting inadvertent pressure on patients to participate in the study. These were patients whom the Medical Director and Director of Nursing agreed could be interviewed for the study. Only those who were judged as capable of giving informed consent were asked to participate.

A scale of 1–10 was used, with 1 being “the least stress you can imagine” and 10 being “the most stress you can imagine.” If the volunteer participants did not rate their stress as 7 or above, they were not enrolled in the study. Initially, question no. 2 was “What are the numbers and types of demands or stressors in your life at this time?” The intention was to further validate the diagnosis with the answer to this question. But, in a pilot-test case, the participant became so focused on the stressors that the investigator was unable to get adequate information about the stress

<table>
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<tr>
<th>Table 1. Structured Interview on Stress Overload</th>
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<tr>
<td>You have been asked to participate in this study because you answered Yes to the question: Are you experiencing stress overload? Stress overload is defined as excessive numbers and types of demands that require action. This interview is to gather more information about your experience. There are no right or wrong answers. The purpose is to describe the stress experience from your own perspective.</td>
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<td>1. On a scale of 1 to 10, what number would you give your experience of stress at this time?</td>
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<td>2. Please describe the stress experience itself. What is it like? How is it affecting you now?</td>
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<td>3. Can you elaborate on your description of this feeling of stress? Can you tell me more about the experience of stress?</td>
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<td>4. Can you describe x (one or more aspects of the experience) any further?</td>
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<td>5. How does this experience of stress compare to other times in your life? Is this the highest amount of stress you have ever had?</td>
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<td>6. Is there anything else that you would like to tell me about your stress experience?</td>
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<td>7. How would someone else, e.g., a nurse, know that you are experiencing stress overload?</td>
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<td>8. Please describe the types of stressors that contribute to this feeling of stress, i.e., the events and occurrences that are stressful to you.</td>
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<tr>
<td>9. Would a nurse be able to help you with your stress overload?</td>
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<tr>
<td>10. Would you like me to help you with methods to reduce your feeling of stress?</td>
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Stress Overload: A New Diagnosis

experience. Thus, the question about numbers and types of stressors was moved to no. 8.

The credibility of these data derived from three strategies. First, the interviews were long enough to describe the stress experience; that is, participants indicated that they were finished describing the experience (Mariano, 1993). Second, the investigators were skilled interviewers with broad bases of clinical experience in assessment of these populations. Third, the dependability and confirmability of the study were established by maintaining an audit trail and submitting the findings to an external reviewer for confirmation of data reduction. Transferability was established by selecting persons for the sample who were believed to be typical of persons who experience stress overload.

Results

The participants described situations that represent excessive amounts and types of demands that require action. For example, in the nonpsychiatric group, one male participant who was the major provider for his family had serious physical health problems in which the decisions he needed to make might mean a healthy life or disability and even death. Also, he had just sold his house which had been on the market for 3 years and now had nowhere to live because, in the meantime, his other options for places to live were not available. He had to find a place to live for a family of seven within 4 weeks. He also had significant problems at work that were prompting him to look for other jobs. He had many job offers, which meant increased economic possibilities but also increased economic risks. Decisional conflicts and an uncertain future were significant stressors for this person. He rated his stress as 9 on a scale of 10.

A female participant who described extensive amounts and types of demands that required action rated herself as an 8 on the 10-point scale, but explained the rating of 8 as “I know it can always get worse, so I refuse to see it as a 10, even though it seems like it is a 10.” One person rated stress level as a 7, another as a 10, and all others as an 8 or 9.

The defining characteristics identified from this sample are in Table 2. In both groups, two to three people described feelings of “being paralyzed” or frozen (e.g., just wanting to be alone, wanting to stay in bed, not getting dressed to start the day). Problems with decisions were prevalent. Concerns about future complex decisions prevented present, simple decisions from being made. Many persons described feelings of being “on edge,” being “impatient” and “short tempered” with people. This was described vividly by psychiatric patients. Participants said that they “couldn’t think as clearly as usual” and described a feeling of “not being myself.” They also described not acting as competent as usual and a wish that other people would realize that this was not their usual self. Feelings of “pressure,” “frustration,” and anger were also described. Subjects described acting out on these feelings and being sorry about it.

In response to the question “Would a nurse or another person know that you were having these feelings?” in quite a few instances, the participants said “No. They would not know unless they asked me.” One person said, “I hide it well.”

Some of the physical symptoms described were headache, pain in the chest, neck, and behind the eyes, being very tired, heart racing at times, stuttering, fluttering of the eyelids, muscle tension, and a feeling of “being sick” or of “going to get sick.” There was evidence that some NANDA I-approved diagnoses may coexist with or be contributing factors to stress overload (e.g., anxiety, sleep pattern disturbance, fatigue, situational low self-esteem, and decisional conflict). For example, a male participant described that the stress overload itself leads him to have less confidence in himself and he starts having negative thinking about his abilities. In this instance, stress overload coexists with situational low self-esteem.

The premise that stress overload may not be associated with ineffective coping was substantiated by these data. The participants described situations in which
use of the best coping strategies would not be effective enough to reduce stress levels. One person in the nonpsychiatric group described that “I must have very effective coping skills just to survive.” The coping skills of participants included skillful ways of mentally and behaviorally blocking some stressors or demands in order to proceed with one demand at a time.

The nursing intervention that subjects stated in response to question no. 9 was listening. This was also substantiated by the findings that the interview itself helped participants to feel better. In response to the question, Would a nurse be able to help you with stress overload?, one person stated, “You can tell some people in your life some things and other people in your life other things, but rarely can you tell anyone else in your life the full nature of your stress experiences.” An intervention that was mentioned by one person was “a nurse can ask questions for clarification.” Examples of this are Can you wait to change jobs? Do you think there might be a way to change that? That same person expressed a concern that nursing interventions may not always be effective, “I wouldn’t mind getting advice from a nurse, but a nurse might oversimplify the situation and assume that I had not already thought about obvious solutions.”

The emphasis of this qualitative study was to describe the stress experience. Even though question no. 8 asked about the stressors that contributed to this experience, there were inadequate data to describe the contributing factors for the stress experiences of these nine participants.

**Discussion**

The findings from this qualitative study indicate that stress overload is a viable diagnosis and the definition is appropriate. Identification and treatment of this diagnosis is important because continued high stress is associated with development of physical and

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**Table 2. Stress Overload**

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<th>Defining characteristics</th>
<th>Literature sources</th>
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<td>Perceives situational stress as excessive, e.g., rates stress level as seven or above on a 10-point scale</td>
<td>Bay et al., 2005; Boardman, 2004; Booth et al., 2005; Choenarom et al., 2005; Cropley &amp; Steptoe, 2005; Eby, 2004; Golden-Kreutz et al., 2005; Goodman et al., 2005; Holmes &amp; Rahe, 1967; Ilgen &amp; Hutchinson, 2005; Lim et al., 2005; Lunney &amp; Myszk, 1997; Lustyk et al., 2004; Motzer &amp; Hertig, 2004; Nielsen et al., 2005</td>
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<tr>
<td>Expresses a feeling of tension or pressure</td>
<td>Ilgen &amp; Hutchinson, 2005; Keil, 2004; Lunney &amp; Myszk, 1997; McNulty, 2005</td>
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<tr>
<td>Expresses difficulty in functioning as usual and in ordinary ways</td>
<td>Lunney &amp; Myszk, 1997; McNulty, 2005; Ryan-Wenger et al., 2005</td>
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<td>Expresses problems with decision making</td>
<td>McNulty, 2005</td>
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<tr>
<td>Expresses or demonstrates increased feelings of anger, impatience, or being short tempered with others</td>
<td>Dinog et al., 2005; Drew et al., 2005; Lunney &amp; Myszk, 1997; McNulty, 2005</td>
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<td>Reports negative impact from stress such as physical symptoms, psychological distress, or a feeling of “being sick” or of “going to get sick.”</td>
<td>Cropley &amp; Steptoe, 2005; Golden-Kreutz et al., 2005; Keil, 2004; Krause, 2004; Lunney &amp; Myszk, 1997; Maller et al., 2005; Ridner, 2004; Ryan-Wenger et al., 2005</td>
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Definition: Excessive amounts and types of demands that require action (Choenarom et al., 2005; Golden-Kreutz et al., 2005; Lunney & Myszk, 1997; Motzer & Hertig, 2004; Selye, 1974)
Stress Overload: A New Diagnosis

psychological illnesses (Booth, Beaver, Kitchner, O’Neill, & Farrell, 2005; Harwood, Locking-Cusolito, Spittal, Wilson, & White, 2005; Holmes & Rahe, 1967; Lim et al., 2005; Lloyd, Smith, & Weinger, 2005; Ridner, 2004; Selye, 1974; Sepa, Wahlberg, Vaarala, Frodi, & Ludvigsson, 2005; Stewart, Cianfrani, & Walker, 2005). For example, in a review of the links between stress and diabetes, Lloyd et al. explained the direct and indirect relationships between stress and metabolic control in diabetes, with possible negative effects on both the autonomic and neuroendocrine systems, and interference with the person’s self-management of the disease. Cropley and Steptoe (2005) found that significantly more physical symptoms, e.g., wheezing and sore throat, were reported by individuals in a chronically high-stress group \((n = 57)\) compared to individuals in a chronically low stress group \((n = 43)\) \((F(2) = 9.5; p < .001)\). In a survey of 401 HIV-positive persons in the state of Alabama, high scores on a general stress scale were negatively associated with mental health status (Stewart et al.). In a prospective 8-year follow-up study, in which psychological distress and pain had been measured at the beginning of the study, a postal questionnaire returned by 4,501 adults, ages 18–75 (65% response rate) showed that individuals in both the high and intermediate groups of psychological distress had increased risks of mortality when compared with those in the low distress group (Robinson et al., 2004).

The defining characteristics generated by this qualitative study are supported by the literature. Numerous studies show that the first defining characteristic, perceives situational stress as excessive, can be present in children and adults at all levels of health and illness (Al-Hassan, & Sagr, 2002; Booth et al., 2005; Choenarom, Williams, & Hagerty, 2005; Cropley & Steptoe, 2005; Drew et al., 2005; Eby, 2004; Golden-Kreutz et al., 2005; Goodman, McEwen, Dolan, Schafer-Kalkhoff, & Adler, 2005; Harwood et al., 2005; Hung, 2005; Ilgen, & Hutchinson, 2005; Kanner, Coyne, Schaefer, & Lazarus, 1981; Lim, Williams, & Hagan, 2005; Neilsen et al., 2005; Ryan-Wenger, Sharrer, & Campbell, 2005; Scollan-Koliopoulos, 2005; Sepa et al., 2005; Stewart et al., 2005). For example, in a study of stress and stressors of 84 patients recovering from myocardial infarctions, it was found that most of the patients experienced moderate stress and 20% experienced high stress. More than half of a sample of 70 women treated for gynecologic cancer, ages 24–83 years, reported four or more concerns perceived as a burden at the time of diagnosis and 6 months afterwards, with high rates of anxiety and depression (Booth et al.). In a comparison of two groups of low income women, abused \((n = 50)\) and not abused \((n = 57)\), abused women had significantly higher stress levels, as measured by identification of difficult life circumstances and stressful life events, than not-abused women \((t = 4.78; p < .05)\) and higher rates of physical health problems \((t = 2.60; p < .05)\). In two studies of children aged 7–12 years old, Ryan-Wenger et al. identified 54 mutually exclusive stressors that contribute to high stress levels in children, including community violence, threat of war, and availability of drugs. These and other studies imply that high levels of stress occur in some people and not others, thus supporting the need to identify those at risk and to conduct careful assessments and diagnoses.

Literature support for each of the defining characteristics—expresses a feeling of tension or pressure, expresses difficulty in functioning as usual and in ordinary ways, expresses problems with decision making, and expresses or demonstrates increased feelings of anger, impatience, or being short tempered with others—is present but comparatively weak. This is because the purpose of most studies is to demonstrate the relationships between stress and other variables, with little or no attention to identification of the signs and symptoms of high stress. Support for the defining characteristic, expresses a feeling of tension or pressure, was noted, however, in a concept analysis of coping and stress. Keil (2004) concluded that “perhaps stress lies somewhere ambiguously between [pressure and tension]” (p. 662). Additionally, in a study of the effects of high- and low-stress conditions with experimental tasks \((N = 62)\), scores on both a 1–10 stress
scale and a tool to measure tension were significantly higher under high-stress conditions compared to low-stress conditions \( (F(1,57) = 9.13; \ p < .01) \) (Ilgen & Hutchinson, 2005). This study examined the responses of two groups of men and women between 21–35 years of age, with no evidence of psychiatric illnesses, and with a history of major depressive disorders. Those with a history of major depression were more susceptible to the experimental high-stress conditions and tended to “give up” in the face of the challenge. Using an index of anxiety, McNulty (2005) found that a high percentage of deployed naval personnel \( (N = 1,195 \) from three aircraft carriers) felt extremely tense \( (40\%) \) or very tense \( (28\%) \) in the predeployment phase and these percentages remained comparable in the mid-deployment and postdeployment phases. In a longitudinal study of work stress factors with 2,270 employees from 20 different companies, a positive association of perceived work stress and mental strain was demonstrated, with correlations ranging from .20 to .40, of various work–stress factors and mental strain for both men and women (Rydstedt, Devereux, & Furnham, 2004).

Support for the defining characteristic, expresses difficulty in functioning as usual and in ordinary ways, is evident in McNulty’s (2005) study of navy personnel, in which large percentages reported being extremely confused \( (62\%) \) or very confused \( (24\%) \). These percentages remained comparable in the mid- and post-deployment phases. In a review of stressors that affect school-age children, Ryan-Wenger et al. (2005) suggested that withdrawing was a symptom of childhood stress, implying difficulty in functioning in usual ways.

Support for the defining characteristic, expresses problems with decision making, is also evident in McNulty’s (2005) study with 57% reporting that they were extremely indecisive and 26% reporting that they were very indecisive in the predeployment phase, with percentages remaining comparable in the mid- and postdeployment phases.

Support for expresses or demonstrates increased feelings of anger, impatience, or being short tempered with others was demonstrated by Drew et al. (2005), who defined stress as frustration and irritability; 39% of the participants \( (56 \) bereaved parents) demonstrated at least moderate stress. McNulty (2005) showed that 4% of male participants \( (n = 923) \) and 3% of female participants \( (n = 259) \) reported anger and abuse. Female personnel, in general, also voiced fears regarding their overall and gender-related safety, implying anger among male personnel. Diong et al. (2005), using structural equation modeling of data from 248 policemen, supported their theoretical model of anger and stress as co-occurring and contributing to psychological distress and higher frequencies of being sick.

The remaining defining characteristic, reports negative impact from stress such as physical symptoms, psychological distress, or a feeling of “being sick” or of “going to get sick,” is supported by two concept analyses and many studies (Cropley & Steptoe, 2005; Golden-Kreutz et al., 2005; Keil, 2004; Krause, 2004; Ridner, 2004; Ryan-Wenger et al., 2005; Sepa et al., 2005). Both Keil’s and Ridner’s concept analyses state that stress contributes to development of physical and psychological symptoms and distress. Ryan-Wenger et al., an experienced researcher of stress and coping in children, advised parents that events may be judged as too stressful for children if they complain of psychosomatic conditions such as headache and stomach ache. In a study of older adults and stress in relation to highly valued roles, Krause concluded “the stressors in highly valued roles affect health primarily by eroding an older person’s sense of meaning in life” (p. S287). Sepa et al. found that the psychological stress of parents also affects the physical health of infants, showing a positive association of high parenting stress and the production of diabetes-related autoimmunity in 1-year-old infants \( (\chi^2(1) = 11.133, \ p < .001) \). In a prospective study of 162 participants, Cropley and Steptoe found that the chronically high-stressed group reported significantly more physical symptoms than the chronically low-stressed group \( (F(2) = 9.5; \ p < .001) \), with no significant differences between males and female participants. In a study of 562 women, aged 25–74,
Stress Overload: A New Diagnosis

Mallers, Almeida, and Neupert (2005) determined that women in the young and middle-age groups with high stress reported more physical health symptoms than older women. They suggested that environmental stressors, including interpersonal relationships, may have more negative effects than biologic stressors. This association of older age women with lower stress was also reported in other studies (Janz et al., 2004).

According to the stress literature, which is much more extensive than the articles cited in this paper, the stressors that contribute to stress overload are many and varied (Table 3). Some stressors can be mitigated, e.g., acculturative stress may be mitigated by using the intervention of “culture brokerage,” while other stressors are less controllable (e.g., race and socioeconomic status or deployment to war zone). In structured interviews of 101 Hispanic clinic patients, Thoman and Suris (2004) found that acculturative stress was a predictor of psychological distress. A study of social disadvantage and adolescent stress found that stress was higher among African American students, those from lower socioeconomic status families, and those with lower perceived socioeconomic status (Goodman, et al., 2005). McNulty (2005) found that deployment to a war zone was associated with extreme individual and family stress and suggested that interventions were needed for these service personnel and their families.

Stress overload occurs when stressors become a burden for an individual or group. This diagnosis does not refer to single time-limited stressors such as the stress of test-taking (Sarid, Anson, Yaari, & Margalith, 2004). Stress overload can occur with one intense, repeated stressor (e.g., family violence) (Carlson-Catalano, 1998), or with multiple coexisting stressors (e.g., relationships with spouses and friends, housing, money, work, legal difficulties) (Cropley & Steptoe, 2005).

Table 3. Contributing Factors to Stress Overload Identified from Literature Sources

<table>
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<tr>
<th>Related factors</th>
<th>Literature sources</th>
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<tbody>
<tr>
<td>Burden of worry related to life events or concerns</td>
<td>Booth et al., 2005; Carlson-Catalano, 1998; Golden-Kreutz et al., 2005; Holmes &amp; Rahe, 1967; Hung, 2005; Kanner et al., 1981; Selye, 1974</td>
</tr>
<tr>
<td>Illness or symptoms of illness</td>
<td>Al-Hassan &amp; Sagr, 2002; Carlson-Catalano, 1998; Davidson et al., 2004; Harwood et al., 2005; Holmes &amp; Rahe, 1967; Ilgen &amp; Hutchinson, 2005; Ridner, 2004; Ryan-Wenger et al., 2005; Selye, 1974; Taxis et al., 2004</td>
</tr>
<tr>
<td>Social factors, e.g., interpersonal relationships, community, family, friends, and/or health providers</td>
<td>Al-Hassan &amp; Sagr, 2002; Boardman, 2004; Carlson-Catalano, 1998; Choenarom et al., 2005; Harwood et al., 2005; Holmes &amp; Rahe, 1967; Krause, 2004; Power, 2004; Ryan-Wenger et al., 2005; So &amp; Chan, 2004</td>
</tr>
<tr>
<td>Low educational level or lack of knowledge</td>
<td>Al Hassam &amp; Sagr, 2002; Booth et al., 2005; Harwood et al., 2005; Al-Hassan &amp; Sagr, 2002; Eby, 2004; Goodman et al., 2005; Harwood et al., 2005</td>
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<tr>
<td>Poverty</td>
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<td>Severe emotional responses, e.g., grief, powerlessness, change in body image or self esteem</td>
<td>Drew et al., 2005; Golden-Kreutz et al., 2005; Hung, 2005; Power, 2004; Ridner, 2005; Ryan-Wenger et al., 2005; So &amp; Chan, 2004</td>
</tr>
<tr>
<td>Inadequate social support</td>
<td>Bay et al., 2005; Booth et al., 2005; Choenarom et al., 2005; Cropley, 2005; Hung, 2005; Ryan-Wenger et al., 2005</td>
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<tr>
<td>Environmental threats, demands, or lack of resources, for example, community, family or school violence, threat of war, excessive demands of others (e.g., for children, excessive homework or over-organized sports and play)</td>
<td>Hannigan et al., 2004; Harwood et al., 2005; Scollan-Koliopoulos, 2005; Sepa et al., 2005; Stewart et al., 2005</td>
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The interventions suggested by the nine participants in this qualitative study that are covered by labels in the Nursing Interventions Classification (NIC) (Dochterman & Bulechek, 2004) are “active listening,” “presence,” “decision-making support,” and “values clarification.” By listening, nurses can help persons with stress overload to make sense of the experience and come to a fuller understanding. Nurses may be more helpful than family or friends because they are not involved in the specific demands being made on patients. Providing “presence” for a period of time (e.g., 15–60 min) may enable persons with stress overload to feel supported. With the intervention of “decision-making support,” nurses can help persons with stress overload to prioritize decisions, separating what may seem like overwhelming tasks to smaller subgroups of tasks. With the intervention of “values clarification” nurses can help persons with this diagnosis to decide the best courses of action to reduce stress (Dochterman & Bulechek).

Implications

The implications for these findings relate to nursing assessment, diagnosis, and interventions, and patient outcomes. With assessment, nurses should be mindful that this diagnosis represents a subjective experience of individuals and groups, a feeling of burden. The best way to obtain valid and reliable information from patients about their experiences is to develop nurse–patient partnerships, in which patients trust nurses enough to share intense experiences. To assess this response, nurses should ask questions such as (a) Are you experiencing stress overload? and (b) On a scale of 1–10, how would you rate this experience? Recently, a 1–5 scale (1 = not at all stressful, 5 = extremely stressful) was successfully used (Eby, 2004; Lim et al., 2005), so a 5-point scale is also an option. Assessment should also include asking how the person feels and how the stress affects their daily routines. Through working in partnership with patients, nurses can validate the diagnosis and decide with patients the interventions that would help to reduce stress.

The interventions that can be offered to patients are those identified through this study and others suggested by literature sources. Additional nursing interventions that should be considered are “environmental management,” “energy management,” “social support enhancement” (Dochterman & Bulechek, 2004), and stress reduction. In circumstances in which environmental factors are contributing factors, e.g., for patients in critical care units (So & Chan, 2004), “environmental management” may reduce the amounts and types of stressors. The NIC intervention of “energy management” may help persons with this diagnosis to prevent fatigue. “Social support enhancement” helps to mediate the effects of high stress (Choenarom et al., 2005; Cropley & Steptoe, 2005; Krause, 2004). An intervention that is not in the NIC and should be developed is stress reduction, defined as helping an individual or group to reduce the amounts and types of stressors that demand action. When the diagnosis of stress overload is available for nurses’ use through the NANDA I taxonomy, the most appropriate nursing interventions can be identified through additional research.

The Nursing Outcomes Classification outcome that directly relates to this diagnosis is Stress Level, with a score of 1 for Severe (i.e., Stress Level), 2 for Substantial, 3 for Moderate, 4 for Mild, and 5 for None. Nurses and patients, working in partnership, identify the overall baseline score using scores on the indicators, e.g., headache, diminished attention to detail, and inability to concentrate on tasks. With the diagnosis of stress overload, most likely the baseline score on stress level will be 1 or 2. If nurses can help patients move even one level on the outcome scale, patients will probably feel some relief from the symptoms of stress overload.

Conclusions

The diagnosis of stress overload can be used as needed by nurses in clinical settings now that it is a
part of the NANDA I Taxonomy. Inclusion in the taxonomy is expected to stimulate further research to validate the defining characteristics and related factors, as well as to identify the most appropriate nursing interventions for various populations. This diagnosis is relevant for community and acute care settings, and for people of all age groups.

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