AN ABSTRACT OF THE THESIS OF

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Title: Selected Factors Impacting Burnout in Professional and Paraprofessional Caregivers in Acute Care and Long-Term Care Health Facilities

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Clara C. Pratt

Burnout is a phenomenon in which the cumulative effects of a stressful work environment gradually overwhelm the defenses of staff members, forcing them to psychologically withdraw. To understand the experience of professional and paraprofessional nurses suffering from burnout requires a close examination of the environments in which they function. This study examined interpersonal, intrapersonal and situational factors expected to contribute to the burnout syndrome among nursing staff who worked in acute care and long-term care health facilities. It also examined for differences in caregivers' burnout, work support, coping strategies, and comfort with patients with poor prognosis for survival by occupational roles, types of facility and professional exposure to patients with poor prognosis for survival. The sample included 312 registered nurses, licensed practical nurses and certified nursing assistants who
worked in both acute care and long-term care facilities. Multivariate analysis of variance and multiple regression were utilized to analyze the data.

Based on the results, interpersonal, intrapersonal and situational factors were all included in the final model which identified specific variables predictive of the various dimensions of burnout. Work environment support and tension-releasing and instrumental coping strategies were the most powerful predictors of burnout. Certified nursing assistants were significantly higher on burnout than registered/licensed nurses. In addition, certified nursing assistants were lower on work support and comfort with patients with poor prognosis for survival than were registered/licensed nurses. Finally, nurses with moderate and high exposure to patients with poor prognosis for survival were significantly more comfortable with such patients than were nurses with lower exposure. Recommendations for future research and practice are presented.
Selected Factors Impacting Burnout in Professional and Paraprofessional Caregivers in Acute Care and Long-Term Health Care Facilities

by

Janette M. Hare

A THESIS

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DEDICATED TO

my husband, Douglas Paul

my children:

Amos Matthew
Kierce Jill
Brynn Noel

my parents and sister

Jean and Joseph Norfleet
Jill Crandall

and to the special memory of

Beverly Jean Andrews

whose belief in me extended
even beyond her life
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Selected Factor Impacting Burnout in Professional and Paraprofessional Caregivers in Acute Care and Long-Term Health Care Facilities

I. INTRODUCTION

Stress is not synonymous with burnout. Rather, burnout is an adaptation to the progressive loss of idealism (Price and Murphy, 1984), energy, and purpose experienced by people working in the human services; furthermore, it results directly from the conditions of their work. According to Price and Murphy (1984), the typical burnout victim is a professional full of idealism and a sense of mission. However, the difficult realities of the work situation threaten the individual's vision of what s/he is able to accomplish on the job. Gradual disillusionment and resignation to the power of the external work environment ultimately give way to the loss of spirit. Storlie (1979) paints a vivid picture of burnout as it occurs in the nurse:

"burnout [is] a highly personal happening inside the nurse -- the literal collapse of the human spirit. It would be more useful and certainly more compassionate to ask what goes on in a professional nurse that transforms caring into apathy, involvement into distance, openness into self-protection, and trust into suspicion."

(Storlie, 1979, p. 2108)
To ask what goes on in professional and paraprofessional nurses suffering from burnout requires a close look at the environments in which they function. The literature is replete with evidence that these environments are highly stressful (Michaels, 1971; Bilodeau, 1973; Cassem & Hackett, 1975; Duxbury & Thiessen, 1979; Johnson, 1979; See Stehle, 1981 for a review of the literature; Keane, 1985). Empirically, nursing stress has been examined in relation to the following factors:


3. Nursing modalities, i.e., primary care vs. team care (Parasuraman & Zammuto, 1982).


Descriptively, stress in nursing has been examined in relation to the following:

2. Social support (Norbeck, 1981; Beardslee & DeMaso, 1982).
4. Types of patients (Vreeland & Ellis, 1969; Friedman, 1973; Bilodeau, 1973).

Burnout is an adaptation to stress which represents a response to an intolerable work situation (Cherniss, 1980) and is defined by Maslach (1976) as the "loss of concern for people with whom one is working" in response to job related stress. More specifically, burnout is a phenomenon in which the cumulative effects of a stressful work environment begin to overwhelm the defenses of staff members, forcing them to psychologically withdraw. Maslach (1982) describes burnout as a syndrome of emotional exhaustion, depersonalization and reduced sense of personal accomplishment that frequently occurs among individuals who work in the human services and in educational institutions. It refers most commonly to a particular kind of response -- the tendency to treat
Staff members who do "people work" are often required to spend considerable time intensely involved with their clients. The work is generally centered around the client's problems which are typically multidimensional, involving social, psychological or physical components. Rarely in such work are there easy or obvious solutions to the clients' problems and the situation easily becomes frustrating. The chronic stress for the staff member can be emotionally exhausting and lead to burnout (Maslach, 1981).

Cherniss (1980) describes burnout as a transactional process consisting of three stages: The first stage concerns an imbalance between resources and demand (stress). The second stage is the immediate, short-term emotional response to the imbalance which leads to feelings of anxiety, tension, fatigue, and exhaustion (strain). Such stress and strain cannot be alleviated through active problem-solving. Consequently, the third stage consists of a number of changes in attitude and behavior, such as a tendency to treat clients in a mechanical and detached manner. Burnout, then, refers to a process which consists of job stress, worker strain, and psychological accommodation.
The costs of burnout in staff turnover are enormous and are felt by clients, fellow staff members, the institution and society (Edelwich and Brodsky, 1980): "These costs include the sizeable financial expense of training new staff, the disruption of client services with the loss in continuity of client-staff relationships, and the lowering of staff morale" (Edelwich and Brodsky, 1980, p. 31). These authors explain that the destructive impact on morale is evidence that turnover is not only a result of burnout, but also a cause of burnout as well. For example, peer solidarity and support are essential for what is often an understaffed facility with undertrained personnel. Typically a community of peers arises out of necessity. When some staff members become discouraged and resign, to be replaced by inexperienced strangers or no one at all, the community is fragmented. The remaining staff have lost a vital source of support and thus become more vulnerable to burnout themselves (Edelwich and Brodsky, 1980).

Researchers investigating factors associated with burnout have studied a variety of people-workers: employees of the Social Security Administration, school psychologists, social workers, teachers, day care workers, mental health workers, corrections officers, and nurses. These studies have provided clues regarding causes and
outcomes of burnout. For example, burnout has been associated with certain factors in the job setting:


4. Greater role conflict; that is, role demands that are inherently incompatible (Westerhouse, 1979; Schwab & Iwanicki, 1981).

5. Low degree of peer support (Maslach & Jackson, 1982).

Maslach (1981) suggests that relationships between burnout and certain demographic variables need further exploration. She states that in particular there should be an analysis of these relationships within occupations because some of the demographic variables can be confounded with the type of work. For example, physicians, police officers, and psychiatrists are typically males, while nurses, social workers and counselors are mostly female.

While some researchers have related personality to burnout (Gann, 1979; Heckman, 1980), Maslach and Jackson (1982) suggest that the problem of burnout can best be understood in terms of the interpersonal and situational sources of job-related stress. They note that the prevalence of the burnout syndrome among a wide
variety of professionals of varied personalities and backgrounds suggests that we should stop our search for "bad people" and start uncovering the operational and structural characteristics of the "bad situations" where many good people function. "We have reached the point at which the number of rotten apples in the barrel warrants examination of the barrel itself" (p. 232).

Although descriptive papers which discuss nursing burnout can be found in the literature (Storlie, 1979; Maslach, 1979), there are surprisingly few published empirical examinations of this syndrome (Jones, 1981; Jackson & Maslach, 1982 as cited in Maslach & Jackson, 1982; Yasko, 1983; West, Horan & Games, 1984; Keane, 1985). Therefore, such empirical work is needed in order to specifically identify the operational and structural characteristics of nursing environments as well as the psychological characteristics of the nurses themselves which are contribute to the burnout syndrome. In other words, the barrel has been adequately described; however, it must be further subjected to scientific inquiry.
JUSTIFICATION

Burnout is produced by external and internal factors. The surrounding situation of emotionally intense involvement with people, the negative focus on problems, the lack of positive feedback or poor peer relations are only part of the story of burnout. What a staff member brings to the situation is just as critical as what the situation brings out of her or him. In other words, the staff member's coping strategies, fears, and values are qualities that help determine how s/he will handle external sources of emotional stress.

The following model is adapted from Vachon (Vachon & Pakes, 1984) and illustrates how the variables of interest might interact to produce a burnout response in nurses (Figure 1). The model identifies interpersonal, intrapersonal and situational factors which are expected to impact burnout.
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Figure 1. Beginning Model
Specific variables hypothesized to contribute to the burnout syndrome in nursing staff are as follows: intrapersonal (coping strategies, fear of death, and comfort working with patients with poor prognosis for survival), interpersonal (work environment support and informal support) and situational (professional exposure to patients with poor prognosis for survival, type of facility, occupational role, shift, hours per week worked, level of education, age, marital and family status).
PURPOSE

The purpose of this study was to examine a model of factors which were hypothesized to impinge upon the six dimensions of burnout in professional and paraprofessional caregivers in acute care facilities and long-term care facilities. This model included the following factors: interpersonal (work environment support and informal support), intrapersonal (coping strategies, comfort with patients with poor prognosis for survival, and fear of death), and situational (professional exposure to patients with poor prognosis for survival, type of facility, occupational role, hours worked per week, shift, age, marital and family status). Unlike previous studies of nursing burnout, this study compared two occupational roles within nursing: professional nurses (registered and licensed practical) and paraprofessional nurses (certified nursing assistants). Also unlike previous studies, the six dimensions of burnout were compared between the two occupational roles across two different work environments, acute care and long-term care facilities. A model relating multidimensional factors in burnout was examined.
DEFINITION OF TERMS

1. Burnout: The syndrome of emotional exhaustion, depersonalization and reduced personal accomplishment that can occur among staff who do some kind of people work (Maslach, 1982).

2. Peer Cohesion: The extent to which workers are friendly and supportive of each other (Moos, 1981).

3. Supervisor Support: The extent to which management is supportive of workers and encourages workers to be supportive of each other (Moos, 1981).

4. Work Involvement: The extent to which workers are concerned and committed to their jobs and are enthusiastic and constructive (Moos, 1981).

5. Informal Support: Perceived support from relationships outside of work, i.e., friends and family.
6. Fear of Death: The emotional reaction involving subjective feelings of unpleasantness and concern based on contemplation and/or anticipation of any of the several facets related to death (Hoelter & Hoelter, 1980).

7. Coping: The constantly changing cognitive and behavioral strategies intended to manage specific demands of work that are appraised as stressful (Lazarus & Folkman, 1984).

8. Patients with Poor Prognosis for Survival: In acute care facilities, "poor prognosis for survival" is defined as survival not expected to exceed two years. In long-term care facilities "poor prognosis for survival" is defined as survival not expected to exceed six months.

9. Comfort with Patients with Poor Prognosis for Survival: The subject's perception of his/her typical behavior while caring for a patient with a poor prognosis for survival.
II. REVIEW OF THE LITERATURE

Burnout is a syndrome of emotional exhaustion, depersonalization and reduced personal accomplishment which can occur among individuals who work closely and extensively with people who are troubled or having problems (Maslach, 1981). What is unique about burnout is that the chronic emotional strain arises from the social interaction between helper and recipient.

Burnout is a relatively new concept. It appeared in the literature in the early 1970's in descriptive papers by Freudenberger (1974) who was part of the free clinic movement. The most productive and well-known empirical researcher on burnout is Christina Maslach of the University of California, Berkeley. Maslach describes three aspects of this syndrome (1982). At the heart of the burnout syndrome is emotional overextension. A person gets overly involved emotionally and feels overwhelmed by the demands imposed by other people. The response to this situation is emotional exhaustion; that is, the worker feels depleted of energy and there appears to be no source of replenishment. This emotional exhaustion is the first aspect of burnout. In the words of a nurse, "When you have to care for so many people, you begin to suffer from
an emotional overload -- it's just too much. I'm like a
wire that has too much electricity flowing through it --
I've burned out and emotionally disconnected from others" (Maslach, 1982, p.2).

Once individuals have succumbed to this kind of
exhaustion, they feel unable to give of themselves and
respond by limiting their involvement with others. They
invest a minimum of energy in their work responsibilities,
particularly those which involve direct client contact.
Their interactions become colored by contemptuous feelings
toward clients and are primarily guided by policy and
regulations. Such behavior is an effort to detach
themselves psychologically from others and represents the
second aspect of burnout -- depersonalization.

Recognizing that they have become detached and
callous, workers often feel distress and/or guilt about
their interactions with clients. They experience a
growing sense of inadequacy and may label themselves a
"failure". At this point, the worker enters the third
aspect of burnout -- a feeling of reduced personal
accomplishment. It is during this time that workers will
either seek counseling or some form of therapy for what
they believe are their own personal problems or they will
change their jobs, often completely abandoning any kind of
work that brings them into stressful contact with others.
In addition to the psychological responses of burnout, there are also psychophysiological responses which may include stress-related disorders such as chronic infections, ulcers and extreme fatigue. Behaviorally, adverse effects on job performance are sometimes present when the worker makes mistakes, is careless, dishonest, and/or treats clients in a disrespectful manner (Maslach, 1982; Jones, 1981; Cronin-Stubbs & Rooks, 1985). Jones (1981) found that staff burnout scores correlated with the total dollar amount of all goods pilfered by nurses. That is, nursing personnel who suffered from burnout, as measured by the Staff Burnout Scale (Jones, 1981), were more likely to steal from the hospital than nurses who scored low on the burnout measure.

The problem of burnout appears to be primarily an organization issue (Maslach, 1982). The structure and organization of the job itself creates stress which produces strain in the worker who then attempts to adapt to the stress. Such adaptation is represented by changes in attitudes and behaviors that provide psychological escape and thus ensure that further stress will not be added to the strain already experienced.
Given the nature and extent of patient contact for nursing staff in hospitals and nursing homes, it follows that the nurses who work in these facilities are susceptible to the burnout syndrome. Recent research on burnout (Maslach, 1978, 1982, Dames, 1983, Yasko, 1983) in acute care nurses indicates that interpersonal, intrapersonal, and situational factors contribute to this costly phenomenon. It appears, however, that no scientific studies exist which make comparisons of burnout between acute care and long-term care nurses. Following is a review of the research findings reported in the literature concerning interpersonal, intrapersonal and situational factors which encompass the variables considered in this study to be predictive of burnout in nurses working in acute care and long-term care facilities.
INTERPERSONAL FACTORS

Work Environment Support and Informal Support.

Moos and his colleagues (1981) devised a measure to assess individuals' perceptions of the social climate of their work environments. They reported the following three domains which comprise the dimension of work relationships: peer cohesion, supervisor support, and work involvement. These relationship dimensions were defined by Moos (1981) as follows: Peer cohesion is the extent to which employees are friendly and supportive of one another. Supervisor support is the extent to which management is supportive of employees and encourages employees to be supportive of one another. Work involvement is the extent to which employees are concerned about and committed to their jobs. These indices of social support in the work environment were noted to have a moderating effect on the psychological influence of work stressors on functioning (Billings & Moos, 1981).

Research on the role of social support in nursing burnout has just begun. Preliminary findings suggest that lack of support at work or from family and friends enhances staffs' vulnerability to burnout (Constable, 1983; Duxbury, Armstrong, Drew & Henly, 1984; Cronin-Stubbs, 1985). However, none of the studies
reviewed explored the relationship of specific dimensions of work relationships to burnout. In addition, comparisons were not made of work relationships and burnout between nurses who work in acute care and long-term care facilities and between professional and paraprofessional staff.

Problems with peer support and communication have been noted as primary sources of stress among nurses. Vachon, Lyall & Freeman (1978) found that staff working on a newly opened palliative care unit for advanced cancer patients reported major problems with the work situation and staff communication just as often as they reported problems watching patients suffer and die. Nurses who believe that they receive more support from their co-workers scored lower on emotional exhaustion, one aspect of burnout. Lower rates of emotional exhaustion have also been associated with greater support and recognition from supervisors (Jackson and Maslach, 1982 as cited in Maslach & Jackson, 1982). In a recent study Cronin-Stubbs and Rooks (1985) found that on-the-job and off-the-job social support was negatively associated with and predictive of burnout. Specifically, expressions of liking, admiration, and respect predicted burnout, while affirmation or acknowledgement by others did not. These researchers concluded that while recognition may promote
job satisfaction, being cared about by others may be more important in counteracting burnout.

According to Maslach (1976), support from supervisors, as well as peer support, appears to mediate the effects of job stress. For example, supervisor feedback about performance was clearly important to nurses. Emotional exhaustion has been found to be higher among nurses who received little feedback from supervisors and among nurses who felt they had little knowledge about how their performance was being evaluated. In addition, nurses scored higher on depersonalization when they had little feedback from supervisors (Jackson and Maslach, 1982 as cited in Maslach & Jackson, 1982).

This was confirmed by Constable (1983) utilizing a sample of hospital-based nurses. In this study supervisor support was found to be one of three major determinants of burnout. High levels of supervisor support were found to mitigate the effects of adversity in the work environment on nurses. Further confirmation was given by Duxbury, Armstrong, Drew & Henly (1984) in a study which examined the relationship between head nurse leadership style and burnout in neonatal intensive care unit staff. Leadership style was considered as a two-factor construct composed of "consideration" and "structure." Consideration was defined as the emphasis on
concern for group members' needs. The behavior associated with this dimension indicates trust, respect, and effective communication. Structure, on the other hand, emphasizes the achievement of organization goals. A structure leader typically organizes group activities in the push for production. Duxbury, et al report that head nurse structure alone was not related to staff nurse burnout. However, structure had a clear effect in combination with consideration. That is, elevated burnout scores were reported for staff nurses whose head nurses' leadership style was characterized by high structure-low consideration. These findings support the premise that a head nurse can promote the organizational goals of high production emphasis and still maintain lower levels of staff nurse burnout when the leader also manifests higher scores on consideration.

In contrast to the importance of co-worker support as it relates to burnout, support from people outside of work (family and friends) has been reported by Jackson & Maslach (1982) to have little relationship to the experience of emotional exhaustion. They did report, however, that nurses who felt a strong sense of personal accomplishment were more likely to discuss their jobs with
friends and to feel supported by them. Only the Jackson and Maslach (1982) study examined informal support in relationship to burnout. Norbeck (1984), however, studied the sources of social support in managing job stress in nurses. Although she did not investigate burnout specifically, her findings are important to the study of burnout. She found that for both married and unmarried subjects, 96% of their support network lists fell into four source categories: spouse or partner, family or relatives, friends, and work or school associates. No more than 1% came from neighbors, counselor, health care provider, clergy or other. Married nurses reported significantly more support from the spouse/partner and family/relatives categories than did unmarried nurses, who in turn reported significantly more support from friends than did married nurses. The two groups did not differ in network size or in the amount of support available to them. Work support explained nearly twice the variance in perceived job stress than the overall measure of support for the married group. For the unmarried group, support from relatives was a more sensitive measure than the total network support score, doubling the explained variance in perceived job stress.
Given the abundant evidence that people who receive help and assistance from informal support systems are less negatively affected by stress (Cassel, 1976; Cobb, 1976; Dean & Lin, 1977; Kaplan, Cassel & Gore, 1977), this variable is considered worthwhile and important to this study. Overall, the presumed importance of both work support and informal support for the caregiver to life-threatened patients is emphasized by Vachon (1979): "If the patient care staff only give of themselves without in some way being replenished, they will ultimately have nothing left to give" (p. 13).
INTRAPERSONAL FACTORS

Coping Strategies.

The ultimate goal of research on burnout is to discover how people can effectively cope with unrelenting job stress and avoid the emotional exhaustion which can result from such stress. Coping has been defined by Lazarus and Folkman (1984) as constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands which are appraised as stressful. They note two distinct types of coping: problem-focused coping and emotion-focused coping. Problem-focused coping represents efforts directed at defining the problem, generating alternative solutions, weighing alternatives, choosing and acting. Emotion-focused coping, on the other hand, represents cognitive processes which are aimed at reducing emotional distress, such as avoidance, minimization, distancing, selective attention, and reappraisal. Thus, Lazarus and Folkman (1984) suggest that problem-focused coping and emotion-focused coping serve two different functions: Problem-focused coping manages or alters the source of stress whereas emotion-focused coping regulates stressful emotions which are in response to the source of stress. Furthermore, Lazarus and Folkman (1984) emphasize that an
individual appraisal of a situation influences the coping process and personal adjustment to the situation.

Appraisal falls into two components: primary and secondary appraisal. Primary appraisal is an initial evaluation that the event is stressful; that is, a judgment of whether or not the event exceeds available resources. Secondary appraisal consists of the individual's assessment of the following: coping resources (things or people) available to deal with the demands of the situation, constraints that prevent the use of a resource, level of threat, and perceived control over the stressful situation. According to Lazarus and Folkman (1984), it is only after the individual has been through this entire appraisal process will s/he act.

Using the Lazarus and Folkman model of stress and coping, burnout can be conceptualized as a negative adaptation to a work situation appraised as unrelentingly stressful. It involves intrapsychic modes of coping with job-related stress which emphasize withdrawal, avoidance, detachment, lowering goals, and blaming others (Cherniss, 1980). Such coping is emotion-focused in the Lazarus and Folkman model. Maslach & Jackson (1982) found that high degrees of burnout in a variety of professions have been associated with withdrawal coping strategies, such as getting away from people or shutting off thoughts about
work, while low degrees of burnout have been associated with social coping strategies, such as talking with others about the job or getting advice. It appears, then, that high degrees of burnout may be associated with emotion-focused coping while low degrees of burnout may be associated with problem-focused coping.

Koocher (1979) described the difficult issues which hospice nurses routinely face and the coping strategies they utilize to cope with these stresses. His descriptive paper is based on information collected during a "stress and burnout workshop" in which the nurses were asked to list the most difficult issues they regularly confronted on the job and the strategies on which they relied to cope with these stresses. Most of the coping strategies suggested as effective by the workshop participants focused on avoiding feelings of being burned out and protecting oneself against feelings of helplessness. The strategies they noted were the following: making use of some type of personal relaxation, working with patients with good prognoses in order to balance working with those with poor prognoses, using humor to release tension, taking time off away from it all, receiving support from co-workers, and controlling emotional investment in patients.
Chiriboga, Jenkins and Bailey (1983) also studied stress and coping among hospice nurses. From a sample of 100 hospice registered nurses, they tested an analytic model of stress that included social and predisposing conditioning factors, stress appraisals, coping strategies, social resources, and psychological adaptation to occupational stress. Adaptive status was the dependent variable and was based on the summation of the following individual measures: 1) length of employment at the hospice, 2) expected tenure at the hospice, 3) current work satisfaction, 4) change in work satisfaction, 5) current perceived effectiveness, 6) change in effectiveness, 7) respondent-judged supervisor's rating of work effectiveness, 8) change in supervisor rating of work effectiveness, 9) current perceived level of stress, 10) stress resolution. Scores for each of these 10 measures were dichotomized and the results summed into a single measure of adaptive status. Entered as sets in a hierarchical regression analysis, stress appraisals and coping strategies proved to be the best predictors of adaptation to stress. The coping strategy set of measures contributed at the trend level (p = .10) to the total variance in the measures of stress adaptation. The most effective coping strategy was the one marked by a sense of professionalism. For example, "maintain my pride and keep
"a stiff upper lip", "choose my words very carefully with the patient", "tell myself that dying is a natural process" all characterized this strategy. Nurses using this strategy tended to perceive death as a basic fact of life, relied on their professional knowledge and value systems to deal more effectively with death. However, use of emotional avoidance as a coping strategy tended to be associated with less favorable outcome (p = .10). In other words, nurses who maintained a professional attitude, but who were able to admit their distress to both themselves and others when under stress, fared best.

The Chiriboga, et al study (1983) also examined social support as a predictor of adaptation to job stress. Interestingly, social support did not contribute as expected to the prediction of overall outcome in the regression analysis, but the presence of supportive spouses and staff did correlate with outcome at the zero order level. However, when social resource measures were entered into the hierarchical regression, much of their predictive strength had been removed. It was hypothesized that perhaps the reason for this weakened association was the association of social resources with coping strategies. By initially entering coping strategies into the regression equation, the predictive variance social resources shared with coping was diminished. On the other
hand, the prior entry of supports robbed the coping strategies of their contribution but did not enhance the contribution of supports. The researchers concluded that rather than social supports themselves providing the needed resource to mediate job stress, social support may provide the nurse with the opportunity to cope more effectively.

Studying coping strategies employed by nurses who function in acute and long-term care facilities will increase our knowledge of both individual and institutional strategies which may impact burnout. Furthermore, examining for a possible interaction between degree of professional exposure to patients with poor prognosis and coping strategies as it relates to burnout will increase our understanding of what strategies may best mediate the emotional strain of working with dying patients.

Fear of Death.

In the examination of health caregivers' fear of death, the focus has been on the inadequacy of psychosocial care of the terminally ill due to the fear and discomfort of the caregivers (Glaser & Strauss, 1966; Kastenbaum, 1967; LeShan, 1969; Menzies, 1970; Liberman, Handal, Napoli & Austrin, 1983; Vickio &
Cavanaugh, 1985; Eakes, 1985). Fear of death and death anxiety have been investigated with a variety of subjects and settings. It has not, however, been investigated in relation to burnout. Consistently, females report higher death fear than males (Templer, Veleber, Lovito, Testa & Knippers, 1983). On the other hand, studies have reported inconsistent findings on the relationship between death fear and age. Several researchers (Templer, Ruff & Franks, 1971; McDonald, 1976; Hoelter & Hoelter, 1980; Templer, et al., 1983; Lattanner & Hayslip, 1984) report no relationship between death fear and age. Others (Lund & Leming, 1975; Kalish, 1976) report that while the older person thinks of death more often than younger adults, they appear to have less fear/anxiety concerning death.

Hoelter and Hoelter (1980) examined the interrelationship between exposure to death and dying and fear of death using a sample of college undergraduates. They found that exposure to death and dying was positively correlated with two dimensions of death fear: fear of the dying process and fear of premature death. In addition, they found that exposure was negatively correlated with fear of being destroyed. This study supports the view that death fear is a multidimensional construct rather than a unidimensional one.
According to Becker (1974), nurses are not alone in their fear of death; rather, such fear is a universal phenomenon. In his Pulitzer Prize winning book *The Denial of Death* (1974), Becker proposes that fear of death is intrinsic to all people. He maintains that such fear cannot be tolerated in the conscious and therefore must be repressed. Furthermore, he states that although sensing one's non-being may be essential, it cannot continue to be looked at directly. As de la Rouchfcauld said, "One cannot look directly at either the sun or death."

Becker maintains that in order to function in a world which seems to be "unordered chaos", people construct a "creative myth". This creative myth is a belief that enables a person to face death with a minimum of repression. He finds the two best collective "creative myths" to be traditional Christianity and Buddhism. Referring to the work of theologian Paul Tillich, Becker emphasizes that such a myth is a call "to the highest and most difficult effort -- and not to simple joy. A creative myth is not simply a relapse in comfortable illusion; it has to be as bold as possible in order to be truly generative" (p. 278-279).

Assuming Becker is correct that fear of death is intrinsic and necessarily repressed, then it would follow
that for nurses working with dying patients the reality of
death would be an attack upon the repressing factors of
death fear. Burnout, then, may simply be another
defensive strategy aimed at maintaining the repression of
death fear and thus protecting the psyche.

If this proposition is supported, it would appear
that strengthening the "creative myth" (that is,
strengthening the individual's personal sense of
purposefulness and meaning) would be a more effective
strategy to help health professionals who work with
critically/terminally ill patients rather than attempting
to alleviate death fear/anxiety as previous
interventionists have proposed (Chandler, 1965;
The literature clearly indicates that many health professionals who care for terminally ill patients feel uncomfortable (Glaser & Strauss, 1965; Kastenbaum, 1967; Pearlman, Stotsky, & Dominick, 1969; Quint, 1973; White, et al., 1983; Rando, 1984). Several studies have attempted to link death anxiety with comfort talking about death to dying and bereaved individuals. Results have been inconsistent. That is, some studies (Nelson, 1979; Liberman, et al., 1983) have concluded that by decreasing an individual's death anxiety it is possible to increase comfort in talking with the dying and bereaved. Others (Vickio & Cavanaugh, 1985; Pratt, Hare, Wright, 1985) indicate that caregivers are able to separate their own anxieties from their willingness to talk about death with bereaved and dying individuals. In spite of these inconsistencies, it is logical that if caregiver discomfort is prolonged (perhaps due to continual exposure to critically/terminally ill patients), emotional exhaustion will likely be the outcome. However, the possibility that comfort working with patients with poor prognosis for survival may be predictive of burnout has not yet been empirically investigated. Evidence of a relationship between degree of exposure to patients with
poor prognosis for survival and comfort working with such patients would have important implications for interventions.
SITUATIONAL FACTORS

Professional Exposure to Patients with Poor Prognosis for Survival.

The literature on burnout generally affirms that as the amount of client contact and severity of the client's problem increases, so does staff burnout (Barad, 1979; Maslach & Pines, 1977; Maslach, 1979; Dames, 1983). Jackson and Maslach (1982 as cited in Maslach & Jackson, 1982) found that the more time spent in direct patient care, the greater the risk of the emotional exhaustion of burnout. For example, physicians who worked for a health maintenance organization reported the percentage of their working time that they spent in various professional activities. The greater the percentage of time they spent in direct contact with patients, the higher their scores on the Maslach Burnout Inventory subscale of emotional exhaustion. The scores were lower for those physicians who spent some of their time in teaching or administration. No findings were reported by these researchers concerning time spent in direct patient care as it relates to emotional exhaustion in nurses.

In addition to amount of client contact, the type
of problem facing the client is another potential contributor to burnout (Maslach, 1978). Maslach notes that some clients may have problems that are more emotionally stressful for staff than others. If the client's problem is particularly difficult, and especially if it is not likely to improve, staff is more prone to emotional exhaustion.

An example of highly stressful client contact would be work with patients who have poor prognosis for survival. There is abundant evidence in the literature which indicates that dying and grieving individuals create an aversive stimulus for many people. It appears that working with dying patients can also pose several emotional problems for health practitioners (Kastenbaum, 1967; Strauss, 1968; Harper, 1977; Koocher, 1979; Rando, 1984). Often death is viewed as an adversary to be overcome and a dying patient may seem a visible sign of the practitioner's failure and powerlessness (Menzies, 1970; Easson, 1970; Vachon, Lyall, Freeman, 1978). This may be especially true when the practitioner is operating with a "rescue fantasy" of saving patients (Bugen, 1979). In addition, dying patients can also arouse thoughts of one's own death or the death of other loved ones (Fulton, 1971; Kavanaugh, 1974; Shanfield, 1981; Kalish, 1981; Raphael, 1983). Maslach (1978) notes that there will be
greater emotional stress for the staff member when s/he looks at the client's situation and thinks "that could be me." Death is an event which is certain to happen eventually to the staff member and thus may arouse strong fears and anxieties. One way staff may handle these feelings is by defensive coping, such as distancing themselves from the person who seems to be "causing" these feelings.

Such defensive coping is discussed by Pruyser (1984) who contends that it is difficult for professionals exposed to patients with terminal illness to maintain equilibrium. Contact with dying patients gives the professional the existential message that death is a foredoomed fact of life. Thus the professional copes with the anxiety resulting from that message by surrounding his or her heart with armour, working in compulsive ways, taking flight into "a hyperaesthetic lifestyle or religionizing professional work" (p. 358).

Koocher (1979) addresses more specifically this same problem of professional exposure to dying patients in a descriptive paper based on a "stress and burnout workshop" conducted for hospice nurses. He reports five major stresses identified by the workshop participants. These stresses which are related to caring for dying patients are as follows: 1) The generalized sense of
helplessness, progressive apathy, and inability to empathize with patients which results from the nurse's sense of being emotionally drained. 2) The difficulty in perceiving the value in one's work; that is, "what is the payoff in this work?" This was an especially acute stress for nurses who felt little or no support from co-workers. 3) The experience of guilt associated with feelings of omnipotence; that is, the assumption by the caretaker that s/he is personally responsible for the patient's well-being even though this is not objectively true. 4) The necessity of dealing with situations in which some aspects of a patient's care or condition are specifically kept secret or are not discussed with certain individuals for their own "protection." 5) The inevitability of working with some patients who are angry or who make heavy use of denial. Nurses report that work with these patients is particularly difficult because it causes the nurse to question the value of his/her efforts.

Although there have been many papers describing the stress of working with patients with poor prognosis for survival, only three studies have examined this variable in relation to burnout and findings were inconsistent. First of all, Lewiston, Conley and Blessing-Moore (1981) measured a population of caregivers to cystic fibrosis patients and a control population from
other areas of specialty pediatrics. The caregivers to cystic fibrosis patients displayed a higher level of emotional exhaustion. On the other hand, they also displayed a lower level of patient depersonalization and an equal sense of personal accomplishment from the job as compared to the controls. Maslach (1981) notes that burnout is a process consisting of three phases—emotional exhaustion, depersonalization, and reduced sense of personal accomplishment. The results of the Lewiston, et al. study may simply mean that their population of caregivers were in the first phase of burnout.

Secondly, Dames (1983) surveyed female graduates of a university nursing school and found that the percentage of time respondents worked in close proximity to terminally ill patients positively related to burnout. However, Dames examined this variable retrospectively as well as prospectively. Therefore, it is not possible to know if the respondent was currently working with patients with poor prognosis for survival. Nine variables in the Dames study combined to predict more than 80% of the variance in burnout scores. The second most predictive variable was high patient contact. High patient contact ratings included general medical and terminal case assignments while all other assignments were rated low patient contact.
Finally, Yasko (1983), who investigated burnout in oncology clinical nursing specialists, reported quite different findings. Overall, the study reported a mean burnout score that was significantly lower than mean burnout scores of other nurse samples tested previously with the same burnout instrument -- the Staff Burnout Scale for Health Professionals developed by Jones (1981). This researcher concluded that perhaps it is likely that nurses who choose to specialize in oncology nursing have previously identified, coped with, and resolved the issues related to cancer and cancer care. They, therefore, no longer perceive caring for patients with this disease as a stressor. Specifically, hours spent in direct contact with cancer patients was not associated with greater degrees of burnout in this nurse sample. It's important to note, though, that it cannot be assumed that cancer patients necessarily have a poor prognosis for survival.

It can be assumed, however, that providing care to patients with poor prognosis for survival is physically and emotionally demanding. Therefore, the higher degree of exposure a nurse has to patients with poor prognosis the more vulnerable to the burnout syndrome s/he is likely to be. Examining this variable of professional exposure to patients with poor prognosis for survival as it interacts with support and coping resources will help
explain this variable's strength in predicting burnout.

Sex.

According to Maslach (1982), men and women are fairly similar in their experience of burnout. Essentially, men show slightly more of one aspect of burnout and women show slightly more of another. Women tend to experience more emotional exhaustion, and to experience it more intensely, than men. On the other hand, men are more likely to have depersonalized and callous feelings about clients. This variation may simply reflect differences in masculine and feminine sex roles. Because of these differences in the socialization of men and women, they may have different strengths and weaknesses with respect to burnout. To the extent that women are more likely to get emotionally involved with people, they run a greater risk of emotional fatigue. Similarly, to the extent that men are less oriented toward close contact with people, they are more prone to show signs of depersonalization.
**Age.**

Clearly there is a relationship between age and burnout (Maslach, 1982). Burnout is greatest when workers are young and lower for older workers. Younger people usually have less work experience than those who are older. Maslach notes that the old adage "older but wiser" seems to be the case here -- with increased age, people are more stable and mature, have a more balanced perspective on life and are less prone to the excesses of burnout. In addition, she explains that burnout is likely to happen in the first few years of one's career. If people have difficulty in dealing with burnout when they are younger and newer to the job, they may leave the profession entirely. Therefore, they are not around five or ten years later to answer questions about the emotional strain of their work. In other words, the older workers are the survivors, the ones who managed the early threat of burnout and stayed on to do well in their careers.

**Marital and Family Status.**

Burnout is also consistently related to marital and family status (Maslach, 1982). Single workers experience the greatest burnout, while those who are married experience the least. Those who are divorced are
closer to singles in terms of higher emotional exhaustion, but closer to the marrieds in terms of lower depersonalization and greater sense of personal accomplishment.

Being childless is also associated with a greater risk of burnout. Contrary to the notion that children are an additional emotional burden which should increase burnout, burnout is lower for professional helpers with families. Maslach points out several reasons why people with families may be less vulnerable to burnout: First, they tend to be older, more stable, mature individuals. Second, their involvement with their family makes them more experienced in dealing with problems and emotional conflicts. Third, a family is often an emotional resource rather than solely a drain. Finally, the person with a family may be more realistically concerned about job security, salary, and benefits and perhaps less idealistic, as compared to the childless worker who feels freer to change jobs rather than to tolerate difficult ones. Partial confirmation of Maslach's observations was reported by Yasko (1983). Examining burnout in oncology clinical nurse specialists, she found no correlation between marital status and burnout. However, she did find a low negative correlation of significance between number of children and degree of burnout. Perhaps the presence
of children, this researcher explained, prevents nurses from investing all their time and energy in the professional role, thus minimizing the expectation that the professional role will meet all their psychological needs. Additionally, if the nurse has children, these children may provide psychological support which may buffer the development of burnout.

**Education.**

People with different levels of education are not dramatically different from one another with respect to burnout. According to Maslach (1982), the differences found in their research are fairly consistent, but complex. Generally, the greatest amount of burnout is found in workers who have completed college but have not had any postgraduate training. Compared to workers who have had graduate education, workers with four-year degrees show the most depersonalization and the least personal accomplishment, and they tend to have more emotional exhaustion. Maslach and her colleagues (1982) also found a high degree of emotional exhaustion for professionals who had postgraduate training; although, on all other dimensions of burnout this group scores the lowest. Overall, they found less burnout for workers with less education, and in particular for those who have had
some college experience but not a full four years.

Maslach (1982) explains that the differences between these groups primarily reflect the emotional demands of their work and not simply their educational background. Education and occupation are interrelated. This may be the reason why the most highly trained helpers experience emotional exhaustion but not the other aspects of burnout. The nature of their jobs may cause greater emotional stress, but their training has equipped them to cope with it more successfully.

_Type of Facility._

Nurses care for patients with poor prognosis for survival in both acute care hospitals and nursing homes. The philosophies and goals which guide patient care differ widely in these two settings. However, no studies examining burnout have compared nurses who function in different types of care facilities. Given the differing values and natures of patient care between these two environments, this variable is presumed to impact upon the nurses' psychological responses to work.
Occupational Role:

Patients receive care from nurses at three levels of skill expertise and licensure: professional and paraprofessional. Professional includes registered nurses (RN), licensed practical nurses (LPN), while paraprofessional are certified nursing assistants (CNA). No study has addressed the possible differences in burnout between professional and paraprofessional staff. Tasks and ultimate responsibility for the patients vary among these groups. For example, professional staff are responsible for carrying out physician's orders and are directly responsible to the physician; paraprofessional staff provide less technical care for patients, e.g., bathing, serving meals, helping to the bathroom. Because of these differences in tasks, it is believed that burnout may vary by occupational role.

However, few LPNs are employed by either hospitals or nursing homes relative to RNs and CNAs. For that reason and because LPNs perform nearly identical patient care tasks as RNs, LPNs and RNs will be included in one group. The primary difference in patient care tasks is that LPNs do not administer intravenous medications as do RNs.
Shift.

Only one study was located which investigated job stress in nursing as it relates to shift. Parasuraman, Drake and Zammuto (1982) examined between-shift variations in job perceptions and job attitudes. They found that shift assignments accounted for significant differences in the perceived prominence of job stressors and in individuals' job attitudes. The results indicated that the second shift accounted for most of the variation in stressors of intershift problems, resource inadequacy and work overload. The greater reported magnitude of these three stressors from nurses on the second shift as compared to nurses on the first and third shifts may be attributed to the fact that staffing levels on the second shift are generally lower than on the first shift. Yet the level of nursing care required remains essentially the same. In addition, support services, such as laboratory testing, are sometimes unavailable after 5 p.m., contributing to the difficulty in role performance. The researchers concluded that these two factors, then, may account for the perceived prominence of such stressors as work overload and resource inadequacy.
Summary.

The review of literature assisted in developing a conceptual model for this study which illustrated how intrapersonal, interpersonal, and situational variables might interact to produce burnout in nursing staff. Burnout, as conceptualized by Maslach (1978), was investigated at six levels: emotional exhaustion-frequency, emotional exhaustion-intensity, depersonalization-frequency, depersonalization-intensity, reduced sense of personal accomplishment-frequency, and reduced sense of personal accomplishment-intensity.

The literature on nurses and burnout is, for the most part, descriptive and exploratory. A few carefully controlled research studies focusing on specific factors proposed to contribute to the burnout syndrome among registered nurses are available. These studies indicate that the type of patients for whom nurses care, the amount of time they spend working with terminally ill patients, the support they receive from coworkers and supervisors, and the coping strategies they use to manage job stress are important variables to consider in the study of burnout. In addition, demographic variables such as age, marital and family status, and shift also have been found to be related to nursing burnout. However, no studies have investigated the possible relationship between
burnout in nurses and fear of death, comfort working with patients with poor prognosis for survival, and informal support. Furthermore, studies examining for differences in burnout among the various occupational levels of the nursing staff, i.e., RN's, LPN's, and CNA's, and between acute and long-term care facilities were nonexistent.

This study, therefore, examined the following variables hypothesized to contribute to the burnout syndrome in nursing staff: **intrapersonal** (coping strategies, fear of death, and comfort working with patients with poor prognosis for survival), **interpersonal** (work environment support and informal support) and **situational** (professional exposure to patients with poor prognosis for survival, type of facility, occupational role, shift, hours per week worked, level of education, age, marital and family status).
III. METHOD

This study examined a model of factors expected to contribute to the burnout syndrome among nursing staff who work in acute care and long-term care facilities. Specifically, it examined the relationship between the dependent variables representing burnout and several independent variables: work and informal support, coping strategies, comfort with patients with a poor prognosis for survival, fear of death, work demographics (professional exposure to patients with poor prognosis for survival, shift, hours per week worked, level of education, type of facility, occupational role) and personal demographics (age, educational level, marital status and family status). It also examined for differences in caregivers' burnout, work support, coping strategies, and comfort with patients with poor prognosis for survival by occupational roles, types of facility, and professional exposure to patients with poor prognosis for survival.
SUBJECTS

Subjects were registered nurses, licensed practical nurses, and certified nursing assistants who worked in two types of facilities in Oregon's Mid-Willamette Valley: acute care hospitals and long-term care nursing homes. Because there are more certified nursing assistants than registered nurses working in nursing homes, registered nurses were oversampled from nursing homes. Therefore, more long term care facilities are included in the sample than acute care facilities.

The following facilities were requested to participate in this research study:

**Acute Care Hospitals:**
- Good Samaritan Hospital - Corvallis, OR
- Lebanon Community Hospital - Lebanon, OR
- Albany General Hospital - Albany, OR

**Long-term Care Nursing Homes:**
- Heart of the Valley Care Center - Corvallis, OR
- Corvallis Manor - Corvallis, OR
- Corvallis Care Center - Corvallis, OR
- Linn Care Center - Albany, OR
- Mennonite Home - Albany, OR
- Villa Cascade Nursing Home - Lebanon, OR
- Benedictine Nursing Center - Mt. Angel, OR
PROCEDURE

The Directors of Nursing Services and Administrators in ten facilities (three acute care hospitals and seven nursing homes) were contacted initially by mail (Appendix A). A follow-up phone call requesting an appointment with the Director of Nursing Services was made in order to answer questions and further discuss the study. During these appointments, consent for participation in the research study was given by all of the facilities. However, each facility's administrator was unwilling to release names and addresses of nursing staff. Therefore, random sampling was not possible.

Surveys were distributed to nursing employees by the Director of Nursing Services in each facility. With the exception of one facility which attached surveys to all nurses' timecards, all others placed a stack of surveys in the nurses' report rooms with a flyer announcing the study and requesting the participation of registered nurses, licensed practical nurses, and certified nursing assistants. Data were collected for a period of six weeks, from January 27 to March 10, 1986. In an effort to increase the response rate, flyers reminding staff to complete the questionnaire were posted
on all nursing units in each facility one week, two weeks and three weeks after the first distribution of surveys.

Survey questionnaires were coded before distribution according to facility. Respondents returned surveys to the researcher in a self-addressed, stamped envelope. Surveys were received by the researcher in three waves: the first (82.3%) wave was received within two weeks after they were first delivered; the second wave (14.2%) was received within two weeks after the first reminder flyer was posted; the third wave (3.5%) was received within two weeks after the final reminder flyer was posted.
INDEPENDENT VARIABLES

The independent variables examined in this study were the following:

1. Work Support
2. Informal support
3. Coping strategies used in response to work stress
   a) Instrumental/problem-focused
   b) Tension-Releasing
   c) Morale Maintaining
   d) Other-Directed
4. Fear of death
5. Comfort working with patients with poor prognosis for survival
6. Work Demographics
   a) Shift
   b) Hours per week generally worked
   c) Type of facility
   d) Occupational Role
   e) Professional exposure to patients with poor prognosis for survival
7. Personal Demographics
   a) Age
   b) Educational level
   c) Marital status
   d) Family status

MEASUREMENT OF INDEPENDENT VARIABLES

Work and Personal Demographic Variables.

Work and personal demographic variables were assessed with individual items on a questionnaire developed by the researcher (Appendix H). Professional exposure to patients with a poor prognosis for survival was measured by one question concerning amount of time spent caring for patients with a poor prognosis for survival (Appendix H). Type of facility was categorized
into two groups: 1) acute care hospitals and 2) long-term care nursing homes. **Occupational role** was categorized into two groups: 1) registered nurses and licensed practical nurses and 2) certified nursing assistants.

**Work Support.**

The quality of social relationships in the work environment was assessed with The Work Relationships Index (Appendix C). The Work Relationship Index is composed of three selected subscales of the Work Environment Scale (Moos, 1981; Moos & Insel, 1974) which assesses the individuals' perceptions of the social climate of their work environments on ten subscales. These three subscales comprise the relationship domain of the Work Environment Scale: Peer Cohesion - the extent to which workers are friendly and supportive of each other; Supervisor Support - the extent to which management is supportive of workers and encourages workers to be supportive of each other; and Involvement - the extent to which workers are concerned and committed to their jobs and are enthusiastic and constructive. Each of these subscales consists of nine true-false items, giving the WRI a total of 27 items. The WRI has a high internal consistency, Cronbach's alpha = .88 (Holahan & Moos, 1981).
At an item level, the WRI measures perceived quality of work environment with respect to its supportiveness (e.g., "Employees often talk to each other about their personal problems"). In addition, empirical evidence from numerous sources supports the construct validity of the WRI as a measure of social support. For example, the WRI is related to other indices of social support in the work environment, is predictive of psychological adjustment and has a moderating effect on psychological influence of work stressors on functioning (Billings & Moos, 1981).

Informal Support.

Support from friends and relatives was measured by five questions (Appendix D) which have been used in one previous study (Wright, 1985). These items assessed the size of informal support network, availability of support, degree of support, and satisfaction with that support. According to Gottlieb (1983), satisfaction is the most important variable in assessing the strength of an informal support system. Therefore, only the satisfaction item ("How satisfied are you with the support that you receive from these people?") was selected for analysis. Responses ranged from 1="not at all satisfied" to 5="very satisfied."
Coping Strategies

Coping behavior is conceptualized as the cognitive and behavioral efforts to manage specific external and/or internal demands that are perceived as stressful (Lazarus and Folkman, 1984). For the purposes of this study, coping behavior was conceptualized as the cognitive and behavioral efforts to manage specific job-related demands which are perceived as stressful. This variable was measured by the Jaloweic Coping Scale (Jaloweic, Murphy, & Powers. 1984, Appendix G) which is a multidimensional scale that has been factor analyzed into four distinct coping strategies: 1) instrumental or problem-focused, 2) tension releasing, 3) morale maintaining, 4) other directed. The scale has 40 items with a 1-5 range for Likert-type responses on frequency for using each strategy: 1=never, 2=rarely, 3=undecided, 4=often, 5=almost always.

A coefficient alpha of .86 was reported (Jaloweic, et al. 1984) for the scale which indicated overall homogeneity for the scale. The stability of the scale was indicated by a two-week test-retest interval which yielded a significant reliability coefficient of .79 for total coping scores. With a one-month interval coefficients were .78, .84, .83. respectively.

Factor analysis was performed on coping scale data using
141 subjects in order to examine construct validity. Ultimately, the four-factor solution provided the most sensible conceptual pattern with the least loss of information.

Fear of Death

Fear of death is operationally defined as an "emotional reaction involving subjective feelings of unpleasantness and concern based on contemplation and/or anticipation of any of the several facets related to death" (Hoeltein & Hoeltein, 1980). The Multidimensional Fear of Death Scale (Hoeltein, 1979, Appendix F) is a relatively new instrument and the most elaborate of the death fear scales (Wass & Forfar, 1982). It consists of 42 items assessing eight dimensions and yielding eight subscales which were derived through factor analysis: 1) fear of the dying process, 2) fear of the dead, 3) fear of being destroyed, 4) fear for significant others, 5) fear of the unknown, 6) fear of conscious death, 7) fear for the body after death, 8) fear of premature death. Likert-type responses ranged from 1-5: strongly disagree, disagree, neutral, agree and strongly agree. The mean reliability (internal consistency) coefficient for the total scale is .75 alpha and each subscale is a reliable
measure of a unique fear of death dimension: fear of the dying process = .80, fear for significant others = .76, fear of the unknown = .73, fear of premature death = .72 (Hoelter, 1980).

With regard to construct validity, theory suggests that fear of the unknown aspects of death is negatively related to religiosity, whereas other types of fear of death relate positively to religiosity. Four of the MFODS subscales had a significant positive correlation with religious orthodoxy: fear for significant others, fear of conscious death, fear of being destroyed, fear for the body after death. The fear of the unknown subscale had a strong negative relationship to religious orthodoxy (Hoelter, 1979). In addition, several subjects were interviewed after completing the scale to ensure they knew what was being measured. Of 35 interviews, all subjects agreed that the instrument measured the various aspects of what they perceived fear of death to be (written correspondence, Hoelter, 1985). Evidence concerning its discriminant validity has also been obtained. All eight of the subscales were differentiated from the Spielberger, et al (1970) Trait Anxiety Scale on the variable of "exposure to death of an immediate family member" (Hoelter, 1980).
In the interest of limiting the survey questionnaire to reasonable length, this study did not use all eight subscales of the MFODS. Four of the subscales were considered to be of greatest interest in studying nurses' fear of death in relation to burnout: fear of the dying process, fear of premature death, fear for significant others, fear of the unknown. Using these four dimensions, the scale consisted of 19 items.

**Comfort with Patients with a Poor Prognosis for Survival**

A review of the literature did not locate a scale which measured this variable. Therefore, a researcher-designed scale (Appendix I) was constructed and piloted with 25 nurses who did not participate in the research project. The six-question scale measures comfort of hospital and nursing home staff who care for patients who have a poor prognosis for survival. Likert-type responses range from 1-5 (1=very uncomfortable to 5=very comfortable) in providing various types of care and interaction with patients with poor prognosis for survival. Scores could range from 5-25. Cronbach alpha for reliability was utilized to assess the internal reliability of this scale, resulting in a coefficient of .95 on the pilot sample.
DEPENDENT VARIABLES

Burnout is defined as a syndrome of emotional exhaustion, depersonalization and reduced personal accomplishment that can occur among staff who do some kind of "people work" (Maslach, 1982). Burnout is not viewed as a dichotomous variable which is either present or absent. Rather, it is conceptualized as a continuous variable, ranging from low to moderate to high degrees of experienced feeling (Maslach, 1981). This construct was measured by the Maslach Burnout Inventory (Maslach & Jackson, 1981) which assessed the frequency and intensity of all three aspects of burnout: emotional exhaustion, depersonalization and personal accomplishment. Thus, this study utilized the following six dependent variables:

1. Emotional exhaustion (intensity)
2. Emotional exhaustion (frequency)
3. Depersonalization (intensity)
4. Depersonalization (frequency)
5. Personal accomplishment (intensity)
6. Personal accomplishment (frequency)

DEPENDENT VARIABLES INSTRUMENT

By using three separate subscales, the Maslach Burnout Inventory (MBI, Appendix I) assessed the various aspects of the burnout syndrome: emotional exhaustion, depersonalization, and lack of personal accomplishment. MBI items are written in the form of statements about
personal feelings or attitudes about work and clients. For this study of nurses the general term "recipients" was changed to "patients" to refer to the particular people for whom the nurse provides care. Each statement was rated on a frequency scale which ranged from 0 ("never") to 6 ("every day") and an intensity scale which ranged from 0 ("never") to 7 ("major, very strong"). The Emotional Exhaustion subscale assessed the nurse's feelings of being emotionally overextended and exhausted by work. The Depersonalization subscale measured an unfeeling and impersonal response towards patients under the nurse's care. The Personal Accomplishment subscale assessed feelings of competence and achievement in the nurse's work with people.

A high degree of burnout was reflected in high scores on the Emotional Exhaustion and Depersonalization subscales and in low scores on the Personal Accomplishment subscale. A moderate degree of burnout was reflected in moderate scores on the three subscales. A low degree of burnout was reflected in low scores on the Emotional Exhaustion and Depersonalization subscales and in high scores on the Personal Accomplishment subscale. Maslach has advised that because our knowledge about the relationships between the three aspects of burnout is limited, the scores for each subscale should be considered
separately and not combined into a single total scores (Maslach & Jackson, 1981).

For each subscale reliability coefficients estimated by Cronbach's coefficient alpha have been reported by Maslach & Jackson (1981) as the following: .90 for Emotional Exhaustion, .79 for Depersonalization, and .71 for Personal Accomplishment. In a study of test-retest reliability (Maslach and Jackson, 1981) data on the MBI were obtained from a sample of graduate students in social welfare, and administrators in a health agency (n=53). The two test sessions were separated by an interval of 2-4 weeks. Test-retest reliability coefficients for the subscales were the following: .82 for Emotional Exhaustion, .60 for Depersonalization, and .80 for Personal Accomplishment. Although these coefficients range from low to moderately high, all are reported as significant beyond the .001 level.

Convergent validity was demonstrated in three ways (Maslach and Jackson, 1981). First, MBI scores were correlated with behavioral ratings made independently by a person who knew the individual well. Second, MBI scores were correlated with the presence of certain job characteristics that were expected to contribute to experienced burnout. Third, MBI scores were correlated with measures of various outcomes that had been
hypothesized to be related to burnout.

External validation of personal experience was provided by a group of 40 mental health workers who were each asked to provide an anonymous behavioral evaluation of a designated coworker who had also completed the MBI (Maslach and Jackson, 1981). As predicted, people who were rated by the coworker as being emotionally drained by the job scored higher on Emotional Exhaustion and Depersonalization. Furthermore, people who were rated as appearing physically fatigued also scored higher on Emotional Exhaustion and Depersonalization. The predicted correlation between coworker ratings of the individual's satisfaction with the job and scores on Personal Accomplishment failed to achieve statistical significance.

The validity of the MBI was further demonstrated by data that confirmed hypotheses about the relationships between various job characteristics and experienced burnout (Maslach & Pines, 1977) and data that confirmed hypothetical relationships between experienced burnout and various outcomes or personal reactions (Maslach, 1976). Finally, the MBI has discriminant validity which was obtained by distinguishing it from measures of other psychological constructs that might be presumed to be confounded with burnout. For example, it was possible that the experience of burnout was nothing more than the
experience of dissatisfaction with the job. Although it would be expected that the experience of burnout would have some relationship to lowered feelings of job satisfaction, it was predicted that they would not be so highly correlated as to suggest that they were actually the same. A comparison of subjects' scores on the MBI and the a measure of "general job satisfaction" provided support for this reasoning. Job satisfaction had a moderate negative correlation with both Emotional Exhaustion and Depersonalization, as well as a slightly positive correlation with Personal Accomplishment. However, because than 6% of the variance was accounted for by any one of the correlations, the notion that burnout was a synonym for job dissatisfaction was rejected (Maslach & Jackson, 1981).
DATA ANALYSIS

The Statistical Package for the Social Sciences X (SPSSX) was used to analyze all data. Cronbach's coefficient alpha for reliability was utilized to assess the reliability of all instruments utilized in this study: Work Relationships Index = .88, Multidimensional Fear of Death Scale = .85, Comfort Scale = .87, Jalowiec Coping Scale = .72, Maslach's Burnout Inventory = .87.

The data were analyzed to determine the relationship between the dependent variables representing burnout and the following independent variables: 1) professional exposure to patients with poor prognosis for survival, 2) work support, 3) informal support, 4) coping strategies (instrumental/problem-oriented, tension-releasing, morale maintaining, other directed), 5) fear of death, 6) comfort with patients with poor prognosis for survival and 7) work demographics (type of facility, occupational role, shift, hours per week worked) and 8) personal demographics (age, educational level, marital status and family status).

Descriptive statistics were generated by the initial data analysis. The specific data analysis procedures utilized to examine each research question are described as follows:
Research Question #1.

Are there significant differences in the six aspects of burnout (emotional exhaustion-frequency, emotional exhaustion-intensity, depersonalization-frequency, depersonalization-intensity, personal accomplishment-frequency, personal accomplishment-intensity) by occupational role (registered or licensed practical nurses and certified nursing assistants)?

Are there significant differences in the six aspects of burnout by caregivers' type of facility (acute care facility and long-term care facility)?

Are there significant differences in the six aspects of burnout by caregivers' degrees of professional exposure to patients with poor prognosis for survival (low, medium and high)?

This research question was answered using a 2 x 2 x 3 Multivariate Analysis of Variance. The MANOVA tested the equality of means using a multivariate F-value. If the multiple F-value was significant, univariate F-tests were examined to determine if there were significant differences when the dependent variables were considered
In univariate F-tests, ANOVA's are performed on single dependent variables which had been adjusted to remove the effects of the other dependent variables (Fink & Kosecoff, 1978). The F-statistic is derived mathematically by dividing the total variation in the dependent variable into components and then comparing different estimates of the variance components with one another. The F-statistic will be smaller if the estimates are similar. If the estimates are not similar, however, then the F-value will be a large number and the null hypothesis can be rejected. When a F-test for an independent variable which is being studied at more than two levels leads to the rejection of the hypothesis of equality of means, all that is certain is that one group's mean is different.

In this study when the F-test revealed that one group's mean was significantly different from the others, post-hoc tests (Fink and Kosecoff, 1978) were conducted to determine which group's mean was significantly different. Specifically, the Neuman-Keuls test and the Duncan test were used to determine which group was significantly different from the others.
Research Question #2.

Are there differences among caregivers' work support, coping strategies, fear of death and comfort in working with patients with poor prognosis for survival by types of facilities, occupational role, and degrees of professional exposure to patients with poor prognosis for survival?

This question also was addressed by Multivariate Analysis of Variance using a 2 x 2 x 3 factorial design.

Research Question #3.

Of the following variables (professional exposure to patients with poor prognosis for survival, work support, informal support, coping strategies, fear of death, comfort working with patients with poor prognosis for survival, personal and work demographics) which are the significant predictors of the six aspects of burnout in professional caregivers?

This question was answered by a series of multiple regression analyses. Multiple regression analyses examine the effects and the magnitudes of the
effects of more than one independent variable on one
dependent variable. From the knowledge of the values of
two or more independent variables, it is possible to
predict to a dependent variable (Kerlinger, 1973).

Because reality must be reduced to manageable
proportions whenever a model is constructed, only a
limited number of independent variables can be included in
a regression model for any situation of interest. The
central problem is that of choosing, for a regression
model, a set of independent variables which is "good" for
the purposes of the analysis. A major consideration in
making this decision is the extent to which a chosen
variable contributes to reducing the remaining variation
in Y after allowance is made for the contributions of
other independent variables that have tentatively been
included in the model.

Stepwise regression is an automatic search
procedure that develops sequentially the subset of
independent variables to be included in the regression
model. This procedure was developed to economize on
computational efforts as compared with the
all-possible-regressions approach, while still arriving at
a reasonably "good" subset of independent variables.
Essentially, this method develops a sequence of regression
models, at each step adding or deleting an independent
variable. The criterion for adding or deleting an independent variable can be stated in terms of the $F$ statistic (Neter, Wasserman & Kutner, 1983). Stepwise regression was utilized to determine which of the independent variables in this study were significant predictors of the six aspects of burnout in professional caregivers.

RESTATEMENT OF PURPOSE

This study tested a model of the major factors hypothesized to contribute to the burnout syndrome in nurses in acute care and long-term care facilities. Additionally, it examined for differences in several work related, personal and demographic variables between registered/licensed practical nurses, and certified nursing assistants who worked in hospitals and nursing homes and who had varying degrees of exposure to patients with poor prognosis for survival. The research findings will further knowledge of burnout in the field of nursing and hopefully will contribute to the development of preventative measures and interventions.
IV. RESULTS

A total of 600 surveys were distributed to ten health care facilities located in the Mid-Willamette Valley of Oregon; 312 were returned, representing a 52% response rate. One hundred fifty-six surveys were received from acute care facilities and 156 from long-term care facilities.

SAMPLE

The sample was 94% female with a mean age of 37. Sixty-two percent of the subjects were married; 20% were single, 13% divorced, 2% separated, and 3% widowed. Sixty-six percent had at least one child. Subjects had been working at their current facility an average of five years and had been in the field of nursing an average of 11 years. Of the total sample, 7% were registered nurses in administration, 55% staff registered nurses, 8% licensed practical nurses, and 34% certified nursing assistants. Registered nurses, both staff and administrators, and licensed practical nurses were pooled for all further analyses.
Of respondents who worked in acute care facilities, 146 were licensed nurses and 10 were certified nursing assistants. For these 156 respondents who worked in acute care facilities, eight specific units were represented as follows:

- General medical: 24%
- Intensive care/coronary care: 21%
- Operating room/recovery room: 11%
- Emergency room: 10%
- Oncology: 9%
- Other: 8%
- Gynecology/obstetrics: 7%
- Newborn nursery: 7%
- Pediatrics: 3%

Of respondents who worked in long-term care facilities, 57 were registered/licensed nurses and 96 were certified nursing assistants. (Three respondents did not report occupational status.)

Of the total sample, 52% worked the day shift (7:00 a.m. to 3:30 p.m.), 31% worked evening shift (3:00 p.m. to 11:30 p.m.) and 17% worked night shift (11:00 p.m. to 7:30 a.m.). Forty-three percent worked a full 40-hour week while 49% worked less than 40 but more than 20 hours, and 8% worked less than 20 hours per week. Five levels
of education were represented in this sample: 5% of the nurses had not completed high school; 28% were high school graduates; 36% held either an Associate of Arts Degree or a nursing diploma from a three-year program; 23% held a Bachelor's Degree, and 8% held a graduate degree.

Nurses reported spending varying amounts of time working with patients who had poor prognosis for survival, i.e., responses ranged from "1 = never" to "9 = eight to nine hours per work day". Responses 1 ("never") through 3 ("32 to 60 minutes") were categorized as low exposure to patients with poor prognosis; 4 ("between 1 and 2 hours") through 6 ("between 4 and 5 hours") were categorized as moderate exposure, and 7 ("between 5 and 6 hours") through 9 ("over 7 hours") were categorized as high exposure to patients with poor prognosis. Forty-four percent of the nurses had low exposure; 42% had moderate exposure and 14% had high exposure to patients with poor prognosis for survival.

Asked on a bipolar scale of 1 to 5 how likely they believe it is that they will be in the field of nursing five years from now, 18% believed it is unlikely (1-2) while 65% believed it is likely (4-5). The remaining fell into the middle of the scale.
Forty-nine percent described themselves as strongly committed to their spiritual beliefs while 8% described themselves as uncommitted. The remaining 43% were slightly committed, fairly committed or undecided.
Research Question #1.

Are there significant differences in the six aspects of burnout (emotional exhaustion-frequency, emotional exhaustion-intensity, depersonalization-frequency, depersonalization-intensity, personal accomplishment-frequency, personal accomplishment-intensity) by occupational role, type of facility, and degrees of professional exposure to patients with poor prognosis for survival?

This research question was answered using a 2 x 2 x 3 Multivariate Analysis of Variance test. That is, the dependent variables (six aspects of burnout) were examined by facility (hospital and nursing home), occupation (registered/licensed nurses and certified nursing assistants), and professional exposure to patients with poor prognosis for survival (low, medium and high). The MANOVA tests equality of means using a multivariate F-value. When the multiple F-value is significant, univariate F-tests determine if there are significant differences when the dependent variables are considered separately.
A significant multiple F main effect ($p < .001$) was found by occupation (Table 1). Univariante F-tests showed that emotional exhaustion-frequency ($F = 5.07, df = 1,276, p < .05$) and depersonalization-frequency ($F = 7.63, df = 1, 276, p < .01$) were significantly different by occupation. That is, certified nursing assistants more frequently felt emotionally overextended and exhausted by their work ($M = 25.6, s.d. = 12.5$) than registered/licensed nurses ($M = 22.8, s.d. = 11.3$) (Table 4). In addition, certified nursing assistants more frequently experienced an unfeeling and impersonal response towards patients in their care ($M = 8.9, s.d. = 7.2$) than registered/licensed nurses ($M = 7.1, s.d. = 5.4$) (Table 4).

A significant multiple F main effect ($p < .05$) was also found by facility (Table 2). However, the univariate tests showed no significance for any of the measures of burnout except at the trend level for emotional exhaustion-frequency ($F = 3.09, df = 1,276, p < .10$). That is, nurses working in long-term care facilities appeared to experience emotional exhaustion more frequently than nurses working in acute care.
TABLE 1

Multivariate Tests of Significance for Six Dimensions of Burnout

Effect of Occupation

<table>
<thead>
<tr>
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<th>Err df</th>
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## TABLE 2

Multivariate Tests of Significance for Six Dimensions of Burnout

<table>
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<th>Test Name</th>
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facilities (long-term care facilities, $M = 25.3$, $s.d. = 12.6$ acute care facilities, $M = 22.0$, $s.d. = 10.5$) (Table 4).

No significant multiple F main effects were found by exposure to patients with poor prognosis for survival (Table 3). Also no interaction effects are reported because the small number of certified nursing assistants in acute care facilities ($n = 10$) makes interpretation of the results questionable.
### TABLE 3

Multivariate Tests of Significance for Six Dimensions of Burnout

#### Effect of Exposure

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<tr>
<th>Test Name</th>
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### TABLE 4

Means, Standard Deviations and Significant Univariate F-Ratios for Six Aspects of Burnout
By Occupation, Facility and Exposure to Patients with Poor Prognosis for Survival (N=312)

<table>
<thead>
<tr>
<th>Variable</th>
<th>Occupation</th>
<th>Facility</th>
<th>Exposure</th>
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<tr>
<td></td>
<td>RN/LPN</td>
<td>CNA</td>
<td>Long</td>
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<tr>
<td>Emotional Exhaustion-Frequency</td>
<td>M 22.8</td>
<td>25.6</td>
<td>5.07*</td>
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<tr>
<td></td>
<td>SD 11.3</td>
<td>12.5</td>
<td>10.5</td>
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<tr>
<td>Emotional Exhaustion-Frequency</td>
<td>M 33.3</td>
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<td>ns</td>
</tr>
<tr>
<td></td>
<td>SD 11.9</td>
<td>13.4</td>
<td>11.7</td>
</tr>
<tr>
<td>Depersonalization-Frequency</td>
<td>M 7.1</td>
<td>8.9</td>
<td>7.63**</td>
</tr>
<tr>
<td></td>
<td>SD 5.4</td>
<td>7.2</td>
<td>4.8</td>
</tr>
<tr>
<td>Depersonalization-Frequency</td>
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<td>ns</td>
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<tr>
<td></td>
<td>SD 7.9</td>
<td>8.0</td>
<td>7.8</td>
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<tr>
<td>Personal Accomplishment-Frequency</td>
<td>M 31.7</td>
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<td>ns</td>
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<tr>
<td></td>
<td>SD 6.7</td>
<td>7.4</td>
<td>6.4</td>
</tr>
<tr>
<td>Personal Accomplishment-Frequency</td>
<td>M 34.5</td>
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<tr>
<td></td>
<td>SD 6.8</td>
<td>8.6</td>
<td>6.5</td>
</tr>
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</table>

*p \( \leq .05\)  **p \( \leq .01\)
Research Question #2.

Are there differences among caregivers' work support, coping strategies, fear of death and comfort in working with patients with poor prognosis for survival by type of facility, occupational role, and degrees of professional exposure to patients with poor prognosis for survival?

This research question was also answered using a 2 x 2 x 3 Multivariate Analysis of Variance test. The dependent variables work support, coping strategies (instrumental, tension-releasing, morale maintaining, and other-directed), fear of death and comfort in working with patients with poor prognosis for survival were examined by type of facility, occupational role and degrees of professional exposure to patients with poor prognosis for survival.

A significant multivariate main effect (p < .001) was found by professional exposure to patients with poor prognosis for survival (Table 5). Univariate F tests examining coping strategies revealed that instrumental coping (F = 3.99, df = 2, 239, p < .05) and tension-releasing coping (F = 4.09, df = 2, 239, p < .05) were significantly different by exposure to patients with
## TABLE 5

Multivariate Tests of Significance for Work Environment Support, Instrumental Coping, Tension-Releasing Coping, Morale Maintaining Coping, Other-Directed Coping, Fear of Death and Comfort with Patients with Poor Prognosis for Survival

**Effect of Exposure**

<table>
<thead>
<tr>
<th>Test Name</th>
<th>Value</th>
<th>Approx. F</th>
<th>Hyp df</th>
<th>Err df</th>
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<td>Wilks</td>
<td>.83629</td>
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<td>466.00</td>
<td>.0001</td>
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</table>
poor prognosis for survival. Instrumental coping referred to behaviors such as trying to maintain some control over the situation and looking at the problem objectively. Tension-releasing coping referred to such behaviors as eating, getting nervous, worrying, cursing, and crying.

The Newman Keuls test and the Duncan test (p < .05) revealed that nurses who had moderate exposure to patients with poor prognosis for survival used significantly more instrumental strategies (M = 42.6, s.d. = 5.4) to cope with their jobs than those with high or low exposure (M = 42.8, s.d. = 5.0, M = 41.0, s.d. = 5.8, respectively). On the other hand, nurses who had high exposure used significantly more tension-releasing strategies (M = 40.2, s.d. = 6.5) to cope with their jobs than those with low or moderate exposure (M = 36.6, s.d. = 6.9 and M = 37.5, s.d. = 7.1, respectively).

Furthermore, the univariate F test found that comfort working with patients with poor prognosis for survival was significantly different by professional exposure to patients with poor prognosis (F = 6.70, df = 2, 239, p < .001). That is, nurses with moderate and high exposure are significantly more comfortable working with patients with poor prognosis for survival (M = 25.7, s.d. = 4.5 and M = 26.6, s.d. = 3.8, respectively) than those with low exposure (M = 24.1, s.d. = 5.0). In other words,
nurses who spend the least time with patients with poor prognosis appear to be less comfortable with such patients compared to those nurses who spend more time.

A significant multivariate main effect (p < .001) was also found for occupational role (Table 6). Univariate F tests revealed that certified nursing assistants and registered/licensed nurses were significantly different in work support (F = 14.86, df = 1, 239, p < .001), tension-releasing coping (F = 4.56, df = 1, 239, p < .05), other-directed coping (F = 5.77, df = 1, 239, p < .05) and comfort with patients with poor prognosis for survival (F = 7.76, df = 1, 239, p < .01). Registered/licensed nurses perceived greater support from their work environments (M = 17.6, s.d. = 5.9) than certified nursing assistants (M = 14.7, s.d. = 6.0) (Table 8). In addition registered/licensed nurses used significantly more tension-releasing (M = 37.9, s.d. = 6.6) and other-directed coping strategies (M = 9.5, s.d. = 1.5) than did certified nursing assistants (M = 36.0, s.d. = 7.9 and 9.0, s.d. = 1.6, respectively). Other-directed coping referred to behaviors such as seeking comfort from family and friends and letting someone else solve the problem. Finally, registered/licensed nurses reported greater comfort in working with patients with poor prognosis for
<table>
<thead>
<tr>
<th>Test Name</th>
<th>Value</th>
<th>Approx. F</th>
<th>Hyp df</th>
<th>Err df</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pillais</td>
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<td>7.00</td>
<td>233.00</td>
<td>.0001</td>
</tr>
<tr>
<td>Hotellings</td>
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<td>233.00</td>
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<tr>
<td>Wilks</td>
<td>.83100</td>
<td>6.76953</td>
<td>7.00</td>
<td>233.00</td>
<td>.0001</td>
</tr>
<tr>
<td>Roys</td>
<td>.16900</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
survival (M = 25.9, s.d. = 4.4) than did certified nursing assistants (M = 23.9, s.d. = 5.0) (Table 8).

No significant main effect was found for work environment support, coping strategies, fear of death or comfort with patients with poor prognosis for survival by facility (Table 7).
TABLE 7

Multivariate Tests of Significance for Work Environment Support, Instrumental Coping, Tension-Releasing Coping, Morale Maintaining Coping, Other-Directed Coping, Fear of Death and Comfort with Patients with Poor Prognosis for Survival

Effect of Facility

<table>
<thead>
<tr>
<th>Test Name</th>
<th>Value</th>
<th>Approx. F</th>
<th>Hyp df</th>
<th>Err df</th>
<th>p</th>
</tr>
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<td>.263</td>
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<td>Wilks</td>
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<td>7.00</td>
<td>233.00</td>
<td>.263</td>
</tr>
<tr>
<td>Roys</td>
<td>.03691</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Variable</td>
<td>Occupation</td>
<td>Facility</td>
<td>Exposure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------------------</td>
<td>------------</td>
<td>----------</td>
<td>----------</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>RN/LPN</td>
<td>CNA</td>
<td>Long</td>
<td></td>
<td>Long</td>
</tr>
<tr>
<td>Work Environment Support</td>
<td>M 17.6</td>
<td>14.7</td>
<td>14.86***</td>
<td>17.0</td>
<td>16.2</td>
</tr>
<tr>
<td>Instrumental Coping</td>
<td>M 42.2</td>
<td>41.3</td>
<td>ns</td>
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<td>41.7</td>
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<tr>
<td>Morale Maintaining Coping</td>
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<td>ns</td>
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<tr>
<td>Tension- Releasing Coping</td>
<td>M 37.9</td>
<td>36.0</td>
<td>4.56*</td>
<td>37.8</td>
<td>36.7</td>
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<tr>
<td>Other- Directed Coping</td>
<td>M 9.5</td>
<td>9.0</td>
<td>5.77*</td>
<td>9.5</td>
<td>9.1</td>
</tr>
<tr>
<td>Fear of Death</td>
<td>M 59.0</td>
<td>58.0</td>
<td>ns</td>
<td>59.5</td>
<td>57.8</td>
</tr>
<tr>
<td>Comfort with Patients w/</td>
<td>M 25.9</td>
<td>23.9</td>
<td>7.76**</td>
<td>25.5</td>
<td>24.8</td>
</tr>
<tr>
<td>Poor Prognosis for Survival</td>
<td>SD 4.4</td>
<td>5.0</td>
<td>4.5</td>
<td>4.9</td>
<td>5.0</td>
</tr>
</tbody>
</table>

*p < .05  **p < .01  *** p < .001
Research Question #3.

Of the following variables (work support, informal support, coping strategies, fear of death, comfort working with patients with poor prognosis for survival, work and personal demographics) which are the significant predictors of the six aspects of burnout in professional caregivers in acute care and long-term care facilities?

This question was answered by a series of stepwise multiple regression analyses done on the six outcome variables (emotional exhaustion-frequency and intensity; depersonalization-frequency and intensity; personal accomplishment-frequency and intensity) which examined the effects and the magnitudes of the effects of the following independent variables on each of the six aspects of burnout:

- Work Environment Support
- Informal Support
- Fear of Death
- Instrument/problem-focused coping
- Tension-releasing coping
- Morale maintaining coping
Other-directed coping
Comfort working with patients with poor prognosis for survival

Work demographics (entered into the regression equation as a block) including
- shift hours per week worked
- exposure to patients with poor prognosis
- facility (acute care and long-term care)
- occupational role (registered/licensed nurses and certified nursing assistants)

Personal demographics (entered into the regression equation as a block) including
- age
- educational level
- family status
- marital status

Altogether Work Environment Support, Tension-Releasing Coping and Informal Support accounted for 46% of the variance in Emotional Exhaustion-Frequency (Table 9). Work Environment Support was a negative predictor of Emotional Exhaustion-Frequency. As Work Environment Support increased, Emotional Exhaustion-Frequency decreased. Thirty percent of the variance in Emotional Exhaustion-Frequency was accounted for by Work Environment Support scores. Taken with Work Environment Support, Tension-Releasing Coping accounts for an additional 13% of variance in Emotional Exhaustion-Frequency. The final significant predictor was
### TABLE 9

**Stepwise Regression for Emotional Exhaustion-Frequency**

<table>
<thead>
<tr>
<th>Step</th>
<th>Entering Variable</th>
<th>B</th>
<th>RSQ</th>
<th>F</th>
<th>df</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
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<td>-1.05771</td>
<td>.30399</td>
<td>108.75</td>
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<tr>
<td>2</td>
<td>Tension-Releasing Coping</td>
<td>+.61255</td>
<td>.43646</td>
<td>96.04</td>
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<td>.0001</td>
</tr>
<tr>
<td>3</td>
<td>Informal Support</td>
<td>-1.73750</td>
<td>.45543</td>
<td>8.35</td>
<td>1</td>
<td>.0037</td>
</tr>
</tbody>
</table>
Informal Support which added 19% to the variance. No other variables were significant predictors of emotional exhaustion-frequency.

Altogether Tension-Releasing Coping, Work Environment Support, Instrumental/Problem-Focused Coping, and Informal Support accounted for 43% of the variance in Emotional Exhaustion-Intensity (Table 10). Tension-Releasing Coping (such as eating, smoking, getting nervous, worrying, cursing, crying) was the best positive predictor of Emotional Exhaustion-Intensity. That is, as Tension-Releasing Coping increased, Emotional Exhaustion-Intensity also increased. Twenty-eight percent of the variance in Emotional Exhaustion-Intensity was accounted for by Tension-Releasing Coping scores. Work Environment Support was a negative predictor of Emotional Exhaustion-Intensity, contributing another 13% to the variance. Taken together with Tension-Releasing Coping and Work Environment Support, Instrumental/Problem-Focused Coping, a negative predictor of Emotional exhaustion-Intensity, and Informal Support, a positive predictor, each added another .90% to the variance. The direction of Instrumental Coping in its relationship to Emotional Exhaustion-Intensity was unexpected and the opposite of Instrumental Coping as it was related to the other dependent variables. However, because it
TABLE 10
Stepwise Regression for Emotional Exhaustion-Intensity

<table>
<thead>
<tr>
<th>Step</th>
<th>Entering Variable</th>
<th>B</th>
<th>RSQ</th>
<th>F</th>
<th>df</th>
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</thead>
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<td>2</td>
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<td>3</td>
<td>Instrumental Coping</td>
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<td>.0446</td>
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<tr>
<td>4</td>
<td>Informal Support</td>
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<td>.4339</td>
<td>3.98</td>
<td>1</td>
<td>.0472</td>
</tr>
</tbody>
</table>
contributed only a small amount to the combined variance, this unexpected direction was not considered to be critical.

Altogether Tension-Releasing Coping, Work Environment Support, Instrumental/Problem-focused coping and Fear of Death accounted for 33% of the variance in Depersonalization-Frequency (Table 11). Again, Tension-Releasing Coping significantly positively predicted Depersonalization-Frequency scores, accounting for 16.5% of the variance in Depersonalization-Frequency scores. Work Environment Support was a negative predictor, accounting for an additional 10% of the variance in Depersonalization-Frequency scores when taken together with Tension-Releasing Coping. A third significant negative predictor of Depersonalization-Frequency was Instrumental/Problem-Focused Coping which added another 4% to the variance. The final significant positive predictor was Fear of Death which added 2% to the variance of Depersonalization-Frequency.

Tension-Releasing Coping, Work Environment Support, Instrumental Coping, and Personal Demographics accounted for 27% of the variance in Depersonalization-Intensity (Table 12). Tension-Releasing Coping strategies significantly positively predicted Depersonalization-Intensity, accounting for 13% of the
### TABLE 11

**Stepwise Regression for Depersonalization-Frequency**

<table>
<thead>
<tr>
<th>Step</th>
<th>Entering Variable</th>
<th>B</th>
<th>RSQ</th>
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<tr>
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<td>Support</td>
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<tr>
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<td>.0005</td>
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</tr>
<tr>
<td>4</td>
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<td>7.43</td>
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</table>
TABLE 12

Stepwise Regression for Depersonalization-Intensity

<table>
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<tr>
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<th>Entering Variable</th>
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<th>RSQ</th>
<th>F</th>
<th>df</th>
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<tr>
<td></td>
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<td>2</td>
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</tr>
<tr>
<td>4</td>
<td>Personal Demographics</td>
<td></td>
<td>.2746</td>
<td>1.93</td>
<td>10</td>
<td>.0428</td>
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</tbody>
</table>
variance in Depersonalization-Intensity scores. Work Environment Support was a significant negative predictor, accounting for an additional 7% of the variance in Depersonalization-Intensity scores when taken together with Tension-Releasing Coping. Instrumental/Problem-Focused Coping was also a negative predictor, accounting for 1.6% of the variance in Depersonalization-Intensity. The final significant predictor was the block of Personal Demographics (age, educational level, marital and family status) which accounted for an additional 5.9% of the variance.

Taken together, Instrumental/Problem-Focused Coping, Comfort, Tension-Releasing Coping and Work Environment Support accounted for 30.6% of the variance in Personal Accomplishment-Frequency (Table 13). In interpreting this regression for Personal Accomplishment, it is important to recall that high burnout is reflected in low scores in Personal Accomplishment-Frequency. Conversely, low burnout is reflected in high scores in Personal Accomplishment-Frequency. High scores in Personal Accomplishment-Frequency were positively associated with Instrumental/Problem-Focused Coping, accounting for 20% of the variance in Personal Accomplishment-Frequency. That is, the more respondents reported relying on instrumental/problem-focused coping
<table>
<thead>
<tr>
<th>Step</th>
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<tr>
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<td>.3062</td>
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<td>1</td>
<td>.0192</td>
</tr>
</tbody>
</table>
strategies, the more frequently they felt greater sense of personal accomplishment and lower sense of burnout. Comfort with patients with poor prognosis for survival contributed an additional 5% of the variance in Personal Accomplishment—Frequency and Work Environment Support added another 1.6% of the variance. High scores on Personal Accomplishment—Frequency were negatively associated with Tension-Releasing Coping, accounting for 3.7% of the variance.

High scores on Personal Accomplishment—Intensity were positively associated with only one significant predictor — Instrumental/Problem-Focused Coping. Again, as nurses more intensely felt a greater sense of personal accomplishment, the more they relied on Instrumental/problem-focused coping strategies. This variable accounted for 13% of the variance for Personal Accomplishment—Intensity (Table 14).
TABLE 14

Stepwise Regression for Personal Accomplishment-Intensity

<table>
<thead>
<tr>
<th>Step</th>
<th>Entering Variable</th>
<th>B</th>
<th>RSQ</th>
<th>F</th>
<th>df</th>
<th>P-Value</th>
</tr>
</thead>
<tbody>
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<td>36.77</td>
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<td>.0001</td>
</tr>
</tbody>
</table>
V. DISCUSSION

The purpose of this study, which utilized a sample of 312 registered nurses, licensed practical nurses and certified nursing assistants, was to examine a model of factors which were expected to impinge upon burnout in professional and paraprofessional caregivers in acute care facilities and long-term care facilities. This model included interpersonal, intrapersonal and situational factors. In addition, the study examined differences in the six dimensions of burnout, work support, coping strategies, and comfort with patients with poor prognosis for survival by occupational roles, types of facilities and professional exposure to patients with poor prognosis for survival. The study utilized the Maslach Burnout Inventory, the Work Relationship Index developed by Moos and Insel, the Multidimensional Fear of Death Scale developed by Hoelter, the Jallowiec Coping Scale and a researcher-designed scale to measure comfort working with patients with poor prognosis for survival. A discussion of the results and recommendations for future research and practice are presented here.
FACTORS MOST PREDICTIVE OF THE SIX DIMENSIONS OF BURNOUT

Interpersonal, intrapersonal and situational factors identified in the model were expected to predict burnout in professional and paraprofessional nursing staff. Specific variables included within these three factors were hypothesized to contribute to the burnout syndrome. The variables were as follows: interpersonal (work environment support and informal support) intrapersonal (coping strategies, fear of death and comfort working with patients with poor prognosis for survival); and situational (work demographics = type of facility, occupational role, professional exposure to patients with poor prognosis for survival, shift and hours worked per week; personal demographics = age, level of education, marital status and family status).

Results revealed that the variables of primary importance in predicting burnout were Work Environment Support, Tension-Releasing Coping, and Instrumental/Problem-Focused Coping. Together these variables predicted four of the six dimensions of burnout. Those variables of secondary importance in predicting burnout in nursing staff were Comfort Working with Patients with Poor Prognosis for Survival, Informal
Support, Fear of Death, and Personal Demographics.

Although, these variables never appeared all together in predicting any one dimension of burnout, one of four secondary variables appeared in five of the six dimensions of burnout. Therefore, the final model is illustrated in Figure 2.
Figure 2. Final Model

PREDICTORS OF BURNOUT

INTRAPERSONAL

Primary
Tension-Releasing Coping
Instrumental/Problem-Focused Coping

Secondary
Comfort with Patients with Poor Prognosis for Survival
Fear of Death

INTERPERSONAL

Primary
Work Environment Support

Secondary
Informal Support

SITUATIONAL

Secondary
Personal Demographics:

age
educational level
marital status
family status
Interpersonal.

Of the interpersonal variables, work environment support was a primary predictor of burnout while informal support was a secondary predictor. Work Environment Support negatively predicted all dimensions of burnout with the exception of personal accomplishment-intensity. Informal Support, i.e., satisfaction with support from family and friends, negatively predicted two dimensions of burnout: the frequency and intensity of emotional exhaustion. Results from this study were consistent with other studies which suggested that lack of support at work or from family and friends enhances nursing staffs' vulnerability to burnout (Constable 1983; Duxbury, Armstrong, Drew & Henly, 1984; Cronin-Stubbs, 1985).

Because of the cross-sectional design of the study, it is not possible to determine the direction of the relationship between burnout and work environment support. It is possible that burnout among staff reduces the quality of the work environment social climate. According to Maslach (1982), once individuals have succumbed to the emotional exhaustion resulting from their jobs, they feel unable to give of themselves; consequently, they respond by limiting their involvement with other people. Such withdrawal would potentially
affect not only the nurses' relationships with their patients, but also their relationships with coworkers. The majority of nurses in this sample suffered a moderate degree of emotional exhaustion. Such emotional exhaustion may have contributed to the work environment, reducing supportive relationships. In other words, burnout and work environment may reciprocally influence one another. The following example may illustrate this possible reciprocal relationship. Overwhelmed by the demands of their jobs, supervisors inadequately support their staff nurses. Inadequately supported by their supervisors and strained by the work itself, staff nurses become less cohesive. As they become emotionally overextended by their work and the social climate becomes less supportive, nurses gradually withdraw, reducing their involvement with their jobs. Thus, reduced supervisor support, peer cohesion, and involvement with work (the three dimensions of Work Environment Support) would be reciprocally related to the burnout syndrome.

In this study support from family and friends was a valuable resource for nurses, buffering them against emotional exhaustion. This finding was in contrast to data reported by Jackson and Maslach (1982) which indicated that support from people outside of work had little relationship to the experience of emotional
exhaustion. Although not specific to nursing burnout, many other studies provided abundant evidence that people who receive help and assistance from informal support systems are less negatively affected by stress (Cassel, 1976; Cobb, 1976; Dean & Lin, 1977; Kaplan, Cassel & Gore, 1977). Therefore, it is not surprising that this variable was negatively related to both the frequency and intensity of emotional exhaustion experienced by nurses in this sample.

**Intrapersonal.**

Of the intrapersonal variables related to the six dimensions of burnout, tension-releasing coping and instrumental/problem-focused coping were primary predictors of burnout while comfort with patients with poor prognosis for survival and fear of death were secondary predictors. Instrumental/problem-focused coping predicted the intensity of emotional exhaustion, the frequency and intensity of depersonalization, and the frequency and intensity of personal accomplishment. Tension-releasing coping predicted the frequency and intensity of emotional exhaustion, frequency and intensity of depersonalization, and frequency of personal accomplishment. Overall, tension-releasing coping appeared to be positively related to burnout while
instrumental coping appeared to be negatively related.

These two coping strategies serve different functions. That is, instrumental/problem focused coping manages or alters the source of stress while tension-releasing coping is emotion-focused and attempts to regulate distressful emotions which are in response to stress (Lazarus and Folkman, 1984). It is important to keep in mind that the tension-releasing items on the Jowic scale are essentially negative behaviors (e.g., smoking, cursing, withdrawing from the situation) and may not be effective behaviors in regulating stressful emotions, particularly over the long term. Thus, it is not surprising that such coping strategies appear to be ineffective in reducing burnout and in fact are related to an increase in burnout.

Findings in this study regarding tension-releasing and instrumental coping were consistent with those of Chiriboga, Jenkins and Bailey (1983) who found that the use of emotional avoidance as a coping strategy tended to be associated with less favorable outcome for hospice nurses. In this study tension-releasing coping behaviors were also emotion-avoiding and were positively related to several dimensions of burnout. On the other hand, the nurses in the Chiriboga et al study (1983) who maintained a
professional attitude, such as maintaining pride and remembering that dying is a natural process, seemed to fare best. Similarly in this study the behaviors associated with instrumental coping strategies, e.g., trying to maintain some control over the situation and looking at the problem objectively, appeared to coincide with those described by Chiriboga et al (1983) as "professional attitude" and also were negatively related to burnout.

Comfort with patients with poor prognosis for survival was an important variable in predicting one dimension of burnout, that is, frequency of personal accomplishment. This dimension of the burnout syndrome refers to the individual's reduced sense of personal accomplishment. Low burnout was reflected in high scores in personal accomplishment. Therefore, as nurses felt less comfortable with patients with poor prognosis for survival, they more frequently felt a reduced sense of personal accomplishment. Maslach (1982) noted that when individuals recognize that they have become detached and callous, they often feel distress and/or guilt about their interactions with clients. They feel a growing sense of inadequacy and may think of themselves as failures. This is a reflection of the third aspect of burnout: reduced personal accomplishment. It follows, then, that nurses in
this study who felt uncomfortable caring for patients with poor prognosis for survival may have perceived themselves to be insensitive, callous and thus a failure as a nurse.

Fear of death was a secondary variable in predicting only one dimension of burnout, the frequency of depersonalization. As nurses were more fearful of death, they more frequently experienced an unfeeling, impersonal response towards patients in their care. Descriptive literature abounds which discusses the dilemmas facing caregivers to the terminally ill and the resulting isolation suffered by these patients in hospitals and nursing homes (Kastenbaum, 1967; Strauss, 1968; Fulton, 1971; Rando, 1984; Pruysyr, 1984). Pruysyr (1984) contends that it is difficult for professionals exposed to dying patients to maintain equilibrium and thus they resort to defensive types of coping, such as "surrounding [their] heart[s] with armour" (p. 358). The relationship found in this study between fear of death and frequency of depersonalization felt by nurses supports Pruysyr's notion. Perhaps the nurses in this study defended against their fears about death by reducing their sensitivity to patients, "armouring their hearts" and providing care which was primarily guided by policy and regulations.
Situational.

The only variables from the situational factor which were important in predicting burnout were Personal Demographics. This relationship was related to Depersonalization - Intensity. In an effort to reduce the large number of independent variables in this study, these personal demographic variables were entered into the regression equation as a block and included age, level of education, marital status and family status. This block of variables appeared to be important only in predicting the intensity of depersonalization, i.e., the effort to detach psychologically from others. Because these variables were entered as a block, it is not possible to interpret their direction in relation to depersonalization. It is important to note, however, that a relatively small percentage (5.9%) of the variance was accounted for by this block of variables. Age, marital status and family status were all noted by Maslach (1982) as having a clear relationship to burnout. She found that burnout was greatest when workers were young and lower for older workers. In addition, single workers experienced the greatest burnout, while those who are married experience the least. Finally, having children was also associated with a reduced risk of burnout. Maslach (1982) concluded that people with families may be less vulnerable
to burnout because they tend to be older, more stable, mature individuals. In addition, their involvement with their family makes them more experienced in dealing with problems and emotional conflicts. Finally, Maslach (1982) and Yasko (1983) both concluded that a family is often an emotional resource rather than a drain.

Regression is essentially a test of correlation, not causality. Therefore, it cannot be concluded that any of these variables are causes of burnout. Rather, these variables may be symptoms of the burnout syndrome. For example, tension-releasing coping is as likely to be symptomatic of burnout as to be the cause of it. As discussed earlier, the relationship between burnout and these variables may be reciprocal -- as one increases the other increases, in cyclical fashion. Whatever the direction of the relationship, clearly, work environment support, informal support, instrumental and tension-releasing coping strategies, fear of death, comfort working with patients with poor prognosis for survival and personal demographics are all important variables to study in relation to nursing burnout.
DIFFERENCES IN THE DIMENSIONS OF BURNOUT, WORK SUPPORT, COPING STRATEGIES AND COMFORT WITH PATIENTS WITH POOR PROGNOSIS FOR SURVIVAL BY OCCUPATIONAL STATUS, TYPE OF FACILITY AND EXPOSURE TO PATIENTS WITH POOR PROGNOSIS

**Occupational Status.** This study demonstrated that occupational status is an important variable which impacts upon burnout, work environment support, coping strategies and comfort working with patients with poor prognosis for survival. It is not possible to compare these findings with those of other studies since no other studies on nursing burnout included certified nursing assistants in their sample. Even though CNA's appear to be understudied in terms of nursing stress, they are clearly a strained group of paraprofessionals whose occupational roles, particularly in extended care facilities, are vital.

This sample of certified nursing assistants was found to differ significantly from registered/licensed nurses on two dimensions of burnout: emotional exhaustion-frequency and depersonalization-frequency. Compared to registered/licensed nurses, CNA's more frequently felt emotionally overextended and exhausted by their work and more frequently experienced an impersonal...
response towards patients in their care. According to
Maslach and Jackson (1981), scores ranging from 18-29
represent a moderate degree of emotional
exhaustion-frequency and scores ranging from 6-11
represent a moderate degree of
depersonalization-frequency. The mean scores on emotional
exhaustion-frequency and depersonalization-frequency for
certified nursing assistants in this sample were similar
to those reported by Maslach and Jackson (1981) from a
sample of 1400 workers in various high-stress occupations,
including nursing.

When compared to registered/licensed nurses,
certified nursing assistants were significantly less
comfortable working with patients with poor prognosis for
survival. Because 94% percent of the CNA's in this sample
worked in long-term care facilities, this difference in
comfort may be particularly important because the number
of patients dying in these facilities is greater. The
difference in comfort levels between CNA's and RN's/LPN's
may reflect the difference in staffing levels between
long-term care and acute care facilities. Because of the
small number of CNA's from acute care facilities (n=10),
this possibility could not be statistically examined.
Rather than working as a team with a registered nurse as
they would in an acute care facility, certified nursing
assistants in long-term care facilities provide the major
portion of the nursing care which patients receive. In addition, they are responsible for providing this care to a greater number of patients. Furthermore, the typical patient in long-term care facilities suffers from multiple, chronic illnesses. Perhaps, then, the dying process of patients in long-term care facilities can be considered more lengthy than the dying process of patients in acute care facilities, thus the nursing care is heavier and the CNA's overextended and more uncomfortable.

In addition, certified nursing assistants in this sample also perceived less support from their work environments than did the registered/licensed nurses. That is, CNA's felt less involved in their work, less cohesion with their peers, and less support from their supervisors than did the professional nursing staff. One of the dimensions of work environment support was involvement which referred to the extent to which nurses were concerned about and committed to their jobs. Given the nature of a CNA's work tasks and the comparatively low status of CNA in relation to other positions in the health field, perhaps this dimension accounts for the lower scores of CNA's as compared to registered/licensed nurses. Although CNA's deliver most of the care received by patients in extended care facilities, they have limited training in terms of both the physical and psychological needs of patients. The work is physically and emotionally
strenuous and they are poorly paid for it, often receiving no more than the minimum wage.

Another explanation for the differences between CNA's and registered/licensed staff on work environment support may also be related to the high percentage of CNA's working in long-term care facilities and a reflection of the poorer staffing levels experienced by CNA's in those facilities. The plight of many certified nursing assistants is clearly expressed by two CNA respondents who wrote:

"The most difficult thing to cope with is the lack of staff, i.e., nurses and aides, and the patient load is too high for good quality care."

"Nursing homes are overpriced for the care these patients receive. Furthermore, as a nurses aide, I know from experience we are underpaid, understaffed and overworked. There are no benefits and the medical insurance costs more than I make in one month!"

Clearly these respondents did not feel valued or supported by their work environments.

Moos (1981) reported a study which examined perceptions of work environment support in a sample of 1607 health care workers. Work environment support scores in this study were comparable to those in the Moos study. No significant main effect was found for work environment support by facility, only by occupation.

Registered/licensed nurses and certified nursing assistants also differed significantly in their use of
tension-releasing and other-directed coping strategies. Registered/licensed nurses reported significantly more frequent use of tension-releasing (e.g., crying, cursing, withdrawing, and blaming others) and other-directed coping strategies (e.g., seeking comfort from family and friends and letting someone else solve the problem) than did certified nursing assistants. Thus, it appeared that professional nurses were generally more expressive in terms of their work stress than were certified nursing assistants. One explanation for this finding might be related to the fact that registered/licensed nurses perceived greater support from their work environments and thus felt more free to be expressive in those environments. Another explanation might be that registered/licensed nurses experienced as much strain from their jobs as did certified nursing assistants; however, their use of both negative tension-releasing strategies and positive other-directed strategies were more effective in mediating this strain. However, it should be remembered that tension-related coping was positively related to burnout so that those CNA's and RN's/LPN's who did use tension-releasing coping had increased burnout.

Type of facility.

Although only a statistical trend was found, it is evident that type of facility is
also a potentially important variable in the study of nursing burnout. Nurses working in extended care facilities more frequently experienced emotional exhaustion. This finding may be related to the occupational status of the nurse since the majority of the respondents in this sample who worked in extended care facilities were certified nursing assistants. This, then, would lend further support to the evidence that certified nursing assistants are at greater risk for burnout. Future studies could examine this further with a sample which included an equal number of professional and paraprofessional staff working in both acute care and long-term care facilities.

**Exposure to patients with poor prognosis for survival.**

Exposure to patients with poor prognosis for survival was another important variable in determining differences in coping strategies. Nurses who had moderate exposure to patients with poor prognosis for survival used significantly more instrumental coping strategies, such as defining the problem and generating alternate solutions, to cope with their jobs than those with high or low exposure. This finding was difficult to interpret because the means for moderate and high exposure were very close ($M = 42.6$, s.d. = 5.4 and $M = 42.8$, s.d. = 5.0, respectively); it is expected that both moderate and high
exposure would have been significantly different from low exposure. This surprising finding might be explained by noting that only 14% of the sample fell into the cell for high exposure, thus making it appear statistically different from moderate exposure.

On the other hand, nurses with high exposure used significantly more tension-releasing strategies (such as cursing, crying, smoking, withdrawing from the situation, and blaming someone else) to cope with their jobs than those with low or moderate exposure to patients with poor prognosis for survival. Maslach hypothesized (1978) that the worker is more prone to emotional exhaustion when the client's problem is particularly difficult, especially if the client is not likely to improve. She also states that there will be greater emotional stress for the staff member who looks at the client's situation and thinks "that could be me."

Even though the six dimensions of burnout in this study were not significantly different by exposure to patients with poor prognosis for survival, it is interesting to note that the nurses who spent more time with patients with poor prognosis for survival relied more heavily on tension-releasing coping strategies. Using the Lazarus and Folkman model of coping (1984), the tension-releasing behaviors represented on the Joloweic Coping Scale are emotion-focused coping; that is,
cognitive processes which are aimed at reducing the emotional distress which is in response to work stress. The majority of the tension-releasing behavior items on the Jaloweic scale are not particularly positive or effective ones, especially when utilized over a long period of time. High degrees of burnout have been associated with withdrawal coping strategies (Maslach and Jackson, 1982), such as these tension-releasing behaviors, while low degrees of burnout have been associated with social coping strategies (Maslach and Jackson, 1982), such as other-directed coping. Findings from this study and the Maslach and Jackson (1982) study would support the hypothesis that high degrees of burnout are related to emotion-focused coping. Because this study was cross-sectional, it may be that burnout is not causal of emotion-focused coping but rather precedes or is reciprocal with emotion-focused coping.
Additionally, this study found that nurses with high and moderate exposure to patients with poor prognosis were significantly more comfortable with such patients than were nurses with low exposure to such patients. Possibly nurses in this sample with high and moderate exposure chose to work with dying patients because they were from the beginning more comfortable with such patients. On the other hand, perhaps they grew more comfortable over time with such patients simply by virtue of exposure. At any rate, both professional (M = 25.9, s.d. = 4.4) and paraprofessional (M = 23.9, s.d. = 5.0) nurses in this sample appeared to be fairly high in comfort with patients with poor prognosis for survival. (Total comfort scores could range from 5 to 30).

This is a surprising finding in view of the literature which generally affirms that dying patients pose several emotional problems for health practitioners (Kastenbaum, 1967; Strauss, 1968; Harper, 1977; Koocher, 1979; Rando, 1984). Caution must be taken, however, in interpreting these high comfort scores as it is possible that social desireability may be at play. That is, nurses who work with patients with poor prognosis for survival may have a difficult time admitting even to themselves that they are not comfortable caring for patients who are so much in need of their professional care.
Unlike findings reported by Dames (1983), this study found no significant effect for any of the dimensions of burnout by exposure to patients with poor prognosis for survival. This lack of significance for this variable was consistent with a study by Yasko (1983) who reported that hours spent in direct contact with cancer patients was not associated with greater degrees of burnout.

Overall, it is clear that certified nursing assistants were more burned out than were registered/licensed nurses. In addition, CNA's perceived less support from their work environments than did registered/licensed nurses which contributed to their risk for burnout. Furthermore, there were differences in coping strategies and comfort with patients with poor prognosis among nurses with high, moderate and low exposure to patients with poor prognosis for survival. Future studies examining nursing burnout, stress and related constructs should further examine the effects of these variables.
LIMITATIONS OF THE PRESENT STUDY

Although results of the present study provided several important findings regarding nursing burnout in acute care and long-term care facilities, certain limitations were encountered. It is possible that because the sampling procedure used in this study was nonrandom that those nurses who were most burned out did not respond to the questionnaire. However, this possibility seems unlikely given the range of burnout scores evident in the sample. In addition, because of the low number of CNA respondents who worked in acute care facilities, results from this study cannot be extended to the general population of CNA's, rather only to those who work in long-term care facilities. Finally, the results of the study only represented relationships and differences between selected variables. They did not indicate a cause and effect.

RECOMMENDATIONS FOR FUTURE RESEARCH

Several suggestions can be made for improving upon the measurement of nursing burnout in future studies. First of all, the Maslach Burnout Inventory (1981) should be recoded on the dimension of personal accomplishment so the direction of that dimension is consistent with the other two. Secondly, several respondents remarked that the instrument was particularly tedious to complete,
citing specifically the difficulty in considering both intensity and frequency on each item. Because the means for frequency and intensity on each of the dimensions of burnout were similar, it seems unnecessary to consider both frequency and intensity. Perhaps the response rate could be improved by measuring only frequency.

Since relatively few certified nursing assistants are employed by hospitals in comparison to the number employed by nursing homes, more or larger hospitals will need to be involved. Therefore, future studies examining differences between registered/licensed nurses and certified nursing assistants in acute care and long-term care facilities should plan to oversample CNA's in acute care facilities.

Findings from this study suggest several other research questions which should be addressed in future studies on nursing burnout. For example, it remains to be clarified whether there are differences in burnout between occupational roles in nursing and types of health care facilities. This interaction could be examined by insuring a more equal number of both occupational roles in long-term care and acute care facilities.

The importance of work environment support in predicting burnout indicates that more detailed study of this variable is warranted. For example, what appears to be lower: the degree of involvement in work, peer
relationships or supervisor support? Is there a precise area in greater need of intervention? Furthermore, the wide range of work environment support scores among the ten facilities suggests that the climate in some facilities is less vulnerable to burnout than others. It would be valuable to identify the specific factors operating in those facilities in which work environment support is higher and the staffs appear to suffer a lower degree of burnout.

Another area for future work is comfort with patients with poor prognosis for survival. Results on the comfort scale do not reflect the same discomfort in caring for patients with poor prognosis for survival among health care providers that the literature suggests (Kastenbaum, 1967; LeShan, 1969; Kalish, 1981; Rando, 1984). For that reason future studies should assess the scale with a social desirability scale. Future work may also attempt to more carefully control for social desirability by combining the survey method of investigation with observational study. In other words, nurses' behaviors with dying patients may indicate lack of comfort while their perception is that they are comfortable. This possibility could be assessed. Future studies also should examine the relationship of comfort to fear of death. If the comfort measure is found to be valid, then it will be a useful tool for future research and interventions.
The personal demographic variables (age, educational level, marital and family status) in the present study were entered as a block into the regression equation. Because this block contributed to some of the variance in the intensity of depersonalization experienced by respondents, future studies should keep these variables separate in order to assess the predictive capability of each of them in relation to burnout.

Finally, the research on burnout is essentially no more than an academic exercise until a comprehensive policy study finally puts a dollar value upon this syndrome. The most convincing argument to promote practices which would reduce burnout is that burnout is costly to the health care facility. Jones (1981) attempted to do this by reporting that nurses who suffered from burnout were more likely to steal from the hospital than nurses who scored low on burnout. The necessary next step in burnout research is to go beyond what Jones found into the many other consequences of burnout, such as medication errors, staff turnover and low morale, in order to approximate the total financial cost of nursing burnout for health care facilities.
IMPLICATIONS FOR PRACTICE

Findings from this study support the view that factors in the work environments may reduce the staff's vulnerability to the various aspects of burnout. Research and interventions to decrease burnout may focus on improving work environments. Maslach (1982) and Cherniss (1980) would agree that this emphasis on work environment is critical to addressing the problem of burnout.

In addition, the issue of understaffing was mentioned many times on the one open ended question in the survey. If understaffing is, in fact, an accurate description of what is occurring in health care facilities, then one step toward reducing burnout among nurses and improving the quality of care for patients would be for facilities to make an accurate assessment of the staffing warranted daily and then to staff at that level. While this would result in increased costs, it is possible that the financial cost of staff burnout far outweighs the cost of adequate staffing.

Furthermore, primary prevention interventions which are incorporated into academic programs may help reduce burnout among beginning professional and paraprofessional nurses. Such interventions can help student nurses to set appropriate goals for themselves and
define successful nursing in realistic terms, thus preparing those individuals whose idealism may put them at greatest risk for burnout. Again such interventions would be supported by burnout research (Cherniss, 1980; Maslach, 1978, 1979, 1981, 1982).

Finally, future work should design and assess interventions which attempt to increase comfort working with patients with poor prognosis for survival. This study indicates that certified nursing assistants in long-term care facilities may be in particular need of such interventions.

SUMMARY

This study examined a model of factors which were expected to impact upon burnout in professional and paraprofessional caregivers in acute care and long-term care facilities. The model included interpersonal, intrapersonal and situational factors. Results showed that all three of the factors were included in the final model which identified variables which were predictive of several dimensions of nursing burnout. Specifically, the intrapersonal factor included tension-releasing coping, instrumental/problem-focused coping, fear of death, comfort with patients with poor prognosis for survival. The interpersonal factor included work environment support and informal support. The situational factor included
personal demographics: age, educational level, marital status and family status. While these several specific variables predicted individual dimensions of burnout, the most powerful predictors across the six dimensions of burnout were work environment support, tension-releasing coping and instrumental/problem-focused coping.

In addition, this study examined for differences in the six dimensions of burnout, work support, coping strategies, and comfort with patients with poor prognosis for survival by occupational roles, types of facility and professional exposure to patients with poor prognosis for survival. Findings revealed that certified nursing assistants were more frequently emotionally exhausted and more frequently experienced an unfeeling response toward patients in their care. In addition, certified nursing assistants perceived less support from their work environments than did registered/licensed nurses and were less comfortable working with patients with poor prognosis for survival. Registered/licensed nurses used significantly more tension-releasing and other-directed coping strategies than did certified nursing assistants.

Furthermore, nurses with high, moderate and low exposure to patients with poor prognosis for survival differed significantly in their comfort with such patients and in their use of coping strategies. That is, nurses with moderate and high exposure to patients with poor
prognosis for survival were significantly more comfortable with such patients than were nurses with low exposure. In addition, nurses with moderate exposure to patients with poor prognosis for survival used significantly more instrumental/problem-focused coping strategies than did nurses with high or low exposure. Finally, nurses with high exposure used significantly more tension-releasing coping strategies than did nurses with moderate or low exposure.

Based upon this study, it is concluded that nursing burnout is an organizational problem. Reaching beyond the study, it is assumed that this problem very likely increases the financial costs of the facility and ultimately decreases the quality of care received by patients. It is expected that the imbalance between resources available to nurses and demands placed upon them may be corrected by focusing upon the supportiveness of the work environment. That is, improving the quality of work environment support would be the most effective intervention aimed at reducing the risk for burnout among nursing staff in both acute care and long-term care facilities.
REFERENCES


APPENDICES
Dear

One nurse has written that unrelieved stress can lead to the literal collapse of the human spirit. You are in a professional position to recognize not only the psychological cost of stress to the individual, but also the financial cost of stress to the care facility. Stress has been associated with high rates of turnover, time lost from work, technical errors, alcohol and drug use.

Although stress has been a popular subject in the field of nursing for several years, little is known about the variety of factors which contribute to or reduce this stress. Are there certain individuals who possess professional coping skills which are more effective in reducing stress or whose personal characteristics put them at lower risk? Are there certain work environments or social conditions which render workers less susceptible to burnout? If this information were available to you, it would benefit you in your staff support and management. Ultimately, it would be cost effective for the facility.

We are conducting a research study which examines the causes of stress in nurses and nursing assistants. In addition, we are interested in the possible differences between not only occupational roles, but also types of facilities in which the nurses work — hospitals and nursing homes. We would be very pleased if you would agree to participate in our research.

This is a survey study and thus will require little administrative time from you. With your permission, we would like our questionnaire distributed to all nursing staff. We will provide a self-addressed, stamped envelope in which they can return their completed questionnaires. In return for your participation, we will be happy to share our findings with you.

We will call you within the next week to answer questions about this study and elicit your support. Thank you for your time and consideration.

Sincerely,

Jan Hare, M.Ed.
Doctoral Candidate

Clara C. Pratt, Ph.D.
Associate Professor

Oregon State University
Department of Human Development and Family Studies

cc: Administrator
January 1986

Dear Caregiver:

Although stress has been a popular subject in the field of nursing for several years, little is known about the variety of factors which contribute to or reduce this stress. We are asking for your assistance with an important research project concerning nurses' adaptation to stress. Through this project we will learn more about the feelings nurses have regarding their jobs, the various ways they cope with these feelings, and the help they receive from others. Your response is essential to this study. While you are not under any obligation to answer any of the questions, it would be very helpful to the nursing profession if you would. Enclosed is a questionnaire that we would like you to complete and mail back to us in the envelope provided.

Be assured that any information you share with us is completely confidential. We will make our conclusions available to you and other professionals but you will never be identified. Several hundred registered nurses, licensed practical nurses, and nursing assistants throughout western Oregon will be requested to participate in this project.

What we learn from you will ultimately help us publish information which can be used to improve the work environments in which nurses function. However, before this can happen, we need to learn more from those of you who know the most about these environments. We will appreciate your help in providing this necessary information. If you have any questions, please call Jan Hare at the above address and phone. Thank you most sincerely for your help.

Sincerely,

Jan Hare, M.Ed.
Clara C. Przyt, Ph.D.

Department of Human Development and Family Studies
APPENDIX C

The Work Relationship Index

We are interested in your perceptions of your work environment. Please indicate whether you consider each of the following statements to be true of your work environment or false.

1=TRUE 2=FALSE (Please indicate either "1" or "2" in the space provided.)

1. The work is really challenging.
2. People go out of their way to help a new feel comfortable.
3. Supervisors tend to talk down to employees.
4. There's not much group spirit.
5. The atmosphere is somewhat impersonal.
6. Supervisors usually compliment an employee who does something well.
7. A lot of people seem to be just putting in time.
8. People take a personal interest in each other.
9. Supervisors tend to discourage criticisms from employees.
10. People seem to take pride in this health care facility.
11. Employees rarely do things together after work.
12. Supervisors usually give full credit to ideas contributed by employees.
13. People put quite a lot of effort into what they do.
14. People are generally frank about how they feel.
15. Supervisors often criticize employees over minor things.
17. Employees often eat lunch together.
18. Employees generally feel free to ask for a raise.
19. It is quite a lively place.

20. Employees who differ greatly from the other in the organization don't get on well.

21. Supervisors expect far too much from employees.

22. It's hard to get people to do any extra work.

23. Employees often talk to each other about their personal problems.

24. Employees discuss their personal problems with supervisors.

25. The work is usually very interesting.

26. Often people make trouble by talking behind others' backs.

27. Supervisors really stand up for their people.
APPENDIX D

Informal Support

1. If you were to list the names of the relatives and friends that are available to you for support in expressing your feelings about your work responsibilities, how many people would you list? ______ people.

2. How easy is it for you to contact these people? (Check one answer).
   _____ Very difficult
   _____ Fairly difficult
   _____ Neither difficult nor easy
   _____ Fairly easy
   _____ Very easy

3. How often do these people help you?
   _____ Never
   _____ Not very often
   _____ Sometimes
   _____ Quite often
   _____ Very often

4. How satisfied are you with the support that you receive from these people?
   _____ Not at all satisfied
   _____ Satisfied a little
   _____ Somewhat satisfied
   _____ Quite satisfied
   _____ Very satisfied

5. Of all these people, is there one specific person with whom you can share your most personal thoughts and feelings?
   _____ NO (go on to next section)
   _____ YES (If yes, what is this person's relationship to you?)
   _____ Spouse  _____ Sister  _____ Personal friend
   _____ Mother  _____ Father  _____ Brother
   _____ Co-worker  _____ Other, please specify relationship

Is this person readily available to you? _____ YES  _____ NO
APPENDIX E

Maslach Burnout Inventory

Please read each statement carefully and decide if you ever feel this way about your job. Beside each question write the number which best corresponds to how often you feel this way and how strongly you feel this way.

<table>
<thead>
<tr>
<th>HOW OFTEN</th>
<th>HOW STRONG</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>3</td>
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<td>4</td>
<td>4</td>
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<td>5</td>
<td>5</td>
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<tr>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>7</td>
</tr>
</tbody>
</table>

0 = Never, 1 = A few times a year or less, 2 = Once a month, 3 = A few times a month, 4 = Once a week, 5 = A few times a week, 6 = Every day, 7 = Every hour

0 = Never, 1 = Very mild, 2 = Barely noticeable, 3 = Noticeable, 4 = Moderate, 5 = Major, 6 = Very strong

1. I feel emotionally drained from my work.
2. I feel used up at the end of the workday.
3. I feel fatigued when I get up in the morning and have to face another day on the job.
4. I can easily understand how my patients feel about things.
5. I feel I treat some patients as if they were impersonal objects.
6. Working with people all day is really a strain for me.
7. I deal very effectively with the problems of my patients.
8. I feel burned out from my work.
9. I feel I'm positively influencing other people's lives through my work.
10. I've become more callous toward people since I took this job.
11. I worry that this job is hardening me emotionally.
12. I feel very energetic.
I feel frustrated by my job.
I feel I'm working too hard on my job.
I don't really care what happens to some patients.
Working with people directly puts too much stress on me.
I can easily create a relaxed atmosphere with my patients.
I have accomplished many worthwhile things in this job.
I feel like I'm at the end of my rope.
In my work, I deal with emotional problems very calmly.
I feel exhilarated after working closely with my patients.
I feel patients blame me for some of their problems.
### APPENDIX F

**Multidimensional Fear of Death Scale**

We are interested in your thoughts and feelings regarding your death, the death of people you love, and the concept of death in general. Please respond by writing the number which corresponds with your answer to each statement.

<table>
<thead>
<tr>
<th></th>
<th>Statement</th>
<th>1=Strongly Disagree</th>
<th>2=Disagree</th>
<th>3=Neutral</th>
<th>4=Agree</th>
<th>5=Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I am afraid of dying slowly.</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td>2</td>
<td>I am afraid of dying in a fire.</td>
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<td>3</td>
<td>I am afraid of experiencing a great deal of pain when I die.</td>
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<td>4</td>
<td>I am afraid of dying of cancer.</td>
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<td>5</td>
<td>I have a fear of suffocating or drowning.</td>
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<td>6</td>
<td>I have a fear of dying violently.</td>
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<td>7</td>
<td>I have a fear of people in my family dying.</td>
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<td>8</td>
<td>If the people I am very close to were suddenly to die, I would suffer for a long time.</td>
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<td>9</td>
<td>If I died tomorrow, my family would be upset for a long time.</td>
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<td>10</td>
<td>Since everyone dies, I won't be too upset when my friends die.</td>
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<td>11</td>
<td>I sometimes get upset when acquaintances die.</td>
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<td>12</td>
<td>If I died, my friends would be upset for a long time.</td>
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<tr>
<td>13</td>
<td>I am afraid there is no afterlife.</td>
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<td>14</td>
<td>I am not afraid of meeting my creator.</td>
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<td>15</td>
<td>I am afraid that death is the end of one's existence.</td>
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<td>16</td>
<td>I am afraid that there may not be a supreme being.</td>
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<td>17</td>
<td>No one can say, for sure, what will happen after death.</td>
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<td>18</td>
<td>I have a fear of not accomplishing my goals in life before dying.</td>
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<td>19</td>
<td>I am afraid I will not live long enough to enjoy my retirement.</td>
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<td>20</td>
<td>I am afraid I will not have time to experience everything I want to.</td>
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<td>21</td>
<td>I am afraid I may never see my children grow up.</td>
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APPENDIX G

Jaloweic Coping Strategies Inventory

How often do you use the following attitudes or behaviors to cope with the stresses related to your job?

1. Hope that things will get better.
2. Try to maintain some control over the situation.
3. Find out more about the situation so you can handle it better.
4. Think through different ways to handle the situation.
5. Look at the problem objectively.
6. Eat; smoke; chew gum.
7. Try out different ways to solve the problem to see which works the best.
8. Draw on past experiences to help you handle the situation.
9. Try to find meaning in the situation.
10. Pray; trust God.
12. Worry
13. Break the problem down into "small pieces."
14. Seek comfort or help from family or friends.
15. Set specific goals to help solve the problem.
16. Accept the situation as it is.
17. Want to be alone.
18. Laugh it off, figuring things could be worse.
19. Try to put the problem out of my mind.
20. Daydream, fantasize.
21. Get prepared to expect the worst.
22. Talk the problem over with someone who has been in the same situation.
23. Actively try to change the situation.
24. Get mad; curse; swear.

1=Never
2=Rarely
3=Sometimes
4=Often
5=Almost Always
25. Cry; get depressed.
26. Go to sleep figuring things will look better in the morning.
27. Don't worry about it, everything will probably work out.
28. Withdraw from the situation.
29. Work off tension with physical activity.
30. Settle for the next best thing.
31. Take out your tensions on someone or something else.
32. Drink alcoholic beverages.
33. Resign yourself to the situation because things look hopeless.
34. Do nothing in the hope that the problem will take care of itself.
35. Resign yourself to the situation because it is your fate.
36. Do anything just to do something.
37. Blame someone else for your problems.
38. Meditation, yoga, biofeedback.
39. Let someone else solve the problem.
40. Take drugs.
JALOWEIC COPING STRATEGIES INVENTORY

**Instrumental/Problem-Focused**
Factor 1:

- Items Number
  - 2, 3, 4, 5,
  - 7, 8, 9, 13,
  - 15, 23, 29, 38

**Morale Maintaining**
Factor 2:

- Items Number
  - 1, 10, 16, 18,
  - 19, 26, 27, 34,
  - 35

**Tension-Releasing**
Factor 3:

- Items Number
  - 6, 11, 12, 17
  - 20, 21, 24, 25, 28
  - 30, 31, 32, 33, 36,
  - 37, 40

**Other-Directed**
Factor 4:

- Items Number
  - 14, 22, 39
On a typical shift, how much work time do you spend caring for a patient or patients considered to have a poor prognosis for survival (i.e., survival is not expected to exceed two years [acute care] six months [long-term care])?

___(1) Never (skip next 6 questions)
___(2) 1 - 30 minutes
___(3) 31 - 60 minutes
___(4) between 1 and 2 hours
___(5) between 3 and 4 hours
___(6) between 4 and 5 hours
___(7) between 5 and 6 hours
___(8) between 6 and 7 hours
___(9) over 7 hours
APPENDIX I

Comfort Working With Patients With Poor Prognosis for Survival

As you read the following questions, think of your typical behavior when you are caring for a patient with a poor prognosis for survival (i.e., survival not expected to exceed two years [acute care] approximately six months [extended care]). Circle the number which corresponds with the best answer.

1. How comfortable are you providing hygienic care to such a patient (e.g., bathing, face washing, tooth brushing, skin care)?

2. How comfortable are you having such a patient assigned to you?

3. How comfortable are you sitting down for at least 10 minutes with such a patient when you believe s/he would like to talk about his or her feelings?

4. How comfortable are you sitting down for at least 10 minutes with the family of such a patient when you believe they would like to talk about their feelings?

5. How comfortable are you being with such a patient as death nears?

6. How comfortable are you being such such a patient at the moment of death?

Not at all comfortable  Very comfortable
1        2        3        4        5
APPENDIX J

Demographics

Caregiver Profile: Please answer the following questions about yourself.

1. What is your occupational position in this facility?
   ___(1) Registered Nurse
   ___(2) Licensed Practical Nurse
   ___(3) Certified Nursing Assistant

2. How long (years and/or months) have you worked in this job in this particular facility? ________

3. What shift do you regularly work?
   ___(1) Days 7-3:30
   ___(2) Evenings 3:00-11:30
   ___(3) Nights 11:00-7:00

4. How many hours per week do you usually work?

5. What is the highest level of education you have completed?
   ___(1) Partial high school (no diploma)
   ___(2) High School Graduate
   ___(3) Associate of Arts Degree
   ___(4) Bachelor's Degree
   ___(5) Graduate Degree

6. Do you presently provide nursing service in a hospice?
   ___(1) No
   ___(2) Yes (If yes, is this service as
       ___a volunteer
       ___a paid employee

   How many hours per week on the average do you provide service? ________

7. What is your sex? ___(1) Female ___(2) Male

8. What is your age? ________

9. ________
10. What is your marital status?
   ___(1) Married
   ___(2) Single (never married)
   ___(3) Divorced
   ___(4) Separated
   ___(5) Widowed

11. How committed are you to your spiritual beliefs?
   ___(1) Uncommitted
   ___(2) Slightly committed
   ___(3) Fairly committed
   ___(4) Strongly committed
   ___(5) I don't know

12. How likely do you believe it is that you will be in the field of nursing five years from now?
Very unlikely 1 2 3 4 5 Very likely

Is there anything else you would like to tell us about the rewards and/or the difficulties in providing nursing care?

We realize that this questionnaire required a great deal of effort to complete and we appreciate your efforts. Please use the envelope that we provided to send it back to us. If the envelope was lost, our mailing address is:

Jan Hare and Clara Pratt
Oregon State University
Department of Human Development and Family Studies
Corvallis, OR 97331