



1985

The Relationships Among Social Support, Alienation, Religiosity, Length of Service and the Burnout Experienced by Nurses' Aides and Licensed Practical Nurses Employed in Skilled Care Nursing Homes

Debra Joan Haley
Loyola University Chicago

Follow this and additional works at: https://ecommons.luc.edu/luc_diss



Part of the [Education Commons](#)

Recommended Citation

Haley, Debra Joan, "The Relationships Among Social Support, Alienation, Religiosity, Length of Service and the Burnout Experienced by Nurses' Aides and Licensed Practical Nurses Employed in Skilled Care Nursing Homes" (1985). *Dissertations*. 2426.

https://ecommons.luc.edu/luc_diss/2426

This Dissertation is brought to you for free and open access by the Theses and Dissertations at Loyola eCommons. It has been accepted for inclusion in Dissertations by an authorized administrator of Loyola eCommons. For more information, please contact ecommons@luc.edu.



This work is licensed under a [Creative Commons Attribution-Noncommercial-No Derivative Works 3.0 License](#).
Copyright © 1985 Debra Joan Haley

301

THE RELATIONSHIPS AMONG SOCIAL SUPPORT, ALIENATION,
RELIGIOSITY, LENGTH OF SERVICE AND THE BURNOUT
EXPERIENCED BY NURSES' AIDES AND LICENSED
PRACTICAL NURSES EMPLOYED IN SKILLED
CARE NURSING HOMES

by

Debra Joan Haley

A Dissertation Submitted to the Faculty of the Graduate
School of Loyola University of Chicago in Partial
Fullfillment of the Requirements for the Degree of
Doctor of Philosophy

October

1985

ACKNOWLEDGEMENTS

I would like to extend special thanks to Dr. Kevin Hartigan for his patient assistance and direction during both the dissertation and internship process. Additionally, I am thankful for his sense of humor and his professionalism.

I would also like to thank Dr. Gloria Lewis for her continued support and guidance as my program advisor, and as a member of this dissertation committee. I am further thankful to Dr. Lewis for her warmth, honesty and perspective on being a female psychologist.

I thank Dr. Elizabeth Brophy for serving on this dissertation committee. This research project was greatly enhanced by her thorough knowledge of the nursing field.

I would also like to thank my family and friends who provided continual support and encouragement throughout my years in the doctoral program. Special thanks to my classmates Tim Lawler, Kathy Occhipinti, Denise Verones, and Linda Rice who have made the last four years both growthful and fun. Also, special thanks to the members of my softball team, Mary Anne Himmes, Connie Kaufman, Grace and John Bausch, Patty Conklin, and Maggie Burke for taking

my tests, listening to my stories, and laughing and being empathic as needed.

Finally, I would like to thank Richard Cozzola for his unwavering patience and support throughout the dissertation process. His computer and culinary skills, as well as his ability to listen have been invaluable assets.

DJH

VITA

Debra Joan Haley is the daughter of Thomas Haley and Helen (Thompson) Haley. She was born on June 21, 1951 in East Cleveland, Ohio.

She graduated from Magnificat High School in Rocky River, Ohio in 1969. She attended Case-Western Reserve University from 1969 - 1971 and Ohio University from 1971 - 1973. Ms. Haley graduated summa cum laude with a BA in Sociology and Honors in General Studies in March, 1974.

In January of 1975, Ms. Haley began working toward her masters in Counseling Psychology at Loyola University of Chicago. She received her MA in June, 1977. Ms. Haley began her doctoral studies in Counseling Psychology at Loyola University in January, 1982.

In the course of her doctoral studies, Ms. Haley was granted two assistantships. She completed a full-time one year predoctoral internship at Cook County Hospital, Chicago, Illinois.

Ms. Haley taught high school for several years. She also worked as a therapist for adults for eight years. Ms. Haley has worked extensively with the elderly and with the chronically and acutely ill in nursing homes, hospitals, and outpatient settings.

TABLE OF CONTENTS

	Page
ACKNOWLEDGMENTS	ii
VITA	iv
LIST OF TABLES	vii
CONTENTS OF APPENDICES	viii
 Chapter	
I. INTRODUCTION	1
Overview	1
The Current Investigation	4
Significance of the Study	8
Purpose of the Study	10
II. REVIEW OF THE LITERATURE	11
Nursing Homes	11
Burnout	16
Historical Perspective	16
Maslach and Colleagues	19
Other Theories of Burnout	29
Social Support	38
Alienation	42
Religiosity	50
Length of Service in the Nursing Field ...	58
III. METHODOLOGY	61
Hypotheses	61
Subjects	62
Selection	62
Description	63
Setting	64
Procedure	67
Pilot Studies	70
Instrumentation	74
Design and Statistical Analysis	82
IV. RESULTS	84

Overview	84
Preliminary Analyses	84
Tests of the Hypotheses	90
Hypothesis One	90
Hypothesis Two	95
Hypothesis Three	97
Hypothesis Four	102
Hypothesis Five	104
Supplementary Analyses	106
Discriminant Analysis	106
Analysis of Covariance	111
Summary	112
 V. DISCUSSION	 116
Overview	116
Recapitulation	116
Analysis of the Results	120
Hypothesis Two	120
Hypothesis Three	121
Hypothesis Four	130
Hypothesis Five	132
Theoretical Implications	135
Applied Implications	138
Limitations of the Study	142
Directions for Future Reseach	145
 REFERENCES	 148
 APPENDIX A	 159
 APPENDIX B	 161
 APPENDIX C	 166
 APPENDIX D	 167
 APPENDIX E	 169
 APPENDIX F	 171

LIST OF TABLES

Table	Page
1. One Way Analyses of Variance Involving Burnout and the Major Independent Variables: Nurses' Aides and LPN's	86
2. One Way Analyses of Variance Involving Alienation Subscale Scores: Nurses' Aides and LPN's	87
3. One Way Analyses of Variance Involving Demographic Variables: Nurses' Aides and LPN's	88
4. Correlations Between Burnout and Major Predictor Variables: Nurses' Aides	91
5. Correlations Between Burnout and Major Predictor Variables: LPN's	92
6. Stepwise Multiple Regressions for Nurses' Aides and LPN's	94
7. Correlations between Burnout and the Subscales of The Alienation Test: Nurses' Aides and LPN's	98
8. One Way Analyses of Variance Testing the Effects of the Various Types of Alienation on Burnout in Nurses' Aides and LPN's	100
9. Discriminant Analysis: Distinguishing Characteristics of High v. Low Burnout in Nurses' Aides	108
10. Classification Results of The Discriminant Analysis: Nurses' Aides	110
11. Analysis of Covariance: Nurses' Aides	113
12. Analysis of Covariance: Nurses' Aides	113
13. Analysis of Covariance: LPN's	114

CONTENTS FOR APPENDICES

	Page
APPENDIX A Letter of Introduction to Study	159
APPENDIX B Additional Demographic Data on Subjects	161
I. Shift Worked	161
II. Work Status	161
III. Race or Ethnic Group	162
IV. Age	163
V. Length of Employment in Present Nursing Home	164
VI. Length of Employment in Field of Nursing ..	165
APPENDIX C Changes in Word Choice to Accommodate Reading Level of Subjects	166
APPENDIX D Nursing Home Phone Survey Form	167
APPENDIX E Results of the Pilot Study	169
I. Correlations Between Dependent and Independent Variables	169
II. Descriptive Statistics	170
APPENDIX F Instrumentation	171
I. The Alienation Test	171
II. The Staff Burnout Scale for Health Professionals	176
III. Work Relationships Index	177
IV. Gladding, Lewis and Adkins Scale of Religiosity	179
V. Demographic Questionnaire	182

CHAPTER ONE

INTRODUCTION

Overview

Stress and its effects on both physical and mental health has become a popular focus for research over the last thirty years. In the last ten years, a particular type of stress, called burnout, has received increasing attention in the literature. Burnout is defined by Maslach (1978) as "a loss of concern for the people with whom one is working" (p. 116). Burnout is characterized by emotional exhaustion, illness and psychosomatic symptoms; a cynical and dehumanized perception of clients; and a deterioration in the quality of care of service given.

Burnout is viewed as a process that develops over time. Although different theorists describe the process of burnout in a variety of ways, the following describes the general process of burnout. A new worker comes to the job with initial energy and enthusiasm and with high ideals of "being helpful." The worker has received little, if any, preparation for the amount and intensity of emotionality inherent in the client-staff interaction. As the worker deals with troubled individuals on a daily basis, he/she

becomes overwhelmed by the range of client problems and his/her own emotional reaction to them. In an attempt to cope with this, the worker begins to withdraw physically, mentally, and emotionally. This withdrawal isolates the worker, increases his/her feelings of lack of success, and contributes to further dehumanizing and distancing by the worker. At this point, the worker begins to experience burnout.

Some researchers suggest that burnout is the result of individual personality factors. Freudenberger (1975), Maloney and Ange (1980), and Fischer (1983) indicate that idealistic, energetic, and charismatic individuals with high expectations are prone to burnout. A larger number of researchers, however, delineate institutional factors as the major cause of burnout. Maslach (1978a), Cherniss (1980b), Pines and Kafry (1977) and others indicate that the following institutional factors are instrumental in producing burnout: high client-staff ratios, poor co-worker relationships, long work hours, ambiguous or ill-conceived institutional rules regarding client-staff interaction, low pay, low status, lack of supervisor support, a deteriorated or chronic client population, an imbalance between stressful and nonstressful job tasks, and a large amount of time spent in direct patient care. These

authors acknowledge the interplay between personal and organizational factors, although they attribute the bulk of the responsibility for burnout to organizational factors. Maslach and Jackson (1982) indicate that because burnout has been found in so many occupations and in so many individuals, it is clearly due to organizational rather than personal factors.

The literature indicates that burnout correlates with indices of personal stress, such as domestic strain, increased usage of alcohol and drugs, mental illness and suicide (Maslach, 1976; Maslach & Jackson, 1979). It also correlates with low morale, absenteeism, turnover, job dissatisfaction, and career changes (Cherniss, 1980b; Veninga, 1979; Maslach, 1978a).

Research has also indicated that the experience of burnout can be moderated by the presence of certain factors. The presence of other factors appears to increase the likelihood of burnout. Among these factors which can moderate or exacerbate burnout are social support (Maslach & Pines, 1977; Pines & Kafry, 1978; Maslach, 1979a; Appelbaum, 1981; Shinn, 1982; Yasko, 1983; Farber, 1983), religiosity (Cherniss & Krantz, 1983; Friel & Tehan, 1982), alienation (Cherniss & Krantz, 1983; Kobasa, 1982), and length of time in the field (Pines & Maslach, 1978; Cronin-

Stubbs, 1983).

The Current Investigation

Although social support can take many forms, Kobasa and Pucetti (1983) and LaRocco, House, and French (1980) suggest that work-related social support rather than family support can help moderate the effect of work-related stress. LaRocco and Jones (1978) delineate the factors of perceived co-worker and supervisor support as important in alleviating job stress. In this study, social support was defined as the extent to which licensed practical nurses and nurses' aides needs for affection, belonging, and security were met in the work environment, as measured by the Work Relationships Index (Holahan & Moos, 1981).

According to Cherniss and Krantz (1983), religiosity and a moral commitment to work are other factors which moderate the experience of burnout. Research conducted on the relationship between religiosity and mental and physical health also lends at least some support to this theory. Maddi and Kobasa's work on hardiness in executives (1984), suggests that commitment helps moderate stress, while alienation exacerbates it. In this study, alienation was measured rather than commitment. Alienation was defined as the extent to which licensed practical nurses and nurses' aides expressed a lack of meaning or a

disconnection from work, social institutions, family, others, and themselves, as measured by The Alienation Test (Maddi, Kobasa, & Hoover, 1979). Religiosity was defined as the extent to which licensed practical nurses and nurses' aides expressed religious beliefs, especially a belief in a personalized deity, religious effort, and consistency in belief and action, as measured by responses on the Gladding, Lewis, and Adkins Scale of Religiosity (1979).

The work of Freudenberger (1975) and Pines and Maslach (1978) suggests that the incidence of burnout increases with the length of time in the helping professions. Cronin-Stubbs' (1983) study of hospital based registered nurses also revealed a significant correlation between burnout and length of time in the field. In this study, length of service in the nursing field was defined as the number of years and months licensed practical nurses or nurses' aides were employed in the health care field as providers of direct care.

Edelwich and Brodsky (1980) suggest that burnout is a problem across the helping professions. A significant amount of research has suggested that burnout is an issue in the health care field, and is particularly a problem for registered nurses in a wide variety of employment settings.

(Yasko, 1983; Ivancevich & Matteson, 1979; Maloney & Ange, 1982; Epting, 1981; Cronin-Stubbs, 1983).

There are a number of factors in nursing and health care which contribute to burnout. These include the following: the emotional stress of caring for ill and dying patients, a shortage of supplies, heavy, unpleasant work that is at times embarrassing, a reduced ability to establish relationships due to the physically and mentally depleted patient population, the repetitive nature of the work, low salaries, and a reduced level of consistent, positive change in patients.

Although burnout and job stress have not been studied in a nursing home setting, it seems clear that the stresses of working with the frail, institutionalized elderly are at least equal, if not greater, than those experienced in other health care settings. Employees in a skilled care nursing home must deal with the aforementioned stressors on a regular basis. Thus, this study measured burnout in persons employed in a skilled care nursing home. In this study, a skilled care nursing home was defined as a religiously affiliated health care facility providing geriatric patients with medical and nursing services that are less intensive than hospital care, but that include procedures whose administration requires the training and

skills of a licensed practical nurse. Burnout was defined as adverse physiologic, psychologic, and behavioral reactions to work stresses perceived by licensed practical nurses and nurses' aides.

Because nursing homes primarily employ licensed practical nurses and nurses' aides, the present study will investigate burnout in paraprofessionals, licensed practical nurses, and nonprofessionals, nurses' aides. Although burnout has largely been described as a phenomenon which affects professionals, it is clear that in the nursing home setting, the factors known to create burnout in providers of nursing care impact directly on both licensed practical nurses and nurses' aides. Because licensed practical nurses and nurses' aides deliver the bulk of direct nursing care in nursing homes (Handschu, 1973; Depp, Arnold, Dawkins, & Selzer, 1983; Feldman, Burke, & Schwarzmann, 1982; Burke, D'Erasmus, & Burger, 1980), there exists a particularly strong possibility that they would experience burnout. In this study, a licensed practical nurse (lpn) was defined as a female who completed one or two years in a school of nursing or vocational training school, and who was licensed by the state of Illinois. A nurses' aide was defined as an employee of a nursing home who, under the supervision of a

licensed practical nurse or registered nurse, was responsible for the personal care of the residents. Nurses' aides assisted with bathing, feeding, eating, walking, toileting, and positioning of elderly patients.

This study also measured several psychosocial variables that are thought to moderate or exacerbate the effects of work stress and burnout. These variables include social support, alienation, religiosity, and length of service in the nursing field.

Significance of the Study

Burnout has consequences for the health care field and its workers on personal, social, and professional levels. Individuals experiencing burnout have lowered self-esteem and harbor negative feelings such as frustration, guilt and anger. Personal responses to burnout range from physical and psychological problems to absenteeism and/or turnover. Job burnout often leads to increased difficulty in relationships with family and friends. It depletes the helping professions of talented, dedicated individuals. It plays a major role in the delivery of poor health care and nursing services. Patients served by burned out health care providers wait longer for help, receive less attention, and may generally receive poorer care (Maslach, 1979b; McConnell, 1982).

Given that burnout has such negative consequences and that it plays such a vital role in the delivery of the quality of health care services, it is an issue that must be studied as thoroughly as possible. Prior to this study, burnout had not been studied in nursing home employees. This study is significant because it yields new information regarding the incidence of burnout in nurses' aides and licensed practical nurses employed in skilled care facilities. The study is further significant because it provides evidence for the need for organizational changes in both health care training programs and in the nursing home industry. These changes should substantially reduce burnout in nursing home employees. This, in turn, should lead to consistent, high quality patient care.

The expanding role of nursing homes in the health care field also underscores the importance of this study. A recent report from Merrill, Lynch, Pierce, Fenner and Smith, Inc. (1979) describes nursing homes as the fastest growing segment of the health care field. Thus, this study is also significant because it contributes knowledge about a neglected or "under" researched facet of the health care system. Given that nursing home usage is expected to continue to rise, it is important that this base be expanded.

Purpose of the Study

This investigation was an attempt to study burnout in the previously unresearched health care setting of skilled care nursing homes. Additionally, burnout was measured in two "new" populations, nurses' aides and licensed practical nurses.

Based on the results of prior research, this investigation also measured four variables that were thought to moderate or exacerbate work stress and burnout. These variables have not been collectively studied to determine their effect on burnout.

Summarily, the present study attempted to address several questions. These included the following: Is burnout a problem for health care providers in nursing homes? Is social support related to burnout? Is alienation related to burnout? Does being religious and seeing a moral purpose in work reduce or eliminate burnout? Is length of employment in the health care field a factor in experiencing or not experiencing burnout?

CHAPTER TWO

REVIEW OF THE LITERATURE

The purpose of this study was to examine the relationships among the variables of social support, alienation, religiosity, and length of time in the nursing field to burnout. The present review will begin with a description of the nursing home industry and the roles of licensed practical nurses and nurses' aides in that industry. Following this, the literature related to burnout will be presented. This review will address the historical roots of burnout, as well as the present theoretical and empirical status today of burnout. Relevant theories and studies, as well as methodological and theoretical problems inherent in the study of burnout will be discussed. Each of the independent variables of social support, alienation, religiosity, and length of time in the field will then be discussed. Relevant theories and research for each of these variables will be presented and critiqued.

Nursing Homes

Historically, homes for the aged were sponsored by churches, philanthropic organizations, and city and county

governments. With the passage of the Social Security Act in 1935, which resulted in the elderly having the funds to purchase board and care in private homes, the nursing home industry came into existence. The industry grew quickly and with little government regulation (California Department on Aging [CDA], 1981).

Advances in medicine and the breakdown of the nuclear family were other factors which contributed to the need for nursing homes. Improved medical care has lowered the death rate, but has greatly increased the number of disabled individuals who require nursing home care. Also, because extended family members no longer routinely live in the same house, neighborhood, or state, family care for the infirm is not as readily available as it was in the past (Butler, 1975; Goodstein, 1981).

In the 1960's, the passage of legislation introducing Medicare and Medicaid made available to all older Americans the funds to purchase nursing home care. This availability of funds brought rapid growth to the nursing home industry. Because the industry grew so quickly and with little outside regulation, poor quality of care and unsafe or substandard physical plants were significant problems. Gradually, both state and federal agencies devised new guidelines and tightened existing regulations and

enforcement procedures in order to ensure a better quality of care. Nursing homes are now also subject to city and county codes and regulations (CDA, 1981).

The rapid growth of the nursing home industry is demonstrated by the following figures. In 1980, the number of nursing home residents was estimated at 1.5 million. By the year 2000, it is expected that there will be 2.8 million nursing home residents. Presently, there are three times as many nursing homes as hospitals in the United States. More inpatient days of care are given in long-term care facilities than in short-term general hospitals (Merrill et al., 1979). This pattern of nursing home expansion and increased usage, is expected to continue given the current push by insurance companies and the government to limit stays in acute care facilities.

Originally, nursing homes were primarily for the elderly. However, over the past 25 years, a significant trend in community mental health has been to deinstitutionalize mental patients and to place them into the community. As a result, some mental patients and those who are developmentally disabled, have found their way into nursing homes (Illinois Citizens for Better Care [ICBC], (1982). Nonetheless, the average nursing home resident tends to be female, 82 years old, white, and often without

any relatives. On the whole nursing home residents are a physically and mentally deteriorated group. Less than 50% can walk unaided, 30% are incontinent, 33% need help eating, 67% need help bathing and dressing, and 55% exhibit some mental impairment. Approximately 80% of nursing home residents will die in the nursing home (ICBC, 1982).

The present study looked at employees of homes in which the resident population was geriatric, and not developmentally disabled or mentally ill with a long standing history of psychiatric hospitalizations. These homes were skilled care facilities which by definition are homes for elderly with significant physical and often mental problems. Registered nurses, although also employed in nursing homes, were excluded from this study because the literature clearly indicates that burnout is a problem for them in a variety of settings (Maslach, 1979; Marshall & Kasman, 1980; Maloney & Ange, 1982; Cronin-Stubbs, 1983). The purpose of this study was to assess burnout in paraprofessionals and nonprofessionals in a nursing home setting. As such, only licensed practical nurses and nurses' aides were included.

A hierarchical medical model of nursing care is ordinarily used in nursing homes (Dawes, 1981). This results in both licensed practical nurses and registered

nurses spending a large part of their time in administrative tasks. Consequently, nurses' aides provide the bulk of patient care (Vladeck, 1980; Burke et al., 1980; Wallace & Brubaker, 1982).

Both nurses and nurses' aides must contend with low pay and low status by virtue of their choice to work in nursing homes (Depp et al., 1983). Further, nurses are frustrated by the lack of physician coverage and the lack of professional support in nursing homes. Another frustration is their largely administrative rather than patient care role (Vivens, 1983). Nurses employed in nursing homes must contend with additional problems such as little opportunity for professional growth, staff and supply constraints, and interaction with difficult or demanding family members (CAD, 1981). A major problem for nurses' aides is the provision of care to residents which is often physically and emotionally taxing, as well as lacking in aesthetic appeal. Aides are also confronted with high patient loads, the management of combative residents, and housekeeping chores. These problems are compounded by the fact that most aides have little training or background in the areas of mental or physical illness, rehabilitation, or the aging process (Dawes, 1981; Hyerstay, 1981).

The above should provide an adequate, albeit non-exhaustive overview of the history and development of the nursing home industry. Further, it offers some background relative to the nursing home population, and the strains inherent in working as a licensed practical nurse or nurses' aide in a geriatric nursing home. Having reviewed the institutional setting, nursing homes, for this investigation, it is appropriate to look at the literature regarding burnout and those factors which are related to burnout in nursing personnel.

Burnout

Historical Perspective. The first articles on burnout appeared in the mid 1970's. Freudenberger (1974, 1975) is credited with coining the term "burnout", as well as with initially identifying the phenomenon of burnout.

Freudenberger, a psychoanalyst in private practice, volunteered his professional services in alternative health care agencies beginning in the late 1960's. Based on his clinical practice and his own and other alternative health care agency volunteers' experience of fatigue and frustration, Freudenberger identified the phenomenon of burnout. He defined burnout as "a state of fatigue or frustration brought about by a devotion to a cause or a way of life that failed to produce an expected reward"

(Freudenberger, 1980, p. 13). Individuals become burned out by exhausting physical and mental resources by excessively striving to reach some unrealistic expectation (e.g., positive growth or change by all clients) imposed by self or others. Given his psychoanalytic background, Freudenberger explained burnout in terms of individual personality styles or characteristics. In explaining burnout in alternative health care institutions, he indicated that highly dedicated and committed workers, as well as highly authoritarian workers were most susceptible to burnout (Freudenberger, 1975). He indicated that these types of workers tend to burnout because they "took on too much, for too long, and too intensely" (Freudenberger, 1975, p. 74).

In his later work with Richelson (1980), Freudenberger acknowledged that organizational and situational factors also had a significant impact on the helper. However, he continued to place greater emphasis on the personality and make up of the individual rather than on the environment and other contextual factors. Thus, Freudenberger and Richelson indicate burnout is primarily experienced by dynamic, charismatic, goal oriented men and women who hold expectation levels of themselves and their clients which are incongruent with reality. That is, these

individuals tend to view themselves as "super-helpers" who can and should help everyone, regardless of the client's desires or motivation for change. Freudenberger and Richelson state that these individuals continue to relentlessly pursue these expectations, even in the face of obvious failure and at the cost of increasing physical and mental stress.

Christina Maslach and Ayala Pines built on Freudenberger's work. They attempted to systematically study the etiology, symptomatology, and treatment of burnout. Using questionnaires and interviews, Maslach and Pines collected data on several thousand types of human service workers. Their studies provided an empirical basis for the study of burnout. Through their exploration and publications, they popularized the concept of burnout, and legitimized its status as a significant social phenomenon (Farber, 1983). Prior to this, burnout was seen as a personal problem, thus, the establishment of it as a social phenomenon is particularly significant.

Maslach and Pines early work clearly delineated the presence of three central factors in burnout. These factors are emotional exhaustion, depersonalization, and personal accomplishment.

Maslach and Pines' approach differs significantly

from Freudenberger's in two major ways. Maslach and Pines work is empirically based, while Freudenberger's work is clinically based. Maslach's work was strongly influenced by Zimbardo's research on dehumanization and depersonalization, while Freudenberger's was influenced by his personal experience and psychoanalytic theory. Secondly, Maslach and Pines are social psychologists rather than clinicians. Due to the nature of their professional training, they explored social and organizational factors as the main determinants in burnout rather than individual personality styles or characteristics.

Maslach and Pines' research stimulated a proliferation of theories and models of burnout (e.g., Fischer, 1983; Edelwich & Brodsky, 1980; Cherniss, 1980b; Harrison, 1983; and Heifitz & Bersani, 1983). Other theorists differ in their attribution of the causes of burnout. One school of thought (e.g., Fischer, 1983) indicates burnout is the result of certain personality factors. A second, and perhaps more comprehensive school suggests that burnout is the result of a complex interplay of personal, organizational, and cultural factors (e.g., Cherniss, 1980; Edelwich & Brodsky, 1980; Harrison, 1983; and Heifitz & Bersani, 1983).

Maslach and Colleagues. Maslach's original study was

conducted between 1973 and 1975 and involved 200 professionals including poverty lawyers, physicians, prison personnel, social welfare workers, clinical psychologists and psychiatrists employed in a mental hospital, child care workers, and psychiatric nurses. The methodology included observations of these professionals at work, personal interviews, and the collection of questionnaire data. The purpose of the study was to delineate the dynamics of burnout. The results indicated that burnout was present among the helping professionals under study. Maslach (1976) determined that the burnout occurred because professionals were unable to cope with the continual emotional stress of client-professional interaction. She found that continual contact with a high volume of troubled individuals was emotionally taxing for the helper. Over time, helpers began to feel overwhelmed by the multiplicity and chronicity of clients' problems. This led to the helpers' focusing only on the clients' problems which in turn led to the helpers feeling unsuccessful or not really helpful. This combination of lack of success and continual emotional arousal resulted in the professionals' loss of concern and feeling for their clients and their treatment of them in a detached and dehumanized manner. The findings revealed the following verbal and nonverbal techniques used by subjects

to achieve detachment: using labels or diagnoses rather than the client's name, intellectualization, making a sharp distinction between job and home life, physical withdrawal, spending less time with patients, and "going by the book." This descriptive study also indicated that burnout led to physical discomfort, which in turn often led to the use of tranquilizers, drugs, and/or alcohol. Burnout appeared to be specifically a problem when the professional was forced to provide care for a large number of persons.

Maslach continued to refine her ideas and explanation of burnout. Very little of the specifics of her methodology are reported in her publications. This information, where available, is reported in the review of her work.

In 1978, Maslach defined burnout as "emotional exhaustion resulting from the stress of interpersonal contact" (Maslach, 1978a, p. 56). She suggested that burnout is a progressive phenomenon beginning with a loss of positive feelings, sympathy and respect for the client, followed by the development of a cynical and dehumanized perception of the client. As burnout advances other negative signs appear, i.e., low morale, absenteeism, turnover, a shift to administrative work, occupational

change, lowered self-esteem, increased mental and physical problems, and more frequent use of drugs and alcohol.

Maslach (1978b) delineated those factors relevant to burnout in health care personnel. She indicated that the development of burnout is a result of medical training which encourages the assumption of a dehumanized view of patients, and which ignores the emotional factors in the practice of medicine. Prolonged and stressful patient contact is always heavily correlated with burnout. Burnout is negatively correlated with the caregivers recognition and awareness of his/her feelings, a social and professional support system, the use of humor, a variety of patient contact, separation between job and personal life, and physical well-being.

Maslach and Pines (1977) studied the burnout process among staff members of day care centers in order to test the hypotheses derived from their earlier research. They were particularly interested in determining whether or not the quality of the professional interaction was dependent upon the number of people for whom the professional was providing care, and the degree to which the client-staff ratio affects staff burnout. Eighty-three subjects from an unspecified number of child care centers completed extensive questionnaires covering the following areas:

individual demographics, job characteristics, attitudes concerning the job and children, and perception of their own mood states. An unspecified number of subjects were also interviewed. The ratios of staff to children ranged from approximately 1:4 to 1:12. The results indicated that the likelihood of burnout becomes greater as the amount of direct, continuous contact between staff members and children increases. A high ratio of staff to children negatively impacts working conditions and staff members' feelings about their jobs. A second finding suggested that longer work hours did not necessarily lead to burnout when the longer work hours involved administrative tasks rather than working directly with children. Observations in this study also revealed a form of positive withdrawal known as "time out." Time-outs are opportunities for staff members to voluntarily choose to do some less stressful work while other staff members take over his/her direct care of the children. The number of staff meetings and their perceived importance was found to be clearly related to better working conditions in the centers. Finally, the quality of work relationships was associated with a greater liking of the job, a greater sense of success, and more good days than bad days.

Maslach and Jackson (1978) report that burnout is a

significant problem for legal service attorneys. Some factors in legal service work which contribute to burnout are excessive caseloads, and often routine, unchallenging legal work. Large caseloads result in poor pre-trial preparation, and also the "slotting and typing" of cases and clients. Maslach and Jackson further indicate that unrealistic expectations on the part of clients and attorneys result in additional frustration, resentment, and ultimately in burnout.

Pines and Maslach (1978) examined institution-related and individual variables in 76 staff members in various mental health facilities in the San Francisco area. The subjects included psychiatrists, psychologists, nurses, social workers, attendants and volunteers who were employed in a state hospital, an army hospital, a county hospital, or a halfway house. The data were collected through interviews which covered participant background information, characteristics of the job, attitudes and feelings about mental health work and patients, and self-perceptions. A significant correlation between the length of time served in the mental health field and a) the loss of enthusiasm for the work, b) the less successful helper-helpee relationships, and c) an increase in anti-humanistic attitudes toward mental illness was found. Other

significant findings indicated that the larger the patient-staff ratio, the less staff members liked their jobs and the greater their tendency to compartmentalize their lives. Also, the less seriously ill the patients and the fewer the work hours, the better were helper-helpee relationships, and when work relationships were good, the staff reported having mostly "good days". When staff-patient interaction was good, staff members liked their work and felt successful and fulfilled. The authors also found that a high frequency of staff meetings correlated with negative and dehumanizing attitudes toward patients. Importantly, staff members who could temporarily withdraw from direct patient care, showed more favorable attitudes toward patients. Longer hours correlated with more staff stress and negative feelings, while work was perceived as less stressful when the general workload was shared. Staff members who believed that they had input into the institutions' policies had a more positive view of themselves and the patients, and those who felt successful on the job had a more positive perception of themselves.

Maslach (1978c) delineated the role that clients play in staff burnout. Client factors which contribute to burnout are the type and severity of problems, the prognosis for change or cure, the personal significance of

the client's problem for the helper, the organizational rules covering client-staff interaction, and the clients' attitudes and reactions to staff behavior. Thus, clients with severe, chronic problems, who elicit countertransference feelings from the helper, and who react passively and/or negatively to the helper's efforts tend to contribute to the burnout of helpers. Additionally, institutional rules which govern the staff-client relationship also contribute to burnout. For example, rules which require staff to elicit financial information before dealing with the client's problem, which restrict the provision of certain services or funds, or which limit the amount of time spent or choice of clients served, all contribute to the worker feeling trapped, helpless, and emotionally stressed.

Maslach and Jackson (1979) studied 130 police couples in California in order to better understand the relationship of burnout to increased family difficulties. The officers were asked to complete the Maslach Burnout Inventory and a lengthy questionnaire covering the areas of work satisfaction and conditions, family relationships, and coping techniques used to deal with stress. The officers' spouses completed a questionnaire about their husbands' job and their behavior at home. The results clearly showed

that higher burnout scores were associated with domestic strains that were absent or mild in the families of officers who reported low burnout. Officers in the top third of the burnout continuum appeared to be alienated from their wives and children and appeared to be at some risk for emotional and behavioral problems. The increased use of alcohol and tranquilizers also correlated with higher burnout scores.

Pines and Kafry (1978) studied occupational tedium among social service workers. Tedium was defined as "a general experience of physical, emotional, and attitudinal exhaustion" (Pines & Kafry, 1978, p. 499). Their work on occupational tedium was derived from prior research in the area of stress, environmental work stress, and burnout. In this study, 129 social service workers attending a workshop on occupational burnout volunteered to complete 5 questionnaires measuring tedium, and internal and external work characteristics. Tedium negatively correlated with the external characteristics of work relationships, work sharing, time-outs, and social feedback from supervisors and colleagues. No internal variables correlated with tedium. Rather, the internal variables correlated with indices of job satisfaction. In terms of organizational factors, caseload was found to be an important correlate of

tedium. On the basis of their findings, Pines and Kafry suggested that social workers might be more than normally sensitive to people as sources of both emotional stress and support. This individual personality trait of sensitivity to others can either increase or decrease the experience of burnout depending on the interpersonal characteristics of the work environment.

Pines and Aronson with Kafry (1981) delineate 3 common antecedents of burnout in the human services. These are the emotionally taxing nature of the work, certain personality characteristics (e.g., sensitivity toward others) and the client-centered orientation which is inherent in the work. They also suggest that burnout may generally be a bigger problem for women than for men. They indicate that women often are socialized to enter the helping professions and to be sensitive. Because women are "supposed to be more sensitive to others", they are more upset by their burned out feelings than men. The authors also note that women often have the added stress of a job at work and at home.

Maslach and her colleagues delineated burnout as a problem among members of the helping professions. They clarified the process of burnout in which professionals begin to feel overwhelmed and exhausted by the chronic

emotional stress of their work, then lose all positive feelings for clients, and finally treat clients in detached ways. Professionals inability to cope successfully with the emotional stress of their jobs leads to the use of detachment techniques which are ultimately harmful to the client and the professional. Detachment techniques employed are detached concern, intellectualization, compartmentalization, withdrawal, and reliance on other staff members. In the studies reported here, burnout correlated highly with turnover, absenteeism, low morale, increased drug and alcohol use, marital difficulties, and emotional and physical difficulties.

As a result of the popularization and legitimization of burnout by Maslach and her colleagues, a number of other theorists and researchers have proffered a range of theories and models of burnout. Those which pertain to burnout in the helping professions will be briefly presented below.

Other Theories of Burnout. The only other author to approach burnout from the perspective of Freudenberg (Freudenberg, 1974, 1975; Freudenberg & Richelson, 1980) is Fischer (1983). He presents a psychoanalytic view of burnout. He differentiates between "worn out" and "burned out" helpers. Worn out workers have lowered self-

esteem due to job stress and environmental pressures. Burned out workers, on the other hand, cling to high sense of self-esteem in the face of job pressures. He suggests that burned out helpers have idealized their occupations, and therefore pursue the "illusion of grandiosity" beyond reasonableness, common sense, and any concern for personal health and well-being. Fischer's view, like Freudenberger and Richelson's, is limited because it focuses solely on the personal characteristics and dynamics of the individual.

Edelwich and Brodsky (1980) represent another school of thought that acknowledges individual factors in burnout, but is primarily concerned with organizational and cultural factors. Edelwich and Brodsky do not present much detail about their subjects or data collection procedures, rather they state that their ideas on burnout are based on interviews with individuals in the helping professions. They define burnout as "a progressive loss of idealism, energy, and purpose experienced by people in the helping professions as a result of the conditions in their work" (Edelwich & Brodsky, 1980, p. 14). Factors which significantly contribute to burnout are the following: noble aspirations and high initial competence of helpers, the lack of criteria for mastery accomplishment, low pay

levels, sexism, inadequate funding and institutional support, inefficient use of resources, and high public visibility coupled with popular misunderstanding and suspicion.

Edelwich and Brodsky view burnout as contagious, although it is not necessarily inevitable. They posit five stages of burnout beginning with Enthusiasm, followed by Stagnation, Frustration, Apathy, and ending with the Intervention stage in which the burnout cycle is broken either positively by the worker or organization making growthful changes or negatively by the worker quitting his job, getting fired, or becoming physically or mentally ill.

Cherniss (1980a, 1980b) also stresses that burnout is a joint result of organizational, cultural, and personal factors. He presents burnout as a process which consists of three stages. In stage one, the helper experiences an imbalance between resources and demands (stress). In the second stage, the helper makes a short-term response to this imbalance by becoming anxious, tense, fatigued or exhausted (strain). In the third stage, the helper makes a number of changes in attitude and behavior, e.g., perhaps he/she begins to treat clients in a detached manner or becomes preoccupied with his/her own needs (defensive coping). In this model, burnout is seen as a transactional

process consisting of job stress, worker strain, and psychological accommodation.

According to Cherniss, burnout initially represents a psychological response to an intolerable situation (i.e., one in which stress and strain cannot be alleviated through active problem solving). Psychological accommodation and the defensive coping mechanisms of emotional detachment, withdrawal, cynicism, and rigidity, ensure that further strain will not be added. A problem with defensive coping is that it contributes to the self-reinforcement of burnout. When the worker withdraws or is cynical, he/she is sure to be less effective with clients. This perpetuates and reinforces the "burnout cycle" for the helper.

Cherniss believes that it is important to distinguish burnout from temporary fatigue or strain and from turnover. While both of these may be signs of burnout, they are not equivalent to the profound, chronic experience of burnout.

Cherniss lists 28 signs of stress and burnout. These range from frequent clock watching to feeling immobilized.

Cherniss and Krantz (1983) note that past research on burnout overlooked an important precursor of burnout, namely the loss of commitment. Cherniss and Krantz suggest that burnout does not begin with stress, but with the loss

of commitment and moral purpose in work. They suggest the focus of research should be on these variables. Their study will be presented in greater detail in the discussion of the variables of alienation and religiosity.

Harrison (1983) presents the Social Competence Model of burnout which takes into account the interplay of relationships between clients, helpers, and the organization. In this model, burnout is not an inevitable consequence of certain occupations, but is rather related to the individual's feelings of perceived competence. The beginning worker is highly motivated to be "helpful", but his/her ability to actually be helpful is determined by the following factors: the severity of the clients' problems, the strength of environmental resources and barriers, and the worker's skills. Harrison states that the major motivation for helpers is the knowledge that one is effectively changing a part of the social environment. When this sense of being "effective" is absent due to client, environmental, or helper deficits, stress and burnout is likely to result.

Parts of this model are supported by the work of Cherniss (1980), and Pines and Aronson (1981) which also emphasizes the importance of competence for the helper. These authors suggest that a feeling of incompetence or

of being unsuccessful is closely correlated with burnout. Cherniss (1979) additionally stresses the impact of institutional barriers in creating burnout.

Heifitz and Bersani (1983) present a model of burnout based on the "disruption of the cybernetics of personal growth" (p. 46). The model assumes helpers have two basic needs. The first is the need to promote growth in others, and the second is the need to grow personally on the job. Growth in self and client are best perceived and measured according to Heifitz and Bersani when milestones or outward measures of success are approached, attained, and passed. Burnout cannot occur when the worker is able to satisfactorily pursue and attain these outward measures of success. When burnout does occur, it is because one or more of the following elements necessary for measuring and attainment are missing: clearly defined goals consistent with the values and priorities of the helper and client; objective reliable milestones reflective of growth in the client and mastery in the worker; a set of reliable and objective short-term indicators of progress toward goals, and procedures for gathering and interpreting data related to short-term indicators, and strategies for adjusting pursuit of goals based on data related to short-term progress.

The importance of clear goals and tasks is underscored by the work of several other researchers. Hackman and Oldham (1975) cite the ability to work on clear cut start-to-finish jobs as a basic component of satisfying work. Cherniss and Egnatios (1978) additionally identify ambiguous objectives as significant source of frustration for community mental health workers.

The current study was based primarily on the work of Maslach and her colleagues. As such, burnout was viewed as a process in which the worker became overwhelmed by the volume and emotional intensity of the client-staff interaction. The helper becomes emotionally exhausted and treats his/her clients in a detached and dehumanized manner. Thus, burnout in this study was seen as a product of social and organizational factors, rather than as the result of certain personality styles or characteristics.

Although there are other theories and models of burnout offered, these are some of the major ones related to burnout in the helping fields. Based on the work of these researchers and theorists, burnout has been examined in a number of occupations and settings. Burnout has been found to be a problem for child care workers (Daley, 1979; Maslach & Pines, 1977), registered nurses employed in public hospitals (Ivancevich & Matteson, 1979), clinical

nursing specialists (Yasko, 1983), career development specialists (Forney, Wallace-Schutzman & Wiggins, 1982), mental health counselors (Warnath & Shelton, 1976), administrators (Veninga, 1979), nurses on high stress pediatric units (Maloney & Ange, 1982), nursing administrators (Clark, 1980), oncology nurses (Epting, 1981), rehabilitation workers (Emener, 1980), ambulance paramedics (Scott, 1980), and hospital based registered nurses in psychiatric-mental health, operating room, intensive care, or medical specialty areas (Cronin-Stubbs, 1983).

There are several problems evident in the research studies and theories already discussed. A major problem is that as burnout has been studied by different persons, its definition has changed and the concept has been rapidly expanded. Maslach (1982) suggests there are at least 15 definitions of burnout found in the literature. Differences in definition have also led to differences in measurement, thus creating problems in terms of comparability of data and results. Additionally, much of the theory about burnout is not empirically based (e.g., Freudenberger, Fischer, Harrison, and Heifitz and Bersani). Although Edelwich and Brodsky's work is empirically based, they do not present enough information to assess whether

their work is empirically sound. The authors state they interviewed professionals in the helping fields. However, they do not give any information regarding the number of subjects, the exact occupations or jobs of the subjects, the types of employer organizations, the interview questions or format, or the length of time over which the study was conducted. Many of the early studies and theories have also assumed a relationship between burnout and other variables without attempting to verify or corroborate that relationship. Shinn (1982) indicates that some researchers have failed to distinguish between concepts like burnout, turnover, and job satisfaction. Although Maslach and Pines and their colleagues' work is empirically sound, they have tended to generalize across work groups and across the helping professions. Additionally, Maslach and her colleagues, as well as many of the other researchers, have talked about burnout as a professional malady, while including both paraprofessionals and nonprofessionals as subjects in their studies.

In this investigation an attempt was made to remedy a number of these problems. Burnout was defined in this study as adverse physiologic, psychologic, and behavioral reactions to stressors perceived by licensed practical nurses and nurses' aides. According to Maslach (1982),

this definition reflects a common core of agreement in the burnout literature. Burnout was measured by the Staff Burnout Scale for Health Professionals (Jones, 1980) which is one of the five major measures of burnout currently in use. The Staff Burnout Scale for Health Professionals was chosen because it is specifically targeted to health care providers. The present investigation was designed to empirically measure burnout and other psychosocial variables that the literature suggests are related. These variables are social support, religiosity, alienation, and length of service in the nursing field. The present investigation involved two populations, licensed practical nurses and nurses' aides. In the domain of nursing, licensed practical nurses are considered paraprofessionals, while nurses' aides are nonprofessionals. Thus, one purpose of this investigation was to assess empirically whether paraprofessionals and nonprofessionals experience burnout. The subjects participating in this study were employed in skilled care facilities. Another purpose of this investigation was to determine whether nursing homes are another work setting in which burnout can occur.

Social Support

Throughout the burnout literature, social support is discussed as a variable or factor which is negatively

correlated with burnout. Both theoretical and empirical evidence for this is provided in the work of Maslach and Pines (1977), Pines and Kafry (1978), Maslach (1979), Appelbaum (1981), Shinn (1982), Yasko (1983), and Farber (1983).

The literature on occupational stress also clearly demonstrates social support to be a factor that decreases occupational stress in the individual. There is, however, disagreement in the literature on the exact mechanisms and the optimal sources of social support that attenuate job stress.

There are two major schools of thought about the relationship between social support and stress. It is important to note that much of the theorizing and research has been on the relationship of life events, social support, and stress (Gore, 1978; Dean & Lin, 1977; Cobb, 1976; Andrews, Tennant, Hewson, & Tennant, 1978; Billings & Moos, 1981). One school of thought supports the "buffering hypothesis" which suggests that the individual's support system helps moderate or buffer the effects of stress upon his/her psychological state. Thus, individuals with little or no social support may be more vulnerable to the negative consequences of stress. Gore (1978) and House and Wells (1978) are some of the proponents of this view. A second

school of thought supports the "main effect" of social support upon distress. According to this position, social support is directly related to psychological well-being, independent of stressors. That is, the psychological functioning of the individual is thought to be directly dependent on the degree of social support possessed by the individual. Proponents of this view are Pinneau (1975, 1976), Andrews et al. (1978), LaRocco and Jones (1978), and Lin, Ensel, Simeone, and Kuo (1979).

Another source of confusion and disagreement has been over the types and sources of social support that are related to work stress. Gore (1978) suggests family support is negatively correlated with stress. Kobasa and Pucetti (1983), however, found that perceived family support had a negative effect on health and stress in certain types of personalities. Their findings suggested that perceived boss support was more important than family support. Kobasa and Pucetti concluded that if social support was to be a successful buffer for executives, then it is work stresses on which it must be effective. The work of House and Wells (1978), LaRocco and Jones (1978), LaRocco, House and French (1980), Paredes (1982), and Winnburst, Marcelissen, and Kleber (1982) all indicate that job related support is more negatively correlated with job

stress and burnout than non-job support. These authors differ in terms of emphasizing the importance of supervisor versus co-worker support. Paredes, House and Wells, and Winnburst et al. suggest supervisor support is more important than co-worker support. LaRocco et al. maintain that co-worker support had a greater impact than supervisor support. LaRocco and Jones found no significant difference between the effect of co-worker and supervisor support.

There have been many methodological and conceptual problems with past research in the area of social support. These problems include the following: lack of a precise definition of social support, inadequate forms of measurement, the theoretical and methodological confounding of life events and social support measures, a failure to distinguish between types and sources of support and the different circumstances in which they are effective in relieving stress, the neglect of the impact of individual personality characteristics, the failure to take into account the ambiguous or negative effects of social support, and a lack of prospective studies (Thoits, 1982; Dean & Lin, 1977; Billings & Moos, 1981; Gentry & Kobasa, 1984; Suls, 1982).

While the present investigation does not address all of the above shortcomings, it does, nonetheless, address at

least a proportion of them. In this study, social support has been limited in scope to work-related support, that is, support provided by co-workers and supervisors. The Work Relationships Index (WES; Moos, 1981; Moos & Insel, 1974), which has both high reliability and validity, was used to measure the perceived quality of the work milieu with respect to its supportiveness. In this investigation the relationship of perceived work-related support to job stress/burnout was studied. The effect of different personality characteristics or individual differences was at least partially addressed through the measurement of the variable of alienation.

Summarily, the present investigation attempted to avoid past methodological and theoretical problems by employing a clear definition of social support and reliable and valid instrumentation (see Chapter Three). Further, this investigation looked at one type or source of support, namely work-related support and its effect on burnout. Individual differences were also taken into account.

Alienation

As discussed earlier, Cherniss and Krantz (1983), reformulated Cherniss' ideas on burnout. The authors state they spent time as observers in a residential setting for mentally retarded people and at a Montessori school for the

emotionally disturbed and mentally retarded. The home for the mentally retarded was operated by a Catholic religious order. Cherniss and Krantz noted that the nuns at this facility had much greater involvement and more continuous contact than is normally found in a human service program. These nuns lived and worked at the residential facility, and interacted with clients 7 days a week, 52 weeks a year. In addition to caring for clients, the nuns also shared in all the heavy and menial housekeeping tasks, such as picking up garbage and scrubbing floors. Although many of these nuns worked at this facility for close to 30 years, they showed no signs of burnout.

The Montessori school was for mentally retarded and emotionally disturbed children excluded from the public school system. The school had adopted the Montessori methodology approximately five years prior to the study. All of the teachers identified with and were certified in the Montessori approach. The teachers reported feeling a great deal of support from their shared ideology and from the "hands on" assistance they received from other teachers when classroom problems occurred. Again, there was no evidence of burnout, although these teachers worked year round with a very difficult population of children.

Because the nuns' and teachers' experience violated

all assumptions and theories of burnout, Cherniss and Krantz were challenged to devise a broadened conceptualization of burnout. Their new formulation indicated that burnout did not begin with stress, but rather with the loss of commitment and moral purpose in work. They further theorized that burnout is least in ideological communities where there is a clear explicit ideology, and where membership is contingent upon identification and adherence to the methodology. They suggest that a formal ideology can sustain commitment in a number of ways. An ideology which places emphasis on intrinsic rewards, and which confers special status on the more routine, unpleasant or aversive aspects of the work, especially contributes to commitment.

Cherniss and Krantz suggest there is a bias against ideological communities in the helping fields. This bias is linked to the professional's desire to maintain a neutral, objective and value-free stance. The authors state that professionals are not comfortable with moral beliefs in work roles or work settings. Nonetheless, Cherniss and Krantz maintain that a "renewal of the moral tradition" in the work place would eliminate burnout in the future.

Cherniss and Krantz have employed observational

techniques and interviews in two settings, the religiously owned home for the mentally retarded, and a Montessori school, in order to test out their new hypothesis on burnout. The present investigation attempted to provide further empirical evidence for the hypothesis that burnout is the result of the loss of commitment and moral purpose in work. Thus, the present study explored the relationship of religiosity and alienation to burnout.

The concept of religiosity parallels Cherniss and Krantz' concept of a clear, explicit ideology conferring a moral purpose on work. This investigator obtained a measure of alienation rather than commitment for both methodological and theoretical reasons. That alienation and commitment are intrinsically related is demonstrated by both Kobasa (1979, 1982, 1984) and Kanungo (1979). In Kobasa's work, she consistently defines commitment as the "absence of alienation", and she measures it with two scales from The Alienation Test. Kanungo asserts alienation and involvement/commitment are opposite poles of the same phenomenon.

According to Johnson (1973), alienation and particularly social alienation is an ancient concept. Alienation was originally employed by theologians as an explanatory concept for the separation of individuals from

their bodies, God, and others. Later, sociologists, such as Marx, Weber, and Durkheim conceptualized alienation in terms of alienation or disassociation from society and work. Alienation was viewed as the result of a lack of individual autonomy, control, and power at work and in society.

Another sociologist, Seeman (1959, 1971) proposed five variants or dimensions of alienation. Each of these referred to a subjectively felt psychological state of the individual created by different environmental conditions. Seeman's 5 dimensions are powerlessness, meaninglessness, normlessness, isolation, and self-estrangement. Although Seeman's categories have been the subject of little empirical study, they nonetheless pave the way for the recognition of alienation as a multidimensional concept. Other alienation studies, according to Kanungo (1979), have centered on broad demographic characteristics such as age and socioeconomic status, epidemiological categories (e.g., alcoholism and criminality), or instrumental social behaviors (e.g., voting).

Kanungo (1979) maintains that psychologists have only recently become interested in the concept of alienation. He indicates that the development of psychological theories to explain the phenomenon of alienation is absent from the

literature. Maddi, Kobasa, and Hoover (1979) proposed that the subjective experience of alienation has played a major role in much humanistic theorizing. However, they also note there has been little provision for developing reliable and valid measures of the state of alienation.

Based on Kanungo and Schacht's (1973) multidimensional conception of alienation, Maddi et al. (1979) developed an alienation test which samples 4 types and 5 contexts of alienation. The types represent major themes in humanistic theorizing, including: powerlessness, or feelings of impotence regarding social and personal affairs; adventurousness, or the inability to feel fully alive unless one is involved in dangerous or extreme undertakings; nihilism, or the active attempt to discredit anything which has meaning; and vegetativeness, or the inability to believe in the truth, importance, or value of anything in which one is engaged. These types of alienation can be found in the individual's relationship to work, social institutions, family, others, and self. The latter serve as the five contexts of alienation.

Maddi, Hoover, and Kobasa (1982) have used this test to study the relationship of alienation to exploratory behavior of an unfamiliar but ordinary environment in undergraduate and graduate students. Their findings

suggest that nihilism and adventurousness are the most inhibitory types of alienation. Further, social institutions, other persons, and the self were found to be the most inhibitory interpersonal contexts for alienation.

In a related body of work, Kobasa and Maddi and others have looked at the personality variable of hardiness as a resistance resource in buffering the noxious effects of stressful events. Hardiness is defined as a combination of the following tendencies: a tendency toward commitment rather than alienation, toward control rather than powerlessness, and toward challenge rather than threat. Individuals possessing commitment are interested in their undertakings and involve themselves wholeheartedly in them. Individuals strong in control believe and act as if they have an effect on events in their lives. Individuals with a tendency toward challenge accept the inevitability of change in their lives and further anticipate changes as occasions for personal growth and development. In this model, hardiness buffers by influencing the coping style which allows the transformation of the events themselves. That is, hardiness leads to transformational rather than regressive coping. Transformational coping involves directly facing stressful events, thinking optimistically about them, and then acting decisively to change them in a

less stressful direction. In several studies, hardiness correlated with health rather than illness, regardless of the amount of stress. In a study of 157 general practice lawyers, Kobasa (1982) found increases in strain were significantly determined by the personality characteristic of alienation, by the use of regressive coping techniques (e.g., increased smoking and drinking, use of tranquilizers to relax, inappropriate expression of anger), and by stress levels. That is, hardiness leads to transformational coping rather than regressive coping. In explaining the results, Kobasa postulated commitment was relevant to stress resistance because it indicated a willingness to believe in what one was doing as well as a willingness to exercise control in personal and social situations. Alienation, on the other hand, leads a person to feel apathetic and powerless in the face of stressful events. Thus, commitment fosters healthy coping techniques that help buffer life stresses, while alienation fosters regressive coping techniques that do little to effectively moderate or buffer stress.

The only other reference to alienation and health status is in the work of Moss (1973). He suggests the person most likely to fall ill is alienated from others and society. He adopts an information processing perspective.

From this perspective, he suggests that lack of integration means the receipt of incongruous information from the environment. He states that individuals fall ill when the information they receive is so incomprehensible, surprising, or inaccurate that it further prevents these alienated individuals from successfully interacting in their social world. Thus, those having few social supports and only a marginal status in society are most in danger of illness, in his opinion.

Summarily, it is clear that Cherniss and Krantz' approach to commitment as an antidote to burnout is fairly unique. Although commitment and alienation as factors in job stress have not been heavily researched by sociologists or psychologists, the related research on hardiness and stress offers at least partial support for Cherniss and Krantz' work. Additionally, Kobasa and Maddi's work on hardiness articulates the mechanisms by which commitment buffers the effect of stress, at least insofar as it is related to health and illness.

Religiosity

Although Cherniss and Krantz have postulated that religiosity or commitment to a religious ideology moderates job stress and/or burnout, this relationship has not been empirically studied. Further, the only other

reference in the literature to this relationship is found in the work of Friel and Tehan (1980) who studied stress and burnout in hospice workers. These authors suggest that the relationship of religiosity and burnout would be an area of fruitful future research.

Religiosity has been studied, however, in relation to variables other than work satisfaction and job stress. A number of investigators have attempted to examine the relationship of religiosity to both physical and mental health. A brief discussion of the research in these areas follows.

Although the results have been varied, a number of researchers have found that religiosity correlates with indices of health and health behavior. One of the earliest studies was conducted by Scotch (1963) in the Zulu community (N=1053). He found that church going Zulu women had a decreased incidence of hypertension compared to non-church goers. However, he also found that the reverse was true for Zulu men. In Zulu society, women were expected to attend church, while men were considered odd if they attended church. Scotch postulated that people who deviate from the social norms of the community were more likely to be hypertensive. Archer, Rinzler, and Christakis (1967) found no significant relationship between the frequency of

church attendance and level of participation in an anti-coronary club. Calahan, Cisin, and Crossley (1969) found a significantly lower rate of heavy drinkers in churchgoers. This relationship held for all groups except Catholic men, who had equal numbers of heavy drinkers in both the church going and non-church going groups. Monk (cited in Comstock and Partridge, 1972), after controlling for sex, race, and age found that patients with cancer of the rectum were less likely to be members of a religious group. This relationship was not obtained for patients with cancer of the colon.

Research from the Israeli Ischemic Study, as reported in Graham, Kaplan, Coroni-Huntley, James, Becker, Hames and Heyden (1978), suggests an increased risk of myocardial infarction among the non-religious or less religious versus the very religious. Religiosity was measured by frequency of attendance at the synagogue. Although adjustments were made for age, the effects of dietary or other differences in habits was not taken into account in this study. Because diet is a significant risk factor in heart disease and because orthodox jews differ markedly in diet from other religious and nonreligious jews, this omission may have confounded the results.

In 1963, unofficial census data for Washington

County, Maryland were collected and studied (Comstock, Abbey, & Lundin, 1970). Additional questions concerning education, housing, smoking, marital history, religious affiliation and frequency of church attendance were asked, along with official census questions. Ninety percent of the 91,909 respondents supplied information to the questions concerning religion. The results of the Washington County studies indicated that churchgoers, in comparison to non-churchgoers, had less incidence of trichomoniasis (Naguib, Comstock, & Davis, 1966), abnormal cervical cytology (Naguib, Lundin, & Davis, 1966), tuberculosis, arterioschlerotic heart disease, emphysema, cirrohsis, and suicide. Adjustments for differences in race, age, and sex did not result in major differences in relative risks.

Graham et al. (1978) examined blood pressure levels of white male heads of households and church attendance. After controlling for the effects of age, body mass, smoking, and socioeconomic status, a consistent pattern of lower systolic and diastolic blood pressure was found in frequent churchgoers in comparison to infrequent churchgoers.

Clearly, the research in the area of religiosity and physical health is scanty. Graham et al. (1978) suggest

the examination of the relationship between religious behavior and health is in its infancy. Additionally, the preceding studies are flawed by a number of methodological and theoretical shortcomings. These studies assume that church attendance affects health, yet no provision is made for the fact that health, especially ill health, can markedly affect church attendance. A number of the studies equate church attendance with religiosity. This is clearly a theoretical error since religiosity is a multidimensional phenomenon, and church attendance is only one aspect of the dimension of religious practice. Further, some of the studies, such as Graham et al., have defined frequent churchgoers as those who attend once or more per week, and non-frequent churchgoers as those who attend less than that. Under this classification system, persons who attend church three times a month are included with individuals who attend church once a year. It seems that the basis for the distinction between frequent and non-frequent churchgoers was arbitrarily chosen and may not accurately reflect the true range of church attendance. Thus, although research in this area of research is promising, there is much work to be done before the relationship of religious behavior to health can be understood.

Researchers have also attempted to examine the

relationship between religiosity and mental health (e.g., Bergin, 1983; Lindenthal, Myers, Pepper & Stern, 1970; Stark, 1971). Results in this area have been contradictory and ambiguous. Bergin (1980) attributes divergent findings to the failure to differentiate the diverse contents, processes, and dimensions of religious behavior in empirical analysis. Bergin (1983) reported a meta-analysis of all studies through 1979 with at least one religiosity measure and one clinical pathology measure. His findings indicated a marginal support for the positive effect of religiosity on mental status, and no support for the hypothesis that religiosity is bad for mental health.

The work of Lindenthal et al. (1970) and Stark (1971) further underscore the positive relationship between religiosity and mental health. Lindenthal, in a study of 1000 New Haven residents, found a negative relationship between mental impairment and church affiliation and attendance. Stark collected data at the Survey Research Center at Berkeley and the National Opinion Research Center at the University of Chicago. His results showed that mental illness and religious commitment are negatively correlated. Bergin (1983) also reports that religious involvement is negatively correlated with social problems, such as alcohol abuse, sexual permissiveness, drug abuse,

and deviant or delinquent acts.

Although the initial research postulates some relationship between religiosity and both mental and physical health, there has been little explanation of how these variables are related. Kaplan (1976) speculates that religious attendance can be helpful to the cardiovascular system. He suggests that the religious social mechanisms of ritual behavior, provision of support, and coping models contribute to the maintenance of hope, the regulation of depression, fear, and anxiety, and the maintenance of social-personal integration. These factors, in combination with religious proscriptions around heavy drinking and smoking, contribute to healthy cardio-vascular functioning. Antonovsky (1979) offers a different explanation of the relationship between religion and health. He classifies religion as one of the major psychosocial generalized resistance resources. As such, in this model, it helps to reduce stress and thereby eliminate stress in two ways. First, according to Antonovsky, religion can help an individual overcome or cope more effectively with a stressor, thereby reducing tension. Secondly, religion offers a consistent set of values and answers which provide individuals with a strong sense of coherence. For Antonovsky, maintaining a sense of

coherence is crucial in eliminating disease and maintaining health.

The relationship between physical and mental health and religiosity has not been clearly or sufficiently examined. Much of the research was conducted in the early 1960's and 70's and was marked by a failure to take into account the multidimensionality of religiosity. In many of these studies, researchers equated religiosity with church attendance or with the expression of belief in a supreme being. By measuring only one of the dimensions of religiosity, research results were clearly limited and at times skewed. Bergin (1983) also suggests that because this early research employed such divergent measures of mental health as well as religiosity, it is not surprising that the results have been so mixed and contradictory.

The dimensionality of religiosity has been established by Glock (1962), Cline and Richards (1965), Broen (1957), and DeJong, Faulkner, and Warland (1976), and King and Hunt (1975). Glock offers five dimensions of religiosity, namely the ideological, ritualistic, experiential, intellectual, and consequential. King and Hunt list 21 dimensions including Glock's five. In the present investigation, religiosity will be measured by the Gladding, Lewis, and Adkins Scale of Religiosity (GLASR).

The GLASR provides a measure of the scope and intensity of religious beliefs across four main factors or dimensions. These are personalized deity, measured by items such as "I believe there is a supreme being or power"; religious belief, measured by items such as "My actions reflect my religious beliefs"; religious effort, measured by items such as "People who are religious need to study the basis of their beliefs"; and consistency of belief and action, measured by items such as "Religious people practice what they preach". The GLASR was chosen because it was one of the few available instruments measuring religiosity. Reliability and validity data are reported in Chapter Three.

The relationship between religiosity and stress and burnout has been minimally examined in the literature. Based on the recent work of Cherniss and Krantz (1983), the current study attempted to explore the relationship between burnout and religiosity in licensed practical nurses and nurses' aides employed in skilled care facilities. The current investigation attempted to overcome past methodological errors by employing an instrument measuring the multiple dimensions of religiosity.

Length of Service in the Nursing Field

The last variable under investigation in this study

was length of service in the field of nursing. This variable was chosen for study based on the work of Freudenberger (1975) and Pines and Maslach (1978). Freudenberger maintains that the stress of helping builds up over time. In a study of mental health professionals reported earlier, Pines and Maslach reported that the longer staff members worked in the mental health field, the less they liked working with patients, the less successful they felt with them, and the more custodial and less humanistic were their attitudes toward mental illness.

In a study of 294 hospital-based registered nurses, Cronin-Stubbs (1983) examined the relationship of occupational stress, work setting, social support, and life stress to burnout. Length of service in the field was not a variable in her study, however, additional analysis of the data revealed that length of service in nursing correlated positively and significantly with burnout ($r = 0.11$, $p = 0.0492$).

Although the literature reveals very little about the relationship between time in the field and burnout, this variable was included in this investigation based on the work of these four researchers and based on the investigators own personal experience. As a social work consultant to four nursing homes for eight years, the

investigator has regularly heard statements from nurses and nurses' aides that after so many years they could no longer cope with the strain and stress of caring for the elderly. Length of service in the nursing field was measured by an item on the demographic questionnaire.

Summarily, the literature demonstrates burnout is a significant social phenomenon that is found across the helping professions. Prior research also indicates that burnout is moderated by social support and religiosity, but exacerbated by feelings of alienation and length of service in the nursing field. In this investigation an attempt has been made to study burnout in a previously unresearched setting -- nursing homes, and population -- licensed practical nurses and nurses' aides. The investigation has also attempted to measure several variables that have not been collectively studied and that are known either to exacerbate or moderate the experience of burnout. These variables are social support, alienation, religiosity and length of service in the nursing field. In this chapter, prior research on all of these variables has been presented. Theoretical and methodological flaws have been discussed. The current investigation has attempted to remedy a number of these shortcomings through the use of clear definitions and reliable and valid instrumentation.

CHAPTER III

METHODOLOGY

This investigator obtained a measure of burnout in licensed practical nurses and nurses' aides employed in long-term care facilities. The variables, social support, religiosity, alienation, and length of service which are thought to mediate the degree of burnout experienced, were also measured. In this chapter, the hypotheses, subjects, procedures, research design, and statistical analysis used in this investigation are described.

Hypotheses

The following null hypotheses were tested:

1. There is no relationship between length of service, social support, alienation, and religiosity and the degree of burnout experienced.
2. There is no relationship between length of service and the degree of burnout experienced.
3. There is no relationship between alienation and the degree of burnout experienced.
4. There is no relationship between religiosity and the degree of burnout experienced.
5. There is no relationship between social support and

the degree of burnout experienced.

Subjects

Selection. The investigator contacted the administrator and Director of Nursing of three religious skilled care facilities and briefly explained the research study. The selection of these agencies was based on prior experience with administrative personnel in each facility. A letter of introduction which described the study in detail and a copy of the instruments was then sent to each of these individuals. A copy of this letter is contained in Appendix A. After recontacting the administrators and Directors of Nursing by phone, and after receiving their approval, the investigator made specific arrangements with the Directors of Nursing for data collection.

It was not possible to randomly select the subjects, therefore all those who met the criteria were invited to participate. The selection criteria included full-time employment as a nurses' aide or licensed practical nurse on the 7:00 - 3:00 or 3:00 - 11:00 shifts for at least three months, and being female.

Individuals from the 11:00 p.m. - 7:00 a.m. shift were excluded from the study based based on prior research (Singer, 1983; Jenkinson, 1981; Davis, 1984) that indicated that working on the night shift was generally more

stressful than working on the 7:00 - 3:00 or 3:00 - 11:00 shifts. A significant difference in stress levels between the shifts might have obscured the relationships among the variables under investigation. Thus, to reduce this potential for error, night shift employees were not included in the study.

Description. The subjects (N=87) were currently employed licensed practical nurses (N=18) and nurses' aides (N=69) on the 7:00 a.m. to 3:00 p.m. and 3:00 p.m. to 11:00 p.m. shifts. All were assigned to provide care to skilled care patients. All of the subjects were female and had been employed at least three months prior to participating in the study.

The subjects ranged in age from 19 to 60. The median category was 31 to 35 years of age. Forty-seven percent of the sample was white, thirty percent black, eight percent Asian American, three percent Hispanic, one percent American Indian, and eleven percent other.

Seventy eight of the subjects worked full-time, and 9 worked part-time. Fifty four worked primarily on the day shift, 27 on the 3:00 p.m. to 11:00 p.m. shift, and one subject rotated shifts. Sixty seven had only one job, 17 held two jobs, two had three jobs, and one had four jobs.

The average subject had a high school education. The

level of education ranged from 8th grade to four years of graduate school. Under Illinois law, subjects employed as licensed practical nurses must have completed at least one year in a post high school training program and must have passed a state licensure exam. Subjects employed as nurses' aides for a period of one year between 1975 and 1980 had received no formal nurses' aide training. However, subjects employed as nurses' aides since that time have completed an approved Basic Nursing Assistant's Training Program.

The length of employment at the present nursing home ranged from 5 months to ten years with the median group having been employed 18 months to two years at the present facility. Length of service in the field of nursing ranged from 5 months to 15 years with the median group having been employed 3 to 5 years.

Appendix B lists other relevant demographic data. Comparative charts of subjects' age, race, job status, shift, and length of employment are included in that appendix.

Setting. All of the homes were skilled care facilities and were owned and operated by religiously affiliated groups. The homes were located in suburban Cook County. The patient population of these homes was

primarily geriatric, although Home A also had a small percentage of younger chronically ill patients (N=7). The patients in all three homes were required to pay for care for at least the first several years of their stay.

There was little difference between the homes in terms of pay scales, amount of vacation time, and other employee benefits. All of the homes had in-service programs offered two to three times a month. The staffing ratios in the three homes approximated one nurse to three nurses' aides on the day shift, and one nurse to four nurses' aides on the 3:00 p.m. to 11:00 p.m. shift. All of the homes had 93 to 96% of their beds filled.

Home A was a Methodist facility with 250 beds. The home is licensed to provide both intermediate (151 beds) and skilled (99 beds) care. Only employees from the skilled care sections of the home were invited to participate in the study.

Three of the sections of the home are designated for skilled care. Each section has approximately 33 beds. On the day shift, 4 nurses and 12 aides are assigned to cover the three areas. On the evening shift, 3 nurses and 11 nurses' aides provide care to patients in these areas.

There were no recent personnel policy changes at this home. However, employees were given an "across-the-board"

cut in pay and in vacation time approximately 10 months prior to the collection of data in this home.

The home is relatively new and attractively decorated. Employees of the home are encouraged to give feedback to supervisors and the administrator via regularly scheduled Employee Council meetings.

Home B is a 295 bed skilled care facility. The home has two floors and the patients requiring the most physical care reside on the top floor.

On the 7:00 a.m. to 3:00 p.m. shift, 10 nurses and 30 nurses' aides provide care to patients. On the 3:00 p.m. to 11:00 p.m. shift, there are 8 nurses and 24 nurses' aides available to care for patients. During the academic year, nursing students from a local university have field placements at this facility. Although these students are themselves in training, they provide a significant amount of care to at least some of the patients.

Home B is a new, well decorated facility. Because the home is affiliated with a hospital, onsite aerobics and personal health care classes are offered regularly to employees for a nominal fee.

Home C is a 128 bed skilled care facility. The home has two floors and the more debilitated patients reside on the second floor. There are 5 nurses and 14 aides on the

7:00 a.m. to 3:00 p.m. shift. On the 3:00 p.m. to 11:00 p.m. shift, there are 4 nurses and 12 nurses' aides to care for patients.

Home C is part of a larger, religiously owned retirement complex. The home is located on a campus that encompasses independent living apartments for senior citizens as well as a shelter care facility.

The home is bright and attractive. Employees are encouraged to discuss problems with supervisors and the administrator at scheduled Employee Council meetings.

Procedure

After securing approval from the administrator and Director of Nursing at each facility, the investigator set a date and time for data collection. The Directors of Nursing at the three homes chose to introduce the study through normal channels, that is, announcements at departmental meetings and floor meetings. The investigator reminded the Directors of Nursing to tell potential participants that all subjects would be paid five dollars, that participation should be voluntary, and that all data would be kept confidential.

On the designated day for data collection, the investigator met with small groups of subjects over the course of several hours. The following instructions were

given to each group:

My name is Debbie Haley and I am working on my Ph.D. at Loyola University. In order to meet the requirements for graduation, I am conducting a study of nurses' aides and licensed practical nurses employed in nursing homes. I am interested in finding out what it is like to work in a nursing home.

I am asking persons who are interested in participating in my study to fill out five questionnaires. It will take anywhere from 25 to 60 minutes to complete these. If you fill out all five questionnaires, I will give you five dollars.

You do not have to answer any questions which you find personally or morally offensive. You are also free to withdraw from the study at any time, however you will not be paid if you do not complete all five questionnaires.

I will return in a few months to present an in-service on my findings.

I will be here in the room to answer any questions you might have. Are there any questions that need to be answered before we begin?

After these instructions, the questionnaires were distributed. The investigator remained in the room to answer questions as they arose about directions for the questionnaires and/or the meaning of individual test items, for example, many of the subjects needed clarification of the directions for The Alienation Test.

Each group of five questionnaires was randomly ordered when presented to each subject. This was done to minimize the effect of fatigue and latency or recency effects on a particular measure.

After each subject completed the questionnaires, the investigator checked the answers to make sure that all of the pages had been completed and that the instructions had

been followed. Subjects were asked to correct any omissions in these areas. The investigator then thanked each subject for her participation and gave her five dollars.

In Home A, subjects (N = 39) from both the 7:00 a.m. to 3:00 p.m. and 3:00 p.m. to 11:00 p.m. shifts were allowed to complete questionnaires on payroll time. Subjects were released from their floors at 45 minute intervals. This gave everyone who was interested a chance to participate in the study, while providing consistent care for the residents.

The subjects from the 7:00 a.m. to 3:00 p.m. shift participated in the study during the last two hours of their shift. The subjects from the 3:00 p.m. to 11:00 p.m. shift participated in the study during the first part of their shift.

In Home B, only employees of the 7:00 a.m. to 3:00 p.m. shift were participants. Subjects (N = 27) were required to complete the questionnaires on non-payroll time, e.g., lunch and coffee breaks.

On the day of data collection, the Assistant Director of Nursing took the investigator to each nursing station and introduced her. She reminded the nursing personnel that the investigator would be stationed in the employee

dining room with the questionnaires from 8:30 a.m. to 5:00 p.m. All but four of the nurses' aides were able to complete the questionnaires during their lunch break. These four subjects completed the remainder of the questionnaires on their afternoon coffee break. Most of the employees (N = 23) at this home participated in the study in the middle of their work day.

In Home C, subjects (N = 21) from both the 7:00 a.m. to 3:00 p.m. and 3:00 p.m. to 11:00 p.m. shifts were allowed to complete questionnaires on payroll time. Nonetheless, a significant number (N = 9) chose to complete the questionnaires on their own personal time. Many of the participants on the 3:00 p.m. to 11:00 p.m. shift arrived one hour early to participate in the study. Several of the employees on the 7:00 a.m. to 3:00 p.m. shift arrived at 3:00 p.m. to begin completing the questionnaires. Three employees came in on their day off solely to participate in the study.

The 7:00 a.m. to 3:00 p.m. shift employees completed the questionnaires near the end of their shift. The 3:00 p.m. to 11:00 p.m. shift employees completed their questionnaires at the beginning of their shift.

Pilot Studies

In an attempt to identify possible reading level

problems with the instruments and the populations chosen, the investigator conducted a pilot study. The questionnaires were administered to persons enrolled in an approved Basic Nurses' Aide Training Program (N=9). Given the amount of education required to be a licensed practical nurse, it was not deemed necessary to administer the instruments to licensed practical nurses for reading level purposes.

The investigator assessed the amount of time it took the nine participants to complete each questionnaire. The investigator also inquired whether there were any problems regarding the vocabulary or concepts used in the instruments.

The pilot study indicated that the instruments could be completed in 25 to 55 minutes by nurses' aides. The pilot study also revealed that minor changes in word choice needed to be made to accommodate the reading ability of the subjects. A complete listing of the changes made is found in Appendix C.

A second pilot study was conducted for the purpose of verifying that the variables and populations chosen for this study were worth investigating in greater detail. Prior to this study, neither of the chosen populations had been studied, nor had the other variables in the study been

investigated in regard to those populations.

The investigator contacted the Illinois Department of Public Health and requested a listing of nursing homes in the city of Chicago. The investigator conducted a phone survey (N = 76) in order to determine the pool from which a nursing home would be randomly selected for the pilot study.

The phone survey included the following questions: What is the administrator's name? What is the address? Is the home proprietary or not-for-profit? Is the home licensed for skilled care? How many beds are there? Is the home composed of medicare, medicaid, or private pay residents? Is the population of the home primarily geriatric, mentally ill, or developmentally disabled? How many licensed practical nurses and nurses' aides work on the 7:00 a.m. to 3:00 p.m. and 3:00 p.m. to 11:00 p.m. shifts on a typical day? A copy of the structured interview form is contained in Appendix D.

After completing the phone survey, the investigator determined that the average skilled care facility in Chicago, had 150 - 250 beds, was privately owned, and provided care to geriatric patients on Medicaid.

The investigator randomly selected one nursing home meeting the above criteria. The administrator and Director

of Nursing were contacted by phone and the study briefly introduced. The investigator then met with the administrator and Director of Nursing in person in order to answer their questions and concerns and to allow them to review the instruments to be used. The investigator returned one week later and administered the instruments to licensed practical nurses (N=4) and nurses' aides (N=14) on the 7:00 a.m. to 3:00 p.m. and 3:00 p.m. to 11:00 p.m. shifts. Subjects completed the questionnaires during their lunch breaks.

Pearson product correlations were used to analyze the data. A summary of those results is contained in Appendix E. The results of the pilot study revealed that licensed practical nurses and nurses' aides employed in nursing homes did, in fact, report high levels of burnout. The degree of religiosity expressed by the subjects correlated significantly with burnout. Length of service in the nursing field, work support, and work commitment did not appear to significantly correlate with burnout.

On the basis of the findings of this pilot study, the variable of work commitment was dropped from the study. In reviewing Kobasa's (Kobasa, 1979; Kobasa & Pucetti, 1983; Kobasa, Maddi, & Kahn, 1982) work, alienation seemed a more promising construct for the major investigation. In the

work stress literature, alienation appears to be more empirically and theoretically related to job stress and burnout than work commitment.

The investigator returned to the nursing home involved in the pilot study approximately two months later. At that time, she presented an inservice to the nurses' aides and licensed practical nurses that explained the purpose and results of the study.

Instrumentation

The variables studied in this investigation were burnout measured by The Staff Burnout Scale for Health Professionals (Jones, 1980), perceived social support measured by the Work Relationships Index (Holahan & Moos, 1981), alienation measured by The Alienation Test (Maddi, Kobasa, & Hoover, 1979), and religiosity measured by the Gladding, Lewis and Adkins Scale of Religiosity (1979). The variable length of service in the field was measured by an item on the demographic questionnaire.

The Staff Burnout Scale for Health Professionals (SBS-HP). The Staff Burnout Scale for Health Professionals was developed by Jones (1980a) to provide an empirical measure of the work stress syndrome called burnout. The instrument has items measuring the psychological, physiological, and behavioral components of burnout. The

SBS-HP is a 30 item, self-administered inventory with an approximate completion time of 5 - 15 minutes. Ten of the thirty items compose a lie scale which measures the tendency of respondents to give answers skewed in the direction of socially desirable responses. The test manual provides means for hospital based nurses and health professionals, and for geriatric counselors and service workers.

Scoring the SBS-HP involves calculating a burnout scale and a lie scale score. In scoring the twenty burnout items, the response checked must be transformed into a numerical score, ranging from 1 - 7 with the number 4 omitted. The scores for all responses are then summed to yield a total burnout score. This score can range from 20 (no burnout) to 140 (severe burnout).

In scoring the lie scale items, all ten items are initially scored by transforming the checked response into a numerical score ranging from 1 - 7 with the number 4 omitted. These numerical scores are then transformed in the following manner: A raw score of 1 on items 3, 12, 15, 23, and 24 is scored as 1, while other responses are scored as 0; a raw score of 7 on items 4, 7, 9, 19, and 20 is scored as 1, while all other responses are scored as 0. These transformed scores are then summed to yield a total

lie scale score ranging from 0 - 10. Higher scores mean an increased tendency to "fake good." Persons scoring 7 or more on this scale are more than likely attempting to give socially desirable answers, and thus Jones (1982) suggests their scores on the burnout scale are questionable.

Jones (1980c) used the SBS-HP to assess burnout in hospital based health care professionals (N = 228) including nurses and social service workers. In these studies, a Spearman-Brown split-half reliability coefficient of .93 and an average item-with-total score correlation coefficient of .71 were obtained.

Validity studies (Jones, 1980c, 1981; Mytych, 1981) indicate that SBS-HP scores are reliably correlated with the following indices of job stress/burnout: turnover, absenteeism, and tardiness rates; measures of serious on-the-job mistakes and patient neglect; various forms of employee deviance, e.g., employee theft; job dissatisfaction; and alcohol and prescription drug use rates.

The Alienation Test. The Alienation Test was developed by Maddi, Kobasa, and Hoover (1979). Because alienation is a multidimensional concept, the test is designed to measure four types and five contexts of alienation. The four types of alienation measured by this

test are vegetativeness, adventurousness, nihilism, and powerlessness. Powerlessness is defined as the belief in the importance of certain goals, but with a feeling of impotence as far as being able to meet these goals. Vegetativeness is defined as the inability to believe in the truth, importance or interest value of anything one is doing. Nihilism is the active attempt to discredit everything that appears to have meaning. The final type, adventurousness, is the interest in extreme and dangerous activities because everyday experiences have lost their meaning. The five contexts of alienation are the interactional contexts of relationship to work, social institutions, family, other persons and self. The total alienation score, which is a composite of the subscale scores of the four types and five contexts of alienation, was the designated measure of alienation in this study.

The Alienation Test is a 60 item, self-administered instrument. It has an approximate completion time of 15 - 25 minutes.

Subjects are required to rate 60 items for personal relevance on a scale ranging from 0 - 100. A zero indicates that the item is "not at all true". One hundred indicates that the item is "completely true". The directions clearly state that the items are worded very strongly and thus

subjects are encouraged to decide the degree to which they agree or disagree.

The 60 items are double keyed. Thus, the test yields an alienation score for each of the five life areas, i.e., work, social institutions, interpersonal relationships, family, and self; for each of the four types of alienation, i.e., powerlessness, vegetativeness, nihilism, and adventurousness; and a total alienation score.

A score for each of the life contexts is achieved by adding together the scores of the 12 items comprising each of the five subsections of the test. The powerlessness score is the sum of every first, fifth and ninth response. The vegetative score is the sum of every second, sixth, and tenth response. The nihilism score is the sum of every third, seventh, and eleventh score, and the adventurousness score is the sum of the fourth, eighth, and twelfth response. The total alienation score is equal to the sum of all 60 responses.

This test has yielded reliability estimates for types, contexts, and total alienation scores. These range on internal consistency (coefficient alpha) from .72 to .95, with a mean of .84, and on stability from .59 to .78, with a mean of .64.

Work Relationships Index (WRI). The Work Relation-

ships Index is designed to measure the quality of work relationships in the work environment (Holahan & Moos, 1981). The WRI was derived from the Work Environment Scale (WES; Moos, 1981; Moos & Insel, 1974). The Work Environment Scale measures an individual's perception of the social climate of his/her work environment across ten subscales. The WRI is derived from the following three subscales: Peer Cohesion, Staff Support, and Involvement. The Peer Cohesion subscale assesses the extent to which workers are friendly and supportive of each other. The Staff Support subscale assesses the extent to which management is supportive of workers and encourages workers to be supportive of each other. The Involvement subscale assesses the extent to which workers are concerned and committed to their jobs and are enthusiastic and constructive. Each of the subscales consists of nine true-false items.

The WRI is a 27 item, self-administered questionnaire. It has an approximate completion time of 5 - 15 minutes.

Holahan and Moos (1981) report that the WRI has high internal consistency (Cronbach's alpha = .88). One month test-retest reliabilities were reported as .83 (Involvement subscale), .71 (Peer Cohesion subscale), and .82

(Supervisor Support). Construct validity of the WRI as an index of social support has been established through several studies. Holahan and Moos (cited in Holahan & Moos, 1981) found a relationship between the WRI and other indices of social support in the work environment. It was also found that the scores on the WRI were predictive of psychological adjustment (Holahan & Moos, 1980).

Holahan and Moos (1981) assert that the WRI measures the perceived quality of the work milieu with respect to its supportiveness. Illustrative of this are the following sample items: Employees often talk to each other about their personal problems; Employees discuss their personal problems with supervisors; and People take a personal interest in each other.

Gladding, Lewis, and Adkins Scale of Religiosity (GLASR). The GLASR (1979) measures the scope and intensity of religious beliefs. A factor analysis of GLASR items revealed the following four main factors: personalized deity, tapped by items such as "I believe there is a supreme being or power"; religious beliefs, tapped by items such as "My actions reflect my religious beliefs"; religious effort, tapped by items such as "People who are religious need to study the basis of their beliefs"; and consistency of belief and action, tapped by items such as

"Religious people practice what they preach."

The scale is composed of 23 statements with a 5 point, likert type response format. It is self-administered and requires approximately 5 - 15 minutes for completion.

Test-retest reliability over a ten week period for introductory college students was reported at .84 (Gladding, Lewis & Adkins, 1981). Test-retest reliability with high school seniors over a two year period showed a correlation of .435 ($p < .05$, two tailed test) (Lewis & Gladding, 1983). Gladding, Lewis and Adkins (1983) found that scale scores discriminated among individuals and groups by denominational affiliation ($p < .01$), worship attendance ($p < .01$), and gender ($p < .01$). Although .435 is a moderate correlation, this is probably an underestimate of the actual correlation because two years is an inordinate amount of time between test and retest procedures.

Demographic Questionnaire. In order to better describe the subjects in this study, the investigator designed a 13 item, self-administered demographic questionnaire. The questionnaire elicited information in the following areas: age, full or part-time employment, 7:00 a.m. - 3:00 p.m. or 3:00 p.m. - 11:00 p.m. shift,

length of time employed at this nursing home, length of time employed in the field of nursing, number of jobs presently held, number of days missed in the last month, amount of on-the-job training, number of times physically ill in the last month, level of education, racial or ethnic background, and whether a relative has ever lived in a nursing home.

Design and Statistical Analysis

The present investigation is considered descriptive research. A "one-shot" case study design was employed (Kerlinger, 1973). No variables were manipulated. Rather two groups of subjects, licensed practical nurses and nurses' aides, were asked at one point in time to complete five questionnaires. These psychometric instruments measured the variables of burnout, social support, alienation, religiosity, and length of time in the field. As reflected in the hypotheses, the investigator was interested in the studying the relationship among these five variables, as well as the relationship of burnout to each of the four independent variables. Pearson Product correlations and one way analyses of variance were used to analyze the relationship between burnout and each of the independent variables. A multiple regression analysis was used to analyze the relationship among the five variables.

Following that statistical analysis, a discriminant analysis was used to enhance the descriptive capacity of the study by distinguishing between high burnout and low burnout individuals. A series of analyses of covariance were also performed in order to assess the impact of the independent variables on burnout with the the variance due to alienation from work removed. The level of significance for all statistical procedures was the .05 level.

CHAPTER IV

RESULTS

Overview

This chapter will provide information regarding the data analysis. The preliminary statistical procedures that were performed to assess the representativeness of the sample will be reported. Supplementary analyses of interest that were performed to clarify and amplify the findings will also be discussed. Data will be summarized in tabular form where appropriate. For all statistical procedures reported, the sample group for nurses' aides was composed of 69 subjects (N=69) and the sample group for licensed practical nurses included 18 subjects (N=18).

Preliminary Analyses

Because the current investigation involved two sample groups of different sizes (N [Aides] =69; (N [LPN's] =18), preliminary statistical analyses were performed to assess whether there were significant differences between the two sample groups with regard to the major dependent and independent variables under study. One way analyses of variance (ANOVA's) were performed using demographic information, the major dependent and independent variables

in the study, and the subscales of The Alienation Test. The results of these one way ANOVA's are reported in Tables 1, 2, and 3.

The one way ANOVA's (Table 1) reveal significant differences between the nurses' aides and licensed practical nurses in social support and alienation total which are two of the major independent variables in this study. Nurses' aides reported receiving significantly less social support in the work environment than licensed practical nurses. Nurses' aides appear to be markedly more alienated than licensed practical nurses (Table 2) as reflected in the significant differences found across all four types (powerlessness, vegetativeness, nihilism, and adventurousness) and five contexts (work, social institutions, interpersonal relations, family, and self) of alienation and in the total alienation score as well.

Additionally, nurses' aides and licensed practical nurses differed in terms of the degree of burnout reported. Nurses' aides reported significantly higher levels of burnout. Because of these significant differences on two major independent variables and on the dependent variable of burnout, the data from the two samples were analyzed separately in the statistical procedures and are reported

Table 1

One Way Analyses of Variance Involving Burnout and the
Independent Variables

Variable	<u>F</u>	<u>p</u>	Interpretation
Length of Service	.116	.734	No significant difference
Social Support	6.608	.012	Aides report less support at work than LPN's
Religiosity	.219	.641	No significant difference
Total Alienation	10.040	.002	Aides are overall more alienated than LPN's
Burnout Scale	4.024	.048	Aides experience significantly more burnout than LPN's
Lie Scale	3.573	.062	No significant difference

Table 2

One Way Analyses of Variance Involving AlienationSubscale Scores: Nurses' Aides and LPN's

Variable	<u>F</u>	<u>p</u>	Interpretation
Work Score	5.780	.018	Aides are more alienated from work than LPN's
Social Institution	7.955	.006	Aides are more alienated from social institutions
Interpersonal Relations	6.501	.013	Aides are more alienated in their relationships
Family Score	5.820	.018	Aides are more alienated from their families
Self Score	7.893	.006	Aides are more alienated from themselves
Powerlessness Score	4.53	.036	Aides feel more powerless
Vegetative-ness	4.65	.034	Aides believe less in the importance of their activities
Nihilism	11.720	.001	Aides believe less in the meaning of life and their activities
Adventurousness	12.640	.001	Aides are more interested in extreme and dangerous activities
Total Alienation	10.040	.002	Aides are overall more alienated

Table 3

One Way Analyses of Variance Involving Demographic
Variables: Nurses' Aides and LPN's

Variable	F	p	Interpretation
Age	.244	.623	No significant difference
Work Status	14.841	.000	More aides work full-time
Shift	.017	.896	No significant difference
Time at This Home	1.816	.181	No significant difference
Jobs Held	1.957	.166	No significant difference
Days Missed in One Month	3.897	.052	Aides missed significantly more days of work than LPN's
On-the-job Training	.925	.339	No significant difference
Days Ill in Month	2.218	.140	No significant difference
Education	6.840	.011	Aides have significantly less education than LPN's
Race	.923	.339	No significant difference
Relative in Nursing Home	2.223	.139	No significant difference

in this manner for each hypothesis.

Demographic differences between nurses' aides and licensed practical nurses are reported in Table 3. This table reveals that more nurses' aides work full-time than licensed practical nurses. Nurses' aides also have less education than licensed practical nurses. Additionally, nurses' aides miss significantly more days of work in a month than do licensed practical nurses.

The difference in amount of education between nurses' aides and licensed practical nurses is to be expected since the amount of training mandated by law is markedly different for licensed practical nurses and nurses' aides. That nurses' aides experience more burnout than licensed practical nurses is also to be expected since nurses' aides provide the bulk of the physically and emotionally demanding care of nursing home residents. Nurses' aides' minimal training precludes a knowledge of the geriatric population, medical and rehabilitation principles, and preparation for the emotional and psychological difficulties of caring for the ill and dying. Consequently, it may be concluded that this lack of preparation could also contribute significantly to burnout in nurses' aides. In prior research with populations other than nurses' aides, burnout and days of work missed were

found to be highly correlated. Thus, it is not surprising that nurses' aides report more days of work missed in a month than do licensed practical nurses who also report burnout.

Tests of the Hypotheses

Hypothesis One: There is no relationship between length of service, social support, alienation, and religiosity and the degree of burnout experienced.

Correlations between the four independent variables, length of service, social support, alienation, and religiosity, and the dependent variable of burnout are presented in Tables 4 and 5. For nurses' aides the only significant correlations were between religiosity and social support, $r = .196$, $p < .05$; and between alienation total and burnout, $r = .410$, $p < .001$. The significant but low correlation between religiosity and social support suggests that nurses' aides who are more religious tend to report greater social support at work. The significant, moderate correlation between alienation total and burnout indicates that nurses' aides who experience burnout appear to be generally more alienated than nurses' aides who do not report burnout. For licensed practical nurses, the only significant correlations are between social support and burnout, $r = -.475$, $p < .02$.; between alienation and

Table 4

Correlations Between Major Dependent and Predictor Variables: Nurses' Aides

	Length of Service	Religiosity	Social Support	Burnout	Alienation
Length of Service	1.000				
Religiosity	.182	1.000			
Social Support	-.153	.196*	1.000		
Burnout	-.033	.072	-.115	1.000	
Alienation Total	-.040	-.139	-.069	.410**	1.000

N = 69

.05 = *
 .01 = **
 .001 = ***

Table 5

Correlations Between Major Dependent and Predictor Variables: LPN's

	Length of Service	Religiosity	Social Support	Burnout	Alienation
Length of Service	1.000				
Religiosity	.493*	1.000			
Social Support	-.234	.040	1.000		
Burnout	.183	-.073	-.475*	1.000	
Alienation	.156	-.088	-.166	.551**	1.000

N = 18

.05 = *
 .01 = **
 .001 = ***

burnout; $r = .551$, $p < .01$; and between religiosity and length of service in the field, $r = .493$, $p < .02$. The moderate negative correlation between social support and burnout suggests that licensed practical nurses who feel supported at work tend not to report high levels of burnout. The significant correlation between alienation and burnout indicates that licensed practical nurses who report burnout appear to feel generally alienated. The last significant correlation suggests that licensed practical nurses who have been in the nursing field for a long period of time tend to be more religious than licensed practical nurses who have been in the field for a relatively short time.

An adequate test of the first hypothesis required that the predictive power of the independent variables be assessed. That is, it was important to assess to what degree the scores on the various independent variables (e.g. social support, alienation, religiosity, and length of service) predicted scores on the the burnout scale for the two groups separately, i.e. nurses' aides and licensed practical nurses. Toward this end, stepwise multiple regressions were performed. The results of the regression analyses are reported in Table 6.

Table 6

Stepwise Multiple Regressions for Nurses' Aides and LPN's:
Alienation Total

Total Alienation Score r=.410 R2=.17

ANOVA

	<u>df</u>	<u>SS</u>	<u>MS</u>
regression	1	4243.01	4243.01
residual	67	21013.54	313.63

F= 13.529p < .001

N(Aides)=69

Total Alienation Score r=.551 R2=.30

ANOVA

	<u>df</u>	<u>SS</u>	<u>MS</u>
regression	1	2628.56	2628.56
residual	16	6153.88	384.62

F= 6.975p < .018

N(LPNS)=18

An inspection of this table reveals that the total alienation score accounted for 17% of the variance for nurses' aides and 30% of the variance for licensed practical nurses. The total alienation score appears to be the only independent variable that is capable of predicting burnout for both nurses' aides and licensed practical nurses. It is also clear that the total alienation score is a better predictor of burnout in licensed practical nurses than it is in nurses' aides. Based on the strength of prior research reported in Chapter II, it was expected that alienation total would have a significant impact on the degree of burnout reported. It was not, however, expected that the other variables in the study would have almost no relationship to burnout.

At least partial support for the rejection of the null hypothesis was provided by the reported correlations and multiple regressions. Hypotheses 2 through 5 are more specific tests of this general hypothesis. The reader is therefore advised to refer to the rejection of hypotheses 3 and 5 as further evidence for the partial rejection of the first hypothesis.

Hypothesis Two: There is no relationship between length of service and the degree of burnout experienced.

As reported in Table 4, the correlation between

length of service and burnout for nurses' aides was $-.033$. This low, nonsignificant correlation suggests that the length of time an individual has worked as a nurses' aide has no practical relationship to the degree of burnout experienced.

In order to further examine the influence of length of service on burnout for nurses' aides, a one way ANOVA was run. A median split was used in the analysis of variance to differentiate high burnout from low burnout in nurses' aides. The result of the analysis of variance was not significant, $F(1, 67) = .1493$ $p < .709$.

The correlation between length of service and burnout for licensed practical nurses was $.183$ (Table 5). This low non-significant correlation suggests that the amount of time a licensed practical nurse has spent in the field of nursing appears to have little impact on the degree of burnout experienced. A one way ANOVA, based on a median split on the dependent variable burnout yielded results that were not significant, $F(1, 16) = .1896$, $p < .669$.

On the basis of these results, there is no evidence to reject the null hypothesis. These findings do not support prior research in this area. In this study, the length of time a nurses' aide or licensed practical nurse had been in the field of nursing clearly did not appear to

have any effect on the degree of burnout reported.

Hypothesis Three: There is no relationship between alienation and the degree of burnout experienced.

The measure of alienation used in the current investigation was the Alienation Test (Maddi, Kobasa, & Hoover, 1979). The Alienation Test yields a total alienation score and 9 subscale scores including four types and five contexts of alienation. The correlations between the subscales of The Alienation Test, as well the total alienation score are reported for nurses' aides and licensed practical nurses in Table 7.

An inspection of Table 7 reveals that all of the alienation subscales and the total alienation score are significantly correlated with burnout for both nurses' aides and licensed practical nurses. Of particular interest is the magnitude of the correlations for licensed practical nurses on the powerlessness, work, and social institutions subscales. Licensed practical nurses who report burnout in these areas appear to experience significantly more burnout than nurses' aides who report alienation in the same areas.

The socialization process inherent in the extended educational training of licensed practical nurses may account for this difference between licensed practical

Table 7

Correlations Between Burnout and Alienation Subscales
and Total Alienation Score

	Aides	LPN's
Vegetativeness	.350**	.532**
Nihilism	.321**	.497*
Adventurousness	.386***	.259*
Powerlessness	.406***	.715***
Work	.277**	.605**
Social Institutions	.283**	.472*
Interpersonal	.369***	.431*
Family	.395***	.392*
Self	.350**	.418*
Total	.410***	.551**

N(Aides)=69

N(LP N's)=18

.05 = *

.01 = **

.001 = ***

nurses and nurses' aides. As part of their education, a socialization process occurs which creates certain expectations about their future occupational roles. That is, licensed practical nurses expect that they will be able to function fairly autonomously and in a decision-making capacity. Further, licensed practical nurses are educated to believe to some degree that nursing is not just a job, rather it is a career chosen to serve others. Finally, licensed practical nurses are at least minimally taught about other social institutions that can enhance or detract from the lives and care of patients. It may well be that when a licensed practical nurse feels disconnected or alienated from the beliefs and expectations she has developed about her role as a licensed practical nurse, burnout is then a natural consequence of this alienation.

Given the strength of the correlations for the total alienation score and all the subscale scores and burnout, for both nurses' aides and licensed practical nurses, the investigator proceeded to further examine the relationship between alienation and burnout. One way ANOVA's based on a median split on the dependent variable of burnout were performed for both nurses' aides and licensed practical nurses. The results of these one way ANOVA's are reported in Table 8.

Table 8

One Way Analyses of Variance Testing the Effects of the
Various Types of Alienation on Burnout in Nurses' Aides
and LPN's

Alienation Subscale Scores	Aides		LPN's	
	<u>F</u>	<u>p</u>	<u>F</u>	<u>p</u>
Vegetativeness	1.7880	.186	2.0361	.173
Nihilism	4.4875	.038*	13.9146	.002*
Adventurousness	5.7532	.019*	.1626	.692
Powerlessness	13.2771	.001*	10.6336	.005*
Work	3.7709	.056	4.6976	.046*
Social	2.7220	.104	4.5745	.048
Interpersonal	8.9362	.004*	9.5717	.007*
Family	6.4376	.014*	.7427	.402
Self	4.6773	.034*	.8189	.379
Total Alienation Score	11.0148	.002*	5.2337	.036*

N(Aides)=69

N(LP N's)=18

Asterisks denote significant findings

A review of this table reveals major differences in the magnitude of significant F ratios for a number of alienation subscale scores. Nurses' aides appear to report significantly more total alienation as well as more alienation from their families and themselves than do licensed practical nurses. Nurses' aides also appear to experience the type of alienation called adventurousness significantly more than licensed practical nurses. That is, nurses aides, who may lack the conviction that their lives are meaningful, report a greater interest in extreme, dangerous, and dramatic activities. In contrast, licensed practical nurses experience two types of alienation, powerlessness and nihilism, to a significantly greater degree than nurses' aides. Thus, licensed practical nurses tend to feel more impotent in terms of being able to meet important or valued goals. Licensed practical nurses also appear to more actively discredit socially accepted values and norms than do nurses' aides.

The results of the ANOVA for the total alienation score for both nurses aides, $F(1,67) = 11.0148$, $p < .01$, and licensed practical nurses, $F(1,16) = 5.2337$, $p < .04$, are statistically significant. Thus, for both nurses' aides and licensed practical nurses, those individuals who report higher total alienation tend to experience burnout to a

greater degree. On the basis of this statistical evidence, it is appropriate to reject the null hypothesis for both nurses' aides and licensed practical nurses.

A stepwise multiple regression, reported in Table 6, revealed that the total alienation score accounted for 30% of the variance for licensed practical nurses, $r = .55$, $R^2 = .30$. For nurses' aides, a stepwise multiple regression (Table 6) indicated that the total alienation score accounted for 17% of the variance, $r = .41$, $R^2 = .17$. On the basis of these regressions, it appears that total alienation is significantly related to and predictive of burnout for both populations. However, the regressions indicate that total alienation is a better predictor of burnout in licensed practical nurses than of burnout in nurses' aides. As discussed earlier, it is hypothesized that the educational training and its inherent socialization process creates expectations and beliefs in licensed practical nurses about their future work roles. When the realities of the work situation are contrary to licensed practical nurses' expectations, alienation results. Burnout often seems to occur when alienation is present. Whether this is a cause and effect relationship is open for discussion.

Hypothesis Four: There is no relationship between

religiosity and the degree of burnout experienced.

Table 4 indicates the correlation between religiosity as measured by the GLASR and burnout for nurses' aides is -.072. The negative, non-significant correlation suggests that the degree of religiosity a nurses' aide expresses has little impact on whether or not she will experience burnout.

A one way ANOVA based on a median split on the dependent variable of burnout was performed in order to further examine the relationship between burnout and religiosity. The results of this analysis of variance were not significant, $F(1,67) = .1466$, $p < .2512$. This non-significant F provides further evidence that high or low religiosity expressed by nurses' aides does not seem to have any relationship as to whether or not they experience burnout.

The correlations between religiosity and burnout for licensed practical nurses (Table 5) was -.073. This non-significant correlation indicates that the degree of religiosity expressed by licensed practical nurses appears to have no impact on the degree of burnout experienced.

A one way ANOVA based on a median split on the dependent variable of burnout revealed no significant difference between licensed practical nurses high in burnout and licensed practical nurses low in burnout and

the degree of religiosity reported, $F(1, 16) = .1466$, $p < .7069$. The results of the ANOVA further underscore the finding that high or low religiosity expressed by licensed practical nurses appears to have no effect on the degree of burnout experienced.

The results obtained for both nurses' aides and licensed practical nurses were not statistically significant. Thus, there is no evidence to reject the null hypothesis. These results are not in the expected direction. Cherniss and Krantz (1983) specifically suggest that a strong religious ideology should moderate, if not eliminate, burnout in helpers.

Hypothesis Five: There is no significant relationship between social support and the degree of burnout experienced.

As reported in Table 4, the correlations between social support as measured by the WRI and the degree of burnout experienced for nurses' aides is $-.115$. This non-significant negative correlation suggests that for nurses' aides, burnout is only minimally related to the degree of social support found in the work environment.

In order to further examine the influence of social support on burnout in nurses' aides, a one way ANOVA was performed. A median split on the dependent variable of

burnout was used in the analysis of variance. The results of this ANOVA were not significant, $F(1,67)= 2.2861$, $p < .14$. This non-significant F provides further evidence that a nurses' aide's perception of being supported at work has little impact on whether she will report high levels of burnout.

The correlation between work support and burnout for licensed practical nurses was $-.475$, $p < .02$. This significant negative correlation indicates that licensed practical nurses who perceive that they receive adequate social support in their work environment tend not to experience burnout.

A one way ANOVA based on a median split on the dependent variable of burnout, yielded significant results, $F(1, 16)= 9.8755$, $p < .006$. This significant F further underscores the relationship between social support and burnout. That is, licensed practical nurses appear not to burn out if they perceive that they are being supported in the work environment by supervisors and co-workers.

The results for nurses' aides and licensed practical nurses are widely divergent for this hypothesis. A lack of significant results for nurses' aides provides no evidence to reject the null hypothesis for that sample. However, the statistically significant results for licensed practical

nurses provide ample evidence to reject the null hypothesis for this sample.

The difference in the results between the two samples may be related to the marked differences in the nature of the work roles between licensed practical nurses and nurses' aides. Licensed practical nurses are expected to make a multitude of important and often stressful decisions. Additionally, licensed practical nurses are accountable for the smooth management of their unit, as well as for the activities of nurses' aides on the unit. Nurses' aides, on the other hand, have little decision-making capacity and are responsible for only a portion of the work that is done on each unit. It may be that the increased responsibility and high stress decision-making required of licensed practical nurses makes them more vulnerable to burnout when social support in their work environment is not available.

Supplementary Analyses

Discriminant Analysis. A discriminant analysis was run in order to distinguish which variables contributed to the experience of high burnout versus the experience of low or no burnout. A discriminant analysis is a statistical procedure which yields a linear combination of variables that maximally distinguish two or more groups. A

discriminant function is a regression equation with a dependent variable, in this case burnout, which represents group membership. The function maximally discriminates the members of a group.

A discriminant analysis was performed only for nurses' aides. A discriminant analysis was not run for licensed practical nurses because the sample size ($N = 18$) was too small to yield statistically and practically significant results.

In the discriminant analysis the major independent variables of social support, religiosity, alienation, and length of service were entered into the discriminant function. Additionally, the subscales of The Alienation Test and demographic data including the following were also entered into the equation: age, full or part-time employment, shift, length of time at the present nursing home, length of time in the field of nursing, number of jobs presently held, number of days missed in the last month, amount of on-the-job training, number of times physically ill in the last month, level of education, race or ethnicity, and whether a relative has ever lived in a nursing home.

The results of the discriminant analysis are reported in Table 9. This table indicates those variables that best

Table 9

Discriminant Analysis: Distinguishing Characteristics of
High v. Low Burnout in Nurses' Aides

Structure Matrix: Pooled Within Groups Correlations

Powerlessness	0.5357
Total Alienation	0.4500
Vegetativeness	0.3967
Work Alienation	0.3786
Lie Scale	-0.3656
Self Alienation	0.3474
Nihilism	0.3433
Interpersonal Alienation	0.3408
Family Alienation	0.3334
Social Institution Alienation	0.3078

Eigenvalue	Canonical Correlation	Wilks' Lambda	Chi- Squared	DF	Signifi- cance
2.5188	0.8461	0.2842	49.697	11	0.0001

differentiate high burnout in nurses' aides (a score of 72 or above on the SBS-HP) from low burnout in nurses' aides (a score of 54 or below on the SBS-HP) in order of their importance. Overall, the analyses reveal that alienation with its various contexts and types is the only psychosocial variable that clearly distinguishes nurses' aides who are burned out from those who are not. Additionally, feelings of powerlessness seem to be a major contributing factor to the experience of burnout in nurses' aides. Thus, nurses' aides who report high levels of burnout feel they have little ability to meet their goals. Further, they are unable to believe in the value of their activities, and tend to discredit societal values and norms. Burned out nurses' aides are alienated from their families, social institutions, themselves, and in their interpersonal relationships. On the other hand, nurses' aides who are not burned out tend to have fairly strong values about the importance and meaning of their activities. They feel capable of meeting their goals. They tend to feel a sense of connection or commitment to their families, themselves, interpersonal relationships and social institutions.

The classification results of the discriminant analysis are reported in Table 10. The results indicate

Table 10

Classification Results of Discriminant Analysis:Nurses' Aides

Group	No. of Cases	Predicted Group Membership	
		Low Burnout	High Burnout
Low Burnout	22	21 95.5%	1 4.5%
High Burnout	25	1 4.0%	24 96.0%
Ungrouped Cases	22	7 31.8%	15 68.2%

Percent of "Grouped Cases" Correctly Classified: 95.74%

N = 69

that ninety-five percent of the nurses' aides reporting high or low burnout were correctly classified by the combination of linear variables in the discriminant function. Thus, the discriminant analysis was both statistically and practically significant in that it correctly placed subjects in high and low burnout groups. This very high accuracy in the classification of subjects further suggests that the discriminant function revealed clear cut differences between nurses' aides who reported burnout and nurses' aides who did not. By revealing the combination of variables which maximally distinguish high from low burnout in nurses' aides, the results of the discriminant analysis provide a more thorough understanding of the variables or factors which impact burnout.

Analysis of Covariance. Because the types and contexts of alienation were so powerful in distinguishing high burnout from low burnout in nurses' aides, further statistical procedures were conducted to determine the importance of the various measures of alienation relative to burnout. A series of analyses of covariance (ANCOVA's) were run in order to estimate the effect of the alienation variables on burnout with alienation from work held constant. Because nearly all of the literature on burnout identifies work in the helping fields as the primary cause

of burnout, the decision was made to covary the effect of alienation from work. Thus, the following variables were employed in the ANCOVA's with the variance associated with alienation from work being held constant: alienation from self, powerlessness, total alienation, religiosity, nihilism, alienation from social institutions, vegetativeness, and work status. The results of the significant ANCOVA's are reported in Tables 11, 12 and 13.

With the variance associated with alienation from work removed in the statistical analysis, only a few variables proved important in differentiating high from low burnout. As reported in Tables 11 and 12, powerlessness and total alienation were the only variables which differentiated high from low burnout in nurses' aides. Table 13 indicates that nihilism is the only variable which differentiates high from low burnout in licensed practical nurses. The psychosocial variables of powerlessness and total alienation for nurses' aides and nihilism for licensed practical nurses are powerful in distinguishing high from low burnout because they are statistically significant even after the effects of the variable of alienation from work have been removed.

Summary

The tests of the hypotheses indicate that Total

Table 11

Analysis of Covariance: Nurses' Aides

Source of Variation	SS	DF	MS	<u>F</u>	<u>p</u>
Within Cells	20421.50	64	319.09		
Regression	68.34	1	68.34	.214	.645
Alienation Total	2171.89	1	2171.89	6.807	.011
Powerlessness	646.29	1	646.29	2.025	.160
Alienation Total by Powerlessness	354.38	1	354.38	1.111	.296

N=69

Table 12

Analysis of Covariance: Nurses Aides

Source of Variation	SS	DF	MS	<u>F</u>	<u>p</u>
Within Cells	20212.52	64	315.82		
Regression	153.98	1	153.98	.488	.488
Religiosity	513.33	1	513.33	1.625	.207
Powerlessness	2169.09	1	2169.09	6.868	.011
Religiosity by Powerlessness	294.12	1	294.12	.931	.338

N=69

Table 13

Analysis of Covariance: LPN's

Source of Variation	SS	DF	MS	<u>F</u>	<u>P</u>
Within Cells	3477.63	13	267.51		
Regression	256.07	1	256.07	.957	.346
Nihilism	1379.09	1	1379.09	5.155	.041
Social Institutions	588.06	1	588.06	2.198	.162
Nihilism by Social Institutions	136.05	1	136.05	.509	.488

N=18

Alienation is the best predictor of burnout in both nurses' aides and licensed practical nurses. Further, evidence was found that all the measured types and contexts of alienation correlated significantly with burnout in both sample groups. The degree of social support reported was found to be inversely related to the amount of burnout experienced by licensed practical nurses. For nurses' aides social support was only minimally related to whether or not burnout was reported. Religiosity and length of time in the field appeared to have little impact on the degree of burnout experienced for both nurses' aides and licensed practical nurses. Supplementary statistical procedures underscored the important role of alienation in distinguishing between high and low burnout. A discriminant analysis performed on the data provided by the nurses' aides revealed that powerlessness was the factor best able to differentiate high from low burnout in nurses' aides. A series of ANCOVA's, performed with the variance associated with alienation from work removed, indicated that powerlessness and total alienation distinguished nurses' aides experiencing high burnout from those experiencing low burnout, while nihilism best differentiated licensed practical nurses who were burned out from those who were not.

CHAPTER V

DISCUSSION

Overview

The focus of this chapter will be to discuss the results reported in Chapter IV. Both theoretical and practical implications of the findings of this study will be addressed. Limitations of this investigation will also be discussed. Finally, directions for future research will be presented. A recapitulation of the study is provided for the the reader's convenience.

Recapitulation

Burnout is a type of stress that has been shown to negatively impact professionals in the helping fields. Individuals who are burned out hold dehumanized and cynical perceptions of their clients, have lowered self esteem, and provide poorer quality of care. In past studies, burnout correlated with marital problems, increased drug and alcohol usage, turnover, absenteeism, and low morale (Maslach, 1976, 1978a, 1978c; Maslach & Jackson, 1978) Burnout has consequences on the personal, professional and societal levels. Personal responses to burnout range from physical and psychological problems to absenteeism and/or

career changes. Burnout depletes the helping professions of talented and dedicated individuals. Further, it plays a major role in the delivery of poor health care and nursing services.

The purpose of this investigation was to study burnout in the previously unresearched health care setting of skilled care nursing homes. Additionally, burnout was measured in two "new" populations, nurses' aides and licensed practical nurses. This investigation also measured four variables that were thought to moderate or exacerbate work stress and burnout. These variables were length of service, alienation, religiosity, and social support. Length of service was measured by an item on the demographic questionnaire. Alienation was assessed through the use of the The Alienation Test. This measure of alienation yields a total alienation score as well as nine subscale scores representing the four types and five contexts of alienation. A measure of social support was obtained through the administration of the Work Relationships Index. Religiosity was determined by the Gladding, Lewis, Adkins Scale of Religiosity. The Staff Burnout Scale for Health Professionals was the instrument chosen to measure burnout.

A standardized administration format was used with

all subjects (N [nurses' aides] = 69; N [lpn's] = 18). Pearson product moment correlations, one way ANOVA's and multiple regression were used to analyze the data. Supplementary statistical analyses on the data included a discriminant analysis and several analyses of covariance. The hypotheses tested in the study included the following:

1. There is no relationship between length of service, social support, alienation, and religiosity and the degree of burnout experienced.

2. There is no relationship between length of service and the degree of burnout experienced.

3. There is no relationship between alienation and the degree of burnout experienced.

4. There is no relationship between religiosity and the degree of burnout experienced.

5. There is no relationship between social support and the degree of burnout experienced.

The results of the tests of the hypotheses revealed that both length of service in the field of nursing and degree of religiosity expressed had little relationship to the amount of burnout reported by nurses' aides and licensed practical nurses. Thus, there was no evidence to reject hypotheses two and four.

Hypothesis five was rejected for licensed practical

nurses, but not for nurses' aides. Licensed practical nurses who reported high levels of work support, also reported low levels of burnout. Social support was only minimally related to burnout for nurses' aides.

Hypothesis three was rejected for both samples. Multiple regression analyses revealed that the total score on The Alienation Test accounted for 17% of the variance for nurses' aides and 30% of the variance for licensed practical nurses. Nurses' aides and licensed practical nurses who reported general feelings of alienation also appeared to experience high levels of burnout.

A discriminant analysis performed on the data supplied by the nurses' aides revealed that alienation with its various types and contexts was the only psychosocial variable that clearly distinguished nurses' aides who were burned out from those who were not. Several ANCOVA's with the variance from work alienation removed were also run. These revealed that powerlessness and total alienation were the only variables that differentiated high from low burnout in nurses' aides. Nihilism was the only variable which differentiated high from low burnout in licensed practical nurses.

Overall, the results of the tests of the hypotheses indicate that burnout does occur in nurses' aides and

licensed practical nurse employed in skilled care nursing homes. As such, it is clear that burnout is a problem for paraprofessionals and nonprofessionals as well as for professionals in the helping fields.

Analysis of Results

In the following section, the findings of the study related to each hypothesis will be discussed. Because hypothesis one is a synthesis of the last four hypotheses, a discussion of the findings related to it will be subsumed in the discussion of the other four hypotheses.

Hypothesis Two. Hypothesis Two stated that there was no relationship between length of service in the nursing field and the degree of burnout experienced. The results of the statistical procedures used to test this hypothesis revealed that for both nurses' aides and licensed practical nurses, the length of service in the nursing field did not appear to have any relationship to whether or not an individual experienced burnout.

Although these results are not in the expected direction, it is important to note that the research base supporting the relationship of length of service to burnout is not a particularly strong one. That is, there have only been three major research efforts (Freudenberger, 1975; Pines & Maslach, 1978; Cronin-Stubbs, 1983) that have

examined length of service as a factor in burnout. None of these three investigations involved nurses' aides or licensed practical nurses. Additionally, Cherniss and Krantz (1983) indicate that the nuns they observed were able to work as helpers for over 30 years without experiencing burnout. As presented in Chapter II, Cherniss and Krantz hypothesize that individuals who are religious and are committed to their work tend not to burnout regardless of the length of service or number of hours of direct contact with clients. It may be that individuals who choose to remain in a field or line of work may make gradual adjustments and accommodations in terms of their involvement in work. Thus, individuals who make such accommodations over time do not burn out as a result of their deinvestment from work.

Hypothesis Three. Hypothesis Three stated that there was no relationship between alienation and the degree of burnout experienced in the sample groups under study. The results of the statistical procedures used to test this hypothesis revealed that for both nurses' aides and licensed practical nurses, feelings of alienation were strongly related to the experience of burnout.

Ten measures of alienation were used in the statistical analysis. These included a total alienation

score, four types of alienation, and five contexts of alienation. One type of alienation, powerlessness, and two contexts, alienation from work and social institutions, correlated highly with burnout in licensed practical nurses. Further statistical analysis revealed that licensed practical nurses who reported feelings of nihilism or powerlessness were far more likely to be burned out than licensed practical nurses who did not report these feelings. For nurses' aides, individuals who were alienated from their families or themselves, or who reported a type of alienation called adventurousness, tended to experience high levels of burnout. For both nurses' aides and licensed practical nurses, total score on The Alienation Test was the best predictor of burnout. The total score on The Alienation Test was a better predictor of burnout in licensed practical nurses than in nurses' aides.

Powerlessness appears to be a particularly important factor in explaining burnout in licensed practical nurses, although it appears to be somewhat less significant in explaining burnout in nurses' aides. As alluded to in Chapter IV, licensed practical nurses differ from nurses' aides in terms of training. In their 1-2 years of post high school training, licensed practical nurses gain a broad range of medical knowledge and are socialized to

expect to manage a nursing unit and to make important nursing decisions. Although licensed practical nurses are paraprofessionals, they, nonetheless, share the host of role expectations inherent in the field of nursing. That is, they expect to provide high quality nursing care and to preserve life whenever possible. Cherniss (1980) underscores the fact that licensed practical nurses share many of the same expectations as registered nurses. He suggests that the length of training is not as important as how closely the work is tied to the personal identity of the worker. Additionally, Cherniss indicates that the demand for competence is very high in nurses. Farber (1983) further notes that helpers such as nurses are particularly vulnerable to issues of competency, power, and control as a result of the expectations they hold for being competent and in control.

Licensed practical nurses employed in nursing homes are also in an environment where control is harder to achieve than in other nursing settings. Nursing homes are often understaffed and short of supplies (CAD, 1981). Although licensed practical nurses are charged with the responsibility of delivering high quality nursing care on their units, it is difficult to provide good care when adequate staff and/or supplies are lacking. Additionally,

most licensed practical nurses have adopted a value system in which the goal of good medical and nursing care is to preserve life. Given the deteriorated physical state of many residents, as well as the statistic that 80% of nursing residents never return home (Vladek, 1980, p. 63), it is clear that licensed practical nurses must deal on a regular basis with the death of patients. The contradiction between the value of saving lives and the reality of frequent deaths in a nursing home population, may significantly contribute to the licensed practical nurses experience of powerlessness.

Licensed practical nurses, as are all medical care providers, are faced with the knowledge that patients can reject and/or thwart even the best of medical or nursing care. Thus, the licensed practical nurse can never fully control her work environment or the results of her work given the fact that the patients' response to treatment cannot be controlled.

For a number of reasons, it seems apparent that licensed practical nurses are vulnerable to feelings of powerlessness. Finifer (1972) states that there is an agreement in the literature that alienation is produced by a discrepancy between strongly internalized aspirations, norms, and values, on the one hand, and the opportunities

perceived by the individual for fulfilling them, on the other. This explanation of the process of alienation may offer a cogent explanation of why licensed practical nurses tend to experience the type of alienation called powerlessness. Licensed practical nurses may experience powerlessness because they expect to be in control and to exert power, and their work in nursing homes does not seem to regularly allow for this. This discrepancy between their values and aspirations and the reality of nursing home work results in their feelings of powerlessness. This in turn, contributes to the experience of burnout.

Licensed practical nurses who are burned out also experience nihilism, another type of alienation, to a greater degree than nurses' aides who are burned out. Nihilism, as defined by Maddi, Kobasa, and Hoover (1981), is the active attempt to discredit everything that appears to have meaning. A possible explanation of this is that licensed practical nurses who experience a marked discrepancy between some of their values and beliefs surrounding nursing, may then overreact and reject or question all of their values. This rejection of values often leads to the experience of burnout. Again, the work of Cherniss and Krantz (1983) explains the relationship of nihilism to burnout. Cherniss and Krantz indicated that

Montessori teachers did not experience burnout because of the ideology they shared. Thus, licensed practical nurses who reject or question the values and belief system of nursing may be more vulnerable to burnout because they no longer have an explicit ideology that reduces the ambiguity and internal conflict inherent in helping service work and because they no longer have standards against which to measure competence.

Finifer (1972) indicates that people become alienated from whatever is producing the discrepancy. Thus, the context of alienation is determined by the object or facet of life which does not measure up to the individual's internalized aspirations, norms and values. The results of the present investigation revealed that licensed practical nurses experiencing burnout were most alienated from work and social institutions. Again, because licensed practical nurses have made an emotional, financial, and intellectual investment in working as a nurse, a rejection or alienation from nursing or their work role as a nurse could easily contribute to burnout by removing the value or meaning of the work.

It is somewhat unclear why licensed practical nurses who are alienated from social institutions tend to experience burnout more than those who are not alienated

from social institutions. It may be that licensed practical nurses have expectations of social institutions (e.g., governmental agencies governing welfare, social security, Medicare, etc.) as a result of their training. When licensed practical nurses discover that these social institutions can impede nursing care or negatively impact patients' lives, it may be that licensed practical nurses become alienated from these "helping institutions" that are not really helpful. This alienation, in turn, may lead to burnout.

The results of this study indicated that nurses' aides who were burned out reported the type of alienation called adventurousness to a significantly greater degree than nurses' aides who were not burned out. Maddi, Kobasa and Hoover (1981) define adventurousness as the interest in extreme and dangerous activities because everyday experiences have lost their meaning. Nurses' aides who experienced burnout were also found to be more alienated from their families and themselves than nurses' aides who did not report burnout.

The type and contexts of alienation that appear significant for nurses' aides, but not licensed practical nurses, may be the result of differences in socioeconomic status. Tallmer, Mayer, and Hill (1977) state that most

nurses' aides are minorities, and that this frequently translates into lowered class status and poverty which have other detrimental side effects. These side effects include crowded living conditions, a high degree of physical deficits, single parent homes, and lack of proper food. Such a physically depriving environment, according to these authors, produces a "survival ethos" among members of the lower class in which the needs of children are denied. As a result, children become prematurely independent with an overreliance on self and a lack of confidence in others. With such a background, it is not surprising that at least some nurses' aides might develop a sense of alienation from their families. In this study, nurses' aides generally reported less social support, in the form of work support, than did licensed practical nurses. If nurses' aides do not feel supported at work, and they are alienated from their families, thereby eliminating another source of support, it makes sense that they might be particularly vulnerable to burnout. This contention could be empirically tested in the future.

That life is inherently meaningful and that individuals should have a sense of their own importance are essentially middle and upper class beliefs. Given that nurses' aides are from the lower socioeconomic class

(Vladek, 1980), they may not have been socialized to expect life to be meaningful or to place great value in themselves. In Maslow's (1954) hierarchy, nurses' aides may be said to be typically dealing with lower order needs (e.g., food, shelter, and safety). Thus, such higher order needs (e.g., self-esteem and self-actualization) may appear relatively unimportant to them. For this population, to place no value on self-love or the meaning of everyday experiences may not be that disruptive or damaging. Thus, it may be that the greater alienation from self and the meaning of everyday activities in nurses' aides is statistically significant but not practically significant.

Separate multiple regressions yielded results indicating that the total score on the Alienation Test was the best predictor of burnout in both nurses' aides and licensed practical nurses. Thus, individuals who actively discredit anything meaningful, who do not believe in or value their activities, who feel impotent to meet their goals, who express interest in dangerous activities, and who feel disconnected from work, social institutions, their families, themselves, and others, are most likely to experience burnout. Licensed practical nurses who express these general feelings of alienation are particularly prone

to burnout. These findings can be explained at least in part by Cherniss and Krantz' (1983) work. Individuals who do not have a meaningful value system or ideology appear to be more prone to burnout because they lack clear guidelines and accepted measures of competence that help the individual reduce internal ambiguity. Total alienation leaves one without access to social support from a number of important sources (e.g., work, family, others, and institutions).

Hypothesis Four. Hypothesis Four stated that there was no relationship between religiosity and the degree of burnout reported by the subjects. The results of the statistical procedures used to test this hypothesis revealed that for both nurses' aides and licensed practical nurses the amount of religiosity expressed did not appear to have any effect on the degree of burnout experienced. These results are clearly in an unexpected direction and are in direct contradiction to the theory of burnout delineated by Cherniss and Krantz (1983).

There are several possible explanations for these surprising results. One explanation involves the instrumentation used in measuring religiosity. The reliability and validity of the GLASR were such that one may not rule out the possibility a factor other than

religiosity was measured. There are only a few developed measures of religiosity and none of these instruments have reliability or validity estimates exceeding the GLASR. Thus, a problem inherent in measuring religiosity is the lack of good instrumentation.

A related explanation of these findings is also based on methodological considerations. Festinger (1953) and others have argued that the relationship between attitudes and behavior is only moderate. Thus, although subjects may profess beliefs and indicate that they live according to these beliefs, attitudinal research does not distinguish between those who consistently behave on the basis of their values and attitudes and those who do not. In this study, it is difficult to know whether nurses' aides and licensed practical nurses expressing a high degree of religiosity really have adopted a religious value system or ideology and are attempting to live it out, or whether they are paying "lip service" to an ideal. It is therefore hard to know whether this study measured religiosity as Cherniss and Krantz (1983) would define it.

A third explanation of these results can be linked to Cherniss and Krantz (1983) description of what makes an ideology, religious or not, more effective. They suggest that an ideology is most effective when it 1) has a clear

focus, and 2) has been translated into specific guidelines for day to day work. They indicated that the Montessori approach was particularly good for teachers in that it provided both a clear focus and distinct guidelines. The nuns in Cherniss and Krantz' study had a religious ideology with a clear focus. Perhaps by living and working in an environment with others sharing the same belief system, the nuns were able to develop specific guidelines for their day-to-day work. This opportunity to work with others who share the identical religious belief system and who integrate this belief system into their work role is not available to most individuals. Thus, for most of the nurses' aides and licensed practical nurses in this investigation the religious ideology to which they ascribe may not be explicit enough concerning the work situation to be so effective as to eliminate or moderate burnout.

Hypothesis Five. Hypothesis Five stated that there was no relationship between social support and the degree of burnout experienced. In this study, social support was limited to work support, i.e., positive affirmation from co-workers and supervisors. The results of the statistical procedures used to test this hypothesis revealed that for nurses' aides the amount of social support received at work was only minimally related to the degree of burnout

experienced. The opposite was true for licensed practical nurses. That is, licensed practical nurses who felt supported by co-workers and supervisors did not report burnout.

The importance of work support to licensed practical nurses may be a function of the nature of their jobs. Licensed practical nurses are in the middle of the power hierarchy in nursing homes. They report to nursing administrators who are usually registered nurses, but supervise and are responsible for nurses' aides. This "middle position" may leave them more vulnerable to the loss of work support from either direction. Additionally, licensed practical nurses must make important emergency medical and nursing decisions. It may be that the stressful decisions and choices a licensed practical nurse must make as a part of her job also increase the need for social support in the work environment. Because licensed practical nurses spend more time as administrators rather than caregivers, they may generally feel more emotionally isolated, and as a result be more affected when work support is not available.

As discussed earlier, nurses' aides may have lower expectations of receiving support in any context including the work environment. Further, it may be more difficult

for nurses' aides to establish and maintain supportive relationships with co-workers because they have less choice or control in the work environment than do licensed practical nurses. Nurses' aides are frequently rotated between different floors and units and they have little choice over lunch or coffee breaks. Both of these practices impinge on nurses' aides ability to develop supportive relationships at work.

The foregoing provides at least some explanation of the results of this investigation. The total score on The Alienation Test seems to be the best predictor of burnout for nurses' aides and licensed practical nurses, although it accounts for only 17% of the variance for nurses' aides and 30% of the variance for licensed practical nurses. This finding is, at least to some degree, in accordance with Cherniss and Krantz (1983) theory that burnout develops as a result of the loss of a moral commitment in work. The presence of social support in the work environment was also found to moderate burnout in licensed practical nurses. Lack of social support has clearly been delineated as a precursor of burnout in the literature in registered nurses and allied health professionals (Maslach & Pines, 1977, Pines & Kafry, 1978, Epting, 1981).

Theoretical Implications

The focus of this investigation has been to study in a new setting and with a new population those variables thought to moderate or exacerbate burnout. The total score on The Alienation Test was the variable that correlated consistently with burnout and which also was able to predict burnout in both nurses' aides and licensed practical nurses. In order to better understand the role of alienation in the burnout process, it is important to discuss pertinent theories related to alienation.

Maddi and Kobasa (1984) postulate that a series of personality characteristics including commitment, control and challenge help executives cope with stressful events in a way that prevents the strain leading to illness. They contend that persons with these characteristics react to stressful situations with transformational coping. This type of coping involves altering events so they are less stressful. According to these authors, a nurses' aide or licensed practical nurse would display transformational coping by discussing work stresses with a supervisor and working toward concrete organizational changes.

The personality characteristic of commitment is defined by Kobasa (1979) as the opposite of alienation. In this theory, commitment is seen as a personality trait

resulting from supportive interactions in a child's early home environment. Alienation is then seen as the result of an early environment lacking in support. This interpretation of alienation would suggest that the burnout associated with alienation is the result of personality factors rather than social or organizational factors.

Another way to conceptualize alienation is to view it as a coping response rather than a personality trait. As reported earlier in this chapter, Finifer (1972) suggests that alienation is a response to a discrepancy between aspirations, values, and reality. Another theory which may also explain alienation is that of learned helplessness. Seligman (1975) developed the learned helplessness model to explain the host of motivational, cognitive and emotional effects that result from the experience of uncontrollability. He suggests that learned helplessness occurs as a result of a lack of contingency between one's behavior and its outcomes. That is, the helpless individual expects a connection between one's behavior and positive outcomes in the environment. According to Seligman, learned helplessness has three deleterious consequences on individuals. First, it impairs motivation. Second, the ability to believe that an intervention has been effective is sharply decreased. Third, the individual becomes

depressed, angry, and/or anxious in response to his/her lack of control. The learned helplessness theory explains the type of alienation called powerlessness particularly well.

It is also possible that alienation is an adequate coping response. In some circumstances, alienation may be the result of a realistic appraisal of the environment. Many theories of burnout suggest that burnout is the result of feeling overwhelmed by the constant emotional demands of work in the human service professions. Therefore, it may be that alienation is a somewhat sane response to a taxing situation.

The results of the study also indicated that for licensed practical nurses where high levels of social support, in the form of support from co-workers and supervisors, were present, burnout was low or absent. The majority of prior studies related to burnout and stress indicate that when social support is present, stress and burnout are reduced (Maslach & Pines, 1977; Pines & Kafry, 1978; Shinn, 1982; Yasko, 1983; Farber, 1983). It is interesting to note that in this study social support was found to be important in reducing burnout in licensed practical nurses, but not in nurses' aides.

Maddi and Kobasa (1984) indicate that for individuals

who are highly invested in work as evidenced by time and energy expended, the most important source of social support is co-workers and supervisors. They further suggest that a by-product of social support, the knowledge and resources that come from associating with capable people engaged in similar efforts can increase transformational coping. Thus, social support may be important for professionals or persons highly invested in their work, but not for paraprofessionals. This study clearly indicated that burnout occurs in nonprofessionals as well. It may be that different factors contribute to the experience of burnout in professionals, paraprofessionals and nonprofessionals. This should be a target for future empirical investigations into burnout.

Applied Implications

Because the total score on the Alienation Test was found to be a variable which predicted burnout in both nurses' aides and licensed practical nurses, its impact needs to be taken seriously. If alienation is seen as the result of upbringing and personality characteristics, then employers can best reduce burnout in workers by employing workers who are not alienated. As such, employers would have to give prospective employees personality inventories. Although this type of testing would be consistent with the

practice and history of industrial and organizational psychology, it poses ethical problems in terms of the possible violation of the rights of prospective employees.

On the other hand, if alienation is seen as a coping response to a difficult situation, then employers might look to organizational factors to eliminate or reduce burnout in employees. From this perspective, both nurses' aides training programs and schools for licensed practical nurses need to provide better and more realistic preparation for the the nursing field and for work in nursing homes. Training should cover the following areas: advantages and difficulties of working in a nursing home, knowledge of nursing home populations, the emotions involved in caring for the ill and the dying, and effective coping mechanisms for dealing with job stresses. Training in assertiveness skills (Scully, 1980) and communication skills (Maslach, 1979b) might also be useful. Such skills would enable nurses' aides and licensed practical nurses to verbalize their feelings and problems and to then work toward constructive change. It seems important that nursing home administrators and Directors of Nursing also arrange for an orientation and inservice program that addresses on an ongoing basis the realities and stresses of working in a nursing home and working with the elderly. Changes in the

above areas would help to reduce discrepancies that lead to alienation.

Because powerlessness has a significant relationship to burnout in both nurses' aides and licensed practical nurses, it seems important to facilitate some sense of control or power for both groups. One way to do this is to provide clear job descriptions and clear expectations of workers. It is also important that the means to meet these expectations be made available. Thus, administrators and Directors of Nursing need to provide clearly and concretely written job descriptions. Also, they need to maintain adequate staffing and supplies so that nurses' aides and licensed practical nurses can meet institutional standards and expectations without adverse levels of strain. Further, both nurses' aides and licensed practical nurses need to have some vehicle for input into administrative decisions which directly affect their jobs. The channels of communication need to be opened up between nurses' aides and licensed practical nurses and between licensed practical nurses and administrators and Directors of Nursing. Perhaps regular bi-monthly or monthly meetings where the focus is current problems and proposed changes would serve this function.

Another important change, aimed toward reducing

powerlessness, is to include nurses' aides on a more regular basis at patient care planning conferences. Although nurses' aides provide the bulk of care to nursing home residents, they often are not privy to the care planning process (Hyerstay, 1981).

The rotation of aides and the lack of flexibility regarding lunches and breaks are other practices that need to be examined. Since these practices limit nurses' aides ability to exert control in the work environment, it may be useful to modify them in some way. Perhaps, rotations should be stopped and nurses' aides should be allowed to negotiate lunch and break times with the nurse in charge of the unit.

Because the presence of work support appears to be related to low burnout in licensed practical nurses, it seems important to facilitate this avenue of support for paraprofessionals and professionals as well. Hay and Oken (1972), Maloney and Ange (1982), Scully (1983), and Maslach (1978b) advocate the use of social support groups in the work setting. Given the middle position of nurses in the power hierarchy in nursing homes and the degree of responsibility with which they are faced, it may be appropriate to establish social support groups led by a professional facilitator in order to help licensed

practical nurses cope more effectively with the stresses of their jobs. This, in turn, should help to eliminate or decrease burnout.

Limitations of the Study

The general purpose of this investigation was descriptive and not predictive. As a consequence, the generalizability of these results to other settings and populations must be considered with caution. This study was conducted in a very specific type of setting. The nursing homes involved were suburban skilled care facilities that were owned and operated by religious groups. The patients in these homes were over 65 years of age and most of them paid privately for their care. There was a limited number of registered nurses in each institution, consequently the bulk of the nursing care was rendered by nurses' aides and licensed practical nurses. It may be that working in this type of home is vastly different from working in other types of homes such as an urban, proprietary nursing home where most of the patients are mentally ill and on public aid. The kinds of ownership, reimbursement for care, patient population, and levels of care in nursing homes make generalizability an issue.

It is also not possible to generalize the results of this study to nurses' aides and licensed practical nurses

employed on the night shift. This study involved nurses' aides and licensed practical nurses employed on the 7:00 a.m to 3:00 p.m. and 3:00 p.m. to 11:00 p.m. shifts. Night shift employees were excluded because prior research had indicated that the night shift is generally more stressful than other shifts.

Another limitation of this study is that two different sample sizes were used. Sixty-nine nurses' aides were included in the study and only eighteen licensed practical nurses. Due to the employment patterns inherent in the nursing home industry, it would be difficult to have equal sample sizes. Nonetheless, such a large discrepancy between sample sizes allows for statistically significant differences that may or may not be practically significant in the smaller population. An effort was made to control for this by choosing a .05 level of significance for all statistical tests.

A further problem with the sample of licensed practical nurses was that six of the eighteen subjects were employed part-time. The investigator had requested at each nursing home that only full-time employees be included in the study. This discrepancy between full and part-time employees was not discovered until the statistical procedures on the data were initiated. A premise in the

literature on burnout is that helpers who care for others on a regular basis tend to experience burnout more readily than those who sporadically provide care. As such, it may be that the number of licensed practical nurses experiencing burnout was underreported because one third of the sample worked part-time rather than full-time.

General shortcomings of the research on burnout are the use of self-report measures and the self-selection of subjects. This study involved both volunteers and 5 self-report questionnaires. Even though subjects were paid five dollars for their participation, it may be that nurses' aides and licensed practical nurses who were truly burned out were too cynical or tired to make time to participate in the study. A Lie Scale on the SBS-HP was able to identify individuals who were "faking good." Although, none of the eighty-seven subjects in the study had scores on the Lie Scale high enough to eliminate them from the study, there were a significant number of subjects (N=16) with elevated scores on the Lie Scale. Thus, a number of subjects may have minimized the degree of burnout reported. Observations of participants at work or having supervisors or co-workers complete questionnaires on subjects' performance might have been a way to diminish this source of statistical error in this type of research.

A final limitation was the measure of religiosity used in this study. As reported earlier, the GLASR has only moderate reliability and validity. Because it appeared to be one of the few available instruments measuring religiosity, and because it could be completed relatively efficiently it was included in the study. Given that this was a relatively weak measure of religiosity, it may be that something other than religiosity was measured in this study (e.g., religious beliefs or an "idealized" rather than actual belief system.)

Directions for Future Research

The results of this investigation suggest new areas for future research. This study measured burnout in nurses' aides and licensed practical nurses employed in nursing homes. Because registered nurses are frequently employed in nursing homes, it might be useful to measure the impact of burnout in professionals, registered nurses, as well as in paraprofessionals and nonprofessionals. This might lend further light on the question of whether burnout is solely a professional issue in the field of nursing. Generally, a "critical study" should be conducted to parcel out the impact of personality factors and dispositions, organizational effects, and social, economic and political variables in order to better predict and describe burnout

in nursing home employees.

Additionally, it would be worthwhile to assess the impact of different measures of burnout on different populations. One of the criticisms of research on burnout has been the use of widely divergent measures of burnout. One way to respond to this criticism would be to employ several different measures of burnout with the same population. Such a comprehensive approach to the measurement of burnout might reveal which instruments measure the same concept/experience in a specific population. The multiple measure assessment of the Type A or Coronary Prone Behavior Pattern (Matthews, 1982) provides an excellent precedent in modern psychology for this recommendation.

Future research might also be directed toward a path analysis of those factors or stressors which lead to burnout. A path analysis would allow for the empirical analysis of the direct and indirect effects numerous variables on burnout. On the basis of a path analysis, interventions to eliminate factors which create burnout can be developed, implemented and evaluated.

Finally, the measurement of religiosity must be reformed with higher levels of psychometric rigor. The recent interest in the role that religion, ideology, and

spirituality play in counteracting the noxious effects of stress should contribute to the development of a psychometrically valid and reliable test of religiosity.

REFERENCES

- A core training program for California's long-term care ombudsman. (1981). San Diego, Calif.: California Department on Aging.
- Andrews, G.A., Tennant, C., Hewson, D.M., and Valliant, G.E. (1978). Life events stress, social support, coping style, and risk of psychological impairment. The Journal of Nervous and Mental Disease, 166(5), 307-316.
- Antonovsky, A. (1979). Health, stress and coping. San Francisco: Jossey-Bass.
- Appelbaum, S. H. (1981). Stress management for health care professionals. Rockville, Maryland: Aspen Systems Corporation.
- Archer, M., Rinzler, S., & Christakis, G. (1967). Social factor affecting participation in a study of diet and coronary heart disease. Health and Social Behavior, 8, 22-31.
- Bergin, A. E. (1983). Religiosity and mental health: a critical reevaluation and meta-analysis. Professional Psychology: Research and Practice, 14(2), 170-184.
- Billings, A. G., & Moos, R. H. (1981). The role of coping responses and social resources in attenuating the stress of life events. Journal of Behavioral Medicine, 4(2), 139-157.
- Broen, W. E. (1957). A factor analytic study of religious attitudes. Journal of Abnormal and Social Psychology, 54, 176-179.
- Burke, R. E., D'Erasmus, M., & Burger, S.E. (1980). Research brief: Training geriatric nursing assistants -- a solution. The Journal of Long-Term Care Administration, 8, 37-41.
- Bulter, R. N. (1975). Why survive? Growing old in America. New York: Harper & Row.
- Cherniss, C. (1979). Institutional barriers to social

- support among human service staff. In R. E. Reid & R. A. Quinlan (Eds.), Proceedings of Symposium on Burnout in the Helping Professions (pp. 1-13). Kalamazoo, Michigan: Western Michigan University.
- Cherniss, C. (1980a). Professional burnout in health service organizations. New York: Praeger.
- Cherniss, C. (1980b). Staff burnout: Job stress in the human services. Beverly Hills: Sage.
- Cherniss, C. & Egnatios, E. S. (1978). Is there job satisfaction in community mental health? Community Mental Health Journal, 14, 309-318.
- Cherniss, C. & Krantz, D. L. (1983). The ideological community as an antidote to burnout in the human services. In B. Farber (Ed.), Stress and burnout in the human services (pp. 198-212). Elmsford, New York: Pergamon.
- Clark, C. C. (1980). Burnout: Assessment and intervention. Journal of Nursing Administration, 10(9), 39-43.
- Cline, V. B. & Richards, J. M. (1965). A factor analytic study of religious belief and behavior. Journal of Personality and Social Psychology, 1, 569-578.
- Cobb, S. (1976). Social support as a moderator of life stress. Psychosomatic Medicine, 38(5), 300-314.
- Colahan, D., Cisin, I. H., & Crossley, H. M. (1969). American drinking practices: A national study of drinking behavior and attitudes. New Jersey: Rutgers University, Center of Alcohol Studies.
- Comstock, G. W., Abbey, H., & Lundin, F. E. (1970). The non-official census as a basic tool for epidemiologic observations in Washington County, Maryland. In T. Kessler & M. L. Levin (Eds.), The community as an epidemiologic laboratory: A casebook of community studies (pp. 73-97). Baltimore: John Hopkins.
- Comstock, G. W. & Partridge, K. B. (1972). Church attendance and health. Journal of Chronic Diseases, 25, 665-672.
- Cronin-Stubbs, D. (1983). The relationships among

occupational stress, life stress, social support, and burnout experienced in nurses working in diverse hospital based specialty areas. Unpublished doctoral dissertation, Loyola University, Chicago.

- Daley, M. R. (1979). Preventing worker burnout in child welfare. Child Welfare, 58(7), 443-450.
- Davis, P. (1984). Night nursing: An aspect of occupational stress. The Australian Nurses Journal, 13(6), 46-47.
- Dawes, P. A. (1981). The nurses' aide and the team approach in the nursing home. Journal of the Geriatric Society, 14(2), 265-277.
- Dean, A. & Lin, N. (1977). The stress-buffering role of social support. The Journal of Nervous and Mental Disease, 165(6), 403-417.
- DeJong, G. F., Faulkner, J. E., & Warland, R. H. (1976). Dimensions of religiosity reconsidered; evidence from a cross cultural study. Social Forces, 54(4), 867-889.
- Depp, F. C., Arnold, E., Dawkins, J., & Selzer, N. (1983). Predicting tenure decisions of psychiatric nursing assistants: Individual and work-related factors. Research in Nursing and Health, 6, 53-59.
- Edelwich, J. & Brodsky, A. (1980). Burn-out: Stages of disillusionment in the helping professions. New York: Human Services Press.
- Emener, W. G. (1980). Professional burnout: Rehabilitation's hidden handicap. Journal of Rehabilitation, 45(1), 55-58.
- Epting, S. P. (1981). Coping with stress through peer support. Topics in Clinical Nursing, 2, 47-59.
- Farber, B. A. (1983). Stress and burnout in the human service professions. New York: Pergamon.
- Feldman, J., Burke, R. E., & Schwarzmann, J. (1982). Analysis of the training of unlicensed long-term care personnel. The Journal of Long-Term Care Administration, 10, 1-10.
- Festinger, L. (1953). Research methods in the behavioral

- sciences. New York: Dryden.
- Finifer, A. W. (1972). Alienation and the social system. New York: Wiley.
- Fischer, H. J. (1983). A psychoanalytic view of burnout. In B. A. Farber (Ed.), Stress and burnout in the helping professions (pp. 40-45). New York: Pergamon.
- Forney, D. S., Wallace-Shutzman, F., & Wiggers, T. T. (1982). Burnout among career and development professionals: Preliminary findings and implications. The Personnel and Guidance Journal, 61, 435-439.
- Freudenberger, H. J. (1974). Staff burnout. Journal of Social Issues, 30, 159-165.
- Freudenberger, H. J. (1975). The staff burn-out syndrome in alternative institutions. Psychotherapy: Theory, Research, and Practice, 12(1), 73-82.
- Freudenberger, H. J., & Richelson, G. (1980). Burn-out: The High Cost of Achievement. Garden City, New York: Anchor.
- Friel, M. & Tehan, C. B. (1980). Counteracting burn-out for the hospice care-giver. Cancer Nursing, 3, 258-293.
- Gladding, S. & Lewis, E. (1979). Religiosity, psychological anomie, and the GLA Scale [summary]. Proceedings of the 87th Annual Convention of the American Psychological Association, 14.
- Gladding, S. T., Lewis, E. L., & Adkins, L. (1981). Religious beliefs and positive mental health: the GLA Scale and counseling. Counseling and Values, 25, 206-215.
- Glock, C. Y. (1962). On the study of religious commitment. Religious Education Research Supplement, 42, 98-110.
- Goodstein, R. K. (1981). Inextricable interaction: Social, psychologic, and biologic stresses facing the elderly. American Journal of Orthopsychiatry, 51(2), 219-229.
- Gore, S. (1978). The effect of social support in moderating health consequences of unemployment. Journal of Health and Social Behavior, 19, 157-165.

- Graham, T. W., Kaplan, B. H., Coroni-Huntley, J. C., James, S. A., Becker, C., Hames, C. G., & Heyden, S. (1978). Frequency of church attendance and blood pressure elevation. Journal of Behavioral Medicine, 1(1), 37-43.
- Hackman, J. R. & Oldhaam, G. R. (1975). Development of the Job Diagnostic Survey. Journal of Applied Psychology, 60, 159-170.
- Handschu, S. S. (1973). Profile of the nurses' aide. The Gerontologist, 13(3), 315-317.
- Harrison, W. D. (1983). A social competence model of burnout. In B. A. Farber (Ed.), Stress and burnout in the human service professions (pp. 29-39). New York: Pergamon.
- Hay, D. & Oken, D. (1972). The psychological stresses of Intensive Care Unit nursing. Psychosomatic Medicine, 34(2), 109-118.
- Heifitz, L. J. & Bersani, H. A. (1983). Disrupting the cybernetics of personal growth: Toward a unified theory of of burnout in the human services. In B. A. Farber (Ed.), Stress and burnout in the human service professions (pp. 46-62). New York: Pergamon.
- Holahan, C. J. & Moos, R. H. (1981). Social support and psychological distress: A longitudinal analysis. Journal of Abnormal Psychology, 90, 365-370.
- House, J. S., & Wells, J. A. (1978). Occupational stress, social support, and health. In A. McLean, G. Black, & M. Colligan (Eds.), Reducing Occupational Stress: Proceedings of a Conference (HEW - NIOSH Publication No. 78-140). Washington, DC: Department of Health, Education, and Welfare.
- Hyerstay, B. J. (1978). The political and economic implications of training in nurses aides. Journal of Nursing Administration, 8, 22-24.
- ICBC Advocacy Training Manual. (1982). Chicago, IL: Illinois Citizens for Better Care.
- Ivancevich, J. M. and Matteson, M. T. (1980). Nurses and stress: Time to examine the potential problem. Supervisor Nurse, 11, 17-22.

- Jenkinson, V. (1981). Night duty and the nurse. Nursing Mirror, 151, 26-30.
- Johnson, F. (1973). Alienation: Concept, Term and Meanings. New York: Seminar.
- Jones, J. W. (1980a). The Staff Burnout Scale for Health Professionals. Park Ridge, IL: London House.
- Jones, J. W. (1980b). Preliminary Manual: The Staff Burnout Scale for Health Professionals. Park Ridge, IL: London House.
- Jones, J. W. (1980c). The staff burnout scale: A validity study. Paper presented at the Annual Meeting of the Midwestern Psychological Association, St. Louis.
- Jones, J. W. (1981). Diagnosing and treating staff burnout among health professionals. In J. Jones (Ed.), The burnout syndrome: Current research, theory and interventions (pp. 107-125). Park Ridge, IL: London House.
- Kanungo, R. N. (1979). The concepts of alienation and involvement revisited. Psychological Bulletin, 86(1), 119-138.
- Kaplan, B. H. (1976). A note on religious beliefs and coronary heart disease. Journal of the South Carolina Medical Association Supplement, 60-64.
- King, M. B. & Hunt, R. A. (1975). Measuring the religious variable: A national application. Journal for the Scientific Study of Religion, 14, 13-22.
- Kobasa, S. C. (1979). Stressful life events, personality, and health: An inquiry into hardiness. Journal of Personality and Social Psychology, 37(1), 1-11.
- Kobasa, S. C. (1982). Commitment and coping in stress resistance among lawyers. Journal of Personality and Social Psychology, 42, 707-717.
- Kobasa, S. C. (1984). Barriers to work stress: II. The hardy personality. In W. D. Gentry, H. Benson, & C. J. deWolff (Eds.), Behavioral Medicine: Work, stress and health (pp. 89-114). The Hague: Martinus Nihjoff.
- Kobasa, S. C., Maddi, S. R., & Kahn, S. (1982). Hardiness

- and health: A prospective study. Journal of Personality and Social Psychology, 42, 168-177.
- Kobasa, S. C., & Pucetti, M. C. (1983). Personality and social resources in stress resistance. Journal of Personality and Social Psychology, 45(4), 839-850.
- LaRocco, J. M., House, J. P., & French, J. R. (1980). Social support, occupational stress, and health. Journal of Health and Social Behavior, 21, 202-218.
- LaRocco, J. M., & Jones, A. P. (1978). Co-worker and leader support as moderators of stress-strain relationships in work situations. Journal of Applied Psychology, 63(5), 629-634.
- Lewis, E. L., & Gladding, S. T. (1983). Test-retest reliability of the Gladding, Lewis, Adkins Scale of Religiosity: A longitudinal study. Psychological Reports, 52, 34.
- Lin, N., Ensel, W. M., Simeone, R. S., & Kuo, W. (1979). Social support, stressful life events, and illness: A model and empirical test. Journal of Health and Social Behavior, 20, 108-119.
- Lindenthal, J. J., Myers, J. K., Pepper, M., & Stern, M. S. (1970). Mental status and religious behavior. Journal for the Scientific Study of Religion, 9, 143-49.
- Maddi, S. R., Hoover, M., & Kobasa, S. C. (1982). Alienation and exploratory behavior. Journal of Personality and Social Psychology, 42(5), 884-890.
- Maddi, S. R. & Kobasa, S. C. (1984). The hardy executive: Health under stress. Homewood, Illinois: Dow Jones-Irwin.
- Maddi, S. R., Kobasa, S. C., & Hoover, M. (1979) The Alienation Test. Journal of Humanistic Psychology, 19(4), 73-76.
- Maloney, M. J., & Ange, C. (1982). Group consultation with highly stressed medical personnel to avoid burnout. Journal of the American Academy of Child Psychiatry, 21(5), 481-485.
- Maslach, C. (1976). Burned-out. Human Behavior, 5, 16-22.

- Maslach, C. (1978a). Job burnout: How people cope. Public Welfare, 36, 56-78.
- Maslach, C. (1978b). The burnout syndrome and patient care. In C. A. Garfield (Ed.), Stress and Survival (pp. 110-120). St. Louis: Mosby.
- Maslach, C. (1978c). The client role in staff burn-out. Journal of Social Issues, 34(4), 111-124.
- Maslach, C. (1982). Understanding burnout: Definitional issues in analyzing a complex phenomenon. In W. S. Paine (Ed.), Job stress and burnout: Research, theory and intervention perspectives (pp. 29-40). Beverly Hills: Sage.
- Maslach, C. & Jackson, S. E. (1982). Burnout in health professions: A social psychological analysis. In J. Suls & G. Sanders (Eds.), Social psychology of health and illness (pp. 227-251). Hillsdale, NJ: Erlbaum.
- Maslach, C., & Jackson, S. E. (1978). Lawyer burn-out. Barrister, 5(2), 52-54.
- Maslach, C., & Jackson, S. E. (1979). Burned-out cops and their families. Psychology Today, 12, 59-62.
- Maslach, C., & Pines, A. (1977). The burn-out syndrome in the day care setting. Child Care Quarterly, 6(2), 100-113.
- Marshall, R. E., & Kasman, C. (1980). Burnout in the neonatal intensive care unit. Pediatrics, 65(6), 1161-1165.
- Maslow, A. H. (1954). Motivation and personality. New York: Harper.
- McConnell, E. A. (Ed.). (1982). Burnout in the nursing profession. St. Louis: Mosby.
- Merrill, Lynch, Pierce, Fenner, & Smith, Inc. (1979). Nursing home industry review. New York.
- Moos, R. H., & Insel, P. (1974). Work Environment Scale preliminary manual. Palo Alto, Calif.: Consulting Psychologists Press.

- Moos, R. H. (1981). Work Environment Scale manual. Palo Alto, Calif.: Consulting Psychologists Press.
- Moss, G. E. (1973). Illness, immunity and social interaction. New York: Wiley.
- Mytych, K. M. (1981). Burnout in the ED nurse. Journal of Emergency Nursing, 7, 265-268.
- Naguib, S. M., Comstock, G. W., & Davis, H. D. (1966). Epidemiologic study of trichomoniasis in normal women. Obstetrics and Gynecology, 27, 607-616.
- Naguib, S. M., Lundin, F. E., & Davis, H. D. (1966). Relation of various epidemiologic factors to cervical cancer as detriments of a screening program. Obstetrics and Gynecology, 28, 451-459.
- Paredes, F. C. (1982). The relationship of psychological resources and social support to occupational stresss and burnout in hospital nurses. (Doctoral Dissertation, University, 1982). Dissertation Abstracts International, 43(3), 881B.
- Pines, A. M., & Aronson, E., with Kafry, D. (1981). Burnout: From tedium to personal growth. New York: The Free Press.
- Pines, A., & Kafry, D. (1978). Occupational tedium in the social services. Social Work, 23, 499-507.
- Pines, A., & Maslach, C. (1978). Characteristics of staff burnout in mental health settings. Hospital and Community Psychiatry, 29(4), 233-237.
- Pinneau, S. R. (1975). Effects of social support on occupational stresses and strains. Paper presented at the meeting of the American Psychological Association, Washington, DC.
- Pinneau, S. R. (1976). Effects of social support on psychological and physiological strains. Dissertation Abstracts International, 36, 5359B. (University Microfilms No. 76-9491).
- Schact, R. (1970). Alienation. Garden City, NY: Doubleday.
- Scotch, N. (1963). Sociocultural factors in the

- epidemiology of Zulu hypertension. American Journal of Public Health, 53, 1205-1213.
- Scott, C. W. (1980). The burn-out syndrome in ambulance paramedics. (Doctoral Dissertation, United States International University). Dissertation Abstracts International, 41(3), 1149-B.
- Scully, R. (1983). The work-setting support group: A means of preventing burnout. In B. A. Farber (Ed.), Stress and burnout in the helping professions (pp. 188-197). New York: Pergamon.
- Seeman, M. (1959). On the meaning of alienation. American Sociological Review, 24, 783-791.
- Seligman, M. E. (1975). Helplessness. San Francisco: Freeman.
- Shinn, M. (1982). Methodological issues: evaluating and using information. In W. S. Paine (Ed.), Job stress and burnout: Research, theory and intervention perspectives (pp. 61-79). Beverly Hills: Sage.
- Singer, G. (1983). Your job and your health: Quality of life in shift work. Lamp, 40(4), 25-28.
- Stark, R. (1971). Psychopathology and religious commitment. Review of Religious Research, 12, 165-176.
- Suls, J. (1982). Social support, interpersonal relations, and health: Benefits and liabilities. In J. Suls & G. Sanders (Eds.), Social Psychology of Health and illness (pp. 255-277). Hillside, NJ: Erlbaum.
- Tallmer, M. Meyer, M., and Hill, G. (1977). Education and consultation on mental health in long-term care facilities: Problems, pitfalls, and solutions. Journal of Geriatric Psychiatry, 10(2), 173-189.
- Thoits, P. A. (1982). Conceptual, methodological, and theoretical problems in studying social support as a buffer against life stress. Journal of Health and Social Behavior, 23, 145-159.
- Wallace, R. W., & Brubaker, T. H. (1982). Biographical factors related to employment tenure: A study of nurses' aides in nursing homes. The Journal of Long-Term Care

Administration, 10, 11-19.

- Warnath, C. F., & Shelton, J. L. (1976). The ultimate disappointment: The burned-out counselor. Personnel and Guidance Journal, 55, 172-175.
- Winnburst, J. A., Marcelissen, F. H., & Kleber, R. J. (1982). Effects of social support in the stressor-strain relationship: A dutch sample. Social Science Medicine. 16, 475-482.
- Veninga, R. (1979). Administrator burnout: Causes and cures. Hospital Progress, 60, 45-56.
- Vladeck, B. (1980). Unloving care: The nursing home tragedy. New York: Basic Books.
- Vivens, S. (1983). Nursing practice and staff turnover in nursing homes. Paper presented at the 36th Annual Scientific Meeting of the Gerontological Society of America, San Fransisco.
- Yasko, J. M. (1983). Variables which predict burnout experienced by oncology clinical nurse specialists. Cancer Nursing, 6, 109-116.

APPENDIX A

February 21, 1985

Dear Mr. Administrator:

I am a graduate student at Loyola University in Chicago. For my dissertation research, I am interested in studying stress in licensed practical nurses and nurses' aides employed in nursing homes. I'm sure you are aware that very little research has been done on any segment of the nursing home industry. It is my hope that by studying stress in nursing home employees, the industry will be better able to address and reduce the problems of absenteeism, tardiness, turnover, neglect and abuse.

I have selected your home as one of the area nursing homes in which I would like to conduct my study. The name of your facility as well as the names of your employees will be kept in complete confidence. I have five questionnaires that I will ask each person in the study to complete. Participants should be able to complete the questionnaires in approximately 30-60 minutes. I will pay all participants \$5.00 upon completion of all five questionnaires.

Ideally, I would like to introduce myself and my study to the licensed practical nurses and nurses' aides on the 7 - 3 and the 3 - 11 shift and to ask for volunteers. I would return the next week and administer the questionnaires to the 7 - 3 volunteers after they had punched out for the day and to the 3 - 11 workers approximately one hour before they began work.

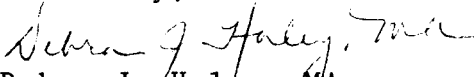
This is a chance for your employees to participate in a professional scientific research project which is aimed at improving the industry in which they have chosen to work.

When the data from all homes have been collected and analyzed, I would be willing to return to your home and offer an in-service on my findings. Hopefully, employees would benefit both personally and professionally in terms of gaining new knowledge about handling job and life stress.

I hope you will give my research request careful consideration. I will be glad to show you the questionnaires I will be using in advance. Keep in mind that I will ask for volunteers to give me less than hour of their time for which they will be compensated. I will call you next week to discuss any questions or concerns you might have.

Thank you for your help.

Sincerely,


Debra J. Haley, MA

APPENDIX B

ADDITIONAL DEMOGRAPHIC DATA ON SUBJECTS

Shift Worked: LPN's and Nurses Aides

	7:00a.m. - 3:00p.m.	3:00p.m. - 11:00p.m.
LPN's	14	4
Nurses Aides	40	29

N (LPN's) = 18

N (Aides) = 69

Work Status: LPN's and Nurses Aides

	Full-time	Part-time
LPN's	12	6
Nurses' Aides	66	3

N (LPN's) = 18

N (Aides) = 69

Race or Ethnic Group: LPN's and Nurses's Aides

	Asian	Black	White	Hispanic	American Indian	Other
LPN'S	0	0	17	0	0	1
Nurses' Aides	7	26	24	3	1	8

N (LPN's) = 18

N (Aides) = 69

Age: LPN's and Nurses' Aides

	Under 21	21-25	26-30	31-35	36-40	41-45	46-50	51-55	Over 55
LPN's	1	5	2	2	2	1	1	2	2
Nurses' Aides	3	16	14	8	10	6	4	2	6

N (LPN's) = 18

N (Aides) = 69

Length of Employment at Present Home: LPN's and Nurses Aides

	Under 6 mos.	6-12 mos.	12-18 mos.	18 mos.- 2 years	2-4 years	Over 4 years
LPN's	4	0	1	2	1	10
Nurses' Aides	15	12	4	2	18	18

N (LPN's) = 18

N (Aides) = 69

Length of Service in Nursing Field: LPN's and Nurses' Aides

	Under 9 mos.	9-18 mos.	18 mos.- 3 years	3-5 years	5-10 years	Over 10 years
LPN's	2	0	4	2	2	8
Nurses' Aides	4	6	9	14	18	18

N (LPN's) = 18

N (Aides) = 69

APPENDIX C

CHANGES IN WORD CHOICE TO ACCOMMODATE
READING LEVEL OF SUBJECTS

Changes made on the Work Relationships Index

1. Changed item # 19 from:

It is quite a lively place.

to:

This is quite a lively place.

2. Changed item # 21 from:

Supervisors exact far too much from employees.

to:

Supervisors demand far too much from employees.

3. Changed item # 27 from:

Supervisors tend to stand up for their people.

to:

Supervisors stand up for their people.

Changes on the Gladding, Lewis, Adkins Scale of Religiosity

1. Changed item # 16 from:

Religion transcends philosophy.

to:

Religion is more important than philosophy.

APPENDIX D

NURSING HOME PHONE SURVEY

Interview Form

Name of Home:

Administrator:

Address:

Director of Nursing:

Phone:

1. Is this home: _____ not-for-profit
 _____ proprietary
2. Is this home religiously affiliated?
 _____ yes
 _____ no
3. What is the number of skilled care beds in this home?
4. What is the number of intermediate care beds?
5. Do the majority of the residents in this home pay for care with:
 _____ private funds
 _____ Medicare
 _____ Medicaid
6. Is the patient population in your home primarily:
 _____ geriatric
 _____ mentally ill
 _____ developmentally disabled
7. How many lpn's and nurses' aides are scheduled to work on a typical day on the 7-3 and 3-11 shifts?

7-3

_____ lpn's
_____ nurses' aides

3-11

_____ lpn's
_____ nurses' aides

APPENDIX E

Pilot Study: Correlations Between Dependent and Independent Variables

	Commit- ment	Health Scale	Work Attitudes	Religi- osity	Work Support	Lie Scale	Burnout Scale	Length of Service
Commit- ment	1.000							
Health Scale	.791 ***	1.000						
Work Attitudes	.961 ***	.929 ***	1.000					
Religi- osity	.311	.028	.200	1.000				
Work Support	-.303	-.201	-.274	.065	1.000			
Lie Scale	.224	.006	.137	.537 *	.457 *	1.000		
Burnout Scale	.328	.191	.277	.515 *	-.185	.015	1.000	
Length Field	-.297	.001	-.178	.171	.267	.035	.396	1.000

N = 16

* = .05
 ** = .01
 *** = .001

Pilot Study: Descriptive Statistics

Variable	Cases	Mean	Standard Deviation
Commitment	16	72.94	12.17
Health Scale	16	59.69	9.16
Work Attitudes	16	132.63	20.21
Religiosity	16	97.75	12.36
Work Support	16	13.38	5.10
Lie Scale	16	4.06	2.93
Burnout	16	71.55	23.24
Length of Service	16	4.44	1.63

N = 16

APPENDIX F

Code No. _____

THE ATTITUDE TEST

The items below consist of statements with which you may agree or disagree. Please indicate how you feel about each item by placing a number from 0 to 100 in the space provided. A zero indicates that you feel the item is not at all true; 100 indicates that you feel the item is completely true.

As you will see, many of the items are worded very strongly. This is so you will be able to decide the degree to which you agree or disagree.

Please read all the items carefully. Be sure to answer all on the basis of the way you feel now.

0	100
not at all true	completely true

THESE ITEMS HAVE TO DO WITH YOUR ATTITUDE TOWARD WORK

1. _____ Those who work for a living are taken advantage of by the bosses.
2. _____ I wonder why I work at all.
3. _____ Most of life is wasted in meaningless activity.
4. _____ If you have to work, you might as well choose a career where you deal with matters of life and death.
5. _____ No matter how hard you work, you never really seem to reach your goals.
6. _____ I find it difficult to imagine enthusiasm concerning work.
7. _____ It doesn't matter if people work hard at their jobs; only a few bosses profit.
8. _____ Ordinary work is too boring to be worth doing.
9. _____ I feel no need to try my best at work for it

makes no difference anyway.

10. _____ I don't like my job or enjoy my work; I just put in my time to get paid.
11. _____ I find it hard to believe people who actually feel that the work they perform is of value to society.
12. _____ If a job is dangerous, that makes it all the better.

THESE ITEMS HAVE TO DO WITH YOUR ATTITUDE TOWARD SOCIAL INSTITUTIONS

1. _____ Politicians control our lives.
2. _____ Our laws are so unfair that I want nothing to do with them.
3. _____ The only reason to involve yourself in society is to gain power.
4. _____ I would drop almost anything in order to join some big cause.
5. _____ Most of my activities are determined by what society demands.
6. _____ In order to avoid being hassled by society, I feel I must go my own way and not get involved.
7. _____ No matter how sincerely you work for social change, society never really seems to improve.
8. _____ My most meaningful experiences have come through participation in a social movement.
9. _____ There are only certain strict paths to follow if one is to be successful in our society.
10. _____ Our society holds no worthwhile values or goals.
11. _____ Why should I bother to vote; none of the candidates will be able to change things for the better.

12. _____ I admire those who participate in protest movements that are full of danger and drama.

THESE ITEMS HAVE TO DO WITH YOUR ATTITUDE TOWARD
INTERPERSONAL RELATIONS

1. _____ Everyone is out to use you toward his own ends.
2. _____ I am better off when I keep to myself.
3. _____ Most people are happy not to know that what they call love is really self interest.
4. _____ Big parties are very exciting to me.
5. _____ Often when I talk with others, I feel insecure about how it will turn out.
6. _____ There is no point in socializing -- it goes nowhere and is nothing.
7. _____ Why bother to try to love or care for people; they'll only hurt you in the end.
8. _____ What really turns me on about mixing with others is the challenge of a group of people disagreeing and arguing.
9. _____ I try to avoid close relationships with people so that I will not be obligated to them.
10. _____ Most social relationships are meaningless.
11. _____ People who believe that "love makes the world go round" are fooling themselves.
12. _____ The best reason for getting involved with other people is participation in some exciting activity.

THESE ITEMS HAVE TO DO WITH YOUR ATTITUDE TOWARD FAMILY

1. _____ When you marry and have children you have lost your freedom of choice.
2. _____ I would just as soon avoid any contact with my

children except an occasional letter.

3. _____ The idea of a family is a social invention to limit individual freedom of action.
4. _____ I would be really exciting to have another, secret life, to add to your family life.
5. _____ My parents imposed their wishes and standards on me too much.
6. _____ Parents work hard for their children only to be disappointed and rejected.
7. _____ The only reason to marry is for convenience and security.
8. _____ Strange though it may seem, it is at times of family crisis that I feel most alive.
9. _____ I am not sure I want to stay married because I don't want to feel tied down.
10. _____ For me, home and family have never had much positive meaning.
11. _____ Families do not provide security and warmth; they just restrict a person and give him many unnecessary responsibilities.
12. _____ What I really like about family life is the huge, action-filled reunions at holiday times.

THESE ITEMS HAVE TO DO WITH YOUR ATTITUDE TOWARD SELF

1. _____ Thinking of yourself as a free person leads to great frustration and difficulty.
2. _____ The human's ability to think is not really such an advantage.
3. _____ The attempt to know yourself is a waste of effort.
4. _____ I am really interested in the possibility of expanding my mind through drugs.

5. _____ No matter how hard I try, my efforts will accomplish nothing.
6. _____ Life is empty and has no meaning for me.
7. _____ People talk about the importance of the individual in order to impress others.
8. _____ Some important people in history had revelations, I wish that would happen to me.
9. _____ Often I do not really know my own mind.
10. _____ I long for a simple life in which body needs are the most important things and decisions don't have to be made.
11. _____ Unfortunately, people don't seem to know that they are only creatures after all.
12. _____ The most exciting thing for me is my own fantasies.

SBS-HP.

INSTRUCTIONS

For each statement check the one answer which best reflects how much you agree or disagree with each statement. Answer according to how you currently feel in each case.

	(1) Agree Very Much	(2) Agree Pretty Much	(3) Agree a Little	(4) Disagree a Little	(5) Disagree Pretty Much	(6) Disagree Very Much
1. I feel fatigued during the workday.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Lately, I have missed work due to either colds, the flu, fever, or other illnesses.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Once in a while I lose my temper and get angry on the job.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. All my work habits are good and desirable ones.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. I experience headaches while on the job.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. After work I often feel like relaxing with a drink of alcohol.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. I never gossip about other people at work.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. I feel that the pressures of work have contributed to marital and family difficulties in my life.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. I am never late for an appointment.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. I often have the desire to take medication (e.g., tranquilizers) to calm down while at work.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. I have lost interest in my patients and I have a tendency to treat these people in a detached, almost mechanical fashion.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. At work I occasionally think of things that I would not want other people to know about.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. I often feel discouraged at work and often I think about quitting.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. I frequently get angry at and irritated with my patients.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. I am sometimes irritable at work.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. I have trouble getting along with my fellow employees.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. I am very concerned with my own comfort and welfare at work.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. I try to avoid my supervisor(s).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. I truly like all my fellow employees.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. I always do what is expected of me at work, no matter how inconvenient it might be to do so.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. I am having some work performance problems lately due to uncooperative patients.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. All the rules and regulations at work keep me from optimally performing my job duties.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Sometimes at work I put off until tomorrow what I ought to do today.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. I do not always tell the truth to my supervisor or co-workers.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. I find my work environment depressing.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. I feel uncreative and understimulated at work.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. I often think about finding a new job.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. Worrying about my job has been interfering with my sleep.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. I feel there is little room for advancement at my place of employment.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. I avoid patient interaction when I go to work.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	(1)	(2)	(3)	(4)	(5)	(6)

Code Number _____

WORK SUPPORT

These are statements about the place in which you work. You are to decide which of these statements is true for the nursing home in which you work and which are false. Circle T if the statement is TRUE or MOSTLY TRUE, Circle F if the statement is FALSE or MOSTLY FALSE .

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

- | | |
|---|-----|
| 16. Few people ever volunteer. | T F |
| 17. Employees often lunch together. | T F |
| 18. Employees generally feel free to ask for a raise. | T F |
| 19. This is quite a lively place. | T F |
| 20. Employees who differ greatly from the others in the organization don't get on well. | T F |
| 21. Supervisors demand far too much from employees. | T F |
| 22. It is hard to get people to do any extra work. | T F |
| 23. Employees often talk to each other about their personal problems. | T F |
| 24. Employees discuss their personal problems with supervisors. | T F |
| 25. The work is usually very interesting. | T F |
| 26. Often people make trouble by talking behind others' backs. | T F |
| 27. Supervisors tend to stand up for their people. | T F |

CODE NUMBER _____

GLASR

Instructions: Circle the answer under each question that best describes your thoughts and feelings.

1. I believe there is a supreme being or power.

definitely agree	slightly agree	don't know	slightly disagree	definitely disagree
---------------------	-------------------	---------------	----------------------	------------------------

2. I believe I have a personal relationship with a supreme being or power that affects my life.

definitely agree	slightly agree	don't know	slightly disagree	definitely disagree
---------------------	-------------------	---------------	----------------------	------------------------

3. I believe in worshipping on a regular basis.

definitely agree	slightly agree	don't know	slightly disagree	definitely disagree
---------------------	-------------------	---------------	----------------------	------------------------

4. I think it is important to belong to a group which believes as I do religiously.

definitely agree	slightly agree	don't know	slightly disagree	definitely disagree
---------------------	-------------------	---------------	----------------------	------------------------

5. People who are religious need to study the basis for their beliefs (e.g., read religious books).

definitely agree	slightly agree	don't know	slightly disagree	definitely disagree
---------------------	-------------------	---------------	----------------------	------------------------

6. I am a religious person.

definitely agree	slightly agree	don't know	slightly disagree	definitely disagree
---------------------	-------------------	---------------	----------------------	------------------------

7. After death I believe that there will be an accounting (i.e. judgment) of my life.

definitely agree	slightly agree	don't know	slightly disagree	definitely disagree
---------------------	-------------------	---------------	----------------------	------------------------

8. I believe a supreme being or power created the world.

definitely agree	slightly agree	don't know	slightly disagree	definitely disagree
---------------------	-------------------	---------------	----------------------	------------------------

9. My actions reflect my religious beliefs.

definitely agree	slightly agree	don't know	slightly disagree	definitely disagree
---------------------	-------------------	---------------	----------------------	------------------------

10. I believe there is more than one true religious faith.

definitely agree	slightly agree	don't know	slightly disagree	definitely disagree
---------------------	-------------------	---------------	----------------------	------------------------

11. People have a right to practice their religious faith no matter how much I disagree with their beliefs.

definitely agree	slightly agree	don't know	slightly disagree	definitely disagree
---------------------	-------------------	---------------	----------------------	------------------------

12. My religious beliefs provide me a purpose for being (living).

definitely agree	slightly agree	don't know	slightly disagree	definitely disagree
---------------------	-------------------	---------------	----------------------	------------------------

13. I believe a supreme being or power ultimately controls all life forces.

definitely agree	slightly agree	don't know	slightly disagree	definitely disagree
---------------------	-------------------	---------------	----------------------	------------------------

14. Religious writings are to be studied regularly.

definitely agree	slightly agree	don't know	slightly disagree	definitely disagree
---------------------	-------------------	---------------	----------------------	------------------------

15. My commitment to religious beliefs is expressed in my political and social actions.

definitely agree	slightly agree	don't know	slightly disagree	definitely disagree
---------------------	-------------------	---------------	----------------------	------------------------

16. Religion is more important than philosophy.

definitely agree	slightly agree	don't know	slightly disagree	definitely disagree
---------------------	-------------------	---------------	----------------------	------------------------

17. My religious beliefs make me feel closer to the world and people around me.

definitely agree	slightly agree	don't know	slightly disagree	definitely disagree
------------------	----------------	------------	-------------------	---------------------

18. My religious beliefs are different from my philosophy of life.

definitely agree	slightly agree	don't know	slightly disagree	definitely disagree
------------------	----------------	------------	-------------------	---------------------

19. Religious beliefs provide answers to life's questions.

definitely agree	slightly agree	don't know	slightly disagree	definitely disagree
------------------	----------------	------------	-------------------	---------------------

20. It is hard to believe that the world just "happened".

definitely agree	slightly agree	don't know	slightly disagree	definitely disagree
------------------	----------------	------------	-------------------	---------------------

21. Regular prayer and/or meditation are important parts of developing strong religious beliefs.

definitely agree	slightly agree	don't know	slightly disagree	definitely disagree
------------------	----------------	------------	-------------------	---------------------

22. Religious people practice what they preach.

definitely agree	slightly agree	don't know	slightly disagree	definitely disagree
------------------	----------------	------------	-------------------	---------------------

23. Fear is the basis of religion.

definitely agree	slightly agree	don't know	slightly disagree	definitely disagree
------------------	----------------	------------	-------------------	---------------------

Do you belong to a church? yes_____ no_____

If yes, what denomination? _____

If you attend church or temple, on the average how often do you attend?

_____ once a week
 _____ once a month
 _____ once every three months

Code Number _____

DEMOGRAPHIC QUESTIONNAIRE

Directions: Please use a check () to indicate your answers to the following questions. All answers will remain confidential.

1. What is your job at this nursing home?

_____(1) nurses' aide

_____(2) licensed practical nurse

2. What is your age?

_____(1) under 21 years old

_____(2) 21 to 25 years old

_____(3) 26 to 30 years old

_____(4) 31 to 35 years old

_____(5) 36 to 40 years old

_____(6) 41 to 45 years old

_____(7) 46 to 50 years old

_____(8) 51 to 55 years old

_____(9) 56 years or over

3. Do you work

_____(1) full-time

_____(2) part-time

4. What shift do you usually work?

_____(1) 7-3

_____(2) 3-11

_____(3) 11-7

5. How long have you worked at this nursing home?

- ____(1) less than six months
- ____(2) between 6 and 12 months
- ____(3) between 12 and 18 months
- ____(4) between 18 months and 2 years
- ____(5) between 2 and 4 years
- ____(6) over 4 years, please give the number _____.

6. How long have you worked in the field of nursing?

- ____(1) less than 9 months
- ____(2) between 9 and 18 months
- ____(3) between 18 months and 3 years
- ____(4) between 3 and 5 years
- ____(5) between 5 and 10 years
- ____(6) more than 10 years

7. How many jobs are you presently working?

- ____(1) 1
- ____(2) 2
- ____(3) 3
- ____(4) more than 3, please give the number _____

8. How many days of work have you missed in the last month?

- ____(1) 0
- ____(2) 1-2
- ____(3) 3-4
- ____(4) 5-6

____(5) 7 or more, please give the number _____

9. How much on-the-job training have you been given?

____(1) less than 1 day

____(2) 1-2 days

____(3) 3-4 days

____(4) 5-6 days

____(5) 7 days or more, please give the number _____.

10. How many times have you been physically ill in the last month?

____(1) 0

____(2) 1-2

____(3) 3-4

____(4) 5-6

____(5) 7 or more, please give the number _____.

11. What is the highest grade of school that you have completed?

grade school								high school				college				graduate				
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21

12. What is your racial or ethnic background?

____(1) Asian American

____(2) Black

____(3) White

____(4) Hispanic

____(5) American Indian

____(6) Other, please specify _____.

13. Have any of your relatives ever lived in a nursing home?

____(1) Yes

____(2) No

APPROVAL SHEET

The dissertation submitted by Debra J. Haley has been read and approved by the following committee:

Dr. Kevin Hartigan, Director
Assistant Professor, Counseling Psychology and Higher Education, Loyola

Dr. Gloria Lewis
Associate Professor and Chairperson, Counseling Psychology and Higher Education, Loyola

Dr. Elizabeth Brophy
Associate Professor, School of Nursing, Loyola

The final copies have been examined by the director of the dissertation and the signature which appears below verifies the fact that any necessary changes have been incorporated and that the dissertation is now given final approval by the Committee with reference to content and form.

The dissertation is therefore accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

11/8/85
Date

Kevin J. Hartigan
Director's Signature