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Burnout and Hopelessness Among Nurses Working on Midwest Community Psychiatric Hospital Units

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BURNOUT AND HOPELESSNESS AMONG NURSES WORKING ON MIDWEST COMMUNITY PSYCHIATRIC HOSPITAL UNITS

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This thesis meets the standards for appearance, conforms to the style and format requirements of the Graduate School of the University of North Dakota, and is hereby approved.

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TABLE OF CONTENTS

LIST OF TABLES

Table Page

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ABSTRACT

This quantitative descriptive study was undertaken to examine burnout and hopelessness in a sample of nurses working on Midwest community psychiatric hospital units. The literature identifies nursing as a stressful occupation; however, a very limited number of studies have examined stress in psychiatric nursing. In spite of the limited research to date, there is evidence in the literature to suggest a relationship between burnout and hopelessness in the nursing profession. The lack of consensus in the literature creates a difficulty in defining burnout; however, essential elements of burnout are consistent and clear throughout the nursing literature, including a sense of hopelessness.

Registered nurses and licensed practical nurses ($\underline{n} = 13$) who work on Midwest community psychiatric hospital units in an inpatient setting were surveyed to determine burnout indicators and the emergence of hopelessness. The nurses were administered the Maslach Burnout Inventory-Human Services Survey (MBI-HSS), Beck Hopelessness Scale (BHS), and a demographic tool developed for this study. Correlational and descriptive statistics were utilized for data analysis.

The findings of this study did not support a causal relationship among burnout and hopelessness. This study, carried out on a small sample representing one group of

nurses, concluded that psychiatric mental health nurses showed some significant indicators for burnout related to the variables that were examined. The study findings supported that a higher degree of hopelessness correlated with a lower degree of Personal Accomplishment. The study findings further identified that burnout, as measured by the MBI-HSS, was a reliable indicator of burnout in this study.

CHAPTER I

INTRODUCTION

Nursing is a potentially stressful occupation. Although a significant amount of research into the subject of stress has been generated, a very limited number of studies have investigated stress in psychiatric nursing. To understand the nature of occupational stress as it relates to psychiatric nursing, it is important to not only look at the intrinsic sources of stress, but also the effects of stress in terms of burnout. The concept of burnout was first introduced into the literature more than 30 years ago. A historical overview of burnout is provided by Freudenberger (1974) and Maslach (1981). According to Freudenberger (1974), burnout occurs more frequently in occupations that involve working in the human services professions. Freudenberger (1980) defined burnout as a state of physical and emotional depletion resulting from working conditions; he further depicted the symptoms associated with burnout as feelings of helplessness and hopelessness, physical and psychological depletion, a sense of unending stress, development of a negative self-concept, and the perception of little to no "payoff" in terms of job outcomes and achievements. This is confirmed by Maslach when he contended that burnout is a physical, emotional, and intellectual exhaustion syndrome manifested by adverse attitude to professional life and other people. Negative self-esteem develops in the individual experiencing chronic fatigue and feelings of helplessness and hopelessness (Maslach, 1981).

Girdano et al. (1996) described burnout as a state of mental and/or physical exhaustion caused by excessive and prolonged stress. According to Pompili et al. (2006), burnout is comprised of three stages which are defined by level of severity. These stages are stress arousal, energy conservation, and exhaustion. The stress arousal stage includes physiological and psychological responses such as persistent irritability and/or anxiety, periods of elevated blood pressure, insomnia, forgetfulness, and grinding of the teeth during sleep. Additional physiological symptoms associated with the arousal stage may include heart palpitations and/or arrhythmias, headaches, and acute gastrointestinal symptoms.

Energy conservation is the initial effort made to avoid decompensation caused by stress. Symptoms of energy conservation include excessive lateness, procrastination, excessive time off, decreased libido, persistent fatigue, social isolation, increased cynicism and resentment, increased use in substances such as nicotine, caffeine, alcohol, or prescription drugs, and excessive apathy (Pompili et al., 2006).

The exhaustion stage of burnout represents the most critical level of burnout and includes symptoms such as chronic sadness or depression, chronic gastrointestinal problems, chronic mental fatigue, chronic physical fatigue, chronic headaches or migraines, chronic social avoidance and isolation, and recurrent suicidal ideation (Pompili et al., 2006).

According to Maslach et al. (1996), the chronic stress that is associated with working intensely with other people can be emotionally draining and lead to burnout. Maslach et al. (1996) conceptualized burnout as a continuous variable ranging from low to moderate to high degrees of experienced feeling rather than as a dichotomous variable

which is either present or absent. Maslach et al. (1996) further posited that burnout is a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur among individuals who work with people in some capacity. The findings in studies conducted by Maslach (1982) and Maslach and Jackson (1981) suggested that burnout can lead to deterioration in the quality of care or service provided by the staff. In addition, burnout appears to be a factor in job turnover, absenteeism, and low morale.

A key aspect of burnout syndrome is increased feelings of emotional exhaustion; as emotional resources are depleted, workers feel less able to give of themselves at a psychological level. Another aspect of burnout is depersonalization, which are negative, cynical attitudes and feelings about one's clients. The development of depersonalization appears to be related to the experience of emotional exhaustion; therefore, these two aspects of burnout should be correlated. A third aspect of burnout syndrome is reduced personal accomplishment, which refers to the tendency to evaluate oneself negatively, in particular to one's work accomplishments (Maslach et al., 1996).

Although nurses as a unified group share similar occupational pressures, there are a number of demands specific to mental health settings (Jenkins & Elliott, 2004). These include the often intense nature of nurse-patient interactions (Cronin-Stubbs & Brophy, 1985) and confronting difficult and challenging patient behaviors on a regular basis (Sullivan, 1993).

Controlling stress was an objective of the Healthy People 2000 initiative. The Healthy People 2010 National Health Promotion and Disease Prevention objectives contain specific risk reduction and education objectives directed toward mental health.

The risk reduction objective is to reduce the suicide rate. The relevance of this is indicated by the results of a study conducted by Pompili et al. (2006), which suggested that hopelessness and suicide risk emerge in psychiatric nurses suffering from burnout. In addition, Peipins et al. (1997) depicted that suicide is among the top five causes of death in nurses, and all nurses, from students to retirees, have higher rates of suicide than the general population. Belanger (2000) suggested that occupational stress for nurses could potentially lead to emotional or psychological trauma, which leads to the existing possibility of suicide among this population.

The Healthy People 2010 education objectives are aimed at improving mental health and ensuring access to appropriate quality mental health services. The Healthy People 2010 initiative describes mental health as a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, the ability to adapt to change and to cope with adversity. Mental health is essential to personal well-being, family and interpersonal relationships, and contribution to community or society. According to the Healthy People 2010 objectives, there is increasing awareness regarding the impact of stress; additional research can help quantify the burden of stress and identify ways to prevent or alleviate it.

Hope is intrinsically linked with caring, and the professional role of the nurse can often influence the generation of hope or hopelessness in the care of patients. Hope is the foundation to all nursing care; the opposing paradigm, hopelessness, has been considered a major risk factor for suicide. The literature indicates a link between suicide and a sense of hopelessness. Several authors, including Collins and Cutcliffe (2003), Hawton and Vislisel (1999), Beck et al. (1985), and MacLeod et al. (1993), support the notion that

hopelessness is an important component of depression in general and suicidal behavior in particular. Hawton and Vislisel (1999) further suggested that a combination of high workload and low autonomy among nurses is likely to cause feelings of hopelessness and job dissatisfaction.

Although the literature supports a relationship between hope and hopelessness as nonlinear concepts and the terminology is often interwoven, the degree of the relationship is not well explicated in the literature. According to Beck et al. (1990) hopelessness is a psychological construct that has been observed to underlie a variety of mental health disorders. According to Raleigh (1992), although there are diverse conceptualizations of hope, there is consensus in the literature on the essential characteristics of the concept. Raleigh (1992) posited that hope is a factor in coping which enables an individual to cope with a stressful situation by expecting a positive outcome. In addition, hope is future oriented and considered to be multidimensional by most theorists.

There is a lack of consensus in the literature regarding the conceptualization of stress. In general, the concept of stress is subjective and relates to how an individual perceives an experience; these perceptions can be either positive or negative. According to Rice (2000), Seyle was the "founding father" of stress response theory which made one of the most significant contributions to the field of stress and coping. General Adaptation Syndrome (GAS) is a hypothesis proposed by Seyle (1976) which gives a detailed description of all the elements associated with the reactions which form the physiological fight or flight response. The three theoretical stages of GAS include alarm, resistance, and exhaustion.

The first stage of GAS, the alarm reaction, is the immediate reaction to a stressor. In the initial phase of stress, individuals exhibit a fight or flight response, which causes one to be ready for physical activity. However, this initial response can also decrease the effectiveness of the immune system, making individuals more susceptible to illness during this phase. During the resistance phase, if the stress continues, the body adapts to the stressors. Changes at many levels take place in order to reduce the effect of the stressor. At the exhaustion stage, the stress has continued for some time. The body's resistance to the stress may gradually be reduced (Seyle, 1976). The following two assumptions are fundamental to the GAS theory. First, any positive or negative demand can provoke the stress response; secondly, regardless of the provoking stressor, the stress response is characterized by the same chain of events and physiological patterns (Seyle, 1976).

Seyle (1976) differentiated between 'eustress' and 'distress'. According to Seyle (1976), 'eustress' facilitates growth, development, and adaptation and 'distress' results in physical and psychological maladaptation. According to Milne et al. (1986), stress within the nursing profession is associated with disturbingly high levels of absenteeism, turnover, error and accident rates, general lack in work performance, and poor staff management relations.

When considering the many indicators of burnout and hopelessness among nurses it is essential to understand that occupational stress may be the greatest predictor of health and care patterns among nurses as a whole. In order to prevent psychosocial dysfunction and promote the mental health of nurses, the primary contributory factors to nursing burnout need to be clearly identified. Examining possible coping strategies that

can be utilized to manage stress in the clinical environment may also serve as an important means to understanding stress and the prevention of burnout. This study will examine burnout and hopelessness among nurses working on Midwest community psychiatric hospital units.

Significance of the Study

Increasing the understanding of the relationship between burnout and hopelessness among psychiatric nurses is important in identifying areas in need of intervention; therefore, the benefit of this study is to help improve knowledge pertaining to this health risk.

Purpose of the Study

The purpose of this study is to investigate burnout and hopelessness in a sample of nurses working on Midwest community psychiatric hospital units.

Review of Literature

North Dakota Nurse Vacancy and Turnover Rates

The nursing shortage in the United States (U.S.) has been officially recognized for some time and the situation is likely to worsen (Health Resources & Services Administration, 2002). According to Holmes (2006), the number of registered nurses (RNs) is growing at its slowest rate in over 20 years and the Department of Labor has identified nursing as the occupation with the highest growth in job vacancies. Higgens (2005) noted that 1/2 of all U.S. nurses will retire from the workforce in the next 15 years; this will result in a shortfall of more than 400,000 RNs. This is estimated to represent a reduction of approximately 20 percent of the required nursing workforce by 2015 and 30 percent by 2020.

In 2005, the North Dakota statewide vacancy rate for RNs was 11 percent. The statewide vacancy rate for licensed practical nurses (LPNs) was five percent for the same year. Although the LPN vacancy rate has remained consistent over the past two years, RN vacancy rate has steadily increased. The statewide vacancy rate for RNs in 2003 and 2004 was five and nine percent respectively (The Center for Rural Health, 2006).

In 2005, the North Dakota statewide RN turnover rate was 20 percent, an increase from 18 percent in 2004 and 15 percent in 2003. The statewide turnover rate for LPNs was 21 percent, an increase from 20 percent in 2004 and 17 percent in 2003 (The Center for Rural Health, 2006).

According to the American Hospital Association there are currently 126,000 unfilled nursing positions in hospitals across the U.S. The Centers for Medicare and Medicaid Services reported that 90 percent of nursing homes and other long term care facilities nationwide do not have adequate nursing staff to provide sufficient care (The Center for Rural Health, 2006).

Factors Influencing Burnout in Nursing

Work-related stress should be conceptualized and studied as a multifaceted problem. In order to gain a better understanding of how the factors relating to occupational stress affect nurses, it is important to examine variables associated with burnout. Studies on burnout have primarily concentrated on occupations which directly serve people and research has clearly demonstrated that burnout is more predominant in the helping professions. Several investigators have observed that the nursing profession is at a higher risk of burnout (Jones, 1982; Kilpatrick, 1989; Maslach, 1982; McConnell, 1982; Perlman & Hartman, 1982). Burnout is a complex phenomenon with numerous

variables. The literature identified some primary correlates of nursing burnout; they include role ambiguity, workload, age, hardiness, active coping, and social support (Duquette et al., 1994). There is a consensus in the literature among investigators who were instrumental in conducting research in this area that burnout typically manifests itself as a psychological, physical, and behavioral reaction in people who have no previous history of psychopathology (Cherniss, 1980; Edelwich & Brodsky, 1980; Jones, 1982; Maslach, 1982; Maslach & Jackson, 1981; Pines & Aronson, 1981). According to the American Psychiatric Association (1989), burnout is not considered an illness and is not equivalent to depression; however, it is reasonable to believe that the manifestations of burnout could potentially lead to physical and/or mental illness if burnout persists over a sustained period of time.

Utilizing the Maslach Burnout Inventory (MBI), Demir et al. (2003) conducted a descriptive, cross-sectional and partly analytical study to investigate the factors causing burnout in the professional and private lives of nurses working in urban university and state hospitals. The most significant findings from this study suggested that higher levels of education, work experience, and higher status within an organization decrease burnout while working night shifts and having problems in relations with co-workers increases it. In addition, Demir et al. (2003) suggested that factors causing burnout in the nursing profession include stressful and even dangerous work environments, lack of support, lack of respectful relations within the health care team, low salaries compared with those of physicians, shift changes, long work hours, inadequate staffing, pressure of the responsibility of providing continuous high levels of care over long periods of time, and

frustration and disillusionment resulting from the difference between job expectations and realities.

It was reported in a study conducted by Motowildo et al. (1986) that nurses experience stress due to factors such as giving care to patients whose lives are in imminent danger, high expectations of patients and their families, excessive work related responsibilities, working with unqualified and relatively small numbers of personnel, and high acuity levels. According to Aiken et al. (2002), there is a higher probability for nurses to experience job burnout and dissatisfaction when they work in hospitals with high patient to nurse ratios. Furthermore, burnout not only has an adverse impact on the health of the nurse, but also on the quality of care clients are offered and thus on society in general. Burnout causes a significant loss of work power. Hoel et al. (2001) reported that 550 million work days are lost in the U.S. each year due to stress related problems.

Above all, the manifestation of burnout appears in the workplace; however, in order to gain a better understanding of mutual interactions between the personal and environmental factors contributing to nursing burnout, it is important to examine other probable relationships and influences associated with nursing burnout. According to Wheeler (1997), job stress may not originate merely from stressors within the clinical environment, but also from stressors at home and in private life. This is confirmed in the literature by other authors, including Gaines and Jermier (1983), Maslach and Jackson (1985), and Walters et al. (1996), who supported the assumption that burnout is influenced in part by private living conditions of nurses. The manifestations of burnout are related to organizational stressors sustained over time, leading to the belief that burnout could be considered a problem of adaptation which interferes with job

performance (Kilfedder et al., 2001). The literature clearly demonstrates that burnout is a phenomenon with multiple dimensions and some factors of burnout are related to the individual and others to the workplace environment.

Oppressed group behavior was examined in a study conducted by Roberts (1983). The findings depicted that nurses' exhibit oppressed group behavior similar to that of the colonized Jews of Nazi Germany. Roberts (1983) stated that the characteristic behaviors of oppression, including low self-esteem; horizontal violence, or aggression that is directed at one's peers; and passive-aggressive behaviors, are all negative attributes seen within the nursing profession. Schlomann (1993) recognized these behaviors in the nursing profession and further built on Robert's research. According to Schlomann (1993), low self-esteem manifests itself in the nurse who keeps trying to achieve more in order to prove his/her worth and stated also that burnout is not a symptom of a sick nurse, but rather a symptom of a sick system.

Organizational Stressors Related to Burnout

In a survey of the state nurses associations, the American Nurses Association (ANA) found that of all possible occupational hazards, nurses are most concerned with job-related stress (Himali, 1995). The ANA voiced concern that nurses face high levels of stress in environments where they have less and less control over their practice. Longer hours, reduced staff, increased responsibility, mandatory overtime, ever-changing shifts, sicker patients and more of them, and floating to areas outside of the area of expertise were identified as concerns nurses have that are related to organizational stressors (Himali, 1995).

Duquette et al. (1994) described organizational stressors as nursing work situations that are stress generating events that can be physical, psychological, or social in nature. Several studies have shown that the numerous organizational stressors produced within the clinical nursing environment support a relationship to burnout (Arsenault & Dolan, 1983; Arsenault et al., 1991; Harris, 1989).

Job satisfaction in staff nurses should be a primary concern of any organization. Fletcher (2001) investigated job satisfaction and dissatisfaction among hospital RNs. Questionnaires were mailed to 5,192 RNs with 1,780 responses included in the study results. When considering patient care issues, many of the respondents in this study had concerns about the idea that patient care lacked quality due to organizational changes in staffing and assignment. Fletcher (2001) also found a positive correlation in job satisfaction with other extrinsic work values such as job security, salary, fringe benefits, and work schedules.

Based on this author's examination, there is evidence in the literature to suggest that job satisfaction is a significant factor in burnout. Different work environments can significantly affect staff burnout rates within organizations (Pines et al., 1981). Pines et al. (1981), Maslach and Pines (1979), and Pines and Kanner (1982) all found burnout to be negatively correlated with satisfaction from work. Hopelessness and loss of idealism with the job have also been found to be significantly correlated with burnout (Pines et al., 1981).

Pines et al. (1981) referred to burnout as an insidious process, in that it is a steady progression or gradual unfolding of decisions or events that leads up to the final result. Pines et al. (1981) further contended that burnout develops in a way that is so gradual the

individual may be unaware it is happening. Mattingly (1977) reported that feelings of burnout manifest themselves in a reluctance to go to work; feeling inadequate, overwhelmed, and impatient; having a strong sense of self-doubt; and occasionally behaving in ways not congruent with one's self-image.

Using a correlational design, the findings for a study conducted by Jenkins and Ostchega (1986) showed that the number of general stressors in the workplace correlated positively with burnout; the primary stressors involved scheduling, number of deaths in the unit, conflicts among colleagues, and interactions with clients and their families. The Staff Burnout Scale for Health Professionals (SBS-HP) and a questionnaire on stressors developed by Yasko (1983) were sent out to a random group of 300 nurses working in oncology units across the U.S.; 152 or 50.7 percent were analyzed.

Topf and Dillon (1988) examined the relationship of stressors in the workplace and burnout in nursing personnel working in six intensive care units (ICUs). The investigators used a multivariate design and tools such as the SBS-HP, MBI, the Disturbance Due to Hospital Noise Scale, and the Nursing Stress Scale (NSS). Nurses working in two university hospitals in the western U.S. were recruited for this study; a participation rate of 75 percent was obtained. Topf and Dillon (1988) found that in ICUs, stress due to noise correlated positively and significantly with burnout; whereas other organizational stressors such as death and dying, conflicts with physicians, insufficient preparation of nurses, lack of support, conflicts with colleagues, workload, and uncertainty concerning treatment did not correlate positively with burnout.

Fong (1993) and Beaver et al. (1986) analyzed the relationship between workload and burnout and found that workload correlated positively with burnout. Using a

convenience sample with a participation rate of 90 percent, Fong (1993) studied nursing teachers in eight nursing faculties of the California State University System. A modified MBI tool was used to measure burnout and the workload was measured with the modified Work Environment Scale and Role Overload Scale. Beaver et al. (1986) utilized a random sample of nurse midwives who were members of the American College of Nurse Midwives with a participation rate of 49 percent. Burnout was measured using the MBI tool and workload was measured with a questionnaire developed by Beaver et al. (1986).

There is limited knowledge on the effects of 12 hour shifts and whether a correlation exists between stress, job satisfaction and working scheduled 12 hour shifts; nevertheless, in an effort to improve nurse recruitment, retention, and maintain costs, several hospitals have reorganized their delivery of care into 12 hour work shifts. A study conducted by Hoffman and Scott (2003) examined the variation in role stress and career satisfaction by shift length among RNs working in a hospital based setting. The study utilized a descriptive cross-sectional research design in which 500 randomly selected RNs received questionnaires. The initial study results indicated that RNs working 12 hour shifts were younger, less experienced, and more stressed than colleagues working 8 hour shifts. The investigators controlled for experience, they found similar RN stress levels. The most important determinants of job satisfaction for all the RN participants in this study were pay, autonomy, and professional status (Hoffman & Scott, 2003).

Cullen (1995) identified four systems that fail nurses; these include the health care system, the institutional system, the societal system, and the nursing system. Cullen (1995) suggested that the health care system contributes to nurse burnout through its

many entities of regulations, reimbursement issues, and mandates. As the pace of admission, stabilization, and discharge of patients increase, it is reasonable to speculate that nurse burnout rates will increase as well. Cullen (1995) further depicted how reimbursement issues influence patients' length of hospital stay; this results in nurses rarely seeing evidence of positive impacts or outcomes, leaving nurses to wonder if they are making a difference in the lives of their patients. Furthermore, Cullen (1995) made a compelling argument which suggests that the health care system has a tendency to blame the nurse for his or her own burnout. According to Cullen (1995), health care systems often imply that the primary causes of nurse burnout are related to the nurse being a perfectionist and too idealistic or the nurse working too much over time and caring too much for his or her patients and not enough for themselves.

Cullen (1995) further suggested that institutional systems create too many barriers and send too many incongruent messages to nurses which can lead to occupational burnout. Cullen (1995) depicted the incongruence of quality care and cost containment and further argues that nurses can not give quality care within a structural environment that is consistently understaffed, under equipped, and burdensome on caregivers. Cullen (1995) also suggests that the work performed by nurses is often devalued or trivialized by the societal system.

According to Cullen (1995), the nursing system itself contributes to burnout and lacks in its ability to prepare nurses to be proactive. Several compelling arguments have been made in the literature to support the notion that nurses have internalized the values of physicians and the medical model to the extent that they are dominated by a system that doesn't value nursing. Although nurses as a unified group are at risk for burnout,

Cullen (1995) suggested that more conscientious nurses have a desire to give their very best and are most vulnerable to burnout. Nurses who are satisfied with the status quo tend to be the least affected by burnout.

Based on this author's examination of the literature, the studies show that stressors in the workplace may contribute to burnout in nursing; however, it would be difficult to generalize the findings of these studies. The literature supports the notion that the type of nursing unit has little influence on burnout among nursing personnel.

Harris (1984) found no significant correlations between general and intensive care nursing units and burnout. This is confirmed by Cronin-Stubbs and Brophy (1985) when they contended that there is no relationship between burnout and nurses working in different areas such as ICU, operating room, psychiatry, and general medical units. Chiriboga and Bailey (1986) further concluded that burnout among nurses was not affected by working in medical-surgical units or critical care units. However, Kaplan's study (as cited in Duquette et al. 1994), found that the type of unit nurses worked on did relate positively with burnout. Kaplan's study (as cited in Duquette et al., 1994), compared the burnout levels among nurses working on oncology units with those working on obstetric units and found more burnout on oncology units. Kaplan selected these two units because they are opposites in terms of acute and chronic care.

Three of the four studies discussed above found no significant differences between burnout and the type of nursing unit. However, Kaplan's study found that the type of unit did relate positively with burnout. Since the measurements of burnout and the types of nursing units are similar in the four studies discussed above, the findings of these studies were compared. Historically distribution of patients on nursing units has

been made according to patient acuity levels and the complexity of nursing problems; therefore, in order to generalize the findings of any of the four studies discussed above, further research is needed to examine burnout in different types of nursing units.

Connolly (1985), Hare et al., (1988), and Yasko (1983) found no significant relationship between burnout and time spent directly with patients. However, there are conflicting sources cited in the literature; Pelletier (1986) found that the time spent in direct contact with patients in psychiatry related negatively with burnout while Lai's study (as cited in Duquette et al., 1994), found that time spent in direct patient contact related positively. Connolly (1985), Lai (as cited in Duquette et al., 1994), and Yasko (1983) all used random samples with participation rates of 74 percent, 100 percent, and 70 percent respectively. Hare et al. (1988) and Pelletier (1986) used convenience samples with participation rates of 52 percent and 69 percent respectively. Each of the investigators, with the exception of Yasko (1983) used the MBI; Yasko (1983) utilized the SBS-HP tool. Due to the comparative designs, diversity and quality of samples and measurement of the same discrete variable, the findings from each of these studies can be compared. Of the studies examined by this author, only one suggested that time spent in direct patient contact contributes to burnout; the other studies suggest that time spent directly with patients was not a contributing factor to nurse burnout.

Sociodemographic Factors Related to Burnout

Studies on sociodemographic variables that may be related to nurse burnout were examined by this author. The primary factors examined were age, sex, civil status, number of children, employment title, education, and experience. With the exception of age, the literature shows that these variables do not play a significant role in the cause of

burnout among nurses. Age was identified in the literature as a relatively good correlate of burnout, with younger nurses being more susceptible to burnout.

Duquette et al. (1994) conducted a literature review exploring nursing burnout and found coping strategies, stress index, and personal accomplishment to be highly predictive factors related to burnout. The data show some variances concerning the relation between burnout and sex and burnout and age. The comparative studies show that among health care workers, nurses are at highest risk of burnout, particularly oncology nurses (Duquette, 1994).

Cash's study (as cited in Dallender et al., 1999), analyzed demographic factors in relation to burnout and found no significant differences between burnout and age, civil status, or number of children. Cash (as cited in Dallender et al., 1999), used a multivariate design and a convenience sample of ICU nurses from seven southern U.S. hospitals with a participation rate of 41 percent. Utilizing the same study design and a random sample of nurses, Williams (1989) found similar results for sex, age, civil status, and number of children. Williams (1989) concluded that age correlated negatively with emotional exhaustion and depersonalization, which, according to Maslach and Jackson (1981), are vital components to burnout.

Findings from a study conducted by Grutchfield (as cited in Duquette et al., 1994), found no significant relationships between burnout and employment title, education, and experience. Grutchfield (as cited in Duquette et al., 1994), used a multivariate study design; however, there was concern for bias as the participants for this study were solicited following a seminar on burnout. Bartz and Maloney (1986) found a significant positive relationship between education and burnout and a negative

relationship between experience and burnout. However, Bartz and Maloney (1986) used a small convenience sample drawn from one hospital where 80 percent of the respondents held a bachelors degree and the average respondent had less than 4 years nursing experience.

Protective Factors Related to Burnout

The literature identified hardiness, social support, and coping strategies as buffering or protective factors in relationship to burnout. The effects of hardiness on nursing burnout have been thoroughly analyzed in the literature. According to Kobasa and Puccetti (1983), hardiness contains three components; challenge, commitment, and control. Challenge is the openness to change and problem solve. Commitment is a feeling of involvement, and control is a sense of personal influence.

Keane et al. (1985) contrasted the burnout experiences of ICU nurses with those of non-ICU nurses. Study findings identified hardiness, rather than particular workplace stressors, to be the variable with significant relationship to burnout among both ICU and non-ICU subjects. Nurses in both clinical settings who measured higher in hardiness had less burnout. Other investigators, including Duquette et al. (1995) and Rich and Rich (1987), suggested that lack of hardiness has a significant positive relationship to nursing burnout.

Simoni and Paterson (1997) examined the relationships among hardiness, coping approach, and burnout in a sample of 440 nurses and found that participants with greater hardiness reported less stress in the form of burnout than did those with less hardiness. Participants using direct active coping mechanisms such as changing the stressor, confronting the stressor, or finding positive aspects in the situation had the lowest

burnout scores; whereas, participants using direct inactive coping mechanisms such as ignoring the stressor, avoiding the stressor, or leaving the stressor had the highest burnout scores (Simoni & Paterson, 1997).

The notion of social support in the workplace involves the support of superiors as well as the support of colleagues. The relationship between burnout and support in the workplace has been studied in a largely diverse nursing population. It appears that the literature supports a negative and statistically significant relationship between social support and burnout and the support of superiors and colleagues is a reliable correlate of burnout (Duxbury et al., 1984; Mallett, 1988; Katz et al., 2005).

The literature identified coping strategies in a variety of ways. Lazarus and Folkman (1984) identified coping as an adaptive strategy individuals use to deal with work related stressors. According to Holahan and Moos (1985), a common way of classifying coping strategies is to distinguish between active strategies and strategies that rely on avoidance. Using a bivariate correlational study design, Ceslowitz (1989) examined the relationship between coping strategies and burnout among 150 randomly selected staff nurses. Ceslowitz (1989) concluded that nurses who experienced increased levels of burnout utilized the coping strategies of escape, avoidance, self-control, and confronting; those who experienced decrease levels of burnout used purposeful problem solving, positive reappraisal, seeking out of social support, and self-control as coping mechanisms.

Heim (1991) implied that nurses who are unable to cope with stressors at work and in private life may experience anxiety and burnout. Several authors, including Beemsterboer and Baum (1984), Barry (1984), Dignam et al. (1986), Duxbury et al.

(1984), Fredeunberger (1974), and Maslach and Jackson (1981), supported the notion that burnout has very serious consequences and has the potential to lead to problems such as job dissatisfaction, quitting of one's job, decrease in self-esteem, difficulty with concentration, social isolation, fatigue, lack of libido, headaches, gastrointestinal problems, sleep disorders, marital and family problems, and alcohol and drug abuse. Folkman et al. (1986) further noted that burnout arising from the inability to adequately cope with stress can lead to considerable financial difficulties.

It is reasonable to believe that the stressors encountered in the nursing profession are unlikely to change; in fact, given the changes that are taking place in health care today, there is potential for a concomitant increase in these stressors. Therefore, further assessment of coping strategies may be a worthy focus to create positive change within the nursing community.

Factors Influencing Burnout in Psychiatric Nursing

Burnout in psychiatric nursing is a phenomenon of great concern. The literature supports the notion that a number of demands exist, which are explicitly related to mental health settings (Cronin-Stubbs & Brophy, 1985; Jenkins & Elliott, 2004; Sullivan, 1993).

In contrast to the relatively large number of studies of stress in general nurses; there have been fewer studies of stress in mental health nurses. Nolan (1993) suggested that of all the mental health professions, in the past 30 years nursing has had to undergo the most dramatic changes. Since the 1960s, when deinstitutionalization of psychiatric mental health hospitals began, mental health services have been dependent on regional centers and contracted and community services, which has led to a radical change in the role of mental health nurses.

The Claybury community psychiatric nurse (CPN) stress study collected data on stress levels in 250 CPNs and 323 ward-based psychiatric nurses (WBPN) in the North East Thames region. Four out of 10 CPNs were found to be experiencing high levels of psychological distress according to the General Health Questionnaire (GHQ) scores. Both CPNs and WBPNs scored highly on scores of occupational burnout, particularly on emotional exhaustion scores. WBPNs scored worse on emotional detachment from their patients and were achieving less personal fulfillment from their work. Both groups of nurses were more satisfied with direct patient care than with their employment conditions, primarily their working environments and for CPNs their relationships with their managers. The study concluded that stress is taking its toll on mental health nurses in terms of absence rates from work, lower self-esteem, and personal un-fulfillment (Fagin et al., 1995 & Fagin et al., 1996).

Pompili et al. (2006) conducted an investigation of 120 nurses working in the psychiatric, general medical and critical care/ surgery units to explore the correlations of level of burnout and defense mechanisms with hopelessness. The participants were administered the MBI, Gleser and Ihilevich's Defense Mechanisms Inventory, and Beck's Hopelessness Scale (BHS). The results of this study indicate that burnout and some of the defense mechanisms predict the level of hopelessness. Furthermore, the results showed that despite the use of variable defense mechanisms, psychiatric nurses in this sample had higher scores for emotional exhaustion and depersonalization compared with the other nurses in the sample. Pompili et al. (2006) contended that nurses working on a specific unit, such as psychiatric, may be at greater risk for burnout in spite of the

use of specific defense mechanisms. Pompili et al. (2006) recommended further studies with larger samples to investigate this subject.

Dawkins et al. (1985) examined stress in psychiatric nursing using an occupational stress scale developed specifically for the study. The results of this study suggested that the main causes of stress were the difficulties of working in a system in which people are expected to follow precisely defined rules and adhere to complex hierarchical administrative policies and procedures. Administration and organizational issues, staff conflict, scheduling, negative characteristics of patients, limited resources, and staff performance were the six categories of stress identified. The stressors identified were similar to those encountered in other areas of nursing; however, the participants of this study were predominately in supervisory roles, making comparisons with other studies difficult.

Dolan et al. (1987) conducted an investigation to assess the relationship between burnout and job satisfaction in two groups of nurses, including general and psychiatric fields of nursing. Job satisfaction as measured by the Job Satisfaction Questionnaire designed for this study was a reliable indicator of burnout. The Maslach Burnout Inventory (MBI) was the tool used in this study to measure burnout. An inverse relationship between job satisfaction and burnout was found in both groups; however, it was found that psychiatric nurses, in having higher levels of job satisfaction than general nurses, also perceived themselves as more burnt out; although the differences were not significant (Dolan et al., 1987).

Summary

Nurses are exposed to multiple demands on their time and energy and the literature clearly supports the popular assumption that the nursing profession is extremely stressful. In addition, the literature shows concerns for the prevalence of burnout in nurses. The burnout process has the potential for creating alarming consequences for both the nurse and their organizations. The literature reveals that the consequences of nurse burnout can be devastating; in addition to causing psychological and physical problems for the nurse, burnout can also result in poor quality care for patients, lost time and decreased productivity, and premature departure from the nursing profession. The literature identified organizational stressors, workload, and role ambiguity as strong correlates of nursing burnout. The literature also identified hardiness and social support as effective coping strategies for counterbalancing stress.

Theoretical Framework

Conceptualization of stress as a response has contributed to the development of several theories and models in nursing science; among those is Roy's Adaptation Model (RAM). The theoretical framework for this study was derived from RAM (Roy, 1984). This model relies heavily on stress theory, the notion of adaptation, and the ability of nursing to facilitate adaptation to stress. For her model, Roy selected the concepts of stressor, stress, and adaptation from stress theory. Roy (1984) defined stress as "a constantly changing point, made up of focal, contextual, and residual stimuli, which represent the person's own standard of the range of stimuli to which one can respond with ordinary adaptive responses" (p.27-28).

Stress, according to Roy (1984), represents the person's adaptive level. Roy defined adaptation as "that which promotes the integrity of the person in terms of survival, growth, reproduction, and mastery" (p.51). According to Roy (1984), a person is a psychosocial being who is in constant interaction with a changing environment. The environment is all encompassing and includes all the conditions, circumstances, and influences surrounding and affecting the development and behavior of a person. The basis to Roy's model is coping with environmental change through adaptation, and the process of adaptation is to occur when the individual responds positively to the change.

Adaptation levels, as defined by Roy (1984), are influenced by focal, contextual, and residual stimuli. Focal stimuli represent the internal or external stimulus most immediately confronting the person and require a behavioral response. Contextual stimuli are all other stimuli in a person's environment that contribute to the behavioral response. Contextual stimuli includes all the environmental factors that present to the person from within or without but which are not the center of the person's attention and/or energy. This denotes other simultaneous stimuli in the environment which lead to the change of perceptions in the individual. Residual stimuli are a more elusive form of stimuli, and individual composition and characteristics are fundamental to the response.

Nurses are constantly confronted with an ever changing environment of circumstances and influences. This reflects the organization system in which nurses are employed. An important socializing influence in the lives of nurses is the work environment. Nurses spend a great deal of time within this environment and thus are subject to the values of that system and the ongoing interactions that occur within that system. The complexity of the work environment creates the need to respond to the

changes so adaptation can occur. Adaptation is essential to coping with the stimuli; however, the adaptive response may be an ineffective response that can lead toward behaviors that place one at risk for burnout.

Roy's model postulated that responses to stimuli are processed through subsystems that include two control mechanisms and four adaptive modes. One control mechanism is the regulator system which responds automatically by way of neural, chemical, and endocrine processes. The second subsystem, the cognator, receives input from external and internal stimuli that involve psychological responses concerned with the process of perception. The four adaptive modes are contained within this second subsystem (Roy, 1984).

Roy (1984) further conceptualized a person as having four modes of adaptation: physiological need, self-concept, role function, and interdependence reaction. Physiological need involves the body's basic need for fluid, nutrition, elimination, rest, exercise, oxygenation, and circulation, which reflect general body regulation. The self-concept mode is the make up of one's beliefs and feelings, which is particularly formed by others' reactions. The role function mode represents the performance of duties based on a given position in society. Interaction with others is a major determinant in the way one performs a role. Lastly, the interdependence mode involves one's relationship with significant others and the support system. This mode is how the need for nurturance and affection are met. The modes of self-concept, interdependence, and role function are especially relevant in terms of the nurse and burnout risk.

These modes reflect the role of nurses who serve as a source of reaction to one's beliefs and feelings, serve as a source of relationships, and can influence one's role in the

work environment. This demonstrates how interrelated and connected one's own adaptation is to others in the environment, and for nurses this can be especially reflective of the work environment. Inadequate response to one's environment can cause adaptation problems resulting in burnout and feelings of hopelessness. A complete understanding of the correlations between burnout and hopelessness needs to be determined in order to accomplish effective adaptation. In addition, a more precise understanding of the causative factors of burnout and hopelessness among nurses is needed to allow nurses to better adapt to the environmental stimuli in an effective manner. This understanding would also better assist organizations to create social support in the workplace and establish interventions for each of the adaptive modes that will promote adaptation and decrease the risks of burnout and hopelessness among nurses.

Domain of Inquiry

This research study will address the following questions regarding burnout and hopelessness among nurses working on Midwest community psychiatric hospital units.

1. The relationship between burnout and hopelessness.
2. The prevalence of burnout and hopelessness.
3. The association of burnout and hopelessness with working different shifts, the number of hours worked per week, and the length of time worked on a psychiatric hospital unit.
4. The association of burnout and hopelessness with intention to leave.

Definitions

For the purpose of this study, the following terms will be defined.

Burnout: A syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment.

Hopelessness: The belief that nothing will turn out right and important goals can never be obtained.

Intention to Leave: The psychiatric nurses' plan to vacate his/her current position within the next 6 months.

Midwest Community Psychiatric Hospital Unit: A hospital unit located geographically in the north central region of the United States.

Midwestern State: A State that is located geographically in the north central region of the United States.

Psychiatric Mental Health Nurse: A registered nurse or a licensed practical nurse with a current nursing license that is practicing his/her nursing on individuals with psychiatric diagnosis in an inpatient Midwest community psychiatric hospital unit and who has completed their orientation period in this setting.

Shifts: Four intervals of time that cover the reoccurring 24 hour work period; this will include days, evenings, nights, and rotating a combination of any of the three previous times.

CHAPTER II

RESEARCH METHODS

Introduction

The purpose of this quantitative descriptive study was to investigate burnout and hopelessness in a sample of nurses working on Midwest community psychiatric hospital units. This chapter will focus on the methodology of the study. The study site, population, and study design are presented. Data collection methods along with data analysis procedures and protection of human subjects are also examined.

Population

The target population for this study included all registered nurses (RNs) and licensed practical nurses (LPNs) that identify themselves as psychiatric mental health nurses who practice in one of the identified study sites. The criterion for inclusion in the study was that the psychiatric mental health nurses needed to spend the majority of their working hours caring for people with mental illness in an inpatient community psychiatric unit. Since the study focused on investigating burnout and hopelessness among nurses working on Midwest community psychiatric hospital units, it was necessary to use only those nurses who practice psychiatric nursing the majority of their working time and who identify themselves as psychiatric mental health nurses. An additional inclusion criterion for the study was that all psychiatric mental health nurses were required to have completed their general hospital orientation as well as their psychiatric unit orientation.

All informants had to be 18 years old and voluntarily consent to participate in the study. The study population represented a mixture of male and female adult psychiatric mental health nurses with diversity in age; however, the mixture was predominately female gender. This investigator gained access to eligible participants through key contact professionals at the study sites. After receiving careful explanation of the study's subject selection, procedure, risk and benefits, and the informational and consent forms from this investigator, a sample size of 33 subjects were identified by the key contact professionals and asked to participate in this research study.

Study Site

The study sites for this research project were two Midwest community psychiatric hospital units located in a rural Midwestern community of approximately 60,000 residents. Both study sites offer inpatient, as well as outpatient, mental health services to the people of the community.

Study Design/Method

A quantitative descriptive design was used to examine the complex factors of burnout indicators and the emergence of hopelessness in psychiatric nurses. The methodology represents an approach utilizing surveys to elicit an understanding of the phenomena of burnout and hopelessness in psychiatric nursing. The goal of this approach was the generation of detailed numerical data as opposed to narrative data, which would allow identification of a multitude of perceptions beyond what can be identified from a qualitative approach. The underlying theoretical perspectives were also examined.

Data Collection

Data collection was conducted over a three month interval from January to March of 2007. This descriptive correlation study utilized a survey approach with a convenience sample. Data were gathered to identify variables associated with nurse burnout and hopelessness utilizing the Maslach Burnout Inventory (MBI) and the Beck Hopelessness Scale (BHS). Data were also gathered on demographic characteristics of the respondents.

Data were obtained by sending surveys through the U.S. mail. The surveys were delivered in individually closed sealed envelopes and distributed to all eligible participants who were procured through key contact professionals within the study sites. Subjects who voluntarily chose to participate in this study completed the surveys and anonymously returned them to this investigator through the U.S. mail in postage paid envelopes which were provided to the participants.

Instruments

Maslach Burnout Inventory

The Maslach Burnout Inventory (MBI) (Maslach et al., 1996) is recognized in the literature as the leading measure of burnout. Based on the assumption that a particular syndrome of burnout emerges in the human services occupations, Maslach et al. (1996) devised an instrument known as the Maslach Burnout Inventory-Human Services Survey (MBI-HSS) to measure the hypothetical aspects of this burnout syndrome. The MBI-HSS consists of 22 items designed to address three aspects of burnout. These subscales include emotional exhaustion, depersonalization, and lack of personal accomplishment.

The Emotional Exhaustion (EE) subscale assesses feelings of being emotionally overextended and exhausted by one's work. The Depersonalization (Dp) subscale

measures an unfeeling and impersonal response toward recipients of one's service, care, treatment, or instruction. The Personal Accomplishment (PA) subscale assesses feelings of competence and successful achievement in one's work with people (Maslach, 1996).

Maslach et al. (1996) conceptualized burnout as a continuous variable ranging from low to moderate to high degrees of experienced feeling. A high degree of burnout is reflected in high scores on the EE and Dp subscales and in low scores on the PA subscale. An average degree of burnout is reflected in averages of scores on the three subscales. A low degree of burnout is reflected in low scores on the EE and Dp subscales and in high scores on the PA subscale.

Beck Hopelessness Scale

The Beck Hopelessness Scale (BHS) (Beck et al., 1974) is a 20 item scale for measuring negative attitudes about the future. Beck et al. (1974) originally developed this scale to predict who would commit suicide and who would not. The powerful predictor of eventual suicide addresses three major aspects of hopelessness, including feelings about the future, loss of motivation, and expectations. In responding to the 20 true or false items on the BHS, participants can either endorse a pessimistic statement or deny an optimistic statement. Research consistently supports a positive relationship between BHS scores and measures of depression, suicidal intent, and suicidal ideation.

Demographic Survey

This researcher developed a demographic survey. The questions on the demographic tool were chosen specifically to address the domain of inquiry and are directly related to the purpose of this study. The demographic tool was reviewed with faculty members to ensure that the questions addressed the purpose of this study.

Instrument Credibility

The MBI-HSS has been found to be reliable, valid, and easy to administer. According to Maslach et al. (1996), longitudinal studies of the MBI-HSS have found a high degree of consistency within each subscale. "The MBI-HSS has desirable psychometric properties, including a substantial general factor underlying the emotional exhaustion and depersonalization subscales, a replicable 2-factor and 3-factor structure, high internal consistency, and a high split-half reliability" (Pompili et al., 2006, p.137).

Validity was demonstrated in various ways. "First, an individual's MBI-HSS scores were correlated with behavioral ratings made independently by a person who knew the individual well, such as a spouse or co-worker. Second, MBI-HSS scores were correlated with the presence of certain job characteristics that were expected to contribute to experienced burnout. Third, MBI-HSS scores were correlated with measures of various outcomes that had been hypothesized to be related to burnout. All three sets of correlations provided substantial evidence for the validity of the MBI-HSS" (Maslach et al., 1996, p.12).

The BHS moderately correlates with the Beck Depression Inventory (BDI); however, research shows that the BDI is a better indicator for predicting suicidal ideation behavior. (Beck and Steer 1993). "The internal reliability coefficients are reasonably high, but the BHS test-retest reliability coefficients are modest" (Beck et al., 1988).

Dowd and Owen (1992) positively reviewed the effectiveness of the BHS instrument and concluded that the BHS was "a well constructed and validated instrument, with adequate reliability" (p.82).

Instrument Reliability for Study

For this study, the Cronbach's Alpha reliability statistic was .92 for the MBI. The Cronbach's Alpha for the MBI subscales PA, EE, and Dp were .74, .94, and .80 respectively. The Cronbach's Alpha for the PA subscale would have increased to .79 if item number four of the MBI "I can easily understand how my recipients feel about things" would have been removed; this item correlated poorly with the scale as a whole. The Cronbach's Alpha for the BHS was .57 which indicates low reliability and it appears that the BHS was not a very reliable scale for this sample.

The BHS was found to maintain a high internal consistency across several clinical samples and this investigator utilized the tool with confidence in this study. However, this investigator found that the BHS was not a good measure for this sample. This investigator found several items on the BHS for which there was no variation in answers. As a result the variation was zero and those items were not included in the reliability test analysis.

Data Analysis

Descriptive statistics were used to characterize the answers to the demographic data. Since this was a quantitative descriptive study, correlational and descriptive statistics were used for data analysis. Statistical analysis was performed through the use of SPSS for Windows. For scoring and interpretation of results for the MBI-HSS, each respondent's test form was scored with a scoring key containing directions for scoring each subscale. Each score was coded as low, average, or high by using the numerical cutoff points listed on the scoring key. The MBI-HSS scores for the group of respondents were treated as aggregate data. Table 1 shows results of the means and

standard deviations for each MBI-HSS subscale that were computed for the entire group and compared to the normative data for mental health as found in Maslach et al. (1996). The MBI-HSS scores were also correlated with other information obtained from respondents, in particular demographic data and hopelessness.

The frequency with which the respondent experienced feelings related to each subscale of the MBI-HSS are assessed using a six-point, fully anchored response format. It is recommended to report Personal Accomplishment as direct computations of item scores rather than as Diminished Personal Accomplishment based on reversed items (Maslach et al., 1996).

Participants for this study were asked to rate each of the 22 items on a scale of 0 (never) to 6 (everyday), and mean scores were calculated for each of the three subscales. The higher the score on emotional exhaustion and depersonalization subscales, the greater the degree of burnout. Low scores on the personal accomplishment reflect a high degree of burnout. The only relevant re-coding required for this study involved all of the personal accomplishment (PA) scale items; the coding was reversed when the items were included with the MBI scale.

The BHS was scored by summing the keyed responses of hopelessness for each of the 20 items. Scoring was facilitated by using the BHS scoring key and through the use of SSPS for Windows. Responses indicating hopelessness appeared within the circles on the score key and received a score of 1. Responses not appearing in circles indicated non-hopelessness and received a score of 0. The BHS score yields only an estimate of the overall severity of an individual's negative attitudes about the future (Beck et al., 1993). Beck et al. (1985) have reported that BHS scores of 9 or more were predictive of

eventual suicide in depressed individuals with suicide ideation who were followed for 5 to 10 years following discharge from the hospital. Coding of the BHS for this study included a score of 1 for all true responses and a score of 0 for all false responses. The BHS was not a reliable scale for the sample in this study; this author believes a Likert scale would have been a more reliable scale in this sample.

Table 1. Comparative Means and Standard Deviations for the Maslach Burnout Inventory (MBI) Subscales

	Maslach Burnout Inventory (MBI) Subscales		
	Emotional Exhaustion (EE)	Depersonalization (Dp)	Personal Accomplishment (PA)
This Study (N=13)			
M	22.69	6.84	38.46
SD	11.15	5.89	5.85
Maslach (N=730)			
M	22.19	7.12	36.53
SD	8.90	4.62	6.37

Protection of Human Subjects

Institutional Review Board (IRB) approval was obtained from the University of North Dakota (UND) before this study began. Additional support and approval were obtained from the study sites through key contact professionals at the sites. Participation in the study was strictly voluntary and by no means interfered or jeopardized the participants' relationship with their employer. Participant identity remained confidential and was at no time revealed in the study results or report. Study results were strictly in aggregate format. Participation in completing the surveys served as participants' consent. The information will be published and presented in a grouped data report.

Assumptions

An assumption of this research study is that the participating psychiatric mental health nurses will answer the survey questions accurately and truthfully. A second assumption of this study is that the participating nurses represent typical psychiatric mental health nurses working on a Midwest community psychiatric hospital unit. A final assumption is that these nurses will accept research focused on them as valuable and participate in this study.

Limitations

There are several limitations to this research study. The study relies heavily on subjective reports of the participants. Also, the participants for this study were from a small population; since the study participants were chosen from one community, the results of this study may be limited in generalization to other Midwestern geographic locations. A final limitation is that nurses who agreed to take part in this study may have been those who were more distressed by their work and considered their participation to be a sort of counseling and a way of seeking help, which may be a source of bias.

CHAPTER III

RESEARCH RESULTS

Introduction

The purpose of this quantitative descriptive study was to investigate burnout and hopelessness in a sample of psychiatric mental health nurses working on Midwest community psychiatric hospital units and to increase the understanding of the relationship between burnout and hopelessness among psychiatric nurses. This study intended to address the following domain of inquiry:

1. The relationship between burnout and hopelessness.
2. The prevalence of burnout and hopelessness.
3. The association of burnout and hopelessness with working different shifts, the number of hours worked per week, and the length of time worked on a psychiatric hospital unit.
4. The association of burnout and hopelessness with intention to leave.

Included in this chapter is a description of the study sample followed by an analysis of the results addressing each domain of inquiry. A summary of the results is presented at the end of this chapter.

Characteristics of the Sample

Selected socio-demographic characteristics of the sample (N=13) are shown in Table 2. All participants were female and Caucasian/White. Ten (76.9%) of the respondents were registered nurses (RNs) and three (23.1%) were licensed practical nurses (LPNs). The median age of the respondents was 40 years to 49 years old. The

marital status of the respondents included eight (61.5%) married, three (23.1%) divorced, and two (15.4%) single. The median amount of time the participant nurses worked in a mental health setting was 2 years to 5 years. None of the participant nurses worked less than one month or more than 10 years in a mental health setting; 38.5% of the nurse participants have worked 2 years to 5 years in a mental health setting, while 30.8% of the nurse participants have worked 5 years to 10 years in a mental health setting. Normal shift work for the participating nurses varied. One (7.7%) nurse participant works day shift; two (15.4%) participants work evenings, three (23.1%) work night shift, and seven (53.8%) nurse participants work rotating shifts. The median number of hours worked in a mental health setting in a typical week by the participant nurses was 30 hours to 40 hours per week; three (23.1%) of the participating nurses typically work less than 10 hours per week and two (15.4%) typically work more than 40 hours per week. The sample in this study was too small to make any generalizations about sociodemographic factors related to nursing burnout; however, the literature supports the notion that age is a relatively strong correlate of nursing burnout.

According to Duquette et al. (1994), "studies on the sociodemographic factors show that sex, civil status, number of children, employment title, and education do not play a great role in producing burnout among nurses. Only age has been identified as a relatively good correlate of burnout, with younger nurses being more susceptible. It would be reasonable to believe that younger nurses see their role as more ambiguous and perceive their workload as more heavy" (p.351).

Table 2. Selected Socio-demographic Characteristics

Variable	#	%
Age		
20-29	2	15.4
30-39	4	30.8
40-49	3	23.1
50+	4	30.8
Marital Status		
Married	8	61.5
Divorced	3	23.1
Single	2	15.4
Job Category		
RN	10	76.9
LPN	3	23.1
Length of time Worked in Mental Health		
< 1 month	0	0
1-12 months	4	30.8
1-2 years	0	0
2-5 years	5	38.5
5-10 years	4	30.8
> 10 years	0	0
Shift Normally Worked		
Days	1	7.7
Evenings	2	15.4
Nights	3	23.1
Rotating	7	53.8
Hours Worked in a Typical Week		
<10 Hours	3	23.1
10-20 Hours	0	0
20-30 Hours	0	0
30-40 Hours	8	61.5
>40 Hours	2	15.4

Research Question Number One:
What is the Relationship between Burnout and Hopelessness?

Since this was a quantitative descriptive study, correlational and descriptive statistics were used for data analysis. Statistical analysis was performed through the use of SPSS for Windows. To provide an answer for research question number one, Pearson's correlation coefficient was used to calculate the linear correlation coefficient between the two variables of burnout and hopelessness. The results of statistical analysis for burnout and hopelessness correlations are shown in Table 3. Although none of the numbers shown in Table 3 are significant at the .05 level, all of the correlates shown are in the expected direction. In fact, the hypothesis that a higher degree of hopelessness correlates with a lower degree of Personal Accomplishment (PA) is supported by these results. In addition, greater percentages had higher scores on the Depersonalization (Dp) and Beck scales.

Table 3. Burnout and Hopelessness Correlations

	Beck Hopelessness Scale (BHS)
Maslach Burnout Inventory (MBI)	.325
Personal Accomplishment Subscale (PA)	-.412
Emotional Exhaustion Subscale (EE)	.249
Depersonalization Subscale (Dp)	.092

Research Question Number Two:
What is the Prevalence of Burnout and Hopelessness?

The mean scores, standard deviations, and results of statistical analysis for the prevalence of burnout and hopelessness are shown in Table 4. Higher mean scores for the personal accomplishment (PA) variables were noticeable among the nurse participants, whereas the lowest mean scores are shown on the Beck scale.

Table 4. Prevalence of Burnout and Hopelessness

	#	%	Range	M	SD
Maslach Burnout Inventory (MBI)			11-70	37.5	17.9
11-24	4	30.8			
29-33	4	30.8			
42-70	5	38.5			
Personal Accomplishment Subscale (PA)			27-45	38.5	5.9
27-39	6	46.2			
40-45	7	53.9			
Emotional Exhaustion Subscale (EE)			7-43	22.7	11.2
7-19	6	46.2			
21-43	7	53.9			
Depersonalization Subscale (Dp)			1-21	6.8	5.9
1-4	5	38.5			
6-21	8	61.6			
Beck Hopelessness Scale (BHS)			33-40	2.8	1.9
33-36	4	30.8			
37-40	9	69.3			

Research Question Number Three:
What is the Association of Burnout and Hopelessness with Working Different Shifts, the Number of Hours Worked per Week, and the Length of Time Worked on a Psychiatric Hospital Unit?

The mean scores and results of statistical analysis are shown in Tables 5, 6, and 7 respectively. The hypothesis that burnout differs in each of the three variables of working different shifts, number of hours worked per week, and the length of time worked in a psychiatric setting is consistent with these results. Nurse participants working rotating shifts have higher mean scores on the Maslach Burnout Inventory (MBI) scale as well as on the Emotional Exhaution (EE) subscale and the Beck Hopelessness Scale (BHS).

One-way ANOVA showed statistical significance for the depersonalization (Dp) subscale in the number of hours that the nurse participants work. Nurse participants

working less than 10 hours per week had markedly higher mean scores on the MBI scale. Higher mean scores for the depersonalization (Dp) variables were also noticeable among nurses working less than 10 hours per week. The length of time worked in a psychiatric setting was significantly associated with MBI scores (highest for those working 1-3 months and 5-10 years), Personal Accomplishment (PA) subscale scores (lowest for those working 5-10 years), and Emotional Exhaution (EE) subscale scores (highest for those in the 1-3 month category).

Table 5. Association of Shift to Burnout and Hopelessness

Burnout Measure	M	SD	F	Sig.
Maslach Burnout Inventory (MBI)			1.905	.199
Days	42.0	-		
Evenings	41.6	16.9		
Nights	18.0	6.2		
Rotating	44.1	18.1		
Personal Accomplishment Subscale (PA)			.646	.605
Days	37.0	-		
Evenings	36.0	9.8		
Nights	42.6	1.5		
Rotating	37.5	6.2		
Emotional Exhaustion Subscale (EE)			2.983	.089
Days	24.0	-		
Evenings	17.5	2.1		
Nights	11.0	3.4		
Rotating	29.0	10.9		
Depersonalization Subscale (Dp)			1.177	.372
Days	8.0	-		
Evenings	12.5	4.9		
Nights	2.6	2.8		
Rotating	6.8	6.5		
Beck Hopelessness Scale (BHS)			1.043	.420
Days	.00	-		
Evenings	2.5	2.1		
Nights	2.3	1.5		
Rotating	3.4	1.9		

Table 6. Association of Hours Worked per Week to Burnout and Hopelessness

Burnout Measure	M	SD	F	Sig.
Maslach Burnout Inventory (MBI)			1.318	.310
<10 Hrs/wk	50.6	20.5		
30-40 Hr/wk	35.2	15.6		
>40 Hrs/wk	26.5	21.9		
Personal Accomplishment Subscale (PA)			.824	.466
<10 Hrs/wk	34.6	7.3		
30-40 Hrs/wk	39.3	5.6		
>40 Hrs/wk	40.5	4.9		
Emotional Exhaustion Subscale (EE)			.446	.652
<10 Hrs/wk	24.0	11.3		
30-40 Hrs/wk	24.0	11.7		
>40 Hrs/wk	15.5	12.0		
Depersonalization Subscale (Dp)			10.281	.004
<10 Hrs/wk	15.3	6.0		
30-40 Hrs/wk	4.2	2.3		
>40 Hrs/wk	4.5	4.9		
Beck Hopelessness Scale (BHS)			1.125	.362
<10 Hrs/wk	2.6	1.5		
30-40 Hrs/wk	3.2	2.0		
>40 Hrs/wk	1.0	1.4		

Table 7. Association of Length of Time Worked in Psychiatric Setting to Burnout and Hopelessness

Burnout Measure	M	SD	F	Sig.
Maslach Burnout Inventory (MBI)			5.340	.022
1-3 months	54.0	-		
3 mo-1 year	28.6	15.9		
2-5 years	25.4	4.50		
5-10 years	55.0	16.2		
Personal Accomplishment Subscale (PA)			4.559	.033
1-3 months	39.0	-		
3 mo-1 year	42.0	4.35		
2-5 years	41.4	2.60		
5-10 years	32.0	5.71		
Emotional Exhaustion Subscale (EE)			4.715	.030
1-3 months	43.0	-		
3 mo-1 year	19.3	10.7		
2-5 years	15.2	3.49		
5-10 years	29.5	9.98		
Depersonalization Subscale (Dp)			1.368	.314
1-3 months	7.00	-		
3 mo- 1 year	4.3	3.5		
2-5 years	4.6	3.5		
5-10 years	11.5	8.4		
Beck Hopelessness Scale (BHS)			.925	.467
1-3 months	1.00	-		
3 mo- 1 year	2.3	2.51		
2-5 years	2.4	1.34		
5-10 years	4.00	2.16		

Research Question Number Four:
What is the Association of Burnout and Hopelessness with Intention to Leave?

The mean scores and results of statistical analysis for the intention to leave are shown in Table 8. The intention to leave was significantly different between the groups for the Emotional Exhaustion (EE) measure. Nurse participants who were undecided had the highest mean score and those answering yes were second. Markedly higher mean scores for the MBI measure were noticeable among nurse participants who were undecided regarding their intention to leave.

Table 8. Association of Intention to Leave with Burnout and Hopelessness

Burnout Measure	M	SD	F	Sig.
Maslach Burnout Inventory (MBI)			1.010	.399
Yes	33.0	-		
No	33.6	18.3		
Undecided	50.3	15.8		
Personal Accomplishment Subscale (PA)			.120	.888
Yes	40.0	-		
No	38.7	5.4		
Undecided	37.0	9.1		
Emotional Exhaustion Subscale (EE)			5.011	.031
Yes	23.0	-		
No	18.1	8.7		
Undecided	36.3	8.3		
Depersonalization Subscale (Dp)			.319	.734
Yes	3.0	-		
No	7.6	6.9		
Undecided	5.6	1.5		
Beck Hopelessness Scale (BHS)			1.391	.293
Yes	2.0	-		
No	2.3	1.4		
Undecided	4.3	3.0		

Summary of the Data Analysis

The small sample size of this study most likely impacted the results. However, in spite of the small sample size, this study identified important and complex correlations between burnout indicators in the nurse participants. Burnout as measured by the Maslach Burnout Inventory (MBI) was a reliable indicator of burnout in this study. However, correlations between burnout and hopelessness were essentially statistically insignificant in this study.

Nurse participants working on a psychiatric unit for 1-3 months had significantly high scores on the MBI and for the Emotional Exhaustion subscale. Nurse participants working 5-10 years also had significantly high scores on the MBI as well as the lowest Personal Accomplishment (PA) subscale scores. It would appear that burnout has a greater impact for those groups of nurses working on a psychiatric unit.

A similar picture emerges in the case of nurse participants working rotating shifts. Nurse participants working rotating shifts have higher mean scores on the MBI scale as well as on the EE subscale and the Beck Hopelessness Scale (BHS).

This study has a number of limitations beyond what was recognized by this author in chapter two. First, the choice of the sample limits generalization of the results. Correlations, although statisitically significant, were weak and hopelessness was indirectly assessed as there was no clear correlation with the Beck Hopelessness Scale that was used in this study. Because of the correlational nature of the data, no definitive statement can be made about the causal relationships among the variables in the domain of inquiry.

CHAPTER IV

DISCUSSION AND RECOMMENDATIONS

Study Summary

This chapter concludes with a summary of the study, its findings, contributions to nursing, additional research opportunities, and summary conclusions.

Stress and burnout present a tremendous challenge to the nursing profession. Recent trends in nursing shortages offer considerable insight in recognizing the need to further investigate this problem. The literature is replete with information surrounding burnout in nurses and the potential implications to their health and to the integrity of the nursing profession; however, there is limited research on stress and burnout in psychiatric nurses. Although the literature recognizes that nursing is a stressful occupation and that psychiatric nursing has unique features requiring distinct skills, stress and burnout in the psychiatric nurse has appeared only more recently in the literature.

The purpose of this quantitative descriptive study was to investigate burnout and hopelessness in a sample of nurses working on Midwest community psychiatric hospital units. Since this was a quantitative descriptive study, the specific aims of the study were accomplished through the use of surveys including a basic demographic tool, the Beck Hopelessness Scale (BHS) and the Maslach Burnout Inventory (MBI). Convenience samples were obtained from two Midwest community psychiatric hospital units. The

sample consisted of 33 psychiatric mental health nurses, with the sample largely representing Caucasian/White females. The response rate for this study was approximately 39% (N=13).

Correlational and descriptive statistics were utilized for data analysis. Statistical analysis was performed through the use of SPSS for Windows. Given the limited knowledge about the relationship between the three aspects of burnout, Maslach et al. (1996) suggested considering the scores for each subscale separately rather than combining them into a single total score. The results of this study were as expected for the correlations between the BHS and the MBI. Although the numbers were not significant at the .05 level, they did support the hypothesis that a higher degree of hopelessness correlates with a lower degree of Personal Accomplishment (PA); which is a subscale of the MBI used to assess feelings of competence and successful achievement in one's work with people.

As previously discussed, the BHS was not a good measure for the sample in this study. Several items on the BHS showed no variation in answers and because the variation was zero those items were not included in the reliability test analysis. Although this investigator utilized the BHS with confidence, an instrument with a continuous variable rather than a categorical variable may have provided a better measure for this sample.

The findings of this study identified that the length of time worked in a psychiatric setting was significantly associated with MBI scores. Nurse participants working 1-3 months and those working 5-10 years showed the highest scores on the MBI scale. Nurse participants working 1-3 months showed the highest Emotional Exhaustion

(EE) scores indicating that this group of nurse participants may be experiencing feelings of being emotionally overextended and exhausted by their work. Whereas nurse participants working 5-10 years showed the lowest scores on the Personal Accomplishment (PA) scale, suggesting that this group of nurse participants may be experiencing feelings of diminished competence and successful achievement in their work.

These findings further suggest that these groups of nurses may be more susceptible to burnout. It would be reasonable to believe that nurse participants in the 1-3 month category perceive their workload as more heavy because they may not have the same level of experience and skills as their colleagues who have worked on the unit for a longer period of time. In addition, lack of professional solidarity may contribute to burnout in this group of nurses as they may not have had enough time to establish any interpersonal relationships with their colleagues.

There are a number of reasonable beliefs as to why nurse participants in the 5-10 year category may be more susceptible to burnout. Health care organizations often make decisions without considering the knowledge and experience of their more seasoned nurses, although decisions are affecting their daily work in a significant way. Nurses with more experience may desire increased autonomy and a work environment that utilizes their extensive knowledge.

Although additional research is needed to further investigate these variables, it is this author's belief that it would be prudent for organizations to develop strategies that would decrease stressors for both novice and experienced nurses. Psychiatric debriefing protocol offers a practical means for communication and allows nurses to reflect on an

experience and gain a better understanding of how they might deal with a similar situation in the future. However, it is questionable if psychiatric debriefings are being utilized to their full potential on the nursing units. These debriefings are often viewed as tools reserved for critical incidents or following a traumatic event. Conversely, debriefing sessions should be utilized and viewed as a learning opportunity in which nurses can gain new ways of understanding the role of the psychiatric mental health nurse and gain a better appreciation for the individual approach in psychiatric nursing.

The findings from this study further suggest that shift work is highly prevalent among nurses and a significant source of stress. Higher mean scores for the Emotional Exhaustion (EE) variables were noticeable among nurses working rotating shifts. In fact, one-way ANOVA showed that nurse participants working rotating shifts had higher mean scores on the MBI scale, the EE subscale, and the Beck Hopelessness Scale (BHS) than those working straight shifts. In terms of number of hours worked per week, nurse participants working less than 10 hours per week had markedly higher mean scores on the MBI scale. Higher mean scores for the depersonalization (Dp) variables were also noticeable among nurses working less than 10 hours per week.

As part of the demographic tool that was developed for this study nurse participants were asked to rate their facility on helping them deal with job stress and burnout using a Likert scale. Although the original scale did not include a fair-poor response, that item was added by one nurse participant and as a result it was included in the scale. The responses are shown in Table 9. The majority of nurse participants gave a fair to poor response rating. Four nurse participants gave a good response rating and the excellent measure received a score of zero.

Table 9. Rate Facility on Helping to Deal with Job Stress and Burnout

Measure	Nurse Participant (N=13)
Excellent	0
Good	4
Fair	6
Fair-Poor	1
Poor	2

The demographic tool used for this study also included an item in which nurse participants were given an opportunity to provide additional comments related to job stress and burnout. This item was left blank by a majority of the respondents; however, the comments that were added did provide valuable insight for this investigator in terms of recognizing areas in need of further research. The additional comments focused primarily on stress generating events from organizational stressors, which were consistent to those identified in the review of the literature for this study.

The overall findings from this study supported the theoretical framework of the adaptation model by Roy (1984). Environmental stimuli do lend toward adaptive responses. When job stressors are present and the work environment does not allow for reasonable resources to cope with these stressors, there is a risk that the nurse will suffer from burnout and may ultimately go on to seek employment elsewhere or be lost to the profession entirely. However, it is important to recognize that the work environment is but one environment that influences stressors and stress response mechanisms.

Contributions to Nursing

This study has given insight into some factors of burnout and has allowed for a greater understanding of burnout in psychiatric mental health nurses. Lacking in the literature was the close examination and understanding of how psychiatric mental health

nurses actually perceive burnout and hopelessness within themselves and within their profession. This understanding would appear instrumental to improving recruitment and retention of psychiatric mental health nurses. In the absence of any formal organizational support systems, nurses' essentially stand alone in dealing with stress and burnout which could potentially lead to the emergence of hopelessness and thus even further threaten the notably depleting supply of psychiatric mental health nurses.

More effective strategies and approaches need to be identified to support nurses who are suffering from job related stressors and burnout. This study was able to provide some novice insight into the issue of burnout and hopelessness among psychiatric mental health nurses. The study findings justify the need to recognize this health phenomenon as one of growing concern in need of continued investigation.

Additional Research Opportunities

The literature supports a relationship between job satisfaction and burnout. Furthermore, it is recognized throughout the literature that difficulties relating to the work environment may undermine a positive approach with patients, particularly psychiatric patients. It would appear beneficial for research efforts to continue to better understand the determinants of job related stress and burnout. It would be advantageous to further examine the relationship between burnout and job satisfaction in psychiatric mental health nurses.

As demonstrated by this study, there is much to be learned about burnout and hopelessness in psychiatric mental health nurses. Repeating the study would appear to be beneficial to the further identification of burnout and hopelessness variables among this population. Although the sample in this study was small (N=13), Table 1 shows no

significant difference in comparative means and standard deviations for the MBI subscales to that of the Maslach study for which a larger sample was utilized (N=730). However, in repeating this study, it would be insightful to use a larger sample; particularly if correlations to the BHS variables are to be examined. To determine an appropriate sample for future studies, a power analysis should be performed. Regardless of future research methodologies, it is apparent that health care organizations must continue to identify burnout symptoms among nurses and refine effective health promotion and prevention strategies to deal with job stress and burnout.

This study identified important and complex correlations between burnout indicators and the length of time worked in a psychiatric setting indicating a need for further research in this area. The literature also supports that different work environments can significantly affect the staff burnout rates within organizations; therefore, it would be interesting to further investigate burnout indicators in psychiatric mental health nurses and compare the variables to nurses working in other specialty areas. Further studies should address the issue of hopelessness more directly.

Finally, the literature speaks to nurses leaving psychiatric mental health nursing to enter into other specialty areas. This study suggests that burnout may be an indication as to why; however, further research is required to determine if burnout is an indicator for retaining the psychiatric mental health nurse.

Summary

Based on the findings of this study, no definitive statement can be made about causal relationships among burnout and hopelessness in psychiatric mental health nurses; however, it can be concluded that the psychiatric mental health nurses in this study

showed some significant indicators for burnout related to the variables. This conclusion is based primarily on the MBI scores as well as the Personal Accomplishment (PA) and Emotional Exhaustion (EE) subscale scores.

Psychiatric mental health nurses will be confronted daily with difficulties; in particular, difficult patient behaviors, heavy work load, lack of personnel, and lack of time. These multiple demands will further accentuate the sources of stress that contribute to professional burnout. Stress and burnout concern the nurse, the nurse's colleagues, work and professional organizations, and ultimately society; therefore, continued research efforts related to stress and burnout are crucial to efforts to increase the level of understanding of this health phenomenon.

APPENDIX A
CONSENT FORM

Appendix A

Burnout and Hopelessness Among Nurses Working on Midwest Community Psychiatric Hospital Units

Gina M. Cook, BSN, RN: Phone Number 701-282-4522
Dr. Bette Ide, PhD, RN: Phone Number 701-777-4531

Consent Form to Participate in Survey Data Collection for Thesis Research

Dear Participant,

I am a graduate student in the College of Nursing at the University of North Dakota. There are currently immense changes taking place in health care in general and in the nursing profession in particular. Although all nurses share common job related stressors and pressures, there are a number of challenges specific to mental health settings. These include confronting difficult and challenging patient behaviors on a regular basis and the often intense nature of nurse-patient interactions. Job burnout is a well recognized health problem; research has clearly identified burnout in psychiatric nurses as a phenomenon of great concern. To add to the understanding of the effects of burnout on psychiatric nurses I am conducting research on the prevalence of burnout in psychiatric nurses and exploring its relationship with hopelessness. Hope is the foundation to all psychiatric nursing care and thus your participation is very important to this study and is gratefully appreciated.

You will be asked to answer questions related to burnout, hopelessness, and basic demographics. The survey will take approximately 30 minutes to complete. Participation is voluntary and data are anonymous. Please do not make identifying marks on the questionnaires or return envelope. At no time will your name be identified on any of the data materials. Only the researchers and people who audit IRB procedures will have access to the data. You may withdraw from the study at any time without consequences. Whether you participate or not will have no impact upon your relationship with your employer. This study is about nurses and is not an evaluation of specific individuals. Only aggregate data from the study will be published in the final report. All data will be kept in a locked cabinet and destroyed after a minimum of three years.

No known risk is associated with participation. Your responses may provide significant insight into your current life situation and reflection on your nursing career. There will be no gift for your participation. The benefit is providing important information that may help to improve nursing practice. Completion of the surveys and returning them to me indicates your agreement to participate.

If you choose to participate, please complete the surveys and return them in the postage paid envelope provided. Further information regarding this research study may be obtained from Gina Cook, 3440 5th Street West, Apt. 109, West Fargo, ND 58078, or by phone at (701) 282-4522, or by e-mail at gina.cook@und.nodak.edu or from Dr. Bette Ide (701-777-4531 or betteide@mail.und.edu). Other questions or concerns can be addressed to Research, Development and Compliance, University of North Dakota (701-777-4096).

Thank you for your time.

Gina Cook, RN, BSN, Masters Candidate
University of North Dakota
College of Nursing

Bette Ide, RN, PhD, Thesis Chair
University of North Dakota
College of Nursing

APPENDIX B
DATA COLLECTION/DEMOGRAPHIC PROFILE SURVEY

Appendix B
Burnout and Hopelessness Among Nurses Working on Midwest Community Psychiatric Hospital Units
Demographic Survey

Demographic Profile:

1. What is your age?

__ 20-29

__30-39

__40-49

__50-59

__60 or older

2. What is your gender?

__ Female __Male

3. What is your race/ethnicity?

__Caucasian/White

__Hispanic

__Black

__Native American

__Other

4. What is your marital status?

__Married

__Divorced

__Single

5. What is your job category?

__ RN __ LPN

6. How long have you worked in a mental health setting? (*including but not exclusively this facility)

__ less than 1month

__ 1 to 3 months

__ 3 months to 1 year

__ 1 to 2 years

__ 2 to 5 years

__ 5 to 10 years

__ more than 10 years

7. Which shift do you normally work?

__ Days __ Evenings

__ Nights __ Rotating

8. How many hours during a typical week do you normally work in a mental health setting? (*including but not exclusively this facility)

__ less than 10 hours

__ 10 to 20 hours

__ 20 to 30 hours

__ 30 to 40 hours

__ more than 40 hours

9. Do you have intentions to leave your current position as a psychiatric nurse within the next 6 months?

__Yes __No __Undecided

10. How would you rate this facility on helping you deal with job stress and burnout?

__ Excellent __ Good

__ Fair __ Poor

11. Any additional comments related to job stress and burnout?

APPENDIX C
DATA COLLECTION
MASLACH BURNOUT INVENTORY-HUMAN SERVICES SURVEY

MBI–*Human Services Survey*

How often:	0	1	2	3	4	5	6
	Never	A few times a year or less	Once a month or less	A few times a month	Once a week	A few times times a week	Every day

How Often 0–6	Statements:
1. _____	I feel emotionally drained from my work.
2. _____	I feel used up at the end of the workday.
3. _____	I feel fatigued when I get up in the morning and have to face another day on the job.
4. _____	I can easily understand how my recipients feel about things.
5. _____	I feel I treat some recipients as if they were impersonal objects.
6. _____	Working with people all day is really a strain for me.
7. _____	I deal very effectively with the problems of my recipients.
8. _____	I feel burned out from my work.
9. _____	I feel I m positively influencing other people s lives through my work.
10. _____	I ve become more callous toward people since I took this job.
11. _____	I worry that this job is hardening me emotionally.
12. _____	I feel very energetic.
13. _____	I feel frustrated by my job.
14. _____	I feel I m working too hard on my job.
15. _____	I don t really care what happens to some recipients.
16. _____	Working with people directly puts too much stress on me.
17. _____	I can easily create a relaxed atmosphere with my recipients.
18. _____	I feel exhilarated after working closely with my recipients.
19. _____	I have accomplished many worthwhile things in this job.
20. _____	I feel like I m at the end of my rope.
21. _____	In my work, I deal with emotional problems very calmly.
22. _____	I feel recipients blame me for some of their problems.

(Administrative use only)

		cat.		cat.		cat.
EE:	_____	_____	DP:	_____	PA:	_____

APPENDIX D
DATA COLLECTION
BECK HOPELESSNESS SCALE

BHS

Date:_____

me:_____ Marital Status:_____ Age:_____ Sex:_____

upation:_____ Education:_____

s questionnaire consists of 20 statements. Please read the statements carefully one by one. If the statement cribes your attitude for the **past week including today,** darken the circle with a 'T' indicating TRUE in the mn next to the statement. If the statement does not describe your attitude, darken the circle with an 'F' cating FALSE in the column next to this statement. **Please be sure to read each statement carefully.**

1.	I look forward to the future with hope and enthusiasm.	Ⓣ Ⓕ
2.	I might as well give up because there is nothing I can do about making things better for myself.	Ⓣ Ⓕ
3.	When things are going badly, I am helped by knowing that they cannot stay that way forever.	Ⓣ Ⓕ
4.	I can't imagine what my life would be like in ten years.	Ⓣ Ⓕ
5.	I have enough time to accomplish the things I want to do.	Ⓣ Ⓕ
6.	In the future, I expect to succeed in what concerns me most.	Ⓣ Ⓕ
7.	My future seems dark to me.	Ⓣ Ⓕ
8.	I happen to be particularly lucky, and I expect to get more of the good things in life than the average person.	Ⓣ Ⓕ
9.	I just can't get the breaks, and there's no reason I will in the future.	Ⓣ Ⓕ
10.	My past experiences have prepared me well for the future.	Ⓣ Ⓕ
11.	All I can see ahead of me is unpleasantness rather than pleasantness.	Ⓣ Ⓕ
12.	I don't expect to get what I really want.	Ⓣ Ⓕ
13.	When I look ahead to the future, I expect that I will be happier than I am now.	Ⓣ Ⓕ
14.	Things just won't work out the way I want them to.	Ⓣ Ⓕ
15.	I have great faith in the future.	Ⓣ Ⓕ
16.	I never get what I want, so it's foolish to want anything.	Ⓣ Ⓕ
17.	It's very unlikely that I will get any real satisfaction in the future.	Ⓣ Ⓕ
18.	The future seems vague and uncertain to me.	Ⓣ Ⓕ
19.	I can look forward to more good times than bad times.	Ⓣ Ⓕ
20.	There's no use in really trying to get anything I want because I probably won't get it.	Ⓣ Ⓕ

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APPENDIX E
STUDY SITE PERMISSION FORMS

August 15 2006

Dear Gina,
This is to let you know that Gail and I as representatives of the Stadter Center are very interested in having you do your topic for your graduate study here. We support your proposal. If there is anything else we can do to be of further assistance please let us know.

Sincerely,

Cathy Obregon RN ADON

Gail Christopher. DON

Gail Christopher RN DON

Altru
Health System

September 20, 2006

To Whom It May Concern:

I am writing to inform you that Gina Cook has been given approval to include the nursing staff from the inpatient Psychiatry unit @ Altru Hospital as a part of the subjects for her research project for her thesis at the University of North Dakota.

Sincerely,

Cindy Rux, RN

Cindy Rux, RN, BSN
Patient Care Supervisor
Psychiatry – Altru Hospital

Altru Hospital
1200 South Columbia Road • P.O. Box 6002 • Grand Forks, ND 58206-6002 • 701-780-5000
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