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Hardiness & Spiritual Well-being as Moderators of Burnout in Professional Nurses

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Hardiness & Spiritual Well-being as Moderators of Burnout in Professional Nurses

by

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Abstract

The purpose of this study was to examine the role of hardiness and spiritual well-being as moderators of burnout in a random sample of professional nurses in Oregon. The first hypothesis stated that higher levels of hardiness and spiritual well-being would be related to lower levels of burnout. A second hypothesis stated that existential well-being would be positively correlated with hardiness. The third hypothesis stated that age, years of experience, spiritual well-being and hardiness would be related to lower burnout. Hardiness and its components of commitment, challenge and control were measured by the Personal Views Survey II. Spiritual well-being, existential well-being and religious well-being were measured by the

Spiritual Well-being Scale. The Maslach Burnout Inventory measured the burnout components of emotional exhaustion, depersonalization and personal accomplishment. A demographic form provided descriptive data of the participants. Results indicated that hardiness and spiritual well-being correlated negatively with emotional exhaustion and depersonalization and positively with personal accomplishment. Existential well-being correlated positively with hardiness and its components of control, challenge and commitment. Age, years of experience, spiritual well-being and hardiness explained 33% of the variance in emotional exhaustion scores and 21% of the variance in depersonalization and personal accomplishment scores. Step-wise regression analysis showed that age of nurse, workplace support and commitment explained 46% of the variance in emotional exhaustion scores. Commitment, time with patients and workplace support explained 33% of the variance in depersonalization scores. Commitment and time with clients explained 27% of the variance in personal achievement scores. These findings suggest that hardiness and spiritual well-being serve as moderators of burnout. Age, years of experience, time spent with patients and workplace support should be considered as contributing factors in reducing burnout. Implications include the need to consider the role of existential significance in nurses' work and in the prevention and reduction of burnout. Provision of mentoring for young, less experienced nurses, time for involvement with people in workload assignments, and workplace support are suggested interventions.

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Chapter 1

Introduction

It is widely acknowledged that nursing is a stressful profession. Death, dying, grief, suffering, heavy workloads, and conflicts with administrators are only a few of the stressors encountered by nurses. Helping professions such as nursing are said to require high levels of interpersonal involvement and commitment, and may inadvertently promote burnout. (Keane, Ducette & Adler, 1985).

Burnout is often linked to stressors that nurses repeatedly deal with in nursing practice. For nurses, burnout is manifested in ways such as exhaustion, physical complaints, depression, negative self-concepts and job attitudes, absenteeism, misuse of legal and illegal drugs, and high suicide rates. Moreover, nurses experiencing burnout are thought to be less sensitive and empathic with patients. Combined with a negative job attitude, such characteristics can lead to poorer quality of care for people needing nursing care (Livingston & Livingston, 1984; McCranie, Lambert, & Lambert, 1987; Richman, Brodish, Haas, & Billings, 1989; Williams, 1989; Wright, Blacke, Ralph & Luterman, 1993).

There is also a continuing concern about a nursing shortage which may reach epidemic proportions. It has been predicted that there will be a shortage of 114,000 nurses by the year 2015. There are fewer individuals entering the profession and a steady increase in those leaving.

Burnout is considered a reason that some nurses leave the profession (Robinson, et al., 1991; Wright, et al., 1993).

Given such implications for the impact of burnout on individuals, the profession and patients, it is important to add to research the antecedents and correlates of burnout. The purpose of this study is to examine the contribution of hardiness, a personality characteristic, and spiritual well-being as positive resources for prevention of burnout in professional nurses.

Literature Review

A review of the literature will address the concepts of burnout, hardiness and spiritual well-being. Research conducted with nurses concerning these concepts will also be presented.

Burnout.

Important developments in the study of burnout began in the 1970's. Maslach (1982) defined the burnout syndrome as a loss of care and interest in recipients of care. The chronic emotional strain of dealing with people experiencing difficulties and problems could lead to a syndrome of emotional exhaustion, depersonalization and reduced personal accomplishment. The repeated emotional involvement with people over time is prevalent in the human service professions where people may feel called to care for other people and their problems (Pines & Aronson, 1988).

The spiritual aspect of burnout was addressed more directly by Freudenberger and Richelson (1980). An "erosion of the spirit" occurs when devotion to a cause, way of life or relationship fails to produce an expected reward. A loss of faith, meaning and purpose in the enterprise of helping is experienced (Grosch & Olson, 1994). Highly motivated, committed and idealistic people who desire to give of themselves to those in need are most susceptible to this erosion of spirit.

Pines and Aronson (1988) have proposed an existential explanation for burnout. They suggest that people need to believe that life is meaningful and that what people do is useful and important. In the modern era people look more to work rather than religion to derive this sense of meaning. Highly motivated people gradually become disillusioned when they fail to achieve existential significance in their work. This failure to accomplish goals and make a significant contribution makes a person susceptible to burnout (Pines, 1993).

Each of these descriptions vary slightly, yet point to a common end result of the burnout process. Highly motivated and committed individuals lose their spirit. Those persons who are excited, feel helpful, desire to give of themselves and are idealistic are most susceptible to this erosion of their spirit.

Burnout research with nurses.

The word "burnout" did not appear in nursing literature until the late 1970s. However, Menzies (1960) first expressed concern about the problem of stress which arose from the professional situations of nurses. Since that time numerous authors and researchers have addressed this issue.

Kramer and Schmalenberg's (1979) seminal work about the dissonance experienced by graduate nurses as they entered the work arena identified ways that new nurses dealt with the conflicts experienced. Reality shock was the name Kramer gave this incongruence or conflict between the education culture values and those of the work culture. As graduate nurses worked through the resolution of this conflict of values, burnout was one of several options available for dealing with the stress of the values conflict.

Other researchers have noted the implications that burnout has for both professionals and patients. Maslach's (1976) studies of professionals including nurses found that involvement with people and overload in the work setting were key factors in the development of burnout.

Characteristics such as age, marital status and education level also related to burnout. Burnout negatively affected work performance, increased marital conflict and contributed to increased personal susceptibility to physical and psychological illnesses. Nurses often coped with the chronic stress of their work by distancing themselves from patients which resulted in decreased quality of service and less involvement with patients.

At first glance, Benner's (1984) work on the developmental process of skill acquisition for professional nurses may not appear to be related to burnout. However, the stress created by the demands of clinical skills development, shifts in thinking, perception and involvement in clinical situations may lead to burnout. Particularly after about 2 years of clinical experience, nurses may question their career choice. They find the work more difficult, become stuck in an analysis mode of clinical judgement, and fail to learn from experience and to get involved with patients. Burnout will most likely occur in this stage (Benner, Tanner, & Chesla, 1992). Benner (1984) considered use of distancing and control strategies to protect against burnout as ineffective. Engagement and involvement with people in clinical situations enables nurses to draw on the resources needed.

Other investigators have examined specific nurse populations for susceptibility to burnout. A study of 200 nurse midwives demonstrated low levels of burnout. Age and years of experience were inversely related with levels of burnout. The number of welfare patients in a caseload was positively correlated with burnout (Beaver, Sharp, & Cotsonis, 1986). Nurse managers were shown to have burnout levels which inversely correlated with involvement with staff and patients (Harris, 1984).

A study of intensive care nurses in an army hospital showed that older age, civilian status, female and less than a baccalaureate degree described those less prone to burnout (Bartz

& Maloney, 1986). Examination of hospice nurses and hospital oncology nurses revealed lower burnout scores for hospice nurses. A positive relationship between perceived work support and lower burnout was found for each group (Bram & Katz, 1989). Workplace support was also related to burnout in bone marrow transplant nurses (Molassiotis & Haberman, 1996), hospital nurses (Robinson, et al., 1991), and pediatric nurses (Oehler & Davidson, 1992). Social support was also associated with less burnout in medical-surgical nurses studied by Ogus (1990).

Demographic variables have been studied for contributions to burnout. Older age (Bartz & Maloney, 1986; Williams, 1989) and more years of nursing experience (Robinson, et al., 1991; van Servellen & Leake, 1993), contribute to lower burnout. Patient characteristics of economic status and type of problems have also been correlated with burnout in nurses (Beaver, et al., 1986; Pagel & Wittman, 1986).

Hardiness.

The concept of hardiness as a personality characteristic was developed to explain why some persons experiencing high levels of stress become ill and others do not. Kobasa (1979) used the existential ideas of strenuousness of authentic living, competence, productive orientation, and propriate striving in developing the concept. The three components of hardiness: control, challenge and commitment form a constellation of action, cognition and emotion which strive for the enrichment of life through development (Lindsey & Hills, 1992). Each component of hardiness is considered a positive resource for encountering life stressors (Kobasa, Maddi, & Kahn, 1982).

Control is a belief that a person can influence or control the events of his or her life experience. This belief is in contrast to feelings and actions of helplessness or powerlessness. Control is not a naive expectation of complete determination of events and outcomes but rather is

a perception that one can have a definite influence through acts of imagination, knowledge, skill and choice (Kobasa, 1979; Kobasa, et al., 1982).

The challenge aspect involves a belief that change and anticipation of change are incentives and stimulants for growth and development. Flexibility and openness provide opportunities for growth and allow integration and effective appraisal of even incongruent events (Kobasa, 1979; Kobasa, et al., 1982; Lindsey & Hills, 1992).

The commitment aspect of hardiness is a tendency to involve oneself with people and events. A sense of meaning and purpose sustains a person and prevents the person giving in or feeling alienated in times of stress. Active confrontation and approach (rather than avoidance) are behaviors which serve as resistance resources against the impact of stress (Kobasa, 1979; Kobasa, et al., 1982; Lindsey & Hills, 1992).

Hardiness research with nurses.

McCranie, Lambert, and Lambert (1987) examined nurses employed in a hospital setting and found that burnout was significantly correlated with higher levels of perceived job stress and lower levels of personality hardiness. Work stressors and hardiness were additive rather than interactive predictors of burnout. Though hardiness had a main effect in reducing burnout, it could not prevent high levels of job stress from leading to high levels of burnout in this study.

A study which examined the burnout moderating effects of hardiness among female staff nurses in an acute care hospital found an inverse relationship of hardiness and burnout. Low hardiness scores and young age were found to be additive in predicting burnout. Low commitment and control sub-scale scores of the hardiness instrument and younger age contributed 57 percent of the variance in burnout scores (Rich & Rich, 1987).

Several researchers have examined the role of hardiness, stress and burnout among nurses who worked in critical care units. Topf (1989) found that hardiness was predictive of occupational stress and burnout. Commitment to work accounted for 24% of the variance across three of four measures of burnout. Wright, Blacke, Ralph and Luterman (1993) found a significant inverse relationship between hardiness and burnout in critical care nurses. This study demonstrated that hardiness was a buffer in the stress-burnout relationship. The commitment construct of the hardiness score accounted for the greater amount of variance with burnout.

Social support (work and non-work) and hardiness were both negatively correlated to burnout in a study of critical care nurses. Social support accounted for 24% of the variance in burnout scores. Work related support however was the better predictor. Scores for commitment were significantly inversely correlated with burnout (Boyle, Grap, Younger, & Thornby, 1991).

In studies of staff or hospital nurses, negative relationships of hardiness with stress and/or burnout have been found. Nurses with higher levels of hardiness experienced less stress and burnout (Collins, 1996; Simoni & Paterson, 1997; Sortet & Banks, 1996; van Servellen, Topf, & Leake 1994). Studies of hardiness in additional nurse populations are few. Nurse educators were examined by Langemo (1990) and found to have high hardiness scores. Higher hardiness scores were associated with less work stress. Geriatric nurses in Canada also demonstrated an inverse relationship of hardiness and burnout. Commitment and control components were significant predictors of the relationship (Duquette, Kerouac, Sandhu, Ducharme, & Saulnier, 1995). Hardiness was positively correlated with challenge and inversely related to threat in student nurses experiencing initial clinical experiences. Social support was significantly correlated with participation in religious activities though not with challenge or threat (Pagana, 1990).

In summary, studies of the relationship of hardiness, stress and burnout in nurses have found an inverse relationship of hardiness with stress and burnout. The commitment and control subscales of the hardiness measure accounted for a large amount of the variance in burnout scores. Older age and years of experience contributed to higher hardiness scores.

Spiritual well being.

The existential dimension of the human experience has been addressed by Adler (social interest), Allport (propriate striving) and Fromm (productive orientation) (Crandall, 1984). Frankl's (1963) logo therapy was based on the premise that spirituality was essential to psychological health. The religious component of spirituality was deemed a unique human quality. Striving for meaning and purpose is considered the core issue of existentialism and thus spirituality.

The development of an instrument to measure spirituality was undertaken by Ellison (1983). Spiritual well-being is experienced when people have purposes to which they commit themselves and which involve ultimate meaning for life. Both existential and religious aspects of meaning of life are considered important for spiritual well-being. The ability to derive meaning from the stresses of life would be greater in those persons with greater spiritual well-being

Spiritual well-being research with nurses.

Basic and graduate nursing students exhibiting higher levels of spiritual well-being demonstrated more positive attitudes towards providing spiritual care to patients. Both religious well-being and existential well-being showed this positive relationship (Soekin & Carson, 1986).

Spiritual well-being and hardiness.

No published research has examined the relationship of spiritual well-being and hardiness in nurses. A significant relationship was found between the commitment subscale of hardiness

and existential well-being in persons with AIDS/HIV (Carson, Soekin & Belcher, 1991). In a second study of persons with AIDS/HIV, both existential well-being and spiritual well-being were positively related to hardiness (Carson & Green, 1992).

Conceptual framework.

The conceptual framework for this study is a model (Figure 1) proposed by Pines (1993) in which the root cause of burnout lies in the existential perspective. People need to believe that their lives are meaningful and they can contribute something useful and important. For contemporary times people often strive for such life meaning in work. When people fail in this existential quest for meaning in their work, burnout will occur.

As the figure demonstrates, highly motivated people enter work with goals and expectations for themselves and their work. These expectations can be universal, profession specific and personal. These expectations combine to serve as a basis for how work can give a sense of meaning to a person's life. The work environment contributes variables which may support or thwart a person's efforts to reach goals and fulfill expectations. If a person experiences success, then a sense of existential significance is experienced. If failure is experienced, burnout will occur (Pines, 1993).

Purpose and Hypotheses

The concepts of hardiness and spiritual well-being have been grounded in existential theory. The purpose of this study was to examine the role of hardiness and spiritual well-being as moderators of burnout in nurses. It was hypothesized that higher levels of hardiness and spiritual well-being will be related to lower levels of burnout. The second hypothesis stated that there would be a positive relationship between existential well-being and hardiness.

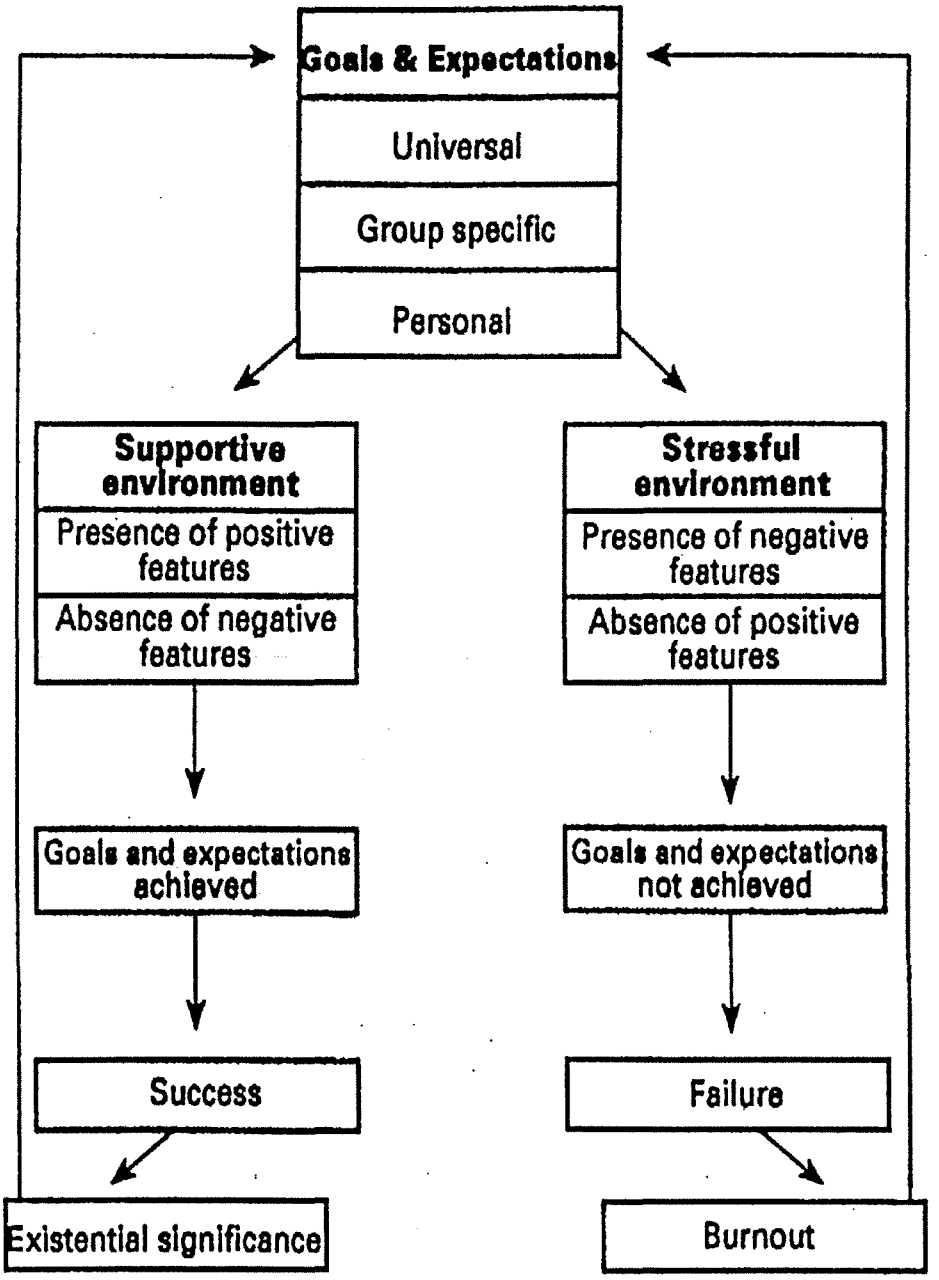

Figure 1. Pines (1993) Conceptual Model of burnout

It was expected that age, years of experience, spiritual well-being, and hardiness would contribute to lower burnout.

Demonstrating the role of spiritual well-being and hardiness as positive resources for protection against burnout in professional nurses is important. Nurses can be educated regarding the need to nurture those aspects of self which can serve as resources in professional work. Acknowledgement of the important role of existential significance can lead to development of ways to support spiritual well-being and hardiness in nurses' professional work. Students in nursing schools can also be prepared with information about burnout and ways to utilize the resources of spiritual well-being and hardiness. Prevention of burnout and promotion of well-being and meaning in work is vital for the education of and retention of those who want to commit to a professional nursing career. It may also be that the knowledge of the role of spiritual well-being and hardiness as positive resources against burnout can be used to reduce the exodus of nurses from the profession.

Chapter 2

Methods

This chapter provides information regarding the collection of data for this research. A description of the participants is followed by information on each of the research instruments. The demographic questionnaire, Personal Views Survey II, Spiritual Well-being Scale, and Maslach Burnout Inventory (Human Services Survey) are each described. The procedures section provides details about how the research was conducted. The chapter concludes with a description of the research design and data collection analysis.

Participants

Potential participants were identified in a random selection process by using the current mailing list of professional nurses registered and residing in Oregon. Ninety one (45.5%) of the 200 randomly selected participants returned questionnaires. Due to omitted data, retirement or unemployment, seventeen data sets were not included in the analysis. The final sample consisted of 70 females and 4 males with an average age of 45.4 years, 18.2 years of nursing experience and 9.2 years of experience in their current position. The majority (64.9%) were married, held a baccalaureate degree or greater (54.1%), worked in a hospital setting (54.1%) and practiced in adult or family nursing (54%). One half of the group spent 50% or more of their time in direct patient care. Most (62.1%) reported adequate or very adequate support received in the workplace. Likewise, the majority (78.4%) agreed or strongly agreed that their expectations were met in the workplace. (see Tables 1 and 2).

Instruments.

Instruments used in this study included The Maslach Burnout Inventory, a demographic questionnaire (designed by the author of this study), the Personal Views Survey II, and the Spiritual Well-Being Scale. Permission to use the instruments was obtained from the Consulting Psychologists Press, Inc., The Hardiness Institute, and Craig Ellison respectively. A description of each research instrument follows.

Maslach burnout inventory.

The Maslach Burnout Inventory (MBI) (subtitled: Human Services Survey) developed by Maslach, Jackson, and Leiter (1996) was used to determine degree of burnout of the participants. This inventory consists of 22 items which assess three components of burnout: emotional exhaustion (EE), depersonalization (DP), and personal accomplishment (PA). The emotional exhaustion sub-scale assesses feelings of being exhausted by one's work and emotionally overextended. An unfeeling and impersonal response toward care recipients is assessed by the depersonalization subscale. The personal accomplishment subscale measures feelings of competence and successful achievement in one's work. Internal consistency reliabilities (Cronbach alphas) are reported at .91 for emotional exhaustion, .79 for depersonalization and .71 for personal accomplishment. The highest reported level of criterion validity is .68. Test-retest reliability coefficients are .82 for emotional exhaustion, .60 for depersonalization and .80 for personal accomplishment.

Table 1

Demographic Characteristics of Subjects

Demographic Variables	N(74)	%
Civil Status		
single	12	16.2
widowed	2	2.7
partnered	3	4.1
married	48	64.9
divorced	9	12.2
Education		
diploma	10	13.5
associate degree	24	32.4
baccalaureate degree	30	40.6
masters degree	8	10.8
Doctorate	2	2.7
Practice setting		
hospital	40	54.1
extended care facility	6	8.1
ambulatory care facility	15	20.3
home health	4	5.4
school of Nursing	3	4.1
drug & alcohol treatment	1	1.4
public health	1	1.4
Other	4	5.4
Clinical Specialty		
family	10	13.5
adult	30	40.5
pediatric	4	5.4
women's health	7	2
psych/mental health	2	2.7
gerontology	8	10.8
midwifery	1	1.4
other	12	16.2

Table 2

Age, Experience and Time with Patients

	M	SD	Range
Age	45.38	10.74	24-74 yr
Years Experience	18.20	10.82	1-45 yr
Current position (in years)	9.16	6.71	1-24 yr
Time with patient(s)	53.38	33.16	0-100%

The Maslach Burnout Inventory is self-administered by marking choices to items with pen or pencil and takes approximately 20 minutes for completion. Inventories are hand-scored using a scoring key. Burnout is indicated by high scores of emotional exhaustion and depersonalization and low scores of personal accomplishment (Maslach, Jackson, & Leiter, 1996).

Demographic questionnaire.

The demographic questionnaire (Appendix A) was designed to assess those factors that have been shown to be associated with hardiness in nurses. Information such as age, marital status, education level, and nursing practice area was assessed. In addition, support in the work place (Duquette, et al., 1995), staff support group access and use (Lederberg, 1989), years of nursing work experience (Melchior, et al., 1997) and total years of nursing experience (Duquette, et al., 1995) were elicited on the form.

Personal views survey II.

The Personal Views Survey II was used to measure hardiness. It is composed of 50 items which use a rating scale of 0 (complete disagreement) to 4 (complete agreement). The survey measures the hardiness of one's beliefs about the interaction between self and world (Maddi, 1997). There are three subscales of the Personal Views Survey II: commitment, control and challenge. These subscales each yield a score which can be combined for a total hardiness score. Both adult and adolescent norms are available (Hardiness Institute, 1994).

The Personal Views Survey II was developed to avoid the measurement difficulties encountered in the earlier version of the measure. The 50 items now yield subscale scores that are internally consistent, moderately correlated with each other and substantially correlated with the total hardiness scale. The Personal Views Survey II also correlates at .93 with the original Personal Views Survey and at .71 when only non-redundant items are used (Maddi, 1997).

Internal consistency has been shown to be .70 to .75 for commitment, .61 to .84 for control, .60 to .71 for challenge, and .80 to .88 for total hardiness. Stability is reported at .68 for commitment, .73 for control, .71 for challenge, and .77 for total hardiness. The existence of the three components of hardiness has been confirmed by factor analysis (Maddi, 1997).

The Personal Views Survey II can be self-administered by marking response choices to items with a pen or pencil. Completion takes about 10 minutes. A computer scoring program is used to obtain subscale and total scores for analysis (Hardiness Institute, 1994).

Spiritual well-being scale.

The Spiritual Well-Being Scale was developed by Ellison (1983) to fill a gap of measurement for spiritual well-being without getting tangled in specific theological issues. It is based on the definition of spiritual well-being put forth by the National Interfaith Coalition on

Aging (1975): Spiritual well-being is the affirmation of life in a relationship with God, self, community, and environment that nurtures and celebrates wholeness (p. 1).

The Spiritual Well-Being Scale is composed of 20 items with a six-point Likert-type response that ranges from strongly agree to strongly disagree with no midpoint. Wording of the items is reversed in approximately half the items to provide control of response set difficulties.

The scale is comprised of two subscales: religious well-being and existential well-being. Each subscale is composed of 10 items. Scores are obtained for religious well-being, existential well-being and a total for spiritual well-being. Correlations between the subscales range from .32 to .62. The correlation between spiritual well-being and religious well-being is .90 and .59 between spiritual well-being and existential well-being (Bufford, Paloutzian, & Ellison, 1990).

Test-retest reliability has been reported to range from .73 to .85 in four samples. Internal consistency was greater than .84 in seven samples. These figures have been suggested as adequate reliability for the Spiritual Well-Being Scale (Bufford, et al., 1990).

The Spiritual Well-Being Scale has good face validity. Factor analysis has shown that the scale items load on two factors. The religious items load on the religious well-being factor. Several existential items loaded on the existential well-being factor with the remainder clustered together. Positive correlations of the Spiritual Well-Being Scale and other standard indicators of well-being such as purpose in life, good physical health and a positive self-concept have been shown (Bufford, et al., 1990).

The Spiritual Well-Being Scale is self-administered in five to ten minutes. Items are scored from 1 to 6. A total score is obtained by summing all item values and ranges from a minimum of 20 to a maximum of 120. Higher scores indicate higher levels of spiritual well-

being (Ellison & Smith, 1991). Norms have been published for several groups including nursing students (Bufford, et al., 1990).

Procedures

Following is a description of the procedures used in this research.

Human participant approval.

Approval for this study was obtained from the Human Subjects Research Committee of George Fox University in accordance with its policies and procedures.

Recruiting participants.

A random sample of 200 was selected from the state board of nursing mailing list of nurses registered and living in Oregon. The potential participants were sent a packet in which a cover letter (Appendix B) describing the research project and inviting participation was enclosed. The demographic questionnaire, Maslach Burnout Inventory, Personal Views Survey II, Spiritual Well-Being Scale, and a postage paid, preaddressed return envelope was included. A return postcard (Appendix C) was the final component of the packet.

The cover letter provided a description of the study and its purposes. Detailed instructions for completion of all forms were included. Assurance that participation was voluntary and instructions that names were not to be put on forms were given. Completion and the return of questionnaires indicated a willingness to participate in the study. The return, postage-paid post card which was mailed to the researcher separately from the other returned materials allowed the nurses to indicate participation in the study. This strategy reduced the number of reminders that were sent to potential participants and also assured anonymity for the respondents (Mangione, 1995).

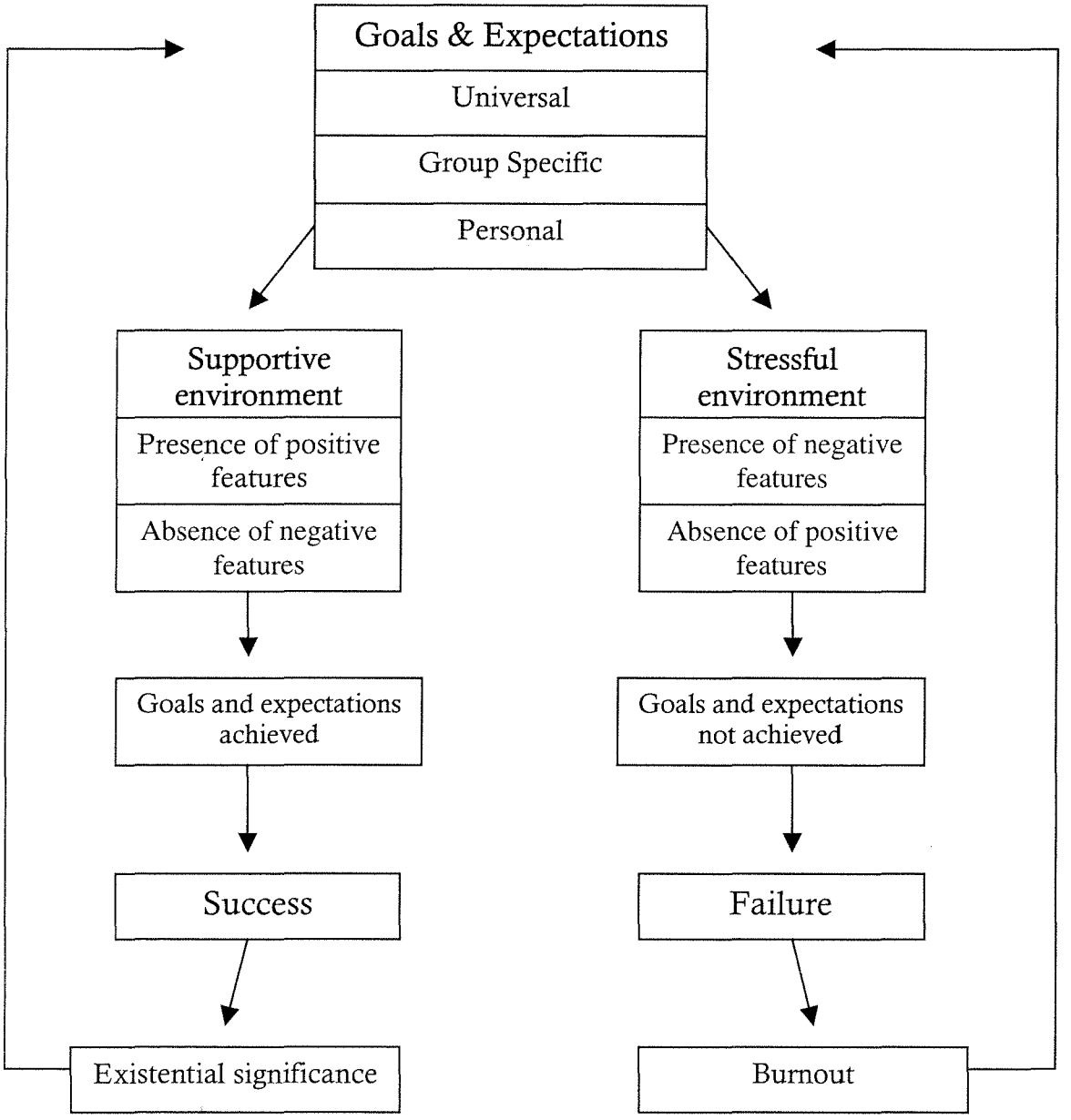

Figure 1. Pines (1993) Conceptual Model of burnout

Design

The purpose of this study was to survey a random sample of professional nurses to determine possible moderating effects of hardiness and spiritual well-being on burnout. Correlation of variables was conducted. A single stage model in which the dependent variable, burnout, was correlated with a set of intercorrelated variables including hardiness, spiritual well-being, and demographic variables was utilized (Pedhauzur & Schmelkin, 1991). Multiple regression analysis was used to determine which independent variables would predict level of burnout.

Data collection and analysis.

Data collection took place during May, 1999. Approximately two weeks after the initial mailing of the research packets to potential participants, reminder postcards (Appendix D) were sent to nonrespondents. A second wave of reminder postcards was sent to nonrespondents two weeks after the first reminders (Mangione, 1995).

Data were analyzed using the Statistical Package for the Social Sciences (SPSS). Calculations of scores for the Maslach Burnout Inventory, Personal Views Survey and the Spiritual Well-Being Scale were conducted using the manual guidelines for each instrument.

Demographic data were compiled to provide descriptive data of the participants. The demographic data were also used to conduct Pearson correlations of specific variables such as age, work experience, years in professional nursing, and burnout scores (Duquette, Kerouac, Sandhu, & Beaudet, 1994; Lederberg, 1989; & Melchior, et al., 1997). Pearson correlations were calculated for hardiness, spiritual well-being and burnout scores.

A correlation matrix of individual demographic variables, burnout scores, hardiness total and subscale scores, and spiritual well-being total and subscale scores was developed using

Pearson correlations. Variables having a significant correlation with burnout scores were entered into a hierarchical multiple regression equation. In particular, multiple regression analysis was used to determine the contribution of spiritual well-being and hardiness to the variance of burnout scores. Stepwise regression analysis was used to evaluate the contribution of additional variables to the variance of burnout scores.

Chapter 3

Results

Statistical analyses were conducted using the Statistical Package for the Social Sciences (SPSS). Results of the analyses are presented in this chapter. Demographic and descriptive data is presented first, followed by reports of hardiness, burnout, and spiritual well-being scores. Results of the hypotheses are reported and followed by a summary.

Demographic and Descriptive Data

Demographic and descriptive data were reported in chapter 2, Tables 1 and 2. The average age of the subjects was 45.4 years. Older age has been shown to be related to lower burnout (Beaver, et al., 1986; Bartz & Maloney, 1986). The average years of experience was 18.2 and average experience in the current position was 9.2 years. Researchers have shown that burnout scores are inversely related to years of experience (Beaver, et al., 1986; Robinson, et al., 1991; van Servellan & Leake, 1993). The majority of the nurses (54.1 %) had a baccalaureate degree or higher. More education has been associated with higher burnout scores (Bartz & Maloney, 1986). A majority of the participants (62.1%) also reported adequate or very adequate support in the workplace. Workplace support has been associated with lower burnout scores (Bram & Kutz, 1989; Molassiotis & Haberman, 1996; Oehler & Davidson, 1992; Ogus, 1990; Robinson, et al., 1991).

Scores for the hardiness total and subscales, burnout scales, and spiritual well-being scale including existential well-being and religious well-being are summarized in table 3. Scores are

reported only for the subscales and a total burnout score is not used. There is not yet enough known about the relationship of the these three aspects of burnout and so each scale is analyzed individually (Maslach, et al., 1996).

The mean hardiness total score was 100.55 (SD = 9.05) with a range of 75-120. This score is in the 40-60 percentile range and is considered average. Control scores ranged from 28-41 (M = 35.95, SD = 3.36). Scores for challenge averaged 28.05 (SD = 3.86) with a range of 20-37. Commitment averaged 36.55 (SD = 3.99) with a range of 24-45. The subscale scores differ by less than 10 points from each other as is expected. These subscales represent related expressions of hardiness (Hardiness Institute, 1994) (Table 3).

Average scores for burnout components were 19.31 for emotional exhaustion, 5.04 for depersonalization and 41.16 for personal accomplishment. These compare to norms for a combined nursing and medicine group (N = 1104) in which the mean for emotional exhaustion was 22.19, depersonalization was 7.12 and personal accomplishment was 36.53 (Maslach, et al., 1996). (Table 3).

Results of the spiritual well-being scale show a mean of 98.53 and a standard deviation of 18.31. The existential well- being subscale had a mean of 51.61 (SD = 14.8). The mean score for religious well being was 46.92 (SD = 6.69). Reported means for basic and graduate nursing students were 48.90 (SD = 7.20), 46.10 (SD = 10.69) and 95 (SD = 15.19) for religious well-being, existential well-being and spiritual well-being respectively (Bufford, et al., 1991). Norms for professional nurses were not available.

Older age was correlated with lower scores of emotional exhaustion ($r = -.29$, $p<.01$) and depersonalization ($r = -.27$, $p<.01$). More years of experience correlated with low emotional exhaustion scores ($r = -.21$, $p<.01$). Level of education was not correlated with burnout scores in

this study. Higher support in the workplace was associated with lower scores of emotional exhaustion (r = -.37, p<.01) and depersonalization (r = -.22, p<.01). Low scores of depersonalization (r = .26, p>.05) and high scores of personal accomplishment (PA) (r =.28, p<.05) were correlated with increased time spent with clients (Table 4).

Results of the Hypotheses

Hypothesis one.

The first hypothesis stated that higher levels of hardiness and spiritual well-being will be related to lower levels of burnout. Persons who have higher levels of hardiness and spiritual well-being will be better able to cope with the stressors of professional nursing and thus experience lower levels of burnout.

Pearson correlations demonstrated that each of the subscales of burnout, emotional exhaustion (r = -.51, p<.01), depersonalization (r = -.37, p<.01) and personal accomplishment (r = .36, p<.01) correlated with hardiness. Spiritual well-being negatively correlated with emotional exhaustion (r = -.195, p<.05) and depersonalization (r = -.24, p<.05) and positively with personal accomplishment (r = .30; p<.01). Existential well-being correlated negatively with emotional exhaustion (r = -.48, p<.01) and depersonalization (r =-.30, p<.01) and positively with personal accomplishment (r =.43, p<.01). No significant correlations were found between religious well-being and emotional exhaustion, depersonalization, or personal accomplishment (Table 5). Regression analysis was conducted using the burnout subscales as dependent variables. Results indicated that hardiness and spiritual well-being did not explain any of the variance in lower levels of burnout in the components of emotional exhaustion, depersonalization or personal accomplishment.

Table 3

Burnout, Hardiness & Spiritual Well-Being Scores

Variables	Range	M	SD	Norms
Burnout				
emotional exhaustion	3-48	19.31	9.69	22.19
depersonalization	0-24	5.04	4.99	7.12
personal accomplishment	20-48	41.16	5.50	36.53
Hardiness				
total	75-120	100.55	9.05	95-102
control	28-41	35.95	3.36	*NA
challenge	20-37	28.05	3.86	*NA
commitment	24-45	36.55	3.99	*NA
Spiritual Wellbeing				
total	53-120	98.53	18.31	95.00**
existential wellbeing	35-60	51.61	14.8	46.10**
religious wellbeing	10-60	46.92	6.69	48.90**

*NA = Not Available **basic and graduate nursing students

Table 4

Correlations of Subject Characteristics and Burnout

	Emotional Exhaustion	Depersonalization	Personal Accomplishment
Age	-.29**	-.27**	-.00
Years experience	-.21*	-.18	-.11
Current position	.14	.18	-.04
Year education	-.01	.04	-.02
Work support	-.37**	-.22*	.16
Time with client(s)	.01	.26*	.28*

*p<.05. ** p<.01. (one-tailed)

Hypothesis two.

The second hypothesis stated that there will be a positive relationship between existential well-being and hardiness. Persons with higher levels of existential well-being would also demonstrate higher levels of hardiness.

Existential well-being correlated significantly with hardiness total scores ($r = .47$, $p<.01$) and with the hardiness component of commitment ($r = .54$, $p<.01$). Additionally existential well-being correlated positively with the hardiness components of control ($r = .36$, $p<.01$) and challenge ($r = .23$, $p<.05$) and commitment ($r = .54$, $p<.01$). Spiritual well-being also correlated with hardiness total scores

($\underline{r}$ = .32, $\underline{p}$<.01); commitment ($\underline{r}$ = .35, $\underline{p}$<.01); and control ($\underline{r}$ = .30, $\underline{p}$<.01). Religious well-being correlated only with control ($\underline{r}$ = .21, $\underline{p}$<.05) (Table 6).

Hypothesis three.

The third hypothesis stated that age, years of experience, spiritual well-being, and hardiness (total) will contribute to low-burnout. It was anticipated that factors of age and years of nursing experience which have been shown to be related to burnout (Bartz & Maloney, 1986; Beaver, et al., 1986; Robinson,et al., 1991; van Servellan & Leake, 1993; Williams, 1989) would combine with spiritual well-being and hardiness to predict lower burnout.

A correlation matrix of descriptive variables, hardiness totals, components of hardiness, spiritual well-being and burnout is shown in Table 7. Regression analysis showed that age, years of experience, spiritual well-being and hardiness explained 33% of the variance in emotional exhaustion scores ($\underline{R}$(73)= .57; F= 8.33; $\underline{p}$<.000). The same factors explained 21% of the variance in depersonalization scores ($\underline{R}$(73)= .46; F= 4.589, $\underline{p}$<.002) and personal accomplishment scores ($\underline{R}$(73)= .46; F= 4.74, $\underline{p}$<.002).

Table 5

Correlations of Hardiness, Spiritual Well-Being & Burnout

	Emotional Exhaustion	Depersonalization	Personal Accomplishment
Hardiness (total)	-.51**	-.37**	.36**
Challenge	-.28**	-.19	.26*
Control	-.38**	-.20*	.17
Commitment	-.57**	-.48**	.43**
Spiritual Well-being	-.20*	-.24*	.30**
Religious Well-being	-.04	-.16	.18
Existential Well-being	-.48**	-.30**	.43**

*p <.05. **p<.01 (one-tailed)

Table 6

Correlations of Hardiness & Existential Well-being

	Existential Well-Being	Religious Well-Being	Spiritual Well-Being
Hardiness (total)	.47**	.18	.32**
Challenge	.23*	.05	.13
Control	.36**	.21*	.30**
Commitment	.54**	.19	.35**

*p<.05 **p<.01 (one-tailed)

Table 7

Correlations of Selected Factors to Burnout

	Emotional Exhaustion	Depersonalization	Personal Accomplishment
Age	-.29**	-.27**	-.001
Years of Experience	-.21*	-.18	-.11
Spiritual Well-Being	-.20*	-.24	.30**
Hardiness (total)	-.51**	-.37**	.36**
challenge	-.28**	-.19	.26*
control	-.38**	-.20	.17
commitment	-.57**	-.48**	.43**

*p<.05 **p<.01 (one-tailed)

Additional Regression Analyses

Additional step-wise regression analyses were conducted to determine which combination of independent variables might best predict low burnout. Commitment, support received in the workplace and age of the nurse explained 46% of the variance in emotional exhaustion scores (Table 8). Commitment, percentage of time spent with patients, and support received in the workplace explained 33% of the variance in depersonalization scores (Table 9). Finally, 27% of the variance in personal accomplishment was explained by commitment and percentage of time spent with patients (Table 10).

Summary

Each of the hypotheses was supported by the data analysis. Higher levels of hardiness and spiritual well-being were associated with lower levels of burnout. However, these factors did not explain the variance in lower burnout scores. Persons with higher levels of existential well-being did demonstrate higher levels of hardiness. Existential well-being correlated with each of the components of hardiness. Age, years of experience, spiritual well-being, and hardiness explained 33% of the variance in burnout scores. Additional analysis is demonstrated Table 8.

Table 8

Emotional Exhaustion: Stepwise Regression Analysis

Independent Variables	Beta	f	R 2	p
Step 1				
Committment	-.49	35.01	.33	.00
Step 2				
Workplace Support	.31	25.14	.42	.00
Step 3				
Age of nurse	-.21	19.70	.46	.00

Table 9

Depersonalization: Stepwise Regression Analysis

Independent Variables	Beta	f	R 2	p
Step 1				
Committment	-.43	21.20	.23	.00
Step 2				
Age of nurse	-.28	14.19	.29	.01
Step 3				
Workplace Support	.22	11.46	.33	.04

Table 10

Personal Accomplishment: Stepwise Regression Analysis

Independent Variables	Beta	f	R 2	p
Step 1				
Committment	-.43	16.37	.19	.00
Step 2				
Percent of Time with patients	.30	13.33	.27	.01

that commitment, age and workplace support explained 46% of the variance in emotional exhaustion scores. Commitment, time with patients, and workplace support explained 33% of the variance in depersonalization scores. Commitment and time spent with patients explained 27% of the variance in personal accomplishment scores. The final chapter will discuss the implications of these findings.

Chapter 4

Discussion

This study examined the possible moderating effects of hardiness and spiritual well-being on levels of burnout in a random sample of professional nurses. Interpretation and discussion of the results of the hypotheses testing, limitations of the study, and recommendations for continued research will be presented here.

Interpretation and Discussion of Results

The hypothesis that higher levels of hardiness and spiritual well-being will be related to lower levels of burnout was supported. Higher hardiness scores were related to lower emotional exhaustion, lower depersonalization and higher personal accomplishment. Although a cause and effect relationship may not be assumed, it may be possible that the coexistence of these variables in the indicated relationships may have an interaction effect. For example, it may be that hardiness provides a protection against emotional exhaustion much like an immune response protects against illness. On the other hand, low emotional exhaustion could allow for time and effort needed for developing greater hardiness. It has been suggested that hardiness may exert its effect on the perception of events (Sortet & Banks, 1996; van Servellen, et al., 1994). Personal differences in expected amount and kinds of work stressors and standards for personal accomplishment in one's work may contribute to differences in reported burnout. These explanations could account for differences in reports of emotional exhaustion, depersonalization and personal accomplishment. Similar explanations could be offered for the relationships of hardiness,

depersonalization and personal accomplishment. It may be that some other variable mediates the relationship between these variables.

The relationship of spiritual well-being to burnout affirms the importance of existential significance in one's work. Nurses frequently describe their work as a "calling." They want to make a difference, relieve suffering and save lives. Nurses need feedback that their work is making such a difference for people. Nurses' own spiritual belief systems must be nurtured as a developmental process. Issues related to meaning and purpose can be addressed in sessions with chaplains or with individuals' spiritual advisors. Supervisors and nurses must bring existential concerns out in the open and not treat this as a taboo subject.

The fit of nurses' expectations and ideals with that of the work environment should be considered in hiring and placement. Appropriate supervisor support has been shown to correlate with lower emotional exhaustion. Supervisors who involve staff nurses in problem solving and organize a work environment for efficiency may assist in support of personal accomplishment (Robinson, et al., 1991). Acknowledgement of the physical and psychological stresses of caring for people who are in less than optimal health must be made. Specific positive feedback from supervisors and among peers can affirm the contribution nurses make to people's welfare. Feedback regarding signs of emotional exhaustion can prompt nurses to take actions to care for themselves. Regular meetings with supervisors or in peer work support groups may assist with perceptions of the work environment, expectations and accomplishments. This can be especially important for beginning nurses.

The second hypothesis that a positive relationship would exist between existential well-being and hardiness was supported. Kobasa (1979) developed the concept of hardiness based on existential principles of authentic living, competence, productive orientation, and propriate striving. Likewise Ellison (1983) based the concept of spiritual well-being upon the core principle of existentialism, which

is striving for meaning and purpose. Commitment to purposes and the ability to derive meaning from stresses of life are key components in both theories. Such a common theoretical basis can explain the correlation of these variables. Personal growth and development in the area of existential well-being may provide resources that support development of hardiness. Explanations of meaning and purpose of life events can be derived from one's spiritual belief system and be extended to stressors and events in one's work. Both challenge and control represent beliefs that a person can influence events and that change is an opportunity for growth. This finding supports Pines (1993) model in which existential significance is a moderating factor of burnout (Figure 1).

Nurses can develop hardiness resources by addressing issues of existential well-being. Workshops, group sessions and individual counsel can assist nurses to examine and nurture their sense of life purpose and life satisfaction. The relationship of existential well-being to possible reduction and prevention of burnout can be acknowledged and supported through such workplace policies as education leave and personal days off that focus on existential activities. Activities that support nurses' commitment and attempts to derive meaning from their work must be genuine and involve nurses themselves. Sharing of goals and ideals by an agency and the nurses could support commitment to involvement with people in a work setting. Chaplains can also offer spiritual support through individual and group activities. Spiritual rituals such as services which focus on nurses and the significance of their work can be used.

Support was found for hypothesis three, which stated that age, years of experience, spiritual well-being, and hardiness would contribute to low burnout. Maturity of years provides the resource of time needed for developing the resources of spiritual well-being and hardiness. Experience provides opportunities to develop and test one's belief system within the context of life events. A perspective for viewing life events within a bigger picture of meaning and purpose is also stimulated by passage of time

and the ability to reflect on life experiences. Additionally, time and experience provides a person with opportunities to discover how to influence or control events, how change is an opportunity for growth and development, and that involvement with people and events actually sustains meaning and purpose (Kobasa,1979).

Mentoring by older, more experienced nurses of younger, less experienced nurses should be implemented for all nurses new to a work setting. The mentoring should include sharing ways to be efficient and accomplish nursing tasks and validating decision making. Practical ways to provide client education and emotional support in an environment of many stressors and possibly less staff and increased workload should be shared. Nurses must be open about the struggles related to work stressors. Having questions and doubts should not be viewed as a weakness in the process of being an excellent nurse. Although autonomy is highly valued in nursing, nurses do not need to be alone or isolated in the experience of being a nurse. Students must be taught to seek and give support so that this behavior is sustained in professional practice. Workload for nurses must be distributed with care. Time for peer interaction is important for not only accomplishing tasks but also for decreasing any sense of isolation. Regular staff meetings or discussion groups in which older nurses provide insights from experiences and their belief systems would assist younger nurses. Issues such as the differences in ideals and practice setting, balancing family and professional lives, and managing emotional situations must be addressed directly and openly. Nurses must be proactive and be supported in exercising control in their work.

The finding that commitment, age and workplace support explained variance in emotional exhaustion scores also supports Pines (1993) model of burnout. Existential significance can contribute to the commitment of involvement with people and events. Workplace support can contribute to a person's sense of contribution to the goals of the environment. Older age brings the experiences of change and the understanding of the degree of control one can exert on events. People learn how to

prioritize time and energy expenditures in meeting goals and expectations. They learn what events they can influence and what expectations are realistic and reasonable in their professional work.

Recognition of the contribution of older nurses should be made through appropriate monetary compensation. Remuneration for mentoring should be given. Additionally, positive letters from supervisors, peers, and clients should be added to nurse's personnel files.

Depersonalization was partially explained by commitment, time with clients, and workplace support. The nursing profession is characterized by high levels of commitment, of involvement with people in various states of health and in various settings (Keane, et al., 1985) Involvement with people is guided by the nursing ethic of caring and that all humans have dignity and worth. These are profession specific goals and expectations as indicated by Pines (1993) model. Time with patients would support the expectation of caring involvement with people. Positive workplace support could encourage caring involvement which acts on the belief of the personhood of each patient. Workload assignments need to include consideration of the necessity of involvement to sustain nurses' commitment.

Commitment and time with patients explained variance in personal accomplishment scores. Competence and achievement in nursing focuses on the goals and expectations of caring for patients. Assisting others to manage actual or perceived threats to health supports the sense of meaning and purpose that sustains nurses in their work. Workload assignments need to include consideration of necessity of involvement with people to sustain nurses' sense of personal accomplishment.

Limitations of The Research

The lack of respondents whose scores indicated high burnout resulted in a data base that was heavily weighted with low to average burnout subscale scores. The sample consisted of older, more experienced nurses who had probably learned how to be efficient, maintain involvement with patients, balance personal and professional lives, and influence events. They

may also have experienced burnout in a previous employment setting, left, and then found a setting that fit their expectations. One participant wrote a letter describing a prior work experience that had resulted in burnout. A new position and work setting resulted in a better fit of "philosophies" and satisfaction with work. Thus this sample may represent professional nurses who have developed successful strategies for coping with the potential of burnout.

Non-responders may have denied stress or felt nothing could help with stress. The request for completion of four questionnaires may have been perceived as requiring more thought, effort, or time by persons experiencing enough stress in their lives. Others may have found a particular questionnaire foreign, contrary, or offensive to their own thinking or beliefs. One person chose not to participate due to disagreement with the spirituality "definition".

The study's reliance on self-reported data must also be considered. Even though anonymity was assured, people may report conditions better that reality. The fact that this was a correlational study must be kept in mind. Cause and effect relationships cannot be assumed.

Recommendations

The study should be replicated but with changes to induce a greater participant response. Ideas include providing an incentive for responding and reducing the number of questionnaires. A non-responder study could be done to determine characteristics of this group. Such information could be useful in future mail surveys for this population and subject matter.

Studies of the kind and amount of workplace support that contributes to low burnout are needed. Colleagues and supervisors could use the information to create the positive environment that supports the goals and expectations of nurses in the workplace. Additionally the amount of time spent with patients that sustains existential well being and commitment should be examined.

Additional studies should address the relationship between spiritual well-being and hardiness. Questions such as how (or if) nurturing spiritual well being would increase hardiness should be examined. Likewise, experimental studies for specific approaches to support spiritual well being and/or hardiness in nurses should be researched for their impact on reduction of burnout.

Longitudinal and/or cross-sectional studies could examine the process of hardiness and spiritual well-being development in nurses. Actual or perceived threats to this development could be identified along with positive ways for managing these processes. Specific strategies related to development of hardiness and spiritual well being should be tested for their effect on burnout. The role of congruence of personal and professional ideals with work setting goals and purposes should be examined in nurses of various ages and years of experience. Mentoring processes could be studied for ways to appropriately support nurses.

Summary

This study examined the role of hardiness and spiritual well being as moderators of burnout in professional nurses. Pines (1993) model of burnout in which existential significance is presented as a root cause or prevention of burnout was used. A mail survey of 200 randomly selected professional nurses who were registered and living in Oregon was conducted. Demographic questionnaires, the Maslach Burnout Inventory (Human Services Survey Form), Personal Views Survey II, and the Spiritual Well-being Scale were used for data collection. Higher levels of hardiness and spiritual well-being correlated with lower levels of burnout. Existential well-being (a component of spiritual well-being) correlated positively with commitment, control and challenge (components of hardiness) and with hardiness. Spiritual

well-being, hardiness, age, and years of experience explained 33% of the variance in burnout scores.

Regression analysis showed additional factors that combined to explain component scores of burnout. Age, commitment and workplace support explained 46% of the variance in emotional exhaustion scores. Variance (33%) in depersonalization scores was explained by time spent with clients, commitment and workplace support. Commitment and time spent with clients explained 27% of the variance in personal accomplishment scores.

These findings suggest that existential significance in nurses' practice should be addressed and supported. Chaplains, spiritual advisors, supervisors and peers can be active participants in such a process. Hiring and placement of nurses should take into account their goals and ideals. Regular, positive feedback, especially from older to younger nurses should be encouraged. Workshops, peer support groups and individual counsel could be used to examine spiritual well-being and legitimize its role in reduction of burnout. Mentoring of younger less experienced nurses by older, more experienced nurses should be a given in all work environments. Workload assignments should be made and monitored so that involvement with people will sustain not drain a nurses' commitment and sense of personal accomplishment. The acknowledgement and nurturing of spiritual well-being and hardiness must begin with nursing students' education and socialization into the nursing profession.

The response to the mail survey produced a sample consisting of a majority of participants with low burnout scores. Future studies should consider ways to increase participant response such as providing incentives and reducing the amount of information requested. Kinds and amounts of workplace support as well as optimal amounts of client contract should be examined for the effects on burnout levels. Longitudinal or cross sectional studies could examine the developmental

processes of spiritual well-being and hardiness. Specific strategies for support of these processes could also be conducted. Mentoring could also be studied for specific, effective strategies that support spiritual well-being and hardiness as positive resources for prevention of burnout.

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Appendix A

Demographic Questionnaire

Background Information

Age:

Sex:____ Male ___ Female

Civil Status: ___ single ___ married
___ separated ___ divorced
___ widowed
___ partnered (living together, not married)

Level of education:

_ diploma
_ associate degree
_ baccalaureate degree
_ nursing
_ other
_ master degree
_ nursing
_ other
_ doctoral degree
_ nursing
_ other

Experience as an RN:_ years

Current employment setting (check one):

_ Hospital
_ Extended Care Facility
_ Ambulatory Care Clinic
_ School/Student Health Center
_ Home Health Setting
_ Correctional Facility
_ Occupational Health Setting
_ School of Nursing
_ Drug/Alcohol Treatment Facility
_ Community/Public Health Setting

Clinical Practice Area (check one):

_ Family
_ Adult
_ Pediatric
_ Womens Health
_ Psych/Mental Health
_ Gerontology
_ College Health
_ Midwifery
_ Other

Time employed in current employment setting ___ years

Indicate percentage of time spent in direct client care each week.
(circle please)

0 10 20 30 35 40 45 50 60 65 70 80 90 100

Indicate the amount of support you currently receive in the workplace. (circle please)

None Some Moderate Adequate Very Adequate

In my current work setting, my expectations are met.
(circle please)

strongly disagree disagree agree strongly agree

Appendix B

Participant Cover Letter

May 1, 1999

Dear Nurse:

Many professional nurses are concerned about the effects of stress on their professional and personal lives. They look for ways to not only manage stress, but to thrive in a challenging career. I am conducting a research study as part of the requirements for a doctoral degree in clinical psychology at George Fox University. The purpose of this study is to examine the relationship of personality hardiness and spiritual well-being to burnout in nurses. Such information could be used in teaching nursing students and assisting professional nurses about ways to reduce and prevent burnout. This study has been approved by the Human Subjects Research Committee of George Fox University.

Nurses who hold a registered nurse license and reside in Oregon were randomly selected from the state board of nursing mailing list. Enclosed are four questionnaires which will take about 30-45 minutes to complete. Your responses will be anonymous because no names or code numbers appear on any of the forms. Your participation is completely voluntary. However your contribution to this research is vital. The findings will have greater significance with greater numbers of nurses participating in the study.

The questionnaires can be returned in the enclosed postage paid envelope. A return postcard indicating you have returned the questionnaires should be mailed separately. This tells me you don't need any reminders while at the same time maintaining anonymity. Completing and returning the questionnaires indicates voluntary consent to participate in the study.

Thank you for your time and assistance that will contribute to the successful completion of this research. If you have any questions about this research, please contact me at 503-591-5837 or my dissertation chair, Clark Campbell, PhD, at 503-554-2753.

Sincerely,

Kathleen M. Sims, M.A.

Appendix C

Return Post Card

Name Label

I have returned my questionnaires and you do not need to send me any additional reminders.

Appendix D

Post Card Reminder

REMINDER:

You have received questionnaires for a study of nurses spiritual well-being, hardiness and burnout. Please complete and return these questionnaires in the postage paid, pre-addressed envelope. Thank you.

Kathleen M. Sims, M.A.

Appendix E

Raw Data Tables

Explanation of Raw Data

Column 1:	Participant number
Column 2:	Age
Column 3:	Gender
Column 4:	Civil Status
Column 5:	Education level
Column 6:	Years of nursing experience
Column 7:	Current employment setting
Column 8:	Clinical specialty
Column 9:	Years of experience in current position
Column 10:	Percentage of time spent with clients
Column 11:	Perceived amount of workplace support
Column 12:	Degree that expectations are met in workplace
Column 13:	Religious well-being
Column 14:	Existential well-being
Column 15:	Spiritual well-being
Column 16:	Challenge
Column 17:	Control
Column 18:	Commitment
Column 19:	Hardiness total score
Column 20:	Emotional exhaustion
Column 21:	Depersonalization
Column 22:	Personal accomplishment

SBJT	AGE	GN	ST	ED	EXPY	EMPCR	PRC	YRCR	%X	SUP	EXP	RWB	EWB	SWB	CHAL	CONT	COM	Hrdyt	EE	DP	PA
1	39	2	5	3	17	3	8	10	80	5	3	60	48	108	21	33	33	87	23	4	43
2	43	2	5	5	21	8	6	7	10	4	3	38	49	87	27	36	33	96	18	7	40
3	42	2	5	2	13	10	1	12	70	5	4	30	49	79	28	35	40	103	22	10	45
4	37	2	5	3	14	1	2	4	30	4	3	34	44	78	23	36	34	93	16	0	42
5	56	2	5	8	30	8	5	7	10	3	3	39	46	85	37	40	43	120	10	3	47
6	34	2	5	3	12	1	4	6	80	4	3	40	49	89	31	37	37	105	17	4	42
7	44	2	6	3	20	1	3	18	90	2	3	36	43	79	27	40	34	101	31	1	32
8	51	2	5	1	29	3	2	3	30	2	3	59	56	115	24	35	36	95	19	2	42
9	43	2	5	2	20	1	2	20	50	2	2	31	35	66	31	31	29	91	32	10	34
10	47	2	6	5	25	1	2	20	0	4	4	10	54	64	29	36	38	103	12	2	40
11	52	2	5	1	32	3	9	12	10	3	2	59	54	113	30	35	40	105	14	4	40
12	44	2	5	3	20	1	2	15	50	5	4	60	58	118	35	36	45	116	8	3	37
13	54	2	6	1	31	1	1	1	100	5	3	58	60	118	29	37	41	107	6	0	46
14	24	2	5	2	1	5	3	1	80	3	2	12	58	70	23	39	37	99	18	7	42
15	46	2	5	2	6	2	6	14	10	4	3	54	52	106	31	40	39	110	18	0	43
16	38	2	5	5	15	3	1	8	80	3	3	47	46	93	28	34	33	95	36	10	34
17	42	2	5	2	14	3	9	12	50	3	2	60	52	112	20	31	24	75	35	12	35
18	36	2	6	3	15	1	9	14	100	2	2	56	54	110	32	40	37	109	48	24	46
19	49	2	4	3	25	11	9	1	50	5	3	37	47	84	28	37	37	102	13	1	33
20	53	2	1	2	13	1	2	13	90	3	2	54	42	96	23	29	27	79	48	21	38
21	37	2	5	4	6	1	2	4	90	4	3	32	58	90	29	32	36	97	11	4	43
22	29	2	5	2	4	2	6	5	30	3	2	59	59	118	28	37	36	101	31	1	45
23	49	2	5	5	15	9	2	1	35	2	3	59	59	118	32	40	40	112	13	8	41
24	55	1	5	2	22	1	9	22	70	5	3	56	58	114	33	36	38	107	15	1	46
25	42	2	1	5	20	1	2	20	50	3	3	33	48	81	32	35	36	103	19	6	43
26	25	2	4	2	1	1	1	5	100	5	3	30	46	76	30	35	37	102	24	17	42
27	61	2	5	2	22	1	9	12	50	4	3	57	58	115	27	28	34	89	26	2	48
28	41	2	5	2	10	11	4	2	20	4	3	60	50	110	24	37	35	96	30	9	40
29	43	2	3	2	4	3	2	2	30	5	3	58	46	104	31	37	32	100	4	3	45
30	35	2	5	2	11	1	2	11	35	3	3	48	49	97	27	41	39	107	20	12	46
31	46	2	5	1	23	1	2	23	20	4	3	51	43	94	24	35	29	88	26	9	34
32	45	1	1	4	16	11	9	7	0	4	3	44	57	101	33	41	35	109	11	6	35
33	50	2	4	3	23	1	4	20	30	3	3	43	42	85	27	37	38	102	16	4	48
34	49	2	5	3	27	1	9	10	100	4	3	22	60	82	31	41	42	114	3	2	48
35	67	2	6	1	45	3	2	17	40	4	3	49	50	99	29	32	36	97	13	1	42
36	45	2	5	3	23	3	9	19	5	4	3	60	58	118	28	37	38	103	31	8	38
37	56	2	5	2	9	2	6	1	45	2	2	60	60	120	28	41	42	111	18	1	47
38	46	2	5	2	10	3	2	1	100	4	3	56	57	113	29	37	36	102	7	4	47
39	53	2	3	3	3	5	3	1	40	4	3	10	43	53	25	29	34	88	18	2	43
40	44	2	6	2	20	3	2	2	10	1	3	59	55	114	36	38	42	116	9	1	42
41	46	2	5	4	20	1	5	19	100	3	3	10	55	65	30	35	35	100	14	11	43
42	54	2	5	5	33	1	2	10	45	2	2	46	39	85	33	34	39	106	23	4	40
43	54	2	6	1	33	1	2	3	45	4	3	60	58	118	30	37	40	107	9	0	48
44	74	2	5	2	34	2	6	3	10	3	2	10	58	68	27	35	38	100	18	3	34
45	25	2	5	3	5	1	2	5	20	4	2	60	60	120	26	35	37	98	22	1	38
46	59	2	5	1	25	1	9	17	40	5	4	60	58	118	25	38	39	102	7	0	44
47	42	2	5	4	8	3	4	2	100	4	3	56	53	109	30	39	38	107	14	5	43
48	47	2	5	3	24	1	1	20	80	4	3	59	56	115	28	38	35	101	20	7	46
49	32	2	5	3	9	1	2	9	90	2	2	35	47	82	21	31	30	82	27	20	39
50	43	2	5	3	12	1	2	11	35	4	3	52	55	107	33	35	39	107	11	2	38
51	39	2	1	2	3	1	1	17	90	4	3	55	53	108	28	36	36	100	10	2	47
52	54	2	5	5	32	8	4	5	30	3	2	28	37	65	23	38	32	93	24	7	20
53	63	2	6	8	40	3	4	6	100	5	4	60	60	120	33	38	42	113	12	0	48
54	26	2	1	5	3	3	1	3	100	5	4	43	51	94	29	35	32	96	33	9	45
55	68	2	5	1	45	1	2	16	80	4	3	40	46	86	22	34	33	89	17	9	32
56	49	2	1	3	28	1	3	9	35	2	2	16	49	65	30	31	36	97	32	3	45
57	57	2	5	1	36	1	2	4	20	5	3	53	59	112	30	41	44	115	5	4	48
58	35	2	5	2	10	2	6	2	90	5	4	60	55	115	30	41	43	114	10	0	48
59	47	2	1	3	26	1	9	8	65	4	3	46	47	93	28	32	36	96	13	4	47
60	47	2	1	4	20	3	9	10	90	3	3	60	58	118	27	40	37	104	18	5	42
61	37	2	5	1	14	2	6	11	20	5	3	60	53	113	21	36	35	92	23	5	35
62	65	2	1	3	36	11	6	1	30	3	3	53	54	107	30	34	37	101	13	4	37
63	29	2	1	3	2	1	2	1	35	4	3	38	37	75	22	37	33	92	24	6	27
64	33	2	1	3	12	1	2	1	100	4	3	46	48	94	30	29	31	90	26	5	35
65	27	2	5	3	3	1	4	3	35	4	3	60	58	118	24	38	38	100	17	1	44
66	41	2	1	3	18	1	2	18	100	4	3	60	60	120	21	39	40	100	10	4	43
67	68	2	5	2	19	3	1	5	20	4	3	53	51	104	23	30	33	86	17	2	41
68	38	1	5	2	2	5	1	1	60	2	2	40	39	79	23	38	37	98	28	3	46
69	45	2	5	2	25	1	9	8	0	3	3	54	47	101	31	35	40	106	36	0	35
70	48	2	6	2	18	1	2	12	10	3	2	60	52	112	32	37	38	107	28	2	33
71	37	1	5	3	12	5	2	10	35	4	3	40	41	81	28	28	30	86	35	10	42
72	39	2	5	3	16	1	2	12	100	5	3	60	53	113	26	38	39	103	18	1	43
73	49	2	5	3	9	1	2	9	90	4	3	60	60	120	29	36	40	105	9	1	45
74	49	2	5	2	28	3	1	24	80	5	4	59	60	119	33	39	41	113	17	7	41

Appendix F

Glossary

Burnout: A syndrome common among human services professionals. It is caused by long-term involvement in emotionally demanding situations that fail to produce expected results. A state of physical, mental and emotional exhaustion gradually sets in and the existential significance of work is lost (Pines, 1988; 1993).

Challenge: One component of the hardiness personality characteristic. It is expressed as a belief that change is normal in life. Change is viewed as an opportunity for growth and development (Kobasa, et al., 1982; Maddi, 1997).

Commitment: A component of the hardiness personality characteristic. It is expressed as an active involvement with people and events sustained by a sense of meaning and purpose (Kobasa, et al., 1982; Maddi, 1997).

Control: A component of the hardiness personality characteristic. It is expressed as a tendency to feel that one can influence the outcome of events (Kobasa, et al., Maddi, 1997)

Depersonalization: Impersonal and unfeeling response towards recipients of care resulting in a negative attitude towards work (Maslach, et al., 1996).

Emotional Exhaustion: Feelings of being or overextended and exhausted by work with people; a feeling that one can no longer give of one's self to others (Maslach, et al., 1996).

Existential Well-being: The sense of relationship to the world about us; includes a sense of meaning and purpose; the horizontal dimension of spirituality (Bufford, et al., 1991).

Hardiness: A personality characteristic that serves as a positive resource when stressful life events are encountered. Conceptualized as a set of interconnected beliefs which encourages transformational coping and enrichment of life through development (Hardiness Institute, 1994; Maddi, 1997)

Personal Accomplishment: In a reduced state, refers to a decline in feelings of competence and achievement in work with people (Maslach, et al., 1996)

Religious Well-Being: The sense of being in relationship to God; the vertical dimension of spirituality (Bufford, et al., 1991)

Spiritual Well-Being: Dimension of the human spirit that is expressed as a need for transcendence. Affirmation of life in relationship to God, self and others that nurtures and celebrates wholeness (Ellison, 1983).

Appendix G

Curriculum Vita

Practicum

1992-93
William Temple
Portland, OR

Population: Adults, couples and families
Supervisor: Susan Bettis, Ph.D., Clinical Director
-time-limited therapy for individuals, couples and families
-psychological assessment (personality, cognitive/intellectual)
-participation in individual and group
supervision, case presentation, clinical training, seminars, staff meetings
-training in family therapy utilizing one-way mirror

Internship

1996-97
Chehlem Youth
& Family
Services
Newberg, OR

Predoctoral Internship in Clinical Psychology
Population: Children, adults and families
Supervisor: Dean Longfellow, Psy.D.
-Lead therapist for Intensive Family Services
-In home therapy for families with at risk children
-psychological assessment of individuals, children and families
-individual therapy for children in residential treatment center
-therapy for families of children in residential treatment
-individual therapy for agency employees
-co-lead parent education and support groups
-collaborate with local children's services department to plan and monitor
treatment for children and their families
-parenting presentations to local community (including cable television)
-participation in individual and group supervision
and staff meetings/trainings

RELATED EXPERIENCE

1984-90	Assistant Professor of Nursing, Linfield College,	Portland, Oregon
1991-present	Associate Professor of Nursing, Linfield College, -classroom teaching, practicum supervision for nursing of children and families -practicum supervision for mental health nursing -classroom teaching, practicum supervision for health promotion of families -member of department curriculum committee and - member of college faculty development committee	Portland, Oregon

PRESENTATIONS

Sims, K.M. & Banks, K. (1994). Religious Orientation Scale & Social Desirability. Presentation at the Christian Association for Psychological Studies Conference, San Diego, California

Sims, K.M. (1996). Working with Terminally Ill Children. Presentation at Statewide Update for Community based Health Care Providers, Portland, Oregon

Sims, K.M. & Ashdown, S. (1997) Parenting Issues (video presentation). Yamhill County Community Access Cable Channel and Chehalem Youth and Family Services, Newberg, Oregon

Sims, K.M. (1998). Broken Vows, Religion's Response to Domestic Violence. Moderator of discussion of video presentation, Linfield College, Portland, Oregon

DISSERTATION

Title: Hardiness and spiritual well-being as moderators of burnout in professional nurses
Chair: Clark Campbell, Ph.D.

ADDITIONAL PROFESSIONAL EDUCATION

New Rules on Reporting Abuse: Hilton, Eugene, Oregon, March, 1999
Presenter: Carol Cole, MPH, RN

Animal Cruelty & Human Violence: Linfield College, Portland, Oregon, June, 1998
Presenter: Randall Lockwood, Ph.D., Pamela Frasch, Josh Marquis, Chris Barton, Marian Tews, MSN, Mary Lee Nitschke, Ph.D.,

Issues in Intervention with Latino Adolescents, Children and Families: George Fox University, Newberg, Oregon, March 1997
Presenter: Joseph M. Cervantes, Ph.D.

Creating Inclusive Communities: Oregon State University Extension Service, McMinnville, Oregon, November 1996
Presenter: Ann Schauber, MS

When an Infant Dies: A Statewide Update for Community based Health Care Providers: AIDS Resources of Oregon, Portland, Oregon, October 1996
Presenter: Bill Cameron, Connie Guist, R.N., Gorjean Armen, R.N., & Cindy Bell, R.N.

Celebrate the Soul, Heal the Whole Person: Youth Services Consortium, Portland, Oregon, March 1996
Presenter: Siang0-Yang Tan, PhD, Edward R. Canada, PhD, Terry Tafoya, PhD, Rev. Cecil Williams, Rev. Dr. Carter Heyward.

Opposite Sexes or Neighboring Sexes, George Fox University, Newberg, Oregon, March 1995
Presenter: M.S. VenLeeuwer, Ph.D.

Providing Services to American Indian Clients, Pacific University and Indian Health Service, Forest Grove, Oregon, May 1995
Presenters: Terry Cross, MSN, Marsha Azur, MSN, Connie Hunt, PhD, Constance Umphred, PhD, Debbie Carter, MD, Diane Ramsey, MSW

When an Infant Dies: A Train the Trainer Conference (Invited participant) Maternal-Child Health Bureau, Albuquerque, New Mexico, July 1995
Presenters: Mary McClain, M.S., Mary Kay Stanck, MS, Dimel Timmel, LCWS, Beverly C. White, MS, Paul Rusinko

Faith Development: George Fox University, Newberg, Oregon, 1994
Presenter: James Fowler, Ph.D.

PROFESSIONAL AFFILIATIONS

American Psychological Association, Student Affiliate
Greater Portland Area-Association for Women in Psychology

REFERENCES

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