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Caregiver Characteristics, Situational Factors, Coping Style, and Personal Adjustment of Hospice Nurses

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by

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Caregiver characteristics, situational factors, coping style, and personal adjustment of hospice nurses

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Abstract

The questions addressed in this study were:

1. Are there any significant relationships between selected personal and professional characteristics of the hospice nurse and his/her ability to cope with work stress?

2. Which personal characteristics of the hospice nurse are the best predictors of adequate adjustment to his/her work?

The sample studied consisted of 79 registered nurse hospice care providers in the state of Oregon.

The survey instrumentation included: a personal data form; the Daily Hassles Scale (DHS), and the Ways of Coping Scale (WOC) by Lazarus and Folkman; the Staff

Burnout Scale for Health Professionals (SBS) by Jones; Olson's Family Adaptability and Cohesion Scale (FACES); a social support scale (SS) by LaRocco, House, and French; and Templer's Death Anxiety Scale (DAS).

Correlational analysis and analysis of variance relating all data to the SBS were used to address the first research question. Stepwise regression was used to answer the second question. Correlational analysis revealed that all of the subscales on the DHS correlated positively with SBS as well as clinical frustration due to lack of funding and SS coworker subscale and SS total scale. Age and WOC Positive Reappraisal subscale were negatively correlated with SBS.

Analysis of variance revealed specific job training, and a regular support group in the hospice program to be significant contributors to the reduction of burnout. Faith in Jesus Christ as the means of access to God's presence after death also contributed to lower burnout levels when compared with nurses who endorsed universalism or an access through good works orientation.

The combined DHS was found to be the best single predictor of staff burnout. The study supports the

notion that the nurse's work situation, home situation, personal beliefs and life philosophy may be more significantly related to burnout than actual clinical situations. It may not be the stressor as much as the personal context into which the stressor is injected which determines burnout.

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TABLE OF CONTENTS

List of Tables

List of Figures

CHAPTER 1

INTRODUCTION

Statement of the Problem

In recent years research has led to a change within the professional community in its understanding about the process of dying. This new understanding has led to changes in terminal or palliative care practices which place new and often heavy physical and emotional demands on those who provide that care. Registered nurses are often the direct terminal care providers in the hospice or hospital setting. Recently, the nature, source, and extent of the stress which accompanies the work of the hospice nurse has become a subject of research and professional discussion.

The practice of hospice care in the United States as an extension of the health care delivery system is in its infancy. Consequently empirical examination of those who deliver direct services in hospice settings is in a similar state. Much of the literature which

exist is anecdotal or seriously flawed. Therefore, attempts to aid the amelioration of the occupational stress experienced by hospice nurses have often been launched based on intuition or research performed on populations of service providers in similar but not necessarily the same work environments.

Purpose

The purpose of this study was to investigate the relationships between a number of personal and professional background characteristics of registered nurses involved in direct palliative care and their ability to cope with the stressors inherent in their work. The researcher was particularly interested in examining such variables as religious beliefs and practices, family size and structure, professional education, and professional experience.

This study utilized seven instruments. A 32-item personal data form was used to measure various demographic variables as well as aspects of religious belief. Templer's Death Anxiety Scale was used to measure the death anxiety of each subject (Templer, 1969). Lazarus and Folkman have developed two measures

which were utilized. The Ways of Coping Scale measured the style of coping behavior used by each respondent in response to a typical work-related stressful event (Folkman & Lazarus, 1988). The Daily Hassles Scale measured the frequency and intensity of stressful events in the life of the respondent at the time of the study (Lazarus & Folkman, 1989). Olson's Family Adaptability and Cohesion Scale was used to test the subject's perception of her/his family's adaptability and cohesion (Olson, Portner, & Lavee, 1985). A modified 15-item Social Support Scale allowed the respondent to estimate the degree of social support perceived as coming from various current relationships (LaRocco, House, & French, 1980). The dependent measure in this study was the Staff Burnout Scale for Health Professionals designed by Jones. It is a 30-item scale designed to measure the degree of burnout experienced by the respondent (Jones, 1980a, 1980b). A full list of variables measured can be found in Appendix A.

This investigation was carried out within a theoretical framework for personal adjustment to occupational stress which is closely related to Lazarus' cognitive-phenomenological model of coping.

Lazarus' model has been modified to tailor its application to the hospice setting. Following the lead of Campbell (1983) and Vachon (1987), this study utilized the modifications to Lazarus' model suggested by Vachon. The outcome of this study provides some insight into the personal and professional characteristics which describe the registered nurse who copes well with the specific stressors of the hospice care setting. It is hoped this study will have an impact on the quality of patient care rendered in the hospice setting due to more efficacious selection, training and support of personnel.

Research Questions

This study was designed to explore the following questions:

1. Are there any significant relationships between selected personal and professional characteristics (listed in Table 1) of the hospice nurse and his/her ability to cope with work stress?

2. Which personal characteristics of the hospice nurse are the best predictors of adequate adjustment to his/her work?

Table 1

Hospice Care Models (Gotay, 1983)

Model	Type	Description
Hospital-centered	Consultative team	Advises and supports regular primary caregivers in symptom control, and emotional and spiritual support.
	Terminal care	Areas where patients and families can receive "hospice-like" care and be prepared for home care.
	Separate unit	Hospice unit housed within an acute-care hospital.

(table continues)

Table 1 (continued)

Model	Type	Description
Freestanding		Focus on requisite care to patients and families; usually offer home care services and bereavement follow-up.
Home Care		Assist family members with terminal care of patient through use of visiting nurses.
	Hospital or freestanding	Home care originates in institutional setting and are supported by the institution.

(table continues)

Table 1 (continued)

Model	Type	Description
	Community based	Family physician is the main terminal care coordinator. Referral made to a number of community-based agencies serving varying supportive functions.
	Independently structured	An actual hospice agency which provides necessary services.
	Wholly volunteer	Exist entirely by volunteer efforts in the community.

(table continues)

Table 1 (continued)

Model	Type	Description
Day care		Provide services such psychotherapy and medical treatments without the need to go to the hospital. Services are not available 24 hours a day.

Rationale

This study is built on the work of Vachon (1987). Vachon conducted a phenomenological study with a multidisciplinary population of hospice personnel. Her study was very useful in the identification of potential variables related to the occupational stress experienced by hospice workers. Vachon also contributed an adequate adaptation of Lazarus'

cognitive-phenomenological theory of coping. However, her methodology suggests weaknesses in the areas of validity and reliability. Her study relied on convenience techniques for acquiring her subjects, raising legitimate questions about the generalizability of her conclusions. Further, the form of data collection used was personal and group interviews as well as collections of anecdotes from conference speakers. This method of data collection also raises obvious problems of validity and reliability. It is likely that data collected in this way is biased by the expectations of the interviewer and the other participants in the group setting. Anecdotes may tend to be vague symbols of some reality of the speaker.

This study attempted to verify and deepen the research done by Vachon. It concentrates on one professional group: registered nurses involved in direct palliative service provision. An attempt was made to comprehensively survey a geographical region, the state of Oregon. This study utilized instrumentation which is undergirded by significant research, allowing for a degree of accuracy in interpretation of the data obtained. It should be noted that this study did not attempt to either examine

the theoretical underpinnings of Vachon's study nor to measure all aspects addressed in her data.

The theoretical framework for this study was based on Lazarus' cognitive-phenomenological model of coping with stress. This model asserts that the person and the environment are continuously interacting with and affecting one another (Lazarus, 1966). The manner in which the person reacts adaptively to the environment is dependent upon her/his appraisal of the stressful event and the person's own ability or resources to deal with the situation. During the appraisal process the person ascertains the personal meaning of the event. The event is judged as either irrelevant, benign-positive, or stressful. The person then appraises his/her resources to respond to the event. This appraisal may depend upon the "degree of ambiguity in the situation, the degree of conflict in it, and the degree to which the person feels helpless" (Campbell, 1983, p. 7).

The person's appraisal contributes to the determination of the behavioral response to the event. Lazarus breaks the behavioral response to stressful events into two basic categories: problem-focused and emotion-focused. Problem-focused behavior is action

aimed directly at addressing or resolving the stressful event. Emotion-focused behavior is aimed at addressing the emotional response which is generated by the stressful event. It is common to find individuals utilizing behaviors from both categories in the process of working through any given situation. Coyne, Aldwin, and Lazarus (1981) further organize behavioral responses in the above categories into the following groups: problem-focused, wishful thinking, mixed, growth, minimizes threat, seeks emotional support, and blames self. Following behavioral attempts to resolve the stressful event, a cognitive reappraisal is made which supplies feedback as to the efficacy of the person's methods. This in turn may result in a modification of the individual's approach to the problem event.

Two sources of variability have not been discussed thus far. The first are individual predispositional factors which may contribute to the cognitive appraisal of the individual such as her/his personal characteristics and background experiences. The second is the net outcome of the ongoing coping process. This outcome may in some way be detrimental or stressful to the individual in itself, as in depression. The

outcome may also contribute positively to the adjustment of the individual by building increased confidence or increased knowledge as a future resource. The reader should refer to Figure 1 for a schematic representation of the model explained above. This study measured selected variables related to predispositional factors sources of stress, ways of coping, and the degree of adjustment to work stress.

Review of the Literature

Recent Developments in Terminal Care

The last 25 years have seen several significant developments in the comprehensive care of the terminally ill and their family members and friends. Much of this activity may be credited to the germinal work of Herman Feifel, the chief clinical psychologist at the Veterans Administration Mental Hygiene Clinic in Los Angeles in the late 1950s and early 1960s. He espoused the idea that until death could be changed from a societal taboo and faced as part of life, there could be no relevant psychology of death (Rizzo, 1978).

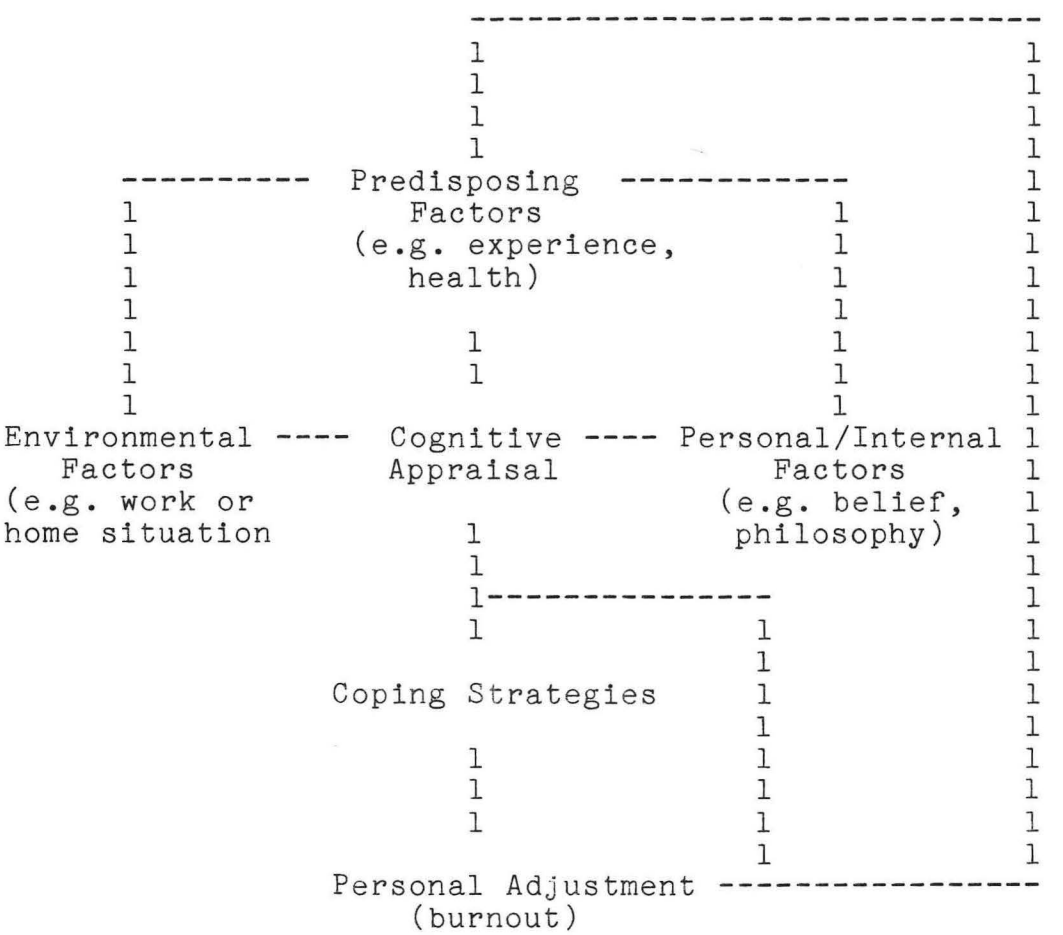

Figure 1. Conceptual model of the coping process.

Later, the work of Elisabeth Kubler-Ross (1969) served to raise the consciousness of the public and the medical community to the importance of doing proper grief work with those affected by terminal illness. She encouraged Western society to break through its denial of death and to deal with it as a natural part of life. Ceciley Saunders, a clinical pharmacologist and medical director of St. Christopher's Hospice in London, is often cited as another important person in the advancement of terminal care (Gotay, 1983; Rizzo, 1978). St. Christopher's is often referred to as a model hospice care program for many American hospice programs.

The National Hospice Organization (NHO) was established in the United States in 1978 to promote and maintain quality care for the terminally ill and their families. Its membership is presently comprised of over 1600 hospice care programs throughout the United States. Many states have their own chapter of the NHO. Hospice programs have increased from 2 in 1974 to more than 1600 in 1990. These statistics demonstrate the rapid growth of the hospice movement in the United States.

Hospice may be defined in several ways. According to the NHO definition (Rizzo, 1978):

> Hospice is a medically directed multidisciplinary program providing skilled care of an appropriate nature for terminally ill patients and their families. Hospice care helps patients and families to live as fully as possible until the time of death--helps relieve symptoms and provide support during the distress (physical, psychological, spiritual, social, economic) that may occur during the course of disease, dying, and bereavement. (p. 1902)

Further, hospice philosophy assumes that acute care policy, which is based on the philosophy of giving care designed to cure an illness, is not appropriate where cure is impossible (Kieth & Castles, 1979). The patient and the family is the unit of care to the extent that they choose and are able (Magno, 1981). The family is also seen as the principle care provider for the patient, and the will of the family is considered as the priority by the professional care providers (Bass, 1985). Hospice programs depend on the spirit of voluntary service and community cooperation

as well as dedicated and devoted leadership (Rizzo, 1978).

The emphasis placed upon returning death to a normal or natural position in the flow of life has given rise to new philosophies related to the types of facilities and specific care which should be made available to the dying and their survivors. Specifically, the hospice movement evolved to provide an alternative to the relatively sterile and impersonal hospital setting as a place to die and to engage in the process of mourning (Bass, 1985; Rizzo, 1978). According to Gotay (1983) there are four hospice care models: hospital-centered approaches, freestanding hospices, home care, and daycare programs. These models are summarized in Table 1.

Characteristics of Hospice Nurses

In 1981 the NHO observed that nurses are the most numerous paid professionals on hospice staffs and that they function in a multifaceted way across a broader span of program services and activities than do other identified groups. Nurses are involved in pain and symptom control, intermittent and continuous skilled nursing and personal care, nutrition, patient and

family assessment and conferences, bereavement support and spiritual counseling, in-service and community education, community relations, program management, and overall supervision. Nurses also provide physical, respiratory, speech, recreational, and occupational therapy, as well as financial counseling (Amenta, 1984). It can be assumed that the quality of care is dependent on the professional caregivers. Since the philosophy and practice of care administered to the terminally ill within a hospice is different from that administered to patients within a traditional acute care setting, it would seem worthwhile to be able to identify the personal characteristics of the caregiver best suited for hospice care practice.

Parallel in the literature to the above-mentioned developments has been the identification of serious stress problems among terminal care providers, and the creation of volumes on treatment strategies to ease these work-related difficulties (Chiriboga, Jenkins, & Bailey, 1983; Gray-Toft, 1980; Gray-Toft & Anderson, 1986; Hayslip & Walling, 1985; La Greca, 1985; Momeyer, 1985). Sources of stress for terminal care providers include: (a) conflict and feelings of alienation from other hospital staff due to perceived inequities in

policies designed to help hospice nurses individualize care; (b) lack of total acceptance of the hospice concept by hospital administrators and physicians; (c) increased work load, especially with difficult patients or families; (d) increased emotional demands on the nurses due to greater emotional involvement with patients and families and the resultant sense of loss upon the death of the patient; and (e) the sense of increased personal vulnerability to death, especially if the nurse has experienced the recent death of a significant other, due to exclusive professional contact with the terminally ill (Gray-Toft & Anderson, 1986). Chiriboga et al. (1983) suggest three additional sources of provider stress. They include: over-identification with patients, irrational feelings of responsibility for patient conditions, and feelings of helplessness about patient care.

Vachon (1987) conducted a survey of 600 hospice caregivers from a variety of professional backgrounds and specialty areas. The subjects were from teaching and community hospitals, hospice care facilities, chronic care hospitals, and volunteer agencies. The interviews were conducted in Canada (74%), the United States (18%), Europe and Australia. She utilized 327

group and individual interviews to accomplish her data collection. Vachon concluded that the majority of stress within the hospice setting originates from the work environment and occupational role rather than from interaction with clients and their families. She lists staff conflict, feelings of depression, grief and guilt, job/home interaction, and feelings of helplessness as manifestations of stress in the hospice worker. Vachon lists occupational stressors as: (a) communication problems with others in the system, (b) role ambiguity, (c) team communication problems, (d) communication problems with administration, (e) role conflict, (f) the nature of the system or institution, (g) inadequate resources, and (h) unrealistic expectations of the organization.

Vachon reported that the hospice workers listed patient/family coping and communication problems as low on the list of stressors. Interestingly, she found that the workers identified patient communication as a stressor when the patient was confused, had different religious convictions or values than the caregiver or came from a different social class. She also found it common for hospice workers to expect themselves to be able to overcome all communication problems with

patients and families. This ideal is not realistic and suggests a characteristic which may be common to hospice workers and may have influenced the data collected by Vachon.

The traditional acute care nurse is also called upon to treat terminal patients. Often in this setting the deaths are unexpected or immediate, not allowing for a relationship to build with the patient. Steffan and Bailey (1979) studied 1800 intensive care unit nurses and concluded that dealing with death and dying was a primary source of distress, especially if the nurse was allowed time to develop emotional ties with the patient. Nurses who deal infrequently with death are more likely to become discouraged and depressed when they come into contact with a dying patient and have less confidence in their ability to provide technical and psychological care which will meet the needs of the patient. Many nurses are particularly uncomfortable with caring for a dying child.

The consensus of studies reported by Martinson, Palta and Rude (1977) was that exposure to death and death education are important variables in shaping the attitudes and confidence of nurses toward terminal care. Simmons and Givens (1972) reported that nurses

who are uncomfortable with terminal care may respond to the dying patient with coping strategies which include decreased involvement with the patient. When contact is unavoidable, the nurse's attention tends to be concentrated on objects, tasks, or equipment rather than on the patient as a person.

In summary, the literature cited identifies many of the personal, social, and professional variables which could describe the nurse who provides hospice services. The literature also points out the possible impact of these variables upon the quality of care rendered to the dying patient and his/her family. Although quality of patient care is not a part of this study, the personal, professional, and social variables suggested by the literature are. The ability of nurses to make personal adjustments which allow them to continue to work effectively in hospice care is critical. The next section examines the dynamics of personal adjustment to the variables explored in this study.

Personal Adjustment

Definition of Personal Adjustment

Personal adjustment is defined in this study as the nurse's adaptation to stressful stimuli presented by his/her environment in a way which contributes or maintains the nurse's overall quality of life. This definition suggests three elements which impact the personal adjustment of the nurse: (a) stressful environmental stimuli; (b) some means of coping with those stimuli, including both personal resources and the nurses' style of coping; and (c) an outcome of that interaction which may improve, maintain, or decrease the nurse's quality of existence.

As cited earlier, there are a number of potential sources of stress within the work environment of the nurse. This study considered only the nurse's coping response to the direct care of her/his patients. Other potential origins of stress were studied as personal characteristics of the nurse but not as determinants of the nurse's style of coping. The description and breadth of coping strategies available to this group of nurses were examined. The degree of contribution of these coping strategies were measured in terms of nurse

burnout or the degree to which the subjects were free from physically, socially, and mentally debilitating symptoms. The overall quality of the nurse's life was measured in terms of the nurse's "burnout" on the levels of cognitive, affective, behavioral, and psychophysiological reactions. These variables were operationalized through the instruments used to measure them in this study: Lazarus' Ways of Coping Scale (Chiriboga et al., 1983; Coyne et al., 1981; Folkman & Lazarus, 1980) and the Staff Burnout Scale for Health Professionals (Jones, 1980a, 1980b). The study explored the relationships between the coping strategies mobilized in response to patient care and their contribution to the personal adjustment of the nurse subjects.

Coping Strategies and Personal Adjustment

Chiriboga et al. (1983) performed a pilot study in which they tested the applicability of Lazarus' Psychological Model of Stress (Lazarus, 1981; Lazarus & Launier, 1978) to the stress issues of a group of hospice nurses. This model includes such elements as: (a) conditioning factors, which include any social or biologically predisposing agent; (b) environmental and

internal demands; (c) stress appraisal; (d) coping strategies; (e) social resources; and (f) adaptive status. The study sample consisted of 100 nurses employed full- and part-time in 20 hospice organizations. The sample represented approximately 80% of the registered nurses of these organizations. Each of the above factors was measured through a written survey. The subjects were also administered a modified version of Lazarus' Ways of Coping Scale. This scale is described in more detail in Chapter 2. The variables were entered into a hierarchical multiple regression analysis utilizing an adaptive status measure as the dependent variable. The outcome of the study indicated that Lazarus' model holds promise as a viable model in the hospice setting. This study concluded that nurses who had the most favorable adaptive status were "those who employed a professional orientation as a coping style, expressed their emotional responses to job-related stresses, [and] resorted to more cognitive or rational coping strategies" (Chiriboga et al., 1983, p. 297). These nurses also had the support of their spouses and staff. Lazarus' view of coping includes behaviors which are directed at modifying the stressors, redefining the

situation, or reducing distress (Dean & Linn, 1977; Lazarus & Launier, 1978; Pearlin & Schooler, 1978). An important factor in the way a provider processes stress related to death and loss is the way in which he or she appraises the stress. The perception of the stress will be heavily weighted by the provider's belief system.

Death Anxiety and Personal Adjustment

The concept of death anxiety is rooted in a theory of Ernest Becker's (1973). Becker theorized that the struggle to deny death is universally human. He believed that humans have an innate fear of death which is the cause of all anxiety and anxiety-reducing behavior. The self-consciousness of humans allows them to foresee their death and then feel it necessary to deny it to avoid terror. Much of human activity is designed to deny and avoid facing mortality. The repression of death is socially institutionalized in many ways. Examples of the social institutionalization of the repression of death include: (a) funeral practices which attempt to make the corpse seem asleep, (b) the idealization of youth, and (c) the myth of immortality that motivates some to erect monuments to

themselves. Becker further wrote that humans can find personal freedom only by foregoing the safety of character defenses and the social order and facing the inevitability of death. Through "unrepression" the "vital lie" is destroyed, and the person is free to rise above despair and live fully.

Templer (1976), citing numerous studies conducted between 1969 and 1975, asserted that there are two factors which contribute to the presence of death anxiety in individuals. The first is one's general state of psychological health. The other is life experiences concerning death. Templer noted that particularly close relationships tend to influence the degree of death anxiety experienced by the individual. Children and parents seem to have very similar death anxiety levels. He also noted that one's general physical health does not correlate with death anxiety.

Inferring from Becker's theory, we can expect nurses to experience death anxiety. The theories of Lazarus and Templer suggest, however, that through the education and experience of nurses, they would come to accept the inevitability of death without being overwhelmed by anxiety. Those nurses who have not come to terms with death would be characterized by the

denial of death as a means of coping. Those nurses who have come to accept death as an end for themselves and their patients may well tolerate the anxiety and turn it to good use. Becker asserts that such people take life seriously, value it, and work to better the human condition. A general decline in a nurse's coping ability may be in response to high levels of death anxiety precipitating a "burnout" condition. Conversely, a decline in a nurse's coping ability might serve to elevate her/his death anxiety. Measurement of death anxiety was accomplished in this study through the use of the Templer Death Anxiety Scale (Templer, 1970).

Religiosity and Personal Adjustment

The role of religion in the adjustment of the individual to the death event was explored in this section. The present study surveyed the beliefs of the respondents in two major areas: their belief concerning the existence and nature of God, and their beliefs about the existence and nature of an afterlife. Along with other positions, the traditional biblical teaching of the Christian church is presented, as it constitutes the cultural heritage of many Americans.

This belief system has potential for transmitting both hope and anxiety in the life of the individual who faces death. Bayly (1977), reporting on a conversation with Kubler-Ross, stated that Dr. Kubler-Ross has observed that those who die most easily fall into two groups. The first is the agnostic or atheist who believe in inexistence after death. The second is the "real Christian who believes there is something after this life and has assurance that it will be his because of his relationship to God by faith" (p. 166). The people who die with the most difficulty are those who are "merely religious." The researcher understands "merely religious" to mean those who hold religion loosely or ambivalently, possibly practicing a form, without true faith or commitment. The present study examined the religious belief systems of hospice nurses both in terms of their basic theological world view and specific beliefs relating to the afterlife.

The biblical view of death differs in many ways from Becker's (1973) view. The Bible speaks of death

in three essential ways (Cook, 1987; Erickson, 1985).[1] It speaks of physical death as the separation of the physical body and the immaterial part of the person (Ecclesiastes 12:7; Luke 23:46). The Bible sees theafterlife as a conscious state of existence, though bodiless, preliminary to an eschatological resurrection when Christ returns to earth to begin a time of judgement at the end of history (Luke 16:9-13; Revelations 6:9-11). It refers to spiritual death as a separation from God due to sin (Ephesians 2:1,5,12). Spiritual death is understood as a condition of relationship between a person and God which occurs prior to physical death. The third type of death discussed in Scripture is eternal death which is the permanent state of separation from God of those who are spiritually dead and have also died physically (Revelations 20:13-15; 2 Thessalonians 1:8-9).

Physical death is the result of the self-sufficient nature of humanity which perceives relationship with and accountability to God, the

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[1] The New American Standard Bible (1960) is the source for all references to Scripture.

creator, as unnecessary (Genesis 2:17; Romans 5:12,21,26, 56). As God is the source of all life, those who choose to move away from that source move toward the absence of life or God and His grace. The Scripture is clear that the spiritual condition of the person at the time of physical death determines the eternal condition of that soul in the afterlife (Hebrews 9:27; Revelations 20:11-15).

The Bible makes clear that death holds much terror for those who die by their own choice outside the grace of God. Death is not inexistence but an eternity of separation from the life-giving grace of God and all of the blessing this may imply. However, for those who have chosen to appropriate the grace of God, the outlook is vastly different. Cook (1987) observes that the fear of death is removed because Jesus Christ has essentially defeated the power of the sin which brought it into being and has rendered its effect only temporary, promising an eventual resurrection which will result in the transformation of the corruptible into the incorruptible (Romans 8:2,23; I Corinthians 15:51-57; 2 Timothy 1:10; Hebrews 2:14-15).

Biblical Christianity sees God as both transcendent and very personal. Other theological

viewpoints, such as deism, would see God as involved in the creation of the universe but having left it behind to run on its own. Still others would see God as a pantheistic God. A pantheist rejects God's transcendence and sees God as radically immanent, so immanent that God becomes identified with the world. God becomes nature and as such is bound by the finiteness of physical law. Either of these positions result in a loss of freedom for the individual and an emphasis on determinism (Feinberg, 1984). One holding these views may tend toward fatalism. Fatalism may lead to a resignation about the inevitability of death which may be easier to cope with than ambivalence.

Many beliefs about the afterlife are held as well. On one extreme are those who believe that death brings total nonexistence. Those who espouse this belief see no credibility to the existence of a soul or functioning beyond the body. Others believe that one continues to exist as energy but not necessarily as any form of personal consciousness. This view seems practically the same as nonexistence in terms of its potential for comfort for the hospice provider.

"Reincarnation is the belief that an individual human soul passes through a succession of lives"

(Enroth, 1984, p. 926). The original doctrines of reincarnation were born in India and were closely related to the laws of karma. This is the idea that evil done in past lives relates to one's present life, while evil in the present life relates to events in future lives. This often led to the belief that life is an endless cycle of pain, suffering, evil, and rebirth. Early Hindu writers believed that one could be reborn as plants or animals as well as humans. This view leaves no room for divine forgiveness or mercy; salvation is earned by the individual.

Modern Western views of reincarnation have eliminated the possibility of being reborn as anything but human and have injected the concept of an ever improving cycle of "more and better lives" (Enroth, 1984, p. 926). For the modern Westerner the goals of reincarnation are to merge with God. Reincarnationists tend to believe in the ultimate divinity of humanity, and hold out the promise of wisdom. The notion of a sovereign, personal God is rejected. This view obviously holds some hope for the person coping with death. It holds no sense of judgement or accountability to a God but a continuation of a

familiar existence ever evolving in a beneficial direction.

Those who believe in the soul and a personal God may hold alternative views to that of biblical Christianity. Universalism is one such belief which holds that all people will be admitted to heaven, or God's presence, after death. This view is based on a view that God's love would not allow anyone to be punished for evil (Eller, 1984). Others hold that one's way into God's presence after death is through the performance of adequate good deeds while alive. This view may include membership in a particular religious group.

An important factor in the way a provider processes stress related to death and loss is the way in which he or she appraises stress. The perception of stress will be heavily weighted by the provider's belief system. The terminal care provider is less apt to experience death anxiety if he or she holds a belief in a benevolent God, or an afterlife, than if he or she believes in an uncertain afterlife experience or one fraught with judgement or punishment which seems arbitrary. Positive religious beliefs may not eradicate death anxiety. They may only repress it or

mediate it (Kuzendorf, 1985). Yet this mediation may increase the provider's adaptive status or personal adjustment.

The debate as to whether religious beliefs help or hinder the individual in personal adjustment has been raging for some time. It is the researcher's observation that hospice programs universally include a pastoral or religious/spiritual component. However, the quality and emphasis on this component may vary widely from program to program. As has been cited above, nurses are often seen as being in the position to participate in spiritual counseling. Campbell (1983), in studying the coping styles and resources of hemodialysis patients, recognized religious beliefs and practices as positive coping tools. Kuzendorf (1985) argues that religion may not reduce death anxiety but rather aids in repressing it. In spite of these limitations there is an absence of adequate empirical research in the area, and the literature has not adequately differentiated between repression and absence of death anxiety. On the basis of the clinical value given to the hospice setting, this variable has been included in the present study.

Spilka, Hood and Gorsuch (1985) have summarized the research on religion and death. They conclude that one's faith may have a strengthening effect on those coping with death. However, they caution that the effect of faith is related to the nature of the belief system of the individual. They assert that faith does not operate in a vacuum. Other variables effect one's view of death and the chosen form of religious involvement. Some of these variables include sex, age, ethnic group, socioeconomic status and education. Further, they concluded that "the cornerstone of support appears to come from beliefs in a benevolent afterlife which is the heart of most Western faiths and many others around the world" (p. 151).

Spilka et al. (1985) further state that there are three functions of religion in death anxiety. Religion provides meaning for death which may provide a degree of consolation for those grieving. Common belief and religious community provide both internal and social support during the grieving process. Religion also offers a sense of control to the individual facing mortality. A person's ability to perform specific rituals and hold prescribed beliefs brings a sense of security and enfranchisement in a benevolent afterlife.

An example of such practice may be prayer, which allows the individual to gain the attention of the One holding authority over matters of life and death. Kubler-Ross (1969) mentions prayer as part of the bargaining process during grieving.

Hauser and Feinberg (1976), in discussing stages of mourning, indicate that most people deal with death on a continuum which comprises the grieving process. Essentially, people can either deny the reality of their finitude, despair their finitude, or face the reality squarely within a positive belief system and utilize it as a catalyst for growth resulting in an amplification of their identity. This dynamic suggests an explanation for the obvious religious presence in the hospice movement. The beliefs represented are generally positive or optimistic in nature concerning the afterlife and the God who administers it. This trend in belief is an obvious asset to the adaptive utilization of Lazarus' model.

The present study utilized a series of items in the Personal Data Form to identify some of the religious beliefs of the respondents and to make an estimate of their religiosity. The concept "death anxiety" could be categorized either as a predisposing

characteristic in Lazarus' model or as a sign of positive adjustment to life stressors. The truth of this observation serves to verify the truly interactive process nature of coping and adjustment to life stress as described in his model.

Family Adaptability, Cohesion, and Personal Adjustment

The Circumplex Model of family behavior, as formulated by Olson, Russell, and Sprenkle (1979, 1980b, 1983), postulates that there are three basic dimensions to family behavior: cohesion, adaptability and communication. Family cohesion is defined as the degree of emotional bonding existent between family members (Olson et al., 1983). The Circumplex Model uses several subfactors to operationalize the cohesion of a family: emotional bonding, boundaries, coalitions, time, space, friends, decision-making, interests, and recreation (Olson et al., 1985). Family adaptability is defined as "the ability of a marital or family system to change its power structure, role relationships, and relationship rules in response to situational or developmental stress" (Olson et al., 1983, p. 5). Specific concepts used to operationalize

family adaptability include: family power (assertiveness, control, discipline); negotiation style; role relationships; and relationship rules (Olson et al., 1985). Communication was not directly measured in this study but is theoretically seen as the tool which facilitates movement in the other two dimensions.

The Circumplex Model allows for four levels of family cohesion: disengaged, separated, connected, and enmeshed. Family adaptability is also conceptualized with four levels: rigid, structured, flexible, and chaotic. It is assumed that a healthy family is one which is moderate in both adaptability and cohesion (Olson et al., 1980b; Olson, Sprenkle, & Russell, 1979). The moderate categories are separated and connected for cohesion, and structured and flexible for adaptability. This assumption is built on the premise that families which are extreme in their adaptability or cohesion will have more difficulty coping with situational and developmental stress. Olson et al. (1985) describe this relationship between adaptability, cohesion and coping as curvilinear. They cite several studies which seem to support these notions.

It is assumed by the writer that part of the basic learning of coping behavior takes place in the family environment. Therefore, it is reasonable to expect that families which are adaptive and cohesive produce individuals with similar propensities. It is also assumed that the nurse's present nuclear family is either an asset or liability in her/his own coping with existent stressors. This study attempted to discover whether there was a relationship between one's family function and her/his personal occupational adjustment. The Family Adaptation and Cohesion Scales (FACES III) was utilized to measure these dimensions (see Chapter 2 for a description of this measure).

Burnout and Personal Adjustment

In the present study, staff burnout is defined as a "syndrome of physical and emotional exhaustion involving the development of negative job attitudes, a poor work-related self-concept, and a loss of concern for clients, patients" (Jones, 1981a, p. 1). This definition is undergirded by the research of Maslach (1978) who linked emotional exhaustion with continual exposure to interpersonal relationships. Pines and Aronson (1981) reached similar conclusions emphasizing

the effect of constant or repeated intense contact with people for extended periods of time.

Jones (1981a) links the following symptoms to health professionals experiencing burnout: (a) increasingly negative attitudes or morale with one's work, (b) increased hostility or apathy directed at one's patients, (c) the tendency to project blame for work frustration and poor performance on the "system" or the patients, and (d) frequent feelings of physical and mental fatigue both on and off the job often resulting in withdrawal from others and job responsibilities. Jones (1981a, 1981b, 1981c) and Pines and Aronson (1981) also found burnout to be related to low morale, job turnover, increased absenteeism, increased staff illness, increased use of alcohol and prescription drugs, and increased interpersonal conflict.

The concept of exhaustion as it relates to stress response was introduced by Selye (1976) who linked adrenocortical activity to stress response. This construct has become known as the General Adaptation Syndrome (GAS). GAS essentially can be described physically as the mustering of physical resources to resist the threat of alarming stimuli. If the stimuli

continue to threaten over time, the ability to resist is depleted, leaving the organism in a state of physical exhaustion or unable to resist the effects of further threat. Selye believes that long-term exhaustion of this type may result in the diseases of adaptation such as: kidney disease, arthritis, and cardiovascular disease.

Selye's theory does not fully allow for the potential psychological activation of the alarm phase of GAS. The work of Frankenhaeuser (Gatchel & Baum, 1983) and Mason (1975) established definite linkages between psychological events and the activation of the GAS response. Lazarus followed by refining an explanation for the mechanism of psychological response to stress. Many of the behaviors listed above could be categorized within Lazarus' theory as ways of coping emitted by the nurse in response to perceived stress. The measure of burnout utilized in this study was the Staff Burnout Scale for Health Professionals (Jones, 1980b).

Summary

Registered nurse palliative care providers face a number of potential stressors including: (a) conflict and feelings of alienation from other hospital staff due to perceived inequities in policies designed to help hospice nurses individualize care; (b) lack of total acceptance of the hospice concept by hospital administrators and physicians; (c) increased work load especially with difficult patients or families; (d) increased emotional demands due to greater emotional involvement with patients and families and the resultant sense of loss upon the death of the patient; and (e) the sense of increased personal vulnerability to death, especially if he/she has experienced recent death of a significant other due to exclusive professional contact with the terminally ill (Gray-Toft & Anderson, 1986). Three further sources of provider stress include: over-identification with patients, irrational feelings of responsibility for patient conditions, and feelings of helplessness about patient care (Chiriboga et al., 1983).

These stressors and their effects are currently understood in terms of several frameworks. The central

theoretical model proposed is that of Lazarus and Folkman (1984) which attempts to explain the coping process in terms of a transactional/ phenomenological model. Other models include those of: Becker (1973) and Templer (1969) in the area of Death Anxiety; Olson, Russell, and Sprenkle (1979) and Olson et al. (1980b, 1983) in the area of family adaptability and cohesion; and the explanations of Jones (1980a, 1980b) in the area of staff burnout. This chapter included an examination of the biblical view of death and research concerning religious beliefs on the process of death and dying. A rationale was presented for the need for further study in this area in an effort to assist those working in the field to better select nurses who will be able to cope with the pressures of the role, to assist those who are already performing the role to do so more effectively, and to assist in the provision of quality care to those patients and families who are served by the palliative care nurse.

The present study is built upon the phenomenological work of Vachon (1987) and is considered exploratory in nature. It was designed to investigate the relationships between various personal and professional characteristics of hospice nurses and

their personal adaptation or adjustment to their role. One limitation of the study is that it was not longitudinal, which must temper the interpretation of the results since the study was framed within a conceptual schema which is essentially process oriented. Emphasis in this study was placed primarily in areas of religious belief and practice, personal experience, professional education, structure of family of origin, and personal working environment. These variables were measured in relationship to various coping styles and outcome measures as a means of determining the present degree of personal adjustment.

CHAPTER 2

METHODS

This chapter will outline the methods to be utilized during the course of this study. The selection of the group studied and the source of the sampling frame will be discussed. The study utilized seven instruments, each of which will be discussed including a description, administration and scoring procedures, reliability and validity information, and how it was specifically applied in this study. Finally, the procedures for data collection will be described.

Definition of Population and Sampling Procedures

The population was comprised of all registered nurses who work in direct service provision positions within hospice programs which are members of the Oregon

Hospice Association (OHA) during the months of September 1989 through February 1990.

Application was made to the Executive Committee of the Oregon Hospice Association. This application briefly explained the study and requested that OHA sponsor the study to enhance the return rate from sampled programs. The application also requested that OHA allow the researcher to utilize its membership roster as a sampling frame. This was accomplished, and the OHA mailed out an explanatory announcement of the study to all member programs and supplied a membership roster.

All member programs of the OHA were solicited to participate in the study. Cooperation from the administrator of each selected program was solicited by mail and telephone follow-up. Each program administrator was requested to distribute the study survey packet to each registered nurse on their staff and to encourage the subjects to participate in the study. All population members within each program were solicited to participate in the study. The total number of nurses in the population was determined by asking each administrator for the number of hospice

nurses presently involved in each program. This information was used to determine response rate.

OHA lists 48 member programs. Twelve of these programs are listed as providing no services at this time, and several others are labeled as currently being developed. The administrators of 31 of the 36 programs which met the basic criteria of providing direct hospice care consented to participate by receiving the protocol and distributing it to their nurses. Two additional administrators agreed to participate but did not comply with the time line for data gathering. Of the 212 protocols sent to nurses, 79 were returned. This yielded a return rate of 37.3%.

Instruments

Seven instruments were used in this study. Several of these instruments were used to measure background characteristics of the subjects. These include: (a) a personal data form developed by the researcher; (b) the Family Adaptability and Cohesion Scale developed by Olson; (c) a social support scale developed by LaRocco, House, and French; and (d) Templer's Death Anxiety Scale. Lazarus and Folkman's

Daily Hassles Scale was used to measure the existence and intensity of non-work stressors. Lazarus and Folkman's Ways of Coping Scale was used to categorize a typical pattern of coping behavior for the subject. Jones' Staff Burnout Scale for Health Professionals was used to measure the present level of burnout for each subject. The instruments are described in the order that they were arranged in the packet given to the subjects (see Appendix B for a copy of each instrument).

Personal Data Form

The Personal Data Form (PDF) was constructed utilizing the principles and format suggestions of Dillman (1978). This instrument was used to measure the designated variables outlined in Appendix A. These characteristics were chosen because they were often mentioned as relevant in the literature survey and upon the suggestion of Dr. Kirschling of Oregon Health Sciences University from her clinical experience (personal communication, November, 1989). Some of the items were adapted from a similar study by Garrison-Peace (1984). The characteristics included, in addition to basic sociodemographics, were: (a)

religious beliefs and practices, (b) belief in life after death, (c) degree of satisfaction with life, (d) degree of satisfaction with work, (e) work environment, (f) work role, (g) experience with professional losses, (h) professional nursing experience, (i) professional nursing education, (j) education in the area of death and dying, and (k) education in the care of dying patients. This form was reviewed by two nurse researchers for clarity, format, and perceived relevance of the data collected to the research population and their activities.

Daily Hassles Scale

Description

The Daily Hassles Scale (DHS) is a rationally derived scale comprised of 117 items. Each item is believed by the developers to be reasonably representative of a source of stress in daily life. The scale was refined through testing with several populations and is administered with a particular time frame in mind for the respondent. The nurses in the surveyed population were instructed to respond to the scale with the previous month in mind.

Scoring

The response format is a four-point Likert scale categorized: none or did not occur (0), somewhat severe (1), moderately severe (2), or extremely severe (3). Two scores can be derived from this scale: A frequency score, which is the number of hassles endorsed by the respondent without regard for severity, and a severity score, which is the average rating of all items that have been endorsed. It is also possible to individually score eight sub-factors which are listed with the Cronbach's alpha for each scale: (a) work (a = .83), (b) household responsibilities (a = .91), (c) health (a = .91), (d) inner concerns (a = .89), (e) financial responsibilities (a = .79), (f) neighborhood/ environmental (a =.89), (g) future security (a = .80), and (h) time pressures (a = .91) (Lazarus & Folkman, 1989). The factor analysis which yielded these sub-factors also suggested the existence of an underlying factor to which all of these sub-factors relate. The developers propose that the degree of relationship between factors reflects the pervasive effect of stress in the perception of daily events. They also assert that in spite of this finding, the ability to categorize subjects by areas of perceived

stress is valuable for research (Lazarus & Folkman, 1989). All of these scales were included in the analysis of data for this study.

Reliability

The authors contend that since hassles reflect states of changeable psychological stress, stability may be a more appropriate measure of the test's dependability than traditional measures of reliability. Stability was computed by utilizing the data from Kanner, Coyne, Schaefer, and Lazarus (1981). This study involved a repeated measures design with nine administrations of the scale, once monthly for 9 months. Stability was computed by correlating each of the successive pairs of measurements from this study and averaging the correlations. Hassles frequency scores were very stable (.79), though severity scores were found to be considerably less stable (.48). The developers suggest that the Hassles scores indicate both trait and state characteristics. Frequency scores more closely approximate trait, while severity scores are more indicative of state. This suggests that although the number of hassles in the respondent's life may not change radically, the way they are appraised is more changeable. Kanner, et al. (1981) also included a

trait measure in their study. It was found that there was a higher average correlation among the monthly measures of frequency (.79) than between the measures of frequency and the trait version of the scale (.38) (Lazarus & Folkman, 1989).

Validity

The Daily Hassles Scale is designed to measure subjective stress. This would imply a high degree of both face and content validity in measuring a respondent's stress state within a given time frame. Lazarus and Folkman (1989) state ". . . there is good reason to believe that a proximal measure of stress based on personal significance provides a better explanation and prediction of psychological stress and emotion, and their effects on adaptational outcomes than any other approach" (Lazarus & Folkman, 1989, p. 23).

Kanner et al. (1981) found a weak correlation between life events and daily hassles (.36), indicating that although there may be some relationship between life events and daily hassles, they more likely measure different domains. Daily hassles are largely thought to be independent of life events and arise out of the chronic demands of everyday living. This observation

is made under the assumption that the life event itself is not inherently stressful; rather it is the appraisal of that event which causes it to be perceived as a hassle (stressor) (Lazarus, 1984; Lazarus & Delongis, 1983).

Kanner et al. (1981) found that hassles scores were strongly related to both affective distress and psychological symptoms (e.g., .34 with Bradburn negative affect scores; between .50 and .60 with the Hopkins Symptom Checklist). DeLongis, Coyne, Dakof, Folkman, and Lazarus (1982) found correlations ranging between .30 and .40 between hassles and somatic health as measured by a somatic health measure developed by the Alameda County Human Population Laboratory. Multiple regression analysis using life events and daily hassles as independent variables and psychological symptoms and somatic health status as dependent variables found that daily hassles explained more variance than did life events. Further, it was established that all of the explanatory variance was attributable to daily hassles. Lazarus and Folkman (1989) suggest that daily hassles ". . . both mediate the effects of life events on adaptational outcomes and independently affect these outcomes" (p. 24).

Staff Burnout Scale for Health Professionals

Description and Scoring

The Staff Burnout Scale for Health Professionals (SBS-HP) (Jones, 1980a; Jones, 1980b) is a 30-item instrument. Twenty items measure the burnout syndrome as described by Maslach and Pines (Maslach, 1976; Maslach & Pines, 1977; Pines & Maslach, 1978). Ten items are designed to constitute a distortion scale to measure tendencies to "fake good" (p. 1). Each item is scored on a six-point Likert scale which is labeled from agree very much to disagree very much. The SBS-HP is designed to measure the burnout syndrome in health care professionals.

The SBS-HP assesses cognitive reactions which are characteristic of the burnout syndrome with such items as "I often think about finding a new job." It measures syndrome-related affective reactions with such items as "I frequently get angry at and irritated with my patients." The scale measures behavioral symptoms with such items as "I avoid patient interaction when I go to work." Finally, the scale measures the psychophysiological dimensions with items such as "I experience headaches while on the job."

The scale is scored to yield one total burnout score. However, Jones (1980c) found that the scale has four factors. These are: (a) a 7-item general dissatisfaction with work factor, (b) a 7-item psychological and interpersonal tension factor, (c) a 3-item physical illness and strain factor, and (d) a 3-item unprofessional patient relationships factor. The SBS-HP measures the current condition of the subject. The SBS-HP has a score range from 20, indicating no burnout, to 140, indicating severe burnout.

Reliability and Validity

Jones (1980c) has reported a Spearman-Brown split-half reliability coefficient of .93 for the SBS-HP. All of the scale items have been found to significantly correlate to the total SBS-HP score ($p \leq .001$). The average item-with-total burnout score correlation was .71 (range, r = .59 to .82).

Jones (1980c) found that patient-to-staff ratios were positively and reliably correlated with SBS-HP scores in a group of health professionals which included nurses, alcoholism counselors, and mental health technicians. Jones (1980e) found that nurses who held high trauma jobs, such as full-time emergency

room or critical care duty, had higher SBS-HP scores than nurses working full-time in low trauma jobs, such as pediatrics or medical-surgical duty. In the same study, Jones found that nurses who work night and rotating shifts also had higher SBS-HP scores than those who worked day shift. He conjectures that these shifts establish a higher degree of conflict with family activities and needs, thus contributing to the stress of the nurse.

Jones (1980c, 1980d, 1981b) found that higher SBS-HP scores significantly correlated with the following: (a) higher job turnover, (b) absenteeism, (c) tardiness rates, (d) increased use of alcohol, (e) prescription "calming" drug use rates, and (f) extended work breaks. He suggests that these behaviors are indicators of the employee's need to withdraw from the pressures of their work setting.

Jones (1980d, 1981a) found that nurses with higher burnout scores are more apt to make serious clinical errors and neglect job duties. He also found that high-scoring nurses are more likely to be dissatisfied with their work, clinical supervision, promotional opportunities, and their relationships with co-workers than nurses with lower scores. Jones (1980d) also

found that there was a significant positive correlation between SBS-HP scores and rates of personal illness among nurses. He cautions, however, that although there is some theorizing about the relationship between stress and illness, it should not be assumed that the relationship is causal. He cites a study by Kobasa (1979) which seems to suggest a formidable place for the mediation of personality factors in this relationship.

Finally, Jones (1981c) found a significant positive correlation between high scores on the SBS-HP and the theft of drugs and hospital supplies by nursing staff. He suggests that this may be an acting out of aggression against the workplace, but cautions that this needs to be experimentally established.

Family Adaptability and Cohesion Scales

Description

The Family Adaptability and Cohesion Scales (FACES III) are designed to test the subject's perception of her/his family's adaptability and cohesion. FACES III is a 20-item test which asks the respondent to assess her/his present or past family characteristics. Each item may be responded to with one of five possible

responses ranging from almost never to almost always. In the present study the respondents were asked to describe their present family situation; if they did not have one, they were asked to respond describing their family of origin.

Family styles of adaptation may range from rigid (low adaptability) to chaotic (high adaptability). Family cohesion may range from low cohesion (disengaged) to high cohesion (enmeshed). The developers have concluded that a healthy family is one which is moderate in both adaptability and cohesion (Olson, Russell, & Sprenkle, 1980a; Olson, Russell, & Sprenkle, 1979). (Please refer to Chapter 1 for a discussion of the concepts measured by this test.)

Scoring

The cohesion score is the sum of all the odd items. The adaptability score is the sum of the even items. These scores were compared to the adult norms found in Olson, Portner and Levee (1985). On the cohesion subscale, the categories are ordered: Disengaged (10-34), Separated (35-40), Connected (41-45), Enmeshed (46-50). On the adaptability subscale the categories are ordered: Rigid (10-19),

Structured (20-24), Flexible (25-28), Chaotic (29-50). This study utilized the subscale scores for analysis.

Reliability

Internal consistency, expressed using Cronbach's Alpha, has been reported as .77 for Cohesion, .62 for Adaptability, and .68 for the total scale. Test-retest measures over 4-5 weeks indicate relationships of .83 for Cohesion and .80 for adaptability.

Validity

Face and content validity are very good. The two subscales are orthogonal (r = .03). Adaptability correlates to social desirability at r = .00. Cohesion correlates to social desirability at r = .39. There is no test data to support concurrent validity in that there are no other tests to compare it to (Olson et al., 1985). However, the construct validity of FACES II (an earlier version of the scale) was supported by a number of studies which demonstrated the scale's ability to distinguish between high and low functioning families. These studies compared various clinical populations to nonclinical populations. The clinical populations successfully discriminated were: (a) schizophrenic and neurotic families who had received therapy from families with no prior therapy (Clarke,

1984), (b) alcoholic families from nonalcoholic families (Bonk, 1984; Olson et al., 1985; Olson & Killorin, 1985), (c) current families of sex offenders from current families of non-offenders (Carnes, 1985), and (d) single-parent families with adolescent juvenile offenders from single parent families with no adolescent juvenile offenders (Olson et al., 1985).

Olson et al., (1985) developed FACES III to improve the reliability, validity, and clinical utility of the FACES II scale. The major objectives were to shorten the instrument, to better support the Circumplex Model by developing two independent dimensions, to eliminate negative items, to simplify scoring and comparison to established norms, to develop items relevant to a number of family forms including couples without children, and to establish a number of norming groups. The developers have been able to establish that these objectives have been achieved in the 20-item FACES III. All current research on the FACES III scale seems to indicate that there is some validity to extrapolating the early construct validity work done on the FACES II to the FACES III.

Ways of Coping Scale

Description and Reliability

The Ways of Coping Scale (WOC) is a 66-item checklist describing a broad range of behavioral and cognitive coping strategies that an individual might use in a specific stressful situation. The items are answered using a 4-point Likert scale with the following response categories: does not apply or not used (0), used somewhat (1), used quite a bit (2), and used a great deal (3). A specific stressful situation is held in mind while answering. In this study the respondent was instructed on the form to think about the last several times they provided care for a terminal patient and his/her family and to answer with these situations in mind.

Coping processes are by definition variable, thereby rendering test-retest measures of reliability inappropriate. Folkman and Lazarus (1988) point out that reliabilities of measures of coping processes tend to fall at the low end of the acceptable range. This is due to the fact that in constructing coping measures an attempt is made to minimize redundancy within each category, which results in groups of relatively independent clusters of coping strategies.

Factor analysis of the WOC yielded eight factors which constitute the empirically-derived subscales of the instrument. The mean coefficient alpha was .70 for the subscales. The subscales, number of items, coefficient alphas, definitions, and examples are presented below (Folkman & Lazarus, 1988):

1. Subscale 1: Confrontive Coping (6 items, $\underline{a}$ = .70). Describes aggressive efforts to alter the situation and suggests some degree of hostility and risk-taking. This subscale includes items such as "Stood my ground and fought for what I wanted."

2. Subscale 2: Distancing (6 items, $\underline{a}$ = .61). Describes cognitive efforts to detach oneself and to minimize the significance of the situation. This subscale includes items such as "Made light of the whole situation; refused to get too serious about it."

3. Subscale 3: Self-Controlling (7 items, $\underline{a}$ = .70). Describes efforts to regulate one's feelings and actions. This subscale includes items such as "I tried to keep my feelings to myself."

4. Subscale 4: Seeking Social Support (6 items, $\underline{a}$ = .76). Describes efforts to seek informational support, tangible support, and emotional support. This

includes items such as "Talked to someone to find out more about the situation."

5. Subscale 5: Accepting Responsibility (4 items, $\underline{a}$ = .66). Acknowledges one's own role in the problem with a concomitant theme of trying to put things right. This includes items such as "Criticized or lectured myself."

6. Subscale 6: Escape-Avoidance (8 items, $\underline{a}$ = .72). Describes wishful thinking and behavioral efforts to escape or avoid the problem. Items on this subscale contrast with those on the Distancing subscale, which suggest detachment. This subscale includes items such as "Had fantasies or wishes about how things might turn out."

7. Subscale 7: Planful Problem Solving (6 items, $\underline{a}$ = .68). Describes deliberate problem-focused efforts to alter the situation, coupled with an analytic approach to solving the problem. This subscale includes items such as "I knew what had to be done, so I doubled my efforts to make things work."

8. Subscale 8: Positive Reappraisal (7 items, $\underline{a}$ = .79). Describes efforts to create positive meaning by focusing on personal growth. It also has a

religious dimension. This subscale includes items such as "Changed or grew as a person in a good way."

Scoring

Two types of scoring are used with the WOC. Raw scores are computed as the sum of the subject's responses to the items that comprise a given subscale. This method does not control for the differences in the number of items in each scale or for individual differences in response rates. According to Folkman and Lazarus (1988), relative scores are computed by:

> (a) calculating the average item score for the items on a given scale by dividing the sum of the ratings on the scale by the number of items on the scale, (b) calculating the sum of the average item scores across all eight scales, and dividing the average item score for a given scale by the sum of the average item scores across all eight scales. (p. 12)

The relative scores describe the proportion of effort represented by each type of coping. This project used the relative scores to categorize the nurse's coping style at the time of the data collection.

Validity

The scale has face validity in that it was originally derived from actual strategies reported by respondents. Construct validity is demonstrated in that the results of the developers' studies are consistent with their theory. The ways that people cope vary with the demands and constraints of the context and also in relation to changes in those demands and constraints as an encounter unfolds (Folkman & Lazarus, 1980, 1985, 1988).

Social Support Scale

Description, Reliability and Validity

The Social Support Scale (SS) is comprised of 20 items which deal with the degree of social support perceived by the respondent in four different groups of relationships: (a) immediate family and close relatives, (b) close friends, (c) people the respondent works with, and (d) his/her supervisor. The decision was made to eliminate the supervisor subscale for this administration to avoid unnecessary reactivity. The social support provided by each group of relationships is measured by five items each. Each of these 5-item

groupings comprise one of four subscales. Therefore, the scale as used will be only 15 items.

The SS was developed by LaRocco et al. (1980) at the University of Michigan Institute of Social Research. The subscales are not highly intercorrelated (r = .11, .34, and .39). They show little social desirability influence and have alpha coefficients ranging from .73 to .83. The relationship between social support and other variables of occupational stress was complex and not clearly established by the study for which this scale was developed. Another study utilizing this scale (Horowitz, Blackburn, Edington, & Kloss, 1988) established an inverse relationship between overall social support (r = -.30), supervisor support (r = -.28) and job stress. This scale, although not definitively tested, appears to have good face validity and therefore was used in this study.

Scoring

The response format is a 5-point Likert scale with the following categories: absolutely yes (1), a lot (2), some (3), just a little (4), and absolutely not (5). The present study altered the response categories on this scale to read: very often (1), often (2),

sometimes (3), not often (4), not at all (5). This was done in order to give the respondents a balanced field of response options, half positive and half negative. The scale is weighted so that the scores may range from 15 to 75 with lower scores indicating more support. The scale was analyzed as a total social support score (range: 15-75), as well as three subscale scores (range: 5-25) corresponding to the three relationship areas. Scores were determined simply by summing the individual item responses.

Death Anxiety Scale

Description and Scoring

The Death Anxiety Scale (DAS) is a 15-item, true-false questionnaire which measures conscious fear of death (Templer, 1969). The DAS is scored by assigning one point to each item answered in the direction of the keyed high anxiety direction. The range of possible scores is from 0 to 15. Means of more than 3600 normal adult and adolescent subjects in seven studies ranged from 4.5 to 7.0, with a standard deviation of approximately 3.0. The mean for a group of normal college students (186) was 6.8 (SD = 3.21) (Templer, 1969).

Validity and Reliability

The DAS has been found to be reliable and to have both construct and criterion validity. Test-retest reliability has been found to be .83. It has a low correlation (r = .03, n.s.) with the Marlowe-Crown Social Desirability Scale, and a low but significant correlation (r = .31, $p < .05$) with a galvanic skin response measure of response to death-related words. It has a positive but low correlation with Taylor's Manifest Anxiety Scale (r = .39, $p < .05$) and the Welch Anxiety Scale (r = .36, $p < .05$) (Templer, 1970). It correlates highly with other death fear scales; for example, Lester's FODD (r = .74).

Procedure for Data Collection

A survey packet was compiled for each subject in the sample. An example of the booklet sent to each subject can be found in Appendix B along with the cover letter and follow-up memo sent to each subject. Each packet was coded with a four-digit code number consisting of a group and subject number for accuracy in coding data for computer entry. A stamped business-

size envelope printed with the return address of the researcher was included in the packet.

The issues considered in selecting the order of the instruments in the packets were: (a) the degree of resistance expected to the items of the instrument, (b) the length of the instrument and its relationship to the fatigue of the subject, and (c) the importance of the instrument to the study. It was anticipated that many of the questions in this survey would generate resistance because of the personal nature of the inquiry. Therefore, an attempt was made to build an air of cooperation in the opening letter. Some of the instruments were lengthy and were presented in between shorter instruments to maintain momentum and to acquire the responses before the subject became fatigued. The first three instruments were vital to the study in that they contained the majority of the background questions, a control measure, and the dependent variable. The total number of items in this survey was 296, and it was estimated that one hour would be sufficient for most respondents to complete the form.

The cover letter and booklet were uniformly ordered and inserted into a 9 X 12 mailing envelope and

sealed. Groups of survey packets were then packaged in accordance with United States Post Office regulations and mailed to the individual hospice programs whose administrators had consented to participate. The surveys were mailed via first class mail to facilitate speedy delivery and response. The program administrators distributed the packets to participating nurses. The respondents returned the completed packets by mail in the envelope provided.

The program administrators declined to release the nurses' names for use in follow-up procedures. Therefore, follow-up consisted of mailing a copy of a reminder memo (see Appendix B) for each nurse to the administrator to be distributed in the same manner as the packets. This reminder memo followed about 10 days after the mailing of the packets. Each administrator was informed that replacement packets were available on request.

The study procedures were submitted to the Human Subjects Research Committee of the Department of Psychology at Western Conservative Baptist Seminary, the investigator's primary institution, for review and approval. It was determined that the research process would have a minimal impact on the sample and,

therefore, represented a minimal risk to their well-being.

Analysis of Data

Scoring and Coding

All instruments were scored by computer utilizing programs adapted to the scoring requirements of each instrument. All item responses were input into the computer to facilitate scoring and future analysis of the research data. All items were pre-coded, and the code was recorded in a code book to aid in the uniform input of data to the computer (see Appendix C). The computer data records were verified against the original instrument forms to assure that errors in coding and input were minimized (Bailey, 1982). All errors were corrected prior to proceeding with the analysis.

Plan of Analysis

This study was designed to explore the relationships of certain nurse characteristics with their ability to work without burnout. The level of measurement for each variable varied with the nature of

the variable. Therefore, a number of statistical techniques were utilized. Statistical analysis was performed by a microcomputer utilizing the Statistical Package for Social Science (SPSS) (Nie, 1975) as a reference for the selection of appropriate programs. The analysis took place in several steps:

1. Step 1. All of the categorical variables were tabulated and frequencies determined. The categories were then collapsed to provide adequately sized cells for further statistical analysis, 15 or more respondents per cell. Non-responses were coded as such and treated as other item response categories. Two or more non-responses warranted exclusion from the regression analysis described in later steps of the subject's responses to the incomplete scale or derived index. A single non-response was replaced by the mean score of the sample for that particular item for purposes of regression analysis only.

2. Step 2. Cronbach' alpha (Cronbach, 1970) was computed on all scales in the study. The minimum acceptable level of reliability was set at $\underline{a} = .60$.

3. Step 3. A series of one-way analyses of variance was performed on all nominal variables to determine group differences. The Burnout Scale for

Health Professionals was utilized as the dependent variable for all of these analyses. The alpha level was set at $p \leq .001$ to provide a rigorous test and reduce the potential for error due to the multiplicity of variables, sample size, and the nature of the instruments (Gravetter & Wallnau, 1985). Those variables which yielded a significant F statistic were to be examined by the Scheffe post-hoc test.

4. Step 4. Correlations (SPSS) were computed between all interval and ordinal data and the Burnout Scale for Health Professionals. The Pearson's Product Moment correlation was used for all correlational analyses to measure the degree of association between variables (Gravetter & Wallnau, 1985). Again, the significance level was set at $p \leq .001$ for the same reasons. Appendix D includes a complete listing of the variables and the corresponding statistical procedures used in executing steps 3 and 4.

5. Step 5. Any ordinal or interval variables which were found to have either low or insignificant linear correlations with the dependent variable were checked for curvilinearity by examining a scatter plot of the variable in relationship to the Staff Burnout Scale for Health Professionals. None of these

variables demonstrated this relationship, and were thus eliminated from further analysis.

6. Step 6. The intention at this point was to attempt to form several burnout risk indices. The clusters of variables identified as potentially making up these indices failed to pass the entrance criteria of statistical significance ($p \leq .001$). In many cases there were no significant variables; in some there would be a single significant variable. The proposed indices included the following variable clusters: (a) physical characteristics index (items 1, 3, 5), (b) family characteristics index (items 2, 6, 7), (c) socioeconomic characteristics index (items 4, 8), (d) professional environment characteristics index (items 9, 12, 13, 14, 15, 16, 17, 18, 19, 24), (e) professional education index (items 10, 11, 22a, 22b, 22c, 23), (f) religious belief index (items 25, 26, 27, 28, 29, 30, 31), and (g) death experience index (items 20, 21).

7. Step 7. All significant variables were cross-correlated. This step served to alert the researcher to those variables which may be strongly correlated with each other and therefore potentially lost in the stepwise regression procedure described in

step 8 (Draper & Smith, 1966). The researcher chose a representative variable from those which were strongly correlated on the basis of practicality of measurement. Only this chosen variable was entered into the regression analysis.

8. Step 8. All significant variables which met the inclusion criteria were entered into a stepwise regression analysis. The variables entered into the regression analysis were limited to a number equaling 1/10 the total number of subjects included in the sample (Agresti & Finlay, 1986). Exclusion of variables from the regression analysis was based on the following criteria: (a) all variables which did not demonstrate a statistically significant relationship with the dependent variable at the $p \leq .001$ level was excluded; (b) in the case of strong relationships between variables, selections were made which included only the variable which was easiest to measure--the others were excluded; and (c) exclusion of significant variables was based on the strength of relationship with the criterion variable. Those with stronger relationships were retained in the analysis. This procedure sorted the variables according to amounts of

variance accounted for by the variable from the most important variable to the least.

The stepwise regression analysis was used to examine how closely the data fits two models suggested by the literature. Model I was described by Vachon (1987), who has predicted that the most potent source of stress for the hospice nurse is not the daily clinical experience of the nurse but rather organizational/institutional issues. This prediction would assume some primacy for the professional environment index, the Daily Hassles job subscale, and the supervisor and worker subscales on the Social Support Scale. Model II was proposed by a number of researchers who inferred that the clinical/relational experiences of the nurse are the source of most stress for the palliative care provider (Chiriboga et al., 1983; Gray-Toft, & Anderson, 1986; Martinson et al., 1977; Simmons & Givens, 1972; Steffan & Bailey, 1979). This model would predict the death experience index and the religious belief index, and the family and friends Social Support subscales would emerge from the regression analysis with some primacy.

When stepwise regression is utilized, the issue of cross-validation must be addressed. The present study

did not include this portion of the analysis. The intent was to explore and isolate variables which deserve more rigorous research in pursuit of knowledge about the relationship between background characteristics and coping among hospice nurses. Therefore, it was felt that the degree of rigor implied by cross-validation was not appropriate. A list of the statistical techniques used to evaluate the significance of each variable in the study may be found in Appendix D.

CHAPTER 3

RESULTS

This chapter begins with a description of the sample. The frequencies of all categorical data and the resultant regroupings of these variables is reported. In addition, the reliability coefficients (Cronbach's Alpha) are reported for all scales and subscales. Statistically significant results of Analysis of Variance (ANOVA) are performed on these variables, and significant correlations are reported between all interval and ordinal data and the dependent variable (Staff Burnout Scale for Health Professionals). Finally, the results of the stepwise regression analysis on the remaining qualifying variables are reported.

Sample Demographics

The 79 respondents were predominately female (96.2%, $\underline{n}$ = 76) and Caucasian (97.5%, $\underline{n}$ = 77). The

mean age of the nurses was 45.2 years (range: 24-69). The majority of respondents were married (73.4%, n = 58) and lived either in a rural community (37.3%, n = 28) or a small city (39.2%, n = 31).

Most of the respondents (91.0%, n = 71) were parents. More than one-third of the sample (36.6%, n = 29) had children under 12 years of age living with them, and 29.1% (n = 23) had children between the ages of 13 and 19 years old living with them. In addition, 20.3% (n = 16) had children 20 years old or older living with them, and 7.6% (n = 6) had a child 26 years old or older living with them.

The family income of the sample was fairly evenly split with 20.3% (n = 16) having an income of less than $29,999, 26.6% (n = 21) having an income of $30,000 to $39,999, 25.3% (n = 20) having an income of $40,000 to $49,999, and 27.8% (n = 20) having an income of $50,000 or more. Just over half (55.1%) of the nurses earned $20,000 to $34,999 in compensation for their nursing practice, while 35.9% earned $19,999 or less and 9% earned greater than $35,000.

Basic education in nursing was reported as follows: diploma program, 29.1% (n = 23); an associate program, 36.7% (n = 29); or a baccalaureate program,

31.6% (n = 25). Only eight respondents (10.3%) reported having a master's degree as their highest degree. The mean number of years of nursing practice in the sample was 17.2 years with a range of 4 to 46 years (SD = 9.97). (Refer to Table 2 for more detail regarding the respondents' demographics.)

The majority of nurses in the sample were employed by a hospital or home health care agency (74.4%, n = 58). The remaining nurses work in freestanding hospice programs or another hybrid program configuration (25.6%, n = 20). Many of the hospice programs were either extensions of home health agencies or subcontracted nursing care from an existing home health agency. The mean percentage of terminally ill patients on the caseload of the participating hospice programs was 53.5% (SD = 43.2). Table 3 illustrates that 53.2% (n = 42) reported average terminal patient caseloads to be 25% or less while 45.6% (n = 37) reported their average caseload to be between 51% and 100% terminal.

The majority of the nurses are compensated for their hospice work (90.7%, n = 68). The mean hours worked by the nurses in a week were 19.0 hours (SD = 15.7). When asked which shift the respondents

Table 2

Frequencies of Demographic Variables (N = 79)

Variables	n	%
Marital status		
Married	58	73.4
Divorced	11	13.9
Widowed	4	5.1
Living together	3	3.8
Separated	2	2.5
Never married	1	1.3
Community		
Small city of less than 100,000	31	39.2
Rural/non-farm	23	29.1
Large city of more than 100,000	9	11.4
Suburban town near a city	7	8.9
Rural/lived on farm	5	6.3
Missing	4	--

(table continues)

Table 2 (continued)

Variables	n	%
Age of children residing at home		
Under 6 years	10	12.6
6-12 years	19	24.0
13-19 years	23	29.1
20-25 years	10	12.7
26-over years	6	7.6
Family income (in dollars)		
< 10,000	1	1.3
10,000-29,999	15	19.0
30,000-39,999	21	26.6
40,000-49,999	20	25.3
> 50,000	22	27.8

(table continues)

Table 2 (continued)

Variables	n	%
Nursing income (in dollars)		
< 5,000	2	2.6
5,000-9,999	9	1.5
10,000-19,999	17	21.8
20,000-34,999	43	55.1
35,000-49,999	7	9.0
Missing	1	--
Highest degree		
Diploma/nursing	18	23.1
Associate/nursing	19	24.4
Baccalaureate/nursing	25	32.1
Baccalaureate/non-nursing	5	6.4
Masters/nursing	2	2.6
Masters/non-nursing	6	7.7
Other	3	3.8
Missing	1	--

Table 3

Frequencies of Percentage Estimates of Terminal Caseload (N = 79)

Caseload % estimates	n	%	Cumulative %
less than 5	1	1.3	1.3
6 to 10	25	31.6	32.9
11 to 15	3	3.8	36.7
16 to 20	9	11.4	48.1
21 to 25	4	5.1	53.2
26 to 50	1	1.3	54.4
51 to 100	36	45.6	100.0

worked, 84.8% (n = 67) reported day shift while 12.7% (n = 10) reported that they had flexible hours. The nurse's position was most commonly described as staff nurse (64.6%, n = 51), followed by 17 supervisor/ coordinators (21.5%).

The sample mean experience in hospice work is 3.4 years and ranged from less than 1 year to 12 years. Twenty-one percent of the sample had worked in hospice

care less than a year; 35.9% had worked in a hospice less than 2 years. The respondents worked at their present program 2.8 years on the average. Twenty-three nurses (29.5%) worked at their present program for less than 1 year, 42.3% (n = 33) worked at their present program for less than 2 years, and 52.6% (n = 41) worked at their present program for less than 3 years. The range of present site experience scores was less than 1 year to 12 years.

For death experience the respondents reported that an average of three patients died as part of their caseload within the last month. The range of reported scores on this item was 0 to 10 (SD = 2.8). The mean number of patients who died with the hospice nurse present in the last month was .6 (range: 0-4, SD = .9). (Refer to Table 4 for a further summary of professional setting variables.)

The majority of nurses had been given specific training in "care of the dying patient" (83.5%, n = 66) and in "death and dying" (86.1%, n = 68). The form of this training included in-service programs (63.3%, n = 50), professional continuing education courses (54.4%, n = 43), college credit courses (22.8%,

Table 4

Frequencies of Professional Setting Variables (N = 79)

Variables	n	%
Program type		
Hospital/home health	40	51.3
Hospital/inpatient	1	1.3
Freestanding	14	17.9
Home Care	18	23.1
Other	5	6.4
Missing	1	--
Work position		
Staff Nurse	51	65.4
Supervisor	17	21.8
Educator	2	2.6
Administrator	1	1.3
Volunteer	7	9.0
Missing	1	--

n = 18), community education programs (19.0%, n = 15), and in some other way (7.6%, n = 6). When asked if they had received specific training for the job they now hold, 57.1% (n = 44) said no.

Only 39.5% stated that their present program offered regular support groups for hospice staff. The majority of the nurses surveyed (55.7%, n = 44) felt frustrated in their clinical work because of a lack of funding to pay for services.

The nurses were asked about their religious preferences. The majority were Protestant (67.1%, n = 53), followed by 12.7% (n = 10) Roman Catholic, 1.3% (n = 1) Jewish; 12.7% (n = 10) had other religious affiliations. Further analysis of the "other" category on this item revealed two nurses who listed "Christian," one Mennonite, one "nondenominational," two Buddhists, one Unitarian, one Native American, one "meditator," and one who believes in "sharing of spirituality/beliefs." Five nurses (6.3%) listed no preference. The respondents were asked to respond to "How important are your religious beliefs and practices?" on a 7-point Likert scale. One respondent on the scale indicated "no importance; have no religion" and seven indicated "Extremely important;

religious faith is the center of my life." The nurses' mean score was 5.2 (SD = 1.7).

The following are responses to a categorical question concerning beliefs about God. Sixty (75.9%) of the respondents indicated that they "do believe that there is a personal God who created our universe and is vitally involved in the details of its operation." Twelve (15.2%) of the respondents indicated that they "don't believe in a personal God, but [they] do believe in a higher power of some kind." Two (2.5%) of the respondents indicated that they "don't know whether there is a God and [they] don't believe there is any way to find out." Two (2.5%) of the respondents indicated that they "do believe that there is a personal God who created our universe but is no longer involved in the operation of it." (See Table 5 for a further summary of religious belief variables.)

Forty-eight nurses (60.8%) indicated they firmly believe there is life after death. Sixteen respondents (20.3%) reported a moderate belief in life after death. The remaining 14 nurses (17.7%) ranged from not sure to firmly believing there is not life after death. Only four nurses endorsed firmly believing there is not life after death (5.1%).

Table 5

Frequencies of Religious Belief Variables (N = 79)

Variables	n	%	Cumulative %
	Belief in God		
Agnostic	2	2.6	2.6
Higher Power	12	15.8	18.4
Deist	2	2.6	21.1
Immanent	60	78.9	100.0
Missing	3	--	
	Belief in afterlife		
No life	6	7.8	7.8
Essence	20	26.0	33.8
Reincarnation	4	5.1	39.0
Heaven/God	47	61.0	100.0
Missing	2	--	
	Afterlife conditions (n = 45)		
Universalist	12	26.7	26.7
Works	5	11.1	37.8
Faith	28	62.2	100.0

Continuing to explore the sample's belief about the afterlife, 59.5% (n = 47) believe that the soul ofthe deceased passes into a spiritual realm which is overseen by a personal God, 25.3% (n = 20) believe that after death the essence of the deceased rejoins that of the universal essence, 7.6% (n =6) do not believe in a life after death, and 5.1% (n = 4) believe that the soul of the deceased is reincarnated at a later time.

Among those nurses who endorsed the belief that the soul of the deceased passes into a spiritual realm which is overseen by a personal God, 62.2% (n = 28) believed that God accepts into the divine presence only those deceased who have faith in Jesus Christ, 26.7% (n = 12) believed that because God loves everyone all of the deceased are accepted into the divine presence, and 11.1% (n = 5) believed that if people perform sufficient good works they will be accepted into God's presence at death. Finally, the respondents were asked to respond to a 5-point Likert scale which asked "to what extent do you believe there is the possibility of a negative life after death (i.e. separation from God; hell, purgatory)?" The item was scored with 1, indicating Firmly believe there is, and 5, indicating

Firmly believe there is not. The mean response of the nurses was 2.5 (SD = 1.5).

Scale Reliability

Cronbach's alpha reliability coefficients were obtained for all of the scales used in this study. All of the scales were found to be reliable at or above a = .60 except two, the Confrontive Coping subscale of the Ways of Coping Scale (a = .57) and the Future Security subscale of the Daily Hassles Scale (a = .52). These scales were dropped from further analysis. The remaining scales and their alpha coefficients are summarized in Table 6.

Mean Scale Scores

The sample means for the Daily Hassles Scales (DHS) were 36.1 for Total Frequency and 1.34 for Total Severity. Table 7 summarizes the mean frequency and severity scores for the DHS subscales as well as other scale descriptors.

The sample mean for the Staff Burnout Scale for Health Professionals (SBS) was 41.39 (SD = 14.99,

Table 6

Cronbach's Alpha Reliability Coefficient for All Scales

Scale	Alpha
Daily Hassles	
Whole scale	.96
Future Security	.52
Time Pressure	.89
Work	.67
Household	.84
Health	.60
Inner Concerns	.83
Financial Concerns	.80
Environmental	.61
Ways of Coping	
Whole scale	.92
Confrontive Coping	.57
Distancing	.64
Self-controlling	.69
Seeking Social Support	.74

(table continues)

Table 6 (continued)

Scale	Alpha
Ways of Coping (continued)	
Accepting Responsibility	.71
Escape/Avoidance	.71
Planful Problem Solving	.75
Positive Reappraisal	.78
Burnout	
Scale	.83
Lie	.66
Death Anxiety	.61
Social Support	
Whole Scale	.90
Family	.90
Friends	.87
Fellow Workers	.90
FACES III	
Cohesion	.91
Adaptability	.77

Table 7

Descriptive Statistics for the Daily Hassles Scales

Variable	M	SD	Minimum	Maximum	N
Whole scale					
Frequency	36.10	20.20	0	88.0	79
Severity	1.34	.31	1	2.3	79
Time pressure					
Frequency	5.25	2.75	0	9.0	79
Severity	.87	.63	0	2.7	79
Work					
Frequency	1.33	1.49	0	6.0	79
Severity	.36	.45	0	2.2	79
Household					
Frequency	5.66	3.01	0	11.0	79
Severity	.70	.48	0	2.5	79
Health					
Frequency	3.54	2.14	0	8.0	79
Severity	.48	.30	0	1.1	79

(table continues)

Table 7 (continued)

Variable	M	SD	Minimum	Maximum	N
Inner concerns					
Frequency	3.04	2.39	0	9.0	79
Severity	.47	.47	0	2.1	79
Financial concerns					
Frequency	2.49	1.91	0	7.0	79
Severity	.50	.51	0	3.0	79
Environmental					
Frequency	2.32	1.91	0	7.0	79
Severity	.40	.35	0	1.3	79

Note. Frequency scores are not standardized. Severity scores are standardized.

range: 19-86). The SBS Lie Scale mean was 3.03 (SD = 2.04, range: 0-8). The respondents' mean scores for the Family Cohesion Scale and the Family Adaptability Scale of FACES III were 37.7 (SD = 7.25) and 27.9 (SD = 5.74), respectively. The Templar Death

Anxiety Scale mean for the sample was 6.4 (SD = 2.48). The Social Support Scale is summarized in Table 8. The subscale means ranged from 8.96 to 11.62.

The Ways of Coping Scale has eight subscales. Results for the subscales are summarized in Table 9. The subscale means ranged from .06 to .23. The Confrontive Coping subscale was found to be unreliable for this sample (Cronbach's alpha = .57) and therefore is not reported.

Table 8

Descriptive Statistics for Social Support Scales

Variable	M	SD	Minimum	Maximum	N
Whole Scale	30.96	7.88	15	54	79
Family	8.96	3.62	5	21	79
Friends	10.44	3.04	5	18	79
Fellow Workers	11.62	3.46	5	21	79

Table 9

Descriptive Statistics for the Ways of Coping Scales

Variable	M[a]	SD	Minimum	Maximum	N
Distancing	.07	.05	0	.22	79
Self-controlling	.08	.07	0	.46	79
Seeking social support	.19	.07	0	.39	79
Accepting responsibility	.22	.08	.030	.41	79
Escape avoidance	.06	.07	0	.45	79
Planful problem solving	.23	.09	0	.56	79
Positive reappraisal	.16	.08	0	.43	79

[a]Means may be interpreted as representing a percentage of utilization of a specific coping style as compared to the others.

Research Question 1

Analysis of Variance

Analysis of Variance and correlational analysis was utilized in this study to address the first research question: Are there any significant relationships between selected personal and professional characteristics (listed in Appendix A) of the hospice nurse and his/her ability to cope with work stress?

The frequency distributions for the categorical items in the Personal Data Form (PDF) were examined to determine how many groups were capable of meeting the numerical criteria for ANOVA of 15 or more cases in each cell. When necessary and possible, item categories were collapsed to produce cells large enough for analysis. Sex, ethnicity, parenting, compensation, and work shift did not demonstrate sufficient variance to warrant analysis. All other variables were analyzed. Three professional characteristics produced statistically significant results: (a) specific training for hospice care, (b) availability of a support group, and (c) religious beliefs about the afterlife.

Training

Using the Burnout Scale as the dependent variable and the two response groups (Group 1: "Yes," 33 cases; Group 2: "No," 44 cases) from PDF item 23, "Did you receive specific training for the job you now hold?" as the independent variable, a significant relationship was found between the lack of specific training for a position in a hospice and burnout as measured by the Staff Burnout Scale for Health Professionals (SBS): $F(1,74) = 9.22$, $p = .003$. The criterion mean for Group 1 was 35.6 ($SD = 11.6$, range: 19-62), and for Group 2 it was 45.8 ($SD = 16.2$, range: 21-86).

Support Group

PDF item 24, "Does your program offer regular support groups for hospice staff?", was also found to have a significant relationship with the SBS: $F(1,73) = 4.26$, $p = .0426$. The two groups used in this analysis were Group 1, "With Support Group" (30 cases), and Group 2, "Without Support Group" (45 cases). Group 1 had a criterion mean of 36.9 ($SD = 14.4$; range: 19-77). Group 2 had a criterion mean of 44.1 ($SD = 15.2$; range: 20-86).

Afterlife

Item 31 of the PDF was collapsed into two response groups for the sake of analysis. Group one was made up of all respondents who endorsed responses one and two, "I believe God loves everyone, all of the deceased are accepted into the divine presence" (12 cases) and "I believe if people perform sufficient good works, they will be accepted into God's presence at death" (5 cases). This group is called Universalist/Works. The second group is all respondents endorsing response four, "I believe that God accepts into the divine presence only those deceased who have faith in Jesus Christ" (28 cases). This group is called Faith. A significant relationship was found between these beliefs and SBS: $F(1,43) = 4.15$, $p = .048$. The Burnout Scale mean for Group 1 was 44.3 ($SD = 14.7$; range: 19-77). The Burnout Scale mean for Group 2 was 36.0 ($SD = 12.3$; range: 20-76). All of these ANOVA comparisons involved only two groups; therefore, utilization of the Scheffe post hoc test as originally planned was inappropriate.

Correlations

All interval and ordinal data was correlated with the Burnout Scale for Health Professionals using the Pearson Product Moment correlation coefficient. The correlations are described in Table 10. The following variables were found to have significant relationships with the Burnout Scale: (a) age (r = -.34, p = .002), (b) all of the Daily Hassles scales (see Table 10 for a summary of the correlation coefficients and alpha levels), (c) the Burnout Lie Scale (r = -.60, p < .001), (d) the Ways of Coping Positive Reappraisal Subscale (r = -.30, p = .011), (e) the Social Support Scale Coworker Subscale (r = .34, p = .003), and (f) the Social Support Scale total score (r = .32, p = .004). (Additional correlational data is available from the author.)

All nonrelated variables were examined for curvilinearity by generating and evaluating a scatter plot for each potential relationship. No evidence of curvilinearity was observed. The abandonment of Eta as a method for this process was based on the danger of violating the assumption that one of the variables must be categorical. The process of generating risk indices to be tested was also abandoned because none of the

Table 10

Correlation Coefficients and Probabilities for All Variables Significantly Related to the Burnout Scale for Health Professionals

Variable	r	p
Personal Data Form		
Age	-.34	.002
Funding	.32	.004
Daily Hassles		
Whole Scale		
Frequency	.65	<.001
Severity	.28	.013
Time Pressure		
Frequency	.43	<.001
Severity	.37	.001
Work		
Frequency	.58	<.001
Severity	.62	<.001

(table continues)

Table 10 (continued)

Variable	r	p
Daily Hassles (con't.)		
Household		
Frequency	.65	<.001
Severity	.64	<.001
Health		
Frequency	.45	<.001
Severity	.46	<.001
Inner concerns		
Frequency	.54	<.001
Severity	.58	<.001
Financial concerns		
Frequency	.31	.006
Severity	.32	.004
Environmental		
Frequency	.42	<.001
Severity	.45	<.001
Burnout		
Lie	-.60	<.001

(table continues)

Table 10 (continued)

Variable	r	p
Ways of Coping		
Positive reappraisal	-.30	.011
Social Support		
Total scale	.32	.004
Coworker	.34	.003

planned variable groups passed the initial screen for significance at the $p < .001$ level.

All of the significant variables were then cross-correlated to check for multicolinearity in preparation for selecting the variables to be entered into the stepwise regression analysis to follow (see Table 11).

Research Question 2

Regression Results

The stepwise regression analysis was utilized to address the second research question: Which personal

Table 11

Correlational Matrix of Significant Variables

Correlations:	Age	Training	Funds
Age			
Training			
Funds	-.33**		
Daily Hassles			
Total			
Frequency	-.24*		
Time			
Frequency		.30**	
Severity	-.28*	.25*	
Work			
Frequency	-.29*	.35**	.31**
Severity	-.31**	.35**	.31**
Household			
Frequency	-.31**		
Severity	-.33**	.24*	

(table continues)

Table 11 (continued)

Correlations:	Age	Training	Funds
Daily Hassles (con't.)			
Health			
Frequency			
Severity			
Inner			
Frequency	-.24*		
Severity	-.24*		
Money			
Frequency			
Severity			
Environment			
Frequency			
Severity			
Social Support			
Total			
Work			

(table continues)

Table 11 (continued)

	Daily Hassles Scale		
Correlations:	Total frequency	Time frequency	Time severity
Age			
Training			
Funds			
Daily Hassles			
Total			
Frequency			
Time			
Frequency	.66***		
Severity	.59***	.84***	
Work			
Frequency	.71***	.43***	.40***
Severity	.66***	.41***	.47***
Household			
Frequency	.84***	.71***	.63***
Severity	.81***	.65***	.76***

(table continues)

Table 11 (continued)

	Daily Hassles Scale		
Correlations:	Total frequency	Time frequency	Time severity
Daily Hassles (con't.)			
Health			
Frequency	.71***	.34***	.27*
Severity	.71***	.41***	.42***
Inner			
Frequency	.79***	.36***	.33**
Severity	.77***	.34**	.41***
Money			
Frequency	.69***	.38**	.41***
Severity	.61***	.32**	.46***
Environment			
Frequency	.68***	.32**	.27*
Severity	.63***	.34**	.33**

(table continues)

Table 11 (continued)

	Daily Hassles Scale		
Correlations:	Total frequency	Time frequency	Time severity
Daily Hassles (con't.)			
Social Support			
Total			
Work			

	Daily Hassles Scale		
Correlations:	Work frequency	Work severity	Household frequency
Age			
Training			
Funds			

(table continues)

Table 11 (continued)

	Daily Hassles Scale		
Correlations:	Work frequency	Work severity	Household frequency
Daily Hassles (con't.)			
Total			
Frequency			
Time			
Frequency			
Severity			
Work			
Frequency			
Severity	.94***		
Household			
Frequency	.63***	.61***	
Severity	.59***	.65***	.89***
Health			
Frequency	.46***	.45***	.58***
Severity	.47***	.51***	.58***

(table continues)

Table 11 (continued)

	Daily Hassles Scale		
Correlations:	Work frequency	Work severity	Household frequency
Daily Hassles (con't.)			
Inner			
Frequency	.60***	.59***	.65***
Severity	.60***	.63***	.62***
Money			
Frequency	.34**	.30**	.46***
Severity	.25	.27*	.44***
Environment			
Frequency	.38***	.31**	.46***
Severity	.34**	.30**	.42***
Social Support			
Total			
Work			

(table continues)

Table 11 (continued)

	Daily Hassles Scale	
Correlations:	Household severity	Health frequency
Age		
Training		
Funds		
Daily Hassles		
Total		
Frequency		
Time		
Frequency		
Severity		
Work		
Frequency		
Severity		
Inner		
Frequency	.65***	.56***
Severity	.72***	.52***

(table continues)

Table 11 (continued)

	Daily Hassles Scale	
Correlations:	Household severity	Health frequency
Money		
Frequency	.50***	.39***
Severity	.60***	.31**
Environment		
Frequency	.45***	.45***
Severity	.48***	.40***
Social Support		
Total		
Work		

(table continues)

Table 11 (continued)

	Daily Hassles Scale	
Correlations:	Health severity	Inner frequency
Age		
Training		
Funds		
Daily Hassles		
Total		
Frequency		
Time		
Frequency		
Severity		
Work		
Frequency		
Severity		
Household		
Frequency		
Severity		

(table continues)

Table 11 (continued)

	Daily Hassles Scale	
Correlations:	Health severity	Inner frequency
Daily Hassles (con't.)		
Health		
Frequency		
Severity		
Inner		
Frequency	.61***	
Severity	.62***	.93***
Money		
Frequency	.37***	.44***
Severity	.35**	.44***
Environment		
Frequency	.40***	.47***
Severity	.39***	.41***

(table continues)

Table 11 (continued)

	Daily Hassles Scale	
Correlations:	Health severity	Inner frequency
Social Support		
Frequency		
Severity		

	Daily Hassles Scale	
Correlations:	Inner severity	Money frequency
Age		
Training		
Funds		
Daily Hassles		
Total		
Frequency		

(table continues)

Table 11 (continued)

	Daily Hassles Scale	
Correlations:	Inner severity	Money frequency
Daily Hassles (con't.)		
Time		
Frequency		
Severity		
Work		
Frequency		
Severity		
Household		
Frequency		
Severity		
Health		
Frequency		
Severity		

(table continues)

Table 11 (continued)

	Daily Hassles Scale	
Correlations:	Inner severity	Money frequency
Daily Hassles (con't.)		
Inner		
Frequency		
Severity		
Money		
Frequency	.45***	
Severity	.56***	.87**
Environment		
Frequency	.43***	.41***
Severity	.40***	.42***
Social Support		
Total		
Work		

(table continues)

Table 11 (continued)

	Daily Hassles Scale	
Correlations:	Money severity	Environment frequency
Age		
Training		
Funds		
Daily Hassles		
Total		
Frequency		
Time		
Frequency		
Severity		
Work		
Frequency		
Severity		
Household		
Frequency		
Severity		

(table continues)

Table 11 (continued)

	Daily Hassles Scale	
Correlations:	Money severity	Environment frequency
Daily Hassles (con't.)		
Health		
Frequency		
Severity		
Inner		
Frequency		
Severity		
Money		
Frequency		
Severity		
Environment		
Frequency	.33**	
Severity	.36***	.94***

(table continues)

Table 11 (continued)

	Daily Hassles Scale	
Correlations:	Money severity	Environment frequency
Daily Hassles (con't.)		
Social Support		
Frequency		
Severity		

	Daily Hassles		Social Support	
Correlations:	Environment	Severity	Total	Work
Age				
Training				
Funds				
Daily Hassles				
Total				
Frequency		.33**		

(table continues)

Table 11 (continued)

	Daily Hassles		Social Support	
Correlations:	Environment	Severity	Total	Work
Daily Hassles (con't.)				
Time				
Frequency				
Severity				
Work				
Frequency		.36***	.36***	
Severity		.34**	.32***	
Household				
Frequency		.32**	.23*	
Severity		.28*		
Health				
Frequency		.25*		
Severity		.31**		
Inner				
Frequency		.44***	.31**	
Severity		.44***	.31**	

(table continues)

Table 11 (continued)

	Daily Hassles		Social Support	
Correlations:	Environment	Severity	Total	Work
Daily Hassles (con't.)				
Money				
Frequency				
Severity		.23*		
Environment				
Frequency		.32**		
Severity				
Social Support				
Total				
Work		.85***		

*$p \leq .05$. **$p \leq .01$. ***$p \leq .001$.

characteristics of the hospice nurse are the best predictors of adequate adjustment to his/her work?

It was determined in the cross-correlation that the Daily Hassles Total Frequency Scales and its subscales are all highly intercorrelated. Therefore,

the Total Frequency score was selected as the best potential predictor based on the strength of its correlation with the dependent variable and its significance level (r = .65, p < .001). There were no other variables which fit the screening criteria for the stepwise regression. Specifically, no other variables had significance levels less than or equal to .001. Therefore, the decision was made to choose other variables to enter into the regression analysis with alpha levels less than or equal to .004. This decision was made based on the reduced number of comparisons to be made and the respectable significance levels represented by this new criterion. The other variables chosen for entry into the regression analysis were age, training, funding frustration, and Social Support Coworkers. The two Social Support subscales also evidenced significant intercorrelation. Therefore, only one of these scales was entered into any one regression analysis. Other scales entered as replacements for the Daily Hassles Total Frequency score were Work Hassles-Frequency; Household Concerns, both Frequency and Severity scores; and Inner Concerns, both Frequency and Severity scores. Each of these

replacements were made one at a time to replace the Total score from the parent scale.

Seven sets of stepwise regressions were performed to determine what combination of 11 predictor variables accounted for the most variance in the criterion variable, the Burnout Scale for Health Professionals. Each time an analysis was performed, Funding Frustrations, Training, and Age were entered into the regression. Each time an analysis was performed, a different Daily Hassles subscale was entered. In the first analysis, the Coworker subscale of the Social Support Scale was entered but was not selected. The Social Support Scale total score was entered into the second analysis and was not selected. It was decided that the Social Support Scale was not likely to be selected, therefore, the Social Support total score was entered into all ensuing analyses. All of the stepwise regression analyses were statistically significant. The following results were obtained.

The first analysis involved selecting from five predictor variables: Age (A), Funding Frustration (FF), Training (T), Daily Hassles Total Frequency score (HTOT), and Social Support Coworker subscale (SC). Three predictor variables contributed: HTOT, A, and T.

The resulting regression equation was Y' = 30.562 + .445(HTOT) - .334(A) + 6.295(T). The regression equation had an overall F of 26.648 which was significant at $p < .0001$. The stepwise regression results and accompanying analysis of variance summary are shown in Table 12. The selected predictor variables accounted for 53.3% of the variance in Burnout. In step one, the predictor HTOT accounted for 44.5% of the variance in Burnout. In step two the addition of A to the equation resulted in an incremental increase in R squared. Using both predictor variables accounted for an additional 4.79% of the variance in Burnout. The addition of T to the equation in step three resulted in another incremental increase in R squared accounting for an additional 4.07% of the variance in the criterion variable.

The second analysis involved selecting from five predictor variables: Age (A), Funding Frustration (FF), Training (T), Daily Hassles Total Frequency score (HTOT), and Social Support Total score (SABC). Three predictor variables were selected: HTOT, A, and T. The resulting regression equation was Y' = 30.562 + .445(HTOT) - .334(A) + 6.295(T). The regression equation had an overall F of 26.648 which was

Table 12

Stepwise Regression with Burnout as Criterion and Age (A), Funding Frustration (FF), Training (T), Daily Hassles Total Frequency Score (HTOT), and Social Support Coworker Subscale (SC) as Predictors

Step	Variable	Multiple R	R Square	Beta	F	Sig.
1	HTOT	.667	.445	.508	57.636	.0000
2	AGE	.702	.492	-.337	34.448	.0000
3	T	.730	.533	6.295	26.648	.0000

Multiple R = .730

R Square = .533

Adjusted R Square = .513

Standard Error = 10.640

(table continues)

Table 12 (continued)

Analysis of variance

	Degrees of freedom	Sum of squares	Mean square
Regression	3	9049.484	3016.495
Residual	70	7923.975	113.2

F = 26.648

Sig. F = .0000

Variables in the equation

Variable	B	SE B	Beta	T	Sig. T
HTOT	.445	.065	.584	6.887	.0000
AGE	-.334	.126	-.221	-2.656	.0098
T	6.295	2.549	.206	2.470	.0160
(Constant)	30.563	7.531		4.058	.0001

(table continues)

Table 12 (continued)

Variables not in the equation					
Variable	Beta in	Partial	Min. toler.	T	Sig. T
FF	.066	.086	.79150	.721	.474
SC	.112	.151	.871	1.271	.2080

significant at $p < .0001$. The stepwise regression results and accompanying analysis of variance summary are shown in Table 13. The selected predictor variables accounted for 53.3% of the variance in Burnout. In step one, the predictor HTOT accounted for 44.5% of the variance in Burnout. In step two the addition of A to the equation resulted in an incremental increase in R squared. Using both predictor variables accounted for an additional 4.79% of the variance in Burnout. The addition of T to the equation in step three resulted in another incremental increase in R squared accounting for an additional 4.07% of the variance in the criterion variable.

Table 13

Stepwise Regression with Burnout as Criterion and Age (A), Funding Frustration (FF), Training (T), Daily Hassles Total Frequency Score (HTOT), and Social Support Total Score (SABC) as Predictors

Step	Variable	Multiple R	R Square	Beta	F	Sig.
1	HTOT	.667	.445	.508	57.636	.0000
2	AGE	.702	.492	-.337	34.448	.0000
3	T	.730	.533	6.295	26.648	.0000

Multiple R = .730

R Square = .533

Adjusted R Square = .513

Standard Error = 10.640

(table continues)

Table 13 (continued)

Analysis of variance			
	Degrees of freedom	Sum of squares	Mean square
Regression	3	9049.484	3016.495
Residual	70	7923.975	113.2

F = 26.648

Sig. F = .0000

Variables in the equation					
Variable	B	SE B	Beta	T	Sig. T
HTOT	.445	.065	.584	6.887	.0000
AGE	-.334	.126	-.221	-2.656	.0098
T	6.295	2.549	.206	2.470	.0160
(Constant)	30.563	7.531		4.058	.0001

(table continues)

Table 13 (continued)

Variables not in the equation					
Variable	Beta in	Partial	Min. toler.	T	Sig. T
FF	.066	.086	.79150	.721	.474
SC	.112	.151	.871	1.271	.2080

The third analysis involved selecting from five predictor variables: Age (A), Funding Frustration predictor variable was selected: HWORKF. The resulting regression equation was Y' = 33.764 + 5.874(HWORKF). The regression equation had an overall F of 38.325 which was significant at $p < .0001$. The stepwise regression results and accompanying analysis of variance summary are shown in Table 14. The selected predictor variable accounted for 34.7% of the variance in Burnout.

The fourth analysis involved selecting from five predictor variables: Age (A), Funding Frustration (FF), Training (T), Daily Hassles Household Concerns Frequency score (HHOUSEF), and Social Support Total score (SABC). Three predictor variables were selected:

Table 14

Stepwise Regression with Burnout as Criterion and Age (A), Funding Frustration (FF), Training (T), Daily Hassles Total Frequency Score (HWORKF), and Social Support Total score (SABC) as Predictors

Step	Variable	Multiple R	R Square	Beta	F	Sig.
1	HWORKF	.589	.347	.589	38.325	.0000

Multiple R = .589

R Square = .347

Adjusted R Square = .338

Standard Error = 12.404

(table continues)

Table 14 (continued)

	Analysis of variance		
	Degrees of freedom	Sum of squares	Mean square
Regression	1	5896.317	5896.317
Residual	72	11077.143	153.849

F = 38.325

Sig. F = .0000

Variables in the equation					
Variable	B	SE B	Beta	T	Sig. T
HWORKF	5.874	.949	.589	6.191	.0000
(Constant)	33.764	1.930		17.498	.0000

(table continues)

Table 14 (continued)

Variables not in the equation					
Variable	Beta in	Partial	Min. toler.	T	Sig. T
AGE	-.186	-.221	.918	-1.911	.060
T	.128	.146	.855	1.247	.217
FF	.122	.140	.861	1.190	.238
SABC	.127	.146	.856	1.242	.219

HHOUSEF, A, and T. The resulting regression equation was Y' = 28.770 + 2.942(HHOUSEF) - .278(A) + 5.448(T). The regression equation had an overall F of 23.504 which was significant at $p < .0001$. The stepwise regression results and accompanying analysis of variance summary are shown in Table 15. The selected predictor variables accounted for 50.2% of the variance in Burnout. In step one, the predictor HHOUSEF accounted for 44.2% of the variance in Burnout. In step two the addition of A to the equation resulted in an incremental increase in R squared. Using both predictor variables accounted for an additional 3.02%

Table 15

Stepwise Regression with Burnout as Criterion and Age (A), Funding Frustration (FF), Training (T), Daily Hassles Household Concerns Frequency Score (HHOUSEF), and Social Support Total Score (SABC) as Predictors

Step	Variable	Multiple R	R Square	Beta	F	Sig.
1	HHOUSEF	.665	.442	.665	57.025	.0000
2	AGE	.687	.472	-.180	31.758	.0000
3	T	.708	.502	.571	23.504	.0000

Multiple R = .708

R Square = .502

Adjusted R Square = .480

Standard Error = 10.991

(table continues)

Table 15 (continued)

Analysis of variance			
	Degrees of freedom	Sum of squares	Mean square
Regression	3	8517.585	2839.195
Residual	70	8455.874	120.798

F = 23.504

Sig. F = .0000

Variables in the equation					
Variable	B	SE B	Beta	T	Sig. T
HHOUSEF	2.942	.465	.571	6.328	.0000
AGE	-.278	.132	-.184	-2.103	.0391
T	5.448	2.670	.178	3.624	.0451
(Constant)	28.770	7.941		3.624	.0005

(table continues)

Table 15 (continued)

Variables not in the equation					
Variable	Beta in	Partial	Min. toler.	T	Sig. T
FF	.010	.127	.805	1.062	.292
SABC	.095	.126	.792	1.058	.294

of the variance in Burnout. The addition of T to the equation in step three resulted in another incremental increase in R squared accounting for an additional 3.56% of the variance in the criterion variable.

The fifth analysis involved selecting from five predictor variables: Age (A), Funding Frustration (FF), Training (T), Daily Hassles Household Concerns Severity score (HHOUSES), and Social Support Total score (SABC). Two predictor variables were selected: HHOUSES, FF. The resulting regression equation was Y' = 21.817 + 19.356(HHOUSES) + 1.729(FF). The regression equation had an overall F of 30.544 which was significant at $p < .0001$. The stepwise regression results and accompanying analysis of variance summary are shown in Table 16. The selected predictor

Table 16

Stepwise Regression with Burnout as Criterion and Age (A), Funding Frustration (FF), Training (T), Daily Hassles Household Concerns Severity Score (HHOUSES), and Social Support Total Score (SABC) as Predictors

Step	Variable	Multiple R	R Square	Beta	F	Sig.
1	HHOUSES	.650	.423	.650	52.749	.0000
2	FF	.680	.462	.203	30.544	.0000

Multiple R = .680

R Square = .462

Adjusted R Square = .447

Standard Error = 11.336

(table continues)

Table 16 (continued)

Analysis of variance			
	Degrees of freedom	Sum of squares	Mean square
Regression	2	7849.870	3924.935
Residual	71	9123.590	128.501

F = 30.544

Sig. F = .0000

Variables in the equation					
Variable	B	SE B	Beta	T	Sig. T
HHOUSES	19.356	2.818	.610	6.868	.0000
FF	1.729	.756	.203	2.288	.0251
(Constant)	21.817	3.288		6.635	.0000

(table continues)

Table 16 (continued)

Variables not in the equation					
Variable	Beta in	Partial	Min. toler.	T	Sig. T
AGE	-.104	-.127	.790	-1.069	.289
T	.160	.210	.901	1.801	.076
SABC	.140	.181	.882	1.541	.128

variables accounted for 46.2% of the variance in Burnout. In step one, the predictor HHOUSES accounted for 42.3% of the variance in Burnout. In step two the addition of FF to the equation resulted in an incremental increase in R squared. Using both predictor variables accounted for an additional 3.96% of the variance in Burnout.

The sixth analysis involved selecting from five predictor variables: Age (A), Funding Frustration (FF), Training (T), Daily Hassles Inner Concerns Frequency score (HICF), and Social Support Total score (SABC). Three predictor variables were selected: HHICF, T, and A. The resulting regression equation was $Y' = 34.617 + 3.031(HICF) + 8.380(T) - .343(A)$. The

regression equation had an overall F of 17.776 which was significant at $p < .0001$. The stepwise regression results and accompanying analysis of variance summary are shown in Table 17. The selected predictor variables accounted for 43.2% of the variance in Burnout. In step one, the predictor HICF accounted for 30.6% of the variance in Burnout. In step two the addition of T to the equation resulted in an incremental increase in R squared. Using both predictor variables accounted for an additional 7.75% of the variance in Burnout. The addition of A to the equation in step three resulted in another incremental increase in R squared accounting for an additional 4.91% of the variance in the criterion variable.

The seventh analysis involved selecting from five predictor variables: Age (A), Funding Frustration (FF), Training (T), Daily Hassles Inner Concerns Severity score (HICS), and Social Support Total score (SABC). Three predictor variables were selected: HICS, T, and FF. The resulting regression equation was $Y' = 14.926 + 16.801(HICS) + 7.540(T) + 1.912(FF)$. The regression equation had an overall F of 19.796 which was significant at $p < .0001$. The stepwise regression results and accompanying analysis of variance summary

Table 17

Stepwise Regression with Burnout as Criterion and Age (A), Funding Frustration (FF), Training (T), Daily Hassles Inner Concerns Frequency Score (HICF), and Social Support Total Score (SABC) as Predictors

Step	Variable	Multiple R	R Square	Beta	F	Sig.
1	HICF	.553	.306	.553	31.717	.0000
2	T	.619	.383	.280	22.067	.0000
3	A	.658	.432	-.227	17.776	.0000

Multiple R = .658

R Square = .432

Adjusted R Square = .408

Standard Error = 11.732

(table continues)

Table 17 (continued)

Analysis of variance

	Degrees of freedom	Sum of squares	Mean square
Regression	3	7339.477	2446.492
Residual	70	9633.983	137.628

F = 17.776

Sig. F = .0000

Variables in the equation

Variable	B	SE B	Beta	T	Sig. T
HICF	3.031	.588	.477	5.516	.0000
T	8.380	2.769	.274	3.027	.0035
A	-.343	.139	-.227	-2.460	.0164
(Constant)	34.617	8.244		4.199	.0001

(table continues)

Table 17 (continued)

Variables not in the equation					
Variable	Beta in	Partial	Min. toler.	T	Sig. T
FF	.131	.157	.814	1.323	.190
SABC	.043	.050	.747	.415	.680

are shown in Table 18. The selected predictor variables accounted for 45.9% of the variance in Burnout. In step one, the predictor HICS accounted for 33.8% of the variance in Burnout. In step two the addition of T to the equation resulted in an incremental increase in R squared. Using both predictor variables accounted for an additional 7.19% of the variance in Burnout. The addition of FF to the equation in step three resulted in another incremental increase in R squared accounting for an additional 4.90% of the variance in the criterion variable.

The four assumptions of multiple regression analyses are that there be: (a) the absence of specification error, (b) the absence of

Table 18

Stepwise Regression with Burnout as Criterion and Age (A), Funding Frustration (FF), Training (T), Daily Hassles Inner Concerns Severity Score (HICS), and Social Support Total Score (SABC) as Predictors

Step	Variable	Multiple R	R Square	Beta	F	Sig.
1	HICS	.581	.338	.581	36.779	.0000
2	T	.640	.410	.270	24.672	.0000
3	FF	.677	.459	.225	19.796	.0000

Multiple R = .677

R Square = .459

Adjusted R Square = .436

Standard Error = 11.453

(table continues)

Table 18 (continued)

Analysis of variance			
	Degrees of freedom	Sum of squares	Mean square
Regression	3	7790.770	2596.923
Residual	70	9182.689	131.181

F = 19.796

Sig. F = .0000

Variables in the equation					
Variable	B	SE B	Beta	T	Sig. T
HICS	16.801	2.869	.522	5.856	.0000
T	7.540	2.721	.247	2.771	.0071
FF	1.912	.759	.225	2.517	.0141
(Constant)	4.926	4.964		3.006	.0037

(table continues)

Table 18 (continued)

Variables not in the equation					
Variable	Beta in	Partial	Min. toler.	T	Sig. T
A	-.147	-.179	.804	-1.509	.136
SABC	.037	.044	.760	.363	.718

multicolinearity, (c) the absence of measurement error, and (d) the conformation of the error term to certain conventions. Through examination of the results of the regression analyses and the correlational matrices for each variable with the criterion variable and theintercorrelation of potential predictor variables, the first two assumptions have been met. The last two were confirmed by examination of standardized residuals through use of a histogram of the standardized residuals and a normal probability plot of the standardized residuals against the expected residuals from a normal distribution. All of the equations satisfied the basic assumptions for multiple regression. All of the equations tested in this

regression analysis proved to be significant predictors of the criterion variable. Table 19 summarizes and compares all of the stepwise regression analyses performed.

Table 19

Summary of Stepwise Regression Analyses

Variables entered	Variable selected	Multiple R	R square
Analysis 1			
Daily Hassles total	Yes	.730	.533
Age	Yes		
Training	Yes		
Funding frustration	No		
Social Support work	No		

(table continues)

Table 19 (continued)

Variables entered	Variable selected	Multiple R	R square
Analysis 2			
Daily Hassles total	Yes	.730	.533
Age	Yes		
Training	Yes		
Funding frustration	No		
Social Support total	No		
Analysis 3			
Daily Hassles work frequency	Yes	.589	.347
Age	No		
Training	No		
Funding frustration	No		
Social Support total	No		

(table continues)

Table 19 (continued)

Variables entered	Variable selected	Multiple R	R square
Analysis 4			
Daily Hassles household frequency	Yes	.708	.502
Age	Yes		
Training	Yes		
Funding frustration	No		
Social Support total	No		
Analysis 5			
Daily Hassles household severity	Yes	.680	.462
Age	No		
Training	No		
Funding frustration	Yes		
Social Support total	No		

(table continues)

Table 19 (continued)

Variables entered	Variable selected	Multiple R	R square
Analysis 6			
Daily Hassles inner concern frequency	Yes	.658	.432
Age	Yes		
Training	Yes		
Funding frustration	No		
Social Support total	No		
Analysis 7			
Daily Hassles inner concern severity	Yes	.677	.459
Age	No		
Training	Yes		
Funding frustration	Yes		
Social Support total	No		

CHAPTER 4

DISCUSSION

This chapter examines the limitations of the study and offers an interpretation of the results of the data analysis in a way which addresses the research questions enumerated in Chapter 1. These results are related to previous work presented in the literature review. Implications of the findings are also discussed including suggestions for further research.

This study attempted to find answers to the following questions:

1. Are there any significant relationships between selected personal and professional characteristics (listed in Appendix A) of the hospice nurse and her/his ability to cope with work stress?

2. Which personal characteristics of the hospice nurse are the best predictors of adequate adjustment to her/his work?

Limitations

This study has several limitations. The response rate precludes generalization from the sample. The study was not longitudinal and, therefore, attempts to study a transactional dynamic process at a point in time. The interaction of the effects studied here may change the outcome over time. The effects of averaging the variables across a number of people and events may serve as a control on this issue. Longitudinal analysis would be necessary in a clinical setting where an evaluation of a single provider's coping style was being undertaken.

The mean Staff Burnout Scale score was relatively low, indicating that the sample was relatively healthy at the time of the survey. It might be speculated that those who were really burned out were too overwhelmed to respond. Several administrators complained about the amount of paper work they were involved with as a result of third-party payment requirements and achieving Medicare certification. Finally, a larger sample may have increased significance levels and may have allowed for more analysis of variables which were dropped out of the study due to empty cells.

Major Findings: Research Question 1

Several variables were found to relate significantly to the level of burnout being experienced by the hospice nurses who participated in the study. For the sake of discussion these variables have been organized into three categories: (a) personal or individual factors, (b) social factors, and (c) work factors. The criterion for categorization of variables as personal is based on the likelihood that stress would result from one's physical characteristics, beliefs, and personal habits of behavior or thought. The group categorized as social is based on the likelihood that stress would result from interaction with others, including family. The third category--work factors--is based on stress that the nurse attributes to the workplace or role.

Personal Factors Related to Burnout

Age

The personal factors will be discussed first. The age of the nurse was shown to be negatively related to burnout (r = -.34, p = .002). This suggests that older nurses, presumably those with greater experience, have

a slight advantage when coping with the stress of hospice care. Age and nursing experience were positively correlated in this sample (r = .59, p < .001). There was a negative correlation of r = -.33 (p = .003) between age and frustration over clinical limitations due to funding levels.

Older nurses were also slightly more likely to view their religious convictions as central in their lives (r = .27, p = .015). Age also showed slight negative correlations with the Daily Hassles Scale total frequency score (r = -.24, p = .034) and with several of its subscales (see Table 11). This data supports the findings of Steffan and Bailey (1979) as well as Martinson et al. (1977) indicating that exposure to the task of hospice care delivery tends to build confidence in the care provider, thereby reducing stress. Another potential issue to be considered is that the older nurse is the "survivor." The older nurse has weathered the test of the task and remained. The younger nurse is just beginning to be tested. There also exists the possibility that younger women lead more stressful lives. Parenthood along with career building efforts may add stressors which the older nurse and her family have grown beyond.

Ways of Coping

The Positive Reappraisal subscale of the Ways of Coping Scale also demonstrated a negative correlation to burnout (r = -.30, p = .011). An examination of the items on this subscale reveals that the person who responds to stress with this style will do so by creating positive meaning in the situation and using it as a growth opportunity (Folkman & Lazarus, 1988). This style has a religious dimension to it. It encourages faith and the exercise of faith. The frequency analysis suggests that positive reappraisal accounts for 15.5% (SD = .08, range = 0-42.8%) of the average respondent's coping behavior in addressing the stress found in patient care settings.

Daily Hassles

The Daily Hassles Scale Inner Concerns subscale demonstrated a positive relationship to staff burnout (frequency: r = .54, p <.001; severity: r = .58, p < .001). The items which constitute the Inner Concerns subscale suggest themes such as loneliness, inability to express oneself, boredom, inner conflict, existential anxiety, and avoidance of confrontation. Face examination of these two scales suggests that they measure people who approach life from polar positions.

A suggestion for further research is to include an examination of personality and ability to cope. It is remarkable that hope and optimism remain important in any attempt to deal with difficult life situations.

The Daily Hassles Scale (DHS) Time Pressures subscale demonstrated low to moderate positive correlations to the SBS (frequency: $r = .43$, $p < .001$; severity: $r = .37$, $p = .001$). The items of this scale suggest a person who is over-committed and is not accomplishing either the pleasurable or personally important things in life. The majority of the nurses in this sample are female and currently married and raising a family. This suggests the possibility of role conflict between work and family pressures. Many hospice positions require some flexibility to meet the needs of patients and their families. This is further supported by the data in this study suggesting that household concerns are positively related to burnout (see the discussion of this issue below). The potential for scheduling conflicts to develop is also a reasonable notion.

Lower correlations were found between the DHS Financial Responsibilities subscale and the Staff Burnout Scale (SBS) (frequency: $r = .31$, $p = .006$;

severity: r = .32, p = .004). This group of stressors may have a relatively low impact on staff burnout due to the relatively adequate income levels of this group of respondents. Other interesting relationships related to the Financial Concerns subscale include a negative relationship with the social support of family and close relatives (frequency: r = -.24, p = .03; severity: r = -.36, p = .001) and a similar positive relationship with death anxiety (frequency: r = .34, p = .002; severity: r = .32, p = .005). The first relationship suggests a slight reduction in family support when financial worries are high. The second relationship may give credence to Templer's (1976) assertion that psychological health is related to death anxiety. Financial stress may contribute to a lack of coping ability which adds to the death anxiety of the nurse, or death anxiety may reduce the nurse's psychological ability to cope with financial matters.

Religious Belief

An analysis of variance demonstrated significantly that the respondent's belief about how one enters into God's presence after death is related to the nurse's burnout. A group of respondents who espoused either a universalistic belief or the belief that entry into

God's presence may be obtained through good works were compared to a group of those who believe that entry into God's presence after death is accessed only by faith in Jesus Christ. Significantly, the universalist/works group experienced greater burnout than the faith in Christ group ($\underline{m}$ = 44.3, $\underline{SD}$ = 14.7; and $\underline{m}$ = 36.0, $\underline{SD}$ = 12.3, respectively). The literature suggests that belief in a benevolent God can be an asset to coping with the fear of death (Spilka et al., 1985). Universalists generally have this view (Eller, 1984). The possible alternative explanations for this outcome are that the mixture of works-oriented people introduced a conditional view of God contaminating the universalist position. On the other hand, the definitive statement of belief by the faith in Christ group may be the deciding factor. The literature suggests that those with definite religious convictions are more likely to cope with death than others (Bayly, 1977).

Social Factors Related to Burnout

Three social factors were found to be significantly related to staff burnout in this sample: (a) household responsibilities, (b) neighborhood/

environmental stressors, and (c) personal support from those individuals the nurse interacts with on a regular basis.

Household Responsibilities

The DHS Household Responsibilities subscale has a stronger relationship to staff burnout than any of the other DHS subscales. It was positively correlated with the SBS (frequency: $r = .65$, $p < .001$; severity: $r = .64$, $p < .001$). This seems to indicate that concerns about running a household and the degree of trouble that it represents is a central factor in the burnout of a hospice nurse. This concept is also evident in the value of this scale as a predictor variable for burnout. This scale accounted for 44.2% of the variance in the SBS in the fourth regression equation ($F(1,72) = 52.75$, $p < .0001$). Hospice nursing makes many demands on a nurse's time which may cause a competition of priorities between home and work.

The Household Responsibility subscale also has a low negative correlation to the importance of religion in the life of the nurse (frequency: $r = -.23$, $p = .039$; severity: $r = -.24$, $p < .024$). This suggests that strong religious beliefs may have a slight stabilizing factor on family life. This will need to

be confirmed in further research. Moderate positive correlations were found between Household Responsibilities and Social Support from Family (frequency: r = .31, p = .006; severity: r = .33, p < .004). Templer's Death Anxiety Scale correlated positively to this scale (frequency: r = .27, p = .015; severity: r = .26, p < .020).

Neighborhood/Environmental Stressors

Moderate positive correlations were noted on the Neighborhood/Environmental subscale of the DHS (frequency r = .42, p < .001; severity r = .45, p < .001). This scale refers to social issues such as pollution and crime as well as conflicts with neighbors or neighborhood deterioration.

Social Support

Low positive correlations were also noted with the total score on the Social Support Scale (r = .32, p < .004). Both of these variables appear to make a small contribution to staff burnout.

Work Factors Related to Burnout

The final category is that of work related variables which may effect the burnout of a hospice nurse. Vachon (1987) hypothesized that it was the

stress of role and institutional expectations which are the central contributors to burnout among hospice workers. This section addresses the data relevant to that classification of stressor.

Support Group

The Coworker subscale of the Social Support Scale has a positive relationship to the SBS (r = .34, p < .003). It may be that nurses perceive more support from coworkers at times when stressors are highest. This is not to say that lack of coworker support is not potentially detrimental to the nurses adaptation to stress. It may be that coworker support becomes more noticeable during times of stress as compared with times when the same support may not be as obvious due to lack of immanent need. Supporting the importance of maximizing coworker support was reinforced by the finding that the lack of a support group for hospice staff was found to have an effect on burnout ($F(1,74) = 4.258$, $p = .0426$). Further, on the Ways of Coping Scale the nurses endorsed Planful Problem Solving 22.6% of the time, Accepting Responsibility 21.5% of the time, and Seeking Social Support 18.6% of the time. This data indicates that these are the most common coping strategies utilized by the nurses. All

of these strategies can be augmented within a support group.

General Working Conditions

The Work subscale of the DHS demonstrated a moderate positive correlation with SBS (frequency: $r = .58$, $p < .001$; severity: $r = .62$, $p < .001$). This scale deals with such issues as job dissatisfaction, difficulties with fellow workers, and not getting enough rest. A nurse who is not happy in her/his position may be at risk for burnout. Work relationships are important contributors to job satisfaction, as is fatigue. Jones (1981a) relates burnout to exhaustion leading to poor work-related self-concept and poor job attitudes. Any of these factors could contribute to this state of being.

Training and Funding

Two other variables may contribute to a nurse's feelings of dissatisfaction with the job. A positive correlation between burnout and clinical frustration brought about due to inadequate funding for services was discovered ($r = .32$, $p < .004$). Funding is a chronic health care issue. It is possible that the issue addressed here is the frustration between what a hospice nurse knows is possible to provide to a

patient, such as adequate symptom management, and what the funding level of the patient will allow. Most of the stressful situations recounted by nurses when answering the Ways of Coping Scale were situations where the nurse knew ways to provide the patient with a "good death" but were frustrated in doing so by various factors including funding.

The lack of specific training for the job presently held was also found to have a significant effect upon burnout ($F(1,74) = 9.221$, $p = .0033$). The nurses stated that their general training in palliative care was adequate. This finding relates more directly to a proper orientation to the specific role in the specific agency presently employing them. There is a difference between knowing what to do and knowing how to do it within the specific resources of the agency or community.

Major Findings: Research Question 2

The regression analysis seems to indicate that the Total Frequency score on the Daily Hassles Scale in combination with whether or not the nurse obtained specific training for the present job and age are the

best predictors of burnout in this sample of nurses. Other important predictor variables are the DHS Household Responsibility, Inner Concerns, and Work subscales. The data seems to most closely fit the observations of Vachon (1987) that the most potent stressors for the hospice nurse are not derived from her/his daily clinical experience but from organizational and institutional issues. The results of this study suggests the addition of personal issues as well. It appears that if the personal and institutional issues of the nurse are addressed, then he/she may be better able to address the clinical work.

The centrality of the Daily Hassles scale undergirds time worn ideas about the connections between stress and burnout (Gatchel & Baum, 1983; Mason, 1975; Selye, 1976). The important points to be taken from this data are that the most strongly correlated scales measure household stressors, work stressors, and inner conflicts. These stressors can account for approximately 31% to 45% of the burnout effect. Chiriboga et al. (1983) support these findings by stressing the importance of support from the nurse's spouse to maintain a positive adaptive status. This study also recommends Lazarus' coping theory as

appropriate in that the critical variables identified in this study suggest a multicausal, interactive dynamic in the process of developing burnout symptoms and coping with stress. Attention must be given to the nurse's situation but also to his/her personal belief system and the cognitive process it supports.

Implications for Preventing Burnout

The prevention of burnout within this sample of nurses could be assisted through utilizing this data for direction in developing or strengthening programs. This study suggests that careful orientation and training in the specific role the nurse is to assume in the hospice would be helpful. Also, the provision of a support group which meets regularly would be beneficial. Such a support group could address staff communication issues as well as the desire for coworker social support. Care should be taken to minimize the degree of job-home conflict. This may include administrative sensitivity to overcommitment on the part of the staff nurse or flexibility in dealing with personal issues. This study seems to add support to encouraging the addition of persons to the program

staff who are older and have a personal style similar to that described as positive and growth-oriented. Religion has been a presence in the hospice setting since its inception. Religion appears to be a potential source for good in the struggle to cope with hospice care. Although the literature suggests that dogmatism can create conflict between patient and nurse, it also suggests that strongly held beliefs can provide a compensating structure to the nurse to assist in coping as well as become a vehicle for hope to the patient and survivors. Further, religion may be a stabilizing factor in the life of the nurse which reduces the stress load encountered in both work and nonwork environments. More research on the relationship between religion and positive adaptation would be useful.

It is suggested that future research could be carried out in several areas. Research which attempts to identify the personality characteristics of the hospice nurse who is well adapted would be helpful in further understanding the role of background characteristics in the process of coping with stress. This research might include standard clinical measures of personality, self-concept, and locus of control.

Further work could be done to establish the effect of various religious belief systems both on the internal stress of the nurse and on the communication patterns with patients and families. A careful analysis of the interaction between a hospice nurse and her/his family life might yield some helpful clues in preventing an exacerbation of stress in both venues.

This study did not find any relationship between grief and burnout which supports Vachon's (1987) findings. Grief is a difficult phenomenon to measure empirically. It is also relatively easy to deny. The findings of this study and Vachon's may be accurate appraisals of the causes of stress in the life of hospice nurses. However, it may also represent a displacement of grief to issues which are more acceptable for professionals to be upset about. More research needs to be done in an attempt to discriminate between what is an actual contributor and what is an object of displacement.

Summary

This study has discovered a number of relationships between personal characteristics of

hospice nurses and their adaptive status on the job. Household stress was isolated as a strong predictive variable of staff burnout, along with work stressors, need for training, and age. These variables accounted for between 45% and 50% of the variance. The religious belief system of the nurse and her/his general outlook on life also appear to be related to burnout. This study supports the work of Vachon (1987) who found that stressors other than clinical experience were key in the generation of burnout in hospice personnel. It would seem that it is not the specific clinical stressor which predicts burnout but rather the context within which it is presented. The context includes the internal, psychological, context of the individual. Lazarus' model of coping and multiple causation for burnout is also supported by the findings of this study. Many directions for further research have been suggested as well.

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Appendix A

Variables Measures Identified by Instrument, Code, and Level of Measurement

Variables Measured Identified by Instrument, Code, and Level of Measurement

Variable	Instrument*	Code	Level of Measurement
Gender	PDF	GEN	Nominal
Marital status	PDF	MAR	Nominal
Age	PDF	AGE	Interval
Community type	PDF	COM	Nominal
Race	PDF	RAC	Nominal
Parenthood	PDF	PAR	Nominal
Number of children	PDF	CHL	Interval
Age of children	PDF	CHA	Interval
Family income	PDF	FIN	Ordinal
Nursing income	PDF	NIN	Ordinal
Type of professional education	PDF	PED	Nominal
Level of professional education	PDF	LED	Nominal
Nursing experience	PDF	RNT	Interval
Hospice type	PDF	HOS	Nominal

(table continues)

(Table continued)

Variable	Instrument*	Code	Level of Measurement
Paid or volunteer	PDF	HPV	Nominal
Hospice hours	PDF	HOT	Interval
Hospice shift	PDF	HSH	Nominal
Hospice position	PDF	HOP	Nominal
Hospice experience	PDF	HEX	Interval
Quantity of patients who died last year	PDF	PTD	Interval
Quantity of deaths witnessed	PDF	DPR	Internal
Care of dying education	PDF	CED	Nominal
Death and dying education	PDF	DED	Nominal
Source of education	PDF	SED	Nominal
Religious denomination	PDF	DEN	Nominal

(table continues)

(Table continued)

Variable	Instrument*	Code	Level of Measurement
Estimate of importance of religion	PDF	RES	
Belief about God	PDF	GOD	Nominal
Belief in afterlife	PDF	AFT	Ordinal
Belief about character of afterlife	PDF	AFN	Nominal
Belief about administration of afterlife	PDF	AFA	Nominal
Belief in possible negative afterlife	PDF	ANG	Ordinal
Coping style:			
Scale 1:			
Confrontive	WOC	CP1	Interval
Scale 2:			
Distancing	WOC	CP2	Interval

(table continues)

(Table continued)

Variable	Instrument*	Code	Level of Measurement
Scale 3:			
Self-Controlling	WOC	CP3	Interval
Scale 4:			
Seek Social Support	WOC	CP4	Interval
Scale 5:			
Accept Responsibility	WOC	CP5	Interval
Scale 6:			
Escape-Avoidance	WOC	CP6	Interval
Scale 7:			
Planful Problem Solving	WOC	CP7	Interval
Scale 8:			
Positive Reappraisal	WOC	CP8	Interval
Family cohesion	FAC	FCO	Interval
Family adaptability	FAC	FAD	Interval
Burnout (work stress syndrome)	BOS	BOS	Interval

(table continues)

(Table continued)

Variable	Instrument*	Code	Level of Measurement
Burnout lie scale	BOS	BOL	Interval
Social support total	SOS	SST	Interval
Social support family	SOS	SSR	Interval
Social support friends	SOS	SSF	Interval
Social support workers	SOS	SSW	Interval
Daily hassles-amount	DHS	DHA	Interval
Daily hassles -intensity	DHS	DHI	Interval
Scale 1: Work	DHS	DH1	Interval
Scale 2: Household	DHS	DH2	Interval
Scale 3: Health	DHS	DH3	Interval
Scale 4: Inner Concerns	DHS	DH4	Interval
Scale 5: Finances	DHS	DH5	Interval
Scale 6: Environs	DHS	DH6	Interval
Scale 7: Future	DHS	DH7	Interval
Scale 8: Time	DHS	DH8	Interval

(table continues)

(Table continued)

Variable	Instrument*	Code	Level of Measurement
Death Anxiety	DAS	DAS	Interval
Derived risk indices:			
Index 1	PDF	DI1	Interval
Index 2	PDF	DI2	Interval
Index 3	PDF	DI3	Interval
Index 4	PDF	DI4	Interval
Index 5	PDF	DI5	Interval
Index 6	PDF	DI6	Interval
Index 7	PDF	DI7	Interval
Support group	PDF	SGP	Nominal
On-site training	PDF	OST	Nominal
Time on job	PDF	TOJ	Interval
Reimbursement	PDF	RMB	Ordinal

* PDF--Personal Data Form

SOS--Social Support Scale

DAS--Death Anxiety Scale

WOC--Ways of Coping Scale

FAC--Family Adaptation and Cohesion Scale

BOS--Staff Burnout Scale for Health Professionals

DHS--Daily Hassles Scale

Appendix B

Survey Packet and Samples of Communications With Subjects


OREGON
HOSPICE NURSE
STUDY

1.

Some information about you would be helpful. Please complete the following:

Q1. Your sex: (circle the number of your answer)
1. FEMALE
2.. MALE

Q2. Your present marital status: (circle the number)
1. NEVER MARRIED
2. MARRIED
3. DIVORCED
4. SEPARATED
5. WIDOWED
6. LIVING TOGETHER, NOT MARRIED

Q3. Your present age: _____ years.

Q4. Which of the following best describes your community?
1. A RANCH OR FARM
2. IN A RURAL AREA, NOT ON A RANCH OR FARM
3. A SUBURBAN TOWN NEAR A CITY
4. A SMALL CITY (LESS THAN 100,000 PEOPLE)
5. A LARGE CITY (MORE THAN 100,000 PEOPLE)

Q5. Which of the following best describes your racial or ethnic identification? (circle the number)
1. BLACK
2. WHITE
3. HISPANIC
4. NATIVE AMERICAN (AMERICAN INDIAN)
5. ASIAN (specify: _____)
6. OTHER (specify: _____)

Q6. Are you a parent or step-parent? (circle the number)
1. NO
2. YES

Q7. If you are a parent or step-parent, how many children do you have living with you in each age group? (If none, write "0".)
___ UNDER 6 YEARS OF AGE
___ 6 - 12
___ 13 - 19
___ 20 - 25
___ 26 - OVER

Q8. Taking into consideration all the sources of income, which of the following ranges is nearest to your expected household income, before taxes, for this calendar year? (circle the number)
1. LESS THAN $10,000.
2. $10,000. - 29,000.
3. $30,000. - 39,999.
4. $40,000. - 49,999.
5. $50,000. OR MORE

1.

Q9. Which of the following ranges is nearest to your expected income, before taxes, from your nursing activity in this calendar year? (circle the number)

1. LESS THAN $5,000.
2. $5,000. - 9,999.
3. $10,000. - 19,999.
4. $20,000. - 34,999.
5. $35,000. - 49,999.
6. $50,000. OR MORE

Q10. What was your basic nursing education? (circle the number)

1. DIPLOMA PROGRAM
2. ASSOCIATE PROGRAM
3. BACCALAUREATE PROGRAM
4. OTHER (specify: _____)

Q11 What is the highest level of education you have attained? (circle the number)

1. DIPLOMA IN NURSING
2. ASSOCIATE DEGREE IN NURSING
3. BACCALAUREATE DEGREE - NURSING
4. BACCALAUREATE DEGREE - NON-NURSING
5. MASTERS DEGREE - NURSING
6. MASTERS DEGREE - NON-NURSING
7. OTHER (specify: _____)

Q12 How many years have you practiced as a registered nurse?

_____ years

Q13. What type of hospice program are you presently involved with? (circle the number)

1. HOSPITAL BASED PROGRAM WHICH INCLUDES HOME CARE
2. HOSPITAL BASED PROGRAM WHICH DOES NOT INCLUDE HOME CARE
3. FREESTANDING HOSPICE PROGRAM
4. HOME CARE HOSPICE AGENCY
5. OTHER (specify: _____)

Q14. My position with the hospice is: (circle the number)

1. Paid
2. Volunteer

Q15. How many hours per week do you spend working for the hospice?

_____ hours

Q16. What shifts do you usually work? (circle the number)

1. DAYS
2. EVENINGS
3. NIGHTS
4. ROTATING
5. FLEXIBLE

1.

Q17. Which of the following best describes your current position? (circle the number)
1. STAFF NURSE
2. HEAD NURSE
3. SUPERVISOR/COORDINATOR
4. EDUCATOR
5. ADMINISTRATOR
6. CLINICAL SPECIALIST
7. OTHER (specify: _____)

Q18 How long have you worked in a hospice care setting?
_____ YEARS _____ MONTHS

Q19 How long have you worked in your present hospice care setting?
_____ YEARS _____ MONTHS

Q20. How many of your patients have died in the last month?
_____ patients

Q21 For how many of these deaths were you present?
_____ deaths

Q22 Have you had specific education in:
a. Care of the dying patient? (circle the number)
1. NO
2. YES

b. Death and dying? (circle the number)
1. NO
2. YES

c. Was this education in the form of: (circle all that apply)
1. COLLEGE CREDIT COURSE
2. PROFESSIONAL CONTINUING EDUCATION COURSE
3. IN-SERVICE PROGRAM
4. COMMUNITY EDUCATION PROGRAM
5. OTHER (specify: _____)

Q23. Did you receive specific training for the job you now hold? (circle the number)
1. YES
2. NO

Q24. Does your program offer regular support groups for hospice staff?
1. YES
2. NO

Q25. To what extent have you been frustrated in your clinical work by a lack of funding available to pay for services? (circle the number)

1	2	3	4	5	6	7
Not frustrated at all		Frustrated at times			Often Frustrated	

1.

Q26. What is your religious preference? (circle the number)
1. PROTESTANT (specify: _____)
2. ROMAN CATHOLIC
3. JEWISH (specify: _____)
4. OTHER (specify: _____)
5. NONE

Q27. How important are your religious beliefs and practices? (cirle the number)

1 2 3 4 5 6 7

No importance; have no religion — Extremely important; religious faith is the center of my life

Q28. Which of the following statements comes closest to expressing what you believe about God? (circle the number)
1. I DON'T BELIEVE IN GOD.
2. I DON'T KNOW WHETHER THERE IS A GOD AND I DON'T BELIEVE THERE IS ANY WAY TO FIND OUT.
3. I DON'T BELIEVE IN A PERSONAL GOD, BUT I DO BELIEVE IN A HIGHER POWER OF SOME KIND.
4. I BELIEVE THAT THERE IS A PERSONAL GOD WHO CREATED OUR UNIVERSE BUT IS NO LONGER INVOLVED IN THE OPERATION OF IT.
5. I BELIEVE IN A PERSONAL GOD WHO CREATED OUR UNIVERSE AND IS VITALLY INVOLVED IN THE DETAILS OF ITS OPERATION.

Q29. To what extent do you believe there is life after death? (circle the number)
1. FIRMLY BELIEVE THERE IS
2. MODERATELY BELIEVE THERE IS
3. NOT SURE
4. MODERATELY BELIEVE THERE IS NOT
5. FIRMLY BELIEVE THERE IS NOT

Q30. Which of the following statements comes closest to expressing what you believe. (circle the number)
1. I DO NOT BELIEVE IN LIFE AFTER DEATH.
2. I BELIEVE THAT AFTER DEATH THE ESSENCE OF THE DECEASED REJOINS THAT OF THE UNIVERSAL ESSENCE
3. I BELIEVE THAT THE SOUL OF THE DECEASED IS REINCARNATED AT A LATER TIME.
4. I BELIEVE THAT THE SOUL OF THE DECEASED PASSES INTO A SPIRITUAL REALM WHICH IS OVERSEEN BY A PERSONAL GOD.

1.

Instructions: If you circled response 1, 2, or 3 on item 30 you have completed this data form. Please begin to answer the questions on the next section of the booklet. Do not respond to items 31 and 32.

If you circled response 4 on item 30 please answer items 31 and 32.

Q31. Which of the following statements comes closest to expressing what you believe. (circle the number)
1. I BELIEVE BECAUSE GOD LOVES EVERYONE, ALL OF THE DECEASED ARE ACCEPTED INTO THE DIVINE PRESENCE.
2. I BELIEVE IF PEOPLE PERFORM SUFFICIENT GOOD WORKS, THEY WILL BE ACCEPTED INTO GOD'S PRESENCE AT DEATH.
3. I BELIEVE THAT MEMBERSHIP IN A PARTICULAR RELIGIOUS GROUP INSURES ACCEPTANCE BY GOD OF THE DECEASED INTO THE DIVINE PRESENCE.
4. I BELIEVE THAT GOD ACCEPTS INTO THE DIVINE PRESENCE ONLY THOSE DECEASED WHO HAVE FAITH IN JESUS CHRIST.

Q32. To what extent do you believe there is the possibility of a negative life after death (i.e. separation from God; hell, purgatory)? (circle the number)
1. FIRMLY BELIEVE THERE IS
2. MODERATELY BELIEVE THERE IS
3. NOT SURE
4. MODERATELY BELIEVE THERE IS NOT
5. FIRMLY BELIEVE THERE IS NOT

Instructions for Section 2

Hassles are irritants that can range from minor annoyances to fairly major pressures, problems, or difficulties. They can occur few or many times in any given time period. Listed on the following pages are a number of ways in which a person can feel hasseled.

When you respond to the items, you must have a specific time period in mind. Please respond to the items with the last month in mind.

Read each item and circle "0" if the item was no hassle for you in the last month. If it was a hassle, indicate how severe the hassle was by circling "1", "2", or "3".

2.

How much of a hassle was this for you?		Severity: None or Did Not Occur	Somewhat Severe	Moderately Severe	Extremely Severe
1.	Misplacing or losing things.	0	1	2	3
2.	Troublesome neighbors.	0	1	2	3
3.	Social obligations	0	1	2	3
4.	Inconsiderate smokers	0	1	2	3
5.	Troubling thoughts about your future	0	1	2	3
6.	Thoughts about death	0	1	2	3
7.	Health of a family member	0	1	2	3
8.	Not enough money for clothing	0	1	2	3
9.	Not enough money for housing	0	1	2	3
10.	Concerns about owing money	0	1	2	3
11.	Cocerns about getting credit	0	1	2	3
12.	Concerns about money for emergencies	0	1	2	3
13.	Someone owes you money	0	1	2	3
14.	Financial responsibility for someone who doesn't live with you.	0	1	2	3
15.	Cutting down on electricity,water, etc.	0	1	2	3
16.	Smoking too much	0	1	2	3
17.	Use of alcohol	0	1	2	3
18.	Personal use of drugs	0	1	2	3
19.	Too many responsibilities	0	1	2	3
20.	Decisions about having children	0	1	2	3
21.	Nonfamily members living in your house	0	1	2	3
22.	Care for pet	0	1	2	3
23.	Planning meals	0	1	2	3
24.	Concerned about the meaning of life	0	1	2	3
25	Trouble relaxing	0	1	2	3
26.	Trouble making decisions	0	1	2	3
27	Problems getting along with fellow workers	0	1	2	3
28.	Customers or clients give you a hard time	0	1	2	3
29.	Home maintenance (inside)	0	1	2	3
30.	Concerns about job security	0	1	2	3

2.

How much of a hassle was this for you?		Severity: None or Did Not Occur	Somewhat Severe	Moderately Severe	Extremely Severe
31.	Concerns about retirement	0	1	2	3
32.	Laid-off or out of work	0	1	2	3
33.	Don't like current work duties	0	1	2	3
34.	Don't like fellow workers	0	1	2	3
35.	Not enough money for basic necessities	0	1	2	3
36.	Not enough money for food	0	1	2	3
37.	Too many interruptions	0	1	2	3
38.	Unexpected company	0	1	2	3
39.	Too much time on hands	0	1	2	3
40.	Having to wait	0	1	2	3
41.	Concerns about accidents	0	1	2	3
42.	Being lonely	0	1	2	3
43.	Not enough money for health care	0	1	2	3
44	Fear of confrontation	0	1	2	3
45	Financial security	0	1	2	3
46.	Silly practical mistakes	0	1	2	3
47.	Inability to express yourself	0	1	2	3
48.	Physical illness	0	1	2	3
49.	Side effects of medication	0	1	2	3
50.	Concerns about medical treatment	0	1	2	3
51.	Physical appearance	0	1	2	3
52.	Fear of rejection	0	1	2	3
53.	Difficulties with getting pregnant	0	1	2	3
54.	Sexual problems that result from physical problems	0	1	2	3
55.	Sexual problems other than those resulting from physical problems	0	1	2	3
56.	Concerns about health in general	0	1	2	3
57.	Not seeing enough people	0	1	2	3
58.	Friends or relatives too far away	0	1	2	3
59.	Preparing meals	0	1	2	3
60.	Wasting time	0	1	2	3

2.

How much of a hassle was this for you?		Severity: None or Did Not Occur	Somewhat Severe	Moderately Severe	Extremely Severe
61.	Auto maintenance	0	1	2	3
62.	Filling out forms	0	1	2	3
63.	Neighborhood deterioration	0	1	2	3
64.	Financing children's education	0	1	2	3
65.	Problems with employees	0	1	2	3
66.	Problems on job due to being a woman or man	0	1	2	3
67.	Declining physical abilities	0	1	2	3
68.	Being exploited	0	1	2	3
69.	Concerns about bodily functions	0	1	2	3
70.	Rising prices of common goods	0	1	2	3
71.	Not getting enough rest	0	1	2	3
72.	Not getting enough sleep	0	1	2	3
73.	Problems with aging parents	0	1	2	3
74.	Problems with your children	0	1	2	3
75.	Problems with persons younger than yourself	0	1	2	3
76.	Problems with your lover	0	1	2	3
77.	Difficulties seeing or hearing	0	1	2	3
78.	Overloaded with family responsibilities	0	1	2	3
79.	Too many things to do	0	1	2	3
80.	Unchallenging work	0	1	2	3
81.	Concerns about meeting high standards	0	1	2	3
82.	Financial dealings with friends or acquaintances	0	1	2	3
83.	Job dissatisfaction	0	1	2	3
84.	Worries about decisions to change jobs	0	1	2	3
85.	Trouble with reading, writing, or spelling abilities	0	1	2	3
86.	Too many meetings	0	1	2	3
87.	Problems with divorce or separation	0	1	2	3
88.	Trouble with arithmetic skills	0	1	2	3
89.	Gossip	0	1	2	3
90.	Legal problems	0	1	2	3

2.

How much of a hassle was this for you?		Severity: None or Did Not Occur	Somewhat Severe	Moderately Severe	Extremely Severe
91.	Concerns about weight	0	1	2	3
92.	Not enough time to do the things you need to do	0	1	2	3
93.	Television	0	1	2	3
94.	Not enough personal energy	0	1	2	3
95.	Concerns about inner conflicts	0	1	2	3
96.	Feel conflicted over what to do	0	1	2	3
97.	Regrets over past decisions	0	1	2	3
98.	Menstrual (period) problems	0	1	2	3
99.	The weather	0	1	2	3
100.	Nightmares	0	1	2	3
101.	Concerns about getting ahead	0	1	2	3
102.	Hassles from boss or supervisor	0	1	2	3
103.	Difficulties with friends	0	1	2	3
104.	Not enough time for family	0	1	2	3
105.	Transportation problems	0	1	2	3
106.	Not enough money for transportation	0	1	2	3
107.	Not enough money for entertainment and recreation	0	1	2	3
108.	Shopping	0	1	2	3
109.	Prejudice and discrimination from others	0	1	2	3
110.	Property, investments, or taxes	0	1	2	3
111.	Not enough time for entertainment and recreation	0	1	2	3
112.	Yardwork or outside home maintenance	0	1	2	3
113.	Concerns about news events	0	1	2	3
114.	Noise	0	1	2	3
115.	Crime	0	1	2	3
116.	Traffic	0	1	2	3
117.	Pollution	0	1	2	3

3.

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

		Agree Very Much	Agree Pretty Much	Agree a Little	Disagree a Little	Disagree Pretty Much	Disagree Very Much
1.	I feel fatigued during the work day.	1	2	3	4	5	6
2.	Lately, I have missed work due to either colds, the flu, fever, or other illnesses.	1	2	3	4	5	6
3.	Once in a while I lose my temper and get angry on the job.	1	2	3	4	5	6
4.	All my work habits are good and desireable ones.	1	2	3	4	5	6
5.	I experience headaches while on the job.	1	2	3	4	5	6
6.	After work I often feel like relaxing with a drink of alcohol.	1	2	3	4	5	6
7.	I never gossip about other people at work.	1	2	3	4	5	6
8.	I feel that the pressures of work have contributed to marital and family difficulties in my life.	1	2	3	4	5	6
9.	I am never late for an appointment.	1	2	3	4	5	6
10.	I often have the desire to take medication (e.g., tranquilizer) to calm down while at work.	1	2	3	4	5	6
11.	I have lost interest in my patients and I have a tendency to treat these people in a detached, almost mechanical fashion.	1	2	3	4	5	6
12.	At work I occaisionally think of things that I would not want other people to know about.	1	2	3	4	5	6
13.	I often feel discouraged at work and often think about quitting	1	2	3	4	5	6
14.	I frequently get angry and irritated with patients.	1	2	3	4	5	6
15.	I am sometimes irritable at work.	1	2	3	4	5	6

3.

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

		Agree Very Much	Agree Pretty Much	Agree a Little	Disagree a Little	Disagree Pretty Much	Disagree Very Much
16.	I have trouble getting along with my fellow employees.	1	2	3	4	5	6
17.	I am very concerned with my own comfort and welfare at work.	1	2	3	4	5	6
18.	I try to avoid my supervisors.	1	2	3	4	5	6
19.	I truly like all my fellow employees.	1	2	3	4	5	6
20.	I always do what is expected of me at work, no matter how inconvenient it might be to do so.	1	2	3	4	5	6
21.	I am having some work performance problems lately due to uncooperative patients.	1	2	3	4	5	6
22.	All the rules and regulations at work keep me from performing my job duties.	1	2	3	4	5	6
23.	Sometimes at work I put off until tomorrow what I ought to do today.	1	2	3	4	5	6
24.	I do not always tell the truth to my supervisor or co-workers.	1	2	3	4	5	6
25.	I find my work environment depressing.	1	2	3	4	5	6
26.	I feel uncreative and unstimulated at work.	1	2	3	4	5	6
27.	I often think about finding a new job.	1	2	3	4	5	6
28.	Worrying about my job has been interfering with my sleep.	1	2	3	4	5	6
29.	I feel there is little room for advancement at my place of employment.	1	2	3	4	5	6
30.	I avoid patient interaction when I go to work.	1	2	3	4	5	6

4.

DESCRIBE YOUR FAMILY NOW: (If you are not living in a family situation presently, describe your family of origin.)

		Almost never	Once in a while	Sometimes	Frequently	Almost always
1.	Family members ask each other for help.	1	2	3	4	5
2.	In solving problems, the children's suggestions are followed..	1	2	3	4	5
3.	We approve of each others friends.	1	2	3	4	5
4.	Children have a say in their discipline.	1	2	3	4	5
5.	We like to do things with just our immediate family.	1	2	3	4	5
6.	Different persons act as leaders in our family.	1	2	3	4	5
7.	Family members feel closer to other family members than to people outside the family.	1	2	3	4	5
8.	Our family changes its way of handling tasks.	1	2	3	4	5
9.	Family members like to spend free time with each other.	1	2	3	4	5
10.	Parent(s) and children discuss punishment together.	1	2	3	4	5
11.	Family members feel very close to each other.	1	2	3	4	5
12.	The children make the decisions in our family.	1	2	3	4	5
13.	When our family gets together for activities, everybody is present.	1	2	3	4	5
14.	Rules change in our family.	1	2	3	4	5
15.	We can easily think of things to do together as a family.	1	2	3	4	5
16.	We shift household responsibilities from person to person.	1	2	3	4	5
17.	Family members consult other family members on their decisions.	1	2	3	4	5
18.	It is hard to identify the leader(s) in our family.	1	2	3	4	5
19.	Family togetherness is very important.	1	2	3	4	5
20.	It is hard to tell who does which household chores.	1	2	3	4	5

Instructions for Section 5

Instructions for Ways of Coping Scale

To respond to this questionaire, you must have a specific stressful situation in mind. Take a few moments and think about the most stressful hospice patient care situation that you have experienced in the **past two weeks.**

By "stressful" we mean a situation that was difficult or troubling for you, either because you felt distressed by what happened, or because you had to use considerable effort to deal with this situation. Before responding to the statements, think about the details of this stressful situation, such as where it happened, who was involved, how you acted, and why it was important to you. While you may still be involved in the situation, or it could have already happened, it should be the most stressful situation that you experienced during the two week period.

As you respond to each of the statements, please keep the stressful situation in mind. Read each statement carefully and indicate, by filling in the appropriate circle, to what extent you used it in the situation. Please respond to each item.

Please write a brief description of your stressful situation below.

5.

		Does not apply or not used	Used Somewhat	Used quite a bit	Used a great deal
1.	I just concentrated on what I had to do next--the next step.	0	1	2	3
2.	I tried to analyze the problem in order to understand it better.	0	1	2	3
3.	I turned to work or another activity to take my mind off things.	0	1	2	3
4.	I felt that time would make a difference--the only thing was to wait.	0	1	2	3
5.	I bargained or compromised to get something positive from the situation.	0	1	2	3
6.	I did something that I didn't think would work, but at least I was doing something.	0	1	2	3
7.	I tried to get the person responsible to change his or her mind.	0	1	2	3
8.	I talked to someone to find out more about the situation.	0	1	2	3
9.	I criticized or lectured myself.	0	1	2	3
10.	I tried not to burn my bridges, but leave things open somewhat.	0	1	2	3
11.	I hoped for a miracle.	0	1	2	3
12.	I went along with fate; sometimes I just have bad luck.	0	1	2	3
13.	I went on as if nothing had happened.	0	1	2	3
14.	I tried to keep my feelings to myself.	0	1	2	3
15	I looked for the silver lining, so to speak; I tried to look on the bright side of things.	0	1	2	3
16.	I slept more than usual.	0	1	2	3
17.	I expressed anger to the person(s) who caused the problem.	0	1	2	3
18.	I accepted sympathy and understanding from someone.	0	1	2	3
19.	I told myself things that helped me feel better.	0	1	2	3
20.	I was inspired to do something creative about the problem.	0	1	2	3
21.	I tried to forget the whole thing.	0	1	2	3

5.

		Does not apply or not used	Used Somewhat	Used quite a bit	Used a great deal
22.	I got professional help.	0	1	2	3
23.	I changed or grew as a person.	0	1	2	3
24.	I waited to see what would happen before doing anything.	0	1	2	3
25.	I apologized or did something to make up.	0	1	2	3
26.	I made a plan of action and followed it.	0	1	2	3
27.	I accepted the next best thing to what I wanted.	0	1	2	3
28.	I let my feelings out somehow.	0	1	2	3
29.	I realized that I had brought the problem on myself.	0	1	2	3
30.	I came out of the experience better than when I went in.	0	1	2	3
31.	I talked to someone who could do something concrete about the problem.	0	1	2	3
32.	I tried to get away from it for a while by resting or taking a vacation.	0	1	2	3
33.	I tried to make myself feel better by eating, drinking, smoking, using drugs, or medications, etc.	0	1	2	3
34.	I took a big chance or did something very risky to solve the problem.	0	1	2	3
35.	I tried not to act too hastily or follow my first hunch.	0	1	2	3
36.	I found new faith.	0	1	2	3
37.	I maintained my pride and kept a stiff upper lip.	0	1	2	3
38.	I rediscovered what is important in life.	0	1	2	3
39.	I changed something so things would turn out all right.	0	1	2	3
40.	I generally avoided being with people.	0	1	2	3
41.	I didn't let it get to me; I refused to think too much about it.	0	1	2	3
42.	I asked advice from a relative or friend I respected.	0	1	2	3

5.

		Does not apply or not used	Used Somewhat	Used quite a bit	Used a great deal
43.	I kept others from knowing how bad things were.	0	1	2	3
44.	I made light of the situation; I refused to get too serious about it.	0	1	2	3
45.	I talked to someone about how I was feeling.	0	1	2	3
46.	I stood my ground and fought for what I wanted.	0	1	2	3
47.	I took it out on other people.	0	1	2	3
48.	I drew on my past experiences; I was in a similar situation before.	0	1	2	3
49.	I knew what had to be done, so I doubled my efforts to make things work.	0	1	2	3
50.	I refused to believe that it had happened.	0	1	2	3
51	I promised myself that things would be different next time.	0	1	2	3
52.	I came up with a couple of different solutions to the problem.	0	1	2	3
53.	I accepted the situation, since nothing could be done.	0	1	2	3
54.	I tried to keep my feelings about the problem from interfering with other things.	0	1	2	3
55.	I wished that I could change what had happened or how I felt.	0	1	2	3
56.	I changed something about myself.	0	1	2	3
57.	I daydreamed or imagined a better time or place than the one I was in.	0	1	2	3
58.	I wished that the situation would go away or somehow be over with.	0	1	2	3
59.	I had fantasies or wishes about how things might turn out.	0	1	2	3
60.	I prayed.	0	1	2	3
61.	I prepared myself for the worst.	0	1	2	3
62.	I went over in my mind what I would say or do.	0	1	2	3
63.	I thought about how a person I admire would handle this situation and used that as a model.	0	1	2	3
64.	I tried to see things from the other persons point of view.	0	1	2	3
65.	I reminded myself how much worse things could be.	0	1	2	3
66.	I jogged or exercised.	0	1	2	3

6.

Please think about members of your immediate family and close relatives. Circle the number which corresponds to the response which best answers the question. To what extent:

		All of the time	Often	Sometimes	Not often	Not at all
a.	Do they make you feel loved?	1	2	3	4	5
b.	Do they do things to make you happy?	1	2	3	4	5
c.	Can you rely on them, no matter what?	1	2	3	4	5
d.	Would they see that you were taken care of, if you needed to be?	1	2	3	4	5
e.	Do they accept you just as you are?	1	2	3	4	5

Now think about your close friends. To what extent:

a.	Do they make you feel loved?	1	2	3	4	5
b.	Do they do things to make you happy?	1	2	3	4	5
c.	Can you rely on them, no matter what?	1	2	3	4	5
d.	Would they see that you were taken care of, if you needed to be?	1	2	3	4	5
e.	Do they accept you just as you are?	1	2	3	4	5

Now think about the people you work with. To what extent:

a.	Do they make you feel loved?	1	2	3	4	5
b.	Do they do things to make you happy?	1	2	3	4	5
c.	Can you rely on them, no matter what?	1	2	3	4	5
d.	Would they see that you were taken care of, if you needed to be?	1	2	3	4	5
e.	Do they accept you just as you are?	1	2	3	4	5

7.

Please respond to each item by marking either T for "This is mostly true about me" or F for "This is mostly not true about me".

True	False		
T	F	1.	I am very much afraid to die.
T	F	2.	The thought of death seldom enters my mind.
T	F	3.	It doesn't make me nervous when people talk about death.
T	F	4.	I dread to think about having to have an operation.
T	F	5.	I am not at all afraid to die.
T	F	6.	I am not particularly afraid of getting cancer.
T	F	7.	The thought of death never bothers me.
T	F	8.	I am often distracted by the way time flies so very rapidly.
T	F	9.	I fear dying a painful death.
T	F	10.	The subject of life after death troubles me greatly.
T	F	11.	I am really scared of having a heart attack.
T	F	12.	I often think about how short life really is.
T	F	13.	I shudder when I hear people talking about a World War III.
T	F	14.	The sight of a dead body is horrifying to me.
T	F	15.	I feel that the future holds nothing for me to fear.

Western Seminary

Dear Oregon Hospice Nurse,

As a hospice nurse you face many daily challenges. Your role is often multifaceted as you work to meet the demands of your patients, their families, and the organization for which you work. The performance of your role may at times lead to stress which ultimately can result in burnout. Much research has been done on the nature of burnout and its prevention. This study is an attempt to fit the realities of your person, and your work experience with the knowledge gained through research. The intention is that the information which you provide will assist in better supporting you and your colleagues in your effort to deliver optimum care while living a balanced life. This study has been encouraged by the Oregon Hospice Association.

Your participation in this study is vital to an accurate understanding of those working in your profession in the state of Oregon. Each hospice nurse is unique and there are not very many of you in Oregon, therefore, it is important that each questionnaire be returned to assure an accurate profile of Oregon hospice nurses.

You may be assured of complete confidentiality. Your responses will be received anonymously. Your employer will not have knowledge of your responses. The questionnaire has an identification number on it for follow-up purposes only. This is so I can ascertain how many nurses have responded from your program. Your name will never appear on the questionnaire. It will require about sixty minutes to finish the questionnaire.

The results of this research will be made available to interested persons in the hospice care profession. You may receive a summary of results by writing "copy of results requested" on the back of the return envelope, and printing your name and address below it. Please do not put this information on the questionnaire itself.

Your response would be very helpful. However, you are under no obligation to participate. The return of this survey booklet will constitute voluntary, informed consent to participate in this study.

I would be most happy to answer any questions you might have. Please write or call. The telephone number is (503) 364-6093. A second contact person would be Dr. Rodger Bufford at (503) 233-8561.

Thank you for your assistance!

Sincerely,

William W. Davis
Project Director

January 22, 1990

Dear Oregon Hospice Nurse,

I trust that you have received the Oregon Hospice Nurse Study Questionnaire from your supervisor and have given careful consideration to your participation in this study. It is important that as many nurses as possible take the time to fill out the questionnaire and mail it in. There are less than 250 registered nurses doing hospice care in the state of Oregon. Each participating nurse adds to the ability of the study to make an increasingly more significant contribution to your work.

If you have already filled out your questionnaire and mailed it in, you have my sincere thanks. If you have not yet filled out your questionnaire, please take time to do so. Data gathering for this study will close on February 3, 1990. Please return your questionnaire by that date. If your questionnaire has been lost or destroyed or if you have any questions about the study, please feel free to call or write me at the address below, and I will rush another copy to you.

Thank you for your consideration in this matter. Your participation is greatly appreciated.

Sincerely,

William W. Davis
Project Director
Mid-Valley Counseling Center
876 Welcome Way S.E.
Salem, Oregon 97302
(503) 364-6093

Appendix C

Coding Information and Raw Data

```
SET BEEP=OFF MORE=OFF PRINT=ON
DATA LIST FILE='DAVIS1.DAT'/ID 1-4 HOSP 6-8 Q1 10 Q2 11
G3 12-13 Q4 14 Q5 15 Q6 16 Q71 18 Q72 19 Q73 20 Q74 21
Q75 22 Q8 24 Q9 25 Q10 26 Q11 27 Q12 28-32 Q13 34 Q14
35 Q15 37-38 Q16 40 Q17 41 Q18Y 43-44 Q18M 45-46 Q19Y
47-48 Q19M 49-50 Q20 51-52 Q21 53-54 Q22A 56 Q22B 57
Q22C1 59Q22C2 60 Q22C3 61 Q22C4 62 Q22 C5 63 Q23 65 Q24
66 Q25 67 Q26 68 Q27 69 Q28 70 Q29 71 Q30 72 Q31 74 Q32
75 HTOT1 81-84(2) HTOT2 90-92(2) H11 98-100(2) H12 106-
108(2) H21 114-116(2) h22 122-124(2) H31 130-132(2)
H32138-140(2) h41 146-149(2) H42 155-157(2) H51 163-
165(2) h52 172-173(2) h6: 179-181(2) H62 187-189(2) H71
193-195(2) H72 201-203(2) H81 209-211(2) H82 217-219(2)
B1 244 B2 245 B3 246 B4 247 B5 248 B6 249 B7 250 BB 251
B9 252 B10 253 B11 254 B12 255 B13 256 B14 257 B15 258
B16 260 B17 261 B18 262 B19 263 B20 264 B21 265 B22 266
B23 267 B24 268 B25 269 B26 270 B27 271 B28 272 B29 273
B30 274 F1 276 F2 277 F3 278 F4 279 F5 280 F6 281 F7
282 F8 283 F9 284 F10 285 F11 286 F12 287 F13 288 F14
289 F15 290 F16 291 F17 292 F18 293 F19 294 F20 295 C2
301-302(2) C3 309-311(2) C4 317-319(2) C5 325-327(2) C6
335-337(2) C7 343-345(2) C6 351-353(2) S1 362 S2 363 S3
364 S4 365 S5 366 S6 367 S7 368 S8 369 S9 370 S10 371
S11 372 S12 373 S13 374 S14 375 S15 376 D1 378 D2 379
D3 380 D4 381 D5 382 D6 383 D7 384 D8 385 D9 386 D10
387 D11 388 D12 389 D13 390 D14 391 D15 392.
MISSING VALUES Q3 Q12 Q15Y Q18M Q19Y Q19M Q20 Q21 (99)
/Q4 Q6 Q9 Q11 Q13 Q14 Q16 Q17 Q22B Q22C1 TO Q22C5 Q23
Q24 Q28 Q29 Q30 Q31 Q32 B1 TO B30 F1 TO F20 S1 TO S15
D1 TO D15 (9).
COMPUTE Q18=(Q18Y*12)+Q18M.
COMPUTE Q19=(Q19Y*12)+Q19M.
RECODE B1 TO B30 (1=7)(2=6)(3=5)(4=3)(5=2)(6=1).
IF (ID = 1201) B14=2.
IF (ID = 1903) B28=2.
IF (ID = 1210) B8=2.
IF (ID = 3202) B18=1.
IF (ID = 2801) B24=0.
IF (ID = 1210) B9=0.
COMPUTE
BURNCUT=B1+B2+B5+B6+B8+B10+B11+B13+B14+B16+B17+B18+B21+
B22+B25+B26+B28+B29+B30.
RECODE B3 B12 B15 B23 B24 (1=1)(2 THRU 7=0).
RECODE B4 B7 B9 B19 B20 (7=1)(1 THRU 6=0).
COMPUTE LIE=B3+B4+B7+B9+B12+B15+B19+B20+B23+B24.
IF (ID = 2405) F3=3.
IF (ID = 2903) F7=4.
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IF (ID = 1309) F4=4.
IF (ID = 0801) F10=4.
IF (ID = 0105) F14=2.
IF (ID = 2601) F10=3.
IF (ID = 1307) F10=3.
IF (ID = 2903) F8=3.
COMPUTE COHES=F1+F3+F5+F7+F9+F11+F13+F15+F17+F19.
COMPUTE ADAPT=F2+F4+F6+F8+F10+F12+F14+F16+F18+F20.
IF (ID = 1201) S8=2.
IF (ID = 2802) S14=2.
COMPUTE SA=S1+S2+S3+S4+S5.
COMPUTE SB=S6+S7+S8+S9+S10.
COMPUTE SC=S11+S12+S13+S14+S15.
COMPUTE SABC=SA+SB+SC.
COMPUTE WCSUM=C2+C3+C4+C5+C6+C7+C8.
COMPUTE WC2 = (C2/WCSUM).
COMPUTE WC3 = (C3/WCSUM).
COMPUTE WC4 = (C4/WCSUM).
COMPUTE WC5 = (C5/WCSUM).
COMPUTE WC6 = (C6/WCSUM).
COMPUTE WC7 = (C7/WCSUM).
COMPUTE WC8 = (C8/WCSUM).
IF (ID = 1307) D2=1.
IF (D1 = 1) DA1=1.
IF (D1 = 2) DA1=0.
IF (D2 = 2) DA2=1.
IF (D2 = 1) DA2=0.
IF (D3 = 2) DA3=1.
IF (D3 = 1) DA3=0.
IF (D4 = 1) DA4=1.
IF (D4 = 2) DA4=0.
IF (D5 = 2) DA5=1.
IF (D5 = 1) DA5=0.
IF (D6 = 2) DA6=1.
IF (D6 = 1) DA6=0.
IF (D7 = 2) DA7=1.
IF (D7 = 1) DA7=0.
IF (D8 = 1) DA8=1.
IF (D8 = 2) DA8=0.
IF (D9 = 1) DA9=1.
IF (D9 = 2) DA9=0.
IF (D10 = 1) DA10=1.
IF (D10 = 2) DA10=0.
IF (D11 = 1) DA11=1.
IF (D11 = 2) DA11=0.
IF (D12 = 1) DA12=1.
IF (D12 = 2) DA12=0.
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IF (D13 = 1) DA13=1.
IF (D13 = 2) DA13=0.
IF (D14 = 1) DA14=1.
IF (D14 = 2) DA14=0.
IF (D15 = 2) DA15=1.
IF (D15 = 1) DA15=0.
COMPUTE
DATOT=DA1+DA2+DA3+DA4+DA5+DA6+DA7+DA8+DA9+DA10+DA11+DA1
2+DA13+DA14+DA15.
SAVE OUTFILE='DAVIS.SYS'.
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22 01100 11516514 42      3000      137      100       50
300       33      100       20       200       18      300
30      600       67   500      129      200       25
664256551666664 536116666646646 435343534362523333 42
67        17      100       83       113      117      143
222112233333343 221112221221221

3003  10 1235422 20000 4433 10.5 41 32 11 06050605 2 0
22 01000 12352322 99      3000      117      200       75
700       78       00       00       600       64       00
00      300       44   100       14      300       38
265212555665433 526444535443345 444444434443535453
167        33      171      283         25      183       14
222222222222222 221122211221222

1402  20 1554222 00001 2411 31.0 11 40 13 03070307 9 0
22 01100 11117514 14      5000      160      300      150
700       89       00       00       700       91      400
70      600      111   300       86      400       88
252533314622562 536126525356662 544444444154234443 52
83        50       86      133         38      100      114
112111121112222 222122211221122

0901 100 1341522 00000 2311 10.0 31 20 13 04000002 4 0
22 00100 21414551 99      2000      100      100       25
200       22      100       20       300       27      200
20      400       44   100       14      100       13
366266666656666 666136656666666 533333433244324332 42
50        33       86       33         13      117       57
111112243222222 211122222222122

1309  10 2236221 00000 5436 10.0 41 20 11 00090009 5 1
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300       33       00       00       100       18      200
20      300       44   200       29       00       00
562321555662665 553425336666636 334925444543244343 32
50       117      257      133         25      150       57
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1308  10 1244122 00110 4333  5.3 11 10 11 03060006 2 0
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700      200      300      100      1100      245      700
100      800      211   700      300      600      125
122213222463252 533225316333335 234444424322344224 32
150       167      171       83       163      133       71
444332222233333 221221211221122
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22 01000 22717513 99     3900     159     200      50
700     167     300     120      700     100     300
50     100      11   300      57     100      13
166526431663263 666216326563266 224252434442425333 42
50       17      57      83       50     117      29
111112222233332 221111112221222

0801  10 1551522 00011 4411 25.0 11 40 13 10001000 9 0
22 01100 21527514 25     3300     112     300     100
200      22      00      00      600      64     500
50     400      44   400      86      00      00
516353552662566 666116424555516 335525442933232434 23
183       50     214     183       75     200      43
332231211111111 221121212211122

2302 100 1240322 01000 4333  8.0 11 20 11 00090009 3 0
22 11100 21317551 99     1100     109     100      25
200      22     100      20      200      18     200
30      00      00    00       00      00      00
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33       33     129     100       63     167     129
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00      00      00      00      500      45     600
60     100      11   200      43     200      38
362441634663563 633225224644336 443243514142413223 51
67       67     143     183       25     133     114
121121222222112 221222212221122

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60     300      33   300      43     500      63
665666565662466 636236636665666 534254534141415132 51
17       50     157     100       88     150      71
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2701 100 1247422 00100 3411 25.0 11 40 11 01060106 2 1
11 00000 21225514 12     7400     120     300     125
900     122     200      40     1000     100     800
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333239999999999 211111212222122

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11 00000 22612322 99      3800      108      100       50
400       56      300       60       500       45      200
20      400       44   100       14      400       63
565263556666654 656126656556656 534355555535242543151
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67        00      100      183         88      183      157
121212222222222 111222221222221

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80      200       22   200       29      300       38
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222123334322222 211212211221112

0605 100 1245422 00100 5435 23.0 31 45 13 05000005 2 0
22 01000 22513242 99      2900      117       00       00
700      111      100       20       800       91      300
30      100       11   100       14       00       00
263543352665664 636145336656516 445434344444334333
100       150      143      217         13      183       29
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1207 100 1243222 00100 5511 20.0 51 99 11 00060006 0 0
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70      100       11   200       71      200       75
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00        00       57      117         00      133       29
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22 01110 22614524 99      5000      142      400      125
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100      600       89    00       00      500       88
146344433656355 535115336442323 535354555535355535253
50       100      171      117        63      167       43
112123222233222 221211111222221

0103  10 1253422 00000 4411 32.0 91 06 11 03060306 3 0
22 00110 22314514 42      1400      136      300       75
200       22       00       00       100       27      100
20      100       22   200       29      200       38
565265465656566 666126656663666 533342333243223232 42
50        00      129       17         13      133       29
111221112222222 221211121221121

3005  10 1233521 00000 4427  5.0 41 08 11 02100210 099
12 10000 22552331 99      6200      166      300      100
500       78      600      220      1000      164      600
90      900      178   100       14      200       38
113213426634253 535455526212216 213124141112242434 23
50        50      114      217         50      150       86
222222233234332 221222222221221

1211 100 1635221 00000 5433  4.0 32 02 11 01090109 1 0
22 00100 12414514 43      3100      148      100       50
200       33       00       00       600       73      200
40      600      111    00       00      100       13
365255334665565 556226666665556 323241333121234332 32
17        50       43       83         00       17      157
222122333233443 221122222222222

1302  10 1344222 00100 4516 24.0 41 40 15 07000200 2 0
22 01100 11416514 14       300      100       00       00
00       00       00       00       00       00       00
00       00       00   200       29       00       00
666666565666666 666126666666666 434433443342332342 34
83        33       71       67         13      100      100
121111111111121 221112221222221

1101 100 1234122 10000 5123 14.0 32 16 11 03060306 0 0
22 11100 22324524 13      2100      100       00       00
600       67      100       20       700       64      100
10      200       22   100       14       00       00
335235343655553 555225335555555 434344313433333133 33
50        50       71      100         00      150       14
322232232233332 221221212221121
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22 01100 22717514 42      2400      221       00       00
800      244       00       00       500      100       00
00       00       00   200       43      300       63
366366325666465 666226235666666 435444434441444342 52
83        67      157      217         50      267      243
111111111111111 211211112222221

0406  15 1240422 01100 4333 12.0 11 04 51 03010301 099
22 11100 11517514 41      3000      117      200       50
700      111      100       20       400       36      100
20       00       00   400       71       00       00
356236535655565 556226636565526 445343523452434341 53
17        17       71       83         25      133       57
021112222222222 222221222221222

0704  25 1253422 00001 5414 32.0 11 99 11 99999999 2 0
12 00110 12417514 41      2800      100      300       75
200       22      200       40       600       55      400
40      200       22   300       43      100       13
356266262666666 656126436666666 435243544154443243 52
00        00       00       00         00       00       00
999999999999999 999999999999999

0201 100 1266222 00001 2211 38.0 11 12 99 01030103 3 1
11 99999 22117514 41      4200      114      200       50
700       78       00       00       800       82      400
60      500       67   200       29      200       38
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33        50      129      167         13      183      186
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60 200 22 00 00 100 13
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90 500 100 300 71 200 38
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22 01000 12217514 41 2500 132 100 50
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Appendix D

Variables Measured Identified by Code, Level of Measurement, and Statistical Technique Applied in Initial Analysis

Variables Measured Identified by Code, Level of Measurement, and Statistical Technique Applied in Initial Analysis

Variable	Code	Level of Measurement	Statistic
Gender	GEN	Nominal	ANOVA
Marital status	MAR	Nominal	ANOVA
Age	AGE	Interval	Pearson
Community type	COM	Nominal	ANOVA
Race	RAC	Nominal	ANOVA
Parenthood	PAR	Nominal	ANOVA
Number of children	CHL	Interval	Pearson
Age of children	CHA	Interval	Pearson
Family income	FIN	Ordinal	Pearson
Nursing income	NIN	Ordinal	Pearson
Type of professional education	PED	Nominal	ANOVA
Level of professional education	LED	Nominal	ANOVA
Nursing experience	RNT	Interval	Pearson

(table continues)

(Table continued)

Variable	Code	Level of Measurement	Statistic
Hospice type	HOS	Nominal	ANOVA
Paid or volunteer	HPV	Nominal	ANOVA
Hospice hours	HOT	Interval	Pearson
Hospice shift	HSH	Nominal	ANOVA
Hospice position	HOP	Nominal	ANOVA
Hospice experience	HEX	Interval	Pearson
Quantity of patients who died last year	PTD	Interval	Pearson
Quantity of deaths witnessed	DPR	Interval	Pearson
Care of dying education	CED	Nominal	ANOVA
Death and dying education	DED	Nominal	ANOVA
Source of education	SED	Nominal	ANOVA

(table continues)

(Table continued)

Variable	Code	Level of Measurement	Statistic
Religious denomination	DEN	Nominal	ANOVA
Estimate of importance of religion	RES	Ordinal	Pearson
Belief about God	GOD	Nominal	ANOVA
Belief in afterlife	AFT	Ordinal	ANOVA
Belief about character of afterlife	AFN	Nominal	ANOVA
Belief about administration of afterlife	AFA	Nominal	ANOVA
Belief in possible negative afterlife	ANG	Ordinal	Pearson
Coping style:			
Scale 1:			

(table continues)

(Table continued)

Variable	Code	Level of Measurement	Statistic
Confrontive Scale 2:	CP1	Interval	Pearson
Distancing Scale 3:	CP2	Interval	Pearson
Self-Controlling Scale 4:	CP3	Interval	Pearson
Seek Social Support Scale 5:	CP4	Interval	Pearson
Accept Responsibility Scale 6:	CP5	Interval	Pearson
Escape-Avoidance Scale 7:	CP6	Interval	Pearson
Planful Problem Solving Scale 8:	CP7	Interval	Pearson
Positive Reappraisal	CP8	Interval	Pearson
Family cohesion	FAC	Interval	Pearson

(table continues)

(Table continued)

Variable	Code	Level of Measurement	Statistic
Family adaptability	FAC	Interval	Pearson
Burnout (work stress syndrome)	BOS	Interval	N/A
Burnout lie scale	BOL	Interval	N/A
Social support total	SST	Interval	Pearson
Social support family	SSR	Interval	Pearson
Social support friends	SSF	Interval	Pearson
Social support workers	SSW	Interval	Pearson
Daily hassles-amount	DHA	Interval	Pearson
Daily hassles -intensity	DHI	Interval	Pearson
Scale 1: Work	DH1	Interval	Pearson
Scale 2: Household	DH2	Interval	Pearson
Scale 3: Health	DH3	Interval	Pearson
Scale 4: Inner Concerns	DH4	Interval	Pearson

(table continues)

(Table continued)

Variable	Code	Level of Measurement	Statistic
Scale 5: Finances	DH5	Interval	Pearson
Scale 6: Environs	DH6	Interval	Pearson
Scale 7: Future	DH7	Interval	Pearson
Scale 8: Time	DH8	Interval	Pearson
Death Anxiety	DAS	Interval	Pearson
Derived risk indices:			
Index 1	DI1	Interval	Pearson
Index 2	DI2	Interval	Pearson
Index 3	DI3	Interval	Pearson
Index 4	DI4	Interval	Pearson
Index 5	DI5	Interval	Pearson
Index 6	DI6	Interval	Pearson
Index 7	DI7	Interval	Pearson
Support group	SGP	Nominal	ANOVA
On-site training	OST	Nominal	ANOVA
Time on job	TOJ	Interval	Pearson
Reimbursement	RMB	Ordinal	Pearson

Appendix E

Vita

VITA

WILLIAM W. DAVIS, M.A.

Personal Information

Business Address: William W. Davis, M.A.
Mid-Valley Counseling Center
876 Welcome Way S.E.
Salem, OR 97302
(503) 364-6093

Home Address: 3269 Lorian Lane S.E.
Salem, OR 97302

Date of Birth: September 12, 1947
Lexington, Nebraska

Marital Status: Married - three children

Education

1. Present — All but dissertation, Doctor of Psychology Degree, Western Conservative Baptist Seminary, Portland, Oregon

   Coursework included concentrations in the following: sociological and psychological theory; research and statistical methods related to the behavioral sciences; social work practice; clinical psychology including treatment and assessment of behavioral and emotional difficulties including marriage and family issues; biblical studies and theology.

2. 1987 — Master of Arts (Clinical Psychology), Western Conservative Baptist Seminary, Portland, Oregon

3. 1978 — Post-graduate work (Pastoral & Counseling Psychology), Western Conservative Baptist Seminary, Portland, Oregon

4. 1976 Master of Arts (Counseling Psychology), Chapman College, Orange, California

5. 1973 Graduate studies (Clinical Psychology), Pepperdine University, Los Angeles, California

6. 1971-73 Bachelor of Science (Social Science), Willamette University, Salem, Oregon

7. 1969-70 Upper Division, California State University, Hayward

8. 1967-68 Upper Division, University of California, Berkeley

9. 1965-67 Lower Division, Diablo Valley College, Concord, California

Experience

1. Volunteer

   1976, Counselor, Fullerton Community Counseling Service, Fullerton, California. Responsible for the management of a 10-family caseload comprised of families of adolescents in crisis. Supervisor: Eric Gruver, Ph.D. (10 hours/week, 34 weeks, 340 hours total)

   1974-76, Member, Counseling Advisory Committee, Counselor, Alpha Center, Placentia, California. Consultant to the director on matters of clinical procedure, volunteer counselor training, program evaluation and management systems. Other responsibilities included a caseload of family and individual counseling cases.

2. Practicum and Internship Experiences

1987 - Present, Psychological Intern, Western Psychological and Counseling Service Center, P.C., Portland, Oregon. This is a predoctoral clinical internship supervised by Rodger Bufford, Ph.D., Wayne Colwell, Ph.D., Paul Sundstrom, Ed.D., and Robert Buckler, M.D. The caseload included individual, marriage and family cases as well as psychological assessment. (2000 hours)

1986-87, Supervision of practicum students in the Pastoral Counseling Program at Western Conservative Baptist Seminary, Portland, Oregon. This included both individual and group supervision as well as personal growth counseling for students. Supervision provided by Dr. Norman Thiessen and Dr. Robert Buckler.

1976, Counselor, Fullerton Family Counseling Service, Fullerton, California. Responsibilities included the management of a 10-family caseload in a YMCA-sponsored program designed to respond to families of adolescents in crisis with temporary foster placement and intensive family counseling. Received training in Satir's conjoint family therapy model under the supervision of Eric Gruver, Ph.D.

1975, Counselor, Alpha Center, Inc., Placentia, California. Responsible for the management of 30 family, individual and group cases over a period of 1-1/2 years. Exposure was gained to treatment of heroin and other drug additions as well as a lower socioeconomic clientele in a barrio environment. Supervised by Quinten DeYoung, Ph.D., of Chapman College.

1972-73, Provided intelligence testing services for the Salem School District under the supervision of Dr. Derthick of Willamette University. Test administered and scored were the Wechsler Intelligence Scale for Children and the Stanford Binet.

1972-73, Group and Individual Counselor, Play Therapist, State of Oregon, Children's Services Division, Salem, Oregon. Responsible for a caseload of 14 clients, along with a group of mothers whose children were in play therapy. Responsible for some client evaluation for supervising caseworkers. Gained instruction in Axline's play therapy techniques as well as psychodynamic therapy and projective testing utilizing children's drawings. Supervised by Laszlo Desofi, MSW, and Jim Friesen, MSW.

1971-72, Group Co-Therapist, Oregon State Hospital, Salem, Oregon. Assisted psychiatric nurse in conducting group therapy on a receiving ward. Attended seminars in Jones' therapeutic community conducted by Dr. Jetmalani, Head of Psychiatric Resident Education.

3. Academic Appointments

1974, Graduate Assistantship, Department of Psychology, Chapman College, Orange, California.

4. Professional Background

1987 - Present, Adjunct Faculty, Western Conservative Baptist Seminary, Portland, Oregon. This position involves teaching courses in: Abnormal Psychology, Basic Counseling Techniques in the Pastoral Counseling Department, Counseling in Ministry, Behavioral Intervention, Theory and Practice of Counseling, and Professional Ethics. Immediate superior: Dr. Norman Thiessen.

1980 - Present, Co-Director, Counselor, Mid-Valley Counseling Center, Salem, Oregon. Responsible for general administrative concerns as well as participation in a group private practice with nine clinicians providing a full range of therapeutic services. Specialties pursued during this practice have been group and individual treatment of adolescents and their families, treatment of sexual offenders, some work with bulimia in young adults, therapy of borderline disorders, obsessive-compulsive disorders and

depression, marital therapy, as well as various existential issues. Workshops conducted during this practice include: Systematic Training for Effective Parenting, both for parents of young children and adolescents; a 1-year course in Lay Counselor Training targeted at volunteers and staff members in church organizations; Crisis Intervention Counseling; Preparing for Parenthood; and Avoiding Burnout for pastors and spouses. Practice included a large amount of public speaking.

1980 - Present, Instructor of Psychology, Western Baptist College, Salem, Oregon. Responsible for instruction in general psychology, abnormal psychology, social science research methods, history and systems of psychology, and family life from parenthood to the empty nest. Immediate superior: Richard Meyers, Chairman, Psychology Department.

1976-80, Private Practice in individual, marriage and family counseling. Associated with the Christian and Missionary Alliance Church in Salem, Oregon. Also responsible for teaching workshops in personal and marriage enrichment, in-service training seminars for pastors, and lay counselor training. Donald Bubna, Senior Pastor.

1975-76, Director of Counseling Services, Alpha Center, Placentia, California. Responsible for the training and supervision of all crisis intervention personnel, the selection and in-service training of all counseling staff and volunteers, and the organization and evaluation of the counseling program, including the development of all necessary administrative systems and management of a large caseload of family, individual and marital counseling. Fred Reyes, Director.

1974-76, Social Science Research Analyst, Drug Program Coordination Office, County Administrative Office, County of Orange, Santa Ana, California. Responsible for the compilation of the 1975 Short-Doyle Drug Abuse Plan for Orange County. Responsible for developing and implementing an on-

going planning process for the Orange County Technical Advisory Committee on Drug Abuse. Responsible for developing and implementing a comprehensive drug abuse needs assessment system for Orange County. Consultant to various public and private drug abuse programs in the area of evaluation and administration. Responsible for reviewing current research and evaluating trends in the Orange County drug abuse community. This work also included establishing liaison with related agencies doing work of interest to the Drug Program Coordination Office.

1974, Staff Aide, Drug Program Coordination Office, County Administrative Office, County of Orange, Santa Ana, California. Responsible for developing and implementing a comprehensive drug abuse needs assessment system for Orange County. Other responsibilities included rewriting and updating the Directory of Substance Abuse Services, 1975, and various liaison and consultation tasks with a wide variety of public and private agencies.

1974, Research Associate to Vincent H. Meyers, Ph.D., PC 1000 Drug Diversion Program Evaluation Project. Participated in the implementation and evaluation of the PC 1000 Drug Diversion Program in Orange County. Responsible for the observation and content analysis of treatment programs both public and private within Orange County. Also responsible for evaluating program evaluation instruments and data gleaned by those instruments.

Publications

1974, "The Evaluation and Status of Drug Diversion in Orange County." The Value of Drug Diversion in the County of Orange, California. Drug Program Coordination Office, Santa Ana, California. (Junior author with Vincent H. Meyers, Ph.D.)

1974, "The Impact of Drug Diversion on the Orange County Criminal Justice System." The Value of Drug Diversion in the County of Orange, California. Drug Program Coordination Office, Santa Ana, California. (Junior author with Bill Miller, M.A.)

1974, "The Impact of Drug Diversion on the Orange County Treatment Staff and Clients." The Value of Drug Diversion in the County of Orange, California. Drug Program Coordination Office, Santa Ana, California. (Junior author with Vincent H. Meyers, Ph.D.)

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