The Relationship of Coping Processes and Burnout

By

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Dedicated to the memory of my brother, Lyndon Wise Miller, who through his struggle with fatal cancer, left his family with a deeper appreciation of the beauty and love that surrounds us and an awareness of strengths we never knew we had.
Abstract

The purpose of this study was to investigate the relationship between the two coping processes of distancing and escape\avoidance and the burnout levels of nursing personnel. The years of employment in nursing service was also investigated for relationship with burnout. The study was performed at a 686 bed hospital located in a major metropolitan area of the midwest and included full-time R.N.'s whose major duties involved direct patient care on a medical-surgical unit. A random sample was chosen from a pool of two hundred to include one hundred participants. Packets were distributed by the nurse managers which included two questionnaires requiring twenty minutes to complete. The Staff Burnout Scale for Health Professionals, by John Jones, measured burnout. The instrument that measured the coping processes was the Ways of Coping Questionnaire, by Lazarus and Folkman. Years of employment service was a self report question. Data collection took place over a one week period. The hypothesis was tested by the use of the Pearson product-moment correlation and the results indicated that there is no significant relationships between burnout and the coping processes of distancing or escape\avoidance. There is no support for any relationship between years employed and burnout. A two-tailed probability correlation for all three comparisons is reported to have a p > .05.
The mean burnout score was 51.68 with SD=15.59. The mean distance score was 4.59 with SD=2.72. The mean escape\avoidance score was 6.06 with SD=5.43.
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Introduction

Background

The complexities of health care are contributing to the increased susceptibility of health professionals, especially nurses, to the occupational stressors that can lead to burnout. Nurses in all types of positions are at risk for job burnout by virtue of the fact that they work closely with many others in helping relationships. Additionally, nurses are becoming more responsible for delivering total patient care activities in general. Such physically and emotionally demanding work is the essence of nursing.

Pines and Aronson (1981) highlighted the applicability of the burnout concept to the helping professions. They defined burnout as "the result of constant or repeated emotional pressure associated with intense involvement with people over long periods of time." These authors further stated burnout to be a "state of mind that frequently afflicts individuals who work with other people and who pour in much more than they get back from their clients, patients, supervisors, and colleagues." They believed that burnout is a syndrome that includes physical, emotional, and mental fatigue. The syndrome includes
feelings of helplessness and hopelessness, a lack of interest, and little enthusiasm for work and life in general.

Stress is a physical, mental, or emotional reaction resulting from an individual's response to environmental tensions, conflicts, and pressures (Greenberg, S. & Valetutti, P. (1980). Cox, T. & Mackay, C. (1976) define stress as a perceptual phenomenon arising from a comparison between the demand on the person and his ability to cope. An imbalance in this mechanism, when coping is important, gives rise to the stress response. If normal coping is ineffective, stress is prolonged and abnormal responses may occur.

Freudengerber (1985) suggests that burnout is the result of failing to cope successfully with stress. Stress is the experience of the disruption of smooth functioning. Coping is what one does about that disruption.

Healthy survival depends upon the ability to cope effectively with stressful problems. When an individual becomes ineffective in managing the stress of frequent emotional contact with others, he or she
experiences emotional exhaustion, depersonalization, and lack of personal accomplishment. According to Maslach (1982), these three attributes comprise the burnout syndrome.

The topic of burnout has been gaining considerable attention since the mid-1970's. Burnout can create negative effects on job performance and magnify physical and emotional health problems. Muldary (1983) describes the burned-out health professional as one who has become ineffective at managing stress. The result of this syndrome was disengagement or distancing from the patient. Maslach (1982) found that when the health professional suffered from burnout and emotional exhaustion, there was behavior that demonstrated a loss of interest in patients. The health care worker maintained a distance, personally withdrawing from intensely stressful encounters. Depersonalization occurred in an attempt to handle the pressures associated with a stressful situation. These resulting behaviors could easily have negative or harmful impact upon the recipient of services.
Since the phenomenon of burnout was first described, it has been the subject of considerable investigation. Researchers have tried to identify all possible causes and results that may be related. Most studies have focused on various personality and environmental factors.

Thomas (1981) attempted to determine varying degrees of occupational stress of oncology, critical care, and medical-surgical nurses. No significant difference was found, yet the study did find that the most stressful aspects of nursing were identified as relationships with physicians, scheduling problems, and relationships with patient families.

Beierholm (1988) questioned the possibility of a difference in burnout levels between wards and length of service. Although he found no significant difference between these two variables, he did find a slightly increased tendency for burnout with day shift nursing personnel and an increase in personal conflict influencing a rise in burnout.

Duxbury (1984) researched the relationship of
various leadership styles, burnout, and nurse satisfaction in neonatal intensive care units. He found burnout scores to be higher and satisfaction scores to be lower among staff nurses when supervised by head nurses whose leadership style is perceived as low consideration-high structure.

Hare (1988) studied environmental issues related to different types of facilities. This study revealed higher burnout levels to be associated more with long term care facilities than acute care facilities. The paraprofessionals who comprised the sample demonstrated more emotional exhaustion and depersonalization than the professional care givers. Bram (1989) also compared different settings and found higher burnout among the sample of hospital based oncology nurses than the hospice nursing staff.

Leiter and Maslach (1988) reported that the results of one study of nurses provided support for the hypothesis that emotional exhaustion would be more prevalent for subjects with a negative interpersonal work environment. Also demonstrated was a positive relationship with pleasant coworker contacts and orga-
nizational commitment. The conclusions of this study led to the findings that stressful interactions with supervisors increase the workers' feelings of emotional exhaustion; high levels of exhaustion lead to depersonalization, unless the coworkers have frequent supportive contact with their coworkers; and as depersonalization persists, the workers' feelings of accomplishment in their work diminish, although supportive interpersonal contact with coworkers may help to decelerate this process.

Although the majority of past research has focused upon the environmental variables that may effect burnout, several investigators have questioned the personal factors that may lead to the syndrome. One researcher realized that stress is designated as such by one individual but not another. Bettelheim (1960), a psychologist and concentration camp prisoner, wrote of those who succumbed to the terrifying experience of being a prisoner. Some reacted to the environment by running against the electrically charged fence, some became the "Muselmanner", or walking dead, and some
found a way to survive the environment, coping in a way that helped their survival.

Other researchers have chosen to investigate those personal factors that may be linked to coping with stress and burnout. Lambert (1987) questioned whether personality hardiness moderates the impact of job stressors on burnout in staff nurses. Consistent with previous research, burnout was significantly associated with higher levels of perceived job stress and lower levels of personality hardiness. Topf (1989) performed a study which provided further support for this hypothesis by demonstrating that greater hardiness, with the dimensions of commitment, control, and challenge, was associated with less stress and less burnout.

Yasko (1983) performed a study which investigated the relationship between personal resources, personal perceptions, and role related variables with burnout. This study revealed that higher levels of burnout were experienced by younger nurses with fewer children, those who received inadequate psychological support at work, those experiencing a high level of stress at
work, those experiencing dissatisfaction with their role, and those who were experiencing feelings of apathy or withdrawal.

Scharf (1988), however, demonstrated that self efficacy or confidence in one's ability or one's perception of how well one can execute certain tasks did not predict the level of burnout.

Other personal factors were part of an investigation by Bartz (1986). This project included a group of intensive care nurses at an army hospital. It was revealed that the subjects who were older, had been in nursing longer, held less than a baccalaureate degree, and were civilian status, scored lower on the burnout measure.

Considerable investigation of associated personal and environmental factors has taken place. Negative environmental factors are pervasive in the employment setting, yet, all nurses do not react to these stressors by becoming burnt out. The ways individuals deal with stress and how they cope may be as important as the actual stressful conditions they experience.
Lazarus and Folkman (1984) developed a process-oriented theory regarding coping in which coping is directed toward what an individual actually thinks and does within the context of a specific encounter and how these thoughts and actions change as the encounter unfolds. Coping, when considered as a process, is characterized by dynamics and changes that are a function of continuous appraisals and reappraisals of the shifting person-environment relationship (Folkman, Lazarus, Dunkel-Schetter, DeLongis, & Gruen, 1986). Shifts may result from coping efforts that are directed outward toward changing the environment, or efforts that are directed inward toward changing the meaning of the event. Shifts may also result from environmental changes independent of the individual. Any shift in the person-environment relationship leads to a reappraisal of what is happening, its significance, and what can be done.

Coping, as defined by Wiesman (1984), is a strategic effort to manage a problem, overcome an obstacle, answer a question, and to dissipate a dilemma or anything that impedes our progress. Coping
processes do not come clearly labeled, with instructions, ready to be put together and used effectively for well-defined purposes. Healthy survival depends upon the ability to cope effectively with stressful problems, and an individual must choose a prospective tactic which matches a designated problem. The overuse of some processes could become rather automatic and habitual. Past researchers stress that all processes have validity and effectiveness when used in the right time, place, and problem. Coping processes become problematic if only a few are used repetitively in the majority of stressful situations.

Avery Wiesman (1984) describes fifteen different coping strategies that are most common. The first, seek information and get guidance, happens to be the most commonly reported strategy. While both nurse and patients may widely use this process in an effort to get guidance about illness and treatment, some may hesitate to do so because of their mistrust in authority.

The second process is share concern; find consolation or a means of getting an ally to alleviate
our misery. If used to extreme, others may begin to shy away from those who continually express needs and become less willing to share true feelings of empathy.

Laugh it off; change emotional tone, is another coping process, and can be used to diffuse a tense situation and to permit a painful conflict or dysphoria to be carried away. Laughter in the wrong situation can express ridicule or hostility.

The fourth process, forget it happened; put it out of your mind, is a form of suppression. Even though suppression can be useful at times and even vitally necessary, the key issue is how we decide which problems are worth dismissing until a later time.

Process five, keep busy; distract yourself, helps one cope by shifting his concern to a nonproblem area. The next process, confront the issue; act accordingly, suggests that one considers the problem and acts in his best judgement. The seventh process, redefine; take a more sanguine view, means to make a virtue out of necessity, turn coercion into a choice, transform a deficit into a gain, and make unpleasantness tolerable.
Coping process eight is resign yourself; make the best of what can't be changed. This strategy suggests submission to defeat and acknowledgement of forces beyond control. Process nine, do something; anything, is an attempt to resolve problems without delay whether it be the use of alcohol or self-destructive behavior.

Review alternatives; examine consequences, process ten, postpones any action until consequences can be examined. Coping process eleven, get away from it all; find an escape somehow, suggests retreat. Process twelve, conform; do what is expected is passive resignation.

Blame someone or something, number thirteen, exonerates one from responsibility. Process fourteen, give vent; feel emotional release, is a way to ventilate and decompress. The last strategy, listed by Weisman, is to deny as much as possible, using avoidance and escape.

Lazarus and Launier (1978) classified coping behaviors into two categories: (1) problem-oriented coping strategies and (2) affected-oriented coping strategies. Problem-oriented strategies tend to
attempt to deal with the stressful situation itself in contrast to affective strategies which deal with stress through the emotion provoked. According to the author's theory of appraisal, when a person is encountered with a harmful or threatening situation, he will employ emotional modes of coping. In contrast, when a situation is appraised as having the potential for improvement, he will employ problem modes of coping. Therefore, it is assumed that coping can either be reactive or anticipatory in a stressful life experience, making it feasible for learned behavior to emerge in balancing one's state of mind.

The stress-coping process developed by Lazarus and Launier (1978), identifies two components of coping: (1) alteration or management of the source of stress, and (2) the regulation of stressful emotions. These two components of coping suggest that coping can be directed toward self or toward environment or both. An individual may use several processes to make himself feel better. (Jaloweic, 1981)

Lazarus emphasized that cognitive appraisal of the stress situation is primary. A secondary appraisal is
then made and the person becomes aware of coping options and resources. In summary it is important to realize that the subject's primary appraisal, or perception, will be important to what coping mechanisms are used. Coping appears to be individualistic and related to one's perception of stressful life experiences.

Stress theories and nursing rationale for support of those theorists are often discussed in the nursing literature. Two prominent theorists, Aquilera and Messick (1978) designed a conceptual framework for helping individuals overcome crisis. They stated that stress is part of the framework because stress can result in a crisis situation if not coped with adequately. These theorists developed many therapeutic interventions aimed at various situational crises. The individual must either solve the problem or adapt to non-solution.

Kimmel (1981) investigated coping and burnout among healthcare personnel. The sample included registered nurses, licensed practical nurses, nurse's aides, and ward clerks. In the findings, two types of
coping related to burnout. Growth coping, a dynamic state of being creatively engaged and productive, was negatively related; self-blame coping was positively related.

McCray (1979) investigated the degree of congruence among health professional's ratings of effectiveness of fifteen coping processes and the self report from cancer patients as to what works for them. Two coping strategies were clearly identified as most effective; take positive action, and seek direction. Six strategies were clearly rated as ineffective: put it out of your mind; do anything, just do something; drink, eat, or smoke; withdraw socially; blame someone; blame yourself.

Kelly and Cross (1985) contrasted coping behaviors and burnout among intensive care nurses and ward nurses. They reported that ward based nurses used crying, eating, and receiving less sleep more frequently than did the ICU nurses. The ward nurses were also more highly stressed than their ICU counterparts.
Simon (1989) studied the method of coping with stress by using humor. In order to prevent the long term effects of stress, such as illness and burnout, humor strategies are suggested to assist in managing stress.

West, Moran, and Games (1984) studied acute care registered nurses and discovered that instruction in coping skills through cognitive restructuring resulted in stress reduction. However, Walpole (1984) reported no significant differences in burnout or role conflict when coping skills were introduced and modeled in a group of thirty nine registered nurses. Keller (1982), using the Bell Coping Scale, studied 103 baccalaureate nursing students and found no significant differences between use of coping methods and burnout.

Chiriboga and Bailey (1986) investigated coping and burnout in 554 registered nurses. Their findings revealed that anticipatory coping, or foreseeing potential difficulties, was negatively related to burnout. Nurses who were less likely to anticipate problems suffered more burnout.
Coping may alleviate emotional distress (emotion focused coping) or aid in dealing with the problem causing the distress (problem-focused coping). Coping may be viewed as a buffer which moderates the impact of stress. Without that buffer, continuous exposure to stress can result in nursing burnout.

Lazarus and Folkman (1988) have distinguished these two processes, distancing and escape\ avoidance, as the ones that are emotion-focused. The stress is directed toward self and not aimed at problem solving behavior. It is the belief of this investigator that if these two processes are used continually when an individual is confronted with stress, the pressures involved in the situation may be internalized. Those individuals who choose to cope in this manner may also suffer from burnout. These two processes will be investigated as to their relationship with burnout.

Escape\ avoidance is described by Lazarus and Folkman (1988) as wishful thinking that uses behaviors that attempt to escape or avoid the problem. Escape offers a replenishment of spirit, on occasion. However, not every escape gets away from the pursuit of what was
left behind. There are fugitives always and everywhere, vainly trying to get away from no one except themselves. Lazarus defines avoidance (1966) as any action which is aimed at interfering with the anticipated harmful confrontation by preventing contact with the agent of harm. Escape may have the implication not only of getting away from harm, but also of avoiding it's continuance in the future. Avoidance is one of the most basic and universal of all tendencies for coping with threat. A real or symbolic danger may be avoided by thinking about something else.

Distancing, the other process of special interest to this study, describes the cognitive efforts to detach oneself and to minimize the significance of the situation. Distancing can be in the form of denial, repression, or apathy. All of these behaviors move the individual away from immediate concern. The nurse may use distancing to specifically disavow information. Obvious facts are culled, unfavorable implications are concealed, and unacceptable consequences are ignored. Denying, repressing the truth, or becoming apathetic closes off the world of uncertainty and fragility, of
fickleness and distress. The danger in these processes is that when one represses the situation or deliberately dismisses it, he forgets that he has options or choices. Unless different strategies are tried when a reasonable problem presents itself, the only outcome is lackluster apathy and surrender.

Past research by Bartz and Maloney (1986) demonstrated that length of time in nursing was negatively related to frequency of emotional exhaustion, frequency of depersonalization, intensity of emotional exhaustion, and intensity of depersonalization.

Statement of Purpose

Past research has found that the practice of effective coping requires the use of a variety of coping processes during the primary and secondary appraisals of a stressful encounter. It is the belief of this investigator that those individuals who choose to confine their coping to the processes that avoid focusing on problem solving issues, may be experiencing the exhaustion and depersonalization of burnout. The
purpose of this study is to determine the relationship between the two coping processes of distancing and escape/avoidance and the burnout levels of nursing personnel. Years of nursing service will also be investigated for relationship with burnout, in an effort to provide an objective measurement.

Hypothesis

1. It is predicted that use of the coping processes of distancing and escape avoidance will be significantly positively related to burnout.

2. It is predicted that years of employment will be significantly positively related to burnout.

Method

Design

This was a quasi-experimental, correlational design. The dependent variable, nursing burnout, was
measured by the Staff Burnout Scale for Health Professionals. The independent variables, the coping processes of distancing and escape/avoidance, were measured by the Ways of Coping Questionnaire. The independent variable of years of employment was a self-report item included within the test material.

Setting

This study was conducted at a 686 bed hospital located in a major metropolitan area of the midwest. Permission to use the facility was granted by the research committee. Testing procedures were effected through the collaboration efforts of the investigator and the chairman of the research committee.

Subjects

The subject pool comprised all nurses who met the following criteria:

1. Currently employed in a medical-surgical unit.
2. Graduate of school of nursing and currently licensed as a Registered Nurse.

3. Full-time employee as defined by the individual institution, and receiving pay for his or her services.


A list of eligible participants who met these criteria was provided to the investigator by each nurse manager. Eligible participants were identified by an employee number only. Each entry included a code that would identify the work unit. From this pool a random sample was drawn, using a fishbowl technique, to include one hundred who would be asked to participate.

Instrumentation

Two instruments were used in this study. The first was the Staff Burnout Scale for Health Professionals, by John Jones. The second was a coping scale named the Ways of Coping Questionnaire, by Lazarus and Folkman.
SBS-HP

This instrument contains thirty items upon which
the degree of burnout is measured. It employs a
6-point Likert scale (agree very much, agree pretty
much, agree a little, disagree a little, disagree
pretty much, and disagree very much) that examinees use
to rate their perceived degree of agreement with the
items.

A single burnout score and a "lie" score, which
the examiner uses to ascertain the degree to which the
examinee may be attempting to "fake good" are obtained.
The SBS-HP is hand scored. The six responses are
assigned the following numerical values: 1) agree very
much, 7; 2) agree pretty much, 6; 3) agree a little, 5;
4) disagree a little, 4; 5) disagree pretty much, 3; 6)
disagree very much, 2. The examiner assigns the
numerical values of the thirty test items according to
the responses marked by the examinee. The scores of
the twenty items that are included on the burnout scale
are summed, yielding a burnout score. Burnout scores,
can range from 20 (no burnout) to 140 (severe burnout).
Scoring of the Lie scale is a little more complicated.
Any of the other five items are given a transformed score of "1" if the raw score was "7". The transformed scores from the Lie scale are summed with total scores ranging from 0 to 10. Those tests with Lie scores registering eight or above were discarded.

Interpretation of an examinee's scores is rather straightforward. Objective scoring of the answers provides a total raw score ranging from 20 to 140 on the Burnout scale and raw scores ranging from 0 to 10 on the Lie scale. The manual notes that the mean burnout score ranges from about 51.1 to 62.2 and the mean Lie scale score was about 2.74. Two other summary studies by Jones found mean scores to be 59.0 for a sample of 49 and 62.6 for a sample of 31 nurses.

Jones (1980) reported a Spearman-Brown split-half reliability coefficient of .93. Because validity is a function of reliability and vice versa, the validity estimate based upon a reliability coefficient of .93 would be about .96.
Ways of Coping Questionnaire

This scale was developed by Lazarus and Folkman (1984) to provide a means of assessing how people cope with the stressors of everyday life. Individuals are asked to focus on a particular stressful encounter that they have recently experienced. The subjects proceed to answer the 66 items by responding to each on a 4-point Likert scale, indicating the frequency with which each strategy is used:

0 indicates "does not apply and/or not used"
1 indicates "used somewhat"
2 indicates "used quite a bit"
3 indicates "used a great deal"

The survey can be completed in approximately 10 minutes. Raw scores are the sum of the subject's responses to the items that comprise a given scale. These scales provide a summary of the extent to which each type of coping was used in a particular encounter. The scores will show coping effort for each of eight types of coping. The following is a descriptive list of the coping scales:
Confrontive coping (describes aggressive efforts to alter the situation and suggests some degree of hostility and risk taking)

Distancing (describes cognitive efforts to detach oneself and to minimize the significance of the situation)

Self controlling (describes efforts to regulate ones feelings and actions)

Seeking social support (describes efforts to seek informational support, tangible support, and emotional support)

Accepting responsibility (acknowledges one's own role in the problem with an effort to put things right)

Escape/avoidance (describes wishful thinking and behavioral efforts to escape or avoid the problem)

Planful problem solving (describes deliberate problem-focused efforts to alter the situation, coupled with an analytic approach to solving the problem)

Positive reappraisal (describes efforts to create positive meaning by focusing on personal growth. It also has a religious dimension)
Although all items on the test will be completed by the subjects, those items which reflect distancing and escape/avoidance will be of special interest in analysis.

The test items that reflect the distancing process are presented as numbers 44, 13, 41, 21, 15, and 12. Those items that reflect escape/avoidance are presented as numbers 59, 33, 40, 50, 47, and 16.

Because the Ways of Coping Questionnaire measures coping processes, which by definition, are variable, traditional test-retest estimates of reliability are inappropriate. Reliability can be evaluated by examining the internal consistency of the coping measures, estimated with Cronbach's coefficient alpha.

Internal consistency estimates of coping measures generally fall at the low end of the traditionally acceptable. As Billings and Moos (1981) point out, those who are constructing coping measures attempt to minimize item redundancy within each coping category, resulting in groups of relatively independent clusters of coping strategies within each category. Furthermore, the use of one coping response may produce
the desired effect. For the original scale, the alpha coefficients of the eight processes are higher than the alphas for most other measures of coping processes, according to Coyne (1987).

The items on Ways of Coping Questionnaire have face validity since the strategies described are those that individuals have reported using to cope with the demands of stressful situations. Evidence of construct validity is found in the fact that the results of the studies performed by the authors of the test were consistent with their theoretical predictions, namely that: (1) coping consists of both problem-focused and emotion-focused strategies, and (2) coping is a process.

In a study in which the Ways of Coping Questionnaire was given to community residing couples in which the wives were aged 35 to 44, Folkman and Lazarus (1986) reported that those high in depressive symptoms used more confrontive coping, self-control, and escape avoidance and accepted more responsibility than did those subjects low in depressive symptoms. In this same sample, psychological symptoms were
positively associated with confrontive coping and negatively associated with planful problem solving.

Aldwin and Revenson (1987) used the Ways of Coping Questionnaire to explore the relation between the eight types of coping strategies and psychological symptoms in a community sample of 291 adults. After controlling for initial levels of stress and symptoms, they found that escapism and self-blame had direct effects on symptoms, specifically, by increasing emotional distress, whereas problem-focused coping strategies showed interactive effects. Sample questions of each instrument are listed in appendix D. In addition to these questions, another question pertaining to years of employment will provide an objective measure.

Data Collection

Meetings with the research committee and nurse managers helped to establish a method of data collection. A list of nurses, who met the subject criteria, was provided to the investigator by the nurse managers from all the medical-surgical units. From that pool, a random sample was drawn, with each
selection coded to identify the unit of employment. Nurse managers at each unit were supplied with a packet for each subject. The nurse managers matched employee numbers to determine which nurses were to receive packets. Packets were then distributed by the managers to each nurse mail box on the testing day.

Packets included an information and instruction sheet, the SBS-HP, the Ways of Coping Questionnaire, and a blank return envelope. The Ways of Coping Questionnaire was relabeled the W-C Nursing Scale to avoid biasing respondents.

The information and instruction sheet, used as a cover sheet, briefly described the purpose of the study, reminded the subjects that they would not be identified by name, outlined any risks, asked for their assistance, informed them of the importance of not discussing the questionnaires with anyone until the collection was complete, and instructed them on how to return the completed questionnaires.

Sealed, unmarked envelopes containing the completed questionnaires were returned to collection boxes located at each medical-surgical unit. The
collection boxes had been provided by the investigator and placed at each unit in an area convenient to collection and away from supervisory offices, to encourage response. The collection boxes were sealed and only the investigator had access. Three days after the tests had been distributed, a post card that served as both a reminder and a thank-you was placed in each of the nurse mail boxes by the nurse managers. Collection took place daily, by the investigator, until collection was complete at the end of seven days.

Data Analysis

This study attempts to show a relationship between the two variables of coping, distancing and escape/avoidance, and burnout. The scores of SBS-HP and the Ways of Coping Questionnaire were measured for significance of association. Correlation analysis produces a coefficient of $r$ that will show how much the two variables move together. Data is from Likert scales, requiring that the correlational analysis selected be Pearson Product correlation. Correlation
was performed of burnout in relation to distancing and correlation was performed of escape/avoidance in relation to burnout. In addition, burnout was correlated with years of nursing service.

Results

The hypothesis was tested by use of the Pearson product-moment correlation and the results indicated that there were no significant relationships between burnout and the coping process of distancing, burnout and the coping process of escape/avoidance, or burnout and the years of employment.

As table one indicates, the correlation ratio found between burnout and the coping process of distancing was stated as \( r = -0.04 \). The ratio found between the coping process of escape/avoidance and burnout was reported as \( r = -0.15 \). The Pearson correlation reported between burnout and the years employed was \( r = -0.11 \). The degrees of freedom reported for each of the correlations were \( df=33 \). A two-tailed
probability correlation for all three comparisons was reported to have a \( p > .05 \).

### Table 1

**Intercorrelations Between Burnout and the Coping Processes of Distancing and Escape/Avoidance and Burnout and the Years Employed in Nursing**

<table>
<thead>
<tr>
<th></th>
<th>Distance</th>
<th>Escape</th>
<th>Yrsem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burnout</td>
<td>-.0375</td>
<td>-.1539</td>
<td>-.1122</td>
</tr>
<tr>
<td>df</td>
<td>34</td>
<td>34</td>
<td>34</td>
</tr>
<tr>
<td>( p = )</td>
<td>.833</td>
<td>.385</td>
<td>.527</td>
</tr>
</tbody>
</table>

As shown in table 2, the reported mean for burnout was 51.68, with a standard deviation of 15.59. The reported mean for the coping process of distancing was 4.59, with the standard deviation at 2.72. The coping process of escape/avoidance revealed a mean of 6.06, and a standard deviation of 5.43.
Table 2

Mean Attribution Scores and Standard Deviations for Burnout and the Coping Processes

<table>
<thead>
<tr>
<th></th>
<th>Mean</th>
<th>Std Dev</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burnout</td>
<td>51.6765</td>
<td>15.5947</td>
</tr>
<tr>
<td>Distance</td>
<td>4.5882</td>
<td>2.7205</td>
</tr>
<tr>
<td>Escape</td>
<td>6.0588</td>
<td>5.4325</td>
</tr>
</tbody>
</table>

A follow up percent of variance procedure, demonstrated in table 3, was done to further investigate the percent of variance shared by the coping processes and burnout and the years of employment and burnout. The percent of variance shared by distancing and burnout was reported as $r^2 = .16$. The percent of variance shared by escape\avoidance and burnout was reported as $r^2 = 2.25$. The percent of variance shared by burnout and years employed was reported as $r^2 = 1.21$. 
Table 3
Percent of Variance Between Burnout and Years Employed and Burnout and the Coping Processes

<table>
<thead>
<tr>
<th></th>
<th>Distance</th>
<th>Escape</th>
<th>Yrsem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burnout</td>
<td>(.0375)^2</td>
<td>(.1539)^2</td>
<td>(.1122)^2</td>
</tr>
<tr>
<td>Burnout</td>
<td>.16</td>
<td>2.25</td>
<td>1.21</td>
</tr>
</tbody>
</table>

The return rate from the nurses sampled was 34%. Eight of the thirty-four test participants had been employed zero to three years. Eight of the thirty-four test participants had been employed four to six years. Seven participants had been employed seven to nine years and eleven nurses had been employed more than ten years. Due to the fact that the nurses were asked to respond to various categories that would reflect their years spent in nursing, an average could not be determined.
Discussion

The results of this study did not support the original hypothesis that the coping processes of distancing and escape/avoidance would be significantly positively related to burnout. There was non-support for the hypothesis that years of employment would be positively related to burnout.

The manual for the Staff Burnout Scale for Health Professionals noted that mean burnout ranges from about 51.1 to about 62.2 for the burnout score. This study reported a mean burnout score of 51.68, which was within the range. However, there are considerable differences between the standard deviations of former research and those of this study. Standard deviations produced by Jones (1980) fell in a range of 16.8 to 20.2. One study by Jones (1980) indicated that SBS-HP mean burnout scores for three groups with N's ranging from 8 to 23, with a total of 49 for the three groups, was 59.0, with a SD = 28.3. In another study of 31 nurses at an emergency room trauma center in one hospital, Jones noted that the mean burnout score was
about 62.6, with a SD = 20.2. Although this study reported similar means, the standard deviations, when compared to the previous studies performed by the test author, were not similar. In the study by Jones which had a reported means of 59.0, the standard deviation was as high as 28.3. This study, which reported a similar means of 51.68, registered a standard deviation of only 15.59.

The main weakness of this study was that not enough test scores fell at the high range end of the burnout scale to allow comparison for association with the selected coping processes and there was not enough general variation in the test scores. In addition, a few test packets were returned with high burnout scores on the SBS-HP and an uncompleted Ways of Coping Questionnaire, which forced the investigator to discard the packet. These facts would lead one to question whether those who may have scored in the upper range of burnout were those who may have chosen not to participate in the study, in spite of all the efforts made to encourage cooperation. The results would also suggest that future studies should involve samples that
have previously demonstrated high burnout test scores. Those participants who had scored high would then be studied for relationship with certain coping processes.

Years of employment was not shown to be positively related to burnout syndrome. Those who have long term employment may have become "comfortable" in their occupation and may have acquired those skills necessary to cope effectively with stress. Those who may have entered nursing and found out early in their career that nursing was emotionally draining, may have already chosen a different field. Further studies, with a larger sample size, may yield different results.

It is suggested that further research be done that relates to the personal factors as well as the organizational factors that contribute to stress so that nurse educators may assist nurses to understand individual stress and coping mechanisms. If nurses understand the stressors that are encountered by an individual and ways with which these stressors may be dealt, then an individual's stressors may be assessed and managed more effectively. Knowledge in this area
may be helpful in containing one's stress within limits, reducing it, or preventing additional stress.

Research aimed at identification of those who have adopted unhealthy coping practices and those who may be more likely to experience burnout, would allow social service and human service organizations to develop training to assist their employees in handling burnout issues. Effective training programs that assist health care professionals in coping with job stressors will enable them to enhance, prolong, and make more comfortable their work experience.

Research is suggested in the area of stress and its relationship to cost containment. As companies assume greater responsibility for health costs, increasing health expense will influence corporations to promote wellness. Costs related to disease, absenteeism, work production, or alcoholism, have spurred business people to take action toward reducing stress and instituting stress management programs.

Stress prevention research aimed at identifying successful intervention programs would assist organizations and human resource professionals in
incorporating a coping skills strategy on a regular basis in an attempt to block the likelihood of a burnout build-up. These programs may include interventions of dieting, exercising, and relaxation techniques, in hope that burnout not reach a level of significance. Further studies might focus on coping skills presentations and their relationship to productivity and job satisfaction. Burnout and worker retention might be an area of importance as far as expanding on existing research. Although there was no relationship determined between burnout and the coping processes that were under investigation, these and other issues may be relevant under different circumstances.
Bibliography


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Yasko, J. M. (1983, April). Variables which predict burnout experienced by oncology clinical nurse
Appendix D
SBS-HP®
By John W. Jones, Ph.D

London House
Leaders in
Human Resource
Assessment

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

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

Susan Folkman, Ph.D. and Richard S. Lazarus, Ph.D.

INSTRUCTIONS

To respond to the statements in this questionnaire, you must have a specific stressful situation in mind. Take a few moments and think about the most stressful situation that you have experienced in the past week.

By “stressful” we mean a situation that was difficult or troubling for you, either because you felt distressed about what happened, or because you had to use considerable effort to deal with the situation. The situation may have involved your family, your job, your friends, or something else important to you. 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 week.

As you respond to each of the statements, please keep this 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.

CONTINUE ON THE OTHER SIDE

DO NOT MARK IN THIS AREA
WAYS OF COPING QUESTIONNAIRE

11. 0 1 2 3 I hoped for a miracle.
12. 0 1 2 3 I went along with fate; sometimes I just have bad luck.
13. 0 1 2 3 I went on as if nothing had happened.
14. 0 1 2 3 I tried to keep my feelings to myself.
15. 0 1 2 3 I looked for the silver lining, so to speak, I tried to look on the bright side of things.
16. 0 1 2 3 I slept more than usual.
17. 0 1 2 3 I expressed anger to the person(s) who caused the problem.
18. 0 1 2 3 I accepted sympathy and understanding from someone.
19. 0 1 2 3 I told myself things that helped me feel better.
20. 0 1 2 3 I was inspired to do something creative about the problem.
21. 0 1 2 3 I tried to forget the whole thing.
22. 0 1 2 3 I got professional help.
23. 0 1 2 3 I changed or grew as a person.
24. 0 1 2 3 I waited to see what would happen before doing anything.
25. 0 1 2 3 I apologized or did something to make up.
26. 0 1 2 3 I made a plan of action and followed it.
27. 0 1 2 3 I accepted the next best thing to what I wanted.
28. 0 1 2 3 I let my feelings out somehow.
29. 0 1 2 3 I realized that I had brought the problem on myself.
30. 0 1 2 3 I came out of the experience better than when I went in.
31. 0 1 2 3 I talked to someone who could do something concrete about the problem.
32. 0 1 2 3 I tried to get away from it for a while by resting or taking a vacation.
33. 0 1 2 3 I tried to make myself feel better by eating, drinking, smoking, using drugs, or medications, etc.
34. 0 1 2 3 I took a big chance or did something very risky to solve the problem.
35. 0 1 2 3 I tried not to act too hastily or follow my first hunch.
36. 0 1 2 3 I found new faith.
37. 0 1 2 3 I maintained my pride and kept a stiff upper lip.
38. 0 1 2 3 I rediscovered what is important in life.
39. 0 1 2 3 I changed something so things would turn out all right.
40. 0 1 2 3 I generally avoided being with people.
41. 0 1 2 3 I didn’t let it get to me; I refused to think too much about it.
42. 0 1 2 3 I asked advice from a relative or friend I respected.
43. 0 1 2 3 I kept others from knowing how bad things were.
44. 0 1 2 3 I made light of the situation; I refused to get too serious about it.
45. 0 1 2 3 I talked to someone about how I was feeling.
46. 0 1 2 3 I stood my ground and fought for what I wanted.
47. 0 1 2 3 I took it out on other people.
48. 0 1 2 3 I drew on my past experiences; I was in a similar situation before.
49. 0 1 2 3 I knew what had to be done, so I doubled my efforts to make things work.
50. 0 1 2 3 I refused to believe that it had happened.
51. 0 1 2 3 I promised myself that things would be different next time.
52. 0 1 2 3 I came up with a couple of different solutions to the problem.
53. 0 1 2 3 I accepted the situation, since nothing could be done.
54. 0 1 2 3 I tried to keep my feelings about the problem from interfering with other things.
55. 0 1 2 3 I wished that I could change what had happened or how I felt.
56. 0 1 2 3 I changed something about myself.
57. 0 1 2 3 I daydreamed or imagined a better time or place than the one I was in.
58. 0 1 2 3 I wished that the situation would go away or somehow be over with.
59. 0 1 2 3 I had fantasies or wishes about how things might turn out.
60. 0 1 2 3 I prayed.
61. 0 1 2 3 I prepared myself for the worst.
62. 0 1 2 3 I went over in my mind what I would say or do.
63. 0 1 2 3 I thought about how a person I admire would handle this situation and used that as a model.
64. 0 1 2 3 I tried to see things from the other person’s point of view.
65. 0 1 2 3 I reminded myself how much worse things could be.
66. 0 1 2 3 I jogged or exercised.
Dear Registered Nurse,

I am a graduate student at Ottawa University. To complete the requirements for my Master's thesis, I am asking that you participate in a research study that will only require approximately twenty minutes of your time.

The purpose of my study is to gather information regarding the occupational stress of nurses. There is no physical or psychological risk involved with participation and you may withdraw from the study at any time. Your answers will be held in strict confidence and neither your name nor the name of the hospital will be identified. Participation will in no way effect your employment.

Please read the brief instructions contained with each questionnaire, take care to answer all questions, seal the completed questionnaires within the envelope and return it to the collection box located at your unit within one week.

Please refrain from discussing the information until collection has ceased. Results will be made available to the hospital at the completion of the study or you may request a copy of the results by mail.

Having been employed in health care for approximately twenty years, I am interested in the issues that effect nurses and am hopeful that you will assist me in this effort.

Sincerely,

Pamela D. Marsh
9912 E. 77st
Raytown, MO 64138