BURNOUT AMONG PSYCHIATRIC NURSES

by

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has been approved

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ABSTRACT

There has been a growing concern over the nursing shortage throughout the United States. Many nurses who experience excessive stress and burnout feel that leaving their jobs and changing careers is the only alternative available to them. Therefore, increased attention is being given to nurses and the eventual burnout they experience. This study was comprised of 15 psychiatric nurses who provide direct care to in-patients in one selected psychiatric hospital setting located in a Southwestern state. The study employed a descriptive research design. The purpose of this study was to determine the level of burnout that exists among psychiatric nurses who work first, second, and third shifts. The research question asked, "What is the level of burnout per shift?" No attempt was made to establish cause and effect. The literature showed that few studies have examined the effect and interactions of shift work and burnout among psychiatric nurses. Psychiatric nurses may experience a different level of burnout depending on which shift they work. Therefore, this study was completed in an attempt to better understand the psychiatric nurse's needs related to burnout and reduce the potential for burnout. The instrument for collecting the
data consisted of the Gillespie-Numeros of Burnout Inventory/Work Survey Form B. The results of the study indicate that the first shift had the highest level of burnout and the second shift experienced the lowest level of burnout. T-test comparisons between the first shift, first and third shift, and second and third shift were also completed. Psychiatric nursing is a unique specialty area within the nursing profession. Research needs to be done on a consistent basis if psychiatric nurses are to cope effectively within their environment and remain actively involved in psychiatric nursing without the threat of eventual burnout.
DEDICATION

I dedicate this thesis to my husband, Daniel, and my daughter, Danielle. To my husband, Daniel, for his constant love, enduring patience and support. For his tremendous technical knowledge and expertise I shall be forever grateful. Despite the burden my schooling may have caused, his love, friendship and understanding provided me with the strength I needed. He reminded me on a daily basis of the love and laughter we share in our lives. I can never thank him enough. To my precious daughter, Danielle, who was less than a year old when I started graduate school. She reminded me to play again, to stop and smell the orange blossoms and to watch the moon rise. Her beautiful smile, hugs, and sparkling blue eyes kept me focused on what was most important in my life. To my beloved parents, Harry and Katharine Meyer, whose unconditional love and support throughout my life and the many hours of babysitting I shall always treasure. They taught me the importance of education and have always supported me in all my educational endeavors.

You are all the miracles in my life
I shall cherish forever!
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CHAPTER 1

INTRODUCTION TO THE PROBLEM

Introduction to the Study

The United States has and continues to experience an ever increasing nursing shortage. Finding sufficient numbers of competent nurses has become extremely difficult for today's hospital administrators. Nurses are the single largest human resource component in hospitals that provide direct patient care. Every year approximately 70% of employed staff nurses resign from their jobs (Hallas, 1980). According to Sigardson (1982) "40% of eligible registered nurses are no longer practicing in their professions" (21).

Psychiatric nursing has been affected by this shortage as well. Hospitals have developed new psychiatric and chemical dependency units and have discovered that nurses in these specialties are difficult to find.

Approximately 17% of Arizona hospitals studied by the Arizona Hospital Association (ArHA) reported a severe shortage of staff registered nurses; 41% indicated a moderate shortage; and 21% (9) a mild shortage. Of those hospitals surveyed (n=42), 21% indicated no overall shortage of registered nurse positions (ArHA, 1987). Burda states, "according to the 1990 survey results, 16% of the hospitals
surveyed considered the nursing shortage severe; 51% described it as moderate; and 33% said it was mild" (Burda, 1992, 34).

Although nurses are generally sensitive to their clients' needs, Patrick (1979) suggests that they are unlikely to apply those skills to themselves. Nurses are expected by themselves and others to provide support and understanding for those they care for. In assessing those health professionals at risk for burnout, Patrick (1984) noted that those who have not established realistic self-expectations and do not practice self-awareness were more likely to experience burnout than others.

Many nurses who experience excessive stress and burnout feel that leaving their jobs and possibly changing careers is the only alternative available to them. Therefore, increased attention is being given to nurses and the eventual burnout they experience.

Background of the Problem

Many theorists have attempted to explain how stress occurs and how it potentially leads to burnout. Antonovsky (1979) stated that "stress is a natural and constant part of life, but the effects of stress can be positive, neutral or negative" (89). Stress is the result of a "substantial imbalance (perceived or real) between environmental demands and the response capability of the individual" (Farber, 1983, 14).
Burnout, a term which is used to describe a process of progressive disillusionment and emotional exhaustion in the helping professions, has been identified and accepted as a growing problem for nurses (Edelwich, 1980). Pines and Maslach (1978) found that psychiatric nurses and mental health workers frequently developed burnout when they worked in conditions they perceived as negative. "Nurses appear to be more vulnerable to stress and eventual burnout than individuals in many other professions" (Constable and Russell, 1986, 26).

Statement of the Problem

Nurses may experience a different level of burnout depending on which shift they work. Few studies have examined the effect and interactions of shift work and burnout among nurses. The studies of Constable and Russell (1986) failed to separate various shifts when examining levels of burnout and stress. Many of the studies that have been conducted were completed in other countries and possibly are not generalizable to nurses in the United States (Jamal, 1981; Matsumoto, 1978; and Verhaegen et al., 1987).

Purpose of the Study

The purpose of the study was to determine the level of burnout that exists among first shift, second shift and third shift psychiatric nurses, in other words, to determine the level of burnout experienced by these psychiatric nurses who provide direct patient care.
Rationale for the Study

Burnout has been identified and accepted as a growing problem for nurses. In addition to its detrimental psychological effects, there is evidence that burnout is related to shift work, low morale, absenteeism, and high job turnover (Maslach and Jackson, 1981; Pines and Aronson, 1981). Furthermore, it may present serious problems in the delivery of care.

Burnout is one of the major factors in job turnover and the exodus of nurses. Burnout is associated with persistent high stress levels. This stress contributes to the depersonalization and dehumanization of nurses' work related behaviors to survive the extreme physical and mental strains confronting them (Wagner, 1982).

This study examined the level of burnout that existed among first shift, second shift and third shift nurses in the specialty area of psychiatry. This was done so that, with the growing nursing shortage, the psychiatric nurse's needs may be better understood and the potential for burnout reduced thereby improving the retention of nurses in this specialty area.

Research Question

What is the level of burnout that exists per shift of psychiatric nurses in one Southwestern psychiatric hospital?

Significance of the Study

This information will be beneficial to potential candidates entering the nursing profession. It is very
common for nurses to work a variety of shifts. Individuals choosing the nursing profession as a lifetime career will be able to make an informed decision knowing the level of burnout that exists with shift work.

Examining the level of burnout that exists for psychiatric nurses who work different shifts will be beneficial to nursing administration. Administration can then assist the nurse manager in developing creative options and alternatives to the nurse who provides direct patient care in order to reduce the potential for burnout. This information can also be advantageous to human resource personnel for future studies.

The level of burnout experienced by nurses working different shifts will impact patient care. In other words, the quality of care that the client receives is contingent upon the nurse's level of burnout. This information can serve as a tool for nurses to examine their own level of burnout and re-evaluate the care that they provide to their clients.

Definition of Terms

For the purpose of clarification within this study, the following terms are defined operationally:

**Burnout**: A process of progressive disillusionment and emotional exhaustion in the helping professions (Edelwich, 1980).

**Psychiatric staff nurse**: A registered nurse who may be a graduate of either a two year associate program, a three
year diploma program, or a four year baccalaureate program with at least one year of psychiatric nursing experience.

**Direct patient care:** Any registered nurse with at least one year of psychiatric nursing experience who estimates spending 50% or more of her or his on-duty time in personally providing services to or interacting with patients and/or significant others.

- **Day shift:** 7:00am-3:30pm.
- **Evening shift:** 3:00pm-11:30pm.
- **Night shift:** 11:00pm-7:30am.

**Assumptions of the Research Design**

Two assumptions are applicable to this study. No attempt was made to control variables other than identifying psychiatric nurses who provide direct patient care. The participants answered honestly due to the trust and confidentiality previously established between the researcher and participants in the study.

**Limitations of the Research Design**

Several limitations are applicable to this study. The sample was small, not randomly drawn, dependent on volunteers and the researcher is a colleague of the participants in the study. This research design was unable to generalize or predict "what will be." The sample is also homogenous in that it was drawn from one private psychiatric hospital with participants in the study having similar characteristics.
Organization of the Remainder of the Study

Chapter two will review pertinent literature and focus on stress and eventual burnout. Chapter three will describe the methodology used, the design of the study, sample and population, instrumentation, data collection and data analysis. The findings of the study will be presented and the data will be analyzed in chapter four. Chapter five will consist of the summary which will provide an overview of the entire study. Conclusions and recommendations will also be identified. Suggestions for future research will be examined.
Chapter 2

REVIEW OF THE LITERATURE

Introduction and Organizational Structure

The literature on burnout focuses primarily on the syndrome as observed in individuals of various human service professions. The following review includes an overview of the work of the major contributors and summarizes their definitions of burnout, their general views of the process and their approaches and/or interventions. The research review is presented in three areas: general literature on burnout, nursing literature on burnout, and nursing and shift work.

General Literature on Burnout

The concept of burnout was initially studied by Freudenberger (1975). He discovered that burnout manifested itself in a wide variety of careers. Burnout, as defined by Freudenberger (1975), means to "...deplete oneself. To exhaust one's physical and mental resources. To wear oneself out by excessively striving to reach some unrealistic expectation imposed by oneself or by the values of society" (16). Burnout results from excessive demands on an individual's energy, strength, or resources and involves physiological, psychological and behavioral dimensions.
(Freudenberger, 1974 and 1975; Stratton, 1986). It has a negative influence in most areas of personal, interpersonal, and organizational functioning.

Freudenberger (1975) identified personal characteristics of individuals who may be susceptible to burnout. They include: (a) dedicated and committed workers whose private lives are not satisfactory and whose work is a substitute for social life, (b) authoritarian workers who use authority and obedience to control others, (c) overworked administrators who see themselves as indispensable and switch roles from manager to worker advocate, and (d) professionals who tend to become over involved and work long hours losing themselves in a workaholic life style.

Freudenberger's early work concentrated on burnout in staff members in free clinics. Drawing from his personal experience with the syndrome and his observation of others, he wrote some of the initial articles describing burnout. His more recent work (1980), based on his clinical practice and his observations, expands the concept to include a large number of life situations involving initial devotion and unrealistic expectations. He describes an individual who is suffering from burnout as "someone in a state of fatigue or frustration brought about by devotion to a cause, way of life, or relationship that failed to produce the expected rewards" (Freudenberger 1980, 13).
When discussing the helping professions, Freudenberg (1980) emphasizes that many circumstances are probably beyond the helper's control. At the same time, he states that helpers tend not to differentiate between failing and "not having success" (Freudenberg, 1980, 152). He believes that there is a strong possibility that helpers bring to their work unrealistic expectations and needs that should be filled elsewhere. Although he sees the environment as demanding and resistant to impact, his emphasis is on the individual's unrealistic expectations, inappropriately directed needs and poor preparation for encountering frustration. "Burnout is limited to dynamic, charismatic, goal oriented men and women or to determined idealists who want their marriages to be the best, their work records to be outstanding, their children to shine, their community to be better" (Freudenberg, 1980, 19). In other words, burnout results from overcommitment and/or overdedication.

Much of the earlier research on burnout was conducted by Maslach. Maslach (1982) expanded the knowledge of burnout by identifying its existence in various helping professions. These professions involve direct contact with different types of clients. The interaction between the professional and the client is often emotionally charged. These clients may be revealing their inner personal selves and are dependent upon the professional for assistance, treatment or cure. Over time, the professional experiences
a gradual loss of caring and is not able to sustain the constant commitment needed in his/her job. Exhaustion sets in and the professional experiences burnout. Maslach and Pines (1977) defined burnout as:

The loss of concern for the people with whom one is working... characterized by an emotional exhaustion in which the professional no longer has any positive feelings, sympathy, or respect for the clients or patients. (100)

In response to continued emotional arousal, the professional may begin to incorporate psychological mechanisms which are intended to defend against disruptive emotions by means of detachment. The overuse of these mechanisms can distance the professional from the client and can lead to dehumanization for both members of the relationship (Maslach and Pines, 1979). Maslach and Pines (1979) define dehumanization as a decrease in awareness of the human attributes of others and a loss of humanity within the relationship.

In their investigation of burnout, Maslach and Pines (1979) considered the effects of prolonged, demanding, unidirectional, interpersonal contact. They acknowledged the existence of a tendency to blame burnout on some inherent trait of the individual but believed that their studies indicated the problem was related to an emotionally demanding environment which historically offered little support or concern to the stresses of the caregiver. As the result of their findings, they have generated multiple
approaches to prevention and/or intervention through both personal and institutional means (Maslach & Pines, 1978).

Maslach and Pines have conducted various kinds of studies in developing their theory. Their early research (Maslach and Pines, 1977) involved 200 individuals of various helping professions. Using detailed interviews, questionnaires and field observation, they identified the changes that individuals experienced in burnout and techniques employed to counteract these changes.

Two research studies followed in which information was gathered regarding institution-related and personal variables. In 1975, Maslach and Pines studied 76 staff members of various mental health settings in the San Francisco area. The second study in 1976 (Maslach and Pines, 1977) focused on 83 child care workers drawn from a number of day care facilities in the same geographical areas. The study of child care workers was designed to control for staff and client ratio. In both of these studies, Maslach and Pines used multiple, detailed questionnaires to look for relationships among personal demographics, job characteristics, attitudes and feelings and self-perceptions.

In a more recent study, Maslach and Jackson (1981), explored the possibility of a relationship between certain demographic variables and the experience of burnout. Although the relationships were not consistent across all subscales, the overall pattern indicated a negative
relationship between age and experienced burnout (Maslach and Jackson, 1981. This is consistent with their finding that burnout is more likely to occur during the first few years of practice. These findings are consistent with Kramer (1974), and Claus and Bailey (1980). Marital status related only to the emotional exhaustion subscale, with those divorced or single scoring significantly higher. More education correlated with higher scores on emotional exhaustion and lower scores on depersonalization. Cherniss (1980) has also contributed to the theory of burnout. He describes the dynamics of the burnout syndrome as:

A process that begins with excessive and prolonged levels of job stress that cannot be alleviated through ordinary, active problem solving. The first stage involves an imbalance between resources and demand (stress). This stress produces a strain in the worker manifested in feelings of tension, irritability, and fatigue. The worker then copes defensively with the job stress by psychologically detaching himself from the job and becoming apathetic, cynical or rigid. These attitudes help the worker to first reduce guilt and frustration associated with the world and then, by blaming the victim or the system, to rationalize his own withdrawal and preoccupation with his own needs. (Cherniss, 1980, 101)

The author published a study which explored burnout in professionals who worked in human service organizations. Using a longitudinal, comparative design, he conducted multiple, in-depth interviews with 28 professionals at intervals throughout their first two years working in public institutions.
Cherniss conceptualizes burnout as a process. He describes ongoing accommodation and adjustment in which "the professional's attitude and behavior change in negative ways in response to job strain" (Cherniss, 1980, 5). The goal of his study was to discover and describe some of the factors in the process that lead to the development of or resistance to burnout.

Cherniss discovered that the work situation is the primary agent in the development of burnout and that personal factors account for the remaining variations. These findings are consistent with Freudenberger's (1975) studies in that both work and personal factors can contribute to burnout.

Cherniss emphasized that 75% of his sample experienced significant work-related strain, a circumstance which he thought unlikely to reflect personal weaknesses. Negative changes in attitude seemed to be associated with high job stress. His sample felt a lack in both the resources and expertise necessary for adequate role performance. The participants of the study dealt with many clients who were difficult and unmotivated and found their autonomy limited by the organization for which they worked. Kramer and Schmalenberg (1993) also identified that an increase in autonomy decreases the potential for burnout. In addition, they experienced a lack of meaning and excitement in their work. "All of these factors were compounded by a lack of
collegiality which resulted in the absence of needed support, guidance and stimulation" (Cherniss, 1980, 209).

In response to these stresses, Cherniss discovered that many new professionals gradually became less idealistic, less willing to critically evaluate their own performance and less willing to trust and respond to clients. These professionals expected less of themselves and their clients and gradually withdrew themselves emotionally from their clients and their workplace. Therefore, they began to look for satisfaction elsewhere.

Cherniss concluded that burnout was a social rather than an individual problem. Freudenberg (1980) did not deny the social aspect of burnout but emphasized that the individual's unrealistic expectations has a greater impact on the potential for burnout. Cherniss proposed individual, group and organizational strategies which could alter stresses as well as provide support and skills for achieving the goal. He recommended that interventions be the result of a joint effort by all who are affected.

The burnout syndrome has been described by many authors. Kahn (1978) describes burnout as:

A syndrome of inappropriate attitudes towards self, often associated with uncomfortable physical and emotional symptoms ranging from exhaustion and insomnia to migraine and ulcer. Deterioration of performance is a frequent additional element in the syndrome. (61)

In assessing health professionals at risk for burnout, Patrick (1984) explained that those who have not established realistic self-expectations and do not practice self-
awareness were more likely to burn out than others. These findings are consistent with Freudenberg (1980). Patrick also discovered two key influences on the development of burnout among seasoned professionals. These included a lack of support from the system and his or her daily job performance. Jamal (1981), Verhaegen et al. (1987), and Webb (1983) also concluded that lack of support is a significant contributing factor to burnout.

Edelwich (1980), is also a major contributor to the concept of burnout. He defined burnout as a "progressive loss of idealism, energy, and purpose experienced by people in the helping professions as a result of conditions of their work" (Edelwich, 1980, 14). Edelwich developed his concept of burnout from his observations and from 261 interviews with both professionals and para-professionals. He used a structured interview which was tailored for the use with different disciplines. He tape recorded detailed information from participants over a two year period.

Similar to Cherniss (1980), Edelwich also defines the dynamics of burnout in terms of a process. Edelwich (1980) emphasizes the progressive disillusionment within the helping profession and identifies the following stages that occur:

1. Idealism: "An initial period of high hopes, high energy, and unrealistic expectations, when one does not yet know what the job is all about" (Edelwich, 1980, 28).
2. Stagnation: "A sense of being stalled once the momentum of initial hope and enthusiasm has decreased in the face of reality" (Edelwich, 1980, 28).

3. Powerlessness: "A feeling experienced when one's lack of success teaches the limits of one's effectiveness" (Edelwich, 1980, 114). There is dissonance caused by the incongruity between one's expectations for performance and what the reality of the situation actually allows. The inability to change the givens of the work situation leads to frustration which ends in burnout if not dealt with constructively (Edelwich, 1980).

4. Apathy: "Progressive emotional detachment in the face of frustration" (Edelwich, 1980, 164). Although one's intention is to shut out the frustrating experiences, there is a good chance that one will eventually isolate oneself from awareness of others' needs and from the experience of caring.

5. Intervention: The steps (both positive and negative) that are taken to break the cycle of disillusionment.

Edelwich clearly states that these stages may occur cyclically and may be repeated. Effective intervention can interrupt the cycle at any point. He does not perceive that the progression to apathy is inevitable. Furthermore, he suggests that the process is occurring all the time to one degree or another.
According to Edelwich (1980), the professional is potentially highly active in changing their experience with burnout. He believes that change for institutions and agencies is a slow process. Therefore, helping professionals need to act on their own behalf. He advocates that individuals should reevaluate their work situation in a realistic manner and how the environment, self, and others effect congruence between reality and expectations.

According to Pines and Aronson (1981), "both burnout and tedium refer to states of physical, mental and emotional exhaustion which are characterized by feelings of hopelessness and helplessness, physical and emotional depletion, and negative attitude towards self and others" (15). Tedium is the result of any prolonged pressure, whereas burnout is defined as "the result of constant or repeated emotional pressure associated with an intense involvement with people over long periods of time" (Pines and Aronson, 1981, 15).

The investigators examined burnout and tedium in participants during numerous workshops and in cross-cultural samples that included 1916 individuals involved in the helping professions. Their correlation studies utilized a self report measure, extensive interviews and observation. They identified several causes of burnout which included emotionally taxing work which demanded both skill and concern, professionals who tended to be particularly
sensitive to others and an orientation that focused on the client and his or her needs.

Pines and Aronson (1981) took a socio-psychological position on the development of burnout, as did Cherniss (1980), thereby, attributing the problem mainly to the situation. They discovered that situational attribution made successful intervention a more likely possibility. The coping strategies which they recommended include vigorous, flexible action at all levels to alter the situation in a way that will promote human values. "Establishing a viable support system is one of the most effective ways of avoiding or diminishing burnout" (Pines and Aronson, 1981, 138).

Farber (1983) suggests that burnout is not a specific event, but rather a unique process to each individual experiencing it and it occurs over time. Cherniss (1980), and Pines and Aronson's (1981) research also describes burnout as a process. Farber (1983) reports that those professionals who are suffering from burnout are "more frequently absent or late for work than their non-burned out colleagues; they become notably less idealistic and more rigid; their performance at work deteriorates markedly; and they may fantasize or actually plan on leaving the profession" (3).

Farber compared the attitudes of burned out professionals to learned helplessness. The burned out individuals give up, because they feel regardless of their efforts they will not receive the rewards they desire.
These findings are consistent with Pines and Aronson (1981). "Both concepts refer to a state in which individuals feel that their actions can no longer effect desired changes in the environment and that, therefore, there is no point in continuing to try" (Farber, 1983, 6). Workers experiencing burnout decrease their input at work to offset the lower payoffs they feel they are receiving.

There are numerous authors and contributors to the syndrome of burnout. Paine (1982) defines a working definition of burnout that is shared by most individuals:

First, there is general agreement that burnout occurs at an individual level. Second, there is general agreement that burnout is an internal psychological experience involving feelings, attitudes, motives and expectations. Third, there is general agreement that burnout is a negative experience for the individual, in that it concerns problems, distress, discomfort, dysfunction, and/or negative consequences. (Paine, 1982, 31-32)

Nursing Literature on Burnout

Susceptibility to burnout in the nursing profession has been well documented. Claus and Bailey (1980) noted that newly employed nurses are prime candidates for burnout because their education creates high expectations that are not met in the reality of the work world. Kramer (1974) studied one-hundred fifty-seven new University of California School of Nursing graduates in 1968, 1969, and 1970. He found a significantly higher level of professional dropout rate and job changes during the two years after graduation. Kramer (1974), as did Claus and Bailey (1980), discovered
there was an increase in turnover among newly employed nurses.

Pines and Maslach (1978) found psychiatric nurses and mental health workers frequently developed burnout when they worked in conditions they perceived as negative. Such conditions included circumstances that dehumanized patients, large case loads, limited staff to patient ratio and limited interactions of staff with patients.

Hulbert (1983) studied 28 hospice workers to determine the coping strategies utilized to manage job stress and to assess experienced feelings of burnout. Three types of coping strategies arose in the study: limited involvement techniques, detached involvement techniques, and avoidance of involvement techniques. The researcher concluded that the use of ineffective coping strategies, having a large number of patients under one's care, and death of a family member within five years led to feelings of burnout. Unlike Pines and Maslach (1978), Hulbert identified a personal stressor that can also negatively impact workers.

Hare (1986) studied interpersonal, intrapersonal, and situational factors which contributed to the burnout syndrome among 312 nursing staff working in long term health care facilities. The study also examined differences in caregivers' burnout, coping strategies, work support, and comfort with patients with poor prognosis of survival among different occupational roles, types of facilities, and professional exposure to such patients. Hare (1986) found
"environmental support, tension releasing and instrumental coping strategies were the most powerful predictors of burnout" (2371-B). Certified nursing assistants had a significantly higher burnout score than registered nurses. Also, nursing assistants and nurses with moderate and high exposure to patients with poor prognosis for survival were significantly more comfortable with such patients than were nursing assistants and nurses with minimal exposure. No correlation was stated between the comfort level and burnout scores of nursing assistants or nurses.

A study completed by Cronin-Stubbs and Rooks (1985) identified stressors associated with burnout in critical care, psychiatric, operating room, and medical nurses. The 296 participants worked in one of three midwestern hospitals. The findings suggested that lower amounts of positive stress and emotional support were associated with higher degrees of burnout. Critical care and medical nurses encountered occupational stressors more frequently and intensely than psychiatric and operating room nurses. There were no significant differences in occupational stress reported by critical care and medical nurses. Both Hare (1986) and Cronin-Stubbs and Rooks (1985) associated minimal emotional support within the work setting as an influencing factor on the level of burnout.

hypothesized that stress would be related to the department to which a nurse was assigned, with emergency, surgery and intensive care departments being the most stressful. The results of the study supported the hypothesis that the surgery unit was stressful, but, in addition, found that psychiatry and medical units were also stressful. Unexpectedly, intensive care and emergency were not extremely stressful units. The researchers suggested that all hospitals have certain units which are more stressful than other units, but which specific units experience this stress varies with different hospitals. "Present findings suggest that different types of stress are unit specific" (Numerof and Abrams, 1984, 96).

Chiriboga and Bailey (1986) studied the sources of burnout in nurses and the influence of the work unit on burnout. There were 544 nurses from medical surgical units and/or critical care units from six different hospitals that participated in the study. Chiriboga and Bailey (1986) found that "23% of the variance in burnout was accounted for by the work environment variables of employee participation at work, low work demands, and low patient demands" (90). Work stress rather than the work environment stress accounted for another 12% of the variance in burnout. The scale Chiriboga and Bailey used to measure work stress levels comprised three variables, with work hassles and distractions being the two significant variables. In addition, reliance on both co-workers and supervisors,
comprising the social support dimension, also had a significant influence on burnout. Chiriboga and Bailey (1986) purported that a coping mechanism that appears to be associated with lower levels of burnout is being able to predict problems that will occur at work. Therefore, just knowing a potential problem or situation is likely to occur appears to make the situation less stressful.

A study by Mohl, Denny, Mote and Coldwater (1982) at Audie Murphy Veterans Hospital examined various stress producing variables in nursing and investigated whether the unit to which the nurse was assigned significantly affected levels of stress. Unlike Numerof and Abrams (1984) who concluded that ICU nurses were more susceptible to stress, Mohl et al. revealed that ICU nurses were not found to differ from nurses assigned to other units. Mohl et al. concluded that factors other than primary unit assignment affected levels of stress. Their findings suggest that work attitude and work relationships were influenced by the unit to which the nurse was assigned. "Staff support appears to be the major determinant of staff morale and distress level" (Mohl et al., 1982, 374). Therefore, burnout was not so much due to the work but rather due to how the nurse got along with co-workers and viewed the work requirements.

Pines and Kanner (1982) suggest that a lack of positive conditions contributes to burnout to a greater extent than does the presence of negative conditions. Their study included 205 professionals and 25 students. The
participants showed a significant inverse relationship between positive conditions and burnout. Pines and Kanner (1982) concluded that "the absence of positive conditions constitutes a unique source of stress that is independent of the presence of negative conditions." (34).

The investigators reported that when comparing American (n=352) and Israeli nurses (n=169), American nurses showed significantly higher levels of burnout which is primarily attributed to different coping styles. American nurses tended to attribute burnout to internal or personal factors, while Israeli nurses attributed burnout to external or environmental circumstances. The American nurses blamed themselves for failure, stress, and eventual burnout, while the Israeli nurses felt that any nurse would experience the same stress they felt, given similar circumstances.

Pines and Kanner also reported that although crisis events may increase burnout, it is the day-to-day routine and lack of support that are a greater cause of burnout. Due to their constant interaction with individuals needing their help, nurses are prone to burnout. Constable and Russell (1986) found that burnout eventually prevents nurses from providing the quality of care expected of them. Repeated findings from the literature suggest that lack of support continues to be a significant cause of burnout.

Kramer and Schmalenberg (1991) studied nursing job satisfaction and retention. "Individual comments from nurses remind us that one can be mightily distressed and
many things can affect how one feels" (Kramer and Schmalenberg, 1991, 53). The researchers correlated high job satisfaction and high self-esteem with autonomy in the workplace thereby reducing the potential for burnout.

Pagel and Wittmann (1986) researched the relationship between personal and job related variables and burnout for 74 pediatric nurses employed in psychiatric and acute care settings. The personal variables studied were marital status, level of education, age, and family responsibilities. The job related variables included employment status, overtime, patient care overload, shift assignments, years in position, and years of nursing experience. The results indicated that "there was a significant relationship of burnout to the variable percentage of children on the unit with social and/or behavioral problems" (Pagel and Wittmann, 1986, 138). Another variable, working overtime, was also positively correlated with higher levels of burnout.

Howse and White (1993) report that unrelieved stress can affect nursing performance and individual health to the point of exhaustion and/or eventual burnout. "Psychologically nurses have responded with higher than expected rates of suicide, substance abuse, and burnout" (Howse and White, 1993, 80). Furthermore, with the continued nursing shortage and increasing health care costs, "external environmental stresses on nurses are intensifying" (Howse and White, 1993, 80). The researchers recently completed a
survey of Canadian hospital nurses. The results suggest that humor can be used as an effective intervention to reduce stress.

In reviewing the literature, the most common sources of burnout for nurses has been (a) dealing with patients' families, (b) an awareness of tremendous responsibility for others accompanied by feelings of incompetence or insecurity, (c) interpersonal conflicts with administrators, physicians, or other nurses, (d) and inadequate staffing and work overload.

The inability of nurses to cope effectively may be due to mental, emotional, physical, or environmental demands. Burnout may occur in any staff, managerial, or administrative nursing setting and may also occur on an individual or group level (Shea, 1986).

Nursing and Shift Work

Several studies have been conducted pertaining to nursing and shift work. Parasuraman, Drake, and Zammuto (1982) studied how shift assignments interact with job stressors. The study was conducted at a large metropolitan hospital and surveyed 327 nurses from a variety of units. The work shift of a nurse was found to have significant univariate effects on five of the six work stressors measured (work overload, interunit conflict, role frustration, intershift problems, and inadequate resources). Parasuraman et al. (1982) also found that "the results indicated that the second shift accounted for most of the
variation in the stressors of intershift problems, resource inadequacy and work overload" (366). Third shift nurses have lower amounts of inter unit conflict but greater role frustration than other shifts (Parasuraman et al., 1982, 365). In addition, night shift nurses had the highest commitment to the organization and the lowest levels of stress and eventual burnout (Parasuraman et al., 1982, 367).

Research has also examined the physical adjustments required when working on third or night shift. Matsumoto (1978) studied daytime sleep patterns following night duty of 5 nurses in Japan and compared these patterns with sleep patterns of nurses who worked the day shift and slept at night. All participants slept fewer hours in the daytime than they did when they slept at night (Matsumoto, 1978). Additionally, the Rapid Eye Movement (REM) stage was shorter. REM is defined as "cyclic movement of the closed eyes observed or recorded during sleep" (Thomas, 1989, 1579). Nurses experiencing lower amounts of REM sleep experienced an increased need or desire for additional sleep.

Webb (1983) also studied whether or not there were permanent effects on the sleep of nurses due to working the night shift. Forty nurses who had no night shift experience were compared to seven nurses who had extensive night experience, seven nurses who were currently working on the night shift, and five nurses who were currently working on the day shift. It was reported that individuals with
extensive night shift experience had a slightly lowered amount of REM sleep, as was found in the Matsumoto study (1978). Individuals currently working on the night shift showed shortened REM latency response and some sleep deprivation (Webb, 1983). Webb (1983) found that nurses with little night shift experience had less effective sleep patterns than the control group, "indicating that the nurses with little night shift experience had not adjusted to the night shift" (282).

Jamal (1981) conducted a study in Canada that compared industrial employees and nurses. Participants in each group were either on fixed or rotating schedules. The researcher examined psychological well-being, job satisfaction, and participation in social activities. Jamal found significant differences between nurses on fixed and rotational schedules. "Nurses who worked on a fixed shift had significantly better mental health, were more involved in their communities, were more committed to their employer and were more satisfied with their jobs" (Jamal, 1981, 546). A higher organizational commitment of married nurses who worked on a fixed shift was also found. The highest absenteeism occurred with single nurses on rotating shifts. Jamal (1981) concluded that fixed shift employees were generally more satisfied and in better health than employees whose shifts are rotated.

Mills et al. (1983) examined the quality of work of thirty nurses on 12.5 hour shifts (three day work week with
an additional eight hour shift the second week) and the personal impressions of the nurses working these shifts. All thirty registered nurses (RNs) at the hospital participated in the 12.5 hour shift test program to determine whether a permanent schedule would be beneficial. Changes in quality of patient care did not occur during the 12.5 hour shift test period. Mills discovered the reported symptoms of fatigue and projected physical impairment did reach statistical significance. Prior to the testing, 96% of the RNs had no 12 hour shift experience. Following the testing period, 96% of the RNs preferred to stay on the 12 hour shifts. The study suggests to schedule longer shifts and fewer workdays for nurses to assist in alleviating stress and reducing the potential for burnout.

Verhaegen and colleagues (1987) studied four medical hospitals and two psychiatric hospitals in Belgium. The participants included 29 full-time permanent night shift nurses, 94 part-time permanent night nurses, and 44 working on rotating night shifts. Verhaegen et al. (1987) found that "permanent full-time night nurses tended to be evening people and more flexible in their sleeping patterns than rotating nurses or part-time night nurses" (1307). Permanent full-time night nurses also had the most favorable impressions of the night shift. Both part-time and full-time night nurses slept less than those on rotating shifts, "indicating that the full-time night nurses have adjusted their sleep patterns to working at night and to sleeping
during the day" (Verhaegen et al., 1987, 1307). Nurses who rotate shifts do not obtain the continuous hours of sleep they require. Verhaegen et al. (1987) also found that nurses on rotating shifts had the highest number of subjective health complaints and interpreted these results as an indication that permanent full-time night nurses are more adjusted than rotating or part-time night nurses. These results indicate that rotating shift assignment creates a greater propensity toward burnout than permanent full-time assignment to third shift. "Shift work creates many disconnected evening and night workers because it puts them 'out-of-step' with their families and with the social life of the rest of the community" (Verhaegen et al., 1987, 774). The results of Webb (1983), Jamal (1981), and Verhaegen et al. (1987) indicate that it is more beneficial to have nurses on a permanent rather than rotating schedule so their sleep patterns can adjust.

Bosch and De Lange (1987) conducted a review examining the overall affects of shift work on industrial employees and compared the results to nurses in the Netherlands. Working on shifts, other than first shift, had been shown to disturb the circadian rhythm of industrial employees. The results of the study of 3500 nurses showed that "mental stress and social well-being affected self report of physical stress. As mental stress increased, physical stress increased" (Bosch and De Lange, 1987, 786). Mental stress was influenced by working conditions of the second
and third shift nurse. Although the nurses on second and third shift reported good health, comparison of them with day shift nurses revealed fewer health complaints among day nurses. When examining the circadian rhythms, Bosch and De Lange (1987) found that the rhythms were disturbed for nurses who worked at night. The most common complaint night nurses reported was fatigue. The researchers reported that both the fatigue and sleeping problems were increased by lower mental well-being. Both industrial workers and nurses experienced significant effects on their social and family life resulting from working night shifts, as well as working on weekends.

Summary

The term burnout describes a process of progressive disillusionment and emotional exhaustion in the helping professions. Agreement exists that burnout occurs as the result of a complicated interaction between the individual and the environment. Individual perception of one's effectiveness in influencing the environment is the basis for one's response to events in the environment. If an individual chronically evaluates their response as ineffective, they may be less motivated to attempt future influence. Burnout may occur in any staff, managerial, or administrative nursing setting and may also occur on an individual or group level (Shea, 1986).
CHAPTER 3

METHODOLOGY

Introduction

This section specifies the description of methodology used, design of the study, sample and population, data collection, and data analysis. The purpose of the study was to determine the level of burnout that existed among first shift, second shift and third shift psychiatric nurses.

Description of Methodology

This study consisted of a single-group, descriptive survey and was used as a diagnostic tool to measure the magnitude of burnout. No attempt was made to establish cause and effect.

Design of the Study

This study employed a descriptive research design. A face-to-face forced-choice burnout questionnaire was distributed to investigate the level of burnout.

Sample and Population

The sample selected for this study was comprised of 18 psychiatric nurses who provide direct care to in-patients in one selected psychiatric hospital setting located in a Southwestern state. Participants were contacted at their place of employment and access to them was approved by the
Human Resources Director. Psychiatric nurses on all shifts who met the following criteria were invited to participate in the study.

1. Spends 50% or more of their time on duty providing direct in-patient care or contact with significant others.

2. Is a registered nurse.

3. Has one year or longer of psychiatric nursing experience.

Participation was voluntary and could have been terminated at any time. Confidentiality was maintained in that all information that was received was reported throughout as group data only.

It was necessary to identify which shift the employee worked in order to complete the study. The only mark on the inventory was one of the following: "D" for day shift, "E" for evening shift, and "N" for night shift. No reference was made to individuals. Participants were informed that return of the completed inventory constituted consent to participate in the study. A cover letter identified each of these points (see Appendix A).

Instrumentation

The instrument for collecting the data was the Gillespie-Numerof Burnout Inventory/Work Survey (GNBI) Form B (see Appendix B). The researcher obtained permission to administer the GNBI from Dr. Gillespie through written documentation and a phone conversation on May, 17, 1993 (see Appendix C). Dr. Gillespie mailed a copy of the GNBI to
this researcher along with the technical manual and data analysis information. The Gillespie-Numerof Burnout Inventory "is a self-report, unidimensional instrument appropriate for both scientific and practice applications" (Gillespie and Numerof, 1984, 2).

The Gillespie-Numerof Inventory (GNBI) Form B allowed participants to identify how often they act or feel about the statements on an 8 point scale ranging from "never" (scored 0) to "always" (scored 7). The inventory consists of 10 statements (items) which took approximately 10 minutes to complete. All items were stated negatively, so it was unnecessary to transpose any of the item score values. "In calculating total scores, small numbers represent a low level of burnout while larger numbers represent more severe burnout" (Gillespie and Numerof, 1984, 3).

"The GNBI is a unidimensional measure of burnout designed to diagnose the severity or degree of burnout" (Gillespie and Numerof, 1984, 4). The GNBI score represents the degree of burnout, but the inventory does not provide any indication about the causes or types of burnout. "Although it is important to learn about these causes, it is necessary first to identify the problem and the degree to which it exists" (Gillespie and Numerof, 1984, 4).

"The reliability of the GNBI is above the conventional level suggested in the psychometric literature, and the 10-item, fixed-response format is brief so that data collection efforts can be comprehensive" (Gillespie and Numerof, 1984,
12). The reliability coefficients reported were derived from samples. "The Alpha coefficients from a sample of 154 health professionals were all over .90, indicating high internal consistency" (Gillespie and Numerof, 1984, 13). Gillespie and Numerof (1984) identify that the GNBI Form B standard error ranges between 1.16 and 1.36 demonstrating a highly stable reliability appropriate for clinical use with individuals.

Data on test-retest reliability of the GNBI was obtained from a sample of health professionals (N=37). "The sample represents a 93% response rate from the health professionals originally requested to participate in the test-retest study" (Gillespie-Numerof, 1984, 14). The test-retest reliability coefficient (Pearson's product-moment correlation) was over .92.

Content validity of the Gillespie-Numerof Burnout Inventory was partly established through the process used to develop the measure (Gillespie and Numerof, 1984). The development of the GNBI began with structured brainstorming session with approximately 40 employees. Through this process, the likelihood of a strong content validity was established.

Gillespie and Numerof (1984) identify that the "evidence for the construct validity of the GNBI was obtained by distinguishing it from measures of other social psychological constructs that have been confused or associated with burnout" (15). It was determined that the
correlation between burnout and other variables (job stress and job dissatisfaction) would not be high enough to suggest that they were actually the same thing. Gillespie and Numerof (1984) "believe that the concept of burnout will reliably and validly serve the needs of both the research and practice communities" (18).

**Data Collection Procedures**

Data were collected by means of the self-administered Gillespie-Numerof Burnout Inventory. Each participant received a cover letter (see Appendix A) and the questionnaire for collecting the data. The responses were analyzed as group data and identities remained confidential. The participants were instructed to return the questionnaires to a mailbox designated "Gillespie-Numerof Burnout Inventories" located on the nursing units.

The researcher made direct contact with potential participants individually so that she might explain the purpose of and the need for the study, time involved, and value of the participants' time and experience to the researcher. Personal contact was intended to establish the researcher's believability, sincerity, and appreciation.

**Data Analysis**

The information obtained was analyzed by the GNBI means and standard deviations. T-test comparisons between the first and second shift, first and third shift, and second and third shift were completed. The total scores for each shift were analyzed to determine the level of burnout per
shift. First, second, and third shift item value means and standard deviations were calculated. The total GNBI item value means and standard deviations were also compiled.

"The Gillespie-Numeroff Burnout Inventory is a unidimensional measure of burnout designed to diagnose the severity or degree of burnout" (Gillespie and Numerof, 1984, 4).

The GNBI total score was computed as:

$$GNBI = \frac{\text{sum } X_i(100)}{C}$$

where $X_i$ is the score value for each item, and $C$ is the highest possible score on the inventory (Gillespie and Numerof, 1984). This number is 70 for Form B when all items have been completed. "Items left blank may be given the average score of all completed items, or they may be omitted as long as corresponding adjustments are made to the $C$ value" (Gillespie and Numerof, 1984, 4). Up to three items may be deleted without jeopardizing the reliability or interpretation of score values.

The scoring procedure produces a score that has a range from 0 to 100. Use of this scoring procedure always produces a score range of 0 to 100 regardless of the number of items that a participant fails to complete. Although, the quality of the score will be questionable if three or more items have been left blank.
CHAPTER 4

PRESENTATION AND ANALYSIS OF THE DATA

The purpose of the study was to determine the level of burnout that exists among first shift, second shift, and third shift psychiatric nurses. The research question asked, "What is the level of burnout per shift?"

The sample selected for this study was comprised of 18 psychiatric nurses. The level of burnout was measured by the Gillespie-Numeros Work Survey: Form B. Eighteen questionnaires were hand distributed by the researcher and 15 (83%) questionnaires were returned. The sample studied included (n=5) day/first shift, (n=5) evening/second shift, and (n=5) night/third shift psychiatric nurses. Each questionnaire consisted of 10 items and all of the 15 questionnaires returned were completed in their entirety.

The researcher began by compiling the sum of the items on each questionnaire per shift to obtain an overall score (see Appendices D, E, and F). These total scores were computed according to the Gillespie-Numeros Burnout Inventory (GNBI) formula (see Appendix G):

\[
GNBI = \frac{\text{sum } X_i}{C} \times 100
\]

The calculated GNBI scores were then totaled for each shift (n=5) to obtain overall scores. The ranges, means and
standard deviations for each shift were then computed. The results indicate that the first shift exhibited the highest level of burnout (mean=38.57) followed by the third shift (mean=34.57) and the second shift experiencing the lowest level of burnout (mean=30.86) as outlined in Figure 1.

Figure 1

Gillespie-Numerof Burnout Inventory

Ranges, Means, and Standard Deviations

<table>
<thead>
<tr>
<th>Shift</th>
<th>Sample</th>
<th>Range</th>
<th>Mean</th>
<th>StdDev</th>
</tr>
</thead>
<tbody>
<tr>
<td>First</td>
<td>5</td>
<td>0-6</td>
<td>38.57</td>
<td>18.25</td>
</tr>
<tr>
<td>Second</td>
<td>5</td>
<td>0-6</td>
<td>30.86</td>
<td>19.09</td>
</tr>
<tr>
<td>Third</td>
<td>5</td>
<td>0-7</td>
<td>34.57</td>
<td>17.44</td>
</tr>
</tbody>
</table>

The item value scores for the same statements were totaled per shift and the means and standard deviations were determined. The results are presented in Figure 2. The first shift results indicate that the statements, "I feel unable to get out from under my work," received the highest score (mean=3.60) and, "My job has me at the end of my rope" received the lowest score (mean=1.60). The second shift results identify that both statements, "I'm fed up with the job," and, "I feel like giving up on the job," received the highest scores (means=3.00). The second shift was consistent with the first shift in that the statement, "My job has me at the end of my rope," received the lowest score (mean=1.00). The third shift was consistent with the second shift in that the statement, "I'm fed up with the job,"
### Figure 2

**Gillespie-Numerof Work Survey: Form B Item Value Means and Standard Deviations for the First, Second, and Third Shift**

<table>
<thead>
<tr>
<th>Item</th>
<th>First Shift (n=5)</th>
<th>Second Shift (n=5)</th>
<th>Third Shift (n=5)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
</tr>
<tr>
<td>I'm fed up with my job.</td>
<td>2.20</td>
<td>1.47</td>
<td>3.00</td>
</tr>
<tr>
<td>I feel crabby at work.</td>
<td>3.00</td>
<td>1.67</td>
<td>2.00</td>
</tr>
<tr>
<td>I feel that everything is caving in at work.</td>
<td>3.40</td>
<td>1.96</td>
<td>1.60</td>
</tr>
<tr>
<td>I feel unable to get out from under my work.</td>
<td>3.60</td>
<td>1.85</td>
<td>1.40</td>
</tr>
<tr>
<td>I'm discouraged about my work.</td>
<td>1.80</td>
<td>1.33</td>
<td>2.40</td>
</tr>
<tr>
<td>I feel buried in my job.</td>
<td>3.20</td>
<td>1.94</td>
<td>2.60</td>
</tr>
<tr>
<td>I feel like giving up on the job.</td>
<td>2.00</td>
<td>1.41</td>
<td>3.00</td>
</tr>
<tr>
<td>I'm disillusioned with my work.</td>
<td>3.00</td>
<td>1.26</td>
<td>2.60</td>
</tr>
<tr>
<td>My job makes me angry.</td>
<td>3.20</td>
<td>2.14</td>
<td>2.00</td>
</tr>
<tr>
<td>My job has me at the end of my rope.</td>
<td>1.60</td>
<td>1.74</td>
<td>1.00</td>
</tr>
</tbody>
</table>

Mean=M  
Standard Deviation=SD
received the highest score. The third shift had the overall highest mean score for this statement (mean=4.20). The third shift results further indicate that both statements, "I feel that everything is caving in at work," and "I feel unable to get out from under my work," received the lowest mean score (mean=1.00).

Each item value score for every questionnaire (n=15) was totaled. The means and standard deviations were then calculated. The results indicate that the statement, "I'm fed up with the job," scored the highest among participants in the study (mean=3.13). The statement, "My job has me at the end of my rope," received the lowest score (mean=1.27) (see Appendix H).

Three T-tests were performed using the mean scores (Figure 1) obtained after the GNBI formula was calculated. The T-test comparisons consisted of the first and second shift, first and third shift, and second and third shift. The results indicate that the study was not statistically significant. The results are displayed in Figure 3.

Figure 3

Gillespie-Numerof Burnout Inventory T-tests

<table>
<thead>
<tr>
<th>Shift</th>
<th>t</th>
</tr>
</thead>
<tbody>
<tr>
<td>First and second shift</td>
<td>.84</td>
</tr>
<tr>
<td>First and third shift</td>
<td>.45</td>
</tr>
<tr>
<td>Second and third shift</td>
<td>-.41</td>
</tr>
</tbody>
</table>
SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Summary

The purpose of the study was to determine the level of burnout that exists among first shift, second shift and third shift psychiatric nurses. The research question asked, "What is the level of burnout per shift?"

The sample selected for this study was comprised of 15 psychiatric nurses who provide direct care to in-patients in one selected psychiatric hospital setting located in a Southwestern state. Participants were contacted at their place of employment. Participation was voluntary and could have been terminated at any time. Psychiatric nurses were invited to participate in the study if they met the following criteria: Spent 50% or more of their time on duty providing direct in-patient care or contact with significant others; was a registered nurse; and had one year or longer of psychiatric nursing experience.

The general literature review on burnout focused primarily on the syndrome as observed by individuals in various human service professions. Nursing literature on burnout and nursing and shift work was also investigated. The literature showed that few studies have examined the...
effect and interactions of shift work and burnout among psychiatric nurses. Nurses may experience a different level of burnout depending on which shift they work. Therefore, this study was completed in an attempt to better understand the psychiatric nurse's needs related to burnout and reduce the potential for burnout.

The study employed a descriptive research design and was used as a diagnostic tool to measure the magnitude of burnout. The instrument for collecting the data consisted of the Gillespie-Numerof Burnout Inventory (GNBI). This face-to-face forced-choice burnout questionnaire was distributed to investigate the level of burnout. No attempt was made to establish cause and effect. The sample included (n=5) day shift, (n=5) evening shift, and (n=5) night shift psychiatric nurses.

The information obtained was analyzed by the GNBI means and standard deviations. T-test comparisons between the first and second shift, first and third shift, and second and third shift were completed. The total scores for each shift were analyzed to determine the level of burnout per shift. First, second, and third shift item value means and standard deviations were calculated. The total GNBI item value means and standard deviations were also compiled.

Conclusions
The results of the study indicate that the first shift had the highest level of burnout and the second shift experienced the lowest level of burnout. The analysis of
the means indicated that the study was not statistically significant. The relationships identified in this study were not strong.

In reviewing the Gillespie-Numenof Burnout Inventory, the results indicate that the statement, "I'm fed up with the job," scored the highest among participants in the study. The statement, "My job has me at the end of my rope," received the lowest score.

The results of the study indicate that the first shift had the highest level of burnout followed by the third shift and the second shift experiencing the lowest level of burnout. Even though the conclusions were not significant, the results are important to the selected hospital studied. In conversations with the participants in the study and the researcher's own experience, the intuitive assumption was that the third shift had the highest level of burnout followed by the second shift and the first shift exhibiting the lowest level of burnout.

It was expected that the third shift had the highest level of burnout for several reasons. There are fewer administrators, physicians and support staff available. Third shift nurses normally do not receive the same medical and administrative support as the nurses on other shifts and therefore rely more upon peer support. Third shift nurses also run with less nursing staff. The night nurse has many more patients to care for resulting in an increased workload. The night shift is expected to answer crisis
calls and perform complete admissions if a client should require in-patient care. Specific personnel are hired for these positions on the first and second shift only. Additionally, the third shift nurses must adapt to a different life style due to the hours (11:00pm-7:30am) that they work. The identified rationale are significant contributing factors to the cause of stress and eventual burnout for the third shift nurse.

The results of this study were surprising to the researcher as they were not conventional. Although the assumption was that the third shift experienced the highest level of burnout, the results indicate that the first shift actually exhibited the highest level of burnout.

There are numerous responsibilities and expectations that the hospital studied requires of the first shift psychiatric nurse. The first shift nurse is responsible for the care of the in-patients as well as the partial hospitalization patients. Patients in the partial hospital program (PHP) attend all the in-patient programs and attend from 8:00am-4:00pm Monday through Friday. The PHP census has been averaging 20. The PHP patients plus the in-patients places an enormous burden on the first shift psychiatric nurse. These nurses are required to counsel, guide, dispense medication, provide medical coverage and document on both groups of patients. These nurses are not compensated with an increase in staff to accommodate the PHP patients. Treatment plans must also be up to date, there is
an increase in visitors on the first shift, and the nurses are expected to attend meetings and in-service training during their shift.

The increase level of burnout on the first shift may also be related to the structural phenomena in the hospital. Physicians are present during the first shift and a multitude of orders are written or changed. Physicians expect immediate response from the nurse to assist them. There is presently no full time unit secretary on the nursing units. Therefore, the nurse must ensure that all secretarial duties are completed. This includes answering phones, scheduling appointments, scheduling staff, and transcribing physician orders. These secretarial duties are extremely time consuming and frustrating to the nurse.

The conclusions indicate that no one specific participant in the study skewed the results. Rather, the first shift nurses in general are experiencing high levels of stress and burnout.

The results of this study are best described as representative of this small sample of participants and, therefore, not appropriate for generalization.

**General Recommendations**

It will be advantageous for the hospital studied to continue with research to investigate the actual causes of burnout on the first shift. Determining the causes of burnout can assist the hospital in implementing changes to reduce and/or irradiate stress and burnout. These changes
will improve the mental health of the first shift psychiatric nurse and enhance the quality of direct patient care. In the interest of quality patient care and retention of adequate levels of nursing personnel to provide direct care, burnout must be addressed on an organizational level.

Perception of the self as being ineffective in controlling the environment may be a personal trait, a situational variable, a cause of burnout or its effect. Consequently, there is a need to generate, implement, and evaluate appropriate interventions which involve the nurses and organization working together as each set of circumstances indicates. Intervention might support the nurse in: evaluating what is controllable in the work setting; identifying expectations; clarifying related values; setting goals; gaining needed strategies and skill for increasing impact and effectiveness; generating sources of support in reaching goals; and accepting what is in fact uncontrollable. Each nurse as an individual has a personal and a professional responsibility to learn to deal as effectively as possible with burnout or any variable affecting their professional competence.

The organization which provides health care is not without involvement and responsibility. Those in leadership positions must be aware of the impact of the work environment and of the nurses' perceptions of their abilities to influence that environment. Leadership must be willing to explore the effects of organizational structure
on its nurses and, consequently, on the nursing care that they are able to deliver. Prevention and interventions on an organizational level to reduce burnout include: increasing the nurse's potential for participation in decision making; increasing the visibility and accessibility of authority; and opening vertical channels of communication within the organization.

If burnout is a continuing process which occurs throughout the nurse's career and heavily influences feelings of competence and self-worth, then intervention should become an on-going activity worth serious and prompt attention. Situations or events that precipitate stress may be minimized if nurses and administrative staff collaborate to relieve the sources of stress.

Programs for the prevention and treatment of burnout will be needed to maintain nurses' emotional and physical well being. These programs should include stress reduction through humor seminars, relaxation techniques, and other innovative therapies which teach nurses how to decrease their stress levels, and thereby decreasing the incidence of exhaustion and burnout. Hopefully these and other measures will be beneficial in decreasing the exodus of nurses from the profession.

If new nurses experience more frequent burnout (Kramer, 1974), prevention may need to begin in the academic setting during the basic preparation of nurses for practice. Nursing students need to be aware of what faces them as
professionals and employees and prepare themselves with strategies to learn to deal with stress and the realities involved in the practice.

Further studies could be done using the data already collected to compare and contrast this sample statistically with other samples, as well as non-psychiatric nurses. Finally, a replication of this study using a larger sample and in different areas of the country, as well as in different psychiatric settings could lead to more generalizable results.

**Recommendations For Future Research**

From this study's content and conclusions, several recommendations can be made for future research. This study implies the need for consistent research methodologies and replication to increase the accuracy of the findings and therefore allow for valid conclusions.

Future research should continue to explore the possible link between the modes of coping and burnout and how they are related. Further research should explore varied nursing specialties and administrative roles examining the incidence/level of burnout, the coping processes that are utilized, and the relationships between coping and burnout.

It is important that more research be conducted to determine whether certain sociodemographic variables are in fact related to burnout outcomes. Exploring the relationship of specific sociodemographic characteristics and burnout as well as the relationship of specific coping
modes with sociodemographic characteristics would be advantageous.

Future research opportunities could also include exploring the relationship of burnout with other variables such as locus of control, type of unit management, nurses' personality characteristics, and/or types of stress perceived by the nurses. Further exploration of the emotional and physiological relationships of specific assigned work shifts with the incidence/level of psychiatric nurses' burnout should also be considered.

Further research is needed to update the available pool of information on the characteristics of psychiatric nurses. Additionally, further studies could be designed to determine if there are subgroupings in psychiatric nursing or is the population fairly homogenous. This may lead to a better understanding historically of where nursing has been and to better predict where nursing is heading.

Psychiatric nursing is a unique specialty area within the nursing profession. Research needs to be done on a consistent basis if psychiatric nurses are to cope effectively within their environment and remain actively involved in psychiatric nursing without the threat of eventual burnout.
Reference List


Hare, J. N. (1986). Selected factors impacting burnout in professional and paraprofessional caregivers in acute care and long-term health care facilities. Dissertation Abstracts International, 47(6), 2371-B.


APPENDIX A

COVER LETTER
Dear Psychiatric Nurse,

I am a graduate student at Ottawa University. I am conducting a research study, under the direction of Dr. S. Snyder, entitled *Burnout Among Psychiatric Nurses*.

The purpose of the research is to determine the level of burnout that exists among psychiatric nurses who work day, evening and night shift. This will be accomplished by asking you to complete the Gillespie-Numersol Burnout Inventory/Work Survey Form B. The inventory contains 10 questions and takes approximately 10 minutes to complete.

I would appreciate your willingness to participate in this study. The name of the hospital and your anonymity will be maintained. In addition, your name will not be connected in any manner with any results of the study. It is necessary to identify which shift you work in order to complete the study. The only mark on the inventory will be one of the following: "D" for day shift, "E" for evening shift, and "N" for night shift.

Results will be reported in statistical form. No reference will be made to individuals. Returning the completed inventory will be considered your consent to participate.

Please place completed inventories in the mailbox labeled "Gillespie-Numersol Burnout Inventories" located on
your nursing unit. Please feel free to contact me if you have questions. Your cooperation is greatly appreciated.

Thank You,

Pamela K. Meyer-Tulledge

Pamela K. Meyer-Tulledge
APPENDIX B

GILLESPIE–NUMEROF BURNOUT INVENTORY/

WORK SURVEY: FORM B
GILLESPIE-NUMEROF WORK SURVEY

Form B

This questionnaire is being filled out by employees. Your responses will remain confidential. Please circle the number which comes closest to the way you act or feel about each statement.

<table>
<thead>
<tr>
<th></th>
<th>Always</th>
<th>Sometimes</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I'm fed up with the job.</td>
<td>7</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>2. I feel crabby at work.</td>
<td>7</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>3. I feel that everything is caving in at work.</td>
<td>7</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>4. I feel unable to get out from under my work.</td>
<td>7</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>5. I'm discouraged about my work.</td>
<td>7</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>6. I feel buried in my job.</td>
<td>7</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>7. I feel like giving up on the job.</td>
<td>7</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>8. I'm disillusioned with my work.</td>
<td>7</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>9. My job makes me angry.</td>
<td>7</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>10. My job has me at the end of my rope.</td>
<td>7</td>
<td>6</td>
<td>5</td>
</tr>
</tbody>
</table>

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APPENDIX C

INFORMED CONSENT
May 17, 1993

Ms. Pam Tulledge
2139 E. Ladonna Dr.
Tempe, AZ 85283

Dear Pam:

Enclosed is a copy of the Gillespie-Numerof Burnout Inventory (Form B) and a copy of the technical manual for this measure. The scoring procedures are discussed on pages 3-4 in the manual. Please let me know if you have any problems in using this measure.

Thank you for your interest in the GNBI. As I said over the phone, I would appreciate learning about the results of your work with this measure.

Sincerely,

David F. Gillespie
Professor
DFG/pc

enclosure: GNBI
APPENDIX D

THE GILLESPIE–NUMEROF BURNOUT INVENTORY/WORK SURVEY FORM: B

INDIVIDUAL ITEM VALUES AND TOTALS FOR THE FIRST SHIFT
<table>
<thead>
<tr>
<th>Item</th>
<th>First Shift (n=5):</th>
<th>Item Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>I'm fed up with my job.</td>
<td>3  3  4  1  0</td>
<td></td>
</tr>
<tr>
<td>I feel crabby at work.</td>
<td>5  2  5  1  2</td>
<td></td>
</tr>
<tr>
<td>I feel that everything is caving in at work.</td>
<td>4  3  6  0  4</td>
<td></td>
</tr>
<tr>
<td>I feel unable to get from under my work.</td>
<td>4  5  6  1  2</td>
<td></td>
</tr>
<tr>
<td>I'm discouraged about my work.</td>
<td>2  1  2  0  4</td>
<td></td>
</tr>
<tr>
<td>I feel buried in my job.</td>
<td>5  4  5  0  2</td>
<td></td>
</tr>
<tr>
<td>I feel like giving up on the job.</td>
<td>2  0  3  1  4</td>
<td></td>
</tr>
<tr>
<td>I'm disillusioned with my work.</td>
<td>3  3  3  1  5</td>
<td></td>
</tr>
<tr>
<td>My job makes me angry.</td>
<td>3  2  5  0  6</td>
<td></td>
</tr>
<tr>
<td>My job has me at the end of my rope.</td>
<td>1  1  5  0  1</td>
<td></td>
</tr>
<tr>
<td>Totals=</td>
<td>32  24  44  5  30</td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX E

THE GILLESPIE-NUMEROF BURNOUT INVENTORY/WORK SURVEY FORM: B

INDIVIDUAL ITEM VALUES AND TOTALS FOR THE SECOND SHIFT
### The Gillespie-Numerof Burnout Inventory/Work Survey Form: B

#### Individual Item Values and Totals for the Second Shift

<table>
<thead>
<tr>
<th>Item</th>
<th>Second Shift (n=5):</th>
<th>Item Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>I'm fed up with my job.</td>
<td>5</td>
<td>2 2 2 2 4</td>
</tr>
<tr>
<td>I feel crabby at work.</td>
<td>2</td>
<td>1 2 2 3</td>
</tr>
<tr>
<td>I feel that everything is caving in at work.</td>
<td>3</td>
<td>1 2 1 1</td>
</tr>
<tr>
<td>I feel unable to get from under my work.</td>
<td>2</td>
<td>0 0 1 4</td>
</tr>
<tr>
<td>I'm discouraged about my work.</td>
<td>2</td>
<td>0 2 3 5</td>
</tr>
<tr>
<td>I feel buried in my job.</td>
<td>3</td>
<td>0 0 4 6</td>
</tr>
<tr>
<td>I feel like giving up on the job.</td>
<td>5</td>
<td>0 3 1 6</td>
</tr>
<tr>
<td>I'm disillusioned with my work.</td>
<td>3</td>
<td>0 2 2 6</td>
</tr>
<tr>
<td>My job makes me angry.</td>
<td>2</td>
<td>0 1 1 6</td>
</tr>
<tr>
<td>My job has me at the end of my rope.</td>
<td>2</td>
<td>0 0 1 2</td>
</tr>
</tbody>
</table>

**Totals:** 29 4 14 18 43
APPENDIX F

THE GILLESPIE–NUMEROF BURNOUT INVENTORY/WORK SURVEY FORM: INDIVIDUAL ITEM VALUES AND TOTALS FOR THE THIRD SHIFT
## The Gillespie-Numerof Burnout Inventory/Work Survey Form: B

### Individual Item Values and Totals for the Third Shift

<table>
<thead>
<tr>
<th>Item</th>
<th>Third Shift (n=5):</th>
<th>Item Values</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>I'm fed up with my job.</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>I feel crabby at work.</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>I feel that everything is caving in at work.</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>I feel unable to get from under my work.</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>I'm discouraged about my work.</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>I feel buried in my job.</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>I feel like giving up on the job.</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>I'm disillusioned with my work.</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>My job makes me angry.</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>My job has me at the end of my rope.</td>
<td>3</td>
<td>0</td>
</tr>
</tbody>
</table>

Totals= 40 6 25 16 34
APPENDIX G

GILLESPIE-NUMEROF BURNOUT INVENTORY (GNBI) SCORES
<table>
<thead>
<tr>
<th>Shift</th>
<th>Sample</th>
<th>Total Scores</th>
<th>GNBI Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Shift</td>
<td>5</td>
<td>32</td>
<td>45.71</td>
</tr>
<tr>
<td></td>
<td></td>
<td>24</td>
<td>34.28</td>
</tr>
<tr>
<td></td>
<td></td>
<td>44</td>
<td>62.85</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5</td>
<td>7.14</td>
</tr>
<tr>
<td></td>
<td></td>
<td>30</td>
<td>42.85</td>
</tr>
<tr>
<td>Second Shift</td>
<td>5</td>
<td>29</td>
<td>41.42</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4</td>
<td>5.71</td>
</tr>
<tr>
<td></td>
<td></td>
<td>14</td>
<td>20.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td>18</td>
<td>25.71</td>
</tr>
<tr>
<td></td>
<td></td>
<td>43</td>
<td>61.42</td>
</tr>
<tr>
<td>Third Shift</td>
<td>5</td>
<td>40</td>
<td>57.14</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6</td>
<td>8.57</td>
</tr>
<tr>
<td></td>
<td></td>
<td>25</td>
<td>35.71</td>
</tr>
<tr>
<td></td>
<td></td>
<td>16</td>
<td>22.85</td>
</tr>
<tr>
<td></td>
<td></td>
<td>34</td>
<td>48.57</td>
</tr>
</tbody>
</table>
APPENDIX H

GILLESPIE-NUMEROOF BURNOUT INVENTORY

TOTALS, ITEM VALUE MEANS AND STANDARD DEVIATIONS
<table>
<thead>
<tr>
<th>Item</th>
<th>Total</th>
<th>Mean</th>
<th>Std. Dev.</th>
</tr>
</thead>
<tbody>
<tr>
<td>I'm fed up with my job.</td>
<td>47</td>
<td>3.13</td>
<td>1.71</td>
</tr>
<tr>
<td>I feel crabby at work.</td>
<td>39</td>
<td>2.60</td>
<td>1.20</td>
</tr>
<tr>
<td>I feel that everything is caving in at work.</td>
<td>30</td>
<td>2.00</td>
<td>1.71</td>
</tr>
<tr>
<td>I feel unable to get out from under my work.</td>
<td>30</td>
<td>2.00</td>
<td>1.90</td>
</tr>
<tr>
<td>I'm discouraged about my work.</td>
<td>36</td>
<td>2.40</td>
<td>1.85</td>
</tr>
<tr>
<td>I feel buried in my job.</td>
<td>38</td>
<td>2.53</td>
<td>2.03</td>
</tr>
<tr>
<td>I feel like giving up on the job.</td>
<td>38</td>
<td>2.53</td>
<td>2.03</td>
</tr>
<tr>
<td>I'm disillusioned with my work.</td>
<td>42</td>
<td>2.80</td>
<td>1.83</td>
</tr>
<tr>
<td>My job makes me angry.</td>
<td>45</td>
<td>3.00</td>
<td>2.19</td>
</tr>
<tr>
<td>My job has me at the end of my rope.</td>
<td>19</td>
<td>1.27</td>
<td>1.44</td>
</tr>
</tbody>
</table>