

EMPLOYMENT LONGEVITY AND TIME SPENT
IN DIRECT PATIENT CARE

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DEDICATION

To

Ron, Joan, Dana, Tara, Sara,

Tammy, and Sasha who have

immeasurably enriched my life.

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CHAPTER 1

INTRODUCTION

One of the major problems facing nursing today is the constant and rapid turnover of nursing personnel--both professional and nonprofessional. Although there are a number of explanations for the turnover problem, most writers (Godfrey, 1975, 1976, 1978a, 1978b, 1978c; Kramer, 1974; Marram, Schlegel, & Bevis, 1974; Pines, Aronson, & Kafry, 1981; Pines & Maslach, 1978; Putney, 1977; Shubin, 1978, 1979; Storlie, 1979) asserted that there is a relationship between what nursing personnel actually experience and/or do in the work situation and turnover rates. These writers further asserted that there is something in the work situation that causes high levels of stress for nursing personnel. The disagreement among these writers is what they perceived to be the cause of the stress in the nursing work environment.

Burnout offers one explanation for the cause of stress in the nursing work environment. Burnout is thought to occur when an individual is placed in an emotionally stressful environment over time (Pines et al., 1981; Putney, 1977). Certain occupations and professions are inherently more stressful than others and nursing is one of these highly stressful occupations or professions (Epting, 1981; Hartl, 1979; Pines et al., 1981; Putney, 1977; Reres, 1977; Selye, 1976; Shubin, 1978, 1979; Smith & Selye, 1979; Storlie, 1979). The burnout theorists

(Pines et al., 1981; Putney, 1977; Reres, 1977; Shubin, 1978, 1979; Storlie, 1979) asserted that nursing personnel are expected to meet the many physical and emotional needs of patients and their families; the nursing personnel give far more than they receive. In time, the most highly effective and productive nursing personnel become physically and emotionally exhausted, or "burnedout". There are essentially two ways the "burnedout" nursing personnel can preserve their actual being or self-hood: (a) they can become "nursing robots" who do the nursing tasks with no emotional investment, or (b) they can change jobs or entirely exit from nursing (Pines et al., 1981; Pines & Maslach, 1978; Putney, 1977; Shubin, 1978, 1979). Either choice results in the loss of once highly effective and productive nursing personnel due to the stress caused by the job itself.

The primary care nursing advocates (Ciske, 1974; Daeffler, 1975; Fairbanks, 1981; Marram, Barrett, & Bevis, 1979; Marram et al., 1974) offered a somewhat opposite explanation for the cause of stress in the nursing work environment. The primary care nursing advocates asserted that if nurses spend a large portion of their work day in direct patient care and its associated responsibilities, they will be highly effective and productive employees, feel satisfied with their jobs, and continue in employment. But, that is not the way nursing is practiced in the present work environment. Instead, nurses are expected to spend great amounts of their work time on nursing tasks, paperwork, and administrative duties. According to primary care nursing advocates, it is this divergence, between the

way nurses desire and believe nursing should be done and the employer's job expectations, that causes nurses' high stress levels, high job dissatisfaction levels, and high turnover rates.

At present we do not know the relationship or the direction of the relationship between the way nurses spend their work time and job turnover. This study was designed to examine the relationship between the amount of time nursing personnel spend in direct patient care and their employment longevity and if educational preparation and/or work experience have any affect on that possible relationship.

Problem of Study

The problem of this study was:

Is there a relationship between employment longevity and the variables percentage of time spent in direct patient care, years of formal education, years of formal nursing education, and years of nursing experience for nursing personnel in a selected psychiatric hospital?

Justification of Problem

The justification for this study was based on several major, closely related, and inter-related issues affecting nursing today: (a) nursing has a high level of job dissatisfaction, (b) nursing has a high turnover rate, (c) nursing has a high professional exit rate, (d) nursing's high levels of job dissatisfaction, turnover, and professional exit have resulted in the worst national nurse shortage (based on number of unfilled positions), ever, (e) nursing's high levels of job dissatisfaction, turnover, and professional exit

are costly, (f) nursing's move towards primary care nursing may have no affect on job dissatisfaction, turnover, and professional exit, although its advocates have asserted that it will.

For 41 years, nurses have consistently reported high levels of dissatisfaction with nursing (Everly & Falcione, 1976; Godfrey, 1975, 1976, 1978a, 1978b, 1978c; Grout, Steffen, & Bailey, 1981; Nahm, 1940, 1948, 1950; Pickens & Tayback, 1957; Wandelt, Pierce, & Widdowson, 1981). Godfrey (1976) found that "44% of the nurses claim to be dissatisfied with their jobs. For comparison, when the 1973 Gallup Poll asked workers if they were satisfied with their jobs, 77% responded that they were satisfied and only 11% described themselves as dissatisfied" (p. 83).

The severity of nurses' job dissatisfaction can be demonstrated by looking at nursing's turnover and profession exit rates; both factors have been found to be positively and directly correlated with job dissatisfaction (Hulin, 1966; Nichols, 1971; Pines et al., 1981; Porter & Steers, 1973; Wandelt et al., 1981).

In the metropolitan areas, where job change is easier due to proximity and number of choices, the turnover rate sometimes reaches 150 to 200 percent. It would seem that many nurses change jobs, hoping to find a difference, but generally find the new position quite like the previous one--and quite as frustrating.

The National Commission of Nursing and Nursing Education (1970) estimated that the staff R. N. turnover rate was 70% per year.

An H. E. W. study ("The Geographic Distribution of Nurses", 1973) found that the mean number of workdays a new, inexperienced R. N. spent on the job before assuming full responsibilities was 39.1, or about eight work weeks.

Therefore, if the actual turnover rate is 70%, the average position is filled each 68 weeks, and the new inexperienced

employee is fully productive 12% of the average tenure (Rowland, 1978, p. 103).

The 70% turnover rate for staff registered nurses (RNs) is 5.4 times higher than the turnover rate for other professional and technical workers (Fairbanks, 1981). In addition, "currently, according to the A. N. A., there are approximately 1,400,000 registered nurses in the United States, but only 70 percent or 988,000 are working. Sixty percent of the employed R. N.'s (592,800) worked on a full-time basis, while 40 percent (395,200) are employed on a part-time basis" ("AJN Report," 1979, p. 475). "One of every four registered nurses in the United States has so withdrawn from the profession as to fail to maintain licensure to practice. Another one of every four nurses in the United States merely maintains a license--and does not practice at all" (Lysaught, 1972, p. 47).

The result of nursing's high turnover and professional exit rates is a severe nurse shortage. The American Hospital Association reports a 100,000 national shortage--the worst ever, with the result that 88% of the nation's hospitals are not able to fill their full-time nursing positions ("Nursing Expo Alleviates Shortage," 1981). This is not a shortage due to a lack of educationally prepared nurses, but a shortage caused by the fact that educationally prepared nurses are choosing not to work in nursing (Archibald, 1971; Bayer, 1967; Wandelt et al., 1981).

The nurse shortage forces nursing administrations to expend great time, effort, and money acquiring, orienting, and trying to

keep enough warm bodies to provide the nursing manpower hours that will meet the needs of the patient populations they are expected to serve (Kaja, 1977; Price & Mueller, 1981). Bayley (1981) estimated it costs \$3,000 to orient a new burn nurse and although costs for a general staff nurse would be somewhat less, they are still significant. The Dallas Times Herald ("Hospitals Offering Bounties for Nurses," 1979) citing the American Nurses' Association, stated that hospitals in Detroit, Minneapolis, Philadelphia, Chicago, and Corpus Christi were paying bounties or rewards of \$100 to \$1,000 to people who help recruit a nurse. But even more important than the financial costs, is the cost to patient care. The nursing shortage hinders nursing's primary goal of providing good, safe, and comprehensive patient care (Anderson & Basteyns, 1981; Cleland, 1965, 1967; Godfrey, 1975, 1976, 1978a, 1978b, 1978c; Grout et al., 1981, Nahm, 1948).

At present there is a major move in nursing to primary care nursing as a means of decreasing nursing's high job dissatisfaction and high turnover rates. High job dissatisfaction and high turnover rates have been a problem for nursing for many years and have not been greatly altered by previous attempts to change the way in which actual nursing care is provided, i.e. case method, functional nursing, and team nursing. Before we move in mass toward primary care nursing, further support is needed for their position that job satisfaction increases and turnover rates decrease, when nurses spend a large portion of their work day in direct patient care activities. It was the purpose of this study to determine if there is a relationship between how much

work time nursing personnel spend in direct patient care and turnover rates, and if education and work experience have an affect on that possible relationship.

Theoretical Framework

The theoretical framework for this study was based on Selye's (1974, 1976, 1977) theory of stress. Selye asserted that the internal environment (the milieu interieur) of a living organism must remain fairly constant; if internal change is too great the organism will die. Homeostasis is defined as "the body's tendency to maintain a steady state despite external changes; physiological stability" (Selye, 1976, p. 467). Selye found, through laboratory testing in 1936, that the body's homeostasis could be upset due to stress which continued over time and that a stereotyped syndrome (a set of simultaneously occurring organ changes) occurred. This syndrome was "characterized by enlargement and hyperactivity of the adrenal cortex, shrinkage (or atrophy) of the thymus gland and lymph nodes, and the appearance of gastrointestinal ulcers" (Selye, 1974, pp. 24-25). Selye further asserted that laws governing life on a cell level are essentially similar in the whole person or even a nation.

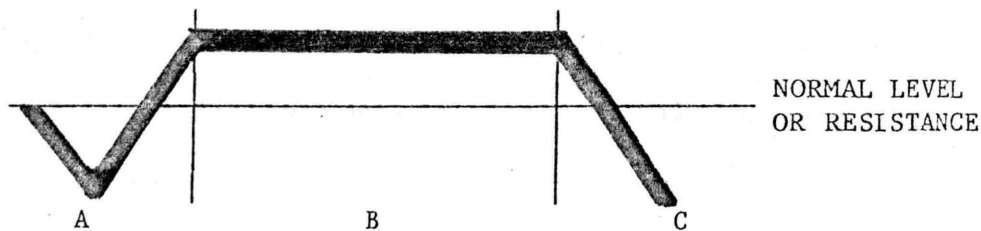
Selye defined stress as "the nonspecific response of the body to any demand made upon it" (1974, p. 14). A stressor is anything which produces stress and disstress is harmful, unpleasant stress (Selye, 1974, 1976). Selye asserted that regarding the experiencing of stress, "it is immaterial whether the agent or situation we face

is pleasant or unpleasant, all that counts is the intensity of the demand for readjustment or adaptation" (1974, p. 15). Selye (1974) further asserted that over the course of evolution, in order to survive, living organisms have had to defend themselves against a great variety of assaults (arising, both from within the body and from the external environment). The assaults are handled by two basic mechanisms: (a) the syntoxic, which ignores the enemy and puts up with him without trying to attack him, and (b) the catatoxic, which results in a fight in an effort to destroy the enemy. When it comes to interpersonal defense reactions, there is a third, additional mechanism possible--flight, which is an attempt to escape the enemy without either just putting up with him or attempting to destroy him.

Selye has demonstrated that animals exposed to continuous stress over long periods of time will go through what he has labeled the general adaptation syndrome, abbreviated G. A. S. Its three stages are explained in Figure 1 (see Figure 1). G. A. S. put simply is that "at first the experience is difficult, then one gets used to it and finally one cannot stand it any longer" (Selye, 1974, p. 22).

Based on the triphasic nature of G. A. S., Selye asserted that the body's adaptability, or adaptive energy, is finite. "After the initial alarm reaction the body becomes adapted and begins to resist, the length of the resistance period depending upon the body's innate adaptability and the intensity of the stressor. Yet eventually, exhaustion ensues" (Selye, 1974, p. 26). We are born with differing amounts of adaptive energy, but no matter how much we received at

birth, eventually it will all be used up and we will die. However, we do have choices regarding how much and how steadily we draw upon our finite supply of adaptive energy.



A. Alarm reaction. The body shows the changes characteristic of the first exposure to a stressor. At the same time, its resistance is diminished and, if the stressor is sufficiently strong (severe burns, extremes of temperature), death may result.

B. State of resistance. Resistance ensues if continued exposure to the stressor is compatible with adaptation. The bodily signs characteristic of the alarm reaction have virtually disappeared, and resistance rises above normal.

C. State of exhaustion. Following long-continued exposure to the same stressor, to which the body had become adjusted, eventually adaptation energy is exhausted. The signs of the alarm reaction reappear, but now they are irreversible, and the individual dies.

Figure 1. The three phases of the general adaptation syndrome (G. A. S.). (From Stress without Distress by Hans Selye, 1974, p. 27).

Employment situations are a frequent cause of stress for individuals, with certain jobs inherently causing high degrees of stress (Pines et al., 1981; Putney, 1977; Selye, 1976). Nursing is one of these inherently stressful jobs (Pines et al., 1981; Putney, 1977; Reres, 1977; Selye, 1976; Shubin, 1978, 1979; Storlie, 1979). Based

on Selye's theory, nursing personnel who are experiencing a high degree of work stress have essentially three interpersonal defense reaction possibilities: (a) the syntoxic, in which they can become "nursing robots", (b) the catatonic, in which they can totally rearrange their work environment to eliminate the stress, or (c) flight, in which they can change jobs or even leave nursing altogether. Hence, high turnover rates can be viewed as one type of response to a highly stressful work environment (Pines et al., 1981).

Although there appears to be total agreement that nursing is an inherently stressful occupation/profession, there is disagreement regarding the cause of the stress in nursing. Primary care nursing advocates (Ciske, 1974, 1979; Daeffler, 1975; Fairbanks, 1981; Marram et al., 1974, 1979; Zander, 1980) have asserted that the major cause of nursing stress is the divergence between the way in which nurses are educated and desire to practice nursing, with an emphasis on providing comprehensive, direct patient care, and the way in which the work situation forces them to practice nursing, with an emphasis on tasks, paperwork, bureaucratic values, etc. The primary care nursing advocates have further asserted that if nurses are allowed to spend their work time providing direct patient care, their level of job satisfaction will increase and their job turnover rate will decrease. The burnout theorists (Freudenberger, 1980; Maslach & Pines, 1977; Pines & Maslach, 1978; Putney, 1977; Shubin, 1978, 1979; Storlie, 1979), on the other hand, have asserted that it is the direct patient care, itself, which causes high levels of stress for nurses and nursing personnel and

results in burnout. They have further asserted that burnout results in both high levels of job dissatisfaction and job turnover.

Herzberg (1959, 1966, 1968) hypothesized that job satisfaction and job dissatisfaction are two unipolar states rather than opposite ends of a bipolar continuum. He asserted that job satisfaction is determined by factors intrinsic to the work and/or job itself and job dissatisfaction is determined by factors extrinsic to the work and/or job itself. Additionally, job satisfaction has been found to be inversely related to job turnover, job dissatisfaction has been found to be directly related to turnover (Hulin, 1966; Nichols, 1971; Wolf, 1981), and high levels of job dissatisfaction have been found to be both an effect and a cause of stress (Hulin, 1966; Nichols, 1971; Pines et al., 1981; Porter & Steers, 1973; Putney, 1977; Wolf, 1981).

At present we do not understand the relationship among stress, job satisfaction/dissatisfaction, and job turnover for nurses and/or nursing personnel. We also do not know if nurses' and/or nursing personnel's job turnover is affected by the amount of time they spend in direct patient care activities. An examination of the variables years of post time-study employment, percentage of time spent in direct patient care, number of years of formal education, number of years of formal nursing education, and number of years of nursing experience should help us increase our understanding of this problem.

Assumptions

For the purposes of this study it was assumed that:

1. Stress is necessary for existence.
2. The organism's response to stress that continues over long periods of time is the same regardless of the stressor.
3. The body's adaptability, or adaptive energy, is finite.
4. People experience varying levels of stress from the work environment.
5. Job turnover is related to stress.
6. Job turnover is related to job satisfaction/dissatisfaction.
7. Direct patient care is a component of nursing.
8. Nursing personnel have a choice regarding continued employment at a particular place.
9. Nursing personnel have some degree of choice in how they spend their work time.
10. Nursing personnel will generally be consistent in the way in which they spend their work time.

Hypothesis

The hypothesis for this study was:

There is no significant relationship between the variable years of post time-study employment and the variables percentage of time spent in direct patient care, years of formal education, years of formal nursing education, and years of nursing experience for the nursing personnel in a selected psychiatric hospital.

Definition of Terms

For the purposes of this study, the following definitions were

formulated:

1. Nursing personnel. Those persons who work under the control and direction of the nursing service department of a psychiatric hospital and are in direct contact with patients. This included RNs, licensed practical nurses (LPNs), and mental health technicians (nurses' aides).
2. Percentage of time spent in direct patient care. The percentage of time a nursing service employee spent in the time-study activities determined to be direct patient care by the panel of experts (see Appendix B and Appendix D for complete derivation). This was computed from the data recorded on the Time-Study and Demographic Data Record (see Appendix A for complete derivation).
3. Years of formal education. The number of years a nursing service employee spent in a classroom setting, i.e. high school, vocational school, college, etc. A high school diploma or equivalent was 12 years, a college diploma was 16 years, and a masters degree was 18 years, as determined by information on the selected hospital's personnel department records and nursing service department records.
4. Years of formal nursing education. The number of years a nursing service employee spent in a classroom setting in which the focus was to teach nursing, i.e. vocational school, diploma school of nursing, college of nursing, etc. LPN was 1 year, an Associate Degree in Nursing (AD) was 2 years, a diploma in nursing was 3 years, a Bachelor of Science in Nursing (BSN) was 4 years, and a Master of Science in Nursing (MS) was 6 years. This was determined by

information on the selected hospital's personnel department records and nursing service department records.

5. Years of nursing experience. The number of years a nursing service employee was employed by a facility providing nursing service and/or nursing education. This included the years a person was employed by the selected hospital's nursing service department before April 1, 1975, the date of the collection of the time-study data, as determined by information on the selected hospital's personnel department records and nursing service department records.

6. Years of post time-study employment. The number of years a nursing service employee continued in employment at the selected hospital from the date of participation in the April 1975, nursing service sponsored time-study until April 15, 1982, as determined by information on the selected hospital's personnel department records and nursing service department records. For the purpose of this study, employees not in employment on April 15, 1982, by reason of retirement were considered as still being in employment at the selected hospital.

Limitations

The following circumstances could not be controlled during the course of this study:

1. It is possible that external events, over which the subjects had limited control, caused some subjects to leave the employment of the selected psychiatric hospital.

2. Some of the data were obtained by self-report and it is not

possible to determine the accuracy of the self-report data.

3. It is possible that patients' needs and availability for direct patient care may differ among the three work shifts.

4. The selected hospital for this study may differ in the amount and type of personnel turnover from other psychiatric hospitals.

5. The sample was not randomly selected.

Summary

High turnover rates are a serious problem in nursing. There appears to be a general agreement in the literature that there is a relationship between stressors in the nursing work situation and high nursing turnover rates. There is disagreement about the nature of the stressor(s). Burnout theorists have asserted that nurses' stress comes from meeting the physical and emotional needs of patients and their families. The primary care nursing advocates have asserted that nurses' greatest source of stress comes from the divergence between the way nurses believe nursing should be practiced and the way in which the work situation forces them to practice nursing.

In order to provide further data about the relationship of direct patient care and nursing turnover, this study was carried out to examine the variables of years of post time-study employment, percentage of time spent in direct patient care, years of formal education, years of formal nursing education, and years of nursing experience for nursing personnel in a psychiatric setting.

CHAPTER 2

REVIEW OF LITERATURE

The review of the literature has been divided into seven sections in order to cover the multiple variables of this study. These sections are: (a) nursing turnover, (b) nursing job satisfaction/dissatisfaction, (c) stress, nursing job satisfaction/dissatisfaction, and turnover, (d) nonjob correlates with nursing job satisfaction/dissatisfaction, stress, and turnover, (e) psychiatric nurses and stress, job satisfaction/dissatisfaction, and turnover, (f) nonprofessional nursing personnel and stress, job satisfaction/dissatisfaction, and turnover, and (g) summary.

Nursing Turnover

Nursing turnover, defined "as the percent of employed nurses who resign from their jobs during a year" (McCloskey, 1975, p. 600) is a long standing nursing phenomenon that has gone from serious and excessive to crisis proportions. Reported nursing turnover rates vary from 40% to an extreme of 150 to 200% (American Nurses' Association, 1954, 1962; Bayley, 1981; Diamond & Fox, 1958; McCloskey, 1975; Rowland, 1978; Saleh, Lee, & Prien, 1965). Fairbanks (1981), utilizing data from the American Nurses' Association, calculated that the national average nursing turnover rate was 42% in 1954, 58% in 1962, and

70% in 1970. The National Commission of Nursing and Nursing Education (Lysaught, 1970) also estimated that the national average for staff RN turnover was 70%, which is 5.4 times higher than the turnover rate for other professional and technical workers (Fairbanks, 1981). Although no more recent national statistics are available, all indications are that the nursing turnover rates have continued to climb since 1970.

High nursing turnover rates are costly because they seriously affect the operation of American hospitals, which are a critically important part of the total system of health-care delivery in the United States. Nursing's high turnover rates affect the ability of the hospital to provide quality patient care, and therefore affects the hospital's effectiveness and productivity. Nursing's high turnover rates also cause a large portion of the hospital's limited resources to be diverted to the recruitment and orientation of nurses (Kaja, 1977; Price & Mueller, 1981; Wolf, 1981) and tends to produce a "ripple effect, in that it places undue burdens on remaining employees which could lead to a worsening of the attrition" (Kaja, 1977, pp. 2-3).

The actual dollars nursing turnover involves are significant and exert an affect on health care costs (Brown, 1978). Bayley (1981) estimated that it costs an additional \$3,000 during the first months of employment to prepare a new qualified burn nurse and reported nursing turnover rates for burn centers varying from 54.8% to 134%. Wolf (1981) stated that it can easily cost \$2,500 to \$3,000 (excluding

the indirect costs of lowered productivity, decreased staff morale, etc.) to replace one RN. The cost involved with nursing turnover is a significant factor in hospital budgets, especially due to its repetitiousness.

When nursing turnover is further analyzed, it is usually divided into two categories: voluntary and nonvoluntary. Price and Mueller (1981) defined nonvoluntary turnover as dismissals, layoffs, retirements, and deaths. They considered voluntary turnover to include all turnover outside of the four areas defined as nonvoluntary turnover. Price (1977) asserted that only 1% of the nurses left for nonvoluntary reasons as defined above.

Most other writers (Bayley, 1981; Behling & Kosmo, 1971; Diamond & Fox, 1958; McCloskey, 1975; Saleh et al., 1965) defined nonvoluntary turnover much less stringently and included additional factors which are more personal and not related to the work situation (family and/or personal reasons, the desire to complete an education, poor health or illness, moving, and transportation problems). According to these writers, voluntary turnover included factors directly related to the work situation, such as the nature of the work, lack of promotion or advancement opportunity, job dissatisfaction, supervision and human relations, a desire to get new experience, poor fringe benefits, and leaving the nursing profession. Most nursing turnover was found to be nonvoluntary and ranged from 54% (Kaja, 1977) to 69% (Saleh et al., 1965).

However, it is often most difficult to gain accurate data on voluntary and nonvoluntary turnover rates. Nonvoluntary reasons for

turnover are often cover-ups for voluntary reasons for turnover.

Unfortunately, true reasons for leaving are often distorted or changed by the employee. For example, a nurse may resign because of the supervision or the work itself, but report the problem as being family-related. Many terminating employees do not want to alienate their employer because of uncertainties about their decision and possible future needs for references or re-employment; therefore, safe, non-threatening reasons are often given (Morris & Schaeffer, 1974, p. 22).

The importance of the voluntary-nonvoluntary turnover debate is one of responsibility. Employers and institutions generally only accept responsibility for the factors related to voluntary turnover and even then it is often a most limited acceptance of responsibility. Institutions and employers prefer to place the causes of turnover outside their sphere of control and responsibility; employers of nurses are no exception to this type of responsibility dodging (Kaja, 1977).

Turnover is generally viewed as a problem of organizational control (Kahn, Wolfe, Quinn, & Snoek, 1964; Price & Mueller, 1981; Wieland, 1979). However, the nursing literature appears to relieve hospitals and institutions of any significant amount of responsibility for nursing's high turnover rate by blaming it on the fact that nursing is an essentially female occupation. Nurses' high turnover rates are blamed on the conflict between nursing employment and the concomitant roles and responsibilities involved with being female in our culture (wife, mother, etc.). Yet, nurses' turnover rates are 7 times higher than females in other industries (Catania, 1964), 3.5 times higher than female clerks in manufacturing (Hulin, 1966), 3 times higher than female teachers, and 1.5 times higher than female

social workers (Price & Mueller, 1981). Unless nurses are somehow significantly different from other female employees, and there is no data to indicate that, nursing's high turnover rate is not due to the fact that its membership is largely female.

Bayer (1967) and Archibald (1971) both asserted that nurses' high turnover rates were related to their employment by hospitals. Bayer concluded from calculations based on the 1960 census, that nurses' high turnover and professional exit rates had resulted in nurses having the greatest labor reserve (people educationally prepared, but not employed) of all female professions--55% for nurses compared to 46% of all professional women, 48% for women working in social welfare occupations, and 37% for women working in elementary and secondary education. Although these calculations are impressive, Archibald (1971) asserted that Bayer failed to look at the labor reserve for women in other jobs in the medical field.

The labor reserve of female physicians and surgeons was, as to be expected, low (21 percent). But for dietitians and nutritionists and for medical and dental technicians, it was higher than for nurses, 63 percent and 61 percent, respectively. Assuming that most dietitians and medical technicians work in hospitals this adds some support to the view that wages and working conditions in hospitals contribute to the low labor force participation of nurses (Archibald, 1971, p. 21).

Further validation, that the hospital, itself, is the cause of much of the job satisfaction problem for nurses is that hospital medical technologists have similar job satisfaction problems (McMahon, Ivancevich, & Matteson, 1977). Additionally, Revans (1968) demonstrated that turnover rates were related to the hospital system as a whole. If

one level of nursing personnel had a high rate of turnover, the other levels would too and vice versa.

Brief (1976) suggested the following model as a means of understanding nursing turnover (see Figure 2).

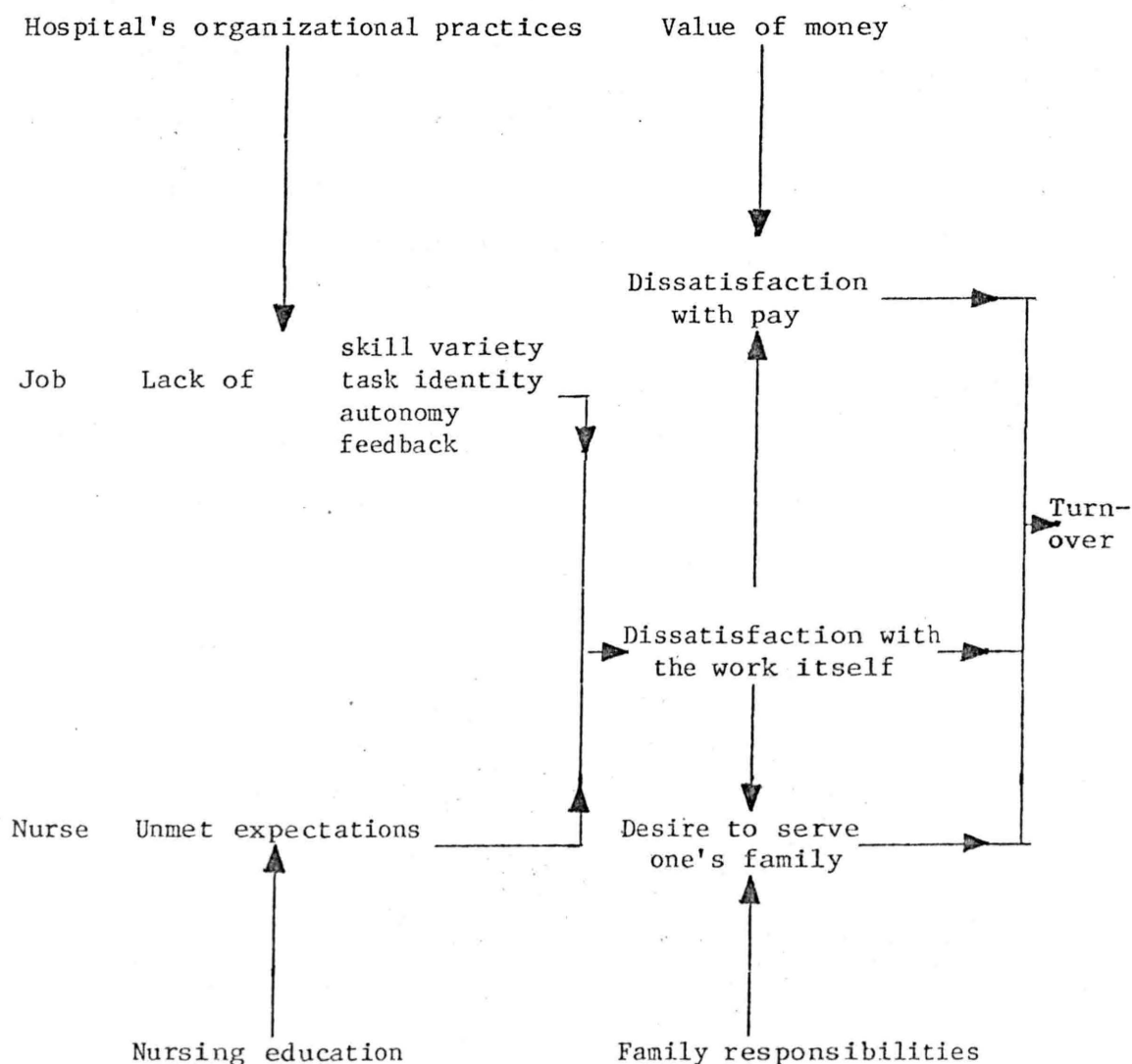


Figure 2. Turnover among hospital nurses: A model. (From "Turnover Among Hospital Nurses: A Suggested Model" by Arthur P. Brief, Nursing Journal of Administration, 1976, 6, 67.)

Brief asserted that although pay and family responsibilities are factors which affect nursing turnover and professional exit rates, the most significant factor is the work itself.

Based on the previous findings from the review of the literature, one might conclude that either nurses are somehow significantly different from other female professionals and other female workers (there is no data that supports the existence of such a difference) or there is something related to the practice of nursing, itself, that is responsible for nurses' high turnover rates. The following literature review on nursing job satisfaction/dissatisfaction suggests that nursing's high turnover rates are directly related to the nursing's extrinsic job factors and, according to Herzberg (1959, 1966, 1968), it is the extrinsic job factors which affect the level of job dissatisfaction.

Nursing Job Satisfaction/Dissatisfaction

Job Satisfaction Theories

There are five major theories of job satisfaction/dissatisfaction. All five theories are interrelated and utilized each other as theoretical building blocks. Herzburg's dual-factor theory and equity theory will be given the most attention.

Herzburg (1959, 1966, 1968) hypothesized that satisfaction and dissatisfaction are two unipolar states, rather than opposite ends of a bipolar continuum. He asserted that job satisfaction was determined by factors intrinsic to the work and/or job itself. Herzberg believed

important motivators or satisfiers are: (a) growth and responsibility, (b) achievement, (c) recognition, (d) advancement, and (e) the work itself. Job dissatisfaction, on the other hand, is determined by hygiene factors, which are found extrinsic to the work itself, such as interpersonal relationships, working conditions, status, salary, benefits, supervision, security, and company policy. According to Herzberg, it is entirely possible that an employee can simultaneously be experiencing a high degree of job satisfaction and a high degree of job dissatisfaction, because satisfaction and dissatisfaction are completely separate issues.

Herzberg based his dual-factor theory on Maslow's (1943, 1970) theory of hierarchy of human needs. Maslow conceptualized human needs as being on an ascending pyramid series of levels, with basic physiological necessities at the lowest level, followed by the needs for safety, needs for social contact, needs for self-respect, and with the need for self-actualization (realization of one's full potential) being the highest need level. Maslow asserted that not until the lower needs are met, can an individual begin to meet his self-actualization needs. Maslow further asserted that although most people have little difficulty filling their lower level needs, only a few people significantly fulfill their self-actualization needs.

Equity theory (Adams, 1975; Lawler, 1968, 1971, 1973; Lawler & Porter, 1967; Porter, 1976; Porter & Lawler, 1969; Weick, 1967) was based upon the theories of cognitive dissonance and discrepancy.

Equity theory is centered on the issue of fairness in the employee-employer exchange with the major concept being relative justice rather than objective gain. The simple, central question being: Do the "inputs" (work, experience, effort, training, loyalty, etc.) balance with the "outcomes" (pay level, status, fringe benefits, working conditions, seniority privileges, etc.)? Additionally, employees obtain normative expectations of just and fair correlations between "inputs" and "outcomes" via a comparison of their own balance of "inputs" to "outcomes" to a reference group, person, or social or status system. The individual is concerned with the question: Do I receive approximately the same salary, status, benefits, etc. that other people in a similar job receive?

Porter (1976) and Porter & Lawler (1969) essentially combined Herzberg's theory and equity theory. They suggested that there are two types of rewards: (a) extrinsic, which are approximately the same as Herzberg's hygiene factors, and (b) intrinsic, which are approximately the same as Herzberg's motivators or satisfiers. In addition, Porter and Porter and Lawler added a third factor: an expectation of a reward. The expectation of a reward refers to the amount of reward an employee perceives is due him based upon his job performance; satisfaction is affected by the size and frequency, as well as the perception of the reward. Porter and Porter and Lawler also asserted that satisfaction is further affected by job performance--being able to perform a job well increases job satisfaction.

Locke (1976) combined the most defensible aspects of Maslow's and Herzberg's theories to hypothesize the following definition of job satisfaction:

Job satisfaction results from the appraisal of one's job as attaining or allowing the attainment of one's important job values, providing these values are congruent with or help to fulfill one's basic needs. These needs are of two separable but interdependent types: bodily or physical needs and psychological needs, especially the need for growth. Growth is made possible mainly by the nature of the work itself (p. 1319).

Locke asserted that: "A job is not an entity but a complex inter-relationship of tasks, roles, responsibilities, interactions, incentives, and rewards. Thus a thorough understanding of job attitudes requires that the job be analyzed in terms of its constituent elements" (p. 1301).

Locke (1976) is an important writer and researcher in the area of job satisfaction. Findings from two of his major studies add important data to the theoretical view of job satisfaction. Locke was involved in two studies that presented strong data that the same classes of events are responsible for both job satisfaction and job dissatisfaction (Locke, 1973; Schneider & Locke, 1971). They found the following eleven categories to be important satisfying or dissatisfying events in the work setting depending on whether the event was positive or negative: (a) task activity, (b) amount of work, (c) smoothness, (d) success, (e) promotion, (f) responsibility, (g) verbal (or implied verbal) recognition, (h) money, (i) interpersonal atmosphere, (j) physical working conditions, and (k) other. Additionally, Locke

(1973, 1976) categorized the agent causing the job satisfaction/dissatisfaction into eight categories: (a) self, (b) supervisor, (c) co-worker(s), (d) subordinate(s), (e) organization, customer(s), (f) nonhuman agent, and (g) no agent (luck, etc.).

In summary, job satisfaction/dissatisfaction is a complicated, multifaceted issue. There is no widely accepted theoretical framework or concrete understanding of job satisfaction/dissatisfaction, although massive effort has been expended. To date there appears to be a rather general understanding of and agreement on some of the important factors involved in job satisfaction/dissatisfaction, but there is no agreement regarding the priorities of these factors and their interactions.

Theoretical Analysis of Nursing Job Satisfaction/Dissatisfaction

The nursing literature, studies, turnover rates, and professional exit rates all indicate that nurses have a serious, probably critical problem with job satisfaction/dissatisfaction. Although there are a large number of articles and a significant number of research studies, no theoretical analysis of nursing job satisfaction was found. In an attempt to fill this void, the theories of Porter (1976) and Porter and Lawler (1969) will be utilized as a framework in discussing the findings from the nursing literature.

Porter (1976) and Porter and Lawler (1969) asserted that job satisfaction involves two types of rewards--extrinsic and intrinsic, with extrinsic factors more often being related to job dissatisfaction and intrinsic factors more often being related to job satisfaction. Hurka

(1974), Longest (1974), and White and Maguire (1973), utilized Herzberg's theory in nursing studies on job satisfaction/dissatisfaction. Their findings supported the validity of utilizing this theory in nursing. Although only one nursing study utilized an intrinsic-extrinsic factor analysis, studies designed to identify nursing job satisfiers/dissatisfiers consistently documented that nursing job satisfiers were related to intrinsic job factors and dissatisfiers were related to extrinsic job factors (Everly & Falcione, 1976; Godfrey, 1975, 1976, 1978a, 1978b, 1978c; Grout et al., 1981; Myrtle & Robertson, 1979; Nahm, 1940, 1948; Pickens & Tayback, 1957; Wandelt et al., 1981).

An additional factor involved with job satisfaction is the expectation and receiving of just and equitable rewards (Porter, 1976; Porter & Lawler, 1969). Brief, Van Sell, Aldag, and Melone (1979) and Annandale-Steiner (1979) found that job satisfaction in nursing is related to the receiving of just and equitable rewards. Nurses have always been poorly paid, received minimal benefits, worked physically hard, had poor working hours, held a low status, and were expected to do dirty, disgusting tasks (Everly & Falcione, 1976; Godfrey, 1975, 1976, 1978a, 1978b, 1978c; Grout et al., 1981; Johnston, 1976; Menzies, 1960; Myrtle & Robertson, 1979; Pickens & Tayback, 1957; Wandelt et al., 1981), yet they have also been expected to be well educated, to carry great responsibility, and to make possible life and death decisions. Additionally, nurses, in the past as well as the present, receive less pay and benefits than teachers and

social workers, the two occupations most similar to nursing--all three occupations being service-oriented, traditionally female, and requiring a similar level of educational preparation (Pines et al., 1981; Price & Mueller, 1981). Although nurses have always acknowledged a significant dissatisfaction with their salaries (Nahm, 1940), it has become an increasingly more important issue, with Wandelt et al. (1981) identifying salary as the number one cause of dissatisfaction with nursing.

The last factor, according to Porter (1976) and Porter and Lawler (1969) which affects job satisfaction is job performance--being able to perform a job well increases job satisfaction. Nurses uniformly agreed throughout the literature that they often lacked the resources (enough time, enough nurses, and enough correctly functioning equipment) needed to do their jobs (Anderson & Basteys, 1981; Cassem & Hackett, 1972; Cleland, 1967; Godfrey, 1975, 1976, 1978a, 1978b, 1978c; Huckabay & Jagla, 1979; Jacobson, 1978; Lancaster, 1976; Laube & Stehle, 1978; Myrtle & Robertson, 1979; Nahm, 1948; Oskins, 1979). Godfrey (1978c) summarized nurses' job satisfaction/dissatisfaction well: nurses reported a general satisfaction with nursing itself, but a general dissatisfaction with the conditions under which they had to practice it.

The extent of nurses' dissatisfaction with nursing is best demonstrated by looking at nurses' professional exit rates. Nursing exit rates are those numbers or percentages that denote educationally

prepared nurses who are not employed in nursing (Kramer, 1974; Kramer & Baker, 1971). "One of every four registered nurses in the United States has so withdrawn from the profession as to fail to maintain licensure to practice. Another one of every four nurses in the United States merely maintains a license--and does not practice at all" (Lysaught, 1972, p. 47). Calculated from the findings of the "AJN Report" (1979), 42% of the educationally prepared nurses are employed full-time in nursing, an additional 28% are employed on a part-time basis in nursing, and 30% are not employed at all in nursing. Kramer (1972) reported that 29% of her sample of new BSN graduates left nursing in the first year following graduation. The 29% did not include those nurses who quit work to start families.

The combination of nurses' high turnover rates and high professional exit rates has resulted in the well publicized nursing shortage and what Brown (1978) referred to as the phenomenon of the disappearing nurse. The American Hospital Association stated that today's shortage of 100,000 nurses is the worst ever--"88% of the nation's hospitals are unable to fill their full-time nursing positions" ("Nursing Expo Alleviates Shortage," 1981, p. H-2). The nursing shortage is not a shortage of educationally prepared nurses, but rather a shortage caused by too few of the educationally prepared nurses being willing to work at the offered salaries (Archibald, 1971; Wandelt et al., 1981; Yett, 1975) or under the present working conditions (Wandelt et al., 1981).

Nursing Studies on Job Satisfaction/Dissatisfaction

There are a number of nursing studies which attempted to identify the nursing job satisfiers and dissatisfiers. These studies had sample sizes of 34 to 17,000, and spanned 41 years, 2 countries, all parts of the United States, all types of nursing specialties, and all levels of nursing personnel, yet they had astoundingly similar findings (Benton & White, 1972; Everly & Falcione, 1976; Godfrey, 1975, 1976, 1978a, 1978b, 1978c; Grout et al., 1981; Longest, 1974; Marlow, 1966; Maryo & Lasky, 1959; Myrtle & Robertson, 1979; Nahm, 1940, 1948, 1950; Pickens & Tayback, 1957; Simon & Olson, 1960; Wandelt et al., 1981).

In these studies, nurses and nursing personnel unanimously ranked patient care as their number one job satisfier. Items closely related to patient care were also viewed, although with significantly less consistency, as being intrinsic, job-related satisfiers and included: (a) helping people, (b) having an intellectual challenge, (c) doing interesting work, (d) doing worthwhile work, and (e) utilizing knowledge and skills. The following are the identified nursing job dissatisfiers (they are not in rank order although the first four were the ones generally ranked as the greatest causes of dissatisfaction): (a) work overload (inadequate staffing), (b) low pay, (c) poor nursing service leadership, (d) unsafe practices, (e) amount of paperwork, (f) communication breakdown, (g) no emphasis on patient care, (h) nurse-doctor professional relationship, (i) work schedule, (j) status-prestige, (k) unsupportive administration, (l) lack of

continuing education opportunities, (m) poor fringe benefits, (n) incompetence of nonprofessional nursing staff, (o) inadequacy of laws regulating the practice of nursing, (p) role ambiguity, (q) limited opportunity for advancement, and (r) lack of authority to do the job. The factors previously listed are real and exist with great regularity in the nurses' work setting (Archibald, 1971; MacAndrew, 1960, Wandelt et al., 1981).

It is important to emphasize that throughout the literature nurses consistently identified patient care and factors closely associated with patient care as their sources of job satisfaction--these are intrinsic job factors and this finding is most supportive of Herzberg's theory. Herzberg's theory is further supported by the additional findings in the literature that the greatest proportion of factors associated with nursing job dissatisfaction are factors extrinsic to the job itself.

Primary Care Nursing

The proponents of primary care nursing utilized the nursing job satisfaction findings and proposed that if nurses spent more time in patient care activities, their level of job satisfaction would be increased, their turnover rates would be reduced, and the quality of patient care would be improved (Ciske, 1974, 1979; Marram et al., 1974, 1979; Zander, 1980). Collings' (1980) study supported the above primary care nursing assertion by finding that nurses and student nurses had extremely high people oriented needs and they needed to be

in a direct helping relationship with people; their job satisfaction level was related to the degree that these needs were met.

Primary care nursing's objectives include: (a) patient centered care, (b) individualized patient care, (c) continuity of patient care, (d) comprehensive patient care, and (e) coordinated patient care, as well as giving the nurses the authority to do the job, allowing maximum nursing autonomy, and holding them accountable for the nursing care they provide and/or are expected to provide. By incorporating these objectives into practice, primary care nursing allows nurses to practice nursing as they were taught in their educational programs (Kramer, 1974; Marram et al., 1974) and in the way the studies on nursing job satisfaction/dissatisfaction documented that nurses desire to practice nursing.

There are two research findings which may be contradictory to the above assertion. Kupst, Schulman, and Dowding (1979) distributed questionnaires on job satisfaction to the personnel with regular patient contact at a children's hospital. About 50% of the questionnaires were returned. They found that the amount of patient contact did not correlate significantly with job satisfaction and that satisfaction with patient care also did not correlate significantly with job satisfaction. Bates and Moore (1975) found that stress scores were highest for personnel with direct patient care responsibilities. Although high levels of stress are usually associated with low levels of satisfaction (Burke, 1976; Freudemberger, 1980; Pines et al.,

1981), the literature does not support this association for nursing regarding intrinsic job factors (patient care).

There are several studies which concluded that primary care nursing improved patient care, increased patient satisfaction, increased nurses' level of job satisfaction, and decreased nursing turnover (Ciske, 1974; Corn, Hahn, & Lepper, 1977; Daeffler, 1977; Eichhorn & Frevert, 1979; Fairbanks, 1981; Marram et al., 1974; McCarthy & Schifalacqua, 1978; Osinski & Powals, 1978; Roberts, 1980). Although these findings sound impressive, all the above studies, except Fairbanks (1981), contained at least one major research methodology problem: (a) an extremely small sample size (as low as 4), (b) a short length of period studied (as low as 2 months), (c) an extremely low rate of return of the data gathering tool (as low as a 23% return rate), (d) the study utilized only 1 hospital unit, and/or (e) the study took place immediately following the implementation of primary care nursing. In addition to the methodology problems of these studies, there is a possibility that the Hawthorne effect was operating. Hence, the findings of these studies must be regarded with caution until there has been further validation.

There are also a number of studies that found no relationship between the utilization of primary care nursing and the level of nursing job satisfaction (Alexander, Weisman, & Chase, 1981; Betz, 1981; Giovannetti, 1980; Joiner, Johnson, & Corkrean, 1981; Steckel, Barnfather, & Owens, 1980). The methodology of this group of studies

was significantly improved over the previous group of studies and had no serious errors, except that these studies also began immediately following the implementation of primary care nursing. However, the methodology (sample size, not a randomly selected sample, etc.) of these studies still places significant limits on the drawing of any conclusions and/or the making of any generalizations. These findings do lend support for Herzberg's (1959, 1966, 1968) theory--that intrinsic job factors do not affect the level of job dissatisfaction.

In summary, job satisfaction/dissatisfaction have been found to be highly correlated with turnover rates--high levels of job satisfaction are correlated with low turnover rates and high levels of job dissatisfaction are correlated with high turnover rates (Hulin, 1966; Nichols, 1971; Porter & Steers, 1973). It is plausible there exists a type of balanced relationship between job satisfiers, dissatisfiers, and turnover. If the job satisfiers outweigh the job dissatisfiers, turnover will be low, with the converse also true--if the job dissatisfiers outweigh the satisfiers, turnover will be high.

Stress and Nursing Job Satisfaction/Dissatisfaction

Stress: Theory and Effects

Selye's (1974, 1976, 1977) theory, which utilized a biological basis, is the most complete and most widely accepted stress theory. The development of his theory began in the 1930's when he observed that most people who were ill shared a common group of general symptoms.

This group of symptoms appeared regardless of age or cause of the illness. True, there were usually specific symptoms which made it possible to make a differential diagnosis, but there remained a kind of general illness syndrome.

Based upon his observations of this general illness syndrome, Selye asserted that the internal environment of a living organism must remain fairly constant; if the magnitude of internal change is too great, the organism will die. Selye (1976) gave the label of homeostasis to this tendency of the body to maintain a steady state regardless of external changes. Selye found that the body's homeostasis could be upset due to stress that continued over time and that a stereotyped syndrome occurred. This syndrome was "characterized by enlargement and hyperactivity of the adrenal cortex, shrinkage (or atrophy) of the thymus gland and lymph nodes, and the appearance of gastrointestinal ulcers" (Selye, 1974, pp. 24-25). Based upon these replicated findings and observations, Selye further asserted that laws governing life on a cell level are essentially similar in the whole person or even a nation.

Selye defined stress as "the nonspecific response of the body to any demand made upon it" (1974, p. 14). A stressor was defined as anything which produces stress and distress as harmful, unpleasant stress (Selye, 1974, 1976). Selye theorized that in the experiencing of stress "it is immaterial whether the agent or situation we face is pleasant or unpleasant, all that counts is the intensity of the demand

for readjustment or adaptation" (1974, p. 15). Over the course of evolution, living organisms learned to defend themselves against assaults via two basic mechanisms: (a) the syntoxic which ignores and puts up with the aggressor, or (b) the catatoxic which fights and attempts to destroy the aggressor. There is an additional type of interpersonal defense reaction--flight, which is an attempt to escape from the aggressor. The effectiveness of these reactions is measured by the degree to which they reduced the stress and if the reactions themselves caused or brought about new or increased stress (Selye, 1974).

Selye demonstrated that animals exposed to continuous stress over long periods of time go through what he has labeled the general adaptation syndrome, abbreviated G.A.S. G.A.S. has three stages: (a) the alarm reaction, in which the body exhibits the changes characteristic of a first exposure to a stressor and the body's resistance is diminished, (b) the stage of resistance, in which the bodily signs, characteristic of the alarm reaction, essentially disappear and the body's resistance rises above normal, and (c) the stage of exhaustion, in which the adaptive energy supply is exhausted, and the signs of the alarm reaction reappear, but now they are irreversible and death ensues (Selye, 1974). G.A.S. put simply is that "At first the experience is difficult, then one gets used to it and finally one cannot stand it any longer" (Selye, 1974, p. 22).

Based on the the triphasic nature of G.A.S., Selye asserted that the body's adaptability or adaptive energy is finite. He proposed

that the length of the resistance period depends upon the body's innate ability to adapt and the intensity of the stressor. Eventually, however, the exhaustion stage ensues, because all the adaptive energy has been utilized and we die. According to Selye (1974, 1976, 1977), we have no control over how much adaptive energy we receive at birth, but we do have choices regarding how much and how steadily we draw upon our finite supply of adaptive energy. Selye asserted that these choices in combination with whatever amount of adaptive energy the individual received at birth determines his aging process, longevity, and, in all probability, his degree of mental health.

Selye's theory of stress is best summarized by the following:

"Although, contrary to public opinion, we must not--and indeed cannot--avoid stress, we can meet it efficiently and enjoy it by learning more about its mechanism and adjusting our philosophy of life accordingly" (1974, p. 21).

Most of Selye's early theoretical assertions were based on repeated observations and the results of laboratory experiments. His later assertions are essentially explanations of the causes of generally accepted patterns. Although some of these assertions have not been empirically proven, his theory is widely accepted in the scientific community.

Menninger (1954) and Lazarus (1966) elaborated on the psychological perspective of Selye's theory. Menninger utilized Selye's concept of homeostasis. He asserted that the ego has the responsibility

for regulating homeostasis by devising compromises among the multiplicity of instinctual, somatic, and environmental demands in order to maintain a tension level which will be least costly to the individual. The individual's degree of mental health is determined by how well the ego is able to perform the above task.

Lazarus (1966) placed much emphasis on the concept of "threat"--the individual must consciously or unconsciously perceive and interpret an event as harmful and/or challenging in order for stress to occur. Although the situations that elicit stress reactions vary for each individual, Lazarus asserted that stress responses can be categorized into motor-behavior reactions, changes in the adequacy in cognitive functioning, physiological changes, and reports of disturbed affects.

Calhoun (1980) compiled the following list of stress-related symptoms. Please note there are symptoms fitting into each of the categories Lazarus listed above.

SYMPTOMS OF STRESS

Physical

| | |
|------------------------------|------------------------|
| Stooped posture | Indigestion |
| Constipation | Hyperactivity |
| Diarrhea | Hyperventilation |
| Dry mouth | Insomnia |
| Cool, clammy skin | Itchy scalp |
| Sweaty palms | Frequent urination |
| Trembling, tics, or twitches | Nausea and/or vomiting |
| Sneezing | Anorexia |
| Impaired sexual function | Carpal-pedal spasm |
| Loss of appetite | Disturbed motor skills |
| Dilated pupils | Chronic fatigue |

Behavioral/Emotional

| | |
|------------------------------|-----------------------|
| Restlessness | Denial |
| Withdrawal | Irritability |
| Sullenness | Panic |
| Defensive behavior | Quarreling |
| Anger | Daydreaming |
| Complaining | Apprehension |
| Crying | Mood swings |
| Excessive drinking (alcohol) | Indecisiveness |
| Excessive smoking | Mistrust |
| Hostility | Disturbed affect |
| Habitual teeth gritting | Gulping meals |
| Nail biting | Lack of satisfaction |
| Reduced personal involvement | from pleasant |
| Blaming others | experiences |
| Critical of self to others | Diminished initiative |

Intellectual

Diminished fantasy life
 Lack of concentration
 Lack of attention to details
 Past oriented rather than future oriented
 Reduced creativity
 Lack of awareness to external stimuli
 Forgetfulness
 Preoccupation

(p. 172)

If the stress continues over too long a period of time and/or becomes too excessive, destructive events occur. These destructive events can be physical, psychological, and/or behavioral. Physical symptoms of destructive stress levels include ulcers, hypertension, cardiovascular disease, general ill health, and accident proneness (Calhoun, 1980; Cronin-Stubbs & Velsor-Friedrich, 1981; Holmes & Rahe, 1967; Margolis, 1980; McLean, 1976; McQuade, 1972; Selye, 1974, 1976). Psychological symptoms of destructive stress levels include emotional outbursts, mental illness, and burnout (Calhoun, 1980;

Holmes & Rahe, 1967; Lazarus, 1966; Menninger, 1954; Pines et al., 1981; Selye, 1974, 1976; Wieman, 1977). Behavioral symptoms of destructive stress levels include burnout, high turnover rates, decreased productivity, unexplained lapses in performance and/or memory, low job satisfaction, high job exit rates, and decreased decision-making ability (Calhoun, 1980; Cleland, 1965, 1967; Freudenberger, 1980; Kahn et al., 1964; McLean, 1976; McCloskey, 1975; Pines et al., 1981; Putney, 1977).

Burnout

Burnout is a stress theory specifically related to occupational stress. Work stressors are extremely significant because so much of a person's time is spent at work (Manuso, 1980). Freudenberger (1980) defined burnout as being "in a state of fatigue or frustration brought about by devotion to a cause, way of life, or a relationship that failed to produce the expected reward. Stated another way: whenever the expectation level is dramatically opposed to reality and the person persists in trying to reach that expectation, trouble is on the way" (p. 13). Storlie (1979) stated that "burnout follows a confrontation with reality in which the human spirit is pitted against circumstances intractable to change. The end result is professional autism. Mandated actions are carried out, but the emotional investment that transforms a task into an art form is missing" (p. 2108). Maslach and Pines (1977) stated that when you burnout, your emotional center goes, there is nothing you really care about, and you have no optimistic feelings--only negative ones.

This all sounds much like a clinical depression, but it is not the same. Although there are certainly individual differences which mediate a person's vulnerability to burnout, burnout's causes are totally extrinsic and arise from external social and environmental conditions, while depression arises from the individual's intrinsic and extrinsic conditions (Pines et al., 1981). Pines et al. (1981) asserted that within a given combination of environmental conditions, burnout becomes essentially inevitable regardless of the individual's degree of mental health and/or coping ability.

Pines et al. (1981) differentiated between tedium and burnout. Both "tedium and burnout are states of physical, emotional, and mental exhaustion. They are characterized by physical depletion, by feelings of helplessness and hopelessness, by emotional drain, and by the development of a negative self-concept and negative attitudes toward work, life, and other people. They are the sense of distress, discontent, and failure in the quest for ideals" (p. 15). They further asserted that although tedium is nearly always a large part of burnout and they are both clusters of exhaustion reactions with similar symptomatology, they differ in origin.

Tedium can be the result of any prolonged chronic pressures (mental, physical, or emotional); burnout is the result of constant or repeated emotional pressure associated with an intense involvement with people over long periods of time. Such intense involvement is particularly prevalent in health, education and social service occupation, where professionals have a "calling" to take care of people's psychological, social, and physical problems. Burnout is the painful realization that they no longer can help people in need, that they have nothing left in them to give (Pines et al., 1981, p. 15).

According to Pines et al., (1981), employees in human services share three common antecedents to burnout: "(1) they perform emotionally taxing work; (2) they share certain personality characteristics that made them choose human service as a career; and (3) they share a "client-centered" orientation. These three characteristics are the classic antecedents of burnout" (p. 48).

Pines et al. (1981) asserted that burnout and tedium have three basic components: (a) physical exhaustion, (b) emotional exhaustion, and (c) mental exhaustion. The physical exhaustion is characterized by weariness, weakness, low energy, chronic fatigue, accident-proneness, frequent headaches, nausea, increased susceptibility to illness, muscle tension in the neck and shoulders, changes in eating habits and/or weight, back pains, nagging colds, psychosomatic complaints, and weariness with an inability to sleep. The emotional exhaustion involves feelings of depression, hopelessness, helplessness, futility, despair, loneliness, discouragement, disenchantment, and entrapment. In extreme cases the emotional exhaustion can lead to mental illness and/or suicidal thoughts (Beck, Weissman, Lester, & Trenxler, 1974). The "mental exhaustion is characterized by the development of negative attitudes towards one's self, toward work, and toward life. People who develop tedium often report dissatisfaction with their work and way of life and a lowered self-concept; they feel inadequate, inferior and incompetent" (Pines et al., 1981, p. 19). They further asserted that the negative attitude burnout victims have

about themselves carries over to a negative attitude about other people, with a subsequent dehumanizing of others. They give the following example: a welfare worker said "I no longer want to work with losers....If they have been the victims of society for so long, they probably deserve it" (p. 19). Burnout's negative attitudes toward one's self and others, often extends to friends, family members, and colleagues, which results in conflict and deteriorating interpersonal relationships when they are needed most (Freudenberger, 1980; Pines et al., 1981).

Burnout's greatest tragedy is that it impacts the most motivated, idealistic, dedicated, effective, and productive workers who pour much more into their work than is returned from the patients, supervisors, and/or clients (Alexander, 1980; Freudenberger, 1980; Pines et al., 1981; Putney, 1977; Storlie, 1979). The greater one's idealism and dedication is; the greater the extent of burnout one will experience (Pines et al., 1981). Pines and Maslach (1978) in previous studies found that workers attempted to combat burnout by utilizing detached concern, intellectualization, compartmentalization, withdrawal, and relying on other staff for advice and support. In spite of these techniques, the studies still indicated that all too often burnout is causing the helping professions to lose their very best members.

Although the burnout experience can make its victim re-evaluate life, reset priorities, and make more realistic goals (Freudenberger,

1980), burnout more commonly results in losses and is a major factor in high job turnover rates, low morale, absenteeism, tardiness, professional exit, nonthinking and nonfeeling professional robots, reduced productivity, and reduced quality in the services provided (Alexander, 1980; Freudenberger, 1980; Maslach & Pines, 1977; Munro, 1980; Pines et al., 1981, Pines & Maslach, 1978; Putney, 1977; Shubin, 1978; Skinner, 1979; Storlie, 1979; Yee, 1981).

Stress and Nursing Burnout

There is a definite relationship between stress and burnout in nursing. A "major underlying factor responsible for burnout, regardless of the setting is stress" (Yee, 1981, p. 14). It will be documented in the following section of the literature review that nursing is an inherently stressful profession. It is well documented in the literature that the stress nurses experience due to their assuming responsibility to care for other peoples' physical, social, and/or psychological needs often makes them burnout victims (Alexander, 1980; Freudenberger, 1980; Munro, 1980; Pines et al., 1981; Pines & Maslach, 1978; Putney, 1977; Shubin, 1978; Skinner, 1979).

A nurse's probability of becoming a burnout victim is greatly compounded by factors extrinsic to the actual practice of nursing, but intrinsic to the nurse, herself, and the nurse's place of employment. Pines et al. (1981) found in their various studies that burnout is related to the following factors: (a) being a female, (b) being a wife and mother employed outside the home, (c) being a wife and mother

employed in the health, social service, or education occupations/professions, and (d) being employed by a large, hierarchial, bureaucratic organization.

Pines et al. (1981) found that being a woman in our culture immediately thrusts a person into role conflict, which is intensified if the woman adds employment outside the home. Wives and mothers employed in the health, social service, or education occupations/professions place themselves in a position of emotional stress double jeopardy--both roles extract similar types of caring behaviors, nurturance, and emotional support. They further found that the stereotype of women who choose the helping professions is relatively accurate; they are people who are especially affectionate, caring, empathetic, and sensitive to the needs of others. Yet, they choose two jobs that are endless (being a good wife and mother and a good nurse, good teacher, or good social worker)--no matter how much they do, there is always more that could be done.

In addition, these endless jobs are often offered by bureaucratic organizations. Pines et al. (1981) found that working in a bureaucratic organization increased the probability of burnout because of the "tedium-causing stress inherent in its bureaucratic nature and burnout-causing stress inherent in the services it provides" (p. 64). "Bureaucratic organizations in general share three antecedents of tedium: (1) overload; (2) lack of autonomy; and (3) lack of rewards. Large agencies that are formal, centralized in decision making, and

hierarchical were found to have high turnover, low job satisfaction and rapid burnout" (Pines et al., 1981, p. 67). It will be documented in the following sections of this literature review that hospitals are bureaucratic, hierarchical organizations whose nursing employees report work overload, lack of autonomy, lack of rewards, low job satisfaction, rapid burnout, and demonstrate a high turnover rate.

Pines et al. (1981) summarized it well with the following assertion: Burnout is essentially inevitable if you are a female, a wife and a mother employed outside the home, employed in a health, social service, or education occupation/profession, and employed by a large bureaucratic organization. These factors that Pines et al. associate with essentially inevitable burnout describe the average nurse, working in the average nursing job, and employed by the average hospital. Hence, it should come as no surprise that burnout is one of today's major nursing issues.

Nursing--A Stressful Occupation

The nursing literature on stress operates on a general assumption that nursing is a highly, inherently stressful profession. This large body of literature falls into several groupings: (a) anecdotal articles on stress in nursing, (b) documentation of stress in nursing via utilization of group indicators, (c) descriptive studies on stress in nursing, (d) general informative articles on the concept of stress and its application to nursing, and (e) advice on the management of nursing stress. There are several recent, well-executed studies which

attempted to identify and rank the stress encountered in the "high stress specialty areas" such as intensive care units, oncology units and the operating room, (Anderson & Basteyns, 1981; Cox, 1981; Donovan, 1981; Gentry, Foster, & Froehling, 1972; Hoffman, 1981; Huckabay & Jagla, 1979; Olsen, 1977; Oskins, 1979; Preston, 1981). Ivancevich and Matteson (1980) utilized similar methodology in an attempt to rank stress for nurses in general. Their findings showed that all nurses have essentially the same stressors as those identified in the "high stress speciality area" studies. Three studies compared stress levels of critical care nursing jobs with non-critical care nursing jobs with differing results. There were no comprehensive studies that attempted to measure and/or document stress in nursing as a whole.

The following 15 items have been identified from the literature as job-related stress agents: (a) work overload (physical and mental), (b) job insecurity, (c) corporation or organizational goals being the absolute priority, (d) nonparticipation in planning and decision-making, (e) poor match of the worker's ability and job expectations--underutilization, (f) ambiguity/conflict of roles, (g) working in unfamiliar areas/experiencing constant change, (h) rapid changes (technical, morale, social), (i) emphasis on perfection, (j) extreme amounts of responsibility--especially for people, (k) ongoing contact with "stress carriers", (l) feelings of immortality (constant exposure to death), (m) resource inadequacy, (n) interpersonal conflict, and (o) unfulfilled ambitions (Bates & Moore, 1975; Calhoun, 1980; Kahn

et al., 1964; Manuso, 1980; McQuade, 1972; Melingo, 1977a, 1977b; Pines et al., 1981; Welford, 1975).

The following review of the nursing literature and research findings will document that the 15 job-related stress agents previously identified exist in nursing.

1. Work Overload (Physical and Mental). There are extensive research findings to document that nurses feel overworked (physically and mentally) and that in reality they are overworked. Many studies found that understaffing and its resultant work overload were the first or second greatest source of identified stress for nurses (Anderson & Basteyns, 1981; Bates & Moore, 1975; Cassem & Hackett, 1972; Cleland, 1965, 1967; Godfrey, 1975, 1976, 1978a, 1978b, 1978c; Grout et al., 1981; Huckabay & Jagla, 1979; Ivancevich & Matteson, 1980; Jacobson, 1978; Lancaster, 1976; Laube & Stehle, 1978; Nahm, 1940, 1948; Oskins, 1979; Pines et al., 1981; Wandelt et al., 1981). Cleland (1967) asserted that "nursing's problem is that no nurse, no matter what her preparation, can give comprehensive nursing care in the ordinary busy medical-surgical unit under present staffing patterns" (p. 108).

2. Job Insecurity. Nurses do not receive tenure, normally do not belong to unions, or receive any other type of job security (Christman, 1979; Johnston, 1976). It is possible for a nurse to be fired without solid evidence of poor or unsafe patient care, or the work situation made so impossible that the nurse leaves by choice. In addition, with the extreme work overload, it would always be

possible to document work not done at all or done inadequately--not due to the nurse's adequacy or inadequacy, but due to the severe time inadequacy. Additionally, nurses receive little communication regarding their job performance unless they make a major error (Godfrey, 1978c; Wandelt et al., 1981). Although nurses do not have job security, studies showed they consider it of much importance (Benton & White, 1972; Marlow, 1966; Pickens & Tayback, 1957; Simon & Olson, 1960).

3. Corporation or Organizational Goals Being the Absolute Priority. Archibald (1971) and Yett (1975) both asserted that nurses' salaries only increase if the nurse shortage becomes so extreme that the hospitals can no longer function. Additionally, hospitals tend to be oligopsonistic or monopsonistic employers who tend to join together in "wage stabilization" agreements, even at the expense of the employees (Archibald, 1971).

4. Nonparticipation in Planning and Decision-Making. Seventy percent of the respondents in the "Job Satisfaction Probe" (Godfrey, 1978a), believed they are usually frozen out of the decision-making process in their place of employment. Some further reported that the setup in their hospital also freezes out nursing administration from any of the decision-making process. Nurses are even forbidden either implicitly or explicitly to make decisions on certain things (Menzies, 1960). Including employees in decision-making is a management principle (Arndt & Huckabay, 1975; Drucker, 1967, 1974; Gruneberg, 1979; Hersey & Blanchard, 1972), yet this principle is seldom utilized

with nurses. Nurses "feel overloaded with work and unable to influence administrative decisions or conflicting demands" (Bates & Moore, 1975, p. 766). Only two quasi-studies on nursing involvement in the decision-making process (Doona, 1977; Smith, Discenza, & Saxberg, 1978) were located. Their findings confirmed the management principle for nurses--that job satisfaction increased when employees are involved in the decision-making process.

5. Poor Match of the Worker's Ability and Job Expectations--Underutilization. Nurses are educated to provide professional, holistic, comprehensive patient care, but the work environment is task oriented (Kramer, 1974) and the work overload is so great that no nurse, regardless of her abilities, can meet the job expectations (Cleland, 1967). Thiry (1977) stated it very well: "Nurses are educated as professionals but in practice are workers" (p. 7). Brief et al. (1979) and Benne and Bennis (1959) both found that nurses' education is underutilized, which results in role stress and this underutilization and its resultant stress increases as nurses come from more professional educational tracks and is not mitigated with time on the job. Krueger (1971) utilized a cluster analysis of nursing activities for LPNs, diploma graduates, BSN graduates, and nurses' aides. She found no clear cut differences between these levels of nursing personnel and their actual function in the workplace. She concluded that there is "a gap between the 'ideal' use of nurses according to their educational preparation and their 'real' use by employment agencies" (p. 676).

6. Ambiguity/Conflict of Roles. Nursing as a whole is still in the process of defining and redefining the nursing role. Only 48% of the respondents to the "Job Satisfaction Probe" (Godfrey, 1978a) reported that they and their supervisor had a very clear understanding of the nature of the respondent's job duties; 11% reported they were groping in the dark. Kramer's (1974) theory of "Reality Shock" was built on her findings regarding the role conflict involved with the way nurses are educated to practice nursing and how their employers expect them to practice nursing. Smith (1965) found that headnurses and nursing school faculty do indeed have different conceptions of nursing. Brief et al. (1979) found that role stress increased with the degree of professional training.

There also exists a major difference between what doctors, patients, and the public perceive as the nurses' role and how nurses' perceive their role (Godfrey, 1978a; Wandelt et al., 1981). Conflicts with doctors (often caused by role ambiguity or role conflict) have repeatedly been found to be a major source of nursing job dissatisfaction and job stress (Anderson & Basteyns, 1981; Grout et al., 1981; Huckabay & Jagla, 1979; Jacobson, 1978; Lancaster, 1976; Laube & Stehle, 1978; Wandelt et al., 1981). Although nurses are not usually directly employed by doctors, doctors have long held great power in defining the nurses' role. Kramer (1974) asserted that there is a built-in misunderstanding and role conflict between nurses and doctors because "in professionalizing, nurses have formed an alliance with the behavior

sciences, while doctors are still primarily oriented to the biological sciences. Therefore, while nurses base their relationships with patients primarily on communication principles and skills, physicians utilize a predominately biological approach" (p. 21).

7. Working in Unfamiliar Areas/Experiencing Constant Change.

Over half of the nurses responding to the "Job Satisfaction Probe" (Godfrey, 1978b) reported they were asked, at least occasionally, to work on another unit. Anderson and Basteyns (1981) findings reconfirmed that being pulled to another unit is a significant source of stress. Selye (1974, 1976) asserted that any type of change results in some degree of stress. A nursing unit is in a constant state of flux (staff, patients, patients' conditions) and uncertainty (an emergency can arise at any moment). Nurses consistently identified this constant change, uncertainty of what will occur next, and the realities of emergencies and death as major sources of stress (Anderson & Basteyns, 1981; Bates & Moore, 1975; Cassem & Hackett, 1972; Godfrey, 1975, 1976, 1978a, 1978b, 1978c; Grout et al., 1981; Huckabay & Jagla, 1979; Jacobson, 1978; Lancaster, 1976; Laube & Stehle, 1978).

8. Rapid Changes (Technical, Morale, Social).

The study by Brosnan and Johnston (1980) documented that change increases stress for nurses, a long held and accepted finding in many other areas. Nash (1975) asserted that not only do nurses face incredible technological changes, they also come face-to-face with society's changes in attitudes and value (such as abortions, death with dignity,

sexual behavior, violence, and the prolongation of life of the terminally ill or severely brain-damaged individuals), which places the nurse in frequent moral and ethical dilemmas (Grout et al., 1981; Jacobson, 1978; Lancaster, 1976; Laube & Stehle, 1978; Mellor, 1977). The rapid changes in society force nurses into a "future shock" (Colls, 1975).

9. Emphasis on Perfection. Nurses are educated to provide holistic, comprehensive patient care--anything less is not good patient care, but the work overload makes good patient care impossible (Bates & Moore, 1975; Cleland, 1965, 1967; Godfrey, 1975, 1976, 1978a, 1978b, 1978c; Kramer, 1974). In addition, a nurse realizes that an error can cause a patient serious injury or even death. The need and desire to provide errorless patient care is repeatedly identified as a major source of nursing stress (Anderson & Basteyns, 1981; Bates & Moore, 1975; Cassem & Hackett, 1972; Cleland, 1965, 1967; Godfrey, 1975, 1976, 1978a, 1978b, 1978c; Grout et al., 1981; Huckabay & Jagla, 1979; Jacobson, 1978; Lancaster, 1976; Laube & Stehle, 1978).

10. Extreme Amounts of Responsibility--Especially for People. Nurses are responsible for planning and providing total patient care at all levels of health and disease (Neuman, 1974). Often a patient's survival and/or quality of future existence is in the hands of the nurse (Anderson & Basteyns, 1981; Cassem & Hackett, 1972; Grout et al., 1981; Huckabay & Jagla, 1979; Ivancevich & Matteson, 1980; Lancaster, 1976; Laube & Stehle, 1978; Oskins, 1979).

11. Ongoing Contact with "Stress Carriers" (Fearful/Anxious People, Demanding Perfectionists). Volicer and Bohannon (1975) identified 49 stressful events associated with the experience of being hospitalized.

12. Feelings of Immortality (Constant Exposure to Death). Menzies (1960) asserted that "nurses confront suffering and death as few other people do" (p. 9). Although nurses frequently deal with death, they identified it as a major source of work stress--often the number one work stressor (Anderson & Basteys, 1981; Cassem & Hackett, 1972; Grout et al., 1981; Huckabay & Jagla, 1979; Jacobson, 1978; Lancaster, 1976; Laube & Stehle, 1978; Oskins, 1979).

13. Resource Inadequacy. Two types of resource inadequacies were identified in the nursing literature--both were often identified as the major source of stress: (a) a chronic, lack of nursing personnel which results in overwork, overtime, and an inability to provide good, safe patient care (Anderson & Basteys, 1981; Bates & Moore, 1975; Cassem & Hackett, 1972; Cleland, 1965, 1967; Godfrey, 1975, 1976, 1978a, 1978b, 1978c; Grout et al., 1981; Huckabay & Jagla, 1979; Jacobson, 1978; Lancaster, 1976; Laube & Stehle, 1978; Nahm, 1940, 1948; Oskins, 1979; Wandelt et al., 1981), and (b) equipment inadequacy (not an adequate amount or not functioning properly) and inadequacy in the physical setup of the unit (Anderson & Basteys, 1981; Bates & Moore, 1975; Huckabay & Jagla, 1979). With "88% of the nation's hospitals unable to fill their full-time nursing

positions" ("Nursing Expo Alleviates Shortage," 1981, p. H-2), it is not hard to realize how extreme and pervasive the resource inadequacy is in nursing.

14. Interpersonal Conflict. Interpersonal conflict between nurses and physicians and/or nurses and nurses (either with peers or supervisors) was found to be a universal and major source of nursing job stress (Anderson & Basteyns, 1981; Cassem & Hackett, 1972; Godfrey, 1975, 1976, 1978a, 1978b, 1978c; Grout et al., 1981; Huckabay & Jagla, 1979; Jacobson, 1978; Lancaster, 1976; Laube & Stehle, 1978; Oskins, 1979; Wandelt et al., 1981).

15. Unfulfilled Ambitions. Many ambitions involve having adequate finances, time, energy, and education. Nurses regularly identified low salaries, lack of educational opportunities, few promotions, few fringe benefits, long, irregular work hours, fatigue, and a lack of a career ladder as significant sources of stress and job dissatisfaction (Benton & White, 1972; Everly & Falcione, 1976; Godfrey, 1975, 1976, 1978a, 1978b, 1978c; Grout et al., 1981; Longest, 1974; Marlow, 1966; Pickens & Tayback, 1957; Simon & Olson, 1960; Strilaeff, 1976; Thompson, 1981; Wandelt et al., 1981; Wolf, 1981).

In addition to the 15 previously discussed job-related stressors, the nursing literature identified several job stressors that are essentially specific to nursing personnel--stressors specifically associated with being employed by hospitals, involved with patient care, and/or involved with the dual career of nurse and mother.

Calhoun (1980) asserted that hospitals are high stress employers. He also asserted that some of the causes for this stress were due to "characteristics inherent in their organization--multiple levels of authority, heterogeneity of personnel, work interdependence and specialization" (p. 171). These are factors Schulz and Johnson (1971) found to be positively correlated with conflict. Hospitals are also complex, relatively large organizations and Kahn et al. (1964) found there to be a direct relationship between the organization's size and the amount of tension and role conflict within the organization.

Additionally, Calhoun asserted that the hospital's organizational stress is further complicated for hospital employees because they are expected to ensure the satisfaction of a significant number of people and groups. Not only the patients and the physicians, but "family members and friends, third-party payers, accrediting bodies, and licensing authorities, all of whom have an interest in the quality and quantity of patient services. The health care team is also influenced by a great number and diversity of professional societies and associations, which sometimes have conflicts in goal orientation and purpose" (Calhoun, 1980, p. 171).

Calhoun further asserted that although some of the most stressful occupations are in the health care field, these stresses are not being dealt with properly. The effect of stress on the development of physical and mental illness has been well established. Colligan, Smith, and Hurrell (1977) studied the relative incidence of mental

health disorders in 130 major occupational categories. When the major occupational categories were rank-ordered for the relative incidence of mental disorders, seven out of the top 27 occupations related to health care. These seven health care occupations were health technologists, LPNs, clinical laboratory technicians, nursing aides, health aides, RNs, and dental assistants. Please note that all three levels of nursing personnel are included in these seven health care occupations that have a high relative incidence of mental disorders.

Colligan et al.'s (1977) findings bring up a major question: Does working in nursing cause or at least greatly affect this high incidence of mental disorders or do people with a propensity toward mental disorders or mental instability gravitate toward nursing? Gentry, et al. (1972) and Menzies (1960) studies concluded that there is no abnormality in the nurses' behavior patterns as portrayed on the MMPI; the psychological and emotional stress was a product of the professional situation. Conclusions must be somewhat limited due to the small sample size utilized in each of these studies.

An additional nursing personnel stressor is the expectation that they do many tasks that "are, by ordinary standards, disgusting, distasteful and frightening" (Menzies, 1960, p. 9). The nurses' daily work places them in intimate contact with the human body's most private functions--often in diseased form (Barnes, 1961).

Nakedness, pain, and the tragedy of death--each at first such a shock--become unusually familiar. Such experiences generally give rise to feelings of anger and anxiety or their affective derivatives (worry, fear, depression, shame, embarrassment, and resentment), which in turn arouse guilt because of a suspicion that: (1) the nurse has no right to feel this way, (2) such feelings are unworthy of her profession, and (3) she will not then be considered a good nurse, who after all should put herself and her own needs aside and think of the patient first (Gentry et al., 1972, p. 793).

A recent NIOSH study (U.S. Department of Labor, Bureau of Labor Statistics, 1976) reported that only 4.8% of the people in low-stress job reported a work injury in the past year, but twice as many (9.7%) high-stress employees reported an injury. These findings were true for off the job injuries also: 22.4% for the high-stress group and 13.7% for the low-stress group (Margolis, 1980). The U.S. Labor Department reported that per 100 full-time employees, hospital employees report a 58% higher incidence of occupational injury and illness than those employed in other service industries (U.S. Department of Labor, Bureau of Labor Statistics, 1976, p. 327).

The preceding literature review has documented that nursing is an intrinsically stressful profession, with additional extrinsic stressors in the work environment. In addition to being a nurse, most nurses also have a second career as a homemaker, wife and/or mother, which is also intrinsically and extrinsically stressful. An assessment of nurses' most important sources of stress found that 62% of the factors were personal stressors and 38% of the factors were professional stressors (Cronin-Stubbs & Velsor-Friedrich, 1981).

Nursing Job Stress and Job Satisfaction/Dissatisfaction

Burke (1976) studied the relationship between 14 sources of occupational stress and 12 aspects of job satisfaction utilizing 228 males employed full-time in one of three professions, i.e. professional engineers, industrial accountants, and chartered accountants. He found that "the occupational stress level was significantly related to the job satisfaction index--the greater the stresses, the lower the satisfaction" (p. 235). The study by Brief et al. (1979) on anticipatory socialization and role stress among RNs supported Burke's finding for nurses. They found that role stress is negatively correlated with job satisfaction for nurses.

Bates and Moore (1975) found that stress scores were highest for hospital staff with direct patient care responsibilities. Nursing studies also identified a high degree of stress related to intrinsic job factors associated with providing patient care, i.e. death of a patient, meeting family needs, emergencies, meeting patients' emotional needs, moral and ethical issues involved with the prolonging of life of patients who are terminally ill or severely brain-damaged, responsibilities and decision-making involved in providing patient care, and knowledge needed to provide patient care. There was also stress associated with extrinsic job factors, i.e. insufficient, malfunctioning equipment, communication and interpersonal problems in the nursing staff, organizational communication problems, conflict and interpersonal problems with the medical staff, large workload,

inadequate staffing, shift rotation, and "being pulled" (Anderson & Basteys, 1981; Cassem & Hackett, 1972; Grout et al., 1981; Huckabay & Jagla, 1979; Ivancevich & Matteson, 1980; Jacobson, 1978; Lancaster, 1976; Laube & Stehle, 1978; Oskins, 1979).

Although Burke (1976) and Pines et al. (1981) both asserted that high levels of stress are associated with high levels of dissatisfaction, the review of the nursing literature appears to place a qualifier on their assertion. Throughout the literature, nurses identified high job stress and high job satisfaction with the intrinsic factors of their job (providing patient care) and high job stress and high job dissatisfaction with the extrinsic factors of their job (salaries, benefits, interpersonal relationships, inadequate staffing, etc.). These findings add further support to Herzburg's (1959, 1966, 1968) dual-factor theory and its applicability to nursing.

If one correlates the findings on stress and the findings on nursing job satisfaction, it could be hypothesized that nurses accept the inherent stress in their job (Selye, 1974) and that the intrinsic rewards of nursing and the nurses' personality needs (Collings, 1980) balance out the stress inherent to nursing, but the nurse is left with essentially no coping ability for the extrinsic job stressors. This hypothesis is supported by the fact that nurses place such extreme emphasis on the extrinsic job dissatisfiers. They also place much greater emphasis on interpersonal factors than other categories of workers (Longest, 1974; Nichols, Springford, & Searle, 1981). Studies have

found that as stress increases, the need for interpersonal relationships and emotional support also increases (Freudenberger, 1980; Pines et al., 1981; Pines & Maslach, 1978).

Stress and Nursing Turnover

Job turnover rates are highly correlated with high stress levels and a high degree of job dissatisfaction (Hulin, 1966; Nichols, 1971; Pines et al., 1981; Porter & Steers, 1973; Wolf, 1981). Mereness (1966) stated that "when anxieties and frustrations become too intense, nurses may abandon their positions entirely" (p. 97). Selye (1974) asserted that when an individual experiences a stressor, one possible reaction is flight, which is an attempt to escape or get away from the stressor. Selye's assertion, simply stated, is that any change (positive or negative) causes stress and a typical response to stress is to try and escape from it. Hence, turnover (leaving or getting away from a job situation) is a normal response to stress, yet turnover results in change, which increases stress.

Nursing turnover results in the following types of changes and/or stresses in the work situation: (a) changes in work patterns, (b) changes in the number of people to do the job, (c) changes in roles, (d) changes in competency levels of staff, (e) shortages in personnel, which results in increased workload, (f) stress related to having a new person(s) around, (g) stress related to orienting and teaching new staff member(s), (h) changes in the staff's social structure and social relationships, which has been found to be of extreme

significance to nurses, and (i) lowered levels of job satisfaction (Bayley, 1981; Godfrey, 1976; Kramer, 1974; Longest, 1974; McCloskey, 1974, 1975; Nash, 1966; Price & Mueller, 1981; Saleh et al., 1965).

In summary, turnover becomes a vicious, circular, self-propagating, and self-perpetuating type of problem: stress causes turnover, which then results in increased levels of stress, which then results in increased turnover, ad infinitum. The end result being the high nursing turnover we are presently experiencing.

Nonjob Correlates with Nursing Job Satisfaction/
Dissatisfaction, Stress, and Turnover

There are four major studies which attempted to identify the differences between nursing personnel who left the employment of the studied hospital and/or institution and those who stayed. The most significant and consistent finding was that nursing personnel with the highest levels of job satisfaction were the most likely to continue in employment and those with the highest level of job dissatisfaction were the most likely to leave employment. Other results were found with significantly less consistency.

Price and Mueller (1981) did an extensive study of nurses from seven voluntary, short-term hospitals. The sample was composed of nurses with the following types of educational preparation: diploma ($n=770$), AD ($n=140$), and BSN ($n=174$). Data were collected via a questionnaire. Their findings indicated that seven variables are statistically significant correlates to nursing job satisfaction:

(a) routinization, (b) instrumental communication, (c) promotional opportunity, (d) participation, (e) amount of time worked, (f) kinship responsibility, and (g) opportunity. Job satisfaction, general training, kinship responsibility, opportunity, and pay were identified as the significant variables of intent to stay, with job satisfaction the most important. Price and Mueller also found that with increased age there is also increased intent to stay, greater job satisfaction, decreased opportunity, better knowledge about the work, fewer close friends, less pay, less general training, and more kinship responsibility. Their findings also indicated that with increased length of service there was increased intent to stay, greater job satisfaction, decreased opportunity, reduced pay, less general training, and more kinship responsibilities. According to Price and Mueller's findings, the variables which predicted nurses who were least likely to leave employment are: (a) a diploma graduate, (b) from the local area, (c) with extensive kin in the area, (d) over 30 years of age, (e) is married, and (f) has children.

Brown (1978) utilized a survey to study 131 subjects from a BSN program and 168 subjects from an AD program in an attempt to identify factors that either retained nurses in the active manpower pool or factors which produced high attrition rates among nurses. Contrary to Kramer (1974) and Price and Mueller (1981), she found no relationship between the type of nursing educational preparation and the working status of the nurses. Although there is no explanation

for this difference in findings, it is important to note that the two most extensive studies found the relationship to exist. Brown identified three personal factors which affected nurses' attrition: (a) being under 30 years of age, and especially under 25 years of age, (b) having children under 6 years of age in the home, and (c) older nurses work a longer time than younger nurses.

Slavitt, Stamps, Piedmont, and Haase (1978) conducted an extensive, well-designed, 2 year study on nursing job satisfaction, utilizing 2 samples ($n=336$ nurses and $n=455$ nursing personnel) from 2 hospitals, and in 2 different years. The respondents included RNs, LPNs, nurses' aides, ward clerks, orderlies, operating room technicians, and child care technicians. Their findings were as follows:

1. Position. The higher the job position, the greater was the level of job satisfaction. Supervisors were the most satisfied followed by staff RNs, LPNs, etc.

2. Unit. Nurses who worked on special care units were the most satisfied with their jobs and those working on medical-surgical units were the least satisfied.

3. Education. RNs with diplomas were more satisfied with their jobs than LPNs or RNs with a BSN or AD degree.

4. Nursing experience. Most satisfied with their jobs were those nursing employees who had more than 10 years of nursing experience and least satisfied were those with 1 to 3 and 3 to 7 years of nursing experience.

5. Years at the hospital. Levels of job satisfaction were low for the first year of employment and then increased after 7 to 10 years of employment at the same hospital.

6. Age. Moderate satisfaction job levels were found in those nursing employees who were less than 20 years of age. The satisfaction levels dropped in the 20 to 29 age group and then increased again.

7. Shift and hours. The night shifts had higher job satisfaction scores than the day shifts. There were essentially no differences between nursing employees who worked full-time and those who worked part-time.

Kramer (1974) did an extensive, landmark study on new BSN graduates (n=218). Kramer found that nursing schools prepared students to provide holistic, comprehensive nursing care (similar to primary nursing care) for one or two patients, but the job expectation was basically task and procedure oriented. Kramer gave the label "Reality Shock" to the result of this divergence between the educational preparation and the job performance expectation. Kramer found "Reality Shock" to be extremely prevalent in new graduates from BSN programs--their professional ideals and values of high patient orientation were not rewarded in the task oriented work setting, which resulted in a professional-bureaucratic role conflict and feelings of role deprivation. The new BSN graduate resolved this conflict in one of three ways: (a) leaving the position or nursing in total, (b) essentially relinquishing her professional values and accepting the bureaucratic values, or (c) for a few,

integrating both sets of values into an integrated bureaucratic-professional biculturalism. Until the professional-bureaucratic conflict was resolved, at least to some degree, "Reality Shock" was highly correlated with low job satisfaction and high turnover rates for new BSN graduates. The variables of increased work experience, specific educational preparation geared toward preparing the new graduate for the real work world, the development of a professional-bureaucratic biculturalism, a high level of self-actualization, and high feelings of competency were found to decrease "Reality Shock" and its correlated low job satisfaction and high turnover and exit rates.

In addition to the previously reviewed studies, there are additional findings of nonjob correlates with nursing job satisfaction/dissatisfaction and stress in the literature. These findings will be discussed in the following two groupings:

1. Nonjob Correlates with Job Satisfaction/Dissatisfaction.

Nichols et al. (1981) found that less experienced nurses felt less positive about their jobs. Pines and Maslach (1978) found that: (a) staff with higher education (some type of graduate degree) were less satisfied with their jobs, (b) staff with the most years of experience had lower levels of job satisfaction, and (c) higher ranking staff had lower levels of job satisfaction. Behling and Kosmo (1971) found no relationship between the type of nursing educational preparation, nurses' marital status, and nurses' job satisfaction. Bullock (1953) found that nurses' job satisfaction

increased as nurses' rank positions increased, i.e. staff nurses' job satisfaction levels were significantly lower than nursing supervisors, etc.

2. Nonjob Correlates with Stress. Olsen (1977) found no relationship between the type of nursing educational preparation and nurses' perception of stress. Brief et al. (1979) found that role stress for RNs increased with the degree of professional training, with BSN prepared nurses experiencing the most stress, and that time on the job did not mitigate these effects. Brief et al. also found that role stress was negatively correlated with job satisfaction. Alonso, Alutto, and Hrebiniak (1972) found that nurses' occupational stress decreased as their years of experience increased. Leatt and Schneck (1980) found no differences among head nurses of varying educational levels in their perceptions of the frequency and the types of stress. Johnson (1979) found that nurses with 1 to 5 years of nursing experience reported significantly more trait anxiety than did nurses with 6 to 10 years of nursing experience and that age and race did not appear to be significantly related to trait anxiety.

In summary, based on the findings in the literature, the most important nonjob correlates with nursing job satisfaction/dissatisfaction, stress, and turnover appear to be: (a) age, (b) type of educational preparation, (c) having children, (d) nursing job level, (e) years of nursing experience, (f) shift, and (g) years

employed at the same hospital. However, there is disagreement as to the direction of the relationships. It is interesting to note that only one study found marital status to be a significant variable and it was a positive correlation between being married and remaining in the job, which is contrary to the findings and implications of the voluntary/nonvoluntary nursing studies (Bayley, 1981; Behling & Kosmo, 1971; Diamond & Fox, 1958; McCloskey, 1975; Saleh et al., 1965).

Psychiatric Nurses and Stress, Job Satisfaction/
Dissatisfaction, and Turnover

Godfrey (1978b) found that psychiatric nurses reported a higher percentage (27%) of job dissatisfaction than any other nursing work setting or speciality. The nursing literature suggests that this higher level of job dissatisfaction may be due to their higher role ambiguity (Davis, 1962; Dietrich, 1976; Hargreaves & Runyon, 1969; Hessler, 1980; Leatt & Schneck, 1980; Ryan, Gearhart, & Simmons, 1977).

There is a body of nursing literature that attempts to document that nurses in different specialties have different personality traits (Cohen, Trehub, & Morrison, 1965; George & Stephens, 1968; Gilbert, 1975; Lukens, 1965; Miller, 1965; Mlott, 1976; Navran & Stauffacher, 1958). Although small personality differences were found between various nursing specialities, nurses' personalities were significantly more alike than different. Grear (1976) found

no measurable personality difference between psychiatric nurses and critical care nurses. However, psychiatric nurses have been found to have the highest level of ego strength (Miller, 1965; Mlott, 1976; Reich & Geller, 1977).

Leatt and Schneck (1980) utilized 153 head nurses from nine speciality areas in an attempt to identify differences in amounts and types of experienced stress. They found that psychiatric nurses had low patient-based stress (dying patients, caring for patients with a poor prognosis), the highest task-ambiguity stress, medium staff movement stress, and medium physician-based stress. Intensive care unit nurses had high patient-based stress, medium task-ambiguity stress, medium-high staff movement stress, and low physician-based stress.

Three studies attempted to differentiate stress levels by nursing specialties. Gentry et al. (1972) found that the sources of stress are the same on a general hospital patient care unit as in an intensive care unit, but they are significantly greater in amount in an intensive care unit. Eick (1978), however, found no significant difference between the amount of stress in nursing work in intensive care settings and general medical-surgical settings. Johnson (1979) found that psychiatric nurses reported significantly lower levels of state anxiety than did nurses on the medical and the surgical units. Psychiatric nurses were also found to have a lower tendency toward anxiety. Johnson asserted that these differences may be due to psychiatric nurses perceiving less anxiety-producing

events in their work environment, using their specific training and work experience to lower their anxiety, and/or being sensitized to the psychological implications of the research instruments and deliberately guarding against revealing their own anxieties.

No literature was found which compared turnover rates to nursing speciality areas. However, one study specifically looked at turnover rates and reasons for turnover in psychiatric nurses. Nash (1966) conducted a study on 64 resigning psychiatric nurses employed at a state psychiatric hospital, which had a 69% nursing turnover rate. Of those who resigned, 52% stated personal reasons for leaving, such as marriage, pregnancy, caring for their children, illness in the family, husband leaving for a job in another town, and poor transportation to work. Another 19% resigned because of professional reasons, such as leaving psychiatry for another field in nursing, professional advancement, further study, and the opportunity to teach. Only 10% stated that they were leaving because of unsatisfactory working conditions, such as salary, salary increases, pay differential for evening and night work, amount of vacation time, and compulsory rotation of shifts. Another 19% gave more than one reason for resigning. Nash stated that the above represented the primary reasons for leaving the job. However, when the nurses were specifically asked, many stated they were dissatisfied with the working conditions. Nash then asserted that although the working conditions were not the primary reasons for

turnover, they may have been a contributory factor. It is important to note that this study's findings for psychiatric nursing turnover are essentially identical with the findings for nursing as a whole and various other nursing specialty areas.

Three studies looked at job satisfaction factors for psychiatric nurses. Dorr, Honea, and Pozner (1980) found that psychiatric nurses' job satisfaction is related to the achievement of therapeutic goals by their patients and having a smoothly run unit. Both factors are related to patient care and are intrinsic job factors. Davis' (1962) study on intrarole conflict and job satisfaction on psychiatric units found that psychiatric nurses have high intrarole conflict, but this did not correlate with low job satisfaction. This unexpected finding was in all probability due to several unique variables in the sample.

The study on job satisfaction factors by Pines and Maslach (1978) will be given extensive focus. It was the only study found that: (a) focused on staff stress and/or burnout in any type of a psychiatric setting, (b) attempted to identify which factors in the psychiatric work setting were associated with stress and/or burnout, (c) attempted to identify the changes that work stress and/or burnout caused in the staff in a psychiatric setting, (d) specifically looked at nurses' and nurses' aides' roles and behaviors in a psychiatric setting, and (e) attempted to correlate the psychiatric staff's personal, work experience, education, and

institutional factors with stress and/or burnout. Additionally, it was a methodologically well executed study.

Pines and Maslach (1978) gathered extensive data on personal, work setting behaviors, and institutional variables for 76 staff members employed by various mental health facilities in the San Francisco area. They utilized extensive questionnaires, interviews, and job and institutional characteristics. The following is a summary of their findings:

1. Patient Population and Patient Care Variables. The larger the ratio of patients to staff, the less staff liked their jobs. Lower-ranking personnel (attendants and volunteers) spent more time in direct patient contact than did higher-ranking staff (psychiatrists and psychologists). The higher the percentage of schizophrenics in the patient population, the less job satisfaction expressed by staff members. The more time staff members had spent working with schizophrenic patients in the past, the less time they currently spent in direct patient contact. Staff who described their patient relationships as close spent more time in direct patient contact and less time in administrative work and less time with other staff members. Additionally, when staff-patient interactions were good, staff members liked their work and felt positively about the institution and life in general.

2. Institutional and Staff Variables. Staff work relationships improved when the patient population was less seriously ill and when

the staff worked fewer hours. They also enjoyed their work more, experienced less stress, felt more successful, and viewed patients more positively. When the work load was shared, staff perceived work as less stressful. Staff who spent a large amount of time in administrative work had lower job satisfaction and liked working with patients less; over time, they became more negative in their attitudes towards patients and the mental health staff. Staff members who felt they had input into the institutions policies and felt free to express themselves had higher levels of job satisfaction and felt more positive about themselves and patients. A high frequency of staff meetings was correlated with extremely negative and dehumanizing attitudes towards patients. Staff members who spent more time with other staff members viewed themselves, their job performance, and patients more negatively. Staff who were able to take "time-outs" (temporarily withdraw from patients to other work activities) when they did not feel like working directly with patients had more positive attitudes towards patients.

3. Personal Variables. Staff members with higher educational preparation (some type of graduate degree) had lower levels of job satisfaction and more negative attitudes toward patients and themselves. Higher-ranking staff spent less time in direct patient contact, more time in administrative work, and tended to have increasingly negative attitudes towards patients and mental health. Higher-ranking staff were more likely to approve of pharmacological inter-

vention; lower-ranking staff, who had more direct patient contact, were less dehumanizing towards patients. The longer staff had worked in mental health, the less they liked working with patients, the more custodial (versus humanistic) they were toward patients and mental illness, and the less successful they felt.

The following concisely summarizes their findings:

Job attitudes were related to some working conditions and to staff members' attitudes toward other staff members and toward themselves. Staff members who liked their work very much had a smaller percentage of schizophrenic patients, worked fewer hours a day, and spent less time in administrative duties. They liked working with patients, liked themselves very much, found self-fulfillment in their work, considered it the ideal job, and felt successful. They also tended to have positive attitudes toward other staff members, to see a good chance of curing schizophrenia and to rate their institution more highly. They did not report becoming as tired during work. (Pines & Maslach, 1978, p. 236)

It is interesting to consider that nursing personnel are the only psychiatric staff members who: (a) regularly spend eight hours each working day in direct patient contact, (b) essentially have no "time-outs", (c) usually have little input into the organizational process, and (d) have essentially no control over the severity of illness of the patient population with which they are in contact. These are all factors Pines and Maslach (1978) found to be related to a high level of job dissatisfaction, a negative attitude towards patients, self, other staff, and/or the institution, and a withdrawal from direct patient contact.

The preceding literature review found some differences between psychiatric nurses, nurses in other specialty areas, and nurses

in total. However, the differences are much less than the similarities between psychiatric nurses, nurses in other specialty areas, and nurses in total. Based on the findings in the literature, it is possible to assert that the research on the various nursing specialties and the research on nursing as a whole is relevant to psychiatric nursing and vice versa.

Nonprofessional Nursing Personnel and Stress, Job
Satisfaction/Dissatisfaction, and Turnover

Most of the nursing literature focuses on RNs, rather than LPNs and nurses' aides. However, 4 studies attempted to identify differences in job satisfaction/dissatisfaction for the various levels of nursing personnel, 1 study looked at personality variables, 1 study compared the amount of direct patient care time with functional nursing level, 1 study compared anxiety levels and the amount of self disclosure, and 1 study compared turnover rates.

Myrtle and Robertson (1979) studied the factors which influence the job satisfaction of nursing personnel. Nurses' aides, like RNs, reported that their greatest job satisfaction came from patient care activities. Additional job satisfiers/dissatisfiers came from the organizational climate and the work team and were also essentially identical to findings previously reported for RNs. The sample size and setting were not reported in the literature.

Weaver and Holmes (1979) conducted a survey on job values, using about half (n=631) of the employees in a moderate sized hospital. They found some differences between RNs, LPNs, and nurses' aides. Table 1 is an abbreviation of their reported findings.

Table 1

Job Outcomes Said To Be the Most Important by Nursing Personnel

| Job Outcome | Nurses | LPNs | Aides |
|--|----------|----------|----------|
| Work important and gives a feeling of accomplishment | 74% | 48% | 35% |
| Chances for promotion | 13 | 28 | 26 |
| High income | 12 | 18 | 30 |
| No danger of being fired | 0 | 3 | 9 |
| Working hours short, lots of free time | <u>1</u> | <u>3</u> | <u>0</u> |
| Totals | 100% | 100% | 100% |
| Number of respondents (631) | (118) | (86) | (23) |

Note. Adapted from Table 2 from "What Hospital Employees Value Most", C. N. Weaver and S. L. Holmes, Hospital Progress, 1979, 60-64.

Their findings indicate a difference among the three levels of nursing personnel regarding the importance of various job outcomes (job satisfiers and dissatisfiers). Additionally, the differences were almost perfectly and progressively related to the amount of formal nursing education, i.e. RNs and nurses' aides being most

different and LPNs being almost exactly in the middle. Their research further suggested that the job satisfaction for all nursing personnel has its most important origins in the nature of the work, the nature of the organizational climate, and the nature of the work team.

Slavitt et al. (1978) did an extensive, methodologically sound study on job satisfaction utilizing RNs, LPNs, nurses' aides, ward clerks, orderlies, operating room technicians, and child care technicians employed by two hospitals. They found that RNs were more satisfied than LPNs except in the areas of task requirements and organizational requirements. Nurses' aides, ward clerks, and the various types of technicians were the least satisfied, especially with pay and job status/prestige. Slocum, Susman, and Sheridan (1972) also found that professional nurses reported significantly higher satisfaction with their job security, prestige within the organization, and job autonomy than did paraprofessional employees.

Gross and Brown (1967) studied 25 RNs and 25 LPNs utilizing the Edwards Personal Preference Schedule and the Survey of Interpersonal Values. They found a number of personality differences between the two groups and inferred from these personality differences that RNs and LPNs have different psychological needs, which result in their having different work satisfiers and dissatisfiers.

Burke, Chall, and Abdellah (1956) did a time-study of nursing activities in a psychiatric hospital. Table 2 is a summary of their findings.

Table 2

Percentage of Time Nursing Personnel Spent With Patients
and Away from Patients.

| Activity | Graduate Nurses | "A" Attendants | "B" Attendants |
|--------------------------------------|--------------------|-------------------|-------------------|
| Total, all activities | 100.0 | 100.0 | 100.0 |
| All activities with patients | 45.7 | 42.2 | 60.1 |
| Physical care with patients | 19.5 | 28.2 | 37.0 |
| Psychotherapy with patients | 26.2 | 14.0 | 23.1 |
| All activities away from patients | 54.3 | 57.8 | 39.9 |
| Indirect patient care | 28.0 | 20.7 | 10.9 |
| Nonpatient care (RN level) | 10.7 | 12.1 | 6.5 |
| Non-nursing | 7.4 | 15.0 | 10.3 |
| Personal | 8.2 | 10.0 | 12.2 |

Note. Adapted from Table 3, Table 6 and Table 7 from "A Time Study of Nursing Activities in a Psychiatric Hospital", C. Burke, C. L. Chall, and F. G. Abdellah, Nursing Research, 1956, 5, 27-35.

Graduate nurses spent 45.7% of their work time in activities with patients, "A" attendants spent 70.4% of their work time in activities

with patients, and "B" attendants spent 97.1% of their work time with patients. These findings are consistent with Pines and Maslach (1978) findings that the staff in lower-ranking jobs spent more time in direct patient contact than higher-ranking staff members.

Johnson (1979) studied 70 RNs and LPNs (the literature did not report the breakdown for these two groups) employed in four types of hospital units. She found that LPNs reported significantly lower levels of anxiety than RNs. Johnson suggested that this could be due to the fact that RNs have more responsibility and are exposed to more anxiety producing events and/or situations in the work environment than LPNs.

Bayley's (1981) five year study on job attrition in a burn center was the only study found which attempted a comparative analysis of turnover rates by nursing functional level. In all five years for which figures were compared, LPNs had a much lower turnover rate. However, the nonprofessional nursing personnel represented such a small percentage of her sample that few conclusions can be drawn. Bayley made a point that improvements in nurse-patient ratios were correlated with an increase in the length of employment for both RNs and LPNs.

In summary, there is a significant body of literature that supports the conclusion that there are differences among the various levels of nursing personnel, but that their similarities are much greater than their differences. The various levels of nursing

personnel differed in their level of job satisfaction/dissatisfaction, amount of time spent in direct patient care, turnover rates, personality variables, and anxiety levels. However, all levels of nursing personnel rank ordered job satisfiers/dissatisfiers almost identically and reported that patient care was their greatest job satisfier. Conclusions must be limited due to methodological weaknesses.

Summary

The nursing literature on job satisfaction/dissatisfaction lends itself to the utilization of Herzberg's dual-factor theory of job satisfaction/dissatisfaction. At present, no nursing theory of job satisfaction/dissatisfaction exists. There is, however, a general agreement that the level of job satisfaction and turnover are closely and inversely related. High nursing turnover rates appear to be related to job dissatisfiers, of which the most common are low salaries, low status, inadequate staffing patterns, work overload, unreasonable expectations, poor working hours/shifts, limited fringe benefits, communication breakdown, limited opportunity for advancement, lack of opportunity for continuing education, and poor interpersonal relationships with peers, supervisors, administrators, and physicians. Nursing job satisfaction, on the other hand, appears to be related to job satisfiers, with patient care being absolutely the most important and unanimous satisfier for all levels of nursing personnel. Additional

nursing job satisfiers include: the challenge of the job, the utilization of one's skills and knowledge, and the feeling of performing a valuable job. The literature lends support to Herzberg's theory, for nursing, i.e. that nursing job dissatisfiers are related to extrinsic job factors, while nursing job satisfiers are related to intrinsic job factors.

Nursing stress is also an important issue and influence in nursing turnover and job satisfaction/dissatisfaction. Many of the identified nursing satisfiers and dissatisfiers are also identified by nurses as stressors. Nurses identify the experiences involved with providing direct patient care (death of a patient, emergencies, prolonging the life of a terminally ill patient, etc.) as being their greatest sources of work stress. Hence, nurses identify their greatest source of job stress as also being their greatest source of job satisfaction.

The advocates of primary care nursing utilized the data that patient care is nurses' absolute, most important job satisfier and asserted that if nurses spent more time in patient care their job stress would decrease, their level of job satisfaction would increase, their level of job dissatisfaction would decrease, and their turnover rate would decrease. Their supporting data, however, are weak. Burnout theorists, on the other hand, have asserted that patient care, itself, is the major cause of nurses' high level of job stress, burnout, and turnover. They have methodologically stronger data

for their assertion. Other factors which have been found to correlate with nurses' job satisfaction/dissatisfaction, stress, and turnover are age, years of nursing experience, continued years at the same hospital, type of nursing education program, and functional nursing level. Although the data are somewhat limited, psychiatric nurses also identify direct patient care as a job stressor as well as a job satisfier. Nonprofessional nursing staff also identify direct patient care as their greatest job satisfier; there are no data identifying it as a stressor for nonprofessional nursing personnel. Although nonprofessional nursing staff have a lower overall level of job satisfaction than professional nursing staff, their job satisfaction values are similar, although weighted somewhat differently.

It is not clear from the literature what influence the amount of patient care time has on nurses' job satisfaction/dissatisfaction, stress, and turnover. However, the weight of the literature supports the idea that direct patient care is an intrinsic job factor and intrinsic job factors essentially affect only the level of job satisfaction. Because turnover is most affected by job dissatisfiers, rather than satisfiers, it can be projected that no relationship will be found between the percentage of direct patient care time and the length of post time-study employment. The literature provides insufficient data to make any predictions regarding the other variables in this study.

CHAPTER 3

PROCEDURE FOR THE COLLECTION AND TREATMENT OF DATA

This was an ex post facto, correlational study, utilizing secondary data (Polit & Hungler, 1978), designed to determine the relationship between the years of post time-study employment (criterion variable) and the predictor variables of the percentage of time spent in direct patient care, number of years of formal education, number of years of formal nursing education, and number of years of nursing experience.

Setting

The hospital used for this study was a private, adult, psychiatric, inpatient, treatment facility. It had a census of 160 inpatients as well as an aftercare program. Functionally, it was divided into several "sections" or units, with 4 units dealing with long-term patients, 1 unit dealing strictly with short-term patients, and 1 unit exclusively for alcoholic patients. Each unit was staffed with RNs, nurses' aides, activity therapists, psychologists, social workers, and psychiatrists and believed quite strongly in a team concept of operation. The majority of the patients were in individual therapy as well as other therapies, such as chemotherapy, group therapy, and milieu therapy. The treatment philosophy was one of

relatively long-term treatment. The hospital staff tried not to treat merely the symptoms, but to also help the patients make more in depth changes in their personality and functioning level.

The patients at the selected hospital were about 50% female and 50% male. They came from all parts of the United States. The majority of the patients were between 15 and 25 years of age, single, had a high school or some college education, and came from either upper-middle or upper socioeconomic class families. The majority of the patients had had previous psychiatric hospitalizations and out-patient treatment. About a third of the patients had a diagnosis of schizophrenia. The majority of the patients admitted to the main hospital were voluntary and had a hospital length of stay between six months and two years.

The selected hospital had a high nursing staff to patient ratio and a low nursing personnel turnover rate. In 1974 the turnover rate for RNs was 21.57% and in 1978 it was 20%. The Associate Director of Nursing estimated it would be about one-third higher for nurses' aides. The nursing staff included 43 RNs, 3 LPNs, and 64 nurses' aides. The approximate staff to patient ratio for the day shift was 1 nursing staff to 3.6 patients, for the evening shift it was 1 nursing staff to 3.9 patients, and for the night shift it was 1 nursing staff for 6.2 patients.

Population and Sample

The population for this study was the nursing personnel

employed by the selected hospital at the beginning of April 1975. The Associate Director of Nursing at the selected hospital requested that all nursing personnel complete time-studies for five days beginning the first full week in April 1975, as a part of an evaluation of nursing service. Nursing personnel who did not return their time-studies were not personally contacted, but several reminders were sent to the nursing units.

A sample of convenience, which is a nonprobability, accidental sampling technique, was utilized for this study. The sample consisted of all nursing personnel who had returned completed time-studies for all five days and who were not in the new employee orientation program. From the approximate 110 nursing service employees, 84 or approximately 76% returned their time-studies. Of those returned, 78 time-studies were useable. The sample included data from 10 nursing personnel who retired during the ensuing years of the study, 2 nursing personnel who were placed on long-term medical disability leaves, and 1 person whose termination was non-voluntary.

Protection of Human Subjects

The data for this study were obtained from personnel department records and nursing service department records. Permission to conduct this study was obtained from the selected psychiatric hospital's nursing service department, Ethical Review Committee, Research Review Committee, and Texas Woman's University's Human Subjects Review Committee.

There was no contact with human subjects. The only human subjects' rights concern was the protection of anonymity, which was handled by having the selected hospital and specifically the nursing service department and personnel department obtain the necessary data for this study from the records. The Associate Director of Nursing at the selected hospital coded the data for analysis purposes. At no time did the researcher have access to any of the subjects' names.

Instrument

The instrument utilized in this study was a researcher generated tool called the Time-Study and Demographic Data Record (see Appendix A for complete derivation). It was designed to record the following information for each subject: (a) the daily total minutes spent in each of the areas designated direct patient care activities, (b) the daily percentage of time spent in direct patient care activities, (c) the five day average percentage of time spent in direct patient care activities, (d) the number of years of formal education, (e) the number of years of nursing experience, (f) the length of post time-study employment, and (g) the subject's code. A panel of experts determined which time-study categories were direct patient care.

This researcher entered the demographic data in the appropriate place on the Time-Study and Demographic Data Record in the following manner. Four numbers were obtained for each subject: (a) 1 number representing the number of years of formal education (a high school diploma or equivalent was a 12, an AD was a 14, a nursing diploma was

a 15, a college degree was a 16, and a masters degree was an 18), (b) 1 number representing the number of years of formal nursing education (an LPN was a 1, an AD was a 2, a diploma in nursing was a 3, a BSN was a 4, and a MS was a 6), (c) 1 number representing the number of years employed in nursing (the actual number of years employed in nursing through April 15, 1975), and (d) 1 number representing the number of years of post time-study employment at the selected hospital (computed from April 15, 1975, through April 15, 1982), which was the turnover rate.

The validity of this researcher generated tool was established by content validity (Polit & Hungler, 1978). The three basic categories of nursing activities used in this study were direct patient care, indirect patient care, and nonpatient care. These categories and the types of activities that they contained are frequently found in the contents of the literature, although the actual names of these categories and activities may differ slightly (Burke et al., 1956; Giovannetti, 1980; Larson, Beaver, Hays, Myers, & Rieter, 1968; Lysaught, 1972; MacKinnon, 1978; Meyer, 1978; Wolfe & Young, 1965). Expert validity, a type of content validity, was also obtained by asking each of five masters prepared psychiatric nurses to complete one Categorization of Time-Study Activities Record (see Appendix D for complete derivation). There was a high degree of agreement (100% agreement on 67% or 12 of 18 items, 80% agreement on 17% or 3 of 18 items, and 60% agreement on 17% or 3 of 18 items) among the panel of experts regarding which nursing activities were direct patient care,

indirect patient care, and nonpatient care (see Appendix B for complete derivation). An agreement of three out of five experts was required to accept an activity as direct patient care. Based on the panel of experts' categorization of the time-study's nursing activities, the following were considered to be direct patient care activities: (a) time with one patient, (b) general "unit" coverage, (c) escorting one patient (to therapy, to clinic, etc.), (d) escorting a group of patients, (e) leisure time activity with patients, and (f) group meetings, with patients there. The reliability of this tool has not been established.

Data Collection

The data were collected by means of the Time-Study and Demographic Data Record (see Appendix A for complete derivation). The time-study data were obtained in the following manner. In March 1975, the Associate Director of Nursing at the participating hospital decided that she would like to conduct a time-study of the nursing service staff as a part of an evaluation of nursing service. She generated her own time-study tool (see Appendix C for complete derivation). Beginning the middle of March, she began to attend the various unit's monthly nursing staff meetings to introduce the purpose and format of the study. She stated that the purpose of the study was to assist in evaluating the nursing service program. Also, she had done a very similar study at her previous place of employment and wanted to compare how the two staffs worked. She also insinuated that she needed to know how the nursing staff was using their time in

order to justify more staff, she did not state anything that she was particularly interested in or what would be weighed more or less heavily. She stated nothing about grouping the categories on the time-study sheet into direct patient care, indirect patient care, or nonpatient care. All nursing staff were expected to participate, but they were given the option of signing their names. She realized the error on the tool (that no place was left to check "Time with one patient") and so she verbally corrected for this. Nursing staff who were unable to attend their March nursing staff meeting received the verbal introduction to the time-study by their section nurse.

In addition to the verbal presentation in which the instructions were presented, the following written instructions were paper clipped to the five time-studies placed in each nursing staff's hospital message box on April 1, 1975:

From time to time, several of you have expressed concern about time: the number of meetings people attend, the amount of time spent escorting patients, the amount of paper work that is done. In an effort to get a clearer picture of how time is actually spent, we are asking that each of you complete the attached checklists for the next 5 consecutive days of work.

The form looks time-consuming but, in actuality it is quite simple; merely mark a ✓ for each 15-minute period of work, denoting the task or activity consuming most of your time during that period.

After the forms are completed and returned to me, I will compile the information and will be happy to share the results. Hopefully, this information will be useful to you in comparing different days, different shifts and different sections.

Thanks for your cooperation. Please return these to me as soon as possible.

The Associate Director of Nursing collected the time-studies when they were completed. She made several reminders asking that the time-

studies please be returned, but never contacted anyone individually. She then became busy and although more than seven years passed, she never completed the analysis of the data. She did, however, keep the returned time-study sheets. These facts about the data are known: (a) no nursing staff overtly refused to participate and all who returned time-studies signed their names, (b) some staff members filled the time-study out at the end of the shift, others every fifteen minutes, and others a few times a shift, and (c) the time-study was done during a normal work week (there were no holidays, suicides, or any other type of major crises on any of the units).

Based on the decisions of the panel of experts (see Appendix B for complete derivation), this researcher extracted from the time-study sample the amount of time spent by each subject in each of the direct patient care activities. Those times spent in direct patient care activities were then collapsed to become the time spent in direct patient care. The total daily time spent in direct patient care by each subject was calculated, as was the percentage of time spent each day in direct patient care. Finally, a five day average percentage of time spent in direct patient care for each subject was calculated. All the above data were entered on the Time-Study and Demographic Data Record (see Appendix A for complete derivation).

The data for the number of years of formal education, the number of years of formal nursing education, the number of years employed in nursing, and the length of post time-study employment were taken from

the nursing service department records and personnel department records by the participating hospital's personnel and nursing service departments. To insure the anonymity of the subjects, the Associate Director of Nursing who was responsible for gathering the above demographic data also coded the demographic data before relinquishing it to this researcher.

Treatment of Data

In order to describe the sample on the relative variables, means were calculated. In order to test the hypothesis, the data were utilized in a five factor multiple regression, utilizing multiple regression as an inferential tool to evaluate the relationships of the variables in the population. The dependent or criterion variable was the years of post time-study employment. The independent or predictor variables were the percentage of time spent in direct patient care, the number of years of formal education, the number of years of formal nursing education, and the number of years of nursing experience. Since percentage is not normally distributed and multiple regression requires that the observations be normally distributed, the arc sin transformation was utilized to normalize this data (Winer, 1971). The level of significance used to test the hypothesis was .05. Calculations were performed on the Texas Woman's University computer using a multiple regression program (Nie, Hull, Jenkins, Steinbrenner, & Bent, 1975).

CHAPTER 4

ANALYSIS OF DATA

This chapter will present the analysis of the data. The presentation of the data analysis will be covered in the following sections: (a) a detailed description of the sample, (b) a report of the findings based on the analysis of the data, (c) a report of the additional findings of the study, and (d) a summary of the findings.

Description of Sample

The sample consisted of the time-studies from 78 nursing personnel who were employed by the selected hospital April 1, 1975. There were 34 RNs, 2 LPNs, and 42 nurses' aides.

The data consisted of the years of post time-study employment, the percentage of time spent in direct patient care, the number of years of formal education, the number of years of formal nursing education, and the number of years of nursing experience. The means for each variable are reported by functional nursing levels in Table 3.

The mean length of post time-study employment for RNs was 4.71 years, with a range of .08 to 7.0 years; for LPNs the mean was 3.31 years, with a range of 1.3 to 7.0 years. The mean for nurses' aides, which was almost identical to the mean for RNs, was 4.76 years with a range of .17 to 7.0 years.

Table 3

Variable Means By Category of Functional Nursing Level

| Variable | RN (<u>n</u> =34) | LPN (<u>n</u> =2) | Nurses' Aides (<u>n</u> =42) |
|--|-----------------------|-----------------------|----------------------------------|
| Years of Post Time-Study Employment | 4.71 | 3.31 | 4.76 |
| Percentage of Time Spent in Direct Patient Care | 49.76 | 63.33 | 68.12 |
| Years of Formal Education | 15.39 | 13.00 | 13.52 |
| Years of Formal Nursing Education | 3.18 | 1.00 | 0.07 |
| Years of Nursing Experience | 11.58 | 8.00 | 9.24 |

RNs spent a lower percentage of their work time in direct patient care than nonprofessional nursing personnel. The mean percentage of time spent in direct patient care for RNs was 49.76%, with a range of 56 to 77%, and for nurses' aides it was 68.12%, with a range of 47 to 92%. For LPNs the mean was 63.33% with a range of 56 to 77%, which was similar to the mean for nurses' aides.

As would be expected RNs had the most years of formal education and formal nursing education. However, it is interesting to note that nurses' aides were slightly better educated than the LPNs. The mean number of years of formal education for RNs was 15.39 years, with a range of 14 to 18 years, for LPNs the mean was 13.0 years, with no variance, and for nurses' aides the mean was 13.52 years, with a range of 8 to 18 years. The mean number of years of formal nursing education for RNs was 3.18 years, with a range of 2 to 6

years, for LPNs the mean was 1.0 years, with no variance, and for nurses' aides the mean was 0.07 years, with a range of 0 to 2 years.

Although the RNs had the most years of nursing experience, this sample was collectively a highly experienced group of nursing personnel. The mean number of years of nursing experience for RNs was 11.58 years, with a range of 0 to 34 years, for LPNs the mean was 8.00 years, with a range of 2 to 14 years, and for nurses' aides the mean was 9.24 years, with a range of 1 to 36 years.

In summary, as would be expected, RNs had more years of formal education and more years of formal nursing education than the LPNs and nurses' aides. It is interesting to note that the nurses' aides had slightly more formal education than the LPNs. Although the RNs had the most years of nursing experience, this sample was collectively a highly experienced group. The RNs and nurses' aides had nearly identical lengths of post time-study employment, with the LPNs being somewhat shorter. RN's spent a significantly lower percentage of time in direct patient care than did LPNs and nurses' aides. Any conclusions regarding LPNs must be limited to their extremely small representation in the sample.

Findings

The hypothesis for this study was: There is no significant relationship between the variable years of post time-study employment and the variables percentage of time spent in direct

patient care, years of formal education, years of formal nursing education, and years of nursing experience for the nursing personnel in a selected psychiatric hospital. In order to test the hypothesis of the study, the data were analyzed using the Nie et al. (1975) multiple regression computer program. The dependent or criterion variable was the years of post time-study employment and the independent or predictor variables were the percentage of time spent in direct patient care, the number of years of formal education, the number of years of formal nursing education, and the number of years of nursing experience.

The findings from the data analysis showed that the variable years of nursing experience was significantly correlated with the variable length of post time-study employment. The correlation coefficient was .409. The test for significance gave an F value of 15.259, which was significant at the .001 level. Table 4 reports the analysis of variance and Table 5 reports the multiple regression analysis.

Table 4

Analysis of Variance of Length of Post Time-Study Employment
With Years of Nursing Experience

| Analysis of Variance | <u>Df</u> | Sum of Squares | Mean Square | <u>F</u> | <u>P</u> |
|-------------------------|-----------|-------------------|----------------|----------|----------|
| Regression | 1. | 13586.91467 | 13586.91467 | 15.25930 | .001 |
| Residual | 76. | 67670.57251 | 890.40227 | | |

Table 5

Multiple Regression of Length of Post Time-Study Employment
With Years of Nursing Experience

Dependent variable: Length of Post Time-Study Employment
Variable entered on step number 1: Years of Nursing Experience

| | |
|-------------------|----------|
| Simple R | 0.40891 |
| R square | 0.16721 |
| Adjusted R square | 0.15625 |
| Standard error | 29.83961 |

Variables in the equation

| Variable | <u>B</u> | Beta | Std error B | <u>F</u> |
|-----------------------------|---------------|---------|-------------|----------|
| Years of Nursing Experience | 0.1494647D+01 | 0.40891 | 0.38262 | 15.259 |
| (Constant) | 0.4039389D+02 | | | |

Variables not in the equation

| Variable | Beta in | Partial | Tolerance | <u>F</u> |
|---|----------|----------|-----------|----------|
| Years of Formal Education | -0.02774 | -0.02916 | 0.92020 | 0.064 |
| Years of Formal Nursing Education | -0.03822 | -0.04176 | 0.99459 | 0.131 |
| Percentage of Time Spent in Direct Patient Care | -0.09899 | -0.10785 | 0.98851 | 0.883 |

Over 15% of the variance of the post-time study length of employment can be explained by the years of nursing experience. The more years of nursing experience, the longer the employee remained at the institution after the time-study.

Relationships between the length of post time-study employment and the percent of time spent in direct patient care, the

number of years of formal education, and the number of years of formal nursing education were not significant. Based on these findings, the hypothesis was rejected.

Additional Findings

Because the data were available, the data were further analyzed by the multiple regression procedure using years of experience, unit on which the person worked, and permanent shift the person worked as the independent or predictor variables and length of post time-study employment as the dependent or criterion variable. The results of this analysis of data showed that the variable years of nursing experience, unit on which the person worked, and permanent shift the person worked were significantly correlated with the variable length of post time-study employment. The correlation coefficient was .500. The test for significance gave an F value of 5.752, which was significant at the .001 level. Table 6 reports the analysis of variance and Table 7 reports the multiple regression analysis.

Table 6

Analysis of Variance of Years of Nursing Experience With
Unit 6, Day Shift, and Evening Shift

| Analysis of Variance | <u>Df</u> | Sum of Squares | Mean Square | <u>F</u> | <u>P</u> |
|-------------------------|-----------|-------------------|----------------|----------|----------|
| Regression | 4. | 21393.38080 | 5348.34520 | 5.75201 | .001 |
| Residual | 69. | 64157.76785 | 929.82272 | | |

Table 7

Multiple Regression of Years of Nursing Experience With Unit 6,
Day Shift, and Evening Shift

Independent Variable: Years of Nursing Experience
Variable Entered on Step 4: Evening Shift

| | |
|-------------------|----------|
| Multiple R | 0.50007 |
| R square | 0.25007 |
| Adjusted R square | 0.20659 |
| Standard Error | 30.49299 |

Variables in the Equation

| Variable | <u>B</u> | Beta | Std error B | <u>F</u> |
|-----------------------------|----------------|----------|-------------|----------|
| Years of Nursing Experience | 0.1721655D+01 | 0.42592 | 0.42706 | 16.253 |
| Unit 6 | -0.2216806D+02 | -0.25535 | 9.16486 | 5.851 |
| Day Shift | -0.1633718D+02 | -0.23303 | 8.80410 | 3.443 |
| Evening Shift | -0.1181114D+02 | -0.16430 | 9.03098 | 1.710 |
| (Constant) | 0.5021213D+02 | | | |

Variables not in the Equation

| Variable | Beta in | Partial | Tolerance | <u>F</u> |
|---|----------|----------|-----------|----------|
| Years of Nursing Education | 0.01222 | 0.01334 | 0.89290 | 0.012 |
| Years of Formal Nursing Education | -0.00434 | -0.00489 | 0.95164 | 0.002 |
| Functional Nursing Level | 0.01766 | 0.01988 | 0.95055 | 0.027 |
| Percentage of Time Spent in Direct Patient Care | -0.07678 | -0.08299 | 0.87604 | 0.472 |

Variables not in the Equation (continued)

| Variable | Beta in | Partial | Tolerance | <u>F</u> |
|----------|----------|----------|-----------|----------|
| Unit 1 | -0.02978 | -0.08299 | 0.92457 | 0.074 |
| Unit 2 | -0.00269 | -0.03307 | 0.91430 | 0.001 |
| Unit 3 | -0.08613 | -0.00297 | 0.95810 | 0.651 |
| Unit 4 | -0.02754 | -0.09735 | 0.89890 | 0.62 |
| Unit 5 | 0.03849 | -0.03015 | 0.94899 | 0.128 |

Twenty-five percent of the variance of post time-study length of employment can be explained by the years of nursing experience, a person working on unit 6, and a person working on the day or evening shift. The more years of nursing experience, the longer the employee remained at the institution after the time-study. Persons working on unit 6 remained at the institution after the time-study, for a shorter time than people working on the other units. Persons working on the day shift and evening shift remained at the institution, after the time-study, for a shorter time than people working the night shift, with people on the day shift remaining for the shortest period of time.

It could be argued that it is not patient contact per se which makes the difference but contact which allows direct and individualized involvement. Hence, an examination of the data utilizing the percentage of one to one time (contact with one patient rather than a group of patients) rather, than the more global percentage

of direct patient care time, was done. In order to determine if the time nursing personnel spent in one to one patient time was related to the length of post time-study employment, that variable was utilized, rather than the percent of time spent in direct patient care, as the criterion variable and the multiple regression was again performed on the original variables of interest. That regression analysis produced no additional findings.

Since the correlation matrix showed high correlation coefficients between percentage of time spent in direct patient care and functional nursing level, an additional analysis was performed to elaborate the significance of those findings. The relationship between the variables was found to be curvilinear, rather than linear. The mean percentage of time spent in direct patient care for RNs was 49.76%, for LPNs the mean was 63.33%, and for nurses' aides the mean was 68.12%. The percentage of time spent in direct patient care was significantly related to the functional nursing level ($r=0.525$, $p=0.00001$). LPNs spent more time with patients than RNs and nurses' aides spent more time with patients than LPNs.

Summary of Findings

The data from the nursing personnel's time-studies and the nursing service and personnel records revealed few variables that were significantly related to the employee's continuing employment. The statistical analysis yielded the following main finding: there is a direct relationship between the years of nursing experience and

years of post time-study employment and no relationship between the percentage of time spent in direct patient care, the number of years of formal education, the number of years of formal nursing education, and the years of post time-study employment. Additional findings were:

1. There was a negative relationship between working on Unit 6 and the length of post time-study employment.
2. There was a relationship between the shift a person worked and the length of post time-study employment, with the day and evening shifts having a significant, negative correlation and the night shift not being significant.
3. Nursing personnel's functional nursing level was related to the percentage of time spent in direct patient care. LPNs spent more time with patients than RNs and nurses' aides spent more time with patients than LPNs.
4. There were no additional findings when the percentage of one to one time was substituted for the percentage of time spent in direct patient care in the original equation.
5. RNs and nurses' aides had significantly different percentages of time spent in direct patient care, yet their lengths of post time-study employment were almost the same.

CHAPTER 5

SUMMARY OF THE STUDY

This chapter will include a summary of this study. Following the summary, the findings will be discussed and compared with the literature. Conclusions and implications will be drawn from the findings and recommendations made for further study.

Summary

Nursing is plagued by two serious and closely related problems--high levels of job dissatisfaction and a long-term increasing turnover rate, which is now reaching crisis proportions. The high turnover rate is costly and presents a hinderance to nursing's central goal and purpose of providing good, safe patient care.

There is a general agreement throughout the literature that nursing is an inherently stressful occupation/profession and that there is something stressful within the nursing work environment, which causes the high levels of nursing job dissatisfaction and turnover. However, there is disagreement regarding the cause of this high degree of stress in nursing. The primary care nursing advocates have asserted that the stress is caused by the divergence between how nurses desire to practice nursing, with a focus on direct patient care, and the way in which the job situation forces

them to practice nursing. On the other hand, burnout theorists have asserted that it is the direct patient care, itself, which is stressful and leads to the high levels of nursing job dissatisfaction and turnover.

At present we do not know the relationship between the way in which nurses spend their work time and job turnover. This study was designed to investigate that relationship and to see if education and work experience have any affect on that possible relationship.

The hypothesis developed for this study was: There is no significant relationship between the variable years of post time-study employment and the variables percentage of time spent in direct patient care, years of formal education, years of formal nursing education, and years of nursing experience for the nursing personnel in a selected psychiatric hospital.

The sample consisted of 78 nursing personnel time-studies. The data were collected by means of a researcher generated instrument called the Time-Study and Demographic Record. Data were analyzed with the multiple regression statistic and the hypothesis was rejected. Although there was no relationship between the percentage of time spent in direct patient care, years of formal education, years of formal nursing education, and the length of post time-study employment, there was a significant relationship between the years of nursing experience and the length of post time-study employment ($r=.409$, $p=.001$), which accounted for over 15% of the variance.

Discussion of Findings

The review of the nursing literature showed a high degree of support for Herzberg's dual-factor theory, although the actual theory was only utilized in three nursing studies. Nurses reported a high degree of satisfaction with nursing (intrinsic factors) simultaneously with a high degree of dissatisfaction with the way they were forced to practice nursing (extrinsic factors) (Godfrey, 1978c).

This study's finding that there was no significant relationship between the years of post time-study employment and the percentage of time spent in direct patient care, or even in one to one patient care time, adds some data to the controversy over the relationship between direct patient care time, stress, job satisfaction/dissatisfaction, and turnover. Primary care nursing advocates have asserted that nursing's high levels of stress, job dissatisfaction, and turnover are due to a serious discrepancy between the way nurses desire to practice nursing, with the major focus on providing direct patient care, and the way in which the work situation forces them to practice nursing. The burnout theorists have offered an essentially opposite explanation. They asserted that it is the direct patient care, itself, which is stressful and results in high levels of job dissatisfaction and turnover. This study's findings did not support either the major assertions of burnout or primary care nursing, but instead it provided further support for the utilization of Herzberg's theory in nursing.

If Herzberg's theory is incorporated into primary care nursing-burnout debate, there appears to be a serious flaw in both the primary care nursing advocates' and burnout theorists' assertions. Both theoretical-conceptual frameworks appear to confound the intrinsic and extrinsic work factors utilized in Herzberg's theory (see Figure 3).

Herzberg: Intrinsic Factor (Direct Patient Care) ➤ Satisfier ➤
 Job Satisfaction ➤ Continuation in Employment
 Extrinsic Factor (Salary, Shift, etc) ➤ Dissatisfier ➤
 Job Dissatisfaction ➤ Turnover

Primary Care Nursing: Intrinsic Factor (Direct Patient Care) ➤
 Satisfier ➤ Job Satisfaction ➤ Turnover

Burnout: Intrinsic Factor (Direct Patient Care) ➤ Dissatisfier ➤
 Job Dissatisfaction ➤ Turnover

Figure 3. The relationship between direct patient care, turnover, and job satisfaction utilizing the conceptual and theoretical frameworks of Herzberg, primary care nursing, and burnout.

The primary care nursing conceptual framework takes an intrinsic job factor (direct patient care) and correlates it with turnover, which, according to Herzberg, is an affect of extrinsic job factors. The burnout theorists take an intrinsic job factor (primary care) and correlates it with job dissatisfaction and turnover, both of which, according to Herzberg, are only related to extrinsic job factors.

The finding that years of post time-study employment was directly related to years of nursing experience is consistent with the findings reported in the literature (Kramer, 1974; Price & Mueller, 1981; Slavitt et al., 1978). One can logically speculate that those

persons who are most dissatisfied will be aware of that relatively early and leave after a short period of time. It is not clear why other nursing personnel do not leave. They may be reasonably satisfied, feel they have less options, be experiencing less job stress, or have factors totally external to the job, itself, which keep them in continued employment.

The additional finding that the functional level of nursing personnel was inversely related to the percentage of time spent in direct patient care is also consistent with the literature (Burke et al., 1956; Pines & Maslach, 1978). Additionally, the finding that nurses' aides and RNs had almost identical lengths of post time-study employment, although nurses' aides spent a significantly higher percentage of time in direct patient care, added further support to the main finding of this study: that the percentage of time spent in direct patient care was not significantly correlated with the length of post time-study employment.

There is no clear explanation for the finding of higher turnover rates for Unit 6. This unit was the only short-term unit in the study and patients admitted there were usually less ill than those admitted on the long-term units. Based on the findings of Pines and Maslach (1978), one would have expected this unit to have the lowest turnover rate. However, since any type of change results in stress (Selye 1974, 1976), this unit would have had more change-related stress due to more rapid changes in the unit's patient

population. Since stress is directly related to turnover (Pines et al., 1981; Selye, 1974, 1976), this could explain why Unit 6 had a significantly lower length of post time-study employment. There is also a small possibility that Unit 6 was experiencing some type of staff interpersonal problems which was different from the other units, and which would have affected the length of post time-study employment. It is documented in the literature that nursing personnel place an unusually high importance on interpersonal relationships in the work environment (Longest, 1974; Nichols et al., 1981). Finally, it is also possible that since Unit 6 was a much smaller unit, the statistics would skew more easily and the length of post time-study employment would be greatly affected just by one person leaving employment.

The finding that the day shift had a significantly shorter length of post time-study employment than the night shift is consistent with the findings of Slavitt et al. (1978). Although nurses seem to prefer the day shift (Benton & White, 1972; Godfrey, 1975, 1976, 1978b; Pickens & Tayback, 1957; Wandelt et al., 1981), apparently working the day shift does not influence their staying in employment. It is also possible, that while waiting for openings on the day shift dissatisfaction builds toward a decision to leave, which then happens after the movement to the day shift. However, the day shift could also have less staff-patient-unit cohesion due to the constant changes (Freudenberg, 1980; Pines et al., 1981; Selye, 1974, 1976)

involved with patients coming and going to their various activities, therapies, and meetings and a constant coming and going of all types of staff members. Additionally, almost all of the many types of meetings are held during the day shift, and Pines and Maslach (1978) found there to be an inverse relationship between the level of job satisfaction and the number of staff meetings. It could also be proposed that people choose to work the night shift due to factors totally external to the job, itself, (child care arrangements, educational goals and schedules, etc.) and that these external factors are relatively long-lasting.

The finding that the evening shift had a significantly shorter length of post time-study employment than the night shift, but longer than the day shift is not discussed in the literature. However, it is probable that it closely relates to the finding regarding the length of employment for the day shifts'. The mitigating difference could be that there is an increased staff-patient-unit cohesion during the evening shift because the patients have fewer activities, therapies, and meetings and most non-nursing staff do not work in the evening, hence almost no meetings occur during the evening shift. Again, factors totally external to the job, itself, are also probably operating.

The finding that there was no significant relationship between the years of post time-study employment and the years of formal education and years of formal nursing education cannot be exactly compared with the findings in the literature, because there are no studies that looked at those exact variables. Even though this study did not

actually attempt to make any comparison between the various types of nursing educational preparation, those types of studies are related and will be discussed because they may increase the understanding of this finding.

Pines and Maslach (1978) found an inverse relationship between increased educational preparation (graduate degree or above) and the level of job satisfaction. Although this may have some inferential value, it is very limited because the sample of this study had only two graduate prepared nurses and low job satisfaction is not necessarily related to turnover. Also, Pines and Maslach (1978) utilized a continuum conceptualization of job satisfaction/dissatisfaction rather than Herzberg's dual-factor theoretical framework. There are several studies which found that BSN prepared nurses have significantly higher turnover rates than diploma prepared nurses (Kramer, 1974; Price & Mueller, 1981; Slavitt et al., 1978), while one study found no difference between the turnover rates for BSN prepared nurses and diploma prepared nurses (Brown, 1978). Why this difference in findings occurred could not be determined, however the two largest, most extensive studies found the relationship between BSN graduates and higher turnover rates to exist.

Conclusions and Implications

Conclusions

Because of the non-random selection of the sample, any conclusions must be limited to the study population. Due to the

small representation of LPNs in the sample, any conclusions regarding them must be limited. It is possible that the utilization of the self-report data produced a possible inaccuracy that may have produced erroneous findings. One apparent difference in this sample and those reported in the literature (American Nurses' Association, 1954, 1962; Bayley, 1981; Diamond & Fox, 1958; McCloskey, 1975; Rowland, 1978; Saleh et al., 1965) is this sample's much lower turnover rate. The other findings of this study are quite consistent with other reported studies in the literature, so that it may be more legitimate to generalize to other populations.

Based on the findings of this study, it can be concluded, that for all levels of nursing personnel:

1. Percentage of time spent in direct patient care is not related to turnover.
2. Educational preparation (nursing and non-nursing) is not related to turnover.
3. Nursing experience is directly related to turnover.
4. The shift a person works may be related to turnover.
5. Specific units on which a person works may be related to turnover.
6. Nursing personnel's functional nursing level may be inversely related to the amount of time spent in direct patient care.

Implications

For more than 41 years, studies have consistently found that

nurses have high turnover rates and report a high level of job dissatisfaction. The studies reported over this long time-span have shown a remarkable similarity and consistency in their findings: that nurses report a high degree of satisfaction with the intrinsic job factors associated with nursing (patient care, challenge of the job, utilization of one's skills and knowledge, a feeling of performing a valuable job, etc.), but also a high degree of dissatisfaction with the extrinsic job factors associated with nursing (low salaries, low status, inadequate staffing patterns, work overload, unreasonable expectations, poor working hours/shifts, limited fringe benefits, communication breakdown, limited opportunity for advancement, lack of opportunity for continuing education, poor interpersonal relationships with peers, supervisors, administrators, and physicians, etc.). However, during this same period of time, nursing has placed essentially its entire focus and effort on changing the way in which patient care is administered (case method, functional nursing, team nursing, etc), which is an intrinsic, not an extrinsic nursing job factor.

The concept of primary care nursing appears to be a valuable and more professional approach to patient care and should result in better patient care and an increased level of nursing job satisfaction. However, the utilization of primary care nursing will, in all probability, have little affect on nursing's level of job dissatisfaction, burnout, turnover, and professional exit, because it

is an intrinsic job factor. Instead, these problems, which have been consistently identified as affecting nurses' level of job dissatisfaction, must be attacked by changing the extrinsic job factors associated with nursing: increasing salaries, increasing fringe benefits, improving working conditions, developing a professional career ladder, improving relationships with peers, supervisors, administrators, and physicians, providing adequate staffing levels, and allowing them more power in organizational decisions. These changes should also increase the probability that nurses who are presently remaining in employment will continue even longer in employment.

In summary, it could be suggested that until the extrinsic job factors, which have been consistently identified with dissatisfaction in nursing for many years, have been at least partially remedied, that the intrinsic changes in nursing, regardless of their value and correctness, will fail to have any long-lasting, significant affect on nurses' levels of stress and job dissatisfaction and their resultant high rates of burnout, turnover, and professional exit. It could be further suggested that nurses' level of job satisfaction will increase and their turnover rates will decrease when they are paid, treated, and viewed as professionals, rather than workers, and given the power and resources that would make it possible to do their job well.

Recommendations for Further Study

Based on the findings of this study and the implications from the literature, the following further studies are recommended:

1. Replication of this study with improved methodology.
2. Additional testing of Herzberg's theory in nursing.
3. Additional, methodologically sound, long-range studies on the affects of primary care nursing on levels of nursing stress, job satisfaction/dissatisfaction, and turnover rates.

APPENDIX A

TIME-STUDY AND DEMOGRAPHIC DATA RECORD

[illegible]

APPENDIX B

SUMMARY OF THE RESULTS OF THE PANEL OF EXPERTS'
CATEGORIZATION OF THE TIME-STUDY ACTIVITIES

The following is a summary of the panel of experts' categorization of the time-study nursing activities. The panel was composed of five masters prepared psychiatric nurses. Three experts must categorize an activity as direct patient for use in this study.

| Nursing Activities | Direct Patient Care | Indirect Patient Care | Nonpatient Care | |
|---|---------------------|-----------------------|-----------------|-----------------------|
| Committee Meeting | | 1 | 1111 | |
| Time with one patient | 11111 | | | |
| Informal Conferences about patients (communicating) | | 11111 | | |
| Time with another staff; giving or receiving supervision | | 11111 | | |
| Unit educational meeting | | 1 | 1111 | |
| Inservice--off unit | | 111 | 11 | |
| Report (shift change) | | 11111 | | |
| General "Unit" coverage | 111 | 11 | | |
| Escorting one patient (therapy, to clinic, etc.) | 1111 | | | One expert left blank |
| Personal time (coffee break, meals) | | | 11111 | |
| Discipline (total unit's nursing staff) or section (total unit's Staff) meeting | | 1111 | 1 | |
| Misc. office work--phone, reports, paperwork | | 111 | 11 | |
| Education--off the hospital grounds | | | 11111 | |
| Escorting a group of patients | 11111 | | | |
| Leisure time activity with patients | 1111 | | | One expert left blank |
| Charting--progress notes, flow sheets | | 11111 | | |
| Group meetings, with patients there | 11111 | | | |
| Team meetings, etc. (staff only) | | 11111 | | |

The following activities recieved three or more X's by the panel of experts in the direct patient care column and for the purposes of this study will be considered direct patient care.

1. Time with one patient
2. General "Unit" coverage
3. Escorting one patient (therapy, to clinic, etc.).
4. Escorting a group of patients
5. Leisure time activity with patients
6. Group meetings, with patients there

APPENDIX C

APPENDIX D

CATEGORIZATION OF THE TIME-STUDY ACTIVITIES

Defintions

Direct Patient Care--The nursing activities that involve nursing personnel being in the actual physical presence of one patient or a group of patients.

Indirect Patient Care--The nursing activities that relate directly to patient care, but during which the patient or patients are not present. This category includes those activities that must be done so that direct patient care can be provided in a safe, continuous and efficient manner.

Nonpatient Care--The nursing activities that may or may not have an indirect effect on the patient and/or his treatment. These activities are primarily related to personnel needs.

Directions

Based on the above definitions and your professional expertise, please indicate which of the following nursing activities you would categorize as direct patient care, indirect patient care, and non-patient care. Place an X in the appropriate box to indicate your categorization for each activity. Each activity may have only one X. After you have completed your categorization, please return it to this researcher in the stamped, self-addressed envelope. Your categorization will be compiled with others as a means of increasing validity for a researcher generated tool to be utilized in a masters thesis. If you have any questions, please call Miriam Miller, 596-8605.

| Nursing Activities | Direct Patient Care | Indirect Patient Care | Nonpatient Care |
|---|---------------------------|-----------------------------|--------------------|
| Committee Meeting | | | |
| Time with one patient | | | |
| Informal Conferences about patients (communicating) | | | |
| Time with another staff; giving or receiving supervision | | | |
| Unit educational meeting | | | |
| Inservice--off unit | | | |
| Report (shift change) | | | |
| General "Unit" coverage | | | |
| Escorting one patient (therapy, to clinic, etc.) | | | |
| Personal time (coffee break, meals) | | | |
| Discipline (total unit's nursing staff) or section (total unit's Staff) meeting | | | |
| Misc. office work--phone, reports, paperwork | | | |
| Education--off the hospital grounds | | | |
| Escorting a group of patients | | | |
| Leisure time activity with patients | | | |
| Charting--progress notes, flow sheets | | | |
| Group meetings, with patients there | | | |
| Team meetings, etc. (staff only) | | | |

APPENDIX E

TEXAS WOMAN'S UNIVERSITY
COLLEGE OF NURSING

AGENCY PERMISSION FOR CONDUCTING STUDY*

THE

GRANTS TO MIRIAM S. MILLER

a student enrolled in a program of nursing leading to a Master's Degree at Texas Woman's University, the privilege of its facilities in order to study the following problem.

Is there a relationship between employment longevity and the variables percentage of time spent in direct patient care, years of formal education, years of formal nursing education and years of nursing experience for nursing personnel in a selected psychiatric hospital.

The conditions mutually agreed upon are as follows:

1. The agency (may) (may not) be identified in the final report.
2. The names of consultative or administrative personnel in the agency (may) (may not) be identified in the final report.
3. The agency (wants) (does not want) a conference with the student when the report is completed.
4. The agency is (willing) (unwilling) to allow the completed report to be circulated through interlibrary loan.
5. Other Items 1 + 2 above are to be
negotiated

Date: August 25, 1981

Miriam S. Miller
Signature of Student

Signature of Agency Personnel

Estelle D. Kuntz R.N., M.S.
Signature of Faculty Advisor

*Fill out & sign three copies to be distributed as follows:
Original - Student; First copy - Agency; Second copy - TWU College of Nursing.

APPENDIX F

TEXAS WOMAN'S UNIVERSITY
Box 23717, TWU Station
Denton, Texas 76204

1810 Irwood Road
Dallas Irwood Campus

HUMAN SUBJECTS REVIEW COMMITTEE

Name of Investigator: Miriam S. Miller Center: Dallas
Address: 2500 Cross Bend Road Date: 5/8/81
Plano, Texas 75023

Dear Ms. Miller:

Your study entitled Longevity of Employment and Time Spent
in Direct Patient Care

has been reviewed by a committee of the Human Subjects Review Committee and it appears to meet our requirements in regard to protection of the individual's rights.

Please be reminded that both the University and the Department of Health, Education, and Welfare regulations typically require that signatures indicating informed consent be obtained from all human subjects in your studies. These are to be filed with the Human Subjects Review Committee. Any exception to this requirement is noted below. Furthermore, according to DHEW regulations, another review by the Committee is required if your project changes.

Any special provisions pertaining to your study are noted below:

Add to informed consent form: No medical service or compensation is provided to subjects by the University as a result of injury from participation in research.

Add to informed consent form: I UNDERSTAND THAT THE RETURN OF MY QUESTIONNAIRE CONSTITUTES MY INFORMED CONSENT TO ACT AS A SUBJECT IN THIS RESEARCH.

____ The filing of signatures of subjects with the Human Subjects Review Committee is not required.

X Other: 1. Will names of subjects be on the time/motion study data and if so, how will the names be dissociated from to protect anonymity.

____ No special provisions apply.

2. Indicate that data will be reported as group data, no individual, can be identified.

Sincerely,

Estelle J. Kutz
Chairman, Human Subjects
Review Committee

at Dallas

PK/srm/3/7/80

MIRIAM S. MILLER
2500 Cross Bend Road
Plano, Texas 75023

August 15, 1981

Mrs. Estelle Kurtz
Chairman, Human Subjects Review Committee at Dallas
Texas Woman's University
1810 Inwood Road
Dallas Inwood Campus
Dallas, Texas 75235

Dear Mrs. Kurtz:

The Human Subjects Review Committee expressed concern regarding the anonymity of the subjects on the time/motion study. The Associate Director of Nursing at the participating hospital will remove the names from the data and replace it with a code. This researcher will not have access to any of the subjects' identity through out the study. All data will arrive precoded by the Associate Director of Nursing. In addition, the data will be reported as group data so that no individual can be identified.

If further clarification is needed, please contact me.

Thank you,

Sincerely yours,

Miriam S. Miller
Miriam S. Miller

MSM/ram

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