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Perceived Stressors, Coping Strategies, and Burnout Pertaining to Psychiatric Nurses Working on Locked Psychiatric Units

by

Richard A. White, RN, BSN

Thesis

Submitted to the School of Nursing

College of Health and Human Services

Eastern Michigan University

in partial fulfillment of the requirements

for the degree of

MASTER OF SCIENCE

in

Nursing

Thesis Committee:

Lorraine M. Wilson, RN, PhD, Chair

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October 21, 2006

Ypsilanti, Michigan

Dedication

This thesis is dedicated to Lynne, my wife and best friend, who has been by my side every step of the way and has given me her time, expertise, and love. Lynne has inspired me to always do the very best that I possibly can and to never, no matter what, give up. I would never have completed this thesis without her words of encouragement. I also want to dedicate this thesis to all of the psychiatric nurses who have gone before me and made a difference in this world.

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I owe special thanks to the team at the White House, particularly Lynne White, April, Misty, Smokey, and Nova. Together they helped transform an idea into a thesis.

I would also like to extend my deepest gratitude to Dr. Jerome Carson, who allowed me to utilize two of the latest research instruments for measuring perceived stressors and coping strategies pertaining to psychiatric nurses. Jerome also offered consultation on a frequent basis from his home in London, England, and played a major role in the success of this scientific research.

I need to give special recognition to all of the psychiatric nurses who volunteered to participate in this study. Without their participation, this study would not have been possible.

Finally, I am deeply grateful to my thesis advisors, Dr. Lorraine M. Wilson, RN, PhD; and Dr. Susan K. Pfoutz, RN, PhD., who offered advice, support, and encouragement through the days of discouragement as well as the final days of optimism and accomplishment.

Abstract

The purpose of this study was to describe perceived occupational stressors, coping strategies, and burnout levels of psychiatric nurses working on locked psychiatric units in southeastern Michigan ($N = 46$), as well as to examine the relationships among demographic factors and these variables. This study utilized a correlation design, adapting the stress, coping, and burnout theoretical frameworks of Seyle, Lazarus, Folkman, and Maslach.

The results indicated that the majority of psychiatric nurses in this study were experiencing low levels of stress and moderate levels of burnout. The findings suggested that staffing issues were an important factor in determining stress levels, and activities outside of work were preferred as methods of coping. Because the majority of research in the area of psychiatric nursing has been conducted outside of the United States, this research provides a baseline from which to address the problem of stress among psychiatric nurses working on locked psychiatric units.

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Chapter I: Introduction

There is a nationwide epidemic among nurses who leave their profession because they report feelings of exhaustion and say they are unable to deliver quality care to patients. *Burnout* is the term often used, and the concept of burnout has attracted considerable attention in the field of nursing. Maslach, one of the first researchers to begin investigating burnout, described it as "a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur among individuals who work with people in some capacity" (Maslach, Jackson, & Leiter, 1996, p. 4). Individuals working in the human service professions are particularly at risk for developing burnout as a result of an emotionally draining occupation (Maslach, 1982).

The nursing profession is a highly stressful occupation (AbuAlRub, 2004; Balevre, 2001; Foxall, Zimmerman, Standley, & Captain, 1990; Hall, 2004; Hillhouse & Alder, 1997; McAbee, 1991; Robinson, Clements, & Land, 2003; Tyler & Ellison, 1994), and when an individual experiences stress over an extended period of time in combination with ineffective coping, it can also lead to burnout (Maslach & Leiter, 1997). Work-related stress is a widespread problem (Stanks, 2005) and has been shown to be costly to both individuals and organizations. Related personal dysfunctions include physical exhaustion, insomnia, substance abuse, and interpersonal problems (Baba, Galperin, & Lituchy, 1999; Farrington, 1995). Greater organizational expenditures are attributed to increased absenteeism, tardiness, staff turnover, low morale, decreased productivity, job dissatisfaction, and court-ordered compensation (Firth & Britton, 1989; Wheeler & Riding, 1994). Moreover, studies have demonstrated that burnout can jeopardize the professional's ability to provide high-quality care to patients (Coffee,

1999; Fagin et al., 1996; Jenkins & Elliott, 2004; Kilfedder, Power, & Wells, 2001).

Occupational Stressors for Psychiatric Nurses

Psychiatric nurses, also commonly known as mental health nurses (MHNs), have undergone specialized training and work in a variety of settings, including community, forensic, long-term, and hospital. They frequently care for patients with an array of psychiatric and psychological illnesses, including depression, anxiety, bipolar disorder, antisocial and borderline personality disorder, and disturbances of thought and perception (such as hallucinations and delusions).

As previously mentioned, the nursing profession is a highly stressful occupation, and MHNs share many of the stressors that affect general nurses (Sutherland & Cooper, 1990), but it is important to point out MHNs are subjected to additional stressors. For instance, violent incidents were found to be one of the most frequently reported work-related stressors. Studies have shown that up to 70% of psychiatric personnel experience some kind of violence at work each year (Love & Hunter, 1996; McKay, 1994; Nolan, Dallender, Soares, Thomsen, & Arnetz, 1999; Soares, Lawoko, & Nolan, 2000). Other stressors frequently encountered by psychiatric nurses include inadequate preparation, potential suicides, physically threatening patients, difficult or demanding patients, verbal abuse, and inadequate staffing in potentially dangerous situations (Cushway, Tyler, & Nolan, 1996; Fagin et al., 1996; Jenkins & Elliott, 2004; Pinikahana & Happell, 2004; Sullivan, 1993).

In addition to being exposed to many of the stressors common to nurses working in the field of psychiatry, psychiatric nurses working specifically on locked units are subjected to additional stress related to high patient-acuity levels. Specifically, patients

requiring placement into this unique type of secure environment are often involuntarily committed as a consequence of a severe mental illness and can be extremely aggressive, violent, and unpredictable and can be a danger to themselves or others. Several research studies have indicated numerous factors affecting the stress and burnout of nursing staff. Factors include patient aggression, perceived threats of physical violence, actual physical violence, dementia, and taking care of clients with disabilities (Barling & Boswell, 1995; Barling, Kelloway, & Frone, 2005; Caldwell, 1992; Chappell & Di Martino, 2000; Cushway et al., 1996; Ever, Tomic, & Brouwers, 2002; Flannery, 1996; Graydon, Kasta, & Khan, 1994; Jenkins, 1996; Leather, Beale, Lawrence, & Dickson, 1997; Rodney, 2000; Sullivan, 1993; Sutherland & Cooper, 1990; Whittington & Wykes, 1992, 1994).

Purpose of the Study

The purpose of this study was to investigate the relationship among perceived stressors, coping strategies, and burnout among psychiatric nurses working on locked psychiatric units. The findings will add to the current body of knowledge pertaining to stress, coping, and burnout experienced by nurses working in psychiatry. The findings can also provide these nurses with a better understanding of occupational stressors, coping strategies, and burnout. In a broader sense, this empirical evidence could assist hospital administrators in the development of delivery systems that promote positive adaptation and facilitate quality care.

Problem Statement

Psychiatric nurses working on locked units provide care for a patient population that requires increased observation and complex treatment modalities. This exposes these psychiatric nurses to a variety of difficult and unique work-related stressors. Empirical

evidence has demonstrated that nurses working in other areas of psychiatry experience a significant level of stress. After conducting an extensive literature review, no research was found about perceived stress, coping strategies, and burnout involving psychiatric registered nurses working on locked psychiatric units. Therefore, this study examined perceived stressors, coping strategies, and burnout among psychiatric nurses working on locked psychiatric wards. The research questions addressed in this study were as follows:

1. Which occupational stressors does the psychiatric nurse perceive as the most stressful and the least stressful in relation to working on a locked psychiatric unit?
2. Which coping strategies are utilized most frequently by psychiatric nurses working on locked psychiatric units?
3. Are age, experience, and education predictors of burnout in psychiatric nurses working on locked psychiatric wards?
4. What are the relationships among occupational stressors, coping strategies, and burnout pertaining to psychiatric nurses working on secured psychiatric units?

Chapter II: Literature Review

The objective for the literature review was to examine the existing body of knowledge pertaining to stress, coping, and burnout experienced by psychiatric nurses. This literature review provided a greater understanding of the aforementioned concepts and occupation. It has also provided guidance and organization for the ideas and theories relating to stress, coping, and burnout.

A search of several databases was conducted by the researcher, and these included CINAHL, MEDLINE, ProQuest, PubMed, PubMed Central, PsychINFO, Psych ARTICLES, Ulrich's Periodicals Directory, World Cat, and the World Wide Web Internet's Google Search Engine. In addition, citations in articles identified by the searches were cross checked. Any papers not identified by the searches but cited by authors were obtained. The following journals were reviewed for additional data: *Journal of Psychiatric and Mental Health Nursing, Journal of Advanced Nursing, International Journal of Nursing Studies, Journal of Psychosocial Nursing and Mental Health Services, Journal of Clinical Nursing,* and *Mental Health Nursing.*

In total, 21 studies were found about psychiatric nurses or psychiatric nursing students and at least one of these three variables: stress, coping, and burnout. The research consisted of psychiatric nurses' working in a variety of settings, such as community mental health, forensic, long-term, and hospital. Fifteen of the studies were conducted in the United Kingdom, two in the United States, and two in Australia; one was conducted in Sweden, and one in the Netherlands.

Stress, Coping, and Burnout Pertaining to Community Mental Health Nurses

Community mental health nurses (CMHNs), also known as community

psychiatric nurses (CPNs), work in the community rather than in hospitals. Four of the aforementioned 21 studies examined stress pertaining specifically to CMHNs. One of these studies, conducted by Pinikahana and Happell (2004), measured stressors, burnout levels, and job satisfaction in CMHNs (N = 136) employed in rural mental health services in Victoria, Australia. This study concluded that workload and inadequate preparation were reported most often as stressful situations. The majority of the CMHNs in this study were found to be satisfied with their jobs and only a fraction of the nurses were experiencing high levels of burnout. However, it is important to point out that the exact type of work setting was not described in detail. For instance, it is only known that the nurses in this study worked in rural and remote settings throughout Australia.

Another study was conducted in 2000 by a group of European researchers utilizing questionnaires to explore stress, coping, and burnout among CMHNs (N = 301). Contrary to the findings of the previously mentioned study, the results indicated that CMHNs were experiencing high levels of stress and burnout. For instance, one half of the participants were found to be emotionally overextended and exhausted and, therefore, unable to provide quality care to their clients. This level of exhaustion was greater for the CMHNs working in urban settings than with those working in rural ones. These psychiatric nurses reported perceiving the most stressful aspects of their job as being workload, poor resources, excessive paperwork, and management problems, as well as a broad spectrum of client-related issues. Coping strategies utilized most often by the CMHNs included peer support, supervision, good communication skills, and a broad range of personal approaches, such as relaxation and belief in one's own abilities. The results of this study were presented in four separate papers (Burnard, Edwards, Fothergill,

Hannigan, & Coyle, 2000; Edwards, Burnard, Coyle, Fothergill, & Hannigan, 2000, 2001; Hannigan, Edwards, Coyle, Fothergill, & Burnard, 2000).

Snelgrove (1998) investigated stress and job satisfaction in three diverse groups of nurses working in the United Kingdom. The sample included health visitors (n = 68), district nurses (n = 56), and CPNs (n =19). Health visitors are qualified nurses with further specialized training in the field of nursing working in various settings throughout the community. District nurses are highly qualified nurses who have undergone further training to enable them to specialize in providing high-quality care to patients in the community. CPNs work specifically with psychiatric patients living either at home or in community-based treatment homes. It is important to note that some stressors were found to be common to all three groups of nurses. This included organizational issues, lack of resources, and administrative duties. However, the researchers found significant differences in the stress levels for each occupational group; and the health visitors reported the highest stress scores and lowest job satisfaction scores. The results of this study highlight the importance of treating nurses according to their specialties as opposed to treating them as a homogeneous profession.

In a comparison study, Fagin and associates (1995) collected data on stress levels pertaining to 250 CPNs and 323 ward-based psychiatric nurses (WBPNs) in the United Kingdom. This study uncovered interesting findings and comparisons between hospital-based psychiatric nurses and their community-based counterparts**.** For instance, a large proportion of both groups of nurses experienced high levels of stress and emotional exhaustion due to the demands of their work. Furthermore, these nurses experiencing high levels of stress were utilizing more sick time, experiencing lower self-esteem, and

feeling unfulfilled in their work. Additionally, the researchers discovered that WBPNs have greater feelings of depersonalization, or detachment from their patients, and a decreased sense of personal accomplishment with their work, as compared to their colleagues working in the community (Fagin, Brown, Bartlett, Leary, & Carson, 1995).

Stress, Coping, and Burnout Pertaining to Forensic Psychiatric Nurses

Forensic mental health nurses (FMHNs) work in an area of nursing that has frequently been singled out as a particularly stressful area of nursing, and therefore, these nurses are at an increased risk for developing symptoms of burnout (Kirby & Pollock, 1995; Savicki & Cooley, 1987). Specifically, these nurses work with a patient population who have generally demonstrated aggressive behavior and have been incarcerated at some point in their lives. They work in a variety of settings, including prisons, clinics, and emergency rooms. Four studies were found pertaining specifically to nurses working in the field of forensics.

Two of the studies conducted by Coffey (1999) and Coffey and Coleman (2001), examined stress and burnout pertaining to forensic community mental health nurses (FCMHNs) working in the United Kingdom. FCMHNs ($N = 104$) participating in this study worked in a variety of community settings, including patients' homes. They also provided treatments and intervention to individuals with severe mental illness who had committed criminal offences. The top three stressors reported by the FCMHNs were lack of community facilities to which clients could be referred, interruptions while trying to work in the office, and the responsibility of giving lectures to other groups of staff. Most of the FCMHNs displayed moderate levels of emotional exhaustion, and half of the participants demonstrated high levels of burnout.

In another study, conducted by Happell, Pinikahana, and Martin (2003), the researchers studied forensic nurses ($N = 51$) in order to measure stress and burnout levels. The nurses worked in a variety of settings associated with a forensic psychiatric service in the Melbourne metropolitan area of Australia. This included a prison, secure hospital environments, and prison-related community programs. The Maslach Burnout Inventory (MBI) and the Nursing Stress Scale (NSS) were the two instruments utilized by the researchers to measure burnout and stress levels, respectively. The results demonstrated that forensic nurses in this study experienced relatively low levels of stress and burnout. The findings differ markedly from the findings of Coffey (1999) and Coffey and Coleman (2001), who identified high levels of stress and burnout among FCMHNs. It is also important to point out that the sample size of the Happell et al. (2003) study was relatively small ($N = 51$), making it difficult to generalize the findings.

Another study examined coping strategies and burnout rates among FMHNs (Ewers, Bradshaw, McGovern, & Ewers, 2002). In this study, 33 qualified FMHNs working in a medium-secure psychiatric unit in the United Kingdom were provided with 20 days of Psychosocial Intervention (PSI) training. The PSI training was designed to educate staff regarding interventions for reducing distress and improving functioning for people with schizophrenia. The researchers hypothesized that by educating staff in PSI, they could improve staff attitudes and beliefs, resulting in decreased burnout rates. The researchers did in fact find a significant improvement in the knowledge base and attitudes of the subjects in the experimental group, as well as a significant decrease in the level of burnout. The findings of this study provide valuable information regarding staff education and burnout as it pertains to nurses working in the specialty field of forensics.

It is also important to note that the overall sample size ($N = 33$) was small, and that the sample size of the control group ($n = 10$) was even smaller.

Stress, Coping, and Burnout Pertaining to Nurses Working in Mental Health Units

A total of three studies were found that investigated occupational stress pertaining specifically to nurses working on acute mental health units. In one of these studies, Jenkins and Elliott (2004) recently set out to examine the relationship between stress and burnout among qualified and unqualified nursing staff ($N = 93$) working in acute adult mental health wards in the United Kingdom. The two groups of participants differed in their perceptions of stress. For example, the main stressor for qualified staff was a lack of adequate staffing. On the other hand, the main stressors for unqualified staff were dealing with physically threatening, difficult, or demanding patients. Fifty percent of both groups demonstrated high levels of burnout. Other stressors reported by both groups included workload, client-related difficulties, organizational issues, conflicts with other professionals, lack of resources, professional self-doubt, and home–work conflict. These findings were consistent with the belief of job-related stressors' leading to staff burnout.

In another study, Sullivan (1993) researched stressors identified by nursing staff ($N = 61$) working in the acute psychiatric in-patient facilities of two health authorities in the United Kingdom. He also sought to assess the effects of stress and identify the types of coping strategies utilized by the nurses working in this type of setting. The results indicated that the stressors most often cited by the nurses were violent incidents, potential suicides, and observation of patients. Other stressors reported less frequently included staffing levels, administrative duties, and feeling overworked. The most frequently utilized coping strategies were social support, problem-solving, and avoidance

techniques. Consistent with the results of previous studies, a high level of burnout was discovered in a majority of the nurses. Most important, reliability and validity were not reported in the study.

Muscroft and Hicks (1998) conducted a study in Birmingham, England, involving 50 psychiatric nurses and 50 general nurses in order to investigate occupational stress and coping among two diverse groups of nurses. Questionnaires were utilized as a means of data collection. The overall results suggested that general nurses report significantly more occupational stress than do psychiatric nurses. It is important to note that the sample size of each group was relatively small.

One study conducted in the United States by Trygstad (1986) consisted of semi-structured interviews with a sample of only 22 qualified nurses working in acute inpatient settings. The researcher sought to identify work-related stressors and factors that assisted the nurses in coping. Trygstad found that the most important determinants of work-related stress were reported to be difficulties in nurses' relationships with either other RNs or the head nurse and in the ability to work together. Unit staff relationships accounted for one third of all stressors identified, and this included inadequate communication and infighting between individuals and groups on the unit. The sample size was extremely small ($N = 22$), and Trygstad did not provide information regarding the representation of this sample of nurses in this study. In other words, she failed to specify whether the sample consisted of registered nurses, licensed practical nurses, or unlicensed staff.

Stress, Coping, and Burnout Pertaining to Psychiatric Nurses Working in a Variety of Settings

Kilfedder et al. (2001) conducted a study examining burnout among psychiatric nurses working in the United Kingdom. The subjects were psychiatric nurses ($N = 510$) employed in a Scottish National Health Service (NHS) trust, which included a range of acute hospital and community settings. Several instruments were utilized to measure stress, coping, burnout, and job satisfaction. The psychiatric nurses in this study had significantly lower levels of burnout as compared to the normative data.

Another study about self-image and burnout among psychiatric staff was conducted by Jeanneau and Armelius (2000) in Sweden. Data were collected from mental health workers ($N = 754$) employed in a variety of mental health care settings, including psychiatric wards, small psychiatric-treatment homes, forensic wards, and community care centers. The researchers discovered that highly burned-out individuals had a significantly more negative self-image than staff who had rated themselves as experiencing low levels of burnout.

One study was found that examined the effectiveness of primary nursing on burnout levels among psychiatric nurses in long-stay settings. A random sample of 161 psychiatric nurses from five psychiatric hospitals located in the Netherlands participated in this longitudinal study. The results indicated that no differences were found in burnout levels after the primary nursing intervention was introduced to the participants. In other words, introducing primary nursing to the staff did not increase burnout rates (Melchior et al., 1996).

Stress, Coping, and Burnout Pertaining to Psychiatric Nursing Students

One study was found that examined stress and coping methods among psychiatric nursing students in the United Kingdom. In this study, students ($N = 35$) were given questionnaires in their 74th week of training. Tully (2004) discovered that students preparing to become nurses in a psychiatric setting were significantly emotionally stressed and that most of the stressors were specific to their education. For instance, three of the most stressful items included the amount of information they were required to learn, exams, and fear of failure. The students reporting increased levels of stress utilized coping methods such as comfort eating, drinking, smoking, taking medications, taking it out on others, and simply wishing things were different. The students reporting lower stress levels utilized more effective coping strategies, such as talking to others, seeking advice, getting assistance, changing things so that the situation might improve, and taking things one step at a time.

A longitudinal study conducted by Kipping (2000) examined 440 psychiatric nursing students' experiences of stress during their time as students and shortly after they began working as nurses in the United Kingdom. Major stressors for students included exams, assessments, written work, placement issues, and student issues. Once the students began their careers as psychiatric nurses, open-ended questions were utilized in order to provide greater detail about the nature of stress. The nurses reported several aspects of their jobs as stressful. These included patient issues, coworker relationships, performance of other staff, changes, and administrative issues. The results of this study provide valuable information for nursing education and can also be applied broadly to psychiatric nursing.

Development of Instruments to Measure Stress in Psychiatric Nurses

Three studies were found that pertain to the development of instruments for measuring stress in psychiatric nurses. Dawkins, Depp, and Selzer (1985) developed an occupation-specific tool by utilizing a modification of the Holmes and Rahe (1967) technique to identify and quantify occupational stress among psychiatric nurses in the United States. They conducted research on 43 psychiatric nurses and instructed them to identify stressful events related to their work from a list of 78 potential work-related stressors. As a result, they designed the Psychiatric Nurses Occupational Stress Scale (PNOSS).

Dawkins and associates (1985) discovered that psychiatric nurses experienced administrative and organizational shortcomings as the most stressful aspects of their jobs. The researchers also discovered that negative patient experiences were viewed by the nurses as causing relatively minimal amounts of stress. Negative patient experiences included dealing with suicidal patients, giving injections in seclusion, and experiencing a patient's death. The sample size was relatively small ($N = 43$), and the majority of participants consisted of psychiatric nurses working in managerial positions. Of the 78 stressors, only 11 were specific to psychiatric nursing. Most important, there was no information available regarding reliability or validity, nor had the scale been developed along psychometric principles. An extensive literature search revealed no research in which this tool had been used by other researchers since the development over 25 years ago.

Cushway and associates (1996) developed the Mental Health Professionals Stress Scale (MHPSS) to measure stress pertaining broadly to mental health professionals. The

scale consists of 42 items and includes seven subscales. It was administered to 154 clinical psychologists and 111 MHNs in the United Kingdom. The MHPSS was shown to discriminate between the two groups of mental health professionals, who might be expected to differ in their sources of stress. The instrument was also found to have good validity and reliability. The researchers found that the most often reported sources of stress identified by the MHNs were physically threatening patients, difficult or demanding patients, and lack of adequate coverage in a potentially dangerous environment. The MHNs in this study worked in either community settings or hospital-based mental health settings. The MHPSS is broad in its measurement of mental health professionals, as it includes stressors experienced by clinical psychologists as well as MHNs.

The Devilliers, Carson, and Leary (DCL) Stress Scale was developed specifically for MHNs working on inpatient units and measures perceived stressors. The questionnaire consists of 30 items comprising five subscales: patient demands, organizational and managerial issues, staffing, future concerns, and job satisfaction. In a study conducted by Fagin and colleagues (1996), 648 ward-based MHNs working in the United Kingdom were examined and scored with this tool. The most stressful situations reported by the MHNs were inadequate staffing to cover in potentially dangerous situations, dealing with changes in the health service, low morale, not being notified of changes before they occur, and knowing that individual patient care is being sacrificed because of lack of staff. The instrument was shown to have good internal and test–retest reliability and good face, content, and concurrent correlational validity. The DCL Stress Scale was utilized in this study to measure stress and will be discussed in further detail.

Development of an Instrument to Measure Coping in Psychiatric Nurses

Only one instrument to measure coping strategies was identified as having been used with nurses working in the field of mental health. In a study conducted by McElfatrick et al. (2000), the European researchers compared two instruments utilized to measure coping: the PsychNurse Methods of Coping Questionnaire (PNMCQ) and the Occupational Stress Indicator (OSI). The OSI was designed for use with individuals in business and industry, and the PNMCQ was designed specifically for psychiatric nurses. The results found the PNMCQ to be a more reliable and clinically relevant choice for identifying coping methods employed by psychiatric nurses. In addition, the OSI coping skills subscales were found to be lacking in reliability and validity, especially in predictive validity. The PNMCQ was utilized in this study to measure coping strategies and will be explained in further detail.

Summary of Literature Review

A substantial amount of research has been conducted in the specialty field of psychiatric nursing. However, the research is limited by various geographical and methodological problems. For instance, the majority of research was conducted in the United Kingdom, and only two of the 21 studies took place in the United States. In addition, almost half of the research consisted of small sample sizes (Dawkins et al., 1985; Ewers et al., 2002; Happell et al., 2003; Muscroft & Hicks, 1998; Snelgrove, 1998; Sullivan, 1993; Trygstad, 1986; Tully, 2004), and some measures used in the studies lacked reliability and/or validity statistics.

Equally important, the research was conducted in numerous areas of psychiatric nursing, such as community mental health, forensics, acute hospital settings, and long-

term environments. The findings for each of these studies cannot be generalized to other areas in the field of psychiatric nursing. For instance, CMHNs generally do not work on locked units but instead work in a variety of community mental health settings. On the other hand, some FMHNs work in locked environments (prisons), but these types of settings have added security measures that are not provided in most locked settings in psychiatric hospitals located in the United States.

Finally, regarding the studies conducted in acute psychiatric hospitals and long-term institutions, the researchers failed to adequately describe the specific types of environment. This is pertinent information because without it there is no way to know whether or not the nurses worked specifically on a locked unit. For instance, many psychiatric hospitals in the United States have both locked and unlocked units. Therefore, it is clearly evident that a significant gap in knowledge exists in today's literature pertaining to psychiatric nurses working on locked units, and this study was designed to help fill that gap.

Chapter III: Conceptual Framework

The conceptual framework chosen for the present study consisted of several theoretical works conducted by four well-established theorists. A conceptual framework is a set of coherent ideas or concepts organized in a way that makes them easy to communicate to others. The purpose of this study was to examine perceived occupational stressors, coping strategies, burnout, and the relationship among the three concepts for psychiatric nurses working on locked units. In order to approach this task in an organized and scientific manner, three theoretical models were used as a guide. These theoretical works are addressed in the following pages and include works by theorists Hans Seyle, Richard Lazarus, Susan Folkman, and Christina Maslach.

Stress

One can hardly pick up a newspaper or magazine or watch television without seeing or hearing some reference to stress. Stress is an unavoidable consequence of life. Hans Selye, a Canadian endocrinologist and renowned stress theorist noted, "No one can live without experiencing some degree of stress all the time" (1956, p. VII). He defined stress as "the nonspecific responses of the body to any demand made upon it" (Selye, 1974, p. 27). Selye began his work in 1926 and developed a conceptual framework for describing stress and the body's responses and adaptations. He called it the General Adaptation Syndrome (GAS), and it has three distinguishable phases: alarm, resistance, and exhaustion. These three phases occur sequentially. Simply stated, if the source of stress sounds the alarm and initiates the GAS and the stress is not removed or coped with, the body progresses to resistance and eventual exhaustion. However, recovery is an alternative outcome to exhaustion when the source of stress is either removed or coped

with effectively (Seyle, 1956).

An underlying concept in Seyle's GAS model is his belief that all living organisms are equipped with a vital force that he called *adaptation energy*. This adaptation is stored in the body and is drawn on whenever organisms have to adapt to demands from outside forces. Seyle describes the state of the body at the alarm stage as the *fight-or-flight response*. This refers to the options available in coping with stressors at this point in the stress response. Seyle found that when his laboratory animals could not fight or flee, they had to adjust to the stimuli by shifting to a lower level but more complex stress response. This response prompted various organs and glands of the animals to produce a variety of hormones, salts, and sugars needed to supply the energy necessary to resist the demands of the stimuli and keep the body in balance. He believed that the effects of the resistance phase of GAS result in the gradual wearing down of what he characterized as weak links, body parts, or systems that bear the brunt of adaptive attempts during the resistance phase. When his animals were no longer able to resist the stimuli acting on them, they broke down, became exhausted, and died (Selye, 1956).

Richard Lazarus is another well-accepted stress theorist. He is credited with developing a unique model explaining how our minds work when perceiving potential stressors. His theory of psychological stress revolves around the belief that people or things become stressors when they pose a threat to our well-being in some way. The threat may be either psychological or physical in nature, and the perception of the stimuli determine whether or not they become stressors (Lazarus, 1966).

Lazarus called the perception of potential stressors a *transaction* and called the actual evaluation of stimuli the *threat appraisal process*. His model involves a three-part

appraisal of the potential stressor: the first appraisal (primary appraisal) determines whether the stressor is a threat; the second appraisal determines whether the individual is capable of coping with the threat; and the third appraisal, the cognitive reappraisal, draws on the information from the first two appraisals (Lazarus, 1966).

In his later work, with colleague Susan Folkman, Lazarus expanded his work on threat appraisal. According to Lazarus and Folkman (1984), stress is a real or perceived imbalance between the environment and an individual's ability to cope or adapt to the imbalance. Individuals endure by continually coping with or adapting to the demands of a constantly changing environment.

Coping

Coping is a vital part of any person's survival in today's fast-paced healthcare environment. Lazarus and Folkman (1984) noted, "Coping serves two overriding functions: managing or altering the problem with the environment causing distress (problem-focused coping), and regulating the emotional response to the problem (emotion-focused coping)" (p. 179). Lazarus defined coping as "not a single act but a constellation of many acts and thoughts engendered by a complex set of demands that may stretch out over time" (1998, p. 207). The choice of coping options is determined by internal and external factors. Personal agenda (e.g., beliefs, values, experience) and resources (e.g., financial or social support) influence the outcome.

Coping behaviors are generally classified as problem-oriented (long-term) or affective-oriented (short-term) methods. The problem-oriented strategies are those used to solve stress-producing problems, whereas the affective-oriented manage the emotional component involved. Short-term coping methods (eating, sleeping, and smoking) reduce

tension temporarily but do not deal directly with the stressful situation. Drawing on past experience and talking it out with others are examples of long-term stress-reduction methods. The problem-oriented strategies are seen as constructive ways of dealing with stress (Keller, 1990).

Burnout

Burnout is a psychological experience that manifests itself in the individual, particularly those individuals who are involved in difficult person-to-person relationships as part of their regular working experiences. A leading pioneer in research on burnout syndrome, Christina Maslach, reported, "Burnout is reaching epidemic proportions among North American workers" (Maslach & Leiter, 1997, p. 1). According to Maslach, burnout develops as a response to a chronic emotional strain, which is the result of dealing with other people, and especially with people who cope with serious problems. Thus, burnout could be considered as a type of professional stress that results from the social interaction between people who provide help and the person who receives that help.

In Maslach's concept of burnout, there are three stress reactions, which occur in a very specific three-dimensional sequence. These stress reactions are characterized by emotional exhaustion, depersonalization, and feelings of little personal accomplishment. Emotional exhaustion refers to excess emotional demands made on people at work, to the point of exhaustion. Depersonalization results when employees see their patients or clients as objects rather than as human beings. The employees become detached or callous and can even dehumanize their clients. This phenomenon is sometimes known as *detached concern*. Feelings of reduced personal accomplishment result when health-care

professionals feel that their actions are not producing positive results (Maslach, 1982).

Model Developed by Researcher

There are three major concepts in this conceptual model that were based on the aforementioned theoretical works conducted by Seyle, Lazarus, Folkman, and Maslach. The three concepts are stressors, coping, and stress outcomes. Stressors consist of external and internal. External stressors comprise major life events, hassles and uplifts, occupational stressors, and adverse physical conditions. Internal stressors comprise physical and psychological influences. An individual's coping strategies are specific efforts that enable an individual to better manage stress. These coping strategies determine what effects stressors will have on stress outcomes. Stress outcomes can be either positive or negative. For instance, if the individual manages to cope effectively with the internal or external stressor, then the individual will experience a positive outcome. If the individual is unable to cope with the stressor, then a negative outcome will result (see Figure 1).

Definition of Terms

Conceptual definition of stress. Stress is defined conceptually as the physical, chemical, and emotional process that produces tension and can cause illness. Stress can be perceived as either positive or negative although stress is generally considered to be negative. There are many events that can be the cause of negative stress for some individuals and positive stress for others. In other words, not all individuals are stressed by the same situation.

Operational definition of stress. The DCL Stress Scale (Fagin et al., 1996) was used in this study to measure perceptions of stress. This instrument is in the form of a

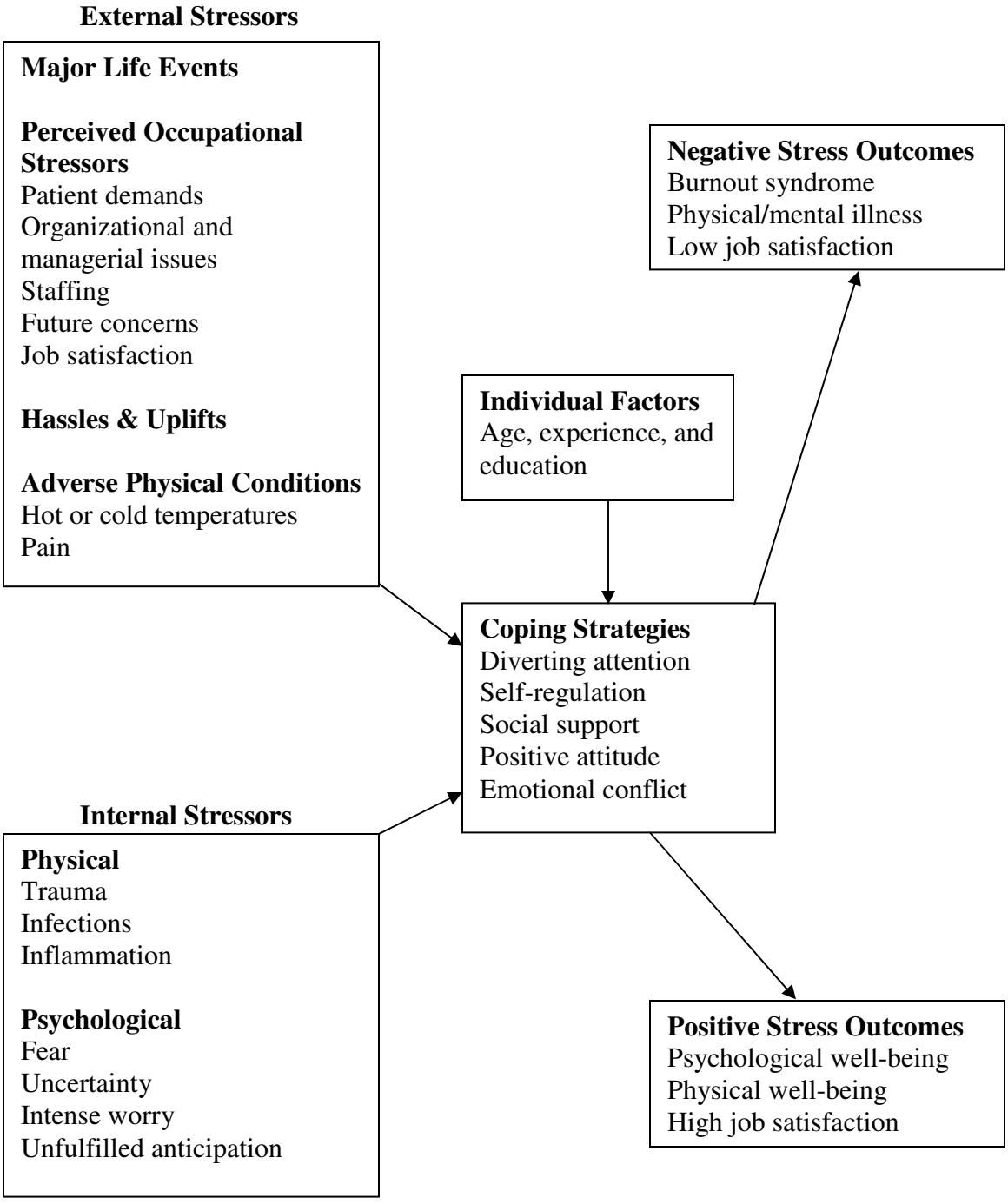

Figure 1. A model of perceived occupational stressors, coping strategies, and stress outcomes. This model was developed by the researcher of this study and was based on the work of Selye, Lazarus, Folkman, and Maslach.

questionnaire and consists of 30 items. The DCL Stress Scale assesses responses related to activities experienced at work by the psychiatric nurse, such as *dealing with disturbed and unpredictable patients*, *having a lack of promotion prospects*, *having to deal with colleagues who don't do their share of the work*, and *having too little time to plan and evaluate treatment*.

Conceptual definition of coping. Coping is a unique set of cognitions and behaviors that are activated by alarming events or excessive demands (stressors). The type of coping strategy utilized by the individual varies and is determined by a variety of factors.

Operational definition of coping. The PsychNurse Methods of Coping Questionnaire (PNMCQ) (McElfatrick et al., 2000) was used in this study to measure the degree to which various coping strategies were utilized by mental health nurses to deal with work-related stress. Some of the items on the survey include *I deal with stress by believing in and feeling good about myself; I deal with stress by managing my time efficiently;* and *I deal with stress by venting to a friend or loved on*e.

Conceptual definition of burnout. Burnout is a physical, mental, and emotional response to constant high levels of stress and ineffective or inadequate coping methods. Burnout produces a variety of feelings and behaviors, including hopelessness, powerlessness, cynicism, resentment, stagnation, and reduced productivity.

Operational definition of burnout. The MBI-Human Services Survey (MBI-HSS) (Maslach & Jackson, 1981) was utilized in this study to measure frequency of burnout. The MBI-HSS consists of 22 items in the form of statements asking the respondent to rate his/her feelings regarding a variety of situations. Some of the statements include *I*

feel emotionally drained at work; *I can easily create a relaxed atmosphere with my recipients;* and *I feel like I'm at the end of my rope.*

Chapter IV: Methodology

Research Design

This study used a descriptive–correlational design to examine relationships among perceived sources of occupational stress, coping strategies, and levels of burnout among registered psychiatric nurses working on locked psychiatric units. An extensive statistical correlational analysis was undertaken to determine whether a correlation existed among the independent variables and dependent variable. *Correlation* simply means that the two factors occur at the same time. According to Burns and Grove (2001), "a correlational study may examine variables in a situation that has already occurred or in a currently occurring situation. No attempt is made to control or manipulate the situation" (p. 256). There was no manipulation of variables in this study.

Correlational studies have a number of advantages. For instance, they are typically fairly easy to conduct and inexpensive to carry out, and almost any variable can be examined. In addition, the correlational method permits the researcher to analyze the relationships among a large number of variables in a single study. Furthermore, correlational studies can provide useful information and are the best choice when an experiment cannot be carried out for certain ethical reasons (Burns & Grove, 2001).

Although correlational studies are useful for generating hypotheses, they do have some limitations. Most important, correlational studies do not establish cause and effect relationships between variables and can be subject to extraneous variables. In other words, these types of studies might not measure the exact effect of one variable on another variable, nor do they say anything about their casual relationship. Also, this type of study does not measure variables over periods of time, but rather it measures at just

one point in time. This simply means that the research results would pertain to the period of time that the research was conducted.

Sample

Sampling is a fundamental method of inferring information about an entire population without going to the trouble or expense of measuring every member of the population. Developing the proper sampling technique can greatly affect the representativeness of the results. This researcher utilized convenience sampling, which allowed the participants to choose whether or not they wanted to participate in the study. It is incumbent on the researcher to clearly define the target population. There are no strict rules to follow, and the researcher must rely on logic and judgment. The population is defined in keeping with the objectives of the study. Ideally, the sample corresponds to the larger population on the characteristics of interest (Burns & Grove, 2001).

The target population for this study consisted of psychiatric registered nurses working on locked psychiatric units within hospital and medical center settings located in southeastern Michigan. This area of Michigan included the counties of Macomb, Monroe, Oakland, Washtenaw, and Wayne. Each participant had to be (a) male or female, (b) 18 years of age or older, (c) employed either part or full time, (d) currently working on a locked psychiatric unit, (e) a Michigan resident, and (f) currently licensed as a registered nurse in the state of Michigan. Exclusion criteria required that participants be under the age of 18 years, licensed practical nurses, nursing assistants, and nurse managers.

Human Subjects Protection

Prior to initiating this study, the researcher submitted a Human Subject Consent

Application Form to the Eastern Michigan University College of Health and Human Services Human Subjects Review Committee for approval. On September 20, 2005, the aforementioned review committee determined that this study met the minimal risk standards, and approval was granted to proceed with this study. A copy of this letter is in Appendix A.

The researcher protected the prospective participants' information through utilization of informed consent. Essentially, this means that prospective research participants must be fully informed about the procedures and risks involved in the research and must give their consent to participate. Involvement in this study was strictly voluntary and did not represent any appreciable risks to physical or psychological safety. All of the participants had the absolute right to withdraw from the study for whatever reason up until the point at which the questionnaires were returned to the researcher. Also, any participant could refuse to answer any question regardless of the reason.

In addition to the participants' informed consent, the participants were also guaranteed confidentially, which means they were assured that identifying information would not be made available to anyone who was not directly involved in the study. For this research, all of the participants were instructed not to sign the implied informed consent to participate in a research study form (Appendix B) or any of the questionnaires. They were also informed that by completing and returning the questionnaires, they were providing the researcher with their consent to participate in this study. Once the questionnaires were received, each participant was assigned a code number for data collection and confidentiality. A post office box was rented specifically for this study, and all of the returned questionnaires were stored in a locked container in a secure

location. Only the researcher had access to the participants' information, thereby maintaining strict confidentiality. No monetary reward was offered for participation in this research.

No set of standards can possibly anticipate every ethical circumstance. Therefore, a process that assures that researchers will consider all relevant ethical issues in formulating research plans is necessary. In order to address such needs, most institutions and organizations have formulated an institutional review board (IRB). Burns and Grove (2001) noted, "The IRB is a committee that reviews research to ensure that the investigator is conducting the research ethically" (p. 213). By reviewing proposals for research, IRBs also help to protect both the organization and the researcher against potential legal implications of neglecting to address the safety and rights of participants.

Measurement Methods

Three data collection instruments were used to operationalize the variables in this study. These included a psychiatric nurse stress questionnaire, a psychiatric nurse coping questionnaire, and a burnout inventory survey. A demographic data questionnaire designed by the researcher was also utilized to collect specific information pertaining to the participants.

Devilliers, Carson, and Leary (DCL) stress scale questionnaire. The DCL Stress Scale developed by Devilliers, Carson, and Leary (Fagin et al., 1996) was utilized in this study to measure perceived stressors (see Appendix C).

The DCL Stress Scale is scored on a 5-point, Likert-type scale: 0 = no stress; 1 = a little stress; 2 = quite a bit of stress; 3 = very stressed; 4 = extremely stressed. This tool consists of 30 items in the form of statements related to the participants' work. The

range of possible scores is from 0 to 120. The higher the score is, the higher is the level of stress the respondent is expected to be experiencing at the time the survey is conducted.

Burns and Grove (2001) noted that the "validity of an instrument is a determination of the extent to which the instrument actually reflects the abstract construct being examined" (p. 399). Face validity for the DCL Stress Scale was established through an expert-panel examination of the items selected for inclusion, and this was facilitated by the instrument's authors. Content validity was developed through a meticulous procedure that involved selecting items believed to be significant stressors for MHNs.

To begin the process of item selection, an initial list of 120 items was generated from numerous sources, including 16 MHNs, stressors identified in previous studies, and existing stress measures. The original MHNs who participated in the initial selection of stressors were asked to analyze the 120 items. For instance, they were asked to rate all of the items as either being *stressful* or *not stressful.* The nurses were also asked to rate the items, on a 5-point, Likert-type scale, from *no stress* to *extreme stress*. The top 60 most stressful items were chosen and rated by the senior researcher. This list of 60 items was then administered to 144 ward-based MHNs. Next, item analysis reduced the total number from 60 to 51. Then, factor analysis was carried out, and after 16 iterations, the list was further reduced to 30 items, and five factors emerged: patient demands (8 items), organizational and managerial issues (8 items), staffing (7 items), future concerns (4 items), and job satisfaction (3 items) (Fagin et al., 1996).

The Cronbach's coefficient alpha statistic was used to estimate the internal

consistency reliability of the 30-item DCL Stress Scale. Cronbach's coefficient alpha has an important use as a measure of the reliability of a psychometric instrument and is expressed as a numerical coefficient. According to Cronk (2004), "Cronbach's coefficient alpha was designed to measure a single construct and determines the degree to which all the items are measuring the same construct" (p. 102). This statistical calculation provided an overall internal consistency reliability coefficient alpha of 0.96 for the DCL Stress Scale.

The test–retest reliability measures were conducted a week apart in a study with 70 MHNs. The Pearson correlation coefficient statistic was used to analyze the DCL Stress Scale's subscale test–retest reliability. Correlations were 0.92 for patient demands, 0.90 for organizational and managerial issues, 0.84 for staffing, 0.80 for future concerns, and 0.88 for job satisfaction. The test–retest correlation coefficient for the overall DCL Stress Score was 0.91 (Fagin et al., 1996). It is important to note that alpha coefficients range in value from 0 to 1. As the value increases, so does the reliability of the generated scale. A correlation coefficient alpha of 1.00 is considered perfect reliability. For an established psychosocial measurement instrument, the lowest acceptable reliability coefficient value is 0.80. For a recently developed instrument, this measure may be as low as 0.70 and still be considered acceptable (Burns & Grove, 2001).

The Cronbach's coefficient alpha statistic was also used to estimate the internal consistency reliability for the DCL Stress Scale in this study. Subscale alpha correlation coefficients for the individual categories were 0.83 for patient demands, 0.67 for job satisfaction, 0.94 for organizational and managerial issues, 0.89 for staffing, and 0.78 for future concerns. Generally speaking, the aforementioned subscale alpha coefficients

meet the criteria of 0.70 for a recently developed psychometric instrument, and they are generally consistent with those of the instrument's developers. The overall alpha coefficient for the DCL Stress Scale in this study was 0.96. This high reliability coefficient of the scale demonstrates very high internal reliability and, coincidentally, is identical to that of the original developers of the DCL Stress Scale (Fagin et al., 1996). Permission was provided by Carson, one of the developers of the DCL Stress Scale, for its use in this study. A copy of this letter is located in Appendix D.

PsychNurse methods of coping questionnaire. The PsychNurse Methods of Coping Questionnaire (PNMCQ) was utilized in this study in order to measure the degree to which various coping strategies were utilized by MHNs (see Appendix E). To date, several instruments have been developed to measure occupational stress in general areas of nursing, but the PNMCQ was devised specifically to measure stressors experienced by MHNs (McElfatrick et al., 2000). McElfatrick and associates (2000) reported, "The coping habits of a single occupational group can only be measured properly if an occupation-specific measure is used" (p. 972). As previously mentioned, stressors encountered by MHNs working in locked environments are quite different from those encountered by nurses working in other areas in mental health and may require unique coping strategies in order to be coped with effectively.

The PNMCQ is in the form of a survey and consists of 35 items comprising five subscales: diverting attention (9 items), self-regulation and self-attitude (6 items), social support at work (6 items), positive attitude toward work role (9 items), and emotional conflict (5 items). The PNMCQ is scored on a 5-point, Likert-type scale: 1 = never; 2 = rarely; 3 = occasionally; 4 = often; and 5 = all the time (McElfatrick et al., 2000).

Permission to utilize the PNMCQ in this study was granted by Carson, one of the instrument's authors (see Appendix D).

Face and content validity of the PNMCQ were established during the beginning stages of the instrument's development. This labor-intensive method began with an initial collection of items from a variety of sources. These sources included interviews with MHNs and several existing measures of coping. Some of the items were also selected from responses to a previous study of MHNs conducted by Carson and associates (1995). In this study, 568 MHNs were asked *What is the main method you use to help you cope with stress*? This method generated an initial list of 108 items. These items were tested further by another group of mental health nurses, and the items that were not believed to be coping strategies by these nurses were eliminated. The remaining 50 items were tested again with a sample of 76 nurses and reduced to 35 items by means of psychometric analysis (McElfatrick et al., 2000).

In addition to validity, the PNMCQ has proven to be reliable when applied to MHNs. In a study conducted by McElfatrick and colleagues (2000), the PNMCQ was administered to 175 MHNs in various areas of Northern Ireland. Cronbach's coefficient alpha was utilized to estimate the internal consistency reliability of the PNMCQ's overall scale and of each subscale. The reliability coefficient alpha for the overall PNMCQ was 0.90. In addition, the reliability coefficient alphas obtained for each of the PNMCQ's five subscales ranged from 0.67 to 0.78 (McElfatrick et al., 2000). These findings indicate adequate reliability, using the aforementioned criterion of 0.70 for a relatively new instrument.

The internal consistency reliability for this study, by computation of Cronbach's

coefficient alpha for each of the PNMCQ subscale categories, was 0.86 for diverting attention, 0.78 for self-regulation and self-attitude, 0.75 for social support at work, 0.87 for positive attitude toward work role, and 0.61 for emotional comfort. These findings also indicate acceptable reliability, using the aforementioned criterion of 0.70 for a relatively new instrument. The overall alpha correlation coefficient for the PNMCQ used in this study was 0.94. This overall alpha correlation coefficient shows that the scale for the sample used in this study had very high internal consistency.

Maslach Burnout Inventory. Several instruments have been designed to measure aspects of burnout syndrome, but the Maslach Burnout Inventory (MBI) is generally recognized as the most valid and reliable indicator of occupational burnout. Development of the MBI began over 25 years ago, and several versions of the MBI currently exist. One of these versions is the MBI-Human Services Survey (MBI-HSS), and this instrument was specifically designed to assess aspects of burnout experienced by staff members in human service institutions and healthcare occupations (Maslach et al., 1996).

As previously mentioned, burnout syndrome consists of three dimensions: emotional exhaustion, depersonalization, and lack of personal accomplishment. These three dimensions are measured by separate subscales. For instance, emotional exhaustion (EE) has nine items and assesses a person's feelings of being emotionally overextended and exhausted by job demands. Depersonalization (DP) consists of five items and measures someone's lack of feelings and impersonal responses to recipients or patients. Personal accomplishment (PA) includes eight items and measures feelings of proficiency and successful achievement in an individual's occupation that pertain to interacting with

other people (Maslach et al., 1996). The MBI-HSS (Appendix F) was used in this study as a means of measuring frequency of experienced burnout.

The MBI-HSS is scored on a 7-point, Likert-type frequency scale: 0 = never; 1 = a few times a year or less; 2 = once a month or less; 3 = a few times a month; 4 = once a week; 5 = a few times a week; 6 = every day. Individuals considered to be experiencing low levels of burnout would score 0-16 on the EE subscale, 0-6 on the DP subscale, and 39 or higher on the PA subscale. Individuals experiencing moderate levels of burnout would score 17-26 on the EE subscale, 7-12 on the DP subscale, and 32-38 on the PA subscale. Individuals considered to be experiencing high levels of burnout would score 27 and higher on the EE subscale, 13 and above on the DP subscale, and 0-31 on the PA subscale (Maslach et al., 1996).

The validity and reliability of the MBI-HSS have been well documented in a number of studies. For instance, Maslach and associates (1996) established construct validity by means of an extensive factor analysis. This lengthy process began with a preliminary form of the MBI-HSS that consisted of 47 items. Each item in the survey consisted of two response formats: frequency and intensity of feelings. This questionnaire was administered to a sample of 605 participants from a variety of health and human services occupations, including nurses and mental health workers. The participants' occupations were selected on the basis of having a high potential for burnout according to previous research (Maslach et al., 1996).

After the first analysis was completed, the initial pool of 47 items was reduced to 25 that met the developers' criteria. These items were then administered to a new sample of 420 participants in order to obtain confirmatory data for the pattern of factors. The

resulting data from the second study were very similar to those of the first; therefore, the two samples were combined (N = 1025), and the 25 items were analyzed again. All of the factors were found to have frequency and intensity ratings that were similar. In addition, three of these factor values were great enough for the items to be considered subscales of the MBI-HSS (Maslach et al., 1996).

Convergent validity of the MBI-HSS was established through a couple of different methods. One method consisted of correlating an individual's MBI-HSS scores with behavioral ratings made independently by someone knowledgeable about the individual, such as a spouse, significant other, or coworker. Another method involved correlating the MBI-HSS scores with the occurrence of specific occupation characteristics that were assumed to contribute to experienced burnout. Last, the MBI-HSS scores were correlated with measures of a variety of outcomes that had been hypothesized to be associated with burnout. The aforementioned correlations provided the developers of the instrument with considerable evidence supporting the validity of the MBI-HSS (Maslach et al., 1996).

Regarding reliability of the MBI-HSS, one published study (N = 1,316) documented by Maslach and associates (1996) demonstrated good internal consistency reliability. Cronbach's reliability coefficient alphas for the subscales were as follows: 0.90 for EE, 0.79 for DP, and 0.71 for PA. Computation of Cronbach's coefficient alpha was accomplished in order to attain the internal consistency reliability of the MBI-HSS subscales in this study (N = 46). The reliability coefficient alphas were 0.93 for EE, 0.81 for DP, and 0.72 for PA. These values demonstrate good internal consistency reliability.

Regarding test–retest reliability, Maslach and associates (1996) reported,

"Overall, longitudinal studies of the MBI-HSS have found a high degree of consistency within each subscale that does not diminish markedly from a period of one month to a year" (p. 12). Several studies have been conducted in order to obtain test–retest reliability for this instrument. In one of the studies conducted by Lee and Ashforth (1993), the researchers found test–retest reliability correlation coefficient alphas of 0.74 for EE, 0.72 for DP, and 0.65 for PA during an eight-month interval. Another study conducted by Leiter and Durup (1996) for a three-month period found test–retest correlation coefficient alphas of 0.75 for EE, 0.64 for DP, and 0.62 for PA. Permission to utilize the MBH-HSS for this study was received from CPP, Inc. and Davies-Black Publishing (see Appendix G).

Demographic data sheet. The demographic data sheet utilized in this research is a 9-item, researcher-developed measure for describing personal characteristics such as gender, age, highest degree received, and experience (Appendix H). Burns and Grove (2001) noted, "Demographic information is analyzed to provide a picture of the sample, which is called the sample characteristics" (p. 185). Demographic results will be presented in percentages.

Data Collection

Unit managers supervising the locked psychiatric units in the aforementioned hospitals and medical centers were contacted via phone to request permission to conduct this research at their respective facilities. Once IRB approval was received for each institution, this researcher scheduled appointments and subsequently gave a brief, oral presentation to the nurses who were present at each location. This presentation included an explanation of the purpose, procedures, risks, benefits, confidentiality, and importance

of voluntary participation. Each participant who met the inclusion criteria was provided with a consent form and an explanation of the research (see Appendix B). Instructions for contacting a representative at EMU for additional information were also printed on the consent form. In addition, each participant received four questionnaires and a self-addressed stamped envelope. The unit managers were given specific instructions to provide each potential participant not present at the time of the presentation with an envelope containing the consent form, questionnaires, and self-addressed stamped envelope. All of the participants were instructed to return the research information to the researcher via U.S. mail upon completion.

Chapter V: Results

Data Analysis

The Statistical Package of the Social Scientists (SPSS) for Windows, Student Version 13.0, was utilized to analyze the quantitative data. Once the surveys were received from the participants, the data were immediately coded and entered into SPSS. Descriptive statistics were utilized to describe the sample characteristics and to evaluate whether the results were normally distributed. Pearson's correlation coefficients were used to determine the strength and direction of relationships among variables. Also, Cronbach's alpha was utilized to estimate the internal consistency of each of the three instruments.

Demographic Data

A total of 100 surveys were delivered to the participants in this study. Fifty-one of the surveys were returned. This number represents a 51% response rate. Five nurses did not fill out a substantial number of responses, and, therefore, their data were excluded from further analysis. Therefore, a final sample of 46 psychiatric nurses ($N = 46$) participated in this study, 38 of whom were female (82.6%) and 8 of whom were male (17.4%). Participants ranged in age from 24 years to 68 years, with a mean age of 48.4 years (SD = 8.9). Regarding ethnicity, 89% of the participants were Caucasian, 6.5% were Asian Americans, and 4.3% were African American. Most of the participants (56.5%) were employed full time (40 hours per week), and the majority of them were married (52%). The mean length of work experience in their current positions was 11.9 years (SD = 8.3), and the mean length of work experience in psychiatric nursing for all staff was 17 years (SD = 8.4). Fifty-seven and one-half percent (57.5%) of the

participants had a bachelor's degree in nursing, 40.0% had an associate's degree, and only 2.5% had completed a master's program or higher level of education. Six participants did not provide data regarding the highest degree they had received. See Table 1 for additional detailed demographic data.

Research Question #1

The objective of the first research question was to determine which occupational stressors the psychiatric nurse perceived as the most stressful and least stressful in relation to working on a locked psychiatric unit. The DCL Stress Scale was utilized to rate the extent to which each potential source of stress at work caused the participants stress. The participants were asked to rate each potential stressor on a 4-point, Likert-type scale: 0 = *no stress* and 4 = *extremely stressed*. A statistical ranking process was undertaken to analyze the scores of all 30 items on all of the completed DCL Stress Scale questionnaires. The mean value for each of the item's scores was ranked in numerical order. This process enabled the researcher to identify the 10 most stressful and 10 least stressful items as rated by psychiatric nurses in this sample. Edwards et al. (2000), Coffey (1999), and Dawkins et al. (1985) all employed this method of ranking in previous studies.

The top stressor was *dealing with difficulties that occur when trying to take action against incompetent staff*. The stressor reported next most frequently was *inadequate staffing coverage in potentially dangerous situations,* and the third was *having to deal with colleagues who do not do their share of the workload* (see Table 2 for a list of the top ten stressors). The least stressful event as perceived by the participants in this study was *having to deal with potentially suicidal patients*. The next least stressful situation

Table 1

Demographic Characteristics of Study Sample (N = 46)

Variable		Number (n)	Percentage (%)
Age in years	18–30	1	2.2
	31–40	8	17.5
	41–50	22	47.7
	51–60	11	23.8
	61–70	4	8.8
Gender			
Females		38	82.6
Males		8	17.4
Ethnic background			
Caucasian		41	89.1
Asian, Asian American		3	6.5
African American		2	4.3
Marital status			
Single		10	21.7
Married		24	52.2
Divorced		8	17.4
Widowed		3	6.5
Other		1	2.2

Table 1 (continued)

Variable	Number (n)	Percentage (%)
Highest degree received	*n* = 40	
Associate's degree	16	40.0
Bachelor's degree	23	57.5
Graduate degree or higher	1	2.5
Missing data	6	15.0
Education level		
Some college	16	34.8
Four years college	21	45.7
Some post graduate or degree	9	19.6
Hours worked per week		
Full-time (40 hours)	26	56.5
Part-time (< 40 hours)	15	32.6
Overtime (> 40 hours)	5	10.9
Length of time at present job		
1–10 years	23	49.9
11–20 years	17	36.8
21–30 years	6	13.1
Length of employment—mental health		
1–10 years	15	32.5
11–20 years	15	32.6
21–30 years	16	34.8

Table 2

The Top Ten Stressors Reported by Psychiatric Nurses (N = 46)

Rank	Activity	Mean (range 0–4)	SD
1.	Dealing with difficulties that occur when you try to take action against incompetent staff	2.54	1.13
2.	Inadequate staffing coverage in potentially dangerous situations	2.46	1.29
3.	Having to deal with colleagues who do not do their share of the workload	2.37	1.04
4.	Conflicts not being settled within the organization	2.33	1.23
5.	Having too little time to plan and evaluate treatment	2.09	1.52
6.	Having to meet the demands of too many patients	2.04	1.19
7.	Not having the appropriate mix of skilled staff on the ward/shift	2.02	1.27
8.	Dealing with physical and verbal abuse from patients or others	2.02	1.18
9.	Low morale and poor atmosphere within the organization	2.00	1.41
10.	Knowing that individual patient care is being sacrificed due to lack of staff	1.98	1.20

was found to be *lack of promotion prospects,* and the third was *staff sickness disrupting the continuity of the ward/unit team's functioning* (see Table 3 for a list of the ten least stressful events reported by psychiatric nurses). It is important to note that the mean of the most stressful event was 2.5 and the mean of the least stressful activity was 1.7.

Research Question #2

The second research question asked which coping strategies are utilized most frequently by psychiatric nurses working on locked psychiatric units. In order to answer this question, the PNMCQ was utilized as a tool to gather specific information pertaining to different types of coping strategies. The participants were provided with a list of 35 strategies for coping with work-related stress. Each coping strategy listed on the PNMCQ could be evaluated by the participant on a 5-point, Likert-type frequency scale ranging from 1 = *never* to 5 = *all the time.* The participants were requested to accurately rate the extent to which they used each coping strategy. The scores of all 35 items on every completed PNMCQ were analyzed by the researcher. The mean values for the items were ranked in numerical order. This provided a method for the researcher to identify the 10 most stressful and 10 least stressful items as rated by psychiatric nurses in this sample. Edwards et al. (2000) employed this method of numerical ranking.

The coping strategy utilized most often by the psychiatric nurses working on locked units was *having pastimes and hobbies outside work*, and the second most often utilized coping strategy was *knowing that my life outside work is healthy and worthwhile* (see Table 4 for a list of the ten most frequently reported coping strategies). On the other hand, the least utilized coping strategy was having *confidential one-to-one supervision,* and the second least utilized coping strategy was *having team supervision* (see Table 5

Table 3

The Ten Least Stressful Events Reported by Psychiatric Nurses (N = 46)

Rank	Activity	Mean (range 0–4)	SD
1.	Having to deal with potentially suicidal patients	1.24	1.14
2.	Lack of promotion prospects	1.33	1.38
3.	Staff sickness disrupting the continuity of the ward/unit team's functioning	1.44	1.09
4.	The worry that there might be further budget cuts	1.44	1.19
5.	Feeling inadequately trained to deal with violent patients	1.46	1.24
6.	Not having sufficient financial resources to attend training courses/workshops	1.48	1.74
7.	Having to deal with disturbed and unpredictable patients	1.54	.91
8.	Not feeling you have the energy to initiate changes anymore	1.54	1.01
9.	Dealing with disagreements within the team about a patient's treatment	1.65	1.18
10.	Insufficient training to work with difficult patients	1.70	1.49

Table 4

The Top Ten Coping Strategies Reported by Psychiatric Nurses (N = 46)

Rank	Activity	Mean (range 0–4)	SD
	I deal with stress….		
1.	By having pastimes and hobbies outside work	4.46	.84
2.	By knowing that my life outside work is healthy, enjoyable, and worthwhile	4.41	.98
3.	By looking forward to going home at the end of each day	4.37	.97
4.	Through being able to draw upon my own knowledge and experience when necessary	4.37	.77
5.	By having confidence in my own abilities to do the job well	4.33	.60
6.	By believing in and feeling good about myself	4.30	1.15
7.	By having a stable home life that is kept separate from my work life	4.30	1.03
8.	By discussing with colleagues problems as they arise at work	4.22	.76
9.	By having a sense of usefulness and purpose	4.17	.80
10.	By being optimistic that everything will work out in the end	4.15	.89

Table 5

The Ten Least Utilized Coping Strategies Reported by Psychiatric Nurses (N = 46)

Rank	Coping Strategies	Mean (range 0–4)	SD
	I deal with stress….		
1.	By having confidential 'one-to-one' supervision	2.76	1.25
2.	Through having team supervision	3.00	1.25
3.	Through having support from my manager	3.13	1.15
4.	By having a satisfying sex life	3.26	1.44
5.	By finding out how others have coped in the same situation	3.44	.83
6.	By knowing that, should I ever need them, support and advice are available	3.65	1.06
7.	By reminding myself that the work I do is being appreciated	3.70	.94
8.	By reminding myself that others have placed their trust in me	3.70	1.09
9.	By taking a moment away from it all to gather my thoughts	3.72	.94
10.	By having a good, positive atmosphere around me at work	3.72	.94

for a list of the ten least utilized coping strategies reported by psychiatric nurses).

Research Question #3

The third research question examined whether age, experience in mental health nursing, and education were predictors of burnout in psychiatric nurses working on locked psychiatric units. Table 6 shows the correlations among these demographic variables and the three burnout dimensions. The independent variables age and education were not statistically significant in determining burnout. However, the number of years of experience working in the field of mental health nursing was significantly correlated with emotional exhaustion. The negative direction of the correlation indicates that less experience is associated with greater emotional exhaustion.

Research Question #4

The final research question examined the relationships among occupational stressors, coping strategies, and burnout among psychiatric nurses working on secured psychiatric units. Bivariate correlation was the procedure employed to investigate these relationships. Stress was represented by the total score on the DCL Stress Scale, and coping was represented by the total score on the PNMCQ. Burnout was represented by the emotional exhaustion, depersonalization, and personal accomplishment scales of the MBI-HSS. It can be seen in Table 7 that the correlation between stress and coping revealed a statistically significant negative relationship ($r = -.62$, $p < .05$). Lower scores on the stress measure (DCL) reflected less stress, whereas higher scores on coping (PNMCQ) reflected greater coping strategies. Thus, the negative correlation suggests that those nurses with greater coping strategies experienced less stress.

Several other correlations among the stress and coping measures were also

Table 6

Means, Standard Deviations, and Correlations among Age, Experience, and Education with Burnout (N = 46)

Variables	Mean	SD	Emotional exhaustion	Depersonalization	Personal accomplishment
Age	48.46	8.87	-.21	-.02	-.04
Experience	17.11	8.42	-.48*	-.17	.06
Education	2.85	.73	.20	.19	.02

*P < .05

Table 7

Bivariate Correlation among the Three MBI Subscales and Stress, Coping, and Burnout Variables

Measure	Mean	SD	DCL	PNMCQ
DCL	54.57	26.06	----	-.62*
PNMCQ	136.80	19.64	----	----
Emotional exhaustion	19.57	12.41	.29	-.53*
Depersonalization	6.78	6.26	.31*	-.54*
Personal accomplishment	36.48	7.85	.27	.05

* $P < .05$

statistically significant. Higher scores on EE and DP suggested burnout. The moderately strong negative correlations with the PNMCQ indicate that as the participant's level of burnout increased, the usage of the participant's coping methods decreased or vice versa. The significant positive correlation of DP and the DCL (r = .31) indicates that the greater the stress was, the greater the burnout was although this relationship was not as high as those with the coping measure.

Levels of Burnout

Regarding burnout, the study sample's mean scores for emotional exhaustion, depersonalization, and personal accomplishment on the MBI-HSS placed them in the average category. This means that the participants of this study were expected to be experiencing an average degree of burnout. When compared with norms from the MBI manual for a broader sample (N = 11,067) (Maslach et al., 1996), the psychiatric nurses in this study sample scored in a similar manner in all three categories. The broader sample comprised teachers, social service workers, medical workers, mental health workers, and a range of other employees (see Table 8).

When the participants in this study were compared specifically to a mental health group (N = 730) consisting of psychologists, psychotherapists, counselors, mental hospital staff, and psychiatrists, the mental health group scored low in all three MBI subscales, indicating a low degree of burnout (Maslach et al., 1996). The participants in this study (N = 46) scored in the average range in all three MBI subscales and, as previously mentioned, demonstrated an average degree of burnout (see Table 8).

Table 8

Mean scores (SD) and Category Levels on the Maslach Burnout Inventory (MBI) Subscales for Psychiatric Nurses in Study Sample (N = 46) in Comparison with Norms

MBI subscales	Study *N* = 46		MBI manual categories	(a) Overall norms *N* = 11,067 (b) Mental health norms *N* = 730
	Mean	(SD)		
Emotional exhaustion	19.5	(12.3)	High ≥ 27 Av. 17-26 Low ≤ 16	(a) 21.0 (10.8) (b) 16.9 (8.9)
Depersonalization	7.1	(6.4)	High ≥ 13 Av. 7-12 Low ≤ 6	(a) 8.7 (5.9) (b) 5.7 (4.6)
Personal accomplishment	36.6	(7.9)	High ≥ 39 Av. 32-38 Low ≤ 31	(a) 34.6 (7.1) (b) 30.9 (6.4)

Note. The data in column 3 and 4 are from *Maslach Burnout Inventory Manual* (3rd ed.) by C. Maslach, S. E. Jackson, & M. P. Leiter, 1996, p. 8.

Chapter VI: Discussion

The primary goals of this study were (a) to examine the most common and least common stressors as perceived by psychiatric nurses working on locked psychiatric units; (b) to assess coping strategies utilized most frequently and least frequently by psychiatric nurses working on locked psychiatric units; (c) to determine whether age, experience, and education were predictors of burnout in psychiatric nurses working on locked psychiatric units; and (d) to explore the relationship among perceived stressors, coping strategies, and burnout pertaining to psychiatric nurses working on locked psychiatric units.

The DCL Stress Scale questionnaire was utilized to determine the frequency of stressors encountered by psychiatric nurses. This measure revealed staffing issues as major sources of stress for psychiatric nurses participating in this study. The stressors most frequently reported by the participants in this study included (a) *dealing with difficulties that occur when they try to take action against incompetent staff*, (b) *inadequate staffing coverage in potentially dangerous situations*, and (c) *having to deal with colleagues who do not do their share of the workload*. Furthermore, 5 of the 10 most frequently reported stressful events related to staffing issues. These findings are consistent with those of several other studies (Burnard et al., 2000; Coffey & Coleman, 2001; Cushway et al., 1996; Fagin et al., 1996; Jenkins & Elliott, 2004; Pinikahana & Happell, 2004; Trygstad, 1986).

In addition to the most stressful sources of stress, the least stressful sources perceived by the psychiatric nurses were issues associated with patient care. Some of the less frequently reported stressors included (a) *having to deal with potentially suicidal patients*; (b) *feeling inadequately trained to deal with violent patients*; (c) *having to deal*

with disturbed and unpredictable patients; and (d) *having insufficient training to work with difficult patients*. No other studies could be found that concurred with this finding. In fact, it is interesting to note that the findings of this study differ markedly from the findings of Cushway et al. (1996) and Sullivan (1993). For instance, Cushway and associates (1996) investigated hospital-based MHNs and found that contact with potentially threatening patients was a major source of stress for the nurses. In Sullivan's study, psychiatric nurses working in acute psychiatric facilities reported violent incidents, potential suicides, and observation of patients as the most frequent stressors (1993).

The results of the statistical analysis for all of the data collected from the DCL Stress Scale questionnaires indicated that the psychiatric nurses working on locked units in this study were experiencing relatively low to moderate levels of stress. For instance, the mean DCL Stress Scale score for the entire sample was 54.57, standard deviation 26.06 (range 0-120). This finding was consistent with several other research studies in the field of psychiatric nursing (Happell et al., 2003; Muscroft & Hicks, 1998; Pinikahana & Happell, 2004; Snelgrove, 1998).

The numerical rankings from the PNMCQ indicated that psychiatric nurses favored informal approaches to coping with occupational stress: *having pastimes and hobbies outside of work*; *knowing that life outside of work is healthy*, *enjoyable and worthwhile*; *looking forward to going home at the end of the day*; *having a stable home life that is kept separate from my work life*; and *having confidence in my own abilities to do the job well* were some of the top-ranking items. The findings were similar to those of Fagin et al. (1995) and Sullivan (1993).

In contrast, the least frequently utilized coping strategies pertained to

management supervision. Specifically, the three least utilized coping strategies included *having confidential one-to-one supervision*, *having team supervision*, and *having support from the manager*. These findings are similar to those of a study conducted by Edwards et al. (2000). In the study conducted by Edwards and colleagues, the researchers found that team supervision, one-to-one supervision, and management support were some of the least utilized coping strategies.

Regarding demographic data, age and level of education did not significantly correlate with symptoms of burnout. Experience in mental health nursing was the only demographic with significant correlation to emotional exhaustion, indicating that psychiatric nurses with more experience demonstrated fewer characteristics of burnout. Only one study addressed this specific question as a part of the research. Kilfedder and associates (2001) studied a sample of psychiatric nurses working in the community and in hospital settings. The researchers found a significant correlation between the nurses with less experience in mental health nursing and depersonalization. In other words, the nurses with less experience were experiencing higher levels of burnout (2001).

As previously mentioned, the final objective of this study was to explore the relationship among perceived stressors, coping strategies, and burnout. The results of this study indicated that psychiatric nurses utilizing effective coping methods frequently experienced less stress. This finding is consistent with previous research that has shown that nurses who utilized effective coping strategies frequently experienced less stress (Coffey & Coleman, 2001; Sullivan, 1993).

Chapter VII: Conclusion

Limitations of the Study

It is necessary to identify the associated limitations of a particular research protocol when interpreting the study findings. This study has several limitations. The sample size was relatively small ($N = 46$). Another limitation of this study was the relatively low response rate of 51%. The absence of information pertaining to the participants who did not return the questionnaires means that the generalization of findings from this study to the wider population cannot be accurately determined. A couple of possible explanations exist pertaining to the low response rate. First, the length of the four questionnaires may have been one reason for the low response rate, especially because the research required each respondent to complete all four questionnaires with a total of 102 questions. Another possible reason for a low response rate is fatigue resulting from work. Specifically, the most stressed-out staff may have felt too exhausted or overworked to take additional time to participate in the study. If this were the case, then these results could be misleading.

The use of self-report questionnaires incurs a risk of measurement error in relation to defensive responses or bias. The generally accepted practice of measuring stress by simply asking subjects to comment on the degree to which certain situations are perceived as being present in their work results in a process of simplification that gives limited attention to the frequency, intensity, and meaning of the various stressors. In addition, utilizing the Likert-type scale as a form of gathering information can have negative consequences (Burns & Grove, 2001). For instance, the instructions for the DCL Stress Scale questionnaire simply instruct the participant to rate the extent to which

each activity causes stress. The rating scale began at 0, which equated to the activity not causing the respondent any stress. It seems rather unrealistic that certain activities listed on the DCL Stress Scale would not cause any stress. As previously mentioned, everyone experiences some degree of stress at all times (Selye, 1956). Another limitation of this study is the general nature of the questions on the PNMCQ. Participants are instructed to record how they think they cope in certain situations rather than identify how they actually cope in practice. In other words, some individuals may inadvertently indicate that they are coping more effectively in order feel better about themselves.

Plans for Dissemination

Nursing research provides a scientific basis to plan, predict, and control the outcomes of nursing practice. Nursing, as an evidence-based area of practice, has been developing since the time of Florence Nightingale. In order to further the development of scientific knowledge, the findings of this research must be communicated to nurses and nurse administrators around the globe. Therefore, plans for disseminating the results of this research include an academic presentation at Eastern Michigan University's (EMU) Annual Scholarly Achievement Day, EMU's Graduate Student Fair, and the Midwest Nursing Research Society and submission to Sigma Theta Tau International's *Journal of Nursing Scholarship*, as well as to the *Journal of the American Psychiatric Nurses Association*. Also, a summary of these findings will be provided to the administration of each facility where the research was conducted.

Implications for Clinical Practice

The findings obtained as a result of this research are significant for hospital administrators and nursing management. For instance, staffing issues were the most

frequently reported sources of stress encountered by psychiatric nurses working on locked psychiatric units. The staffing issues were *dealing with difficulties when taking action against incompetent staff*, *having inadequate staffing coverage in potentially dangerous situations*, and *having to deal with colleagues not doing their share of the work*. Therefore, staffing issues are important factors in determining stress levels of psychiatric nurses working on locked psychiatric units. With this in mind, nurse managers should place a high emphasis on nurse-to-patient ratios and other types of staff-related problems in the workplace in order to improve the quality of work-life for nurses.

The rankings from the PNMCQ pertaining to coping strategies indicated that participants in this study preferred informal approaches to coping with occupational stress. The coping methods utilized most often by psychiatric nurses in this study were *having outside interests and hobbies*; *having a healthy, enjoyable life outside of work*; and *looking forward to going home at the end of the day*.

The coping strategies utilized the least were *having confidential one-to-one supervision*, *team supervision*, and *having support from the manager*. Addressing these factors may help to increase an individual's ability to cope effectively and as a result reduce experienced levels of stress and burnout. Administrative action is essential in order to reduce levels of stress and burnout experienced by the psychiatric nurse. A collaborative effort by both managers and nurses is also needed.

Recommendations for Future Research

Some of the findings of this study did support findings of several previous studies with regard to the perceived sources of stress experienced by psychiatric nurses working on locked psychiatric units. One recommendation is to incorporate qualitative methods

in order to gain additional in-depth knowledge. Burns and Grove (2001) noted, "Qualitative research is a means of exploring the depth, richness, and complexity inherent in phenomena" (p. 61). Open-ended questions would provide a means for participants to give additional details that were not on the questionnaires, specifically, more detail regarding the participant's behaviors, emotions, attitudes, and motivations pertaining to the aforementioned concepts.

This study was limited in the number of psychiatric nurses included ($N = 46$). Researchers may attempt to increase the sample size by surveying psychiatric nurses working throughout an entire state or even across the United States. A larger sample size may provide a sample with a broader range of demographic data, which may in turn produce a more diverse sample and increase the statistical power of the study. It is important to note that the majority of previous research in this area has been conducted in countries other than the United States. It is hoped that more research pertaining to psychiatric nursing will be conducted in the United States in the future.

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Appendices

Appendix A

College of Health and Human Services Human Subject Review Committee Approval Letter

EASTERN MICHIGAN UNIVERSITY

September 20, 2005

Richard A. White, RN, BSN
c/o Lorraine Wilson, PhD, RN
Eastern Michigan University
Ypsilanti, MI 48197

Dear Mr. White,

The CHHS Human Subject Review Committee finds that your request entitled "Perceived Stressors, Coping Strategies, and Burnout Pertaining to Psychiatric Nurses Working on Locked Psychiatric Units", submitted on 8/15/05, meets the Minimal Risk Standards and is approved for initiation with the following conditions:

- Change statement in last paragraph of Informed Consent to "Dr. Stephen Sonstein, College of Health and Human Services Human Subjects Review Committee Chair".

Sincerely,

Stephen A. Sonstein, PhD
Chair, CHHS Human Subjects Review Committee

Department of Associated Health Professions. 315 Everett Marshall Building. Ypsilanti, Michigan 48197
Health Administration: 734.487.4094 • Clinical Laboratory Sciences: 734.487.3223 • Occupational Therapy: 734.487.4094

Appendix B

Implied Informed Consent to Participate in a Research Study

Study Title: Perceived Stressors, Coping, and Burnout Pertaining to Psychiatric Nurses Working on Locked Psychiatric Units.

Investigator: Richard A. White, RN, BSN

Purpose

You have been selected to participate in a research study in partial fulfillment of the requirements for my Master of Science Degree in Nursing at Eastern Michigan University. This research will focus specifically on stress, coping and burnout pertaining to psychiatric nurses working on locked psychiatric units. Burnout is a major factor relating to the current nursing shortage and there have been multiple studies linking stress to burnout. Coping is a mechanism frequently utilized to combat burnout. The goal of this proposed project is to identify the most common work-related stressors pertaining to psychiatric nurses working on locked units. This useful information can then be utilized by other healthcare professionals and hopefully changes will be implemented that could possible reduce the amount of stress in the nurses' work environment.

Procedures

If you agree to participate, you will be asked to fill out some questionnaires. The questionnaires should take about 20-30 minutes to complete. The questions in the questionnaire are specific in nature and pertain to stressful events related to your professional practice, how you deal with stressful events and how you feel about certain situations or stressful events. After you complete the survey, you will put it into the pre-addressed envelope with postage provided, seal it and mail it back.

Risks

The research study procedures involve no foreseeable risks or harm to you. The study involves completing the questionnaires about stress, coping, burnout and demographic information. Some of the questions about your feelings and experience of stressful situations may evoke emotions in you that make you uncomfortable. You can choose, at any time, not to answer a question or withdrawal from the study altogether prior to mailing in the questionnaires. If you decline to participate, you may return the blank survey or destroy it. Once you mail in the questionnaires you cannot request to withdrawal from the study, because it would be impossible to identify specific surveys.

Benefits and Compensation

You will receive no monetary gift for participation in the study. There is no guarantee or promise that you will receive direct benefits from this study, however, from the items of the questionnaire, you may possibly learn more about stress, coping and burnout.

Confidentially

Please **DO NOT** sign your name to any of the forms as all responses will be kept confidential. Questionnaires will be mailed to a post office box rented exclusively for this study, will be kept in a locked file, and shredded upon completion of the study. Only the research committee will have access to anonymous individual data. Again, the data will be handled confidentially at all times. The results of the study will be made available in a paper presented to Eastern Michigan University faculty, students, professional colleagues and possibly published in a professional journal. The developers of the instruments will receive a copy of the data. If you wish to receive a copy of the research results, please email me at richardallenwhite@hotmail.com.

Voluntary Participation

Your participation is completely voluntary. You are under no obligation to participate. Again, subsequent to your consent, you may refuse to participate at any time during the study without penalty, but once you mail in the questionnaires you cannot request to withdrawal from the study since we cannot identify your specific survey form. You are free to ask any questions about the study through my advisors, Dr. Lorraine Wilson, R.N., Ph.D., Professor of Nursing, or Susan Pfoutz, R.N., Ph.D., Professor of Nursing, Eastern Michigan University at (734)-487-2341. If you have any questions or concerns about ethical issues or your rights, please contact Dr. Steven Sonstein, College of Health and Human Services Committee Chair, at (734)-487-1238.

Implied Informed Consent

By completing and returning these questionnaires, you verify that:

- You have understood the purpose of this study
- You have voluntarily agreed to participate
- You are at least (18) years of age

Please return your completed questionnaires in the attached envelope. Thank you for your time in contributing to this research study. Your role is important in representing professional nurses in the field of psychiatry.

Appendix C

Devilliers, Carson, and Leary (DCL) Stress Scale

The following items have all been found to be potential sources of pressure/stress at work. Pressure/stress can be understood as problems you find difficult to cope with, resulting in you feeling worried or anxious. Please work through the questionnaire carefully; circling the number next to each item which best indicates the extent to which each item causes you stress. Be sure to answer every item.

0 = This activity causes me no stress
1 = This activity causes me a little stress
2 = This activity causes me quite a bit of stress
3 = I feel very stressed by this activity
4 = I feel extremely stressed by this activity

How much stress does each of the following activities cause you?

	Activity	**No stress**	**A little stress**	**Quite a bit of stress**	**Very stressed**	**Extremely stressed**
1	Having to deal with disturbed and unpredictable patients	0	1	2	3	4
2	Conflicts not being settled within the organization	0	1	2	3	4
3	Dealing with difficulties that occur when you try to take action against incompetent staff	0	1	2	3	4
4	The threat of redundancy	0	1	2	3	4
5	Lack of promotion prospects	0	1	2	3	4
6	Inadequate security measures on wards/units	0	1	2	3	4
7	Lack of positive feedback from supervisors	0	1	2	3	4
8	Having to deal with colleagues who do not do their share of the workload	0	1	2	3	4
9	Dealing with changes in the health service system	0	1	2	3	4
10	The discrepancy between your job description and what you are expected to do	0	1	2	3	4

DCL Stress Scale

	Activity	No stress	A little stress	Quite a bit of stress	Very stressed	Extremely stressed
11	Feeling inadequately trained to deal with violent patients	0	1	2	3	4
12	Dealing with disagreements within the team about patient's treatment	0	1	2	3	4
13	Staff sickness disrupting the continuity of the ward/unit teams functioning	0	1	2	3	4
14	Not having sufficient financial resources to attend training courses/workshops	0	1	2	3	4
15	The lack of an adequate financial reward for the job	0	1	2	3	4
16	Dealing with physical and verbal abuse from patients or others	0	1	2	3	4
17	Not feeling you have the energy to initiate changes anymore	0	1	2	3	4
18	Difficulty in working with particular colleagues	0	1	2	3	4
19	The worry that there might be further budget cuts	0	1	2	3	4
20	Having to deal with potentially suicidal patients	0	1	2	3	4
21	Low morale and poor atmosphere within the organization	0	1	2	3	4
22	Inadequate staffing coverage in potentially dangerous situations	0	1	2	3	4
23	Insufficient training to work with difficult patients	0	1	2	3	4
24	Lack of consultation from management about influential structural changes	0	1	2	3	4
25	Not having the appropriate mix of skilled staff on the ward/shift	0	1	2	3	4
26	Having to meet the demands of too many patients	0	1	2	3	4

DCL Stress Scale

	Activity	No stress	A little stress	Quite a bit of stress	Very stressed	Extremely stressed
27	Insufficient communication and consultation between staff at a professional level	0	1	2	3	4
28	Knowing that individual patient care is being sacrificed due to lack of staff	0	1	2	3	4
29	Having too little time to plan and evaluate treatment	0	1	2	3	4
30	Not being notified of changes before they occur	0	1	2	3	4

Appendix D

Permission Letter for Use of the DCL Stress Scale and PNMCQ

Monday, August 15, 2005

Dr. Jerome Carson
84, Canon Road
Bromley,
London, England
BR1 2SP
United Kingdom

Dear Dr. Jerome Carson,

My name is Richard White and I am currently a graduate student at Eastern Michigan University. I am researching perceived stress, coping and burnout pertaining to psychiatric nurses working on locked psychiatric units for my thesis paper. I am writing you requesting permission to utilize the PsychNurse Methods of Coping Scale that was developed by you and your colleagues and published in the 2000 issue of Personality and Individual Differences "Assessing Coping Skills in Mental Health Nurses: is an Occupational Specific Measure Better than a Generic Coping Skills Scale?"

I am also requesting permission to utilize the DCL Stress Scale, which you also helped to develop and published in the International Journal of Social Psychiatry Vol. 42 No. 2, 1996 titled "Stress, Coping and Burnout in Mental Health Nurses: Findings from Three Research Studies.

I DR JEROME CARSON am granting Richard A. White, RN, BSN permission to utilize the PsychNurse Methods of Coping Scale and the DCL Stress Scale for his thesis research.

Sincerely,

Richard White, RN, BSN
1040 Depot Street
Pinckney, Michigan 48169
USA

Appendix E

The PsychNurse Methods of Coping Questionnaire (PNMCQ)

THE PSYCHNURSE METHODS OF COPING QUESTIONNAIRE

The following items represent some of the different methods a mental health nurse might use to cope with work related stress. For each item, please circle the number which most accurately describes the extent to which you use the stated strategy. The key is as follows;

1 = Never 2 = Rarely 3 = Occasionally 4 = Often 5 = All the time

I DEAL WITH STRESS….

1.	By making plans for myself that have nothing to do with work.	1	2	3	4	5
2.	By having confidence in my own abilities to do the job well.	1	2	3	4	5
3.	By having confidential 'one-to-one' supervision.	1	2	3	4	5
4.	By knowing that there are those who care about me.	1	2	3	4	5
5.	By discussing with colleagues problems as they arise at work.	1	2	3	4	5
6.	By having a stable home life that is kept separate from my work life.	1	2	3	4	5
7.	Through being able to draw upon my own knowledge and experience when necessary.	1	2	3	4	5
8.	Through having team supervision.	1	2	3	4	5
9.	By reminding myself that others have placed their trust in me.	1	2	3	4	5
10.	By knowing that, should I ever need them, support and advice are available.	1	2	3	4	5
11.	By having a satisfying sex life.	1	2	3	4	5
12.	By believing in and feeling good about myself.	1	2	3	4	5
13.	Through having support from my manager.	1	2	3	4	5

1 = Never	2 = Rarely	3 = Occasionally	4 = Often	5 = All the time

I DEAL WITH STRESS….

14.	By taking a mature view of the situation.	1	2	3	4	5
15.	By talking to people that are close to me.	1	2	3	4	5
16.	By having a steady partner to turn to	1	2	3	4	5
17.	By managing my time efficiently.	1	2	3	4	5
18.	By knowing that I can depend on other members of staff.	1	2	3	4	5
19.	By having a sense of usefulness and purpose	1	2	3	4	5
20.	By knowing that my life outside work is healthy, enjoyable and worthwhile.	1	2	3	4	5
21.	By reminding myself that the work I do is being appreciated.	1	2	3	4	5
22.	By detaching myself from work matters when necessary.	1	2	3	4	5
23.	By making a concerted effort to keep myself relaxed and in control.	1	2	3	4	5
24.	By having a good, positive atmosphere around me at work.	1	2	3	4	5
25.	By venting to a friend or loved one.	1	2	3	4	5
26.	By looking forward to going home at the end of each day.	1	2	3	4	5
27.	By being optimistic that everything will work out in the end.	1	2	3	4	5
28.	By having pastimes and hobbies outside work.	1	2	3	4	5
29.	Through sleeping restfully.	1	2	3	4	5
30.	By having the freedom to express my views openly.	1	2	3	4	5

1 = Never	2 = Rarely	3 = Occasionally	4 = Often	5 = All the time

I DEAL WITH STRESS….

31.	By finding out how others have coped in the same situation.	1	2	3	4	5
32.	Through the satisfaction I derive from seeing a task through to completion.	1	2	3	4	5
33.	By reminding myself that I am doing my best to help.	1	2	3	4	5
34.	By taking a moment away from it all to gather my thoughts.	1	2	3	4	5
35.	By searching for a positive side to every problem.	1	2	3	4	5

Appendix F

Maslach Burnout Inventory Human Services Survey (MBI-HSS)

Christina Maslach • Susan E. Jackson

MBI HUMAN SERVICES SURVEY

The purpose of this survey is to discover how various persons in the human services or helping professions view their jobs and the people with whom they work closely. Because persons in a wide variety of occupations will answer this survey, it uses the term recipients to refer to the people for whom you provide your service, care, treatment, or instruction. When answering this survey please think of these people as recipients of the service you provide, even though you may use another term in your work.

On the following page there are 22 statements of job-related feelings. Please read each statement carefully and decide if you ever feel this way about your job. If you have never had this feeling, write a "0" (zero) before the statement. If you have had this feeling, indicate how often you feel it by writing the number (form 1 to 6) that best describes how frequently you feel that way. An example is shown below.

Example:

HOW OFTEN:	0 Never	1 A few times a year	2 Once a month or less	3 A few times a month	4 Once a week	5 A few times a week	6 Every day

HOW OFTEN:

0 – 6	Statement:
_____	I feel depressed at work.

If you never feel depressed at work, you would write the number "0" (zero) under the heading "HOW OFTEN." If you rarely feel depressed at work (a few times a year or less), you would write the number "1." If your feelings of depression are fairly frequent (a few times a week, but not daily) you would write a "5."

CPP, Inc.
3803 E. Bayshore Road • Palo Alto, CA 94303

MBI HUMAN SERVICES SURVEY

HOW OFTEN:	0 Never	1 A few times a year	2 Once a month or less	3 A few times a month	4 Once a week	5 A few times a week	6 Every day

HOW OFTEN 0-6	Statements:
1. _____	I feel emotionally drained from my work.
2. _____	I feel used up at the end of the workday.
3. _____	I feel fatigued when I get up in the morning and have to face another day on the job.
4. _____	I can easily understand how my recipients feel about things.
5. _____	I feel I treat some recipients as if they were impersonal objects.
6. _____	Working with people all day is really a strain for me.
7. _____	I deal very effectively with the problems of my recipients.
8. _____	I feel burned out from my work.
9. _____	I feel I'm positively influencing other people's lives through my work.
10. _____	I've become more callous toward people since I took this job.
11. _____	I worry that this job is hardening me emotionally.
12. _____	I feel very energetic.
13. _____	I feel frustrated by my job.
14. _____	I feel I'm working too hard on my job.
15. _____	I don't really care what happens to some recipients.

MBI HUMAN SERVICES SURVEY

HOW OFTEN:	0 Never	1 A few times a year	2 Once a month or less	3 A few times a month	4 Once a week	5 A few times a week	6 Every day

HOW OFTEN 0-6	Statements:
16. _____	Working with people directly puts too much stress on me.
17. _____	I can easily create a relaxed atmosphere with my recipients.
18. _____	I feel exhilarated after working closely with my recipients.
19. _____	I have accomplished many worthwhile things in this job.
20. _____	I feel like I'm at the end of my rope.
21. _____	In my work, I deal with emotional problems very calmly.
22. _____	I feel recipients blame me for some of their problems.

Appendix G

Permission Letter for Use of the MBI-HSS Instrument

Research Material

Dear Customer,

Enclosed you will find the MBI-Human Services Surveys, MBI-Human Services Demographic DataSheets, MBI Scoring Keys, and the MBI Manual you requested.

If you would like to order additional surveys, call Customer Service at 800-624-1764. Thank you for your interest in CPP materials.

Sincerely,

Jeffrey Hayes
Senior Vice President
CPP, Inc
www.cpp.com

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1055 Joaquin Road, Suite 200, Mountain View, CA 94043
Tel: 650.969.8901 Fax: 650.969.8608 www.cpp.com

Appendix H

Demographic Data Sheet

Your sex:

_____(1) male _____(2) female

Your age:

_____ Years

Are you (check only one group)

_____ (1) Asian, Asian American

_____ (2) Black, Afro-American

_____ (3) Latino, Hispanic, Mexican American

_____ (4) Native American, American Indian

_____ (5) White, Caucasian

_____ (6) other, (please specify _____)

Marital status:

_____ (1) single _____(3) divorced _____ (4) widowed

_____(2) married _____ (5) other (please specify _____)

What was the highest level you completed in school? (Check only one answer)

_____ (1) some college

_____ (2) completed four years of college

_____ (3) some postgraduate work or degree

_____ (4) other (please specify _____)

Please check the highest degree you have received:

_____ (1) A.A.

_____ (2) B.A./B.S.

_____ (3) M.A./ M.S.

_____ (4) Other

How many hours per week do you work at the job indicated above?

_____ Hours per week

How long have you been at your present job?

_____ Years

How long have you been employed for this general type of work?

_____ Years