

Examining Burnout in Direct Care Personnel in an Intermediate Care Facility for the
Mentally Retarded

A Thesis Presented to
the Faculty of the Frances Payne Bolton School of Nursing
Case Western Reserve University

In Partial Fulfillment of the requirements
For the degree of Doctor of Nursing Practice

By

Amanda Alisa Teal Townsend MS, APRN, FNP-C

Examining Burnout in Direct Care Personnel in an Intermediate Care Facility
for the Mentally Retarded

Abstract of Thesis

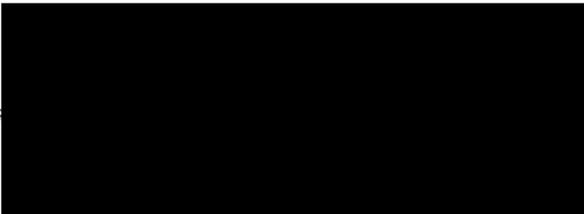
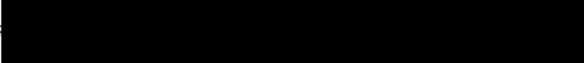
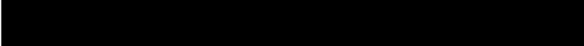
Presented to
the Faculty of the Frances Payne Bolton School of Nursing
Case Western Reserve University

In Partial Fulfillment of the requirements
For the Degree of Doctor of Nursing Practice

By

Amanda Alisa Teal Townsend MN, APRN, FNP-C

Approved:

 , Member
 , Member
 Chairperson

Date 3/4/2010

Abstract

The purpose of this descriptive, cross-sectional study was to examine burnout in direct care personnel in an Intermediate Care Facility for the Mentally Retarded (ICF/MR). Burnout exacts high personal costs from direct care personnel working in Intellectual Disabilities (ID) Services (Hastings, Horne & Mitchell, 2004). There are also organizational costs from employee turnover, decreases in productivity, and potential harm to clients.

The conceptual framework guiding this descriptive correlational study was a middle range theory of caregiver stress based on Roy's adaptation model (Tsai, 2003). The setting was an ICF/MR located in the Southeastern United States. Eligibility for participation was limited to direct care workers who were not nursing staff. Participants were required to be able to read and write English and be willing to complete a four part questionnaire (Demographic, Work Related, Maslach Burnout Inventory-Human Services Survey [MBI-HSS], Center for Epidemiological Studies Depression symptoms index [CESD-10]).

A convenience sample of 56 direct care personnel from all three shifts on an ICF/MR in the Southeast participated in the study. The majority of the respondents were middle-aged, with a mean age of 43.76 years. The sample was comprised primarily of married, African-American, women who had completed high school.

High levels of burnout were found on two of the three subscales of the MBI-HSS: Emotional Exhaustion ($M = 25.32$) had a median of 26.50 and a SD of 14.33; and, Depersonalization ($M = 9.05$) had a median of 7.50 and a SD of 7.73, compared

to other normative samples. High depressive symptom scores on the CESD-10 ($M = 20.45$), median of 20.00 and SD of 6.08, were also found in this sample. The survey participants expressed a desire for a worksite program to help manage caregiver work stress.

In ICF/MR's and other long-term care settings, direct care personnel play a key role in the health care delivery system. Advanced Practice Nurses (APRNs) are in positions of authority and have the professional preparation to assist organizations with strategies to improve the work environment and decrease the chance of burnout occurring in their care teams. Policy development and education are two ways APRNs can contribute professionally to the effort to decrease burnout and improve overall patient care.

Copyright© (2010) by Amanda Alisa Teal Townsend

RULES COVERING USE OF THESES FROM THE FRANCES
PAYNE BOLTON SCHOOL OF NURSING, CASE WESTERN RESERVE
UNIVERSITY

Unpublished theses or research reports submitted to the Frances Payne Bolton School of Nursing, Case Western Reserve University, and deposited in the Library, are open for inspection, but are to be used with due regard to the rights of the authors. The author and the School of Nursing grant the privilege of loan or purchase of microfilm or photocopy to accredited borrowers provided proper credit is given in subsequent written or published work.

[REDACTED] Author

[REDACTED] May L. Wykle, Dean, School of Nursing
Amanda Alisa Teal Townsend

[REDACTED]
March 4, 2010

Dedication

To my wonderful family who have provided unwavering support to me through every step of this journey. Steve, Colleen, Christian and Mama, each of you have personally sacrificed for me to achieve this professional dream and I will be eternally grateful. Thanks for being the most wonderfully supporting and encouraging family.

I love y'all!

Acknowledgements

Dedicated to Dr. Diana Morris for your extraordinary research vision and for your inspiration and guidance during a challenging journey. Special thanks to Dr. Elizabeth Click and Dr. Susan Tullai-McGuinness for your guidance and expertise throughout this research journey. Thanks also to Case Western Reserve University and my colleagues at The Department of Disabilities and Special Needs for all your support. A special thanks to Jim Gruber, Darlene White and Greg Graham for your patience and assistance with statistics.

CONTENTS

Abstract.....	iii
Authorization.....	vi
Acknowledgements.....	vii-viii
List of Tables.....	x
List of Figures.....	xi
Chapter 1 Introduction.....	1
Chapter 2 Literature Review	12
Chapter 3 Methods.....	20
Chapter 4 Results	29
Chapter 5 Discussions	43
References	51
Appendix A Informed Consent Document	54-56
Appendix B Four Part Burnout Survey	57-63
Appendix C HRC approval	64
Appendix D Research Review Committee.....	65
Appendix E MBI-HSS Subscale Frequency Data.....	66-68
Appendix F Proof of Purchase MBI-HSS.....	69

List of Tables

TABLE	PAGE
Table 1: Demographic and personal characteristics of sample participants.....	31
Table 2: MBI-HSS subscale data.....	33
Table 3: Descriptive work related variables for direct care workers.....	36-37
Table 4: Bivariate correlation between work related characteristics and burnout....	38

List of Figures

FIGURE	PAGE
Figure 1: Conceptual Framework.....	7

Chapter 1

Introduction

The purpose of this descriptive, cross-sectional study was to examine burnout in direct care personnel in an Intermediate Care Facility for the Mentally Retarded (ICF/MR). Direct care personnel face a challenging job. In 1999, the Supreme Court's Olmstead ruling reshaped the landscape of ICF/MR's. Individuals and families were given greater community choice options, with only the most medically and psychiatrically fragile receiving services in the ICF/MR settings (Parish & Lutwick, 2005). Direct support personnel are the primary care providers to those with Intellectual Disabilities (ID) in ICF/MR settings. They assist developmentally disabled individuals with all daily activities including personal care, health care, transportation, advocacy, and financial management issues (Hewitt & Larson, 2007). Direct support personnel work long hours, are poorly paid, receive minimal benefits, and are often affected by injury and depression (Zimmerman et al., 2005). Turnover rates among direct support personnel have long been a problem in the field of ID for the last 30 years, with current direct support personnel turnover rates as high as 52% in some areas of the United States (Hewitt & Larson). The following areas will be addressed in this chapter: problem background, purpose, research question, conceptual framework, nursing theory guiding the study, significance to nursing and assumptions.

Problem Statement

The Department of Disabilities and Special Needs' (DDSN) service delivery approach is called "person-centered services." According to the DDSN, "The primary purpose of the person-centered approach is to help individuals with severe, life-long disabilities live more meaningful, fulfilling lives by increasing choice and control" (DDSN, accessed January 27, 2009). There have been few studies involving burnout in direct care personnel working in ICF/MR settings in the last 10 years. During this period, significant changes in how care is delivered to those with mental retardation have occurred following the Olmstead Supreme Court ruling of 1999. These changes may have had effects on those delivering care. The problem being investigated is the level of burnout experienced by direct care personnel working at an Intermediate Care Facility for the Mentally Retarded (ICF/MR).

Background

Burnout is an important concept and has been defined as "...a state of physical, emotional and mental exhaustion that occurs when workers feel overburdened by the demands of long term involvement in emotionally demanding situations" (Skirrow & Hatton, 2007, p. 112). Causes of burnout are over commitment, unrealistic job expectations, imbalance between employee resources and client demands, organizational lack of control, and lack of support (White, Edwards, & Townsend-White, 2006). Burnout has been studied in a number of different occupations around the world and in various work settings. Some of these settings involving nursing staff include hospitals, long term care centers, home health

agencies and psychiatric facilities located in Australia, Canada, Sweden, British Columbia and the United States. From these studies, we find as burnout increases so does nurse absenteeism (Davey, Cumming, Newburn-Cook, & Lo, 2009). Kennedy (2005) also found the number of sick days used significantly correlated with stress and burnout ($r = .30$, $p = .01$). Conflict resolution styles were strong predictors of morale, burnout and job satisfaction for nursing staff in long term care settings, with cooperative conflict resolution the only style found to positively effect morale, burnout, and job satisfaction (Montoro-Rodriquez & Small, 2006). Prolonged job stress negatively affects the quality of work provided by nurses and received by their clients (Kennedy).

The research site's state system consistently serves those with more extensive disabilities (83.8%) as compared to the national average (76.3%). During 2008, 94 residents out of 117 at the selected research site were diagnosed as having severe to profound mental retardation. One hundred were reported to have behaviors requiring special staff attention and 74 required medication for psychiatric conditions (National Residential Information Systems Project, 2008).

Some of the most recent findings on burnout in direct care personnel came from a Japanese nationwide survey (Ito, Kurita & Shiiya, 1999). In the survey, demographic variables of age, marital status and gender were not associated with burnout. This is contrary to previous studies reporting that females and younger staff have higher incidence of burnout. Longer work hours (45 or greater) and care for

more severely ill clients were not associated with burnout. Having supervisor support was reported to decrease the chance of burnout (Ito et al.).

Thus far, researchers have reported contradictory findings on the existence of burnout among direct care personnel working with individuals who have intellectual disabilities (Skirrow & Hatton, 2007). Because stress can affect the caregiver as well as the person with intellectual disability who is receiving the care, management has a growing interest in the well-being of staff providing direct care to those individuals (Hastings, Horn & Mitchell, 2004). The caregiver can become overwhelmed by the emotional aspects of the job, causing exhaustion. The loss of energy increases stress, often resulting in burnout and withdrawal of employment (White et al., 2006). Therefore, the purpose of the current study was to determine the level of burnout in direct care personnel in an ICF/MR in the Southeastern United States.

Significance for Nursing

National workforce initiatives addressing the retention of direct care personnel included a priority to address work force burnout (Hewitt & Larson, 2007). The study provided insight into the degree of burnout in direct care personnel who cared for people with intellectual disabilities. Knowledge about and strategies to manage burnout are critical to the long term care of individuals served by the ICF/MR.

The effects of burnout are known to negatively affect work life and patient care. These negative effects have been shown to include increased use of sick time, tardiness, workers' compensation claims, increased workplace violence/conflict, and

increased incidence of substance abuse (Kennedy, 2005). The loss of a familiar staff member affects continuity of care, thus adversely effecting client wellness outcomes. Nursing continues to be interested in the various aspects of care giving. Stress that affects the caregiver in turn can have a negative effect on those receiving care. Therefore, the study of burnout in paid unlicensed caregivers is of an interest to the nursing profession who supervise the unlicensed staff.

Psychological distress of direct care personnel is of interest to employers and supervisors from a moral and legal perspective (Skirrow & Hatton, 2007). Approximately one-third of direct support personnel surveyed working in the field of intellectual disability have some form of stress/depression or a mental health issue. This is of concern because these staff members are often some of the most important people in the client's life (White et al., 2006). In long term care centers, direct care personnel are the primary caretakers for those with intellectual disabilities and carry out structured programs of basic health, safety and training. Low morale, absenteeism and burnout are often correlated with high direct care personnel turnover (Hewitt & Larson, 2007).

Multiple federal and state initiatives have been developed since 2001 to explore personnel issues in providers of direct support to people with developmental disabilities. These initiatives were supported by the U.S. Department of Health & Human Services Systems Change grants; Medicaid and Medicare Services; National Direct Services Workforce Resources Center; and the Better Jobs, Better Care initiative funded by the Robert Wood Johnson Foundation. The number and breadth

of these various initiatives is indicative of the significance afforded to addressing workforce issues.

Conceptual Framework

Conceptual Model

The caregiver stress model guided this study. This midrange theory of caregiver stress is based on Roy's adaptation model and has been used to explain stress experienced by caregivers (Tsai, 2003). Figure 1 illustrates the linkages between the caregiver stress model (third level) as described by Tsai.

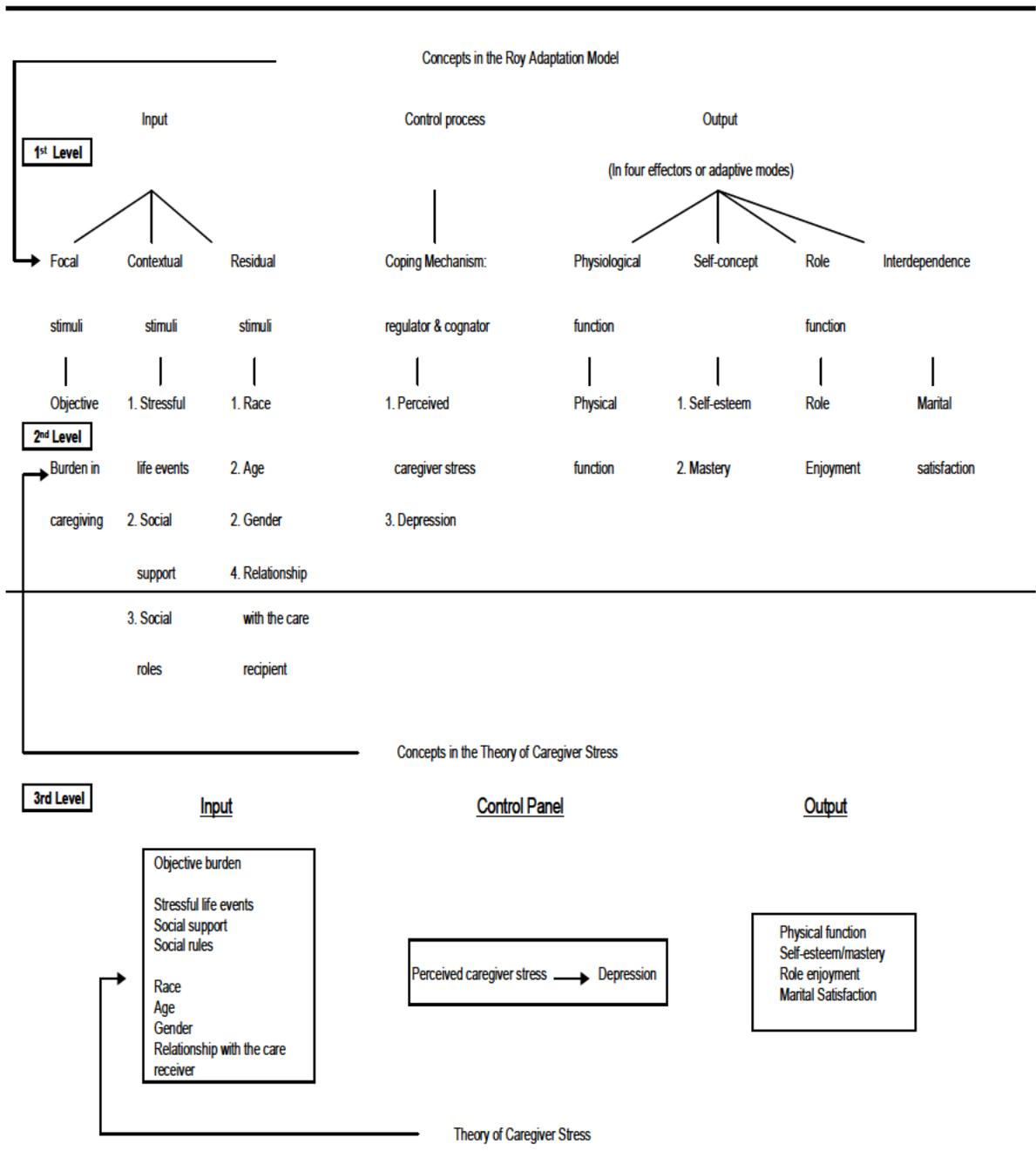


Figure 1. Conceptual Framework

Caregiver Stress Model

Tsai's caregiver stress model was chosen to explain caregiver stress for the research study. The theory of caregiver stress is a relatively new midrange theory, and is an appropriate fit for the concept of burnout in an ICF/MR agency. It provides a way to test caregiver stress in states involving chronic condition caregiving. In this theory, the adaptation level is not identified because adaptation represents combined effects of environmental, focal, contextual and residual stimuli (Tsai, 2003).

In the input phase, the caregivers' objective burdens (duties or tasks associated with caregiving) are the focal stimuli. Contextual stimuli are the stressful life events, social support and social roles. The residual stimuli are race, age, gender, and relationship type. Stressful life events challenge the caregiver and have an additive effect on the caregiver's burden. Social support from family, relatives and friends may help reduce the caregiver's burden. One's social roles are defined by the responsibilities in other aspects of one's life beyond caregiving. Residual stimuli encompassing the caregiver race, age, gender, and relationship with the client all contribute to the focal stimulus or objective burden of caregiving (Tsai, 2003).

In the caregiver stress model, the inputs received by the direct care personnel progress into the control process, or coping mechanism, of the staff. Based on the direct care personnel's ability to manage the inputs and handle the control processes, four output categories, or adaptive modes, are possible. The four output categories include: physical function; self esteem/mastery; role enjoyment; and, marital satisfaction. The direct care personnel's caregiver burden may affect more than one

of these modes of behavior. Together, the four outputs provide a picture of the direct care person's perceived stress. Depression may be a direct outcome of the caregiver's stress and may mediate the effects of other variables on the four adaptive modes (Tsai, 2003).

Additionally, the caregiver who works more hours in direct patient care can experience greater caregiver stress. This stress can have an adverse effect on the caregiver's health. In the theory of caregiver stress, any perceived stressful life event has an additive affect on the stress and burden experienced by the caregiver in the direct care role. Simply put, the caregiver/direct care person experiencing a stressful life event will experience higher stress. The perceived stress can be reduced by social support buffers (Tsai, 2003).

Caregivers with stronger, more developed social supports would be expected to report lower levels of caregiver stress than those with less social support. Direct care workers who have other social roles in addition to that of a caregiver have better physical and mental health (Tsai, 2003). Caregivers with high levels of stress may develop stress dynamic coping responses. Such caregivers often present with changes in functional ability, poor self-esteem, decreased role enjoyment, problems in marital relationships, and depressive symptoms (Tsai).

Assumptions

The assumptions for the proposed study on burnout are:

- 1) Caregivers can respond to environmental changes.

- 2) Caregivers' perceptions influence how caregivers respond to environmental changes.
- 3) A caregiver's adaptation is a function of both his/her environmental stimuli and adaptive level. (Tsai, 2003).

Research Questions

Therefore the following research questions were addressed in this study:

- 1) What are the demographic and personal characteristics of direct care personnel in an ICF/MR in the Southeastern United States?
- 2) What is the level of burnout in direct care personnel in an ICF/MR in the Southeastern United States?
- 3) What work related characteristics of direct care personnel in an ICF/MR in the Southeastern United States are related to burnout?

Theoretical Definitions

ICF/MR

An Intermediate Care Facility for the Mentally Retarded (ICF/MR) is required to provide "active treatment." Individuals served in ICF/MR are often non-ambulatory, and have one or more of the following conditions: seizure disorder, mental illness, behavior issues, visual and/or hearing impairments. These institutions have four or more beds designated by funds from Medicaid to provide diagnosis treatment and rehabilitation services to persons with developmental disabilities in a 24 hour supervised residential setting (Department of Health and Human Services, accessed January 27, 2009).

Direct Care Personnel

Direct care personnel are the unlicensed staff who are paid to care for people with intellectual disabilities and, like family, often report the “subjective burden of caring” (White et al., 2006). They are described by the US Department of Labor as the frontline, paid, non-licensed healthcare workforce in long term care facilities (U.S. Department of Labor, Bureau of Labor Statistics accessed May 18, 2009). Direct support personnel provide most of the hands-on care and know the most about the individual’s mood, health, daily care requirements and activities and are often called direct care providers (Zimmerman et al., 2005).

Burnout

Burnout has been defined as mental exhaustion that occurs when a worker feels overburdened by the long term nature of a taxing work situation (Skirrow & Hatton, 2007). Burnout is identified as a syndrome affecting those working in human services and occurs when work demands are greater than available resources (Hastings et al., 2004). It is a state of physical and emotional exhaustion occurring when health care workers feel overburdened by the demands of their jobs.

Chapter 2

Literature Review

The purpose of this descriptive study was to examine burnout in direct care personnel in an Intermediate Care Facility for the mentally retarded. A review of the literature for the last ten years was conducted using CINAHL, Medline, Pub Med, ERIC, ProQuest and Psych Info using the following keywords: “direct support personnel”, “Intermediate Care Facility for the Mentally Retarded (ICF/MR)”, “burnout”, “long term care”, “retention”, and “Maslach Burnout Inventory”. The focus variable was burnout and the search process led to obtaining seminal works. Difficulties finding and keeping competent direct support personnel to work with people with developmental disabilities continue to be a challenge for individuals, families, providers and policy makers (Hewitt & Larson, 2007).

History of Burnout in Healthcare

Over the past two decades, burnout among professional caregivers has received increased attention (Rupert & Morgan, 2005). Documentation exists that health care personnel experience a troubled conscience when they are unable to provide the good quality care they feel their clients need and deserve (Glasberg, Eriksson & Norberg, 2007). Several steps can lead to burnout but they do not always follow an orderly progression. These steps are: mental and physical exhaustion,

indifference, a sense of failure as a professional and a person, and being “dead inside” (Spinetta et al., 2000).

Burnout in nursing has been studied in a number of settings around the world. Findings vary in level/degree of burnout experienced by nurses. The studies found are often descriptive and are not tightly controlled.

In Happell, Pinikahara, and Martin’s (2003) study in Australia, stress reported by nurses in a forensic psychiatric facility was found to be in the low level range of burnout on the Maslach Burnout Inventory. Of note from this study, the least reported stressor was lack of staff support for nursing activities. This may account for the lower than expected levels of stress.

Several other findings concerning burnout exist. Ayalon, in a 2007 study in one of Israel’s long term care facilities involving 122 direct care staff, found those who reported being “higher” on the social ladder had higher positive caregiving experiences and reported less burnout. Montoro-Rodriquez and Small (2006) found conflict resolution style influences psychological morale, occupational stress and job satisfaction. In a literature review of predictors of nurse absenteeism in hospitals from 1986-2006, Davey and colleagues (2009) found that with increased reports of burnout and job stress, more short term absenteeism was reported.

In a descriptive correlational study of 125 RN, LPN and CNAs examining stress and burnout in long term care staff, RN’s had the highest level of stress followed by CNA’s (Kennedy, 2005). The number of sick days used was significantly correlated with stress and burnout ($r = .30, p = .01$). A significant

correlation was also found between stress and inadequate preparation to meet the emotional needs of the clients and performing required job duties (Kennedy).

According to Spinetta and colleagues (2000), burnout can affect not only the individual but also the interdisciplinary team, client, and family, resulting in overall dissatisfaction, loss of enthusiasm and idealism with work, leading to compromised interactions within the work setting. Dunwoodie and Auret (2007) found that “burnout has been associated with lower productivity and effectiveness at work, patient and staff dissatisfaction and increased rates of absenteeism and job turnover” (p. 694). Other researchers reported that absenteeism and staff turnover have an indirect effect on the quality of life of clients with intellectual disabilities by reducing the organization’s efficiency, continuity of care and lack of a skilled competent workforce (White et al., 2006).

Factors Related to Burnout

A number of studies have investigated the degree of burnout in direct care personnel working in the field of intellectual disabilities with somewhat conflicting findings (Skirrow & Hatton, 2007). According to Skirrow and Hatton’s meta-analysis of 15 studies of direct care personnel working with adults with intellectual disabilities “...the levels of burnout are somewhat lowered in this population compared with normative samples and there appeared to be a trend of burnout rate decreasing steadily over the past 20 years” (p. 131). In a study by Lawson and O’Brien (1994), only eight of the direct care staff subjects came from an ICF/MR in

the USA. This was the most recent of only three studies from the United States included in the meta-analysis.

Three core features have been identified in the phenomenon of burnout: emotional exhaustion, depersonalization or cynical attitude, and lack of personal accomplishment (Dunwoodie & Auret, 2007; Rupert & Morgan, 2005). According to Grasberg et al. (2006), “emotional exhaustion seems to be highly correlated with general work stressors or demands such as workload...depersonalization seems to correlate more with patient factors... [and] personal accomplishments...with individual or personality factors” (p. 393). Factors or causes of burnout identified by White and colleagues (2006) include: “(1) individual factors (e.g. over commitment, unrealistic job expectations); (2) interpersonal factors (e.g. imbalance between employee resources and client demands); (3) nature of the work (e.g. caring or emotional labor); (4) organizational factors (e.g. quantitative job demands, lack of control and lack of support)” (p. 503).

The determinants of burnout are complex. Work stressors related to burnout involve (1) high workload and time pressures; (2) role ambiguity; (3) staff conflicts; and, (4) decreasing autonomy (Grasberg et al., 2007). The influence gender has on the role of stress and burnout is inconclusive (Grasberg et al.; McCarty, Zhao & Garland, 2007). Younger employees report greater burnout than their older colleagues (Grasberg et al.). Burnout has been linked to job strain, depressive symptoms, job satisfaction, job characteristics and dissatisfaction (Hastings et al., 2004).

Measurement of Burnout

The level of burnout is most often measured using the Maslach Burnout Inventory-Human Services Survey (MBI-HSS) (Hastings et al., 2004). The MBI-HSS has been used to measure burnout in a number of helping and service oriented professions around the world. The MBI-HSS has three subscales. The emotional exhaustion subscale is most responsive to the organizational environment and interactions that comprise human service work (Maslach, Jackson & Leiter, 1996). The depersonalization subscale measures impersonal or unfeeling attitudes towards care recipients. The personal accomplishment subscale gauges ones self-perception of professional competence and achievement in caregiving. It is not as closely linked to emotional exhaustion and may develop in parallel with exhaustion, each arising from encounters with distinct problems in the organizational environment (Maslach et al.).

Grasberg and colleagues (2007), explored factors that may contribute to burnout among health care personnel. Regression analysis described a model that explained 59% of the variation in emotional exhaustion. The factors found to be associated with emotional exhaustion were:

‘having to deaden one’s conscience, and ‘stress of conscience’ from lacking the time to provide the care needed, work being so demanding that it influences one’s home life, not being able to live up to others’ expectations,

having to lower one's aspirations to provide good care [and] deficient support from co-workers. (p. 392)

Further, Hasson and Arnetz (2007) found work-related exhaustion to be the strongest (inverse) predictor in a staff's reported work satisfaction.

In a qualitative study exploring factors related to job satisfaction in long term care workers in Australia, data were collected through focus group interviews with 27 nurses and nursing assistants. Moyle, Skinner, Rowe and Gork (2003) found that job satisfaction was related to workplace flexibility, a team environment, and the type of residents. Dissatisfaction was related to working with unskilled or poorly trained staff, tension with role expectations, and increasing overtime.

Burnout also has been explored among palliative care physicians in Australia using the Maslach Burnout Inventory. The findings of the study did not support a higher burnout level in palliative care physicians. Specifically, Dunwoodie and Auret (2007) found emotional exhaustion (mean 17.5, range 1-47) and depersonalization (mean 4.5, 0-24) within the low range with personal accomplishment (mean 39, 32-46) falling within the average range. The conclusion drawn was that the levels of burnout in palliative medicine were not higher than other specialties (Dunwoodie & Auret).

In a prospective study of Finnish dentists, Ahola and Hakanen (2007) utilized the MBI and the Beck Depression Inventory to measure burnout, job strain and depressive symptoms. Study findings revealed that a reciprocal relationship exists between burnout and depressive symptoms. Job strain predisposed participants to

depressive symptoms through burnout. Also, job strain increased a persons risk of burnout directly related to depressive symptoms. Ahola and Hakanen found that of the burnout sufferers without depressive symptoms at baseline, 23% reported depressive symptoms after three years. For those who had depressive symptoms at baseline, 63% had burnout at follow up.

Burnout Among Direct Care Personnel

In the first large nation-wide study of burnout in direct care personnel conducted in Japan in 216 social welfare facilities for the mentally retarded, 3774 staff were surveyed (Ito et al., 1999). In this study, the 2277 direct care personnel experienced higher levels of burnout than reported by facility directors and middle managers. For these workers, having supervisor support was significantly associated with less burnout. Factors not found to be associated with burnout were age, marital status, gender, severity of disability of individuals supported, frequency of night shift, longer number of hours worked, or participation in training programs (Ito et al.).

In a meta-analysis of 15 studies of levels of burnout in direct care personnel caring for individuals with intellectual disabilities, Skirrow and Hatton (2007) found a trend that burnout appeared to be decreasing. These studies were conducted in the United Kingdom, Holland, Spain, Australia, Canada and the United States. Three studies were conducted in the United States prior to 1994. Only one of the three studies was conducted at a large state-run facility. Thus there is a need to better

understand burnout in direct care staff based on current work environments, practice regulations, and resident populations in ICF/MR facilities.

Summary

Several gaps have been identified in the literature on burnout specific to direct care personnel working with adults affected with intellectual disabilities. First, there is a lack of recent studies examining the level of burnout among direct care personnel in ICF/MR in the United States. Second, there has been no systematic development and evaluation of workplace interventions to address burnout in the ICF/MR setting. Skirrow and Hatton (2007) call for strategies aimed to address and reduce burnout in the work setting. Specifically, Hastings and colleagues (2004) identify the need to explore interventions to help staff cope with workload pressures and prevent burnout.

Chapter 3

Methods

The purpose of this descriptive study was to examine burnout in direct care personnel in an Intermediate Care Facility for the mentally retarded. In this chapter, the following areas are discussed: design, setting, sample, measures, procedures, data management and analyses, and protection of human subjects.

Design

A descriptive, correlational design was used to examine burnout in direct care personnel working in an ICF/MR. The strength of the design is that it may allow for the generation of theory, identification of clinical practice issues, and the justification of current practice (Burns & Grove, 2004).

Setting

The setting used for the study was the common work and programming areas of an ICF/MR in the Southeastern United States. The ICF/MR is one of five regional centers which houses approximately 120 mentally retarded residents. The site was chosen for its convenience and availability of subjects. Approximately 425 employees work at the site. Of those employees, approximately 190 are direct care personnel. Care is delivered following a standard staffing pattern of three, eight hour

shifts with some adjustments for acuity and requirements on a 24 hour, seven day a week coverage pattern.

Sample

The sample for the study was a convenience sample of permanent, facility-employed, direct care personnel from all three shifts at the ICF/MR. The duties of the direct care staff include assisting clients with ID in day-to-day activities of personal care, basic health/hygiene, transportation, advocacy and financial management (Hewitt & Larson, 2007). A non-random convenience sampling method was chosen for sample accessibility, limited expense and inability to obtain a random sample. Descriptive studies do not have power analyses conducted to determine sample size (Burns & Grove, 2004). Personnel meeting the following criteria were eligible for the study: 1) non-nursing employed personnel providing direct care to developmentally disabled individuals; 2) must have been able to spend the required 20 minutes to complete the four part questionnaire and able to read and write English. Anyone not employed in direct care of those with developmental disabilities, or any nursing personnel were excluded. There were 118 surveys distributed and 56 returned for a response rate of 47.5%.

Measures

Direct Care Personnel

Direct care personnel were defined as non-licensed healthcare personnel providing direct hands-on daily care and assistance with activities of daily living to individuals with intellectual disabilities.

Burnout

Level of burnout was measured as the scores on the Maslach Burnout Inventory (MBI) indicating low, moderate or high degrees of burnout experienced. The MBI-Human Services Survey was designed to assess emotional exhaustion (EE), depersonalization (DP), and lack of personal accomplishment (PA) and was utilized to measure burnout. The scores for each subscale were summed separately. These were the primary components (subscales) of the burnout syndrome.

The instrument was developed by Maslach and colleagues (1996) and contained 22 statements the respondents were asked to rate from 0 = never to 6 = every day. A high degree of burnout was indicated by high scores on the EE and DP subscales and a low score on the PA subscale. The range of burnout experienced on the MBI subscales were: high (high third), average (middle third) and low (lower third).

The range on the EE subscale is normalized for mental health occupations: low (≤ 13), average (14 – 20) and high (≥ 21). The normalized range on the DP subscale is low (≤ 4), average (5-7), and high (≥ 8). The normalized range of PA is: low (≥ 34), average (33 – 29), and high (≤ 28). Cronbach's coefficient alpha ($n = 1,316$) was used to determine internal consistency (Maslach et al.). The subscale reliability coefficients were: .90 for EE, .79 for DP, and .71 for PA with the standard error for each subscale respectively of: EE = 3.80; DP = 3.16; and, PA = 3.73. Convergent validity was demonstrated by correlating individuals' MBI-HSS scores with independent behavioral ratings (Maslach et al.).

Demographic Variables

Five demographic data questions were developed by the primary investigator (See Appendix B). The demographic data were used to describe participant age in years, gender, ethnic background, marital status, and highest level of school completed. Participants were asked to write their age in the space provided. They were to circle the correct answer for the following questions: What is your gender? (male = 1, female = 2); What is your ethnic background? (1 = Asian/Asian American, 2 = Black/African American, 3 = Latino/Hispanic, 4 = Native American/American Indian, 5 = White/Caucasian, 6 = Other (please specify) _____); What is your marital status? (1 = Single, 2 = Married, 3 = Divorced, 4 = Widowed, 5 = Other (please specify) _____); What is the highest level of school you completed? (1 = completed high school/GED, 2 = completed 2 years college (AA), 3 = completed four years of college (BS, BA), 4 = completed post graduate work (MS, MA), 5 = other (please specify) _____).

Work Related Data

Individual work related data were obtained by an investigator-developed 11 item work related data sheet. Items included: How long have you worked at this facility? Years ___ Months ___; How long have you worked with mentally disabled people? Years ___ Months ___; How many days of work have you missed in the past year due to illness? ___; Do you participate in any stress reducing activities? 1= yes, 2 = no. If yes, list what stress reducing activities you do: (____ _); Would you like to have a worksite program developed to help decrease your stress

level? 1 = yes, 2 = no. If yes, in what types of programs would you take part on the worksite? (_____); How much stress do you experience from your work role? (Place an X along the line that shows how much stress you have experienced, [Not at all stressful to extremely stressful]); On average, how many hours of overtime do you work during a month? _____; Do you work a second job? 1 = yes 2 = no; If you work a second job on average, how many hours each week are you working in another job? _____.

Depressive symptoms were measured using the CESD-10 item short form. The CESD-10 measured the frequency of depressive symptoms (Kohout, Berkman, Evans, and Cornoni-Huntly, 1993). The CESD-10 was reported to have acceptable internal consistency and reliability with Chronbach's alpha of .80 (Kohout et al.).

For the CESD-10 item short form, participants were asked to circle the number that indicates how often in the past week they have felt this way: (1) Rarely or none of the time/less than a day, (2) some or little of the time (1-2 days), (3) occasionally (3-4 days), and (4) most of the time (5-7 days). A cut off score of 16 means the person should be screened for depression (Kohout et al., 1993). See Appendix B for the CESD-10 items.

Procedure

Recruitment

Approval for access to the ICF/MR site was also granted by the Research Review Committee for the study. A waiver of consent of signature was obtained to further protect confidentiality and privacy for the direct care workers. Then an

Internal Review Board (IRB) application was submitted to Case Western Reserve University (CWRU) IRB for approval. Case Western Reserve University IRB granted study exemption status for the study.

Recruitment was conducted by the primary investigator. The researcher was onsite and available to answer any questions if needed. Prior to direct contact by the primary researcher, a flyer explaining the purpose of the study was posted inviting participation.

Data Collection

The primary investigator explained the study. A survey packet was given to each potential volunteer that contained the informed consent document, an instruction sheet for participants, and a study questionnaire. If a prospective volunteer was willing to participate in the research study, the participant was directed to complete the self-administered questionnaire containing demographic and work related items, the CESD-10, and the MBI-HSS, return it in the envelope provided, and put the envelope in a secured collection box placed in each common work area. Those who did not wish to participate in the study were instructed to put everything back in the envelope and put it in the collection box as well. Returning the completed questionnaire was considered consent to participate in the study. The questionnaire took approximately 20 minutes to complete. A Wendy's Jr. Frosty coupon was given to each prospective volunteer in appreciation for considering participating in the study.

Data Management

The data were manually entered into Statistical Plan for the Social Sciences (SPSS) 16.0 files. Each questionnaire was assigned an identification number. The identification number was used to match the electronic record with the paper record of the instrument. The questionnaire's identification number was not a participant identifier. Each instrument was checked by visual inspection for complete data. Data cleaning was done by running frequencies on all variables once data entry was completed. Any discrepancies were checked against raw data from the respective questionnaire.

Data Analysis

The Statistical Package of Social Sciences (SPSS) 16.0 was used to analyze the data. Descriptive data analysis was used to calculate absolute number, frequencies, mean score and standard deviation for levels of burnout and to describe demographic characteristics of the sample. A one-tailed Pearson's Product Moment Bivariate correlation was conducted to analyze the relationships between burnout and work related characteristics of direct care personnel in an ICF/MR.

RQ1: What are the demographic and personal characteristics of direct care personnel in an ICF/MR in the Southeastern United States?

The demographic variables yielded nominal/categorical data: gender, ethnic background, and marital status. Nominal/categorical data was descriptively analyzed using absolute numbers and percents. The demographic variable *highest level of school completed* yielded ordinal level data. Ordinal data was descriptively analyzed

using absolute number and percent. The demographic variable *age* was analyzed using measures of central tendency (mean, median, range) and percent.

RQ2: What is the level of burnout in direct care personnel in an ICF/MR in the Southeastern United States?

Descriptive Statistics to analyze mean, median, minimum and maximum, range and standard deviation for scores on each of the respective subscales: EE, DP, and PA.

RQ3: What work related characteristics of direct care personnel in an ICF/MR in the Southeastern United States are related to burnout?

The work related variables yielded interval data. The variables included length of time working at the facility and with mentally retarded; the number of sick days used during the past year; the number of overtime hours worked in a month; report of participation in any stress reducing activities; and, inquiry into the desire to have a work site stress reduction program developed. Participants also were asked to report if they worked a second job, and the number of hours worked per week. Using a visual analog scale, participants were asked to record how much stress they experienced from their work role. Pearson product moment correlation statistics were used to explore the relation between worker related factors and the burnout scores.

Protection of Human Subjects

The primary investigator obtained approval from the Research review committee at DDSN for site access, and from Case Western Reserve University's IRB to conduct the study. The primary researcher was CREC certified and explained

the study to the direct care personnel using a prepared script. This study posed no foreseeable risks or discomforts. Only minimal inconvenience of approximately 20 minutes was required to complete the self-administered questionnaire. Participation was voluntary and the primary investigator was on campus to answer any study related questions. Protection of participants' confidentiality was enhanced through the use of a waiver of consent signature. Participants were informed that by completing the questionnaire and returning it to the secured study collection box that they were agreeing to participate in the study. Those not wishing to participate were asked to return the blank materials to the envelope and return them to the survey collection box.

Data were maintained in a locked filing box in the primary investigator's home. Data will be kept for three years following analysis of the data. Only the primary investigator will have access to the data.

Summary

The purpose of the study was to measure burnout in direct care personnel caregivers working with those with developmental disabilities. A descriptive correlational research design was utilized for the study. A convenience sample of 56 direct care personnel took part in a four-part one-time survey at an ICF/MR in the Southeast. Statistical analyses involved the use of SPSS and Excel for descriptive and correlational statistics.

Chapter 4

Results and Discussion

The purpose of this study was to examine burnout in direct care personnel working in an Intermediate Care Facility for the Mentally Retarded. In this study, the participants completed a self-administered questionnaire that included demographic items, the MBI-HSS, the CESD-10, and work-related characteristics items. The results of the three research questions were analyzed for discussion.

Results

RQ1: What are the demographic and personal characteristics of direct care personnel in an ICF/MR in the Southeastern United States?

The demographic characteristics for the sample were analyzed using descriptive statistics. Fifty four direct care personnel respondents indicated their age; the mean age was 43.76 years with a SD 10.992, and a range of 21 years to 63 years of age. Two respondents elected not to report age. Participants included 45 (80.4%) females, and 10 (17.9%) males with one non-reporting gender (1.8%) (n = 55). Black/African American participants comprised 96.4% (n = 54) of the respondents, with one Native American/Indian and one Caucasian. Of the 56 participants, 41.1% (n = 23) were single; 42.9% (n = 24) were married; 10.7% (n = 6) divorced; and 5.4% (n = 3) marked other. The highest level of education reported by 42.9% (n = 24) of the participants was High School Diploma/GED. Participants reporting two

years of college comprised 30.4% (n = 17) of the sample. Other responses included: completed four years of college, 19.6%, (n = 11); completed postgraduate, 5.4%, (n = 3); and, other, 1.8% (n = 1).

Several personal characteristics were found in this study. The mean CESD score for the participants was high at 20.45, suggesting depressive symptoms. When asked, most respondents, 73.2% (n = 41), denied participating in stress reducing activities. A majority, 63.5% (n = 33), however, desire some type of stress reduction program to help manage their work stress. The demographic and personal characteristics of the study are found in Table 1.

Table 1 Demographic and personal characteristics of Direct Care Personnel

Age	(n = 54)
Mean	43.73
Median	44.5
Standard deviation	10.992
Range	42
Minimum	21
Maximum	63
Gender	(n = 55)
Male	10 (18.2%)
Female	45 ((81.2%)
Ethnic background	(n = 56)
Black/ African American	54 (96.4%)
Native American/ American Indian	1 (1.8%)
White/ Caucasian	1 (1.8%)
Marital status	(n = 56)
Single	23 (41.1%)
Married	24 (42.9%)
Divorced	6 (10.7%)
Other	3 (5.4%)
Highest level of school completed	(n = 56)
Completed HS/ GED	24 (42.9%)
Completed 2 years of college	17 (30.4%)
Completed 4 years of college (BS/BA)	11 (19.6%)
Completed Postgraduate (MS/MA)	3 (5.4%)
Other	1 (1.8%)
Participate in a stress reducing program	(n = 56)
Yes	15 (26.8%)
No	41 (73.2%)
Desire a stress reducing program	(n = 52)
Yes	33 (63.5%)
No	19 (36.5%)
CES-D score	(n = 56)
Mean	20.45
Median	20.00
Standard deviation	6.08
Range	30
Minimum	10
Maximum	40

RQ2: What is the level of burnout in direct care personnel in an ICF/MR in the Southeastern United States?

The mean score on the Emotional Exhaustion (EE) burnout subscale was 25.32, with a range of 0 to 54, SD 14.334, and, median of 26.50. This indicates that respondents scored in the high mean emotional exhaustion burnout category. Direct care personnel had a Depersonalization (DP) mean score of 9.05, range of 0 to 30, SD 7.733, and median of 7.50. The mean scores represent a high DP score. On the Personal Accomplishment (PA) subscale, the mean score was 32.88, range of 9 to 48, SD 8.28, and, median of 34.50 for direct care personnel. The PA mean scores were in the average burnout range for the MBI-HSS burnout inventory. (See Table 2 for MBI-HSS Burnout Studies Subscale data and Appendix E for Frequencies and Percentages.)

Table 2 Descriptive Data for MBI-HSS subscales

	Emotional Exhaustion	Depersonalization	Personal Accomplishment
n Valid	56	56	56
Missing	0	0	0
Mean	25.32	9.05	32.88
Median	26.50	7.5	34.50
Std Deviation	14.33	7.73	8.38
Range	54	30	39
Minimum	0	0	9
Maximum	54	30	48

RQ3: What work related characteristics of direct care personnel in an ICF/MR in the Southeastern United States are related to burnout?

Several work related characteristics were analyzed using descriptive statistics. The length of time worked at the facility had a mean of 12.71 years and the length of time working with the mentally retarded mean was 14.03 years. Both of these values were significantly larger than the length of time reported by participants in an unpublished study by Horne from 2002 cited by Hastings and colleagues (2004). The mean time in that study for working with developmentally disabled persons was approximately five and a half years. The number of days missed from work had a mean of 11.02 days per year and a median of 5.00. The amount of overtime reported was a mean of 7.6 hours per month with a median of 5.00 and a standard deviation of 8.43, or approximately one day of overtime a month. (See table 3.1 and 3.2).

Table 3.1 Descriptive Statistics for Work Related Characteristics of Direct Care Personnel

Worked at center (n = 55)	
Mean	152.62 months / 12.71 years
Median	112.00 / 9.3
Standard deviation	133.21 / 11.1
Range	381 / 31.75
Minimum	3 / 0.25
Maximum	384 / 32.0
Worked with MR (n = 54)	
Mean	168.44 months / 14.03 years
Median	124.00 / 10.33
Standard deviation	137.76 / 11.48
Range	381 / 31.75
Minimum	3 / 0.25
Maximum	384 / 32.0
Missed work (n = 53)	
Mean	11.02 days per year
Median	5.00
Standard deviation	28.95
Range	180
Minimum	0
Maximum	180
Overtime worked (n = 53)	
Mean	7.60 hours per month
Median	5.00
Standard deviation	8.43
Range	39
Minimum	0
Maximum	39

Table 3.2 Descriptive Statistics for Work Related Characteristics of Direct Care Personnel

Work a second job (n = 56)	
Yes	14 (25%)
No	42 (75%)
Number hours at second job (n = 54)	
Mean	3.87 hours per week
Median	.00
Standard deviation	7.47
Range	28
Minimum	0
Maximum	28
Place an X on the line/stress (n = 53)	
Mean	5.36 (on a scale of 0 to 10)
Median	6.00
Standard deviation	3.41
Range	10
Minimum	0
Maximum	10

A one-tailed Pearson's product moment bivariate analysis was used to determine the relationship between work related characteristics and burnout. Emotional exhaustion had a significant positive correlation ($r = .647, p = 0.01$) to the work related stress. The depersonalization subscale had a significant positive relationship to the work related stress ($r = .496, p = 0.01$). The personal accomplishment (PA) subscale was significantly negatively correlated ($r = -.252, p = 0.05$) with the *length of time worked at the facility* and had a significant negative correlation ($r = -.229, p = 0.05$) with *how long you have worked with mentally disabled people*. Personal accomplishment had a significant negative response ($r = -.269, p = 0.05$) with *how many work days have you missed this past year due to illness*. The burnout subscale score for PA decreased the longer one works at a facility caring for the developmentally disabled. The CESD-10 scores ($r = .581, p = 0.01$) had a significant positive correlation with the scores for work role stress. No other correlations were found to be significant. (See Table 4.)

Table 4 Pearson Product Correlation between Burnout and Work Related Characteristics in Direct Care Personnel

Variables	1	2	3	4	5	6	7	8
1. Emotional Exhaustion	–							
2. Depersonalization		–						
3. Personal Accomplishment			–					
4. CES-D				–				
5. Worked at Facility (m)			-.25*		–			
6. Worked with MR (m)			-.22*			–		
7. Work Days Missed			-.26*				–	
8. X on analogue stress scale	.64**	.49**		.58**				–

* = significant at 0.01 level (1-tailed)

** = significant at 0.05 level (1-tailed)

Discussion

RQ1: What are the demographic and personal characteristics of direct care personnel in an ICF/MR in the Southeastern United States?

The sample in this study was comprised predominantly of middle-aged African American women who had obtained a high school diploma. Participants were roughly divided between married and single. The demographic characteristics of the sample are similar to characteristics of workers reported in previous studies on direct care workers. According to Hewitt and Larson (2007), direct care workers historically have been women between the ages of 20 to 44 from varied minority ethnic backgrounds.

The mean score on the CESD short form was 20.45, with a median of 20.00 and a standard deviation of 6.08. According to Kohout and colleagues (1993), “It has become commonly accepted that persons who score 16 or above on the CES-D... are likely to be clinically depressed” (p. 189). In this study, high scores on the emotional exhaustion and depersonalization subscales were correlated with higher scores on the CESD-10 depressive symptoms scale. In a study of dentists, Ahola and Hakanen (2007) found that job strain predisposed one to depression related to burnout; and that job strain predisposed one to burnout if the individual was experiencing depressive symptoms, in a reciprocal relationship. Further, it has been suggested that workers who report feeling depressed may have fewer resources to meet the demands of their work and this may predispose them to burnout (Ahola & Hakanen). Previous research concerning workers in the field of developmental disabilities

indicates that one third experience stress levels consistent with mental health problems (Hastings et al., 2004). By these criteria, the participants in this sample would warrant closer observation for depressive symptoms.

Participants in the current study, often those reporting higher burnout and depression scores, would like a program developed to help them deal better with their work stress. The types of programs requested by study participants were: 1) low impact aerobic activities (walking program, use of gym); 2) stress reduction classes (counseling, meditation); and, 3) improved working conditions (2-15 min breaks per shift, improved client staff ratio, improved benefits). Interventions to improve the work environment for those caring for the developmentally disabled have been recommended by researchers to improve retention, decrease absenteeism and burnout, and improve overall workforce outcomes (Hewitt & Larson, 2007).

RQ2: What is the level of burnout in direct care personnel in an ICF/MR in the Southeastern United States?

In this study of direct care personnel from the Southeastern United States, a high mean burnout score ($M = 25.32$) on the emotional exhaustion MBI-HSS subscales was found among direct care personnel. The depersonalization subscale mean ($M = 9.05$) also was at a high level. Personal accomplishment was in the average range ($M = 32.88$). This is of concern because those with increased emotional exhaustion may no longer have the psychological resources to fully attend to a patient's emotional needs. When depersonalization levels are high, staff may view the client less as a person and more as an object. The fear is that the client will

be treated impersonally or even harshly by the staff member (Maslach et al., 1996). Currently, the study participants' PA scores indicate that they are able to do their jobs satisfactorily.

The results of this study are consistent with the high levels of burnout found in the large nationwide Japanese study by Ito and colleagues (1999). These findings, however, are higher than those from an international meta-analysis of burnout among direct care workers by Skirrow and Hatton (2007). These authors interpreted their findings as indicating that the level of burnout in direct care workers caring for those with developmental disabilities was somewhat lower than normative samples.

Previous studies examined in the meta-analysis were conducted under a markedly different paradigm for ID care. Vast changes in the landscape of intellectual disabilities care in the U.S. occurred after the Supreme Court's Olmsted ruling in 1999. The ruling essentially depopulated the ICF/MR facilities, leaving only the most medically and psychiatrically fragile individuals in full-time institutional care. This decision effectively concentrated the caregiver burden experienced by the available direct care staff. The unprecedented economic collapse and subsequent staff reductions which occurred at the time the current study was conducted may also have some bearing on the considerably higher burnout score indicated by the sample of direct care personnel participating in the study.

RQ3: What work related characteristics of direct care personnel in an ICF/MR in the Southeastern United states are related to burnout?

There is a lack of consistent research findings on burnout and work factors in direct care personnel working with developmental disabilities (Skirrow & Hatton, 2007). The average direct care staff in an earlier study had worked with the developmentally disabled for approximately 5.5 years (Hastings et al., 2004). In this study, a negative relationship was found between the length of time participants worked with developmentally disabled persons and the participants' scores on personal accomplishment. This means that the longer one had worked with developmentally disabled persons, the lower level of PA scores s/he reported. Kennedy (2005) also reported an inverse relationship between burnout and personal accomplishment and a direct correlation between number of sick days used and stress and burnout. Similarly, this current study found that increased usage of sick days had a significant correlation with poor personal accomplishment scores. However, Ito and colleagues (1999), found that having supervisor support can reduce the effects of burnout in direct care staff.

Chapter 5

Summary

The purpose of this descriptive correlational study was to examine burnout in direct care personnel in an ICF/MR in the Southeastern United States. In today's healthcare environment, there is increased interest in work stress and caregiver stress. However, little is clearly understood about the burnout level of direct care personnel working in an ICF/MR in the United States. These personnel often fill the role of surrogate family members to the individuals with developmental disabilities. Professional caregivers for those with developmental disabilities have often experienced a great deal of subjective burden of caring, similar to that borne by the family caregivers (White et al., 2006). This study sought to provide greater insight into the level of burnout experienced by primary institutional caregivers of individuals with developmental disabilities.

Fifty six direct care personnel from one facility volunteered to take part in this descriptive correlational study. All interested staff at the facility were given an opportunity to participate; the response rate was 47.5%. Of those who elected to participate, the majority were middle aged African American women providing disabilities care for approximately 12 years.

Pertinent findings

Overall, direct care personnel reported high burnout levels on the emotional exhaustion and depersonalization subscales. The scores on EE and DP were correlated with higher CESD-10 depressive symptoms scores. The mean scores for the emotional exhaustion subscale were 25.32 and for the depersonalization subscale were 9.05. The comparative normative sample mean score for the emotional exhaustion subscale is 16.89, and for the depersonalization subscale is 5.72. The implications, according to Hastings et al. (2004), are that higher emotional exhaustion scores in direct care givers might indicate withdrawal of emotional support from a patient or client. Similarly, it is feared that higher depersonalization scores may result in inappropriate or hostile actions towards clients. Personal accomplishment has a higher mean of 32.88, compared to the normative 30.87 (Maslach et al., 1996).

Higher levels of burnout have been associated with high staff turnover, lower morale and increased absenteeism (Hewitt & Larson, 2007). Some studies around the world have indicated that burnout among direct support staff working in the field of intellectual disabilities may be on the decline (Skirrow & Hatton, 2007). This study did not support this finding.

Limitations

The results of this study are limited due to the use of a convenience sample, small sample size, and a single data collection site. These limitations inhibit the study's generalizability. There are further limitations in the generalizability and

internal validity of this study because of the special needs of those being cared for and the current recent economic crisis. These changes have impacted state and federal funding resulting in ongoing staff reductions, staffing pattern changes, and worker stress. Therefore, study results may not be representative of direct care personnel levels of stress and burnout in long-term care, no matter what the population receiving care, given ongoing economic uncertainty and constraints. In addition, these participants, who work with persons with developmental disabilities, face different caregiving demands and burden than other LTC direct care personnel.

Implications for Nursing Knowledge

The purpose of this study was to examine the level of burnout in direct care personnel in an ICF/MR in the Southeastern United States. The findings suggest that these caregivers experience high levels of burnout and high levels of depressive symptoms. In the theory of caregiver stress, objective burden is related to the chronic care associated with taking care of the developmentally disabled individual. Care demands, in turn, can activate the caregiver's coping mechanism which, subsequently, prompts direct care personnel to utilize available physical and psychological resources to cope with the caregiving burden.

If coping resources are inadequate, the caregiver may perceive stress which, according to Tsai's theory of caregiver stress, can lead to depressive symptoms. Furthermore, stressful life events may have an additive effect (over and above the objective burden) on this process (Tsai, 2003). The higher burnout scores and depressive symptom scores may indicate the additive effects of these stressful life

events, including family stressors and illness, this depression can have an effect on the caregiver's physical health (sick days), self esteem (PA), role enjoyment (EE and DP) or marital satisfaction, which was not addressed in this study.

The theory of caregiver stress is relatively new and has not been extensively tested. This study appears to support the basic constructs of the theory. However, more deliberate testing of the theory will likely be necessary to quantify its applicability. Clearly, more research is indicated in the area of caregiver stress, specifically among those who care for individuals with developmental disabilities, dementia and neurological or neurodegenerative compromises.

Implications for Nursing Practice

Two of the key work related characteristics correlating to burnout and depressive symptoms are time working at the ICF/MR and time working with developmentally disabled individuals. Spinetta and colleagues (2000) found that "burnout in health care professionals...often manifests itself as a multistep process progressing slowly over time" (p. 122). Burnout can be prevented or reversed in health care personnel if targeted interventions are implemented early in the progression toward burnout. Advance practice nurses who can identify risks for work related stress and recognize burnout, can play a key role in developing and recommending possible intervention strategies.

Advanced practice nurses are prepared to monitor and recognize the signs and symptoms of burnout and depression and to teach these skills to nurse managers. Managers are responsible for fostering a positive supportive work environment,

evaluating the workload among assigned direct care personnel, and monitoring personnel for stress and burnout. Thus nurse managers with the support of APRNs, play a critical role in monitoring the level of stress experienced by all team members and the affects of quality on patient care

Advanced practice nurses, particularly clinical nurse specialists, are often responsible for developing and monitoring health promotion strategies to improve the work environment and help decrease burnout risk in their assigned care teams. Work stress has already been shown to be significantly correlated to burnout in a direct care staff working in a nursing home setting. Kennedy (2005) notes that nurse managers need to be encouraged to assess work related issues leading to burnout in their staff and assist in developing strategies to help improve the work environment. It is therefore important that APRNs work closely with nurse managers in long-term care centers.

Implications for Nursing Policy

Advanced practice nurses are in a position to assist organizations in the development and implementation of policies to assist in the prevention of burnout in team members. Employee exercise and stress management programs could be developed and tailored to help meet the needs of the specific service organization. Often this could be accomplished at little or no cost to the organization through the utilization of locally available resources.

Continued exploration by organizations into the development of policies and procedures to better manage work stress and help prevent burnout is needed.

Multiple state and federal initiatives related to identifying and improving the work environment for long term care, direct care workers have been recommended. Such interventions in the workplace encourage recruitment and retention of a stable direct support workforce which, in turn, helps to ensure long range continuity of care for the clients (Hewitt & Larson, 2007), and reduces staff turnover costs associated with recruitment and training.

Advanced practice nurses have the opportunity to take an active leadership role providing care not only for their residents but also for their care teams. Spinetta and colleagues (2000) identified workplace tension caused by low social support, too many demands, and staff cutbacks as a “major cause of burnout” (p. 123). Study participants identified several programs or activities that they believed would help to manage their work related stress. These include: exercise classes, aerobics, walking, longer breaks, improved working conditions, counseling and meditation. Thøgersen-Ntoumani, Fox and Ntoumanis (2005) concluded that “...exercise is associated directly and indirectly with high well-being in various facets of employees’ lives” (p. 609).

Implications for Nursing Education

Nurses currently play a fundamental role in direct care personnel’s education and training in ICF/MR’s. Nurses can assist direct care personnel to manage their work stress by educating their assigned care teams on the emotional requirements of caring for those with developmental disabilities. Currently, most training and education programs offered to direct support personnel focus on basic job functions.

Very little time is given to the instruction of the unique physical and emotional needs of caring for those with severe to profound mental retardation. Direct care personnel have consistently reported their training to be inadequate to prepare them for their job responsibilities (Hewitt & Larson, 2007).

Recommendations for future research

More research is needed in the area of burnout, depressive symptoms and work related characteristics in direct support personnel working in the field of developmental disabilities. Future research is needed to determine whether environmental or personal factors are significant in the development of burnout in direct care personnel. Studies might determine what intervention programs are most effective in decreasing burnout and caregiver stress or if supervisor support reduces burnout among direct care personnel working in an ICF/MR. These issues are of importance to nurses working in the field of developmental disabilities, long term care and mental health nursing.

Summary

The purpose of this study was to explore burnout in direct care personnel in an ICF/MR in the Southeastern United States. A volunteer sample of 56 direct care personnel participated. The respondents were primarily female African American high school graduates who were split fairly evenly between married and single. The participants had worked with the developmentally disabled, on average, for approximately 12 years.

Burnout was substantiated in two of three MBI-HSS subscales. High scores on the CES-D 10 were also found in this sample. These results would seem to highlight the need for more research and effective strategies to decrease caregiver stress. This problem may be difficult to address effectively as already overburdened agencies are facing huge budget cuts in the wake of the recent global economic collapse. Nevertheless, modest person-centered programs of care for our individuals and their caregivers should be explored in order to ensure the long term health of all stakeholders.

References

- Ahola, K. & Hakanen, J. (2007). Job strain, burnout, and depressive symptoms: A prospective study among dentists. *Journal of Affective Disorders*, *104*, 103-110.
- Ayalon, L. (2007). Subjective socioeconomic status as a predictor of long-term care, staff burnout and positive caregiving experiences. *International Psychogeriatrics*. *20*(3) 521-537.
- Burns, N. & Grove, S.K. (2004). *The Practice of Nursing Research: Conduct, Critique, and Utilization (5th Ed.)*. St. Louis: Elsevier Saunders.
- Davey, M.M., Cumming, G., Newburn-Cook, C.V. & Lo, E.A. (2009). Predictors of nurse absenteeism in hospitals; A systematic review. *Journal of Nursing Management*, *17*(3) 312-30.
- Department of Disabilities and Special Needs Accessed January 27, 2009.
URL omitted to protect identity of research site, per their request.
- Department of Health and Human Services Center for Medicare & Medicaid Services: Certification & Compliance: Intermediate Care Facilities for the Mentally Retarded (ICFs/MR). Accessed January 27, 1009.
http://www.CMS.hhs.gov/certificationandcompliance/09_ICF/MRS.asp.
- Dunwoodie, D.A. & Auret, K. (2007). Psychological morbidity and burnout in palliative care doctors in Western Australia. *Internal Medicine Journal*, *37*, 693-698.
- Glasberg, A.L., Eriksson, S., & Norberg, A. (2007). Burnout and 'stress of conscience' among healthcare personnel. *Journal of Advanced Nursing* *57*(4), 392-403.
- Happell, B., Pinikahana, J., & Martin, T. (2003). Stress and Burnout in Forensic psychiatric nursing. *Stress and Health*, *19*, 63-68.
- Hasson, H. & Arnetz, J.E., (2007). Nursing staff competence, work strain, stress and satisfaction in elderly care: A comparison of home-based care and nursing homes. *Journal of Clinical Nursing*, *16*, 468-481.
- Hastings, R.P., Horn, S. & Mitchell, G. (2004). Burnout in direct care staff in intellectual disability services: A factor analytic study of the Maslach Burnout Inventory. *Journal of Intellectual Disabilities Research*, *48*, 268-273.

- Hewitt, A. & Larson S. (2007). The Direct Support Workforce in Community Supports to Individuals with Developmental Disabilities: Issues, Implications, and Promising Practices. *Mental Retardation and Developmental Disabilities Research Reviews*, 13, 178-187.
- Ito, H., Kurita, H., & Shiiya, J. (1999). Burnout among direct care staff members of facilities for persons with mental retardation in Japan. *Mental Retardation*, 37, 477 – 481.
- Kennedy, B. (2005). Stress and burnout of nursing staff working with geriatric clients in long-term care. *Journal of Nursing Scholarship*, 37(4), 381-382.
- Kohout, F.J., Berkman, L.F., Evans, D.A., & Cornoni – Huntly, J. (1993). Two Shorter Forms of the CES-D Depression Symptom Index. *Journal of Aging and Health*, 5, 179-193.
- Lawson, D.A. & O'Brien, R.M. (1994) Behavioral and self-report measures of staff burnout in developmental disabilities. *Journal of Organizational Behavior Management*, 14, 37-54.
- Maslach, C., Jackson, S.E., & Leiter, M.P., (1996). *Maslach burnout inventory manual* (pp. 1-17). Mountain View: CPP.
- McCarty, W., Zhao, J.S. & Garland, B.E. (2007). Occupational stress and burnout between male and female police officers: Are there any gender differences? *Policing an International Journal of Police Strategies & Management*, 30(4), 672-691.
- Montoro-Rodriguez, J., & Small, J.A. (2006). The role of conflict resolution style on nursing staff morale, burnout, and job satisfaction in long term care. *Journal of Aging and Health*, 18(3), 385-406.
- Moyle, W., Skinner, J. Rowe, G. & Gork, C. (2003). View of job satisfaction & dissatisfaction in Australian long-term care. *Journal of Clinical Nursing*, 12, 168-176.
- National survey by the association of public developmental disabilities administrators and the University of Minnesota of Public residential facilities and special units for persons with intellectual disabilities and related developmental disabilities (ID/DD)* (2008) [Tabular data]. Minneapolis, MN: National Residential Information Systems Project

- Parish, S. L. & Lutwick, Z. E. (2005). A critical analysis of the emerging crisis in long- term for people with developmental disabilities. *Social Work, 50*(4), 345-355.
- Rupert, P. & Morgan, D.J. (2005). Work setting and burnout among professional psychologists. *Professional Psychology: Research and Practice, (36)*5, 544-550.
- Skirrow, P. & Hatton, S. (2007). ‘Burnout’ amongst direct care workers in service of adults with intellectual disabilities: A systematic review of research findings & initial normative data. *Journal of Applied Research in Intellectual Disabilities, 20*, 131-144.
- Spinetta, J. J., Jankovic, M., Ben Arush, M.W., Eden, T., Epelman, C., Greenberg, M.L., et al. (2000). Guidelines for the recognition, prevention, and remediation of burnout in healthcare professionals participating in the care of children with cancer: Report of the SIOP working committee on psychosocial issues in pediatric oncology. *Medical and Pediatric Oncology, 35*, 122-125.
- Thøgersen-Ntoumani, C., Fox, K., and Ntoumanis, N., (2005). Relationships between exercise and three components of mental well-being in corporate employees. *Psychology of Sport and Exercise, 6*, 609-627.
- Tsai, P.F. (2003). A middle-range theory of caregiver stress. *Nursing Science Quarterly, 16*(2), 137-145.
- White, P. Edwards, N., and Townsend-White, C. (2006). Stress and burnout amongst professional careers of people with intellectual disabilities: Another health inequity. *Current Opinion in Psychiatry, 19*, 502-507.
- Zimmerman, S. Williams, C., Reed, P.S., Boustani, M., Preisser, J.S., Heck, E., et al. (2005). Attitudes, stress, and satisfaction of staff who care for residents with dementia. *The Gerontologist, 45*, 96-105.

Appendix A

INFORMED CONSENT DOCUMENT

Descriptive Study to Examine Burnout in an Intermediate Care Facility for the Mentally Retarded

You are being asked to participate in a research study to examine the level of burnout in direct care personnel working in an ICF/MR. Your participation in this study is requested because you work as a direct care staff in an ICF/MR ([REDACTED]). Your participation in this study is strictly voluntary. Please read this form and ask any questions you may have before agreeing to participate in this research study.

You must be 18 years of age or older and able to read, write and understand English. You must be considered a fulltime employee, working /37.5 hours or greater as a direct care staff .

Permanent employee working

Amanda Alisa Townsend RN, MS, FNP-C & Dr. Diana L. Morris RN, PhD are the researchers from Case Western Reserve University, are conducting this study.

Background Information

The purpose of this research is to examine burnout in direct care personnel in an intermediate care facility for the mentally retarded (ICF/MR). Burnout is a syndrome characterized by emotional exhaustion, depersonalization, and reduction in personal accomplishment. Specifically this syndrome affects those working in human services and occurs when the work demands are greater than the available resources (Hastings, Horn & Mitchell, 2004). The study will provided no direct benefits to the participants but the information gained from the study will be available to benefits direct care personnel and, in turn, the individuals they serve.

Procedures

If you agree to be a participant in this research, we would ask you to do the following things:

1. Keep a copy of the informed consent for your own records.
2. Complete the questionnaire using a pen to mark your answers. This takes most people 15 to 20 minutes to complete.
3. Return the completed questionnaire to the survey envelope and place in the sealed survey collection box provided

Risks and Benefits to Being in the Study

There are no foreseeable risks to taking part in this study.

There are no known direct benefits to participants for agreeing to take part in this study.

Compensation

You will receive no compensation or payment for taking part in this study.

Confidentiality

The records for this research will be kept private and confidential. We are not asking you to sign anything or place your name anywhere in order to further protect your confidentiality. Privately, you can look at the study information in the research packet and decide if you wish to volunteer to take part in the study. If you decide to participate in the study, complete and return the questionnaire. Taking part in this study or not taking part in this study will have no effect on your current or future standing with ██████████ Department of Disabilities and Special Needs (██████ DDSN); or your current or future standing with Case Western Reserve University. Each questionnaire was assigned an ID number at the time the research packets were put together.

Returned questionnaires will be kept in a locked file in Ms. Townsend's home. Ms. Townsend will have access to the questionnaires. Also, The University review board responsible for protecting human participants and regulatory agencies can access the study records. The questionnaires will be destroyed 3 years after the study ends. In any sort of report that might be published, no information that may make it possible to identify a participant will be included.

Voluntary Nature of the Study

Your participation is voluntary. You can choose to stop participation in the study at any time after you begin to answer the questionnaire. If you choose to participate or not to participate, it will not affect your current or future relations with the University or ████████ DDSN. There is no penalty or loss of benefits for not participating or for discontinuing your participation.

You will be provided with any significant new findings that develop during the course of the research that may make you decide that you want to stop participating.

Alternative to study Participation

The only alternative to taking part in the study is to not volunteer to take part in the study.

Contacts and Questions

The primary researcher conducting this study is Alisa Townsend RN, MS, FNP-C. You may ask any questions you have now. If you have any questions later, you may contact Ms Townsend at (████) █████-████ or ██████████

Please keep this consent form for your own records.

Statement of Consent

I have read the above information. I have received answers to the questions I have asked. I consent to participate in this research. I am at least 18 years of age.

By completing and returning the questionnaire to the research survey collection box, you will have given your consent to take part in this study.

Thank you for your time.

Appendix B

Please answer the following questions about yourself.	
Office Use Only	1. _____ Case ID#
<p>Directions: Please write in the answer to the questions in the space provided.</p> <p>2. What is your age in years?</p> <p style="text-align: center;">_____</p> <p style="text-align: center;">Yrs.</p>	
<p>Directions: Please circle the correct answer.</p> <p>3. What is your gender?</p> <p style="padding-left: 100px;">Male = 1</p> <p style="padding-left: 100px;">Female = 2</p> <p>4. What is your ethnic background?</p> <p style="padding-left: 100px;">Asian/Asian American 1</p> <p style="padding-left: 100px;">Black/African American 2</p> <p style="padding-left: 100px;">Latino/Hispanic/Mexican 3</p> <p style="padding-left: 100px;">Native American/American Indian 4</p> <p style="padding-left: 100px;">White/Caucasian 5</p> <p style="padding-left: 100px;">Other (please specify)</p> <p>_____</p>	

5. What is your marital status?

(Please **circle** the correct answer)

- | | |
|------------------------|-------|
| Single | 1 |
| Married | 2 |
| Divorced | 3 |
| Widowed | 4 |
| Other (please specify) | _____ |

6. What is the highest level of school you completed?

(Please **circle** the best answer)

- | | |
|--|-------|
| Completed high school/GED | 1 |
| Completed 2 years college (AA) | 2 |
| Completed four years of college (BS, BA) | 3 |
| Completed postgraduate work (MS, MA) | 4 |
| Other (please specify) | _____ |

7. What is the highest level of school you completed?

(Please **circle** the best answer)

- 1 Completed high school/GED
- 2 Completed 2 years college (AA)
- 3 Completed four years of college (BS, BA)
- 4 Completed postgraduate work (MS, MA)
- 5 Other (please specify)

Case ID #

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 professionals 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) in the space before the statement. If you have had this feeling, indicate *how often* you feel it by writing the number (from 1 to 6) that best describes how frequently you feel that way. An example is shown below.

Example

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

How Often

0-6

Statements:

1. _____ 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."



1055 Joaquin Road, 2nd Floor
Mountain View, CA 94043
800-624-1765 www.cpp.com

MBI-Human Services Survey Copyright 1986 by CPP, Inc. All rights reserved. This copyrighted publication is not offered for sale; it is for licensed use only, and this only by appropriately qualified professionals whose qualifications are on file with and have been accepted by CPP, Inc. CPP reserves all rights beyond the limited scope of this license, including, without limitation, all rights under U.S. and International copyright and trademark laws. No portion of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or means or by any means, electronic, mechanical, photocopying, recording, or otherwise, without the prior written permission of CPP. This copyrighted publication may not be resold, sublicensed, assigned, redistributed, otherwise transferred, or used in any manner by any party other than the person or entity to whom it is licensed for use by CPP; any violation of these restrictions may infringe CPP's copyright under 17 U.S.C. § 106(7), and any such violation shall automatically terminate any license to use this publication. The CPP logo is a registered trademark of CPP, Inc. Printed in the United States of America.

11 10 09 08 07 45 44 43 42 41 40 39 38 37

3463

Case ID #

MBI-Human Services Survey

The purpose of this survey is to discover how various people in the human services field feel about their work.

How often:	0	1	2	3	4	5	6
	Never	A few times a year or less	Once a month or less	A few times a month	Once a week	A few times a week	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.
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.

(Administrative use only)

EE: _____ cat. DP: _____ cat. PA: _____ cat.

Below is a list of ways you might have felt or behaved during the past week. Please circle the number that indicates how often during the past week you have felt this way.

How often.....	Rarely or none of the time (less than a day)	Some or little of the time (1-2 days)	Occasionally (3-4 days)	Most or all of the time (5-7 days)
a. Did you feel depressed?	1	2	3	4
b. Did you feel that everything you did was an effort?	1	2	3	4
c. Was your sleep restless?	1	2	3	4
d. Were you happy?	1	2	3	4
e. Did you feel lonely?	1	2	3	4
f. Were people unfriendly?	1	2	3	4
g. Did you enjoy life?	1	2	3	4
h. Did you feel sad?	1	2	3	4
i. Did you feel that people disliked you?	1	2	3	4
j. Could you not "get going"?	1	2	3	4

Case ID# _____

Now we would like to ask some questions related to your work in long term care.

Directions:

Please **write** or **circle** the correct answer.

1. How long have you worked at this facility?

Years _____ Months _____

2. How long have you worked with mentally disabled people?

Years _____ Months _____

3. How many days of work have you missed in the past year due to illness?

4. Do you participate in any stress reducing activities?

Yes = 1

No = 2

If yes, list what stress reduction activities you do:

5. Would you like to have a worksite programs developed to help decrease your stress level?

Yes = 1

No = 2

If yes, what type of programs would you take part on the worksite?

6. How much *stress* do you experience from your work role?

Place an X along the line that shows how much stress you have experienced.

Not at all _____ Extremely
Stressful _____ Stressful

7. On average, how many hours of overtime do you work during a month?

8. Do you work a second job?

1 = Yes

2 = No

9. If you work a second job on average, how many hours each week are you working in another job?



Growing the economy . . . one graduate at a time.

June 15, 2009

To: Alisa Townsend, RN, MS, FNP-C
Nurse Practitioner
● ● Center

From: Winfield Brown, Chairperson [redacted]
● ● Center Human Rights Committee

Re: RESEARCH PROPOSAL APPROVED

Mrs. Townsend, thank you for allowing the ● ● Center's Human Rights Committee to review your research proposal during our June 4, 2009 meeting.

You gave a very thorough and concise presentation and answered all of our questions. After discussion the HRC unanimously approves and endorses your proposal to assess burnout in direct care staff.

In accordance with DSN directives, we feel that you have insured that the rights and welfare of the participants are being protected.

Good luck as you move forward with your research

[REDACTED], Ph.D.
State Director
[REDACTED]
Associate State Director
Operations
[REDACTED]
Associate State Director
Policy



COMMISSION
[REDACTED] Chairman
[REDACTED]
[REDACTED] Vice Chairman
[REDACTED] MD, MBA, CPE
[REDACTED] Secretary
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

3440 Harden Street Ext [REDACTED]
PO Box 4706, [REDACTED]
V/TTY: [REDACTED]
Toll Free: 888/[REDACTED]
Website: [REDACTED]

MEMORANDUM

TO: Amanda "Alisa" Townsend, RN, MS, FNP-C - [REDACTED] Center
FROM: Dr. Kathi Lacy, Associate State Director-Policy [REDACTED]
RE: Your request to conduct research study at [REDACTED] Center
DATE: August 25, 2009

The [REDACTED] Research Committee met last week to review your proposal to conduct a research study at [REDACTED] Center. The study will determine if full-time direct care personnel working at [REDACTED] Center experience burnout and work stress. The study is being conducted in concert with Case Western Reserve as a degree requirement for Doctor of Nursing Practice.

You have met all requirements including, IRB approval and approval by the [REDACTED] Center Human Rights Committee. This includes the inclusion of the CES-D 10 short form to screen for depression and the addition of six questions to the survey.

After careful review, the Committee has approved your research proposal. The Committee is hopeful that if you do determine there is burnout and stress experienced by direct care personnel, that [REDACTED] Center would develop some modest interventions to help prevent or reduce work stress and burnout.

The best of luck to you.

cc: Mr. Ed Hickey, Facility Administrator [REDACTED] Center

P.O. Box 739 [REDACTED] Phone: [REDACTED]
Phone: [REDACTED]
DISTRICT I [REDACTED] Phone: [REDACTED]
[REDACTED] Phone: [REDACTED]
[REDACTED] Phone: [REDACTED]
DISTRICT II [REDACTED] Phone: [REDACTED]
[REDACTED] Phone: [REDACTED]
Sales/Center - Phone: [REDACTED]

Appendix E

MBI-HSS Burnout studies subscale frequency and percentages.

Emotional exhaustion		
Valid responses	Frequency	Percent
0	1	1.8
1	1	1.8
3	2	3.6
4	2	3.6
5	3	5.4
8	1	1.8
9	2	3.6
12	2	3.6
14	2	3.6
17	1	1.8
19	1	1.8
21	1	1.8
22	3	5.4
23	1	1.8
25	2	3.6
26	3	5.4
27	3	5.4
28	1	1.8
29	1	1.8
30	1	1.8
32	3	5.4
33	2	3.6
35	2	3.6
36	3	5.4
39	1	1.8
40	2	3.6
41	1	1.8
42	4	7.1
45	1	1.8
47	1	1.8
54	2	3.6
Total	56	100.0

Depersonalization		
Valid Responses	Frequency	Percent
0	9	16.1
1	2	3.6
2	1	1.8
3	5	8.9
4	3	5.4
5	1	1.8
6	5	8.9
7	2	3.6
8	2	3.6
9	3	5.4
10	1	1.8
11	2	3.6
12	4	7.1
13	2	3.6
16	5	8.9
17	1	1.8
18	3	5.4
20	1	1.8
22	1	1.8
25	1	1.8
30	2	3.6
Total	56	100.0

Personal Accomplishment

Valid Responses	Frequency	Percent
9	2	3.6
13	1	1.8
21	3	5.4
23	1	1.8
25	2	3.6
27	2	3.6
28	2	3.6
29	3	5.4
30	2	3.6
31	3	5.4
32	4	7.1
33	2	3.6
34	1	1.8
35	4	7.1
36	5	8.9
37	3	5.4
38	2	3.6
39	1	1.8
40	7	12.5
42	2	3.6
43	1	1.8
47	1	1.8
48	2	3.6
Total	56	100.0

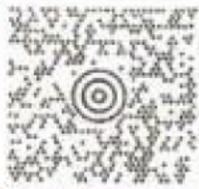
2 LBS

1 OF 1

SHIP TO:

DDSN

[Redacted address lines]

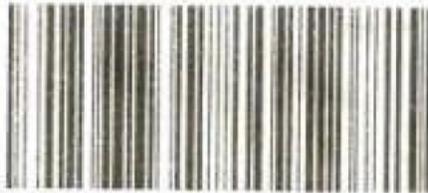


295 0-02



UPS GROUND

TRACKING #: 1Z [Redacted] 4840



BILLING: P/P

REF 1:881074

US 10 2 20 1P054 64 0R 10-2009

UPS is a registered trademark of United Parceles of America, Inc. © 2009 United Parceles of America, Inc. All rights reserved. UPS, the UPS logo, and the color brown are trademarks of United Parceles of America, Inc. in the United States and other countries. UPS, the UPS logo, and the color brown are registered trademarks of United Parceles of America, Inc. in the United States and other countries. UPS, the UPS logo, and the color brown are registered trademarks of United Parceles of America, Inc. in the United States and other countries.

UPS Inc.
1001 Avenue Road, 2nd Floor
Mountain View, CA 94035

SHIP TO
DELIVER TO
DDSN
[Redacted]
United States of America
Country: USA
City: [Redacted]
881074 26

