

DISSERTATION

COMBATING EMPLOYEE BURNOUT IN LONG-TERM CARE

Submitted by

Katherine Ferrara

School of Education

In partial fulfillment of the requirements

For the Degree of Doctor of Philosophy

Colorado State University

Fort Collins, Colorado

Spring 2013

Doctoral Committee:

Advisor: George Morgan

Co-Advisor: Vicky Buchan

Louise Quijano

Leann Kaiser

ABSTRACT

COMBATING EMPLOYEE BURNOUT IN LONG-TERM CARE

Employee burnout in long-term care is a growing concern due to the changing demographics of individuals admitted to nursing homes in the United States. There is an increase in the number of admissions to nursing homes that include residents with dementia or some form of major mental illness. In addition to having some form of mental disorder, over half of these individuals also have some type of challenging behavior such as verbal or physical aggression. In spite of these changing demographics, there is a lack of adequate training for staff in these settings to care for this population. Lack of training and poor stress management coping skills can contribute to burnout. Burnout can have detrimental effects on the organization, the individual and the residents served in nursing homes.

An eight session skills based intervention derived from the Cognitive-Behavioral therapeutic foundation was designed to educate employees on stress management skills and skills to effectively manage challenging resident behaviors. The skills based intervention was implemented in eight sessions to three different nursing homes that had a minimum of a 40% resident population with some form of mental disorder as a diagnosis. This study used a pretest/posttest comparison group design. Change scores on the data collection instruments were analyzed to determine the effect of the intervention on employee level of burnout as well as level of knowledge of behavior management techniques, for the intervention group only.

Results indicated no statistically significant difference between the experimental and comparison group on change scores pertaining to level of burnout. There was, however, a significant gain in knowledge of behavior management techniques from pre to post intervention.

Other constructs measured that are considered characteristics of burnout included tardiness and absenteeism. There was significant decrease in frequency of absenteeism comparing pre to post intervention in the experimental group. There was no significant change from pre to post intervention in the area of tardiness. A participant evaluation was administered to experimental group participants. Results of a participant evaluation indicated participants had a positive experience with the intervention. Participants felt an increase in level of support from co-workers and increase of knowledge on how to effectively care for residents with challenging behaviors.

The length of time of the intervention may have been too short to achieve the desired results of a significant decrease of level of burnout from pre to post intervention. Evaluations revealed the majority of participants would have liked more time for the intervention. Also, vicarious trauma was not a consideration for the development of the intervention or as a contributing factor to burnout in the participants of this study. The majority of participants in the experimental group were classified as non-direct care staff, included members of the activities, social services and business office.

It is recommended to include vicarious trauma as a contributing factor of burnout and to include interventions to combat vicarious trauma in future studies. It is further recommended for future studies to have the length of time of the intervention increased to greater than eight sessions. A final recommendation would be to limit participants to both the experimental and comparison groups to those who are classified as direct care staff.

TABLE OF CONTENTS

ABSTRACT	ii
LIST OF TABLES	vii
CHAPTER 1: INTRODUCTION	1
Conceptual Underpinnings for the Study	3
History of Concept of Burnout	5
Statement of the Problem	7
Study Significance	8
Purpose of the Study	9
Research Questions	9
Study Limitations	10
Researchers Perspective	11
CHAPTER TWO: LITERATURE REVIEW	13
Burnout	13
Definitions	13
History of Burnout Research	14
Features of Burnout	17
Contributing Factors	18
Burnout in Long-term Care	20
Interventions for Burnout	22
Participatory Action Research	23
Mindfulness Meditation	26
Clinical Supervision	27

Peer Support Group.....	28
Individuating Life History	29
Skills Based Training.....	31
Research Questions.....	34
Theoretical Framework and Intervention for this Study.....	36
Conclusion	41
CHAPTER THREE: METHODS	43
Research Questions and Hypotheses	43
Methodological Strategy.....	46
Design	46
Efficacy of Proposed Methodology to Address the Research Questions	46
Procedure and Description of the Intervention	47
Reliability and Validity of the Study	50
Setting.....	51
Sampling and Assignment to Groups	51
Instruments.....	53
Data Analysis	55
Background.....	55
Data Analysis Method.....	57
Method to Represent and Summarize Data Collected	58
Summary	59
CHAPTER 4: RESULTS	60
Descriptive Analysis	60

Descriptive Characteristics of Study Sites	60
Descriptive Characteristics of Respondents.....	61
Reliability.....	64
Analysis of the Research Questions.....	65
Research Question 1	65
Research Question 2	66
Research Question 3	66
Participant Evaluations	67
Summary.....	69
CHAPTER FIVE: DISCUSSION.....	71
Major Findings.....	73
Discussion.....	75
Conclusions.....	81
Recommendations.....	81
REFERENCES	84
APPENDIX ONE: INTERVENTION	90
APPENDIX TWO: PROFESSIONAL QUALITY OF LIFE SCALE	100
APPENDIX THREE: KNOWLEDGE OF BEHAVIOR MANAGEMENT QUESTIONNAIRE	104
APPENDIX FOUR: PARTICIPANT EVALUATION	116
APPENDIX FIVE: PARTICIPANT DEMOGRAPHICS	118
APPENDIX SIX: PROCESS LOGIC MODEL	120

LIST OF TABLES

Table 1. Burnout Etiology and Interventions.....35

Table 2. Number of Residents with Mental Disorders at Each Site61

Table 3. Group Characteristics62

Table 4. Comparison of Between Groups Change Scores on the ProQOL Instrument.....65

Table 5. Pre to Posttest Change in the Experimental Group Knowledge Test Scores
on the ProQOL Instrument.....66

Table 6. Participant Evaluation Response Themes.....68

CHAPTER 1: INTRODUCTION

The phenomenon of employee burnout in the healthcare industry is gaining more attention in research and in organizational development and improvement, not only in the United States, but in Europe and Canada as well. The potential losses due to burnout in the health care industry for employers and employees are extensive. Losses at the employer level include high staff turnover rate, extended sick leave and an increase in worker's compensation claims. Employees may suffer stress related medical ailments such as high blood pressure or gastrointestinal ailments, (e.g., GERD or ulcers), and psychological effects such as depression or anxiety related disorders.

Clients are also at risk for suffering as a result of staff burnout. The clients may experience a decrease in quality of care and increased potential for abuse. Kennedy (2005) studied the effects of staff burnout on residents in nursing homes and found a positive correlation between job stress and the employee's ability to perform essential job tasks. Results in Kennedy's (2005) study also concluded that prolonged job stress negatively impacts the quality of life for the residents.

There are many possible factors contributing to burnout which include: lack of control over influencing decisions directly related to the job; unclear job expectations; dysfunctional workplace dynamics, (i.e., a boss who is a micromanager); mismatch of values; poor job fit; and extreme activities such as overwhelming job responsibilities or having tasks that are monotonous, (Mayo Clinic, 2006). Jackson (1999) found a positive correlation between staff burnout and working in a setting where clients engage in aggressive behaviors, such as yelling and hitting. Ekstedt (2003) found that staff with poor coping skills who are feeling overwhelmed

are at a greater risk to become burned out than staff with effective stress management coping skills.

My study focused on employee burnout in nursing home settings. Employees recruited for participation were those who have direct contact with residents and included, but were not limited to, licensed nursing staff, certified nursing assistants, social workers, activities staff, dietary staff and housekeeping staff. A nursing home is defined as a skilled nursing facility that provides 24 hour care to individuals who do not require hospital level of care and who are unable to be cared for in their homes (Sahyoun, Pratt, Lentzner, Dey & Robinson, 2001).

In addition to some form of physical disability it is common for persons admitted to nursing homes to also have some form of mental disorder. Approximately 50-70% of persons admitted to nursing homes have Dementia (Healthinaging.org, 2012). Berry (2012) found challenging behaviors, to include aggression, are exhibited by over 50% of individuals with a Dementia diagnosis. The Sanford Center for the Aging (2008) postulates that over 50% of residents with Dementia exhibit challenging behaviors that include wandering, yelling out and aggression to include physical and verbal forms.

It is also common for the nursing home to admit individuals with some form of serious mental illness such as depression, anxiety or schizophrenia. Serious mental illness is defined as, “Individuals, 18 years of age and older, who have a severe and/or persistent mental or emotional disorder that seriously impairs their functioning relative to such primary aspects of daily living as personal relations, living arrangements, or employment” (Virginia State government, 1990). Grabowski, Aschbrenner, Feng and Mor (2009) discovered there are approximately 500,000 residents with serious mental illness, not including Dementia, living in nursing homes across the

United States. This number is greater than that of individuals residing in all other types of healthcare institutions combined, such as a psychiatric hospital setting (Grabowski, et al., 2009).

There is a positive correlation between residents with serious mental illness and challenging behaviors. McCarthy, Blow and Kales (2004) estimate approximately 68% of individuals with serious mental illness residing in nursing homes exhibit some form of challenging behavior. Challenging behaviors include verbal and/or physical aggression, wandering or socially intrusive behaviors.

Conceptual Underpinnings for the Study

Inadequate staff training to care for residents with challenging behaviors has been determined to be a problem that has the potential to lead to employee burnout. Molinari et al., (2008) surveyed 206 nursing home staff that cared for individuals with mental illness. Results indicated that 25% of those surveyed believed nursing homes were an inappropriate place to care for individuals with serious mental illness. Two-thirds of the participants reported difficulty in caring for this population. In addition, participants indicated a need for training for those who work in a nursing home setting. The differences between those trained compared to those untrained in the area of mental health were obvious. For example, those who received adequate training saw these clients as unique individuals as opposed to grouping them according to their diagnosis. Trained employees were able to develop creative solutions to manage challenging behaviors that may arise as a result of the mental illness. Untrained staff was prone to becoming frustrated and experienced frequent barriers as to how to effectively care for these clients.

In addition to inadequate training to care for the residents with serious mental illness there exists a lack of training for staff to care for residents with a primary diagnosis of Dementia. Research demonstrates a correlation between the deficit in staff training and a negative impact on

resident's quality of life. It has not been a priority with policy makers to mandate standardized training for staff in this setting. Corporations who own and operate nursing homes have not been willing to provide fiscal support to improve staff training (Maas, Specht, Buckwalter, Gittler & Becheni, 2008).

A surprising and somewhat disturbing result regarding the effects of burnout on nursing home residents is the connection between staff burnout and resident abuse. The World Health Organization (2010) defines elder abuse as, "a single, or repeated act, or lack of appropriate action occurring within any relationship where there is an expectation of trust which causes harm or distrust to an older person" (http://www.who.int/ageing/projects/elder_abuse/en/). One study of 577 randomly selected nurses in nursing homes found 36% of staff had witnessed abuse and 10% of staff admitted to committing an abusive act on a resident (Shinan-Altman & Cohen, 2009). These researchers hypothesized that staff experiencing burnout were more prone to have an attitude of acceptance towards elder abuse.

Shinan-Altman and Cohen (2009) theorized that types of staff most likely to commit or condone resident abuse were the Certified Nursing Assistant's (C.N.A). Reasons for this include the following: CNAs have the most contact with the residents; are the least educated; receive the lowest pay; and have the least authority in the decision-making process occurring within the nursing home. The instruments used in this study included: (a) the Maslach Burnout Inventory (MBI) to measure level of burnout; (b) the work-stressors questionnaire to measure quantity of work stressors; (c) the perceived control questionnaire which measures employees perception about how much control they have in their environment with regards to the decision-making process; and (d) attitudes towards elder abuse questionnaire, developed for their study. The attitude towards elder abuse questionnaire consisted of 7 vignettes asking participants to identify

the most appropriate action to take with regards to situations described. All forms of abuse were represented in the vignettes to include the following: physical, sexual, psychological, financial exploitation, neglect and violation of resident's rights. Shinan-Altman and Cohen (2009) found a statistically significant positive correlation between burnout and work related stress and attitudes condoning resident abuse. The researchers concluded that work stressors increase development of burnout which leads to increase in attitude condoning elder abuse.

Burnout produces multiple negative outcomes not only on the individual level, but on the organizational and client level, as well. The individual's physical and mental well-being is affected. Organizations suffer financial losses resulting from high staff turnover and frequent absenteeism and tardiness of employees. Residents entrusted in the care of employees experiencing burnout are at higher risk to suffer abuse and can expect diminished quality of care.

History of Concept of Burnout

Burnout is a term coined by Herbert Freudenberger in 1973. Freudenberger was a psychologist working in New York with the "free clinic movement" (Freudenberger, 1989, p. 1). The free clinic movement was an alternative health care model developed in the 1960's to serve young adults who were anti-government. Practitioners were from multi-disciplinary backgrounds and included doctors, nurses, social workers and psychologists. They were either paid employees or volunteers (Freudenberger, 1989).

Freudenberger (1989) stated professionals were drawn to the free clinic with the idyllic belief they were going to change the world. This somewhat irrational belief is what Freudenberger partially attributes to the development of burnout. Freudenberger defined burnout as, "a state of fatigue or frustration brought about by devotion to a cause, way of life, or relationship that has failed to produce the expected reward" (1989, p. 12). Freudenberger (1974)

stated people who are most prone to burning out are those who are the most “dedicated and committed to their positions, have poor work boundaries and who have an over excessive need to give” (p. 161).

Freudenberger believed this was a phenomenon that occurred one year into practice in free clinics. Cherniss (1980) concurred with Freudenberger regarding the time frame of the development of burnout. Cherniss found burnout to commonly occur in employees new to the profession. Within one year, the ideals which drew them into the profession were directly challenged by their actual experience.

With regard to interventions that combat burnout, several recommendations have been made. In earlier times, Freudenberger (1974) recommended strategies such as taking time off from work. Freudenberger (1989) also recommended breaking up the monotony of the usual day to day work routine such as taking on administrative duties to reduce client contact time which, in turn, reduces burnout. Offering employees continuing education, giving lots of support and increasing use of volunteers to deplete patient demands, were other suggestions made by Freudenberger (1974).

In contrast, Maslach (1976) believed burnout to be related to social and situational factors as opposed to individual factors. Techniques including development of a social support system and preparing professionals while still in the educational setting would help ward off this syndrome. Current research has recommended interventions such as creating a more balanced job effort and reward system increasing social support and clarifying roles to ward off burnout (Lavoie-Tremblay, et al., 2004; Munn-Giddings, Hart & Ramon, 2005).

Fusilier and Manning (2005) maintain the presence of a social support system at work and effective coping skills to manage stress will reduce the strain often imposed by stress.

Endicott (2006) supports the belief that excessive stress can accelerate burnout. Providing resources to combat stress will reduce the likelihood of burnout occurring.

Freudenberger (1989) provided many suggestions to future researchers on burnout that remain relevant today. Freudenberger recommended researchers move away from focusing primarily on the individual experiencing burnout and consider organizational factors which may contribute to this phenomenon. Freudenberger suggests we consider this phenomenon in terms of “organizational burnout” not solely as “individual burnout” (p. 5). This is aligned with what Munn-Giddings, et al. (2005) found in their research. Supervisors have to be involved with burnout interventions to alter the culture of the agency. Absent this condition it is unreasonable to assume that burnout can be fully resolved.

Statement of the Problem

Studies on burnout in the health care industry have been conducted primarily in the hospital setting. “Little is known about burnout in long-term care facilities,” (Ross, et al., 2002, p. 132). My study focused on burnout in the long-term care setting, specifically in nursing homes. Medline Plus (2012) defines a nursing home as, “A place for people who don't need to be in a hospital but can't be cared for at home. Most nursing homes have nursing aides and skilled nurses on hand 24 hours a day” (p.1).

Change in the demographics of residents in the US nursing homes has created a need for employees of these agencies to be equipped with proper knowledge regarding how to effectively care for this population. Lack of proper training affects resident quality of life and can contribute to burnout. Sprang, Whitt-Woosley and Clark (2007) found specialized training can reduce the level of burnout. Molinari, et al. (2008) states specialized training to work with the mentally ill population will increase the comfort level of staff who works with this population. Ideally, staff

should be provided with training for all psychiatric symptoms and effective techniques to manage disruptive behavior which is prevalent among individuals with mental illness. In addition, training should be ongoing (Molinari, et al., 2008).

Study Significance

My study focused on healthcare employees, specifically in long-term care settings, who work with individuals with some form of serious mental illness and Dementia. I incorporated an intervention strategy designed to target key factors that contribute to burnout, as found in the literature. I provided a necessary contribution to the long-term care industry by addressing a significant concern that is likely to persist. The outcome of my study will be a tool for long-term care organizations to use to combat employee burnout. After employers and employees agreed to participate, the intervention was implemented and at low cost to the organization.

According to the 2004 National Nursing Home survey 67% of residents living in nursing homes have some form of mental disorder (cdc.gov, 2011). The University of Nevada at Reno Sanford Center for the Aging estimates the prevalence of challenging behaviors, such as verbal and physical aggression, among residents with a psychiatric disorder is 50% (University of Nevada, Reno Sanford Center for the Aging, 2008). Inadequate resources such as training to care for this population increase the risk for staff to develop burnout (Jackson, Templeton, & White, 1999). Burnout has the potential to adversely affect quality of resident care. This study tested the effectiveness of a skills based intervention technique. This intervention was believed to have practical significance as it is easy to implement and low cost to the facility. In addition, this study contributed empirical knowledge to the field of social work, fulfilling this researcher's ethical responsibility under the NASW Code of Ethics.

Purpose of the Study

The purpose of this study was to determine the effectiveness of a skills based intervention in reducing burnout in long-term care employees who work with individuals with serious mental illness and dementia. Educating employees on effective techniques to work with a difficult population will help the long-term care organizations feel comfortable in continuing their practice of caring for individuals with a serious mental illness or dementia. The continued growth of admissions to nursing homes with individuals with some form of mental disorder creates a need to the build skills of employees in order to create a greater quality of life and safety for the residents.

Research Questions

There were five research questions to guide my study. The first question focused on whether or not the intervention was successful in decreasing the level of employee burnout in the experimental group. Research question #1 consisted of: (a) Was there a difference in the change of level of burnout from pre to posttest between the experimental and the control group? (b) Was there a change in the level of burnout form participants in the experimental group comparing pre and posttest?

The second question addressed knowledge acquired by the experimental group in skills related to use of effective behavior management techniques to reduce challenging behaviors in the residents. Research question #2 was: Was there a change in the level of knowledge about effective behavior management techniques among participants in the experimental group comparing pre and posttest?

The third research question addressed behaviors associated with burnout specifically addressing employee rates of tardiness and absenteeism. Research question #3 was: (a) Was

there a difference in the change from pre to posttest in the frequency of absenteeism and of tardiness between the experimental and control group? (b) Was there a difference in the frequency of absenteeism and tardiness in the experimental group from before to after the weekly skills based intervention?

The fourth research question addressed potential impact on the residents of burnout in their caregivers. Research question #4 was: Was there a difference in the change of frequency of staff to resident abuse occurrences between the experimental group and the control group from before to after a weekly skills based intervention?

The fifth research question focused on potential impact on the residents with challenging behaviors from caregivers who lack adequate training and skills to care for them. Research question #5 was: Was there a difference in the frequency of resident psychiatric hospitalizations between the residents in the care of the experimental group and residents in the care of the control group from before to after a weekly skills based intervention?

Study Limitations

This study was conducted in 3 separate long-term care facilities. In all of the facilities there was a minimum of 30% resident population with some form of mental disorder including either serious mental illness or dementia. Due to scheduling conflicts and the time commitment involved to participate in this study there was difficulty with obtaining desired sample sizes for both the experimental and comparison group. In addition, each facility had undergone budget cuts. It was difficult for the facility to spare staff to participate in the study and pay them for their time. Originally this researcher had hoped for at least 30 participants of each group. After the conclusion of the study there were a total of 22 participants for the experimental group and 9 for the wait listed comparison group.

Staff members in long-term care facilities were hesitant to admit problems with their jobs out of fear of retribution from their supervisors. To reduce the problem, this researcher requested the Nursing Home Administrator in each of the different facilities to speak to their employees about the study, to provide support for their participation. Information obtained during the study was kept confidential to enable participants to have a sense of security with their employment position.

The setting for my study was the natural work environment of the participants. Because it is not a controlled setting, there was a threat to the internal validity of this study. Another limitation to my study was generalizability due to the purposive sampling method. This study was a pretest/posttest comparison group design. This was not a randomized design therefore internal validity was reduced.

Researchers Perspective

With 13 years in the health care industry, 8 specific to the long-term care setting, I have had first-hand experience with burnout. Close to 5 years ago, in the facility in which I was formerly employed, there was an incident involving a staff member verbally abusing a resident. During an investigation, the employee disclosed that she had been feeling unsupported from her co-workers and felt a diminished sense of confidence in her delivery of services to clients. That employee had even gone to her supervisor requesting time off due to feeling exhausted and overwhelmed. The employee admitted to the allegation of abuse.

After the incident, that employee was granted permission to return to work pending her compliance with a corrective action plan. This plan included apologizing to the resident and participation in weekly peer support group to help combat burnout. I was tasked with the responsibility of establishing and facilitating the weekly peer support group. The experience was

both rewarding and eye opening. I learned just how prevalent burnout was among the employees. From that time it has been a personal interest of mine to develop an intervention that would successfully combat burnout in employees in long-term care who work with individuals with mental illness. This in turn would place staff in the position to provide the highest quality of care to the residents.

The choice of focus for the intervention was derived from this experience. The staff member who perpetrated the abuse against the resident felt she lacked adequate support as well as feeling inept to cope with work related stress. The deficiency in confidence in her ability to care for the population was an indicator of the need for training. I wanted to target work related stress management coping skills as well as effective behavior management coping skills. I believed these would be two areas that could positively impact employees experiencing burnout.

CHAPTER TWO: LITERATURE REVIEW

Individuals who work in long-term care facilities make up a variety of professional disciplines including: nursing, social work, business office personnel, dietary and housekeeping staff, to name a few. Disciplines that have direct contact with the residents, such as nursing staff and social services staff, are considered caregivers. Kartman (1983) stated empathy is an ideal trait for a caregiver. A person high in empathy is, “someone who has the ability to place himself in another’s position and feel what the patient feels with appreciative perception and understanding” (p. 52). The very thing that is inherent in good care providers is the same that can be detrimental in becoming burned out on the job. Particularly vulnerable are those employees who do not have good boundaries in balancing their needs with the needs of the clients (Kartman, 1983). This section will examine burnout including: (a) definitions; (b) features; (c) contributing factors; (d) burnout in relation to long-term care employees; (e) and interventions. The theoretical foundation of this study as well as the proposed intervention will be introduced and discussed.

Burnout

Definitions

Perhaps one of the most commonly used definitions of burnout comes from Maslach and Jackson (1981) who state, “Burnout is a syndrome of emotional exhaustion and cynicism that occurs frequently among individuals who do ‘people-work’ of some kind” (p. 99). Pines and Aronson (1988) defined burnout as, “a state of physical, emotional, and mental exhaustion caused by long-term involvement in emotionally demanding situations” (p. 9). In spite of the different definitions there is perhaps one agreed upon component of burnout which is emotional exhaustion (Cox, Tisserand, & Taris, 2005).

History of Burnout Research

Christina Maslach is a well-known researcher of the subject of burnout. Maslach and Jackson (1981) believed burnout to be prominent in the human services field. There are several features unique to this industry which creates circumstances conducive to the development of burnout. Employees in the human services field often work with individuals experiencing strong negative emotions such as anger, fear and despair. Answers to their complicated troubles are not so clear. The ambiguity leads to frustration in the workers. The workers experience a diminished sense of personal accomplishment and ability to perform essential work tasks. These dynamics are what contribute to the development of burnout.

Maslach and Jackson's (1981) study was exploratory in nature. Participants were selected based on their identifying feelings of burnout. They were interviewed, given questionnaires to complete and observed for the purpose of identifying common characteristics of individuals experiencing burnout. The three essential features of burnout identified were: emotional exhaustion, negative attitude towards others and lack of personal accomplishment. Maslach and Jackson's 1981 study resulted in the development of the Maslach Burnout Inventory (MBI). This instrument has sustained time. The MBI remains one of the most frequently used instruments to measure burnout in studies conducted in present times.

Since its genesis, burnout has had many different definitions and beliefs in terms of causes, characteristics, and treatment interventions. There have been over 5500 studies and books published on the subject (Borritz, 2005). Borritz states that early research between the 1970's through the late 1980's focused primarily on the causes of burnout. The research during this time was more observationally based and less founded in theory. For example, Wessells (1989) identified causes of burnout to include: (a) professionals who measure job success in

terms of outcome as opposed to the process; (b) place unrealistic expectations on oneself to be in control of variables beyond one's control, such as other people's emotions; (c) and transfer stress to a third party as opposed to dealing directly with the source. These features are closely aligned to Maslach and Jackson's findings. To summarize empirical literature produced during this time period indicated burnout was believed to be a work-related condition resulting from individual and interpersonal factors augmented by emotional demands and organizational factors.

During the late 1980s through the end of the 1990s there were over 1000 studies published on burnout (Borritz, 2005). These studies were primarily cross-sectional in design. This moved away from the attempts to determine causal factors of burnout into studying common attributes associated with the experience of burnout (Borritz, 2005).

Schaufeli and Peeters (2000) reviewed literature of burnout conducted through 1999. This literature review identified three different types of stressors associated with the experience of burnout. The stressor types were identified as physiological stressors, psychological stressors, and behavioral stressors. Physiological stressors refer to somatic symptoms such as headaches, heart palpitations, difficulty breathing, and high blood pressure. Psychological stressors refer to a decrease in job satisfaction, and an increase in symptoms such as anxiety and depression. Behavioral stressors refer to behaviors such as absenteeism from work, high staff turnover, and use of drugs and alcohol as coping mechanisms.

More recently, Endicott (2006) cited similar characteristics regarding mood indicators of burnout that include anger, cynicism, depression and anger. In addition, Endicott found individuals exhibiting behaviors such as absenteeism and excessive use of substances such as alcohol were exhibited when experiencing burnout. Based on these researchers it is evident that beliefs regarding the experience of burnout have remained stable and consistent over time.

Recent research has been longitudinally based in design and has continued the focus on the experience of burnout as identified by the individual. Borritz (2006) conducted a literature review on burnout research during this most recent time period of the late 1990s to the present. Borritz included 13 studies that had greater than 1 year follow-up period, a response rate of over 50% or participants that included diversity in occupational classification. Conclusions from these studies indicated dynamics such as having an overwhelming caseload, high levels of emotional demand, loss of sense control within one's position and diminished sense of support as primary factors that lead to emotional exhaustion. Emotional exhaustion is the one component that professionals agree upon as the prominent feature of burnout in the literature.

Borritz states the current belief reflected in the research regarding the nature of burnout is that it is a "complex phenomenon with multi-factorial causation" (p. 10). Burnout is a result of chronic exposure to negative stressors causing stress reactions in individuals. Present day research is more centered around causes of burnout with less focus on its consequences. This may be an attempt to identify and implement preventative measures to deter burnout.

Burnout research has greatly contributed to the human services field. Professionals now feel they are able to openly discuss their experiences. Support groups, workshops and seminars are appearing to address relief from burnout. Businesses are realizing it is in their best interest to establish wellness programs to deter the financial impacts of burnout. Employees are feeling more comfortable in admitting feelings of exhaustion and frustration. Seeking help for burnout is a positive move and promotes professional growth (Freudenberger, 1989).

There are still accomplishments yet to be made. Freudenberger (1989) encouraged researchers to focus more on quantitative based research methodology to study burnout. He encouraged use of quantitative instruments, such as the Maslach Burnout Inventory (MBI) to

help measure features of burnout objectively. Freudenberger (1989) believed the MBI could be used both within and outside the human services profession. Individual coping strategies to manage stress should be included as well as differences in burnout experience between men and women. Political factors contributing to burnout should be taken into consideration, such as lack of funding from the federal government can increase caseloads. If this is the case then interventions at the political level need to be included in order to address burnout at its source. Finally, preventative strategies should be a central focus (Freudenberger, 1989).

Features of Burnout

Burnout includes many different symptoms. Benson and Magraith (2005) cite depression, cynicism, boredom, loss of compassion and discouragement among the symptoms. Maslach and Jackson (1981) mention emotional exhaustion, lack of personal accomplishment and depersonalization as major dynamics involved with burnout. Emotional exhaustion is defined as, “feelings of being emotionally extended and exhausted by one’s work,” (Densten, 2001, p. 834). Lack of personal accomplishment is defined as, “lack of feelings regarding both job competence and achievement in one’s work” (Densten, 2001, p. 834).

Ekstedt and Fagerbeg (2003) used a phenomenological approach to examine the lived experience of the time preceding burnout. The participant criterion in this study were high burnout scores as determined by the Shirom-Melamed Burnout Questionnaire (SMBQ), met DSM-IV criteria for Unspecified Maladjustment Disorder, and had taken more than three months of sick leave from work. Interviews were conducted in a stress clinic and lasted for a period of 45-90 minutes. These interviews were tape recorded and transcribed verbatim. No information was provided regarding job descriptions or places of employment for any of the participants.

There were 5 themes revealed from the interviews which included: lack of inner incentive; feeling responsible; threatened self-image; reaching the bottom line; and cutting off. Physiological symptoms were also described. These symptoms included: pain; frequent infection; sleep impairment; emotional instability; memory deficit; loss of performance; impaired cognition; and overwhelming fatigue.

Though data derived from the results was rich, generalizability was compromised due to the sample size of six. The lack of description of employment tasks and environments for each of the participants was another limitation. Different jobs create unique dynamics to cultivate burnout. Healthcare employees often have high levels of burnout (Collins & Long, 2003). There are burnout indicators, such as low morale and absenteeism, which are common to most work settings (Collins & Long, 2003). However, specifically studying burnout in healthcare employees may yield different results from added dynamics such as caring for others.

Contributing Factors

Burnout can affect anyone and carries with it several consequences. Freudenberger (1974) states it's the "dedicated and committed" who are most prone to burnout (p. 159). There are several unique factors to the health care industry that increase the likelihood of an employee to experience burnout. Benson and Magraith (2005) cite "professional isolation, working with a difficult client population, working long hours with limited resources, unable to define success, unreciprocated giving, and failing to live up to one's expectations" (p. 497).

Smith, Davey and Everly (2006) believe burnout results from overlong exposure to one or more negative stressors. Shirom (2005) names work related characteristics and the dynamics of one's personal environment as causes of burnout. Other factors include: (a) workload; (b) lack of effective leadership/management; (c) the price of caring; (d) high responsibilities with

relatively low involvement in the decision-making process; (e) shift work; (f) lack of rewards; (g) and working short staffed (Ekstedt & Fagerberg, 2005).

Barber and Iwai (1996) conducted a study to determine which factors could be pinpointed as having the most profound impact on the development of burnout. Using a sample size of 75 long-term care employees who were involved in the direct care of residents, Barber and Iwai (1996) hypothesized that the work environment, which included role conflict and role ambiguity, would be the best predictors of burnout. Included in the sample were nurses, certified nurse's assistants (CNA), and social workers all employed in long-term care facilities caring for residents with a diagnosis of Alzheimer's and other forms of Dementia. In addition to examining the work environment the researchers studied staff characteristics, workload and caregiver involvement and their impact on staff experience of burnout.

The definition of role conflict stems from Role theory. Role conflict results from inconsistencies of expectations placed on an employee. Role conflict results in increased stress, dissatisfaction with one's role in the agency and decrease in work performance. Role ambiguity is a concept founded in Classical Organization theory and Role theory. Role ambiguity is the result of an employee not clearly understanding designated tasks, authority to make decisions regarding tasks and the expected outcomes of tasks. Role ambiguity can result in a hesitancy of employees to make decisions and the use of the trial and error approach to task completion (Rizzo, House, & Lirtzman, 1970).

The hierarchical multiple regression method was employed to examine results of a self-administered questionnaire given to participants. Additional data was gathered by use of the emotional exhaustion measurement component of Maslach's Burnout Inventory and an instrument developed by Rizzo, House, and Litzman (1970) designed to measure role conflict

and role ambiguity. Results indicated that the combination of role conflict and role ambiguity contributed more to the development of burnout than any other variable measured; with role conflict having a higher impact.

Another dynamic which is common among the population of long-term care clients that can lead to staff burnout is the prevalence of aggressive behaviors in the work environment. Tariot, Podgorski, Blazina, and Leibovici (1993) found 91% of their sample of 80 clients in long-term care had at least one behavior problem. Additionally, they found that 50% of the sample had 4 or more behavioral problems. In the study, 29% had received psychiatric care prior to admission to the nursing home and 61% after admission to the nursing home. Aggressive behaviors of residents can increase stress among caregivers and lead to resident hospitalization (Shah, Chiu, & Ames, 2000).

In organizations where staff burnout is likely employee morale is negatively affected. Low employee morale leads to poor staff retention rate and inability to attract qualified staff to fill positions (Priebe, Fakhoury, Hoffmann, & Powell, 2005). Shirom (2005) states burnout has significant economic consequences for an organization. In addition burnout has substantial impact on the employees which affects their social and psychological well-being.

Burnout in Long-term Care

Over half the population of residents in nursing homes across the United States has some form of mental disorder. Healthinaging.org (2012) estimates between 50-70% of the nursing home resident population has a mental disorder, with Dementia being the most common. In addition to Dementia, nursing home residents typically have a co-occurring mental illness such as Depression (Fullerton, McGuire, Fang, Mor, & Grabowski, 2009).

In addition to the increase of individuals with Dementia, nursing homes are also experiencing an increase of admissions of individuals with some a severe mental illness (SMI). Fullerton, et al. (2009) found 560,000 individuals with mental illness were residing in nursing homes compared to the 51,000 that were in a psychiatric hospital. Other statistics suggest up to 20% of individuals residing in nursing homes have SMI (Levin-Epstein, 2006). Molinari, et al. (2008) define SMI as “severe psychiatric problems (excluding dementia) that significantly interferes with day-to-day functioning and may lead to chronic disability” (p. 68). Examples of SMI diagnoses include: schizophrenia, bipolar disorder, major depressive disorder, and other psychotic disorders.

Bartels, Miles, Dums and Levine (2003) state that nursing home settings account for 89% of all older adults with severe mental illness in comparison to other healthcare settings. The Tariot, et al., (1993) study indicated that, of the 80 participants, 91% had some form of mental disorder. Though inconsistent data make it difficult to accurately count the number of individuals with mental illness living in nursing homes, it is apparent the number is steadily increasing (Levin-Epstein, 2006).

There are several contributing factors to account for this trend. “Economic issues, relative availability of facilities, and lack of community acceptance of people with mental illnesses often leave no choice but to place such individuals in nursing homes”, (Levin-Epstein, 2006, p. 52). In spite of the increase in resident population of persons with mental illness, staff is not receiving adequate training to properly care for this unique group. Inadequate training is also a problem found in caring for the Dementia population. Berry (2012) found that only about 10% of staff was trained to care for nursing home residents with Dementia.

The consequences of inadequate training adversely affect both staff and the residents in their care. Craig and Phom (2006) found staff knowledge of mental illness is positively correlated with quality of care to this resident population. University of Nevada Sanford Center for the Aging (2008) found a decrease in prevalence of challenging behaviors among residents with Dementia when residing in a facility where staff received adequate training to care for this population.

Collins and Long (2003) stated deficits in resources, such as training, can lead staff to develop a reduced sense of personal accomplishment at work. This is an indicator of burnout. Kartman (1983) stated that an individual must have adequate knowledge and skills to effectively complete the functions of the job. In addition it is necessary for employees to possess positive problem-solving skills to manage the stress which often goes hand in hand with the work of a caregiver. Without these skills the employee is more prone to develop burnout.

Interventions for Burnout

The literature contains diverse opinions as to the etiology of burnout and implementation methods to decrease burnout. Interventions such as the formulation of an organizational participatory action group, use of a stress management relaxation technique, use of clinical supervision, use of a peer support group, use of individuating life history, and use of a skills based training group have been researched for effectiveness in decreasing burnout. Studies pertaining to these strategies are presented here for review.

Participatory Action Research

Lavoie-Tremblay, Bourbonnais, Viens, Vezih, Durand, and Rochette (2004) used a participatory action research approach to study burnout on a long-term care unit of a Canadian hospital. The authors hypothesized that due to changing policies in the Canadian healthcare system, burnout and absenteeism would likely occur at a higher frequency. The participants were selected because the unit on which they were employed had double the rate of absenteeism, at 8.26%, of the overall hospital mean in a one year period of time. There were 60 participants from multi-disciplines including: nursing, social work, administrative, and physical therapy.

A participatory organizational intervention was developed for this study. Of the 60 participants, 17 formed a focus group with the intent to define present work constraints and develop action plans to address each work constraint. The focus group met 6 times, each for a 1 day period. They identified a total of 350 work constraints. Following the implementation of the action plans, evaluation was conducted for their effectiveness.

Instruments were administered as pre and post intervention period, with a 1 year follow-up post intervention. The instruments used included: (a) Job Content Questionnaire ($\alpha=.68-.85$); (b) the Psychiatric Symptom Index ($\alpha=.89$); and (c) Neidhammer and Siegrist (1988) instrument to measure the perceived efforts/rewards imbalance in the workplace. Absenteeism rates were measured by management. There was a pre test response rate of 98% and a post test response rate of 80%. Drop in response rate was attributed to participants leaving their positions or scheduling conflicts.

The results of this study indicated a statistically significant increase in the balance of the effort/reward system and decrease in job strain. Absenteeism rates decreased to 1.86% during the study period. Results also yielded a statistically significant decrease in sense of support offered

by management and an increase in psychological distress. Participants' sensed management did not give priority to the study's purpose which was to increase quality of care for the patients and to improve the work environment. In spite of the contract signed by management to conduct this study and to carry out the recommendations derived from the work groups, management did not seem to buy-in to the significance of the study. The increased psychological distress may have resulted from additional duties added to the normal day to day tasks as the work groups proceeded to implement recommended interventions. There was also a sense of increased distrust among the different work groups. The sense of distrust began years prior to the study with budget cuts. Examining current work styles for methods of improvement created a sense of paranoia among employees not involved in the study as they felt their work was being questioned. This led to unfavorable attitudes towards the work groups involved in the study, explaining the increase in psychological distress.

There were several limitations to this study. The intervention was considered to be time consuming and involved tremendous commitment from volunteers. The sample size involved in the generation of the intervention (n=17) was relatively small. This bars results from feasible generalizability. The interventions may be specific only to the period of time in which the study was conducted as it pertained to current work responsibilities and the work environment. Further budget cuts could precipitate another restructuring of the work organization, rendering the current work constraints and interventions non-applicable.

Munn-Giddings, Hart and Ramon (2005) also incorporated use of a participatory action research approach to target burnout in healthcare and social work organizations in England. The researchers believed that work stress and burnout have a negative impact on the quality of care delivered to clients in these types of organizations. The researcher' utilized information obtained

from UK surveys administered to healthcare employees. This data indicated workers associated burnout and work-related stress to several different elements. These included: (a) role confusion; (b) ambiguity; (c) workload; (d) excess in client load; (e) increase in administrative duties; (f) lack of control over one's work (g) role conflict; (h) and ongoing organizational changes. The researchers felt the intervention needed to target organizational as well as individual changes, as elements of burnout and work-related stress are derived from both entities.

Participants consisted of what is considered to be a frontline practitioner. This position has the most direct contact with clients. They were all employed within the National Health Trust and Social Services department. They met for 5 participatory workshops, lasting approximately 2 ½ hours per session that met every other week. The instrument for this study was the Maslach Burnout Inventory (MBI).

Key issues identified by the participatory groups included: (a). work stress located in the organizational culture and senior management style; and (b). feeling powerless within their job role. There was a low response rate which the researchers attributed to two reasons. The first is that the participants feared retribution from management for their involvement in this study. The second is admitting to feeling stress and/or burnout is considered to be weak in the British culture. The participants were reluctant to admit to these feelings.

The participants who scored the highest on the MBI had the highest client load. Stress impacted the physical health, coping and functioning ability of the participants and impacted work, home and relationships. The work groups recommended support groups to be implemented as a technique to help manage ongoing stress and prevent burnout. This recommendation is low cost and relatively easy to implement.

In the Munn-Giddings, et al., (2005) study there were several barriers identified. The first is that management was controlling regarding which employees were able to participate in the work groups. Management was reluctant to take recommendations into consideration. They had a tendency to lay blame for work stress and burnout on the employee rather than taking organizational factors into consideration. These issues diminish the quality of this intervention. It would seem to be a contradiction to the best interest of management, who lose productivity as a result of employee absenteeism from burnout.

Mindfulness Meditation

Galantino, Baime, Macguire, Szapary, and Farrar (2005) tested the effectiveness of Mindfulness Meditation (MM) on reducing psychological stress associated with burnout. Using a quasi-experimental design in a university hospital setting, the researchers solicited 84 volunteers of various disciplines to participate. The researchers hypothesized that a decrease in psychological stress, as measured by the level of salivary cortisol, would occur following the 8-week MM intervention. Participants' mood, level of burnout, and level of empathy towards patients were also tested with repeated measures.

Using the salivette method, cortisol levels were collected on each of the participants' pre and post intervention. In addition, three separate questionnaires were administered, pre and post intervention. These instruments included: (a) The Profile of Mood States short form; (b) Maslach Burnout Inventory; and (c) the Interpersonal Reactivity Index. The response rate for pre and post completion of the questionnaires was 82%. The response rate for pre and post collection of cortisol levels was 61%.

Results yielded a statistically significant decrease in emotional exhaustion ($p=.002$). There were also statistically significant improvements in mood ($p=.001$). There was no change in

the levels of cortisol. The researchers speculated that the results of the cortisol levels may be attributed to the fact that they were collected at a time when the participant was not experiencing acute stress. Overall, results indicated participants learned how to effectively manage stress.

The strength of the Galantino, et al., (2005) was compromised due to absence of a control group. The variables with collecting cortisol levels lent to additional limitations with this study. If examining results on the questionnaires alone, MM intervention was effective in alleviating stress and burnout. Patient satisfaction improvement was also reported.

Clinical Supervision

Hyrkas (2005) incorporated use of the non-experimental associational approach to examine the relationship between clinical supervision and burnout. Participants were selected from 1 of 14 sites connected with Tampere University Hospital. Criteria for inclusion were a minimum of 6 months of clinical supervision with a healthcare employee as the supervisee. The total number of participants was 569. The data collection instruments included: 1. the Manchester Clinical Supervision Scale (alpha=.867); 2. Maslach Burnout Inventory (alpha=.736-.903); 3. a short version of the Minnesota Job Satisfaction Scale (alpha=.719-.861). All instruments were pilot tested.

Results indicated clinical supervision was enhanced when the supervisor had undergone formal clinical supervision training and the clinical supervision was conducted on a 1:1 basis, as opposed to in a group format. If the clinical supervision had been occurring over two years, supervisees reported higher levels of satisfaction. Clinical supervision was reported to be beneficial to mental health professionals as burnout was found to be highest among psychiatric nurses.

A follow-up study would be beneficial to test the effectiveness of a consistent type of clinical supervision with the inclusion of a control group. The effectiveness of clinical supervision within the first 2 years is limited, with lower reports of satisfaction by the supervisees. Researchers attributed this to the supervisee not fully understanding how to use clinical supervision to their maximum benefit. Also, it takes time to develop a trusting relationship in which the supervisee feels completely comfortable with the supervisor.

Peer Support Group

Peterson, Bergstron, Samuellsen, Asberg, and Nygren (2008) used a randomized experimental control group design to study the effectiveness of a peer support group to decrease burnout. Participants were drawn from a sample of healthcare employees in a city council area of Sweden. All participants met the criteria of scoring above the 75th percentile of the Oldenburg Burnout Inventory. Participants were randomly assigned to groups, n=80 for the control group and n=51 for the experimental group.

There were six data collection instruments. These instruments included: 1. the General Nordic Questionnaire for psychological and social factors at work (alpha=.70); 2. The Oldenburg Burnout Inventory (alpha=.70); 3. The Hospital Anxiety and Depression Scale (alpha=.80); 4. The Short Form Health Survey for validity and general health (alpha=.70); 5. a short interview at 7 and 12 months post intervention to ask participants about changes in their work conditions; and 6. Participants' self-reported evaluation of the peer support group.

Results indicated that both groups had decreases in areas such as exhaustion, disengagement, quantitative demands of work tasks and mood symptoms. The intervention group had a statistically significant difference in their decrease in quantitative demands of work tasks and improvement in their overall health. Peer group evaluations revealed positive aspects of the

group such as the ability to talk to others in similar situations, increase in a sense of belonging, and relief of symptoms of burnout.

The researchers cited one limitation to this study which was an underrepresentation of male participants. Participants used the problem-based approach in the peer support group to devise their own action plans to combat self-identified symptoms of burnout. This approach was considered useful as it increased participants buy-in to the intervention through use of personal experiences. However, it may have been helpful to provide expert insight of burnout for the participants to consider when formulating interventions.

Individuating Life History

Hillman, Flicker, LeGendre, and Traczok (2005) used a pre/post test comparison group design to study the effectiveness of use of an individuating life history as a means to increase the positive perception staff holds of clients with aggressive behaviors. Increasing the positive perception was believed to have a preventative effect on staff prone to develop burnout due to the client population of which they served. This study used a convenience sample of 43 which included participants from the nursing discipline (RNs, LPNs, and C.N.A.s). Participants were employed in a long term care facility.

Participants were divided into 3 groups. One group received the individuating life history intervention, 1 group received medical history information only and the 3rd group received no information. Information was provided on 15 newly admitted residents. The variable of newly admitted was chosen because researchers believed the staff did not know the residents long enough to have developed a positive or negative perception about them. Of the residents chosen to participate 52% had aggressive behaviors, e.g. hitting, biting, kicking, and 39% had dangerous behaviors, e.g. self-injurious behaviors, which occurred sometimes or occasionally. A one page

information sample, containing data specific to the type of intervention, was provided to participants in each of the 2 groups who were to receive information.

Researchers chose the Nursing Home Problem Behavior Scale (NHPBS) developed by Ray, et al (1992) to measure serious problem behaviors among residents of nursing homes. The Semantic Differential (SD) was chosen to rate staff's attitudes towards the sample of residents. Finally, to measure perceived rewards for caregivers of adults the Rewards of Caregiving Scale was used.

Results did not substantiate the hypothesis which was use of the Individuating Life History intervention would help to increase positive perception among staff of residents with aggressive behaviors. The researchers did find, however, that there was no difference in the Rewards of Caregiving Scale results. This indicated that staff continued to find intrinsic rewards for their chosen profession in spite of the residents' aggressive behaviors. The researchers suggested the following interventions to help improve staff perception and to prevent burnout: (a) adequate staffing patterns; (b) inform all staff of the resident's social history through use of the individuating life history intervention; (c) employ preventative measures to decrease aggressive behaviors by studying resident pattern of aggressive behaviors.

There was one major limitation in this study which was the researchers' minimization of the impact of aggressive behaviors on staff. In spite of the altruistic motivation of staff to choose employment in this profession, it is rather difficult to expect staff to not be affected by working with a resident population that places the staff at risk for getting hit, bit, kicked or at the very least screamed and cursed at. The researchers cited the importance of preventative measures to decrease aggressive behavior occurrences. By providing staff with knowledge and skills to identify early indicators of potentially aggressive behaviors and interventions to prevent such

behavior, the staff performs their job more effectively and in turn helps to prevent burnout. Though this was suggested, no means to incorporate this into practice was provided. This researcher intends to provide such means to organizations who serve an aggressive resident population.

Skills Based Training

Winship (2008) conducted a quasi-experimental repeated measures study with a skills based intervention. The participants were employees of an adult psychiatric inpatient hospital in England. The premise of the intervention was the belief that burnout can undermine the professional's self-esteem and reduce creativity with regards to decision-making and treatment planning in working with individuals with severe mental illness.

Participants included 18 volunteers all Mental Health Workers in the hospital. Participants engaged in 6 full day training sessions which were delivered over a 12 week period of time. Training consisted of evidenced based skills education to use in working with individuals with severe mental illness. The skills were considered to be a basic introduction to essential generic therapeutic skills. The training was new for some of the participants, and provided a refresher course for the more seasoned employees.

In addition to skills training, staff received weekly group clinical supervision. The employee would come to supervision and present a case with a specific scenario involving the employee's attempt to implement learned skills from the training in an interaction or intervention with a client. The other participants would provide feedback to that employee regarding the intervention to help the employee increase effectiveness in utilizing learned skills with client care.

The instruments used in this study involved a skills exam to measure the employee's knowledge of skills taught in the training session, 3 instruments to measure interpersonal information of the employee, and the Maslach Burnout Inventory (MBI). Results indicated a statistically significant increase among participants' knowledge of skills in working with this population. In addition, there was an increase in overall job satisfaction, a decrease in emotional exhaustion and an increase in a sense of personal accomplishment, as measured by the MBI. It is interesting to note that participants' level of perceived stress, self-esteem, and psychological distress remained stable during the training period.

Winship suggested the need for further research to develop a deeper understanding of the interplay between employee stress in challenging clinical situations and how it relates to burnout. Winship recommended that evidenced-based approaches be taught in conjunction with interventions designed to decrease employee level of stress and burnout. In this study, Winship failed to provide a clear definition of burnout. Though, the use of the MBI presumes that he subscribes to Maslach's definition. There were a variety of instruments used to measure interpersonal factors, such as self-esteem and stress, which can be useful in ruling out these other factors to focus specifically on burnout.

Burnout, as viewed in this study, interferes with employee skill delivery in working with clients with mental illness. The Winship study assumed staff that was poorly trained in this area would be more vulnerable to developing burnout. This belief is supported by Densten (2001) findings that personal accomplishment, as measured by the MBI, can result from two different types of scenarios. The first would involve lack of clarity regarding tasks to be accomplished, which is an organizational factor. The second would be the employee lacked the training to be competent to perform the task. Winship's (2008) intervention helped to reduce levels of

employee burnout by targeting the areas of personal accomplishment, as measured by the MBI. However, it continues to remain unclear how personal accomplishment relates and functions with regards to the other two factors measured by the MBI, emotional exhaustion and depersonalization.

Taken from the study introduced in the dynamics of burnout section, Barber and Iwai (1996) made suggestions on interventions to decrease burnout that results from role conflict and role ambiguity. Barber and Iwai (1996) stated that “given the stress frequently inherent in their work, human service personnel are at considerable risk for burnout” (p. 102). The researchers suggested organizations to take the lead on implementing measures to alleviate role conflict and role ambiguity. The researchers reported steps to take to accomplish this goal including:

(a) provide staff with the necessary resources to complete their assignments; (b) avoid assigning a primary care worker tasks in 2 or more departments that have conflicting interests and policies of operation; (c) develop consistent rules and institutional policies for the completion of work assignments; (d) use consistent criteria to measure work performance for employees who are assigned to 2 or more departments (Barber & Iwai, 1996, p. 113).

In examining the connection of social support to burnout, the researchers included a limited version of the constitution of a social support system. Rather than opening up social support to include personal support systems, the researchers focused only on the support system in the workplace. The study showed that the employees did not access their co-workers for support to address feelings of burnout. As a result lack of social support did not have much bearing on the development of burnout. The researchers mentioned that if they had broadened their definition of an employee’s social support system to include personal supports results might have been different. See Table 1 for visual summarization of articles presented in this paper.

There is a gap in the literature focusing on employees in the long-term care setting. Limited research revealed a study in this area that produced an intervention which was found to be ineffective. The limitations presented and lack of understanding of the unique dynamics of a long-term care setting exemplifies the gap in literature and the need for further research on effective interventions to decrease employee burnout in long-term care. Statistics provided in the beginning of this section point out staggering numbers of individuals residing in long-term care with some form of mental disorder which produces aggressive behaviors. The number of individuals admitted to nursing homes who are among this population is increasing. Staff members in this setting who work with this population are more at risk than ever to develop burnout. This risk substantiates the need for research to be conducted to identify effective interventions to combat burnout in this setting.

Research Questions

The following questions presented here were used in my study to guide the research process.

RQ#1: (a) Was there a difference in the change of level of burnout from pre to posttest between the experimental and the control group? (b) Was there a change in the level of burnout for participants in the experimental group comparing pre and posttest?

RQ#2: Was there a change in the level of knowledge about effective behavior management techniques among participants in the experimental group comparing pre and posttest?

Table 1

Burnout Etiology and Interventions

Author and Year	Sample	Design	Intervention	Results	Limitations
Ekstedt and Fagerberg (2003)	8 participants- Self-identified with burnout, > 3 months sick leave from work	Phenomenological approach	N/A	5 themes emerged from experience of time preceding burnout- 1. inner incentive; 2. feeling responsible; 3. threatened self-image; 4. reaching the bottom line; 5. cutting off	1. lack of description of employment tasks 2. small sample size
Lavoie-Tremblay, Bourbonnais, Viens, Vezaha, Durand, and Rochette (2004)	60 participants, multi disciplines employed in a Canadian hospital	Participatory action research	Participatory organizational intervention	1.increase in the balance/effort reward system 2. decrease in job strain 3. decrease in absenteeism	1. time consuming 2. 17 participants in the design of the intervention
Munn-Giddings, Hart and Ramon (2005)	Participants worked in the National Health Trust and Social Services department in England	Participatory action research	Participatory action research approach	1.low response in study due to employee fear of retribution for involvement in the study and admitting to stress is considered to be weak in the British culture	1. Controlling management 2.Management reluctant to accept recommendations
Galantino, Baime, Macguire, Szapary, and Farrar (2005)	84 participants employed in a university hospital	Quasi-experimental	Mindfulness Meditation	1. decrease in emotional exhaustion 2. improvement in mood	1. no control group 2. variables with collecting cortisol levels
Hyrkas (2005)	569 participants employed in Tampere University hospital sites	Non-experimental associational	Clinical supervision	1.highest level of satisfaction when CLINICAL SUPERVISION > 2 years 2. beneficial for mental health workers	1. no control group 2. poor data explaining decreased satisfaction in clinical supervision (1-2 yrs)
Winship (2008)	18 mental health workers employed in a psychiatric inpatient hospital in England	Quasi-experimental	Skills-based intervention	1.statistically significant increase in knowledge, job satisfaction, and sense of personal accomplishment and a decrease in emotional exhaustion	1.Unclear results on the relationship of personal accomplishment to emotional exhaustion and depersonalization
Hillman, Flicker, LeGendre, and TRaczok (2005)	43 nurses in a long-term care facility	Quasi-experimental	Individuating Life History	1.no change in staff perception towards residents with aggressive behaviors	1.minimization of impact of aggressive behaviors on staff 2. Lack of means for preventative measure to decrease burnout
Barber and Iwai (1996)	75 direct care workers in long-term care facility	Hierarchical multiple regression	No intervention	1.role conflict and role ambiguity are best predictors of burnout	1. Narrow inclusion of social support system
Peterson, Bergstron, Samuellsen, Asberg and Nygren (2008)	131 healthcare employees in Sweden	Randomized experimental	Peer support group	1.statistically significant decrease in quantitative work tasks 2. statistically significant improvement in overall health	1. underrepresentation of males 2. no expert involvement in formulating the intervention

RQ#3: (a) Was there a difference in the change from pre to posttest in the frequency of absenteeism and of tardiness between the experimental and control group? (b) Was there a difference in the frequency of absenteeism and tardiness in the experimental group from before to after the weekly skills based intervention?

RQ#4: Was there a difference in the change of frequency of staff to resident abuse occurrences between the experimental group and the control group from before to after a weekly skill based intervention?

RQ#5: Was there a difference in the frequency of resident psychiatric hospitalizations between the residents in the care of the experimental group and residents in the care of the control group from before to after a weekly skills based intervention?

Research questions one and three have two parts. Part A consists of comparing change scores on test instruments between the comparison and experimental groups. Part B consists of comparing scores from pretest to posttest in the experimental group only. Research questions three, four and five contain constructs that are characteristics or indicators of burnout.

Theoretical Framework and Intervention for this Study

The overarching theme of this study centers on employee response to stress which contributes to the development of burnout. This, in turn, adversely affects work attendance, frequency of resident to resident and staff to resident abuse occurrences, and frequency of resident psychiatric hospitalizations. The Systems theory provides a clear framework for this theme. Payne (2005) describes Systems theory as, “focusing on the connection between and resources of families and groups and their effective functioning” (p. 143).

The focus is on the process in how interactions occur within relationships. Information (input) to a system is received, processed (throughput), and a response (output) is provided. The interacting system which provided the input receives a response through the feedback loop. With burnout, the employee is vulnerable to stressful input (resident's difficult behavior), inaccurately process the information (e.g. "I must be doing a bad job taking care of the resident which is why he is acting this way") and a dysfunctional output is given in response (e.g. "I can't do my job" increasing potential to develop burnout). With a change to one part of the system, e.g. the staff response to stress, other parts of the system are affected, e.g. instances of resident to staff abuse occurrences (Payne, 2005).

Using the Systems Theory, other theories are incorporated into the intervention. Cognitive Behavioral theory (CBT) is the framework for the intervention. Payne (2005) describes CBT as an integration of Social Learning theory and Cognitive theory. Social Learning theory states "most learning is gained by people's perceptions and thinking about what they experience" (Payne, 2005, p. 121). Cognitive theory is, "behavior affected by perception or interpretation of the environment during the process of learning" (Payne, 2005, p. 121). CBT interventions for this study incorporates skills training, problem-solving and cognitive restructuring.

The intervention is based on CBT techniques delivered in an eight session training course, as found in Appendix 1. Each session focused on a different topic while adhering to skill development of the participants. Examples of the topics addressed include: understanding mental illness, and identifying symptoms of different mental illnesses included in the definition of SMI; behavior management interventions designed to decrease aggressive behaviors in residents; and education on stress management coping skills for employees.

The Cognitive-behavior theoretical foundation was chosen because of its short-term approach that produces long-lasting results (Pucci, 2010). In addition, CBT focuses on: (a) participants finding meaning in the process; (b) use of a goal-directed approach; (c) is person-centered; (d) uses a collaborative approach with the facilitator and participants; (e) and it empowers participants to develop self-change skills (Rosenbaum, 1998). The latter feature of CBT is perhaps the most beneficial. It implies that use of CBT will assist participants in developing skills that will serve them in the future beyond the intervention and without the need for the presence of a facilitator. It is the intent of this researcher to produce sustained positive results in building skills for employees for alleviating burnout.

Use of a CBT based approaches to manage work related stress has been researched. One study conducted by Gardner, Rose, Mason, Tyler and Cushway (2005) attempted to delineate between the two separate theoretical foundations of CBT. The researchers wanted to determine whether a cognitive based approach would produce a more effective result in reducing work-related stress when compared to a behavioral based approach. This study used a convenience sample of 138 employees of the British National Health service. Participants were divided into three separate groups. There were two experimental groups, one cognitive and one behavioral based intervention, and one wait listed control group.

The researchers defined stress as a, “constellation of cognitive, affective, and motivational processes activated by the demands of living, and in particular of the workplace” (Gardner, et al., 2005, p. 138). The Transactional model of stress was the foundation for this study. According to the Transactional model stress can be perceived by the individual as harm, threat, challenge or a chance for change. If the individual believes there will be a possible negative outcome then a secondary appraisal of the stress factor will commence. The secondary

appraisal is a self-evaluation to determine whether or not adequate coping skills exist to manage the stress. If inadequate resources are available to manage the stress the individual is at increased risk to experience negative consequences as a result of the stressor. Per the researchers in this study for healthcare employees those stressors can include absenteeism, low rate of staff retention, and early retirement.

The Gardner et al., (2005) intervention included three half day workshops. Multiple data collection instruments were included to collect pre, post and follow-up test data to measure stress levels among participants, stress at work for mental health professionals, excess worrying, level of support systems available at home and work, and coping skills. A factorial ANCOVA was used to measure the effectiveness of the interventions. Results at the follow-up period indicated the cognitive intervention produced the best results. However, both interventions had sustained and positive results when compared to the wait list control group.

Brunero, Cowan and Fairbrother (2008) studied the effectiveness of a CBT based workshop to reduce work related stress among new graduate nurses. A sample size of 18 nurses who were halfway through their first year of practice volunteered to participate in this study. The intervention consisted of a one day, 8 hour, workshop facilitated by two nurse consultants who received specialized training in CBT. The workshop was divided into three components. The first was education regarding the definition of work-related stress, theoretical model of CBT, participants identifying current work stressors and applications of CBT principles to these stressors. The second component included introduction of the ABC model (Activating event-beliefs about the event-consequences as a result of the belief), which is a CBT intervention technique designed to increase self-awareness of one's own participation in the development of stress. The final component of the workshop was to teach participants how to apply the ABC

model to their identified work stressors to help modify the belief and impact of the stressors. Participants were also provided with reading and self-directed learning material to use after the workshop.

The two instruments used in the Brunero et al. (2008) study included the Nurse Stress Scale ($\alpha = .89$) and a brief questionnaire developed by the researchers asking participants to rate their level of stress at work, at home, and overall stress level using a 10 point Likert scale. The Wilcoxon Signed Rank test was used to analyze pre and post test results. A statistically significant decrease in level of stress as rated by the brief questionnaire was found at $p < .05$. The stress level of work decreased from level of 5 (pretest) to 4 (posttest). Stress level outside of work decreased from level of 5 (pretest) to level of 4 (posttest). Overall stress level decreased from 5 (pretest) to 3 (posttest). A statistically significant decrease in stress levels as measured by the Nurse Stress Scale was also found at the $p < .05$ level from 70.5 (pretest) to (66.0) posttest, $t = -1.60$.

Brunero et al. (2008) found benefits from the CBT intervention. The CBT intervention helped to modify irrational beliefs secondary to the stressful event which led to improved emotional and behavioral responses. Additionally, the CBT helped to increase self-awareness among the participants regarding their role in the development of stress. This can be an empowering experience as participants are taught they can actively participate in modifying that role in order to decrease the amount of perceived stress in their lives.

CBT based interventions have been found through research to have a positive impact on work related stress. CBT interventions are typically brief when compared to other therapeutic theoretical foundations, bringing a faster sense of relief to participants. It is educationally based and skills are taught which the participants can employ long after the intervention has concluded

to produce sustained positive results. CBT uses an inductive method to teach participants that their thoughts can be viewed as hypotheses or guesses which can be analyzed and changed if found to be irrational and produce negative consequences (National Association of Cognitive-Behavioral Therapists, 2008).

Conclusion

With the increase of admissions to long-term care facilities of individuals with some form of a mental disorder the need is essential now more than ever to assist employees in managing burnout. With this influx of a behaviorally challenging population, employees are struggling to meet the needs of this new kind of resident. Inability to implement effective behavior management techniques is a second concern and often results in psychiatric hospitalization of the resident. Therefore, it is a professional responsibility to employees to help prepare them to take care of this population.

Burnout has specific consequences in the long-term care setting. Collins (2003) found that employees who experience burnout have an increase in the frequency of sick calls, and an increase in feeling indifferent towards clients. This can lead to staff turnover which affects client relationship with and ability to form trust in staff and negatively impacts the financial status of the facility. Per Hoyle (personal communication January 8, 2013) the average cost of training a new employee is \$15,000 - \$20,000, depending on the position held by the employee. Additionally, employee burnout in long-term care places clients at an increased risk for abuse and/or neglect as a result of staff indifference.

Continuing education is crucial in fostering worker competency and confidence to perform essential job tasks. In addition, continuing education serves to break up the monotony of day to day job functions. It aids in professional growth and can breathe new life into the worker's

perspective of job tasks and responsibilities. No matter what intervention is used, it is evident that the responsibility of preventing and/or treating burnout lies with both the organization and the employee.

CHAPTER THREE: METHODS

A quantitative method was employed to study the effects of a weekly skills based intervention to decrease level of burnout in long term care employees. This was a quasi-experimental study with one independent variable, the weekly skills based intervention. Treatment was originally intended to be randomly assigned to 2 of the 3 long-term care facilities chosen to be the setting for the study. However, facilities wanted the intervention implemented as immediately as possible. All of the Nursing Home Administrators required education for their staff to be offered in exchange for allowing their facility to become a study site.

In the interest of obtaining an adequate sample size, the choice to participate in this study was open to all employees in each of the settings, but some employees were on a wait list for a later intervention. Due to scheduling conflicts, participants were not able to be randomly assigned into groups. The quantitative method was appropriate as it allows the researcher to maintain an objective stance with regards to the data collection process and data analysis (Morgan, Gliner, & Harmon, 2006).

Research Questions and Hypotheses

This study examined the effectiveness of a skills based intervention to decrease burnout in long-term care employees. To direct this study, the following research questions were used:

RQ#1: (a) Was there a difference in the change of level of burnout from pre to posttest between the experimental and the control group? (b) Was there a change in the level of burnout for participants in the experimental group comparing pre and posttest?

RQ#2: Was there a change in the level of knowledge about effective behavior management techniques among participants in the experimental group comparing pre and posttest?

RQ#3: (a) Was there a difference in the change from pre to posttest in the frequency of absenteeism and of tardiness between the experimental and the control group? (b) Was there a difference in the frequency of absenteeism and tardiness in the experimental group from before to after the weekly skills based intervention?

RQ#4: Was there a difference in the change of frequency of staff to resident abuse occurrences between the experimental group and the control group from before to after a weekly skill based intervention?

RQ#5: Was there a difference in the frequency of resident psychiatric hospitalizations between the residents in the care of the experimental group and residents in the care of the control group from before to after a weekly skills based intervention?

Alternate Hypothesis #1: (a) Participants of the experimental group had lower levels of burnout than that of the comparison group following the weekly skills based intervention. (b) Participants of the experimental group had lower levels of burnout after the intervention than what they had prior to the start of the intervention.

Alternative Hypothesis #2: Participants of the experimental group had more knowledge of effective behavior management techniques to reduce challenging behavior among residents than they had prior to the weekly skills based intervention.

Alternative Hypothesis #3: (a) Participants of the experimental group had less frequency of absenteeism and tardiness at work than that of the comparison group following the weekly skills based intervention. (b) Participants of the experimental group had less frequency of tardiness and absenteeism after the intervention than what they had prior to the start of the intervention.

Alternative Hypothesis #4: Participants of the experimental group had fewer instances of staff to resident abuse than that of the comparison group following the weekly skills based intervention.

Alternative Hypothesis #5: Residents in the care of the experimental group participants had fewer instances of psychiatric hospitalizations than the residents in the care of the participants of the comparison group following the weekly skills based intervention.

Part B of questions one and three, in addition to research question two, measured change within the experimental group only. Questions three, four and five were considered characteristics and outcomes of burnout. Questions three, four and five were treated as secondary, opposed to a primary, questions answered in this study.

Research questions four and five could not be answered in this study. I interviewed each of the nursing home administrators to gather supplemental data, including frequency of staff to resident abuse occurrences, after the study had been concluded. With regards to research question four, it was discovered organizational policies existed that would have called for the termination of an employee who was found guilty through investigation of perpetrating abuse against a resident. Unlike the staff member discussed in Chapter One, there would not have been the opportunity to rectify the situation and allow the staff member a second chance. Therefore any of the participants that may have been involved in a staff to resident abuse occurrence, where the abuse was substantiated, would have been terminated and subsequently not available for or dropped from the study. None of the participants in either the control or the comparison group at all three study sites had ever been the perpetrator of abuse against a resident in their facility in instances where the abuse was substantiated through investigation.

With regards to research question five, it was impossible to distinguish between residents solely in the care of the participants of the experimental group and residents solely in care of participants of the comparison group. Per the supplemental data gathered after the intervention had concluded, there was only one instance of psychiatric hospitalization in the data collection period. This occurred at study site one. The administrator had no way to distinguish which, if any, members of either the experimental or the comparison group were caring for the resident at the time leading up to and until the resident was hospitalized.

Methodological Strategy

Design

This was a quasi-experimental pretest-posttest comparison group design. A comparison group was in place to allow this researcher to test the effects of the intervention. With one independent variable the CBT intervention or not, and pre-post changes as the dependent variable, this study is also known as a single-factor design with two levels (Morgan, et al., 2006). The intent of this study was examine whether the intervention would have the desired effect of a reduction in the level of employee burnout in long-term care facilities with a high population of residents with some form of mental disorder.

Efficacy of Proposed Methodology to Address the Research Questions

The quasi-experimental pretest-posttest comparison group design was the most appropriate method. The primary purpose of this study was to test the effectiveness of the intervention designed to reduce level of burnout among long-term care employees. This study contained an active independent variable with two levels. The dependent variable, changes in the level of employee burnout was the main outcome measured for this study. These factors support use of the quasi-experimental design (Morgan, et al., 2006).

Procedure and Description of the Intervention

Three separate nursing facilities were incorporated into this study. Treatment interventions were implemented in all of the facilities. Non-experimental group participants were wait-listed comparison group members. The intervention was offered to members of the comparison group after the experimental group was finished.

I educated the nursing home administrators of each of the focal facilities on burnout, consequences of burnout to long-term care organizations, and the proposed benefits of the study for the facility. This education was intended to reduce any stigma the nursing home administrator may have towards employees who identify as experiencing burnout. Reducing stigma helped to create an environment that was both safe and comfortable in which the participants could engage the study.

To recruit participants I conducted an all staff in-service on burnout. The nursing home administrator was asked to co-facilitate this discussion to show his/her support of the study. Employees were educated on the signs and symptoms of burnout, its etiology and the consequences. Following these in-services, all employees were asked to volunteer for the study. The opportunity to participate was open to all employees with no disqualifying variables in order to obtain the desired sample size for each group. Demographic data of each of the participants was collected prior to the start of the intervention.

I recruited a research assistant to co-facilitate the intervention for one of the experimental groups. The research assistant was trained by me to conduct the intervention prior to the start of the first intervention session. In addition, the research assistant sat with me during the intervention sessions for the first four sessions to receive additional in vivo training.

Attendance was taken at each session. Scheduling for the intervention varied in each of the different study sites to accommodate each of the nursing facilities. At study site #1 the experimental groups met one hour per week for a total of eight sessions. At study sites #2 and #3 the experimental groups met an average of two hours per week for a total of four weeks, eight sessions. All participants of the experimental group at each of the three study sites participated in 100% of the sessions, with the exception of one employee who was terminated following the first intervention session at study site #2.

Cognitive Behavioral Therapy is an educational, hands-on process that can promote change among participants in a relatively short period of time. A noticeable decrease in symptoms can be experienced in a few weeks (Beck Institute, 2012). CBT based interventions included a pre-established specific agenda for each session in which specific skills were taught. The intervention was participant directed. The primary role of the facilitator was to educate the participants. Homework was an essential part of the CBT skill development process to ensure adequate understanding of the material presented. Additionally, use of homework helped to build participants level of self-sufficiency in employing learned CBT skills and techniques to manage stress.

A positive relationship between therapist and client, or in this case between researcher and participant, is highly encouraged. However, it is not necessary for the participant to develop complete trust in the researcher for meaningful learning and change to occur. This made CBT a practical approach for the intervention as I did not have an established relationship with all the participants prior to the start of the intervention (National Association of Cognitive-Behavioral Therapists, 2009).

Part of the intervention included techniques created by the Crisis Prevention Institute (CPI) to manage challenging behaviors in clients. This researcher obtained permission from CPI to use the interventions prior to the start of the study. CPI was established in the 1970s to train professionals who work with clients that have disruptive and/or dangerous behaviors on how to safely and effectively manage these behaviors. Training has been going on for over 30 years, with over six million human services professionals trained in CPI techniques (crisisprevention.com, 2012).

Each of the eight sessions had a specific pre-established agenda and written materials to accompany the session. Homework was assigned at the end of each session for participants to complete prior to the start of the next session. The homework was encouraged, but not required for attendance at the next session. The following is a detailed description of concepts that were taught at each of the sessions:

Session one. (a) introduction of CBT theory; (b) participants self-identified current work stressors; (b) introduction of other skills to be taught related to increasing understanding of common diagnoses of mental disorders found in long-term care settings and low-level behavior management techniques to implement in order to manage challenging behaviors which result from symptoms of the resident's mental disorder.

Session two. (a) explanation of the ABC model (A= activating event; B= beliefs about the event; C= consequences resulting from beliefs about the event), which was the foundation for the CBT approach in teaching stress management coping skills; (b) define irrational beliefs as described in the CBT theory and the method to dispute irrational beliefs.

Session three. (a) CBT based coping skills to manage stress such as thought dispute, increasing positive self-talk, distraction, and relaxation.

Session four. (a) other CBT coping skills to manage stress such as: time management, importance of a healthy lifestyle, and developing positive problem-solving skills; (b) setting goals to commit to continued practicing of CBT learned skills to manage work-related stress; (c) use of a peer support group to help manage work-related stress.

Session five. (a) information on the diagnosis of Schizophrenia; (b) information on the diagnosis of Schizoaffective disorder; (c) information on the diagnosis of Major Depression; (d) information on the diagnosis of Bipolar disorder.

Session six. (a) basic principles of behavior modification to include operant conditioning and use of positive reinforcement to shape behavior; (b) use of prompting and cueing to assist with training of new skills or behaviors

Session seven. a) low-level interventions to manage challenging behaviors such as use of active listening, reflection, validation, distraction and effective limit setting.

Session eight. (a) building self-awareness to develop healthy boundaries with the residents; (b) use of peer support group for continued opportunity to learn and practice effective behavior management techniques.

Approval from the Colorado State University Human Subjects committee was obtained prior to the start of this study. A copy of the approval letter is included as an appendix to the dissertation.

Reliability and Validity of the Study

Cook and Campbell (1979, as cited in Morgan, et al., 2006) identified four components to assess for the validity of the research. These components include: (a) measurement reliability and statistics; (b) internal validity; (c) overall measurement validity of constructs; and (d) external validity. Potential threats pertaining to this study are addressed in the following sections.

Setting

I had potential access to seven Denver-metro area long-term care facilities. Each of the facilities was assessed to determine which were most closely matched based on the criteria of: (a) minimum of 30% resident population with a primary diagnosis of some form of mental disorder; (b) resident population capacity; and (c) percentage of residents with Medicaid as the primary payer source. The top three facilities most closely matched were initially chosen for inclusion in this study.

Residents with some form of mental disorder are documented on the diagnostic code list maintained by the Health Information Manager (HIM) in each of the facilities. The percentage was calculated taking the total number of residents listed with some form of mental disorder divided by the total resident population.

The natural work environment in which this study occurred was a threat to internal validity. There was a lack of control of extraneous variables which may have affected the outcome of the dependent variable measurement. However, use of the natural setting increased the external validity of this study (Morgan, et al., 2006).

Sampling and Assignment to Groups

Participants were selected using a non-probability sampling method. All employees at each of the three focal facilities were invited to participate in this study. Participants were chosen from each and every different department in the long-term care facility. These departments include: registered nurse (RN); licensed practical nurse (LPN); certified nursing assistant (CNA); social services staff (SS); activities staff (ACT); dietary staff (DS); housekeeping staff (HS); health information manager (HIM); business office staff (BO); admissions and marketing staff (AMS); and administrative assistants (AA); and nursing home administrators (NHA). Because

the sample only included volunteers from these nursing homes, the external validity or generalizability of the sample is somewhat limited.

Also, participants were assigned to the experimental or comparison group based on scheduling availability, per the request of the nursing home administrator. Their preference and this method may have potentially weakened the internal validity of this study. It is classified as a weak pretest-posttest quasi-experimental design because participants were afforded the opportunity to self-select into a group (Morgan, et al., 2006).

There would have been a cutoff of 15 members per group at each of the study sites to meet minimum criteria for sample size to use parametric statistics. However, there were not that many volunteers that completed the intervention. At study site #1 there was one volunteer for the experimental group and one volunteer for the comparison group. At study site #2 there were ten volunteers for the experimental group and eight volunteers for the wait list comparison group. At study site #3 there was five volunteers for the first experimental group and six volunteers for the comparison group. The comparison group at the 3rd study site became the participants of the 4th experimental group because they received the intervention later.

Scheduling and budgetary constraints were identified as potential barriers to recruiting volunteers to participate in the study. I tried to minimize the impact of these barriers by making access to the intervention as convenient as possible. I scheduled intervention groups based on requests made by the participants. Minimal time was requested from each of the participants for the intervention, at only 1-2 hour per week. The interventions were conducted in the primary place of employment for each of the groups. These measures helped with recruitment and helped to decrease the threat of attrition which may have been higher if the intervention was less

convenient for the participants to attend. These measures tended to decrease the internal validity threat of attrition (Morgan, et al., 2006).

The participants and I were aware of which participants were assigned to the comparison group and which participants were assigned to the experimental groups. Consequently, the external threat of interaction of selection and experimental treatment remains a risk (Maxim, 1999).

In addition, I had a prior established relationship with members of the experimental group at study site three. Hence, the threat of reactive effects of experimental arrangements, otherwise known as the Hawthorne effect (Maxim, 1999), was present.

This was a quasi-experimental study which means the groups in this study are nonequivalent groups. This was a threat to the study's internal validity. Without random assignment to groups it is difficult to make absolute conclusions regarding cause and effect (Morgan, et al., 2006). Caution will be used when discussing generalizability of the results because there are limitations to both internal and external validity.

Instruments

The Professional Quality of Life Scale (ProQOL) tool, as found in Appendix 2, was used to measure burnout. This tool was developed by Figley (1996) and revised by Hudnall- Stamm (1997). This is a 30 item self-assessment scale that has three subscales measuring compassion satisfaction, burnout, and compassion fatigue. The ProQOL uses a 6-level Likert scale rating for each item, ranging from 0=never to 5=very often. The alpha reliabilities for this scale are as follows: Compassion Satisfaction alpha = .89; Burnout alpha = .71; and the Compassion Fatigue alpha = .80 (Hudnall -Stamm, 1997). The construct validity of the ProQOL has been "well established with over 200 articles in the peer review literature" (Hudnall -Stamm, 2005, p.9).

For the purpose of this study, compassion fatigue and compassion satisfaction were not included in the data testing and analysis process. These two constructs are more associated with vicarious trauma. Untreated vicarious trauma can lead to burnout (Bloom, 2003). However, vicarious trauma as the cause of burnout was not included in the development of the research questions or the intervention for this study.

The Knowledge of Behavior Management Questionnaire (KMBQ), as found in Appendix 3, is the instrument that was used to measure the level of staff knowledge of behavior management techniques to effectively deal with challenging resident behavior in the long-term care setting. This instrument was developed by Blair and Eldridge (1997). It is a 30 item multiple choice instrument with one correct out of four possible responses to each item. This instrument measures staff knowledge on four dimensions of resident behavior to include: (a) identifying and assessing resident behavior; (b) recognizing environmental influences on behavior; (c) identifying and using behavioral procedures to promote and maintain desired behaviors; (d) identifying and using behavioral procedures to reduce and extinguish undesired behaviors. This instrument was developed for individuals with a high school education. It was pilot tested on 203 long-term care employees of all disciplines to include CNA.s, LPNs, RNs, social workers, and activities staff. The reliability rating is $\alpha = .87$. The validity score is 98% using the inter-rater method to measure content. The knowledge tested on this instrument is based on behavior management techniques derived from CBT techniques. The CBT techniques are designed to modify challenging behaviors and promote pro-social behaviors in residents. This instrument was chosen because it is grounded in use of CBT techniques and because it was specifically designed for nursing home staff.

Reliability of both instruments is measured to be greater than .70, which is the minimum level for an instrument to be considered reliable (Morgan, et al., 2006). Both the ProQOL and KMBQ have been instruments in use over 5 years and have retained the same reliability and validity data. This reduced the potential threat of instability to this study's measurement reliability and statistics. As the time period for this study was intended to be 8-10 weeks, there was little room for maturation to affect changes in instrument scores pre and post intervention.

Nursing home administrators in nursing facilities already track employee rates of tardiness and absenteeism. Therefore it was not necessary to develop additional instruments to capture this data.

A participant evaluation, as found in Appendix 4, was also developed and administered to participants in the experimental group only. Participants voluntarily completed the evaluations after the intervention was complete. The evaluation consisted of four areas for participants to rate the content of the course. The areas included: (a) most helpful parts of the intervention; (b) suggestions to add to the intervention to make it more relevant and useful; (c) what, if anything, was not useful in the intervention; and (d) evaluation of the schedule, length and frequency of the course. The evaluation also contained one area for participants to rate the facilitator of the course, me and the co-facilitator who conducted groups at study site one.

Data Analysis

Background

For selection of the appropriate statistics, the following steps are recommended: (a) determine the level of measurement for the dependent variable; (b) determine the number of levels in the independent variable; and (c) determine whether the design is between or within groups (Morgan, et al., 2006).

Part A of the first research question can be classified as a “basic difference question”. This type of question is used when the levels of the independent variable are used to divide the participants into groups. In this study the two groups that divide the participants include the experimental group (E) and the comparison group (C). The groups are then used for comparison on results of the change scores of the dependent variable from the ProQOL. To answer difference questions it was logical to incorporate use of difference inferential statistics (Morgan, et al., 2006). Part B of research question one is a within group basic difference question measuring change scores on the ProQOL within the experimental group only from pre to post intervention.

There is one dependent variable in this study for research question 1: level of employee burnout. The level of measurement for the Pro-QOL IV is scale, or approximately normally distributed. Scale is appropriate as the variable has more than five ordered levels of measurement. (Morgan, Leech, Gloeckner, & Barrett, 2004).

Research question two is a within group basic difference question measuring change of level of knowledge of behavior management techniques pre and post in the intervention group only. The KMBQ score has many levels or scores (ranging from 0-30 on each questionnaire) and is classified as a scale variable.

Part A of research question three was answered by comparing change scores for the E and C group of each of the two variables measured. These variables include: staff tardiness and absenteeism. Each of these variables also has more than five levels, and both are classified as scale data. This was a between-groups design as each participant will experience only one group condition. Part B of research question three was answered by comparing change scores of staff tardiness and absenteeism in the experimental group only from pre to post intervention.

To reduce the likelihood of a Type I error, a preset confidence level was made at .05. This is the most common level used in research and journals (Morgan, et al., 2006).

Data Analysis Method

Data collected from the ProQOL, KMBQ, and Supplemental Data Sheet, which recorded information on rates of tardiness and absenteeism, was inputted into a database. Once complete, I checked for errors in the data collected. This was done by going through each of the data collection instruments and ensuring all data was complete. An expert research data analyst was used to enter the information from the database into the Statistical Package for the Social Sciences (SPSS). The research data analyst also performed all statistical analyses on data collected. Results were reviewed with this researcher to ensure understanding of the information.

The next step was to perform exploratory data analysis (EDA). The research data analyst conducted the EDA to generate numbers from the data which was then used to compute descriptive statistics and run frequency distributions. Among other things, the frequency distributions determined if there was skewness to the data (Morgan, et al., 2004).

One purpose of this study was to determine if a weekly skills based intervention would reduce the level of employee burnout in long-term care settings. In order to answer this question, information on employee level of burnout would need to be gathered, tested and analyzed from before and after the intervention for both the E and C groups. To accomplish this, mean scores for the E (intervention) group on the pretest ProQOL IV were calculated and subtracted from the mean scores for the E group on the posttest ProQOL IV in order to produce a change score for the E group. Likewise, a C (comparison) group change score was computed. The independent *t* test was conducted on change scores for the level of burnout to determine if the two groups differed significantly on level of change was measured by the ProQOL IV.

This method was appropriate as it allowed me to evaluate the effects of the intervention (Morgan, et al., 2006). The change score analysis approach is the most “straightforward approach” for analysis in this type of study design, the quasi-experimental pretest posttest comparison group design (Morgan, et al., 2006, p. 218). The statistical test method was conducted to answer research questions #1, part A, and #3, part A. If results indicated a test (p) value of $<.05$ then the data had statistical significance. Therefore, it could be concluded that the weekly skills based intervention was effective in reducing employee level of burnout. A post hoc test is not necessary to conduct if a “statistically significant p value” comparing two groups is obtained (Morgan, et al., 2006).

To address research question #2, and questions #1 and #3 part B, the 95% confidence interval (CI) was used rather than the more typical paired samples t test to determine if the experimental (E) group changed significantly. If the upper and lower bounds of the CI do not include zero, I can say there was a statistically significant change. This analysis provides essentially the same information as the paired t test.

Coding was the method used to organize and interpret the data collected on the participant evaluation forms. The qualitative data analysis method used was typology. This entailed creating a list of mutually exclusive categories as identified in the coding method to examine responses from the participant evaluation forms (Qualitative Data Analysis, 2010).

Method to Represent and Summarize Data Collected

A descriptive table was incorporated to provide visual representation of the demographics of each of the participants. This table included: group, gender, level of education, and job title; it can be found in Appendix 5. Tables were also included to show the results of each of the

different hypothesis tests conducted to answer the research questions (Morgan, et al., 2004). A table was also created to depict themes identified from the participant evaluations.

Summary

This study was a quasi-experimental pretest-posttest comparison group design. The focus was to test the intervention to combat long-term care employee burnout in psychiatric nursing homes. In addition, this research sought to determine if the knowledge level of employees regarding effective behavior management techniques to reduce challenging behavior in residents' increased following the intervention. The intervention design was grounded in CBT. The relationship between staff level of burnout and quality of care provided is grounded in the Systems Theory, the overarching framework to this study.

CHAPTER 4: RESULTS

Demographic data of the study sites and of participants is presented first. These data were obtained through the nursing home administrators of each of the study sites and through a participant roster form which was completed in each of the three study sites. Following demographics, there is a presentation of analysis of the reliability the Pro QOL instrument.

Data is next presented for results of the research questions from chapter 3. First, analysis of results of the Pro QOL instrument is exhibited to answer research question 1, which focuses on changes in staff level of burnout. The KMBQ is next presented to address research question 2, which centers on the staff level of knowledge of behavior management techniques. To answer research question 3, supplemental data was collected on participant rate of tardiness and absenteeism.

The *t* tests were conducted to compare change scores on the Pro QOL, tardiness and absenteeism between the experimental and control groups. Confidence intervals were obtained to measure change scores from pretest to posttest within the experimental group on the Pro QOL, KMBQ and the supplemental data. Last presented are themes identified on participant evaluation forms for the experimental group participants only. Qualitative analysis and presentation of data was used to analyze this information.

Descriptive Analysis

Descriptive Characteristics of Study Sites

There were three separate sites used in this study. They are titled Site 1, Site 2 and Site 3. Sites were chosen based on the following criteria: total resident occupancy and percentage of residents with some form of mental disorder diagnosis. Table 2 depicts the study site information. These three sites have similar number of residents and similar relatively high

percentages of residents with mental disorders. However, site 2 which included 9 of the 9 comparison group participants was the smallest nursing home and had the highest percentage of residents with mental disorders.

Table 2

Number of Residents with Mental Disorders at Each Site

Study Site	Total number of residents	Percentage of residents with a mental disorder
Site 1	104	42%
Site 2	85	55%
Site 3	110	40%

Descriptive Characteristics of Respondents

Table 3 summarizes the experimental (E) and comparison (C) group characteristics. Characteristics contained in Table 3 are separated out according to study site. The characteristics are presented in percentages based on the total participants for that group either E or C. Characteristics include total number in groups separated out from E and C group, gender, and discipline. The percentage of discipline labeled “other” category contains disciplines that are anything other than nursing staff, nurse manager or CNAs.

This descriptive information is presented, in Appendix 5, for each of the 31 participants. Participants of the experimental group have an E that precedes their participant identification number. Participants of the comparison group have a C that precedes their participant identification number. At site 3 all participants were included in the E group.

Table 3

Group Characteristics

Study Site	Group Size n	%Female	%RN or LPN	%CNA	%Nurse Manager	% Other Disciplines	% with AD or higher
Site 1	E=1	100	0	0	0	100	0
	C=1	100	0	0	100	0	0
Site 2	E=10	70	0	20	0	80	30
	C=8	75	50	25	12.5	12.5	63
Site 3	E=11	73	28	0	18	54	73
	C=0	-	-	-	-	-	-
Total	E=22	73	14	9	9	68	50
	C=9	77	44	22	22	11	56

All disciplines were invited to participate in this study. There is variability in the level of education among staff depending on their discipline within the nursing home. The average level of education for a CNA is a 6 week certification course. The average level of education for a RN is a 2 year associate degree. Those labeled in the table as “RN, LPN or CNA” under discipline are considered direct care staff. Nurse Managers are not considered to be direct care staff. Nurse Managers can hold a RN or LPN license. Nurse Managers have some type of managerial position within the nursing home; e.g. the Director of Nursing. The average level of education for both the Activities and Social Services disciplines is a Bachelor’s degree. Members of the maintenance and housekeeping departments hold a high school diploma (H.S. diploma).

Note that Table 3 indicates that most (73 and 77 percent) of participants were female and there approximately the same percentage in the E and C groups. However, a smaller portion of the experimental group (23%) was in direct care positions than the C group where 66% were in

direct care. The E and C groups had similar percentages of persons with an associate's degree (AD).

Study site 1 contained one member of the total E group participants and one member of the total participants for the C group. The E group member was employed in the medical records department. This staff member had completed a high school education and was currently on her Bachelor's degree in Social Work. The member of the C group at study site 1 is a LPN, and also a nurse manager.

Study site 2 contained 10 members of the total E group participants and eight members of the total C group participants. Of the E group participants, three were male and seven were female. In the E group, four had completed a Bachelor's degree, four possessed a high school diploma and two completed the six week CNA certification course. Two members in the E group at this study site were employed in the business office. Four members of the E group at this study site worked in the activities department. The remaining two were CNAs who are considered direct care staff.

There were eight of the total C group participants at study site two. Participants of the C group at study site 2 consisted of six females. Of these participants, two were CNAs, four were RNs, there was one nurse manager, one administrative assistant, and the nursing home administrator. The nursing home administrator had a Bachelor's of Gerontology degree. The RNs had an associate's degree, and the nurse manager had a Bachelor's of nursing degree. The CNAs had completed the 6 week certification course and the administrative assistant had a high school diploma.

Participants at study site three contained eleven members of the E group total number of participants. This was equivalent to half the total number of E group participants in the study.

Seven of these participants were female. The nursing home administrator was a member of this group. He possesses a Bachelor's degree in Health Administration. There were two nurse managers and two RNs, who worked as part of the direct care team. These four participants all have associates degree in nursing. There were two members of the social services department contained in this group and of these two one possesses a Bachelor's of Social Work degree and the other is currently in her second year of college working towards a Bachelor's of Social Work degree. There was one member of the dietary department who was a Registered Dietician with a Bachelor's degree. The member of the activities department had a Bachelor's degree. The final member of this group was in the maintenance department. This participant had a high school diploma. A more detailed description of participant demographics is contained in the appendix of the dissertation.

Reliability

The Professional Quality of Life Scale (Pro QOL) was given to all participants to measure level of burnout. Using the Cronbach's alpha test to measure internal consistency reliability scores were obtained from both the pre (a) and post (b) tests taken by all participants. The reliability score obtained for burnout on the pretest was .70. The reliability score obtained from the posttest results was .68.

There were 10 items that measured burnout on the ProQOL. The internal reliabilities of the pretest score of .70 is considered adequate. The posttest reliability score of .68 is marginal, as it is less than the desired result of .70. One explanation for the posttest results is participants may not have been agreeing with themselves in the way they answered the scale items.

Next data collected to answer each of the research questions are presented.

Analysis of the Research Questions

Research Question 1

Part A: Was there a difference in the change of level of burnout from pre to posttest between the experimental and the control group? Part B: Was there a change in the level of burnout for participants in the experimental group comparing pre and posttest?

To answer part A of this question an independent *t* test was used to compare pre/post change scores on the ProQOL between both groups. Table 4 depicts the results.

Table 4

Comparison of the Between Groups Change Scores on the ProQOL Instrument

Variable	Change					
	<i>N</i>	<i>M</i>	<i>SD</i>	<i>t</i>	<i>df</i>	<i>p</i>
Change Burnout				.15	29	.884
E group	22	-1.41	6.37			
C group	9	-1.78	6.24			

Resulting *p* values are not less than .05. Therefore, there is no significant difference in change scores between the experimental and the comparison groups on level of burnout from pre to post intervention. Both groups went down a little on the burnout scales.

In response to part B of question #1, the 95% confidence interval was -4.23 for the upper bound and 1.41 for the lower bound. As this interval contains 0 it is cannot be considered a statistically significant change of level of burnout in the E group from pre to post intervention.

Next, the KMBQ test results are presented.

Research Question 2

Was there a change in the level of knowledge about effective behavior management techniques among participants in the experimental group comparing pre and posttest?

Table 5 displays the results of the 95% confidence interval calculated to measure change scores within the experimental group.

Table 5

Pre to Posttest Change in the Experimental Group Knowledge Test Scores on the KMBQ

	Pretest	Posttest	Mean Change	95% Confidence Interval for pre to post change Lower bound	Upper bound
Knowledge	57	68	12	6.14	17.95

Results indicate a significant increase in staff level of knowledge of behavior management techniques as measured by the KMBQ as 0 is not contained within the bounds of the confidence interval. Thus, we can be quite sure that the change in the larger population would be at least partially due to this intervention.

Research Question 3

Part A: Was there a difference in the change from pre to posttest in the frequency of absenteeism and of tardiness between the experimental and control group? Part B: Was there a difference in the frequency of absenteeism and tardiness in the experimental group from before to after the weekly skills based intervention?

Data were collected for participants of both groups to measure rates of tardiness and absenteeism. Tardiness and absenteeism are indicators of burnout. These data were collected to provide supporting evidence for the ProQOL measurements of level of burnout and to answer research question three.

For research question 3A, independent t -tests were used to compare the change scores for the E and C groups. There was not a significant difference for either tardiness ($t = .63, p = .53$) or for absenteeism ($t = 1.28, p = .21$).

For part B, results of the 95% confidence intervals were calculated for change scores of the tardiness and absenteeism variables. Change scores for the rate of tardiness for the experimental group were not significantly different. The lower bound was $-.14$ and the upper bound was $.05$. Because this includes zero, I cannot be confident that rates of tardiness decreased. However, the change score for the rate of absenteeism for the experimental group was significantly different. The lower bound was $-.42$ and the upper bound was $-.04$. The interval did not contain zero; therefore, I can be confident that rates of absenteeism decreased. Four of the participants in the experimental group had fewer absences following the intervention.

Although not part of research question 4, results for the comparison group indicated that there was no significant difference in rates of either tardiness, with a lower and upper bounds of $.00$ and $.00$ respectively, or absenteeism with a lower bound of $-.38$, and an upper bound of $.38$, pre and post intervention time periods.

Participant Evaluations

There were 15 participants, which was a 68% completion rate, from the experimental group that completed evaluations on the intervention. Table 6 exhibits the themes that were identified from the evaluation responses.

Table 6

Participant Evaluation Response Themes

Theme	Participant Response
Length of Course	4 participants indicated they would have liked the course to be longer. 1 participant felt the course was too long for some of the topics.
Support of Co-Workers	8 participants responded their favorite part of the course was building support with their co-workers.
Improved Behavior Management Skills	5 participants commented their favorite part of the course was the increase in level of knowledge of effective behavior management techniques.
Participant Discipline	1 participant felt the course was not relevant to her job. This participant believed the course was primarily directed towards social services and nursing staff.

The following are quotes from the participant evaluations related to themes identified above. In reference to the theme of the length of the course the following statements were made. “I would have personally enjoyed spending more time learning more.” Another participant said, “I would have liked to go deeper into different psychiatric diagnoses.” One participant simply said, “More time!”

Gaining the support and understanding of co-workers were frequently identified as the most relevant part of training for the participants. One participant stated, “It was an incredible opportunity to share feelings about similar experiences of other employees.” Another participant remarked, “I was able to help by saying let me do this for you and can you help someone with

me also?” This comment was made in relation to staff supporting each other in the care of challenging clients.

The identified theme of improved behavior management skills was derived from statements such as these made by participants. “Learned different ways to deal with difficult patients.” Another participant commented, “Actually a great deal of this course was helpful not only to work but learning characteristics of different disorders helped me learn how to interact with some of my residents better.” This statement was also made, “I was able to talk about things that are bothersome in the workplace and learn ways to deal with difficult behaviors.”

Comments on the participant evaluations suggested in spite of the absence of significant change in level of burnout, the intervention was a positive and beneficial experience for E participant group members. Perhaps it was the positive experience of this group that facilitated the decrease in rates of absenteeism in members of the E group from pre to post intervention. The request for more time on the intervention provides some evidence to support the outcome of significant decrease in rates of absenteeism as being attributed to the intervention. The unintended benefit of group support suggests the need for further research on this topic and will be further discussed in chapter five.

Summary

The results of data collected indicated a significant increase in the area of knowledge of behavior management skills for members of the experimental group as well as a decrease in rates of absenteeism in this group. Results showed no significant differences in levels of burnout between groups, or within the E group, when measuring pretest to posttest change scores. Data supported the result of no significant change in the reduction of tardiness for the experimental group. The results of the participant evaluations were mainly positive as evidenced by the above

stated comments. The feedback contained on the participant evaluations indicate the weekly skills based intervention was helpful in areas other than what was measured by the ProQOL instrument. Inferences on the results of this data are presented in chapter five.

CHAPTER FIVE: DISCUSSION

The purpose of this study was to determine the effectiveness of a skills-based intervention in reducing the level of burnout in nursing home employees that work in facilities with a high percentage, minimum of 30%, of residents with some form of mental disorder diagnosis.

Nursing homes are seeing an increase in admissions of residents with some form of mental disorder (Fullerton, McGuire, Fang, Mor, and Grabowski (2009). Yet there is lack of formal training to educate the staff on how to effectively care for this challenging population (Berry, 2012). With this change of dynamic among the resident population, an alteration of role is occurring with what nursing homes have traditionally been used for; i.e., to care for the elderly population with primarily medical concerns. These factors are contributing to an increase in employee level of burnout in this setting. Traditionally, burnout has been studied in the hospital setting when focusing on healthcare employees. This study aimed to increase knowledge regarding burnout in employees of nursing homes.

This study employed a quantitative method to study the effects of a weekly skills based intervention on nursing home employee level of burnout. The intervention was based on principles of Cognitive-Behavioral therapy (CBT) techniques as well as evidenced based practices created by the Crisis Prevention Institute (CPI) to manage challenging behaviors in clients. There were eight sessions which were approximately one hour in length per session. All nursing home disciplines with some form of resident contact were invited to participate in the study. There were a total of 22 participants for the experimental group and 10 for the wait listed comparison group. Due to budget and schedule constraints participants were unable to be randomly assigned to groups; they all self-selected into groups. At study site 3 all participants

were members of the experimental group. Participants that were initial members of the wait listed comparison group received the intervention immediately after the initial experimental group. Therefore, they became members of the experimental group.

Three nursing homes were chosen as study sites. The study sites were selected based on a minimum of 30% of the total population of residents that had a diagnosis of some form of mental disorder, either a serious mental illness or dementia. The sessions occurred at each of the study sites for participant convenience.

There were four data collection instruments included in this study. The first consisted of the ProQOL, which measured staff level of burnout. The second instrument was the KMBQ, a knowledge based questionnaire which measured nursing facility staff level of knowledge of behavior management techniques. The KMBQ was administered solely to members of the experimental group. The third data collection instrument was the participant evaluation, which was administered to members of the experimental group only. The fourth data collection instrument was an information sheet containing data collected from the nursing home administrators on participant demographics, as well as rates of tardiness and absenteeism.

Research question #1 contained two parts. Part A measured participants' change scores on the ProQOL from pre to post intervention between the experimental and comparison group. An independent t test was conducted to analyze this data. Part B of question #1 measured change scores on the ProQOL from pre to post intervention in the experimental group only.

Research question #2 included measuring change scores on the Knowledge of Behavior Management Questionnaire (KMBQ) in the experimental group only from pre to post intervention. The paired t test was used to obtain these results.

Research question #3 was answered by obtaining 95% confidence intervals on the changes in rates of tardiness and absenteeism. Part A of this question compared change of rates of tardiness and absenteeism between the experimental and comparison group from pre to post intervention. Part B of this research question measured change scores of rates of tardiness and absenteeism for the experimental group only.

Finally, a participant evaluation was administered to the experimental group, which 15 participants completed. There were four themes identified from the evaluations. The themes included: (a) length of course; (b) support of co-worker; (c) improved behavior management skills; and (d) intervention being geared towards specific participant disciplines and not relevant to all disciplines.

Major Findings

The results of the intervention showed no significant difference between E and C groups in measuring pre to post intervention change scores on staff level of burnout. There was no statistically significant difference in the level of burnout for the experimental group only from pre to post intervention. The rates of tardiness and absenteeism when comparing E and C groups on change from pre to post intervention indicated no statistically significant difference. There was no statistically significant difference in the staff rates of tardiness from pre to post intervention in the E group.

However, there was a statistical difference in level of knowledge in change score from pre to post intervention in the experimental group. Densten (2001) found that a “lack of feelings regarding both job competence and achievement in one’s work” (p. 834) to be a characteristic of burnout. There was no significant impact on level of burnout in the experimental and comparison group from pre to post intervention. It is possible the intervention could have helped to prevent

the development of burnout by providing an opportunity for employees to increase their knowledge of skills to effectively care for a challenging population. This increase of knowledge was also a theme identified from participant evaluations which are further described below.

Additionally, there was a statistically significant decrease in rates absenteeism within the experimental group from pre to post intervention, with four staff members having a decrease in rate of absenteeism. Lavoie-Tremblay, Bourbonnais, Viens, Vezih, Durand, and Rochette (2004) also found a decrease in rates of employee absenteeism with use of a participatory action research intervention. The form of the intervention in this study shares one commonality with the participatory action research model. The intervention for this study offered a safe place for participants to share their work related frustrations and stressors that could lead to burnout. In response to identified problems, solutions were offered to assist employees to prevent the development of burnout. This process could have led to the significant decrease in absenteeism found in the experimental group participants.

The responses of participants on the evaluation forms were positive. Participants commented that one of the benefits of the intervention was the feeling of receiving support from their co-workers. Support in the sense that their co-workers could understand what they were experiencing and offer support to help staff provide better care for the residents.

The formulation of a peers support group helps decrease the sense of isolation which is a characteristic of burnout identified in the Eksted and Fagerberg (2003) study. Use of a peer support group intervention was found to be effective in the Peterson, Bergstron, Samuellsen, Asberg, and Nygren (2008) study. These researchers found a decrease in characteristics of burnout which included: (a) exhaustion; (b) disengagement; (c) quantitative work demands; and (d) negative mood symptoms. The positive attributes resulting from increased sense of support of

co-workers, identified by participants in this study, shared commonalities with the Bergstron, et al., (2008) study. These commonalities included: (a) support in completing work tasks; and (b) increased sense of connection with co-workers.

Additionally, Borritz (2006) found that a diminished sense of support can lead to emotional exhaustion, which is a feature of burnout. The unanticipated benefit of the increased sense of support from co-workers found in this study may have prevented participants from becoming emotionally exhausted, thereby deterring the development of burnout.

The theme of participant increase in their level of knowledge of how to effectively care for a challenging population is consistent with the statistical significant increase in level of knowledge from pre to post intervention as measured by change scores on the KMBQ. Participants felt they had gained skills on how to care for their clients. Because of the skill gain, participants stated on the evaluations they feel they are more effective in their job performance and can better relate to the residents with challenging behaviors.

The participants stated they felt the intervention could have been delivered over a longer period of time. The increase in sense of support by their co-workers and increase in knowledge may have been contributing factors to the decrease in staff rates of absenteeism, which was statistically significant from pre to post intervention within the experimental group. A longer intervention period may have made more of an impact on the change scores in employee level of burnout from pre to post intervention.

Discussion

There was no statistical difference in change scores between groups from pre to post intervention in staff level of burnout. There was only one participant identified as experiencing burnout, per measures on the ProQOL instrument, prior to the start of the intervention. That

participant did not complete the intervention as she was fired after the first intervention session was complete. Originally, recruitment for both experimental and comparison group members were going to be limited to those who were found to be experiencing burnout, as measured by the ProQOL instrument. This criterion was changed due to the low volunteer rate of employees to participate in the study. If this criterion was upheld it is likely there would have been more of an impact on staff level of burnout from pre to post intervention.

The intervention was based on the CBT theoretical foundation which included homework for participants to practice skills learned during session and apply them to actual work situations. The homework was not made mandatory by me as I did not want failure to complete the homework to become a reason for participants to drop out of the intervention. The completion rate of the homework was low. During the check in period conducted at the start of each of the eight sessions, most participants admitted to not doing homework. Other than time spent doing role play in session, the participants did not have much opportunity to practice learned skills. This factor could also have been a reason there was no statistical significant decrease in level of burnout in the experimental group from pre to post intervention.

Another consideration was the difference between the E and C groups in the percentage of participants who were direct care staff. The majority of participants in the E group were categorized as other disciplines, such as members of the activities or social services departments. The participants of the E groups who were not direct care staff have less exposure to the residents. This may reduce the likelihood of their developing of burnout. If they were not experiencing burnout prior to the start of the intervention, then it is likely to assume they would not have had a reduction in level of burnout from pre to post intervention.

In addition, there are other identified causes of burnout other than what was taken into consideration for this study. This study focused on the following two contributing factors to burnout: (a) poor stress management skills in staff; and (b) lack of training to care for a difficult population.

Other contributing factors to burnout, as identified by Benson and Macgrath (2005) include: “working long hours with limited resources” and “failing to live up to one’s expectations” (Benson & Macgrath, 2005, p. 497). The construct of limited resources as a contributing factor to burnout appeared in one other study discussed in chapter two. Edstedt and Fagerberg (2005) listed working short staffed as a workplace dynamic that could lead employees to develop burnout. This dynamic was not addressed in the intervention for this study. If this was a major source of contribution to participants feeling burnt out, then an outcome with no significant change might be expected as staffing shortages would have remained in place after the intervention.

There is one more potential cause of burnout that is worthy of discussion. Untreated vicarious trauma is another cause of burnout. Vicarious trauma can be defined as the “cumulative transformative effect on the helper of working with survivors of traumatic life events” (Bloom, 2003, p.459). Individuals with severe mental illness are 11 times more likely to be victims of a violent crime than that of the general population (Teplin, 2005). Therefore it is likely that residents with severe mental illness in the care of nursing homes have been victims of violent crimes. This dynamic creates a potential for staff to develop vicarious trauma.

One method to treat vicarious trauma is to gain support from co-workers who have had similar difficulties in caring for a challenging client population. This helps to normalize the experience and to reduce the potential for feeling disconnected.

A theme that emerged from the participant evaluations was the positive support participants felt they received from their co-workers. In addition, participants gained an understanding that their co-workers had shared difficult experiences in working with residents with challenging behaviors. It is possible vicarious trauma may have been a prominent feature leading to burnout among participants of the experimental group. Further exploration of vicarious trauma in this population is recommended for future studies.

Another contributing factor to burnout is “professional isolation” according to Benson and Macgrath (2005, p. 497). Building a support system at work could help decrease the sense of separation that a person may experience when feeling burned out. Peterson, et al., (2008) also found positive results in decreased employee burnout through use of a peer support group.

With this information, the development of the co-worker support system in this study should have led to a decrease in participant level of burnout. However there was no statistically significant change from pre to post intervention in participant level of burnout. Barger and Iwai (1996) may offer an explanation as to why this result occurred. They added a workplace support system for employees into their study’s intervention as a means to target employee burnout. What they found is that they limited the employee support system with a focus on the workplace support system, not including personal support systems. In their study employees were not likely to reach out to co-workers for support. Barber and Iwai (1996) believed if they had included use of a personal support system they would have had more positive results in change in level of burnout from pre to post intervention.

Perhaps, if the time of the intervention was increased, participants would have had more time to develop a stronger sense of support from co-workers. Multiple participants of this study stated they wished the length of time of the intervention was longer. Additional time would have

created the opportunity for participants to feel more comfortable and to open up during sessions to receive support from their co-workers. This may have had a more positive impact on the level of burnout from pre through post intervention.

The CBT skills based intervention included training to increase staff knowledge to care for a population of residents with some form of mental disorder, which correlates to higher instances of challenging behaviors. Tariot, et al. (1993) found 91% of a sample size of 80 residents in a nursing home had at least one challenging behavior. The Sanford Center for the Aging identified challenging behaviors in over 50% of nursing home residents with a diagnosis of dementia. Challenging behaviors included physical and verbal aggression, unable to care for themselves and wandering.

Participants identified knowledge gained to care for challenging clients as one of the benefits of the intervention. There was a significant increase in staff level of knowledge as measured by the KMBQ following the intervention. However, the same results could not be guaranteed if the intervention was to be used in future studies. It is unknown to what extent the researcher's style of training impacted the results. Even if standardized training occurred using this same intervention, it is expected that the facilitator would have an impact on how the information is delivered. A difference in delivery style would influence the extent of which the participants absorb the knowledge.

Schaufeli and Peters (2000) reviewed research conducted on employee burnout through 1999 and found absenteeism from the workplace to be a common characteristic of employees experiencing burnout. This was supported through research conducted by Endicott (2006).

Results of this study revealed a statistically significant decrease in employee rate of absenteeism for the experimental group from pre to post intervention. Absenteeism is supported

by research to be an indicator of burnout. However, in spite of the decrease in absenteeism for this study there was no statistical decrease in employee level of burnout for the experimental group as measured by the ProQOL. This would suggest absenteeism may be a result of a cause other than burnout.

The Systems theory was the overarching theory of this study, chosen to illustrate how one system, the employees, affects another system, the residents. This is the micro level of focus. There was significant change at this level in staff level of knowledge on behavior management techniques. To achieve more sustainable change it is necessary to take the intervention to higher levels within the systems framework. This would involve change at the mezzo, the nursing facility, and the macro, the healthcare industry, levels. Freudenberger (1989) also encouraged organizations to become involved with managing and preventing burnout.

As part of the agreement to use the nursing facilities as study sites, I agreed to meet with the nursing home administrators (NHA) after the intervention was concluded and provide recommendations. This helped to facilitate change at the mezzo, the nursing facility, level. Recommendations provided were based on the results of data analysis, to include participant evaluations. One recommendation provided was to incorporate regularly scheduled training in the area of behavior management techniques. A second recommendation was to incorporate a peer support group. Both interventions can be implemented at low cost to the facility.

Change at the macro level, the healthcare industry, could include incorporating this training into the CNA certification course so they would have advanced knowledge in the care of residents with mental disorders. Training in the area of effective behavior management techniques is not currently an established part of the CNA certification course. This would be a proactive technique to prevent burnout and increase the quality of care provided to the residents.

Conclusions

This study focused on the nursing home environment which has not been traditionally studied as a setting for examining burnout in healthcare employees. With the increase of admissions to nursing homes of residents with some form of mental disorder, there is increased potential for staff in nursing homes to become burnt out. This study offered a possible intervention to use to combat employee burnout in this setting. Though there was no statistical difference in the level of burnout resulting from the intervention in this study, participant evaluations revealed positive effects that could impact employee burnout if measured by an instrument other than the ProQOL. The development of a positive peer support group system may have had a more positive impact on the level of burnout if the length of time of the intervention was increased. An instrument designed to capture employee feeling of support and how this impacts burnout would be appropriate to address this construct.

An additional contribution to the field which this study made was evidence to support the benefits of providing training to nursing home employees to care for residents with challenging behaviors. Berry (2012) found only about 10% of nursing home staff received adequate training to care for residents with challenging behaviors. Adequate training has an additional positive impact on resident's quality of life (Craig & Phom, 2006).

Recommendations

I recommend further research on the topic of employee burnout in nursing homes. Research identifies a connection of employees working under prolonged stress and with clients that have aggressive behaviors as a contributing source of burnout. The increase of admissions to nursing homes of residents with mental disorders and the connection of challenging behaviors with residents with serious mental illness or dementia create an environment where employee

burnout is likely to occur. Participants identified the development of a positive peer support system as one benefit to have participated in the intervention of this study. A future study with a similar intervention with increased length of time for the intervention would be beneficial to further evaluate the benefits of a positive peer support group on employee level of burnout.

A second recommendation is to include staff to resident ratio as criteria for inclusion of a study site. The construct of staffing shortages as another contributing factor to burnout was not examined in this study. Focus on this area would help to obtain information regarding whether or not this is a continued concern in the nursing home industry and how this dynamic interplays with the increase of resident admissions with challenging behaviors.

A third recommendation would be to limit participants to those classified as direct care staff only. Those who are considered to be direct care staff have the most contact with the residents and are among the least educated to care for a challenging population. The majority of the direct care staff members have only the Certified Nursing Assistant Certificate, which is a six week course post high school. Their frequency of contact and lack of education leave them most vulnerable for the development of burnout. Therefore, they are the ideal target participant group for an intervention, such as the one developed for this study, designed to combat employee burnout.

A fourth recommendation would be to rearrange the order in which the intervention was delivered. The focus of the first half of the intervention was on the participant's work related stress management skills. This entailed the participants to discuss experiences at work in which they experienced stress in order to teach the participants how to reframe the situation, using CBT skills, to reduce stress associated with the situation. The participants may have been more comfortable discussing their work related stress experiences after having time to become more

comfortable with the group and the facilitator. Therefore to start off with the education piece related to diagnoses and behavior management techniques may help ease the participants into the process and increase their level of comfort with discussing personal experiences with work related stress.

The instrument used to measure burnout in this study was the ProQOL IV. This instrument measured burnout, compassion satisfaction and compassion fatigue, with only burnout scores used in the analysis portion of this study. One of the most popular alternate instruments to use to measure burnout is the Maslach Burnout Inventory (MBI). This instrument measures characteristics of burnout that include: emotional exhaustion, negative attitude towards others and personal accomplishment. Use of this instrument may be more sensitive to burnout related features and may be a better predictor in level of burnout than the ProQOL IV. Therefore, it is recommended to use an instrument such as the MBI in future studies.

The KMBQ contained four dimensions of knowledge of behavior management techniques that include: (a) identifying and assessing resident behavior; (b) recognizing environmental influences on behavior; (c) identifying and using behavioral procedures to promote and maintain desired behaviors; (d) identifying and using behavioral procedures to reduce and extinguish undesired behaviors. For future studies using this instrument, it may be helpful to distinguish between the four dimensions when conducting data analysis to determine in which dimension the change occurred. Thereby providing useful information on how the intervention may possibly need to be modified in order to increase the likelihood of significant improvement occurring in all of the four dimensions.

REFERENCES

- Barber, C. & Iwai, M. (1996). Role conflict and role ambiguity as predictors of burnout among staff caring for elderly dementia patients. *Journal of Gerontological Social Work, 26*(1),101-116.
- Bartels, S., Miles, K., Dums, A., & Levine, K. (2003). Are nursing homes appropriate for older adults with severe mental illness? Conflicting consumer and clinician views and implications for the Olmstead decision. *Journal of the American Geriatrics Society, 51*, 1571-1579.
- Beck Institute (2012). Cognitive-behavior therapy. Retrieved from <http://www.beckinstitute.org/what-is-cognitive-behavioral-therapy/>.
- Benson, J, & Magraith, K. (2005). Compassion fatigue and burnout. *Australian Family Physician, 34*(6), 497-498.
- Berry, R. (2012). Survey on challenging behavior in care homes. *Journal of Quality Research in Dementia, 2*. Retrieved from <http://www.courseindex.com/content/dementia-and-challenging-behaviour-in-the-care-home/>.
- Blair, C. & Eldridge, E. (1997). An instrument for measuring staff's knowledge of behavior management principles (KMBQ) as applied to geropsychiatric clients in long-term care settings. *Journal of Behavioral Therapy and Experimental Psychiatry, 28*(3), 213-220.
- Borritz, M. (2006). Burnout in human services work- causes and consequences. Retrieved from, <http://www.arbejdsmiljoforskning.dk/upload/MB-phd.pdf>.
- Brunero, S., Cowan, D., & Fairbrother, G. (2008). Reducing emotional distress in nurses using cognitive behavioral therapy: a preliminary program evaluation. *Japan Journal of Nursing Science, 5*(2), 109-115.
- Cherniss, C. (1980). *Professional burnout in human service organizations*. New York, NY: Praeger Publishers.
- Collins, S., & Long, A. (2003). Working with the psychological effects of trauma: consequences for mental health-care workers- a literature review. *Journal of Psychiatric and Mental Health Nursing, 10*, 417-424.
- Cook, T., & Campbell, D. (1979). *Quasi-experimentation: design and analysis for field settings*. Chicago, Il: Rand McNally.

- Cox, T., Tisserand, M., & Taris, T. (2005). The conceptualization and measurement of burnout: questions and directions. *Work & Stress, 19*(3), 187-191.
- Craig, E., & Phom, H. (2006). Consultation-liaison psychiatry services to nursing homes. *Australian Psychiatry, 14*(1), 46-53. Retrieved from the PsycINFO database.
- Crisis Prevention Institute (2012). History of caring. Retrieved from <http://www.crisisprevention.com/About-CPI>.
- Densten, I. (2001). Re-thinking burnout. *Journal of Organizational Behavior, 22*, 833-847.
- Ekstedt, M. & Fagerberg, I. (2003). Lived experiences of the time preceding burnout. *Journal of Advanced Nursing, (49)1*, 59-67.
- Endicott, L. (2006). *Self-care of the professional: managing compassion fatigue and burnout in one's practice*. Presented at NACSW Convention in Philadelphia, PA.
- Freudenberger, H. (1974). Staff burn-out. *Journal of Social Issues, 30*(1), 159-165.
- Freudenberger, H. (1989). *Professional burnout in medicine and the helping professions. Chapter 1: Burnout: past, present and future concerns*. New York, NY: The Haworth Press.
- Fullerton, C., McGuire, T., Feng, Z., Mor, Z., & Mor, V. (2009). Trends in nursing home admissions: 1999-2005. *Psychiatric Services, (60)*, 965-971.
- Fusilier, M., & Manning, M. (2005). Psychosocial predictors of health status revisited. *Journal of Behavioral Medicine, 28*(4), 347-358.
- Galantino, M., Baime, M., Maguire, M., Szapary, P., & Farrar, J. (2005). Short communication: Association of psychological and physiological measures of stress in health-care professionals during an 8-week mindfulness meditation program: mindfulness in practice. *Stress and Health, 21*, 255-261.
- Gardner, B., Rose, J., Mason, O., Tyler, P., & Cushway, D. (2005). Cognitive therapy and behavioural coping in the management of work-related stress: An intervention study. *Work & Stress, 19*(2), 137 - 152.
- Grabowski, D., Aschbrenner, K., Feng, Z., & Mor, V. (2004). Mental illness in nursing homes: variations across the state. *Health Affairs, 28*(3), 689-700.
- Healthinaging.org (2012). Nursing homes basic facts and information. Retrieved from <http://www.healthinaging.org/aging-and-health-a-to-z/topic:nursing-homes/>.

- Hillman, J., Flicker, S., LeGendre, L., & Traczok, K. (2005). The pervasiveness of patient aggression among elderly residents in long-term care: implications for intervention and prevention. *Psychology of Aggression*, 69-88.
- Hudnall-Stamm, B. (1997-2005). Professional Quality of Life: Compassion Satisfaction and Fatigue Subscales, R-IV (ProQOL).
- Hyrkas, K. (2005). Clinical supervision, burnout, and job satisfaction among mental health and psychiatric nurses in Finland. *Issues in Mental Health Nursing*, 26, 531-556.
- Jackson A.G., Templeton G.J. & Whyte J. (1999). An overview of behaviour difficulties found in long-term elderly care settings. *International Journal of Geriatric Psychiatry*, 14, 426-430.
- Kartman, L. (1983). People helping people. *Activities, Adaptation, and Aging*, 3(4), 49-57.
- 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.
- Lavoie-Tremblay, M., Bourbonnais, R., Viens, C., Vezina, M., Durand, P. & Rochette, L. (2004). Improving the psychosocial work environment. *Journal of Advanced Nursing*, 49(6), 655-664.
- Levin-Epstein, M. (2006). Placement of mentally ill individuals in nursing homes: today's legal warfare. *Nursing Homes Magazine*, 52-54.
- Maas, M., Specht, J., Buckwalter, K., Gittler, J., & Bechen, K. (2008). Nursing home staffing and training recommendations for promoting older adults' quality of care and life: part 1 deficits in the quality of care due to understaffing and undertraining. *Research in Gerontological Nursing*, 1(2), 123-133.
- Maslach, C. (1976). Burned-out. *Journal of Human Behavior*, 5, 16-22.
- Maslach, C., & Jackson, S. (1981). The measurement of experienced burnout. *Journal of Occupational Behavior*, 2, 99-113.
- Maxim, P. (1999). *Quantitative research methods in the social sciences*. New York, NY: Oxford University Press.
- Mayo Clinic (2006). Job burnout: know the signs and symptoms. Retrieved from <http://www.mayoclinic.com/health/burnout/WL00062>.

- McCarthy, J., Blow, F., & Kales, H. (2004). Disruptive behaviors in veteran's affairs nursing home residents: how different are residents with serious mental illness. *Journal of American Geriatrics Society*, 52(12), 2031-2038.
- Medlineplus (2012). Nursing homes. Retrieved from <http://www.nlm.nih.gov/medlineplus/nursinghomes.html>.
- Molinari, V., Merritt, S., Mills, W., Chiriboga, D., Conboy, A., Hyer, K., & Becker, M. (2008). Serious mental illness in Florida nursing homes: need for training. *Gerontology & Geriatrics Education*, 29(1), 66-83.
- Morgan, G., Gliner, J., & Harmon, R. (2006). *Understanding and evaluating research in applied clinical settings*. Mahwah, NJ: Lawrence Erlbaum Associates, Inc.
- Morgan, G., Leech, N., Gloeckner, G., & Barrett, K. (2004). *SPSS for introductory Statistics use and interpretation*. Mahwah, NJ: Lawrence Erlbaum Associates.
- Munn-Giddings, C., Hart, C., & Ramon, S. (2005). A participatory approach to the promotion of well-being in the workplace: lessons from empirical research. *International Review of Psychiatry*, 17(5), 409-417.
- National Association of Cognitive-Behavioral Therapists (2008). What is CBT? Retrieved from: <http://www.nacbt.org/>.
- National Nursing Home Survey (2004). Nursing home care. Retrieved from <http://www.cdc.gov/nchs/fastats/mental.htm>.
- Neuman, W., & Krueger, L. (2003). *Social work research methods, qualitative and quantitative applications*. Boston, MA: Pearson Education.
- Payne, M. (2005). *Modern social work theory*. Chicago, IL: Lyceum Books.
- Peterson, U., Bergstrom, G., Samuelsson, M., Asberg, M., & Nygren, A. (2008). Reflecting peer support groups in the prevention of stress and burnout: A randomized controlled trial. *Journal of Advanced Nursing*, 63(5), 506-516.
- Pines, A. & Aronson, E. (1988). *Career burnout: causes and cures*. New York, NY: Free Press.
- Priebe, S., Fakhoury, W., Hoffmann, L., & Powell, R. (2005). Morale and job perception of community mental health professionals in Berlin and London. *Journal of Social Psychology*, 40, 223-232.
- Pucci, A. (2010). *Cognitive-behavioral therapy: the basics of helping people get better*. Retrieved from <http://www.nacbt.org/basics-of-cbt.htm>.

- Qualitative Data Analysis (2010). Methods of qualitative data analysis. Retrieved from <http://www.qualitative-data-analysis.com/methods-of-qualitative-data-analysis.html>.
- Ray, W., Taylor, J., Lichtenstein, N., & Meador, K. (1992). The nursing home problem behavior scale. *Journal of Gerontology*, 47(1), m9-16.
- Rizzo, J. & House, R. (1970). Role conflict and ambiguity in complex organizations. *Administrative Science Quarterly*, 15, 150-163.
- Rosebaum, M. & Ronen, T. (1998). Clinical supervision from the standpoint of cognitive-behavior therapy. *Psychotherapy*, 35(2), 220-230.
- Ross, M., Carswell, A., & Dalziel, W. (2002, September). Staff burnout in long-term care facilities. *Geriatrics Today*, 132-135.
- Sahyoun, N., Pratt, L., Lentzner, H., Dey, A. & Robinson, K. (2001). The changing profile of nursing home residents: 1985-1997. *Centers for Disease Control and Prevention, Aging Trends*, 4. Retrieved from <http://www.cdc.gov/nchs/data/ahcd/agingtrends/04nursin.pdf>.
- Sanford Center for the Aging (2008). Managing difficult behaviors. Retrieved from <http://www.unr.edu/sanford/resources/caregive.aspx>.
- Shah, A., Chiu, E., & Ames, D. (2000). Aggressive behavior and environmental characteristics in Australian nursing homes. *Aging and Mental Health*, 4(1), 43-47.
- Shaufeli, W., & Peeters, M. (2000). Job stress and burnout among correctional officers: a literature review. *International Journal of Stress Management*, 7(1), 19-49.
- Shinan-Altman, S., & Cohen, M. (2009). Nursing aides' attitudes to elder abuse in nursing homes: the effect of work stressors and burnout. *The Gerontologist*, 49(5), 674-684.
- Shirom, A. (2005). Reflections on the study of burnout. *Work & Stress*, 19(3), 263-270.
- Smith, K., Davey, J., & Everly, G. (2006). An assessment of the construct distinctiveness of stress arousal and burnout. *Psychological Reports*, 99, 396-406.
- Sprang, G., Whitt-Woosley, & A., Clark, J. (2007). Compassion fatigue, burnout and compassion satisfaction: factors impacting a professional's quality of life. *Journal of Loss and Trauma*, 12, 259-280.
- Tariot, P., Podgorski, C., Blazina, L., & Leibovici, A. (1993). Mental disorders in the nursing home: another perspective. *American Journal of Psychiatry*, 150, 1063-1069.

Virginia State Government (1990). Definition of serious mental illness. Retrieved from <http://www.dbhds.virginia.gov/documents/manuals/OMH-ContinuityCareAppendixM.pdf>.

Wessells, D. (1989). *Professional burnout in medicine and the helping professions. Chapter 2: the etiology of job stress*. New York, NY: The Haworth Press.

Winship, B. (2008). Research summary: the effect of whole team training in evidence-based interventions on the knowledge, well-being and morale of inpatient mental health workers. *Journal of Psychiatric and Mental Health Nursing*, 15, 784-786.

World Health Organization (2010). Elder abuse. Retrieved from http://www.who.int/ageing/projects/elder_abuse/en/.

APPENDIX ONE: INTERVENTION

Session One

1. Introduce CBT theory:
 - a. CBT is based on the assumption that one's own thoughts cause feelings and behaviors, not an external source such as people, situations or events. The benefit of CBT is it empowers the participant to understand the role one plays in the development of stress, thereby it is within the power of that individual to change their response which in turn will reduce stress in their life. It is an educationally based intervention in which participants are taught how to recognize their irrational responses to stress and how to modify those responses using CBT coping skills such as thought dispute, distraction, positive self-talk and relaxation. If an individual can learn to develop a calmer response to a stressor it will then lead to a reduction in the negative impact of that stressor (National Association of Cognitive-Behavioral therapists, 2009).
2. Ask participants to identify current work stressors. Apply the CBT model using 2-3 of the work stressors to illustrate the concepts of CBT.
3. Provide an overall description of other skills to be learned in the intervention:

Understanding different diagnoses of severe mental illness (Schizophrenia, Schizoaffective disorder, Bipolar Mood disorder, and Major-depressive disorder) that are commonly found among nursing home residents.
4. Homework: start a thought journal. Record at least 2 stressful events that occur in the workplace between now and the time of the next session. Record thoughts, emotions and behaviors produced in response to the event.

Session Two

1. Review of homework from 1st session.
2. Introduce the ABC model which will be the foundation of the CBT model for teaching stress management coping skills
 - a. A: activating event
 - b. B: beliefs about the event
 - c. C: consequences resulting from beliefs about the event
3. Define and describe irrational beliefs (what is occurring in the “B” phase of the ABC model) and how to dispute irrational beliefs: (powerstates, 2009)
 - a. All or nothing thinking: thinking in absolute terms such as “always” or “never”.
To combat this thinking error think of a situation when the event did not occur, try to find evidence to dispute the belief that it is “always” or “never” happening
 - b. Overgeneralization: taking isolated events and generalizing to other cases. To combat this thinking error become aware of yourself engaging in this thought process and modify your way of thinking to keep the focus on the isolated situation
 - c. Mental Filtering: focusing only on the negative. To combat this thinking error write down the positives received in addition to the negatives to lend attention to the positives.
 - d. Disqualifying the positive: When someone gives a compliment the automatic thought or response is to think of some reason other than one’s own worthiness is the cause of the compliment. For example, if your boss tells you that you did a good job, your automatic response may be, “I just got lucky” instead of validating

the compliment as a reflection of your worth. To combat this thinking error accept the compliment with a simple “thank you” and make a list of personal strengths and accomplishments to focus on when feeling diminished sense of self-worth.

- e. **Jumping to conclusions:** assuming something is negative in the absence of evidence to support this belief. To dispute this thinking error think of evidence you may have to support this conclusion, if none then leave yourself open to the possibility that it may not be negative. You may also identify the purpose this thought serves in your life and possible consequences of this thought if you allow it to continue.
- f. **Magnification and catastrophizing:** Exaggeration of negatives. To combat this focus on the situation at hand and think rationally with evidence about what potential outcomes may be to reduce the feeling of becoming overwhelmed as a result of the situation or event.
- g. **Emotional reasoning:** making arguments or arriving at conclusions based on emotions and how you feel rather than objective reasoning. Learn to separate out emotions from thoughts to build a better understanding of the connection between thoughts and emotions and how one can control and/or modify thoughts to change emotional responses and make reality based and reasonable decisions.
- h. **Shoulding:** Must and can’t thinking. What is beyond your control. An irrational belief about the way things “should” or “ought” to be. To dispute this belief ask yourself if there is some law or concrete evidence to support this as something that “should” be or is it a personal preference. If it is a personal preference can

you change that preference or adapt to a different way to reduce the negative impact of the situation or event.

- i. Personalization and blame: accepting responsibility for situations that have little to do with yourself and are beyond your control. Ask yourself to realistically analyze whether or not you can be held responsible or blamed for the situation or event.
4. Apply ABC model to work stressors identified in the first session
 5. Homework: Record at least 2 stressful events at work that occur between now and the time of the next session in your thought journal. Use the ABC worksheet (see attachment) to process the events. This will help to build awareness of personal involvement in the development of stress and to increase buy-in into this intervention by empowering participants to change their response to reduce work-related stress.

Session Three

1. Review of homework from last week's session. Evaluation of the ABC exercise, was it helpful? Was it user friendly? Did participants understand how to complete the worksheet? Do participants believe this exercise to be useful?
2. Ask participants to identify current coping skills or strategies used to manage stress.
3. Introduce other CBT based skills to manage stress:
 - a. Review of the thought dispute process to produce positive outcomes
 - b. Positive self-talk: Through use of the thought journal you have developed an increase in self-awareness of what situations or events trigger negative thoughts about yourself. It is suggested to identify your negative self thoughts. Once you have done this modify the negative thoughts into positive thoughts about yourself.

Practice is essential in producing the desired change and lasting results of replacing negative self-talk with positive self-talk. When you catch yourself engaging in negative self-talk consciously replace that thought with the identified positive thought and repeat this to yourself about 10 times (Kelly and Devonshire, 2007).

- c. Distraction: By redirecting your attention to focus on something neutral or relaxing you can interrupt or stop the negative impact of the stress inducing situation or event (youspsychology.com, 2010)./
 - d. Relaxation techniques: meditation, yoga, listening to music, any activity that helps you to relax.
4. Homework: Complete thought journal and ABC worksheet on a least 2 stressful events that occur between now and the time of the next session. Practice one positive coping skill learned in this session to help reduce the negative effects of the situation or event.

Session Four

1. Review of homework. Evaluate the effectiveness of the stress management coping skill used. Is there a different skill that could have been used that may have produced a more positive result?
2. Introduce more CBT based coping skills (Segal, Horwitz, Jaffe-Gill, Smith and Segal, 2008):
 - a. Time management: prioritize tasks, break tasks down into small manageable steps, take planned breaks, give yourself enough time to complete the tasks
 - b. Health lifestyle: exercise, healthy food choices, avoid excess use of alcohol, and get plenty of sleep.

- c. Positive problem-solving skills: approach problem solving with a solution focused intent. Be calm and focus on the facts, avoid blame. Identify 2-3 possible solutions. Analyze outcomes of each solution and implement the solution with the best outcome. Evaluate the effectiveness of the solution to modify the solution if needed.
3. Setting goals to help manage work related stress:
 - a. Continue use of thought journal and ABC worksheet
 - b. Continued use of coping skills
 - c. Developing and practicing healthy habits to manage stress
 - d. Commitment from each participant regarding what they will practice every day to help manage work-related stress. Write down goal and place in an area where they can see it every day as a reminder of their commitment to the goal.
4. Homework:
 - a. Complete thought journal on 2 stressful work events that occur between now and the time of the next session. Use ABC worksheet to process the event or situation. Implement coping skill to manage the stress.
5. Suggest developing a peer support group in which participants would have a safe and confidential place to go and express work related stress and get support and feedback from the group on how to manage the stress and improve the situation using CBT based skills.

Session Five

1. Schizophrenia:
 - a. Review of the attached information sheet

2. Schizoaffective disorder
 - a. Review of the attached information sheet
3. Examples of behaviors and characteristics observed in residents participants work with that are diagnosed with either Schizophrenia or Schizoaffective disorder. Examples of challenging behaviors residents may have as a result of symptoms related to their diagnosis.
4. Bipolar disorder: Review of the attached information sheet
5. Major Depressive disorder: Review of the attached information sheet.
6. Examples of behaviors and characteristics observed in residents participants work with that are diagnosed with either Major Depression or Bipolar disorder. Examples of challenging behaviors residents may have as a result of symptoms related to their diagnosis.
7. Homework:
 - a. Complete thought journal on thoughts specific to residents that are diagnosed with either Schizophrenia or Schizoaffective disorder and have challenging behaviors as a result.
 - b. Complete thought journal on thoughts specific to residents that are diagnosed with either Major Depression or Bipolar disorder and have challenging behaviors as a result.

Session Six

1. Review of last week's material and of the homework. Any surprises on how residents impact us?

2. Low level interventions to manage challenging behaviors (from the Crisis Prevention Institute):
 - a. Identifying change or increase in resident's behavior that may indicate the need for staff intervention to help support the resident and de-escalate to prevent a crisis from occurring.
 - i. Anxiety stage: noticeable change or increase of behavior. Ask participants to provide examples of anxious behaviors of residents.
 - b. Interventions to implement to intervene effectively when a resident is exhibiting signs of anxious behaviors:
 - i. Active listening:
 1. Listen carefully to what the person is saying
 2. Be nonjudgmental
 3. Give undivided attention
 4. Use restatement to clarify the message
 5. Allow silence for reflection
 - ii. Reflection: reflect the residents behavior back to him or her to help build awareness in the resident of how their behavior is affecting others. Offer suggestions on alternate, pro-social behavior the resident can use to get needs met that won't produce a negative response.
3. Use of CBT techniques to modify behavior such as:
 - a. Operant conditioning
 - b. Prompting and cueing to train clients on developing new skills

4. Use of role play to assist participants with building understanding and level of comfort in practicing the above mentioned behavior management techniques.
5. Homework:
 - a. Thought journal to record stressful situation involving a resident with mental illness. Record behavior management technique used to minimize or deter the challenging behavior. Record resident response to the intervention, was it effective? Did it produce the desired result?
 - b. Practice and record stress management coping skill used to minimize the negative impact of the resident's challenging behavior on you. Was it useful?

Session Seven

1. Review of last week's homework.
2. Behavior management techniques continued:
 - a. Review of anxiety and the importance of early intervention and use of low-level behavior management techniques.
 - i. Validation: validate the resident's feelings about an event. Their experience is very real to them and they need to feel accepted and supported in their feelings about a situation or event.
 - ii. Distraction: similar to what was learned in session three. Positive distraction techniques to use with residents to help decrease their level of anxiety. Examples: listening to music, taking a walk, or playing a game.
 - iii. Setting limits: helping residents to make a choice.
 1. Clear and simple

2. Reasonable
3. enforceable
3. Use of role play to assist participants with building understanding and level of comfort in practicing the above mentioned behavior management techniques.
4. Homework:
 - a. Thought journal to record stressful situation involving a resident with mental illness. Record behavior management technique used to minimize or deter the challenging behavior. Record resident response to the intervention, was it effective? Did it produce the desired result?
 - b. Practice and record stress management coping skill used to minimize the negative impact of the resident's challenging behavior on you. Was it useful?

Session Eight

1. Review of last week's homework
2. Building self-awareness to develop health boundaries with residents. Review attached information and worksheet.
3. Use of peer support group to manage work related stress and to offer opportunity to get feedback and suggestions on successful behavior management techniques to minimize challenging behaviors.
4. Thank participants.

APPENDIX TWO: PROFESSIONAL QUALITY OF LIFE SCALE

ProQOL R-IV

PROFESSIONAL QUALITY OF LIFE SCALE

Compassion Satisfaction and Fatigue Subscales—Revision IV

[Helping] people puts you in direct contact with their lives. As you probably have experienced, your compassion for those you *[help]* has both positive and negative aspects. We would like to ask you questions about your experiences, both positive and negative, as a *[helper]*. Consider each of the following questions about you and your current situation. Select the number that honestly reflects how frequently you experienced these characteristics in the *last 30 days*.

0=Never 1=Rarely 2=A Few Times 3=Somewhat Often 4=Often 5=Very Often

1. I am happy.
2. I am preoccupied with more than one person I *[help]*.
3. I get satisfaction from being able to *[help]* people.
4. I feel connected to others.
5. I jump or am startled by unexpected sounds.
6. I feel invigorated after working with those I *[help]*.
7. I find it difficult to separate my personal life from my life as a *[helper]*.
8. I am losing sleep over traumatic experiences of a person I *[help]*.
9. I think that I might have been “infected” by the traumatic stress of those I *[help]*.
10. I feel trapped by my work as a *[helper]*.
11. Because of my *[helping]*, I have felt “on edge” about various things.
12. I like my work as a *[helper]*.
13. I feel depressed as a result of my work as a *[helper]*.

14. I feel as though I am experiencing the trauma of someone I have *[helped]*.
15. I have beliefs that sustain me.
16. I am pleased with how I am able to keep up with *[helping]* techniques and protocols.
17. I am the person I always wanted to be.
18. My work makes me feel satisfied.
19. Because of my work as a *[helper]*, I feel exhausted.
20. I have happy thoughts and feelings about those I *[help]* and how I could help them.
21. I feel overwhelmed by the amount of work or the size of my case^[work]load I have to deal with.
22. I believe I can make a difference through my work.
23. I avoid certain activities or situations because they remind me of frightening experiences of the people I *[help]*.
24. I am proud of what I can do to *[help]*.
25. As a result of my *[helping]*, I have intrusive, frightening thoughts.
26. I feel “bogged down” by the system.
27. I have thoughts that I am a “success” as a *[helper]*.
28. I can't recall important parts of my work with trauma victims.
29. I am a very sensitive person.
30. I am happy that I chose to do this work.

© B. Hudnall Stamm, 1997-2005. *Professional Quality of Life: Compassion Satisfaction and Fatigue Subscales, R-IV (ProQOL)*. <http://www.isu.edu/~bhstamm>. This test may be freely copied as long as (a) author is credited, (b) no changes are made, and (c) it is not sold.

Copyright Information

© B. Hudnall Stamm, 1997-2005. *Professional Quality of Life: Compassion Satisfaction and Fatigue Subscales, R-IV (ProQOL)*. <http://www.isu.edu/~bhstamm>. This test may be freely copied as long as (a) author is credited, (b) no changes are made other than those authorized below, and (c) it is not sold. You may substitute the appropriate target group for *[helper]* if that is not the best term. For example, if you are working with teachers, replace *[helper]* with teacher. Word changes may be made to any word in italicized square brackets to make the measure read more smoothly for a particular target group.

Disclaimer

This information is presented for educational purposes only. It is not a substitute for informed medical advice or training. Do not use this information to diagnose or treat a health problem without consulting a qualified health or mental health care provider. If you have concerns, contact your health care provider, mental health professional, or your community health center.

Self-scoring directions, if used as self-test

1. Be certain you respond to all items.
2. On some items the scores need to be reversed. Next to your response write the reverse of that score (i.e. 0=0, 1=5, 2=4, 3=3). Reverse the scores on these 5 items: 1, 4, 15, 17 and 29. Please note that the value 0 is not reversed, as its value is always null.
3. Mark the items for scoring: a. Put an **X** by the 10 items that form the **Compassion Satisfaction Scale**: 3, 6, 12, 16, 18, 20, 22, 24, 27, 30. b. Put a **check** by the 10 items on the **Burnout Scale**: 1, 4, 8, 10, 15, 17, 19, 21, 26, 29. c. **Circle** the 10 items on the **Trauma/Compassion Fatigue Scale**: 2, 5, 7, 9, 11, 13, 14, 23, 25, 28.

4. Add the numbers you wrote next to the items for each set of items and compare with the theoretical scores.

APPENDIX THREE: KNOWLEDGE OF BEHAVIOR MANAGEMENT QUESTIONNAIRE

This is a test of your knowledge of behavior management. Please read each item and set of answers carefully. Each item has one correct answer. Please circle the number next to the answer you believe to be the best for each item. Be sure to answer every question.

(1) As a part of the patients' social environment, staff in health care institutions:

1. Are expected to behave exactly as patients behave.
2. Influence how patients behave by the way they behave themselves.
3. Know instinctively what patients are thinking.
4. Eventually learn to behave in a way that is exactly opposite to the way patients behave.

(2) Which of the following would you consider a behavior?

1. The client is walking to the dining room at breakfast time.
2. The client is thinking about the meal being prepared.
3. The client is depressed.
4. The client is hungry.

(3) You are retraining a patient to bathe himself. You initiated the training by saying "turn on the water and stand under the shower". This is an example of:

1. A gestural prompt.
2. Physical guidance.
3. Modeling.
4. A verbal prompt.

(4) A patient was throwing herself to the floor and crawling around whenever she became frustrated as a result of staff preventing her from entering the nurse supervisor's office to talk with the supervisor. Because of fear of reprimand from administrators, the staff were giving in to the patient's demands whenever she threw herself to the floor. As a result the patient threw herself on the floor more and more frequently. Eventually the staff came up with a plan to extinguish the behavior. Which approach is likely to achieve the staff's goal?

1. Quarrel with the patient as soon as she throws herself on the floor.
2. Ignore the patient during the time she spends lying on the floor.
3. Assign a staff to speak to her softly during the period she spends lying on the floor.
4. Check her vital signs every ten to fifteen minutes during the time she stays on the floor.

(5) Which of the following would you say is operant behavior'?

1. A demented patient who wandered into the unit secretary's office is urinating into one of the file cabinets.
2. A delirious patient hides from the staff who he accuses of trying to cut him into little pieces with their pens.
3. A patient who at first was too shy to dance at the party has not stopped dancing since staff and patients began telling her how well she dances.
4. A demented patient takes off his clothes and lies in the hallway during visiting time.

(6) If a patient's behavior has been increasing in frequency because it was being positively reinforced, completely ceasing to reinforce the behavior will cause the behavior to:

- I. Increase faster and faster.
2. Slowly decrease in frequency, then increase rapidly.
3. Decrease in frequency, then stop all together.
4. Neither decrease nor increase in frequency.

(7) A patient has been whining a great deal whenever she wants staff attention. On three occasions during the afternoon the staff ignored the whining behavior until it ceased. Then, following a brief period of no whining, staff chatted with the patient for five minutes. Things seemed to be going well until change of shift. While staff on the departing shift were preparing to leave, the patient approached one and made a request in a whiny voice. The departing staff ignored the patient's whining. However, an incoming staff, visually upset by her co-worker's response to the patient's behavior, rushed to satisfy the patient's demands. You would expect the incoming staff's behavior to have which of the following effects on the patient's behavior:

1. The patient would be very upset with the incoming staff.
2. The patient would cease whining all together.
3. The patient would cease whining for the moment but will continue to whine in the future.
4. The patient would ignore what the incoming staff said.

(8) A patient was informed by staff that he would not be allowed to attend an off-unit activity because he had missed more than half of the planned therapy sessions that he had agreed to participate in. Upon hearing this, the patient became violently angry and began throwing his

belongings around his room causing much destruction. The information the patient received that caused his angry outburst can be referred to as:

1. The antecedent for his behavior.
2. The reinforcing schedule.
3. The behavioral consequence.
4. The prompting model.

(9) Which of the following statements is likely to be most effective in getting a client to attend the activities group on the unit?

1. If you attend the activities group, you will be able to join the group on a bus ride this evening.
2. You can go on a group bus ride now, if you promise to attend the activities group later today.
3. If you don't attend the activities group then you won't be able to go on a bus ride.
4. I would suggest that you attend the activities group since it is important for your overall improvement.

(10) Over the last two weeks, you noticed that it takes four care givers to give a patient a bath and that he shouts throughout the procedure. In response to the patient's shouting, the care givers become visibly frustrated and angry and repeatedly plead with him to stop shouting. Often, the care givers are all talking to the patient at the same time. The patient shouts even louder and for longer periods as the care givers plead with him and become more and more frustrated. The care givers can best extinguish the patient's shouting by:

1. Shouting louder than he does.
2. Ignoring his shouting and not pleading with him.

3. Designating a specific staff to hold his hand and sing to him during the bathing procedure.
4. Having two staff talk to him only about matters other than the bathing procedure.

(11) What do we mean when we say a client has "excess disability"?

1. The client has a broken leg and spends much of his time in bed.
2. Care givers are encouraging the client to do tasks he cannot do for himself.
3. The client is relying on care givers to do simple self-care tasks which he can do for himself.
4. The care givers are performing tasks which the client cannot perform for himself.

(12) The procedure you would use to establish a behavior that is not presently performed by an individual is:

1. Shaping.
2. Extinction.
3. Primary scheduling.
4. Alternative modeling

(13) A client often cries loudly over small matters that bother him. How should staff react to best reduce his crying?

1. Use a mild punishment when he cries.
2. Reward him whenever he reacts without crying.
3. Provide him with something tangible when you suspect he will begin crying.
4. Inform him that he should not cry over small matters.

(14) Which principle is most important to remember when withdrawing reinforcement to extinguish a problem behavior?

1. A behavior that takes a long time to develop usually takes a very short time to be modified.
2. Extinction can occur only with punishment.
3. Withdrawing reinforcement should be done rapidly for extinction to be effective.
4. The problem behavior will probably get worse before it gets better.

(15) You are attempting to get a patient to dress himself independently. After he has put on his shoes independently, as he did the day before, you hold his hand affectionately, you smile with him, and you tell him that he has done well.

This is an example of your using:

1. An antecedent schedule.

Knowledge of Behavior Management Questionnaire 219

2. Negative reinforcement.
3. Social reinforcement.
4. Physical guidance.

(16) You are helping a client to get up and get dressed. Which of the following strategies that you use to assist this client would you consider a prompt?

1. You tell the client verbally to get up and get dressed.
2. You use hand signals to tell the client that you want him to get up.
3. You physically assist the client to get out of bed.
4. All the above.

(17) A patient's son always came to pick her up at 4:00p.m. to go home for the weekend. She can read time but since she doesn't have access to a clock, around 10a.m. on Fridays she starts asking care givers if her son has arrived. She does this often until he finally shows up. To stop this behavior the first thing you should do is:

1. Ignore her requests until 4:00p.m., then tell her to watch for him through the window.
2. Ask her son to call before he leaves home so she will know that he is on his way.
3. Place a large wall clock in her room and also have an alarm go off at 4:00p.m.
4. Clearly tell her that to keep asking about her son's arrival doesn't help time to go faster.

(18) Suppose you want a patient to ask for ice cream only during snack time, and not throughout the entire day. Which of the following would you do to make this happen?

1. Ask her why she wants ice cream so often and explain how she should behave.
2. Tell her "No, we don't have any ice cream" when she asks.
3. Ask to have the doctor write an order for her to only have ice cream at snack time.
4. Give her ice cream when she asks for it at snack time only and not at other times

(19) You have noticed that a patient stands at the doorway to his room with his pants unzipped several times a day. Which of the following would be the best initial approach to stop this behavior?

1. Calmly walk with him to his room and scold him for unzipping his pants.
2. Watch to find a pattern to his unzipping, that is, who is in the area when he unzips and how the person or persons respond to his behavior.

3. Keep him locked in his room so that others do not copy the behavior.
4. Hold his hands and tell him that unzipping his pants in public is "bad".

(20) If you are trying to describe behaviors you wish to change in a client, you would be interested only in behaviors that are:

1. Important and observable
2. Believable and important
3. Observable and measurable
4. Realistic and believable.

(21) People over age 65 are best able to learn new behaviors:

1. Through repeated practice
2. Only if they are very bright
3. If their mistakes are not corrected repeatedly by family members
4. Only if they discuss their problems with therapists.

(22) Which of the following is not an important step in a behavior change program?

1. Decide on the particular behavior that you wish to change.
2. If necessary, break the selected behaviors down into small steps.
3. Make certain that the person feels ashamed for his misbehavior.
4. Select the proper time and situation for measuring the behavior

(23) A patient is spending a considerable amount of time in bed complaining of feeling sick. You have written a plan to provide social reinforcement when he is out of bed and attends to his ADLs. As the plan is implemented, the patient begins to do his ADLs and begins to feel well enough to attend work therapy off the unit. What does this tell you about his illness?

1. He was probably feeling fine all along and was faking illness.
2. The behavioral plan probably corrected the illness.
3. There were probably some aspects of the illness under the control of environmental events.
4. The illness was probably all in his head.

(24) Which is a list of behaviors?

1. Noisy, selfish, and cooperative.
2. Hits, spits, and writes.
3. Depressed, eats, and angry.
4. Aggressive, withdrawn, and wanders.

(25) A client sometimes curses but only in front of the volunteer. The volunteer has been shocked and makes his feelings clear to the patient. Which is the best approach for the volunteer care giver to take to stop the client's cursing?

1. Wash the client's mouth out with soap.
2. Explain to the client the reasons such words are not used.
3. The volunteer should tell the client how bad the client is and that he does not like the client when he uses those words.
4. Ignore the client's cursing and interact with him only when he is not cursing.

(26) Staff have targeted a client's negative behavior for reduction. The care plan directs staff to ignore the patient when he exhibits the targeted behavior. One staff member becomes alarmed when he notices that the targeted behavior increased shortly after the plan was started. In your response to the alarmed staff, which one of the following statements would be correct:

1. It is normal for the targeted behaviors to initially increase while reinforcements are withdrawn.
2. This is an indication that the patient will not change his behavior.
3. Generally, this indicates that staff are not interacting with the client according to the care plan.
4. If staff continue to follow the present care plan, eventually other non-targeted behaviors will decrease as dramatically as the targeted behavior.

(27) A patient is sitting in the lobby-reception area banging her fist on the tray of her gerichair. This banging happens only during visiting hours when the lobby area becomes noisy. Because of the disturbance created by this patient, other patients move away and visitors hurry by if they can. You can best prevent the banging by:

1. Telling her firmly "No banging Ms. Williams".
2. Giving her some crackers to stop her for a while.
3. Having her sit in a less busy area.
4. Calmly reminding her not to bang her fist on the tray.

(28) A patient gets irritated easily and starts cursing at staff who are encouraging him to feed himself independently. What should you do to stop him from cursing?

1. Curse back at him to show him what it is like.

2. Ask him politely to stop cursing.
3. Stare at him straight in the eye and tell him to stop.
4. Ignore the cursing and only pay attention when he speaks appropriately.

(29) A client is unable to tell you what special things he likes. Which of the following is the best way of learning what you could use as a reward?

1. Find out what all the other clients like and choose the most popular as the reward.
2. Watch the client to see what he likes or responds to and use that as the reward.
3. Unfortunately, there is no other way of finding out what a client likes or dislikes unless he tells you.
4. Try presenting several things you find rewarding and see which of them the client responds to.

(30) Several times a day a patient asks for ice cream. Normally, she gets ice cream with her dinner although staff sometimes give her ice cream whenever she asks for it. If you want her to stop asking for ice cream at times other than dinner time, what would you do?

1. Give her ice cream every time she asks, so she will get sick of it.
2. Tell her, "Ice cream is served only with dinner", and then pay attention to her only when she talks about something else.
3. Tell her "no" when she asks for ice cream, unless you feel she deserves it.
5. Only give her ice cream if she does not speak between meals

Answers: Knowledge of Behavioral Management Questionnaire

1. 2 6. 3 11. 3 16. 4 21. 1 26. 1

2. 1 7. 3 12. 1 17. 3 22. 3 27. 3

3. 4 8. 1 13. 2 18. 4 23. 3 28. 4

4. 2 9. 1 14. 4 19. 2 24. 2 29. 2

5. 3 10. 2 15. 3 20. 3 25. 4 30. 2

APPENDIX FOUR: PARTICIPANT EVALUATION

Name of **trainer: Katie Ferrara, LCSW and Lisa Wagner, MS**

Please evaluate the intervention in which you participated to combat employee burnout in long-term care.

1. Content

a) Was the training relevant and useful to my daily work practices? Please identify what was particularly helpful to you about the course content.

b) What would you suggest to be added to the course to increase relevancy and usefulness?

c) What, if anything, did you find not useful about the course? What do you suggest be removed from content?

d) Evaluate the schedule, to include frequency and length of course. Did you feel the length was appropriate to learn content? Do you have suggestions regarding the scheduling of the course?

2. Presenters:

a) Please provide feedback on the presentation method/style of Katie Ferrara.

b) Please provide feedback on the presentation method/style of Lisa Wagner.

APPENDIX FIVE: PARTICIPANT DEMOGRAPHICS

Participant	Study Site	Gender	Discipline	Level of Education
E1	1	F	Medical Records	H.S. Diploma
C1	1	F	Nurse Manager	1 year college
E2	2	M	Business Office	Bachelor's degree
E3	2	F	Business Office	Bachelor's degree
E4	2	F	Activities	Bachelor's degree
E5	2	M	Activities	H.S. diploma
E6	2	F	Activities	H.S. diploma
E7	2	F	Activities	H.S. diploma
E8	2	F	CNA	6 week certification
E9	2	F	Housekeeping	H.S. diploma
E10	2	M	Maintenance	H.S. diploma
E11	2	F	CNA	6 week certification
C2	2	M	CNA	6 week certification
C3	2	F	Nurse Manager	Associates degree
C4	2	F	CNA	6 week
C5	2	F	RN	certification
C6	2	F	RN	Associates degree

C7	2	M	Admin Assistant	Associates degree
C8	2	F	Nurse Manager	H.S. diploma
C9	2	F	NHA	Bachelor's degree
E12	3	M	NHA	Bachelor's degree
E13	3	F	RN	Bachelor's degree
E14	3	F	SS	Associates degree
E15	3	F	Activities	H.S. diploma
E16	3	F	Dietary	Bachelor's degree
E17	3	F	Nurse Manager	Bachelor's degree
E18	3	F	Nurse Manager	Associates degree
E19	3	F	LPN	Associates degree
E20	3	M	Maintenance	One year post
E21	3	F	SS	H.S.
E22	3	F	RN	H.S. diploma
				Bachelor's degree
				Associates degree

APPENDIX SIX: PROCESS LOGIC MODEL

<i>Needs Assessment</i>	<i>Resources</i>	<i>Activities</i>	<i>Outputs</i>	<i>Short-Term Outcomes</i>	<i>Long-Term Outcomes and Impact</i>
<p>1.Literature review determined a gap in research of employee burnout in long-term care</p> <p>2. pre-test of PROQOL IV for pretest measure of burnout in the sample; pretest score on KMBQ for experimental group exhibiting a gap in knowledge of behavior management techniques</p>	<p>1.A researcher and researcher assistant needed to carry out the intervention</p> <p>2. Two sample groups- a. experimental consisting of a minimum of 30 participants; b. weight listed control group with a minimum of 30 participants</p> <p>3. Minimum of 3 long term care facilities to participate</p> <p>4. CBT based intervention</p>	<p>1.Researcher and assistant, and organization, to introduce the project in the 3 different facilities & recruit participants</p> <p>2. Researcher and assistant to conduct testing session to obtain pretest data</p> <p>3.Researcher & assistant to do intervention for 1 or 2 hours per week x 8 sessions in facility of employment</p> <p>4. Researcher to use organizational space to obtain posttest data</p>	<p>1.pretest/posttest of the PROQOL</p> <p>2.pretest/posttest of the KMBQ (experimental group)</p> <p>3. completion of 8 CBT skill based training sessions to increase knowledge of behavior management techniques and to increase skills to combat burnout to a minimum of 30 long-term care staff (experimental)</p>	<p>1. Experimental group: a. decrease in employee level of burnout; b. increase of employee knowledge of behavior management techniques; c. decrease in absenteeism and tardiness rates</p>	<p>1.Experimental group facilities: a. sustained improvement in staff retention rate; b. financial improvement due to reduction in staff turnover; c. improved quality of care of residents</p> <p>2. improved management of Medicaid</p>