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Burnout, Job Stress, and Job Satisfaction in Two Public Health Nursing Units

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BURNOUT, JOB STRESS, AND JOB SATISFACTION
IN TWO PUBLIC HEALTH NURSING UNITS

By

D'Arcy John Helmer
B.A., Carleton University, 1979

THESIS

Submitted in partial fulfillment of the requirements for the Master of Arts degree
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Abstract

This thesis examines burnout, job stress, and job satisfaction in two public health nurse organizations, located in two different regions. A total of 35 individuals were interviewed, and 31 individuals were surveyed. The major finding was the experience of burnout is a complex experiential synthesis of the constructs job satisfaction, morale, job stress, and self perception. Data suggest intraorganizational processes mediate burnout and the shift from job satisfaction to job dissatisfaction.
My advisor, Fred Binding, and committee members Bob Morgan and Jim Dudeck deserve credit for their constructive suggestions and support. Current and Ex public health nurses deserve credit for their candor, and without their time and energy commitments the research would not have been as extensive. Airi Koivula, Rosemary Melchin, and Anne Barszczewski deserve credit for their perseverance and patience with regard to their contributions toward data analysis. The Faculty of Graduate Studies deserves credit for the resource funding which was provided to help fund this project. Directors of nursing, from respective health units, deserve credit for their willingness to negotiate and facilitate this research project. Thanks to all.

Sincerely,

D'Arcy Helmer
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Introduction

In recent years, most health and social service organizations have had to deal with resource cutbacks. Community demands for health and social service continue to escalate, though there may not be comparable increases with respect to resource expenditures within human service organizations. Ultimately, resource shortages become sources of stress for human service staff, and for members of the community. Although stress experienced by community members as a result of interaction or lack of interaction with human service agencies is of concern, this thesis focuses on stress as experienced by public health nurses.
Review of the Literature

Job Stress

Selye (1950, 1978) defines stress as a state manifested by a specific syndrome which consists of all the nonspecifically-induced changes within a biologic system. By nonspecifically, Selye meant adaptation to a problem by the body, regardless of the nature of the problem. Other investigators have defined stress as an action or situation which places physical and/or psychological demands on the individual (Douglass, 1977; Howard, Cunningham, and Rechnitzer, 1978). For the purpose of this investigation, job stress is defined as a condition resulting from the impact of stressors on the person in the context of the job.

Experiencing the phenomenon of job stress is an individual one indeed. Howard et al. (1978) noted that the experience of stress was significantly determined by the goals set by the person, and the energy expended to reach the goals. Stress symptoms developed were found to be related to age, sex, culture, and educational background. Thus personality and personal biography are likely key variables in the experience of stress.
The link between the stressors and the stress experience was found to be personality and personal biography (Warr and Wall, 1975; Coopersmith, 1967). Achievement motivation leads some people to expend tremendous amounts of energy for the attainment of goals, and the evaluation of performance against high internal standards. Ironically, such a high pace lifestyle may have satisfying and stressful elements which may be addictive for the person (Howard et al., 1978). However, satisfaction in the high pace lifestyle, mentioned above, depends upon successful performance which may be inhibited by contextual factors.

Beehr, Walsh, and Taber (1976) found satisfaction of higher order ego needs depends upon the successful performance of a challenging role, however, contextual stressors such as work overload, role ambiguity, and non-participation may frustrate successful role performance. Contextual stressors in the work context may be difficult to handle, and therefore may influence the impact of stress on the individual. Similarly, Howard et al. (1978) state that it is not the responsibility per se that is stressful, rather, it is the responsibility without the power to influence outcomes that has the greatest stress potential.

Howard et al. (1978) suggest the relationship between job pressure and job performance is an inverted "U" function. As job pressure increases performance increases up to a point and then declines thereafter. Howard et al.
(1978) refer to excessive job pressure as resulting in "burnout," and too little job pressure as resulting in "rustout." However, what determines the impact of stressors, on the individual, probably depends on how the person conceptualizes these stressors, his/her ability to control the onset and offset of stressors, and how he/she chooses to respond.

**Burnout**

It seems that there are as many definitions of what burnout is as there are investigators working in the area. One group defines burnout as involving increased feelings of emotional exhaustion, the development of negative attitudes toward clients, and the tendency to evaluate oneself negatively (Pines and Maslach, 1978; Maslach, 1978a; Maslach and Jackson, 1978). Freudenberger (1977a, 1977b) defines burnout as a set of symptoms: cynicism, negativism, inflexible and almost rigid thought patterns, a closed mind about change and innovation, a paranoia of peers and administrators, a condescending attitude, lack of communication with colleagues, withdrawal, developing a sense of helplessness and hopelessness about clients, and speaking of clients in negative terms. Furthermore, Freudenberger describes burnout as a never ending cycle of accelerating effort and decelerating reward, a treadmill of his/her own making.
Cherniss, Egnatios, Wacker, and O'Dowd (1981) define burnout as an increasing tendency to view clients as objects rather than people; a decline in hope, idealism, and optimism; and increasing compartmentalization and withdrawal from work as one turns to the non-work aspects of life for the fulfillment of higher order needs. Mitchell (1977) conceptualizes burnout as occurring in three consecutive stages: physical fatigue, psychological fatigue, and spiritual fatigue. For Kahn (1978), burnout is a syndrome of inappropriate attitudes toward clients and toward oneself.

Howard et al. (1978) claim that burnout is a condition that grows out of extreme job pressure, and that burnouts may still enjoy their work because the job satisfaction that is attained from living at an accelerated pace moderates the stressful aspects of this accelerated pace. Kemp (1977) defines burnout as an addiction to one's own biochemistry, specifically to a high level of adrenalin production. Vash (1980) conceptualizes burnout as a number of burnout styles resulting from extreme job pressure: dropping out completely; dropping out to another location; staying and showing little concern for organizational goals and those people in it; complaining about physical symptoms; having no principles and adopting the principles of a superior; and the person who goes by the book.
Collectively, the literature indicates there is no consensus among investigators with regard to a precise definition of burnout. However, in most cases, burnout involves a deterioration in work efficiency, and a loss of motivation to continue in the work. Furthermore, the process of burnout as an experiential progression has yet to be documented from the helpers perspective. Lack of consensus with respect to the definition of burnout has likely prompted the myriad of purported causes and theoretical orientations. Several investigators have noted the potential influence of individual factors in the burnout process.

Freudenberger (1977b) suggests that unresolved experiences in the helper's biography may contribute to burnout through "countertransferential experiences." Maslach (1976) claims that helpers may be on a variety of ego trips: a self sacrificing dedication to the client ego trip, a self fulfilling ego trip, a self aggrandizement ego trip, or an ego trip to deny a personal problem. Each ego trip may predispose the helper to burnout due to stress, or feelings of lack of accomplishment. Mitchell (1977) says that many people are in the helping profession because the work they do is consistent with their personal values. High expectations for gratification from the work may leave the person open to burnout if job satisfaction escapes, depending upon the intensity of the work involvement
Cherniss (1978) suggests that several individual factors may cause burnout. These factors are the extent of one's non-work commitments and gratifications, career goals, general coping skills and resources, previous job success, initial self-esteem, and awareness concerning stress.

Cherniss believes that professional mystique, a set of expectations shared by society about helping professionals, may cause burnout. These expectations are that credentials imply competency; clients are generally trusting, co-operative, and grateful; professional work is varied, stimulating, and intellectually absorbing; professional relations are collegial; professionals have autonomy in their work; and that professionals remain compassionate and committed. Pines and Kafry (1978) suggest that since the helpers are the primary instruments that failure is apt to be personalized. Feeling pressure from within to work and help, and pressure from outside to give (e.g. organizational pressure, client pressure, societal pressure) may cause burnout (Freudenberger, 1974).

Cherniss (1978) argues to the extent that the programs role structure produces role strain the helper will experience burnout. Organizational factors cited as influencing burnout were the availability of resources and the professional power and autonomy to use them, the amount of challenge and stimulation in the work, and the structural
supports and rewards. Cherniss' work (1978) suggests iatrogenic intraorganizational environments facilitate burnout. Iatrogenic intraorganizational environments mean environments within organizations which create worse situations for helpers, instead of facilitating helper well-being and their work obligations.

Maslach (1978a) suggests that several situational factors mediate the burnout process. These situational factors are the amount and quality of client contact, opportunities for work breaks, the presence of social professional support groups, and the development of interpersonal skill programs which would better prepare individuals for work with clients. With regard to client contact, Maslach (1978b) suggests that the type of problem(s) facing the client, the rules governing the client-helper relationship, the nature of the staff member's relationship with the client, the client's stance, and the reactions to staff may all affect burnout.

As the literature suggests, there are several factors which may contribute toward burnout. These factors are personal factors, intraorganizational factors, interorganizational factors, and societal factors.

The author believes that burnout may be conceptualized as a process where the continual thwarting of premium personal/professional values results in a loss of self respect (negative shift in self perception), in the context
of stress coming from any or all of personal factors, intraorganizational factors, interorganizational factors, and societal factors.

Burnout literature focuses on inputs to burnout processes, what individuals think and feel when they are burnt-out, and methods for coping with burnout, yet documenting the process of burnout experientially, from the helper's perspective, has been ignored.

Job Satisfaction

Job satisfaction research has focused on identifying factors which contribute to satisfaction and dissatisfaction. Examination of the process of shifting from a state of being satisfied with specific aspects of the job or the job in general to a state of dissatisfaction with specific aspects of the job or the job in general has been for the most part ignored.

Pines and Kafry (1978) found that when certain internal and external job factors were not met these factors become sources of stress and dissatisfaction. Internal job factors cited were challenge, autonomy, success with regard to helping people, and feedback from the work. External factors cited were good relations with colleagues, tasks which involve teamwork, a support system, the availability of time outs, and feedback from colleagues and superiors.
Cherniss and Eganatios (1978) found staff dissatisfaction in community mental health was a function of factors which influence the staffs' sense of accomplishment, and feelings of inadequacy with regard to lack of training and supervision for task obligations. Herzberg (1959) claims that satisfaction comes from task factors which indicate that the staff person's performance was successful, and that the opportunity for personal growth exists in the work.

Herzberg's (1959) two factor theory attempts to explain satisfaction and dissatisfaction on the job. The assumption is that when factors which contribute to satisfaction are not met these factors do not contribute to dissatisfaction, rather, they go to a neutral point. Similarly, the factors contributing to dissatisfaction when not met do not contribute to satisfaction, rather, they go to a neutral point. Melichercik's (1980) research does not support Herzberg's two factor theory as he found intrinsic job factors contributed to satisfaction and dissatisfaction on the job. House and Wigdor (1967) claim that Herzberg's theory is not tenable because what is satisfying for one person may be dissatisfying for the next person. Other investigators believe a person's expectancies are important with regard to determining satisfaction and dissatisfaction on the job.

Vroom and Deci (1972) believe a person's motives and preferences are important in determining the affective
response to the work they have chosen. Furthermore, the person's affective response to the discrepancy between what the individual thinks he/she should receive and what is actually received determines whether the individual is predominately satisfied or dissatisfied. Bass and Ryterband (1979) claim the degree to which a person's expectancies are met with regard to material, social, and psychic rewards determines the degree of satisfaction with the job. Melichercik (1980) argues what people expect from their work influences their attitudes toward certain aspects of the work. When needs and perceived need satisfaction are in greatest harmony, job satisfaction is greatest (Kuhlen, 1963; Applewhite, 1965; Schaffer, 1953; Elizur and Tziner, 1977).

Perhaps greater understanding of job satisfaction could be attained by examining the process where job satisfaction shifts to job dissatisfaction. Examining shifts in job satisfaction may illuminate when stress is perceived in constructive and destructive ways, and personal values which are thwarted/supported during these shift processes.
Burnout, Job Stress, and Job Satisfaction

The phenomena of burnout, job stress, and job satisfaction are related. The purpose of this section is to present some relationships between burnout, job stress, and job satisfaction, and to specify the dominant focus of this investigation.

As alluded to previously, from my viewpoint burnout is a process of the loss of self respect in the context of job stress resulting from any or all of personal factors, intraorganizational factors, interorganizational factors, and societal factors. Burnout, for most individuals, involves some deterioration of the person's system (personal attributes and milieus where the person works/lives), in the context of stressors which may be perceived positively and/or negatively; and job satisfaction may increase or decrease depending on how the individual perceives and deals with stressors. For the purpose of this investigation, job stress may be defined as a condition resulting from the impact of stressors on the individual in the context of her job. Thus, burnout may be viewed as a unique condition of job stress.

To complicate the model, burnouts may have different levels of job satisfaction. Some burnouts try to overcome job stress by working harder; their high pace lifestyle is
sometimes associated with high levels of job satisfaction which may moderate stressful aspects of their lifestyle. Other burnouts may be satisfied with some aspects of work and dissatisfied with other ones. Still other burnouts may be totally dissatisfied with work. Given that there may be an inverse relationship between stress symptoms and job satisfaction (Howard et al., 1978), for most individuals, the claim that the escape of job satisfaction may predispose people to burnout (Kahn, 1978) may be plausible. In summary, burnout processes cannot be examined in a vacuum, because job stress and job satisfaction interweave burnout processes.
Statement of Purpose

The purpose of this thesis is to define the experience of burnout in public health nursing, and to examine where job satisfaction shifts to job dissatisfaction.

Operational Definitions

The operational definitions that follow are based on themes that were identified in the data.

Burnout was measured by the person's self report of being "burnt-out" or the number of statements which indicated a lack of motivation to continue working.

Job stress was measured by the number of stressors that were reported affecting the person in the context of the job.

Stressors were measured by the number of different factors people reported as being stressful.

Job satisfaction was measured by the reported number of different aspects of the work and work situation that resulted in positive thoughts and feelings.

Job dissatisfaction was measured by the reported number of different aspects of the work and work situation that resulted in negative thoughts and feelings.

Negative self perception was measured by the reported number
of negative thoughts and feelings that the individual had about herself.

**Dissatisfaction with intraorganizational climate** was measured by the reported number of negative thoughts and feelings relating to the work situation within the organization.

**A sense of adequate preparation for task obligations** was measured by the number of reported factors that contribute to thoughts and feelings of personal competency with respect to task obligations.

**Thwarting of personal/professional values** was measured by the reported number of times that factors which are important to the individual in the context of the job were not acknowledged (e.g. lack of an adequate professional support system).

**Experimental Questions**

1. How do personal/professional values relate to where job satisfaction shifts to job dissatisfaction? Mitchell (1977) says that some people are in the work they do because the work is consistent with their values, which leaves them open to burnout depending on the intensity of their involvement.

2. How does self perception relate to where job satisfaction shifts to job dissatisfaction? Several investigators have noted that burnout involves the tendency to

3. How does personal biography relate to where job satisfaction shifts to job dissatisfaction? Howard et al. (1978) found that stress symptoms were related to age, sex, culture, and educational background.

4. How does the perception of the organization relate to where job satisfaction shifts to job dissatisfaction? Cherniss (1978,1979) found that a number of organizational factors, such as the availability of resources and professional power to use them, may cause burnout.

The experimental hypothesis is that personal/professional values, self perception, personal biography, and the perception of the organization are significant factors for understanding where job satisfaction shifts to job dissatisfaction, and for adequate conceptualization of the experience of burnout in public health nursing. This hypothesis will be tested by evaluating each experimental question with respect to data generated by group participants, in this investigation. Specifically, each experimental question will be evaluated utilizing data from the investigator's content analysis, and tested with Chi-Squares, and T-tests.
Method

Participants

Five samples were utilized in this investigation. Sample one consists of fifteen individuals who have worked in the same unit (for our purposes UNIT A) sometime in the last five years, though are not currently working in UNIT A for whatever reason. The author is choosing to label nurses in this group Ex public health nurses, although these individuals may be working in public health at another unit. Selection of individuals, for sample one, relied on a public health nurse network and a criterion of having worked in UNIT A within the last five years. The network was tapped by asking each interviewee, at the close of the interview, for names of additional potential interviewees.

Sample two consists of forty-four individuals who currently work in public health at UNIT A. These forty-four individuals were the full complement of public health nurses at UNIT A, and had equal opportunity to participate in survey data collection.

The third sample consists of ten individuals from UNIT A who were randomly selected from twelve individuals who volunteered to be interviewed. The rationale for randomly
selecting ten individuals was for nonparametric statistical convenience.

Sample four consists of sixty currently active public health nurses who work in a health unit located in a different region than UNIT A (for our purposes UNIT B). Sixty nurses was the full public health complement at UNIT B, and had equal opportunity to participate in survey information collection.

The fifth sample consists of ten individuals from UNIT B who volunteered to be interviewed.

Procedure

Information in this investigation was collected by two surveys and interviews.

************************************************
* Phase 1: collection *
* of survey and         *
* initial interview    *
* information           *
************************************************

* Phase 2: in-depth *
* interviews         *

Procedure Phases
The public health nursing survey was administered to those individuals still active in public health (samples 2 & 4) and those individuals who volunteered to participate in survey information collection. Items for the public health nursing survey were developed from the literature review on burnout. The survey has several foci. These foci are organizational perception, personal biography, stress, competency, person resources utilized, and personal/professional values. (See Appendix A for information on survey items.) Surveys were returned to the investigator by mail. The survey return rate from individuals at UNIT A was 38%, and the return rate from UNIT B was 23%. These low return rates may affect the validity of survey information, because it may be the case that only dissatisfied individuals participated.

Interviews were conducted with Ex public health nurses (sample 1), and with individuals who volunteered to participate in an interview from UNITS A and B (samples 3 & 5). Interviews varied in duration from one to four hours.

Ex public health nurses were interviewed twice, and current public health nurses who participated in interviews were interviewed once. Currently active public health nurses were only interviewed once because of time pressures under which they work.

Information gathered from public health nurse surveys, and initial interviews with Ex public health nurses served
as preparatory information for subsequent interviewing. Although, feeding back information from prior interviews and survey information involves the methodological risk of contaminating subsequent data, as a result of leading subjects, the benefits of **breaking the ice** with regard to discussing sensitive information and emotionally charged issues, and potentially receiving **rich** data, were thought to be worthwhile. The interviewing was conducted by the investigator. The schedule for the first interview, with Ex public health nurses, had identical questions as in the public health nursing survey.

At the close of interview one (for Ex public health nurses) the interviewee was asked to complete, when she had the time, the Maslach survey of professional occupations (1978). The return rate was 87%. Current public health nurses did not complete the Maslach Survey of Professional Occupations because of time pressures under which these individuals work. The occupational survey utilized is a modified version of Maslach's (1978) survey. The modifications involve background information. The occupational survey is found in Appendix B.

After initial interviewing was complete in-depth interviews were conducted. Specifically, in-depth interviews were conducted with Ex nurses and active nurses (UNITS A & B) who chose to participate in an interview. A summary of information developed during the initial phase of
interview and survey information collection was presented to the interviewee during the in-depth interview and the interviewee's comments (confirmations, disagreements, elaborations) with regard to the information were solicited.

Specifically, information obtained from Ex public health nurses during the initial phase of interviewing, was presented to them and to nurses at UNIT A who volunteered to be interviewed. Information developed by individuals who participated in survey information, at UNIT A, was presented to nurses from UNIT A who volunteered to be interviewed. Survey information developed by individuals at UNIT B was presented to nurses who chose to participate in an interview, from UNIT B.

Initially, interview and survey information were content analysed independently, by the investigator and two analysts who were unaware of the purpose of the study. A modified Q-sort procedure was utilized to translate the thematic-content analysis information into a form suitable for Chi-Square analyses.

Inter-analyst reliability checks were performed with the Q-sort procedure. Frequency information was recorded for operational definitions which were not involved in the Q-sort procedure (job stress, burnout, job satisfaction, and job dissatisfaction), and T-tests for independent samples were computed. Inter-analyst reliability checks were computed on the frequency information recorded for the
operational definitions mentioned above. For more details of the analytical procedure see Appendix D.
Results

The major findings are that the experience of burnout is an experiential synthesis of the constructs job satisfaction, morale, self perception, and job stress; and intraorganizational processes mediate burnout.

Content Analysis

Tables 1, 2, and 3 (Appendix E) report category schemes developed by the investigator and two analysts who were blind to the purpose of the study, and independently undertook the analysis. The results of the investigator's content analysis follow. Data relevant to experimental questions is reported, and unused data may be useful in future research.

INTERVIEW

Ex Public Health Nurse Interview Information

Of the Ex public health nurses interviewed, 87% of these nurses made statements which suggest they experienced burnout when they were working at UNIT A. The comments that
follow were made by different individuals, and are relevant to burnout processes.

Most days I just wanted to get to the end of the day; another day another dollar attitude. I was fortunate because I had the option to work or not to work. I lost self-esteem and motivation to continue in the work.

So much energy was expended coping with the administration that there was little energy left to work with clients.

Loss of morale came from frustration with the administration, and not from interactions with clients. Frustration was a function of lack of support, lack of acknowledgement, and due to administrative attitudes toward nurses.

Frustration I experienced at the unit carried over into interactions with clients and family life. Most nurses would say the frustration experienced at the unit did not affect their work efficiency, because their satisfaction was coming from community work. Satisfaction had to come from somewhere if one was to continue to work.

Those individuals who burnout do so because of staff-administrative relations and the added strain of the work itself.

I was miserable because of the lack of time and how the administration structured the work. I had high expectations of myself, and the work situation prevented me from fulfilling these expectations.

Nurses who were too idealistic and inflexible with regard to accepting the way the administration handled things burnt-out.

Low morale, for me, was a function of my expectations with regard to what I wanted in the job, dealing with the bureaucracy, and community work which was boring because I was accustomed to teaching and surgery.
I think low morale, at the unit, was a function of focusing on negatives, self-fulfilling prophecy, and the administrative orientation toward nurses.

I began to work less and less, contributing fewer innovative ideas, which kept the administration off my back.

According to 87% of individuals, they came to expect less of themselves because of frustration with the work situation. Ninety-seven percent of Ex public health nurses said "The administrative way of handling things was a key factor in the loss of personal respect." All Ex public health nurses said "The morale was low at the unit."

Most nurses thought their personal/professional value expression was facilitated by the nature of the work, and inhibited by administrative structuring of the work and time constraints (Appendix F, Table 4).

Facilitation/inhibition of personal professional values likely has impact on job satisfaction (Appendix F, Table 5). Nurses indicated job satisfaction came from community work, and job dissatisfaction was a function of intraorganizational processes.

According to all Ex public health nurses (100%), "The administration functioned autocratically. No input was sought from nurses for: policy making decisions, individual preferences for participation in programs, assessing visiting priorities in the community, new programming, or reorganizing existing programming." "There was no changing
the status quo even if the idea was a good one," according to 50% of these nurses.

"Administrative expectations, of staff, made the working conditions poor," according to all Ex public health nurses. These expectations included "...rules about how the work was to be done and what not to do, thus you were not utilizing your knowledge; you were expected to be good in all work obligations, consequently, individual strengths and weaknesses were not recognized; monthly visiting quotas; setting priorities; and carrying out obligations that were in conflict with and sometimes went against community needs."

All individuals (100%) indicated they experienced two ways of dealing with the work situation: a)"...ignoring the administration and doing your own thing," and, b)"...becoming totally frustrated and angered because of the work situation."

Communication between staff nurses and administration was poor, and similarly communication between nurses and regional representatives was poor, according to all Ex public health nurses.

With regard to feedback, all individuals (100%) said it was "...frustrating not to be getting feedback on how you were doing in various nursing obligations." "Having a supervisor accompany you one afternoon a year, to do an assessment of your work, was worthless," according to 37% of
Ex public health nurses. All Ex public health nurses said "The administration were quick to give out negatives if any incident occurred, and gave out few positives." Feedback and good communication processes are integral parts of a professional support system (Appendix F, Table 6).

For most nurses, a formal support system was inoperative. "The supervisor and director were so overloaded they could not help you with job stress. The medical officer of health was not approachable." With regard to job stress, a number of stressors were identified (Appendix G, Tables 7 & 8).

Most stressors identified were intraorganizational stressors (e.g. administrative orientation toward nurses), rather than client related, personal, or interorganizational. Some stressors contributed toward feeling least worthwhile (Appendix H, Table 9).

Feeling least worthwhile was primarily caused by intraorganizational processes (e.g. lack of support from the administration), and secondly by client interactions (e.g. child abuse situations).

Experimental Questions

1. Facilitation of personal/professional values, for most Ex public health nurses, occurred with regard to community work. Personal/professional values were not facilitated by
time constraints and the way in which the administration structured the work, rather, these values were hindered.

2. According to 97% of nurses no longer working at UNIT A, the administration contributed toward negative self perceptions on the part of nurses; value expression was inhibited, in part, because of the way administration structured the work (83% of nurses); and dissatisfaction came from the unit as a place to work (20%).

3. The administration did not acknowledge and effectively utilize the strengths and weaknesses acquired by nurses from past experience.

4. Perception of the organization relates positively to job dissatisfaction since the administration was perceived as "autocratic"; communication processes were perceived to be poor; a formal support system was perceived to be non-existent; and administrative expectations of nurses made working conditions poor.

**Active Public Health Nurse Interview Information Unit A**

According to 50% of active nurses (UNIT A) who were interviewed, they experienced a loss of morale since starting work. Comments relevant to burnout processes, made by different individuals, are reported below.

I have experienced a loss of morale since I started the work, because the administrative policies have inhibited me from doing what I consider to be my professional role.
Low morale is a function of the person's expectations they bring to the work not being fulfilled. Young nurses are hardest hit because of the way the administration loads demands on them.

I feel worn out and totally frustrated with the work situation. I get up in the morning and wonder how I am going to get through another boring day. The whole day is meaningless for me.

Low morale comes from within the nurse; a general life situation; self fulfilling prophecy; and a tendency to focus on negatives and not positives in the work.

My efficiency has been lowered because of the frustration I experience and verbalize at the unit. Because of my high profile, the administration squashes me at any opportunity they get which does not leave me feeling very good.

Low morale is a problem and has become progressively worse since a major change in senior management.

Low morale is a function of not having a permanent supervisor on our team. Supervisors are key people with regard to morale at the unit. If we get a permanent supervisor who can stay healthy we will stay healthy.

According to 90% of nurses interviewed at UNIT A, they came to expect less of themselves because of the frustration with the work situation. "The administrative way of handling things is key in the loss of personal respect," as reported by 80% of nurses. Of the nurses interviewed at UNIT A, 90% indicated "The morale is low at the unit."

Personal/professional value expression was facilitated and inhibited as shown in Appendix F, Table 4.

One individual stated "Once I strove to do my best, and
now I just do what I can do." Facilitation of personal/professional values is likely related to job satisfaction.

Job satisfaction came from community work, and dissatisfaction came from intraorganizational processes (Appendix F, Table 5).

All (100%) public health nurses interviewed at UNIT A said "The administrative functions autocratically. No input was sought from nurses for: policy making decisions (according to 90% of nurses at UNIT A); individual preferences for participation in programs (90%); assessing visiting priorities in the community (90%); new programming (90%); or reorganization of existing programming (90%)." Nurses interviewed (20%) at UNIT A claim they have more input into planning processes than ever before.

According to all nurses (100%), a number of administrative expectations make the working conditions poor. These expectations, as reported by 90% of nurses interviewed at UNIT A, were "...rules about how the work was to be done and what not to do, thus you were not utilizing your knowledge; you were expected to be good at all work obligations, consequently, individual strengths and weaknesses were not recognized; monthly visiting quotas; setting priorities; and carrying out obligations that were in conflict with and sometimes went against community needs."
According to all individuals (100%), they "...ignored the administration." As reported by 90% of individuals interviewed at UNIT A, when they could not ignore the administration they were "...totally frustrated and angered with the work situation." One nurse (10%) stated "You cannot ignore the administration, do your own thing, and feel good about yourself." All nurses interviewed (100%) at UNIT A indicated "Confronting the administration results in no changes being made."

Communication between management and staff nurses is poor, and similarly, communication between nurses and regional officers is poor, according to all active nurses interviewed at UNIT A.

For each nurse feedback on a continuous basis was a part of prior experience, and the lack of feedback about how they were doing in the work was frustrating. As indicated by 90% of individuals interviewed at UNIT A, "The administration gives out few positives, and are quick to give out negatives if any incident occurred." All nurses (100%) said "The lack of a formal support system contributes to poor working conditions (Appendix F, Table 6)."

Lack of a formal support system was reported as a stressor, and for nurses interviewed at UNIT A stressors are documented in Appendix G, Table 10.

Few stressors were client related, rather, intraorganizational stressors were predominant.
Intraorganizational factors (e.g. having to handle abortions under the table) were predominantly responsible with respect to feeling least worthwhile (Appendix H, Table 9).

**Experimental Questions**

1. Personal/professional values were facilitated by community work, and were inhibited by time constraints and the way in which the administration structured the job.

2. Administrative handling of things was responsible for negative self perceptions, according to 80% of active nurses interviewed at UNIT A. Also, interorganizational processes contributed toward job dissatisfaction (80% of active public health nurses-UNIT A) and poor working conditions (100% of nurses).

3. Administrative expectations of staff nurses did not acknowledge and effectively utilize staff resources which they had accumulated from past experience.

4. Job dissatisfaction came from intraorganizational processes as indicated by 90% of active nurses interviewed at UNIT A. Factors affecting perception of organizational climate are communication processes, administrative expectations of nurses, the availability of formal resource people, and an autocratic management.
Active Public Health Nurse Interview Information Unit B

As reported by 90% of nurses interviewed at UNIT B, they acknowledged that they have experienced burnout. Comments made by different individuals which are relevant to burnout processes are reported below.

People who burnout have negative images of themselves which probably affects the quality of the care/service that they offer. I suspect that some burnouts are just there for the paycheck.

I accompanied a burnt-out nurse who left a mother feeling inadequate about her childcare when her childcare was quite good. I think burnout really affects the quality of care. In problem family situations a burnt-out nurse may set off a crisis, thus making the situation worse, and feeds a negative attitude about public health nurses.

Burnout is occurring in isolated cases. Nurses burnout because of unrealistic expectations of what the job should be offering them, and their lack of awareness with regard to bureaucracies. Those who overextend themselves have poor self images, are out to prove something to themselves in the work environment, and tend to have a depressive orientation. Overextension and subsequent burnout is going to lower your efficiency as a helper.

With regard to the effects of burnout on clients, I think it depends on whether the helper internalizes or projects her emotional/physical drain. I tend to drive myself to continue to give, rather than having a negative impact on clients.

Burnout occurs because the nurse's values/expectations are incongruent with organizational values, and she refuses to change. I have six months to go before I quit, and my husband (a student) and baby are the only reasons I am working.

If you overextend yourself you get sick. People who burnout do not invest in themselves; their work efficiency is low; and they may create worse problems for their clients.
Low morale is a function of personal/professional expectations that I bring to the work. Burnout occurs in phases, and depending on where you bring the burnout process to a halt determines how burnout affects you and your clients. If you halt the burnout process in its early stages there may be little or no effect on you or your clients. If the burnout process develops, work efficiency may be considerably impaired, nurse-client trust/rapport may be negatively influenced, community attitudes toward public health nurses may be negatively affected ("She does not care.'), and clients may shut you out completely.

If burnout occurs as a short phase, even if you open up a can of worms with a problem family you can follow-up fast. However, if burnout is long-term, the helper may create more problems for the client and the health and social service system.

A number of things positively relate to the loss of morale. These are personal and professional life, self-esteem, and work efficiency.

I have support systems in my professional and personal life, and burnout still occurs because of my expectations of myself.

According to one individual (10%) interviewed at UNIT B, "I have high expectations of myself. My expectations and experience make me vulnerable because the administration is so progressive and asks me about taking on new obligations. When I am not reinforced, by the administration, for saying no I end up draining myself." In this progressive public health environment, personal/professional value expression, in the context of a job, is attained (Appendix F, Table 4).

Without obstructions with respect to personal/professional value expression, the work situation is set up for high levels of job satisfaction potentially attainable (Appendix F, Table 5).
One nurse interviewed from UNIT B, commented on how the work environment has positive impact on staff satisfaction.

"The support system is excellent. Early in my public health career a parent threatened to take me to court, and the director of nursing and medical officer of health backed me completely saying 'We will handle it from our level.' A good support system promotes excellent working conditions which has positive impact on staff satisfaction." A good support system provides a number of resource people for dealing with job stress (Appendix F, Table 6).

"The work environment is super; good staff management relations; good supervisory support; an open door directorship; and a terrific collegial support system."

All nurses interviewed (100%) at UNIT B, said "The communication between decision makers and front line workers is good. The efforts made by management to keep nurses informed of decision making processes are good." Few stressors were a function of intraorganizational processes, as reported by nurses interviewed from UNIT B (Appendix G, Table 11).

Client related issues (e.g. when clients refuse contact or are too dependent) were mentioned most frequently with regard to feeling least worthwhile (Appendix H, Table 9).
Experimental Questions

1. A progressive organizational environment facilitated the expression of personal/professional values (all nurses interviewed at UNIT B), and contributed positively toward job satisfaction. Ninety percent of nurses interviewed claimed they were very satisfied with their work, and one individual (10% of nurses interviewed at UNIT B) was dissatisfied with her job.

2. Nurses who were interviewed from UNIT B did not provide any information about self perception.

3. Some comments presented above indicate that if expectations which nurses bring to the job are not satisfied then this will contribute toward job dissatisfaction.

4. Communication processes, resource people available for dealing with stress, a formal support system, and a progressive organizational environment combine to make up an environment which is perceived in a positive way by most nurses (UNIT B).
Of the nurses who participated in survey information from UNIT A, 35% of these nurses made statements which suggest they were experiencing burnout. Statements made by different nurses which may be relevant to burnout processes are reported below.

Job satisfaction varies from feeling it makes no difference to feeling that my job is very worthwhile. The former feeling is more prevalent.

If you want to follow through with your personal values you have to do so without your supervisor knowing which affects your professional values. They do encourage a caring attitude but limit you in your expression. (e.g. Do not visit in the hospital but home visiting is OK).

Actually I do not worry too much about how and why decisions are made any more. Any attempt I have made to effect change has been thwarted, so I gave up.

I feel like I am out there doing my thing, and nobody in the system knows what I am doing or cares. It seems difficult to effect change within the system.

I feel the more you get involved the unhappier you get because you see more problems. (e.g. You find out about other units and realize how unpleasant we have things).

Some nurses thought public health allows for the expression of personal/professional values in the context of a job, and other nurses thought their value expression was
inhibited (Appendix F, Table 4).

In a previous position, at another health unit, I could pick the medical officer of health's brain, whereas here I cannot.

At times it seems like a constant battle to apply both personal and professional values to this job. The administration encourages a caring attitude but limit you in your expression e.g. Do not visit in the hospital but home visits are OK. If you want to follow through with personal values, in the context of a job, you have to do so without your supervisor knowing which then affects your professional values. Priorities are in the wrong place, numbers not people, quantity not quality. This message is constantly given and results in low job satisfaction.

One individual (six percent of nurses surveyed at UNIT A) stated "...Work does allow for the expression of personal/professional values, less so than before though." Facilitating and/or inhibiting personal/professional value expression likely has impact on job satisfaction (Appendix F, Table 5).

The availability and quality of support systems likely has impact on job satisfaction.

One individual surveyed from UNIT A stated:

Public health can be a very isolated job unless you have the support from your co-workers. Rewards from clients are few and far between. This is why I feel the supervision should support you and let you know how you are doing periodically, either good or bad work.

According to 29% of nurses surveyed at UNIT A, "The communication between management and staff is grossly poor." As reported by 18% of individuals surveyed, "The director
and supervisors make decisions, tell nurses during meetings, allow feedback, ignore feedback, and continue with the decision." Communication between nurses and supervisors is good, according to 18% of nurses surveyed from UNIT A. One nurse said "I feel that other nurses are doing a better job, which is a common feeling among nurses, perhaps, because we are working in isolation so much of the time with no feedback as to what kind of a job we are doing." Quality and quantity of communication processes likely reflect the quality and quantity of resources available for coping with job stress (Appendix F, Table 6).

One individual surveyed (six percent) at UNIT A stated, "There have always been stresses in public health, but I feel there are more now and to a greater degree (Appendix G, Table 12)."

As indicated by Appendix H, Table 9, some stressors contributed toward feeling least worthwhile.

Experimental Questions

1. Most nurses survey from UNIT A were satisfied with their work (75%), and thought their personal/professional values were expressed (53%). Others were dissatisfied with the job (18% of nurses surveyed from UNIT A), and some nurses surveyed claimed the administration hindered the expression of their personal/professional values (12% of nurses).
2. Comments presented above indicate that some nurses surveyed from UNIT A had negative self perceptions due to the nature of the work situation. Lack of feedback in the work contributed toward negative self perceptions. Also, comments indicate that the work situation contributed toward job dissatisfaction.

3. Nurses surveyed from UNIT A did not provide information about past experience related to current work.

4. Communication processes, lack of feedback, and the lack of a formal support system contribute toward negative perceptions of the organization and job dissatisfaction.

Public Health Nurse Survey Information Unit B

No nurse surveyed from UNIT B made any statement which suggested burnout was occurring. Most nurses claimed the job allows for the expression of personal/professional values (Appendix F, Table 4).

Value expression is probably related to job satisfaction. Examine Appendix F, Table 5 for information on job satisfaction, with regard to individuals surveyed from UNIT B. Opportunities for attaining job satisfaction are broad in a health unit with a progressive philosophical orientation.
As reported by 14% of individuals surveyed at UNIT B, "The unit's orientation is very progressive with regard to implementing new ideas." One individual (seven percent) said "There are ample opportunities to develop special skills within a generalist program." A progressive philosophical orientation toward health care may be facilitated by good communication processes.

One nurse surveyed (seven percent), at UNIT B, claimed "Although the director has final say, she seeks advice from supervisors, who relay decisions in progress to nurses, and the director asks for our input." As indicated by 50% of nurses surveyed at UNIT B, "Communication is good within the unit, and good lines of communication exist right to the top of the management hierarchy." One individual stated "I think the communication is excellent in the unit." However, one nurse surveyed (seven percent) claimed "The communication has improved during the last few years. Specifically, the management has persisted with regular meetings for communication purposes. Management attempts to keep us informed of decisions, and the rationale for these decisions." One individual surveyed (seven percent) at UNIT B, said "Information and decisions take a long time to filter down, and input from nurses is not always sought and/or utilized." Good communication processes exist, and similarly, there are formal resource people available for coping with job stress (Appendix F, Table 6).
According to 14% of individuals surveyed, formal resource people worked out so well that they did not require informal resource people with regard to job stress (Appendix G, Table 13).

Although time constraints was perceived as a stressor, time constraints contributed to feeling least worthwhile. Factors contributing toward feeling least worthwhile are reported in Appendix H, Table 9.

Experimental Questions

1. All nurses surveyed from UNIT B were satisfied with their work, and thought that their personal/professional values were expressed (86% of nurses surveyed).
2. No information was reported with respect to self perception from individuals who participated in survey information (UNIT B).
3. Nurses from UNIT B did not provide survey information about past experience related to current work.
4. Positive perceptions of the organization were facilitated by good staff-management relations, staff involvement in decision making, communication processes, a formal support system, and opportunities to develop special nursing skills. Opportunities for attaining job satisfaction are broad in this organizational environment.
Chi-Square Analyses

Chi-Square tests were computed for all group-pairs which developed interview information, and for those groups surveyed. Results are reported separately in Appendix I, Table 14 for each category of Chi-Square analyses.

1. Ex and active nurses at UNIT A reported significantly greater thwarting of personal/professional values, in the context of the job, than did nurses at UNIT B.

2. Nurses interviewed at UNIT A reported a significantly greater number of negative self perceptions than did nurses interviewed at UNIT B.

3. No Chi-Square testing the adequacy of task preparation was statistically significant.

4. Both Ex and current nurses at UNIT A indicated significantly greater levels of dissatisfaction with intraorganizational climate than did nurses at UNIT B.

T-tests

Appendix I, Table 15 reports the means and standard deviations, for each group, as a function of job stress, job satisfaction, burnout, and job dissatisfaction. T-tests were
computed between all group-pairs which developed interview information, and between groups surveyed. T-test results are reported in Appendix I, Table 16 for each category.

Individuals in UNIT B reported significantly greater job satisfaction than individuals affiliated with UNIT A (Ex and active nurses).

Nurses affiliated with UNIT A (Ex and active nurses) reported significantly greater levels of job dissatisfaction than did nurses affiliated with UNIT B.

Survey information generated by individuals from UNIT A indicated significantly higher rates of burnout than did survey information from individuals at UNIT B.

Maslach Survey of Professional Occupations

T-tests were computed, utilizing normative information (Maslach & Jackson, 1978) and information generated by Ex public health nurses. The tests determined if there were any statistically significant differences between sample and population means, for the subscales emotional exhaustion, depersonalization, and personal accomplishment. No T-test was found to be statistically significant. That is to say, there were no statistically significant differences in the means for subscales emotional exhaustion, depersonalization, and personal accomplishment.
Internal Validity

To assess the internal validity, of the work, inter-analyst reliability checks were computed utilizing the pearson product-moment correlation. Simple r coefficients are reported, for Q-sort and frequency ratings, for the investigator and each analyst.

Simple r's computed for the Investigator and Analyst One were thwarting of personal/professional values r=.89; negative self perception r=.92; a sense of adequate task preparation r=.92; dissatisfaction with intraorganizational climate r=.87; job stress r=.93; job dissatisfaction r=.95; burnout r=.76; and job satisfaction r=.76.

For the Investigator and Analyst Two the simple r's were thwarting of personal/professional values r=.72; negative self perception r=.94; a sense of adequate task preparation r=.86; dissatisfaction with intraorganizational climate r=.83; job stress r=.98; job dissatisfaction r=.96; burnout r=.66; and job satisfaction r=.78.

Out of 192 scores Analyst One and Analyst Two agreed on 143 scores indicating 74% agreement. The rationale for not having Analysts One and Two make ratings on a substantial number of the same protocols was limited resources.

Tables 1, 2, and 3 (Appendix E) illuminate the similarities and differences in category schemes developed by the Investigator and the two Analysts.
Discussion

Since all members of the analysis team developed similar category schemes this suggests the content analysis results, reported by the investigator, have good internal validity. Similarly, simple r's reported with respect to Q Sorts and frequency counts suggest good internal validity with regard to the investigator's Q-Sorts and frequency counts.

With respect to the experimental hypothesis that personal/professional values, self perception, personal biography, and the perception of the organization are significant factors for understanding where job satisfaction shifts to job dissatisfaction, and for adequate conceptualization of the experience of burnout in public health nursing, data support this hypothesis. However, the hypothesis is supported with the qualification that the above processes (burnout and shifts in job satisfaction) are predominantly mediated by intraorganizational processes.

Results of Chi-Squares and T-tests (for frequency counts) support the experimental hypothesis and content analysis results, consequently this information will not be discussed here. T-tests computed for the subscales of Maslach's Survey of Professional Occupations were not statistically significant, perhaps because of defense mechanisms and/or the lack of job situation items.
Collectively, the data suggest the experience of burnout is an experiential synthesis of the constructs job satisfaction, morale, self perception, and job stress. Also, intraorganizational processes mediate the experience of burnout.

For discussion purposes, data from groups associated with UNIT A are discussed as individual groups or as pooled groups. Similarly, groups from UNIT B are discussed as individual groups or as pooled groups. The rationale for speaking in terms of individual groups or pooled groups is that organizational patterns common to all groups within an organization may be discussed, and/or patterns prototypical to one or two groups may be discussed. However, there is confounding in the practice of pooling groups, because some individuals participated only in survey information, some nurses were only involved in interview information, and others were involved with both survey and interview information. I will now turn to an evaluation of experimental questions, raised previously, with respect to the experimental hypothesis.
1. HOW DO PERSONAL/PROFESSIONAL VALUES RELATE TO WHERE JOB SATISFACTION SHIFTS TO JOB DISSATISFACTION AND THE EXPERIENCE OF BURNOUT?

Data on facilitation/inhibition of personal/professional values and aspects of the work which contribute toward job dissatisfaction, from the iatrogenic environment group (UNIT A) suggest administrative attitudes/orientation(toward nurses)/expectations(of nurses) contribute toward lowering morale, increasing rates of burnout, and shifts in job satisfaction toward greater job dissatisfaction. Iatrogenic environment means intraorganizational processes which make the situation worse for helpers.

Experientially, burnout may be, in part, an interweaving of low morale, job dissatisfaction, and thwarting of nurse' intraorganizational expectations, for some individuals in the iatrogenic environment group (UNIT A). Cherniss (1978) illuminated the potential of organizational processes with regard to facilitation/inhibition of burnout processes. Iatrogenic intraorganizational processes may encourage burnout.

In contrast, the supportive environment group (UNIT B) inhabit an intraorganizational environment with an administration which has a progressive orientation toward health care, and may facilitate the burnout of individuals who tend to overwork (take on too much), and simultaneously
facilitate the acknowledgement of their personal/professional values. Experiencing burnout may be an experiential synthesis of job satisfaction, high morale, extreme fatigue, and intraorganizational facilitation of personal/professional values for some individuals, in the supportive environment group (nurses interviewed from UNIT B), who have high personal expectations.

Kemp's (1977) reference to burnout as an addiction to one's own biochemistry, specifically to a high level of adrenalin production, seems apropos. Do some individuals physiologically need high levels of adrenalin circulating in order to feel good? Perhaps others are easily influenced by external situations that affect a locking into overdrive with respect to workload. Alternatively, perhaps some nurses experience a combination of physiological need and susceptibility to external situations. External situations, for the supportive environment group (UNIT B), stem from a progressive philosophical orientation toward health care by an administration which encourages taking on new obligations.

Intraorganizational situations which do not facilitate the well-being of nurses, supervisors, and director may facilitate negative self perceptions. In contrast, intraorganizational situations which facilitate the well-being of nurses, supervisors, and the director may facilitate positive self perceptions.
2. HOW DOES SELF PERCEPTION RELATE TO WHERE JOB SATISFACTION Shifts TO JOB DISSATISFACTION AND THE EXPERIENCE OF BURNOUT?

Interestingly, the iatrogenic environment group acknowledged that intraorganizational processes were key in the loss of self respect and with regard to causing job dissatisfaction. Information generated by the supportive environment group suggests that intraorganizational processes facilitate job satisfaction, nurse well-being, and the belief burnout can be constructively resolved.

Data support Howard et al.'s (1978) work, because burnout occurred when individuals were experiencing high levels of job satisfaction, and burnout also occurred when individuals were experiencing low levels of job satisfaction. Self perception may covary positively with job satisfaction. For example, a high level of job satisfaction might co-occur with predominantly positive self perceptions.

Contrary to what some investigators believed, burnout does not necessarily co-occur with negative self perception (Pines and Maslach,1978; Maslach,1978b; Maslach and Jackson,1978; Kahn,1978; and Hall, Gardner, Perl, and Stickney,1979). However, negative self perceptions may be positively related to the shift from job satisfaction to job dissatisfaction, in situations where iatrogenic
intraorganizational processes predominate organizational processes. On the other hand, nurses with predominantly positive self perceptions who tend to overwork, in a progressive intraorganizational environment, may burnout.

It is fascinating that intraorganizational processes may influence nurse' self perception, job satisfaction, the duration of burnout, and the perceived potential for constructive resolution of burnout processes (e.g. attempting to openly deal with burnout, or becoming more entrenched in burnout processes by utilizing defenses). What we have experienced in our personal biographies may influence our susceptibility to burnout.

3. HOW DOES PERSONAL BIOGRAPHY RELATE TO WHERE JOB SATISFACTION SHIFTS TO JOB DISSATISFACTION AND TO THE EXPERIENCE OF BURNOUT?

Our personal biographies likely feed a set of expectations which we bring to a job. According to information generated by the iatrogenic environment group staff perception of administrative attitudes/orientation/expectations suggests staff have different expectations of what the work situation should be offering (e.g. feedback, autonomy, support, being treated like adults). Unacknowledged staff' expectations likely contribute toward job dissatisfaction and burnout.
Perhaps, most individuals in the supportive environment group were, for the most part, fulfilled with regard to their expectations of management. Their fulfillment may have had a positive impact on rates of burnout, durations of burnout, and perspectives on the potential for resolution of burnout processes. Perhaps past experience with public health organizations under examination, for nurses, has influenced nurse' expectations with regard to administrative orientation/support/attitudes, and these expectations have impact on helper well-being and the quality of service provided.

The suggestion is that intraorganizational environments which are not supportive of helper well-being, and often present staff with no win situations (double bind situations) result in a decrease in helper motivation to provide high quality service, and increase the potential for iatrogenic service. A good intraorganizational environment, from a staff perspective, likely has positive impact on staff satisfaction.

4. HOW DOES PERCEPTION OF THE ORGANIZATION RELATE TO WHERE JOB SATISFACTION SHIFTS TO JOB DISSATISFACTION AND TO THE EXPERIENCE OF BURNOUT?

Most nurses in the iatrogenic environment group perceived negative intraorganizational processes as a
primary source of job dissatisfaction, low morale, stress, and the loss of self respect.

In contrast, information generated by individuals in the supportive environment group suggests intraorganizational processes have positive impact on staff. Intraorganizational processes facilitate nurse well-being, have positive impact on job satisfaction, are supportive of good morale, support constuctive attitudes toward job stress because of excellent support systems, and encourage/discourage burnout depending on personal factors (e.g. encourage burnout if the individual tends to take on too much work).

To summarize, data suggest personal/professional values, self perception, personal biography, and organizational perception are important factors with regard to understanding where job satisfaction shifts to job dissatisfaction and for adequate understanding of the burnout experience. However, intraorganizational processes, whether these processes facilitate or inhibit nurse well-being, are crucial for understanding where job satisfaction shifts occur and for understanding the experience of burnout.

As mentioned previously, there is no consensus in the burnout literature with regard to a precise definition of burnout. This investigation illuminates the construct of burnout as a complex experiential synthesis of the
constructs morale, job satisfaction, job stress, and self perception.

Burnout, in this study, was shown to be a function of several measurable variables. These variables are morale, job satisfaction, stressors, those who overwork and those who do not, self perception, personal and organizational value harmony, interorganizational and intraorganizational climate. Future research might involve a longitudinal multiple regression study with predictor variables morale, job satisfaction, a stressor typology (e.g. intraorganizational stressors, client interaction stressors), different personality types (type A & type B), self perception, personal/professional value expression/inhibition, and intraorganizational/interorganizational climate, with burnout as the dependent variable might be worth doing with regard to further refining the concept of burnout.

Interestingly, nurses in the iatrogenic environment group (active public health interview information) did not utilize the term burnout in response to low morale questions, yet individuals in the supportive environment group (active public health interview data) did utilize the term burnout in response to low morale questions. Lack of reference to burnout by individuals in the iatrogenic environment group may be a function of defenses, because an intraorganizational environment which is not supportive of
helper well-being may influence nurses to believe, as a survival mechanism, that their well-being and the quality of service they provide is not affected in a deleterious way. Perhaps differences in the utilization of defenses, for individuals in different organizational environments (e.g. iatrogenic environment, supportive environment), is related to stressors which predominate respective work contexts.

Perhaps, qualitative differences with regard to stressors, for individuals in different organizational environments, result in qualitatively different burnout experiences. Individuals in the iatrogenic environment group perceived stressors as predominantly intraorganizational, whereas, individuals in the supportive environment group perceived stressors as predominantly personal. Perhaps, intraorganizational stressors, and personal stressors make different quantitative contributions to the duration of burnout, and with regard to the qualitative experience of the burnout process, in different organizational situations.

Nurses in the supportive and iatrogenic environment groups differ markedly with regard to their perceptions of what causes burnout/low morale. Individuals in the iatrogenic environment group (active public health interview information) thought low morale was primarily caused by intraorganizational processes and second by personal factors.
In contrast, individuals in the supportive environment group (active public health interview information) thought burnout was primarily caused by personal factors and second by person and situation factors. It may be reasonable to assume the perceived causes of burnout/low morale are positively related to iatrogenic behavior (helpers who create worse problems in the process of helping), for some individuals.

Intraorganizational processes, in the public health organizations under examination, may be primarily responsible for encouraging/discouraging iatrogenic behavior. Of course, this is not to naively suggest iatrogenic behavior occurs only as a result of intraorganizational processes, rather, intraorganizational processes may be mediating iatrogenic behavior more so than other factors (personal factors, interorganizational factors, societal factors, and their interactions), in the organizational situations under examination.

Intraorganizational processes, for individuals in the supportive environment group, probably discourage the development of entrenched burnout (long-term burnout—several weeks or months) and iatrogenic behavior. Burnout and iatrogenic behavior are likely discouraged because of the concern for staff well-being, excellent support systems, good communication processes, and staff involvement in decision making processes. However, burnout may be
encouraged by the unit's **progressive orientation** toward health care in combination with **high personal expectations**, for some individuals in the supportive environment group. Once entrenched in the burnout process, the unit's progressiveness and time pressures in the work may encourage iatrogenic behavior.

Individuals in the iatrogenic environment group experience different intraorganizational processes. Clearly, the iatrogenic environment group inhabit an intraorganizational environment which is not constructive with regard to facilitating their well-being (e.g. poor support systems, poor communication processes, and an iatrogenic administrative orientation toward staff). One assertion, which stems from these data, is iatrogenic intraorganizational environments encourage entrenched burnout and iatrogenic behavior on the part of nurses, supervisors, and the director of nursing.

However, there are consultation activities which could be undertaken on staff and management levels, at UNITS A and B. At UNIT A, staff could hold a workshop with regard to developing a formal professional support system, examining various ways of improving communication processes with management, and discussing how to cope best with an authoritarian management.

On the management level at UNIT A, a consultant could meet with a group consisting of the medical officer of
health, the director of nursing, supervisors, and other key individuals to discuss organizational patterns which were illuminated by the research; and to discuss some constructive changes which could be made, and the cost-benefits of implementing these changes.

At UNIT B, staff could hold a workshop to discuss the assessment of physical and emotional resources which one has to expend in the work situation, and strategies for dealing with management and the work when one has reached the limit of physical and emotional resources available.

On the management level at UNIT B, a consultant could meet with management to discuss research results, the signals which indicate an individual is near her physical and emotional resource limit on the job, and appropriate strategies for dealing with people who are near their resource limitations.

My message expresses concern for the well-being of helpers in human service organizations, and how the level of helper well-being has direct impact on the well-being of community members. To facilitate the well-being of helpers, and to minimize the development of iatrogenics, it may be useful to consider the role of intraorganizational processes. Intraorganizational processes deserve attention and corresponding action of individuals holding the political purse strings in the health and social service system. The well-being of primary helpers, supervisors, and
the director has important implications for rates of burnout and iatrogenic behavior occurring; ultimately for the well-being of community members.
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APPENDIX A

PUBLIC HEALTH NURSE SURVEY
The purpose of this exploratory investigation is to define the phenomenon of the experience of job stress, burnout, job dissatisfaction, or however you choose to label the phenomenon.

The current investigation is exploratory and collaborative in nature, so feel free to write comments perhaps with regard to the appropriateness or inappropriateness of any question for you. I would appreciate any information with regard to questions that you think should be included with regard to the studying of job stress.

After the questions that follow, write a paragraph in the space provided. If you require additional space feel free to write on the back of the page. There is a page at the back for your comments and/or questions that you think ought to be included.

Be assured that all questionnaires are STRICTLY CONFIDENTIAL. I am interested in all responses taken together as a group, rather than the responses of any one individual. Results will be reported in general form.

Thank you for your co-operation.

D'Arcy Helmer
Wilfrid Laurier University.
Overall how satisfied are you with your work?

What are the aspects of your work that leave you feeling most worthwhile? What are the aspects that leave you feeling least worthwhile?

What were your motives for pursuing a Public Health Nursing career? Does your work allow you to express the personal and professional values that are important to you in the context of a job?
Have you modified any of the values and principles that you had when you were a student nurse? Could you elaborate on this modification process if modification of values and/or principles occurred?

What is the most stressful part of being a Public Health Nurse
(a) initially? (b) What have you moved through?
(c) What is stressful now?
In the last two weeks think of your least successful contact. How much could you have actually influenced the contact? Do you think the non-productivity was set up before you arrived?

Imagine that you just had an afternoon of stressful visits. A person at the office is a formal resource person. A friend or family member is an informal resource person. How many formal and informal resource bases do you have with regard to coping with job stress? Describe the resources you have.

How much gratification do you expect from your work life relative to your non-work life?
Could anyone be successful, capable, and competent in all aspects of the work?

Think about the Health and Social Service System. To your knowledge what are the lines of communication between the decision makers with respect to resource allocation and front line workers?
Comments and Questions
APPENDIX B

THE SURVEY OF PROFESSIONAL OCCUPATIONS
Any job requiring that a person help or care for others is a job that involves special talents and abilities in relating to people. It may also involve a good deal of stress, depending upon the demands of the job and the limited resources available. The purpose of this questionnaire is to discover how various professionals view their job and the people they work with closely.

The current investigation is exploratory and collaborative in nature, so feel free to write any comments perhaps with regard to the appropriateness or inappropriateness of any question for you. I would appreciate any information with respect to questions that you think should be included with regard to the phenomenon of job stress, burnout, job dissatisfaction, or whatever you choose to call the process.

Be assured that all questionnaires are STRICTLY CONFIDENTIAL. Information that is provided will not be connected to any name or position. I am interested in the answers of all respondents taken together as a group rather than the responses of any one particular respondent. Results will be reported in a general form and never with reference to any individual.

The term "recipient" is used for referring to the type of people for whom you provide your service, care, or treatment.

Thank you for your co-operation.

D'Arcy Helmer
The Survey of Professional Occupations

Your name__________________________________________________________

Marital status:  Single________
Married________
Divorced________
Widowed________
Other (please specify)______________________________________________
If married, how long have you been married to your current spouse?___________________________Years.

How long have you been a nurse?_________________________________________Years.
How long have you been at your present job?______________________________Years.

Of your total working time, indicate what percentage of the time you spend:
  In direct contact with recipients ______ %
  In direct contact with other staff ______ %
  Professional training ________________ %
  Administration duties ________________ %
  Other (please specify)___________________ %

  Total: 100%

Approximately how many hours a week are you in direct contact with recipients?

________ hours.
On the following pages are several statements of job-related feelings you might have. Please read each statement carefully and decide if you ever feel this way about your job. If you have never had this feeling, check the box marked "NEVER" and go on to the next statement. However, if you have experienced this feeling, indicate HOW OFTEN you feel it by circling the appropriate number on 6-point scale. Then, decide HOW STRONG the feeling is when you experience it by circling the appropriate number on the 7-point scale. An example is shown below.

Frequency of Feeling: HOW OFTEN:

NEVER
A FEW TIMES A YEAR OR LESS

A FEW TIMES A MONTH OR LESS
ONCE A MONTH OR LESS
ONCE A WEEK
A FEW TIMES A WEEK
EVERY DAY

Intensity of Feeling: HOW STRONG:

1 2 3 4 5 6 7

VERY MILD, MODERATE, MAJOR, VERY STRONG,
BARELY NOTICEABLE

Example:

00. I feel depressed at work.

NEVER HOW OFTEN: 1 2 3 4 5 6

HOW STRONG: 1 2 3 4 5 6 7

If you occasionally feel depressed at work (say a few times a month) you would circle the number 3. If, when you do feel depressed, it is a fairly strong feeling, but not as strong as you can imagine, you would circle a 6.
<table>
<thead>
<tr>
<th>HOW OFTEN:</th>
<th>A few times a year</th>
<th>Monthly</th>
<th>A few times a month</th>
<th>Weekly</th>
<th>A few times a week</th>
<th>Daily</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HOW STRONG:</th>
<th>Very mild</th>
<th>Moderate</th>
<th>Very strong</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>4</td>
<td>7</td>
<td></td>
</tr>
</tbody>
</table>

1. I feel emotionally drained from my work.  
   NEVER HOW OFTEN: 1 2 3 4 5 6  
   □ HOW STRONG: 1 2 3 4 5 6 7

2. I feel used up at the end of the workday.  
   NEVER HOW OFTEN: 1 2 3 4 5 6  
   □ HOW STRONG: 1 2 3 4 5 6 7

3. I feel similar to my recipients in many ways.  
   NEVER HOW OFTEN: 1 2 3 4 5 6  
   □ HOW STRONG: 1 2 3 4 5 6 7

4. I feel personally involved with my recipients' problems.  
   NEVER HOW OFTEN: 1 2 3 4 5 6  
   □ HOW STRONG: 1 2 3 4 5 6 7

5. I feel fatigued when I get up in the morning and have to face another day on the job.  
   NEVER HOW OFTEN: 1 2 3 4 5 6  
   □ HOW STRONG: 1 2 3 4 5 6 7

6. I feel uncomfortable about the way I have treated some recipients.  
   NEVER HOW OFTEN: 1 2 3 4 5 6  
   □ HOW STRONG: 1 2 3 4 5 6 7

7. I can easily understand how my recipients feel about things.  
   NEVER HOW OFTEN: 1 2 3 4 5 6  
   □ HOW STRONG: 1 2 3 4 5 6 7

8. I feel I treat some recipients as if they were impersonal "objects."  
   NEVER HOW OFTEN: 1 2 2 4 5 6  
   □ HOW STRONG: 1 2 3 4 5 6 7

9. Working with people all day is really a strain for me.  
   NEVER HOW OFTEN: 1 2 3 4 5 6  
   □ HOW STRONG: 1 2 3 4 5 6 7
10. I deal very effectively with the problems of my recipients.
   NEVER HOW OFTEN: 1 2 3 4 5 6
   □ HOW STRONG: 1 2 3 4 5 6 7

11. I feel burned out from my work.
   NEVER HOW OFTEN: 1 2 3 4 5 6
   □ HOW STRONG: 1 2 3 4 5 6 7

12. I feel I'm positively influencing other people's lives through my work.
   NEVER HOW OFTEN: 1 2 3 4 5 6
   □ HOW STRONG: 1 2 3 4 5 6 7

13. I've become more callous toward people since I took this job.
   NEVER HOW OFTEN: 1 2 3 4 5 6
   □ HOW STRONG: 1 2 3 4 5 6 7

14. I worry that this job is hardening me emotionally.
   NEVER HOW OFTEN: 1 2 3 4 5 6
   □ HOW STRONG: 1 2 3 4 5 6 7

15. I feel very energetic.
   NEVER HOW OFTEN: 1 2 3 4 5 6
   □ HOW STRONG: 1 2 3 4 5 6 7

16. I feel frustrated by my job.
   NEVER HOW OFTEN: 1 2 3 4 5 6
   □ HOW STRONG: 1 2 3 4 5 6 7

17. I feel I'm working too hard on my job.
   NEVER HOW OFTEN: 1 2 3 4 5 6
   □ HOW STRONG: 1 2 3 4 5 6 7

18. I don't really care what happens to some recipients.
   NEVER HOW OFTEN: 1 2 3 4 5 6
   □ HOW STRONG: 1 2 3 4 5 6 7

19. Working directly with people puts too much stress on me.
   NEVER HOW OFTEN: 1 2 3 4 5 6
   □ HOW STRONG: 1 2 3 4 5 6 7
20. I can easily create a relaxed atmosphere with my recipients.

NEVER HOW OFTEN:  1  2  3  4  5  6
☐  HOW STRONG:  1  2  3  4  5  6  7

21. I feel exhilarated after working closely with my recipients.

NEVER HOW OFTEN:  1  2  3  4  5  6
☐  HOW STRONG:  1  2  3  4  5  6  7

22. I have accomplished many worthwhile things in this job.

NEVER HOW OFTEN:  1  2  3  4  5  6
☐  HOW STRONG:  1  2  3  4  5  6  7

23. I feel like I'm at the end of my rope.

NEVER HOW OFTEN:  1  2  3  4  5  6
☐  HOW STRONG:  1  2  3  4  5  6  7

24. In my work, I deal with emotional problems very calmly.

NEVER HOW OFTEN:  1  2  3  4  5  6
☐  HOW STRONG:  1  2  3  4  5  6  7

25. I feel recipients blame me for some of their problems.

NEVER HOW OFTEN:  1  2  3  4  5  6
☐  HOW STRONG:  1  2  3  4  5  6  7
APPENDIX C

TECHNICAL INFORMATION FOR THE SURVEY

OF PROFESSIONAL OCCUPATIONS
### Descriptive Statistics For The Intensity Dimension of Three Subscales

<table>
<thead>
<tr>
<th></th>
<th>Emotional Exhaustion</th>
<th>Depersonalization</th>
<th>Personal Accomplishment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Female</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>492</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>3.61</td>
<td>1.98</td>
<td>4.99</td>
</tr>
<tr>
<td>SD</td>
<td>1.47</td>
<td>1.52</td>
<td>.95</td>
</tr>
<tr>
<td><strong>Male</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N</td>
<td>433</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>3.02</td>
<td>2.33</td>
<td>5.05</td>
</tr>
<tr>
<td>SD</td>
<td>1.46</td>
<td>1.56</td>
<td>1.00</td>
</tr>
</tbody>
</table>
APPENDIX D

ANALYTICAL PROCEDURE
Analytical Procedure

Interview and public health survey information was content analysed with regard to themes. A theme is defined as an incident, a thought process, a viewpoint, or a description of a feeling.

The interview and survey information was examined independently by the investigator and two third year psychology students who were blind to the study. Initially, each person independently examined the information and recorded each theme that they encountered on a separate index card. When recording a theme, the protocol number was recorded on the index card to facilitate further analyses. After themes were recorded for all protocols, each person put the themes that went together in separate piles. Then, each member of the analysis team assigned a name to each pile of themes that he/she had sorted. A separate category was utilized for those themes that did not fall into any category. At this point, each team member had a set of categories (names assigned to each pile of themes), and the analysis proceeded independently for each team member with the five samples. Frequency data were recorded for each sample with regard to the categories utilized by each team member.

A modified Q-sort procedure (Stephenson, 1953) was independently undertaken by members of the analysis team, for the purpose of assisting in coding the information for the Chi-Square analyses. Frequency information with regard
to the thematic-content analyses was intended to contextually inform the Chi-Square analyses.

The investigator undertook the sorting procedure with every protocol. Two third year students, each with 25% of the protocols from each sample, which were randomly selected, undertook the sorting procedure. Before dealing with specific categories for each sorting procedure, a generic method for proceeding with each sort will be outlined.

"First, take the index cards and sort the cards into a pile for each protocol number. Take all the themes that you have generated for one individual protocol." Step two involves dividing the individual protocol themes into broad categories. "Put the themes that are most like the operational definition of the category under analysis in pile one. Put the themes that are least like the operational definition of the category under analysis in pile two, and put the themes that you are ambivalent about in pile three."

"On a seven point scale, the number "1" represents those themes that are most like the operational definition of the category under analysis. A "7" represents those themes that are least like the operational definition of the category under analysis. The number "4" on the scale represents those themes that you are ambivalent about with regard to the operational definition of the category under analysis. Themes that are somewhat like or somewhat unlike the
operational definition of the category under analysis are assigned accordingly to one of the scale numbers "2, 3, 5, or 6." Now that you understand the seven point scale in relation to the sorting procedure, take pile one and sort these themes into one of the scale numbers "1, 2, or 3" depending on their degree of likeness to the operational definition of the category under analysis. Take pile two and sort the themes into one of the scale numbers "5, 6, or 7" depending on the degree to which the theme is unlike the operational definition of the category under analysis. Take pile three and place each theme on the scale number which corresponds to the theme. If you are ambivalent about making a finer discrimination (e.g. Is the theme a "1","2", or "3"?) then leave the theme in the broad category, in this case "1". The frequency with which themes occur on each number of the seven point scale is recorded for each protocol that undergoes sorting." The purpose of recording the frequency for each scale number is so that an inter-analyst reliability check can be undertaken between each analyst and the investigator, utilizing the pearson product-moment correlation.

The next step is to determine which category to code the individual protocol for the Chi-Square analysis. Frequencies for the scale numbers "1" to "3" are added together (call their sum group 1). Similarly, frequencies for the scale numbers "5" to "7" are added (call their sum group 2). The frequency for the scale number "4" is dealt
with differently depending on whether its frequency is an odd number or an even number. If the frequency is an even number then divide the number by two and add the answer to group 1 and group 2. However, if the frequency is an odd number add one to the group that goes against the predicted direction of the relationship (outlined in (a) to (d) below). One is added to the group that goes against the predicted direction of the relationship to make the Chi-Square test more conservative. I now have two numbers, one for group one, and the other for group two. The larger of the two numbers indicates the category which is to be coded 1, for the protocol, in the Chi-Square analysis. The method outlined above with regard to coding for the Chi-Square analysis is generic regardless of the operational definition of the category under analysis."

Sections (a) to (d) define the predicted direction of the relationships between the operationally defined categories, burnout, and where job satisfaction shifts to job dissatisfaction.

(a) Perhaps the thwarting of personal/professional values on a continuous basis is partly responsible for the shift of job satisfaction to job dissatisfaction, and burnout.

**Thwarting of Personal/Professional Values**

1 2 3 4 5 6 7

MOST LIKE MOST UNLIKE
(b) Negative self perception may have a positive relationship with where job satisfaction shifts to job dissatisfaction, and with burnout.

Negative Self Perception

1 2 3 4 5 6 7

MOST LIKE MOST UNLIKE

(c) Certain aspects of one's personal biography such as previous work experience, and the adequacy of educational preparation with regard to dealing with current task obligations may predispose some individuals to job dissatisfaction and perhaps burnout. Inadequate preparation for task obligations probably relates positively to predisposing some individuals to job dissatisfaction and burnout.

A Sense of Adequate Preparation for Task Obligations

1 2 3 4 5 6 7

MOST LIKE MOST UNLIKE

(d) Perhaps overall job satisfaction is a function of the degree of satisfaction with intrinsic factors (factors inherent in doing the task) and extrinsic factors (situational factors). The individual's perception of the organization with regard to the resources available, administrative policy, and the working relations between staff and administration may significantly determine job satisfaction and influence burnout. Dissatisfaction with
intraorganizational climate likely relates positively with job dissatisfaction and burnout.

**Dissatisfaction with Intraorganizational Climate**

There were a number of operational definition categories where frequency information was recorded for designated protocols. The investigator recorded frequency information for each protocol, and other members of the analysis team recorded frequency information for their selected protocols. These operational definition categories are job stress, burnout, job satisfaction, and job dissatisfaction. The investigator did independent sample T-tests (two-tailed) for each category (Appendix E, Table 16). An inter-analyst reliability check was computed utilizing the pearson product-moment correlation between each analyst and the investigator.

The Maslach survey of professional occupations (1978) has four subscales: emotional exhaustion, depersonalization, personal accomplishment, and personal involvement. Refer to Appendix C for technical information with regard to Maslach's survey of professional occupations. T-tests for a difference between a sample mean and a population mean were computed for each subscale to determine if there were any significant differences between Maslach and Jackson's (1978) data, and the descriptive statistics obtained from sample one.
APPENDIX E

TABLES 1 TO 3
Table 1

Investigator's Category Scheme

**Support systems**-availability-quality-adequacy-functioning of support systems

**Communication**-communication within the health unit-between nurses and management-interorganizational-quality/quantity rapport/trust dimensions of communication processes

**Feedback processes**-positive and negative feedback from clients and management-evaluations of work perceived validity of these evaluations

**Burnout/Low morale**-contributing factors-effects of burnout/low morale-experience of burnout-job turnover self perceptions

**Ideas for change**-e.g. program and policy changes-administrative receptivity to ideas for change

**Comparative information**-comparing the job as it is now with past experience

**Administrative attitudes/orientation/expectations of staff**

**Staff response to administrative politics/orientation**

**Personal/professional values**-expression of values in the context of a job-shifts in values/principles important aspects of a job-expectations with respect to self and the job

**Job satisfaction/dissatisfaction**-nurse perception of her level of satisfaction-contributing factors toward satisfaction/dissatisfaction

**Perceived competence/capability/success**-comments on obligations where nurses felt competent and those obligations where they felt they needed help-staff perception of managerial competency

**Feeling least/most worthwhile**-aspects of the job which contribute toward feeling least/most worthwhile about oneself

**Stress/frustration/problematic issues**-intraorganizational-stressors-client interaction stressors-frustrating issues-problematic issues

**Work/non-work expectations for gratification**-percentage of gratification expected-consequences of these expectations

**Least successful contacts**-information about least least successful contacts with clients and organizations

**Motives for pursuing public health**

**Other**-themes that do not fit in any other category
Table 2

Analyst's #1 category scheme

Formal sources of support or resources
Communication
Suggestions for improving public health
General comments about specific people in administration
Positive comments on public health work
General complaints
Reasons for leaving public health
Administrative orientation
Coping-dealing with the work situation
Modification of values
Value expression
Job satisfaction
Preparation for public health nursing
Probability of being 100% successful in public health
Sources of most worthwhile feelings
Sources of least worthwhile feelings
Sources of stress
Percentage of gratification expected from work and non-work
Reasons for least successful visits
Reasons for choosing public health as a job
Others
Table 3

Analyst's #2 category scheme

Formal resource people—e.g. colleagues
Informal resource people—e.g. friends or family members—
methods of coping with job stress
Communication—quality/quantity of communication between
  nurses and administration
Feedback—importance of feedback processes—
  consequences of having so
  little feedback
Burnout—contributing factors—how it affects
  them and their work
Low morale—what causes it and what it affects—
  how to work through it
Improvements—improvements to the public health
  system—to programs—to the unit
Comparison—comparative information—other units—personal
  biography
Comments about administration
Reactions to the politics of the job
Feelings about the health unit
Frustration
Personal reflections—whether they were prepared to deal with the
  job—likes/dislikes
Expression of personal/professional values—whether
  for value expression—some state how
  they do it
Modification of values and principles
Job satisfaction—whether or not they are satisfied—
  reasons for satisfaction
Competence, success, and capability—whether they
  believe anyone can be successful
  in all aspects of the work
Feeling most worthwhile—contributing factors
Feeling least worthwhile—contributing factors
Job stress—aspects of the work that were stressful
Gratification—expected gratification from work
  and non-work—some give reasons
  for these levels
Least successful contacts
Motives—reasons for pursuing public health
Other—anything that does not fit into previous categories
APPENDIX F

TABLES 4 TO 6
Table 4

Personal/Professional Value Expression In The Context Of A Job For All Groups

EXIA—Ex public health nurse interview information-UNIT A
IA—Public health nurse interview information-UNIT A
IB—Public health nurse interview information-UNIT B
SA—Survey information-UNIT A
SB—Survey information-UNIT B

<table>
<thead>
<tr>
<th></th>
<th>EXIA</th>
<th>IA</th>
<th>IB</th>
<th>SA</th>
<th>SB</th>
</tr>
</thead>
<tbody>
<tr>
<td>n</td>
<td>15</td>
<td>10</td>
<td>10</td>
<td>17</td>
<td>14</td>
</tr>
<tr>
<td>Personal/professional values expressed</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>53%</td>
<td>86%</td>
</tr>
<tr>
<td>Sometimes allows for the expression of personal/professional values</td>
<td></td>
<td></td>
<td></td>
<td>14%</td>
<td></td>
</tr>
<tr>
<td>Personal/professional value expression inhibited due to lack of time and the way administration structured the job</td>
<td></td>
<td></td>
<td></td>
<td>83%</td>
<td>90%</td>
</tr>
<tr>
<td>Administrative hinderances to the expression of personal/professional values</td>
<td></td>
<td></td>
<td></td>
<td>12%</td>
<td></td>
</tr>
</tbody>
</table>
Table 5

Job Satisfaction/Dissatisfaction
For All Groups

EXIA—Ex public health nurse interview information-UNIT A
IA—Public health nurse interview information-UNIT A
IB—Public health nurse interview information-UNIT B
SA—Survey information-UNIT A
SB—Survey information-UNIT B

<table>
<thead>
<tr>
<th></th>
<th>EXIA</th>
<th>IA</th>
<th>IB</th>
<th>SA</th>
<th>SB</th>
</tr>
</thead>
<tbody>
<tr>
<td>n=15</td>
<td>n=10</td>
<td>n=10</td>
<td>n=17</td>
<td>n=14</td>
<td></td>
</tr>
<tr>
<td>Very satisfied with their work</td>
<td>90%</td>
<td>40%</td>
<td>79%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfied with their work</td>
<td>40%</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderately satisfied with their work</td>
<td>35%</td>
<td>21%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Satisfied with community work and dissatisfied with the unit as a place to work</td>
<td></td>
<td></td>
<td></td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td>Dissatisfaction as a function of administrative orientation toward nurses and lack of feedback in many obligations</td>
<td></td>
<td></td>
<td></td>
<td>90%</td>
<td></td>
</tr>
<tr>
<td>Dissatisfied with the job</td>
<td></td>
<td></td>
<td></td>
<td>10%</td>
<td>18%</td>
</tr>
</tbody>
</table>
Table 6

Resources For Coping With Job Stress
For All Groups

EXIA—Ex public health nurse interview information-UNIT A
IA—Public health nurse interview information-UNIT A
IB—Public health nurse interview information-UNIT B
SA—Survey information-UNIT A
SB—Survey information-UNIT B

<table>
<thead>
<tr>
<th></th>
<th>EXIA</th>
<th>IA</th>
<th>IB</th>
<th>SA</th>
<th>SB</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n=15</td>
<td>n=10</td>
<td>n=10</td>
<td>n=17</td>
<td>n=14</td>
</tr>
<tr>
<td>Colleagues and supervisors</td>
<td>33%</td>
<td>90%</td>
<td>59%</td>
<td>86%</td>
<td></td>
</tr>
<tr>
<td>Colleagues only</td>
<td>47%</td>
<td>23%</td>
<td>14%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supervisor when she is not too busy</td>
<td></td>
<td>80%</td>
<td></td>
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<tr>
<td>Colleagues if you could find a colleague during the day</td>
<td></td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Formal resources non-existent</td>
<td></td>
<td>20%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inadequate resources</td>
<td></td>
<td>10%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical officer of health and assistant medical officer of Health</td>
<td></td>
<td>14%</td>
<td></td>
<td></td>
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</tbody>
</table>
APPENDIX G

TABLES 7, 8, 10, 11, 12, 13
**Table 7**

Stressors Reported by Each Group

<table>
<thead>
<tr>
<th></th>
<th>EXIA</th>
<th>IA</th>
<th>IB</th>
<th>SA</th>
<th>SB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative orientation toward nurses</td>
<td>77%</td>
<td>90%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work overload</td>
<td>67%</td>
<td>80%</td>
<td>14%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of orientation toward task obligations</td>
<td>60%</td>
<td>60%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of a professional support system</td>
<td>57%</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The variety of obligations you are responsible for</td>
<td>53%</td>
<td>90%</td>
<td>21%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visiting the office because you would hear a stressful story</td>
<td>57%</td>
<td>60%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A sense of lack of completion</td>
<td>57%</td>
<td>90%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rigidity filtering down from top management levels</td>
<td>53%</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Autocratic management</td>
<td>53%</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visiting quotas</td>
<td>50%</td>
<td>100%</td>
<td>12%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Getting superficial help with a case problem from a supervisor</td>
<td>50%</td>
<td>60%</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Paperwork</td>
<td>50%</td>
<td>100%</td>
<td>12%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Computer work</td>
<td>50%</td>
<td>100%</td>
<td>90%</td>
<td>21%</td>
<td></td>
</tr>
<tr>
<td>Problem families</td>
<td>50%</td>
<td>90%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Issue</td>
<td>EXIA</td>
<td>IA</td>
<td>IB</td>
<td>SA</td>
<td>SB</td>
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<td>----------------------------------------------------------------------</td>
<td>------</td>
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</tr>
<tr>
<td>Being encouraged not to work in the office</td>
<td></td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Politicing with regard to how power comes down from above</td>
<td></td>
<td>90%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not knowing where you were at with the work</td>
<td></td>
<td>90%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical officer of health, director of nursing, and supervisors unloading their' stress on nurses</td>
<td></td>
<td>80%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Setting priorities and leaving the rest out</td>
<td></td>
<td>80%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meetings because there was no chairperson to keep us on track</td>
<td></td>
<td>70%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public health-school system relations</td>
<td></td>
<td>70%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No changing the status quo with regard to procedures</td>
<td>70%</td>
<td>12%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Having to go to court</td>
<td></td>
<td>60%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preschool assessments because of lack of screening information</td>
<td></td>
<td>60%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Getting to know the area</td>
<td>60%</td>
<td>70%</td>
<td>23%</td>
<td>14%</td>
<td></td>
</tr>
<tr>
<td>Negotiating my role as a public health nurse</td>
<td></td>
<td>50%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Winter driving</td>
<td></td>
<td>50%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Informal administrative expectations</td>
<td></td>
<td>50%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Covering for someone on vacation</td>
<td></td>
<td>50%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time constraints</td>
<td>90%</td>
<td>29%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Support the dying patient</td>
<td></td>
<td>90%</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>
Unmotivated clients 90% IA 14% SB
Organizing the workload 90% IB 18%
Fatigue 90%
Feeling helpless to improve the lives of problem families 80%
The shift from student to professional 80%
Learning new policies at the unit 80%
Feeling obligated to monitor the situation 80%
Family violence 80%
Dealing with abusive clients 80%
No let up for recharge 80%
Clients who do not trust me 70%
lack of impact visibility 70%
Responsibilities in the work 70%
Trying to make a good impression on all contacts 70%
Working alone 50%
Feeling incompetent 50%
Bringing health care where it is not always wanted though there is a need 35%
Intraorganizational processes 23%
Dealing with the administration 18%
Poor parenting 18%
Making decisions 12% 14%
Learning to be independent 12%
<table>
<thead>
<tr>
<th></th>
<th>EXIA</th>
<th>IA</th>
<th>IB</th>
<th>SA</th>
<th>SB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowing that I do not always have specific knowledge</td>
<td></td>
<td></td>
<td></td>
<td>12%</td>
<td></td>
</tr>
<tr>
<td>Getting to know the district</td>
<td></td>
<td></td>
<td></td>
<td>12%</td>
<td></td>
</tr>
<tr>
<td>Orientation processes</td>
<td></td>
<td></td>
<td></td>
<td>12%</td>
<td></td>
</tr>
<tr>
<td>Knowing when the client is ready for intervention or discharge</td>
<td></td>
<td></td>
<td></td>
<td>12%</td>
<td></td>
</tr>
<tr>
<td>Driving</td>
<td></td>
<td></td>
<td></td>
<td>12%</td>
<td></td>
</tr>
<tr>
<td>Lack of supervision</td>
<td></td>
<td></td>
<td></td>
<td>12%</td>
<td></td>
</tr>
<tr>
<td>Not being informed of program changes when agency personnel have been informed</td>
<td></td>
<td></td>
<td></td>
<td>12%</td>
<td></td>
</tr>
<tr>
<td>Lack of community resources</td>
<td></td>
<td></td>
<td></td>
<td>12%</td>
<td></td>
</tr>
<tr>
<td>Lack of client compliance</td>
<td></td>
<td></td>
<td></td>
<td>12%</td>
<td></td>
</tr>
<tr>
<td>Child abuse cases</td>
<td></td>
<td></td>
<td></td>
<td>21%</td>
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### Table 8

**Stressors Reported By Ex Public Health Nurses At Unit A**

<table>
<thead>
<tr>
<th>Stressor</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Administrative orientation toward nurses</td>
<td>77%</td>
</tr>
<tr>
<td>Work overload</td>
<td>67%</td>
</tr>
<tr>
<td>Lack of orientation toward task obligations</td>
<td>60%</td>
</tr>
<tr>
<td>Lack of a professional support system</td>
<td>57%</td>
</tr>
<tr>
<td>The variety of obligations you are responsible for</td>
<td>53%</td>
</tr>
<tr>
<td>Visiting the office because you would hear a stressful story</td>
<td>57%</td>
</tr>
<tr>
<td>A sense of lack of completion</td>
<td>57%</td>
</tr>
<tr>
<td>Rigidity filtering down from top management levels</td>
<td>53%</td>
</tr>
<tr>
<td>Autocratic management</td>
<td>53%</td>
</tr>
<tr>
<td>Visiting quotas</td>
<td>50%</td>
</tr>
<tr>
<td>Getting superficial help with a case problem from a supervisor</td>
<td>50%</td>
</tr>
<tr>
<td>Paperwork</td>
<td>50%</td>
</tr>
<tr>
<td>Computer work</td>
<td>50%</td>
</tr>
<tr>
<td>Problem families</td>
<td>50%</td>
</tr>
</tbody>
</table>
### Table 10

**Stressors Reported By Nurses Interviewed At Unit A**

<table>
<thead>
<tr>
<th>Stressor</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative orientation toward nurses</td>
<td>90%</td>
</tr>
<tr>
<td>Work overload</td>
<td>80%</td>
</tr>
<tr>
<td>Lack of orientation toward task obligations</td>
<td>60%</td>
</tr>
<tr>
<td>Lack of a professional support system</td>
<td>100%</td>
</tr>
<tr>
<td>Visiting the office because you would hear a stressful story</td>
<td>60%</td>
</tr>
<tr>
<td>A sense of lack of completion</td>
<td>90%</td>
</tr>
<tr>
<td>Rigidity filtering down from top management levels</td>
<td>100%</td>
</tr>
<tr>
<td>Autocratic management</td>
<td>100%</td>
</tr>
<tr>
<td>Visiting quotas</td>
<td>100%</td>
</tr>
<tr>
<td>Getting superficial help with a case problem from a supervisor</td>
<td>60%</td>
</tr>
<tr>
<td>Paperwork</td>
<td>100%</td>
</tr>
<tr>
<td>Computer work</td>
<td>100%</td>
</tr>
<tr>
<td>Problem families</td>
<td>90%</td>
</tr>
<tr>
<td>Being encouraged not to work in the office</td>
<td>100%</td>
</tr>
<tr>
<td>Politicizing with regard to how power comes down from above</td>
<td>90%</td>
</tr>
<tr>
<td>Not knowing where you were at with the work</td>
<td>90%</td>
</tr>
<tr>
<td>Medical officer of health, director of nursing, and supervisors unloading their stress on nurses</td>
<td>80%</td>
</tr>
</tbody>
</table>
Nurse interview information - UNIT A

Setting priorities and leaving the rest out 80%

Meetings because there was no chairperson to keep us on track 70%

Public health-school system relations 70%

No changing the status quo with regard to procedures 70%

Having to go to court 60%

Preschool assessments because of lack of screening information 60%

Getting to know the area 60%

Negotiating my role as a public health nurse 50%

Winter driving 50%

Informal administrative expectations 50%

Covering for someone on vacation 50%
<table>
<thead>
<tr>
<th>Stressors Reported By Nurses Interviewed At Unit B</th>
</tr>
</thead>
<tbody>
<tr>
<td>The variety of obligations you are responsible for 90%</td>
</tr>
<tr>
<td>Computer work 90%</td>
</tr>
<tr>
<td>Getting to know the area 70%</td>
</tr>
<tr>
<td>Time constraints 90%</td>
</tr>
<tr>
<td>Supporting the dying patient 90%</td>
</tr>
<tr>
<td>Unmotivated clients 90%</td>
</tr>
<tr>
<td>Organizing the workload 90%</td>
</tr>
<tr>
<td>Fatigue 90%</td>
</tr>
<tr>
<td>Feeling helpless to improve the lives of problem families 80%</td>
</tr>
<tr>
<td>The shift from student to professional 80%</td>
</tr>
<tr>
<td>Learning new policies at the unit 80%</td>
</tr>
<tr>
<td>Feeling obligated to monitor the situation 80%</td>
</tr>
<tr>
<td>Family violence 80%</td>
</tr>
<tr>
<td>Dealing with abusive clients 80%</td>
</tr>
<tr>
<td>No let up for recharge 80%</td>
</tr>
<tr>
<td>Clients who do not trust me 70%</td>
</tr>
<tr>
<td>Lack of impact visibility 70%</td>
</tr>
<tr>
<td>Responsibilities in the work 70%</td>
</tr>
<tr>
<td>Trying to make a good impression on all contacts 70%</td>
</tr>
<tr>
<td>Working alone 50%</td>
</tr>
<tr>
<td>Feeling incompetent 50%</td>
</tr>
</tbody>
</table>
### Table 12

<table>
<thead>
<tr>
<th>Stressors Reported By Nurses Participating In Survey Information At Unit A</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Visiting quotas</td>
<td>12%</td>
</tr>
<tr>
<td>Paperwork</td>
<td>12%</td>
</tr>
<tr>
<td>No changing the status quo with regard to procedures</td>
<td>12%</td>
</tr>
<tr>
<td>Getting to know the area</td>
<td>23%</td>
</tr>
<tr>
<td>Organizing the workload</td>
<td>18%</td>
</tr>
<tr>
<td>Bringing health care where it is not always wanted though there is a need</td>
<td>35%</td>
</tr>
<tr>
<td>Intraorganizational processes</td>
<td>23%</td>
</tr>
<tr>
<td>Dealing with the administration</td>
<td>18%</td>
</tr>
<tr>
<td>Poor parenting</td>
<td>18%</td>
</tr>
<tr>
<td>Making decisions</td>
<td>12%</td>
</tr>
<tr>
<td>Learning to be independent</td>
<td>12%</td>
</tr>
<tr>
<td>Knowing that I do not always have specific knowledge</td>
<td>12%</td>
</tr>
<tr>
<td>Getting to know the district</td>
<td>12%</td>
</tr>
<tr>
<td>Orientation processes</td>
<td>12%</td>
</tr>
<tr>
<td>Knowing when the client is ready for intervention or discharge</td>
<td>12%</td>
</tr>
<tr>
<td>Driving</td>
<td>12%</td>
</tr>
<tr>
<td>Lack of supervision</td>
<td>12%</td>
</tr>
<tr>
<td>Not being informed of program changes when agency personnel have been informed</td>
<td>12%</td>
</tr>
<tr>
<td>Lack of community resources</td>
<td>12%</td>
</tr>
<tr>
<td>Lack of client compliance</td>
<td>12%</td>
</tr>
<tr>
<td>Stressor</td>
<td>Percentage</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>------------</td>
</tr>
<tr>
<td>Work overload</td>
<td>14%</td>
</tr>
<tr>
<td>The variety of obligations you are responsible for</td>
<td>21%</td>
</tr>
<tr>
<td>Computer work</td>
<td>21%</td>
</tr>
<tr>
<td>Getting to know the area</td>
<td>14%</td>
</tr>
<tr>
<td>Time constraints</td>
<td>29%</td>
</tr>
<tr>
<td>Unmotivated clients</td>
<td>14%</td>
</tr>
<tr>
<td>Making decisions</td>
<td>14%</td>
</tr>
<tr>
<td>Child abuse cases</td>
<td>21%</td>
</tr>
</tbody>
</table>
APPENDIX H

TABLE 9
Table 9
Factors Contributing Toward Feeling Least Worthwhile For All Groups

EXIA—Ex public health nurse interview information-UNIT A  
IA—Public health nurse interview information-UNIT A  
IB—Public health nurse interview information-UNIT B  
SA—Survey information-UNIT A  
SB—Survey information-UNIT B

<table>
<thead>
<tr>
<th>Factor</th>
<th>EXIA</th>
<th>IA</th>
<th>IB</th>
<th>SA</th>
<th>SB</th>
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<tbody>
<tr>
<td>n=15</td>
<td></td>
<td>n=10</td>
<td>n=10</td>
<td>n=17</td>
<td>n=14</td>
</tr>
<tr>
<td>Paperwork</td>
<td>63%</td>
<td>100%</td>
<td>100%</td>
<td>18%</td>
<td>29%</td>
</tr>
<tr>
<td>Lack of a sense of accomplishment</td>
<td></td>
<td>80%</td>
<td>100%</td>
<td>35%</td>
<td>14%</td>
</tr>
<tr>
<td>Charting</td>
<td>57%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of administrative support</td>
<td>57%</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Doing something with the awareness that there were more important things to be done</td>
<td>57%</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of primary preventive work</td>
<td>50%</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Having the education without the power to utilize it</td>
<td>50%</td>
<td>80%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Petty incidents occurring at the unit</td>
<td>50%</td>
<td>90%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Problem family visits</td>
<td>50%</td>
<td>90%</td>
<td>12%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child abuse situations</td>
<td>50%</td>
<td>80%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work overload</td>
<td>70%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Having to handle abortions under the table</td>
<td>70%</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Going to court</td>
<td>60%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inadequate orientation</td>
<td>50%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time pressures</td>
<td>100%</td>
<td>21%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Issue</td>
<td>EXIA</td>
<td>IA</td>
<td>IB</td>
<td>SA</td>
<td>SB</td>
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<td>------</td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
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</tr>
<tr>
<td>When clients refuse contact or are too dependent</td>
<td></td>
<td>90%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of praise</td>
<td>90%</td>
<td>14%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coordinating other agency obligations</td>
<td></td>
<td>80%</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>When public health is called in and no nursing involvement is necessary</td>
<td></td>
<td>80%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hostile clients</td>
<td></td>
<td>70%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lack of community resources</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>12%</td>
</tr>
</tbody>
</table>
APPENDIX I

TABLES 14 TO 16
### Table 14

Chi-Square Analyses

(n=15) EXIA-Ex public health nurse interview information-UNIT A  
(n=10) IA-Active public health nurse interview information-UNIT A  
(n=10) IB-Active public health nurse interview information-UNIT B  
(n=17) SA-Survey information-UNIT A  
(n=14) SB-Survey information-UNIT B  

(i) Thwarting of personal/professional values

<table>
<thead>
<tr>
<th></th>
<th>EXIA</th>
<th>IA</th>
<th>IB</th>
<th>IB</th>
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<td>15</td>
<td>2</td>
<td>8</td>
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<td>3.71</td>
<td>3.81</td>
<td>8.96</td>
<td>1.52</td>
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</table>

(ii) Negative self perception

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<tr>
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<th>IA</th>
<th>IB</th>
<th>IB</th>
<th>SA</th>
<th>SB</th>
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<tr>
<td></td>
<td>5</td>
<td>7</td>
<td>1</td>
<td>9</td>
<td>4</td>
<td>13</td>
</tr>
<tr>
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<td>0.03</td>
<td>3.71</td>
<td>3.81</td>
<td>1.52</td>
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</table>

(iii) A sense of adequate preparation for task obligations

<table>
<thead>
<tr>
<th></th>
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<th>IA</th>
<th>IB</th>
<th>IB</th>
<th>SA</th>
<th>SB</th>
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<td></td>
<td>10</td>
<td>15</td>
<td>8</td>
<td>2</td>
<td>14</td>
<td>3</td>
</tr>
<tr>
<td>CHISQ</td>
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<td>3.26</td>
<td>2.22</td>
<td>0.06</td>
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</table>

(iv) Dissatisfaction with intraorganizational climate

<table>
<thead>
<tr>
<th></th>
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<th>IA</th>
<th>IB</th>
<th>IB</th>
<th>SA</th>
<th>SB</th>
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<td></td>
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<td>15</td>
<td>2</td>
<td>8</td>
<td>10</td>
<td>7</td>
</tr>
<tr>
<td>CHISQ</td>
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<td>17.65</td>
<td>13.33</td>
<td>6.42</td>
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</tr>
</tbody>
</table>
### Table 15
Means and Standard Deviations of Category Frequencies

(n=15) EXIA--Ex public health nurse information-UNIT A  
(n=17) SA--Survey information-UNIT A  
(n=10) IA--Interview information-UNIT A  
(n=14) SB--Survey information-UNIT B  
(n=10) IB--Interview information-UNIT B

<table>
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<tr>
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<th>Standard Deviation</th>
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Table 16

T-Test Results For Frequency Categories

(n=15) EXIA--Ex public health interview information-UNIT A  
(n=10) IA--Interview information-UNIT A  
(n=10) IB--Interview information-UNIT B  
(n=17) SA--Survey information-UNIT A  
(n=14) SB--Survey information-UNIT B

(i) Job satisfaction

EXIA * IA \( t(23) = .45 \)  
EXIA * IB \( t(23) = 6.28, *p < .001 \)  
IA * IB \( t(18) = 4.99, *p < .001 \)  
SA * SB \( t(29) = 2.62, *p < .01 \)

(ii) Job dissatisfaction

EXIA * IA \( t(23) = .59 \)  
EXIA * IB \( t(23) = 14.78, *p < .001 \)  
IA * IB \( t(18) = 16.83, *p < .001 \)  
SA * SB \( t(29) = 2.46, *p < .05 \)

(iii) Burnout

EXIA * IA \( t(23) = .79 \)  
EXIA * IB \( t(23) = 1.47 \)  
IA * IB \( t(18) = .60 \)  
SA * SB \( t(29) = 2.47, *p < .05 \)

(iv) Job stress

EXIA * IA \( t(23) = .09 \)  
EXIA * IB \( t(23) = .22 \)  
IA * IB \( t(18) = .13 \)  
SA * SB \( t(29) = 1.35 \)