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Taking the Pulse of Texas Nursing Facility Social Workers: A Study of the Attitudes of Texas Nursing Facility Social Workers about Their Work

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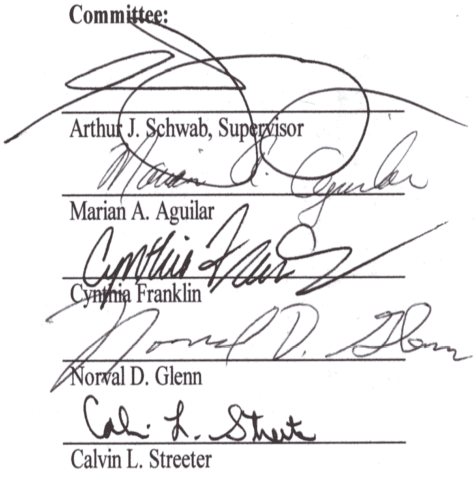

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Taking the Pulse of Texas Nursing Facility Social Workers: A Study of the Attitudes of Texas Nursing Facility Social Workers about Their Work

by

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Dedication

This work is dedicated to the social workers, aides, nurses, administrators, activity directors, housekeepers, laundry workers, maintenance workers, kitchen workers and office workers who labor daily to make life safe, interesting, and joyful for the residents of Texas nursing homes.

Acknowledgements

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Taking the Pulse of Texas Nursing Facility Social Workers: A Study of the Attitudes of Texas Nursing Facility Social Workers about Their Work

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The University of Texas at Austin, 2002

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Taking the Pulse of Texas Nursing Facility Social Workers: A Study of the Attitudes of Texas Nursing Facility Social Workers About Their Work is a study of burnout among social workers in Texas nursing facility social workers. Burnout is measured using the Maslach Burnout Inventory. Factors potentially related to burnout are grouped in the categories of the Courage and Williams model: characteristics of the social worker, characteristics of the nursing facility as an employer, characteristics of nursing facility residents as clients. A measure of the stigma associated with nursing facilities is added to the model as a fourth category. Stigma is shown to be a factor in burnout for nursing facility social workers.

All Texas nursing facilities were included in the survey mailing. Of the 302 respondents, 20.5% scored in the high category for emotional exhaustion burnout, 10.4% scored in the high category for depersonalization burnout, and 5.5% scored in the high category for personal accomplishment burnout. Characteristics of the social worker that influence burnout are age, ethnicity, time employed, and Duttweiler Internal Control Index. Burnout decreases with age. Hispanic social workers have lower levels of burnout than other ethnic groups, and African American social workers have higher levels of burnout than other ethnic groups. Burnout increases as time employed increases. Characteristics of the work environment that influence burnout are spending time with clients, understanding state requirements, adequacy of staffing in the facility, and job structure. Burnout is influenced by the social worker's perception of the residents' ability to cope.

Two scales measuring the perception of nursing facility stigma, professional respect scale and misunderstood scale, show a relationship to burnout. The Courage and Williams model of factors related to burnout was supported in that at least one variable from each category was related to burnout.

The respondents were predominantly Caucasian females with a mean age of 41.1 years. Responses were received from a sample that proportionally matched Texas facilities in ownership and size.

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Chapter 1: Introduction

PURPOSE OF THE RESEARCH

The subject of the research documented in this dissertation is burnout among nursing facility social workers. Although research regarding nursing facility social workers as a unique group is limited, two studies conducted in Texas in the past five years indicate a short tenure among nursing facility social workers in Texas. Working with the nursing facility population is resonant with the core values of social work. Nursing facility residents are vulnerable and facing life changes and adaptation at a difficult time. Like children, the elderly in our society are marginalized. Those who enter the nursing facility have lost the skills and abilities needed to live without twenty-four hour a day nursing care and extensive assistance with the activities of daily living. Some suffer from the effects of chronic, debilitating conditions such as Alzheimer's or other dementias. Others have lost cognitive functioning as a result of strokes, heart attacks, or other circulatory impairments. Some nursing facility residents have normal mental function but are dealing with chronic illness or end state terminal conditions. For most nursing facility residents, age has brought with it losses in sight, hearing, and taste. Chronic pain from arthritis, osteoporosis, and other debilitating diseases is common. Lack of medical knowledge about unique needs of the geriatric population results in poor choices of drugs and misinterpretation of symptoms. In addition to the effects of aging on their functioning, nursing

facility residents are adjusting to a new living environment, new people in their lives, and new activities.

From the perspective of the social worker's focus on the person-in-environment, the nursing facility and its residents provide a unique opportunity to practice the skills that distinguish social work from other professions. The role of the nursing facility social worker requires assessment, case management, advocacy for the individual client, individual and group counseling, resource development, and the opportunity to advocate for the nursing facility population (Haulotte & Purvis, 1996). Nursing facility social workers have roles in helping residents adjust to the nursing home environment, improving residents' relationship with their families, making the nursing home a therapeutic community, and improving the nursing home-community relationship (Dhooper, 1997).

Nursing facility social work is not a dead-end position. In addition to the characteristics of the work itself, nursing facility social workers have opportunities to advance professionally into consultation, teaching, or management positions. Experienced nursing facility social workers are potentially employable by either the state or the Joint Commission on Healthcare Accreditation as a long-term care surveyor. However, despite what would seem to be an attractive employment choice for social workers, not all of the nursing facility social worker positions in Texas are filled by persons with actual social work education. Previous studies of Texas nursing facility social workers (including individuals with all licensing categories) indicate that the average time

in the job is between one and a half and two years (Gleason-Wynn, 1995; Murray, 1996). My purpose in conducting this research is to document the extent to which nursing facility social workers experience burnout and to examine the factors in the environment that contribute to the development of burnout.

PERSONAL INTEREST IN NURSING FACILITIES

My personal experience with nursing facilities began in 1988 when my mother broke her hip. As a Medicare recipient, she was eligible for 21 days of post-operative care and physical therapy in a skilled nursing facility. She was only a temporary resident, but I was impressed with the differences in the facility and my memories from childhood of visiting elderly relatives at a nursing home. I was struck with the personal attention to every detail of her day. The staff was very eager to learn about her every preference for food, daily schedule, dress, and entertainment. Later I would learn that such attention to detail about each resident is required by federal rule, but I found it very different from a hospital experience.

In 1991 after my father died, my mother returned to the same nursing facility as a resident. I had thought she might be able to live alone after his death, but it became obvious that he had been covering for her level of cognitive impairment, and living alone was beyond her capacity. I was living in Texas, and she was in her home in Alabama, and the nursing facility was the only alternative in the community until I was able to make arrangements to move her to an assisted living facility in Texas. She was in the nursing facility in Alabama for about five months while I made arrangements for her to come to Texas. During

that time she became the president of the resident council. She also distinguished herself by taking notes on everything she thought was problematic about the facility. When the surveyors came to visit she brought out her notepad to go over her comments. She wrote to me, “They were very interested in what I had to say.” I am sure that was true.

She moved to Texas and lived in an assisted living facility until her money for private pay ran out. Like many working people of the depression/war generation, my parents lived a very modest, frugal life, counting pennies and saving all they could for old age. Despite saving what must have seemed to them to be an ample sum, at least four times my father’s highest annual salary, she had about enough money to pay for a year in private pay assisted living. After that money was gone, her only option was to enter a skilled nursing facility with her expenses paid by Medicaid. Fortunately, I had experience with Medicaid as a state worker, and I knew how to navigate the eligibility system.

She lived in a nursing home in Austin from 1993 until her death in 1999. On at least two occasions the staff of the nursing facility saved her life by recognizing that she was having a heart attack and caring for her until she could be sent to the hospital. She experienced extended loss of oxygen to the brain during her first heart attack and lived the last five years of her life with severe dementia. During the years my mother lived in the nursing home, I met many nurses, administrators, social workers, nurse aides, dietary staff, residents, volunteers, and family members. I saw many acts of love and kindness, and many mistakes and problems. The nursing home always seemed to me to be a very

vibrant world. It is not a perfect world, but it generally seemed to be largely populated by people with an unusual level of dedication to their work.

WHY STIGMA?

I began working in the nursing facility industry in Texas in 1993. Because I worked for a trade association that represents nursing facilities, I had the opportunity to interact with many individuals who work in facilities all over Texas and in other states. In my discussions with nursing facility staff, I have heard a theme emerge about the difference in perception between people who work in nursing facilities and those whose only experience is through the lens of the media or second hand observation. People who work in nursing homes experience a pervasive negative feedback about their chosen work. It is not uncommon for a nursing home employee to be asked how she can work in such a depressing place. Many professionals find that their experience in the nursing home is discounted if they choose to apply for another job. Nurses are told by other nurses that their skills are not up to date if they have been working in a nursing home. Social workers are told, by other social workers, that they are wasting their time on nursing home residents because they are only in the nursing home waiting to die. Nursing home administrators, the only health care administrators required by law to have a license, have become so dispirited that only 2400 individuals are currently licensed in Texas, a state with over 1100 facilities. Social workers frequently choose to practice their profession with society's most challenged and challenging members. Working with troubled adolescents, drug abusing adults, child abusing parents, abused children, families

living in poverty or the homeless is not easy or, usually, financially rewarding work. However, such work is generally respected and the willingness to seek solutions to such intractable problems is rewarded with admiration of friends and family. Nursing facility employees do not enjoy a similar respect. In fact, even other professionals speak in negative terms about nursing facilities and the people who work in them.

As the literature review will show, there is an implicit assumption among professionals, journalists, bureaucrats, and politicians that nursing homes give bad care. In my work, I heard references to the general public's fear of nursing homes. For example, I served on the Services Committee for the Austin Area Alzheimer's Association. The association provides support groups for family members who are caring at home for an individual with Alzheimer's. It can be a challenge to find a suitable location for the groups in small towns, and nursing facilities are an obvious choice because there is usually at least one in every small town, good meeting space is usually available, the buildings are always open, and refreshments are available. In addition, administrators are always eager to host activities that attract potential resident families to visit the building. However, social workers who lead the groups report that some caregivers react very negatively to coming to the nursing facility for a meeting.

Observing this phenomenon over time, I began to wonder how this public perception affects the attitude of people who work in nursing facilities. Texas has over 1100 nursing homes, with at least one licensed social worker, one licensed nurse, and one licensed administrator for every home. It does not seem reasonable

to believe that literally thousands of licensed nurses, social workers, administrators, therapists, dieticians, and physicians would continue to work in the nursing facility industry if, as the public seems to think, nursing homes are terrible places where residents are given poor care, neglected, and abused. What would be the motivation for these professionals? Is it feasible that thousands would risk their licenses, even if the ethical considerations could be ignored?

It is possible that social workers have resistance to stigma. Social workers are drawn to work with stigmatized populations. As the literature review on stigma will show, groups such as prisoners, persons with mental and emotional illnesses, racial and ethnic minorities, immigrants, persons in poverty, persons with HIV/AIDS, adopted children, and welfare recipients are all stigmatized. All are likely to be clients of social workers. Does the stigma associated with these groups become attached to social workers who work with them? And if it does, how does that stigma effect the social worker as a practitioner and as a person? Does it affect a nursing home social worker to read, as the literature review will show, that he or she is working in the "black hole of health care"?

Documenting the combination of media, political, and bureaucratic attention that has resulted in the current positioning of nursing home in the public consciousness would be a project far beyond the scope of this dissertation. In one sense, how the image emerged of the nursing home as a dismal, depressing place where old people are abused and neglected is not relevant to this project. My interest is in how this pervasive opinion, which I am calling "nursing home

stigma," affects nursing home professionals and whether it contributes to their burnout.

The purpose of this research is not to resolve the questions of the quality of care provided in nursing facilities. The quality of care conversation has been continuing and unresolved at state and federal levels, and the most determined efforts of advocates and industry groups seem to make no difference. My goal is not to delve into care issues but to explore the existence of the construct, nursing home stigma, and to determine if it affects the social worker's level of burnout on the job. My master's degree in social work was in administration and planning, and my work experience has been in administration and management, not in direct practice. My concerns and contributions lie in the area of human resources, so I have crafted this research and dissertation to address the needs and perceptions of the human resource element of nursing facility social work.

SOCIAL WORKERS AND BURNOUT

Beginning in the late seventies and early eighties, social workers began to systematically study and define the phenomenon of burnout as an explanation of turnover. The origin of the term is attributed to Herbert J. Freudenberger, who first described the frustration and lack of effectiveness that developed as free clinic counselors became frustrated and exhausted with their work counseling drug abusers. Other writers followed, and researchers Ayala Pines, Gary Cherniss, and Christina Maslach, among others, refined and developed the construct. Maslach developed the scale for measuring burnout that is used as the dependent variable in this research.

Burnout, as is it defined by these early writers, is related to intense work with people. Burnout differs from ordinary job boredom or frustration in that the original values that attracted the worker to the field are assailed by the nature of the job experience. In the theory of burnout, the social worker comes to the job with the expectation that his or her efforts will result in an improved life or condition for the clients. However, the social worker quickly discovers the multivariate nature of the client's world, and the difficulty of relating the social worker's actions to the client's outcomes. This lack of direct feedback or measurement of effectiveness is a central concept to burnout. Confounding frustrations such as too much paper work, inadequate resources for clients, bureaucratic barriers, low pay, long hours, and lack of professional respect can contribute to burnout.

One goal of this research is to bring the accumulated knowledge about burnout and the conditions that are associated with it to the nursing facility social worker. The literature on burnout is rich with information and insights, but the literature on social workers in nursing facilities is limited, so the opportunity exists to enhance our knowledge about nursing facility social work using the knowledge that has been developed through study of other social work settings.

IMPORTANCE TO SOCIAL WORK

The need for social workers in nursing facilities can be expected to increase as the population of older persons increases in relation to the rest of the population. The population 65 years of age and over will increase about two percent a year between 1987 and 2020 while the rest of the population increases

at about one percent. By 2020, about 23 million people will be over 75 years of age. The over-75 group may equal almost 40 million people by 2040. In regard to social workers specifically, the National Institute of Aging report says that the number of full-time equivalent professionally trained social workers needed to serve older persons and their families is estimated to be in the range of 40,000 - 50,000 in the year 2000 and 60,000-70,000 in 2020. The care of older persons may typically comprise one-third to two-thirds of the future workload of most physicians and other types of health care personnel (National Institute of Aging, National Institutes of Health, 1987).

Social workers agree that serving the elderly will be an important part of social work in the future. In a survey of 472 members of the National Association of Social Workers, respondents perceived that the area of aging would be much larger and more important in the future (Peterson, 1990). If the stigma of aging has any influence on the supply or availability of professionals to serve the rapidly aging population of the future, it is an important issue for social work to address.

Licensed nursing facilities are required by law to have a social worker on staff or contract. The Omnibus Budget Reconciliation Act of 1987 (OBRA), passed in 1987 and enacted in 1990, requires every facility over 120 beds to hire a full time social worker and smaller facilities to have a social worker for a proportionate amount of time. “Qualified” is defined in the federal rules as a person who meets state requirements for licensure or certification, or has a bachelor’s degree in social work or a related degree. The Texas Department of

Human Services, the state agency that regulates Texas nursing facilities, has interpreted the federal requirement to mean that the nursing facility social worker must hold a permanent or provisional license issued by the Texas Board of Social Work Examiners (Texas Department of Human Services, 2000). Under this interpretation of the rule, individuals licensed in Texas as Social Work Associates, Licensed Social Workers, and Licensed Master Social Workers are qualified to work in nursing facilities. Texas currently has just over 1100 licensed nursing facilities, requiring approximately the same number of licensed social workers.

The very name "long-term care" implies that the clients, in this case nursing facility residents, are expected to remain in need of service for an extended period. Nursing facility federal requirements are built around the assumption that the nursing facility is the resident's home and a premium is placed on a home-like environment (Texas Department of Human Services, 2000). Consistency of staff could be assumed to be valuable and to enhance quality of care. Indications that the average tenure of a nursing facility social worker is between one and half and two years raises the question about burnout of social workers in long-term care (Gleason-Wynn, 1994; Murray, 1996).

Attracting and keeping social workers in nursing facilities is challenging. A 1990 report funded by the Administration on Aging summarized the contrast between the need for and the interest in working with the elderly population. According to the report, the rapid increase in the over-75 segment of the population will increase the need for services to the elderly, but social workers

are reluctant to serve the elderly. Competing employment opportunities, insufficient faculty and student interest, and a sharing by social workers of society's negative bias towards the elderly contribute to this hesitation to seek employment in settings working with the elderly (Greene, Barusch, & Connelly, 1990).

Two studies conducted in Texas provide the only demographic information available on Texas nursing facility social workers. In 1994, Gleason-Wynn found that about 60% of nursing facility social workers have a social work degree (46.9% BSW and 13.2% MSW). The remaining 40% do not have social work education, and presumably practice with the SWA license. Murray found substantially the same numbers in 1996. Including individuals with all licensing categories, Murray found that the average time in the job is only 1.5 years (Murray, 1996). Gleason-Wynn found the average time in the current job to be 2.08 years (Gleason-Wynn, 1994). The short tenure may indicate that some factor is systematically influencing Texas nursing facility social workers to leave nursing facility practice.

Although skilled nursing facilities are only one of many settings in which social workers are employed to work with the elderly, the information about the attitudes that nursing facility social workers hold towards their work is relevant to the social work profession. The federal requirement for social workers and the needs of the population served by nursing facilities combine to create a need for insight into the challenges faced by social workers who choose the nursing facility for their practice setting.

RESEARCH QUESTIONS

In her study of nursing facility social workers, Murray's description of the intent of long-term care social workers to stay in their position reveals a very puzzling finding. Although 89% of BSWs, 85.7% of MSWs, and 92.1% of other respondents reported planning to remain in long-term care, the median length of time in the current position for all respondents was 1.5 years, and the median length of time elsewhere in the field of aging was three years (Murray, 1996). These sets of figures are hard to reconcile. An average tenure of 1.5 years in position would indicate a high rate of turnover, conflicting with the intent to stay. The purpose of this study is to examine the factors that influence the nursing facility social worker to leave the position.

In social work, burnout is always suspected when turnover is high in a practice area. As the literature review will show, there are numerous examples in the literature of studies of burnout among social workers in general and burnout studies among other positions in long-term care. However, no researcher has specifically addressed the burnout of nursing facility social workers and the subsequent effect on longevity in the position.

The purpose of this study is to measure the extent of burnout among nursing facility social workers and determine the extent to which factors related to characteristics of the clients (nursing facility residents and family), characteristics of the employer (the nursing facility), characteristics of the social worker, and attitudes of the community (a construct identified as "nursing home stigma") are associated with the occurrence of burnout.

Models for examining worker's motivation, job satisfaction or burnout have been used in other social work settings. Courage and Williams (1986) developed a three dimensional model with variables categorized as characteristics of the care provider, the organization, and the care recipient.

Characteristics of the care provider are personality, demographics, professional status, and expertise. Characteristics of the organization are task, structure, power/authority, resources, functions, and roles. Characteristics of the care recipients are individual behaviors, demographic characteristics, chronicity, acuity, and complexity.

While this structure has strong potential for isolating the elements of the job of the nursing facility social worker that contribute to burnout, it may overlook a fourth dimension that I have chosen to call "nursing home stigma." Placing the four (three from Courage and Williams and the fourth, nursing home stigma) dimensions in the nursing facility context, I propose that burnout will be associated with the social worker's perception that nursing facility social work is a career choice that carries with it stigma of nursing facilities.

It is reasonable to assume that the characteristics of nursing facility clients do not vary significantly from facility to facility, although social workers may experience differences that are specialized to certain types of nursing facilities. For example, some nursing facilities cater to the private pay market, while others are populated primarily by residents whose expenses are paid by public funds through the Medicaid program. It is also reasonable to assume that characteristics of the organization do not vary in major ways among facilities. Although nursing

facilities vary in governance (individual ownership, small and large chains, for-profit, not-for-profit), the rigid requirements for licensing and certification for Medicaid funding result in uniformity of task, structure, power/authority, functions and roles. Some roles and tasks, including the social worker's job function, are dictated by regulation and should not vary considerably from facility to facility.

I propose a study of nursing facility social workers to answer the questions:

- Are some nursing facility social workers more vulnerable than others based on demographic or personality characteristics?
- Is burnout related to characteristics of the nursing facility as an employer?
- Is burnout related to the characteristics of nursing facility residents?
- Is burnout related to the social worker's perception of nursing home stigma?

The methodology I propose to use is a survey. The Maslach Burnout Inventory will be used to measure burnout (dependent variable). The survey instrument will be the vehicle for collecting data on social worker's perceptions of each of the four independent variables (characteristics of nursing facility social workers, characteristics of the nursing facility as an employer, characteristics of residents and families as clients, and societal bias regarding nursing facilities.) Analysis of data from this instrument will be used to develop a picture of burnout

among nursing facility social workers and determine which dimension is most influential to the social worker's burnout.

It is my hope that the findings of this research will provide insight and information into the lives and needs of nursing facility social workers. The need for social workers to work with the elderly in the future will be great. Many of the issues that affect the lives of the elderly and the social service network that serves them are complex and multi-layered. Questions of adequate health care, housing, transportation, and a workforce for the aging population are major social issues. Political will and the ability of the economy to support an aging population are at the heart of those issues. The need for providing adequate services and supports for the elderly will be so crucial in the future that every barrier needs to be examined. If the stigma associated with aging and consequently with those who serve the aged in any setting, including nursing facilities, is a barrier to social workers entering or staying in that field, it needs to be identified. If stigma proves to be unimportant to social workers' working in the field, then time and attention can be turned elsewhere. In either case, it is my hope that this study will serve a useful purpose in helping the social work profession develop a better and more accurate understanding of those who practice in the field of nursing facility social work.

Chapter 2: Literature Review

ORGANIZATION OF LITERATURE REVIEW

Previous research and writing that could possibly be relevant to the question of burnout among nursing facility social workers is broad and vast, but at the same time, very little has been written specifically about this population. Much has been written on burnout in social workers, but very little has been written about nursing facility workers in any profession. Many factors have been associated with burnout, and each of these factors opens a door to a library of literature focused on that particular factor. This literature review covers material relating to each of the factors that potentially contribute to burnout, and the list of factors is long. In order to impose some logical order on the contents, the literature review in this chapter is organized in sections that correspond to the categories in the modified Courage and Williams model: characteristics of the social worker, characteristics of the human service organization, and characteristics of the care recipient or client. The review begins with a discussion of the dependent variable, burnout.

The general literature relevant to the dependent variable, burnout in social workers, is reviewed first, followed by a discussion of the Maslach Burnout Inventory, the specific burnout instrument that is used for the measurement of the dependent variable. Burnout emerged as a topic in the literature in the 1970s, and the most active time of research and writing was in the decades of the 1970s and 1980s, although some work was still being published into the 1990s. The literature shows how theories of burnout have changed over time and emerged

from different orientations. Some writers regard burnout as a social issue, others as a philosophical question, and some as an economic model. Maslach Burnout Inventory has been the subject of hundreds of studies, and the most pertinent are covered here.

The next section reviews models that have been developed to explain, organize, or define the factors that influence burnout. This section ends with the Courage and Williams model, the model that is used in the current research project. The Courage and Williams model organizes the independent variables into three categories: characteristics of the care provider (nursing facility social worker), characteristics of the human service organization (nursing facility), characteristics of the care recipient (nursing facility residents). The next three sections of the literature review are organized by these three topics.

The independent variable that is added to the Courage and Williams model in this research is a construct labeled "nursing facility stigma." Since this construct is an idea original with the author, there are no articles specifically on this subject. The literature chosen for this section falls into two categories. The first category is stigma as focus for research. The second category is somewhat unconventional. It consists of writings from the nursing facility literature that provide examples of the use of nursing facility stigma in the professional literature by academic writers.

In the review of the literature, I did not find any study that specifically addressed burnout in nursing facility social workers, the construct of nursing

facility stigma, or variables that were similar to these either as a dependent or independent variables in a study.

DEFINITIONS AND DESCRIPTIONS OF BURNOUT

The idea of "burnout" as a condition affecting social service workers first emerged in the early seventies and was described as a phenomenon that affected both professional and volunteer workers in health clinics, hot lines, and other settings that require close contact with persons in distress. Although burnout was first described in terms of human service workers, the concept was never exclusively applied to social workers, nurses, or teachers. Legal aide attorneys, dentists, and other professionals were identified in the early literature as candidates for burnout. Herbert J. Freudenberger (1974) is frequently credited with originating the term "burnout" when he wrote a description of experiences in a free clinic. He does not attempt a definition or construct of burnout, but uses description to picture burnout in terms of physical and behavioral indicators. He describes the symptoms of burnout as quickness to anger and instantaneous irritation. In Freudenberger's description, burnout sufferers are suspicious and paranoid, take risks, and may use legal or illegal drugs. Freudenberger believes that the dedicated and committed are the most vulnerable to burnout. He offers interventions directed towards renewing the worker's energy though rest, time away, change of duties, and other means to relieve pressure and build up the worker's resilience.

From the earliest writings in the area, writers have had difficulty distinguishing burnout from closely related feeling states. Maslach and Schaufeli

point out that burnout first emerged as a social problem, not as a scholarly construct, and therefore the initial concept was shaped by pragmatic rather than academic concerns. As a result, burnout is not clearly distinguished from exhaustion, frustration, and other similar symptoms. The initial focus of writing in the area was on clinical descriptions of burnout. Freudenberger's work is an example of clinical description. The second, empirical phase shifted the emphasis to systematic research and assessment of the phenomena. Researchers who study burnout have been concerned with integrating burnout with other conceptual frameworks during both phases (Maslach & Schaufeli, 1993).

Another major seminal writer in the early literature, Cherniss, defines burnout as a change in attitude and behavior in response to a demanding, frustrating, unrewarding work experience (Cherniss, 1980). Arthur points out that burnout may not be a distinct phenomenon apart from stress, although she suggests it is a progressive syndrome (Arthur, 1990).

In an effort to determine similarities and separateness among the constructs of burnout and depression, Meier (1984) used three types of self report instruments with a sample of teachers and found that burnout measures met criteria for construct validity but correlated substantially with measures of depression, weakening support for burnout's discriminant validity. Meier concluded that burnout is a "fuzzy" construct because it is a feeling state and immune to precise definition.

Although burnout is not limited to human services professions, it is frequently associated with the people-helping professions. Human service

professionals are presumed to be more vulnerable because the idealistic expectations of helpers are frustrated by the realities of working in a flawed system with human beings. Initial high hopes and energy, combined with unrealistic expectations, give way to stagnation and indifference (Edelwich and Brodsky, 1980).

Hobfoll and Freedy offer a theory of burnout termed "conservation of resources" (COR) as an overarching framework to understand the nature of stress as a human phenomenon tied to experience regardless of the setting. They point out that burnout is a slow process, as opposed to other forms of stress such as death of a loved one. Conservation of resources theory assumes that individuals strive to obtain and maintain that which they value ("resources") and when circumstances at work (or elsewhere) threaten the individual's maintaining or obtaining resources, stress ensues. In the conservation of resources model, loss has more effect than gain, and any form of loss in the workplace generates stress. In this model, loss (or lack) of future opportunity (such as lack of opportunity for advancement) generates stress because the individual has invested resources (time, effort) into not only present circumstances but also into the opportunity to advance. If the opportunity fails to materialize or is not present, stress results. Hobfoll and Freedy speculate that is it possible that teachers, nurses, and social workers are especially vulnerable because they have limited upward mobility (Hobfoll & Freedy, 1993).

The notion that burnout could be clearly identified and defined has never been established without challenges. Burisch appears to despair of defining

burnout, describing it as a generic name for certain ill-defined types of crises or a fuzzy set of symptoms or a fuzzy set of people with symptoms. In a literature review he counted more than 130 symptoms that were cited in relation to burnout, although none of these symptoms is unique to burnout, i.e., not found in other constructs such as depression. He observes, however, that burnout processes often start when some goal or goals have remained unfulfilled for a long enough time despite attempts to reach them (Burisch, 1993).

Pines offers an existential definition of burnout. In her definition, burnout is a negative state of physical, emotional, and mental exhaustion that is the end result of a gradual process of disillusionment. It is typically found among highly motivated individuals who work over long periods of time in situations that are emotionally demanding. She argues that people need meaning in their lives, and the failure to find meaning causes burnout. However, it is not the failure per se but rather the feeling that one's efforts, and consequently one's self, are insignificant and meaningless (Pines, 1993).

Heifetz and Bersani propose that the common theme in discussions of burnout is some sort of motivational erosion: dedication becomes apathy, altruism becomes contempt, and insomnia replaces the impossible dream. The implicit assumption is that burnout is preceded by commitment. Their model assumes two basic needs on the part of the human services provider: a need to promote growth in others, and a need to grow personally on the job, measured by the professional's subjective experience of growth. When burnout occurs, it is

because the professional does not perceive growth in clients and/or self (Heifetz & Bersani, 1983).

Burnout is assumed to be a phenomenon that affects the individual, but some researchers have extended the concept to the organizational level. Borland (1981) offers a typology of burnout for an entire organization starting with four types identified, acute individual burnout, chronic individual burnout, transient group burnout, and full-blown departmental burnout.

Karger (1981) suggests that burnout is closely related to worker alienation, a Marxist concept, and not an experience unique to human services workers. He maintains that coping strategies on the part of individuals or amelioration strategies on the part of employers by manipulation of workplace conditions are making adjustments to the symptoms rather than reaching the heart of the problem. Social workers are alienated, he maintains, because the social service delivery system is designed to depress costs rather than reach the stated social goals. Alienation is a functional response to the "dehumanizing, mechanistic, and overwhelming chore of participating in a program geared for financial, rather than public, accountability."

Not every writer is content to use the term burnout. Pines and Kafry (1978) used the term "tedium," defined as a general experience of physical, emotional, and attitudinal exhaustion. The experience is characterized by feelings of strain and burnout, emotional and physical depletion, and by negation of one's self and one's environment. In their terms, tedium is the experience of distress

and discontent with one's work and way of life, the sense of failure, and the feeling that one cannot take it anymore.

The definitions and descriptions of burnout assume that burnout is a phenomenon that develops over time and progresses in intensity as time in the burnout inducing situation increases. However, a longitudinal study conducted with two measurements a year apart found that burnout is a relatively stable phenomenon. About two-thirds of the subject's burnout classification did not change. Among those whose level of burnout changed, about equal proportions increased and decreased (Poulin & Walter, 1993).

A term that has recently emerged in the literature is "compassion fatigue." Although originally intended to describe the reaction of the general public to repeated news of social injustice, compassion fatigue has also been used to describe the condition of the individual whose feelings of empathy and concern have been exhausted. Used in relation to human service workers, it is a term that describes a condition closely resembling burnout with the emphasis on loss of compassion toward the client. Countertransferance is implied in compassion fatigue. Leon, Altholz, and Dziegielewski (1999) point out that there is little literature addressing the compassion fatigue problem as it affects professionals working with the elderly, although they believe that working with the elderly puts social workers in a high risk group because of the limited resources available and the inevitable declines and losses in the client's life.

With clinical description, Marxist theory, existential theory, and pragmatic concerns such as the resource conservation theory, and other

definitions and descriptions available, the researcher has a variety of approaches to choose from in selecting a dependent variable. To further complicate comparisons of research projects, many researchers choose to use a related, but different, variable for the dependent variable. Turnover, job satisfaction and intent to turnover have all been used as dependent variables in research related to burnout. In some research, the main concern is not burnout itself, but the presumed consequences of burnout such as turnover or decrease in productivity. Intent to leave or turn over is often used as a dependent variable. However, Iglehart points out that turnover is not always a negative and can serve the useful function of ridding the agency of burned out staff (Iglehart, 1990).

Another issue in relating burnout to turnover is that any model linking burnout to job exit can be expected to have only moderate explanatory power. Many factors are related to the decision to leave a job, including factors that are completely unrelated to the job, such as spouse's employment or the availability of another job (Drake & Yadama, 1996).

In an example of research that focuses on the job satisfaction and intent to turn over as dependent variables, Vinokur-Kaplan and Chess used two questions as the dependent variable in a study of job satisfaction and retention of social workers in various settings. Job satisfaction is measured by the question, "All in all how satisfied are you with your job?" Intention to turn over is measured by "Taking everything into consideration, how likely is it that you will make a genuine effort to find a new job with another employer within the next year?" (Jayaratne & Chess, 1984; Vinokur-Kaplan, Jayaratne, & Chess, 1994). Although

responses to questions such as these could be used to infer burnout, the measurement is indirect.

Job satisfaction and burnout have been treated as separate, but related, functions. Both factors were considered in two consecutive surveys of job satisfaction and burnout in national samples of health care workers between 1979 and 1989. These studies found that role conflict, role ambiguity, lack of comfort, and dissatisfaction with financial rewards emerged as significant predictors of depersonalization and burnout (Siefert, Jayaratne, & Chess, 1991).

MASLACH BURNOUT INVENTORY

The most extensive development of burnout as a construct has been done by Christina Maslach and several co-researchers whose work culminated in the Maslach Burnout Inventory (MBI). The MBI was developed specifically for use with human service worker populations. It uses three subscales (emotional exhaustion, depersonalization, and reduced personal accomplishment) to measure the extent of burnout. Burnout is conceptualized as a continuous variable, ranging from low to moderate to high degrees of experienced feeling. The MBI has been the object of extensive research and has a well documented history of validity and reliability studies (Maslach, Jackson, & Leiter, 1996).

The Maslach Burnout Inventory was first introduced in 1981 when interest in burnout was high, but guiding theory had not been developed and little empirical research had been done. In the intervening years, the MBI has been the subject of many reliability and validity studies. It has been used in many countries and translated into many languages. The original form was developed

for human services professionals. Subsequent forms have been developed for educators and, most recently, a version for general populations.

The MBI defines burnout as a syndrome with three components: emotional exhaustion, depersonalization, and reduced personal accomplishment. Burnout in human services occurs when staff-client interaction is centered on the client's current problems. The difficulty of finding solutions for the client's problems results in a situation that becomes more ambiguous and frustrating. Working continuously with people in difficult situations results in chronic stress, drain on emotional reserves, and eventual burnout. Increased feelings of emotional exhaustion are a key element of burnout.

Emotional exhaustion leads workers to believe that they are no longer able to give of themselves psychologically, leading to negative or cynical attitudes about clients. As workers start to see the client as perpetrators of their own troubles, depersonalization, the second component, begins to take place. The development of depersonalization is related to emotional exhaustion, so these aspects of burnout should be correlated.

Reduced personal accomplishment, the third component, is the tendency for the worker to evaluate one's self and one's work with clients negatively. When the worker sees the client as unresponsive or unsuccessful in experiencing improvement in the presenting problem, the worker must reach the conclusion that his or her efforts have been unsuccessful. Over time, the worker may come to feel that the task of helping the client to make a change may be futile or hopeless,

leading to unhappiness and dissatisfaction with accomplishments on the job (Maslach, Jackson, & Leiter, 1996).

The MBI measures each of the three aspects of the burnout syndrome: emotional exhaustion, depersonalization, and lack of personal accomplishment. A separate subscale measures each aspect. Each subscale is scored individually. Burnout, as measured by the MBI, is conceptualized as a continuous variable, ranging from low to moderate to high degrees of experienced feeling. The Personal Accomplishment subscale is scored as direct computations and not reversed scored. A high degree of burnout is reflected in high scores on the Emotional Exhaustion and Depersonalization subscales and in low scores on the Personal Accomplishment subscale. An average degree of burnout is reflected in average scores on the three subscales. A low degree of burnout is reflected in low scores on the Emotional Exhaustion and Depersonalization subscales and in high scores on the Personal Accomplishment subscale. Scores are considered high if they are in the upper third of the normative distribution; average if they are in the middle third, and low if they are in the lower third.

Items for the MBI human services survey (HSS) were designed to measure the hypothetical aspects of the burnout syndrome. Items were taken from interview and questionnaire data collected during earlier, exploratory research and review of established scales. Items are statements about personal feelings and attitudes. The original item pool was reduced to 22 items, nine in the emotional exhaustion sub-scale, eight in the personal accomplishment subscale, and five in the depersonalization subscale. The early forms measured both frequency and

intensity dimensions, but since fairly high correlations between the two dimensions were found, only the frequency dimension is assessed. At least seven independent studies have replicated the component analysis in the initial developmental research. Reliability studies were based on samples not used in the item selections, and test-retest studies have found a high degree of consistency within each subscale for periods of one month to a year. Studies of convergent validity and discriminant validity give evidence that the MBI is measuring an independent and distinct construct (Maslach, Jackson, & Leiter, 1996).

Pierce and Molloy (1989) conducted a construct validity study using a sample of 750 questionnaires completed by teachers in post primary schools in Melbourne, Australia. This study is important because it used a sample of people who use English but live in a different culture than the population used for the original instrument development. Using a principal components factor analysis to examine construct validity, the researchers identified the same three factors identified by Maslach and Jackson.

In another cross-cultural study of the construct validity and reliability of the MBI in a non-western setting, the instrument was administered to 223 Jordanian teachers and the responses subjected to principal factor analysis. The results provided some evidence that burnout can be affected by job-related stressors but not by the service recipients. The findings revealed an acceptable level of reliability (Abu-Hilal & Salameh, 1992).

Not every study supports the three-factor structure of the MBI. Walkey and Green (1992), using six independent sets of data from previous studies, found

evidence for a two-factor structure, the larger of which they labeled the "Core of Burnout." The "Core of Burnout" is related to the emotional exhaustion and depersonalization, and the second factor is related to the personal accomplishment subscale. Walkey and Green propose that "Core of Burnout" is a previously unrecognized factor that underlies both the emotional exhaustion and depersonalization subscales. No other authors appear to have adopted this variation in using the MBI.

Wallace and Brinkerhoff conducted another study that challenges the reliability and validity of the MBI in 1991. They concluded that depersonalization is a problematic variable, found to be associated with both high and low levels of several key variables, such as work related stress, often associated with burnout. They concluded that emotional exhaustion subscale is the only highly reliable and valid indicator of burnout.

Confirmatory factor analysis has been used to examine the reliability and validity of the MBI, specifically its three-factor structure. Although a factor analysis found the MBI valid and reliable, there was some inconsistency in the way the various subconstructs related to each other. Some researchers recommend first examining the interfactor correlations to see if they are in the hypothesized direction before proceeding with other analysis (Drake & Yadama, 1995).

In contrast, support of the three-factor structure was found in a study that compared a human service worker sample with a non-human service worker sample. Depersonalization indicators do not form a coherent factor in the non-

human service sample, but support for the full three-factor model was found in the human service worker sample (Evans & Fischer, 1993).

Another study using a sample of 219 supervisors and managers in a large human service agency found support for the three-factor model, with emotional exhaustion and depersonalization being highly correlated (Lee and Ashforth, 1990).

The Maslach Burnout Inventory Manual cites 109 published articles that were either used as sources in the development of the MBI, studied the reliability and validity of the MBI, or used the MBI as the dependent variable in research. Although agreement about the usefulness of the instrument is not universal among researchers in the area of burnout, it stands out as the strongest, most widely recognized instrument in the field.

MODELS FOR ORGANIZING FACTORS RELATED TO BURNOUT

Researchers have employed many models in an attempt to identify factors that are related to the occurrence of burnout. Since each researcher defines burnout in his or her own terms, the selection of independent variables is influenced by the construct selected for burnout. The model used for burnout research depends on the researcher's primary interest. Some research reflects an interest in a particular client population and looks for characteristics of the population that may relate to burnout. Other researchers are interested in a particular work setting.

One review of the job satisfaction literature and burnout literature in relation to social workers identified factors related to burnout to fall into three

categories: work related, client related, and worker related. Work related factors included low work autonomy, lack of challenge on the job, low degrees of support, role ambiguity, work in public sector, low professional self-esteem and low salary, dissatisfaction with agency goals, minimal use of coping strategies at work, difficulties in providing services to clients, negative attitudes toward the profession, high degree of work pressure, and bad agency functioning. Client related factors included negative impressions of the clients, empathy, personal involvement in client's problems, and involvement in the client worker relationship. Worker related factors included chronic minor hassles of daily living, family income, attitudes toward the profession, years of experience, and low education. (Soderfeldt, Soderfeldt, Bjorm, & War, 1995).

Gleason-Wynn and Mindel offer a much-simplified model that includes only two categories of independent variables, work environment and personal. (Gleason-Wynn & Mindel, 1999.)

In a panel study, Poulin used change in job satisfaction as the dependent variable and three categories of predictor variables, job tasks, organizational characteristics, and demographic characteristics. The job task variables and organizational characteristics were found to be significantly associated with change in job satisfaction. None of the demographic characteristics were significantly associated with the dependent variable (Poulin, 1994).

In a review of the models currently available, Maslach expressed her disappointment with all of them, pointing out that in several instances the predictor variables were restatements of the dimensions of burnout. For example,

using “intent to quit” as a predictor of burnout raises the cause and effect question (Maslach, 1987). Although new models have been conceptualized since Maslach made her observation, her caution about inadvertently using a circular model is still appropriate.

COURAGE AND WILLIAMS MODEL

Courage and Williams developed a three dimensional model with variables categorized as characteristics of the care provider, the organization, and the care recipient (Courage & Williams, 1986). This model avoids the circular definition problem by avoiding temporary feeling states of the care provider (frustration, fatigue, etc) and including both personal and environmental characteristics.

Characteristics of the care provider include personality characteristics, demographic characteristics, professional status, and expertise. Personality characteristics refer to being empathetic, idealistic, altruistic, assertive or unassertive, impatient, intolerant, submissive, fearful or able/unable to establish limits within the helping relationship. Demographic characteristics include age, marital and family status, and education. Professional status refers to the degree to which the care provider adheres to the standards or works within the legal bounds of a profession. Expertise refers to the knowledge and skills of the care provider in relation to the expectations of the employing human service organization.

Characteristics of the human service organization include task variables, structure, power/authority, resources, functions, and roles. The most relevant task

variable related to burnout is the extent to which the task requires intense and repeated involvement with people. Structure of the organization determines the relationship between care recipients, care providers, and supervisors. Organizational structures vary in flexibility and accommodation of needs of both the care providers and recipients. Rigid, inflexible structures are expected to increase the risk of burnout. Power/authority refers to the degree to which the care provider has the power to make decisions that affect the care recipients. Inability to make decisions that affect outcomes for care recipients is expected to contribute to care provider burnout. Human services organizations may lack adequate resources (time, funding, staff, physical environment) to provide the quality of services required for the need of the care recipient. Lack of reasonable resources can contribute to burnout in care providers who may be put in a posture of competing for limited resources or failing to provide quality service because of inadequate resources. Functions of the human service agency may not be entirely clear. Although all human service agencies presumably exist to meet the needs of the care recipient, multiple outside controls and expectations may blur the function and create a confusing set of expectations for care providers. Role conflicts can contribute to burnout when the expectations of the care recipients differ from the expectations of the employer or the care provider.

Characteristics of care recipients include individual behaviors, demographic variables, chronicity, acuity, and complexity. Individual behaviors that might provoke stress include behaviors such as anger, anxiety, hostility, and despair, especially if the entire caseload is displaying negative affects. In

discussing demographic variables, Courage and Williams assume that the very young and the very old require more resources from the caregiver, thereby increasing opportunities for burnout, but no evidence is given for this assumption. Chronicity, acuity, and complexity are treated in a similar manner to age, and the assumption is that care recipients with chronic, acute, or complex problems burden the caregiver and therefore increase the likelihood of burnout in the care provider. Courage and Williams cite research only in the case of chronicity.

Courage and Williams offer a structure for assessing human service delivery situations and for predicting the potential for burnout to occur, but their article is devoted to explanation of the theory and does not offer any examples of its application. It is necessary to look at other research reports to find whether Courage and Williams variables have been shown to be related to burnout (Courage & Williams, 1986).

The next sections apply the Courage and Williams model to the literature review. The articles are grouped into sections that correspond with the three groups of factors in the model, starting with characteristics of the care provider and continuing to characteristics of the human service organization and the care recipient.

Characteristics of the Care Provider (Social Worker) Related to Burnout

In a study of retention plans and job satisfaction of gerontological social workers, Poulin and Walter found that social workers who work with the elderly appear to derive a great deal of satisfaction from their contact with elderly clients. In terms of personal factors, the respondents' health rating and self-esteem are

significantly associated with job satisfaction. The respondents' age and level of education were not associated with job satisfaction (Poulin & Walter, 1992).

Quam and Whitford, in one of the few studies specific to nursing home social workers, reached a sample of 330 Minnesota nursing home social workers. In their sample, 70 percent were under 40 years old, almost 95 percent were female, 63 percent had an undergraduate degree in social work, 46 percent held a BSW, and the mean number of years as a nursing home social worker was 5.58. The purpose of this study was to look at training needs of nursing home social workers, and respondents indicated a need to know more about behavior problems of the elderly, medical language and prescription information, mental health issues, cognitive changes in aging, and how to work with families (Quam & Whitford, 1992).

Using the MBI as the dependent variable, Poulin and Walker studied a non-random convenience sample of 1196 social workers who work with the elderly and who belong to either the National Association of Social Workers or Gerontological Society of America. The survey respondents were 88.9% female, 93.1% Caucasian, and the mean age was 41.7. Of the respondents, 99% completed college and 76% had master's degrees. Three personal variables were significantly associated with depersonalization: self-esteem, gender, and age. Four of the five personal variables were significantly associated with emotional exhaustion: self-esteem, health, hours worked, and age. The only personal variable associated with personal accomplishment was self-esteem (Poulin & Walter, 1993). In a follow-up panel study of the same sample, Poulin found no

relationship between any of the demographic characteristics and job satisfaction (Poulin, 1994).

LeCroy and Rank found that the social worker characteristic associated with burnout was gender, with females scoring lower on negative feelings towards clients than males. Females scored lower than males on an index of closeness to clients. This study population was not specific to social workers working with an elderly population (LeCroy & Rank, 1987). Decreased emotional support from supervisors and coworkers has been found to be predictive of emotional exhaustion and depersonalization for females but not for males. Increased client contact has been associated with decreased personal accomplishment for women and with increased depression, emotional exhaustion, and increased sense of personal accomplishment for men. Having an intent to quit is an important stressor for both men and women (Himle, Jayaratne, & Chess, 1987).

In a study of burnout among hospital social workers that work with AIDS patients, Oktay found age associated with burnout, with younger workers experiencing more burnout than older (Oktay, 1992).

Demographic variables are easier to define and therefore compare from study to study, but the more abstract variables of personality factors are difficult to compare across research findings. However, since the model in use for this study includes personal variables, it is important to examine how personal variables have been used in studies of burnout among social workers.

Although their research did not focus on social workers, Chappell and Novak found that nursing assistants who listed a greater number of family members supportive of their work were less likely to experience job pressure (Chappell & Novak, 1992). Their observations are relevant to the current study because nursing assistants work in the same environment as nursing facility social workers.

Davis-Sacks, Jayaratne, and Chess found that support from spouse decreased the effects of burnout on child protective workers. Emotional support has been found to play a role in ameliorating job stress, and perception of competence on job appear to alleviate feelings of burnout. (Davis-Sacks, Jayaratne, & Chess, 1985; Jayaratne & Chess, 1984).

Examining the possible buffering effects of emotional, approval, informational, and instrumental support, Himle and Jayaratne (1991) found that instrumental support moderates the stress of workload and the effect of role conflict on the personal accomplishment dimension, but social support did not have a buffering effect. However, Miller (1991) observes that the findings about social support could indicate that social workers who are experiencing burnout may generate social support in response to burnout, so a positive relationship between social support and burnout does not necessarily mean that social support does not have a buffering effect because the two have a positive correlation. Johnson and Stone (1987) found a relationship (positive correlation) between Type A behavior and the personal accomplishment scale on the MBI. However, the sample was small (47), and the authors suggest that the Type A behavior

pattern may tend to seek out and thus identify and experience personal accomplishment when it occurs.

Carpenter (1996) investigated the motives of students taking courses in gerontology and geriatrics and found that students were motivated by subjective, humanistic motives rather than objective, concrete motives. The top four ranked motives were to understand other's aging, service to an undervalued group, personal experience with elders, and to understand one's own aging.

In examining twenty-five personal factors that influence turnover in nursing facility administrators, Rubin and Shuttlesworth (1986) found only three that were associated with turnover. One of the three was having a close, caring relationship with a debilitated relative. The second was whether the administrator became attracted to nursing home administration while working in another capacity in a nursing home, and the third was the reason for being attracted to a career in nursing homes. The low-turnover group was more likely to give one of three reasons: (1) stimulated by relatives who worked in nursing homes, (2) affection for the elderly and enjoyed working with them, (3) recruited by a friend for a vacant position but had not previously been attracted to nursing home administration. The high-turnover group was more likely to give the reasons (1) wanted to help people, and (2) wanted to reform or improve care in nursing homes.

In reviewing the literature that examines personal variables related to burnout, it becomes evident why Maslach cautioned against using personality variables. "Although personality variables are certainly relevant in the overall

analysis, the prevalence of the phenomenon and the range of seemingly disparate staff people who are affected by it suggest that the search for causes is better directed away from identifying the bad people and toward uncovering the characteristics of the bad situations where many good people function" (Maslach, 1978).

Despite Maslach's warning, the Courage and Williams model encourages the use of personal characteristics as a variable. In reviewing the literature for possible relevant personality characteristics, the one I have found that seems most closely related to the interests of my study is the theory known as locus of control. Locus of control theory assumes that people vary in the degree to which they depend on reinforcement from within their own belief system and values or from feedback from external sources such as friends, coworkers, supervisors, and family. Locus of control theory is, in turn, grounded in social learning theory.

Social learning theory utilizes three basic constructs in the measurement and prediction of behavior: behavior potential, expectancy, and reinforcement value. Behavior potential is defined as the potentiality of any behavior's occurring in any given situation as calculated in relation to any single reinforcement or set of reinforcements. Expectancy is the probability held by the individual that a particular reinforcement will occur as a function of a specific behavior in a specific situation. Reinforcement value is defined as the degree of preference for any reinforcement to occur if the possibility for any reinforcement were present (Rotter, 1980, 1982). Reinforcement or reward is universally recognized as crucial to the acquisition and performance of skills and knowledge.

However, people perceive and react differently to rewards. One of the determinants of reaction to reward is the degree to which the individual perceives that reward follows from, or is contingent upon, his or her own behavior or attributes versus the degree to which he or she feels that the reward is controlled by forces outside the self. When a reinforcement is perceived by the individual as not being contingent upon the individual's actions, the belief is labeled "external control." When the person perceives that the reward is contingent on his or her behavior, the belief is labeled "internal control" (Rotter, 1966).

Rotter and many colleagues developed and tested instruments to measure locus of control and conducted numerous studies on many different populations. In spite of its widespread use, the Rotter I-E scale has been criticized for low item total correlations, multidimensionality of the scale, its format, and inclusions of items that are not representative of the scale, such as social system control and political causality.

The Internal Control Index (ICI) was developed to meet the need for a more sensitive measure of locus of control that eliminates some of the major problems encountered with other instruments (Duttweiler, 1984.) The Internal Control Index was developed from a list of items based on variables that seem most pertinent to internal locus of control: cognitive processing, autonomy, resistance to influence attempts, delay of gratification, and self-confidence. It is important to note that the Internal Control Index does not measure external versus internal locus of control. It measures high to low internal response patterns.

A try-out test was administered and 548 usable sets of data obtained. Based on item and factor analysis, 28 items were chosen for field test and administration and construct validation. Convergent validity was evaluated by the correlation with Mirel's Factor I of the Rotter I-E Scale. As a result of the item and factor analysis, five items were revised. Convergent validity with the Mirel's Factor I scale was significant. The authors of the ICI conclude that it may be a stronger, more reliable instrument for measuring internal locus of control in adults than previously developed measure (Duttweiler, 1984). However, it is not supported by the large body of further research that would be desirable to refine the instrument and to present a strong testimony for its reliability and validity.

Despite reservations about the possibly incomplete and somewhat untested nature of the ICI, it is the instrument that I have chosen to use in my research as a suitable measure for the personal variable required in the Courage and Williams model. It measures the personal variable that would appear to have the most obvious impact on the construct I am studying, nursing home stigma. Social workers who have a high level of internal locus of control should be less susceptible to the effects of nursing home stigma, an external reinforcement. While the list of personal variables that impact an individual's attitude toward work is potentially endless, the locus of control orientation stands out as clearly related to the degree to which the opinions of others impact the social worker's level of commitment to the job.

The Rotter scale developed to measure internal/external locus of control would be the other choice in lieu of the ICI. It is longer and has questions that

refer to very specific situations instead of general or generic questions. The ICI is relatively short (28 questions), and the questions are generic and could easily be answered based on work experiences that occur in the nursing facility setting (Corcoran & Fischer, 2000).

The literature on characteristics of the care provider offers a wide array of choices for identifying potential factors to examine. This study uses the Courage and Williams model as a screen for selecting a set of personal characteristics that are important in the nursing facility setting as predictors of burnout.

The next section addresses the second category in the Courage and Williams model, the human service organization.

Characteristics of the Nursing Facility as a Human Service Organization

Courage and Williams define the characteristics of the human service organization as grouped into task variables: structure, power/authority, resources, functions, and roles. Individual research projects usually look at some, but not all, of these characteristics and often include others not in the Courage and Williams model. Salary is most often included. In addition, studies of burnout among social workers span many job settings, and it is necessary to include settings very different from the nursing facility to find studies that touch on all the elements of the Courage and Williams model.

In a study of burnout among social workers working with patients with cystic fibrosis, the authors obtained demographic data, MBI burnout scores and five factors in the job environment: (1) hours providing services to patients with cystic fibrosis, (2) hours providing services to patients with other life-shortening

and chronic illnesses, (3) interdisciplinary team support, (4) supervisory support and (5) years in the current position. Low burnout scores were found to be significantly associated with team support and supervisory support (Coady, Kent, & Davis, 1990).

In a study of public eligibility workers, salary and workload assignments were significant predictors of job satisfaction (Barber, 1986).

Using a convenience sample, Koeske and Koeske determined that, under certain conditions, demanding workloads are associated with worker burnout. The most critical condition was low social support, particularly low coworker support. A secondary condition was a perception of being ineffective with clients (Koeske & Koeske, 1989).

Two hundred and seventy five randomly selected social workers practicing in Massachusetts were studied for factors associated with job satisfaction and burnout. The variables significantly associated with burnout were perception of autonomy and funding source influence. The only variables significantly associated with job satisfaction were perception of autonomy and bureaucratization. The authors conclude that workers are most satisfied when they have autonomy, are not limited by demands of funding sources, and are not stifled by bureaucracy (Arches, 1991).

Conway, Williams, and Green identified two sets of facets of job satisfaction. One set was based on closed ended questions, and the other on open-ended questions. In the closed ended question model, fairness (promotion/management) entered first, followed by agency importance to me,

organization of work tasks, training/performance evaluation, physical work environment, supervisor, fair pay/classification, organizational structure, work group, time/stress, affirmative action. Promotion was the most important facet mentioned in both models, along with training, supervision, upper management, pay, organizational structure, work stress, and physical work environment/equipment (Conway, Williams & Green, 1987).

In one of the few studies using a sample of nursing facility social workers, Kruzich and Powell found that social workers perceived themselves as having greatest influence in care planning and resident transfer, quite a bit of influence in making changes in care plans, and some influence in planning care, but only a little to some influence in determining medication changes or placing restrictions on resident activity. The findings support the difficulty of operating as the (usually) lone social worker in the host (healthcare) environment. Social workers in non-profit and government facilities perceived themselves as having more influence than those in for-profit facilities. Social worker influence was greater in facilities with highly autonomous administrators (Kruzich & Powell, 1995).

Banaszak-Holl and Hines studied the organizational factors that are associated with nurse aide turnover in nursing homes. Although this study did not include social workers, the characteristics of nursing homes as an employer are relevant to the current study. The authors found that aide turnover was associated with aide involvement in care planning. Facilities that had aide involvement in care planning had turnover rates 50% lower than those that did not. The only other factor that was associated with aide turnover was proprietary status, with

turnover rates 1.7 times higher in for-profit homes (Banaszak-Holl & Hines, 1996).

Packard found that participation in decision-making correlated significantly with performance, and performance with job satisfaction in a study of social workers in children's protective services (Packard, 1989). Policy changes and workload assignments have been found to be important factors in job satisfaction for social workers working in organizational settings (Barber, 1986).

A survey of 188 psychiatric social workers indicated an overall positive level of job satisfaction. Job satisfaction was found to be primarily determined by position satisfaction, and the major correlate of position satisfaction was professional respect received from other disciplines (Marriott, Sexton, & Staley, 1994).

Butler examined the impact of the job itself, work context, and individual worker characteristics on job satisfaction, and found that work intensity, task significance, task variety, frequency career change considered, and difficulty in finding current job were significantly associated with job satisfaction among social workers who were not in private practice (Butler, 1990).

Role conflict (defined as the simultaneous occurrence of two or more role pressures so that compliance with one makes it difficult to comply with the other) and role ambiguity (defined as the degree to which clear information is absent with regard to role expectations, methods of fulfilling a role, and/or the consequences of role performance) accounted for 57% of the total explained variance in the measure of emotional exhaustion from the Maslach Burnout

Inventory in a study that examined caregiver characteristics, care giving involvement, work environment, and social support (Barber & Iwai, 1996). Role conflict has been shown to expose social workers to both burnout and job dissatisfaction (Um & Harrison, 1998).

Nursing home social workers and administrators were asked to rate the relative importance of resident and family psychosocial needs and the frequency of functions performed by or expected to be performed by social workers to meet those needs. The results indicated strong agreement among social workers and administrators on priority psychosocial care needs and suggested that there may be some consensus between these groups about appropriate psychosocial care in nursing homes (Vourlekis, Gelfand, & Greene, 1992). Agreement on social work priorities could indicate a degree of professional respect, and Gillespie found in a study of protective services workers that professional respect is negatively correlated with active burnout (Gillespie, 1982).

In a study of hospice nurses, social workers, and directors, Kulys and Davis (1987) found that two thirds of the nurses studied believed nurses better qualified or just as qualified as social workers to carry out tasks such as crisis intervention, advocacy, and coordination of adequate support systems. Hospice directors saw only one area (providing financial information) in which they believed social workers to be more qualified than nurses. In twelve remaining areas, including the psychosocial functions, they saw nurses and social workers as equally qualified. Kulys and Davis concluded that nurses are expanding their

activities into the psychosocial arena, resulting in poor role definition when both professions are providing services to the same client group.

Roberts (1989) describes the dilemma of social workers in health care who encounter a conflict between medical and social work values. She identifies conflicting values in five areas: (1) saving life vs. quality of life, (2) patient autonomy in setting treatment goals, (3) attitudes toward objective versus subjective data, (4) responses to patients with emotional problems, and (5) differing perspectives on interdisciplinary team roles.

Powell used a survey of social workers practicing in Wisconsin to examine the relationship between burnout and alienation. He found that nursing home social workers felt the least isolated of all social workers studied, but the most self-estranged. He suggested that nursing home social workers are involved in providing patient care in concert with a small group of employees of other disciplines, but may be expected to perform tasks that are not consistent with their sense of self or values. He suggested that some dimensions of alienation may be strongly related to burnout (Powell, 1994).

Burnout presupposes that the worker is dissatisfied with the clients' progress. Inadequate care in the nursing facility would inevitably have an effect on resident outcomes and therefore relate to social worker burnout. While acknowledging the lack of any standard, accepted measure of quality care, Aaronson, Zinn, and Rosko (1994) determined that not-for-profit facilities provide significantly higher quality of care to Medicaid recipients and to private pay residents as evidenced by better staffing and better outcomes for residents at

risk for adverse outcomes. Sheridan, White, and Fairchild (1992) also found that staff members' job attitudes, opinions regarding elderly residents, and perceptions of the organization's climate varied between the successful for-profit and not-for-profit homes. As these studies indicate, respect in all its various forms is a major factor in job satisfaction. Because there is generally only one social worker in the facility, professional respect from the other members of the team can be expected to be an important factor in preventing burnout.

Some studies have focused on the differences in nursing facilities based on the business model, but none of these studies have been related to burnout. Elwell (1984) found that government and not-for-profit facilities spend slightly more per patient than do for-profit facilities, although most of the higher than average spending in government owned facilities was for administration. Aaronson, Zinn, and Rosko (1994) found that for-profit facilities had higher proportions of Medicaid patients than not-for-profits and were less likely to have private pay, assisted living units. For-profit facilities were likely to have a greater proportion of high-risk residents. Sheridan, White, and Fairchild (1992) compared for-profit and not-for-profit nursing facilities and found significant variance on dimensions of work attitudes, supervisors' leadership behaviors, and organizational climate.

Mullins, Nelson, Busciglio, and Weiner (1988) examined the impact of organizational structure and supervisory power on job satisfaction among nursing home personnel for all departments, including social service. Organizational structure variables included standardization, formalization, coordination,

participation, centralization, motivation, and manager's power. Formalization, standardization, and coordination were positively correlated with job satisfaction. The results indicated that nursing facility employees are most satisfied in an environment where individual efforts are rewarded, either by mechanisms built into the overall structure of the organization or by managers' individual propensity to motivate by rewarding good work and refraining from the use of coercion.

In their study of factors affecting turnover among nursing facility administrators, Rubin and Shuttlesworth (1986) found that eight organizational factors significantly discriminated the high- and low-turnover groups. These eight were (1) degree of impersonality or bureaucratization, (2) emphasis on efficiency, (3) autonomy over one's own work, (4) staff morale, (5) size of staff, (6) opportunity to influence organizational policy, (7) time demands of the work, and (8) insufficient resources to meet licensure pressures. Although this study was conducted on administrators, not social workers, it provides important information about organizational variables in the nursing home setting.

The idea that nursing facilities are not pleasant places to live or to work is implicit in the idea of nursing facility stigma. Although the question of stigma is addressed separately, it is related to the issues of how well the nursing facility functions as an employer. Studies of the conditions of the work environment and employment all revolve around central issues of freedom, autonomy, adequacy of recourses for assisting clients. As in the issues of personal characteristics, the

Courage and Williams model serves as a screen and organizing mechanism for potential factors related to the nursing facility as an employer.

The next section addresses the third and final component in the Courage and Williams model, characteristics of the care recipient.

Characteristics of the Nursing Facility Residents as Clients

Courage and Williams' model assumes that characteristics of clients can contribute to burnout in the social worker. The characteristics of clients include individual behaviors, demographic variables, chronicity, acuity, and complexity. If, as Courage and Williams assume, a caseload of clients with chronic and complex problems contributes to burnout, then burnout would be inevitable in nursing facility social workers. Nursing home residents, by definition, have chronic and severe medical problems. Since nursing home placement is considered a last resort, it is reasonable to expect that many nursing facility residents lack social and family supports that would have allowed them to stay in a different setting. Social workers are trained and educated, and, one presumes, choose to work with persons with important personal problems. If difficult clients are related to burnout, the question becomes, "How much is too much?"

Maslach identifies important client factors as type and severity of the client's problems, the prognosis of change or cure, and the degree of personal relevance for the staff member of the client's problems, and the client's reaction to the staff. She points out that staff is often in a no-win situation; they hear only the negatives, not the positives. She also points out that clients may have

unrealistic expectations about the extent of personal warmth and caring they can legitimately expect from the social worker (Maslach, 1978).

Corcoran (1987) found that social work practitioners with higher levels of burnout have negative impressions of their clients. Specifically, they have more negative impressions of clients interpersonally and intellectually, controlling for practitioners' age and experience. However, negative impressions were not related to the gender of the client.

Stav, Florian, and Shurka (1987) compared levels of burnout among social workers working with physically disabled veterans, those working with civilian disabled persons and bereaved families, and social workers in social welfare agencies. On the personal accomplishment factor, those working with physically disabled veterans showed the lowest levels of burnout. On a frequency and intensity of personal involvement factor, those in social welfare agencies showed the lowest level, indicating that the social workers involved with disabled and bereaved persons showed higher levels of burnout.

In the article most closely related to the current research, Green (1986) reviewed case examples of social workers she encountered conducting a consultation on managing countertransference for a 500-bed private nursing home. She concluded that the ongoing care of frail, ailing, or dying clients and their eventual deaths would affect caseworkers' attitudes and perhaps even their ability to perform on the job. She believes that countertransference and death anxiety among social workers in the nursing home can be managed through appropriate self-awareness and supervisory conferences.

Research that attempts to find a relationship between burnout and client characteristics has to address the problem of distinguishing cause and effect. Do social workers who see their clients as hopeless cases burn out, or do burned-out social workers see their clients as hopeless cases? Most of the literature seems to assume that social workers have an expectation that their clients will change in a positive way, which may be an impossible outcome for many nursing facility residents. No study that I have been able to find addresses how nursing facility social workers define success with their clients. However, the definition of success must be appropriate for the client's life situation for social workers who experience any job satisfaction or success.

Since the job functions of nursing facility social workers include working with families, the family members are clients as well as the resident. However, since the family members are not primary clients, the relationship is different in nature. Family members are invited to participate in care planning for the resident, and the social worker is most likely to become involved if a need for problem solving arises. I could find no references in the literature to the relationship between the social worker and the resident's family, but the interaction with family members must have an impact on social worker burnout.

The next section addresses the variable that is not in the Courage and Williams model, nursing facility stigma. Although no literature talks specifically about nursing facility stigma, the general topic of stigma, especially as it relates to racial and ethnic groups has received much attention in research and writing.

STIGMA IN THE LITERATURE

Stigma studies abound in the literature. The causes, effects, symptoms and characteristics are studied and described. Articles have been written on stigma as it affects (among others) Alzheimer's victims and their families (Blum, 1991), adoption (March, 1995; Wegar, 2000) wheelchair users (Cahill & Eggleston, 1995), HIV/AIDS patients (Minuzo, 1998; Wright & Coyle, 1996), tuberculosis patients (Kelly, 1999), welfare recipients (Davis & Hagen, 1996), persons with mental retardation (Angrosino, 1992; Dudley, 2000), persons with mental illness (Lyons & McLoughlin, 2001), prisoners and parolees (Edwards, 2000), lesbians (Blinde, 1992), family members of murderers (May, 2000), and, of course, various racial and ethnic groups (Gilbert, 1996; Harvey 2001).

I did not find any studies that focused on stigma associated with an institution. A study of stigma associated with an institution could be helpful in the investigation of nursing facility stigma, but I could not locate any. There are studies of stigma for individuals as a result of being associated with an institution such as the military or prison, but almost all studies of stigma are focused on people with certain characteristics rather than institutions.

Definitions of stigma vary with the nature of the study and the individual writer's concept of stigma, but a definition developed to describe stigma associated with psychiatry could be applied to other manifestations of stigma. Psychatric stigmatization has been defined as "the inappropriate and erroneous association of mental illness with something disgraceful or shameful" (Lyons & McLoughlin, 2001). So great is the stigma associated with mental illness that a

study of prisoners and college students favored ex-convicts over ex-mental patients (Edwards, 2000).

The association between a label (i.e., mental illness) and a stigma is a theme that carries over into literature on stigma from many professions. The question of whether using a label decreases or increases stigma is important in the stigma literature associated with disabilities. For example, does the term "dyslexia," when applied to a child with learning disabilities, contribute to stigma or reduce it by giving a non-judgmental name to the child's condition? (Riddick, 2000).

Blinde associates stigma with the degree to which a group violates social norms. In her study population, women athletes violate the gender norms and experience stigma imposed by all others except women athletes, primarily in the form of being identified as lesbians. She conceptualizes stigma as the attribution of characteristics to those in the outside group by those who are not in the group. She notes that her study population uses self-segregation as a coping mechanism to deal with stigma. This study population is an example of a stigma applied to a group based on an activity choice (participating in college level athletics) rather than a permanent condition such as disease or disfigurement (Blinde, 1992).

In a study of the caregivers of persons with Alzheimer's disease, Blum focuses on coping strategies and finds that caregivers' accounts suggest that stigma management by the Alzheimer caregiver moves through two distinct phases: the first marked by collusion with the person with Alzheimer's; the second by realignment and collusion with an expanding circle of others. Blum's

study sample, caregivers, is a good example of stigma by association in which the consequences of stigma are experienced by association with others rather than by any attributes of the individual (Blum, 1991).

An ethnographic study of the treatment of wheelchair users found that reactions to wheelchair users in public places fall into two categories, nonperson treatment and infringements of privacy rights. Examples of wheelchair users encounters in public are used to describe how stigma influences the behavior of those in the non-stigmatized group, which in turn influences the attitudes and behaviors of those in the stigmatized group. Many studies of stigma, such as this one, are focused on the applied aspects stigma rather than definitions or descriptions of the construct of stigma (Cahill, 1995).

The extent to which members of a stigmatized group internalize or identify with the stigma and the strategies they employ to control internalization is a frequent subject for study. Davis and Hagen found that women who receive welfare use a technique called estrangement to differentiate themselves from other welfare recipients and avoid identifying with the stigmatized group (Davis & Hagen, 1996). A study of adult adoptees who sought reunion with their biological mothers found that an effect of reunion was to ameliorate the feelings of stigmatization that adopted adults felt (March, 1995).

Adoption, adoptees, and families with adopted children were the subject of a stigma study that tied the stigma of adoption to the stigmas associated with illegitimacy and infertility. The stigma of adoption is also related to the common

belief that adoptees come from an inferior gene pool, as evidenced by the inability of the birth parents to care for their child (Wegar, 2000).

Families of murderers, as a stigmatized group, have a special consideration. Unlike race, ethnicity, or religion, kinship to a murderer is generally acquired later in life, and family members generally had no reason to develop skills for coping with stigma prior to the event. A study of this group revealed that their experience of stigma emerged from two key domains of common sense: first, that everyday understandings of the cause of murder is rooted within perceptions of poor parenting and bad familial socialization. A second source of stigma is derived from commonsense notions of what murder is. Everyday constructions of murder focus almost exclusively on the dangerous stranger. Murder is understood as the evil actions of unknown predators. This article suggests that the perception of stigma among people who have a relative convicted of murder is shaped by their own sense of shame, their own suspicion of toxicity (May, 2000).

Not all studies of stigma focus on a particular group. Gardner examined the meaning of public spaces for members of stigmatized groups, some of whom are identifiable by their appearance. He found that public spaces held special significance for members of stigmatized groups in general, but individuals reacted to being in public spaces in very different ways. Some avoided the experience of public spaces while others deliberately chose behaviors or other techniques to call attention to their stigmatized status in public spaces (Gardner, 1991).

Most studies of the effects of stigma on members of the stigmatized group are qualitative in nature. Two researchers, Gilbert and Harvey, attempted to quantify the effects of stigma. Harvey maintained that the degree to which stigmatized group members actually feel stigmatized is crucial to a complete understanding of the relationships between social stigma and psychological processes. He developed a pencil and paper scale for use with ethnic minorities to a measure of feelings of social stigmatization (Harvey, 2001). The value of measuring the impact of stigma was implied in the work of Gilbert, who also developed a scale for measuring stigma vulnerability, the extent to which individuals in a stigmatized group were likely to interpret encounters as examples of stigma in ambiguous situations (Gilbert, 1996).

Some studies of the effects of stigma on an identified group do not demonstrate that stigma is always associated with negative outcomes for the group members. In a study of women with HIV/AIDS, contrary to the prediction of the researcher, perceived stigma was found to have positive effects; those who felt stigmatized because of their HIV-positive status were more likely than those who did not feel stigmatized to report the presence of social support. In this study, stigma was measured by the question "Do you feel people look down on, or stigmatize, you because you are HIV+?" (Minuzo, 1998).

Some researchers have taken a macro level approach to the study of stigma to examine the impact of stigma on policy or the implications for professional practitioners (Herek, 1999; Kaus, 2001; Dudley, 2000; Roper & Anderson, 1994). Other practice-related studies focus on the relationship between

stigma and the patient's capacity or willingness to comply with treatment regimens (Kelly, 1999; Stimmel, 2001). Yet another approach is to examine stigma through newspaper and popular media portrayal of the stigmatized group (teenage mothers) compared to the self-descriptions of group members (Kelly, 1996). The responsibility for professional practitioners to be active campaigners to eliminate stigma associated with their client group is another macro approach (O'Reilly, 2001).

A distinction made between stigma that is associated with membership in a group and stigma that is associated with individual attributes. Social stigma involves membership in a devalued group and may correspond to what is generally understood as " minority status" in our society; individual stigma refers to possession of a single discrediting attribute. Types of stigma and the problems they pose for the individual vary greatly. Discrimination distinctly associated with the economic and political exploitation of certain groups is different in nature and consequences from discrimination on the basis of individual discrediting attributes (Feree, Marx, & Smith, 1979). Recognizing that all stigmas are not equal, Ray and Lee (1988) designed a study in which exchange students from developing countries were asked to identify a "master stigma," the characteristics (i.e., race, religion, nationality, accent) which had strongest negative effect on their relationships with others.

Although definitions of stigma, the intensity and importance of its effects, and the methodology for approaching its study vary widely, the appearance of stigma studies across various human service professions speaks to its importance

and pervasiveness. Since social work addresses interaction between the person and his or her environment or setting, and stigma is a function of both the individual and the social milieu, stigma is an obvious target of study for the social work profession.

The next section of this review takes an unconventional approach. The literature that discusses ageism in our culture and the stigma associated with old age is the conventional approach of summarizing another writer's material. However, some articles are reviewed not for their content but as examples of stigma in action.

AGING AND NURSING HOME STIGMA IN THE LITERATURE

Reviewing the literature for references to nursing home stigma is a very different process from reviewing literature related to other variables in this research. Nursing home stigma does not appear in a construct in previous research. Part of the purpose of this research is to determine if nursing home stigma can be identified and measured. The search of the literature is seeking examples of the unconscious use of nursing home stigma by writers in the academic literature. Almost every article about nursing homes, whether in a juried journal or a tabloid newspaper, makes reference to terrible conditions with no attempt to document or offer specific examples. Writers appear to assume that the reader will accept allegations of bad nursing home care without any question or expectation of evidence or persuasive argument that care is, indeed, bad.

An example of a professional writer's unconsciously stigmatizing nursing homes occurs in the writing of Rosalie Kane, a highly respected social worker

who frequently writes on nursing home topics. In an editorial in *Health and Social Work*, Kane decries the fact that "so many nursing home patients are consigned to an open-ended sentence of years of depersonalized, routinized, medicalized life . . . if nursing home patients who reached hospice eligibility were whisked away to hospices, the paradox is that their dying months might represent an improvement in the quality of their recent lives" (Kane, 1981). In a book coauthored by Kane with her husband and Dick Ladd, former Texas Commissioner of Health and Human Services, the authors state, "Publicly supported long-term care services . . . are woefully inadequate. They depend largely on a service — the nursing home in its typical incarnations — which is hated and dreaded as a lifestyle choice by almost everybody" (Kane, Kane, & Ladd, 1998).

Bruce Vladeck, who went on to become director of the long term care regulatory division of the Health Care Financing Administration, wrote in the forward of his book, *Unloving Care: The Nursing Home Tragedy*, "The shabby treatment accorded the elderly inmates of the nation's nursing homes . . . " Writing in 1980, Vladeck proposes a strategy for improving long term care by moving out of nursing homes all but "those who are entirely helpless and entirely beyond help." He fears, however, that facilities serving only this population would become " the worst kind of human warehouses." His solution is to staff these facilities with a "system of rotating young people, recently graduated from high school or college through one-year stints as nursing home aides (long enough to capture their openness and enthusiasm, short enough to get them out

before total cynicism and disillusionment take over)" (Vladeck, 1980). Vladeck's comments indicate that he did not consider that professionals could find rewarding work in caring for the "entirely helpless."

The names of the books about nursing facility are very revealing. Three years prior to the publication of Vladeck's book, *Unloving Care,* U. S. Senator Frank E. Moss co-authored a book entitled *Too Old, Too Sick, Too Bad: Nursing Homes in America* (Moss & Halamandaris, 1977). Chapter One is entitled, "Nursing Homes: The Greatest Fear of the Elderly." In an introduction to a book entitled *Old Age: The Last Segregation*, Ralph Nader uses Jonathan Swift's concept of a modest proposal to suggest that nursing homes are paid by the government to kill old people so that they will not be a burden on society. In his version of the true purpose of Medicaid, he contends that nursing homes are designed to keep the elderly out of sight so that their mass extermination will not be obvious to the general public (Townsend, 1971).

Some writers may be trying to make their writing more compelling and motivational when they write phrases like, "our simplistic view of the nursing home as the black hole of the health services system, into which people go to experience the inevitable, if mysterious, shattering of their lives and from which they never return" (Brannon, 1992).

The belief that life in a nursing home is a miserable existence is widely held among caregivers of the elderly. Of those caretakers surveyed, 94.5% agreed with the statement that "It's better to stay out of nursing homes as long as you can." In the same study, 72.2% agreed with the statement, "nursing homes are

lonely places to live in," and 79.5% agreed with "People go to a nursing home only when there is no other place to go" (Cafferata & Stone, 1992).

Vladeck's assumption that the working with very needy residents would inevitably lead to cynicism and disillusionment provides an example of the connection between ageism and the attitude toward institutions and individuals who care for the old. Moss acknowledges the connection when he says that the all-encompassing fear of nursing homes is rooted in contemporary attitudes toward aging and the aged. Allen and Burwell (1980) define ageism as "any attitude, action, or institutional structure that subordinates a person or group because of age, or any assignment of roles in society based on age…it can be individual, cultural, or institutional. The existence of ageism as a construct as easily identified and measured as sexism or racism has been well documented. The existence of ageism is sufficiently accepted that Kogan reviewed the usefulness of instruments used to define and measure it over a twenty-five year period (Kogan, 1979). In an editorial in *The Gerontologist*, Cook (1992) says that ageism is a problem similar to racism and sexism in that not only a single characteristic is used to devalue and entire group but also we assume a link exists between systematic stereotyping and discrimination. Nuessel analyzed the language used to depict the elderly and found it be overwhelmingly negative in scope (Nuessel, 1982).

The *Encyclopedia of Aging* defines ageism as a process of systematic stereotyping and discrimination against people because they are old. The psychological mechanism of ageism makes it possible for others to avoid dealing

with the realities of aging and ignore social issues that affect the elderly. Ageism makes it possible for society to avoid responsibility for the aged.

Writers who study ageism have linked ageist attitudes to specific services and programs for the elderly. Grant concluded through a literature review that ageism has an effect on healthy aging and demonstrates that stereotyping can affect the shape and nature of programs for the aged. She argues that service providers should target negative attitudes in themselves, their professional institutions, their clients, and their communities. She suggests changes in professional development, research, and program planning (Grant, 1996). Gesino and Siegel encountered enough resistance in students to a career working with the elderly to stimulate them to develop a teaching model with an apprenticeship framework to introduce students to the idea of working in long term care facilities. The program was specifically designed to overcome their students' negative bias toward elders and specifically toward elders residing in nursing homes (Gesino & Siegel, 1995).

Kelchner (1999) points out that as the resources available to meet social needs are strained by demands, ageism negatively impacts the proportion of resources available to the elderly. She points out that sometimes the most in need, because they are the weakest, received the least because they lacked the capacity to advocate effectively. Ageism works against the needs of the elderly compared to other groups in need of social service resources.

In a macro level discussion of the need for social workers to work with the growing aging population, Scharlach, et. al. clearly ties the stigma of aging to the reluctance of social workers to work with the elderly.

> Social work practice with older adults is a highly stigmatized field of practice. The stigma stems in large part from negative stereotypes of the elderly as well as deterministic views of aging as a process of irreversible physical, psychological, and social losses. This perspective on aging and the elderly contributes to the view that aging service positions are not adequately challenging, creative, dynamic, and valued by peers and consumers. Moreover, outcomes such as personal dignity and improved quality of life are often devalued by a society increasingly concerned only with managing care and containing costs (Scharlach, Damron-Rodriguez, Robinson, & Feldman, 2000).

Writing on the subject of gerontology and professional power, Powell (2001) is equally clear. "The narrative of aging begins and ends with the problematization (sic) of economic, social, and physical decline. In western culture in particular, the aging body is the bottom line, subject to decay. In terms of physical, social, and economic power, old age is seen as a write-off."

In an article that speaks most compellingly about the effects of ageism on those who work with the elderly, Vin-Vogel, writing from her experience as a geriatric social worker in a community mental health center, contends that social workers who work with the elderly experience the feelings of deviance, vulnerability, isolation, tokenism, and devaluation that are characteristic of the elderly clients with whom they work. In her experience, social work with the elderly is seen as a lower prestige type of work than work with other client groups. According to her report, her social worker friends asked if she were really interested in geriatrics or just needed a job (Vin-Vogel, 1988).

In the preface to his book, *Why Survive? Being Old in America*, Robert Butler summarizes the contradictory attitude Americans hold toward aging when he says that we pay lip service to the idealized image of grandma and grandpa, but we see old age as decay, decrepitude, disgusting, and undignified dependency. He points out that our national policy mirrors these contradictions, using the rhetoric of honoring the elderly while under-funding programs and services that they need for a dignified existence (Butler, 1975).

CHAPTER CONCLUSION

A large volume of literature addressing the variables involved in this research project is available. To identify the research and writing most relevant to the concerns of this project, I have used a rule of thumb that a source should combine references to at least two of the variables (burnout and nursing facilities, social workers and chronic clients, etc.). However, if an article appeared to be particularly pertinent to one of the variables, it was included even if it did not follow this rule. The organizational structure for this literature review has been the modified Courage and Williams model. This model is used to organize the factors examined in the research, and it creates a logical organizational structure for the literature review.

I found no articles that specifically address burnout in nursing facility social workers. No researcher has attempted to define or measure nursing facility stigma. The lack of research on burnout among nursing facility social workers and the lack of identification of nursing home stigma as a potential influence on

social workers create an opportunity for the original research that I propose to undertake.

The next chapter describes the research questions and the research design.

Chapter 3: Methodology

INTRODUCTION

The purpose of this chapter is to describe the design of the research and the research questions and to explain the choice of methodology. Because the investigation of nursing home stigma is introduced for the first time in this research, a description of how stigma is measured is included in this chapter. The research questionnaire is described, including a description of the items that represent each domain in the Courage and Williams model. A description is provided of exploratory items that are included in the instrument for possible future use. Finally, a description is provided of the data gathering strategy. The chapter begins with a description of the research design using the Courage and Williams model.

RESEARCH DESIGN USING THE COURAGE AND WILLIAMS MODEL

The research documented in the literature reviewed in the previous chapter offers many examples of studies that address issues of burnout, studies that look at burnout among social workers, and studies that address burnout of other long term care professionals, but none that examine burnout among nursing facility social workers. The research questions addressed by the current study are specifically directed to burnout among nursing facility social workers, its prevalence, and factors associated with it.

The research findings indicate that employment conditions, support from coworkers and supervisors, personality issues, characteristics of clients, and

support from family and friends all affect burnout. The model that I have chosen to adapt for this research project is the one developed by Courage and Williams that organizes the variables into categories of those related to the care provider (the nursing facility social worker), the human service organization (the nursing facility), and the care recipients (the nursing facility residents and their families.) Schematically, the Courage and Williams model is represented in Figure 3.1

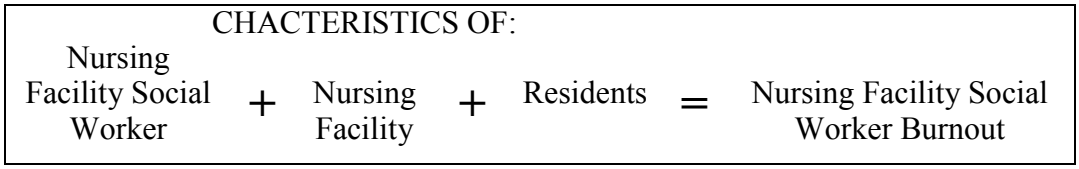

Figure 3.1: Courage and Williams Equation of Factors Contributing to Burnout.

The diagram above adapts the Courage and Williams model to the current research by substituting specific labels for the generic labels.

The Courage and Williams model provides additional guidance on the elements that make up each of the broad categories. These elements are:

Characteristics of Care Provider (Nursing Facility Social Worker):

- Personality Characteristics
- Demographic Characteristics
- Professional Status
- Expertise

Characteristics of Human Service Organization (Nursing Facility):

- Task
- Structure
- Power/Authority

- Resources
- Functions
- Roles

Characteristics of Care Recipient (Nursing Facility Residents and Families):

- Individual Behaviors
- Demographic Characteristics
- Chronicity
- Acuity
- Complexity

The Courage and Williams model omits a category that may be an influential factor in burnout for nursing facility social workers. Courage and Williams do not consider any possible influence on burnout caused by external factors in the environment outside of the work setting. As the literature review demonstrated, nursing facilities are widely considered, even in the professional literature, to be negative environments characterized by human suffering and inhumane conditions. In order to account for the possible influence of this characterization of nursing facilities on social workers who choose nursing facilities as their arena of practice, I have added a fourth category and labeled it "nursing home stigma." With the addition of this fourth category of variables that impact burnout, the variable side of the revised model is illustrated in Figure 3.2.

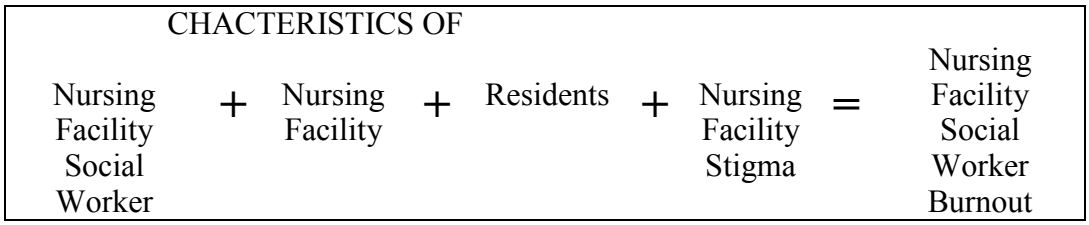

Figure 3.2: Factors Contributing to Burnout, Modified.

This model is the basis identifying and organizing a set of factors to examine for possible influence on nursing facility social worker burnout. The model provides the structure for answering the research questions, which are discussed in the next section.

RESEARCH QUESTIONS

I propose to explore the following research questions using the modified Courage and Williams model:

- Are some nursing facility social workers more vulnerable than others based on demographic or personality characteristics?
- Is burnout related to the characteristics of nursing facility residents or families?
- Is burnout related to characteristics of the nursing facility as an employer?
- Is burnout related to the social worker's perception of nursing home stigma?

To answer these questions, data is collected on each of the four categories of the modified Courage and Williams model. The data is used in multiple regression analysis. The measure of burnout used for the dependent variable in

the analysis is the score on the Maslach Burnout Inventory (MBI). The MBI yields a score on each of three subscales that cannot combine into a single score. Because each of the three subscales represents a separate dimension of burnout, three multiple regression analyses will be required to obtain a complete picture of the relationship of the variables in the modified Courage and Williams model and burnout. The outcomes from the three multiple regression analyses are the source of answers for the research questions.

For the purpose of answering the research questions, the answer will be "yes" to the question if any variable in the model category has a significant relationship with any one of the three subscales of the dependent variable. Table 3.1 illustrates the possible relationships between the dependent and independent variables. The question marks in the table represent to possible appearance of a significant relationship.

Table 3.1
Factors Related to Burnout for Nursing Facility Social Workers

	Subscales of Burnout		
	Emotional Exhaustion	Depersonalization	Personal Accomplishment
Characteristics of Social Worker	?	?	?
Characteristics of Nursing Facility	?	?	?
Characteristics of Residents	?	?	?
Nursing Home Stigma	?	?	?

Collecting data is accomplished by a written survey, and the next section discusses why a written survey is the methodology of choice for this study.

RATIONALE FOR QUANTITATIVE METHODOLOGY

To collect data with which to test the hypotheses I have chosen to use a written survey instrument. I chose a survey design for several reasons, some directly related to the topic, and some related to my interests in the content and in the methodology.

The primary reason for selecting a quantitative, rather than qualitative, methodology is that quantitative methods are most useful for exploring questions that represent applications of well-developed theory. Although there is still debate over whether burnout is a construct or a collection of constructs, previous research and writing have provided a well-developed theory base for burnout. Qualitative research is usually used in areas where theory development is the goal. In this research project, the primary goal is to apply the previously developed theory to a new setting. Qualitative methods are used in the development of the new construct, nursing facility stigma, but the primary research hypotheses are tested with quantitative methodology.

A second reason for use of survey methodology is to reach as many nursing facility social workers as possible. Since very little is known or documented about nursing facility social workers, a survey presents the opportunity to gather additional information about education, licensure, work time spent in various work tasks, and demographic information.

A third reason for using a survey design is that the instrument chosen for the dependent variable, the Maslach Burnout Inventory, is a written instrument with a traditional Likert-type response scale. Since that portion of the information gathering process is a written survey, using a written survey to gather information on the independent variables is an appropriate match.

The research design has two major sections, the nursing home stigma scale development and the hypothesis testing. The stigma scale development uses both quantitative and qualitative methodologies, and the hypothesis testing uses only quantitative methods.

FOUR CATEGORIES OF THE MODIFIED COURAGE AND WILLIAMS MODEL

The Courage and Williams model contains three categories, and a fourth category is added to create the modified version for this research project. The following sections describe the four categories, beginning with nursing facility stigma.

Stigma Scale and Modifications

No measure of the stigma associated with nursing homes is available in the literature. In order to use the stigma construct in this research, it was necessary to develop a scale to measure social worker's perceptions of stigma. The process of developing the scale is described in Appendix 2. The scale development effort did not result in evidence to support one scale to measure nursing facility stigma. Therefore, I decided to alter the original plan and substitute the two scales that did emerge from the development process, Respect Scale and Misunderstood Scale.

Characteristics of the Care Provider

The Courage and Williams model considers that the characteristics of the care provider are an important source of variance in burnout. Domains within the category are personality, demographics, professional status, and expertise. In the survey instrument the questions to measure demographic characteristics and professional status are included in Section 1 of the questionnaire. Items included in professional status include education and licensure. The complete questionnaire is reproduced in Appendix A.

The questions that make up the expertise scale are imbedded in Section 2 of the questionnaire, and a complete description of the development of the expertise scale is provided in Chapter 4. The expertise scale asks for the social worker's opinion of his or her preparedness for carrying out the important functions of the job.

The domain of personality characteristics is more difficult to capture in one question or a series of questions. This domain is very broad, and the number of instruments that are available to measure personality is large. Courage and Williams (1987) describe the personality characteristics that are relevant to burnout as those that render the care provider vulnerable to self-depletion in the service of others. Some of the characteristics that might render the social worker vulnerable are unassertiveness, impatience, intolerance, submissiveness, fearfulness, and an inability to establish limits within the helping relationship.

Looking for a thread of commonality among the personality characteristics suggested by Courage and Williams, I concluded they each are

linked to an external/internal locus of control orientation. Unassertiveness, impatience, intolerance, submissiveness, fearfulness, and an inability to establish limits all involve relationships with others and come from a posture in which the individual reacts to the actions and attitudes of others rather than relating to others based on an internalized set of values or beliefs. Since part of this study examines the effect of stigma on the social worker, internal/external locus of control as a personality measure is appropriate because of the presumption that those with an internal locus of control would be less affected by the perception of stigma.

The instrument I have chosen to use as the measure of locus of control is the Internal Control Index developed by Duttweiler (1984). Although this instrument is acknowledged to be in a developmental stage itself, it has many advantages for the current study. The initial testing of the instrument indicated an estimated reliability of .84, the presence of a strong principle component, two replicable factors, and evidence for convergent validity. The questions are generic and free of any specific references to culture. From the practical point of view, the instrument is available for use and has a relative short (22) number of questions.. Length is an issue because of the total number of questions in the final survey document. The ICI uses a five point Likert scale, although the response categories are not the same as the other questions in the research instrument.

Characteristics of the Human Service Organization

The next category in the Courage and Williams model is the human service organization. The human service organization is further divided into

domains of task, structure, power/authority, resources, functions and roles. The items and scales that represent each of these domains are included in Section 2 of the questionnaire, and a complete description of the items and scales in included in Chapter 4.

In the Courage and Williams model, the aspect of organizational structure that is relevant to burnout is the extent to which the structure has the flexibility to meet both the needs of the care provider (social worker) and the care recipient (resident). The power/authority element refers to the degree to which social workers have decision making rights relative to the services provided to the resident. In the nursing facility setting, the decision making point is the formal, mandated care plan. A series of questions about the social worker's involvement in the care plan is included in Section 2 of the questionnaire, and the power/authority scale is described in Chapter 4.

The domain of function addresses the extent to which competing and conflicting outside controls exert influence on the operations of the organization and thus introduce ambiguity and confusion into the work environment. In the nursing facility setting, the dominant outside control is state regulation.

The domain of role addresses the role behavior expected of the social worker and the nature of the interconnection between positions. In the nursing facility setting, the important interconnecting positions are administrator, director of nursing, activity director, and other professionals such as therapists.

Characteristics of the Care Recipient

The final category in the Courage and Williams model is the care recipient. Courage and Williams include demographic characteristics of the client group. However, the nursing facilities population, by definition, has very little variation. All the residents of long-term care facilities have a need for extended care in a congregate setting. In the case of the Medicaid population, specific criteria related to the need for twenty-four hour nursing care and assistance with the activities of daily living are imposed by the state as a condition of Medicaid eligibility. I elected not to use any questions related to demographics because of the likelihood of a lack of variance in the responses.

The remaining components of the care recipient category are individual behaviors, chronicity, acuity, and complexity. In this study, the care recipient category is represented by scales that measure the social worker's perception of the resident's level of depression and ability to cope with the circumstances of the resident's life in the facility.

Summary of Independent Variables

The four categories of the model, characteristics of the social worker, characteristics of the nursing facility, characteristics of the residents, and stigma require a total of 21 variables. Table 3.2 illustrates the relation of the categories, the domains, and the 21 variables. This table is used throughout this report to provide a reminder of how the variables are related to one another and to the model.

Table 3.2
Independent Variables

Category	Domain	Independent Variable
Care Provider (Social Worker) Characteristics		
	Demographic	Age
		Ethnicity
		Gender
	Professional Status	Time Licensed
		License Type
		Education
		Organization Member
		Time Employed
	Personality	Internal Control Index
	Expertise	Expertise Scale
Human Service Organization (Facility) Characteristics		
	Task	Spend time (item)
	Function	Understand requirements (item)
	Structure	Structure Scale
	Power/Authority	Power/Authority Scale
	Resources	Human Resources Scale
		Material Resources Scale
	Role	Role Scale
Care Recipient (Resident) Characteristics		
	Chronicity, acuity, and complexity	Residents Depressed Scale
		Residents Cope Scale
Nursing Facility Stigma		Professional Respect Scale
		Misunderstood Scale

Each of the 21 variables is potentially related to burnout as measured by the Maslach Burnout Inventory, discussed in the next section.

DEPENDENT VARIABLE: MASLACH BURNOUT INVENTORY

The dependent variable for this study is the Maslach Burnout Inventory that is described in detail in the literature review. The MBI yields scores on three subscales: emotional exhaustion, depersonalization, and personal accomplishment. These subscales do not combine into a single score, so three measures of burnout are used to evaluate the potential factors. In order to use the MBI it is necessary to obtain permission from the publisher, Consulting Psychologist Press. The required information and fees were submitted to Consulting Psychologist Press, and permission was obtained in September 2001. In keeping with the terms of the permission agreement, the MBI was retyped into the instrument without changes except for minor formatting changes required to fit it into the document.

EXPLORATORY ITEMS

In addition to the questions that address the categories of independent variables, questions are included to capture data that might provide additional insight into causes of burnout and/or turnover. Reponses to these questions are not used in the burnout model. These items are included strictly for exploratory purposes. These questions include why the respondent left the previous facility, plans for future employment if the respondent plans to change jobs, and information (if known) about the previous incumbent of the position.

Another set of questions gathers information about the nursing facility. These questions about the demographics (size, location, ownership) of the facility in which the respondent works are included for the purpose of assessing the representativeness of the respondents and are not included in the regression analysis.

DATA COLLECTION STRATEGY

The data collection strategy has two elements, the design of the survey instrument and distribution of the instrument.

Survey Instrument

The instrument is divided into four sections. The first section contains demographic questions about the social worker, length of experience and length of employment, and characteristics of the facility. The first section also contains a series of questions about the social worker's intent to leave the current position, possible future plans, and the previous social worker's career path after leaving the facility. The final series of questions in the first section asks about the number of hours a week social workers spend in various types of work activity (resident care, administrative tasks, non-social work tasks, managing, or counseling with other employees).

The second section contains the questions that represent the constructs in the independent variables, characteristics of the care provider, characteristics of the human service organization, characteristics of the care recipient, and nursing facility stigma. A decision was made to group similar or related questions in this section. The section contains 37 questions, and some of the questions sound

different only by a word or phrase. For example, five questions start with the phrase "I feel I am well prepared for…" and then describe some aspect of the job. Grouping similar questions presents a risk of influencing the respondent to make the same response to all the statements. However, grouping the questions could also reduce frustration on the part of the respondent who might think "Didn't I just answer this question?" and then search back through the instrument looking for the same question. In addition, grouping similar questions could have the effect of influencing the respondent to really think about the subtle differences in responses to similar questions. For example, if the question "I feel I am well prepared for working with nursing facility residents" is followed immediately by "I feel I am well prepared for working with the families of nursing facility residents," the respondent may be induced to consider his or her own skill level in a more specific response, rather than a global or general response to preparedness for the job (Rubin & Babbie, 1993).

I considered the value of pretesting for question order effect by designing two instruments with the same questions arranged in different orders (one with questions grouped, one with questions randomly distributed) to administer to random samples taken from the target audience. Analysis of the responses would inform the decision on the question order for the completed instrument. However, I decided not to add this additional step for two reasons. The first reason was limitation of time and resources to complete the project, and the second was the further degradation of the available pool of respondents. Since the pool of respondents is limited to the individuals who could be reached through the

available list of Texas nursing facilities, and ten percent were already used for the scale development sample, I decided not to further reduce the pool by using a second developmental sample.

The third section contains the Duttweiler Internal Control Index, and the last section is the reproduction of the Maslach Burnout Inventory. Appendix 1 contains a copy of the survey instrument.

Instrument Distribution and Data Collection

A packet containing the complete instrument, the human subjects review required letter, a brief note of explanation, and a self-addressed return envelope were mailed on October 4, 5, and 6, 2001, with a requested return date of October 31, 2001. A University of Texas at Austin School of Social Work address was used to increase the credibility of the research and encourage response.

The total number of packets mailed was 1,054, the number remaining from the original list of 1171 after 117 were used for the validation sample of the nursing facility stigma scale. The labels were addressed to "Social Worker or Current Administrator," followed by the address of the nursing facility. The enclosed note asked the administrator to give the questionnaire to the facility social worker if it arrived on the administrator's desk.

To encourage a response, a post card was mailed ten days after the survey to the same list. The post card asked recipients to complete and return the survey, and gave a telephone number and email address to call or email if a questionnaire had not been received. In addition, both trade associations, the Texas Health Care Association and the Texas Association of Homes and Services for the Aged,

published a notice in their newsletters that the survey had been mailed. These strategies had a modest effect, resulting in several contacts from social workers or administrators who did not receive a copy. Seven additional surveys were mailed in response to these requests.

Fifteen envelopes were returned marked by the post office as unable to deliver due to address errors. Some of these were hand-marked "vacant" or "closed." Since nursing facility closures had been occurring during the year preceding the data collection, it is reasonable to count the fifteen returned envelopes as representing closed facilities, lowering the effective sample size to1039. A total of 385 usable surveys were returned, for a return rate of 37%. Results from these 385 were used in the data analysis and hypothesis testing.

CHAPTER CONCLUSION

This investigation of nursing facility social worker burnout is based on a modification of the Courage and Williams model of factors related to burnout. The 21 factors considered for their importance to burnout are organized into four categories, characteristics of the care provider, characteristics of the human service organization, characteristics of the care recipients, and nursing facility stigma. Data is collected via a written survey instrument on 21 independent variables and the dependent variable. The dependent variable, the score on the Maslach Burnout Inventory, has three subscales that cannot be combined. Three multiple regression analyses are planned. Each analysis uses one of the three subscales as the dependent variable and all 21 of the dependent variables. Findings from these analyses are used to answer the four research questions:

- Are some nursing facility social workers more vulnerable than others based on demographic or personality characteristics?
- Is burnout related to the characteristics of nursing facility residents?
- Is burnout related to characteristics of the nursing facility as an employer?
- Is burnout related to the social worker's perception of nursing home stigma?

Chapter 4 reports the responses to the questionnaire items and the findings from the three regression analyses.

Chapter 4: Findings

Introduction and Organization of Chapter

The purpose of this chapter is to report the findings from the survey of nursing facility social workers, results of the data analysis, and relationships between the independent and dependent variables. The report of the findings from the survey contains three types of data items: independent variables, dependent variables, and data to determine if the sample is representative of the population. The independent variables are organized in the categories of the modified Courage and Williams model. The dependent variable, burnout, is represented by the three subscales of the Maslach Burnout Inventory. Scores are reported for the three scales. Demographic data for the respondents and data regarding the size, location, and governance of the facilities in which they are employed are reported as a measure of the representativeness of the sample.

The last portion of the chapter reports the findings of the three regression analyses (one for each subscale) and reports the independent variables that show a relationship to burnout.

The discussion of the data begins with information to evaluate how well the sample represents nursing facility social workers in Texas.

Representativeness of the Sample

How well the sample represents the population of nursing facility social workers in Texas is an important question. Three sources of evidence are available to evaluate how well this sample represents the population. One source

of evidence is the demographic characteristics of the respondents, another is the characteristics of the facilities, and a third is response rate.

Response rate was discussed in detail in chapter three. From a sampling frame of 1,039, a total of 385 usable surveys were returned, for a return rate of 37%. The return rate is acceptable for a mailed survey.

Two other researchers have studied the same population. The data from this sample can be compared to samples from previous studies conducted by Murray and Gleason-Wynn. A survey instrument mailed to all Texas nursing facilities was the data collection tool for each of the previous two studies. Murray did not report age, gender, or ethnicity for her sample. The current sample is 4.2 years older than Gleason-Wynn's sample. Based on a chi square analysis, the percentage of African-American and Hispanic respondents increased, and the percentage of Anglo respondents decreased. The percentage of males and females was the same for both samples.

Murray reported licensure status for her sample. Based on chi square analysis, the percentage of social worker associates and licensed social workers is the same for both samples. The percentage of licensed master social workers and licensed master social workers – advanced clinical practioners is higher in the current sample, and the percentage of respondents with no license is lower.

Because of differences in reporting categories, only two categories can be compared, those with master of arts degrees and those with master of social work degrees. The percentage of respondents with master of arts degrees remained the

same, and the percentage of respondents with master of social work degrees increased.

Although all nursing facilities operate under the same state and federal regulations and are held to the same standards in state and federal inspections, facilities can vary in ownership, location, and size. Location, size and ownership can, in turn, result in differences in resources available, physical environments, and staffing. Location, size and ownership are not considered in the characteristics of the human service organization in the Courage and Williams model, but they are reported here to examine how well the sample represents the population of nursing facilities in Texas. Percentages of facilities reporting various types of ownership, location, and size are compared to population data obtained from the Texas Health Care Association and based on a 1999 cost report database. Location of the facilities in which respondents are currently employed is described in Table 4.1.

Table 4.1
Location of Nursing Facilities in the Sample Reported by Percentage

	Current Study	THCA
Urban	33.5%	47%
Rural	41.6%	Not reported
Suburban	21.0%	53%

Size of the nursing facilities in which respondents are employed is reported in Table 4.2.

Table 4.2
Size of Nursing Facilities Reported by Percentage

	Current Study	THCA
Fewer than 60 residents	10.4%	14%
60 to 120 residents	53.8%	58%
Over 120 residents	33.5%	28%

Ownership of the nursing facilities in which respondents are employed is reported in Table 4.3.

Table 4.3
Ownership of Nursing Facilities Reported by Percentage

	Current Study	THCA
For profit, 10 or fewer in ownership	36.4%	47%
For profit, 11 or more in ownership	39.7%	37%
Not for profit	19.0%	16%
Publicly owned	1.8%	3%

No conclusions can be reached about geographical distribution, since the categories are not comparable. The current sample is over-represented in large facilities, multi-facility ownership facilities (11 or more facilities in ownership), and over-represented in the not-for profit category. The sample is under-represented in small ownership and publicly owned categories.

Using evidence from the characteristics of the social workers and the characteristics of the facilities represented, caution should be used in generalizing

the conclusions from this study to the general population. The discussion of the independent variables begins with the next section.

INDEPENDENT VARIABLES

The model used in this research, adapted from Courage and Williams, examines the relationship between four categories of independent variables and social worker burnout, with the fourth category being the nursing facility stigma construct added to the original three categories in the Courage and Williams model. The three original categories of independent variables in the Courage and Williams model are characteristics of the social worker, characteristics of the human service organization (nursing facility), and characteristics of the clients (nursing facility residents). Some variables are represented by individual items, and others are represented by scales. Scales are used when the domain is too complex to be represented by a single item. This section reports the findings of individual items and scales that are used in the independent variable side of the regression analysis.

Table 4.4 reviews the independent variables.

Table 4.4
Independent Variables

Category	Domain	Independent Variable
Care Provider (Social Worker) Characteristics		
	Demographic	Age
		Ethnicity
		Gender
	Professional Status	Time Licensed
		License Type
		Education
		Organization Member
		Time Employed
	Personality	Internal Control Index
	Expertise	Expertise Scale
Human Service Organization (Facility) Characteristics		
	Task	Spend time (item)
	Function	Understand requirements (item)
	Structure	Structure Scale
	Power/Authority	Power/Authority Scale
	Resources	Human Resources Scale
		Material Resources Scale
	Role	Role Scale
Care Recipient (Resident) Characteristics		
	Chronicity, acuity, and complexity	Residents Depressed Scale
		Residents Cope Scale
Nursing Facility Stigma		Professional Respect Scale
		Misunderstood Scale

Category: Care Provider (Social Worker)

Characteristics of the care provider are included in the model to determine if individuals with certain personality, demographic, professional, or expertise characteristics have greater vulnerability to burnout. Table 4.5 highlights the characteristics of nursing facility social workers that are examined for their possible effects on social worker burnout.

Table 4.5
Independent Variables

Category	Domain	Independent Variable
Care Provider (Social Worker) Characteristics		
	Demographic	Age
		Ethnicity
		Gender
	Professional Status	Time Licensed
		License Type
		Education
		Organization Member
		Time Employed
	Personality	Internal Control Index
	Expertise	Expertise Scale

Demographic Domain

Two other researchers (Gleason-Wynn, 1994; Murray, 1996) sampled the same population, and data from those two samples (in some data items) are available for comparison. The demographic characteristics of the respondents from the three samples are reported in Table 4.6.

Table 4.6
Age, Gender, and Ethnicity Characteristics of Texas Nursing Facility Social Workers by Percent

	Current Study	Gleason-Wynn	Murray
Respondents	385 (37%)	326 (29.3%)	491 (43.2%)
Mean Age in Years	41.1	37.2	Not Reported
Anglo	78.4%	87.1%	Not Reported
Hispanic	9.6%	5.8%	Not Reported
African-American	6.2%	4.3%	Not Reported
Asian	0.8%	0.9%	Not Reported
Other	3.6%	1.2%	Not Reported
Female	85.2%	85.0%	Not Reported
Male	14.3%	14.4%	Not Reported

Professional Status Domain

Professional status includes time licensed, license type, education, organization member, and time employed. One puzzling finding regarding license type is the report that 2.6 percent of the current sample and 8.1 percent of Murray's sample report no license, although the social worker is required by nursing facility regulation to be licensed. Nothing in the current research or Murray's report of research accounts for the employment of unlicensed persons as social workers.

The slight increases in the reported percentages of Licensed Master Social Workers and Licensed Master Social Worker – Advanced Clinical Practitioner

along with the decrease in the number of unlicensed individuals would appear to be positive indicators of an enhancement in professionalism since the earlier studies. However, the current available measures, taken at two points in time, are not sufficient to document a trend. Additional measures over time would be necessary to make a conclusive determination.

The licensure status of the respondents and similar data from the other two samples are reported in Table 4.7.

Table 4.7
License Type of Texas Nursing Facility Social Workers by Percent andTime Licensed

	Current Study	Gleason-Wynn	Murray
Social Work Associate	25.7%	Not Reported	26.7%
Licensed Social Worker	51.4%	Not Reported	54%
Licensed Master Social Worker	13%	Not Reported	8.4%
Licensed Master Social Worker – ACP	6.8%	Not Reported	2.9%
None	2.6%	Not Reported	8.1%
Time licensed – mean years	7.17%	Not Reported	Not Reported

Because of the close tie between education and licensure status for social workers, education level can be used for two purposes: to confirm the licensure status findings and as an independent measure of professionalism. Differences in

reporting categories for education create an initial impression that the current sample has fewer respondents with bachelor's degrees than earlier samples, but the reporting category of "some graduate work" includes those who reported an undergraduate degree plus some graduate work, accounting for the apparent difference.

The increase in the percentage of persons with a master's degree in social work and the decrease in the percentage of persons with bachelor's degrees with majors other than social work is an encouraging sign for the level of professionalism in nursing facility social work, but additional measures over time would be required to reach a definitive conclusion.

The education of the respondents and similar data from the other two samples are reported in Table 4.8.

Table 4.8
Education of Texas Nursing Facility Social Workers by Percent

	Current Study	Gleason-Wynn	Murray
Some College, no degree	1.3%	Not Reported	1.0%
BA, not BSW	18.7%	29.8	26.4%
BSW	37.7%	46.9	53.1%
Some graduate work	14.8%	Not Reported	Not reported
MA, not MSW	8.1%	9.5%	7.0%
MSW	19.5%	13.2%	11.1%
Ph. D.	0.0%	0.6%	0.2%

Time employed is an important question in the study because part of the initial impetus for research in this area came from the findings in Gleason-Wynn's and Murray's samples of short tenure in the current position. The current study asks questions about tenure (if any) in a previous position as nursing facility social worker, total tenure in nursing facility social work, and the total number of nursing facilities in which the respondent has been employed as a social worker. A question about membership in professional organizations is included in the current study to add further information about the professionalism of nursing facility social workers.

Looking only at time employed in the current position yields a picture of short tenure for most nursing facility social workers. A very different picture emerges when the findings from the questions about previous experience and total time employed in nursing facility social work are presented. It would appear from the findings of the current study that nursing facility social workers are more experienced in their field of practice than previous studies have revealed.

The percentage of respondents reporting professional membership appears to be very different between the current study and Gleason-Wynn's, but much of the difference may be due to the way in which the questions about professional membership are asked in the different surveys.

Time employed in nursing facility social work, number of facilities of employment, and professional membership data are reported in Table 4.9. In addition to the variables that are represented in the model, the number of facilities

in which the social worker has been employed is included for interest, but it is not a variable that is included in the burnout regression analysis.

Table 4.9
Time Employed in Years, Number of Facilities of Employment by Mean, and Professional Membership by Percent

	Current Study	Gleason-Wynn	Murray
Years of employment in current facility	2.59[1]	2.08	1.50
Years of employment in previous facility	2.50	Not reported	3.0[2]
Years of tenure as nursing facility social worker	4.95	Not reported	Not reported
Total number of facilities in career	3.65	Not reported	Not reported

[1]Includes only those who have worked in more than one facility
[2]Years of experience in field of aging; nursing facility experience not reported.

To summarize the findings from the demographic and professional status characteristics of the current sample, the respondents to this survey show some differences in their characteristics from the respondents in the two previous samples of Texas nursing facility social workers. Licensure status is very similar, with some movement towards the higher levels of licensure. Education is similar, with some increase in the percentage of persons with a master's degree in social work, which is in keeping with the higher levels of licensure.

The next domain of the characteristics of the social worker is personality.

Personality Domain

The score on the Duttweiler Internal Control Index (ICI) represents personality. The total number of respondents who answered all 22 items on the Internal Control Index scale is 351. The Internal Control Index has a possible score range of 28 to 140, with higher scores reflecting higher internal locus of control. The scores in this sample ranged from 69 to 135, with a mean of 111.44 and a standard deviation of 11.6. The next chapter contains a discussion of how this data compares to normative samples.

Expertise Domain

Developing a measure of how nursing facility social workers perceive their expertise or preparedness for their job requires an initial step of determining how nursing facility social workers use their time. Expertise on a task or function is only relevant to a job if the job tasks require that it be applied.

The set of questions on how nursing facility social workers spend their time is included to evaluate the usefulness of potential items in a scale to measure self-perceived expertise. Although these findings are not used in the regression analysis, they are useful for evaluating the value of the expertise scale items. The amount of time social workers spend in various types of activities is reported in Table 4.10.

Table 4.10
How many hours a week do you spend on

Activity	Hours Worked Per Week by Percent				
	≤5	6 to 15	16 to 30	≥31	Total*
Resident care	4.9%	29.9%	45.7%	19.0%	99.5%
Administrative tasks	11.7%	57.9%	26.8%	3.4%	99.8%
Case aide tasks	78.7%	18.7%	1.3%	.3%	99.0%
Managing or supervising	91.7%	4.4%	1.0%	1.3%	98.4%
Counseling other employees	90.6%	8.3%	0.0%	0.0%	98.9%

*Total may not equal 100% due to missing data.

These data clearly indicate that nursing facility social workers spend the majority of their time in resident care. Although administrative tasks are the second most time consuming category after resident care, seventy percent of the respondents report spending fifteen or fewer hours per week in administrative tasks. Very little time is spent in activities that are outside the role of social worker, specifically case aide tasks, managing or supervising, or counseling other employees.

Six questions are included in the survey to address the domain of expertise. However, since the responses on the amount of time spent indicated that social workers spend very little time in management duties or counseling with other employees, those two items are eliminated from the expertise scale, and the remaining four items are examined for appropriateness for use as a scale. The mean scores for the individual items and the reliability data for the scale are

reported in Table 4.11. Items were scored on a scale of one to five, with five being "agree" and one being "disagree."

Table 4.11
Expertise Scale

Item	Mean	Std. Dev.
I feel I am well prepared for working with nursing facility residents.	4.51	.82
I feel I am well prepared for working with families of nursing facility residents.	4.56	.71
I feel I am well prepared for my administrative duties in the nursing facility.	4.37	.89
My knowledge and skills are adequate for the demands of nursing facility social work.	4.55	.74
Expertise Scale	4.49	.67
Principal Component Analysis and Scale Reliability		
Number of Components		1
Percent of Variance for One Component		72
Alpha Score		.87

Summary of Care Provider (Social Worker) Category

This section reports the findings in the demographic, professional status, personality, and expertise domains. Age, ethnicity, and gender information shows that the study population is primarily older, white, and female. Professional status information shows that the population is similar to previous studies, with some increases in education and license type as indicators of professionalism. The

Duttweiler Internal Control Index has no direct comparatives. Comparison to means from other studies using the index as a measure are included in the next chapter. The expertise scale indicates nursing facility social workers feel that they are well prepared for their job duties. Implications of these findings will be discussed further in the next chapter.

The next section reports on the second category in the Courage and Williams model, the human service organization (facility).

Category: Human Service Organization (Facility)

This section reports the findings that describe the nursing facilities in the sample. As a reminder of the characteristics of the human service organization that are included in the Courage and Williams model, Table 4.12 reviews the domains and variables included in the human service organization category.

Table 4.12
Independent Variables

Category	Domain	Independent Variable
Human Service Organization (Facility) Characteristics		
	Task	Spend time (item)
	Function	Understand requirements (item)
	Structure	Structure Scale
	Power/Authority	Power/Authority Scale
	Resources	Human Resources Scale
		Material Resources Scale
	Role	Role Scale

Task Domain

The domain of task in the Courage and Williams model is based on the body of research that relates burnout to work overload, the significance of the work performed, and the adequacy of time available to spend with clients. Task is considered a characteristic of the organization under the assumption that the management practices of the organization determine what type of work the social worker performs, how reasonable the workload is, and the adequacy of time to spend with the client. As reported in the previous section, nursing facility social workers report spending the majority of their work time with their clients, the facility residents. The variable used to represent the domain of task is represented by one item. The response to that item is reported in Table 4.13. As with the previous items, this item was scored on a scale of one to five, with five being "agree" and one being "disagree."

Table 4.13
Task Item

Item	Mean	Std. Dev
I can spend as much time as I need to with residents and their families.	3.84	1.31

Function Domain

The domain of function in the Courage and Williams model represents the degree to which the organizational structure serves the welfare of the clients and is free from external control that influences the practice of the social worker. The domain of function can be illustrated by a hypothetical example from managed

care. A social worker or nurse functioning as a case manager may determine that a certain course of treatment or a specific provider is most appropriate for a client, but the option of providing that particular treatment or specific provider may be controlled by the cost factor requirements or restrictions imposed by the managed care organization. Function addresses the extent to which competing and conflicting outside controls exert influence on the operations of the organization, thus introducing ambiguity and confusion into the work environment. Since the primary source of external control influencing the nursing facility environment is the set of state and federal requirements, the domain of function is represented by one item related to the state requirements. This item is reported in Table 4.14. As with the previous items, this item was scored on a scale of one to five, with five being "agree" and one being "disagree."

Table 4.14
Function Item

Item	Mean	Std Dev
I clearly understand the state requirements for social services in the nursing facility.	4.40	.90

Structure Domain

In the Courage and Williams model, the aspect of organizational structure that is relevant to burnout is the extent to which the structure has the flexibility to meet both the needs of the care provider (social worker) and the care recipient (resident and family). Structure includes the issues of creative freedom and flexibility versus bureaucratic rigidity in conducting daily business. A two-item

scale, reported in Table 4.15, represents the domain of structure. These items also were scored on a scale of one to five, with five being "agree" and one being "disagree." The low alpha of this scale may indicate a lack of clarity in the construct or may be a function of the small number of items in the scale.

Table 4.15
Structure

Item	Mean	Std Dev
My pay is reasonable for my job.	3.43	1.34
My nursing facility management encourages flexibility and creativity in meeting the residents' needs.	4.06	1.04
Scale	3.75	.96
Principal Component Analysis and Scale Reliability		
Number of Components		1
Percent of Variance for One Component		64
Alpha Score		.44

Power/Authority Domain

The next domain in the model is power/authority or the degree to which the organization allows the social worker to make decisions regarding the client. In the nursing facility setting, the decision making point is the formal, mandated care plan. The extent to which the social worker is active in the development of the resident care plan is an indicator of the power/authority the social worker can

exercise in decisions about the resident. A three-item scale, reported in Table 4.16, represents the domain of power/authority.

Table 4.16
Power/Authority Scale

Item	Mean	Std Dev
My assessments and opinions are respected by other professionals in the facility.	4.22	.94
I am actively involved in developing the residents' care plans.	4.44	.93
I participate on the care plan team.	4.73	.74
Principle Component Analysis and Scale Reliability		
Scale	4.47	.68
Number of Components		1
Percent of Variance for One Component		62
Alpha Score		.67

Resources Domain

The domain of resources in the Courage and Williams model refers to the extent to which the human service organization has adequate resources to meet the needs of the clients. Six items are included in the survey to address the domain of resources. Principal component analysis conducted on the original six-item scale revealed two components, one related to human resources and one related to material resources. Therefore two scales, human resources and material

resources, represent the domain of resources. These two scales are reported in Tables 4.17 and 4.18.

Table 4.17
Human Resources Scale

Item	Mean	Std Dev
My nursing facility has adequate social work staffing to provide the care the residents need.	3.79	1.29
My nursing facility has adequate nursing staffing to provide the care the residents need.	3.65	1.24
My nursing facility has adequate dietary, maintenance, and housekeeping staffing to meet the residents' need.	4.22	1.01
Scale	3.89	.95
Principal Component Analysis and Scale Reliability		
Number of Components		1
Percent of Variance for One Component		64.5
Alpha Score		.71

Table 4.18
Material Resources Scale

Item	Mean	Std Dev
My nursing facility has adequate medical supplies to meet the residents' needs.	4.51	.83
My nursing facility has adequate resources and supplies such as food, linens, and toiletries to meet the residents' needs.	4.55	.88
My nursing facility has adequate food supplies to meet the residents' needs.	4.75	.67
Scale	4.60	.69
Principal Component Analysis and Scale Reliability		
Number of Components		1
Percent of Variance for One Component		76.1
Alpha Score		.84

Role Domain

The domain of roles addresses the role behavior expected of the social worker and the nature of the interconnection between positions. Previous research has shown that role incongruity or confusion about role expectations may be related to burnout. The domain of role is represented by four questions relating to the understanding of the role of the social worker by other key positions in the facility. The scale representing the domain of role is reported in Table 4.19.

Table 4.19
Role Scale

Item	Mean	
In my nursing facility, the functions and the responsibilities of the social worker are clearly understood by the administrator.	4.09	1.17
In my nursing facility, the functions and the responsibilities of the social worker are clearly understood by the director of nursing.	4.03	1.12
In my nursing facility, the functions and the responsibilities of the social worker are clearly understood by the activity director.	4.18	1.03
In my nursing facility, the functions and the responsibilities of the social worker are clearly understood by other professionals such as therapists.	4.15	.98
Scale	4.11	.86
Principal Component Analysis and Scale Reliability		
Number of Components		1
Percent of Variance for One Component		.64
Alpha Score		.81

Summary of Human Service Organization Category

The characteristics of the nursing facility as a human service organization and as an employer are central to the issues in this research. Implicit in the notion of burnout is the idea that the conditions of employment have a negative effect on the social worker by restricting opportunities to perform the job in a professionally satisfying manner. Social workers are assumed to have the best interests of the client as their central motivation. The purpose of the human

service category is to assess the extent to which the social worker's desire to act in the best interest of the client is supported or thwarted by the organization.

The responses describing the nursing facility as an employer are very important in the context of this research. The assumption that nursing facilities do not act in the best interests of the residents and therefore are in conflict with the professional and ethical standards of the social worker is implicit in the notion of nursing facility stigma. A fuller discussion of the implications of the findings from this domain is included in the next chapter.

The third Courage and Williams category, the care recipient, begins with the next section.

Category: Care Recipient (Resident)

As a reminder of the model and the relationship of the characteristics of the care recipient, the nursing facility resident, Table 4.20 reviews the characteristics of the care recipient category.

Table 4.20
Independent Variables

Category	Domain	Independent Variable
Care Recipient (Resident) Characteristics	Chronicity, acuity, and complexity	Residents Depressed Scale
		Residents Cope Scale

Chronicity, Acuity, and Complexity Domain

Much of the research in the field of burnout, especially in the early years, focuses on the potential for human services workers to develop negative attitudes towards the clients and to become frustrated by lack of observable change in the

client's behaviors, attitudes, or feelings. Social work intervention assumes that some change is needed, and lack of change can be a signal that the intervention, and therefore the social worker, has failed. In a predictable cycle, a sense of failure leads to frustration, which leads to blame, and eventually the social worker develops distain or bitterness toward the very person or group he or she originally wanted to serve.

Courage and Williams include demographic characteristics of the client group in this domain. However, the nursing facilities population, by definition, has very little variation. All the residents of long-term care facilities have a need for extended care in a congregate setting. In the case of the Medicaid population, specific criteria related to the need for twenty-four hour nursing care and assistance with the activities of daily living are imposed by the state as a condition of Medicaid eligibility. No questions related to demographics are included because of the likelihood of a lack of variance in the responses.

In addition to demographics, components of the care recipient domain as described by Courage and Williams include individual behaviors, chronicity, acuity, and complexity. Four items are included in the survey to represent the domain of resident characteristics. Using principal component analysis, the four items load on two components, one related to the residents' level of depression, and one related to the residents' ability to cope. The two scales representing the domain of resident characteristics are reported in Tables 4.21 and 4.22.

Table 4.21
Residents Depressed Scale

Item	Mean	Std Dev
Many of the residents in my facility are depressed.	3.60	1.22
Many of the residents in my facility are anxious, angry or experiencing despair.	3.03	1.21
Residents Depressed Scale	3.32	1.06
Principal Component Analysis and Scale Reliability		
Number of Components		1
Percent of Variance for One Component		76.7
Alpha Score		.70

Table 4.22
Residents Cope Scale

Item	Mean	Std. Dev
I admire how well many of residents cope with the losses brought about by age or illness.	4.17	.90
Many of the residents in my facility have excellent coping and adapting skills	3.50	1.09
Residents Cope Scale	3.84	.86
Principal Component Analysis and Scale Reliability		
Number of Components		1
Percent of Variance for One Component		74.5
Alpha Score		.66

Summary of the Care Recipient Category

If coping and depression are regarded as opposite and mutually exclusive options, the responses to the two scales at first appear to be in conflict. It appears from the responses to these scales that the respondents believe that any one individual resident may sometimes cope and sometimes be depressed, or they see some residents who cope and some who are depressed. Perhaps both conditions exist.

The final category is the addition that the current research makes to the burnout model. It is nursing facility stigma, a unique working condition that applies only in this setting.

Category: Nursing Facility Stigma

Once again, to place the category of nursing facility in the context of the complete model, Table 4. 23 highlights the category.

Table 4.23
Independent Variables

Category	Domain	Independent Variable
Nursing Facility Stigma		Professional Respect Scale
		Misunderstood Scale

Appendix 2 gives a detailed description of the development of the nursing facility stigma related scales. Based on the analysis of the data from items included for the purposes of measuring nursing facility stigma, two scales represent this domain. The first scale, designated “professional respect,” consists

of four items. The second scale is designated "misunderstood." The two scales are reported in Tables 4.24 and 4.25.

Table 4.24
Professional Respect Scale

Item	Mean	Std Dev
In my community, being a nursing facility social worker is a prestigious occupation.	2.88	1.12
When I tell people I am a nursing facility social worker, most people have a pretty good idea of what I do.	1.97	1.02
Among social workers, working in a nursing facility is a prestigious career choice.	2.61	1.08
Working in the nursing facility brings me respect from other social workers who work in home health, the hospital, hospice, etc.	3.58	1.11
Professional Respect Scale	2.77	.80
Principal Component Analysis and Scale Reliability		
Number of Components		1
Percent of Variance for One Component		54.8
Alpha Score		.72

Table 4.25
Misunderstood Scale

Item	Mean	Std Dev
When I tell people I work in a nursing facility, they often tell me about a bad experience with a nursing home that they had or someone told them about.	3.66	1.24
Some people think that I work in a nursing facility because I cannot get a social work job anywhere else.	2.08	1.18
I have friends in social work who do not understand why I would work in a nursing facility.	2.99	1.39
People ask me, "How can a social worker help anybody in a nursing home, aren't they just there to die?"	2.49	1.38
Misunderstood Scale	2.81	.95
Principal Component Analysis and Scale Reliability		
Number of Components		1
Percent of Variance for One Component		53.6
Alpha Score		.71

Since the stigma scales are the original contribution in this research, there is some disappointment in not developing a strong, reliable, and valid scale to measure the effects of nursing facility stigma on the people who work in the industry. The next chapter has a more complete discussion of the implications of the responses to the two scales and how they might be improved for future use.

This section concludes the report of independent variables. Four categories, 11 domains, and 21 independent variables are included in the model. The next section describes the responses to the dependent variable, burnout.

DEPENDENT VARIABLE: MASLACH BURNOUT INVENTORY

The dependent variable in this study is burnout, as measured by the score on the Maslach Burnout Inventory (MBI). The MBI yields a score for each respondent in each of three subscales: emotional exhaustion, depersonalization, and personal accomplishment. The emotional exhaustion subscale assesses feelings of being emotionally overextended and exhausted by one's work. The depersonalization subscale measures an unfeeling and impersonal response toward the recipients of one's service, care, treatment, or instruction. The personal accomplishment subscale assesses feelings of competence and successful achievement in one's work with people (Maslach, Jackson, & Leiter, 1966).

These three subscales do not combine into a single score, so each subscale is considered separately in regression analysis. Each subscale score can be placed into one of three categories of the range of experienced burnout, low, average or high. Table 4.26 reports the percentage of respondents in each category of the three subscales.

Table 4.26
Percentage of Respondents in Each Range of Experienced Burnout

	Range of Experienced Burnout		
Subscale	Low	Average	High
Emotional Exhaustion	47.3%	31.2%	20.5%
Depersonalization	70.1%	18.7%	10.4%
Personal Accomplishment	73.0%	20.0%	5.5%

The respondents in this survey appear to experience the most burnout in the emotional exhaustion subscale, and the least in the personal accomplishment subscale. In two of the three subscales, over 70% of the respondents fall into the low category, indicating low levels of experienced burnout in the sample.

Although the MBI provides cutoff limits to group the scores into levels of perceived burnout (low, medium and high), the authors strongly recommend that the original numerical scores be used when statistical analyses are performed, citing the improved power of statistical analysis when the full range of scores is used. The dependent variable is the score of each of the three subscales on the MBI. The mean scores and standard deviations for each subscale are reported in Table 4.27, although the scales are not the same for the three subscales, and the mean scores are not comparable.

Table 4.27
Mean Score and Standard Deviations for Maslach Burnout Inventory Subscales

Subscale	Mean	Standard Deviation
Emotional Exhaustion	18.70	11.22
Depersonalization	4.42	4.36
Personal Accomplishment	39.89	6.56

This section has described the dependent variable, the score on each of the three subscales of the Maslach Burnout Inventory. The previous section described the 21 independent variables. Three regression analyses are required to test the relationship between each of the dependent variables and the set of 21 dependent variables. The next section describes the results of those tests.

REGRESSION ANALYSES OVERVIEW

Multiple regression analysis is used to determine the independent variables that show a relationship with each of the dependent variables. Table 4.28 illustrates the complete list of independent variables for each dependent variable.

Table 4.28
Independent and Dependent Variables

Emotional Exhaustion	Depersonalization	Personal Accomplishment
Age	Age	Age
Ethnicity	Ethnicity	Ethnicity
Gender	Gender	Gender
Time Licensed	Time Licensed	Time Licensed
License Type	License Type	License Type
Education	Education	Education
Organization Member	Organization Member	Organization Member
Time Employed	Time Employed	Time Employed
Internal Control Index	Internal Control Index	Internal Control Index
Expertise Scale	Expertise Scale	Expertise Scale
Spend Time	Spend Time	Spend Time
Understand Requirements	Understand Requirements	Understand Requirements
Structure Scale	Structure Scale	Structure Scale
Power/Authority Scale	Power/Authority Scale	Power/Authority Scale
Human Resources Scale	Human Resources Scale	Human Resources Scale
Material Resources Scale	Material Resources Scale	Material Resources Scale
Role Scale	Role Scale	Role Scale
Residents Depressed Scale	Residents Depressed Scale	Residents Depressed Scale
Residents Cope Scale	Residents Cope Scale	Residents Cope Scale
Professional Respect Scale	Professional Respect Scale	Professional Respect Scale
Misunderstood Scale	Misunderstood Scale	Misunderstood Scale

The following sections report a summary of the outcomes of the regression analysis for each of the three dependent variables.

Outcomes with Emotional Exhaustion Dependent Variable

Table 4.29 reports the variables that entered into the model for the regression equation with the dependent variable emotional exhaustion.

Table 4.29
Summary of Regression Analysis for Variables Predicting Emotional Exhaustion Scale Scores (N = 274)

Variable	B	SE B	b
Age	-4.813E-03	.002	-.180**
Ethnic: Hispanic	-.105	.052	-.105***
Ethnic: African-Am	-3.585E-02	.066	-.028
Ethnic: other	-6.280E-02	.078	-.041
Gender: Male	-9.696E-03	.043	-.012
Time Licensed	-3.840E-02	.003	-.069
License: LMSW	.129	.146	.150
License: LMSWACP	.118	.150	.105
License: SWA	.103	.111	.150
Education: LSW	8.107E-02	.112	.136
Education: BSW	-3.054E-02	.142	-.050
Education: Some grad	-4.254E-02	.141	-.048
Education: BA	-3.367E-02	.136	-.044
Education: MA	-1.818E-02	.143	-.016
Education: MSW	-5.641E-02	.164	-.077
Org Member	2.539E-02	.036	.037
Time Employed	4.011E-02	.019	.114***
ICI	-6.516E-03	.001	-.240*
Expertise Scale	-1.782E-02	.029	-.041
Spend Time	-2.923E-02	.014	-.129***
Understand Regs	1.008E-02	.022	.029
Structure Scale	-5.846E-02	.019	-.186***
Power/Authority	4.817E-02	.027	.111
Human Resources	-2.876E-02	.021	-.089
Material Resources	-3.580E-02	.028	-.083
Role Scale	-2.385E-02	.022	-.067
Res Depressed	2.759E-02	.015	.099
Res Cope	1.947E-02	.018	.057
Respect Scale	-1.156E-02	.022	-.030
Misunderstood	2.366E-02	.017	.076

Note: $R^2 = .365$; *p < .001, **p < .01, ***p < .05.

Emotional Exhaustion[1] burnout decreases as age, Internal Control Index, spend time item, and structure scale increase. Burnout increases with time employed. In the ethnicity categorical variable, Hispanics have lower emotional exhaustion scores than other ethnic groups.

Outcomes with Depersonalization Dependent Variable

Table 4.30 reports the variables that entered into the full sample model for the regression equation with the dependent variable depersonalization.

[1]The Internal Control Index variable is supported in the split sample validation analysis. The other variables are not supported in the validation analysis.

Table 4.30
Summary of Regression Analysis for Variables Predicting Depersonalization Scale Scores (N = 274)

Variable	B	SE B	b
Age	-9.968E-02	.026	-.252*
Ethnic: Hispanic	-.929	.882	-.062
Ethnic: African-Am	-1.868	1.022	-.101
Ethnic: other	-1.000	1.248	-.044
Gender: Male	.627	.668	.051
Time Licensed	1.282E-02	.052	.016
License: LMSW	1.652	2.160	.132
License: LMSWACP	.178	2.274	.011
License: SWA	2.038	1.556	.201
Education: LSW	1.628	1.567	.185
Education: BSW	1.884	2.273	.208
Education: Some grad	1.534	2.251	.119
Education: BA	2.466	2.179	.217
Education: MA	3.137	2.307	.189
Education: MSW	2.642	2.579	.243
Org Member	-7.632E-02	.566	-.008
Time Employed	.114	.069	.105
ICI	-6.391E-03	.023	-.161***
Expertise Scale	-.171	.451	-.026
Spend Time	3.321E-02	.213	.010
Understand Regs	-.360	.342	-.071
Structure Scale	-.276	.296	-.060
Power/Authority	.207	.428	.032
Human Resources	-.785	.327	-.163***
Material Resources	-.705	.444	-.102
Role Scale	-.142	.348	-.027
Res Depressed	-.217	.234	-.052
Res Cope	-.204	.279	-.040
Respect Scale	1.708E-02	.335	.003
Misunderstood	.731	.264	.157**

Note: $R^2 = .256$; *p < .001, **p < .01, ***< .05.

As age, Internal Control Index, and human resources scale scores increase, depersonalization burnout decreases[2]. Social workers who feel more misunderstood experience higher levels of depersonalization towards residents.

Outcomes with Personal Accomplishment Dependent Variable

Table 4.31 reports the variables the regression analysis with the dependent variable personal accomplishment.

[2] None of the independent variables are supported in the split sample validation analysis.

Table 4.31
Summary of Regression Analysis for Variables Predicting Personal Accomplishment Scale Scores (N = 278)

Variable	B	SE B	b
Age	2.627E-02	.037	.047
Ethnic: Hispanic	.439	1.163	.020
Ethnic: African-Am	-3.463	1.435	-.129***
Ethnic: other	-.409	1.732	-.013
Gender: Male	1.622	.956	.093
Time Licensed	8.127E-02	.075	.069
License: LMSW	-5.094	3.098	-.285
License: LMSWACP	-3.967	3.238	-.165
License: SWA	-.735	2.292	-.051
Education: LSW	-.768	2.284	-.061
Education: BSW	-4.033	3.162	-.311
Education: Some grad	-1.715	3.123	-.091
Education: BA	-3.083	3.029	-.190
Education: MA	-2.850	3.209	-.121
Education: MSW	1.404	3.581	.091
Org Member	.946	.786	.066
Time Employed	-265	.097	-.170**
ICI	.131	.032	.232*
Expertise Scale	.642	.632	.069
Spend Time	.131	.300	.027
Understand Regs	1.023	.476	.142***
Structure Scale	-3.430E-02	.413	-.005
Power/Authority	.640	.598	.069
Human Resources	.155	.458	.023
Material Resources	-.244	.617	-.025
Role Scale	-9612E-02	.496	-.013
Res Depressed	-3.295E-02	.326	-.066
Res Cope	.898	.388	.125***
Respect Scale	1.566	.470	.193**
Misunderstood	.786	.368	.118***

Note: $R^2 = .301$; *p < .001, **p < .01, ***<.05.

Social workers with higher scores on the Internal Control Index[3], understand state requirements item, residents cope scale, and respect scale show lower levels of burnout on the personal accomplishment subscale. As time employed increases, personal accomplishment burnout increases. Social workers who feel misunderstood experience higher levels of burnout on the personal accomplishment subscale. African Americans have higher levels of personal accomplishment burnout than the other ethnic groups.

Summary of Independent Variables with Each of the Three Dependent Variables

Reviewing the independent variables in the context of their relationship to all three dependent variables, only the Internal Control Index is related to all three dependents. Age, ethnicity, and time employed are related to two out of three. The factors that clearly show no importance to burnout in this study are gender, time licensed, license type, organization member, expertise scale, power/authority scale, material resources scale, role scale and residents depressed scale. Table 4.32 summarizes the variables demonstrating a relationship with any of the three dependent variables.

[3] The Internal Control Index variable is supported in the validation analysis. The other variables are not supported in the validation analysis.

Table 4.32
Summary of Outcomes of Three Regression Analyses

Emotional Exhaustion	Depersonalization	Personal Accomplishment
Age	**Age**	Age
Ethnicity	Ethnicity	**Ethnicity**
Gender	Gender	Gender
Time Licensed	Time Licensed	Time Licensed
License Type	License Type	License Type
Education	Education	Education
Organization Member	Organization Member	Organization Member
Time Employed	Time Employed	**Time Employed**
Internal Control Index	**Internal Control Index**	**Internal Control Index**
Expertise Scale	Expertise Scale	Expertise Scale
Spend time	Spend time	Spend time
Understand Requirements	Understand Requirements	**Understand Requirements**
Structure Scale	Structure Scale	Structure Scale
Power/Auth Scale	Power/Auth Scale	Power/Auth Scale
Human Resources Scale	**Human Resources Scale**	Human Resources Scale
Material Resources Scale	Material Resources Scale	Material Resources Scale
Role Scale	Role Scale	Role Scale
Residents Depressed Scale	Residents Depressed Scale	Residents Depressed Scale
Residents Cope Scale	Residents Cope Scale	**Residents Cope Scale**
Professional Respect Scale	Professional Respect Scale	**Professional Respect Scale**
Misunderstood	**Misunderstood**	**Misunderstood**

CHAPTER CONCLUSION

This chapter has reported the size and representativeness of the sample, the description of 21 independent variables and three dependent variables, and the outcomes of three regression analyses to test the relationships among variables. Sufficient evidence is present to support a conclusion that the sample is adequate to represent the population and generalizations from the findings are appropriate. Eleven of the 21 independent variables showed a relationship to at least one of the three dependent variables.

Chapter 5 will continue the discussion of the factors that influence nursing facility burnout with a composite portrait of the Texas nursing facility social worker, consideration of the research questions in light of the evidence from the regression analysis, and recommendations for practice, policy, education and research.

Chapter 5: Discussion

Introduction and Organization of the Chapter

The purpose of this chapter is to give context to the findings of this research by summarizing the contribution of new information to the knowledge about this field of social work practice and offering recommendations for policy, practice, education and research. The chapter opens with a composite portrait of the Texas nursing facility social worker and continues with a discussion of the findings, analyzing the factors associated with burnout in two ways. The first analysis looks at the factors that related to each subscale of burnout. The second analysis examines the categories of the modified Courage and Williams model. The research questions raised in the chapter are answered by examining whether each model category contains factors that show a relationship to burnout.

The final section of the chapter offers recommendations for policy, practice, education and research, organized by categories of the independent variable. This chapter opens with a composite portrait of the Texas nursing facility social worker and her (or rarely, his) facility, residents, and perceptions of nursing facility stigma.

Portrait of the Texas Nursing Facility Social Worker

The aging of the population has turned the attention of policy makers, educators, and practitioners in all professions to the need for developing a strong cadre of professionals from all fields who are prepared to work with the elderly. One of the most difficult barriers to recruiting and training an adequate number of

social workers to work with older adults is the perception that social work in the field of aging consists primarily of working in institutional settings with demented or bedridden clients who cannot be helped. Potential practitioners have little understanding of the tremendous diversity of the aging population, even among those who are institutionalized, demented or bedridden, the complexity of providing effective service, the high levels of knowledge and skill required, or the range of services provided (Scharlach, et. al., 2000).

The purpose of presenting this portrait of Texas nursing facility social workers is to provide a glimpse into the people who do the work, the environment in which they work, and their perceptions of their clients, the residents.

The Social Worker

This examination of burnout levels is the first study of burnout using Texas nursing facility social workers as the study population. In 1993, Poulin and Walter conducted a national study of burnout among social workers who work with elderly people in a variety of settings. That study also used the Maslach Burnout Inventory as the measure of burnout. In the current study, dimension of burnout that affected the largest number of social workers was emotional exhaustion, with 20.5% of the respondents scoring in the high range. In the next category, 10.4% of respondents scored in the high range for depersonalization. In the final category, personal accomplishment, 5.5% of respondents scored in the high range. Table 5.1 compares the results from this population with the Poulin and Walters findings.

Table 5.1
Percentage of Respondents in Each Range of Experienced Burnout

Subscale	Range of Experienced Burnout					
	Low		Average		High	
	Poulin and Walter	Current Study	Poulin and Walter	Current Study	Poulin and Walter	Current Study
Emotional Exhaustion	39.6%	47.3%	34.1%	31.2%	26.3%	20.5%
Depersonalization	71.2%	70.1%	21.6%	18.7%	7.1%	10.4%
Personal Accomplishment	68.1%	73.0%	24.2%	20.0%	7.7%	5.5%

The results from this study are similar to Poulin and Walter's 1993 findings. Gleason-Wynn (1994) did not study burnout, but her study found that over 90% of her respondents, also Texas nursing facility social workers, were satisfied with their jobs. Of the respondents, 54.5% report that they are not at all likely to make a genuine effort to find a new job within the year.

The respondents are well educated and have appropriate credentials for many types of social work positions. The incumbents in nursing facility social work positions would appear to have many options for employment in the field of social work if they choose to seek other venues of practice. Of the respondents, 51.4% of are Licensed Social Workers, and almost 20% are Licensed Master Social Workers. The remaining 25% are Social Work Associates. Of the Social Work Associates, only 4% do not have a college degree, and 17% have a master's degree. The mean age, 41.1 years, points toward a mature cohort. As a group, Texas nursing facility social workers are professionally well educated and have

ample experience to learn the requirements of their jobs. This combination of education and experience is reflected in the response to the expertise scale that asks a series of questions about how well prepared the respondent feels to work with nursing facility residents, families, and administrative requirements. The mean score on the expertise scale is 4.49 out of a possible five.

The mean score on the Duttweiler Internal Control Index, 111.44, is difficult to interpret, since the author of the index does not provide a categorization of scores in high or low groups. For comparison purposes, Duttweiler (1984) reported mean scores in her developmental sample. She reported a mean of 114.5 for individuals age 41 to 50, a mean score of 107.7 for college graduates, and a mean score of 112.1 for professionals. Using these numbers as a comparison, the nursing facility social workers sample appears to be very close to the sample used by Duttweiler to develop the scale in terms of age, education, and professional status characteristics.

The average length of time in nursing facility social work is 4.95 years, and the reported length of time in the current facility and the immediate previous facility is 2.5 years each. These two numbers confirm each other, but the average number of facilities in which the social worker has been employed, 3.65, does not fit the pattern. However, the 3.65 facilities in the career figure may be accounted for those who work for, or consult with, more than one facility at the same time. Given the evidence that burnout increases and job satisfaction decreases with time on the job, the length of tenure in the same position may be a positive sign that social workers are attuned to their own needs and making changes when the

job is no longer providing the environment or challenges they need for job satisfaction.

Most of the social workers' time is spent in resident care, with 65% of respondents reporting spending 16 hours a week or more in resident care. Administrative tasks take up the most time after resident care, with very little time spent in case aide work, managing or supervising, or counseling with other employees.

The overall portrait that emerges of the Texas nursing facility social worker is a mature, experienced, well-educated professional who feels well prepared for the job. More of the social worker's time is spent working with the residents than any other activity, and burnout levels are about the same as those of other social workers working with aging populations. The next section describes the social worker's working environment, the nursing facility.

The Facility

The pattern of responses to questions related to the working conditions for the social worker point toward an environment that supports an opportunity for a professionally satisfying work experience. Although it was referenced in the earlier section, reviewing how much time the social worker spends in various tasks helps to define the social worker's job. How the social worker spends time is summarized in Table 5.2.

Table 5.2
How many hours a week do you spend on:

Activity	Hours Worked Per Week by Percent				
	<5	6 to 15	16 to 30	>31	Total*
Resident care	4.9%	29.9%	45.7%	19.0%	99.5%
Administrative tasks	11.7%	57.9%	26.8%	3.4%	99.8%
Case aide tasks	78.7%	18.7%	1.3%	.3%	99.0%
Managing or supervising	91.7%	4.4%	1.0%	1.3%	98.4%
Counseling other employees	90.6%	8.3%	0%	0%	98.9%

The response to the question about how social workers spend time shows that almost 65% of the respondents spend 16 or more hours a week in resident care. Administrative tasks account for most of the time not spent in resident care, which is understandable in light of the regulatory requirements for documentation of resident care. Very little time is spent in activities unrelated to resident care such as case aide work, managing or supervising, or counseling other employees. The mean response to the question "I can spend as much time as I need to with residents and their family" was 3.84 on a 5 point scale, with 5 being "Strongly agree."

The structure scale combined a question about reasonable pay with a question about flexibility and creativity on the job. Table 5.3 displays the questions in the structure scale.

Table 5.3
Structure

Item	Mean
My pay is reasonable for my job.	3.43
My nursing facility management encourages flexibility and creativity in meeting the residents' needs.	4.06
Scale	3.75

The power/authority scale addresses the question of the degree to which the social worker influences decisions about resident care. The response to this scale was 4.47, indicating a high level of participation in decisions regarding the residents' care. Table 5.4 repeats the items and responses to the power/authority scale.

Table 5.4
Power/Authority Scale

Item	Mean
Other professionals respect my assessments and opinions in the facility.	4.22
I am actively involved in developing the residents' care plans.	4.44
I participate on the care plan team.	4.73
Scale	4.47

These responses clearly indicate that the social worker exercises power and authority in decisions regarding the residents' plans of care. However, resident care takes place in the context of available resources. Two scales asked about the facility's availability of adequate human and material resources to

provide for the residents' needs. The responses to the human resources scale (3.89) and material resources scale (4.60) indicate that resources are adequate.

The role scale measured the extent to which the respondent feels that the other professionals in the facility understand the social workers' role and functions. Table 5.5 reviews the items in the role scale. The response to this scale, 4.11 on a 5-point scale, points towards an environment of professional respect within the facility and understanding of the social worker's role by peers.

Table 5.5
Role Scale

Item	Mean
In my nursing facility, the functions and the responsibilities of the social worker are clearly understood by the administrator.	4.09
In my nursing facility, the functions and the responsibilities of the social worker are clearly understood by the director of nursing.	4.03
In my nursing facility, the functions and the responsibilities of the social worker are clearly understood by the activity director.	4.18
In my nursing facility, the functions and the responsibilities of the social worker are clearly understood by other professionals such as therapists.	4.15
Scale	4.11

In summary, the picture of the nursing facility that emerges from this study is a supportive work environment that provides support, resources, time and professional latitude for the performance of the social worker's job.

The Residents

Two scales asked about the nursing facility residents as clients, one asking how well social workers perceive the residents cope, and one asking about the residents' level of depression. Tables 5.6 and 5.7 review the items in the two scales.

Table 5.6
Residents Depressed Scale

Item	Mean
Many of the residents in my facility are depressed.	3.60
Many of the residents in my facility are anxious, angry or experiencing despair.	3.03
Residents Depressed Scale	3.32

Table 5.7
Residents Cope Scale

Item	Mean
I admire how well many of residents cope with the losses brought about by age or illness.	4.17
Many of the residents in my facility have excellent coping and adapting skills.	3.50
Residents Cope Scale	3.84

Although these responses could be contradictory, they may be indicating that social workers perceive that both conditions are present: that is, there is mild agreement that many residents are depressed, and there is slightly stronger agreement that many residents are coping with their condition in life. Social

workers may perceive that depression and coping skills are compatible with one another for individual nursing facility residents, or they may perceive that coping and depression are about equally present among the residents as a group. In either case, nursing facility social workers have the opportunity to work with residents who are experiencing a variety of responses and reactions to the environment, and the social worker is challenged to develop an appropriate approach for each resident's individual need. Working with nursing facility residents offers the social worker many professional challenges and requires a wide repertoire of skills.

Perceptions of Nursing Facility Stigma

The responses to the two scales representing nursing facility stigma were mixed. The scales are reviewed in Tables 5.8 and 5.9.

Table 5.8
Professional Respect Scale

Item	Mean
In my community, being a nursing facility social worker is a prestigious occupation.	2.88
When I tell people I am a nursing facility social worker, most people have a pretty good idea of what I do.	1.97
Among social workers, working in a nursing facility is a prestigious career choice.	2.61
Working in the nursing facility brings me respect from other social workers who work in home health, the hospital, hospice, etc.	3.58
Professional Respect Scale	2.77

Table 5.9
Misunderstood Scale

Item	Mean
When I tell people I work in a nursing facility, they often tell me about a bad experience with a nursing home that they had or someone told them about.	3.66
Some people think that I work in a nursing facility because I cannot get a social work job anywhere else.	2.08
I have friends in social work who do not understand why I would work in a nursing facility.	2.99
People ask me, "How can a social worker help anybody in a nursing home, aren't they just there to die?"	2.49
Misunderstood Scale	2.81

The respondents in this study do not experience a high degree of professional respect from the community, but they do not feel misunderstood. An important clue to this finding may have been provided by the focus group conducted during the development of the scale. Focus group discussion indicated that social workers experience respect and admiration from friends and family because of their willingness to work in an environment and with a population that is widely believed to be difficult.

The response to the professional respect scale is much lower than the responses to the role scale or the power/authority scale. It appears that social workers experience more professional respect inside the facility than they do from the larger community.

The question that is included in the survey as a confirmatory item for scale development, "I believe there is a stigma associated with nursing homes in American culture," received a score of 4.46. It appears that nursing facility social workers can clearly distinguish the general cultural stigma from their personal experience.

In summary, the Texas nursing facility social worker appears to be a competent professional working in a supportive, but not perfect, environment. He or she is aware of the stigma of working in a nursing facility, but is not strongly affected by it personally. The next session of this chapter begins the discussion of the factors that are important to burnout by examining the independent variables that show a relationship with each of the three subscales of the Maslach Burnout Inventory.

INDEPENDENT VARIABLES RELATED TO EACH MBI SUBSCALE

Since the Maslach Burnout Inventory makes clear distinctions among the three subscales of burnout, it is important to examine which factors contribute to burnout for each subscale.

Emotional Exhaustion

A review of the definition of the emotional exhaustion dimension of burnout is helpful in appreciating the implications of the variables that show a relation to it. The emotional exhaustion subscale assesses feelings of being emotionally overextended and exhausted by one's work. The questions that make up the emotional exhaustion subscale are listed in Table 5.10

Table 5.10
Items in the Emotional Exhaustion Subscale

I feel emotionally drained from my work.
I feel used up at the end of the workday.
I feel fatigued when I get up in the morning and have to face another day on the job.
Working with people all day is really a strain for me.
I feel burned out from my work.
I feel frustrated by my job.
I feel I'm working too hard on my job.
Working with people directly puts too much stress on me.
I feel like I'm at the end of my rope.

The respondents were more affected by emotional exhaustion burnout than either of the other two dimensions, with 20.5% scoring in the high range, 32.1scoring in the average range, and 47.3% scoring in the low range. Poulin and Walter's (1993) national survey of social workers working with elderly people found similar results with 26.3% in the high range, 34.1% in the average range, and 39.6 in the low range. Emotional exhaustion has been shown to be related to feelings of emotional distance from friends and family, increased anger, unpleasant contacts with supervisors and peers, insomnia, increased use of alcohol and drugs, and wanting to be alone rather than spending time with family (Maslach, Jackson & Leiter, 1996).

Table 5.11 reviews the characteristics of nursing facility social workers that show a relationship to emotional exhaustion.

Table 5.11
Summary of Outcomes Emotional Exhaustion Regression Analyses

Emotional Exhaustion	**Depersonalization**	Personal Accomplishment
Age	**Age**	Age
Ethnicity	Ethnicity	**Ethnicity**
Gender	Gender	Gender
Time Licensed	Time Licensed	Time Licensed
License Type	License Type	License Type
Education	Education	Education
Organization Member	Organization Member	Organization Member
Time Employed	Time Employed	**Time Employed**
Internal Control Index	**Internal Control Index**	**Internal Control Index**
Expertise Scale	Expertise Scale	Expertise Scale
Spend time	Spend time	Spend time
Understand Requirements	Understand Requirements	**Understand Requirements**
Structure Scale	Structure Scale	Structure Scale
Power/Auth Scale	Power/Auth Scale	Power/Auth Scale
Human Resources Scale	**Human Resources Scale**	Human Resources Scale
Material Resources Scale	Material Resources Scale	Material Resources Scale
Role Scale	Role Scale	Role Scale
Residents Depressed Scale	Residents Depressed Scale	Residents Depressed Scale
Residents Cope Scale	Residents Cope Scale	**Residents Cope Scale**
Professional Respect Scale	Professional Respect Scale	**Professional Respect Scale**
Misunderstood	**Misunderstood**	**Misunderstood**

In this study, factors contributing to emotional exhaustion are age, ethnicity, time employed, Internal Control Index, spend time, and structure scale.

As the age of the social worker increases, the level of burnout decreases. Poulin and Walter (1993) report age specifically related to emotional exhaustion. Barber and Iwai (1996) and Oktay (1992) also report age as a factor in burnout, but they do not report which dimension of burnout. Poulin and Walter suggest that age may be measuring self-selection rather than maturity, and older workers always may have been less susceptible to burnout and therefore survived the test of time. Oktay suggests that older people may invest less of themselves or have more realistic expectations for the job. Another possible explanation is that older workers have developed better coping skills or learned to conserve their emotional resources. However, emotional exhaustion increases with time employed, so coping skills or other behaviors learned from experience on the job would not appear to account for the relationship of age and burnout.

Another possible explanation for the relationship of age to emotional exhaustion is cohort effect, but a longitudinal panel study would be required to determine if resistance to burnout is a cohort characteristic rather than a quality that develops with increasing age.

Hispanic social workers have lower levels of emotional exhaustion than other groups. Additional research would be required to offer any suggestions about why Hispanic social workers would be less prone to emotional exhaustion.

The emotional exhaustion score decreases as the Internal Control Index score increases. The Internal Control Index is designed to measure where a person looks for, or expects to obtain, reinforcement. An individual with an internal locus of control believes that reinforcement is based on his or her own

behavior. Locus of control has two factors, self-confidence and autonomous behavior, that is, behavior that is independent of social pressure (Corcoran & Fischer, 1994). A social worker looking for external reinforcement from co-workers, clients, or other external resources is more open to emotional exhaustion than one who receives reinforcement from internal or self-validation. The relationship between the Internal Control Index score and emotional exhaustion is compatible with Gleason-Wynn's 1994 finding that self-esteem correlates with job satisfaction for nursing facility social workers.

Social workers who can spend adequate time with their residents have lower levels of emotional exhaustion. The low levels of emotional exhaustion burnout in this study may be related to the fact that almost 65% of the respondents reported spending 16 or more hours a week in resident care. Poulin and Walter reported finding that percentage of time spent with clients related to emotional exhaustion. One possible explanation for this relationship is that social workers who can spend adequate time with their residents find the relationship emotionally satisfying, thus avoiding emotional burnout.

Structure scale showed an inverse relation with emotional exhaustion. Table 5.12 reviews the structure scale.

Table 5.12
Structure

Item	Mean
My pay is reasonable for my job.	3.43
My nursing facility management encourages flexibility and creativity in meeting the residents' needs.	4.06
Scale	3.75

Gleason-Wynn found compensation satisfaction related to job satisfaction. Pay may be related to burnout in an indirect fashion if inadequate compensation results in stress in other areas of life, resulting in an overall higher level of emotional exhaustion. That explanation is only speculative, since this study did not ask about total family income, which would be the determinant of stress resulting from living on an inadequate budget.

Flexibility, creativity, job autonomy and participation in client-related decision-making have been found to be important in other studies. In this study, the flexibility and creativity, as part of the structure scale, are shown to be important. The opportunity to be flexible and creative on the job assumes that variety, autonomy, and self-direction are available to the social worker. Freedom to use professional creativity may offer variety and self-expression that protect the social worker from emotional exhaustion.

In summary, the four of the six factors, age, ethnicity, time employed, and Internal Control Index that affect emotional exhaustion are related to the social worker as an individual. Only two, spend time and structure scale, are related to the conditions of employment. This division will be discussed further in the

section of this chapter that discusses the factors in relation to the modified Courage and Williams model.

Depersonalization

The depersonalization dimension of burnout affects the relationship between the social worker and the client by changing the way the social worker interprets the client's actions and motivations. Social workers in this dimension of burnout objectify clients and treat them as cases rather than people. In extreme cases, the social worker emotionally becomes the victim and the client is the perpetrator whose actions are seen as deliberately defiant or resistant. The five items in the depersonalization subscale describe an unfeeling and impersonal response to clients (Maslach, Jackson, & Leiter, 1996). Table 5.13 reviews these five items.

Table 5.13
Items in the Depersonalization Subscale

I feel I treat some recipients as if they were impersonal objects.
I've become more callous toward people since I took this job.
I worry that this job is hardening me emotionally.
I don't really care what happens to some recipients.
I feel recipients blame me for some of their problems.

In this study, 10.4% of social workers report high levels of depersonalization, 18.7% report average, and 70.0 report low. Although these numbers are generally more positive than the emotional exhaustion subscale,

there is still cause for concern that over 10% of the social workers are experiencing high levels of depersonalization toward their residents. One of the great fears about nursing facilities is that the residents lose their identity and are treated as objects instead of people. In medicine and nursing this kind of depersonalization often takes the form of thinking in terms of the disease or injury rather than of the person. Is the nurse taking care of the broken hip or the person whose hip is broken? Depersonalization has consequences for the resident. It engenders anger, frustration, and dissatisfaction with the service provided by the facility.

Table 5.14 reviews the factors that have a relationship to depersonalization.

Table 5.14
Summary of Outcomes of Depersonalization Analysis

Emotional Exhaustion	Depersonalization	Personal Accomplishment
Age	**Age**	Age
Ethnicity	Ethnicity	**Ethnicity**
Gender	Gender	Gender
Time Licensed	Time Licensed	Time Licensed
License Type	License Type	License Type
Education	Education	Education
Organization Member	Organization Member	Organization Member
Time Employed	Time Employed	**Time Employed**
Internal Control Index	**Internal Control Index**	**Internal Control Index**
Expertise Scale	Expertise Scale	Expertise Scale
Spend time	Spend time	Spend time
Understand Requirements	Understand Requirements	**Understand Requirements**
Structure Scale	Structure Scale	Structure Scale
Power/Auth Scale	Power/Auth Scale	Power/Auth Scale
Human Resources Scale	**Human Resources Scale**	Human Resources Scale
Material Resources Scale	Material Resources Scale	Material Resources Scale
Role Scale	Role Scale	Role Scale
Residents Depressed Scale	Residents Depressed Scale	Residents Depressed Scale
Residents Cope Scale	Residents Cope Scale	**Residents Cope Scale**
Professional Respect Scale	Professional Respect Scale	**Professional Respect Scale**
Misunderstood	**Misunderstood**	**Misunderstood**

Again, as with emotional exhaustion subscale, age and a higher score on the Internal Control Index are related to lower levels of depersonalization. Some of the speculation about why age is related to burnout was discussed in relation to age and emotional exhaustion. An additional factor may be present with

depersonalization. Older social workers are closer in age to their residents. Perhaps older social workers are able to identify more closely with their residents and be less distracted by the signs of aging.

Social workers with a higher Internal Control Index score may be more likely to make their own individual assessments of their residents and rely less on stereotypes based on age or condition.

As the social worker's perception that the facility has adequate human resources increases, the level of experienced burnout on the depersonalization subscale increases. Since the human resources scale combined questions about different types of staffing in the facility, it is useful to examine how responses to the individual items relate to levels of burnout. Table 5.15 shows the mean score for each item in the human resources scale by burnout level.

Table 5.15
Mean Scores on Human Resources Scale Items
by Level of Depersonalization Burnout.

	Level of Depersonalization Burnout		
Item	Low	Medium	High
Social work staff	3.39	3.49	3.22
Nursing staff	3.79	3.33	3.13
Support staff	4.29	4.08	3.91

With the exception of the social work staff item, the score on the item consistently goes down as the level of depersonalization increases. The social work item has the smallest range of scores of any of the three items. The level of

depersonalization experienced by the social worker may be more influenced by the adequacy of the nursing and support staff than by the social work staff. Since nurse aides (considered part of the nursing staff) are the largest single group of employees in the facility, it is possible the major influence on social worker burnout may be the number of nurse aides in the facility.

Depersonalization is logically connected to adequacy of staff. Low staffing levels results in lack of smooth routines in the facility, lack of time for individual attention of residents, and a sense of being rushed and frenetic in daily activities. Nurse aides are responsible for the basic activities of daily living including bathing, dressing, eating, and personal care such as toileting. (Stone & Wiener, 2001). Residents who are not adequately cared for in these areas may be angry, hungry, dirty, foul smelling, and completely uninterested in social interaction. Short-staffed facilities may be an environment conducive to the development of depersonalization.

Poulin and Walter (1993) found organizational resources inversely related to the depersonalization subscale.

The relationship between depersonalization and the misunderstood scale is the first appearance of the possible effect of nursing facility stigma on the social worker. As a reminder of the items that make up this scale, Table 5.16 reviews the items and their means.

Table 5.16
Misunderstood Scale

Item	Mean
When I tell people I work in a nursing facility, they often tell me about a bad experience with a nursing home that they had or someone told them about.	3.66
Some people think that I work in a nursing facility because I cannot get a social work job anywhere else.	2.08
I have friends in social work who do not understand why I would work in a nursing facility.	2.99
People ask me, "How can a social worker help anybody in a nursing home, aren't they just there to die?"	2.49
Misunderstood Scale	2.81

The more the social worker feels misunderstood, the greater the feeling of depersonalization toward clients. Any explanation of why being misunderstood relates to depersonalization is speculation, but perhaps lack of positive reinforcement for their work causes social workers to question the value of their work, and, by extension, the value of the clients. Perhaps social workers who feel misunderstood by others are more likely to also feel misunderstood by their clients, resulting in depersonalization.

Of the four items that show an effect on depersonalization, two, age and Internal Control Index, are characteristics of the social worker. One factor, human resources scale, is a characteristic of the facility. The last factor, misunderstood scale, represents nursing facility stigma. The next section examines the factors that affect the final dimension of burnout, personal accomplishment.

Personal Accomplishment

The personal accomplishment subscale contains eight items that describe feelings of competence and successful achievement in one's work with people (Maslach, Jackson, & Leiter, 1996). The eight items that comprise the subscale are reported in Table 5.17

Table 5.17
Items in the Personal Accomplishment Subscale

I can easily understand how my recipients feel about things.
I deal very effectively with the problems of my recipients.
I feel I'm positively influencing other people's lives through my work.
I can easily create a relaxed atmosphere with my recipients.
I feel exhilarated after working closely with my recipients.
I have accomplished many worthwhile things in this job.
In my work, I deal with emotional problems very calmly.

The personal accomplishment subscale shows the lowest levels of burnout of the three scales with 5.5% in the high range, 20.0% in the average range, and 73.0% in the low range.

Table 5.18 reviews the independent variables that show a relationship with personal accomplishment.

Table 5.18
Summary of Outcomes of the Personal Accomplishment Regression Analysis

Emotional Exhaustion	Depersonalization	Personal Accomplishment
Age	**Age**	Age
Ethnicity	Ethnicity	**Ethnicity**
Gender	Gender	Gender
Time Licensed	Time Licensed	Time Licensed
License Type	License Type	License Type
Education	Education	Education
Organization Member	Organization Member	Organization Member
Time Employed	Time Employed	**Time Employed**
Internal Control Index	**Internal Control Index**	**Internal Control Index**
Expertise Scale	Expertise Scale	Expertise Scale
Spend time	Spend time	Spend time
Understand Requirements	Understand Requirements	**Understand Requirements**
Structure Scale	Structure Scale	Structure Scale
Power/Auth Scale	Power/Auth Scale	Power/Auth Scale
Human Resources Scale	**Human Resources Scale**	Human Resources Scale
Material Resources Scale	Material Resources Scale	Material Resources Scale
Role Scale	Role Scale	Role Scale
Residents Depressed Scale	Residents Depressed Scale	Residents Depressed Scale
Residents Cope Scale	Residents Cope Scale	**Residents Cope Scale**
Professional Respect Scale	Professional Respect Scale	**Professional Respect Scale**
Misunderstood	**Misunderstood**	**Misunderstood**

African American social workers are less likely to experience higher levels of burnout on the personal accomplishment subscale than other ethnic groups. Additional research would be required to develop any insight about why African-Americans would experience a different level of personal accomplishment in nursing facility social work. However, it is interesting that in both instances in which ethnicity shows a relationship with any dimension of burnout, it is a minority ethnic group that shows lower level of burnout than the majority group.

As with emotional exhaustion, personal accomplishment burnout increases with the length of time employed. Once again, as the Internal Control Index score increases, personal accomplishment burnout decreases. Poulin and Walter (1993) found self-esteem related to personal accomplishment.

As understand state requirements increases, personal accomplishment burnout decreases. Understanding the state requirements is critical for successful job performance, so social workers who score high on this item could be expected to feel higher levels of personal accomplishment in relation to their work.

The residents cope scale is the only resident-related independent variable to have any relationship with any of the three dependent variables. Table 5.19 reviews the questions in the residents cope scale.

Table 5.19
Residents Cope Scale

Item	Mean
I admire how well many of residents cope with the losses brought about by age or illness.	4.17
Many of the residents in my facility have excellent coping and adapting skills.	3.50
Residents Cope Scale	3.84

Social workers who agree with the statements in the scale may experience lower levels of personal accomplishment burnout because they are able to see the positive effects of their work in the attitudes of their residents. Poulin and Walter (1993) found client functioning related to personal accomplishment.

Both the misunderstood scale and the respect scale show a relationship personal exhaustion scale. As the perception of professional respect increases, the level of burnout on the personal accomplishment scale decreases. This relationship is logical, since the professional respect scale represents the feedback the social worker receives from peers and associates, and increased levels of positive feedback could lead to increased feelings of accomplishment.

The relationship with the misunderstood scale is harder to interpret. As the misunderstood scale increases, the level of burnout on the personal exhaustion subscale decreases. It is not clear how feeling misunderstood is related to increased feelings of personal accomplishment, unless working in a misunderstood field is viewed as a character strength in itself and therefore a source of personal accomplishment. Because of the lack of a strong theory or

logical explanation to support this variable, it could be expected to fail to be supported in additional research.

This section has examined the factors as they relate to each of the three dependent variables. One factor, the Internal Control Index, is important to all three dimensions. Age, ethnicity, time employed, and misunderstood scale are important to two out of three dimensions. The remaining six important factors (spend time, structure scale, human resources scale, understand requirements, residents cope scale, and professional respect scale) are each important to only one dimension. The next section looks at the modified Courage and Williams model and examines which categories of the model proved to be important in any dimension of burnout.

INDEPENDENT VARIABLES IN THE MODIFIED COURAGE AND WILLIAMS MODEL

Table 5.20 reviews the variables in the model that are, or are not, associated with burnout. The bolded variables have a relationship to one, two or three dimensions of the Maslach Burnout Inventory. This discussion examines how the variables are grouped into the categories of the modified Courage and Williams model, regardless of the dimension of burnout.

Table 5.20
Independent Variables

Category	Domain	Independent Variable
Care Provider (Social Worker) Characteristics		
	Demographic	**Age**
		Ethnicity
		Gender
	Professional Status	Time Licensed
		License Type
		Education
		Organization Member
		Time Employed
	Personality	**Internal Control Index**
	Expertise	Expertise Scale
Human Service Organization (Facility) Characteristics		
	Task	**Spend time (item)**
	Function	**Understand requirements (item)**
	Structure	**Structure Scale**
	Power/Authority	Power/Authority Scale
	Resources	**Human Resources Scale**
		Material Resources Scale
	Role	Role Scale
Care Recipient (Resident) Characteristics		
	Chronicity, acuity, and complexity	Residents Depressed Scale
		Residents Cope Scale
Nursing Facility Stigma		**Professional Respect Scale**
		Misunderstood Scale

At least one variable from each category of the model is shown to be important in burnout. The research questions ask whether the variables in each category are related to burnout, and the information in Table 5.20 provides the answers.

Care Provider (Social Worker) Category

Research question: *Are some nursing facility social workers more vulnerable than others based on demographic or personality characteristics?*

Texas nursing facility social workers experience burnout to varying degrees, according to the type of burnout: emotional exhaustion, depersonalization, or personal accomplishment. Social workers experience higher levels of emotional exhaustion than they do depersonalization or personal accomplishment. Hispanic social workers are less vulnerable to burnout than other groups, and African American social workers are more vulnerable to burnout than other ethnic groups. Older social workers are less vulnerable than younger ones. Gender does not appear to make a difference.

In the professional status domain, only time employed is important, with burnout increasing as length of time employed in the field increases. The length of time the social worker has been licensed, the license type, social worker's education, and organizational membership status are not important in burnout. The social worker's perception of how well prepared he or she is for the job is not an important factor in burnout.

Human Service Organization (Facility) Characteristics

Research question: *Is burnout related to characteristics of the nursing facility as an employer?*

Four of the seven variables in the human service category are important in burnout. The adequacy of time to spend with residents is important, as is the social worker's understanding of the state requirements. The job structure, represented by adequacy of pay and freedom on the job, is important. The adequacy of staffing in the facility is important.

In the characteristics of the facility category, three items showed no relationship with any burnout subscale. These three items are power/authority scale, material resources scale, and role scale. Of these items, the most surprising are power/authority scale and role scale. Other researchers have found that role conflict contributes to burnout and professional respect from other disciplines decreases it (Um & Harrison, 1998; Barber & Iwai, 1996; Marriott, Sexton, & Staley, 1994). The response to the power/authority scale in this study is very positive, indicating that respondents are very actively involved in decision making related to residents. The response to role scale indicates that the role of the social worker is understood by the other professionals in the facility. Lack of variance may have been an issue in the failure of these items to show a relationship with burnout. Material resources scale also has very strong positive scores and lack of variance may have been an issue.

Care Recipient (Resident) Category

Research question: *Is burnout related to the characteristics of nursing facility residents?*

One of the two factors in this category is important in burnout. The social worker's perception of how well the residents cope with their situations is associated with the level of burnout in the social worker.

Nursing Facility Stigma Category

Research question: *Is burnout related to the social worker's perception of nursing home stigma?*

Both of the scales related to nursing facility stigma are important in burnout. The professional respect scale shows a logical relationship to burnout, but the relationship of burnout and the misunderstood scale is difficult to interpret.

In summary, the data collected for this study provided sufficient evidence to answer the research questions, and the answers are confirmed by other, similar studies. There are some cautions about interpretation of the data that are discussed in the next section, strength and weaknesses of the study.

STRENGTHS AND WEAKNESSES OF THE STUDY

A strength of this study is the attempt to survey the entire population of nursing facility social workers in Texas. A corresponding weakness was the level of total response (385 out of 1100), and the reduction of that number to 305 usable cases due to data loss. Although the number of social workers practicing in nursing facilities is not a large portion of the total population of social workers, it

is an important area of practice that deserves study and attention. A larger response would have provided a higher confidence level in the results. Using a mailed, paper instrument, especially since the instrument could only be mailed to the nursing facility and not to the individual, is not ideal. An on-line instrument possibly could have increased the response rate.

A second strength of this study is that the results confirm findings from similar studies. Since social workers working with the elderly do not receive a lot of attention from the research community, it is a positive that there is a trend of similar responses in the studies that are available.

An initial goal of this research was to develop a scale to measure the effects of nursing facility stigma on social workers who work in nursing facilities. The two scales that were developed provide some insight about the perceptions of the social workers, but they do not have the power or clarity to help us understand how, or if, the cultural stigma associated with nursing facilities affects practitioners. In retrospect, the initial phase of scale development may have needed more time and attention. Many of the items in the initial item pool were dropped after the development sample. Possibly a larger development sample or a second development sample study would have retained more of the original items.

A challenge in studying stigma is distinguishing between confirming that the stigma actually exists in a culture and measuring or identifying its effect on various groups. The literature review reflects this tension in studies of stigma related to race and other conditions. This study of nursing facility stigma may

have lacked clarity about exactly which aspect of stigma the construct was intended to measure. The two constructs, respect and misunderstood, emerged as a result of the scale development, rather than the scale development confirming the constructs.

As with other burnout studies, a gap exists between the measure of burnout and tangible results of burnout. Burnout does not necessarily equate to job change, and job change is not in itself good or bad for the individual or the employer. However, it is a strength of this study that the dependent variable is burnout, and it is clearly distinguished from job satisfaction, intent to turnover, or job tenure. This study could have been made stronger by including a measure of successful job performance to compare with burnout, but developing a measure of successful job performance would be an entire study in itself.

The strong, and therefore skewed, responses to many of the items in the instrument are both a strength and a weakness. As a strength, the strong responses leave little doubt about how the nursing facility social workers feel about some items. As a weakness, the lack of normality and linearity with the dependent variable compromise the ability of the analysis to find significant relationships and possibly be could the product of an acquiescent response set due to the matrix format (Rubin & Babbie, 1993). Although it cannot be ruled out, two factors argue against the acquiescent response set. First, the responses are congruent with similar responses documented by other researchers. Second, the skewed responses were seen in the MBI scores also, and those items were not in a matrix format.

As a researcher, I could have wished for more normally distributed variables, higher values for relationships between variables, and stronger evidence for conclusions. Because some of the variables are not confirmed in the split sample validation analyses, caution must be used in interpreting them, and I have looked for confirmation of my findings in similar research as a means of compensating.

As a social worker and a person who cares about nursing facility residents, I have to be glad to see that nursing facility social workers are not plagued by mass burnout, the working conditions support good social work practice, and those individuals who choose to practice in nursing facilities are relatively immune to the social stigma associated with their chosen field.

RECOMMENDATIONS

Recommendations based on Characteristics of the Social Worker

The nursing facility social workers in this study are primarily mid-career and show low levels of burnout. The social work profession and the nursing facility industry both have an opportunity to build on this strength by offering continuing education and practice development specifically targeted for social workers working with elderly clients.

The most fertile recruiting fields may be with mature practitioners who are looking for a new challenge, rather than among traditional students or new graduates. The mean age of social workers in this study was 41, and the mean length of time licensed was just over seven years. The mean length of service as a nursing facility social worker was almost five years. Together, this data points to

an individual who is in his or her mid-30s before entering the practice field. While including gerontology in undergraduate and graduate curriculum is important (and will be discussed in the recommendations for education), offering it in continuing education settings might reach an audience of current social workers who are interested and ready for a career change to gerontological social work

Recommendations based on Characteristics of the Nursing Facility

This research project developed information about the burnout levels, associated factors, and working conditions of Texas nursing facility social workers as a group, but it did not develop comparative information about differences between practice settings based on the characteristics of those settings such as governance, urban or rural location, or size. Additional information can be obtained from further analysis of this data set. Another useful area in investigation would be examining the working conditions for social workers practicing in facilities that have adopted some of the innovations in management such as the Eden Alternative, the Wellspring Model, or the Pioneer Homes approach (Stone & Wiener, 2001). The emerging management styles emphasize resident and staff control of the environment and emphasize the social model of resident care over the medical model that dominates the traditional nursing facility paradigm. The predominance of the social model could reasonably be expected to elevate the role of the social worker, and research in this area could be useful for the profession. However, there is evidence that administrators and nurses have expectations that nurses can perform many social work functions as

well as social workers. In a study of hospice nurses, social workers, and directors, Kulys and Davis (1987) found that two thirds of the nurses studied believed nurses better qualified or just as qualified as social workers to carry out tasks such as crisis intervention, advocacy, and coordination of adequate support systems.

Recent writing in long-term care literature has emphasized that policies and programs in the United States are balanced toward a model of nursing home care that emphasizes technical quality over quality of life (Kane, 2001). Another way of describing the dichotomy is to describe it as a difference between the medical model and the social model of care. Research will be required to determine if new and emerging models effectively use the professional skills of the social worker, both in direct services and in systems planning.

Some changes in the way social workers function in the nursing facility appear to have occurred between Gleason-Wynn's research in this area in 1994 and the current study. In Gleason-Wynn's study, social workers indicated they are expected to fulfill multiple responsibilities such as marketing, admissions, and case aide tasks as well as social work. The current research did not evidence role confusion as a major issue and gave support to the conclusion that the role of the social worker is understood by other professionals in the building. Also, the percentage of time spent in various tasks indicated that social worker time is being used appropriately and not spent in non-social work tasks. Additional research would be required to show conclusively that improvement in the social

workers' role or status has occurred in the intervening time between the two studies.

As for strategies that nursing facility managers can use to maintain a low level of burnout among social workers, the most obvious and direct would be to improve the structural aspects of the nursing facility environment by offering higher pay. However, the question of pay for all long term care employees is inexorably tied to the entire question of how long term care is financed, and the current dependency of the industry on Medicaid as the primary funding source places severe restrictions on pay and benefits for all employees. Because of the dependency on public programs for financing all aspects of long-term care, pay is primarily an issue of public policy, driven more by reimbursement than by market forces. In December 2001, the Center for Medicaid and Medicare released a report to Congress on the appropriateness of minimum nurse staffing ratios in nursing homes. The report states, "The amount of money that nursing homes have to spend on staffing and other necessities is heavily dependent on public payment systems." Some facilities have no income except Medicaid and Medicare. Decisions made at the federal and state levels about the funding levels for aging services have a ripple effect. Inadequate funding results in reduced or inadequate services, which in turn has a negative impact on the professionals who work in the service field.

Studies have consistently shown that pay in long-term care, dependent as it is on government reimbursement, is alarmingly lower than pay for similar work in other settings that have income from private sources such as insurance

(Decker, Dollard, & Kraditor, 2001). Although facility ownership and management has an important role to play in efficient management of resources, no organization, profit or non-profit, can consistently have expenses that exceed income. As long as Medicaid and Medicare remain the major sources of income for nursing facilities, staffing of the facility in terms of both staff/resident ratios and staff reimbursement is an issue of state and federal policy.

A second need is for additional time to spend with residents and families, which would presumably come from reduction of administrative tasks. The paperwork burden in nursing facilities is related to the regulatory requirements for documentation. Efforts to reduce documentation requirements and increase the proportion of staff time available for resident care would have to be a mutual effort of practitioners, regulators, and rule makers.

Social workers can build on the strengths identified in the areas of role recognition, participation in care planning, and expertise. Social workers and nursing facility management may need to work in their community to develop a better understanding of the role of the nursing facility social worker with other social workers in the community, such as those working in hospitals and home care. The opportunity is present to extend the understanding of the social worker role that appears to have developed inside the facility to those outside the facility.

Recommendations based on Nursing Facility Stigma

The true value of a nursing facility stigma scale, if a validated one were successfully developed, might be to examine the effects of stigma on social workers who consider working in the field, rather than focusing on social workers

who are in the field. Stigma may be a major factor in diverting people from work in nursing facilities, a possibility that leads to the next recommendation that involves a change in the practice of how research is reported and a caution about assumptions in research writing.

The responses from the social workers in this study are incompatible with adjectives and descriptions offered in the professional literature. The responses in this study, grounded in daily nursing facility reality, cannot be reconciled with descriptions such as "patients are consigned to an open-ended sentence . . . of depersonalized, routinized, medicalized life" (Kane, 1981). It is difficult to imagine that the social workers represented in this sample are working in "the nursing home in its typical incarnations — which is hated and dreaded as a lifestyle choice by almost everyone" (Kane, Kane, & Ladd, 1998). Neither can one reconcile the findings of this study with the suggestion that the respondents are working in "the black hole of the health services system, into which people go to experience the inevitable, if mysterious, shattering of their lives" (Brannon, 1992).

Researchers who use unsupported and inflammatory pejoratives to describe nursing facilities, and, by extension, the professionals who practice in them, are failing to extend professional courtesy and respect to their colleagues who practice in nursing facilities. While this rhetorical technique may be appropriate for those representing themselves as consumer or grass roots advocates or for politicians and news reporters, vituperative language is not acceptable for professional researchers and writers.

Stone and Wiener (2001) write that the success of efforts to recruit, retain, and maintain a long-term care workforce depends in part on how society values the job. Reading the professional literature cannot be encouraging to social workers who may be interested in pursuing practice in long term care when they read descriptions such as the ones cited in the literature review chapter. An argument could be made that nursing facility social workers have become desensitized to nursing facility conditions or have developed a unique set of normative values around care of nursing facility residents. In other words, perhaps the portrait of the nursing facility social worker in this research is a picture of a social worker who has adjusted to a low set of expectations. If this were the case, one would expect the newcomers to show lower levels of personal accomplishment or higher levels of personal exhaustion, but the data shows the opposite.

As a result of consumer demand, changes in federal rule to encourage more in-home and community services, and the recent *Olmstead* Supreme Court decision that requires the state to provide the least restrictive option for recipients of state long term care services (Texas Commission for Health and Human Services, 2000), emphasis in long term care research and writing is directed toward services that maintain individuals in their own homes. While this change in emphasis is universally welcomed, it is often accompanied by an unsupported disparagement of the care provided in institutional settings as a technique for reinforcing the need for alternatives. The demand for all forms of long-term care will only grow with the increases in the elderly population that are coming as the

baby boom cohort ages. The need for objective, dispassionate research to examine quality of life and quality of care, workforce preparedness, working conditions, and economic factors will increase. Research that is detached from the practice field or that accepts without challenge the stigma associated with nursing facilities and other services for the elderly will not be a viable contributor in the development of new paradigms of care.

Social Workers for the Aging Population

Although this study focuses on nursing facility social workers, the issue of a trained and prepared workforce to serve the need of the growing aging population is not limited to nursing facilities. As the range of services and choices of supports grows with consumer demand, the possibilities for key positions for social workers increase. However, attracting enough social workers to work with the aged will challenge the profession. A 1990 report funded by the Administration on Aging summarized the contrast between the need for and the interest in working with the elderly population. According to the report, the rapid increase in the over-75 segment of the population will increase the need for services to the elderly, but social workers are reluctant to serve the elderly. Competing employment opportunities, insufficient faculty and student interest, and a sharing by social workers of society's negative bias towards the elderly contribute to this hesitation to seek employment in settings working with the elderly (Greene, Barusch, & Connelly, 1990).

The social workers who responded to this survey have shown that working with the elderly in nursing homes offers a professionally rewarding

experience. The challenge to the profession and the long-term care industry will be communicating to potential future practitioners the value and rewards of working with the elderly in various settings and eliminating barriers that interfere with a successful job experience.

Investment in the future of aging services involves more than funding of services. Development of a prepared workforce is central to a system that is capable of caring for those who cannot care for themselves. As part of the John A. Hartford Foundation of New York City's multi-year "Strengthening Geriatric Social Work Initiative," the Council on Social Work Education (CSWE) has received a grant to implement Strengthening Aging and Gerontology Education for Social Work (SAGE-SW). SAGE-SW involves a network of social work organizations, faculty practitioners, employers, aging organizations and other professionals in needs assessment and strategy development.

Through its research efforts, SAGE-SW has determined that:

- A significant portion of social work faculty and students are not fully aware of the range of settings and practice opportunities in gerontology;
- Social work education has not made significant efforts to prepare all students for this growing aging population;
- The value of social work in aging services is not well-recognized; and,
- A majority of gerontological practitioners are in need of continuing education (SAGE-SW Newsletter, 2001).

Working with the Gerontological Society of America, the Hartford Foundation has funded the Hartford Geriatric Social Work Faculty Scholars

Program. This project identifies and develops outstanding junior social work faculty members committed to teaching, research, and leadership in geriatric social work. Working with SAGE-SW, the Hartford Foundation has funded a grant to the Council on Social Work Education to increase the geriatric content in the curricula of schools of social work by training social work faculty and to develop and distribute geriatric educational materials. By the end of the grant, more than 400 baccalaureate and master's level social worker faculty will have learned how they can increase the geriatric content of the foundation courses in social work curricula. This program is part of an initiative to improve social work practice with older adults through better education and training programs. The initiative is composed of three parts:

1. building a consensus on standards for geriatric social work education and establishing a clearing house for geriatric teaching tools;
2. creating a cadre of faculty members committed to research and teaching about the needs of older adults; and
3. developing geriatrically-rich field training sites.

Three Texas schools of social work (Baylor University, the University of North Texas, and the University of Texas at Austin) have received grants to participate in education enrichment programs.

The social work education community has recognized, addressed, and is actively pursuing strategies to meet the need for social workers in the field of aging. My only recommendation in this area is that all fields of practice for aging

be treated equally, and that the nursing facility social work be included as a legitimate choice for social workers in the aging field.

CONCLUSION

Public policy questions of developing the future workforce for the needs of the aging population will have to take into account educational preparation, career development and progression opportunities, compensation, and prestige. When the United States was challenged to provide a workforce for the space program, a comprehensive response was developed to attract and keep talented individuals in the required feels of engineering, mathematics, and science. The coming changes in demographic realities presents the same sort of human resources challenge. Questions of financing educational preparation and adequately funding service are difficult, but perhaps more challenging is developing a public policy and posture that elevates the status of working with the elderly. Imagination, creativity and the art of public relations will be required to create a social environment that would give elder care workers of all professions the esteem afforded today's space industry workers. The distance between "stigmatized" and "honored" is long, but it historically has been traversed in social movements such as civil rights and gender equality. Social work's heritage of social activism and advocacy gives the profession tools with which to provide leadership in an evolving social paradigm of respect and honor for elders and the people and institutions that provide for their needs.

Demographers, social service planners, and politicians all preach preparing for the coming age wave. The social work profession can benefit from

looking to those who are currently working with the oldest and frailest for models of how to practice and how to educate future practitioners. As a profession, it is our obligation to support and encourage those who make this career choice, and that support may include taking the initiative in challenging the stigma associated with old age and those who work with the old. At the very least, it is our professional obligation not to participate in reinforcing stigma and stereotypes.

In a public policy forum sponsored by the Texas Department on Aging, Keith Perry, Executive Director of Sears-Methodist Foundation, a longtime provider of long-term care services, housing, and other programs for the aged, cited the example of other cultures in which the aged and those who serve them are "put on a pedestal." In his opinion, until our society extends the level of respect and admiration expressed by the pedestal metaphor, we will never adequately provide for the needs of our elders (Texas Department on Aging, 2001).

In testimony to the United States Senate Special Committee on Aging on February 27, 2002, Elizabeth J. Clark, PhD, ACSW, MPH, Executive Director of the National Association of Social Workers, said

> Public perception may be the proverbial straw that breaks the back of the professional social worker practicing in the geriatric setting. Common perceptions (or misperceptions) are that working with older Americans not only is depressing but is synonymous with working with the sick and dying. A perception also exists that there are few personal, professional, and societal rewards for working with older Americans.
>
> Social work would support efforts to shift the dominant notion of older Americans from deficits-based to strengths-based. Instead of pathologizing this part of the lifecycle, professional social workers can help our nation to consider older Americans as valuable resources to

> society. Just as national policy and communication campaigns have proven effective in moving public perception, this same approach needs to be applied to the aging population (Clark, 2002).

This study has been an attempt to give voice to the social workers practicing in Texas nursing facilities and to add their opinions and perceptions to the mix of ideas that swirl around how we choose to care for the oldest and frailest. The social work profession functions at multiple levels: the individual level, the policy level, and the public opinion level. Exchange of information and understanding among social workers is essential to development of a coherent voice for elderly persons and the social workers who serve them. The public discussion about long term care and how it is offered will continue, as will the need for individuals and families to make decisions about care for themselves and their loved ones. The obligation of the social work profession is to use its influence, credibility, and imagination to picture accurately the current reality and envision a better future.

Appendix 1: Cover Letter and Survey Instrument

Taking the Pulse of Texas Nursing Facility Social Workers:

A Study of Attitudes of Texas Nursing Facility

Social Workers about Their Work

Dear Nursing Facility Social Worker:

You are invited to participate in a study of the attitudes of Texas nursing facility social workers about their work. My name is Jane Norwood, and I am a doctoral candidate in Social Work at the University of Texas at Austin. This study is my dissertation research project. You are being asked to participate in the study because you are employed as a social worker in a Texas nursing facility. If you participate, you will be one of approximately 1,000 people in the study.

The purpose of this study is to gather information on how various aspects of the nursing facility social worker's job affects the worker's attitude towards working in nursing facility social work.

If you decide to participate, please complete and return the enclosed questionnaire to me. A return envelope is enclosed for your convenience. Your response is anonymous. All responses I receive will be used in a data analysis to determine which factors are associated with social worker's attitudes toward nursing facility social work.

As a result of completing this survey, you will be asked to reflect on your work, your work environment, and your feelings about your work and working

environment. You may be at risk of discovering or uncovering feelings about your work or work environment previously unexamined. You could encounter a previously unidentified need for job related counseling or guidance. Job related counseling or guidance will not be provided in relation to this study.

The potential benefit to you as a participant in this study is similar to the risks: that is, you could discover or uncover feelings about your work or work environment previously unexamined. The potential benefit to the social work profession is greater understanding of the dynamics that affect social workers practicing in nursing facilities. The potential benefit to the nursing facility industry is greater understanding of the dynamics that affect social workers as employees. The potential benefit to society is an addition to the body of knowledge about the practice of social work in a population that is expected to grow dramatically in the near future.

Since the information you return will be anonymous, your responses will not be linked to your name in any written or verbal report of this research project.

Your decision to participate or to decide not to participate will not affect your present or future relationship with The University of Texas at Austin.

If you have any questions about the study, please ask me. If you have any questions later, you may call me at 512-891-0755 or you may call my supervisor, Professor James Schwab, at 512-471-9816. If you have any questions or concerns, at any time, about your treatment as a research participant in this study, call Professor Clarke Burnham, Chair of the University of Texas at Austin

Institutional Review Board for the Protection of Human Research Participants at 512-232-4383.

You may keep this letter for your records.

You are making a decision whether or not to participate. Your return of this questionnaire indicates that you have decided to participate in the study.

Thank you so much for your help. I hope that this study will prove useful to both the nursing home industry and the social work profession, and, indirectly, to the residents of our Texas nursing facilities.

Please return by October 31, 2001. An envelope is enclosed for your convenience.

Sincerely,

Jane Norwood, LMSW,

University of Texas School of Social Work,

1925 San Jacinto Blvd., Austin, Texas 78712

Section 1: Questions about Yourself	
1. In what year did you receive your Texas social work license?	____
2. What type of license do you hold? (circle one) 1. SWA 2. LSW 3. LMSW 4. LMSW-ACP or AP 5. none	
3. In what year were you born?	19____
4. Are you a member of NASW or another professional social work organization?	1. Yes 2. No
5. What is your level of formal education? (circle the number of your highest level of formal education)	1. High school graduate 2. Some college, no degree 3. AA or other junior college degree 4. BA or other four-year college degree, not BSW 5. BSW 6. Some graduate work 7. Master's or other graduate degree, not MSW 8. MSW 9. Ph D or other doctoral degree, not social work 10. Ph D in Social Work or DSW
6. Your gender?	1. Female 2. Male
7. Your ethnicity?	1. Hispanic American 2. African-American 3. Asian-American 4. Native American 5. Caucasian 6. Pacific Islander 7. Other
8. Are you currently working or consulting as a social worker in a licensed nursing facility?	1. Yes 2. No
9. For how many years (total in your career) have you been employed as a nursing facility social worker? (Include time as a consultant if you were providing direct services to residents and families.)	_____total years
10. How many nursing facilities have you worked in or consulted with in your career?	
11. If you have worked in more than one facility, how long have you worked in the facility you work in now?	_____ years_____months
12. How long did you work in your previous facility?	_____ years_____months

1

Figure A1 — 1: Survey Instrument, page 1.

13. If you have worked in more than one facility, why did you leave your last facility?

1. Better pay	2. Better working conditions
3. Better hours	4. Not compatible with management
5. Burnout	6. Facility sold to new management
7. Facility closed	8. Reasons unrelated to nursing facility (moved to another town, etc.)
9. Terminated by management	10. Resigned or asked to resigned due to ethical conflicts

14. Did the person who preceded you in your current job . . .

1. Go to work in another nursing facility as a social worker?	2. Go to work in another nursing facility in another capacity?
3. Stay in the same facility in another capacity?	4. Go to work as a social worker but not in a nursing facility?
5. Leave social work?	6. I don't know

15. Taking everything into consideration, how likely is it that you will make a genuine effort to find a new job within the next year?

1. Not at all likely	2. Somewhat likely
3. Likely	4. Very likely
5. Definitely	

16. If you answered likely, very likely, or definitely to the previous question, would you . . .

1. Go to work in another nursing facility as a social worker?	2. Go to work in another nursing facility in another capacity?
3. Stay in the same facility in another capacity?	4. Go to work as a social worker but not in a nursing facility?
5. Leave social work?	6. I don't know

Answer questions 17 – 27 about the facility in which you are currently working. If you are a consultant, answer for the facility you consider your primary client. Circle the number of your answer.

17. Is the facility in which you are currently working. . . 1. Urban 2. Rural 3. Suburban

18. Is the facility in which you are currently working. . . 1. 60 or fewer beds 2. 60 - 120 beds 3. more than 120 beds

19. Does your facility have residents on Medicaid? 1. No 2. Yes, a few 3. Yes, a majority of residents

20. Does your facility have residents on Medicare? 1. No 2. Yes, a few 3. Yes, a majority of residents

21. Does your facility have private pay residents? 1. No 2. Yes, a few 3. Yes, a majority of residents

22. Is the facility in which you are currently working. . .
1. For profit - 10 or fewer facilities in ownership
2. For profit - 11 or more facilities in ownership
3. Not for profit
4. Publicly owned

Please continue to page 3 . . .

Figure A1 — 2: Survey Instrument, page 2.

23. How many hours a week do you spend on resident care (including direct contact with residents and families, consultation with other staff members such as care planning meetings, and working with community resources)?	1. 5 or fewer hours 2. 6 to 15 hours 3. 16 to 30 hours 4. more than 31 hours
24. How many hours a week do you spend on administrative tasks (such as paper work, documentation, marketing, attending staff meetings unrelated to resident care, providing in-service training)?	1. 5 or fewer hours 2. 6 to 15 hours 3. 16 to 30 hours 4. more than 31 hours
25. How many hours a week do you spend on tasks that do not require you to use your social work skills (such as monitoring resident smoking, taking residents to appointments, or helping families with paper work)?	1. 5 or fewer hours 2. 6 to 15 hours 3. 16 to 30 hours 4. more than 31 hours
26. How many hours a week do you spend managing or supervising other employees?	1. 5 or fewer hours 2. 6 to 15 hours 3. 16 to 30 hours 4. more than 31 hours
27. How many hours a week do you spend counseling with other employees or acting as an advocate for other employees?	1. 5 or fewer hours 2. 6 to 15 hours 3. 16 to 30 hours 4. more than 31 hours

Please continue to Section 2 below – Your opinions about your job

Section 2 - Your opinions about your job. Answer Section 2 using the following scale:
5=Agree 4=Somewhat Agree 3=Neither Agree nor Disagree 2=Somewhat Disagree 1=Disagree

28.	Many of the residents in my facility are depressed.	5	4	3	2	1
29.	I admire how well many of residents cope with the losses brought about by age or illness.	5	4	3	2	1
30.	Many of the residents in my facility are anxious, angry or experiencing despair.	5	4	3	2	1
31.	Many of the residents in my facility have excellent coping and adapting skills.	5	4	3	2	1
32.	I feel that I am well prepared for working with the nursing facility residents.	5	4	3	2	1
33.	I feel that I am well prepared for working with the families of nursing facility residents.	5	4	3	2	1
34.	I feel that I am well prepared for my administrative duties in the nursing facility	5	4	3	2	1
35.	I feel that I am well prepared for counseling with or serving as an advocate for other employees in the facility.	5	4	3	2	1
36.	I feel that I am well prepared for management or supervisory responsibilities in the facility.	5	4	3	2	1
37.	My knowledge and skills are adequate for the demands of nursing facility social work.	5	4	3	2	1
38.	I clearly understand the state requirements for social services in the nursing facility.	5	4	3	2	1

3

Figure A1 — 3: Survey Instrument, page 3.

39.	My pay is reasonable for my job.	5	4	3	2	1
40.	My nursing facility management encourages flexibility and creativity in meeting the residents' needs.	5	4	3	2	1
41.	My assessments and opinions are respected by other professionals in the facility.	5	4	3	2	1
42.	I can spend as much time as I need to with the residents and their families.	5	4	3	2	1
43.	I am actively involved in developing the residents' care plans.	5	4	3	2	1
44.	I participate on the care plan team.	5	4	3	2	1
45.	My nursing facility has adequate medical supplies to meet the residents' needs.	5	4	3	2	1
46.	My nursing facility has adequate resources and supplies such as food, linens, and toiletries to meet the residents' needs.	5	4	3	2	1
47.	My nursing facility has adequate food supplies to meet the residents' needs.	5	4	3	2	1
48.	My nursing facility has adequate social work staffing to provide the care the residents' need.	5	4	3	2	1
49.	My nursing facility has adequate nursing staffing to provide the care the residents' need.	5	4	3	2	1
50.	My nursing facility has adequate dietary, maintenance, and housekeeping staffing to meet the residents' need.	5	4	3	2	1
51.	In my nursing facility, the functions and the responsibilities of the social worker are clearly understood by the administrator.	5	4	3	2	1
52.	In my nursing facility, the functions and the responsibilities of the social worker are clearly understood by the director of nursing.	5	4	3	2	1
53.	In my nursing facility, the functions and the responsibilities of the social worker are clearly understood by the activity director.	5	4	3	2	1
54.	In my nursing facility, the functions and the responsibilities of the social worker are clearly understood by other professionals such as therapists.	5	4	3	2	1
55.	My family is proud of my work in the nursing facility.	5	4	3	2	1
56.	When I tell people I work in a nursing facility, they often tell me about a bad experience with a nursing home that they had or someone told them about.	5	4	3	2	1
57.	In my community, being a nursing facility social worker is a prestigious occupation.	5	4	3	2	1
58.	Some people think that I work in a nursing facility because I cannot get a social work job anywhere else.	5	4	3	2	1
59.	When I tell people I am a nursing facility social worker, most people have a pretty good idea of what I do.	5	4	3	2	1
60.	Among social workers, working in a nursing facility is a prestigious career choice.	5	4	3	2	1
61.	Working in the nursing facility as a social worker brings me respect from my family.	5	4	3	2	1
62.	Working in the nursing facility brings me respect from other social workers who work in home health, the hospital, hospice, etc.	5	4	3	2	1
63.	I have friends in social work who do not understand why I would work in a nursing facility.	5	4	3	2	1
64.	People ask me, "How can a social worker help anybody in a nursing home, aren't they just there to die?"	5	4	3	2	1
65.	I believe there is a stigma associated with nursing homes in American culture.	5	4	3	2	1

5=Agree 4=Somewhat Agree 3=Neither Agree nor Disagree 2=Somewhat Disagree 1=Disagree

Figure A1 — 4: Survey Instrument, page 4.

Section 3: Your attitudes and approaches

Please read each statement. Where there is a blank _____, decide what your normal or usual attitude, feeling, or behavior would be. Please circle the letter that represents your choice for the blank in the sentence.

A = RARELY (Less than 10% of the time)
B = OCCASIONALLY (About 30% of the time)
C = SOMETIMES (About half the time)
D = FREQUENTLY (About 70% of the time
E = USUALLY (More than 90% of the time)

Of course, there are always unusual situations in which this would be the case, but think of what you would do or feel in most normal situations.

66.	When faced with a problem I _____try to forget it.	A B C D E
67.	I _____ need frequent encouragement from others for me to keep working at a difficult task.	A B C D E
68.	I _____ like jobs where I can make decisions and be responsible for my own work.	A B C D E
69.	I _____ change my opinion when someone I admire disagrees with me.	A B C D E
70.	If I want something, I _____ work hard to get it.	A B C D E
71.	I _____ prefer to learn the facts about something from someone else rather than have to dig them out for myself.	A B C D E
72.	I will _____accept jobs that require me to supervise others.	A B C D E
73.	I _____ have a hard time saying "no" when someone tries to sell me something I don't want.	A B C D E
74.	I _____ like to have a say in any decisions made by any group I'm in.	A B C D E
75.	I _____ consider the different sides of an issue before making any decisions.	A B C D E
76.	What other people think _____ has a great influence on my behavior.	A B C D E
77.	Whenever something good happens to me I _____ feel it is because I've earned it.	A B C D E
78.	I _____ enjoy being in a position of leadership.	A B C D E
79.	I _____ need someone else to praise my work before I am satisfied with what I've done.	A B C D E
80.	I am _____ sure enough of my opinions to try and influence others.	A B C D E
81.	When something is going to affect me I _____ learn as much about it as I can.	A B C D E
82.	I _____ decide to do things on the spur of the moment.	A B C D E
83.	For me, knowing I've done something well is _____ more important than being praised by someone else.	A B C D E
84.	I _____ let other peoples' demands keep me from doing things I want to do.	A B C D E
85.	I _____ stick to my opinions when someone disagrees with me.	A B C D E
86.	I _____ do what I feel like doing not what other people think I ought to do.	A B C D E
87.	I _____ get discouraged when doing something that takes a long time to achieve results.	A B C D E
88.	When part of a group I _____ prefer to let other people make all the decisions.	A B C D E
89.	When I have a problem I _____follow the advice of friends or relatives.	A B C D E
90.	I_____ enjoy trying to do difficult tasks more than I enjoy trying to do easy tasks.	A B C D E
91.	I_____ prefer situations where I can depend on someone else's ability rather than just my own.	A B C D E

5

Figure A1 — 5: Survey Instrument, page 5.

92.	Having someone important tell me I did a good job is _____more important to me than feeling I've done a good job.	A B C D E
93.	When I'm involved in something I_____ try to find out all I can about what is going on even when someone else is in charge.	A B C D E

Thanks for answering so far. . .just one more section

Section 4: Your Feelings about Your Job

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

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

Example:

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

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

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

Figure A1 — 6: Survey Instrument, page 6.

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

HOW OFTEN

0 – 6 Statements:

1._____ I feel emotionally drained from my work.

2._____ I feel used up at the end of the workday.

3._____ I feel fatigued when I get up in the morning and have to face another day on the job

4. _____ I can easily understand how my recipients feel about things.

5._____ I feel I treat some recipients as if they were impersonal objects.

6._____ Working with people all day is really a strain for me.

7._____ I deal very effectively with the problems of my recipients.

8._____ I feel burned out from my work.

9._____ I feel I'm positively influencing other people's lives through my work.

10._____ I've become more callous toward people since I took this job.

11._____ I worry that this job is hardening me emotionally.

12._____ I feel very energetic.

13._____ I feel frustrated by my job.

14._____ I feel I'm working too hard on my job.

15._____ I don't really care what happens to some recipients.

16._____ Working with people directly puts too much stress on me.

17._____ I can easily create a relaxed atmosphere with my recipients.

18._____ I feel exhilarated after working closely with my recipients.

19._____ I have accomplished many worthwhile things in this job.

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

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

22._____ I feel recipients blame me for some of their problems.

7

Figure A1 — 7: Survey Instrument, page 7.

Thank you for completing this questionnaire!

Please return it to:

Jane Norwood, LMSW
University of Texas School of Social Work
1925 San Jacinto Blvd.
Austin, TX 78712.

By October 31, 2001

If you receive this questionnaire close to or after the return date,
PLEASE RETURN IT AS QUICKLY AS YOU CAN

8

Figure A1 — 8: Survey Instrument, page 8.

Appendix 2: Stigma Scale Development

INITIAL SCALE DEVELOPMENT STEPS

The attempt to develop a scale to measure the degree to which nursing facility social workers are affected by a construct labeled nursing facility stigma became, in many ways, the central challenge of this research. The results of the scale development work did not yield a scale that can unequivocally claim to measure the nursing facility stigma, but the two scales that emerged from the process are useful in examining the effect of cultural attitudes on nursing facility social workers' level of burnout.

The stigma scale development procedure generally followed the format suggested by DeVellis (1991) in *Scale Development: Theory and Applications* and by Springer, Abell, and Hudson (Springer, Abel, & Hudson, in press.) The first step in the process is to determine what is to be measured using theory as a starting point and clarifying the construct. The construct to be measured in this scale is nursing home stigma, defined as a pervasive belief among Americans that nursing home life is inherently negative and living in a nursing home is always a condition to be avoided. A scale assumes that the construct exists or is perceived in degrees, and that the degree of perception will vary in its effect on individuals. The purpose of the nursing home stigma scale developed for this research is to determine the effect on nursing facility social workers of their perception of the extent to which they experience evidence of nursing home stigma in their personal network and information sources.

Based on the literature review, nursing home stigma is conceptualized as a variant of ageism in American society. Ageism is well documented in the literature. Although it was beyond the scope of the literature review for this research, it is useful to think of attitude toward the aged in contemporary American society in contrast to those societies in which elders are held in high regard and treated with honor (Sung, Kyu-taik, 2000). Although the authors whose statements about nursing facilities were cited in the literature review would most likely object to a characterization of their comments as a form of ageism, the testimony from Vin-Vogel regarding the attitude of her colleagues and fellow social workers most eloquently expresses the extension of ageism to those who work on behalf of or with elderly clients. Her sense that her work was devalued by colleagues because she elected to work with an elderly client population directly ties ageist, anti-elderly attitudes to those who work with that population. Following this line of reasoning, nursing facilities, caring for the oldest, frailest persons, are characterized as, to quote Brannon, "the black hole of health care."

Step two in DeVellis's format is generation of an item pool. The generation of items began on an informal basis. In the eight years that I worked as education director of a professional long term care association, I had the opportunity to spend many days in education programs with nursing facility professionals. During the break and lunch times I have had the opportunity to have many informal conversations about the topic of nursing facility stigma. I sometimes asked questions, but more often just listened to conversations and

comments related to the topic. From ideas gathered in these informal conversations, I generated an initial pool of items that might represent the nursing home stigma construct.

A second source of ideas for items was a written survey of Texas licensed nursing facility administrators that I conducted in 1998 (Baker, 1998). This survey questioned nursing facility administrators about their intent to remain in the profession and explored reasons for leaving the profession or the industry. The relevancy of the responses of nursing facility administrators is that they work in the same environment as the social worker and are subject to the same external influence.

The third source was Vin-Vogel's article, especially her comments about other social workers, assuming she could not get another job in another area of social work.

The third step is to determine the format for measurement. For this scale, a Likert format is used. The items are presented as a declarative sentence, followed by response options indicating the degree to which the respondent agrees with the statement. This format was chosen because the purpose of this scale is to determine the extent to which the respondent agrees that the items resonate with his or her personal experience. Although a scale that allows the respondent to gauge the frequency with which items are encountered could be used, an agree/disagree scale was selected so that the items in the stigma scale could be integrated into the other items in the research instrument without requiring a new set of instructions or a new category of responses.

Step four is having the initial item pool reviewed by a panel of experts. Qualitative methodologies were used for this step. A convenience sample was taken from social workers employed in nursing facilities in the Austin, Texas area. An organized group of long term care social workers, including those employed in nursing facilities, assisted living facilities, home health, and related programs, meets for a monthly luncheon/education meeting in Austin. The mailing list for the group has about 100 names and addresses. A postcard was sent to this list about ten days prior to the February 2001 meeting. The postcard explained that a researcher would like to meet with nursing facility social workers for about an hour immediately before or after the regular monthly meeting of the group. At the February meeting, three people met with this researcher before the meeting and one met after. Although this number of participants was smaller than I had hoped, the similarity of their comments indicated that it was unlikely that including additional subjects would yield new or different comments.

At the two meetings, attendees were asked first to read and sign the informed consent form to comply with human subjects standards. An opportunity to ask questions about the consent form and the research project was offered. Participants were then asked to complete a draft instrument consisting of the demographic questions and the items for the stigma scale. The purpose of the research was explained, and participants were asked to give feedback on the scale items and demographic questions.

As a result of these meetings, a change was made to the question about why the social worker left the last facility where he or she worked. A response

was added to indicate that the social worker resigned or was asked to resign due to an ethical conflict with management. No changes to the stigma scale were proposed, and the feedback indicated that the questions do represent the kind of situations and comments that are encountered by nursing facility as a result of their choice of employment. One comment that was made during these meetings led to the title of this dissertation. One social worker commented that her family admires her for her willingness to work in a nursing home, and she frequently hears the comment that "you must be a very special person" to have patience to work with the elderly, especially the very old and the very sick.

In relation to the questions which make up the stigma scale, the most positive comment came from one participant who said that the questions made her laugh because they were so true to her own experience. As the subjects read and answered the questions, they sometimes chuckled or grinned. When asked, they confirmed that they were smiling because of the sense of resonance with their experience as nursing home social workers. No one suggested any substantive changes to the questions or any deletions.

Step 5 in DeVellis's process is to consider the inclusion of validation items. Although including validation items has many advantages, such as controlling for social desirability in responses and possibly testing for divergent or concurrent validity. However, since no instruments are available to measure divergent or concurrent validity relative to the stigma scale, no validation items were included at this stage.

The sixth step in the instrument development process is to administer the items to a development sample. DeVellis states that the development sample should be large and proposes 300 as an adequate number. However, he acknowledges that smaller samples can be used if only one scale is being developed. He cautions that a sample that is qualitatively rather thanquantitatively different from the target population is more threatening to the development of a valid scale than a small sample size. A consideration in regard to sample size for the scale development sample for this research is the size limitation of the population. Explaining the limitation on the total sample size requires a digression from the description of the scale development process.

Texas has slightly over 1100 licensed nursing facilities, and the exact number of social workers employed by or consulting with nursing facilities is unknown. The nursing facility licensure rules require that each nursing facility with one hundred and twenty beds have a full time social worker, either on staff or on contract. Smaller facilities are required to have a part time social worker, either on staff or on contract in proportion to the number of beds. The rule does not require that facilities over 120 beds have a 1:120 ratio of social workers to beds. Neither does the rule prohibit an individual social worker from contracting to provide services to more than120. For example, no rule prohibits one social worker from contracting with three 80-bed facilities. The only limitation on the number of facilities or the number of beds is the social worker's ethical consideration.

There is no list of the names of nursing facility social workers. The state requires as a condition of licensure that nursing facilities report the name of the administrator, but no reporting of names is required for the other professionals in the facility. Without a list of the names of the social workers, the only way to make contact is to address an envelope to "social worker" at the nursing facility address. Although the number of nursing facilities is known, the number of social workers is not known. Each nursing facility could have one or more social workers, and the any nursing facility social worker could be providing services to one or more facilities. Given the number of unknowns, the only reasonable assumption is that the number of social workers is approximately equal to the number of facilities. Using this line of reasoning, the number of nursing facility social workers in Texas should be about 1100, considering that some nursing facilities have more than one social worker, and some social workers work for more than one nursing facility.

Since the size of the sampling frame is relatively small, and the instrument delivery mechanism (mailed written survey) has inherent problems in yielding a good return rate, I decided to limit the size of the sample for the stigma scale validation phase of the research to one tenth of the total population. A mailing label list of all licensed nursing facilities was obtained from the Texas Health Care Association. The list contained 1171names and addresses and was sorted by zip code and then alphabetical order within the zip code. Starting with a random number, every tenth label was drawn for a total of117. The zip code and alpha sort should yield a sample that is geographically spread across the state

and randomly distributed among facilities of different size, business plans, ownership, and major revenue source.

The survey instrument, consisting of the demographic questions, co-worker support questions, stigma scale questions, human subjects review letter, a brief note from the researcher asking for a response, and a stamped, self-addressed envelope was mailed on May 11, 2001, with a requested return date of May 24, 2001.

A second, non-random, convenience sample was obtained by visiting a training session for nursing facility social workers at Southwest Texas State University on May 4, 2001. This group of subjects received the same material that was included in the mailed material except for the note from the researcher asking for a response. Since I was present at the training session specifically to ask for the participants to complete the survey instrument, I was able to make a verbal request and the written note was not necessary.

Twenty-three usable samples were obtained from the Southwest Texas training program. Forty-three usable samples were returned from the mail-out for a return rate of 36.7 percent. The results from the total of 66 were analyzed to determine which items would be retained in the final scale. Although this sample size is small and does not meet DeVellis's standard of three hundred for a developmental sample, it does meet his requirement that the sample be qualitatively representative of the study population.

Considering the small total population, I made the decision to work with a smaller sample size for the developmental sample rather than reduce the sample

size for the full data collection instrument. To avoid test-retest complications in the final sample, the final sample mailing will not include the 117facilities that were used in the developmental sample. This solution does not completely avoid the possibility that any given social worker will be included in both the developmental sample and the final sample. A social worker could have changed facilities between the two mail-outs. No record could be made of the names of the facilities of the social workers attending the Southwest Texas training program without violating anonymity.

DEVELOPMENT SAMPLE STEP

The sample used for development of the stigma scale consisted of a total 67 responses. All respondents were current nursing facility social workers. The mean age was 42.3 years, ranging from 24 to 71. The mean length of time licensed as a social worker was 8.4 years, ranging from less than 1 to 26 years. Respondents worked in an average of 3.7 nursing facilities during their careers. Mean length of time in the current facility was 2.75 years, ranging from 6 months to 13 years. For those who had worked in at least two facilities, the mean length of time in the previous facility was 1.7 years. The mean total length of time spent as a nursing facility social worker was 4.7 years.

Table A2.1

Licensure type of respondents in scale development sample

Licensure Type	Percentage
Social Work Associate	16.4
Licensed Social Worker	46.3
Licensed Master Social Worker	22.4
Licensed Master Social Worker — Advanced Clinical Practitioner	10.4
None	3.0

Licensure type information is relevant to the qualifications of the respondents to be included in the sample and addresses the generalizability of the sample to the universe of nursing facility social workers. Including Social Work Associates is controversial because individuals with that licensure status are not required to have professional social work education and do not qualify for membership in professional social work associations. However, they are included in this sample because their licensure status meets the state requirements of the definition of social worker in the nursing facility context. To omit them from this study on the grounds that they are not social workers would eliminate a large portion of the potential respondents and would yield a sample not representative of the population.

SCALE ITEMS

The original stigma scale included in the developmental sample consisted of 18questions. After examination of the findings from the developmental

sample, eight items were eliminated from the scale before conducting factor analysis on the remaining ten items.

The items related to the social worker's family were eliminated from the scale based on the examination of the mean scores. The item, "My family is proud of my work in the nursing facility" had a mean score of 4.42 (on a five-point scale). The item "Working in the nursing facility as a social worker brings me respect from my family" had a mean score of 3.99. These scores were not in the predicted direction if the items were associated with a stigma related to working in the nursing facility. This finding was foreshadowed by the comments in the focus groups. Social workers in the focus groups indicated that their families may not understand their desire to work in the nursing facility, but they are very supportive of their choice and sometimes express respect and admiration for a job that they perceive as very difficult. In the words of one participant, "My family tells me that they think I must be a very special person for being willing to work in a nursing home."

The family related items were eliminated from the scale because the results were not in the predicted direction, but they are retained in the final instrument as an item in the caregiver independent variable. The two items have a correlation of .6325 and were retained as a two-item scale.

The second group of items eliminated from the stigma scale were the items related to the image portrayed in the media. Although the means for the items in this category were in the predicted direction, the mean scores were

extreme and the items offered little variance to contribute to the scale. Mean scores are shown in Table A2.2:

Table A2.2

Mean responses from the developmental sample to items about the media

Item	Mean
The national news media's portrayal of nursing facilities is mostly accurate.	2.15
The local news media's portrayal of nursing facilities is mostly accurate.	2.53
The image of nursing facilities portrayed in newspapers and television reflects what my facility is like.	1.60
The news media generally portray a very negative image of nursing facilities.	4.09

While these four items might be effectively used as a scale to measure nursing facility social worker's attitudes about media coverage, the content of the items does not have a clear connection to the content of the remainder of the items in the stigma scale. It is clear from the results that the respondents believe that the negative image in the media of nursing facilities is neither accurate in general nor an accurate reflection of their own facility. Although an argument can be made that the perceived negative and inaccurate media image of nursing facilities is either a cause or an effect of nursing facility stigma, the connection between perceived media image and the nursing facility social worker's perception of stigma is not as clear. These items were eliminated because they do

not have the personal connection to the social worker that is characteristic of the items that remain in the scale.

The final group of items that was eliminated from the scale consisted of two items that describe actions of the nursing facility social worker that do not necessarily relate to the perception of stigma. One question, "I sometimes avoid telling people that I work in a nursing facility," had a mean of 2.0, a response that is not in the predicted direction for the stigma scale. One possible interpretation of this finding is that social workers may perceive the stigma associated with nursing facilities but still choose to tell people that they work in a nursing facility. Since working with misunderstood and undervalued populations is a basic value in social work, social workers may not be hesitant to tell others about their work, even if the response can be expected to be colored by a stigma associated with nursing facilities.

The second item that involves an action on the part of the social worker is "I am proud to tell people that I work in a nursing facility." The mean response for this item was 4.12, a response not in the predicted direction to support nursing facility stigma. Taking pride does not necessarily indicate that the social worker does not perceive stigma. Pride could be associated with recognizing that stigma exists and choosing nursing facility social work despite the associated stigma.

After the elimination of these eight items from the scale, ten items remain. The mean scores for the remaining items are displayed in Table A2.3.

Table A2.3

Items remaining in scale

Item	Mean
When I tell people I work in a nursing facility, they often tell me about a bad experience with a nursing home that they had or someone told them about.	3.61
Some people think that I work in a nursing facility because I cannot get a social work job anywhere else.	2.03
In my community, being a nursing facility social worker is a prestigious occupation. (Reverse coded)	3.31
When I tell people I am a nursing facility social worker, most people have a pretty good idea of what I do. (Reverse coded)	4.21
Among social workers, working in a nursing facility is a prestigious career choice. (Reverse coded)	3.60
Working in the nursing facility brings me respect from other social workers who work in home health, the hospital, hospice, etc. (Reverse coded)	2.59
I have friends in social work who do not understand why I would work in a nursing facility.	2.72
People ask me if it is depressing to be around all those old, sick people.	4.27
People ask me, “How can a social worker help anybody in a nursing home, aren’t they just there to die?”	2.73
The public does not understand nursing facility social workers do.	4.05

Factor analysis was used to determine if a structural relationship exists among the 10 variables, if the variables demonstrate sufficient correlation to

constitute a scale, and if factors can be extracted that may be interpreted in a way that supports the construct of nursing home stigma.

With the reduction in the number of scale items to ten, it is feasible to conduct the factor analysis on the available sample size. Hair, Anderson, Tatham, and Black (1995) advise that factor analysis cannot be conducted on a sample smaller than 50, and the size should be 100 or larger. However, the minimum acceptable size is at least five samples for each variable. Using that criteria, the current sample size, 67, is minimally acceptable. With a sample of this size and relatively low ratio of samples to items, a cautious interpretation is advised.

Since some amount of multi-collinearity is desirable, the correlation matrix was scanned for correlations above .3. Eight of the ten items had two or more correlations above .3. The remaining two items each had at least one correlation of .29. Bartlett's Test of Sphericity has a significance of .000, indicating that there are significant correlations among at least some of the variables. The Kaiser-Meyer-Olkin Measure of Sampling Adequacy score is .745, a score described as "middling."

Examining the rotated component matrix to determine if the extracted factors can be identified reveals three components. Using a minimum factor loading of .65 as a criteria based on the sample size, four items load on the first component: prestigious occupation, prestigious career choice, professional respect, and people have a pretty good idea of what I do. Remembering that these

items were reverse coded and the mean score (not reversed) for the four items was 1.57, I have labeled this factor "professional respect."

Four items load on the second factor. These items are: cannot get another job, tell about bad experiences, friends don't understand, and people ask how help. The theme that unites these items is lack of understanding of the social worker's role, and I have chosen to call this factor "misunderstood."

The remaining two items, public not understand and depressing, load on the third factor. From a content perspective, these items would not appear to be different in quality from the "misunderstood" factor. I omitted these two items and ran the factor analysis again. The factors load in the same two groupings as in previous analysis.

Using each of the factors as an independent scale creates two scales, a scale measuring lack of professional respect, and a scale measuring misunderstanding of the nursing facility social worker role. A factor analysis and reliability analysis was then conducted on each of the two separate scales.

The four-item lack of professional respect scale had an alpha of .8026. In the factor analysis, all correlations were above .389. Kaiser-Meyer-Olkin Measure of Sampling Adequacy was .765, and Bartlett's test of sphericity was significant at the .000 level. All four variables loaded on the first component, which accounted for 62.87 percent of the variance.

The four-item misunderstood scale had an alpha of .7525. In the factor analysis, all correlations were above 3.93. The Kaiser-Meyer-Olkin Measure of sampling adequacy was .769, and Bartlett's Test of Sphericity was significant at

the .000 level. The first component accounted for 57.87 of the variance, and all four variables loaded on the first component.

No scales measuring similar constructs were used to test for convergent validity or discriminant validity. These steps were omitted because of a lack of scales appropriate for using to determine either convergent or discriminant validity.

In conclusion, the findings from the development sample failed to support a single scale for measuring nursing home stigma. To improve the evidence for the validity and reliability of the scales, the final instrument contains a single question to use as evidence of convergent validity. In addition, the larger, second sample can be used for additional reliability and factor analysis.

SCALE DEVELOPMENT — FINAL SAMPLE

The second stage of scale development was continued using the results from the sampling of the remaining 90 percent of nursing facilities that were not included in the development sample. A complete description of the data gathering process and the demographic characteristics of the respondents are included in Chapter 4. A total of 385 usable surveys were returned, for a return rate of 37% of those mailed to good addresses. The second phase of the scale development was conducted using these responses.

The mean scores for the four items remaining in the professional respect scale are shown in Table A2.4.

Table A2.4

Professional respect scale items

Items	Mean	SD.
In my community, being a nursing facility social worker is a prestigious occupation.	2.88	1.12
When I tell people I am a nursing facility social worker, most people have a pretty good idea of what I do.	1.97	1.02
Among social workers, working in a nursing facility is a prestigious career choice.	2.61	1.08
Working in the nursing facility brings me respect from other social workers who work in home health, the hospital, hospice, etc.	3.58	1.11

Using factor analysis, all items load on one component that explains 54.8 percent of the variance. The Kaiser-Meyer-Olkin Measure of sampling adequacy was .716, and Bartlett's Test of Sphericity was significant at the .000 level.. Reliability analysis shows inter-item correlations above .3, except for one. The alpha score is .7204.

Mean scores for the items in the misunderstood scale are shown in Table A2.5.

Table A2.5

Misunderstood scale items

Items	Mean	SD.
When I tell people I work in a nursing facility, they often tell me about a bad experience with a nursing home that they had or someone told them about.	3.66	1.24
Some people think that I work in a nursing facility because I cannot get a social work job anywhere else.	2.08	1.18
I have friends in social work who do not understand why I would work in a nursing facility.	2.99	1.39
People ask me, "How can a social worker help anybody in a nursing home, aren't they just there to die?"	2.49	1.38

In the factor analysis, all items load on the first component that explains 53.6 per cent of the variance. The Kaiser-Meyer-Olkin Measure of sampling adequacy was .769, and Bartlett's Test of Sphericity was significant at the .000 level. In the reliability analysis, two correlations were below .3, and the Alpha coefficient was .7080.

Since these scales had originally been conceptualized as a measurement of the effect of nursing facility stigma on the respondents, findings from these scales were compared to two other scales developed specifically to measure stigma. A scale developed to measure the vulnerability of African American students to the perception of prejudicial treatment (Gilbert, 1996) consisted of two factors. Factor 1, labeled Prejudice Attributions in Stranger Encounters, had a reliability of .52 as measured by Cronbach's coefficient alpha in the developmental sample. Factor 2, labeled Prejudice Attributions in Interpersonal Encounters, had a

reliability of .66 in the developmental sample as measured by Cronbach's coefficient alpha. The coefficient alpha reliability for the total five item scale was .60.

Another scale measuring stigma, the Stigmatization Scale, developed to measure individual differences in the phenomenological impact of social stigma, yielded a single factor solution with an alpha of .90 (Harvey, 2001).

Since two other scales are included in the instrument developed for this research, the alpha score for those scales were also examined. Reported alpha for the Duttweiler Internal Control Index was .84 and .85. (Duttweiler, 1994). Reliability coefficients for the subscales of the Maslach Burnout Inventory were as follows: .90 for Emotional Exhaustion, .79 for Depersonalization, and .71 for Personal Accomplishment.

Using these other scales as a guide for an acceptable level of reliability, the alpha levels for the Lack of Professional Respect Scale and the Misunderstood scales appear to be, exactly as DeVellis said, "middling." While not as high as could be desired or, as Harvey's scale demonstrates, obtained, scores are respectable enough to include the two scales in the hypothesis testing phase of analysis and the basis of reliability.

The next test for a meaningful and useful scale is to use one or more of the means of comparing the outcomes on the scale to other scales or items (convergent or discriminant construct validity), an observation or condition (criterion validity). While the description of this process is clear, the numerical cut-off, or level of acceptability for the correlation between the scale and the

variable against which it is matched, is not (Rubin & Babbie, 1993). In describing the process of developing rapid assessment instruments, Springer, Abell and Nugent (in press) caution against using a strict criterion (numerical cut-off) to interpret validity coefficients. They suggest that the validity coefficient should be evaluated in relation to similar coefficients for other instruments that measure the same construct, used for the same kind of decisions about clients or research subjects, and intended for the same purpose.

One question included in the final instrument was intended to be used as a basis for convergent construct validity. The question was, "I believe there is a stigma associated with nursing homes in American culture." The mean response was a resounding 4.46. Unfortunately for the purposes of scale development, the lack of variation in the responses to this item made it a poor candidate for a high correlation with scales in which one hopes for variance.

Returning to the stigma scales used for benchmarks in the reliability test, Gilbert found a correlation of .38 between her stigma scale and related construct. Harvey used a variety of construct measurement tools representing powerlessness, goal disruption, personal self-esteem, collective self-esteem, mastery and interaction anxiety. He found significant correlations ranging between .21 and .75 with his stigma scale.

I found the following correlations between the stigma question, the misunderstood scale, and the respect scale as reported in Table A2.6.

Table A2.6

Correlations among stigma, misunderstood scale, and respect scale

Item or scale	Correlations	
	Misunderstood	Respect
Stigma	.278	-.156
Misunderstood		-.244

All correlations were significant at the .01 level (2-tailed). Neither of these scales can meet the rigorous standards set by Harvey or the more modest standard set by Gilbert. While it is encouraging that the correlations are significant and in the expected direction (positive for stigma and misunderstood and negative for stigma and respect), the strength of the relationships do not support an argument that either of these two scales can make a claim to measure stigma associated with nursing facilities.

CONCLUSIONS

After examination of the findings related to scale development from the full sample, I decided to alter the original plan for hypothesis testing and substitute the two scales, Respect and Misunderstood. Of course, the one item about stigma is also available for hypothesis testing. Although it was disappointing not to find a scale that clearly and definitely measures nursing facility stigma, the two more subtle ideas of Respect and Misunderstood can still be useful in examining factors associated with burnout in nursing facility social workers.

References

Aaronson, W. E., Zinn, J.S., & Roske, M.D. (1994). Do for-profit and not-for-profit nursing homes behave differently? The Gerontologist, 34, 775 - 786.

Abu-hilal, Maher M. & Salameh, Kayed M. (1992). Validity and reliability of the Maslach Burnout Inventory for a sample of non-western teachers. Educational and Psychological Measurement, 52, 161-169.

Allen, J. A. & Burwell, N. Y. (1980). Ageism and racism: Two issues in social work education and practice. Journal of Education for Social Work, 16 (2), 71 – 77.

Angrosino, Michael V. (1992). Metaphors of stigma. Journal of Contemporary Ethnography, 21 (2), 171 – 200.

Arches, J. (1991). Social structure, burnout, and job satisfaction. Social Work, 36 (3), 202-206.

Arthur, Nancy M. (1990). The assessment of burnout: A review of three inventories useful for research and counseling. Journal of Counseling & Development, 69, 186-189.

Banaszak-Holl, Jane & Hines, M. A. (1996). Factors associated with nursing home staff turnover. The Gerontologist, 36 (4), 512-517.

Barber, Clifton E. & Iwai, M. (1996). Role conflict and role ambiguity as predictors of burnout among staff caring for elderly dementia patients. Journal of Gerontological Social Work, 26 (1/2), 101 – 116.

Barber, G. (1986). Correlates of job satisfaction among human services workers. Administration in Social Work, 10 (1), 25-38.

Blinde, Elaine M. and Taub, Diane E. (1992). Women athletes as falsely accused deviants: Managing the lesbian stigma. Sociological Quarterly, 33 (4), 521 – 135.

Blum, Nancy S. (1991). The management of stigma by Alzheimer family caregivers. Journal of Contemporary Ethnography, 20 (3), 263 – 285.

Borland, J. J. (1981). Burnout among workers and administrators. Health and Social Work, 6 (1), 73 – 78.

Brannon, D. (1992). Toward second-generation nursing home research. Gerontologist, 32, 293 – 294.

Burisch, M. (1993). In search of theory: some ruminations on the nature and etiology of burnout. In Wilmar B. Schaufeli, Christina Maslach, & Tadeusz Marek (Eds.), Professional burnout: Recent developments in theory and research, (pp. 75 – 93). Washington, DC: Taylor and Francis.

Butler, B. B. (1990). Job satisfaction: Management's continuing challenge. Social Work, 35 (2), 112-117.

Butler, Robert (1975). Why survive? being old in America. New York: Harper and Row.

Cafferata, Gail Lee and Stone, Robyn (1992). Community care givers' attitudes toward nursing homes. The Journal of Long-Term Care Administration, Winter, 33 – 35.

Cahill, Spencer E. & Eggleston, R. (1995). Reconsidering the stigma of physical disability: Wheelchair use and public kindness. Sociological Quarterly, 36 (4) 681 – 699.

Carpenter, Brian D. (1996). Why students are interested in the elderly: An analysis of motives. Gerontology and Geriatrics Education, 16 (4), 41 – 51.

Center for Medicaid and Medicare. (2001). Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes: Report to Congress. [on line] Available: http://cms.hhs.gov.

Cherniss, Gary (1980). Professional Burnout in Human Services Organizations. New York: CHS, Inc.

Chappell, N. L. & Novak, M. (1992). The role of support in alleviating stress among nursing assistants. The Gerontologist, 32 (3), 351 – 159.

Clark, Elizabeth J. (2002). Patients in Peril: Critical Shortages in Geriatric Care [on-line]. Available: www.naswdc.org/nasw/announcements/.

Coady, Carole A., Kent, Virginia D., & Davis, Patricia W. (1990). Burnout among social workers working with patients with cystic fibrosis. Health and Social Work, May, 116 – 124.

Conway, P. G., Williams, M. S., & Green, J. L. (1987). A model of job facet satisfaction. Journal of Social Work Education, 23 (1), 48-57.

Cook, Fay L. (1992). Ageism: Rhetoric and reality. The Gerontologist, 32, 3, 292 – 293.

Corcoran, K. (1987). The association of burnout and social work practitioner's impressions of their clients: Empirical evidence. Journal of Social Service Research, 10, 7 – 66.

Corcoran, Kevin & Fischer, J. (2000). Measures for Clinical Practice: A Sourcebook. New York: The Free Press.

Courage, M. M., & Williams, D. D. (1986). An approach to the study of burnout in professional care providers in human service organizations. Journal of Social Service Research, 10 (1), 7-22.

Damron-Rodriquez, Joanne, Robinson, Barrie, & Feldman, R. (2000). Educating social workers for an aging society: a vision for the 21st century. Journal of Social Work Education, 36 (3), 521 – 540.

Davis, Liane V. & Hagen, Jan L. (1996). Stereotypes and stigma: what's changed for welfare mothers. Journal of Women & Social Work, 11 (3), 319 – 338.

Davis-Sacks, M. L., Jayarane, S. & Chess W. (1985). A comparison of the effects of social support on the incidence of burnout. Social Work, 30 (3), 240 – 44.

Decker, Frederic H., Dollard, Jeannine K., & Kraditor, K. (2001). Staffing of nursing services in nursing homes: Present issues and prospects for the future. Seniors Housing & Care Journal, 9 (1), 3 – 15.

DeVellis, Robert F. (1991). Scale development: theory and applications. Newbury Park, CA: Sage Publications, Inc.

Dhooper, Surjit S. (1997). Social work in health care in the 21st century. Thousand Oaks, CA: Sage Publications, Inc.

Drake, Brett, & Yadama, Gautam N. (1995) Confirmatory factor analysis of the Maslach Burnout Inventory. Social Work Research, 19 (3), 184 – 193.

Drake, Brett, & Yadama, Gautam N. (1996) A structural equation model of burnout and job exit among child protective services workers. Social Work Research, 20(3) 179 – 188.

Dudley, James R. (2000). Confronting Stigma within the Services System. Social Work, (45) 5, 449 – 456.

Duttweiler, Patricia C. (1984). The internal control index: A newly developed measure of locus of control. Educational and Psychological Measurement, 44, 209 – 221.

Edelwich, Jerry & Brodsky, A. (1980). Burn-Out: Stages of disillusionment in the helping professions. New York: Human Sciences Press.

Edwards, K. A. (2000). Stigmatizing the stigmatized: a note on the mentally ill prison inmate. International Journal of Offender Therapy and Comparative Criminology, 44 (4), 480 – 489.

Elwell, F. (1984). The effects of ownership on institutional services. Gerontologist, 24, 77 – 83.

Evans, Brian K. & Fischer, Donald G. (1993). The nature of burnout: A study of the three-factor model of burnout in human service and non-human service samples. Journal of Occupational and Organizational Psychology, 66, 29 – 38.

Ferree, Myra Marx & Smith, Eliot R. (1979). A cognitive approach to social and individual stigma. Journal of Social Psychology, 109, 87 – 97.

Freudenberger, H. J. (1974). Staff burnout. Journal of Social Issues, 30, 159 – 165.

Gardner, Carol B. (1991). Stigma and the public self. Journal of Contemporary Ethnography, 20 (3), 251-263.

Gesino, Jack Paul & Siegle, E. (1995). Training gerontological social workers for nursing home practice. Gerontology and Geriatrics Education, 15 (4), 69-82.

Gilbert, Dorie M. (1996). A multivariate analysis to explore personality correlates of stigma vulnerability. Unpublished doctoral dissertation, University of Texas at Austin, Austin.

Gillespie, David F. (1982). Correlates for active and passive types of burnout. Journal of Social Service Research, 4 (2), 1 – 15.

Gleason-Wynn, Patricia. (1994). The effects of organizational, client, and personal variables on job satisfaction and intention for job turnover among nursing home social workers. Unpublished doctoral dissertation, The University of Texas at Arlington, Arlington.

Gleason-Wynn, Patricia & Mindel, Charles H. (1999). A proposed model for predicting job satisfaction among nursing home social workers. Journal of Gerontological Social Work, 32 (3), 65 – 79.

Grant, Linda D. (1996). Effects of ageism on individual and health care providers' responses to health aging. Health and Social Work, 21 (1), 9 – 15.

Greene, R. (1986) Countertransference issues in social work with the aged. Journal of Gerontological Social Work, 9 (3), 79 – 87.

Greene, R. R., Barusch, A. S., & Connelly, J. R. (1990). Social work and gerontology: Status report. Washington, DC: Association for Gerontology in Higher Education.

Hair, Joseph, Anderson, Rolph E., Tatham, Ronald L., & Black, William C. (1995). Multivariate data analysis with readings (4th ed.). Upper Saddle River, New Jersey: Prentice Hall.

Harvey, Richard D. (2001). Individual differences in the phenomenological impact of social stigma. Journal of Social Psychology, 141 (2), 174 – 190.

Haulotte, Shirley & Purvis, P. (1996). Claiming your space: how to earn acceptance and explain your role. In John S. McNeil, (Ed.), Guidelines for nursing home social workers. Institute for Quality Improvement in Long Term Health Care series report 96-3. (pp 15 – 30). San Marcos, Texas: Southwest Texas State University, Institute for Quality Improvement in Long Term Care.

Heifetz, Louis J. & Bersani, Henry A., Jr. (1983). Disrupting the cybernetics of personal growth: Toward a unified theory of burnout in the human services. In Barry A. Farber (Ed.), Stress and Burnout in the Human Service Professions (pp. 46 – 64) Elmsford, NY: Pergamon Press.

Herek, Gregory M. (1999). AIDS and stigma. American Behavioral Scientist, 42 (7), 1106 – 1207.

Himle, David P. Jayaratne, S. & Chess, W. (1987). Gender differences in work stress among clinical social workers. Journal of Social Service Research, 10, 41 – 56.

Himle, David P. & Jayaratne, S. (1991). Buffering effects of four social support types on burnout among social workers. Social Work Research and Abstracts, 27 (1), 22 – 28.

Hobfoll, Steven & Freedy, J. (1993). Conservation of resources: a general stress theory applied to burnout. In Wilmar B. Schaufeli, Christina Maslach, and Tadeusz Marek, (Eds.), Professional burnout: Recent developments in theory and research, (pp. 115 – 129) Washington, DC: Taylor & Francis.

Iglehart, A. P. (1990). Turnover in the social services: Turning over to the benefits. Social Service Review, 64, 649 – 657.

Jayaratne, S., & Chess, W. (1983). Some correlates of job satisfaction among social workers. Journal of Applied Social Sciences, 7 (1), 1 – 17.

Jayaratne, S., & Chess, W. (1984). Job satisfaction, burnout, and turnover: A national study. Social Work, 29, 448 – 453.

Johnson, M. & Stone, G. L. (1987). Social workers and burnout: A psychological description. Journal of Social Service Research, 10, 67 – 75.

Kaas, Merrie J. (2001). One to three: Eliminating the stigma of mental illness. Creative Nursing, 7 (1), 9-11.

Kane, Rosalie. (2001). Long-term care and a good quality of life: Bringing them closer together. The Gerontologist, 41, 293 – 304.

Kane, Rosalie A. (1981). The nursing home and assorted ironies. Health and Social Work, 6 (1), 2 – 3.

Kane, Rosalie A., Kane, Robert L., & Ladd, Richard C. (1998). The heart of long term care. New York: Oxford University Press.

Karger, H. (1981). Burnout as alienation. Social Service Review, 55, 271 – 283.

Kelchner, Elizabeth S. (1999). Ageism's impact and effect on society: Not just a concern for the old. Journal of Gerontological Social Work, 32 (4), 85 – 100.

Kelly, Deirdre M. (1996). Stigma stories. Youth & Society, 27 (4), 421 – 440.

Kelly, P. (1999). Isolation and stigma: The experience of patients with active tuberculosis. Journal of Community Health Nursing, 16 (4), 233 - 243.

Koeske, Gary F. & Koeske, Daimon R. (1989). Workload and burnout: can social support and perceived accomplishment help? Social Work, May, 243- 248.

Kogan, N. (1979). Beliefs, attitudes and stereotypes about old people: A new look at some old issues. Research on Aging, 1 (1), 11.

Kruzich, Jean Marie & Powell, William E. (1995). Decision making influence: An empirical study of social workers in nursing homes. Health and Social Work, 20 (3), 215 – 222.

Kulys. R. & Davis, M. A. Sr. (1987). Nurses and social workers: Rivals in the provision of social services? Health and Social Work, 12, 101 – 112.

Labor Market for Social Work (2001). News from SAGE-SW [on-line]. Available: www.cswe.org/sage/newsletter11.htm.

LeCroy, C. W., & Rank, M. R. (1987). Factors associated with burnout in the social services: An exploratory study. Journal of Social Service Research, 10 (1), 23-39.

Lee, Raymond T. & Ashforth, Blake E. (1990). On the meaning of Maslach's three dimensions of burnout. Journal of Applied Psychology, 75 (6), 743-747.

Leon, Ana M., Altholz, Judith A. S., & Dziegielewski, Sophia F. (1999). Compassion fatigue: Considerations for working with the elderly. Journal of Gerontological Social Work, 32 (1), 43 – 63.

Lyons, Declan & McLoughlin, Declan M. (2001). Recent advances psychiatry. British Medical Journal 323, 1228 – 1231.

March, Karen. (1995). Perception of adoption as social stigma: Motivation for search and union. Journal of Marriage & the Family. 57 (3), 653 – 661.

Marriott, Anne, Sexton, Sorne, & Staley, D. (1994). Components of job satisfaction in psychiatric social workers. Health and Social Work, 19 (3), 199 – 205.

Maslach, C. (1978). Client role in staff burnout. Journal of Social Issues, 34 (4), 111-124.

Maslach, C. (1986). Burnout research in the social services: A critique. Journal of Social Service Research, 10 (1), 95 – 105.

Maslach, Christina & Schaufeli, W. (1993). Historical and Conceptual Development of Burnout. In Wilmar B. Schaufeli, Christina Maslach, & Tadeusz Marek, (Eds.), Professional burnout: Recent developments in theory and research, (pp. 96 – 114) Washington: Taylor & Francis.

Maslach, Christina, Jackson, Susan E., & Leiter, Michael P. (1996). Maslach burnout inventory, third edition, Palo Alto, CA: Consulting Psychologist Press, Inc.

May, H. (2000). Murderers' relatives. Journal of Contemporary Ethnography, 29 (2), 198 – 222.

Meier, S. (1984). The construct validity of burnout. Journal of Occupational Psychology, 57, 221 – 219.

Miller, Leonard S. (1991). The relationship between social support and burnout: Clarification and simplification. Social Work Research and Abstracts, 27 (1), 34 – 38.

Mizuno, Y. (1998). Effects of sociodemographic factors, stage of illness, and perceived stigma on the identity. Sociological Spectrum, 18 (1) 5 – 19.

Moss, Frank E. & Halamandaris, Val J. (1977). Too old, too sick, too bad: Nursing homes in America. Germantown, Maryland: Aspen Systems Group.

Mullins, Larry C., Nelson, Carnot E., Busciglio, Henry, and Weiner, Hilary (1988). Job satisfaction among nursing home personnel: The impact of organizational structure and supervisory power. The Journal of Long-Term Care Administration, Spring, 12 – 17.

Murray, Y. (1996). Education in gerontology in Texas schools of social work. Institute for Quality Improvement in Long Term Care series report 96-1. San Marcos: Southwest Texas State University, Institute for Quality Improvement in Long Term Care.

National Institute of Aging, National Institutes of Health. (1987). Personnel for health needs of the elderly through the year 2020. (DHHS-NIAH Pub. No. 87 - 2950). Washington, DC: U. S. Department of Health and Human Services.

Nuessel, F. (1982). The language of ageism. The Gerontologist, 22 (3), 272 – 276.

Oktay, Julianne S. (1992). Burnout in hospital social workers who work with aids patients. Social Work, 37 (5), 432 – 439.

O'Reilly, K. (2001). Destigmatizing mental illness. Creative Nursing, 1, 3 – 4.

Packard, T. (1989). Participation in decision making, performance, and job satisfaction in a social work bureaucracy. Administration in Social Work, 13 (1), 59-73.

Peterson, D. A. (1990). Personnel to serve the aging in the field of social work: Implications for education professionals. Social Work, 35 (5), 412-415.

Pierce, C., Mark, B., & Molloy, Geoffrey N. (1989). The construct validity of the Maslach Burnout Inventory: some data from down under. Psychological Reports, 65, 1340 – 1342.

Pines, Ayala M. (1993). Burnout: An existential perspective. In Wilmar B. Schaufeli, Christina Maslach, & Tadeusz Marek (Eds.), Professional burnout: Recent developments in theory and research, (pp. 75 – 93). Washington, DC: Taylor and Francis.

Pines, A. & Kafry, D. (1978). Occupational tedium in the social services. Social Work, 23, 499 – 507.

Poulin, John E. (1994). Job task and organizational predictors of social worker job satisfaction change: A panel study. Administration in Social Work, 18 (1), 21-38.

Poulin, John E. & Walter, C. A. (1992). Retention plans and job satisfaction of gerontological social workers. Journal of Gerontological Social Work, 19 (1), 99 - 114.

Poulin, John. E. & Walter, C. A. (1993). Burnout in gerontological social work. Social Work, 38 (3), 305-310.

Poulin, John E. & Walter, C. A. (1993). Social worker burnout: A longitudinal study. Social Work Research & Abstracts, 29 (4), 5 – 7.

Powell, Jason L. (2001). Theorizing gerontology: The case of old age, professional power, and social policy in the United Kingdom. Journal of Aging & Identity, 6 (3), 117 – 135.

Powell, William E. (1994). The relationship between feelings of alienation and burnout in social work. Families in Society: The Journal of Contemporary Human Services, 229 – 235.

Quam, Jean K. & Whitford, Gary S. (1992). Educational needs of nursing home social workers at the baccalaureate level. Journal of Gerontological Social Work, 18 (3-4), 143 – 156.

Ray, Melvin C. & Lee, Motoko Y. (1988). Effects of stigmas on intergroup relationships. The Journal of Social Psychology, 129 (6), 855 – 857.

Riddick, B. (2000). An examination of the relationship between labeling and stigmatisation with special reference to dyslexia. Disability & Society 15 (4), 653 – 667.

Roberts, C. (1989). Conflicting professional values in social work and medicine. Health and Social Work, 14, 211 – 218.

Roper, Janice M. & Anderson, Nancy Lois R. (1994). Stigma. Clinical Nursing Research, 3 (4), 294 – 297.

Rotter, Julian B. (1966). Psychological monographs: General and applied. Washington, D. C.: American Psychological Association.

Rotter, Julian B. (1980). Social learning and clinical psychology. New York: Johnson Reprint Corporation.

Rotter, Julian B. (1982). The development and application of social learning theory. New York: Praeger Publishers.

Rubin, Allen & Babbie, Earl. (1993). Research methods for social work, second edition. Pacific Grove: Brooks/Cole Publishing Company.

Rubin, Allen & Shuttlesworth, G. (1986). Turnover among nursing home administrators: An exploratory study. Journal of Long Term Care Administration, Summer, 25 – 29.

Scharlach, Andrew, Damron-Rodriguez, JoAnn, Robinson, Barrie, & Feldman, R. (2000). Educating social workers for an aging society: A vision for the 21st century. Journal of Social Work Education, 36 (3), 521 – 539.

Sheridan, John E., White, John, & Fairchild, Thomas J. (1992). Ineffective staff, ineffective supervision, or ineffective administration? Why some nursing

homes fail to provide adequate care. The Gerontologist, 32, (2), 344 – 341.

Siefert, Kristine, Jayaratne, Srinika, & Chess, Wayne A. (1991). Job satisfaction, burnout, and turnover in health care social workers. Health and Social Work, 16 (3), 193 – 202.

Soderfeldt, Marie, Soderfeldt, Bjorm, & War, Lars-E. (1995). Burnout in social work. Social Work, 40 (5), 638-646.

Springer, David, Abell, Neil, & Hudson, W. (in press). Creating and validating rapid assessment instruments; part one. Research on Social Work Practice.

Springer, David, Abell, Neil, & Nugent, William R. (in press). Creating and validating rapid assessment instruments: part 2. Research on Social Work Practice.

Stav, A., Florian, V., & Shurkan, E. Z. (1986). Burnout among social workers working with physically disabled persons and bereaved families. Journal of Social Service Research, 10 (1), 81 – 105.

Stimmel, Glen L. (2001). Maximizing treatment outcome in depression: strategies to overcome social stigma and noncompliance. Disease Management Health Outcomes, 9 (4), 179 – 186.

Stone, Robin, & Wiener, Joshua (2001). Who will care for us: Addressing the long-term care workforce crisis. Washington: Urban Institute.

Sung, K. (2000). Respect for elders: Myths and realities in east Asia. Journal of Aging and Identity, 5 (4), 197 – 205.

Texas Department of Human Services (2000). Nursing facility requirements for licensure and medicaid certification. Austin, Texas.

Texas Department on Aging (2001). Policy roundtables: Odessa housing summary. [on-line]. Available: www.tdoa.state.tx.us.

Texas Health and Human Services Commission (2001). Texas promoting independence plan. [on-line]. Available: www.hhsc.state.tx.us.

Townsend, Claire (1971). Old age: The last segregation. New York: Grossman Publishers.

Um, Myung-Yong & Harrison, Dianne F. (1998). Role stressors, burnout, mediators, and job satisfaction: A stress-strain-outcome model and an empirical test. Social Work Research, 22 (2), 100 – 116.

Vin-Vogel, N. (1987). The geriatric worker in a community mental health clinic: Role problems and challenges. Journal of Gerontological Social Work, 11, 73 – 85.

Vinokur-Kaplan, Diane, Jayaratne, Srinika, & Chess, W. (1994). Job satisfaction and retention of social workers in public agencies, non-profit agencies, and private practice: The impact of workplace conditions and motivators. Administration in Social Work, 18 (3), 93 – 121.

Vladeck, Bruce C. (1980). Unloving care: The nursing home tragedy. New York: Basic Books, Inc.

Vourlekis, B. S., Gelfand, D.E., & Greene, R. R. (1992). Psychosocial needs and care in nursing homes: Comparison of views of social workers and administrators. The Gerontologist, 32 (1), 113-119.

Walkey, Frank H. & Green, Dianne E. (1992). An exhaustive examination of the replicable factor structure of the Maslach Burnout Inventory. Educational and Psychological Measurement, 52, 309 – 323.

Wallace, J. E. & Brinkerhoff, M. B. (1991). The measurement of burnout revisited. Journal of Social Service Research, 14, 85 – 111.

Wegar, Katarina. (2000). Adoption, family ideology, and social stigma: Bias in community attitudes. Family Relations, 49 (4), 363 – 371.

Wright, Clare & Coyle, A. (1996). Experiences of AIDS-related bereavement among gay men. Mortality, 1 (3), 267 – 283.

Vita

Margaret Jane Norwood was born on January 21, 1946, in Ft. Benning Georgia on the leading edge of the baby boom. The only child of James and Margaret Spivey, she was the heir to their dreams for an education denied to them by poverty. Jane and her fourteen first cousins, the first generation of their family to go to college, have, at last count, a total of 27 earned academic degrees among them. Jane graduated from Auburn University (Bachelor of Arts, with honors, English, 1968), St. Edwards University (Bachelor of Social Work, 1982), and the University of Texas at Austin (Master of Science in Social Work, 1985). She has been employed as a manager for the Texas Department of Human Services, the Texas Workers Compensation Commission, and the Governor's Management Center. She was Director of Quality for the Texas Health Care Association, and is currently lead researcher for the Texas Department on Aging. She has presented seminars for national and international conferences including the American Health Care Association, the American Society for Training and Development, and the Public Authority for Education and Training, Kingdom of Kuwait. Jane and her husband Larry have four children, Heather, Jonathan, Sarah, and Adam.

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