

4-1992

Perceived Social Support and Burnout Among Nurses Working with Chronically Ill and Dying Pediatric Patients

Jean Johnson

Follow this and additional works at: https://knowledge.e.southern.edu/senior_research



Part of the [Nursing Commons](#)

Recommended Citation

Johnson, Jean, "Perceived Social Support and Burnout Among Nurses Working with Chronically Ill and Dying Pediatric Patients" (1992). *Senior Research Projects*. 142.

https://knowledge.e.southern.edu/senior_research/142

This Article is brought to you for free and open access by the Southern Scholars at KnowledgeExchange@Southern. It has been accepted for inclusion in Senior Research Projects by an authorized administrator of KnowledgeExchange@Southern. For more information, please contact jspears@southern.edu.

Perceived Social Support and Burnout
Among Nurses Working with Chronically Ill
and Dying Pediatric Patients

Jean Johnson

Nursing Research Class

Dr. Leona Gulley

Division of Nursing

Southern College of SDA

16 April 1992

Abstract

This study focuses on the prevalence of burnout and its relationship to social support among nurses caring for chronically and terminally ill children. A convenience sample of 30 pediatric nurses were given surveys consisting of a demographic sheet, Maslach Burnout Inventory, Social Support Scale, and open-ended questions. The 14 completed and returned questionnaires were used in this nonexperimental, correlational study. Using the Student "t" distribution it was determined that the mean emotional exhaustion burnout subscore was significantly (.05 confidence level) higher in the tested sample than in the normative sample. God/Higher Power and co-workers were rated as the most helpful sources of social support. No correlation (using the Pearson "r") was found between the burnout scores and social support scores. Greater burnout awareness and prevention measures are needed. Further study with a larger, random sample is recommended.

Table of Contents

Abstract	2
Introduction	3
Problem statement	3
Review of literature	5
Theoretical framework	8
Research hypothesis	9
Statistical hypothesis	9
Definition of terms	9
Purpose	10
Methodology	10
Research design	10
Sample	10
Data collection	11
Assumptions and limitations	13
Scope	14
Data analysis	15
Discussion	17
Interpretation of findings and conclusions	17
Implications for nursing	18
Recommendations for further study	19
References	20
Appendix A: Data collecting tool	23
Appendix B: Raw Maslach Burnout Inventory data	27
Appendix C: Raw Social Support Scale data	27
Appendix D: Open-ended question replies	29
Table 1. Demographic characteristics	34
Table 2. Correlation coefficients of burnout subscales to social support scores	35
Table 3. Means and standard deviations for Maslach Burnout Inventory subscales	35
Table 4. Source analysis of social support	36

Perceived Social Support and Burnout
Among Nurses Working with Chronically Ill
and Dying Pediatric Patients

Introduction

Problem Statement

A nurse's education stresses care for not only the physical, but the mental, spiritual, and emotional needs of the patient and family members. The care of persons who endure chronic, life-shortening or terminal illnesses frequently necessitates extended contact between patients, families, and staff members, giving opportunity for the assessment and intervention regarding the psycho-emotional needs.

This care is not without cost to the nurse, however. Henlee points out that although nurses are schooled to give emotional support to dying patients and their families, more often it is the nurse who needs support (1987). The clinical significance of this is highlighted by Blake who states, "An emotionally deprived nurse cannot supply the emotional nourishment that a sick child or adult requires" (in Pagel & Wittmann, 1986).

Studies show the death of a child most difficult to handle (Benoliel, 1988), yet nurses practicing in the

pediatric setting must deal with this on a regular basis. In the care of children with diseases such as cancer or cystic fibrosis, treatment is often regular and intermittent over a long period of time, encouraging the development of close relationships between staff members, patient and family. When the child dies, this can produce personal grief as well as professional loss.

Vachon and Pakes observe that if the stress of caring for dying children and their families is not addressed, it may escalate to a level at which the care given becomes ineffective and "dehumanized" (1985).

The intensity of the stress described and the assertion that care becomes "dehumanized" and ineffective brings to mind Maslach's description of burnout: a "syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur among people who work closely with others (cited in Coady, Kent, & Davis, 1990, p. 117)."

Numerous studies of stress related to the care of critically ill and dying adults have been published, but research specific to burnout among nurses dealing with the pediatric population is limited. In light of burnout's negative consequences to staff functioning and patient care, this is an area which needs serious investigation.

This study explored the prevalence of burnout and its relationships to possible mediating factors among nurses who care for chronically ill and dying children and young adults. A better understanding of these relationships could provide insight into interventions to reduce nurse burnout.

Review of Literature

The search was conducted by a systematic review of the entries for "stress," "burnout," "pediatric nursing" and related topics from 1986 through 1990 in the Cumulative Index to Nursing & Allied Health Literature. Miscellaneous other articles were found using the Social Sciences Index, a MEDLINE search, and the references cited in research articles.

According to Beemsterboer and Baum, the study of burnout, although undertaken by a number of researchers, still lacks a standard definition and a clear set of criteria (1984). Most agree, however, that it is a result of "chronic work stress" and involves negative affect (Offermann, 1985).

A study of stress on oncology wards (patient age unspecified) in West Germany measured the correlation between stressors and physical symptoms. For nurses it found work/private life interference and problematic

nurse/patient interactions most strongly associated with physical distress (Ulrich & FitzGerald, 1990).

Cooper and Mitchell undertook a comparison between hospice and hospital nurses caring for critically ill and dying patients. They compared demographic variables and eight stressor factors by multiple regression analysis to job satisfaction, free-floating anxiety, somatic anxiety, depression, and poor overall mental health. Lack of support and involvement predicted all five problems for hospice nurses. Although the authors state that support and involvement "do not appear to be important factors" for overall mental health of hospital nurses, it also predicted four of the classes for hospital nurses, exceeded only by problems with the work-home interface. Other factors were not consistent for prediction between categories (1990).

In a children's hospice in England a study of stress in caregivers of dying children reported most (75%) scoring within the acceptable range. High stress scores were very closely linked ($p < 0.01$) to unresolved grief from past relative death and/or the death of a close friend or relative during the past year. General problems included difficulty creating a balance between work and home. All participants cited informal staff

support to be the most important coping factor. (Woolley, Stein, Forrest, & Baum, 1989).

Burnout and its relationship to personal and job-related demographic variables among acute-care pediatric nurses was studied by Pagel and Whittmann. Evidence of burnout was found. The only variable with which it was significantly related was "Percentage of children on unit with behavioral or emotional problems." No subjective variables were tested (1986).

The one study identified which specifically addresses burnout among professionals serving patients suffering chronic life-shortening pediatric illness deals not with nurses but with social workers. Those who perceived team support had higher personal accomplishment scores and those who perceived their supervisors to be supportive had lower depersonalization scores. Both of these indicate low risk of burnout. The other significant relationship found was between the spending of 31 to 41 hours per week serving the chronically ill, and high scores on emotional exhaustion and depersonalization scales, indicating high burnout risk (Coady et al., 1990).

Although dealing with diverse populations, each of the studies reviewed (except that by Pagel and Whittmann which did not test subjective social factors) highlights

a connection between stress or burnout and social factors such as support from co-workers or influence from home.

Theoretical Framework

The rationale for this study is based on Imogene King's interaction model for nursing and the "buffer theory" of social support from the social sciences.

According to King, each individual is an open, total "personal system." Interacting individuals, such as the nurse and patient, form "interpersonal systems," and all function within wider "social systems." Because of the dynamic interactions between systems, an event in one system will affect each of the others (1981). Thus a stresser in the patient's personal system, such as illness and death, will influence the nurse's system with which it interacts, which will in turn affect and be affected by the social system.

The "buffer theory" of social support proposes that social support reduces the ill-effects of negative stressors (Alloway & Bebbington, 1987; Rankin & Monahan, 1991). Studies show that perceived support is generally more predictive of adjustment to stressful events than is actual received support (Wethington & Kessler, 1986).

Cohen and McKay suggest that the stress buffering effect of social support may occur by a modification of

the assessment of the stresser's potential threat or masterability (cited in Wethington & Kessler, 1986). Since negative stress (distress) occurs "only when the event is evaluated as threatening and coping capacities are evaluated as inadequate (Wethington & Kessler, 1986)," a nurse who perceives that adequate social support is available should experience lesser degrees of stress and be less likely to suffer from burnout, which occurs as a result of intense and prolonged interpersonal stress.

Research Hypothesis

Nurses who perceive that adequate social support is available will experience lesser burnout than will those who report inadequate support.

Statistical Hypothesis

There is no correlation between reported social support availability and burnout levels. This will be tested at the 0.05 significance level.

Definition of Terms

Burnout. A "syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment" occurring among those who work closely with people (Maslach & Jackson, 1986b, p. 1) as measured in this study by score on the Maslach Burnout Inventory (MBI).

Perceived social support. Appraisal that support from interpersonal relationships is available, measured here by the Social Support Scale (SSS).

Stresser. Person, object, or event which provokes an energy response by an individual (King, 1981, p. 98).

Purpose

The purpose of this study was to explore the prevalence of burnout and its relationship to possible mediating factors such as social support among nurses who care for chronically ill and dying children and young adults.

Methodology

Research Design

A nonexperimental, correlational design was used in this study. The relationships between social support, stress, and burnout are complex and the variables are beyond the control of the researcher. Determination of correlation, however, between perceived social support and burnout could be very useful in designing formal or informal programs to better meet the needs of staff nurses working in high-loss areas.

Sample

From the population of all nurses who care for hospitalized pediatric patients with chronic, terminal illnesses, this study focused on the nurses who work on

a general pediatrics unit at a children's hospital in Tennessee which has a well-known chronic population of patients admitted for exacerbations of cystic fibrosis, cancer chemotherapy and complications, and chronic renal failure, as well as patients with acute processes. Surveys were distributed to a convenience sample of thirty current staff RNs who had completed at least six months in their current positions and consented to participate. Fourteen of the fifteen surveys returned were complete.

Data Collection

Data collection for this study was done by distributing questionnaires to all nurses employed on the floor to be filled out at their convenience. This format was selected because of its flexibility to fit into the varied schedules of the respondents and to encourage unbiased answers by preserving anonymity. To avoid influencing answers according to the respondent's preconceptions of burnout, this issue was not discussed. The questionnaire was called "Pediatric Nursing Survey" with the MBI portion labeled "Human Services Survey" as recommended by Maslach and Jackson (1986b). Because of the use of a confidential questionnaire and voluntary participation, no harm or violation of subject rights should have occurred.

The questionnaires included demographic data, the Maslach Burnout Inventory (MBI), the Social Support Scale (SSS), and open-ended questions regarding types of support found least and most helpful in dealing with the illness and death of patients.

The MBI (Maslach & Jackson, 1986a) consists of 22 statements of feelings to be categorized by frequency using a six-point, fully anchored Likert format. The scores are divided into three subscales to assess different aspects of burnout: emotional exhaustion, depersonalization, and low personal accomplishment. It is scored using the scoring key supplied by the author of the test. Higher scores on the emotional exhaustion and depersonalization subscales and lower scores on the personal accomplishment subscale reflect higher degrees of burnout (Maslach & Jackson, 1986b). For instrument validity and reliability data, the reader is referred to Lynn Offermann's critique of the MBI (1985), the manual for its administration (Maslach & Jackson, 1986b), and a confirmation of its three-factor structure by Green and Walkey (1988).

Social support was measured using the SSS (Funch, Marshall, & Gebhardt, 1986) in which possible sources of support were ranked by a four-point Likert scale according to how helpful they were perceived to be by

the respondent or left blank if the source is not applicable. The SSS was scored using two separate methods. One, the SSS-P1, is the mean perceived support score computed only from the available sources. It is a measure of perceived support and is not affected by the number of types of available sources. The other, the SSS-P2, is the overall mean with unavailable sources scored as "one" or "not at all helpful," thereby reducing the possible support score of those with fewer sources and measuring a combination of perceived and structural support (Funch et al., 1986). Validity and reliability data are presented in Funch et al. (1986).

Assumptions and Limitations

Underlying this study are the assumptions that nurses are affected by the patients for whom they care, that stress experienced as a result of this interaction may lead to burnout, and that the nurse's response to the stress is influenced by factors in her environment. It is also assumed that the answers given reflected the true feelings of the participants.

When drawing conclusions from the data, the limitations of the sample must be recognized. Because of the complex nature of the roles played by these nurses and the interrelationships between the variables, it is nearly impossible to isolate the sources of

stress. The proximity to death and dying is one stresser, but other factors such as long work hours, personality conflicts, or tension from outside of work could also have had an effect. The fact that all of the respondents were co-workers, sharing a social system, increases the possibility that an untested common factor could have influenced the results. Another limitation is presented by the small sample size and lack of randomization.

Despite the many limitations, however, a field study such as this has certain advantages over those done under laboratory conditions. Because the subjects of study are wholistic human beings, no single measure or simple "x leads to y" can fully describe the observed responses. The looser control of a field study allows description of the responses of those in the midstream of daily duties, with greater application of the results to the work setting.

Scope

Because of the very small sample and lack of randomization the results obtained are not conclusive and cannot be taken as representative of the larger population of nurses who care for chronically ill or dying pediatric patients. This study would be well

used, however, as a pilot to guide further research in this area.

Data Analysis

A total of 15 of 30 surveys were returned. Fourteen of these were complete and usable for analysis. The demographic data of the completed surveys is summarized in Table 1.

To determine the relationship between the MBI subscale scores and the social support scores, the Pearson "r" linear correlation coefficient was used (Table 2). No significant correlations were found at the .05 significance level.

Because no control group was used in the design of this study, the scores of the study sample were compared with those of the subjects on whom the MBI was normed (Table 3). Emotional exhaustion scores for the sample ranged from 14 to 41 with a mean of 26.43 (high extreme of moderate level) and a median of 28.0, indicating a high level of burnout for the group. To test whether the mean of the sample population was greater than that of Maslach's subgroup of medicine (22.19), which was in turn higher than that of the normative population (20.99), a one-tailed Student "t" distribution was used. At the .05 confidence level the critical value is 1.771 for a sample with 13 degrees of freedom (Triola, 1989,

p. 721). The test statistic, $t = 2.115$, was well within the range of significance, supporting the claim that the sample population had higher emotional exhaustion scores, thus greater risk of burnout, than Maslach's medical or normative samples.

Depersonalization scores for the study sample ranged from 1 to 18, with a mean of 8.29, falls between the mean scores for the Maslach medicine subgroup (7.12) and the normative sample (8.73), all within the moderate range of burnout.

Ranging from 25 to 44, the personal accomplishment score had a mean of 34.79, intermediate between 34.58 and 36.53, the mean scores for the normative data and the medicine subgroup. This is within the moderate range of burnout.

For the SSS, neither normative data nor control sample data were available to compare with the results of the test sample data. Possible scores range from 1 to 4. The mean of the data when analyzed using the SSS-P1 method is 2.83, higher than that obtained by using the SSS-P2 (2.54). That is to be expected since with the SSS-P2 the total possible decreases when any of the measured support sources is unavailable.

The analysis of the SSS by source replies (Table 4) reveals that God/Higher Power and co-workers were

reported by every participant as being either "usually helpful" or "completely helpful." Supervisors and friends were ranked next highest, being marked "usually helpful" or "completely helpful" 57% of the time. The rankings of each of the other categories were varied. Support group was not scored (not applicable) by 57% of the sample, but by those who did mark it, it was scored as usually or completely helpful by 66.7%.

Discussion

Interpretation of findings and conclusions

The statistical analysis of the data did not support the hypothesis of correlation between social support and burnout. Because of the small sample size and the aspects of social support and work environment which the participants share, the validity of these results is questionable.

The nurse's replies to the open-ended questions can help clarify the variables which need further exploration and point out specific strategies for combating burnout. (See Appendix D for complete staff replies to open-ended questions.)

The factors identified by the staff as most difficult about their work included long hours, demanding parents, co-worker gossip, and frustration at being unable to better help the children, as well as the

death of patients. Those identified as most rewarding were positive feedback from patients and families and the feeling of contributing in the recovery of the child.

The elements identified as most helpful in coping with sickness and death were sharing feelings with co-workers, faith in God, accepting death as an end of suffering, and spending time away from the situation. Lack of sharing emotions and inadequate time to grieve were cited as least helpful. Support groups and grief counseling were the most frequent suggestions for services that could be provided by the hospital to assist the nurse.

The "buffer theory" that perceived social support reduces the ill-effects of negative stressors, while not supported by the statistical data, is supported by the open-ended question responses as well as by the reviewed literature.

Implications for nursing

The significantly high emotional exhaustion burnout scores highlight the importance of burnout awareness in nursing. Supervisors and staff can benefit by learning about and applying burnout prevention strategies. Time and space provided at or near the workplace for grief work and social support are possible measures.

Recommendations for further study

The factors that may effect burnout are many, and further research is needed. A larger, random sample, taken from several work sites, would decrease the weight of confounding factors inherent to a sample who shares work conditions, supervision, patients, and social support. This would greatly improve the generalizability of the results. Research on the link specifically between grief and emotional exhaustion among this population of nurses might also provide valuable insights.

With increased knowledge in this area, better burnout prevention strategies can be developed, leading to increased nurse job satisfaction and a higher quality of patient care.

References

- Alloway, R., & Bebbington, P. (1987). The buffer theory of social support: A review of the literature. Psychological Medicine, 17, 91-108.
- Beemsterboer, J., & Baum, B. H. (1984). Burnout: Definitions and health care management. Social Work in Health Care, 10(1), 97-109.
- Benoliel, J. Q. (1988). Health care providers and dying patients: Critical issues in terminal care. Omega, 18(4), 341-363.
- Coady, C. A., Kent, V. D., & Davis, P. W. (1990). Burnout among social workers working with patients with cystic fibrosis. Health and Social Work, 15(2), 116-124.
- Cooper, C. L., & Mitchell, S. (1990). Nursing the critically ill and dying. Human Relations, 43(4), 297-311.
- Funch, D. P., Marshall, J. R., & Gebhardt, G. P. (1986). Assessment of a short scale to measure social support. Social Science and Medicine, 23(3), 337-344.
- Green, D. E., & Walkey, F. H. (1988). A confirmation of the three-factor structure of the Maslach Burnout Inventory. Educational and Psychological Measurement, 48(3), 579-585.

- Henlee, S. M. (1987). Helping staff cope with grief. Nursing Management, 18(9), 33-34.
- King, I. M. (1981). A theory for nursing. New York: John Wiley & Sons.
- Maslach, C., & Jackson, S. E. (1986a). Maslach Burnout Inventory (Survey). Palo Alto, CA: Consulting Psychologists Press, Inc.
- Maslach, C., & Jackson, S. E. (1986b). Maslach Burnout Inventory: Manual (2nd ed.). Palo Alto, CA: Consulting Psychologists Press, Inc.
- Offermann, L. R. (1985). Maslach burnout inventory. In D. J. Keyser & R. C. Sweetland (Eds.), Test critiques (Vol. 3, pp. 419-426). Kansas City, MO: Test Corporation of America.
- Pagel, I. S., & Wittmann, M. E. (1986). Relationship of burnout to personal and job-related variables in acute-care pediatric settings. Issues in Comprehensive Pediatric Nursing, 9, 131-143.
- Rankin, S. H., & Monahan, P. (1991). Great expectations: Perceived social support in couples experiencing cardiac surgery. Family Relations, 40(3), 297-302.
- Triola, M. F. (1989). Elementary statistics (4th ed.). Redwood City, CA: The Benjamin/Cummings Publishing Company, Inc.

- Ulrich, A., & FitzGerald, P. (1990). Stress experienced by physicians and nurses in the cancer ward. Social Science and Medicine, 31(9), 1013-1022.
- Vachon, M. L. S., & Pakes, E. (1985). Staff stress in the care of the critically ill and dying child. Issues in Comprehensive Pediatric Nursing, 8(1/6), 151-182.
- Wethington, E., & Kessler, R. C. (1986, March). Perceived support, received support, and adjustment to stressful life events. Journal of Health and Social Behavior, 27, 78-89.
- Woolley, H., Stein, A., Forrest, G. C., & Baum, J. D. (1989). Staff stress and job satisfaction at a children's hospice. Archives of Disease in Childhood, 64(1), 114-118.

Appendix A: Data collecting toolPEDIATRIC NURSES SURVEY

This study is for the purpose of better understanding the feelings and needs of nurses who care for chronically ill and dying children and young adults. Understanding is needed so that more effective ways of helping can be developed.

Please complete the following questions carefully and honestly. Anonymity will be maintained. Since all answers will be pooled, it will not be possible to identify any individual participant.

Completion of this questionnaire will typically take 20 to 30 minutes and implies voluntary consent to participation.

Demographic Data

Age _____ years Sex: Female Male

Are you (circle only one)

Asian Black Hispanic Native American White Other

Marital Status

Single Married Divorced Widowed Other

What is your last completed degree?

LPN AS diploma BSN MSN

other (please specify) _____

How long have you worked as a nurse? _____

How long have you worked in your present position? _____

How many hours per week do you work? _____

Please estimate what percent of your time at work is spent nursing patients with chronic, life-shortening illnesses.

0-19% 20-39% 40-59% 60-79% 80-100%

How many of your patients died in the past year? _____

Have you experienced the death of a close relative or friend unrelated to work in the past year? yes no

Human Services Survey

Please complete the attached Human Services Survey following the printed instructions.

Human Services Survey

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

On the following page there are 22 statements of job-related feelings. Please read each statement carefully and decide if you ever feel this way *about your job*. If you have *never* had this feeling, write a "0" (zero) before the statement. If you have had this feeling, indicate *how often* you feel it by writing the number (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."



Consulting Psychologists Press, Inc.
3803 E. Bayshore Road • Palo Alto, CA 94303

Copyright © 1986 Consulting Psychologists Press, Inc. All rights reserved. No portion of this material may be reproduced by any means without written permission of the Publisher. Printed in the U.S.A.

Social Support Scale

When a person is dealing with a chronically ill and dying patient, the people around sometimes help and sometimes make things harder, even if they don't realize it. Please circle the answers below which best indicate how helpful these people are. If a source is not relevant for you, leave the line blank.

	Not at all helpful	A little helpful	Usually helpful	Completely helpful
Coworkers	1	2	3	4
Supervisors	1	2	3	4
Spouse	1	2	3	4
Family members	1	2	3	4
Friends	1	2	3	4
Support group	1	2	3	4
Church	1	2	3	4
God/Higher Power	1	2	3	4

Open-ended Questions

Please answer the following as completely as possible. (You may use the reverse side if needed.)

1. What do you find most difficult about your work?

2. What do you find most rewarding?

3. What helps you most to cope with the sickness and death which you encounter?

4. What do you find least helpful?

5. What services could the hospital provide to help you better deal with the chronically ill and terminal patient?

Congratulations, you're finished!

Thank you very much for participating. It may have been difficult for some of you to sit quietly and think about this aspect of your work, but your willingness to do so is appreciated. Your knowledge and experience are important and will be useful in better understanding the reality of, and in learning to better support, the pediatric nurse.

Appendix B: Raw Maslach Burnout Inventory data

Respondent	Score and Burnout Level					
	Emotional Exhaustion		Depersonalization		Personal Accomplishment	
1	20	Mod	8	Mod	35	Mod
2	23	Mod	7	Mod	43	Low
3	19	Mod	7	Mod	35	Mod
4	35	High	11	Mod	25	High
5	30	High	6	Low	35	Mod
6	33	High	16	High	39	Low
7	27	High	10	Mod	29	High
8	14	Low	3	Low	44	Low
9	41	High	18	High	32	Mod
10	29	High	5	Low	39	Low
11	20	Mod	1	Low	37	Mod
12	30	High	4	Low	28	High
13	30	High	13	High	34	Mod
14	19	Mod	7	Mod	32	Mod

Appendix C: Raw Social Support Scale data

Support Source	Support Rank													
	Respondent													
	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Co-workers	3	4	3	3	3	3	3	3	3	3	3	3	3	3
Supervisors	1	3	2	2	3	3	3	2	2	2	3	3	3	3
Spouse	2	1		3	4	3		2	2	2	4	4		
Family members	2	2	3	2	2	3	3		2	2	4	4	1	3
Friends	3	2	3	2	2	3	3		2	2	3	4	3	3
Support group						3			2	1	3	3	4	
Church			2	2	4	4	3		2	2	3	3	3	
God/Higher Power	4	3	3	4	4	4	3	3	3	3	4	4	4	4

Respondent	Support Score	
	SSS-P1	SSS-P2
1	2.50	2.12
2	2.50	2.12
3	2.67	2.25
4	2.57	2.38
5	3.14	2.88
6	3.25	3.25
7	3.00	2.50
8	2.50	1.75
9	2.25	2.25
10	2.12	2.12
11	3.38	3.38
12	3.50	3.50
13	3.00	2.75
14	3.20	2.38

Appendix D: Open-ended question replies

1. What do you find most difficult about your work?

Some patients are very difficult in that they are very demanding. At times I'll have every one of my families that are demanding.

Dealing with the parents of a child who has just died. Parents who are uncaring in attitude toward their children.

Feeling frustrated when there is nothing else you can do for your patient to make them better.

Always giving out till you feel drained. No one seems to give back to the caregivers to refill what is drained.

The emotional stress and physical stress. I am completely exhausted after a day's work.

Long hours

Discipline of staff

I find organizing my day most difficult, especially on busy days.

Supervisors who don't seem to care about the individual worker

Co-workers who complain frequently

Co-workers who gossip

Not being able to work through the loss of one patient before another one or more dies

Long hours

Things I've not dealt with before

Trying to become familiar with new things i.e. equipment, procedures

Not taking the frustrations, depression, etc. home with me

Demanding parents

Dealing with demanding parents and/or patients.

When there is a heavy workload with dying or difficult patients, I feel I can't accomplish all I want to do i.e. spend more time with my patients and their families.

No one to listen

Twelve-hour shifts

Not being able to help children who are in chronic pain

When a patient dies

2. What do you find most rewarding?

When a patient improves and goes home it is satisfying to know I may have had a part in their recovery.

Feeling that I have really contributed to this person's healing

The children: their smiles, their "thank-you's," their recoveries or remissions

Little smiling faces!

Helping patients and families

Helping patients physically
Helping patients and family emotionally
Patient teaching

The contact with the children. Their hugs and smiles can make my day. I also find it rewarding to feel like I'm doing my part to help cure them or treat them.

Having someone say "thank-you"

Seeing people improve

A child's smile.
Teaching families about a child's illness/situation and having them respond positively to you!

Teaching when you know someone is listening and you can help them.

Being told or showed that my work and presence has helped them in some way while they are in the hospital.

Seeing a patient go home healthier

When a child gets better and is able to run around again.
When I have helped a parent through a minor crisis and they thank me.

A very sick kid gets well and goes home

Knowing I'm there to help

The joy given and received from each patient. With every chronically ill patient I always find joy! Even if this includes being thankful that he/she will soon be relieved of their pain.

3. What helps you most to cope with the sickness and death which you encounter?

I really don't know. I have seen a lot of children die, most of them I felt as if they were my own. I often wonder if perhaps I just suppress it. I worry about the day that it all comes out.

Being able to get away from it for a few days at a time
Having other activities I enjoy doing

To talk with coworkers about the patient and be reassured that I did everything I could.

Knowing that most people get better and that those who die are no longer suffering

Talking with fellow employees.
Knowing that this is my job and to help keep patients as comfortable as possible during their stay.

Realize it's not my fault when death occurs
Feeling that all kids go to heaven

I vent my grief in private.
I get family and nursing support.
It helps to see the other nurses grieving along with me.

Good friends and co-workers who will listen and talk about the person who has died and can express and listen to your feelings.
Spending quiet time alone with God and His word--especially the Psalms.
Reading good articles, books, etc. dealing with such topics.

Other staff members

Going to a quiet place for crying and prayer.

Support of co-workers

A belief in a higher power, higher purpose

My co-workers and faith in God

God and a very big heart! I feel for every patient I take care of. For some I know that their sickness will get better that helps me cope, for others the alternative is worse. Just knowing the pain will eventually be better regardless of the sad fact that it involves death. Also a good cry with a friend or family member or co-worker helps.

That most of our patients get well. The ones that do die, knowing they no longer have to suffer.

4. What do you find least helpful?

I find it difficult to say the right things to the patient and the family members. Sometimes the family is not helpful and sometimes they are, depending on the situation.

Non-"medical" friends

Fighting my own emotions--trying to be strong for the family

Admitting a patient right after a death

Difficulty in finding someone to listen

Those close to you don't understand your need to mourn

Getting involved with (or just caring for) a terminally ill child soon

The fact that I'm not oriented on the computer. I hate to ask for help. I'd rather do it myself.

Hostile family

Hiding emotions and not letting myself cry or get upset.

No time to grieve

No understanding from the hospital that you need help to deal with your loss.

Not talking to others about it and keeping it inside trying to ignore it.

People who say "How can you stand to work with sick children"

I don't like to talk about it and dwell on it.

I find holding it all in and asking myself why or what could I have done to prevent this?

5. What services could the hospital provide to help you better deal with the chronically ill and terminal patient?

Inservices on dealing with our own feelings towards death and feelings towards chronically ill patients

The hospital psychologist has offered to have group therapy with the nurses to have them talk through their feelings and I think that would be a great idea!

Counseling services, either individual or group, by people who have been where you are and know what you mean. Not a desk jockey who mouths cliches.

I can't think of any

The support of coworkers is wonderful because they go through it with you!

An intermediate unit for chronic/terminal patients with a lower nurse/patient ratio would help.

Hospice inservices
Grief therapists
Stress management seminars

Support group
Share pictures
Library of resources
Work on the scrapbook of memories that Dottie tried to start years ago

I would like a chapel close to Children's. I won't go over to Erlanger and leave the floor.

Inservice on stress relief?

Group grief counseling

Support and discussion groups held on a regular basis

More information

More types of information and a monthly support type group for people faced with these situations.

**Table 1. Demographic Characteristics
of Sample (n = 14)**

Characteristic	n	%
Age		
20-30	5	35.7
31-40	5	35.7
41-50	4	28.6
Sex		
Female	14	100.0
Marital status		
Single	3	21.4
Married	9	64.3
Divorced	2	14.3
Race		
Caucasion	14	100.0
Educational level		
AS	5	35.7
Diploma	3	21.4
BS	6	42.9
Years as a nurse		
0- 5	7	50.0
6-10	2	14.3
11-15	3	21.4
16-20	1	7.1
20-25	1	7.1
Years in present position		
0- 5	10	71.4
6-10	1	7.1
11-15	2	14.3
16-20	1	7.1
Shifts per week (12-hour)		
3	8	57.1
3-4	5	35.7
6	1	7.1
Estimated percent of time with chronically ill		
0-19	2	14.3
20-39	7	50.0
40-59	3	21.4
60-79	1	7.1
No answer	1	7.1
Number of patients who died in past year		
0- 5	8	57.1
6-10	3	21.4
11-15	1	7.1
No answer	2	14.3
Death of close relative or friend in past year		
Yes	3	21.4
No	11	78.6

Table 2. Correlation Coefficients of Subscales to Social Support Scores

	r ^a Value		
	Emotional Exhaustion	Depersonalization	Personal Accomplishment
SSS-P1	-.076995	-.191035	-.269831
SSS-P2	.294335	-.0319067	-.302542

^aAn r value of $>.5326$ would indicate a correlation between the burnout component and support score.

Table 3. Means and Standard Deviations for Maslach Burnout Inventory Subscales

Group	Score ^a		
	Emotional Exhaustion	Depersonalization	Personal Accomplishment
Pediatric Nurses (n = 14)			
M	26.43	8.29	34.79
SD	7.51	4.86	5.44
Maslach normative data (n = 11,067) ^b			
M	20.99	8.73	34.58
SD	10.75	5.89	7.11
Maslach subgroup medicine (n = 1,104) ^c			
M	22.19	7.12	36.53
SD	9.53	5.22	7.34

^aSubscale categorization: emotional exhaustion (low = 0-16, moderate = 17-26, high = ≥ 27), depersonalization (low = 0-6, moderate = 7-12, high = ≥ 13), personal accomplishment (low = ≥ 40 , moderate = 32-38, high = 0-31) (Maslach & Jackson, 1986b)

^bNormative sample data include teachers, postsecondary educators, social service workers, medical workers, mental health workers, and others (Maslach & Jackson, 1986b).

^cMedical workers include physicians and nurses.

Table 4. Source Analysis of Social Support

	N/A		Not helpful		A little helpful		Usually helpful		Completely helpful	
	n	%	n	%	n	%	n	%	n	%
Co-workers	0	0.0	0	0.0	0	0.0	13	92.9	1	7.1
Supervisors	0	0.0	1	7.1	5	35.7	8	57.1	0	0.0
Spouse	4	28.6	1	7.1	4	28.6	2	14.3	4	28.6
Family members	1	7.1	1	7.1	6	42.9	4	28.6	2	14.3
Friends	1	7.1	0	0.0	5	35.7	7	50.0	1	7.1
Support group	8	57.1	1	7.1	1	7.1	3	21.4	1	7.1
Church	4	28.6	0	0.0	4	28.6	4	28.6	2	14.3
God/Higher Power	0	0.0	0	0.0	0	0.0	6	42.9	8	57.1