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GEROPSYCHIATRIC NURSING STAFF: THE ROLE OF EMPOWERMENT,
GERIATRIC CAREGIVING SELF-EFFICACY, AND EMOTIONAL LABOR AT
WORK

A dissertation submitted in partial fulfillment of the requirements for the degree of
Doctor of Philosophy at Virginia Commonwealth University

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December 2010

Acknowledgements

The completion of my dissertation would have been impossible were it not for the support of many people in my life. Thank you to my husband John, who has seen me through every stage of this project with his love and support. Without you, I could not have done this! To my daughter Lily, I was pregnant with you when I proposed my dissertation and now you are almost two years old – having you in my life only makes the completion of my dissertation and my doctoral degree sweeter. Thank you to my parents, Robert and Mary Smolen, who provided child care on little notice, in-house editing, support and love all along this process. You were there for me when I needed you most. To my sisters and brother, thanks for your support and confidence in me and always being interested in my graduate education. Next, thank you to my best friend Kerri Kim, who has given me support, love and motivation when I needed it, and who knows exactly what this task entails. Thanks also to my friend and colleague Katie Campana-Scherer, whose enthusiastic support I have always appreciated – thanks for being there in the final hours! Finally, I want to thank Dr. Andrew Heck for his assistance with planning the execution of my project at PGH and for providing me with a great geropsychologist mentor. I would also like to thank my advisor and dissertation chair Dr. Vicky Shivy, who has continued to support and encourage my research interest in geriatric nursing stress and supported my professional development throughout my graduate career.

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Abstract

GEROPSYCHIATRIC NURSING STAFF: THE ROLE OF EMPOWERMENT, GERIATRIC CAREGIVING SELF-EFFICACY, AND EMOTIONAL LABOR AT WORK

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A dissertation submitted in partial fulfillment of the requirements for the degree of Doctor of Philosophy at Virginia Commonwealth University.

Virginia Commonwealth University, 2010.

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The current research examined the influence of the emotional labor strategies of faking emotion and suppression of emotion, empowerment, and geriatric caregiving self-efficacy on the relationship between work stress and emotional exhaustion—one dimension of burnout—for a sample of nursing staff members employed in a state-level geriatric psychiatric hospital. The total sample included 79 participants, which included registered nurses ($n = 15$), licensed practical nurses ($n = 23$), and human service care workers ($n = 41$) who completed the Stress in General scale (Stanton, Balzer, Smith, Parra, & Ironson, 2001), Maslach Burnout Inventory (Human Services Survey; Maslach, Jackson & Leiter, 1996), Discrete Emotions Emotional Labor Scale (Glomb & Tews, 2004), Psychological Empowerment Scale (Spreitzer, 1995), and Geriatric Nursing Self-efficacy Scale (Mackenzie & Peragine, 2003). The mean emotional exhaustion score for the sample fell in the *moderate* range of burnout. First, it was hypothesized that work stress and emotional labor strategies (i.e., faking emotion and suppression of emotion) would have positive relationships with the

burnout domain of emotional exhaustion while empowerment and geriatric caregiving self-efficacy would have negative relationships with this outcome. Next, a series of regression analyses tested emotional labor (i.e., faking emotion and suppression of emotion), empowerment, and geriatric caregiving self-efficacy as moderators for the relationship between stress and burnout. Results indicated that study variables were all related to emotional exhaustion in the expected direction, although several relationships fell short of statistical significance. In addition, emotional labor was a significant predictor of emotional exhaustion, with suppression of emotion playing a larger role. There was no support for the potential moderating role of emotional labor or empowerment on the relationship between work stress and burnout. However, geriatric caregiving self-efficacy was a significant moderator of this relationship. More specifically, when staff reported high work stress, those who had low self-efficacy experienced the highest emotional exhaustion values. However, when self-efficacy was high for this group, their emotional exhaustion scores decreased. For this sample, higher levels of self-efficacy appeared to play a protective role from experiencing more emotional exhaustion when in a high stress condition.

Geropsychiatric Nursing Staff: The Role of Empowerment, Geriatric Caregiving Self-Efficacy, and Emotional Labor at Work

The nursing shortage that began in 1998 has improved in many areas of the country due to substantial increases in nurse employment (Buerhaus, Auerbach & Staiger, 2009). However, despite the fact that approximately 581,500 new nursing jobs are expected between 2008 and 2018 (Bureau of Labor Statistics, 2010), a major nursing shortage is projected by 2020. Estimates of this shortage range from 300,000 to a million nurses by 2020-2025 and will occur as the demand for nurses increases steadily while their average age declines and large numbers of nurses retire (Buerhaus, 2008; U.S. Department of Health and Human Services, 2004). Lessons learned from the recent nursing shortage highlight negative outcomes for both staff and patients (Buerhaus, Staiger, & Auerbach, 2004; Hannan, Norman, & Redfern, 2001). Given the current and projected growth in the older adult population (Field & Cassel, 1997; Wan, Sengupta, Velkoff, & DeBarros, 2005), the projected nursing shortage becomes a serious problem when considering the increasing needs of geriatric patients. The demand of geriatric nurses is great, indeed. Less than 1% of registered nurses in the U.S. hold certification in gerontological care (Kovner, Mezey, & Harrington, 2002). In addition to experiencing an increased need for nursing services, a significant number of older individuals will require psychiatric care, as well. Nursing staff who attend to the needs of a geriatric population experiencing significant psychiatric problems are a unique worker group whose work experiences demand more research attention.

The recent crises in retention of nursing staff have been especially apparent for those working in geriatrics (Kovner et al., 2002). This issue not only applies to registered nurses, but also to nursing assistants. Problems in staffing for registered nurses have been highlighted above; similar problems exist for nursing assistants, who also show high levels of

turnover on the job (Cohen-Mansfield, 1997). Both nurses and their assistants provide essential care for older adults, and a thorough investigation of nursing staff's experiences should include both of these worker groups. However, relatively few researchers have targeted nursing assistants. Burnout is a work outcome that has serious implications for nursing staff and is frequently assessed in research efforts.

Burnout is a phenomenon first defined by Maslach and Jackson (1981) that occurs at work, and describes workers' feelings of emotional exhaustion, depersonalization, and reduced personal accomplishment. This work outcome has been often explored for nurses (Cocco, Gatti, Lima & Camus, 2003; Fagin et al., 1996; Kilfedder, Power & Wells, 2001; Mann & Cowburn, 2005), but less frequently for nursing assistants (Barber & Iwai, 1996; Chappell & Novak, 1994; Kennedy, 2005). Burnout was evaluated in the current research for both nurses and their assistants (i.e., licensed practical nurses and nursing assistants).

Before examining factors that might be associated with burnout, it is important to identify a guiding model for understanding stress at work. Hobfoll's (1989) conservation of resources (COR) theory of stress suggests that work stress is the result of a mismatch between the work environment and the worker's ability to obtain or maintain psychological resources. When perceived resources are outweighed by demanding work circumstances, heightened stress levels follow. Psychological resources may include individual characteristics, possessions, or knowledge; these resources must be valued by the individual. A number of researchers in the occupational stress literature have applied this theory successfully, accounting for the relationship between work resources and stress coping methods, as well as job strain (Ito & Brotheridge, 2003; Grandey & Cropanzano, 1999).

Although COR theory was not specifically tested in the current research, it guided conceptualization of relationships among variables of study.

Influences on Burnout

A number of different factors affect burnout for nursing staff. The relationship between stress and burnout seems fairly clear in the literature, with high levels of stress leading to more negative work experiences (Cocco et al., 2003; Hannan et al., 2001; Kennedy, 2005). However, the precise mechanisms by which various work experiences affect the relationship between stress and work consequences are not clear. Variables of interest in the present research include emotional labor demands, empowerment, and geriatric caregiving self-efficacy.

Emotional labor. Emotional labor, a construct first defined by sociologist Arlie Hochschild (1983), describes the often undervalued care demands of work. Performance of emotional labor strategies involves an attempt to manage emotions at work, and can include either faking non-felt emotions or suppressing felt emotions, in accordance with organizational display rules. Emotional labor performance is a highly relevant demand for nursing staff (Bolton, 2000; Staden, 1998), although a paucity of sound research has explored this variable for geriatric nursing staff, in particular.

Empowerment. Empowerment occurs when a worker possesses values that are well-matched to job demands, believes that he or she has necessary skills for successful job performance, feels control over work, and can influence work outcomes (Spreitzer, 1995; 1996). In other words, empowerment at work is associated with a worker's belief that he or she can shape the work role and context. Experiencing high levels of empowerment protects

nursing staff from experiencing burnout (Hochwalder, 2007; Hochwalder & Brucefors, 2005).

Geriatric caregiving self-efficacy. Self-efficacy exists when an individual believes that he or she possesses the ability to achieve goals (Bandura, 1997). More specifically, geriatric caregiving self-efficacy was targeted in the present research. Self-efficacy in this domain refers to workers' beliefs that they have knowledge about dealing with co-workers, managing patient problems, and interacting with patients' families (Mackenzie & Peragine, 2003). Research has shown that the experience of geriatric caregiving self-efficacy is associated with a reduction in burnout and lowered stress levels (Dunn, Elsom, & Cross, 2007; Mackenzie & Peragine, 2003).

Given results demonstrating the importance of investigating nursing staff's experience in a variety of domains, the current study targets several work-related constructs that are likely related to job burnout. Realities of a changing population and nursing workforce suggest that research efforts, especially in geropsychiatric care, are of the utmost importance. These realities, combined with compelling research findings, demonstrate the need for the current research.

Overview of the Current Study

An increasing population of elders (Field & Cassel, 1997) combined with the stressful work experiences documented for geriatric nursing staff (Cocco et al., 2003; Kennedy, 2005), and the need for geriatric nurses (Kovner et al., 2002) set the stage and establish the need for this study. Research efforts that target both nurses and their assistants are lacking, but would provide important information about what factors serve to protect these workers from negative work consequences or to exacerbate such outcomes. Moreover, the work outcome of

burnout is highly relevant to nursing staff's decisions to remain on the job, or to seek employment elsewhere. The emotion work performed by nursing staff often goes unnoticed by others, but may have a profound impact on work experiences, leading to increased burnout for some. Sound research methods using validated measures of emotional labor are not frequently found in the nursing literature. In fact, the studies that were located tended to focus on registered nurses, but not nursing assistants. The present study addresses this problem. In addition, strength-based work factors, such as empowerment and geriatric caregiving self-efficacy on the part of the nursing staff appear to play an important role in work outcomes; yet, these factors are examined less frequently (Hochwalder, 2007; Mackenzie & Peragine, 2003). The current study, guided by COR theory (Hobfoll, 1989; Hobfoll & Freedy, 1993), consolidates these concepts into a unified view of the geriatric psychiatric nursing experience by testing hypotheses that have received preliminary research support.

Based on the preceding discussion, three primary and two secondary hypotheses for the present research were tested:

Hypothesis 1. Level of nursing work stress will have a direct and positive relationship with the burnout domain of emotional exhaustion.

Hypothesis 2a. Emotional labor strategies of suppression and faking of emotions will have a direct and positive relationship with emotional exhaustion.

Hypothesis 2b. Emotional labor strategies of suppression and faking of emotions will moderate the relationship between work stress and emotional exhaustion in a magnifying manner such that emotional labor and stress will affect emotional exhaustion in the same direction.

Hypothesis 3a. Empowerment and geriatric caregiving self-efficacy will have a direct and negative relationship with emotional exhaustion.

Hypothesis 3b. Empowerment and geriatric caregiving self-efficacy will moderate the relationship between work stress and emotional exhaustion in a buffering manner as to weaken the effect of stress on emotional exhaustion.

Literature Review

An Aging Population

Since 1900, the percentage of Americans 65 years and older has more than tripled, and now comprises almost 12% of the U.S. population. Moreover, the older population itself is getting older. The number of individuals in all age groups (65-74; 75-84; and, 85 and older) has increased exponentially since 1900. Of these groups, the *oldest old* group (those over 85 years) is increasing faster than any other age category (Wan et al., 2005). A substantial increase in the number of older people is projected to occur between 2010 and 2030. Furthermore, the older population in 2030 is predicted to be twice as large as in 2000, growing from 35 million to 72 million and representing nearly 20% of the total U.S. population (Wan et al., 2005).

Older adults are more likely to experience chronic conditions as they age (e.g., long-term illnesses like arthritis, hypertension, heart disease), thereby creating a heightened need for care services, either at home or in a facility (Atchley & Barusch, 2004). In addition, elders may take longer than their younger counterparts to recuperate from acute illnesses which are temporary in duration (Atchley & Barusch, 2004). Medical advances combined with societal changes have allowed for an increase in longevity; however, certain members of this subgroup of elders will experience significant physical and mental illnesses associated

with advanced age, and various forms of medical and psychological care will be required to meet their needs. Much of the care that will be needed will be provided by registered nurses and nursing assistants, who were the focus of the present investigation.

Geriatric Care Providers

Nurses. Although the skills of gerontological nursing care staff are in high demand, the recent nursing shortage and difficulty attracting nursing students to geriatric care prevents this demand from being met (Regenstreif, Brittis, Fagin & Rieder, 2003). Despite the fact that employment of hospital registered nurses has increased since 2001 (Buerhaus et al., 2004), a significant nursing shortage is expected by 2020 (Buerhaus, 2008; U.S. Department of Health and Human Services, 2004). Shortages in geriatric nursing are of particular concern. Of the approximately 2.2 million registered nurses in the U.S., less than 1% are certified in geriatrics, and similar percentages of advanced practice nurses, gerontological nurse practitioners and clinical specialists in geriatrics are found (Kovner et al., 2002). As noted by Regenstreif and colleagues (2003), organizations such as the John A. Hartford Foundation have made financial contributions to geriatric nursing programs nationally to address this problem. Despite these efforts, the supply of nursing care staff for older adults appears greatly exceeded by the demand for their services (Kovner et al., 2002).

Even if prevalence rates of mental illness for older adults remain constant, the number of individuals with mental illness will rise (Gatz & Smyer, 2001). This outcome calls attention to the urgent need to recruit and retain geriatric psychiatric nursing staff who care for patients exhibiting psychiatric symptoms. It is this specific population of workers, and issues related to retention, that are targeted in the current research. Not all individuals who show psychiatric symptoms are housed in institutional settings or receive outpatient

psychiatric care. Many of these individuals may live in nursing home settings. Therefore, a review of research investigations in both psychiatric hospitals and other care settings is required to provide a comprehensive view of the literature. Both nurses and their assistants play important caring roles in these institutions.

Nursing assistants. In all geriatric care settings, nursing assistants work alongside registered nurses, tending to the day-to-day needs of patients. Nursing assistants, who may also be called nurse's aides or care workers, help care for physically or mentally ill patients in hospitals and mental health settings. Their specific job tasks vary, but involve aspects of patient care, ranging from assistance in activities of daily life (i.e., eating, dressing, bathing) to answering calls for help, monitoring patient problem behaviors, escorting patients around the hospital or off-site, and communicating with the patient's care team. In many cases, nursing assistants provide more face-to-face contact with patients than nurses.

Nursing assistants are an integral part of the care and treatment of patients, although their experiences tend to be neglected in the literature. Researchers have estimated that nursing assistants make up 60 to 70% of all care staff and assist with 80 to 90% of personal care in long-term geriatric institutions (Diamond, 1988; Waxman, Carner, & Berkenstock, 1984). Turnover rates and staff shortages for nursing assistants are very high (Cohen-Mansfield, 1997) and, despite industry attention focused on creating high quality non-professional staff, problems with retention continue to be significant. Low retention rates create problems in psychiatric care, such as a break in the continuity of patient care, disruption in supportive relationships between staff and patients, and increased occurrence of patient symptoms of dementia. From the view of the organization, problems with retention result in high replacement training costs, lost productivity, decreased quality of care, and

lowered staff morale (Brannon, Zinn, Mor, & Davis, 2002). Findings are mixed with regard to factors predicting the loss of nursing assistants, with no clear variables consistently related to such outcomes (Brannon et al., 2002). Therefore, research clarification is needed to identify the unique concerns of this worker group.

Nursing Staff Stress: Sources and Explanations

Although research has not clearly identified the factors responsible for low retention of nursing assistants, more is known about the experience of nurses. One factor influencing the current nursing staff shortage, and the decreased number of students pursuing nursing, is the stressful nature of this caring work (Baldwin, 1999; Bennett, Lowe, Matthews, Dourali, & Tattersall, 2001; Clegg, 2001; Kirkcaldy & Martin, 2000). More specifically, Bennett et al. (2001) described results from a survey study in two large teaching hospitals in the United Kingdom showing negative mood and low levels of work satisfaction for nurses. Moreover, high levels of reported stress have been associated with conflicts with balancing caring and efficiency demands, and with managing emotion at work (Gattuso & Bevan, 2000). Working with geriatric clients in a long-term care facility setting appears particularly stressful for nurses (Cocco et al., 2003; Kennedy, 2005). These nurses deal with patients who commonly show symptoms of dementia. Geriatric nursing assistants also show high levels of stress at work (Kennedy, 2005), but little research attention has been paid to them. Given that nursing assistants commonly have more direct patient contact and responsibilities than do nurses, it seems reasonable to assume that their stress levels are at least comparable to those of nurses. Cocco and colleagues (2003) point to the need to research formal caregiver stress, as little is known about level of stress and burnout in institutional caregivers as compared to family caregivers.

Burnout for Nursing Staff

The experience of stress for nurses and nursing assistants can lead to symptoms of burnout. Burnout, as defined by Maslach and Jackson (1981), is comprised of three components: emotional exhaustion, depersonalization, and reduced personal accomplishment. Emotional exhaustion relates to a feeling of being emotionally drained. Depersonalization involves approaching patients, or others, in an impersonal manner. And, reduced personal accomplishment involves diminished feelings of competence and success. Burnout is an important outcome in this area of research, and creates problems for retention (Ballard, Lowery, Powell, O'Brien, & James, 2000; Barber & Iwai, 1996; Cocco et al., 2003; Kennedy, 2005; Kilfedder et al., 2001). Studies of professional caregivers have shown that burnout is associated with negative outcomes for workers and for patients. For instance, professional caregivers of individuals with dementia show considerable stress, and are at increased risk of experiencing burnout (Astrom, Nilsson, Norberg, & Winblad, 1990; Ballard et al., 2000; Barber & Iwai, 1996).

Influences on Nursing Staff Outcomes

Within the context of continuing care settings for older adults, multiple factors may serve to exacerbate or protect against burnout for nursing staff. These negative work experiences, as previously highlighted, are striking (Ballard et al., 2000; Castle, Degenholtz, & Rosen, 2006; Cocco et al., 2003; Cohen-Mansfield, 1997), and it is of the utmost importance to understand the processes leading to such outcomes, given the projected nursing staff shortage (Buerhaus et al., 2004) and low retention rates for nursing assistants (Cohen-Mansfield, 1997). Factors influencing burnout may include nurse-related issues, patient characteristics, or aspects of the particular organizational setting. Some factors are

directly related to work outcomes, while others affect employee outcomes more indirectly. Importantly, a gap in the literature exists with regard to linking worker perceptions to quality of care and outcomes for older adults residing at long-term care facilities (Hannan et al., 2001) and, therefore, examination of such relationships is warranted. In their review article, Hannan et al. (2001) summarize studies conducted on the relationship between work satisfaction, work stress, quality of care, and resident well-being, and conclude that quality of care is in part a function of work-related stress. Improving quality of patient care involves minimizing staff burnout, as well as developing appropriate interventions for staff. The authors conclude that the relationship among work satisfaction, stress experienced by care staff, quality of care, and well-being of older people is complex and warrants further exploration (Hannan et al.).

Professional burnout develops over time, and is impacted by many factors. Some of these factors may put workers at risk of negative work-related outcomes, while others serve to protect them from experiencing negative consequences at work. Certain work experiences will preserve a worker's store of resources, while others will deplete them. It is the combination of individual, patient, and organizational characteristics that influences how risk factors are associated with negative work-related outcomes for nurses and nursing assistants. Research is needed to isolate salient factors for nursing staff in each of these domains. Without such investigations, an integrated understanding of nursing staff's working lives will not be achieved.

A variety of individual factors serve to influence nursing staff's responses to work stress in the geriatric psychiatric setting. The individual factors targeted in the current investigation included staff-related factors and organizational factors. Measures of nursing

staff empowerment and geriatric caregiving self-efficacy comprised the staff-related factors, while measures of emotion management demands captured the organizational demands of nursing work. Identification of factors that are most strongly predictive of burnout could inform interventions designed to reduce these symptoms for workers. How these factors influence nurses and nursing assistants may differ as a function of their job responsibilities and status in the organization.

Organizational responses also play a role in determining work-related outcomes for nursing staff in addition to worker and patient characteristics. Organizational settings in geriatric care may range from assisted living facilities to nursing homes to psychiatric hospitals. Lopez (2006) investigated organizational rules about emotional demands of care at three different nursing homes, and found different styles at each of these institutions. The demands ranged from being required to quietly accept abuse from patients, and to show indifference to patient suffering, to a different setting in which development of meaningful social interaction between staff and patients was valued. This qualitative study highlights the importance of organizational factors for nursing staff work experiences.

Emotional labor. Gerontological nursing staff's perceptions of emotional management demands and organizational climate may serve to amplify or buffer negative work-related outcomes. Emotional labor was defined by Hochschild (1983) as the "management of feeling to create a publicly observable facial and bodily display" (p. 7), and has been shown to be relevant for nurses (Bolton, 2000; DeCastro, 2004; James, 1992; Staden, 1998). Although various conceptualizations of this construct have been suggested, most researchers agree that emotional labor involves managing emotions such that they are

consistent with organizational display rules. Display rules are expectations regarding which emotions are appropriate in certain situations (Goffman, 1959).

In 1983, Hochschild introduced the construct of emotional labor in her book, *The Managed Heart: The Commercialization of Feeling*. One of Hochschild's central arguments was that managing emotions at work requires effort. Emotional regulation occurs when people (a) manage the emotions that they have, (b) manage them when they have them, and (c) manage how they experience and express them. Hochschild suggested that jobs requiring regulation of emotion have several characteristics in common. First, they involve face-to-face or voice-to-voice contact with the public. In other words, an immediate display of affect is required. Second, these jobs require that a certain emotional state or reaction is produced in the customer or client by the worker. For example, nurses and nursing assistants are expected to calm patients and families and encourage their satisfaction with medical care. Third, the supervisor or employer in jobs requiring emotional labor can indirectly control the emotional displays of workers. This control over emotional display involves power differentials between varying positions at work and implied, but not stated, rules of behavior in the workplace.

Hochschild (1983) also suggested that emotions can be managed by using one of two techniques, which she termed surface acting or deep acting. Surface acting techniques involve modifying outward displays to be congruent with organizational display rules. Hochschild said that when surface acting techniques are used, others are deceived about an individual's feelings, but individuals are not deceiving themselves about their feelings. The work of professional actors, for example, uses surface acting techniques. Deep acting techniques, on the other hand, occur when individuals try to modify their internal feelings to

be consistent with display rules. In this case, individuals displaying the emotions deceive or convince themselves of actually feeling the required emotions. Hochschild gives the example of Delta Airlines flight attendants learning to suppress anger at passengers who insult them. In a training class for experienced flight attendants, workers identified various ways to implement deep acting techniques. For example, they “purposefully took some deep breaths,” repeatedly told themselves, ‘don’t let him get to you,’ and considered that a passenger who drinks too much alcohol may be scared of flying (Hochschild, p. 55). During training, flight attendants were encouraged to “act as if the airplane cabin were [her] home, and to think of a passenger as if he were a personal guest in [her] living room” (Hochschild, p. 105). This type of pretending is said to be so deep that the self is altered. Thus, surface acting and deep acting techniques produce similar behavioral displays through different means. Regardless of the means used to produce the display, however, Hochschild asserts that after engaging in emotional labor over a long period, emotive dissonance will develop. Emotive dissonance occurs when a difference between feeling and feigning emotion has to be maintained, and this may result in psychological strain. She suggests that workers attempt to avoid this strain by changing their feelings, as in the use of deep acting techniques, or changing their outward display of emotion, as in surface acting.

In the current study, the conceptualization of emotional labor as suggested by Glomb and Tews (2004) was utilized. This view highlights the importance of employees’ reactions to organizational display rules and focuses on behavioral expression and non-expression of felt or unfeared emotions in accordance with display rules. More specifically, they hypothesize that emotional labor can occur both when emotions are outwardly shown and when emotions are kept inside. An advantage of this approach is that it accounts for the underlying felt

emotion that may occur when an individual conforms to display rules. This conceptualization also points out that emotional labor could involve not only expressing situationally appropriate emotion, but also not expressing inappropriate emotion, as well as genuinely felt displays. These different possibilities for the motivations behind an expressed behavioral display or non-expressed behavioral display provide a richer picture of emotional labor. Existing emotional labor surveys might ask participants to indicate if the way they act and speak matches what they really feel. However, the response to this type of question will not allow researchers to find out the underlying motivation for the behavior. Glomb and Tews emphasize the importance of identifying whether emotions are positive (i.e., love, happiness) or negative (i.e., sadness, hate), as well as the intensity of the emotion (contentment versus enthusiasm).

Emotional demands at work are highly relevant for nursing staff. Bolton (2001) asserted that nursing is an occupation characterized by extensive emotion work, and she presented data in support of the notion that nurses can handle their emotional demands by presenting an “acceptable face” at work (p. 85). Furthermore, nurses report that managing emotions on the job is important to their own professional role identity (Fagermoen, 1997). They express concern about the degree of emotional engagement—one aspect of emotional labor—they display to patients, and see emotional engagement as a necessary aspect of providing quality care to patients (Henderson, 2001). A concept similar to emotional labor, *stress of conscience*, was examined for a sample of 50 nurses and 96 nursing assistants caring for older adults (Juthberg, Eriksson, Norberg, & Sundin, 2008). Stress of conscience, or a troubled conscience, can result when professional caregivers perform job tasks that are expected from the organization, but in conflict with individuals’ morals and values. Juthberg

and colleagues (2008) found that experiencing such demands at work was strongly related to emotional exhaustion. Taken together, these results suggest that emotional labor is an inevitable and important part of the working life of nursing staff.

Emotional labor also appears particularly relevant for nursing staff working with psychiatric populations. Mann and Cowburn (2005) used a quantitative design to assess emotional labor in a sample of 35 mental health nurses. Although only 35 nurses participated in the study, they were asked to consider individual interactions with patients, and on average each nurse completed three or four questionnaire packets, resulting in 122 completed questionnaires from the participants. Mann and Cowburn surveyed these nurses on a variety of dimensions relating to emotional labor, including duration and intensity of patient interactions, emotions expressed, surface acting and deep acting techniques, and perceived level of stress experienced associated with the interaction. Results suggested that emotional labor was positively correlated with stress from interactions and daily stress levels. In addition, higher levels of emotional labor were reported when the intensity of interactions was deeper and a variety of emotions was experienced. Finally, surface acting techniques were stronger predictors of emotional labor than deep acting.

Some limitations of this study were the small sample size, and low response rate. Response rate was recorded at 29%, which was influenced by two factors. First, staff completed the lengthy questionnaire during their busy work day and second, the researchers attempted to survey nurses at three different psychiatric hospitals, and one hospital was unable to participate due to low staffing. Although nursing assistants have not been targeted for research in this area, they are likely to experience similar demands. Gattuso and Bevan (2000) argue that nurse well-being is related to the well-being of patients. Demonstrating the

emotional work associated with gerontological nursing, they conducted qualitative study of three female nurses experienced in gerontological care, and found that high levels of stress were related to conflicts with balancing caring and efficiency demands and difficulty managing emotions. Gattuso and Bevan stated that change is needed to recognize and value emotion work, and suggest that emotion work in aged care presents unique stressors.

Emotional labor has been explored in other populations, and discussion of the results helps to clarify the role of this demand for workers. Duke, Goodman, Treadway and Breland (2009) examined how organizational support would moderate the relationship between emotional labor demands and work outcomes in retail service firm employees. Perceived organizational support was tested as a moderator between the relationship between perceived emotional labor and job satisfaction/job performance. The researchers found support for their hypotheses, demonstrating that the negative effects of emotional labor on job satisfaction were lowest for those who perceived high levels of organizational support. Moreover, the negative effects of emotional labor on job performance were lowest for employees who perceived high levels of organizational support. Duke et al.'s results suggest that workers' perceptions of the work environment do play a significant role in how they manage the stress of emotional labor. In addition, Chau, Dahling and Diefendorff (2009) asked how emotional labor (specifically, surface acting and deep acting) influence emotional exhaustion, turnover intentions, and turnover among bank tellers. Results revealed that workers who engaged in emotional labor (e.g., surface acting) became emotionally exhausted, thought about withdrawing from the job, and then finally quit.

In their editorial on the recent explosion in emotional labor research, Hunter and Smith (2007) concluded that the study of emotional labor has increased understanding of the

important role of emotion management in individuals' working lives, and has clarified how it can positively and negatively impact workers and clients. They pointed out that sources of emotional labor vary based on work environment. For example, nursing staff may engage in emotional labor especially when in distressing clinical situations. Finally, the authors called for acknowledgment of the significance of emotions in health care work. As noted earlier, a review of the literature on emotional labor revealed only a limited amount of research exploring the experience of nursing assistants. These demands are likely as striking for nursing assistants as they are for nurses themselves.

Returning to discussion of the Lopez (2006) study, specific demands for the degree and frequency of emotional labor performance were observed to impact organizational climate at the three nursing homes targeted. In his case study examining each of these homes, Lopez spent approximately 100 hours observing nursing staff and also interviewing nursing home administrators, managers, and charge nurses. He found that the homes varied with regard to the degree of emotional labor demands. At the first nursing home, the organizational approach was dominated by demands for emotional labor, in which workers were required to accept abuse from patients and show indifference to the suffering that organizational routines imposed on patients. At the second nursing home, management allowed workers to express feelings more honestly, but workers were required to perform emotional labor to ignore patients' loneliness and pain. At the third nursing home, organizational routines were unique, in that meaningful social interactions were encouraged between caregivers and residents. In sum, emotional labor demands in geriatric settings are highly relevant for geriatric nursing staff. Although emotional demands of care may vary

from one facility to the next, individual workers must cope successfully with this work requirement in order to avoid negative work-related consequences.

Empowerment. Psychological empowerment in the workplace is best defined by Spreitzer (1995; 1996), who states that it is comprised of the four dimensions of meaning, competence, self-determination, and impact. Meaning refers to a match between an employee's values and the job demands. Competence is the extent to which the worker believes that he or she has the skills and abilities necessary for good performance on the job. Self-determination involves how much control a worker feels over his or her work, and impact refers to how much the employee believes that he or she can influence outcomes at the workplace.

Hochwalder (2007) examined the effect of empowerment and work environment characteristics for registered and assistant nurses, and tested the effect of these variables on burnout symptoms. In particular, he examined empowerment as both a mediator and a moderator between work environment aspects and burnout. For 838 nurses and 518 nursing assistants in Sweden, empowerment had a negative relationship with burnout. Higher staff levels of empowerment were associated with lower burnout for both registered and assistant nurses. In addition, empowerment was found to have a mediating effect between work environment—in particular for control and social support—and burnout. When the workers felt more control and support in the environment, higher empowerment was reported, which led to lower burnout. Hochwalder also found support for the moderating effect of empowerment on the relation between work environment and burnout, although he stated that only 3 of 18 possible moderator effects were found. Differences between workers in these two professional groups were revealed in the moderator analyses. For instance, when

emotional exhaustion was used as the outcome, the association between social support and emotional exhaustion was more negative for nursing assistants than for nurses. In addition, when depersonalization was examined, the association between this variable and work demand was more strongly positively related for nursing assistants than for nurses. Assistant nurses who had high empowerment and an increase in control experienced less depersonalization; for those with low levels of empowerment, more control led to more depersonalization. Another difference between nurses and nursing assistants was that the connection between social support and personal accomplishment was more striking for nurses than for nursing assistants. Some important implications of such findings are that both individual differences in level of empowerment and group differences in terms of profession should be considered when designing workplace interventions aimed at improving employee health. In sum, empowerment was important in predicting burnout over and above work situational factors, whereas improving the work environment was positively correlated with sense of empowerment, and higher levels of empowerment were related to lower burnout.

Hochwalder and Brucefors (2005) also explored the impact of empowerment on outcomes. For a sample of 2011 nurses and nursing assistants in Sweden, they found that increased empowerment was related to decreased health problems, as measured by burnout, general mental health, and sick leave. The four subscales of empowerment (e.g., meaning, competence, self-determination, and impact) were significant predictors of variance in outcomes. More specifically, the four empowerment dimensions accounted for an additional 12-18% of variance in burnout (e.g., emotional exhaustion, depersonalization, personal accomplishment). Higher levels of empowerment were related to higher levels of emotional exhaustion and depersonalization and lower levels of personal accomplishment. More

recently, Zurmehly, Martin and Fitzpatrick (2009) examined empowerment in a study of 1335 nurses to assess the relationship between nurse empowerment and intent to leave their current position and/or profession. The nurses least likely to leave their positions had significantly higher empowerment scores than those most likely to leave their current position. Nurses who reported they planned to leave the profession had the lowest empowerment scores, while those who indicated they did not plan on leaving the profession had the highest empowerment scores. These findings highlight the importance of the staff experience of high levels of empowerment, and suggest the relevance of this variable in determining staff outcomes. In terms of influences on empowerment, in their study of 600 Canadian nurses, Laschinger, Finegan, Shamian and Wilk (2001) found that when nurses had access to information, received support, had access to resources necessary to do their jobs, and had available learning opportunities, they experienced higher levels of empowerment. High levels of empowerment, in turn, led to lower job strain and higher job satisfaction (Laschinger et al.).

Geriatric caregiving self-efficacy. Self-efficacy has been used as a predictor of work outcomes, and is defined as a person's belief in his or her ability to achieve certain goals (Bandura, 1997). Mackenzie and Peragine (2003) studied professional caregivers of people with dementia in long-term care facilities, including nurses, licensed practical nurses, and nursing assistants, and found that greater caregiving self-efficacy was associated with decreased caregiver stress. Moreover, they developed an intervention to enhance self-efficacy for managing the challenges associated with providing geriatric nursing care, and an inventory to measure it specifically for this population. This intervention taught nursing staff strategies for managing difficult patient behaviors, as well as strategies for coping with

difficulties working with colleagues and the patients' families. Mackenzie and Peragine reported that their intervention led to lasting improvements in caregivers' knowledge and confidence in their abilities to manage challenging team, resident, and family situations. Short-term reductions in caregiver burnout also were noted, as were improvements in the personal accomplishment domain of burnout. On a related note, Dunn and colleagues (2007) argue that there might be direct relationships among mental health nurses' caregiving self-efficacy and ability to safely and effectively manage patient aggressive behavior, which is a common symptom noted in patients diagnosed with dementia.

Organizational climate. Management practices and policies can influence workers in their day-to-day working lives. Nursing staff at 25 different nursing homes in the United States were surveyed, and facilities that were labeled as having a poor working environment were perceived by workers as valuing professional status and a detached management style over human relationships (Sheridan, White, & Fairchild, 1992). In addition, ineffective management was associated with negative interactions between staff and residents (Sheridan et al., 1992). Work climate also was found to have a significant impact on job morale and functioning for a sample of 405 staff members at 14 different nursing facilities, including nursing assistants, nurses, and other professional staff such as physicians and social workers (Schaefer & Moos, 1996). Of these 405 staff, 97 were nurses and 179 were nursing assistants. Work climate was especially important for outcomes such as intent to stay in the job, high job-related distress, depression, and physical symptoms for workers (Schaefer & Moos, 1996).

Organizational style was found to be important in other research. For example, a participative management style was related to lower job stress and higher job satisfaction for

nurses in two studies (Leveck & Jones, 1996; Robertson et al., 1995). In addition, Jenkins and Allen (1998) investigated the effect of the quality of social interactions between staff and residents and involvement of staff in decision making on staff burnout and distress at two elder care homes in the United Kingdom. They found a link between perceived involvement of staff in decision making and fewer negative staff-resident interactions. Staff reporting higher levels of personal accomplishment had a significantly higher number of staff-resident interactions. In sum, burnout was less likely to occur when staff were involved in decision making at the organization.

Bowers, Luring, and Jacobson (2001) explored ways in which work conditions, including staffing, affect how nurses in long-term care do their job and the quality of their care. Findings included that time was an important work condition: when nurses had too little time and too many interruptions, they coped by developing ways to keep up or catch up, such as minimizing time spent on required tasks, creating new time and redefining work responsibilities. Adverse consequences were noted for quality of care, such that increased time pressure led to a decrease in quality of care. In order to provide the best quality of care for patients, it appears that maximizing positive working conditions for nursing staff is important.

Barber and Iwai (1996) surveyed 75 staff providing direct care to elders with a dementia diagnosis, and found that work environment characteristics accounted for more than 60% of the explained variance in burnout outcome. Most of this variance was explained by *role conflict* factors. Role conflict occurs when two or more role pressures occur at the same time, and compliance with one role makes it difficult to also act in accordance with the other role (Rizzo et al., 1970). The authors concluded that staff burnout and, specifically,

emotional exhaustion, was strongly related to work environment characteristics. Moreover, staff characteristics, workload and involvement, and social support did not play a large role in burnout outcomes. Role conflict and role ambiguity, which occur when clear information about role expectations and consequences of role performance is lacking (Van Sell, Brief & Schuler, 1981), were important in predicting the frequency and intensity of emotional exhaustion. Although organizational climate was not formally assessed in the current study, such findings are important to consider within the context of geriatric nursing work.

Conservation of Resources (COR) Theory of Stress

In order to understand the specific aspects of work stress for nursing staff, it is important to define this construct in general. Work stress is a construct comprised of the many factors that influence an individual's relationship with work. Sources of work stress may vary from the actual job a person is performing, to the people with whom one works, to the physical environment and surroundings of a workplace. Hobfoll's (1989) conservation of resources (COR) theory further elucidates the definition of work stress. This theory, which was used to guide the present research, suggests that work stress occurs when work circumstances threaten an individual's ability to obtain or maintain resources sufficient for psychological health. Hobfoll stated that "people strive to retain, protect, and build resources and that what is threatening to them is the potential or actual loss of these valued resources" (p. 516). Types of resources that people might strive for include objects (e.g., owning property, car), conditions (e.g., employment, financial security), personal characteristics (e.g., high self-esteem, positive outlook), and energies (e.g., time, money, knowledge) that individuals value. Hobfoll stated that these threats and actual losses should not be assessed in a purely subjective way; rather, these appraisals should be validated using objective and

shared social standards of what constitutes a resource loss. Moreover, COR theory makes predictions about behavior not only during stressful times, when individuals attempt to prevent loss of resources, but also in times of low stress, when people seek gains and accumulation of resources. Hobfoll's development of this theory was, in part, a reaction to other commonly used theories of stress (e.g., Lazarus & Folkman, 1984) that could not predict outcomes, and that were based solely on individual appraisals.

COR theory has been used in a number of studies in the occupational stress literature. Ito and Brotheridge (2003) applied COR theory to an investigation of resources, coping strategies, and emotional exhaustion for 600 government employees, and found general support for their hypotheses. Having higher levels of resources was positively associated with using active coping methods and negatively associated with coping by avoidance. In addition, higher levels of resources were associated with lower levels of emotional exhaustion. Other researchers have used COR theory to connect resource loss with work-family conflict and job strain for a sample of 326 university professors (Grandey & Cropanzano, 1999). Grandey and Cropanzano (1999) explored the outcomes of role stress and work-family conflict, and found support for COR theory. For instance, as chronic work and family stressors depleted resources over time, professors reported job and family dissatisfaction and tension, life distress, and poorer physical health. Importantly, the experience of these negative consequences was associated with wanting to minimize loss of resources by intending to leave the job. More recently, Cheung and Tang (2009) used a cross-sectional design to survey emotional labor, work family interference, and quality of work life in a sample of Hong Kong Chinese service employees using Hobfoll's COR theory to guide their hypotheses. They found that while the emotional labor act of surface acting

was significantly correlated with work family interference, deep acting and expression of naturally felt emotion were not related to work family interference. Moreover, quality of work life mediated the relationship between surface acting and work family interference. Work family interference was defined as occurring when pressures from both work and family roles make it difficult to satisfy demands in both roles. Surface acting, deep acting, and expression of naturally felt emotion significantly predicted quality of work life after controlling for demographics and display rules.

COR theory has also been used to conceptualize burnout at work (Hobfoll & Freedy, 1993), and to examine how emotional demands at work may or may not lead to burnout (Brotheridge & Lee, 2002). Hobfoll and Freedy (1993) suggested that prolonged exposure to work demands that threaten an individual's resources leads to strain, which may be expressed by emotional exhaustion, one dimension of burnout at work. A problem occurs when employee resources are used more quickly than resources can be added, leaving workers at risk of experiencing work stress and strain. Brotheridge and Lee (2002) also were successful in applying COR theory to workers' attempts to cope with emotional demands on the job. Coping with emotional demands at work requires the use of resources, and therefore such demands may be a threat to existing resources. They examined the relationship between emotional labor demands and burnout for service employees ranging from food service workers to health professionals (Brotheridge & Lee). In this study, emotional labor was conceptualized as a demand requiring the use of resources, and therefore was seen as a threat to existing employee resources. Brotheridge and Lee revealed that workers tried to cope with work demands in ways that would conserve resources, and that aspects of the customer service interaction influenced the experience of burnout. For instance, the type of emotional

labor performed in the service interaction and the outcome of that interaction determined whether or not workers felt emotionally exhausted. When there was a loss of expected rewards from the service interaction, workers perceived an overall loss of resources, and experienced emotional exhaustion. Applied to the current research, COR theory (Hobfoll, 1989) might suggest that emotional labor performance is a threat to resources, while nursing staff empowerment and geriatric caregiving self-efficacy are conceptualized as resources gained.

Patient-Centered Model of Care

To this point in the current literature review, the experience of both nurses and nursing assistants providing geriatric care has been examined in terms of sources of stress, work outcomes, and influences on work outcomes. The multivariate nature of this research has been demonstrated, as individual worker, patient, and organizational factors all combine to affect outcomes for workers and patients. For a comprehensive view of nursing staff's experience, the model of delivery of health care services needs to be identified. A recent trend in health care has been a focus on patient-centered care. This approach to care can be broadly defined as aspects of service delivery ranging from patient involvement in individual care to public involvement in health policy decisions (Gillespie, Florin, & Gillam, 2004). Person-centered care engages the patient in a positive way and aims to maintain and improve well-being (Kitwood, 1997) while always putting people at the heart of nursing care (Barker, 2003). Despite wide agreement among health professionals that this model of care is optimal, its utilization and understanding of its core philosophies are not always consistent (O'Donovan, 2007). Moreover, a basic shift is needed in the way that staff members view

patients with psychiatric illnesses, including dementia, in order to deliver patient-centered care (Kitwood, 1997).

An approach similar to patient-centered care is termed the *Recovery Model*, and this approach has been implemented at all state-level psychiatric facilities in Virginia. Consistent with a patient-centered model of care, the Recovery Model includes encouraging patient empowerment, which may be translated into increased involvement in treatment and discharge planning, attendance at and participation in multidisciplinary treatment team meetings, involvement in patient advocacy groups, and psycho-education on stigma associated with receiving services for mental illness. The Recovery Model is defined as a “holistic approach to mental health that seeks to optimize a person’s experience by promoting mental wellness” (Piedmont Geriatric Hospital Recovery Training Curriculum, 2007). The development of the Recovery Model was based on meetings held by the Piedmont Geriatric Hospital (PGH) Recovery Committee and review of relevant literature (Deegan, 1988; Goldstein, 2001; Jacobson & Greenley, 2001). As stated in PGH Recovery training materials, the Recovery Model holds that a view of mental illness that focuses on the person, and not just on symptoms, will help to reach recovery from psychiatric illness. It is a process that gives both patients and their families the support necessary to re-establish hope and empower them with needed skills to live a meaningful life. Increased staff awareness of patient symptoms and course of patient illnesses is also a part of patient-centered care. Other aspects of the professional caregiver’s role include power sharing, exchange of information, shared decision-making, and a view of the professional as an expert consultant on a journey.

With regard to outcomes of the implementation of a person-centered model of care, dementia specific training—which gives workers greater understanding about their patients’

symptoms—has been shown to decrease absenteeism at work and increase job satisfaction (Maas, Buckwalter, Swanson, & Mobily, 1994). In addition, Schrijnemaekers and others (2003) conducted research in the Netherlands which examined the impact of emotion-oriented care on professional caregivers in homes for elders. Emotion-oriented care involves the validation approach to interaction with patients, and is similar conceptually to person-centered care. For homes that received emotion-oriented care rather than traditional care, modest positive results were found for worker job satisfaction and burnout. Although this study included a large sample of 300 professional caregivers, no information was reported on the professional group in which these caregivers belonged. However, the study highlights how a more person-centered approach to care can influence workers themselves, in addition to patients.

Coogle, Head, and Parham (2006) offered training to improve dementia care for nursing assistants and nursing aides serving patients diagnosed with Alzheimer's disease, and provided intensive person-centered training. The authors pointed out that the fact that nursing assistants and aides, all of whom are classified as direct-care workers, are not typically valued in their work and experience few training opportunities or support and recognition at work. One finding of the study was that training led to an increase in *extrinsic job satisfaction*. Extrinsic job satisfaction is related to contextual factors of the job such as environment, rather than satisfaction with the work itself. This finding was influenced by the focus in the training program on communication and cooperation with coworkers and relationships with supervisors. Therefore, it appears that implementing a patient-centered model of care may improve work-related outcomes for nursing staff and enhance the experience of patients and residents.

Statement of the Problem

As the proportion of older individuals requiring medical and mental health services will increase exponentially in coming years (Field & Cassel, 1997; Gatz & Smyer, 2001; Wan et al., 2005), special attention must be given to the health care professionals working with these individuals on a daily basis. Both nurses and nursing assistants provide essential care for older adults housed in long-term care facilities, but the stressful nature of their caring work (Baldwin, 1999; Cocco et al., 2003) puts them at risk of experiencing negative work-related outcomes such as high levels of stress, and symptoms of burnout (Barber & Iwai, 1996; Brannon et al., 2002; Castle et al., 2006; Kennedy, 2005), in addition to high turnover rates (Cohen-Mansfield, 1997).

The present research examines affective consequences of geriatric nursing work, including staff stress and burnout within the context of a geriatric psychiatric hospital that has recently implemented the Recovery Model of care. Factors influencing these outcomes, such as performance of emotional labor strategies, staff empowerment, and geriatric caregiving self-efficacy were investigated. Researchers have called for comprehensive study of the experience of nursing staff in geriatric settings that connects the worker experience to the patient experience (Hannan et al., 2001). Although patient outcomes were not assessed in this study, identification of staff factors that are likely to affect work outcomes for nursing staff are likely to also impact patients. Moreover, the recent implementation of patient-centered models of care at psychiatric hospitals, such as the one at which the present research was conducted, provides a unique opportunity to investigate how such a model might influence worker experiences.

Hypotheses are informed by empirical findings in the nursing staff and work stress literatures and are guided by COR theory (Hobfoll, 1989). The role of moderator variables on the stress-outcome relationship was explored. As elaborated below, a moderator variable is one that influences the relationship between two variables depending on the level of the moderator (Holmbeck, 1997). For instance, individual nursing staff-related factors and organizational demands are potential moderators of the stress-outcome relationship.

Overall, this research explores the role of work-related stress, emotional labor and self-perceived nursing competence factors (i.e., empowerment and geriatric caregiving self-efficacy) on the work outcome of burnout. Stanton, Balzer, Smith, Parra and Ironson (2001) identified two important dimensions of work stress – a) stress resulting from time pressure demands, and b) stress resulting from a sense of feeling threatened and overwhelmed at work. The present study clarifies the role of these two dimensions of work stress in predicting burnout. Based on the results of previous research, it is expected that the dimensions of work stress will individually and collectively demonstrate significant relationships with job burnout (Barber & Iwai, 1996; Brannon et al., 2002; Castle et al., 2006; Chappell & Novak, 1994; Cocco et al., 2003; Cohen-Mansfield, 1997; Fagin et al., 1996; Hannan et al., 2001; Kennedy, 2005; Ward & Cowman, 2003).

One focus of the present study is the impact of emotional labor on the relationship between nursing work stress and the work outcome of burnout. Other research has established that emotional labor demands are highly relevant to geriatric nursing staff (Gattuso & Bevan, 1999; Juthberg et al., 2008), but emotional labor has not been explored in a rigorous manner specifically in a geriatric nursing population. On the basis of previous research in psychiatric nurses (Gattuso & Bevan, 2000; Juthberg et al., 2008; Mann &

Cowburn, 2005), who found that higher frequencies of emotional labor performance and demands were associated with more work-related stress for workers, it is hypothesized that higher frequencies of emotional labor performance will be directly and positively related to burnout. The present research also explores the role of suppression and faking of emotion as moderators of the stress-outcome relationship. Results supporting the moderating role of emotional labor in predicting work outcomes are drawn from research in other populations (e.g., Chau et al., 2009), as this variable has not been tested as a moderator specifically for geriatric nursing staff. These researchers demonstrated that the performance of emotional labor strategies was predictive of emotional exhaustion for a sample of bank tellers.

Finally, this study explores the influence of nursing self-perceived competence (i.e., empowerment and geriatric caregiving self-efficacy) on the relationships between nursing work stress and burnout. Geriatric caregiving self-efficacy (Dunn et al., 2007; Mackenzie & Peragine, 2003) and staff empowerment (Hochwalder, 2007; Hochwalder & Brucefors, 2005) appear to be particularly important influences on work experiences. More specifically, the literature shows that these variables are negatively related to burnout. Hypotheses test the expectation that greater levels of staff empowerment and geriatric caregiving self-efficacy will have direct and negative relationships with burnout. Using COR as a framework (Hobfoll, 1989) and based on research findings reported above, it is suggested that higher empowerment and geriatric caregiving self-efficacy levels will play moderating, or buffering, roles against experiencing burnout. When nursing staff feel empowered and efficacious in their geriatric work demands, it is expected that they will be less likely to experience burnout. Although self-efficacy has not been specifically tested as a moderator on the relationship between stress and work outcomes for geriatric nursing staff, preliminary

empirical support was found for the moderating role of empowerment when burnout was considered for nurses and nursing assistants (Hochwalder, 2007).

Method

Participants

Participants consisted of nursing staff employed at Piedmont Geriatric Hospital (PGH), a state-level geriatric psychiatric inpatient hospital located in Burkeville, Virginia. PGH is a 135-bed hospital operated by the Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services, and is the only state facility in Virginia that exclusively serves the needs of individuals 65 and older who require mental health treatment. The population of interest for the present study consisted of all nursing staff who provide direct services to patients. For staff employed at PGH, the population of interest consisted of approximately 30 registered nurses (RN's), 38 licensed practical nurses (LPN's) and 100 human service care workers (HSCW's). It was estimated that the response rate would fall between 40% and 60%. Actual sample size was 80 participants, reflecting a response rate of approximately 48%, and included 15 RN's, 23 LPN's and 41 HSCW's. One participant did not report job type. Table 1 presents the number and percentage of RN's, LPN's, and HSCW's in the study sample and the hospital population. As shown in Table 1, the representation of these staff groups in the sample approximated that of the hospital population. Clearly, the distribution of staff in the study sample was representative of the hospital population.

Table 1

Percentage of Nursing Staff Groups Sampled as Compared to Staff Population at PGH

	<u>Current sample</u>	<u>Population at PGH</u>
Staff group	Number (%)	Number (%)
Registered nurses	15 (18%)	30 (18%)
Licensed practical nurses	23 (29%)	38 (23%)
Human service care workers	41 (52%)	100 (60%)

The RN group included unit nurses, nurse managers, and clinical nurse specialists. These individuals interact with patients on a daily basis within one of four hospital units at PGH. Unit nurses and nurse managers are most actively involved in day-to-day care of patients, but clinical nurse specialists also engage in significant patient interactions. Unit nurse coordinators, of whom there only are four at PGH, were not included as participants, due both to their participation in pilot testing of the study questionnaire and their limited interaction with patients.

Registered nurses assess patient health problems and needs and develop and implement nursing care plans for patients, in addition to maintaining medical records (O*Net Online, 2008). In the Commonwealth of Virginia, a nursing license is required for employment at PGH. A second nursing staff group sampled was LPN's. LPN's work under the supervision of registered nurses and, as part of the treatment team, provide basic patient care and treatment and respond to patient needs. A third group sampled was HSCW's, who provide direct patient care by helping patients to perform activities of daily living in a safe and therapeutic environment.

Nursing staff had an average age of 47.9 years ($SD = 12.4$), average years of nursing experience of 16.8 years ($SD = 11.9$) and average time worked at PGH of 7.7 years ($SD = 8.4$). Age, years of nursing experience, and years worked at PGH were examined for each of the three nursing groups and are presented in Table 2.

Table 2

Mean, Standard Deviation, and Range for Descriptive Variables Based on Job Type

Job type	Descriptive variable	<i>M</i>	<i>SD</i>	<i>Range</i>
Registered nurses ($n = 15$)				
	Age	53.6	11.5	32 – 71.3
	Yrs. nursing exp.	25.8	11.9	9 – 41.6
	Yrs. PGH exp.	5.6	4.1	0.33 – 12
Licensed practical nurses ($n = 23$)				
	Age	47.9	10.6	31 – 63.7
	Yrs. nursing exp.	17.7	13.0	1.3 – 40
	Yrs. PGH exp.	8.7	11.2	0.08 – 36.3
Human service care workers ($n = 41$)				
	Age	45.7	13.4	21.3 – 66.1
	Yrs. nursing exp.	13.1	9.4	0.08 – 35.6
	Yrs. PGH exp.	7.9	7.9	0.08 – 29.1

Note. Yrs of nursing exp. = Years of nursing experience; Yrs of PGH exp. = Years of experience at Piedmont Geriatric Hospital.

Of the 80 total cases, 92.5% were female. However, 2 cases did not report gender, which accounted for 2.5% of participants, and the remaining 5% comprised the male nursing staff. This distribution is typical of gender concentrations in the nursing field, and this researcher thus decided to retain these workers in the sample. Of the total sample, 77 cases reported race/ethnicity. The race/ethnicity distribution of the sample was as follows: 58.8%

identified as Black/African American, 36.3% identified as White/Caucasian, and 1.3% identified as American Indian/Alaskan Native. With regard to job shift, 41 staff members (51.3%) were surveyed during the day shift, 20 during the evening shift (25.0%), and 17 (21.3%) during the night shift. Two workers did not report shift on the study survey (0.03%).

In order to determine the appropriateness of aggregating the three nursing groups into one sample, a one-way between subjects analysis of variance was performed with job type as the independent variable and emotional exhaustion as the dependent variables. Results of this analyses revealed that the group emotional exhaustion means for RN's ($M = 22.7$), LPN's ($M = 22.1$) and HSCW's ($M = 21.8$) were statistically similar, $F(2, 74) = .03, p = .973$. Based on these results and the finding that the current sample was representative of the hospital population at PGH, all three nursing groups were aggregated into one overall nursing staff sample for all study analyses. Descriptive statistics for each

As suggested by Cohen (1992), sufficient power must be present to detect significant findings. Given an effect size of .15 and use of the statistical technique of multiple regression, a sample size of 76 participants is adequate to achieve a power level of .80 when 3 predictors are used and α is set at .05 (Cohen). These guidelines were used to assess if adequate sample size was obtained before statistical analyses were performed. In addition, post-hoc power analyses were performed using the computer program G-Power (Faul & Erdfelder, 1992) based on the use of multiple regression analyses with α set at .05 and a medium effect size, and revealed a value of .82 for power. Therefore, sufficient power was present to run the proposed analyses.

Design

The present study used self-report questionnaires. The design was cross-sectional, and

variables of interests were examined for three nursing staff groups (RN's, LPN's, HSCW's) all surveyed within a one-month time frame. The three nursing staff groups were aggregated into one overall nursing staff sample.

Measures

The means, standard deviations, ranges and alpha values for all study variables are presented in Table 3 (see Results section). Reliability values for each study variable are reported below.

Demographics. Participants were asked to provide their age, gender, job type, job shift, racial/ethnic background, and the number of years they have worked in the nursing profession, as well as the number of years they have worked at PGH (see Appendix A).

Work stress. Work stress was assessed using the Stress in General Scale (SIG; Stanton et al., 2001, see Appendix B). The SIG includes two subscales, the 7-item SIG-Pressure subscale and the 8-item SIG-Threat subscale. Participants were provided with a list of words describing stress at work, and were asked to indicate if these words describe their job. Response options were Yes, No or Cannot Decide. The SIG-Pressure subscale includes items such as “demanding, hectic, relaxed, pressured” and is reported to correlate highly with time pressure. The SIG-Threat subscale sample items include “nerve-racking, hassled, overwhelming, irritating” and is purported to a measure a more serious level of stress that indicates a threatening and negative quality to the work experience. Stanton and colleagues (2001) present evidence supporting the distinction of these two SIG factors, each of which measures a unique aspect of work stress. Reliability coefficients were reported to be strong, .88 for the SIG-Pressure subscale and .82 for the SIG-Threat subscale. In the current study, Cronbach's α values for the two subscales were .74 and .83, respectively. Scale totals were

computed for each subscale with reverse coding for positive items (i.e., “relaxed, under control”) and evaluated separately in the present research.

Burnout. Burnout was assessed with the well-known and frequently used Maslach Burnout Inventory (MBI; Maslach et al., 1996). The Human Services Survey form of this inventory was used in the current study (see Appendix C). This inventory measures three aspects of the burnout syndrome, including emotional exhaustion (EE), depersonalization (DP), and lack of personal accomplishment (PA). When an individual scores highly on the MBI-EE (Maslach Burnout Inventory - Emotional Exhaustion) subscale, being emotionally overextended and exhausted by one’s work are likely. When scores on the DP subscale are elevated, this means that an unfeeling and impersonal response toward patients’ care and treatment is given. Finally, the PA subscale assesses the degree to which the worker feels competent and successful in work with other people. According to the authors, a high degree of burnout is associated with high scores on the EE and DP subscales, combined with low scores on the PA subscale (Maslach et al., 1996). A low degree of burnout is related to low scores on EE and DP, with high scores on PA.

For the purposes of the present research, MBI-EE was selected as the measure of burnout due to its high relevance to the geriatric nursing staff, and research findings that show the strong relationship between emotional exhaustion and negative work outcomes, such as leaving the job, satisfaction with growth, physical and psychological distress (Cocco et al., 2003; Hannan et al., 2001; Hochwalder, 2007; Hochwalder & Brucefors; Kennedy, 2005). In addition, past research shows the connection between emotional exhaustion and outcomes such as difficulty with family and friends (Jackson & Maslach, 1982).

On this measure, participants were asked to indicate how often they have experienced certain feelings about their job. Responses to the MBI-EE scale are given on a 7-point scale that ranges from 0 (*never*) to 6 (*every day*). Example items from the EE scale include “I feel emotionally drained from my work” and “I feel burned out from my work.” Reliability coefficients for the MBI-EE subscale of this form (HSS) are excellent. Using a sample size of 1316 participants, Cronbach’s α values of internal consistency were .90 for the EE subscale, and the standard error of measurement was 3.80 (Maslach et al., 1996). Reliability coefficients in the current study were .89 for MBI-EE. In addition, the two to four week test-retest reliability coefficient was .82 for MBI-EE for a sample of graduate students in social welfare and health care administrators (Maslach et al., 1996). Other authors show similar test-rest reliability coefficients, with intervals between testing sessions that ranged from three months to one year (Jackson, Schwab, & Schuler, 1986; Lee & Ashforth, 1993; Leiter, 1990; Leiter & Durup, 1996). Maslach, Jackson and Leiter (1996), in the MBI manual, state that the MBI-Human Services Survey does appear to measure the enduring state of burnout. Moreover, convergent and discriminant validity were also demonstrated by Maslach and colleagues.

Emotional labor. The Discrete Emotions Emotional Labor Scale (DEELS; Glomb & Tews, 2004) was used to assess the frequency of emotional labor strategies used by nursing staff (see Appendix D). The DEELS includes three subscales, which are genuine expression, faked expression, and suppression. Two of these subscales—faked expression (DEELS-Faking) and suppression of emotions (DEELS-Suppression)—were included in the study, as they are the most likely of the subscales to influence work outcomes. Each of the subscales

asked participants to consider fourteen distinct positive and negative emotions relative to their interactions with patients over a 6-month period. The directions state:

We would like to know about the emotions you express to others, such as customers, clients, coworkers, and supervisors, and emotions that you feel but do not express while on the job. That is, we are interested in what you express through your body language, facial expressions, tone of voice, etc. Consider your experiences at work over the past 6 months (Glomb & Tews, 2004, p. 18).

The authors give instructions at the beginning of each subscale, stating that they “would like to know how often you feel and express various emotions to others on the job” (Glomb & Tews, 2004, p. 18). Participants indicated the frequency with which they express or suppress 14 discrete emotions. Responses are given on a 5-point scale that ranges from 1 (*many times a day*) to 5 (*never*). The 14 discrete emotions listed, as suggested by previous research (Shaver, Schwartz, Krison, & O’Connor, 1987) include (a) irritation, (b) anxiety, (c) contentment, (d) sadness, (e) concern, (f) disliking, (g) aggravation, (h) fear, (i) happiness, (j) distress, (k) liking, (l) hate, (m) anger, and (n) enthusiasm. For example, the faked subscale asks, “How often do you express feelings of irritation when you really don’t feel that way?” On the remaining items in the faking subscale, each of the 13 other emotions is substituted for irritation. In addition, the suppression subscale asks, “How often do you keep irritation to yourself when you really feel that way?” For the remaining 13 items in the suppressing subscale, each of the remaining emotions is substituted for irritation. Nursing staff were asked to think about their work experiences over the past 6 months when responding to items.

Confirmatory factor analysis was used to provide evidence for the six-factor structure of the DEELS (Glomb & Tews, 2004), based on the positive and negative, genuine, faking, and suppression dimensions of the scale. Discrete emotions were combined to create positive and negative subscales for the genuine expression, faking, and suppression dimensions. Internal consistency was demonstrated by a range of Cronbach's α from .80 (genuine) to .87 (faked) for the positive emotion subscales, and .86 (genuine) to .94 (suppression) for the negative emotion subscales (Glomb & Tews, 2004). This scale was validated by its authors, and also was used in an unpublished study of graduate nursing students (Smolen-Hetzel, 2006) wherein internal consistency estimates were excellent for both the faking (Cronbach's $\alpha = .92$) and suppression (Cronbach's $\alpha = .89$) subscales. In the current study, reliability coefficients for the faking and suppression subscales were .87 and .85, respectively.

Geriatric caregiving self-efficacy. Geriatric caregiving self-efficacy was assessed with the Geriatric Nursing Self-Efficacy Scale (GNSES; Mackenzie & Peragine, 2003, see Appendix E). This scale was developed based on Bandura's (1997) definition of self-efficacy, and was created to address the lack of available instruments relevant to professional caregivers of older adults. This brief 9-item measure reflects common sources of caregiver stress, as identified by long-term care nursing administrators and from the results of a quality of work life survey performed by Mackenzie and Peragine (2003). Three dimensions are measured, each of which is related to perceived knowledge about: (a) improving teamwork and coping with conflict among co-workers, (b) managing patients' challenging behaviors, and (c) ways of coping with conflict and building relationships with patients' families.

Participants were instructed to rate how confident they are that they could "remain calm, resolve the problem, and achieve a positive outcome" in nine different situations. For

example, one situation states “You are extremely busy, you are behind in your work, and one of the residents is following you around and trying to grab your arm.” Another situation says, “Every time you see one of the residents, she asks: ‘When do I get to go home?’ This has been going on for months.” Response options are provided on a 7-point rating scale, ranging from 1 (*not at all confident*) to 7 (*very confident*).

Good internal consistency was revealed for the GNSEES, as the Cronbach’s α was found to be .96 and the average item-total correlation was .83. Test-retest reliability coefficients ranged from .56 to .72 for control and intervention groups of geriatric nursing staff (Mackenzie & Peragine, 2003). Cronbach’s α was .89 in the current study for the GNSEES.

Empowerment. Empowerment was measured using the Psychological Empowerment Scale (PES; Spreitzer, 1995, see Appendix F). The PES is a 12-item scale that has been employed in a number of studies and has been administered to workers ranging from nurses to low wage service workers. It was used specifically for nurses and nursing assistants in Sweden by Hochwalder (2007) and by Hochwalder and Brucefors (2005). Internal consistency estimates were .72 for a sample of industrial workers and .62 for a sample of insurance workers in Spreitzer’s (1995) original article on the scale development and validation. In addition, moderate test-retest stability was shown when a five month interval occurred between data collection points. Validity estimates are around .80 (Spreitzer, 1995; 1996). The scale contains four dimensions, including meaning, competence, self-determination, and impact. From their work with nurses and nursing assistants, Hochwalder and Brucefors demonstrated internal consistency estimates of .82 for the meaning dimension; .87 for competence; .85 for self-determination; and .89 for impact. An internal consistency

estimate of about .87 for overall empowerment was found for nursing staff (Hochwalder). In this study, Cronbach's α for the overall scale was .89.

Each of the four dimensions is measured by three items. For example, the statement "The work I do is meaningful for me" is one item on the meaning dimension; "I am self-assured about my capabilities to perform my abilities" loads onto the competence dimension; "I have considerable opportunity for independence and freedom in how I do my job" is an item on the self-determination dimension; and, "My impact on what happens in my department is large" is part of the impact dimension scale. Response options are given on a 7-point rating scale, ranging from 1 (*strongly disagree*) to 7 (*strongly agree*). A total mean score for empowerment can be computed, and was used for analysis in the current study.

Procedure

Recruitment took place at PGH during day, evening and night shifts in the spring of 2010, once both University and PGH Institutional Review Board approval were obtained. The support of nursing administration at PGH was important to the execution of this study. The director of nursing at PGH was informed of the potential benefits to the hospital and staff of participation in the study and fully supported this research effort. Potential participants were notified by nursing administration that they would be receiving information regarding an upcoming research study to be conducted with PGH nursing staff. This notice gave them brief information about the study, and specified when they would be asked to provide informed consent and complete a packet of questionnaires about their work experiences.

Informed consent was obtained in a small group format in unit conference rooms at PGH on several different dates in order to maximize response rate. The primary investigator

consented staff members and was available to answer questions while they were filling out the questionnaire. Further, no PGH staff members were present during this time in order to avoid the potential of perceived coercion to participate in the study. Efforts to maximize response rate were guided by methods articulated by Bourque and Fielder (2003) in conducting self-administered research. After hearing a brief description of the study and providing informed consent to participate, nursing staff was then given a packet of questionnaires and asked to complete the packet during the meeting time. Two forms of the questionnaire were created, Survey Versions 1 and 2, which reflected counterbalancing order of measures to control for order effects in participants' responses. Of total participants, 43 (53.75%) completed Survey Version 1 and 37 (46.25%) completed Survey Version 2. An independent samples t test revealed no significant differences in emotional exhaustion scores between the group who received Survey Version 1 ($M = 21.4$) and the group who received Survey Version 2 ($M = 23.0$), $t(76) = -0.56$, $p = .578$. The packets contained a brief set of instructions, demographic questions, and measures of work stress, burnout, emotional labor, empowerment, and geriatric caregiving self-efficacy. Time taken to complete the questionnaire packet was approximately 25 to 30 minutes.

Results

Preliminary Analyses

Prior to analysis, data entry checks were performed via examination of variable frequencies (e.g., minimum and maximum values, identification of extreme values and missing cases) to assure quality of the information. In addition, this researcher performed manual inspection of data entry and verified that it was accurate. Data then were checked for the presence of outliers using descriptives, histograms, and box plots. Casewise diagnostics

were also examined using Cook's *D* and Mahalanobis distances to identify outliers. Based on these procedures, no outliers were identified.

In terms of individual participants' missing data, this researcher substituted missing items with a mean score of that participant's responses for the scale of interest, provided that at least 75% of scale items were completed. The following number of cases met criteria for imputation of individual scales: 10 cases for the DEELS-Faking subscale, 5 cases for the DEELS-Suppression subscale, 2 cases for the SIG-Pressure subscale, 1 case for the SIG-Threat subscale, 1 case for the MBI-EE subscale, and 0 cases for the GNSES or PES measures. Skewness and kurtosis values and normality plots for study variables were examined to assess normality of data. Transformation of variables was performed for identified variables in order to reduce problems with skewness and kurtosis, and to improve the normality of variable distributions per the recommendation of Tabachnick and Fidell (2001). As such, square root transformations were used on the PES and the GNSES. Logarithmic transformations were used on the SIG-Pressure subscale. As suggested by Cohen, Cohen, West & Aiken (2003), all continuous variables were centered following the procedure outlined in order to minimize problems with multicollinearity. Centering involves a transformation of scores achieved by subtracting the sample mean from each participant's score on the variables (Aiken & West, 1991).

Correlational analyses. A correlation matrix was constructed for all variables and is presented in Table 3. Results indicated that both work stress subscales were significantly positively correlated with emotional exhaustion, an aspect of job burnout. Empowerment and geriatric caregiving self-efficacy were both negatively correlated with emotional exhaustion. More specifically, the negative correlation between geriatric caregiving self-efficacy and

emotional exhaustion was statistically significant ($r = -.25, p = .027$), while the relationship between empowerment and emotional exhaustion approached significance, $r = -.22, p = .056$. Suppressing emotion was positively correlated with emotional exhaustion. Faking emotion was also positively related to work outcome, but fell short of statistical significance. As expected, the two subscales of work stress were highly positively correlated. Other correlations among demographic and experience variables were in the expected direction. For example, age and years of nursing experience were strongly positively correlated.

Table 3

Zero-order Correlations for Study Variables

Variable	1	2	3	4	5	6	7	8	9	10
1. Age in years	--									
2. Yrs nursing exp.	.64***	--								
3. Yrs PGH exp.	.37**	.53***	--							
4. SIG-Threat	-.10	-.04	.05	--						
5. SIG-Pressure	.07	.20	.08	.55***	--					
6. DEELS-Faking	-.02	-.07	-.07	.07	-.08	--				
7. DEELS-Suppress	-.06	.01	-.06	.30**	.28*	.31**	--			
8. GNSES	.30*	.18	-.12	-.34**	.03	-.30**	-.11	--		
9. PES	.31*	.16	.16	-.32**	-.15	-.09	-.24*	.17	--	
10. MBI-EE	-.19	-.07	-.04	.68***	.50***	.18	.40***	-.25*	-.22	--

Note. $N = 80$. Yrs nursing exp. = Years of nursing experience; Yrs. of PGH experience = Years of experience at Piedmont Geriatric Hospital; Stress in General Threat subscale (SIG-Threat) and Pressure (SIG-Pressure) subscales are from Stanton, Balzer, Smith, Parra, & Ironson, 2001; Discrete Emotions Emotional Labor Scale Faking subscale (DEELS-F) and Suppression subscale (DEELS-S) are from Glomb & Tews, 2004; Geriatric Nursing Self-Efficacy Scale (GNSES) is from Mackenzie and Peragine, 2003; Psychological Empowerment Scale (PES) is from Spreitzer, 1995; Maslach Burnout Inventory – Emotional Exhaustion subscale (MBI-EE) is from Maslach, Leiter, & Jackson, 1996.

* $p < .05$. ** $p < .01$. *** $p < .001$.

Descriptive statistics, including means, standard deviations, range and Cronbach's reliability α , were computed for all study variables and are shown in Table 3. Of note, the mean emotional exhaustion score was 22.1 ($SD = 12.8$), which falls in the *moderate* range of burnout (Maslach et al., 1996). This value is consistent with an average level of emotional exhaustion of 22.19 reported by a sample of 1104 physicians and nurses in the normative sample (Maslach et al., 1996).

Table 4

Mean, Standard Deviation, Range and Reliability Coefficients for Study Variables

Study Variable	<i>M</i>	Range	<i>SD</i>	α
Age	47.9	21.3 – 71.3	12.4	--
Yrs of nursing exp.	16.8	0.1 – 41.6	11.9	--
Yrs of PGH exp.	7.7	0.1 – 36.3	8.4	--
MBI-EE	22.1	0 – 50	12.8	.89
GNSEs	51.3	20 – 63	9.7	.89
DEELS-F	24.7	14-70	9.3	.87
DEELS-S	28.6	6-62	11.3	.85
PES	61.0	24 – 83	10.5	.82
SIG-Threat	13.1	0 – 24	7.2	.83
SIG-Pressure	15.8	0 – 21	5.3	.74

Note. Yrs of nursing exp. = Years of nursing experience; Yrs of PGH exp. = Years of experience at Piedmont Geriatric Hospital; Stress in General Threat subscale (SIG-Threat) and Pressure (SIG-Pressure) subscales are from Stanton, Balzer, Smith, Parra, & Ironson, 2001; Discrete Emotions Emotional Labor Scale Faking subscale (DEELS-F) and Suppression subscale (DEELS-S) are from Glomb & Tews, 2004; Geriatric Nursing Self-Efficacy Scale (GNSES) is from Mackenzie and Peragine, 2003; Psychological Empowerment Scale (PES) is from Spreitzer, 1995; Maslach Burnout Inventory – Emotional Exhaustion subscale (MBI-EE) is from Maslach, Leiter, & Jackson, 1996.

Potential covariates (i.e., age, years of nursing experience, years worked at PGH, job type, job shift, ethnicity) were explored using one-way between subjects ANOVA's and correlational analyses (e.g., intercorrelation matrix) to assess their impact on the study dependent variable. Job type (RN, LPN, or HSCW) did not result in significant differences in emotional exhaustion, $F(2, 74) = .03, p = .97$. Therefore, it was not entered in the regression analyses. In addition, neither job shift nor ethnicity resulted in significant differences in emotional exhaustion and were not entered in regression analyses, $F(2, 73) = 1.18, p = .31$ and $F(2, 72) = .023, p = .977$, respectively. Correlation coefficients for continuous variables (i.e., age, experience, PGH experience) were examined, and were found not to be significantly related to emotional exhaustion. These variables, then, were not used as covariates in regression analyses.

SIG test authors Stanton et al. (2001) highlighted the importance of treating SIG-Threat and SIG-Pressure as two distinct subscales. SIG-Pressure taps time pressure demands while SIG-Threat appears to represent a more serious threatening and negative quality to the work environment. Given the distinct nature of these two subscales, their relative impact on the dependent variable was explored using a simple regression analyses. In this analysis, both variables were simultaneously regressed on emotional exhaustion. Results revealed that whereas SIG-Threat significantly predicted emotional exhaustion, SIG- Pressure did not. Moreover, while the significant unique contribution of SIG-Threat to variance in the dependent variable was 21% ($\beta = .56, p < .001$), SIG-Pressure subscale contributed just 3%, $\beta = -.20, p = .05$ (see Table 4). Due to both the relevance of the more serious nature of work stressed assessed by the SIG-Threat subscale and preliminary findings, it was used in regression analyses as the measure of work stress.

Table 5

Regression Analyses Summary for Work Stress Subscales Predicting Emotional Exhaustion

Variable	B	SE B	β	R ²	sr ²
<i>Emotional Exhaustion</i>				.49**	
Work stress – Pressure subscale	-24.87	12.48	-0.20		.03
Work stress – Threat subscale	1.01	0.18	0.56**		.21**

Note. $N = 78$.

** $p < .01$.

Testing of Hypotheses

The ability of measures of work stress, emotional labor and staff self-perceived competence (i.e., empowerment and geriatric caregiving self-efficacy) to predict the job outcome of emotional exhaustion was tested using multiple regression analyses. Two separate analyses were conducted to assess the influence of emotional labor and nursing self-perceived competence on work outcome. In both of these analyses, the predictor variables were simultaneously regressed on emotional exhaustion. These analyses showed the combined and unique predictive strength of each of the independent variables (e.g., combined effect of two emotional labor strategies, unique effect of suppression of emotion).

A series of hierarchical multiple regression analyses also were used to test hypotheses pertaining to moderator effects. These analyses were performed following the procedure suggested by Baron and Kenny (1986) and others (Frazier, Tix & Baron, 2004; Holmbeck, 1997). According to Holmbeck (1997), a moderator variable affects the relationship between two variables, such that the predictor variable's impact on the outcome variable varies

depending on the level of the moderator. In other words, moderators show when or for which participants a predictor is more strongly related to an outcome measure.

The analyses were completed as follows: With emotional exhaustion as a dependent variable, work stress (SIG-Threat subscale) scores were entered into the first step of the regression analysis. In Step 2 of each analysis the potential moderator was entered into the equation, and in Step 3 the interaction term (e.g., Work Stress X Self-efficacy, Work Stress X Empowerment) was entered and tested for significance. This final step made it possible to examine the way in which the moderator variable influenced the relationship between stress and work outcome.

Hypothesis 1. Level of nursing work stress will have a direct and positive relationship with the burnout domain of emotional exhaustion.

Examination of zero-order correlations (see Table 2) reveals that work stress was significantly positively correlated with emotional exhaustion ($r = .68, p < .001$). Therefore, support for Hypothesis 1 is shown. In addition, work stress had a significant main effect for emotional exhaustion when it was entered in Step 1 of regression analyses for suppression of emotion ($\beta = .68, p < .001$), faking of emotion ($\beta = .67, p < .001$), geriatric caregiving self-efficacy ($\beta = .68, p < .001$) and psychological empowerment, $\beta = .68, p < .001$. These results also support Hypothesis 1.

Hypothesis 2a. Emotional labor strategies of suppression and faking of emotions will have a direct and positive relationship with emotional exhaustion.

Table 5 presents the results of the analysis of the regression of emotional labor on emotional exhaustion. As hypothesized, the two emotional labor strategies together predicted a statistically significant proportion of variance in the dependent variable, $R^2 = .15, F(2, 73)$

= 6.5, $p = .003$. As indicated in Table 4, suppression of emotion was significantly related to emotional exhaustion ($r = .40, p = .002$) as hypothesized, and uniquely predicted significant variance in this variable, $sr^2 = .12, p = .002$. The corresponding correlations for faking of emotion were not significant. The significant relationships between emotional labor and emotional exhaustion were accounted for by the suppression emotional labor subscale. Therefore, Hypothesis 2a was partially supported.

Table 6

Regression Analysis Summary for Emotional Labor Subscales Predicting Emotional Exhaustion

Variable	B	SE B	β	R^2	sr^2	r
<i>Emotional Exhaustion</i>				.15**		
Faking Emotion	0.10	0.16	0.08		.01	.18
Suppressing Emotion	0.42	0.13	0.36**		.12**	.40**

Note. $N = 76$

** $p < .01$.

Hypothesis 2b. Emotional labor strategies of suppression and faking of emotions will moderate the relationship between work stress and emotional exhaustion in a magnifying manner such that emotional labor and stress will affect emotional exhaustion in the same direction.

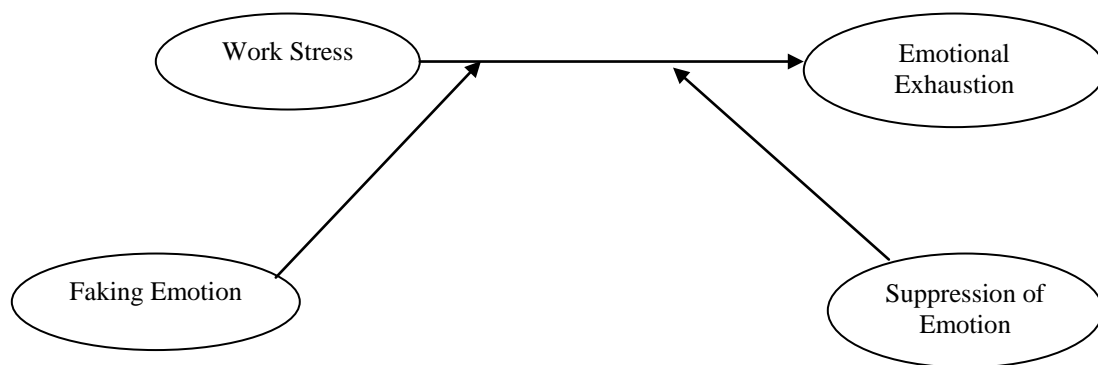


Figure 1. Faking Emotion and Suppression of Emotion as Moderators Between Nursing Stress and Emotional Exhaustion

Moderator effects for emotional labor were examined in hierarchical regression analyses conducted separately for suppression and faking subscales. As shown in Table 6, the introduction of suppression of emotion into the regression equation accounted for a significant additional 5% of variance in emotional exhaustion, beyond that found for work stress, $F(2, 74) = 37.45, p < .001$. Therefore, suppression had a significant main effect for the dependent variable, predicting increased emotional exhaustion, $\beta = .22, p = .01$. The effects of suppression as a moderator were then examined in Step 3 of the regression analysis shown in Table 6. As indicated, moderator effects were not significant, $\beta = -.01, p = .956$. Thus, Hypothesis 2b was not supported.

Table 7

Hierarchical Regression Analyses Predicting Emotional Exhaustion with Work Stress and Suppression of Emotion

Variable and step	B	SE B	β	R^2	ΔR^2	sr^2
<i>Emotional Exhaustion</i>						
Step 1				.46***		
Work Stress	1.22	0.15	.68***			.46***
Step 2				.50*	.05*	
Work Stress	1.11	0.16	.61***			.34***

Table 7 continued

Hierarchical Regression Analyses Predicting Emotional Exhaustion with Work Stress and Suppression of Emotion

Variable and step	B	SE B	β	R^2	ΔR^2	sr^2
Suppression	0.26	0.10	.22*			.05*
Step 3				.50	.00	
Work Stress	1.11	0.16	.61***			.34***
Suppression	0.27	0.11	.23*			.04*
Work Stress X Suppression	0.00	0.01	-.01			.00

Note. $N = 78$

* $p < .05$. *** $p < .001$.

Table 8 presents the results of the multiple regression analysis for the Faking Emotional Labor subscale. The results indicate that Faking emotion was a poor predictor of emotional exhaustion ($\beta = .14, p = .092$), with no moderator effect, $\beta = -.09, p = .28$.

Table 8

Hierarchical Regression Analyses Predicting Emotional Exhaustion with Work Stress and Faking of Emotion

Variable and step	B	SE B	β	R^2	ΔR^2	sr^2
<i>Emotional Exhaustion</i>						
Step 1				.45***		
Work Stress	1.20	.15	0.67***			.45***
Step 2				.47	.02	
Work Stress	1.19	.15	0.66***			.44***
Faking	0.20	.12	0.14			.02
Step 3				.48	.01	
Work Stress	1.19	.15	0.66***			.44***
Faking	0.21	.12	0.15			.02
Work Stress X Faking	-0.02	.02	-0.09			.01

Note. $N = 77$

*** $p < .001$.

Hypothesis 3a. Empowerment and geriatric caregiving self-efficacy will each have a direct and negative relationship with emotional exhaustion.

Table 9 presents the results of the analysis of the regression of empowerment and geriatric caregiving self-efficacy—two variables representing the concept of perceived competence at work—on work outcome. As hypothesized, empowerment and self-efficacy together predicted significant levels of variance in emotional exhaustion, $R^2 = .10$, $p < .05$, $F(2, 74) = 3.96$, $p = .02$. As indicated in Table 3, empowerment was related to emotional exhaustion in the expected direction, but the correlation did not reach statistical significance, $r = -.22$, $p = .056$. In addition, self-efficacy was significantly related to emotional exhaustion ($r = -.25$, $p = .027$) as hypothesized. Therefore, the significant relationships between empowerment/self-efficacy and emotional exhaustion were accounted for by a combination of both of these subscales. Partial support for Hypothesis 3a was demonstrated.

Table 9

Regression Analyses Summary for Empowerment and Geriatric Caregiving Self-Efficacy Predicting Emotional Exhaustion

Variable	B	SE B	β	R^2	sr^2	r
<i>Emotional Exhaustion</i>				.10*		
Empowerment	4.39	2.60	.19	.03		-.22
Self-efficacy	45.86	23.25	.22*	.05		-.25*

Note. $N = 77$

* $p < .05$.

Hypothesis 3b. Empowerment and geriatric caregiving self-efficacy will each moderate the relationship between work stress and emotional exhaustion in a buffering manner as to weaken the effect of stress on emotional exhaustion.

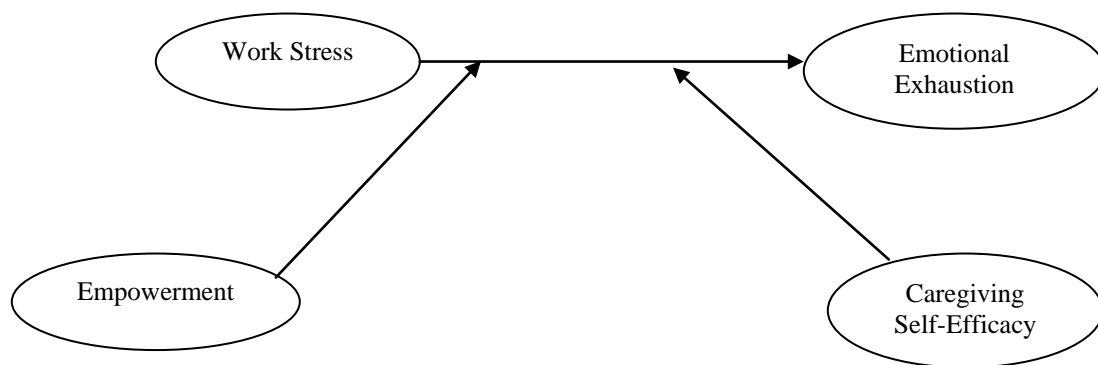


Figure 2. Empowerment and Geriatric Caregiving Self-Efficacy as Moderators Between Nursing Stress and Emotional Exhaustion

Moderator effects for empowerment and geriatric caregiving self-efficacy were examined in hierarchical regression analyses conducted separately for each variable. As shown in Table 10, there was no main effect for empowerment on emotional exhaustion, $\beta = .01, p = .92$. The effect of empowerment as a moderator was then examined in Step 3 of the regression analysis shown in Table 10. As indicated, the moderator effect was not significant, $\beta = .52, p = .70$.

Table 10

Hierarchical Regression Analyses Predicting Emotional Exhaustion with Work Stress and Empowerment

Variable and step	B	SE B	β	R^2	ΔR^2	sr^2
<i>Emotional Exhaustion</i>						
Step 1				.46**		
Work Stress	1.22	.15	.68**			.46**
Step 2				.46	.00	
Work Stress	1.22	.16	.67**			.41**
Empowerment	.21	2.10	.01			.00
Step 3				.46	.00	
Work Stress	.28	2.42	.16			.00
Empowerment	.19	2.11	.01			.00

Table 10 continued

Hierarchical Regression Analyses Predicting Emotional Exhaustion with Work Stress and Empowerment

Variable and step	B	SE B	β	R^2	ΔR^2	sr^2
Work Stress X Empowerment	.10	.26	.52			.00

Note. $N = 77$

* $p < .05$. ** $p < .01$.

Table 11 presents the results of the multiple regression analysis for the geriatric caregiving self-efficacy scale. As shown, the introduction of self-efficacy into Step 2 of the regression equation did not predict additional variance in emotional exhaustion, $\beta = .03$, $p = .57$. The effects of self-efficacy as a moderator were then examined in Step 3 of the regression analysis shown in Table 11. Even after control of work stress and self-efficacy, the interaction for stress and self-efficacy explained a significant increase of 5% in the variance in emotional exhaustion, $F(3, 74) = 25.32$, $p < .001$. Self-efficacy was found to significantly moderate the relationship between work stress and emotional exhaustion, $\beta = -6.36$, $p < .01$. The interaction term uniquely predicted 5% of the variance in emotional exhaustion (see Table 10 for sr^2 value). Simple slopes were examined for nursing staff who had high levels (+ 1 *SD*) and low levels (-1 *SD*) of geriatric caregiving self-efficacy under low and high work stress conditions. As shown in Figure 3, nursing staff members who reported low stress and also low self-efficacy experienced low emotional exhaustion. Similarly, those reporting low stress and high self-efficacy also experienced low emotional exhaustion. Further examination of Figure 3 reveals that when reporting high stress, staff members who had low self-efficacy experienced the highest emotional exhaustion values. However, when self-efficacy was high for this group, their emotional exhaustion scores decreased. Thus, higher levels of self-

efficacy appeared to play a protective role from experiencing more emotional exhaustion when in a high stress condition. Therefore, partial support for Hypothesis 3b was shown.

Table 11

Hierarchical Regression Analyses Predicting Emotional Exhaustion with Work Stress and Geriatric Caregiving Self-efficacy

Variable and step	B	SE B	β	R ²	ΔR^2	sr ²
<i>Emotional Exhaustion</i>						
Step 1				.46**		
Work Stress	1.22	.15	.68**			.46**
Step 2				.46	.00	
Work Stress	1.20	.16	.67**			.39**
Self-efficacy	6.52	18.43	.03			.00
Step 3				.51**	.05**	
Work Stress	12.67	4.23	7.02**			.06**
Self-efficacy	13.80	17.92	.07			.00
Work Stress X Self-efficacy	-6.39	2.38	-6.36**			.05**

Note. N = 78

*p < .05. **p < .01.

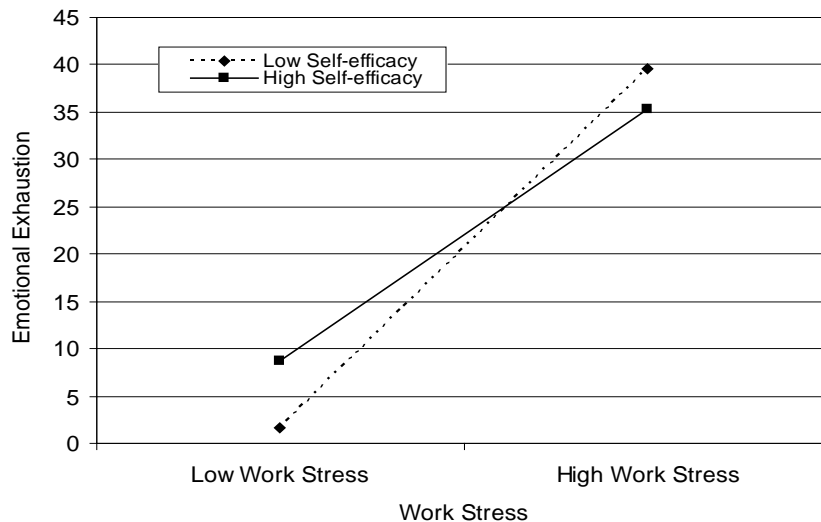


Figure 3. Emotional Exhaustion Score as a Function of Geriatric Caregiving Self-Efficacy and Level of Work Stress in a Sample of 78 Geriatric Nursing Staff Members

Discussion

Study results contribute meaningfully to the literature on stress in geriatric psychiatric nursing. Specific types of work stress predictive of emotional exhaustion in this sample were identified, and the role of emotional labor performance and self-perceived nursing competency in predicting one aspect of burnout (i.e., emotional exhaustion) was explored.

As predicted, the results of this study found that stress was a significant predictor of emotional exhaustion. These findings are consistent with much of the relevant literature (e.g., Baldwin, 1999; Barber & Iwai, 1996; Cocco et al., 2003; Kennedy, 2005), but also suggest that work stress deriving from a negative affective experience (SIG-Threat) may play a larger role in predicting work outcomes than does stress stemming from time pressure demands (SIG-Pressure). The fact that the SIG-Threat subscale demonstrated a strong effect on work outcome in this sample of geriatric nursing staff workers provides evidence to support Stanton and colleagues' (2001) assertion that evaluating these two subscales individually is important. It may be that the dimension of work stress assessed by the SIG-Threat subscale captured a salient negative aspect of work stress that is especially relevant in the nursing environment at PGH. On the other hand, the results for time pressure suggest that this dimension of stress may be less relevant to the geriatric psychiatric nursing environment in general.

As previously discussed, the average emotional exhaustion score for the sample as a whole, including all three nursing staff work groups, was in the moderate range of burnout. Closer inspection of emotional exhaustion data reveals that 50 out of 79 participants, roughly 63% of the sample, reported scores classified as moderate ($M = 21.7$, $SD = 3.1$) to high ($M = 35.5$, $SD = 6.2$) levels of burnout. The remaining 28 participants reported emotional

exhaustion scores in the low range of burnout ($M = 8.1$, $SD = 4.5$), reflecting approximately 35% of the sample. This finding highlights the stressful nature of geriatric psychiatric nursing work, and the general experience of nursing staff in this sample in dealing with these work demands. Given that more than half of nursing staff workers surveyed reported moderate to high levels of emotional exhaustion, the need to investigate factors protective against experiencing this negative work outcome is striking.

As indicated above, the results for emotional labor partially supported the experimental hypotheses. Although the two emotional labor subscales of faking and suppression of emotion significantly predicted emotional exhaustion, this effect was due exclusively to the strong effect for suppression of emotion. Faking emotion did not have the same influence on emotional exhaustion as did suppressing emotion. Other researchers (Bolton, 2000; DeCastro, 2004; Staden, 1998) have speculated that emotional labor is a highly relevant demand for nursing staff; this study confirms its relevance to a sample of geriatric workers in a psychiatric setting and highlights the potential importance of suppression of emotion in predicting work outcomes. In the present research, suppression of emotion was directly related to higher levels of work stress. Perhaps the act of suppressing felt emotion, rather than faking non-felt emotion, is related to higher levels of stress for nursing staff. The finding that suppression of emotion was indicative of negative work outcomes in this sample suggests the potential utility of targeting healthy emotion management techniques in staff training interventions. Increased education on the role of emotional labor performance at work and its associated consequences, combined with strategies for effective management of this demand, may serve to improve the working lives of geriatric nursing staff.

The results for empowerment and geriatric caregiving self-efficacy were generally consistent with experimental hypotheses. Although both empowerment and self-efficacy were related to emotional exhaustion in the expected direction, only the correlation between geriatric caregiving self-efficacy and emotional exhaustion was statistically significant. It may be that the influence of empowerment on emotional exhaustion in this sample was not strong enough to protect against this negative work outcome. A larger sample may be necessary to adequately explore this issue. This finding is in contrast with other studies that have shown that empowerment plays a protective role against emotional exhaustion for nursing staff (Hochwalder, 2007; Hochwalder & Brucefors, 2005). More specifically, Hochwalder (2007) showed that empowerment played a moderating role between work environment (i.e., demands, control, social support) and emotional exhaustion, such that those with higher work demands who also were more empowered experienced lower emotional exhaustion scores as compared to workers who reported lower levels of empowerment. Although empowerment did not show a similar moderator effect in the current study, a clear result of the present research was that higher levels of empowerment and geriatric caregiving self-efficacy were related to lower levels of work stress. Moreover, Zurmehly, Martin and Fitzpatrick (2009) showed that higher levels of empowerment for nurses were related to significantly lower intent to leave their current position, pointing out the protective nature of empowerment.

Significantly, the present study revealed that geriatric caregiving self-efficacy moderated the relationship between work stress and emotional exhaustion such that higher levels of self-efficacy protected nursing staff in this sample against worse burnout outcomes. In the context of the Conservation of Resources (COR; Hobfoll, 1989) theory of stress,

results suggest that increased levels of geriatric caregiving self-efficacy may serve to increase workers' store of resources, which in turn may make them less vulnerable to high stress working conditions. These results are consistent with research reported by Mackenzie and Peragine (2003), who found that caregiving self-efficacy played a protective role against experiencing burnout for a sample of geriatric professional caregivers. This finding for self-efficacy is important because it suggests that interventions aimed at enhancing self-efficacy at work may buffer of effects of stress on burnout. Moreover, the fact that nursing staff workers who have poor coping skills experience high levels of burnout points to the importance of intervention (Fagin et al., 1996). Importantly, the literature suggests that the potential to improve workers' self-efficacy is great (Dunn et al., 2007; Mackenzie & Peragine, 2003).

As discussed above, the results of the present study suggest the utility of intervention programs that target the development of emotion management skills and skills to enhance nursing staff caregiving self-efficacy. It seems likely that the development of skills in the emotion management domain will complement the development of skills regarding geriatric caregiving self-efficacy. Clearly, there is conceptual overlap between the two skill areas, in that they both involve accurately assessing work demands and responding to those demands. According to Bandura (1997), self-efficacy involves the belief that certain outcomes will have positive impacts on one's environment and that one is capable of performing the actions that will produce change.

An additional finding of this study was that the application of COR theory to the conceptualization of geriatric psychiatric nursing staff stress proved useful in understanding this worker group's experience of stress at work. Emotional labor demands, conceptualized

as a threat to existing resources, were in fact positively correlated with both stress and emotional exhaustion. In addition, when workers reported higher levels of empowerment and geriatric caregiving self-efficacy they also experienced lower stress and lower emotional exhaustion in general. This result supports the conceptualization of these two variables related to nursing staff self-perceived competency as psychological resources that serve to protect against the experience of work stress. Another unique quality of the current sample was the implementation of the Recovery Model of care at this facility, which is relatively uncommon in geriatric settings. The focus of this model on inclusion of patients in decision making regarding care, involvement of family, and the view of the organization as patient-focused rather than provider-focused is likely to impact the organization as a whole, and in turn, its employees. In such an organization, it seems that staff workers as whole would experience higher levels of empowerment and caregiving self-efficacy, as compared to health settings in which a more traditional medical model of care is espoused.

Limitations

One limitation of the current study was that in order to assure confidentiality, information was not gathered regarding the unit on which the nursing staff worked (i.e., Dementia, Forensic, Admissions, & Medical units). These different units may provide additional information about work environment for nursing staff, and this information might provide a richer data set. PGH is a unique institution, in terms of its exclusive geriatric patient base, location in a rural setting, and adherence to the Recovery Model of care. Nursing staff members employed in lower status positions, such as human service care workers and licensed practical nurses, tend to live in rural areas closer to the location of the hospital and may be less mobile than their counterparts higher in educational and financial

status. On the other hand, registered nurses may have more job opportunities in a larger geographical area and may be more mobile in obtaining employment. These factors may limit the generalizability of findings to the larger population of geriatric psychiatric care providers. An additional factor to consider is the role of race and ethnicity in the experience of nursing staff empowerment, caregiving self-efficacy, and the threat dimension of stress (SIG-Threat) at work. Although race and ethnicity did not result in significant differences in variables of interest in the present study, examination of the role of racial and ethnic identity is an important factor to consider. Those workers possessing ethnic minority status may perceive lower levels of these factors at work and may also have to work against discrimination in the workplace (i.e., from patients and other co-workers), which is likely to decrease their store of psychological resources and make them more likely to experience stress at work.

In terms of specific measures used in this study, patterns of missing participant data show that multiple nursing staff members omitted responses to both of the DEELS subscales (i.e., Faking and Suppression). The fact that higher occurrences of missing data were observed on this measure indicates that it may be a more complicated measure in format and readability. As compared to measures on which no participants had missing data, such as the GNSSES, this pattern of response was concerning. Therefore, although emotional labor demands appear highly relevant to geriatric psychiatric nursing staff, it is possible that an alternate measure of emotional labor using more simple language and presented with increased ease of reading would more accurately assess staff emotional labor demands. An additional finding was the strong correlation between the SIG-Threat subscale and emotional

exhaustion ($r = .68, p < .001$), which may present issues related to multicollinearity between these two variables.

Another limitation of the study is its reliance on self-report data. Given the nature of data collection techniques, nursing staff may have masked or over-reported stress levels, burnout, self-efficacy, empowerment and frequency of emotional labor due to social desirability. It may be appropriate in future research to measure social desirability, in an effort to statistically control for this factor. Another issue that may have influenced results was the study coordinator's inability to access staff members not present on days of data collection. Those workers may in fact represent the most highly stressed section of the nursing staff work population. Therefore, the effect of a possible non-response bias may have influenced results.

Future Directions

Viewed collectively, the results of the present research suggest several key elements of an intervention program to teach nursing staff how to more effectively cope with job-related stress. Such an intervention would include education that serves to enhance empowerment, geriatric caregiving self-efficacy, and the use of healthy emotion management strategies. Given that evaluation of emotional demands in the nursing setting is in its early stages, no intervention research targeting this variable to date was found. In addition, the application of the concept of empowerment in interventions for geriatric nursing staff populations is likely to positively impact worker outcomes. In general, interventions that aim to increase employee control are related to positive health benefits (Egan et al., 2007). Interventions targeting self-efficacy are more readily found in the literature and results are promising. For example, researchers have established the effectiveness of interventions

aimed at enhancing self-efficacy mastery of specific job skills in populations of geriatric professional caregivers (Mackenzie & Peragine, 2003) and nursing staff in general (Edwards & Burnard, 2003; Freedy & Hobfoll, 1994; McLeod, Densley & Chapman, 2006). More specifically, Mackenzie and Peragine (2003) first identified three key sources of stress (i.e., conflict among colleagues, management of challenging patient behaviors, and management of conflict with patients' families) and then used methods recommended by Bandura (1997) to increase self-efficacy. These methods included mastery experiences, vicarious experiences, verbal persuasion, and monitoring physiological states and were implemented by use of group role-playing, practice with team, resident and family common scenarios, observation of colleagues, and constructive feedback received from fellow participants and group leaders. In addition, a supportive learning environment was provided in order to prevent a high level of physiological arousal during the intervention. Participants were given a training manual and posters summarizing intervention points were posted in common nurse work areas to enforce key learning points. As compared to a control group, the intervention group demonstrated higher levels of caregiving self-efficacy post-intervention, and these scores were further increased at 3-month follow up (Mackenzie & Peragine, 2003).

Due to the fact the little research on self-efficacy interventions for professional geriatric nursing caregivers has been conducted, other interventions delivered to the general nursing population were examined. Freedy and Hobfoll (1994) targeted mastery of skills, one component of self-efficacy, in a nursing stress intervention which resulted in significant decreases in psychological distress. In addition, Oman, Richards, Hedberg and Thoresen (2008) examined the effectiveness of an 8-week intervention teaching self-management skills (i.e., concentration, stress reduction, meditation) on enhancing relational caregiving self-

efficacy for a sample of health professionals, including nurses and physicians. This intervention led to significant enhancements in caregiving self-efficacy that were maintained over time (Oman et al.). In their 2003 review on mental health nurse stress interventions, Edwards and Burnard concluded that effective stress management techniques taught in interventions included relaxation, behavioral techniques, stress management, and therapeutic skills training. Another intervention program delivered to inpatient mental health nurses focused on teaching nurses skills to manage patient problem behaviors (i.e., behavior modification skills) and included homework tasks applying concepts, videotape resources, and feedback on skill development over the course of the 4-week intervention (McLeod, Densley, & Chapman, 2006). Results indicated that this intervention program improved nurses' attitudes toward patients but did not affect nurse stress or burnout. Therefore, overall results of intervention studies show the potential utility of improving geriatric caregiving self-efficacy, which may in turn serve to decrease emotional exhaustion and stress at work.

The field would benefit from future studies investigating similar concepts with larger sample sizes and with the addition of semi-structured interviews of staff to capture a richer picture of the nursing experience. Suggested directions for future research include investigation of the role of social support, person-centered care orientation, and attitudes toward older adults as moderators between stress and work outcomes. In addition, studies evaluating the efficacy of nursing interventions as discussed above would serve to improve the quality of nursing staff working lives in a broad sense. Further research is needed to clarify how these factors may differentially impact different groups of nursing staff workers, such as registered nurses, licensed practical nurses and nursing assistants. As noted in previous discussion, nursing assistants carry the brunt of face-to-face interactions with

patients, licensed practical nurses commonly distribute patient medications and provide some direct patient care, and registered nurses tend to oversee many patients and have less face-to-face contact with their patient base. The inherent power hierarchy present in nursing staff populations suggests that members of each worker group may perceive different levels of control and support in their working environments, which are likely related to the experience of stress at work. Moreover, geriatric caregiving self-efficacy is one variable that may be related to status in the organization. Although group-level differences were not examined in the current study, research addressing these questions is much needed. In addition, the relation of empowerment and geriatric caregiving self-efficacy to effective coping skills is another area for exploration.

Major initiatives required to provide geriatric behavioral health workers adequate training and support are outlined by Stephen Bartels in his chapter contribution to the Substance Abuse and Mental Health Service Administration (SAMHSA) action plan regarding older adults and the behavioral health workforce (U.S. Department of Health and Human Services, SAMHSA, 2007). He highlights important background statistics regarding the shortage of health providers working with psychiatric populations who have specific expertise in geriatric issues, consistent with facts regarding the aging population and nursing staff shortage previously discussed in the current research. Bartels notes that adequate education and training for staff working in geriatrics is essential, but goes beyond this to suggest a number of initiatives that would serve to address the current and future shortage of workers trained specifically in geriatrics and psychiatric care. More specifically, these suggestions include incentive programs such as student loan repayment for both undergraduate and graduate tuition, expansion of certification required by health

professionals to work in geriatric psychiatric care, and increasing awareness of geriatric careers for students in health fields (U.S. Department of Health and Human Services, SAMHSA, 2007). Beyond simply providing professional workshops, Bartels notes the importance of a larger systems change that emphasizes implementation of newly learned skills in a supportive learning environment. He also suggests that eliminating disparities between reimbursement rates for geriatric and psychiatric or mental health services as compared to other health care services would serve to attract and retain skilled workers in this field. These policy-level changes are essential to provide the education and support needed by geriatric nursing staff working in psychiatric care.

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Appendix A

Demographic and Work Questionnaire

1) What is your date of birth? _____ (month) / _____ (day) / _____ (year)

2) What is your gender? Please check the box that applies.

Female

Male

3) What is your ethnicity? Please check the box(es) that apply.

European American/White

African American/Black

Latino/a American

Asian American

Native American

Pacific Asian

Middle Eastern

Indian American

Other: _____

4) What is your job description?

Registered Nurse

Licensed Practical Nurse

Nurse Manager

Human Service Care Worker

Clinical Nurse Specialist

5) What shift do you work most of the time?

Day Shift

Evening Shift

Night Shift

6) How many months and years have you worked at PGH?

Months: _____ Years: _____

7) How many months and years of nursing experience do you have?
Months: _____ Years: _____

Appendix B

Stress in General (SIG) Scale

Instructions: Do you find your job stressful? For each of the following words or phrases, circle: 1 for “**Yes**” if it describes your job, 2 for “**No**” if it does not describe it, or 3 for “**?**” if you cannot decide.

	Yes	No	?
Demanding	1	2	3
Pressured.	1	2	3
Hectic	1	2	3
Calm.	1	2	3
Relaxed.	1	2	3
Many things stressful	1	2	3
Pushed.	1	2	3
Irritating.	1	2	3
Under Control.	1	2	3
Nerve-racking	1	2	3
Hassled.	1	2	3
Comfortable.	1	2	3
More stressful than I'd like.	1	2	3
Smooth-running	1	2	3
Overwhelming.	1	2	3

Appendix C

Maslach Burnout Inventory – Human Services Survey (MBI-HSS)

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 word *recipients* to refer to the people for whom you provide your service, care, treatment, or instruction. When answering the survey, please think of these people as recipients of the service you provide, even though you may use another term in your work.

The following 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.

HOW OFTEN:	0	1	2	3	4	5	6
	Never	A few times a year or less	Once a month	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.

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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.

Appendix D

Discrete Emotions Emotional Labor Scale (DEELS)

Instructions: In the following sections, we would like to know about the emotions you express to others, such as customers, clients, coworkers, and supervisors, and emotions that you feel but do not express while on the job. That is, we are interested in what you express through your body language, facial expressions, tone of voice, etc. **Consider your experiences in your clinical nursing work over the past six months.** The following sections may seem somewhat similar, so please read the instructions carefully.

Expressing emotions you do not feel (Faking emotions)

In this section, we would like to know how often you express emotions in your clinical nursing work when you really do not feel these emotions (i.e., **how often you fake emotions you really don't feel**). Please circle the number that describes how frequently you express certain emotions when you do not feel them.

	I express this many times a day when I do not feel it	I express this a few times a day when I do not feel it	I express this a few times a week when I do not feel it	I express this a few times a month when I do not feel it	I never express this when I do not feel it
Irritation	5	4	3	2	1
Anxiety	5	4	3	2	1
Contentment	5	4	3	2	1
Sadness	5	4	3	2	1
Concern	5	4	3	2	1
Disliking	5	4	3	2	1
Aggravation	5	4	3	2	1
Fear	5	4	3	2	1
Happiness	5	4	3	2	1
Distress	5	4	3	2	1
Liking	5 5	4 4	3 3	2 2	1 1

Hate						
Anger	5	4	3	2	1	
Enthusiasm	5	4	3	2	1	

Keeping emotions to yourself (Suppressing emotions)

In this section, we would like to know about emotions you do not express during your clinical nursing placement but feel like expressing. That is, we are interested in how often you keep certain emotions to yourself **(i.e., how often you suppress emotions you feel)** because you feel you should not express them on the job. Please circle the number that describes how often you keep certain emotions to yourself when you really feel them.

	I keep this to myself many times a day	I keep this to myself a few times a day	I keep this to myself a few times a week	I keep this to myself a few times a month	I never keep this to myself	I never feel this
Irritation	5	4	3	2	1	0
Anxiety	5	4	3	2	1	0
Contentment	5	4	3	2	1	0
Sadness	5	4	3	2	1	0
Concern	5	4	3	2	1	0
Disliking	5	4	3	2	1	0
Aggravation	5	4	3	2	1	0
Fear	5	4	3	2	1	0
Happiness	5	4	3	2	1	0
Distress	5	4	3	2	1	0
Liking	5	4	3	2	1	0
Hate	5	4	3	2	1	0
Anger	5	4	3	2	1	0
Enthusiasm	5	4	3	2	1	0

Appendix E

Geriatric Nursing Self-Efficacy Scale (GNSES)

Instructions: For each of the following situations, how confident are you that you could remain calm, resolve the problem, and achieve a positive outcome? **Please circle the appropriate number.**

1. You are extremely busy, you are behind in your work, and one of the residents is following you around and trying to grab your arm.

Not at all confident 1 2 3 4 5 6 7 **Very confident**

2. The husband of a newly admitted resident constantly instructs you on how to care for his wife. It seems that nothing you do is good enough for him.

Not at all confident 1 2 3 4 5 6 7 **Very confident**

3. A nurse on your shift approaches you at the nursing station and demands to know why you are working so slowly.

Not at all confident 1 2 3 4 5 6 7 **Very confident**

4. One of the residents often swears and curses at other residents and staff. While you are helping him with his wheelchair, he curses and nearly kicks you.

Not at all confident 1 2 3 4 5 6 7 **Very confident**

5. You are at the nursing station and you see a resident's daughter walking briskly towards you. She looks very upset and angry.

Not at all confident 1 2 3 4 5 6 7 **Very confident**

6. A colleague of yours is avoiding you for some reason. This is making your job difficult because you work closely with him.

Not at all confident 1 2 3 4 5 6 7 **Very confident**

7. Every time you see one of the residents, she asks: "When do I get to go home?" This has been going on for months.

Not at all confident 1 2 3 4 5 6 7 **Very confident**

8. The son of one of the residents corners you, blames you for ignoring his mother, and demands that you spend more time looking after her.

Not at all confident 1 2 3 4 5 6 7 **Very confident**

9. A colleague of yours is constantly comparing herself to you, insisting that the residents and their families prefer the care she provides to your care.

Not at all confident 1 2 3 4 5 6 7 **Very confident**

Appendix F

Psychological Empowerment Scale (PES)

Listed below are a number of self-orientations that people may have with regard to their work role. **Using the following scale, please indicate the extent to which you agree or disagree that each one describes your self-orientation.**

1	2	3	4	5	6	7
Very Strongly Disagree	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Very Strongly Agree

- _____ I am confident about my ability to do my job.
- _____ The work that I do is important to me.
- _____ I have significant autonomy in determining how I do my job.
- _____ My impact on what happens in my department is large.
- _____ My job activities are personally meaningful to me.
- _____ I have a great deal of control over what happens in my department.
- _____ I can decide on my own how to go about doing my own work.
- _____ I have considerable opportunity for independence and freedom in how I do my job.
- _____ I have mastered the skills necessary for my job.
- _____ The work I do is meaningful to me.
- _____ I have significant influence over what happens in my department.
- _____ I am self-assured about my capabilities to perform my work activities.

Vita

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