

**OCCUPATIONAL WELL-BEING AND BURNOUT IN PERSONAL
SUPPORT WORKERS WORKING LONG TERM CARE
FACILITIES**

by

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DEDICATION

To Isaac and Ilesh – best supports, best friends, best loved.

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ABSTRACT

Personal Support Workers (PSWs) who work in nursing homes may be at risk of developing burnout; however, those PSWs who meet their occupational needs may have a decreased risk. This study was designed to examine the relation between burnout and occupational well-being in a sample of PSWs working in nursing homes. PSWs working in two nursing homes were recruited to complete the Maslach Burnout Inventory (MBI) and the Occupational Well-Being Questionnaire (OWBQ) (N=20). The MBI generates three subscale scores, that is, Emotional Exhaustion (EE), Depersonalization (DP), and Personal Accomplishment (PA). Persons with higher levels of burnout are expected to score higher on the EE and DP subscales and lower on the PA subscale. Rasch analysis was used to convert participant ordinal responses to the OWBQ into equal interval linear occupational well-being measures (in logits). A moderate inverse association was found between participants' OWB measures and their MBI EE subscale scores ($r=-0.41$, $p=0.07$) whereas only a low inverse association ($r=-0.37$, $p=0.11$) and a low positive association ($r=0.25$, $p=0.30$) was found between participants' OWB measures and their MBI DP and PA subscales respectively. Participants' years of work experience were also moderately related to their MBI EE subscale scores ($r=0.48$, $p=0.04$). The findings of this study provide some evidence that there may be an association between the degree to which individuals are able to meet their occupational needs and the experience of burnout at work; however, further studies with larger samples using mixed methods are needed.

LIST OF ABBREVIATIONS USED

CCM	Culture Change Model
DP	Depersonalization
EE	Emotional Exhaustion
LTC	Long Term Care facility
OWB	Occupational Well-Being
OWBQ	Occupational Well-Being Questionnaire
MBI	Maslach Burnout Inventory
PA	Personal Accomplishment
PSW	Personal Support Worker

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CHAPTER 1: INTRODUCTION

The population of older adults in Ontario is increasing. In 2011, there were 1,878,325 individuals in Ontario aged 65 years and older representing 14.6% of the province's overall population and this number is expected to double over the next twenty years (Sinha, 2012). This change in population demographics has been recognized to be significant from a health policy perspective, because despite their low percentage in the population nearly half of the health care spending is being allocated to the care of older adults (Sinha, 2012). In an effort to contain rising healthcare costs while maintaining quality of care, Ontario's Ministry of Health and Long Term Care (MOHLTC) has developed the Seniors' Strategy to identify and address gaps and opportunities in the way health care services are delivered to Ontario's seniors (Sinha, 2012).

Long term care is a sector of the health care system that is primarily dedicated to the care of seniors. At present, 636 long term care facilities (LTC facilities) in Ontario provide care for 113, 424 Ontarians (Canadian Institute of Health Information, 2014). Of these, the largest group of residents by diagnosis is those with dementias (61.9%). Additionally, 73% of residents require an extensive level of assistance for their personal care and activities of daily living, with 11.5% being totally dependent for all care (CIHI, 2014). The high proportion of residents with extensive care needs has cost implications, as more personnel are required to provide this care. As the province prepares to address the health care needs of its seniors in the future, it has been recommended that the services delivered in LTC facilities be expanded to include care of those with more complex health issues requiring higher levels of medical care (Sinha, 2012). Whether

these increased demands will be supported with increased funding has not been made clear.

In Ontario, the average ratio of Personal Support Worker (PSW) staff to residents in LTC facilities has been reported to range from 11:1 to 13:1 by the Health Professionals Regulatory Advisory Council (HPRAC, 2006) with the numbers being higher for those working on the night shift. PSWs provide the majority of care to residents in LTC facilities (HPRAC, 2006). However, this level of care-related responsibility is not reflected in the remuneration offered to these workers. For example, in the nursing home sector within Toronto, Ontario where the Principal Investigator (PI) works PSWs working the day shift typically provide care for up to 10 residents, and earn an entry level wage of \$18/hour (Lei, personal communication, August 7, 2014). These factors may be sources of stress for this group of healthcare workers as they may feel rushed to manage all their work responsibilities, while receiving limited compensation for all the care they provide.

In addition to the high level of care responsibility and low wages, PSWs are also unregulated workers; therefore education and training for PSWs is not standardized and often basic training does not cover the complex situations these workers may encounter in their daily work life (D'Hondt, Kaasalainen, Prentice, & Schindel Martin, 2012). As a work environment, LTC facilities can present specific challenges due to limited resources of time (e.g., heavy caseloads), equipment (e.g., not available when needed, not appropriate for larger residents), environment (e.g., cold shower rooms which contribute to residents' discomfort during care), and limited training in dementia and managing challenging behaviors (D'Hondt et al., 2012). As PSWs are primary care providers to

vulnerable individuals they are required to manage these challenges as they try to provide care to residents. All of these challenges can create a stressful work environment, which can have an impact on the well-being of PSWs.

While work is an important part of PSWs' daily life, it is probably not the only occupation in which they engage. Occupation has been defined as encompassing "all the activities and tasks of everyday life for all people" (p. 40, Canadian Association of Occupational Therapists, 2007). Over time, by engaging in a multiplicity of occupations, individuals develop occupational repertoires. Occupational repertoire refers to the full range of occupations in which individuals engage that have the potential to either enhance or undermine their health and well-being (Davis & Polatjko, 2010). In addition to work, PSWs' occupational repertoires may include occupations such as child rearing, house cleaning, meal preparation, hobbies and sports activities. Many of these occupations may enable PSWs to experience their lives in a positive and meaningful way, thereby providing opportunities to enhance health and well-being. However, for many PSWs, work may be the primary occupation around which they organize their waking hours. If, over a prolonged period of time, PSWs experience their work as too challenging, stressful or overwhelming, they may experience burnout.

Burnout refers to a prolonged response to imbalances and chronic emotional and interpersonal stressors on the job (Maslach, Schaufeli, & Leiter, 2001). The experience of burnout among healthcare providers, such as PSWs, has the potential to exert a widespread negative effect not only in the care residents receive but also in the health of those caring for them. Burnout has been reported to have negative effects on the workers' health which can lead to increased sick time and turnover in staff and affect the quality of

service that service providers deliver (Maslach et al., 2001). In a study of nurses working in nursing homes Evers, Tomic and Brouwers (2002) found that the likelihood of experiencing burnout is increased when residents exhibit aggressive behaviors. In another study of nurses, Rai (2010) found that high workload, role conflicts and stress levels in the workplace contributed to higher levels of burnout in nurses. While these studies focused on nurses working in LTC facilities, there is little reason to assume that the findings from these studies are not equally applicable to PSWs. Thus, there is benefit in exploring the presence of burnout in these healthcare providers as the findings from such studies may not only shed light on the prevalence of burnout amongst PSWs but may also contribute towards designing potential interventions to reduce its impact in this population.

However, it is also important to remember that while work often accounts for a large percentage of how health care professionals such as PSWs organize their time, persons' occupational repertoires can be comprised of any number of other occupations. Thus, burnout should be examined in conjunction with persons' occupational well-being, that is, the extent to which they derive satisfaction and a sense of well-being from their full range of occupations or occupational repertoires (Doble & Santha, 2008). In some cases, burnout may spill over and adversely affect individuals' ability to derive satisfaction from their non-work related occupations. PSWs at greater risk for burnout may also be at risk for experiencing decreased levels of occupational well-being if their occupational repertoires do not enable them to adequately meet their occupational needs. Moreover, if PSWs experience increasing levels of burnout at work, their ability to engage in and derive meaning and satisfaction from their work may be reduced. It is

possible that non-work occupational experiences might buffer the potentially negative effects of burnout. For example, if a PSW has a habit of going for a walk with her family after dinner every day, this occupation might provide the PSW with an opportunity to experience companionship and pleasure, thereby serving an important rejuvenating function. This, in turn, may enable her to better handle the stresses associated with her paid work.

It is also possible that while some individuals may perceive the challenges associated with their work in a negative light, others may reframe their experiences such that they derive positive meaning and satisfaction from them. For example, a PSW may frame her work with residents with dementia (including those residents who present with behavioral concerns) in positive terms. She may view residents as individuals who deserve respect and dignity; she may believe it is important to care for those who are vulnerable and may take pride in her ability to elicit positive interactions from her clients. Such views may serve to provide a protective function against burnout as she would perceive her work as a positive experience and herself as a successful worker. This in turn would lead to an enhanced experience of occupational well-being.

Examining the association between burnout and occupational well-being has the potential to offer a new perspective on the assessment, treatment, and prevention of burnout. Thus, there is great benefit in exploring the experiences of burnout and occupational well-being among PSWs. The purpose of the study was to examine the relationship between the perceptions of burnout and occupational well-being among a sample of PSWs employed in nursing homes.

Since the relationship between occupational well-being and burnout has not been examined previously, this study provides a new way of conceptualizing burnout and its implications. More specifically, the concept of occupational well-being provides an overarching construct within which burnout can be seen as occupying the depleted end of the occupational well-being continuum. If an inverse association is found between occupational well-being and burnout, it may lay the groundwork for future research that can confirm this relationship, as well as identify factors that can enhance persons' occupational well-being to decrease their risk of developing burnout.

CHAPTER 2: LITERATURE REVIEW

2.1 LONG TERM CARE FACILITIES (LTC FACILITIES) IN ONTARIO

The health care system in Ontario is being organized so it can continue to meet the future healthcare needs of seniors (Sinha, 2012). Demographic, economic and legislative changes at the system level eventually filter down to affect relations between workers and their clients at the bedside in health care organizations such as LTC facilities. For example, system level changes challenge LTC facilities to incorporate cutbacks in funding while reorganizing service provision to residents in their care. At the individual level these larger systemic and organizational changes impact the ability of workers to provide care and directly influence the relations between workers and residents. LTC facilities in Ontario are juggling the competing demands of the health care system with the care needs of individual residents. These competing demands contribute to unique challenges in this sector of the health care system.

The MOHLTC Long Term Care Act, which came into effect in 2010 (MOHLTC, 2010) has added a significant degree of legislation that governs the daily life of those working in LTC facilities in Ontario. Three hundred and thirty five items in the law now legislate every aspect of a facility's functioning, from requirements regarding facility structures (e.g., doors, grab bars and bed rails), to reporting, use of restraints, pets and the frequency of baths for residents (i.e., minimum of twice a week). Additionally, the MOHLTC has instituted unannounced visits, including dietary, environmental and compliance visits, as well as complaint investigations (HPRAC, 2006). These changes have significantly shaped work life in LTC facilities as these organizations attempt to balance the needs of individual residents in their care while meeting the legislative

requirements of the LTC Act. In some instances these requirements have enforced changes in practice at the bedside, to the detriment of effective individualized care.

An example of the impact of these changes is the use of computer based programs like the Resident Assessment Instrument-Minimum Data Set (RAI-MDS) for assessment and care planning, which has been made mandatory for all LTC facilities in Ontario since 2009 (Kontos, Miller, & Mitchell, 2010). The assessment of physical care requirements using this computer program assists in the development of individualised care plans based on identified care needs. While the MDS has been noted to be good at capturing residents' physical condition, it has been pointed that this program is not as effective in capturing residents' psycho-social well-being and personal preferences (Kontos et al., 2010). As a result, residents' preferences, beliefs and values, which would significantly add to the care team's ability to provide individualized care, are not captured by this program which could undermine quality of care (Kontos et al., 2010).

This gap in information becomes particularly salient when we consider that those currently being admitted to Canadian residential facilities have significantly greater physical and mental health care needs. A large proportion of residents living in LTC facilities in Ontario (61.9%) have dementias and cognitive impairments (CIHI, 2014). Providing care to these individuals presents special challenges. Cognitive status has been noted to be the most important predictor of physically and vocally aggressive behavior (Beck et al., 1998), with 25% of residents with cognitive impairments exhibiting assaultive behaviors during showers (Somboontanont et al., 2004). Impaired communication in individuals with cognitive impairment has been associated with all forms of aggression (Talerico & Evans, 2002). Nurses who care for persons with

Alzheimer's disease and other dementias have been found to spend as much as 40% of their time managing challenging resident behaviors (Mackenzie & Peragine, 2003). Knowledge of appropriate communication strategies and personal preferences regarding care and daily routines can assist in decreasing these behaviours during care (Somboontanont et al., 2004). However, this information is not captured by the RAI and no longer readily available to careproviders. Gaps in team communication and the communication impairments of residents under their care may hinder PSWs ability to provide quality care, and are likely to contribute to worker stress.

While the studies discussed above identify individual factors that make caring for people with dementia challenging, more research is needed to confirm that working with individuals with dementia can increase the risk of work stress for paid careproviders. A systematic review recently conducted to examine the research on stress in staff working with people with dementia in 24-hour care settings concluded that staff working in LTC facilities did not have a high prevalence of psychological stress or high levels of symptoms of stress (Pitfield et al., 2011). However, the review findings need to be interpreted with caution. The majority of studies reviewed initially were rejected due to lack of rigour. The review only included five quantitative studies, many of which had small sample sizes, low response rates, and different criteria to establish burnout. Thus, the conclusion of the systematic review may be more due to the methodological limitations of the studies reviewed rather than actual low levels of stress in workers in LTC settings caring for people with dementia. Although the findings of this systematic review contradict the findings of the studies discussed previously, the review reinforces

the importance of conducting further research examining the relationship between stress and care for residents with dementia.

Work organization factors such as staffing and workload in Canadian LTC facilities have been shown to be a source of stress for paid careproviders who work in these facilities. Recent studies, using cross-national data, have assisted in painting a clearer picture of the working environments of LTC facilities in Canada, including those in Ontario. Studies comparing LTC facilities in Canada (in the provinces of Ontario, Manitoba and Nova Scotia) with those in Scandinavia have found some significant differences (Armstrong, Armstrong, Banerjee, Daly, & Szebehely, 2011; Banerjee et al., 2012; Daly & Szebehely, 2012). Like Canada, the Scandinavian countries of Denmark, Finland, Norway and Sweden have a public health system and large, aging populations (Banerjee et al., 2012). However, the population in Canadian facilities is increasingly mixed in terms of those from racialized and cultural groups. At the same time, more of those working in residential care are women who are immigrants and/or racialized women (Armstrong et al., 2011). These factors contribute to a more socially complex and culturally heterogenous work environment in Canadian LTC facilities. For example, lack of language fluency on the part of either resident or care worker may affect the understanding (and therefore delivery) of care requests. Working with cognitively impaired residents who have communication impairments can further complicate such communication gaps and contribute to stressful care-related interactions.

Canada, compared to the Scandinavian countries has the highest proportion of for-profit facilities and also the highest proportion of workers who report they have too much to do (Armstrong et al., 2011). In an effort to increase profits, for-profit facilities may

prioritize cutting costs such as those associated with staffing, which would explain the finding that a higher proportion of Canadian workers reported having too much to do.

Insufficient staffing levels and inadequate resources (e.g. only one diaper provided per shift for residents) were the primary reasons over-burdened Canadian workers were unable to provide adequate care, and had no time for social engagement (Armstrong et al., 2011). The authors noted that organizational failures such as not providing adequate training and staffing (e.g., overworked staff feeling rushed to provide care to frail, often cognitively impaired residents in a task-focused manner) constituted a type of institutionalised violence on the workers. According to authors, these organizational failures created conditions which increased the likelihood of workers experiencing violence from residents under their care (Banerjee et al., 2012). Lack of time, resources and support in their work environment are all likely to add to the work stress experienced by PSWs.

It is worth considering whether the manner in which services are structured in Canadian LTC facilities contributes to increasing worker stress, which can lead to the vulnerability of residents living in these facilities. Workers who feel rushed to complete all the tasks on their caseload with limited time and resources may not be as attentive to the manner in which they provide care. In such a work environment, there may be a risk that the stress that workers experience can escalate into abuse of vulnerable residents. Differences between rates of abuse in the community versus LTC facilities have been noted in a systematic review of international studies (Cooper, Selwood, & Livingston, 2008). The review grouped studies based on prevalence of abuse, and site of abuse (home versus care setting). Community based studies reported on abuse from different sources

(e.g. family members, home care workers and staff in day program and hospital emergency departments). LTC facility based studies reported on abuse by staff towards residents. In summarizing the findings of various studies, the reviewers noted that a third of family members reported significant abuse towards an elderly family member in the community. In the LTC setting, one in six workers reported committing psychological abuse (e.g. shouting, verbally threatening) and one in ten reported physical abuse (e.g. pushing, excessive use of restraints) (Cooper et al., 2008). These figures suggest that the prevalence of abuse by LTC facility staff is lower than abuse by family members in the community. However another finding of the review, that over 80% of nursing home staff had observed abuse occurring, suggests that staff might be denying abusive acts. The reviewers noted that the act of abuse did not necessarily imply intent and in many cases the staff may not have viewed their own actions in this light (Cooper et al., 2008). The findings of this review raise concerns. One reason for these levels of abuse may be that the workplace stress experienced by workers is unknowingly translating into worrisome care practices. It is possible that where workers themselves are recipients of violent behaviour from residents on a daily basis, there may be a risk that abusive behaviour towards residents is normalized by some workers. The consequences of workplace stress and burnout therefore, may extend past the workers themselves to include the residents under their care.

An additional source of stress can come from residents' families. Care of older adults, traditionally a family role, has now been organized as a paid service situated in facilities and governed by bureaucracy and legislation. In this context, families and paid careproviders have to negotiate relationships with each other even as they attempt to

address the resident's care needs from their own perspectives. Bauer (2006) noted that when the model of care in LTC facilities is primarily a medical model, family members can occupy an ambiguous position where they are viewed both as ancillaries and obstacles to care. The tension between organizational and familial imperatives has been identified by researchers who found that the top two reasons for conflict between staff and family were specific care needs of the resident and the overall quality of care (Vinton & Mazza, 1994). Pillemer, Hegeman, Albright, and Henderson (1998) concluded that facility policies and practices sometimes hinder staff and families from working well together. The authors noted that ambiguity regarding divisions of labour sometimes exist between staff and families. In these instances families want to share in care, particularly social and emotional tasks, however staff may lack the knowledge, time or ability to skillfully integrate families into the way care is provided. Additionally, family members may seek to advocate for their loved ones and ensure individualized care, however requests for specific care activities can further challenge busy careproviders to address individual needs in an institutional setting (Abrahamson, Sutor, & Pillemer, 2009). In this manner, the very organization of paying for care becomes a contributor to conflict between family and staff. This conflict has the potential to negatively impact staff stress levels and can have ongoing implications for the relationship between the two groups. A study that conducted a secondary data analysis examining conflict between staff and families found that conflict can result in high stress in staff (Abrahamson, Anderson, Sutor, Anderson, & Pillemer, 2010). The researchers found that for staff, the stress resulting from this conflict peaks early in the relationship, thereby causing early negative effects in staff and family interactions. It is possible that early conflicts set the stage for

future negative interactions and therefore, ongoing stress. Thus, for staff working in LTC facilities the experience of communicating and interacting with families, addressing their concerns and demands, can be a potential source of conflict and stress.

Apart from legislative changes that have impacted LTC facilities the Culture Change Movement (CCM) has added a new dimension to the manner in which care services in LTC facilities are organized and delivered (Koren, 2010). The CCM represents a fundamental shift in thinking about nursing home facilities from health care institutions to person-centered homes offering LTC services. Some of the principles espoused by the CCM are resident direction of care, a homelike atmosphere and close relationships between residents and staff (e.g. consistent assignments). CCM models of care advocate for smaller groups, private rooms, and higher staff complements. The CCM requires an individualized approach to care. In care contexts such as LTC facilities where staffing is limited, this approach may actually contribute to additional pressures for staff who already have limited time to complete their tasks. The principles of the CCM have influenced legislation such as the MOHLTC Act (2010) mentioned above, which seeks to address the psycho-social needs of residents even as it attempts to regulate care provision in a physically safe and accessible environment. Ironically, it is the legislation of LTC facilities that has proved to be a barrier to the implementation of the CCM. To meet legislation requirements LTC facilities are built to resemble hospitals, and care by nurses and nursing aides skews to clinical orientation. Legislation, in this instance, even when it attempts to facilitate person-centered care, actually reinforces a task-focused approach to care (Dodson & Zincavage, 2007). Thus, even as PSWs are encouraged by the CCM to implement individualized care routines, legislative requirements, such as the minimum of

two showers a week required by the LTC Act (2010) ensure that the focus of shift assignments remains on the provision of care-related tasks, regardless of residents' individual preferences. In this context, meeting the requirements of legislation may detract from PSWs' ability to provide the individualized care endorsed by the CCM and can be a source of stress.

Although worker autonomy is promoted by the CCM as a source of enhanced quality of care and job satisfaction, employees' access to empowerment structures to enhance provision of individualized care has not been uniformly adopted (Caspar, O'Rourke, & Gutman, 2009). For example, part of the empowerment process requires LTC facilities to change their organizational processes to ensure that PSWs are given access to more information, resources and support. Caspar, O'Rourke, and Gutman (2009) conducted a comparative study to examine the empowerment of care staff in facilities with three different models of the CCM versus those with no CCMs. The authors found that PSWs working in facilities with any model of the CCM reported greater empowerment than those working in facilities without a CCM model. This was not the case for PSWs' reported ability to make individualised decisions. PSWs working within two CCM models reported greater independence in decision making compared to those working with no CCMs. No differences were found between PSWs working within the third CCM model and facilities with no CCMs. These findings suggest that some CCMs enhance PSW empowerment and ability to provide individualized care more than others. It is possible that PSWs felt empowered simply because of the increased attention given to them during the implementation of the CCM models in the facilities. Of interest was the finding that there was no difference in Registered Nurses' empowerment and

decision-making abilities across facilities, regardless of whether or not the facility had a CCM. This led the authors to note that those in LTC facility with the least resident contact had the most control in determining care decisions and were less affected by changes in models of care. Conversely, for care aides, the CCM offers new opportunities for empowerment and decision-making regarding care. However this empowerment and decision making autonomy may not be not uniform across the different CCMs. Thus, even though the CCM articulates benefits for staff within the care model, more research is needed to map out how well the different CCMs support these benefits.

As part of the shifting landscape that constitutes health care in Canada today, LTC facilities are experiencing multiple, often conflicting pressures, even as they struggle to provide care to vulnerable residents with decreasing resources. In attempting to meet benchmarks set by legislation and culture change, LTC facilities may run the risk of marginalizing those who do the majority of care work in these facilities: PSWs.

2.2 PSWS WORKING LTC FACILITIES

PSWs are unregulated health care workers. While they are integral to most health care teams, it is difficult to accurately estimate the size of the PSW workforce in Ontario due to the fact that different terms (e.g., PSW, Patient Service Associate, and Attendant Care Worker) are used to describe their roles in different sectors. As well, there are several educational and training paths that can lead to employment as a PSW and employers often report part-time and casual workers' hours as Full Time Equivalent (FTEs) positions rather than actual number of staff in their employ (HPRAC, 2006).

Care work, such as the work done by PSWs, has been identified as being deeply relational, however within market economies care work is immaterial (does not produce

material goods) so it has been devalued and not respected (Lanoix, 2013). Dodson & Zincavage (2007) noted that in their study of certified nursing assistants, or CNAs, (the term used for PSWs in the United States) 90% of CNAs were female and 75% were from ethnic minorities. In Canada, 95% of PSWs are women (Armstrong et al., 2011) and provide between 80-90% of all resident care and yet they receive the least amount of training, the lowest pay in healthcare, and are rarely consulted when care decisions are made and implemented (Caspar et al., 2009). Thus, the low status of care labour may be further attributed to the fact that the majority of individuals who provide care themselves come from groups that may lack the power to change the way their work is perceived and remunerated within larger systems. Thus, the lack of respect and value given to their jobs can be an additional source of stress for workers who may already feel disempowered.

The work PSWs do is neither simple nor routine. Surveys of a total of 3,490 workers working in LTC facilities in the Canadian provinces of Ontario, Manitoba and Nova Scotia, and in the Scandinavian countries of Norway, Sweden, Finland and Denmark were conducted to compare the experiences of workers in LTC facilities (Daly et al., 2011; Banerjee et al., 2012; Daly & Szebehely, 2012). Canadian workers experience high demand, low control and low support environments in LTC facilities. Compared to Sweden, Canada has a more vertical division of labour and more demanding work conditions for PSWs (Daly & Szebehely, 2012). On an average day shift, Canadian PSWs on average have a case assignment of 19.6 residents. This number indicates the actual reality of work life in LTC facilities in Canada; while official staff-to-resident ratios are reported to be lower (e.g., the 1:10 reported for Toronto in the Introduction above) staff shortages and absences result in much higher workloads than those endorsed

officially. In Canada, 46.2% PSWs reported that they worked short staffed daily (Daly et al., 2011). In comparison, the average numbers for the same shift in Scandinavia are: 6.2 residents per PSW in Denmark, 7.7 residents per PSW in Norway, 8.5 residents per PSW in Sweden, and 15 residents per PSW in Finland (Daly et al., 2011). It is no surprise that Canadian PSWs reported the highest levels for having too much to do (Daly et al., 2011). A direct result of the staffing levels in Canadian LTC facilities has been the way in which violence is experienced by Canadian PSWs. Sixty one percent reported experiencing some form of violence as a daily occurrence compared to 18% of Scandinavian workers (Daly et al., 2011). Working short-staffed likely contributed to staff feeling rushed to provide care, contributing to increased stress in both worker and resident resulting in violent behaviour from the resident. An additional finding was that violence towards staff was expected, normalized and under-reported with a lack of managerial support to prevent violence (Daly et al., 2011).

The lack of adequate staffing and the added complexity of working in a multi-cultural environment have been identified as factors influencing the relationship between the PSW and the resident (Janes, Sidani, Cott, & Rappolt, 2008). Others have noted the lack of power in the LTC system of both the PSW and client (Bourgeault, Atanackovic, Rashid, & Parpia, 2010) which shaped and limited the relationships the two parties were able to develop within the context of organized care provision. These system level factors may contribute to the quality of care and the relationship that PSWs have with their residents, thereby contributing to PSWs' experience of stress.

At times, system and organizational level changes aimed at improving efficiencies have served to further marginalize PSWs' knowledge and expertise. For example, the

computerized RAI-MDS documentation in LTC facilities has pre-formatted selections regarding care and serves as an efficient way to capture care given to residents. However, this formatting ignores PSWs' knowledge of the resident which is a key factor enabling them to provide individualised care (Kontos et al., 2010). For example, a pre-formatted documentation system with only drop-down menu options does not give the PSW the option of documenting the specific strategies she uses to successfully provide care to an individual resident. Knowledge of such strategies may be critically important to successful care provision when working with cognitively impaired residents.

Additionally, working with residents with cognitive impairments requires PSWs to be flexible in their approach, able to embrace challenges, while maintaining composure (Janes et al., 2008). None of this highly skilled, complex care provision is captured in pre-formatted systems like the RAI-MDS. In fact, these documentation formats may reinforce the notion that PSWs' work simply consists of routine, unvaried care-related tasks. Additionally, those PSWs who are new and unable to access the knowledge of their more experienced colleagues may experience greater discouragement and stress. Thus, the adoption of automated documentation processes such as the RAI-MDS has inadvertently led to PSWs' perspectives being marginalized and disregarded and may contribute to their perception of not being respected within care teams.

Residents with dementia, such as Alzheimer's Disease, Vascular dementia and Lewy Body Dementia, often engage in challenging behaviors such as screaming, wandering, hoarding, and exit-seeking, and direct verbally and physically abusive behavior towards staff and/or other residents (Evers et al., 2002). PSWs must address these behaviours while also providing routine care. The relationship between PSWs and

cognitively impaired recipients of care may increase the risk of PSW burnout. For example, if the recipient is aggressive, anxious or not responsive to the PSW's efforts, the PSW may experience interactions with such individuals as unrewarding, which may increase their risk of burnout (van Dierendonck, Shaufeli, & Buunk, 1998). Furthermore, PSWs may be prevented from addressing residents' needs and preferences by inadequate training, time constraints or inflexible policies and procedures (Somboontanont et al., 2004). As the Canadian population ages, the number of long-term care residents with dementias will increase (Alzheimer's Society, 2010). With limited staffing and resources at their disposal, the complexity of the work of PSWs in LTC facilities, and the resultant stress arising from it, can be expected to increase.

In the context of providing care to individuals with dementia, the implementation of the CCM in LTC facilities has the potential to contribute to PSW stress. Authors of a research study in the United States found that in facilities implementing the CCM, the model was translated into a family model of care. In this model of care, workers were encouraged to think of residents under their care as family members. This was done to promote empathy and patience in care workers when caring for residents who were sometimes uncooperative (Dodson & Zinbavage, 2007). However, the authors found that heavy caseloads created stress, were exhausting and strained the credibility of the family model. Based on the findings of the study, the authors concluded that the misinterpretation of a model that actually seeks to empower workers created a source of significant stress and distress for workers who found their workplace fictive "family" competing with their real family for their time and attention.

Care work, as noted earlier, is considered to be unskilled work, even though it requires complex and flexible communication, interaction and decision-making skills. Yet, this expertise is not formally recognized and acknowledged in LTC facility settings. In one study, not one participant felt completely satisfied by the recognition they received in their workplace (Janes et al., 2008). In another study, the researchers uncovered the poor inter-professional regard for PSWs within their nursing home care teams, as PSWs perceived that nurses questioned the soundness of their clinical assessments and disregarded their contribution to the care plan (Kontos et al., 2010). The lack of respect and inclusion of PSWs' perspectives has been identified elsewhere, where 18 out of 19 LTC facilities followed in the study were found to not include PSWs in routine care conferences (Dodson & Zincavage, 2007).

All these factors contribute to a work environment in which PSWs work with limited resources, little respect or acknowledgement for their contributions to residents' care. Exposed to violence, marginalized amongst their colleagues, PSWs may experience high stress, thereby making them vulnerable to experiencing burnout.

2.3 BURNOUT

Burnout, defined as a prolonged response to imbalances and chronic emotional and interpersonal stressors on the job (Maslach et al., 2001), was first recognized and conceptualized in the 1980s as consisting of three dimensions – emotional exhaustion, depersonalization, and reduced personal accomplishment or inefficacy (Maslach & Jackson, 1981). Emotional exhaustion represents the individual stress dimension of burnout. Depersonalization, that is, a callous, negative or excessively detached response to other people, represents the interpersonal context dimension of burnout (Maslach &

Goldberg, 1998; Maslach et al., 2001). Reduced personal accomplishment or inefficacy represents the self-evaluation dimension of burnout and is reflected by feelings of incompetence and lack of achievement and productivity within the work setting (Maslach & Leiter, 2008). Maslach and colleagues (2001) proposed that depersonalization is the initial self-protective response to emotional exhaustion. However, if burnout continues unchecked, there is a risk that depersonalization will lead to dehumanization.

While burnout is expressed at an individual level, systemic work conditions may increase the likelihood that staff working within a particular setting will experience burnout (Maslach & Goldberg, 1998). Maslach and colleagues (2001) noted that burnout arises when the relationship people have with their work goes awry. Imbalances between work demands and available resources; imbalances between role demands and personal values; and chronic stressors such as conflict between clients, colleagues and managers can all contribute to a work environment characterized by unrealistic expectations and constant emotional tension (Maslach & Goldberg, 1998). Consequently, research in the area has focused on the situational and organizational impact on individuals' experience of burnout (Duffy, Oyebode, & Allen, 2009; Maslach, 2003). For example, cutbacks in funding in human service jobs mean that staff members are expected to manage workloads previously covered by a greater number of staff. No studies of PSWs' experience of burnout were located, but studies of nurses working in nursing homes demonstrate nurses are at increased risk of burnout when the level of aggressive behavior demonstrated by residents increases (Evers et al., 2002), when workload demands are great, and when role conflicts and stress are present (Rai, 2010). Burnout can lead to increased costs to the individual and to the health care system through decreased personal

well-being and increased staff sick leave, decreased productivity and staff turnover (Cordes & Dougherty, 1998; Maslach & Jackson, 1982; Puig et al., 2012). It can also compromise the quality of care received by nursing home residents. Staff who experience burnout are less likely to be willing to help residents and more likely to express negative emotional responses in response to residents' behaviors (Todd & Watts, 2005).

Finally, two organizational factors have been identified as contributing to burnout – the first being an imbalance of demands over resources and the second being the potential for value conflict as organizations and employees in the 21st century reduce their commitment to each other (Schaufeli, Leiter, & Maslach, 2009). Anecdotally it has been noted that decreased human resources have created increased demands as a smaller number of PSWs are expected to provide care to the same number of residents (Lei, personal communication, August 7, 2014). As organizations struggle to adapt to system-level changes, at the individual level these cut-backs may be viewed as a lack of caring or concern for staff by management and create value conflicts where staff in caregiving positions perceive that their employers do not value their well-being (Maslach et al., 2001). Additionally, the imbalance of demands over resources created by these cut-backs and the disparity between workers' personal values and those of the organizations (a new feature of the twenty-first century, according to the authors) for which they work can contribute significantly to the experience of burnout (Schaufeli et al., 2009). These factors create additional vulnerability to burnout for those working in human services jobs, such as PSWs in LTC facilities.

2.4 OCCUPATIONAL WELL-BEING

While burnout represents an extremely negative subjective experience, the construct of well-being, and more specifically occupational well-being, provides a broader framework for examining persons' experiences. However, the use of the terms "well-being" and more particularly, "occupational well-being" within the literature has been criticized (Aldrich, 2011). As Aldrich (2011) identified, these terms have often been used without being clearly defined. Researchers outside the profession of occupational therapy (e.g., Sitaloppi, Kinnunen, & Feldt, 2009; Saaranen, Tossavainen, Turunen, Kviniemi, & Vertio, 2007) typically refer to occupational well-being as the well-being derived solely from paid occupations. This use reflects the more common and everyday view of occupations as work, employment, or one's chosen career rather than recognizing that occupations refer to everything that people do during the course of everyday lives (CAOT, 2007; Davis & Polatajko, 2010; Wilcock, 2006). Within this broader understanding of occupation, occupational well-being refers to the well-being derived from participation and engagement in meaningful and valued occupations which may include but is not exclusively derived from paid work (CAOT, 2007). However, even when occupation is understood at this broader level, the connection between engagement in occupations and individuals' well-being is rarely made explicit. For example, Wilcock (2006) used proxy constructs such as physical, mental and social well-being to define the experience of well-being derived from occupations. Similarly, Hasselkus (2006) used terms such as the good life, positive health, active living and a sense of coherence to describe well-being. Other authors have used the concept in their writings without defining it (Krupa & Clark, 2004; Reid, 2008). The authors' use of proxy terms or lack of

definitions to describe the concept of occupational well-being suggests a lack of clarity in understanding and defining the concept itself. In fact, these definitions identify the possible positive effects that occupations might have on persons' general well-being, rather than defining occupational well-being per se. As a result, the experience of well-being that arises from participation and engagement with occupations is not fully captured. Secondly, proxy terms such as physical and mental well-being or positive health and active living direct our attention away from well-being derived from occupations to other dimensions of psychosocial functioning. Finally, the lack of clearly defined concepts has an impact on research application. The rigor of the research is compromised when researchers attempt to operationalize inadequately defined constructs. The incomplete articulation of the concept of occupational well-being can be seen in studies where researchers met limited success when they attempted to define the concept of well-being by administering multiple assessments which they assumed would capture aspects of the concept (Persson, Eklund, & Isacsson, 1999).

In an effort to bring clarity to the concept of occupational well-being, Doble and Santha (2008) proposed that occupational well-being is the subjective experience of satisfaction that persons derive when their occupational repertoires, including but not limited to work, enable them to satisfactorily meet their occupational needs. By highlighting the concept of occupational needs, Doble and Santha (2008) focused attention on what persons derive from engaging in occupations. Occupational needs, that is, needs for accomplishment, affirmation, agency, coherence, companionship, pleasure and renewal, help to explain why persons will perceive occupational experiences to be satisfying and unsatisfying. Persons' needs for accomplishment are met when they

engage in occupations that enable them to learn and utilize new skills, master components of an occupation, produce tangible outcomes, or help others. For example, a PSW may experience accomplishment when she is able to successfully incorporate new communication strategies when working with a resident with aphasia. Persons' needs for affirmation, which is affirmation of occupational performance and occupational choices, are met when they receive affirmation of their worth and value from others, as well as when they themselves recognize that the things they do are worthwhile and valuable. For example, a PSW may experience affirmation when a resident smiles and pats his hand at the end of care provision or when he feels that he was successful in providing reassurance to calm an anxious resident. Affirmation may be experienced when the PSW's efforts to calm the anxious resident are acknowledged and appreciated by supervisory or managerial staff. The need for agency is met when individuals perceive that they are able to exert influence or control those aspects of their occupational lives that are important or valuable to them. Decisions regarding participating in occupations, setting priorities, developing routines for performing occupations, utilizing skills and delegating some occupations to others can all contribute to meeting the need for agency. For example, a PSW may address her needs for agency when she organizes morning care routines with her residents so she can incorporate residents' preferences for wake-up times and care routines. The need for coherence is met when individuals engage in occupations that enable them to generate evidence that confirms who they are and want to become. When individuals participate in occupations that provide them with connections between their pasts, presents and futures, they may experience coherence. A PSW may experience coherence if she and her sibling decide to trace their ancestors and create a scrap book to

share with family. The need for companionship is met when individuals engage in occupations with others. Shared occupations can foster a sense of belonging and mitigate feelings of loneliness and isolation. When a PSW converses with a resident about similar childhood experiences, she may experience coherence and companionship. The need for pleasure can be met in daily rituals and in intense experiences of participating in occupations that provide an avenue for individuals to experience joy, pleasure, and contentment. Additionally, pleasure may be enhanced when individuals engage in occupations with others. For example, a PSW may address her need for pleasure by ensuring that, regardless of her work schedule, she takes time to bake cookies with her child once a week. Finally, the need for renewal is met when occupations enable individuals to experience physical and mental renewal and enable them to approach other occupations with a fresh perspective, provide inner peace, relief or shut off the stresses and demands of everyday life. Thus, a PSW may experience renewal when he listens to his favorite music on his way home via public transit after a busy and stressful work shift.

The concept of occupational well-being is not the only concept that seeks to identify how engagement in occupations can contribute to well-being in individuals. The concept of occupational balance, described as lifestyle balance (Matuska & Christiansen, 2008), finds some overlap with occupational well-being as defined by Doble and Santha (2008). Lifestyle balance is conceptualised by Matuska and Christiansen (2008) as based on how the configuration of everyday occupations meets essential human needs. According to the authors, lifestyle balance is achieved when individuals are able to “(1) meet basic instrumental needs necessary for sustained biological health and physical safety; (2) have rewarding and self-affirming relationships with others (3) feel engaged,

challenged, and competent; (4) create meaning and a positive personal identity; (5) organize their time and energy in ways that enable them to meet important personal goals and renewal” (p. 11, Matuska & Christiansen, 2008). As with the Doble and Santha’s (2008) definition of occupational well-being, Matuska and Christiansen (2008) acknowledge that occupations enable individuals to relate with others, to feel engaged and to create meaning. However, unlike Doble and Santha, Matuska and Christiansen focus on a balance in occupations, rather than the experience of engagement in occupations (either individually or globally). While not explicitly stating so, the focus on balance implies that occupational well-being is dependent on spending a certain amount of time in certain kinds of occupations; if we spend more than the appropriate amount of time, we risk experiencing imbalance. This perspective imposes external criteria such as time use as a way of defining balance and therefore, well-being. Not surprisingly, research attempting to correlate occupational balance with well-being has failed to find such correlations (Anaby, Backman, & Jarus, 2010).

An occupational well-being perspective, rather than imposing external criteria of a balance of certain occupations, focuses attention on how individuals experience occupations and the meaning they derive from them. This perspective is similar to studies exploring health and well-being in different groups. In a study of 103 individuals with persistent mental illness, researchers found that the way occupations are perceived, rather than the doing of these occupations per se, may contribute to these occupations being perceived as promoting health (Eklund & Leufstadius, 2007). This suggests that the individual's experience of engagement in occupations may constitute a more significant factor in the experience of well-being than simply the doing of occupations. In other

words, the meaning that individuals ascribe to their occupations and the satisfaction they derive from them may be more important than how successfully they may be deemed to have completed them. Eklund and Leufstadius (2007) concluded that individuals' perceived meaning of occupations and satisfaction with occupational performance, rather than their actual performance of the occupation, should be used to establish criteria for successful outcomes in therapeutic interventions. This finding supports Kuo's (2011) view that individuals engage with their worlds through occupations in transactive relationships to actively create positive experiences.

Similarly, occupational well-being, as defined by Doble and Santha (2008), shifts the focus away from what (and how much) people are doing to whether the occupations in which they engage enable them to meet their occupational needs. This perspective posits that well-being is not dependent on the experience of occupational balance, but rather on how adequately occupations meet individuals' occupational needs. As such, the concept of occupational well-being gives primacy to the meaning the individual derives from his/her occupations, their sense of engagement with these occupations and may help to explain the findings of Eklund and Leufstadius (2007) mentioned above. Similarly, a qualitative study of Mayan women found subjects who were reporting either a lack of balance in their occupations or a limited repertoire of occupations (Ekelman, Bazyk, & Bello-Haas, 2003). Interestingly, these women still reported a sense of well-being deriving from the very occupations that contributed to the lack of balance or their limited repertoire. These findings suggest that well-being deriving from occupations may not be completely dependent on the experience of occupational balance and in fact, individuals may derive a sense of well-being from those occupations that most meet their

occupational needs, even when these occupations contribute to lifestyle or occupational imbalance.

Furthermore, Doble and Santha's (2008) conceptualization of occupational well-being acknowledges the dynamic, interactive relationship between individual and context. Thus, the influence of personal factors (e.g., expectations, competencies, mood, attitude and past experiences) as well as environmental factors, (e.g., available occupational opportunities that can enable or hinder individuals from meeting their occupational needs) is acknowledged. Finally, Doble and Santha (2008) noted that individuals may give primacy to certain occupational needs over others and that the relative importance of these needs may vary over a lifetime. Thus, the subjectivity of the experience of occupational well-being is highlighted. Aldrich (2011) fails to acknowledge that, unlike other authors, Doble and Santha (2008) have created a framework within which the construct occupational well-being can be more clearly understood.

Doble and Santha's (2008) conceptualization of occupational well-being provides researchers with a possible explanatory framework for exploring potential conceptual relationships, such as those between occupational well-being and burnout. For example, occupational well-being may help explain why some individuals are more resistant or less vulnerable to burnout; that is, individuals who develop occupational repertoires that enable them to adequately meet their occupational needs may be more resilient and thus, better able to deal with those factors that contribute to burnout. Conversely, those individuals whose occupational repertoires do not enable them to adequately address some or all of their occupational needs, will not only experience lower levels of

occupational well-being but be more vulnerable and at greater risk of experiencing burnout. In other words, occupational well-being may serve as a protective factor. Moreover, individuals may be more able to effect positive changes in their level of occupational well-being in contrast to their level of burnout since they are likely to be able to exert more control in incorporating meaningful occupations into their lives than in effecting change in their work environments. The process of selecting these occupations itself may enable them to meet occupational needs such as affirmation and agency, while also opening avenues to experience companionship, pleasure and renewal. They may be able to more easily integrate new occupations in their lives that will help renew or rejuvenate their energies so they can more effectively handle challenges in the workplace.

2.5 INTERVENTIONS TO ADDRESS BURNOUT

Burnout intervention programs fall into three categories (Awa, Plaumann, & Walter, 2010; Westermann, Kozak, Harling, & Nienhaus, 2014). Person-directed interventions are usually cognitive behavioral measures aimed at enhancing job competence (by improving skills) and personal coping skills, social support or different kinds of relaxation exercises. Organization-directed interventions usually implement changes in work procedures like task restructuring or increasing job control or the level of participation in decision-making. The third category of intervention is a combination of the two. The assumption underlying the first is that providing individuals with skills (whether work related or aimed at enhancing well-being) will enhance their ability to cope with work-related stress, and decrease the risk of burnout. Organization-directed interventions aim to empower individuals and thus reduce their experience of work-related stress. In two systematic reviews of burnout interventions, the authors (Awa et al.,

2010; Westerman et al., 2014) found that a combination of person and organization-directed interventions had longer lasting positive effects of twelve months and over compared to those that were directed at individuals or organizations only. The review indicated that emotional exhaustion was the most influenced by burnout interventions, regardless of type of intervention, while positive changes in other burnout dimensions of depersonalization and personal accomplishment usually did not last over six months.

Of the types of person-directed interventions examined, some studies that provided burnout intervention to staff working in LTC facilities addressed psychosocial factors (Mackenzie & Peragine, 2003) or developed clinical skills (McGilton, Boscart, Fox, Sidani, & Rochon, 2009). In a study by Tveito and Erikson (2008), a more novel person-directed intervention was examined. In addition to the psychosocial intervention, participants were required to engage in a predefined and prescriptive set of physical exercises to relieve stress. This intervention protocol was based on the idea that regular engagement in physical exercise, in addition to psychosocial interventions (e.g. psychoeducation), would be more effective in reducing the participants' risk for burnout than interventions that provided psychosocial interventions only. While this intervention served to engage participants in a specific activity, the expectation that persons would engage in a prescribed set of physical exercises failed to consider that well-being is enhanced when persons engage in personally meaningful occupations (Doble & Santha, 2008; Wilcock, 2006) and that physical activities might not be a personally meaningful choice for all participants.

In a recent pilot study, a comprehensive approach was used to develop the practice knowledge and coping skills of PSWs working in long-term care with residents

with dementia (Figueiredo, Barbosa, Crus, Marques, & Sousa, 2013). Thus, the intervention was designed to prevent or reduce the likelihood that staff would experience work-related stress and burnout. Six PSWs participated in eight sessions conducted by a psychologist, physical therapist, and gerontologist. Sessions included education on dementia, training in care techniques, individualized assistance during the provision of morning care with video recordings of care provisions to help assess resident behavior, and education on coping skills. At the end of the intervention, participants reported that the program enabled them to acquire new knowledge, demystified pre-existing beliefs about dementia, and enhanced group cohesion, feelings of self-worth and positive coping. However, the level of expertise needed, and the intensity of resources required mean that this type of intervention is unlikely to be a feasible option for addressing burnout among staff in most long-term care settings.

All the interventions reported above take a prescriptive approach in identifying what is to be targeted in the burnout intervention, i.e. knowledge, skills and/or specific abilities. What remains uncovered is whether these topics are truly relevant or meaningful to individual participants and therefore likely to be retained in the long-term. Burnout interventions developed using an occupational well-being perspective would focus attention on how the intervention would meet and address the occupational needs of individual participants. An occupational well-being based intervention could be designed to address individuals' unmet occupational needs by incorporating and giving primacy to the value that different occupations have for individuals. For example, in contrast to the intervention used in the study by Tveito and Erikson (2008), participants may be more likely to continue to incorporate stress-relieving occupations into their occupational

repertoires when they are provided with opportunities to identify how they will engage in occupations that are personally meaningful to them. An additional advantage of participants being able to self-select meaningful occupations may be that there would be a greater likelihood of their continuing to engage in these occupations, thus extending the long-term benefits of an occupational well-being based intervention. Of the interventions reported above, while immediate positive effects following the intervention were noted, no data on long term effects, i.e. greater than three months, was provided as follow-up evaluation was not part of the study design. Thus, it is unknown whether the benefits of the intervention were maintained over a longer period of time.

In conclusion, PSWs, as a group, experience challenging work conditions with little reward or acknowledgement for the work they do. And yet, the service provided by these workers is not only necessary, but the need for it is likely to increase in the near future. If the study findings disprove the null hypothesis that there is no association between occupational well-being and burnout, then the alternative hypothesis that there is an association can be accepted. Findings disproving the null hypothesis could lead to further research which could explore how enhancing occupational well-being can enable PSWs' to experience of their work in more positive ways and buffer them against the deleterious effects of stress and burnout.

CHAPTER 3: RESEARCH DESIGN

This exploratory correlational study was designed to: a) examine the perceptions of burnout and occupational well-being among a sample of PSWs employed in nursing homes and b) explore the relationship between their perceived experiences of burnout and occupational well-being. Participants completed self-report questionnaires designed to evaluate the two constructs under study, that is, burnout, using the Maslach Burnout Inventory (MBI) (Maslach & Jackson, 1981), and occupational well-being, using the Occupational Well-Being Questionnaire (OWBQ, Version 5) (Doble, 2010). According to Maslach and Jackson (1981), persons experiencing burnout will report high levels of emotional exhaustion, high levels of depersonalization, and low levels of personal accomplishment. It was hypothesized that there would be an inverse relationship between burnout and occupational well-being such that PSWs who experienced higher levels of burnout (i.e., higher levels of emotional exhaustion and depersonalization and lower levels of personal accomplishment) would be more likely to report lower levels of occupational well-being, and conversely, that PSWs who reported higher levels of occupational well-being would experience lower levels of burnout (i.e., lower levels of emotional exhaustion and depersonalization and higher levels of personal accomplishment). The emotional exhaustion (EE) and depersonalization (DP) subscales of the MBI have an inverse relationship with the personal accomplishment (PA) subscale. Therefore it was hypothesized that the association between occupational well-being and two components of burnout (i.e. emotional exhaustion and depersonalization) would be an inverse one and between occupational well-being and personal accomplishment would

be a positive one. Since there had been no prior theoretical conceptualization or empirical research relating these two constructs, this was an exploratory hypothesis.

3.1 SAMPLE

Upon receiving Ethics Approval, the PI sent emails to the Directors of Care of the six LTC facilities where the PI provides education and consultation services. In the email, the PI provided information on the study and invited the LTC facilities to participate in the study. Of the six, only two LTC facilities agreed to participate. Thus, participants for the study were recruited from these two facilities.

The LTC facilities that agreed to participate could be categorised as medium sized, non-profit organizations. One facility provided care to 203 residents while the other had 128 residents. Organizationally, both facilities had similar structures with an Administrator, a Director of Care, an Assistant Director of Care and other administrative positions such as reception duties, accounting, and bookkeeping.

Neither LTC facility had any specialized in-house services such as Advanced Practice Nurses or Social Workers. Both facilities had in-house employees providing Recreation/Activation therapy programs, and third-party contracts for physiotherapy (PT) services. Occupational therapy (OT) and Speech and Language Pathology (SLP) services were available in a very limited way. OT services were typically provided through the same company that provided PT services although increasingly, the physiotherapists were assessing residents for seating, positioning and mobility aids, rather than referring residents to occupational therapists. SLP services were made available through the Community Care Access Centre.

In the larger LTC facility, the Resident Care Coordinator (RRC) had a diploma in Gerontology and a background in community-based programmes for seniors, and served as the liaison between residents/families and the staff and administration. The RRC also provided facility tours to individuals interested in applying to the nursing home. There was no such position in the second facility and the Receptionist provided facility tours.

An important difference between the two facilities is that they were located in different Local Health Integration Networks (LHINs). As a result, they did not have access to the same programs and services. The larger LTC facility, for example, had access to a centralized team of nurses and personal support workers that could come into the facility and work with the staff to conduct assessments and develop intervention plans to manage responsive behaviours in residents with dementia. The smaller facility, being in a different LHIN, did not have access to this program.

The facilities both had significant staffing and administrative cutbacks during the study period. The smaller facility experienced much more turmoil than the other (three complete changes in administrative staff in less than 24 months). As a result, at the time of the study this facility was experiencing significant issues in ensuring that services were being provided in accordance with legislation and had received compliance visits from the Ministry of Health and was asked to improve processes as well as staff compliance with professional and regulatory legislation.

Potential participants were recruited from the 179 PSWs who were part-time and full-time employees of these facilities in the city of Toronto between September and November 2012. A convenience sampling strategy was used. The only inclusion criterion was that the individual had to be a PSW working in one of the two participating nursing

homes. There were no exclusion criteria for PSWs. In keeping with recommendations regarding sample size for correlational research (Gall, Gall, & Borg, 2007), the goal was to recruit a minimum of 30 participants.

The recruitment procedures were designed to ensure potential participants did not in any way feel coerced or pressured to participate in the study. Strategies were put in place to protect participant anonymity and mitigate any concerns potential participants might have felt about their information being shared with the facility's management and administrative personnel.

The PI took steps to ensure that management and administration were not seen to be involved with any aspect of recruitment, sharing information about the study or handing out and collecting study packages. Thus, the PI handled all these procedures.

Recruitment was initiated by posting study information sheets and recruitment flyers (see Appendices A and B) on staff notice boards in staff rooms, and on education and communication boards within each of the two nursing homes. Potential participants were provided with a brief verbal description of the study by the PI at the end of 37 routine in-services offered within the two nursing homes during the recruitment period (i.e., September, October and November 2012). Since PSWs are expected to participate in the in-services offered when they are on-duty, it was assumed that all potential participants had at least one opportunity to learn about the study.

Those PSWs who wanted to learn more about the study were asked to stay behind for a few minutes at the end of each in-service session. A total of 71 packages were distributed to PSWs who expressed an interest in participating in the study (i.e., 39.7% of the potential participants expressed an interest in participating in the study).

3.2 PROCEDURES

The PI briefly described the study – purpose, risks, benefits, what would be required of participants and the process to ensure confidentiality. Study packages were distributed and reviewed with the potential participants. The study packages included an Information Sheet (Appendix A), and Instruction Sheet (Appendix C), a Demographic Data form (Appendix D), and the two Questionnaires – the MBI (Maslach, Jackson, & Leiter, 1996) (Appendix E) and the OWBQ (Doble, 2010) Appendix F).

Participants were asked to complete the questionnaires on their own time but were encouraged to complete the study package in a single day. Potential participants were given an opportunity to pose any questions they had and were also given the opportunity to call the PI if they had further questions.

To ensure their anonymity, participants were instructed to not put their names on any of the questionnaires when they returned their completed study packages. Moreover, the names of the 71 PSWs who took study packages were not recorded. However, this also meant that they could not be contacted personally to remind them to complete and return their packages.

Participants were asked to place their completed questionnaires within the next two weeks in the sealed envelopes that were provided, and then place these in sealed boxes located in the staff lounges. The completed study packages were removed from the sealed boxes twice a week. One week after the study packages were made available, general notices to remind participants to return their completed study packages (see Appendix G) were posted on the staff notice boards.

Of the 71 study packages distributed to interested PSWs, only 21 (29.6%) surveys were returned. The period of participant recruitment was affected by major financial trouble at one of the two participating nursing homes. Due to budget shortfalls, there were significant cutbacks in staffing at the frontline and management level, including the dismissal of key management personnel. In November, in the week prior to the PI's scheduled in-services at one of the nursing homes, staff did not receive their paycheques. The reason for the delay was coincidental and due to clerical error however, since it followed right after the staffing cutbacks, several staff expressed concern to the PI that the delay was due to more serious issues and that the facility itself might be shut down.

In November 2012, when the PI realized that the target number of 30 would not be reached, she contacted her colleagues to see if any of their nursing homes would be interested in participating. Initial interest was expressed by two nursing homes in December however when the PI followed up in January 2013, there was no response. The PI was advised by her colleague that both the nursing homes that had initially expressed interest had had changes in administrative staffing and were experiencing significant administrative reorganization. Provincially, budgetary cutbacks in the long term care sector at the beginning of 2013 resulted in staff layoff at both the participating facilities as well in facilities across the city, causing significant upheaval. Between the initial phase and the second phase of attempting to recruit LTC facilities, a total of 16 nursing homes were contacted however, attempts to enlist more facilities in the study were not successful.

3.3 INSTRUMENTATION

3.3.1 Demographic Data Form

Demographic information pertaining to age, gender, length of employment in years, job status (part-time versus full-time), and whether the participant had other care responsibilities in addition to their job (this could include caring for children, parents, someone with significant care needs or another care related job) were requested (see Appendix D). The purpose of gathering this demographic information was to describe the sample and examine whether these factors were related to the experience of burnout as factors such as weekly working hours have been found to be related to dimensions of burnout (Evers et al., 2002). Similarly, factors such as being older and having more years of experience have been associated with more strain (Brodaty, Draper, & Low, 2003). The purpose of including whether staff had additional care responsibilities was to explore whether added care responsibilities contributed to the experience of burnout.

3.3.1 Maslach Burnout Inventory (MBI)

The MBI (Maslach et al., 1996) (Appendix E) is a 22 item standardized, self-administered evaluation that can be completed in 10 minutes. Within the MBI, burnout is conceptualized as high levels of emotional exhaustion (EE), high levels of depersonalization (DP) and low levels of personal accomplishment (PA). According to Maslach and colleagues (1996) the three dimensions of burnout must be examined individually. Therefore, rather than generating a total burnout score, separate DP, EE and PA subscale scores are generated.

Each item is rated using a seven-point Likert scale to evaluate how frequently respondents experience each situation. Response options are: never (0), a few times a year or less (1), once a month or less (2), a few times a month (3), once a week (4), a few times a week (5), and every day (6). The EE subscale is comprised of nine items including “I feel emotionally drained from my work.” The DP subscale is comprised of five items including “I don’t really care what happens to some recipients.” For these two subscales, higher ratings reflect high levels of DP and EE. The PA subscale is comprised of eight items including “I can easily create a relaxed atmosphere with my recipients.” In contrast to the DP and EE items, the PA items are positively worded. Thus, a higher subscale score is indicative of higher levels of personal accomplishment. Those experiencing burnout are expected to report low levels of personal accomplishment.

MBI scores are generated in two ways first, for categorization purposes and secondly, for statistical analysis. For categorization purposes, the items within each of the three subscales are simply totaled and then categorized as being high, average or low. Therefore, burnout is indicated by high EE subscale scores (i.e., scores of 27 and higher), high DP subscale scores (i.e., scores of 13 and higher), and low PA subscale scores (i.e., scores of 31 and lower). Average levels of EE (scores between 17 and 26), DP (scores between 7 and 12), and PA (scores between 32 and 38) are indicative of a moderate level of burnout. Low EE (16 and less) and DP (6 and less) subscale scores accompanied with high PA subscale scores (39 and higher) are indicative of low levels of experienced burnout. However, the test developers failed to explain how to interpret mixed patterns of subscale scores (e.g., low EE subscale scores, high DP subscale scores, and low PA subscale scores). For research purposes, subscales scores are generated by adding the

response ratings for each item and dividing the total by the actual number of items answered by the respondent in each subscale. This means that subscale scores for all respondents can still be generated even if respondents fail to rate one or more items. These subscale scores are subsequently used for all statistical analyses.

On initial testing, the MBI yielded satisfactory reliability coefficients - Cronbach's alpha ranging from 0.76 and 0.89 (Maslach & Jackson, 1981). Since its introduction, the MBI has been widely tested by different researchers and found to be reliable and valid for use with nurses internationally (Poghosyan, Aiken, & Sloane, 2009), workers in public child welfare services (Yadama & Drake, 1995), staff working in services for people with intellectual disability (Hastings, Horne, & Mitchell, 2004) and in jobs outside the human services (Taris, Schreurs, & Schaufeli, 1999). The MBI has been validated and used both as a self-administered, as well as a researcher-administered questionnaire. However, the test developers specifically noted in the test manual (Maslach et al., 1996) that the MBI subscale scores should not be used for diagnostic purposes due to insufficient research on the patterns of scores as indicators of individual dysfunction.

3.3.3 Occupational Well-Being Questionnaire (OWBQ)

The OWBQ (Doble, 2010) (Appendix E) is a standardized, self-administered questionnaire that takes less than 10 minutes to complete. The OWBQ measures respondents' levels of self-reported occupational well-being, that is, the extent to which respondents perceive that their everyday occupations enable them to address their occupational needs of accomplishment, affirmation, agency, coherence, companionship, pleasure and renewal. Thus, unlike other questionnaires designed to evaluate respondents' level of satisfaction with their everyday occupations, no reference is made

to any specific occupations. Instead, respondents completing the questionnaire consider the extent to which their own unique repertoire of occupations, as diverse as they might be, enable them to meet their needs for accomplishment, affirmation, agency, coherence, companionship, pleasure, renewal, and usefulness. Respondents rate each item using a 4-point Likert scale in which response options range from “rarely” (1), “sometimes” (2), “often” (3), and “always” (4). Sample items include: “I [*rarely, sometimes, often, always*] do things that give me great enjoyment”; and “I [*rarely, sometimes, often, always*] reflect on my goals and accomplishments.” The participants’ raw ordinal OWBQ item scores are transformed into equal-interval linear measures of occupational well-being using Winsteps® (*Version 3.70.0*) (Linacre, 2010) a Rasch software analysis program.

The OWBQ has been developed using the principles of the Rasch model. Rasch analysis addresses some of the statistical limitations of assessments using ordinal scales by focussing on objective measurement (Bond & Fox, 2007; Velozo, Forsyth, & Kielhofner, 2006). The Rasch model is a probabilistic model that converts raw ordinal data into interval data by using logistic transformation (logit or Log-Odds unit). This allows for the treatment of scores as measures. A hallmark of item development for Rasch-based measures is the clear definition of the construct being measured and the requirement of unidimensionality - that each item measure only the construct that is being assessed. Goodness-of-fit for test items and person-fit measures ensure that the items, and the subjects taking the test, fit along a continuum on the scale. The rigor of this model ensures that measures using ordinal scales are able to provide statistically rigorous data that are valid and reliable. Rasch measurement is grounded in the assertion that most

persons will experience easier items as relatively easy and most persons will experience harder items as relatively hard.

To summarize, each item in Rasch-based assessments measures only the construct that the assessment has been designed to measure ensuring that Rasch-based assessments provide valid data. Item difficulty helps to separate subjects based on ability and also helps to identify unexpected patterns of responses, for example when subjects score difficult items as easy or vice versa, or show limited variability in their responses.

The difficulty of the items comprising the OWBQ was estimated on the basis of those who completed the test during its development, that is, they provided the empirical data to determine which items were experienced as more difficult and which items were experienced as relatively easy (Doble, personal communication, August 28, 2014).

Valid OWB measures can only be generated when the test items are neither too easy nor too hard for a respondent. When a test is too easy, a respondent will assign the highest possible rating to all items; when a test is too hard, a respondent will assign the lowest possible rating to all items. Thus, participants' ordinal ratings are reviewed to determine if any of the participants assigned all 24 items with the rating "always" or "rarely" (Doble, personal communication, August 28, 2014).

Although the OWBQ has not been published, the reliability and validity of the measures generated using the OWBQ have been confirmed during the development of the questionnaire through a number of pilot studies in which the OWBQ was administered using different methods (e.g., face-to-face administration by a researcher/clinician and self-administration) to healthy adults, adults with diverse health conditions (e.g., multiple sclerosis, rheumatoid arthritis, schizophrenia, spinal cord injuries, stroke), as well as

older adults living in a LTC setting (Doble, personal communication, February 21, 2012). For example, Santha (2005) conducted research using the OWBQ with 48 mothers of preschool children for her Master's thesis. She found that not only did 95.8% of the items of the OWBQ cohere to a unidimensional construct, but they also varied in difficulty. Additionally, valid measures of occupational well-being were also generated for 91.7% of the participants. This finding showed that the OWBQ was able to identify that the measures of 8.3% of the participants were not valid (i.e. their responses to OWBQ items did not fit expected patterns and therefore, could not be considered valid). In various unpublished pilot studies, moderate correlations were found between participants' occupational well-being measures and their levels of mental health and life satisfaction (Doble, personal communication, February 21, 2012). In a small study of 10 older adults and adults with arthritis who completed the OWBQ twice within three to six days, their Time 1 and Time 2 measures were strongly correlated with $r = .95, p < 0.001$ (Doble, personal communication, February 21, 2012).

While higher measures indicate higher levels of occupational well-being, guidelines for categorizing persons' level of occupational well-being as high, moderate or low have not yet been established. However, the findings of a study of 237 persons with multiple sclerosis offer some insights into how to interpret the measures (Doble, personal communication, January 29, 2014). In addition to completing the OWBQ, participants categorized their occupational lives as either "satisfying" or "not satisfying" (i.e., either or constrained, unmanageable or lacking meaning). Those who experienced their occupational lives as "satisfying" were significantly more likely to report higher levels of occupational well-being than those whose occupational lives were "not satisfying" ($t = -$

7.28, $p < .001$). Those respondents who reported their occupational lives as “satisfying” had a mean OWB measure of 1.17 logits ($SD=1.17$). In contrast, the mean OWB measure of those who indicated their occupational repertoires were “unmanageable/unbalanced” was 0.00 logits ($SD=1.25$). Moreover, those who reported their occupational lives were unsatisfying (lacking meaning) had a mean OWB measure of -0.07 logits ($SD=.98$) while those who described their occupational lives as constrained (i.e., lacked opportunities to engage in the occupations they wanted to do) had a mean OWB measure of -0.43 logits ($SD=.92$). Thus, the results of this study suggest that higher levels of OWBQ measures were associated with higher satisfaction with occupational lives.

3.4 DATA ANALYSIS

First, statistical analyses were computed using the Statistical Package for Social Science (SPSS) version 20 to provide a description of the sample. More specifically, the mean and standard deviations of the participants’ ages and years of experience were calculated. Frequency distributions were determined for categorical variables, that is, gender, job status and other care responsibilities.

Participants’ MBI subscale scores were generated in two ways. First, mean subscale scores were generated based on the number of subscale items each participant rated. The samples’ means, ranges and standard deviations for each of the three MBI subscales were calculated. Secondly, the participants’ three MBI subscale scores were generated by summing the subscale items. The scores generated using this second method were used to categorize the participants’ MBI subscale scores as low, moderate or high according to the guidelines provided in the test manual (Maslach et al., 1996). Using these guidelines, three groups of participants were identified. The first group consisted of

those who met the criteria for burnout (i.e., had scores of 27 and higher on the EE subscale, scores of 13 and higher on the DP subscale, and scores of 31 and less on the PA subscale). Validation studies for the MBI have found emotional exhaustion and depersonalization to be consistently correlated and more correlated with measures of psychological and physiological strain than personal accomplishment (Maslach et al., 1996). Therefore, in the current study, participants' scores on the EE and DP subscales were considered to be more important when identifying participants who met the criteria for burnout. Thus, participants who had high EE and DP subscale scores in the Burnout group. In the second group, participants that had low EE and DP subscale scores and high PA subscale, as per the guidelines provided in the manual, were categorized as having No Burnout. In the third group, those who met the criteria for burnout on the basis of one or two subscales only were categorized as being At Risk for Burnout. However, since the test developers specifically noted in the test manual (Maslach et al., 1996) that the MBI subscale scores should not be used for diagnostic purposes due to insufficient research on the patterns of scores as indicators of individual dysfunction, these categorizations were interpreted with caution.

Since valid OWB measures can only be generated when there is some variability within each person's responses to the individual OWBQ items, the participants' ordinal ratings were reviewed to determine if any of the participants assigned the same rating to all 24 items, whether that rating was "rarely," "sometimes," "often," or "always." In fact, one participant assigned a rating of "always" to each of the 24 OWBQ items. Since a valid measure could not be generated in this case, the participant's data were not included in this study. The remaining 20 participants' raw ordinal OWB scores were converted

into equal interval, linear measures using Winsteps® (*Version 3.70.0*) (Linacre, 2010), a Rasch software analysis program. These measures were used in all subsequent analyses.

At present there are no established cut-offs for determining levels of OWB measures (Doble, personal communication, August 7, 2014). Thus, as noted above, first, participants' ordinal ratings were visually examined to ensure that participants' responses exhibited variability in their responses. The participants' OWB measures were then plotted on a linear continuum in order to visually appraise the range of the sample's self-reported occupational well-being. The mean, standard deviation (*SD*) and range of the participants' OWB measures were calculated and examined.

For the purpose of this study, the OWB mean and *SD* were used to determine the levels of OWB for the sample. The mean, or the average of the sample measures, was deemed as the point representing the mid-point of the sample's measures. The *SD* was used to explore the distribution of the sample and to establish OWB levels for the sample.

Those whose OWB measures were greater than \pm two *SD* from the mean for the sample were identified as "very high" and "very low," as their measures were located along the more extreme ends of the linear continuum of occupational well-being. Participants whose OWB measures were one *SD* from the mean but less than ± 2 *SD* were identified as "high" and "low", while those whose measures were within one *SD* were identified as experiencing an "average" level of OWB.

The relation between participants' MBI subscale scores and OWBQ measures were examined. First, scatter plots were generated and examined so that the expected relation between the constructs could be examined, and to determine if there were any outliers. Secondly, Spearman correlations were calculated using SPSS Version 20 to

examine the relations between the participants' OWB measures and each of their three MBI subscale scores. The strength of the correlations was interpreted using the following guidelines: $r=0$ to $.19$ = negligible, $r=.20$ to $.39$ = low, $r=.40$ to $.59$ = moderate, $r=.60$ - $.79$ = high/strong, and $r=.80$ to 1.00 = very high/very strong (Kielhofner, 2006).

Futhermore, the p values of the associations were examined. Examining the p value of a correlation is important when deciding whether to reject the null hypothesis, i.e., that no relationship exists between the two variables (Gall et al., 2007). The lower the p value, the higher the probability that the result obtained is due to a true association between the two variables, rather than due to the characteristics of the sample itself, i.e. sampling error (Rowntree, 2004). The sample size for this study was small, which reduces the power to find statistical significance. The p value is represented as a number between 0 and 1, with a statistically significant relationship usually being established at a p value of ≤ 0.05 (Rowntree, 2004). For this study, the significance of the relationship was established at a p value of ≤ 0.05 .

Participants' MBI burnout ranking (i.e., categorization as experiencing "Burnout", "No Burnout", or being "At Risk for Burnout") and levels of OWB measures (i.e., categorization as "Very High", "High", "Average", "Low", or "Very Low") were examined in relation to their "job status" (i.e., full-time versus part-time), "other care responsibilities" (i.e., did or did not have other care responsibilities), and "number of years of experience as a PSW" to identify any discernable patterns. Grouping the data in this manner helped identify patterns between variables, e.g. high levels of burnout and other care responsibilities. In addition, as part of the exploratory analysis, Spearman correlations were computed between the demographic variables of years of experience,

and age, with the three MBI subscales and the OWBQ measures to explore the strength of their relations.

CHAPTER 4: RESULTS

Of the 71 study packages distributed to interested PSWs, only 21 (29.6%) surveys were returned to the researcher, with an overall response rate of 11.7% from the total available pool of 179 potential participants. However, some data were missing; more specifically, age ($n=3$), number of years of work experience ($n=1$), and gender ($n=1$). Since one participant's OWBQ responses were not included in the analyses (i.e., having rated all 22 OWBQ items with the highest possible rating, that is, "always", there was no variability her responses and a valid measure could not be generated), the total sample available for analyses was 20. Thus, the total sample size available for analyses was 20 participants.

The sample was overwhelmingly female (94.5%, $n=19$) and mostly middle-aged ($M=47.9$ yrs, $SD=11.1$ yrs; range: 24 to 66 years, $n=17$). Of the 19 who reported their number of years of experience, 65% reported having more than 10 years of work experience ($M=13.4$ yrs, $SD=7.2$ yrs, range: 1 to 31 yrs). Most (70%, $n=14$) reported that they worked as PSWs on a full-time basis. Sixty-five percent ($n=13$) reported that they had no other care responsibilities outside of their work role.

All participants ($N=20$) completed the MBI and the OWBQ. The ranges, means and standard deviations of their MBI subscale scores are presented in Table 1. There was a wide range of scores on each of the MBI subscales.

Table 1: Means, standard deviations, and ranges of MBI subscales (n=20)

Mean MBI Subscale Item Scores

	EE	DP	PA
<i>M(SD)</i>	2.51 (1.56)	1.46 (1.50)	4.41 (0.99)
Range	0.33 – 5.56	0.00 – 5.04	2.50 – 6.00

Note: EE = Emotional Exhaustion, DP = Depersonalization, PA = Personal Accomplishment

The percentage of participants’ MBI subscale scores that were considered to be high, moderate and low are presented in Table 2. As noted earlier, higher scores on the EE and DP subscales and lower scores on the PA subscale are considered to be indicative of experienced burnout. For the EE and PA subscales, a fairly equivalent proportion of the participants’ scores fell into the high, moderate and low categories. However, the pattern was somewhat different for the DP subscale where 70% of the participants’ DP subscale scores were categorized as low. Thus, even though 60% within this sample were experiencing moderate to high levels of emotional exhaustion, this was not, in most cases, accompanied by equivalent levels of depersonalization.

Table 2: Percentage of participants whose MBI subscale scores were categorized as High, Moderate and Low

MBI Subscales	Levels of Burnout		
	High	Moderate	Low
EE	35%	25%	40%
DP	10%	20%	70%
PA	35%	30%	35%

When the pattern across each of the participants' three MBI subscale scores were examined, only one (5%, Participant 20) of the 20 participants had subscale scores that were indicative of high levels of burnout (i.e., a high EE subscale score, a high DP subscale score, and a low PA subscale score). However, the pattern of MBI subscale scores of an additional four other participants (i.e., Participants 4, 5, 9 and 10) had high EE subscale scores, moderate DP subscale scores and low to moderate PA subscale scores. Emotional exhaustion and depersonalization have been found to be consistently correlated and more correlated with measures of psychological and physiological strain than personal accomplishment (Maslach et al., 1996). The four participants with high EE and moderate DP subscale scores may be seen as close to meeting the criteria for burnout. Thus, for the purposes of this study, these five participants (25% of the sample) were categorized as having burnout.

Another five participants (25%) (Participants 1, 6, 8, 14, and 15) had variable MBI subscale score patterns such that they met the criteria for burnout on the EE and/or PA subscales only. Their scores on these two subscales suggested that they were not experiencing their work life in an optimal way. Therefore, they were considered to be at risk of developing burnout. However, in contrast to what would be expected if they were experiencing burnout, all five participants reported low levels of depersonalization. These participants' MBI subscale categorizations are presented in Table 3 with those subscale scores that were indicative of burnout being highlighted. In contrast, 10 participants (50%) had MBI subscale scores that indicated that they were not experiencing burnout (Participants 2, 3, 7, 11, 12, 13, 16, 17, 18, and 19).

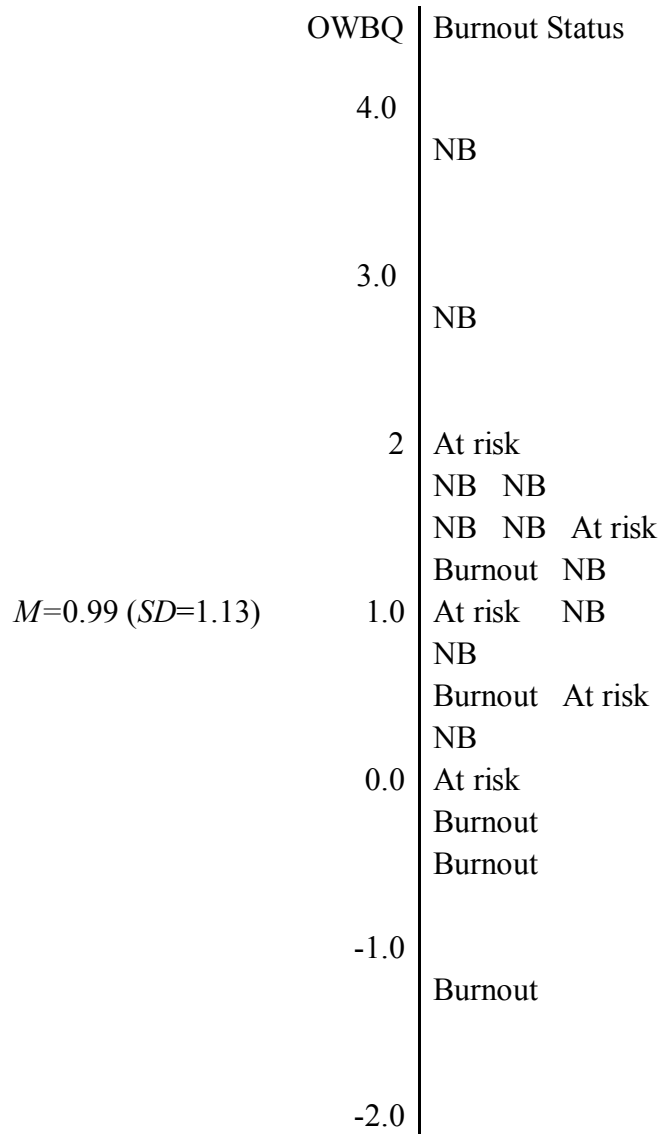
Table 3: MBI subscale categorizations of participants with variable response patterns

Participant Number	MBI Subscale Categorizations (Subscale Scores)		
	EE (Score)	DP (Score)	PA (Score)
001	High (32)	Low (0)	Low (31)
006	Moderate (19)	Low (4)	Low (20)
008	Moderate (22)	Low (6)	Low (25)
014	Moderate (17)	Low (2)	Low (22)
015	High (32)	Low (6)	Moderate (32)

There was a considerable range in the participants' OWB measures with measures ranging from -1.2 to 3.7 logits, $M = 0.99$ ($SD=1.13$) (see Figure 1). Participants whose OWB measures were $\geq \pm 2 SD$ from the sample's mean OWB measure (i.e., 3.26 logits and above, -1.28 logits and lower) were categorized as experiencing very high and very low OWB respectively. Participants whose measures were $\pm 1 SD$ from the sample's mean OWB measure but less than $\pm 2 SD$ were categorized as experiencing High (i.e. between 2.13 and 3.25 logits) and Low OWB (i.e. between -0.15 and -1.27 logits) respectively. Finally, participants whose OWB measures were within $\pm 1 SD$ of the sample's mean OWB measure (between -0.14 and 2.12 logits) were categorized as experiencing Average OWB. Using this criteria one participant was deemed to be in the "very high" group (Participant 13), and one in the "high" group (Participant 2). There were no participants who fell in the "very low" group" while three (Participants 4, 9 and 20) were in the "low" group. The remaining participants, comprising 80% of the sample fit in the "average" group. Further examination of the "average" group showed that, of

the eight participants whose OWB measures were one *SD* above the mean (Participants 1, 7, 8, 10, 11, 12, 16, and 18), five were in the No Burnout group, two were in the At Risk group and 1 (Participant 10) was in the Burnout group. In contrast, of the participants whose OWB measures were one *SD* below the mean (Participants 3, 5, 6, 14, 15, 17, and 19), two were in the No Burnout group, three were in the At Risk group and two were in the Burnout group (Participants 3 and 5). Thus, broadly speaking, in the “average” group, participants who had higher levels of OWB also endorsed lower levels of burnout.

Figure 1: Distribution of Participants' OWBQ Measures Presented on the Basis of Their Burnout Status



NOTE: NB= did not meet criteria for burnout; At Risk = met some criteria for burnout (i.e., met criteria for burnout on one or two MBI subscales only); Burnout = met criteria for burnout (i.e., met criteria for burnout on at least two MBI subscales and had moderate scores on third subscale)

The mean OWB measure of the Burnout group was 0.08 logit ($SD=0.90$). Three of the five participants in the Burnout group, had “low” OWB measures (i.e., between -0.15 and -1.26 logits). In fact, three of these five participants had the lowest levels of OWB in the sample. The five participants in the At Risk for Burnout group reported a somewhat higher mean level of OWB ($M=0.93$ logit, $SD=0.81$, Range= 0.04 to 2.04 logits). All participants in the At Risk group had OWB measures in the “average” range, with three out of the five having measures below the mean for the sample. While there was some variability in the OWB measures of those within the No Burnout group (Range= 0.21 to 3.69 logits), their mean OWB measure was much higher than the Burnout group at 1.55 logits ($SD=1.02$). Thus, broadly speaking, as expected, the majority of participants in the Burnout group reported lower levels of OWB while those in the No Burnout group reported higher levels of OWB.

As anticipated, a moderate inverse association was found between the participants’ OWB measures and MBI EE subscale scores ($r=-0.41$, $p=0.07$). In contrast, the strength of the correlations between the participants’ OWB measures and the other MBI subscales was unexpectedly low. More specifically, a non-significant low inverse association ($r=-0.37$, $p=0.11$) and a non-significant low positive association ($r=0.25$, $p=0.30$) was found between participants’ OWB measures and their MBI DP and PA subscale scores respectively.

For the three correlations reported above, the p values for OWB measures and EE, DP and PA were 0.07, 0.11 and 0.30 respectively. None of the correlations were statistically significant as the p values were all $\geq .05$. Of the three, only the relationship between OWB measures and EE was close to being statistically significant. The p value

of the OWB measure and EE subscale score was .07, which indicates a 93% confidence level that there is an association between the two variables. The *p* values for the OWB measures and DP and PA subscale scores are much higher and there is less confidence that there are associations between these variables.

Thus, strictly speaking, these findings did not statistically support accepting the alternative hypothesis being explored in this study, i.e., higher levels of burnout would be associated with lower levels of occupational well-being in PSWs working in nursing homes and vice versa. In this study, the relationship between OWB measures and EE subscale scores was the only one where the association was close to statistical significance. However, the direction of the relationship between OWBQ measures and the DP and PA subscales (inverse and positive, respectively), was as hypothesized by the study.

Exploratory analyses were also conducted to examine differences between the three identified burnout subgroups, i.e. those with Burnout, those At Risk and those with No Burnout. Tables were created categorizing the three burnout groups with the five OWBQ levels, and with the demographic variables of age, years of experience and other care responsibilities (presented in Appendix J). Due to the small sample sizes within each of the subgroups (in some instances comprising one or two occurrences only), no statistical analyses were done to determine if the subgroups were significantly different.

As noted above, those in the Burnout group had the lowest mean OWB measure ($M=0.08$), compared to those in the At Risk ($M=0.93$) and No Burnout groups ($M=1.55$). All of those in the Burnout group ($n=5$) reported working full-time, while 80% of the At Risk group ($n=5$) and 50% of the No Burnout group ($n=10$) reported working full-time.

More of those in the Burnout group also reported having other care responsibilities compared to those in the other two groups (i.e., 80% versus 20% for each of the other two groups). While those in the No Burnout group ($n=10$) had the least years of experience with a mean of 11.5 years ($SD=8.75$), those in the other two groups had more work experience (Burnout group: $M=14.4$ yrs, $SD=6.35$; At Risk group: $M=17$ yrs, $SD=0.82$). However, the range in years of work experience within both the No Burnout and Burnout groups was much greater (Range=1-31 yrs and Range=8-22 yrs, respectively) than that of the At Risk group (Range=16-18 yrs). The correlations between the participants' years of work experience and their scores on the three MBI subscales were also examined. Negligible associations were found between the participants' years of work experience and their DP ($r=0.18$, $p=.46$) and PA ($r = -0.18$, $p =.47$) subscale scores. However, a statistically significant association was found between years of work experience and their scores on the EE subscale ($r=0.48$, $p=0.04$).

CHAPTER 5: DISCUSSION

Burnout has been extensively studied in the past 30 years (Schaufeli et al., 2009). Most of this research has been on individuals' experience solely within the workplace without giving any consideration to their broader occupational lives. PSWs working in LTC facilities experience numerous work-related stresses which might increase their risk of experiencing burnout. However, PSWs' broader occupational lives, by meeting their occupational needs, might contribute to a decreased experience of burnout. For this exploratory study, it was hypothesized that if PSWs were able to meet their occupational needs through their occupational repertoires, they might be likely to experience decreased levels of burnout. The construct of occupational well-being focuses attention on the satisfaction and meaning people derive from their occupations, regardless of the actual number of occupations in which they engage or the amount of time they spend engaging in each occupation. The subjective nature of occupational well-being directs our attention to the fact that even those who have limited occupational repertoires may experience higher levels of occupational well-being if their occupations enable them to meet their needs. Therefore, the relationship between PSWs' experiences of emotional exhaustion, depersonalization, and personal accomplishment within their workplace and their overall levels of occupational well-being (i.e., well-being that is derived from all of their occupational experiences) was examined in this study.

Given the small sample size of this study and lack of statistical significance, any speculations regarding the relationship between these two constructs can only be made with humility and circumspection. Therefore, at this point it can be said that the findings

of the study do not disprove the null hypothesis that there is no association between the two constructs.

Even though the study was unable to disprove the null hypothesis, in a limited way, findings from this study offer intriguing insights about factors that may enhance or limit persons' ability to meet their occupational needs and thereby have an impact on work-related burnout. The purpose of the study was not to examine the prevalence of burnout in PSWs working in LTC facilities; however, the finding that 60% of the sample reported moderate to high levels of emotional exhaustion is of concern as it suggests that these individuals are experiencing work as stressful and emotionally draining. This finding lends further credence to the importance of examining the effect of non-work occupations in buffering individuals against the stresses inherent in paid caregiving occupations.

While we recognize the limitations inherent in the findings derived from small sample sizes, it is worth noting that the direction of the associations between the OWBQ measures and the three dimensions of burnout were as predicted by the hypothesis. This finding suggests that the two constructs are related and further studies are needed to better understand the strength of the relationship.

How PSWs experience burnout in relation to their overall experience of occupational well-being provides a good starting point to explore the relationship between the two constructs. In this study, PSWs in the No Burnout group had a higher mean OWBQ measure than those in the At Risk group, while those in the At Risk group in turn had a higher mean OWBQ measure than the Burnout group. This broadly suggests that PSWs with lower levels of burnout are meeting their occupational needs more

satisfactorily compared to those with higher levels of burnout. While this study did not explore the specific repertoires that affect individuals' occupational well-being and burnout experiences, certain demographic factors may be important in mediating this experience.

The findings of this study suggest that additional care responsibilities outside of paid work may affect PSWs' ability to meet their occupational needs and increase their risk of burnout. Possibly, occupations which are similar in nature limit PSWs' occupational repertoires as well as constraining their ability to meet specific occupational needs. This may lead to a decreased ability to tolerate work-related stresses and increase the risk of burnout. All five participants in the Burnout group reported that they worked full-time, with four of these participants also reporting that they had other care responsibilities outside work. In contrast, among the ten participants who constituted the No Burnout group, only half worked full-time and only 20% reported having other care responsibilities. When PSWs' have additional care responsibilities outside their paid work the predominance of care-related occupations may limit their ability, energy and available time to engage in occupations that enable them to meet occupational needs.

Another factor which has been noted to have an impact on the experience of burnout is prolonged exposure to the stresses and imbalances of work life (Maslach et al., 2001). When individuals experience high levels of stress for prolonged periods of time, it may deplete their ability to tolerate these stresses and lead to burnout. In the study, PSWs in the Burnout and At Risk groups had a higher mean number of years of experience than the No Burnout group. On initial examination, these findings appear to support the research of Maslach and colleagues (2001). However, the group reporting the highest

mean number of years of experience was the At Risk group. This group also had a higher mean OWBQ measure than the Burnout group. It would be of interest to explore this group further. For the purpose of the study, the PI deemed this group of PSWs as being At Risk for Burnout. Thus, the PSWs in this group were seen as existing in an intermediate stage, possibly moving towards burnout. The fact that the mean OWBQ measure for this group was lower than that of the No Burnout group suggests the PSWs in this group may be experiencing greater work related stress and a decreased ability to meet their occupational needs. However, it is equally possible that the PSWs in this group are experiencing lower levels of burnout, despite having longer years of service, because they have developed occupational repertoires that enable them to meet their occupational needs. Exploring the perspectives of PSWs in this group would be valuable in shedding light on the impact that occupational well-being may have on experienced burnout.

Further examination of the association between occupational well-being and the three dimensions of burnout is warranted. Emotional exhaustion can cause individuals to distance themselves emotionally and cognitively at work. In a study with male police officers, researchers found that officers experiencing stress were more likely to display anger and spend time away from families (Jackson and Maslach, 1982). Other researchers have found that care workers experience ethical conflicts, which cause stress, when they are faced by work situations in which they feel constrained to provide less than adequate care (Juthberg et al., 2010). In these situations, the researchers found the work experience affected these workers' home life negatively. A moderately strong relationship, that was close to being significant, was found between emotional exhaustion and occupational well-being in the current study. There is a possibility that emotional exhaustion deriving

from work could deplete PSWs' experience of occupational well-being, which may negatively affect their home life and their ability to engage in occupations with their family members.

PSWs' ability to meet their occupational needs through non-work occupations may be having a mitigating impact on experienced burnout. The challenges PSWs in LTC facilities face in their work life were extensively documented earlier. However, in this study, strictly speaking, only one participant (Participant 20) met the criteria for burnout. While 60% ($n=12$) of the participants reported moderate to high levels of emotional exhaustion, 70% ($n=14$) reported low levels of depersonalization. Maslach and Leiter (2008) have suggested that the reason why depersonalization has a strong relationship with emotional exhaustion is because it is a coping response to emotional exhaustion. And yet, the findings of the current study did not appear to support this progression. It would be worthwhile to consider whether the PSWs who participated in the study are able to resist the progression to a depersonalized approach towards their residents (a reassuring finding) because they are meeting their occupational needs through their non-work occupations. Further research to identify factors that enhance the occupational well-being of PSWs is needed as it is equally important that these workers be able to experience their work life in more positive and less stressful ways.

Similarly, identifying the relationship between personal accomplishment and occupational well-being may help enhance PSWs' experience of their work. As the third dimension of burnout, personal accomplishment encompasses workers' experience of themselves as effective, efficacious beings in their work life. Those with burnout experience low levels of personal accomplishment in their work life (Maslach et al.,

1996). Participants in the sample were roughly equally divided in reported levels of personal accomplishment on the PA subscale. Again, the experience of the PSWs in the At Risk group may merit further exploration. Four participants in this group reported low levels of personal accomplishment and one reported a moderate level. However, all had average OWBQ measures, with the measures of two of the five participants being above the mean OWBQ. This suggests that even though these individuals are not satisfied with their work-related efficacy, they may be meeting their occupational needs such as accomplishment and agency through participation in other non-work related occupations. Thus, it is possible that participation in other occupations may enable individuals to continue to see themselves as efficacious and effective individuals despite the frustrations presented by their paid occupation.

The findings of the study raise some intriguing possibilities of how PSWs experience their occupational repertoires and how these repertoires have an impact on their perceptions and experiences of their paid occupations. Findings from additional research could assist employers to actively support staff by developing programs and services that serve to reduce the impact of work-related stress, e.g. on-site daycare for staff with young children to reduce the impact of additional care responsibilities, employee support programs that offer opportunities to engage in diverse occupations of interest to staff, such as book clubs, discounted gym membership, and recognition and acknowledgement of those staff with longer years of service.

5.1 LIMITATIONS OF THE STUDY

The participants of this study formed a small, non-random sample. Therefore, the findings of this study could reflect an over-estimation or under-estimation of experienced burnout among PSWs and make it difficult to generalize these findings to the larger population..

Demographically, the sample was overwhelmingly female (94.5%), middle-aged (M=49.7 years), with 65% reporting more than 10 years of experience. The high percentage of participants identifying themselves as female is reflective of the larger population of PSWs. Some of the studies cited earlier noted that 95% of PSWs tend to be female (Dodson & Zinbarg, 2007; Armstrong, et al., 2011). The mean age of the study sample appeared somewhat higher than what the PI observed in the participating facilities, the PI frequently observed younger PSWs working in the facilities. It is possible that older workers were more interested in participating in the study, which may have had affected the sample mean age, as well as on the number of years of experience.

The sample size was smaller than the 30 recommended for correlational studies (Gall, Gall, & Borg, 2007). In addition, the sample was not random. Participants were recruited using a convenience sampling strategy to ensure that participants did not feel pressured in any way to participate in the study. As such, the low response rate was disappointing. It is possible that some workers did not participate because no remuneration was offered or they perceived participation as onerous. As a result of the size and composition of the sample, it is not possible to generalize the findings of the study to the larger population of PSWs. Future studies might consider offering a small remuneration or options such as completing the instruments on-site to encourage

participation. The size of the sample also had an impact on the statistical analyses that could be conducted and therefore on the findings of the strength of the relationship between OWB and the three dimensions of burnout.

Organizational differences between the facilities that participated in the study and other facilities in Ontario and Canada may also limit the generalizability of our findings. Participating facilities were independent, not-for-profit organizations, which may have been an important factor determining whether they agreed to participate. Administrators of city run homes, as well as for-profit LTC facilities have to get higher levels of administrative approval to participate in research studies (Sirioupoulis, personal communication, August, 2012). In fact, most policies and procedures governing such facilities are developed centrally and are rigidly applied to all facilities regardless of differences in size of facility, geographic location or resident population. Independent nursing homes, such as the two that participated in the study, may have had more flexible policies and procedures. More autonomy in decision-making may have affected administrators' agreement to participate in the study.

The study was not designed to examine organizational similarities and differences between LTC facilities. However, it is possible there may have been additional organizational differences between the participating facilities and centrally administered facilities that had an impact on the findings, and generalizability of the study. For example, staff working in some of the for profit nursing homes where the PI provides services have complained that care provider roles are very rigidly defined, such that all PSWs provide all resident personal care and nurses are not allowed to assist in any personal care activities. The PI has not observed similar constraints in the not for profit

nursing homes. Thus, the findings may have been different if our sample included facilities with varying organizational structures.

Although expanding the criteria for burnout did not affect the correlational analysis for the three MBI subscales and the OWBQ measures it may have biased our findings when we conducted analyses using the categories. If the MBI manual guidelines had been strictly followed, the results would have shown fewer PSWs experiencing burnout, as only one person would have met the burnout criteria, i.e. 5% of the sample instead of the 25%, as categorized in this study. The number of participants who were categorized as not experiencing burnout would have remained unchanged at ten. However, using the MBI manual criteria, nine participants would have been “uncategorizable” as the manual does not provide guidelines for categorizing scores that fall outside the theoretical model of burnout (i.e. High EE, High DP and Low PA subscale scores indicating high burnout; Average EE, Average DP and Average PA subscale scores indicating average burnout; and Low EE, Low DP and High PA indicating low burnout).

Not being able to categorize participants in the Burnout, No Burnout and At Risk categories would have affected the exploration of the similarities and differences between these groups. The ability to categorization of study participants enabled the PI to explore and identify possible associations between burnout categories and occupational well-being. This exploration identified a trend between the categories and the mean OWBQ measures. Such as, the No Burnout group had the highest mean OWBQ measure, the At Risk group had a lower mean OWBQ measure, and the Burnout group had the lowest mean OWBQ measure of the three groups.

The categorization was also useful for exploring the impact of demographic variables on burnout; such as job status, years of experience and other care responsibilities. Participants with full-time job status, higher mean years of experience, and care responsibilities outside of work appeared more frequently in the Burnout and At Risk groups. Thus, categorizing participants in this way facilitated additional analyses examining possible association between burnout and occupational well-being.

Perhaps interpreting the MBI scores in this way introduced a bias into the findings. However, it can be suggested that this categorization was useful as it assisted in identifying that half of those who participated in the study were not experiencing their work life optimally and enabled the PI to explore inter-group differences.

The intent of the study was to examine the relationship between occupational well-being and burnout in PSWs. When designing the study, the expectation was that the larger sample sizes of quantitative research would help to generalize the findings of the study to the larger population. Quantitative measurement has been identified as being useful for differentiating one characteristic from another and standardization of measurement instruments serves as one of the most important and effective methods for reducing measurement error (Kielhofner, 2006). The rationale for the study design was therefore, appropriate. However, given the low participation rate in retrospect, it seems that the study would have benefitted from a mixed methods approach. Qualitative research methods allow for the naturalistic discovery of a phenomenon, and allow researchers to capture in depth the unique way in which individuals experience the phenomenon of interest (Luborsky & Lysack, 2006). More questions on the demographic form regarding their occupational experiences might have helped to provide richer

information on PSWs' occupational repertoires and whether these were contributing to a decreased experience of burnout. Including a test of job satisfaction may have helped to provide clearer information on the full range of satisfaction at work and not just the negative end of the continuum, as evaluated by the MBI. Participant interviews might have helped provide more in-depth information on the experience of burnout and occupational well-being. For example, Participant 1 had high EE, low DP, and low PA subscale scores. However, her OWB measure was 2.04 (while still in the "average" range, her OWB measure was well above the mean). Similarly, Participant 10 had high EE, moderate DP and high PA subscale scores and had an OWB measure of 1.24 (again, in the "average" range but above the mean). In both these instances, qualitative interviews would have helped shed light on how the unexpected patterns of MBI scores actually translate into the participants' perception of their work life as well as providing information about the participants' occupational repertoires and how these might be meeting their occupational needs.

While the purpose of the study was to examine the relationship between individuals' experiences of burnout and occupational well-being, organizational factors may have had an impact on the findings of the study. It has been pointed out that situational and organizational factors have a significant impact on burnout (Maslach, 2003). During the period of the study, both nursing homes experienced significant organizational change that was a result of system level changes being implemented by the Ministry of Health and Long Term Care in Ontario. Staffing cutbacks at the bedside and within the interdisciplinary team (budgets for physiotherapy services were reduced by 50%) are likely to have increased workload stresses for PSWs working in nursing homes.

The impact of these changes was not captured by the study as it was not part of the study design. The stresses engendered by these changes may have had an impact on participant recruitment and may be reflected in the finding that 60% of the PSWs in the study reported moderate to high levels of emotional exhaustion.

While the MBI has been widely used in research on burnout as noted above, some concerns relating to its development should be addressed. The MBI was developed using traditionally used Classical Test Theory (CTT) (Kielhofner, 2006). Although CTT outlines stringent criteria to establish reliability and validity of measurement instruments, all of these calculations are made using ordinal ratings that do not accurately reflect “the amount” of the constructs being evaluated; that is, the distances between each gradation in rank is not equal (Merbitz, Morris, & Grip, 1989; Wright & Linacre, 1989). For example, in the MBI, the distance between a rating of 0 or “never” and 1 or “a few times a year or less” is not the same as 1 or “a few times a year or less” and 2 or “Once a month or less.” Therefore, the application of mathematical functions (adding, generating mean scores) to the ordinal scores of the MBI is questionable. Additionally, the ranking of an individual as experiencing High, Average or Low levels of experienced burnout based on subscale scores raises concerns about the validity of interpreting the subscale score in this manner. For example, two subjects could rank their responses in very different ways and yet get similar scores. Thus, an individual who responded with high numerical ranking to only four items on the nine item Emotional Exhaustion subscale might receive a similar score to an individual who responded to all nine items with a lower numerical ranking for each of those nine items. The limitations of interpreting total subscale scores are highlighted in this example and echo the test developers’ caution about using the MBI as

a diagnostic tool (Maslach et al., 1996). Finally, the practice of giving equal weight to the three MBI subscales when they are, in fact, comprised of diverse numbers of items is questionable.

A question rarely raised when using well-established questionnaires such as the MBI is whether the scores generated for each participant are valid. The importance of this becomes more apparent in this study because the OWBQ was designed using the Rasch model (Doble, 2010) and uses this same model to transform ordinal scores to equal interval linear measures. The Rasch model enables the researcher to identify items and subject responses that do not fit the expectation of the Rasch model (Bond & Fox, 2007). This, in turn, reduces error and allows for statistically rigorous research. In this study, a valid OWB measure of one of the 21 participants could not be generated because she assigned the highest possible rating to all 22 OWBQ items. Thus, in this case, the OWBQ was “too easy” a test for the participant; that is, the items were not sufficiently challenging to be able to accurately estimate where the participant should be placed along the linear continuum of occupational well-being. It is also possible that this participant’s ratings reflect a failure to give too much thought to the items and to over-estimate her occupational well-being. Regardless of the reason for the participants’ responses, Rasch methodology enables us to know that we do not have a valid indicator of this participant’s occupational well-being. There is no way for users of the MBI to assess whether the scores generated are valid or not, nor does the test manual provide any guidelines regarding how such scores should be treated. Thus, if a participant responded to all items with a six (“everyday”), using the test manual as a guide, his or her subscale scores would be accepted as valid and categorized as high EE, high DP and high PA.

Additionally, there are questions about the conceptual model of burnout as operationalized in the MBI. Even on initial testing, the personal accomplishment subscale was found to be independent of the other subscales and the authors themselves noted that personal accomplishment could not be assumed to be the opposite of emotional exhaustion and depersonalization (Maslach et al., 1996). In fact, the authors have noted that the correlations between the personal accomplishment subscale and the other subscales are low (Maslach et al., 1996). This finding has been replicated in independent studies (Önder & Basim, 2008) and researchers have cautioned against the use of cut-off points to classify individuals by burnout scores in cross-national studies due to differences in burnout scores being found in North American and European studies with European participants consistently reporting lower levels of burnout (Schaufeli & van Dierendonck, 1995).

5.2 FUTURE DIRECTIONS

This exploratory study attempted to examine the relation between burnout and occupational well-being in a sample of PSWs working in two nursing homes in Toronto. Further studies using larger samples would help to establish the strength of association between OWB and the three dimensions of burnout. Mixed methods research would help to provide more in-depth information about the potential protective function of occupational repertoires, and the impact of demographic factors such as job-status and additional caregiving responsibilities on the experience of burnout.

Given that the conceptualization of occupational well-being is still in its early stages, a mixed methods approach could be used to explore how participants experience occupational well-being in their everyday lives. Findings from such studies may assist in

confirming and adding to the conceptualization of occupational well-being in an iterative process. How persons experience occupational well-being, the manner in which personal and contextual factors interact to influence the experience of occupational well-being, and the factors that enhance persons' experience of occupational well-being are some of several aspects of this construct that are yet to be explored.

Publication of the OWBQ would enable further research and testing by a peer-review process. Further research by peers would add to the findings of the validation studies, extending the use of the OWBQ and contributing to its further evolution.

Given the concerns raised about the MBI above, a study to examine the MBI using Rasch measurement methodology would establish whether the instrument really needs three subscale scores, or whether, a single linear measure could be generated. Rasch measurement would allow test developers to establish item difficulty. In the case of the MBI, if we accept the hypothesis that emotional exhaustion precedes depersonalization, the items relating to emotional exhaustion would be located lower on the linear continuum than depersonalization, i.e. they would be "easier" than the "harder" depersonalization items, thereby helping to confirm the conceptualization of a temporal model of burnout. Rasch would also help to establish whether personal accomplishment actually belongs to the construct of burnout and how it relates emotional exhaustion and depersonalization.

A Maslach and Leiter study (2008) examining the early predictors of burnout had a significant limitation in the way in which work engagement was conceptualized and assessed. The authors chose to see low burnout scores on the MBI (i.e. low scores on the EE and DP subscales and high scores on the PA subscale) as an indication of work

engagement. One can argue that just because an individual does not endorse feeling burnt out, it does not mean that he or she is engaged with his or her work. Low scores on the MBI, as noted by the developers in the test manual (Maslach et al., 1996), were originally meant to be seen as indicating low burnout, not work engagement, and using the MBI scores as a way to assess work engagement raises questions about the validity of this study's findings. An alternate approach might be to use a measure such as the OWBQ in combination with the MBI and qualitative information from participants to help generate a more comprehensive picture of participants' experience of burnout as well as the well-being they derive from the full repertoire of their occupations and whether high levels of OWB mitigate the transition to burnout of individuals with unstable scores.

A potential participant group for such a study may be exemplified by the At Risk group in the current study. Three out of the five participants in the At Risk group had OWB measures in the Average to High range. It would be enlightening to test this group at a later time, to see if the unstable MBI scores are affected by the high OWB measures of this group, i.e. whether occupational well-being affects the direction of participants' MBI subscale scores. If high OWB measures are found to relate to decreased levels of burnout at the later time of assessment, this would serve to confirm the hypothesis that occupational well-being can serve as a buffer against burnout. This would be an interesting study, particularly since both the nursing homes which participated in the study meet Maslach and Leiter's (2008) criteria for workplace incongruity with staffing cutbacks and increased workloads since the study began. In this context, if occupational well-being is found to serve a protective function, this would have significant implications for future research in interventions to manage and reduce burnout with

greater attention and support being given to individuals' ability to direct and participate in occupations of their own choosing which meet their occupational needs.

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APPENDIX A – STUDY INFORMATION SHEET

Title of Study: Occupational Well-Being and Burnout in Personal Support Workers

Researcher: Sangita Singh, MSc (OT - Post-Professional) Candidate
School of Occupational Therapy, Dalhousie University
Halifax, NS

Thesis Supervisor &

Contact Person: Susan Doble, PhD, Associate Professor
School of Occupational Therapy, Dalhousie University
Halifax, NS B3H 3J5
Email: susan.doble@dal.ca

Introduction: This research study is being conducted as the Researcher's thesis research for her graduate degree through the School of Occupational Therapy, Dalhousie University. Taking part in this study is voluntary and your participation will be kept confidential. You will not be asked to provide your name. If you decide to participate, the information you provide will **not** be shared with your employer or managers. Your work and job at the nursing home will **not** be affected if you decide to not take part in the study. Once you submit the completed questionnaires, you will not be able to withdraw from the study, as the data will be collected anonymously – that is, the researcher will not be able to link the completed questionnaires to individual participants.

The purpose of the study, the benefits, risks, inconvenience or discomfort you might experience are described below. Taking part in this study may not benefit you personally, but the researchers may learn things that will benefit others. If you are interested in participating or have any questions about this study, please contact Sangita Singh at (416) 469-6580, ext. 3314.

Purpose of the study: Persons who work in the helping professions have been identified as being at risk for experiencing burnout. The purpose of this study is to see whether the level of burnout reported by Personal Support Workers (PSWs) employed within nursing homes is related to the level of well-being they derive from their full range of occupations. By occupations we mean everything a person does, including occupations related to taking care of one's self, one's leisure activities, as well as those occupations engaged in with family and friends.

Who can participate in the study? You can participate if you:

- Are a Personal Support Worker (PSW) working in Chester Village or Ina Grafton Gage nursing home, in the City of Toronto.
- Are willing to spend about 20 minutes to complete two questionnaires.

What you will be asked to do? You will be asked to complete a brief demographic data sheet, the 22-item Maslach Burnout Inventory, and the 24-item Occupational Well-Being

Questionnaire. The Maslach Burnout Inventory evaluates whether you are experiencing burnout at work. The Occupational Well-Being Questionnaire measures the level of well-being you derive from your everyday occupations. You will not be asked to provide your name. After you complete these questionnaires, you will place them in the provided envelope and place the envelope in a sealed and marked box in your staff room. It should take no more than 20 minutes to complete these questionnaires. Your participation in the study ends after you have returned the questionnaires.

Compensation: You will not be paid to complete these questionnaires.

Possible Benefits: You will not benefit directly from participating in this study. However, completing the questionnaires may help you to recognize the value and importance some of your occupations have in your life. Completing the Occupational Well-Being Questionnaire may help you to identify the ways in which your daily occupations contribute to your well-being. Your participation will help the researchers to develop a better understanding of how the well-being PSWs derive from their everyday occupations relate to their experience of burnout in paid work. Completing the questionnaires may also help you to identify your potential for burnout and enable you to seek assistance before the concern becomes more significant.

Possible Risks and Discomforts: Although it is unlikely, it is possible that you may feel upset answering some of the questions on the forms. If you do not want to answer a question, you may skip it. It is possible that you may realize that the satisfaction you gain from your everyday occupations is limited. In the event you feel you need assistance in dealing with this situation, you can contact your family physician for advice or contact your Employee Assistance Program, if this is available through your employer.

Confidentiality: There will be no way for the researchers to identify you. Your name will not be put on any of the questionnaires. The questionnaires will not have any information on them that will enable you to be identified personally. All of the completed questionnaires will be stored in a locked filing cabinet in the researcher's office. In accordance with a Dalhousie University policy, five years after the findings of this study have been published, all forms will be destroyed.

How the information will be used: The findings of this study will be used to prepare the principal researcher's master's thesis, and may be published in academic papers or presented in scholarly conferences. Only the totals of the data collected will be shared and no personal information related to you will be shared during any presentation or publications that arise from this research. Only summary findings will be shared with employers. No personal information, including your decision to participate in the study, will be shared with your employers and managers.

As the information is being collected anonymously, the researcher will not be able to provide participants with individual results. Once the study is completed, findings from the study will be presented to the PSWs of participating nursing homes during in-service sessions.

Questions: If you have any questions or comments about this research, you can contact Sangita Singh at (416) 469-6580, ext. 3314.

Problems or Concerns: In the event that you have any difficulties with, or wish to voice any concerns about any aspect of your participation in this study, you can contact Catherine Connors, the Human Research Ethics/Integrity Coordinator at Dalhousie University's Office of Human Research Ethics and Integrity for assistance at (902) 494-1462.

Completing and returning the forms will be considered as your consent to participate in the study.

Participants Needed

Are you a
Personal Support
Worker (PSW)?



YOU ARE INVITED TO PARTICIPATE IN A STUDY EXAMINING THE RELATION BETWEEN PERSONAL SUPPORT WORKERS' SENSE OF WELL-BEING AND WORK EXPERIENCES.

You will be asked to complete two questionnaires. This will take about 20 minutes to do. You will not be asked to provide your name. You will return the completed questionnaires in a sealed envelope and then place the envelope in a sealed box in your staff lounge that will be picked up by the researcher. Your responses will NOT be shared with employers or managers. (See accompanying Information Sheet for details).

Sangita Singh, Psychogeriatric Research Consultant, will provide more information about the study at the end of the educational sessions on (DATE). Study packages will be available for pick up during these sessions.

If you have any questions about this study, please contact Sangita Singh at (416) 469-6580, ext. 3314.

*Sangita Singh, BSc(OT), OTReg(ON), Psychogeriatric Resource Consultant
MSc (OT - Post-Professional) Candidate, Dalhousie University
(416) 469-6580, ext. 3314*

APPENDIX C – INSTRUCTION SHEET

INSTRUCTIONS

1. Thank you for your assistance.
2. Do **NOT** remove the staple or separate the sheets.
3. Do **NOT** put your name on any of the questionnaires.
4. You may complete these questionnaires at your leisure, however please complete them both on the **same** day.
5. You can skip any questions that you do not wish to answer.
6. Please return all completed forms in the sealed envelope that has been provided to you.
7. Please return your completed forms by [DATE].
8. If you have any questions, please contact Sangita Singh at (416) 469-6580, ext. 3314.

THANK YOU FOR YOUR PARTICIPATION.

APPENDIX D – DEMOGRAPHIC DATA FORM FOR QUESTIONNAIRES

DEMOGRAPHIC DATA COLLECTION FORM

My current age (in years): _____

My gender: _____

The length of time I have worked in nursing homes (whether in Canada or elsewhere): _____ (in years)

Current PSW employment status (circle one only):

Full-time

Part-time

Casual

I have major care-giving responsibilities at home (e.g., I care for small children or elderly parents/relatives or someone with significant care needs or I work in another job in which I provide care?) (Circle one response only):

YES

NO

If YES, please describe below:

PLEASE COMPLETE AND RETURN THE FORMS BY: _____ [date]

APPENDIX E – MASLACH BURNOUT INVENTORY

4/17/12

Mail :: NEW ORDERS: Mind Garden: Sales Receipt for Order 21289

Date: Tue, 17 Apr 2012 13:41:10 -0400 [10:41:10 AM PDT]

From: info@mindgarden.com

To: SangitaSingh01@gmail.com

Cc: info@mindgarden.com, bobmost@msn.com, mindgardeninfo@gmail.com, ken@mindgarden.com

Subject: Mind Garden: Sales Receipt for Order 21289

The following order was placed with Mind Garden, Inc. Your order contains at least one paper product. You will be notified via email when we ship that part of your order.

We appreciate your business. If you have any questions about your order please contact us by either replying to this e-mail or calling our office at 1-650-322-6300.

Sales Receipt for Order 21289

Placed on Tuesday, April 17, 2012 at 10:41 am (PDT, UTC-7)

Ship To:

Sangita Singh
SangitaSingh01@gmail.com
416-690-7433

159 Bastedo Avenue
Toronto ON M4C 3N2
CA (Canada)

Bill To:

Sangita Singh
SangitaSingh01@gmail.com
416-690-7433

159 Bastedo Avenue
Toronto ON M4C 3N2
CA (Canada)

Product	Code	Quantity	Price/Each	Total
MBI Manual Format: shipped paper document	MBI-Manual(paper)	1	\$40.00	\$40.00
MBI Reproduction License Human Services Survey Licenses: 100 Format: shipped paper document	MBI-License(paper)	1	\$110.00	\$110.00
			Shipping: FedEx International Economy:	\$61.66
			Sales Tax:	\$0.00
			Order Total:	\$211.66

Payment method: Visa

This order has been paid in full.

Our privacy policy is available here .

Shipping options are dated from when Mind Garden SHIPS your product not from when you PLACE your order.

Returns and Exchanges:

If a shipment is refused, the customer is responsible for the return shipping costs. This amount will be deducted from the credit.

Manuals or Workbooks which we print and ship to you may be returned within thirty days of purchase. To receive credit (minus shipping charges), products must be in resaleable condition and accompanied by a copy of the original sales receipt.

Returns must be sent to Mind Garden by certified mail or other traceable method.

Prior to returning a manual, please contact Mind Garden via phone or email for return authorization.

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up to a quantity of 100 within one year of April 18, 2012.

MBI-Human Services Survey

Christina Maslach & Susan E. Jackson

*The purpose of this survey is to discover how various persons
in the human services, or helping professionals view their job
and the people with whom they work closely.*

Because persons in a wide variety of occupations will answer this survey, it uses the term *recipients* to refer to the people for whom you provide your service, care, treatment, or instruction. When answering this survey please think of these people as recipients of the service you provide, even though you may use another term in your work.

Instructions: On the following pages 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 the number "0" (zero) in the space before the statement. If you have had this feeling, indicate *how often* you feel it by writing the number (from 1 to 6) that best describes how frequently you feel that way. An example is shown below.

Example:

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

How Often
0-6

Statement:

1. _____ I feel depressed at work.

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

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up to a quantity of 100 within one year of April 18, 2012.

For Dissertation and Thesis Appendices:

You cannot include an entire instrument in your thesis or dissertation, however you can use up to three sample items. Academic committees understand the requirements of copyright and are satisfied with sample items for appendices and tables. For customers needing permission to reproduce three sample items in a proposal, thesis, or dissertation the following page includes the permission form and reference information needed to satisfy the requirements of an academic committee.

Putting Mind Garden Instruments on the Web:

If your research uses a Web form, you will need to meet Mind Garden's requirements by following the procedure described at <http://www.mindgarden.com/how.htm#instrumentweb>.

All Other Special Reproductions:

For any other special purposes requiring permissions for reproduction of this instrument, please contact info@mindgarden.com.

Sample items from the Maslach Burnout Inventory

For rating scale, please see Appendix Db above.

How often
0-6

Statements:

I feel emotionally drained from my work.

I feel used up at the end of the workday.

I feel frustrated at my job.

APPENDIX F – OCCUPATIONAL WELL-BEING QUESTIONNAIRE

OCCUPATIONAL WELL-BEING QUESTIONNAIRE

Read each item very carefully. There are no right or wrong answers. Use a highlighting pen to mark the phrase or circle the phrase (i.e., *rarely, sometimes, often, or always*) that **best describes your experience**. We expect that the phrases you choose will vary from item to item.

Item #	Item	Examiner Use Only
1	I [<i>rarely, sometimes, often, always</i>] spend my time doing things that I really want to do.	
2	I [<i>rarely, sometimes, often, always</i>] set clear priorities about how I will use my time.	
3	I [<i>rarely, sometimes, often, always</i>] look forward to how my day will unfold.	
4	I [<i>rarely, sometimes, often, always</i>] do things that are consistent with my values.	
5	I [<i>rarely, sometimes, often, always</i>] do things that give me great enjoyment.	
6	I [<i>rarely, sometimes, often, always</i>] try hard when I do things.	
7	I [<i>rarely, sometimes, often, always</i>] know that others appreciate my skills and efforts.	
8	I [<i>rarely, sometimes, often, always</i>] do things that make me feel relaxed and content.	
9	I [<i>rarely, sometimes, often, always</i>] reflect on my goals and accomplishments.	
10	I [<i>rarely, sometimes, often, always</i>] do things that have a positive effect on others.	
11	I [<i>rarely, sometimes, often, always</i>] complete what needs to be done.	
12	I [<i>rarely, sometimes, often, always</i>] have enough to do to fill my days.	
13	I [<i>rarely, sometimes, often, always</i>] feel good when I do fun, spur-of-the-moment things.	
14	I [<i>rarely, sometimes, often, always</i>] use my time effectively.	

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Item #	Item	For Examiner Use Only
15	I [<i>rarely, sometimes, often, always</i>] enjoy the time I spend with others.	
16	I [<i>rarely, sometimes, often, always</i>] do whatever it takes to achieve my goals and desires.	
17	I [<i>rarely, sometimes, often, always</i>] do things that support my health.	
18	I [<i>rarely, sometimes, often, always</i>] find others to do things with me.	
19	I [<i>rarely, sometimes, often, always</i>] do things that offer me a challenge.	
20	I [<i>rarely, sometimes, often, always</i>] do things that make me feel energized and renewed.	
21	My efforts [<i>rarely, sometimes, often, always</i>] make me feel good.	
22	I [<i>rarely, sometimes, often, always</i>] do those things that are really important to me.	
23	I [<i>rarely, sometimes, often, always</i>] feel confident in my abilities when I do things.	
24	I [<i>rarely, sometimes, often, always</i>] do things so I can spend time with others.	

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Reminder Notice

Did you
participate in
the PSW
study?



Please make sure you return your
completed questionnaires in the sealed
box in the staff room by **(Date)**.

THANK YOU!!

*Sangita Singh, BSc(OT), OTReg(ON), Psychogeriatric Resource Consultant
M.Sc. (OT - Post-Professional) Candidate, Dalhousie University
(416) 469-6580, ext. 3314*

APPENDIX H – LETTER OF SUPPORT



3555 Danforth Avenue, Toronto, Ontario M1L 1E3 Tel: 416-466-2173 Fax: 416-466-6781 www.chestervillage.ca

May 14, 2012

Sangita Singh, B.Sc. (OT), M.Sc.
OT - Post-Professional Candidate
School of Occupational Therapy
Dalhousie University, Halifax,
NS B3H 3J5

Re: Occupational Well-Being and Burnout in Personal Support Workers working in nursing homes.

We agree to assist Sangita Singh, a graduate student in occupational therapy, in the process of recruiting participants by allowing her to approach Personal Support Workers in our nursing home, for her proposed research project conducted under the supervision of Dr. Susan Doble. This consent is contingent upon the project receiving approval from the Dalhousie University Health Sciences Research Ethics Board. The extent of our involvement in the research project will be limited to allowing Sangita Singh to approach the PSWs working in our organization to obtain their informed and voluntary consent to participate in the study and allowing her to place sealed boxes in the staff rooms to collect completed questionnaires.

In return for the above mentioned support, we will expect a summary of the findings generated by Sangita Singh's thesis work, written in lay-language, by the completion of her studies forecasted for July 2013. We are not expected to incur any costs associated with the printing and distribution of any of the study materials.

Sincerely yours,

Chief Executive Officer

Director of Care

OPERATED BY THE BROADVIEW FOUNDATION: TAXATION REGISTRATION NO. 11881 9317 RR0001

MEMBER OF:

DVBA

OANHSS

Accredited By:

carf INTERNATIONAL

APPENDIX I – LETTER OF SUPPORT

Letter of support

Date:

To: Sangita Singh, B.Sc. (OT), M.Sc. (OT - Post-Professional Candidate)
School of Occupational Therapy, Dalhousie University, Halifax, NS B3H 3J5

Re: Occupational Well-Being and Burnout in Personal Support Workers working in nursing homes.

I/We agree to assist Sangita Singh, a graduate student in occupational therapy, in the process of recruiting participants by allowing her to approach Personal Support Workers in our nursing home, for her proposed research project conducted under the supervision of Dr. Susan Doble. This consent is contingent upon the project receiving approval from the Dalhousie University Health Sciences Research Ethics Board. The extent of our involvement in the research project will be limited to allowing Sangita Singh to approach the PSWs working in our organization to obtain their informed and voluntary consent to participate in the study and allowing her to place sealed boxes in the staff rooms to collect completed questionnaires.

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Director of Care
Ina Grafton Gage Home
40 Bell Estate Rd
Scarborough, Ontario
M1L 0E2
(E) erobinson@iggh.org
(P) 416-422-4890 ext 223
(F) 416-422-1613

APPENDIX J – PARTICIPANT CATEGORIZATION TABLES

Number of Participants by Categorized Levels of Occupational Well-Being and Burnout Categories

	Occupational Well-Being Categories				
	Very High ≥3.26 n=1	High 2.13 – 3.25 n=1	Average -0.14 – 2.12 n=15	Low -0.15 - -1.27 n=3	Very Low ≤-1.28 n=0
Number experiencing burnout (n=5)	0	0	2	3	0
Number at risk (n=5)	0	0	5	0	0
Number no burnout (n=10)	1	1	8	0	0

OWBQ Measures, Mean Years of Work Experience, Percentage Employed full-time and Percentage with other Care Responsibilities by Burnout Categorizations
Measures and categorical variables for the three Burnout categorizations

	Groups		
	Burnout Group (n=5)	At risk (n=5)	No burnout (n=10)
Mean OWB in logits (<i>SD</i>); Range	0.08(0.90); 1.24-1.23	0.93(0.81); 2.04-0.04	1.55(1.02); 3.69-0.21
Mean years of work experience (n=19)	14.4	17 (n=4)	11.5
Percentage employed full-time	100%	80%	50%
Percentage with other care responsibilities	80%	20%	20%