

WOMEN'S HEALTH, OCCUPATIONAL, AND LIFE EXPERIENCES:

A LIFE-CYCLE PERSPECTIVE

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ABSTRACT

Almost 40% of the Canadian workforce shows signs of progressive burnout. For a variety of reasons, stress within the workplace appears to be increasing. The popular press and academic journals suggest that chronic job stress, or burnout, will be the most significant workplace issue in the new millennium. Although both men and women suffer from stress and burnout, it appears that women are at a greater risk than men.

Unfortunately, research on the relationship between women's stress and their health has not kept pace with the popularization of the problem. We could understand this relationship better if we had more information about women, their health history (including phases of development over the life span), and occupational history.

Relatedly, as the baby-boomer generation ages to mid-life, there appears to be a sea change on the horizon: one in which women are demanding answers and knowledge about the process of menopause and its effect on their lives, inside and outside the home.

To fill this void, the proposed research will address the life change of women, and specifically, how their stages of development and occupational and health histories relate to the experience of burnout.

Yield and overcome;
Bend and be straight;
Empty and be full;
Wear out and be new;
Have little and gain;
Have much and be confused.

Therefore wise men embrace the one
And set an example to all.
Not putting on a display,
They shine forth.
Not justifying themselves,
They are distinguished.
Not boasting,
They receive recognition.
Not bragging,
They never falter.
They do not quarrel,
So no one quarrels with them.
Therefore the ancients say,
“Yield and overcome.”
Is that an empty saying?
Be really whole,
And all things will come to you.

Lao-Tzu (604-531 B.C.)

(Cited in A. Stoddard [1995], *The art of the possible*. New York, NY: Avon. p. xv).

Lao-Tzu writings were the foundations of Taoism.

**To my family:
who supported me with love, understanding, and encouragement**

and

**to the memory of my Mother who chose to die just as she lived—with courage, dignity and
a caring attitude toward others. Mom, you are my daily reminder of all the goodness in
the world. Bless you.**

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Prologue

The events that led to this study unfolded in a serendipitous manner. I brought to this research endeavor 22 years of nursing experience in management and staff nurse positions, both in hospital-and community-based practices, and in rural and urban settings. To this end, over the years, I became increasingly frustrated with the way conventional medicine assesses health in general, but specifically, the manner in which women's health concerns are addressed. For instance, when individuals seek medical attention for a specific health concern, usually just one organ or specific body system is assessed. As well, conventional medicine—to its detriment albeit financial profit—is noted for creating health-care provider dependence. For years, now, I have wanted to find an alternative to the biomedical model—a system that would foster autonomy and self-reliance.

I believe that it is through the advancement of one's education that valuable insights can be achieved, both personally and professionally. So, upon my return to university, I chose to complete an independent study in the area of *biofeedback* to initiate my exploration of an alternative health care modality that promotes short-term reliance on a health care provider whereby the individual is able to manage his/her own care with confidence and independence. While at a biofeedback workshop in San Francisco I talked with a doctoral student who described her study involving the treatment of menopausal ailments using biofeedback techniques. Upon my return from the workshop I pursued with enthusiasm and interest the menopause literature because I too was interested in

some area of women's health pertaining to biofeedback. My persistent searches aided the delightful discovery of a new phenomenon in the current literature concerning a *feminine life-cycle perspective*.

Unfortunately, our social system views life-cycle transitional stages as pathological states. However, it was my intention to develop a study that looked at menopausal stages in a positive light—negating the current societal view that menopausal women are *non-productive, hormonally challenged beings*. Nurses are an aging occupational group, approaching menopause themselves, so the fit and timing of my study was ideal. My results support the findings of other life-cycle authors and is the only study of its kind that looks at life-cycle, health, job involvement, burnout, and hardiness using both survey and interview data collection methods.

After the decision was made to study nurses' lives, I decided that I would take the opportunity to ask practice-based questions that were relevant to my concerns. I believe the questions that surfaced were a direct result of the recollection of the numerous conversations with my nursing colleagues, involving discussions about medical ailments, of all sorts, and their concern with burnout. After listening to so many similar anecdotal stories, I wanted to explore the evidence on the prevalence of burnout within the nursing profession. I also wanted to understand why some individuals coped better than others. Hence, Professor Boudreau suggested the addition of two measures within the WHOLE Profile, the Job Involvement Scale and the Personal Views Survey relating to personality hardiness. So with the recollection of Professor Thorpe's teaching to develop research

questions from practice-based concerns I pursued my research with passion. This thesis before you offers a complete account of the research story as it unfolded during the last 18 months.

CHAPTER I

Women's Health, Occupational, and Life Experiences:

A Life-Cycle Perspective

Background

Humanity's greatest potential for growth and wisdom comes from embracing change and all its lessons. The natural cycles of life bring about change and the potential for growth to all living organisms. Both men and women respond to a variety of cyclical influences, including the calendar, the seasons, and the 24-hour rhythm of the day. Moreover, women have added opportunities for growth and development as they are guided throughout the menopausal life-cycle by hormonal cycles that occur from menarche to menopause and beyond. Menarche is defined as the onset of the menses while menopause refers to the cessation of menses.

With the increasing trend of women in paid employment and the expansion of women's roles within society, as well as the recent phenomenon of women living one-third of their lives after menopause, more research is needed in this area. Essentially, insights into how work and health affect each other are needed. To this end, a study promoting a menopausal life-cycle perspective of women in the workplace was developed. Of particular interest was the need to understand occupational and life experiences of women at various life-cycle stages (i.e., pre-, peri-, and post-menopausal). Specific information was acquired from women in the nursing profession, in a variety of positions, and at various stages of their lives regarding their health, burnout, personality hardiness, and job involvement status.

According to Northrup (1998), “We cannot hope to reclaim our bodily wisdom and inherent ability to create health without first understanding the influence of our society on how we think about and care for our bodies” (p. 3). Schaeff (1985) asserts that the way our society behaves is harmful to women and both genders participate fully in patriarchy. Unfortunately, some perspectives based on an analysis of society as a patriarchy are associated with blaming men; however, as a society, we have to move past blame to resolve the inertia in which our society has become immersed and move away from a system that harms women (Schaeff & Fassel, 1988).

Moreover, information in the current literature suggests that disease manifestation is a byproduct of our thought processes, referred to as the mind-body connection. We are creating health consequences that directly affect our physiology (Kabit-Zinn, 1993). This same author states that “stress is the response to the demands placed on your body and mind” (p. 121). *Eustress*, a term coined by Selye (1956), denotes positive stress or stress that creates productivity in our lives. *Distress*, according to Selye (1956), refers to the negative stress in our lives. On balance, there appears to be more long-term bad stress, versus good stress, across the adult life span. Chronic on-the-job stress, (referred to as burnout in this thesis) is a pathological condition involving our negative thought patterns that, if left unchecked, may lead to illness.

Burnout is described in both the popular and academic literatures as reaching epidemic proportions creating difficulties in achieving optimal health. A comprehensive book on global burnout reports an astounding fact—almost 40% of the Canadian workforce shows signs of progressive burnout (Golembiewski, Boudreau, Munzenrider, & Luo, 1996).

Reinforcing this view, Borysenko (1996) reports that 75% of all visits to physicians are related to anxiety and stress.

Similar results from a Health Promotion Survey from Health and Welfare Canada (Adams, 1993) indicate that Canadians' stress levels are on the rise. Sixty percent of Canadians surveyed in 1990 (versus 48% in 1985) reported their lives were very or somewhat stressful. In 1994, the Conference Board of Canada estimated that stress-related problems cost Canadian businesses 12 billion dollars a year (Fischer, 1994). Moreover, the three leading causes of death in North America, heart disease, cancer, and stroke, are all preventable with stress being singled out as the common denominator in all of these killer diseases (Business Specialties, 1995).

Building on this discussion of the relationship between health and stress, intervention strategies need to accommodate the shift in thinking that has transpired in our society challenging our views about women's well being in personal and occupational life experiences. Borysenko (1996) states that this shift toward a positive view of women's bodies is evolving because the Post World War II, Baby-Boomer generation is fostering a world view that interprets one's biology, spirituality, and intellect through a life-cycle perspective. Borysenko (1996) also describes women from the Boomer generation as those females who were born after World War II (between the years 1946 to 1964). These women were the last generation of women to be raised in the tradition where women were cast as appendages and helpmates of men and who conformed to a single role—that of homemaker.

Purpose of the Study

The need for advancing knowledge and improving the health of women provided the impetus for this study with the following major purpose identified:

To describe the relationships among health, job involvement, burnout, and personality hardiness, in relation to women's occupational and personal life experiences throughout the menopausal life-cycle.

Research Questions and Hypotheses

This research was guided by two research questions, one for the survey component, and one for the interview component.

Survey Research Question

The research question that provided direction for the survey component was: How does a randomly selected sample of registered nurses in a western Canadian province describe their professional and personal life experiences, in relation to health, job involvement, burnout, and hardiness at various stages throughout the menopausal life-cycle?

Hypotheses

Specific hypotheses were stated as follows:

1. Nurses who rate high on job involvement will experience lower phases of burnout.
2. Nurses with increased personality hardiness will experience lower phases of burnout.
3. Nurses with increased health *ailments* will experience more advanced burnout levels.
4. There will be differences in the experiences of burnout as it relates to various menopausal life-cycle stages. The specific directionality of these differences remains

uncertain.

Interview Research Question

The research question guiding the interviews was: How does a purposefully selected sample of registered nurses describe the meaning of their occupational and life experiences, in particular, burnout, from the perspective of their current menopausal life-cycle stage?

Significance of the Study

This research has both theoretical and practical significance for a host of stakeholders including the participants, their families, health providers, academics, policy makers, managers, administrators, and researchers. I believe it is possible to begin the process of awakening the inner voice of nurses through a single research project such as this one.

Theoretically, both survey and interview data collected from this study have the potential to further the understanding of the relationships among health, job involvement, burnout, and hardiness from a menopausal life-cycle perspective. Accordingly, the potential exists to narrow the gap in the current literatures on life-cycle stages, burnout, and gender. In particular, the present study may suggest that the Phase Model approach to burnout should include issues of gender (i.e., menopausal life-cycle stages). Empirically, the focus is narrow and is based on describing and explaining personal and professional experiences as they relate to registered nurses in a western Canadian province. For instance, this study affords an opportunity to further “test” the Phase Model with individuals in a specific professional discipline (i.e., nursing). For example, nurses responding to this study may provide information about how various menopausal life-

cycle stages affect, if at all, occupational roles and responsibilities in nursing.

By virtue of their work, nurses have an ongoing relationship with patients, colleagues, and the public in various stages of illness and health at all stages of the life-cycle. From a practical perspective, then, nurses are probably in the best position to offer an enlightened awareness of the myths and negativity surrounding women's health and menopausal life-stage transitions. In the end this research may provide the impetus for both workers and administrators to be prevention- and solution-oriented toward improving the current workplace situation. To sum up, the overall significance of this research lies in its attempts to enhance our understanding such that working relations can lead to healthier environments whether inside or outside the home.

Assumptions

A number of assumptions were relevant to this study:

1. Nurses were the best sources of data to explain and describe their individual health history, especially their life-cycle stages. The profession of nursing is predominantly female, which allows them to speak to their feminine life-cycle experiences, as well as their occupational life experiences.
2. Insights into their occupational and life-cycle experiences could be gained by asking nurses to describe their thoughts, values, life, and occupational experiences. Nursing is a diverse profession comprising practitioners, educators, and managers, and at least one of the participants who agreed to be interviewed represented each area of nursing practice.
3. Participants' perceptions were accurate expressions of their thoughts, beliefs, values, feelings, and experiences. Derogatis and Coons (1993) state that self-reported perceptions

from an individual are very valuable because the information is derived *from* that person and *not* a third party's interpretation and *not* an observation of the individual.

4. Life-cycle experiences to some extent were unique for, or specific to, each participant.

It was anticipated that insights into the meaning that nurses give to their occupational and menopausal life-cycle experiences would emerge through their individual reflections and stories.

5. The researcher, in interacting with the participants, was an appropriate instrument to collect interview data.

Organization of Thesis

This thesis includes five separate chapters. The first chapter presents the statement of the problem, purpose and significance of the study, and research questions and hypotheses. Chapter II follows with a literature review, while Chapter III features the methodology used in this thesis. Chapter IV reports on the survey and interview results and Chapter V offers a discussion and interpretation of the findings. An epilogue completes the thesis.

CHAPTER II

Literature Review

This review of the literature contains a summary of the topics that provide the conceptual basis for this thesis on women's health, occupational, and life experiences. A life-cycle perspective, chosen for this women-centred research, challenges the status quo and fosters a healthy and holistic view of women at all stages of their work lives. A historical perspective of the prevailing situation, or *Zeitgeist*, of our times addressing patriarchy and a related focus on the medicalization of women's bodies initiates the discussion in this chapter. In part, this explanation includes information inviting a new wave of change regarding women's biology. Selected literature topics also offered for review in this Chapter include: menopause as developmental life-cycle stage, menopausal life-cycle and occupational health, and a menopausal life-cycle perspective and treatment of the assumptions underlying the life-cycle approach.

Prevailing Zeitgeist of Our Times

The negativity associated with the prevailing *Zeitgeist* of our times begins the discussion, with a specific focus on patriarchy and medicalization of the body. Fortunately, signs of a more positive change surface from these initial discussions.

Patriarchy—A Dysfunctional System

Patriarchy is associated with the myth of unquestionable authority of men and fathers. Generations of male dominance reinforced the myth that males were superior to females. Schaefer and Fassel (1988) describe the prevalence of patriarchy within society in general and in the major institutions in particular, as a dysfunctional, *addictive* system. Hoffman

(1995) states that rather than pursue the study and treatment of male problems such as aggression, fear of intimacy, and unrelatedness, the biomedical model of health, a major institution within society, has focused on 'pathologies' within women. Schaeff and Fassel (1988) assert that addictive systems have been described as societies that are either preparing for war or recovering from war. Such societies elevate the values of destruction and violence over values of nurturing and peace. The addictive system fears emotional responses and highly values the control of emotions because it is so out of touch with them. An addiction serves to provide numbness so that one is out of touch with what one knows and feels. Schaeff and Fassel (1988) conclude that today's patriarchal society and, many organizations within society, foster dysfunction. They focus part of their attention on the dysfunction of one major institution in particular—the biomedical model of health.

Schaeff and Fassel (1988) claim that western medicine views the human body as a war zone rather than a natural system that is homeostatically designed toward health. Supporting their claim is the number of military metaphors that run rampant through the language of Western medical care (i.e., the disease or tumor is "the enemy" or "killer" T cells). Also, the preference for drugs and surgery as treatments is part of the aggressive patriarchal or addictive approach to disease. Entrenched beliefs exist that the disease-care system is supposed to support one's health and that medical doctors and medical science is omnipotent. The addictive system has a history of socializing health-care practitioners as well as women to believe that normal bodily functions such as menstruation, menopause, and childbirth are to be viewed as medical conditions requiring treatment and management.

Medicalization of Women's Bodies

Female bodies, long associated with cycles and subject to the flow of natural rhythms, are seen as especially emotional and in need of management. Northrup (1998) states: "Just as women's bodies have become pathologized and medicalized by the patriarchal, addictive system, so too has every function unique to women, menopause included" (p. 432). *Medicalization* is described as the process of labeling conditions as diseases or disorders as a basis for providing medical treatment of some kind (Conrad, 1992). Northrup (1998) reiterates in her book, *Women's Bodies, Women's Wisdom*, that the only ages when female endocrine processes escape potential *management* are the years *before* the age of menarche and *after* the age of 70 years. She explains that these years for girls and women are even more devalued in our culture and she believes that otherwise society would have figured out a way to manage them too. Martin (1987) asserts that women's bodies in menopause are commonly described in terms of "production" or "failed production." Martin points out further that since menopausal women are no longer using their energy in childbearing, their systems are described in our society in terms of functional failure or decline.

According to Hoffman (1995), cycles are a real part of women's lives yet women struggle to make their cycles and even themselves invisible to the world due to societal expectations. In doing so, women are unconsciously reproducing the bias that women's natural functions make them sick, crazy, or are an embarrassment. Prior (1992), an endocrinologist and researcher, concurs that our culture, including the medical profession, tends to blame women's reproductive systems for disease, making menopause a point in

time rather than a process, and labeling it a deficiency disease. She believes this perspective is a reflection of prejudicial and nonscientific thinking.

Lee, Hanley, and Hopkins (1999) note that multinational drug companies and other participating medical professionals started the promotion of hormone therapy for healthy menopausal women as a means of preventing heart disease and osteoporosis. Instead of focusing their prevention strategies on natural hormones they moved quickly to develop synthetic drugs that could be patented and, therefore, create profits for themselves—at the expense of women’s health. Some authors go even further and challenge the estrogen studies on which pharmaceutical companies base their marketing ploys because of methodological flaws (Kamen, 1997; Lee, Hanley, & Hopkins, 1999; Lee & Hopkins, 1996). Only recently, after an appalling history of synthetic hormone drug use, are the estrogen studies being more closely scrutinized and evaluated (Lee & Hopkins, 1996).

Further evidence for the medicalization of women’s bodies can be found in the dysfunctional attitudes that exist within the medical community (e.g., medical doctors). For instance, premenstrual syndrome (PMS) is defined as a wide range of physical and emotional symptoms that precede (usually by seven to ten days) the menstrual period (O’Leary Cobb, 1993). However, in 1987, PMS, was included for the first time and remains today a diagnostic category in the *Diagnostic and Statistical Manual of Mental Disorders*, listed as *premenstrual dysphoric disorder* (American Psychiatric Association, 1994, pp. 715-716). Nonetheless, the entire burden must not be ascribed to the medical community alone. They do not work in isolation of other social groups. Indeed, other institutions such as the school, family, and the church could all be described as conspiring

partners in the negative perceptions of women and their health.

Consider Borysenko's (1996) statement that "until recently, almost all studies excluded women [from psychological research] because menstrual cycling might produce mood or perceptual changes that would complicate data" (p. 8). Many religions throughout history believe that the menstrual cycle is associated with shame and degradation. Throughout western history menstruating women were thought to be unclean and this perspective has been passed down to generations of women. Women have been taught that they are more physically vulnerable; they can't swim or bathe or wash their hair when menstruating even though there is no scientific basis for these beliefs. For generations, these and other myths about menstruation have served only to keep women fearful of a natural bodily process (Northrup, 1998). Northrup also professes that, until recently, studies about diseases and their treatments often did not include women for many of the "reasons" described. Since women have been included in studies, we are discovering such pertinent information like the protective properties that estrogen has on the heart (Borysenko, 1996).

"Menopausal and post-menopausal women clearly have health needs that are different from those of younger women, and different from males of the same age range" (Hill, 1996, p. 113). The need to study women's health with respect to their various menopausal life-cycle stages is all too obvious.

Using 50 as a proxy for menopause, about 25 million women pass through menopause each year, and we estimate in 1990 there were 467 million post-menopausal women in the world, with an average age of about 60 years. By 2030, the world population of menopausal and post-menopausal women is projected to be 1.2 billion, with 47 million new entrants each year. (Hill, 1996, p. 113)

With an overall life expectancy for women rapidly approaching 80-plus years in North

America, women can expect to live nearly half their adult lives for 35 or more years following menopause (Northrup, 1998). Northrup further explains that the years surrounding menopause constitute the stage of a woman's life known as the climacteric or more commonly, the *change of life*. Mid-life years span between the ages of 45 to 65 years. In our culture, women are most valued for their biology during the reproductive stage lasting up to 30 years maximum (Northrup, 1998).

Fortunately, the negativity associated with menopause, in both the professional and popular literature, is currently undergoing a sea change as women from the Baby-Boomer generation now enter menopause. Northrup (1998) claims that since the Baby Boomers are approximately five times more numerous than preceding generations, the climacteric experience will never be the same when the Boomers are finished with it. Women are becoming more outspoken on issues of health and their well-being in their workplaces—both inside and outside the home. For instance, Boomer women are responsible for changing the definition of health from an *absence of disease* to include a holistic perspective of the individual (Northrup, 1998). Changes are also occurring because of women's awareness and opposition to a pathological trend in our western culture to *medicalize* the ordinary biological events of a woman's life such as pregnancy and menopause. A healing perspective of health is offered by new wave health experts that view various medical ailments, even endometriosis and pre-menstrual syndrome (PMS) as not simply biochemical imbalances. Rather, these ailments are signs that women are out of touch with the cycles and rhythms of their bodies, their feelings, and their souls (Lee, Hanley, & Hopkins, 1999).

Notwithstanding Northrup's (1998) writings and several other noteworthy contributions (i.e., Borysenko, 1996; Lee, Hanley, & Hopkins, 1999; Levinson, 1996), there has been a paucity of attempts to delineate the menopausal change within women utilizing a life-cycle perspective. Fundamental to the development of any life-cycle perspective is the growing number of authors writing on the topic of menopause (i.e., Lee, Hanley, & Hopkins, 1999; Northrup, 1998; O'Leary Cobb, 1993; Sheehy, 1995).

Inviting a New Wave of Change—A Positive View of Women

A modern-day perspective of the menstrual cycle is emerging with positive reviews from women because it is an enlightened portrayal of women's cyclical nature. According to Northrup (1998), the menstrual cycle is a time for tuning into our cyclic nature and celebrating it as a source of power. She states that the macro-cosmic cycles of nature, such as the ebb and flow of the tides and the changes of the seasons, are reflected on a smaller scale in the menstrual cycle of the individual body. This same author also reports:

studies have shown that peak rates of conception and probably ovulation appear to occur at the full moon or the day before. During the new moon, ovulation and conception rates are decreased overall, and an increased number of women start their menstrual bleeding. Scientific research has documented that the moon rules the flow of fluids (ocean tides as well as individual body fluids) and affects the unconscious minds and dreams. (Northrup, 1998, p. 104)

She also states that the timing of the menstrual cycle, the fertility cycle, and giving birth follow the moon-dominated tides of the ocean. Borysenko (1996) argues that environmental cues such as light, the moon, and the tides play a role in regulating women's menstrual cycles and fertility. Both Borysenko (1996) and Northrup (1998) describe how women receive and process information differently at various times

throughout their menstrual cycles. For instance, these authors allege that many women find that they are at their peak of expression and have lots of energy at the onset of their cycle until ovulation. At mid-cycle women seem to be receptive to others and new ideas (Northrup, 1998, p. 104). Pre-menstrually, or after ovulation, women may feel more inward or reflective. The moon, too, has a period of time when it is covered with darkness and then, at the onset of a new moon, it is visible to us again. Finally, Northrup (1998) reports that women who live together in natural settings tend to ovulate at the same time of the full moon with menses and self-reflection at the dark of the moon.

The establishment of truths and accurate scientific information are replacing the myths that have surrounded menstruation in the past. Women today have created an enlightened view of women's cycles, which is evidence of women's healing. Current thinking is creating a sensitivity toward the complexity of their modern lives (Borysenko, 1996). More books on menopause have been written by leading feminists such as Germaine Greer (1992) and by doctors and other researchers than on any other topic in the field of women's health (Northrup, 1998). Canadian author, Janine O'Leary Cobb (1988, 1993), founder and the first editor of the Canadian menopausal newsletter, *A Friend Indeed*, and author of *Understanding Menopause*, presents the message that women's concerns need to be taken seriously. A menopausal life-cycle perspective is a holistic approach that views women's lives differently, meaning with a positive attitude, today and into the future.

Seasons of a Woman's Life

Women in our society are deemed responsible for the family including family

relationships in need of repair or revitalization, in addition to the care of children and elderly parents. However, women in mid-life are re-evaluating this role as care giver in order to move past the boundaries of procreation, nurturing, and child-rearing capabilities. Levinson (1996) offers biographic interviewing as the source of obtaining information from 45 women—15 homemakers and 30 women with corporate or academic careers for his book, *The Seasons of a Woman's Life*. He identified two internalized figures within women's psyches: the traditional homemaker figure was one archetypal image, the anti-traditional figure the other. He describes the internal struggles between these two archetypes as warring voices that steer women into reconsidering their life structures, including work and marriage. He names the specific concept *gender splitting*, which describes the splitting between the domestic sphere and the public occupational sphere; female homemaker and the male provisioner within a traditional marriage enterprise; women's work and men's work, feminine and masculine within self. Levinson states, "gender splitting is encouraged by the existence of a patriarchal society in which women are generally subordinate to men, and the splitting helps to maintain society" (p. 414).

Levinson (1996) claims the middle years are devoted to healing and establishing balance and seeking authenticity in relationships. He states that women's core essence is defined by *relationality*—one's concept of self-in-relation. He also describes mid-life women as being in *transition*. It is his view that a transitional period involves three main developmental tasks: termination of the existing life structure, individuation, and, initiation of a new structure. However, he explains that the three tasks may be interwoven throughout a transitional period and the individual may not follow these tasks in

consecutive order or in a necessarily smooth progression. Thus, he describes a transition as both an ending and a beginning. As a beginning, there is an exploring of new possibilities and altering the existing relationships and searching for aspects of self and world where new relationships might evolve. At the end of a transitional stage it is time to make more long-term choices and give these choices meaning and commitment to start building a life structure around them. These choices initiate the beginning of the next structure building period. He believes that *transition* is a process of change involving considerable separation and loss that eventually forms a bridge to the next transitional stage.

Menopause as a Life-Cycle Developmental Stage

Currently, there is a growing trend in the popular and academic literature supporting the study of women's lives through an adult life-cycle perspective. Attempts to view menopause in terms of life-cycle stages can be traced to some of the earliest writings on development and social change (e.g., Giambattista Vico, 1668-1744) to even more recent times (cited in Boudreau, 1993). Two categories of models have been described in the literature—adult and occupational (Boudreau, 1993). The occupational models offered by Super (1957), Dalton, Thompson, and Price (1977), and Schein (1987) emphasize the time involving work-related experiences whereas adult models (e.g., Belenky, Clinchy, Goldberger, & Tarule, 1986; Gould, 1978; Kegan, 1982) deal broadly with growth and experiences over the entire life-cycle. Wallis (1992) believes that instead of grouping information of patients by organ systems, it would be more appropriate to look at life stages and how to maintain health in each stage (cited in Feldman, 1997, p. 154). In the

same article, Dr. Pinn (1997) agrees with this holistic approach and encourages the research establishment to address gender differences in studies by taking into account hormonal variation of the participants (e.g., pre- or post-menopausal or hormone therapy).

Three contributors deserve recognition when discussing the emergence of menopause as a life-cycle developmental perspective. For one, Gail Sheehy (1995) contributed immensely to the conceptualization of the life-cycle. Her groundbreaking, in-depth work consists of both interviews and surveys, including longitudinal studies that provide a rich source for gaining a well-rounded perspective on the study of the mid-life years. Several surveys were distributed, including returns from 687 women and 110 men who supplied a larger context for group interviews from the *Professional Women's and Men's Survey*; 630 women and 394 men returned the *Family Circle Survey* and an astounding 6,000 women responded to the *New Woman Survey*. Those responding to her surveys and interviews were typically middle-class Caucasians in America. Sheehy (1995) acknowledges that none of her research or the major longitudinal studies cited in her book include people who are struggling for survival, illiterate persons, seriously ill persons, or those at the poverty level. Sheehy (1995) posits that women are held responsible for the family including family relationships, in addition to the care of children and elderly parents. Women have always had these demands; however, today, women approaching menopause are re-evaluating this role as care givers in order to move past the boundaries of procreation, nurturing, and child-rearing capabilities. It is apparent that each time the Baby-Boomer generation arrives at a new stage in the life-cycle, they have redefined and changed it.

Borysenko (1996), a second leading author expanding the study of women through a life-cycle concept, offers a very intriguing view of the feminine life-cycle as specific periods of time in the life span of a female separated into seven-year segments. She extends the conceptualization of the life-cycle to encompass one's spirituality; a familiar concept in Northrup's (1998) book and Sheehy's (1995) writings. Borysenko (1996) explains that the stories in her book were drawn from years of clinical experience. She addresses the study of the feminine life-cycle by first asking questions like: "How do the physiological changes we undergo in a monthly cycle during our reproductive years, and the continuing changes that occur after menopause, serve our evolution?", and "What are the larger, cosmic cycles that entrain and lock us into these powerful rhythms?" (p. 4). She refers to the themes of seven-year cycles in sources as varied as the works of C. G. Jung, the Torah, the New Testament, the plays of Shakespeare, American folk wisdom, Native American tradition, Buddhist lore, the philosophy of the Greek mathematician Pythagoras, and naturally, in the phases of the moon that change every seventh day and "to which women's reproductive rhythms and hormonal pulses correspond" (Borysenko, 1996, p. 4). She describes the feminine life-cycle in age bands of seven years including two distinct developmental stages identifying menopause as a life-cycle stage: ages 42 to 49 years, *The Mid-Life Metamorphosis: Authenticity, Power, and the Emergence of the Guardian*, and ages 49 to 56 years, *From Herbs to Hormone Replacement Therapy (HRT): A Mindful Approach to Menopause* (Borysenko, 1996, p. xiv).

The third significant contributor to the menopausal, life-cycle writing is Canadian author, O'Leary Cobb (1993) who argues for the need to describe menopause as a

transitional stage in a woman's life that must move past the medical domain. She wonders why female adolescence—a transitional stage between non-reproductive and reproductive status—can be discussed by psychologists, social workers, physicians, and adolescents themselves, whereas menopause—a transition between reproduction and non-reproduction—has somehow become the domain of gynecologists. O'Leary Cobb's (1993) message comes from her own experiences and the thousands of women who subscribe to her international newsletter, *A Friend Indeed*. The newsletter's statement of purpose is simple yet incisive:

The intention of A FRIEND INDEED is not to suggest dogmatic prescriptions or pat solutions. I have neither the expertise nor the audacity to deal with individual, or what may very well be complex problems. The intention is to explore menopause as mythology, as biology, as feelings; to offer moral support to those who need it; to offer an exchange of information from woman to woman; and to gather together in one place relevant information so that women can make knowledgeable decisions. (O'Leary Cobb, 1984, p. 5)

O'Leary Cobb's (1993) *Understanding Menopause* is noted for its clear non-medical language, useful information, and genuine support and caring offered to women of all ages who are interested in menopause as one of the transitional life stages in women's lives. In particular, she offers her book as a guide to what menopause is, how to prepare for it, signs and symptoms of its onset, physical concerns such as hormone therapy, hot flashes, osteoporosis, and lack of sexual desire. She also addresses a woman's psychological and emotional states during menopause, providing information on marriage at midlife, female friendships, and the aging process in general.

Experience described by these three authors has led to the conclusion that a profound change is required in our society's approach to women's lives, one that embraces their

whole being, and emphasizes “*transformation* (emphasis added) over treatment” (Greenwood & Nunn, 1994, p. 3). Reconstituting their wholeness is the spiritual quest or inner journey that women experience during their life-cycle transitional stages. After reading about the feminine life-cycle and the menopause literature the insight was developed by this researcher (i.e., myself) to view women’s life experiences through a menopausal life-cycle perspective. A menopausal life-cycle perspective takes into account a developmental process (i.e., pre-, peri, post-menopause) that life-span developmentalists note is lacking from the adult developmental literature.

Women have basic biological markers (i.e., life-stage transitions induced by their hormones and regulated largely by their menstrual cycles) that distinguishes their genetic make-up from that of men. There is a need to include women in research so the findings can benefit women in their own right by taking into consideration their complete being—a part of which is their hormonal make-up. Most women proceed through the journey of their transitional stages by employing self-understanding and intuition.

Self-Understanding

The interplay between various life domains offers the potential for self-understanding, validating one’s capabilities, liking oneself, and providing balance in one’s life. Self-understanding is defined by Brennan and Rozenzweig (1990) as “each women’s cognitive construct of her personal characteristics and the way in which current roles, relationships, and work are congruent or do not fit with these characteristics” (p. 529). One thing is clear, women have different perceptions of self and morality. They bring to the life-cycle a different point of view and order human experiences in terms of different priorities

(Gilligan, 1982). Northrup (1998) adds that there is a gender-specific element to the way that most women communicate, think, and speak. She names this pattern of speech as *multimodal* or spiral to describe women's way of using both hemispheres of the brain and the intelligence of the body at the same time. She explains that in most women, the corpus callosum, the part of the brain that connects the right and left hemispheres, is thicker than it is in men. Men characteristically use mostly their left hemispheres to think and to communicate their thoughts; their reasoning is usually linear and solution-oriented. In comparison, women recruit more areas of the brain, meaning both hemispheres of the brain, when they communicate. The right hemisphere has richer connections with the body than the left hemisphere and, therefore, women have more access to their body wisdom when speaking and thinking. Schultz (1998), who is a neuropsychiatrist and a doctor of philosophy in behavioral neuroscience, concurs with Northrup. Intuition is an example of responding to our body's wisdom.

Intuition

Intuition is part of the spiritual quest or inner journey needed to reintegrate our denied or repressed parts of ourselves. De Becker (1997), a well-known author and homicide detective explains: "Intuition is something that many want to dismiss as a coincidence or a gut feeling when in fact it is a cognitive process, faster than we recognize and far different from the familiar step-by-step thinking we rely on so willingly" (p. 28). He surmises it is "knowing without knowing why" (p. 28). Generally, women are thought to employ intuitive thinking frequently in their lives; however, both genders utilize intuition. "We think conscious thought is somehow better, when in fact intuition is soaring flight

compared to the plodding of logic” (De Becker, 1997, p. 28). He states that just when our intuition is most basic, people tend to think of it as magical or supernatural. He notes that intuition is a gift we all have, whereas, retention of knowledge is a skill. The body processes thoughts in many ways; however, some thoughts are processed just more quickly than others. Northrup (1998) concurs that intuition is just one part of our body’s wisdom.

Menopausal Life-Cycle and Occupational Health

Many authors (i.e., Borysenko, 1996; Lee, Hanley, & Hopkins, 1999; Northrup, 1998; O’Leary Cobb, 1993; Sheehy, 1995) have contributed immensely to the emerging menopausal life-cycle approach offered in this thesis. These “new wave” pioneers base their views on years of practice-based experiences rather than findings from a specific research study. Two talented popular press writers, O’Leary Cobb (1993) and Sheehy (1995), offer information and support to women of all ages and focus on the process leading up to menopause. Nonetheless, a gap still exists concerning the occupational health needs of women utilizing a menopausal life-cycle perspective. After child-rearing responsibilities have diminished women are entering their second adulthood (Sheehy, 1995). Women may be changing careers and perhaps seeking employment for the first time that is closely connected to their value and belief system as well as their perceived life purpose. This phenomenon has resulted in the need to assess women in their occupational environment. For purposes of manageability, three aspects of occupational health are featured in this study, the first of which is job involvement.

Job Involvement

Job involvement entails being involved in the decision making process in one's work (White & Ruh, 1973). Participation in decision making was consistently related to job involvement, motivation, and identification with the organization, according to the seminal work of White and Ruh (1973). They designed a study "to investigate directly the moderating effects of individual values on the relationships between participation in decision making and attitudes toward the job" (p. 507). Their sample included all "employees in 19 separate plants of six manufacturing organizations in the Midwest [US]" (p. 508). Of the 4,162 surveys distributed, 2,755 (66%) were returned. The participants were about 35 years of age with approximately 4 years of work experience, on average; 51% were males and 49% were females. Their educational background varied—the median level was the twelfth grade, 37% had not completed high school, and 19% had some education beyond high school. The relationships between participation in decision making and job involvement, motivation, and identification with the organization were more positive for individuals who attach high importance to ten specific values than for individuals who attach low importance to each value. The values include: a sense of accomplishment, equality, freedom, independent, responsible, self-controlled, participation, ambitious, capable, and imaginative. Those individuals who rate high in job involvement scores were labeled *active copers* and those with low scores were viewed as *passive copers*.

Job involvement has remained an important organizational covariant throughout the years especially in relation to the study of burnout (Golembiewski & Boss, 1992). It was

for this reason that job involvement was included in the present study.

Hardiness

A second aspect of occupational health that pertains to the focus of this study is personality hardiness. Hardiness can be described as a coping mechanism that is inherent in varying degrees in one's personality that serves to buffer the stress-illness relationship, promoting health in the event of life change and stress (Kobasa, 1979). She developed a hypothesis that executives who did not succumb to illness after the effects of stressful life events possessed a sense of personality hardiness. She described hardiness as having "a stronger commitment to self, an attitude of vigorousness toward the environment, a sense of meaningfulness, and an internal locus of control" (p. 1). Kobasa and Maddi (1982) studied 2000 employees and found that the stress survivors had three important attitudes: challenge, commitment, and control.

Borysenko (1996) offers a description of challenge, commitment, and control as it relates to Kobasa's (1979) description of hardiness. Challenge refers to a specific frame of reference. Any event that disrupts the status quo can be seen either as a threat or as a challenge to invent a new future. When we cling tightly to our perceptions of life, change looks like a threat. However, when we are open to new possibilities, change is seen as a challenge. Commitment relates to the meaning we give to our activities of life. When we believe in what we are doing, the challenges along the way are not viewed to be so taxing. People committed to their jobs, who find meaning in their experiences or suffering, fare better than people who don't. Control is considered the greatest paradox of all these three attitudes. Lack of control in humans leads to anxiety, depression, and defects in the

immune system. Yet, when we try to control everything in our lives, we lose sight of challenge because everything looks like a threat. Someone with a controlling personality eventually succumbs to feelings of extreme frustration, anger, and guilt. The concept of hardiness has also been a popular topic in not only business but also health-care and nursing studies and it has been linked to the study of burnout. For these reasons hardiness was used as an organizational covariant or marker in this study.

Stress and Burnout

A third aspect and focus of this study relating to occupational health is occupational stress and burnout. “Generally, burnout is seen as a long-term reaction to occupational stress” (Gorter, Albrecht, Hoogstraten, & Elkman, 1999, p. 209). The term burnout was first formally introduced in the seventies to refer to a phenomenon that was observed among social workers who had to deal with emotionally needy and demanding individuals (Freudenberger, 1974).

Several researchers are responsible for influencing the general direction that stress research has taken over the years. In particular, the work of Cannon (1929) is recognized as a catalyst for the study of stress. Subsequent to Cannon’s work, Selye (1956) developed the General Adaptation Syndrome. Selye (1956), in his seminal work, states that a person is bombarded with various stressors that he suggests upset the “constancy of the internal environment” (p. 27). He explains that stressors can be either harmful or energizing to the person. Those stressors that have an energizing effect and generate constructive energy are termed *eustress*. Selye (1983) states that when we experience too many stressors at one time we may experience *distress*, and burnout may result if these

stressors come from the workplace. Following Selye, Lazarus (1966) offered the psychological transactional model of stress while Golembiewski, Munzenrider, and Carter (1983) developed the Phase Model approach to burnout. Finally, Leiter (1988) presented a model of psychological evaluations of work settings. Each model has provided greater insight into the complex concept of stress *on and off the job*. However, what is lacking from the current burnout literature is an approach that involves the *process* of life and, in particular, women's lives (i.e., a menopausal life-cycle approach).

Barnett (1997) observes that historically the stress literature has focused on the worker role of men and linked job conditions to men's stress-related outcomes, especially cardiovascular disease and Type A Personality. In contrast, the role of women has focused on family conditions, especially marriage, childbirth, and menopause, and linked these events to women's mental-health outcomes, especially depression. Three dichotomous relationships have been set up: men versus women; physical versus mental health; and work experiences versus family experiences. This approach translates to a focus on *physical health* outcomes for men and *mental-health* outcomes for women (Barnett, 1997). She claims that not so long ago our society believed that menstruating women were considered dirty and should be isolated for health reasons, or that exercising their intellect women would damage their reproductive organs. Continued reliance on flawed and insensitive paradigms is a major social issue that needs to be challenged. Questioning insensitive paradigms is also a major focus for the research study described herein. The situation becomes even more problematic when one examines three specific sources of distress associated with dominant societal attitudes, stereotyping, *the invisible*

woman phenomenon, and the multiple roles in women's lives.

Stereotypical Attitudes

Women in our society work in environments where stereotypical attitudes remain prevalent. For example, women in nursing have experienced their share of stereotypical attitudes. Historically, the gender difference and the hierarchical structure of the doctor-nurse relationship have been problematic. Even with the increase of female doctors in recent times, stereotyping has not decreased. Fagin (1992) asserts that for some reason the women's movement did not penetrate into hospitals to homogenize role expectations and behaviors. Women physicians often do not want to be linked with nurses because of the assumption that they will be seen as being subordinate to men. Also, nurses are affiliated with acting in maternal ways, which often is associated with a needed service, yet devalued in status. In general, stereotyping and stigmas have debilitating effects on individual members of a group, creating win-lose conflicts as opposed to the ultimate goal of win-win dynamics (Matuszek, Nelson, & Quick, 1995).

The Invisible Woman Phenomenon

According to Karasek and Theorell (1990), women are over-represented in occupations with low job-decision latitude whereas men are employed in high-decision jobs. This structural explanation confirms why women experience less perceived control at the work site. Heaney (1997) states that the social psychological explanation emphasizes gender differences in cognition and behavior. She concludes that within the same occupation, women and men have differential access to control. In the case of participation and influence in decision-making it may be more difficult for a woman to

gain the attention of decision-makers. She calls this notion the *invisible woman phenomenon*. She claims that women are ignored much of the time even when they are taking the lead in an interaction or making worthwhile contributions in the workplace. For example, Travis (1988) also observes that there appears to be an all too familiar phenomenon in the work setting that when a male reiterates the same suggestion that a female has originally presented it is only then acknowledged with enthusiasm and hence adopted as the male's idea.

Life Domains/Roles

A third source of distress in women's workplaces, according to some researchers, is due to women undertaking multiple roles within various life domains. "A life domain is a sphere of development in which a woman relates to others, takes on one or more roles, and performs activities that she views as necessary for the maintenance of those roles and relationships" (Brennan & Rosenzweig, 1990, p. 528). At various times in their lives women are involved with occupational work as well as ongoing involvement with home, education, neighborhood, friendship, religion, extended family, government, and the arts. They may take on multiple roles within a single domain. Domestically, a woman may be a wife, mother, and daughter and produce goods and services based on these roles. Despite their participation in the work force, women continue to bear the brunt of family responsibilities such as housework and childcare (Gray, Lovejoy, Piotrkowski, & Bond, 1990; Hochschild, 1989; Pleck, 1985; Stein, 1984). Essentially, women work a double-shift when they are employed and when they work in the home and community (e.g., nurturing children and child care, kin work—elder/parent care, and household duties).

Nurses, in particular, have multiple roles that include a caring role both at work and in the home. Unfortunately, in the current literature, there is a paucity of well-defined theoretical frameworks, for organizing and integrating the relationships between multiple roles and increased stress. There are several studies that indicate women's attitudes, beliefs, and expectations with their employment and circumstances surrounding it are important determinants for who will experience positive outcomes (Barnett & Baruch 1985; Baruch, Biener, & Barnett, 1987). Repetti, Mathews, and Waldron (1989) concur with other authors that across various studies the relationship appears to be moderated by a number of subjective factors such as perceived quality and meaningfulness of the roles for the person and the person's satisfaction with these roles. Although some findings focus on the positive outcomes of women's multiple roles, there is yet to be an overall consensus relative to this result. However, what is agreed upon is that social change has increased the roles women maintain both inside and outside the home at all stages of the menopausal life-cycle.

Toward a Definition of Burnout

The experience of burnout represented in media and research circles ranges from descriptions of momentary states of low energy, to severe depression requiring hospitalization, and all conditions in-between. Although many writers discuss burnout, there is a lack of consensus regarding how to define and operationalize this concept. Maslach and Jackson (1981) developed a self-report measure, the *Maslach Burnout Inventory* (MBI), which measures burnout according to three dimensions: *depersonalization*, or the tendency to view others as things or objects rather than as

feeling, valuing persons; *personal accomplishment*, or the degree to which a person sees himself or herself doing well on worthwhile tasks; and, *emotional exhaustion*, or the feelings of being emotionally overextended and exhausted by one's work. Thus, Maslach and Jackson (1986) describe burnout as "a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur among individuals who do 'people work' of some kind" (p. 1). Responses to the MBI permit assigning each individual a score on these three dimensions.

Golembiewski, Munzenrider and Carter (1983) introduced the Phase Model of Burnout, based on the earlier work of Maslach and Jackson (1981). The Phase Model extends the description of the three MBI dimensions and proposes an eight-phase model of burnout based on two conventions:

1. An individual's three dimension scores can be coded as High (HI) or Low (LO), based on norms from a large population (i.e., Golembiewski, Munzenrider, & Carter, 1983).
2. The three dimensions are not equally significant in burnout. *Depersonalization* is considered the least virulent contributor to burnout and *emotional exhaustion* the most severe. The eight-phase model of burnout is presented in Table 2.1. It is important to note that *personal accomplishment* is reversed, so a LO assignment on that dimension indicates an individual is doing well on a task perceived as worthwhile. Essentially, phases VI, VII, and VIII are considered the advanced phases of burnout.

For over a decade, the Phase Model has been used by researchers to document the worldwide plague of worker burnout. In Golembiewski, Boudreau, Munzenrider, and Luo (1996), over 31,000 individuals from 12 countries on 3 continents were classified in

Table 2.1***Phase Model of Burnout***

	<i>Phases of Burnout</i>							
	I	II	III	IV	V	VI	VII	VIII
Depersonalization	LO	HI	LO	HI	LO	HI	LO	HI
Personal Accomplishment (reversed)	LO	LO	HI	HI	LO	LO	HI	HI
Emotional Exhaustion	LO	LO	LO	LO	HI	HI	HI	HI
Participants by Phases in Percentages (<i>N</i> = 31,000)	21.7	5.8	12.6	9.7	6.3	12.5	7.3	24.1

these phases. The last line in Table 2.1 offers a summary of the percentages of men and women classified in each of the eight phases of burnout. The proportions shock most observers because so many persons are classified in the advanced phases (43.9%). Moreover, one might suspect that the samples used over-represent *healthy* organizations. The question arises, would uncaring managers or executives authorize a survey with potentially serious implications for disability insurance, if they believed their organizations were unusually stress-producing for large proportions of their workforce? It is also likely that, generally, individuals in the more advanced phases of burnout are less likely to complete and return any type of survey.

The summary distribution in Table 2.1 places over four in ten workers in one of the three most-advanced phases of burnout (i.e., 43.9% in stages VI, VII, VIII). Such a

finding suggests a social problem of substantial magnitude that no one can afford to ignore. To be sure, burnout cannot be described as a fleeting experience. Available data covering a few weeks to a year, suggest that, more or less, one-third of all phase assignments remain the same, and about 50% vary plus or minus one phase (Golembiewski et al., 1996). Futurists predict that burnout is a contemporary phenomenon likely on the rise. The Phase Model approach is arguably the most systematic attempt to examine the experience of burnout (Golembiewski et al., 1996). The MBI has been used in over 90% of the published studies on burnout (Schaufeli, 1999). For these reasons, the Phase Model and the MBI were used in the measurement of burnout in the present study.

Nurses, Hardiness, and Burnout

Related to the present focus on burnout and hardiness, the following findings are noteworthy to the discussion of nurses' occupational lives. Ouellette (1993, same person as Kobasa) reports that nurses "turned the research spotlight on themselves by using hardiness as a way of better understanding and potentially relieving burnout in their ranks" (p. 84). She claims if hardiness can be taught there is the potential to relieve burnout in the nursing profession as well as other occupations. Keane, Ducette, and Alder (1985) found that nurses who were characterized as more *hardy* experienced lower levels of burnout than nurses lower in hardiness. Other researchers report similar findings (i.e., Lambert & Lambert, 1987; McCranie, Lambert, & Lambert, 1987; Pagana, 1990; Simoni & Paterson, 1997; Topf, 1989).

With the current environment in nursing and all its changes, hardiness emerges as a

theme that so fittingly describes the characteristics of those individuals who choose to remain actively involved in the profession of nursing (Fox, Aiken, & Messikomer, 1990). According to Maslach and Jackson (1982), the loss of control nurses feel is not simply a matter of lacking power over others but rather control over their ability to care for patients in a manner consistent with their deeply held values. Lambert and Lambert (1987) report that if hardiness could be taught nurses may be the first to take advantage of such an educational experience. Interestingly, Borysenko (1996) believes that hardiness *can* be learned through the process of meditation. The question of whether hardiness is something innate or learned remains open to debate.

Simoni and Patterson (1997) recently investigated “the relationships among the personality construct of hardiness, coping behaviors, and burnout in the context of the nursing workplace” (p. 178). Three measures were used in their study: hardiness was measured using Kobasa and Maddi’s (1982) 36-question Hardiness Measure (second generation, short form), coping approaches and burnout were categorized using the Pines and Kafry (1982, cited in Simoni & Paterson, 1997) coping taxonomy and burnout measure respectively. From a population of 13,650 nurses in one American state, they randomly selected 1,049 individuals. Although 529 (50.4%) individuals responded to the mailed survey, the usable surveys ultimately reduced the sample size to 440. The mean age of nurses was 35.8 years; 307 nurses held associate (45.5%) or baccalaureate (24.3%) degrees. The nurses reported an average of 11.1 years of experience, 339 (77%) worked in acute care settings, and 263 (59.8%) worked the day shift. Simoni and Paterson (1997) reported that “participants who measured highest in hardiness measured lower in

burnout” (p. 182). Supporting the hardiness theory, they concluded:

Despite the coping strategy used, subjects with greater hardiness reported less stress in the form of burnout than did those with lower levels of hardiness. This [finding] is congruent with the premise that the cognitive assessment of stressor severity is influenced by hardiness; stressors are seen as manageable by those who are hardy. (Simoni & Paterson, 1997, p. 183)

A Menopausal Life-Cycle Perspective—More Holistic Than Biological

Throughout this chapter, the menopausal life-cycle has been featured as part of the new wave of change. To end this chapter, two opposing views are contrasted. The biomedical view of health, derived from systems theory, reflects an imbalance in the operationalization of the concept of wholeness. Systems theory says that individuals are systems made up of smaller systems, which are at the same time part of larger systems. Conventional medicine does not assess the whole individual but rather assesses a body system in a singular fashion and external to the whole person. Conversely, a holistic view is based on theory espousing that “human beings exist as individual points of awareness within a conscious universe and as such are already ‘whole’” (Greenwood & Nunn, 1994, p. 236). A holistic model involves the melding of one aspect of the biomedical model (i.e., one’s biology) but extends the philosophy to be more healing and positively oriented. The basic assumptions of the biomedical model versus the holistic model of health are presented in Table 2.2.

Comparing these assumptions, it is easy to recognize the specific advantages of the holistic model to the individual. For instance, it is anticipated that most women in the menopausal life-cycle stages would prefer to be considered as whole biological beings who can contribute to their well-being through their cognitive, affective, psychological

Table 2.2***Basic Assumptions of the Biomedical Model of Health and a Holistic Model of Health***

Biomedical Model Assumptions	Holistic Model Assumptions
based on systems theory and therefore illness focused	based on holistic theory and therefore whole person in relation to one's environment focused
conventional model of health	healing model of health
curative model	caring model
focused on women's biology, and specifically, women's "pathology" throughout life-cycle transitions	focused on women's feelings as well as their intellect, biology, spirituality, and a positive, healing view of life-cycle transitions
illness has external cause (e.g., bacteria or virus)	ailments arise from "self" (totality of an individual, consisting of body, mind and spirit) creating a response to a perceived stressor within one's physical environment (e.g., no external cause)
individual responsible for cause and effect of illness in relation to linear time (i.e., past and future orientation to disease)	individual responsible for one's response to stressors or ailments in the present moment (i.e., present time orientation), awaiting one's attention to healing
doctor has authority	individual is the only authority
doctor has the power to heal	power to heal lies within the individual
individual is helpless	individual is responsible for changing behavior

and spiritual senses. Importantly, each woman is "the only authority" to describe her personal circumstances and the primary individual responsible for changing her behavior. Therefore, the menopausal life-cycle perspective is more aligned to the assumptions of the holistic model.

As women become more cognizant of the importance of a holistic approach to their health, consciously or unconsciously, they acknowledge the wisdom and power inherent in their monthly menstrual cycles as well as their menopausal life-cycle transitions, thus challenging the assumptions of the biomedical model. This thesis is a tangible outcome of such involved and enlightened awareness.

Summary

Several writers contributed significantly to the concepts central to this study. In particular, the literature describing the new wave of change integral to the menopausal and life-cycle perspectives is foundational to this study. The leading contributors in this field are more popular and less academic in their writings. In fact, no research studies were found that directly investigated menopausal life-cycle stages of women and the relationships among occupational health. Thus, the research design for a study on a menopausal life-cycle perspective of women's lives described in the following chapter and the topic of this thesis is unique and offers a promising contribution to our existing knowledge base. Chapter III presents a detailed description of both the survey and interview methods used in this research study.

CHAPTER III

Methodology

This chapter begins with a brief description of the rationale for the chosen methodology, and a triangulation of methods. Subsequently, the chapter is divided into two major sections—the survey and the interview methods. For the survey sections, the methodology includes: participants, sampling selection, **Women’s Health Occupational Life Experiences (WHOLE) Profile**, procedure, and proposed data analyses. For the interviews, the methodology is presented as follows: participants, sampling selection, setting, measure, and procedure. Finally, the chapter concludes with a comment about ethical considerations and summary.

Rationale for a Triangulation of Methods

In this descriptive and model-testing study, data were collected through the use of surveys and interviews. Glaser and Strauss (1967) argue that both interview and positivist (e.g., survey) data are useful tools. They state that “both forms of data are necessary—not quantitative used to test qualitative, but both used as supplements, as mutual verification, and most important for us, as different forms of data on the same subject, which, when compared, will each generate theory” (Glaser & Strauss, 1967, p. 18). They also state that generating theory is independent of the kind of data used and believe that:

When the main emphasis is on verifying theory, there is no provision for discovering novelty, and potentially illuminating perspectives. . . . When generation of theory is the aim, however, one is constantly alert to emergent perspectives that will change and help develop his theory. (Glaser & Strauss, 1967, p. 40)

Other authors assert that methods are not paradigm specific and that, although certain

methods have been typically linked with particular paradigms, there is no philosophic basis for this association (Ford-Gilboe, Campbell, & Berman, 1995). They agree that there is no logical reason why qualitative and quantitative methods cannot be used together since the real issue is to match methods with the purposes of the study. Morse (1994) theorizes:

In those countless studies that combine quantitative and qualitative techniques in a *triangulated* [italics added] design, only rarely is an attempt made to integrate the two components of the study. Rather, they are treated like two separate studies in one project. *This treatment is unfortunate because even a single comparison of the results of the two components could lend confirmation to and thus strengthen the argument.* (p. 289)

Triangulation is the term used to describe the combining of methods within a single study. The word “triangulation” refers to a navigational term, in which two known or visible points are used to plot a third unknown point (Knafl & Breitmayer, 1991). In the late 1950s, the term was first used in the social sciences to refer to the use of multiple methods to converge on a single construct (Campbell, 1956). Triangulation of *methods* and *concepts* was used in this study to corroborate the findings of each component of the study and to enhance the validity of the findings.

According to Lincoln (1991), the role of the researcher in the interpretivist paradigm is that of a “passionate participant. . . . actively engaged in facilitating the multivoice reconstruction of his or her own construction as well as those of all other respondents” (cited in Denzin & Lincoln, 1994, p. 115). The Interactive Approach, developed by Maxwell (1996), assumes that there is not one reality but many. Janesick (1994) states that the aim of qualitative research is to look for the meaning and perspectives of the

participants in the study. Further, Janesick (1994) observes that we will be able to gain insights and knowledge from the researchers, and the individuals participating in the study have the potential to gain insights into their own situation. Essentially, what constitutes good science is a slow movement toward the use of both interview and survey methods in the field of health research (Janesick, 1994). Corner (1991) suggests that by using different research methods within a single study there is an added richness in, and a deepening of understanding of, the phenomenon under study.

Survey

Participants

The survey sample comprised 2000 female registered nurses randomly selected from the professional registry in a province in western Canada. Participants were selected by the provincial nursing association from a total of 17,500 registered nurses. Thus, a random sample of 2000 represents 11.4% of the nursing population within the selected province. It was anticipated that the sample would include female nurses who were actively registered with their association, working full- or part-time within various positions in hospital, community, or academic institutions. Further, to enhance anonymity and confidentiality, an agency external to the association distributed the WHOLE Profiles.

Sampling Selection

A random sample was used to survey nurses in this study. Random sampling is described as the selection of a sample such that each member of a population (or sub-population) has an equal probability of being included (Polit & Hungler, 1999).

WHOLE Profile

The Women's Health: Occupational and Life Experiences (WHOLE) Profile (see Appendix A for a complete copy) was developed for purposes of obtaining information about women in various stages throughout their menopausal life-cycle. This approach provides an holistic perspective of a woman's life, one that accommodates both occupational and personal life experiences.

The WHOLE Profile, an eight-page survey, includes two major parts. Part I addresses questions pertaining to demographics, health-care history, and general health (including menopausal life-cycle stages), while Part II includes questions about occupational experiences and four separate measures: the Job Involvement Scale (White & Ruh, 1973), a modified version of the MBI (Golembieski, Munzenrider, & Carter, 1983), the Personal Views Survey (Kobasa, 1979), and the Marlowe-Crowne Social Desirability Scale (Crowne & Marlowe, 1960).

Part I–WHOLE Profile

Demographic variables—questions 1-4. The demographic variables documented marital status, number of children, age, and date that participants answered the WHOLE Profile.

Health-care history and general health variables—questions 5 to 23. The health questions covered health-care practices, frequency of hospitalization, frequency of exercise, and use of health screening measures such as pelvic examinations and self-breast examination. Also, several questions were developed to measure health symptoms, chronic illness, and menopausal life-cycle stages.

Women's hormonal status was determined by self-reported menstruation patterns and responses to questions pertaining to the endogenous or exogenous production or use of hormones. Endogenous hormones refer to hormones produced within one's own body while exogenous hormones refer to hormones received in the form of menopausal or contraceptive hormone therapy. Pre-menopausal women were defined as those women who had been menstruating regularly with cycle lengths of 24 to 35 days during the past 12 months. A separate category was designed for those women menstruating with either endogenous or exogenous hormones.

Peri-menopausal women, in this study, were defined as those women who experienced menstrual irregularity (several cycle lengths of greater than 6 weeks) but who had menstruated within the past 12 months. Pre- and peri-menopausal stages were eventually combined for purposes of data analyses to provide clarity for the reader. This collapsed stage was entitled the *combined pre-menopausal stage* and was labeled *pre-menopausal* in the ground breaking work of Lee and Hopkins (1996). The *combined pre-menopausal stage* signifies to the time preceding menopause when hormone changes are occurring.

Post-menopausal women were those women who had experienced cessation of menstruation for at least 12 months or more. Several categories were created to identify the proportion of women deemed to be post-menopausal due to the cessation of menstruation caused by natural aging of the ovaries and those deemed to be post-menopausal caused by surgical removal of the uterus and both ovaries (hysterectomy with bilateral oophorectomy); uterus (hysterectomy and ovaries remain intact); uterus and one ovary (hysterectomy with unilateral oophorectomy); or removal of both ovaries (bilateral

oophorectomy).

A specific classification was designed for those women who were not menstruating due to pregnancy, breast feeding, medication, heavy exercise, rapid weight loss, illness or unknown. This category was entitled secondary amenorrhea (see Appendix B for a glossary of this term and selected definitions).

Part II–WHOLE Profile

Work Profile—questions 24-26. Work Profile questions included work status as well as an indication of hours spent in various roles. Participants were to indicate their actual hours spent per week in each role, including unpaid overtime hours, in the week prior to completing the Profile.

Four distinct measures are also included in the WHOLE Profile:

Maslach Burnout Inventory (modified MBI)—question 27. For each question in the modified MBI, participants were instructed to write a number on the blank space provided, indicating the degree to which the statement was *like* or *unlike* them. In the modified MBI there were 23 statements with a choice of numbers between one and seven. They were also instructed to make certain that they use low numbers to describe statements that were unlike them, and high numbers to describe statements that were like them. Maslach and Jackson (1981) report the reliability coefficients for the three subscales of the MBI as: 0.90 for emotional exhaustion, 0.79 for depersonalization, and 0.71 for personal accomplishment when using Cronbach's alpha. Over 90% of published burnout research has used some version of the MBI (Schaufeli, 1999). On balance, the psychometric quality of the MBI appears quite high with several recent studies offering

support for the factorial, convergent, predictive, and discriminant validity of this most popular burnout measure (Maslach, Jackson, & Leiter, 1996; Schaufeli & Enzmann, 1998).

Job Involvement Scale—question 28. White and Ruh (1973) developed the Job Involvement Scale to measure Active and Passive job involvement. Active job involvement denotes being actively involved in one's job while passive job involvement means not being involved. For each of the questions in the Job Involvement Scale participants checked the appropriate box indicating the statement that came closest to describing their attitude or behavior. There were nine statements in total in the Job Involvement Scale with a five-point response scale for each statement, for example, *never, seldom, occasionally, often, and always*. White and Ruh (1973) report the reliability coefficient of their scale as 0.87, using Cronbach's alpha. There are several scales measuring a person's orientation towards a particular job, or job involvement dating back to the 1960s (Cook, Hepworth, Wall, & Warr, 1981). The measure of job involvement used in this study "has attractive measurement properties and has often been used in research with the phases" (Golembiewski et al., 1996, p. 99).

The Personal Views Survey—question 29. The Personal Views Survey was developed by Kobasa (1979). The 50-question, third generation, version of the Personal Views Survey was used in this Profile. Each statement was followed by a four-point scale on which 0 was *not at all true*, 1 was *a little true*, 2 was *quite a bit true*, and 3 was *completely true*. The participants were instructed to indicate how they felt by circling a number from 0 to 3 in the space provided. Kobasa (1979) reports the reliability

coefficient of the Personal Views Survey as 0.79, using Cronbach's alpha. The Personal Views Survey represents a third-generation measure of hardiness that has been used by researchers for well over a decade to examine the stress-illness relationship. Most researchers would also agree with the claim that this measure has demonstrated construct validity (Ouellette, 1990, 1993).

Marlowe-Crowne Social Desirability Scale—question 30. The Marlowe-Crowne Social Desirability Scale was developed by Crowne and Marlowe (1960). The Social Desirability Scale measures the tendency of individuals to report socially acceptable responses in order to obtain approval. For each question, participants circled either *true (T)* or *false (F)* to indicate their response to 10 specific statements from a shortened version of Marlowe-Crowne Social Desirability Scale (i.e., Fischer & Fick, 1993). Fischer and Fick (1993) report the reliability coefficient of this measure as 0.88, using Cronbach's alpha.

Procedure

A total of 25 female undergraduates participated in a pilot study of the WHOLE Profile. As a result of the pilot study, the instrument was altered to reflect the improvements suggested by the pilot participants. For example, there were alterations to one of the questions pertaining to marital status. An additional three questions were added to improve the Profile including questions regarding menstruation attitudes, work setting, urban or rural settings, and one of the thesis committee members suggested using a short version of the Marlowe-Crowne Social Desirability Scale (Crowne & Marlowe, 1960). Other minor changes were made resulting in the final version offered in Appendix A.

Estimated time to fill out the Profile was 45 minutes. Further, the pilot study provided an opportunity to work through the various analytical procedures (e.g., coding and analyses) using the Statistical Package for the Social Sciences (SPSS, 1998).

Each package included a letter of introduction (see Appendix C), the eight-page WHOLE Profile, and a response postcard with an invitation to participate in an interview as well as to receive a summary of the findings. The survey was mailed on March 15, 1998, by an outside agency to the professional body, which selected the random sample from its registry of 17,500 members. There was only one mail-out of the Profiles with no attempt to follow up and increase the response rate, in part, due to costs and the distribution procedure.

Data Considerations

Analyses of the survey data were done using the SPSS (1998) computer program. Descriptive statistics that utilize frequencies, means, medians, and standard deviations were computed to summarize the data. Also, selected correlations, reliabilities, and post-hoc multiple comparisons were calculated and presented.

Median Splits for Job Involvement and Hardiness

A typical convention in this type of research is to split the raw scores at the median for high and low assignments. Job involvement totals were summed from the nine questions in the scale. The median split for the job involvement scale and the modified MBI were taken from a large population study done by Golembiewski and Munzenrider (1988). For job involvement, participants with scores higher than 30 were deemed to be actively involved in their job (actives), while those with scores less than, or equal to, 30 were

classified as being passive in their job involvement. For the modified MBI, there were 23 statements, scores on the personal accomplishment subscale were reversed but not for the subscales of emotional exhaustion or depersonalization. Results of the modified MBI indicated that the median splits for the three sub-scales, depersonalization, personal accomplishment (reversed), and emotional exhaustion were 18, 26, and 23 respectively. The hardiness scores were reversed so all the responses were in the same direction. Scores from the Personal Views Survey were divided into low hardiness and high hardiness. Scores higher than this study's sample median of 77 were deemed high, while those individuals whose scores were less than, or equal to, 77 were classified as having low hardiness.

Missing Values

To ensure the integrity of the data set, all data were double-inputted into the computer. A computer program calculating the differences of both data sets was utilized to ascertain a perfect data set resulting in no differences. Only one data set was then used for the statistical calculations of the data. Missing data, because the participant left the question blank due to refusal to respond to a particular question, were defined as *user-missing*. Data that were missing because the question did not pertain to the participant were labeled *system-missing data* and were not used in the statistical calculations. User-missing values in the Profile dealing with the demographics, health-care history, general health, and the first column of the work Profile responses (questions 1 to 26) were ignored and treated as system-missing, and were rejected outright from any calculations. However, user-missing values for three occupational measures within the Profile were

accommodated by substituting one value for up to every ten questions per measure. This protocol involved three of the measures within the WHOLE Profile: the Job Involvement Scale, modified MBI, and the Personal Views Survey.

Job Involvement Scale

From the raw data (no substitution of means), 673 responses out of the possible 2000 responses indicated a 33.7% response rate. However, means were substituted for those cases that satisfied the formula of one missing value in the nine-statement job involvement scale. All those cases that had more than one missing value were rejected outright. There were 12 means in total substituted in the job involvement scale, which then accounted for a total of 683 valid cases or a 34.2 % usable response rate. The difference between before and after substitution of means in the job involvement scale was .5%.

Maslach Burnout Inventory (modified)

From the raw data (no substitution of means), 646 responses out of the possible 2000 responses indicated a 32.3% response rate. However, means were substituted for those cases that satisfied the formula of three, or less than three, missing values in the complete 23-statement MBI. All those cases that had more than three missing values were rejected outright. A total of 31 means were substituted for the MBI, which then was calculated to be 678 valid cases or a 34% response rate for this measure. The difference between before and after substitution of means in the MBI (modified) measure was 1.7%.

Personal Views Survey

From the raw data (no substitution of means), 539 responses out of the possible 2000

responses indicated a 27% response rate. Means were then substituted for those cases that satisfied the formula of five, or less than five, missing values in the complete 50-statement hardiness scale. All those cases that had more than five missing values were rejected outright. There were 136 means substituted for the hardiness scale with a total of 677 valid cases, which presents a 33.9 % response rate for this measure after the means were substituted. The difference between before and after substitution of means in the hardiness measure was 6.9%.

Marlowe-Crowne Social Desirability Scale

No means were substituted for the Marlowe-Crowne Social Desirability Scale. The total number of individuals responding to the Marlowe-Crowne Social Desirability Scale were 671, which presents a 97% response rate.

Interview

Participants

Eight individuals from the survey sample ($n = 692$) participated in the interviews. This sample of eight individuals was purposefully selected to include both rural and urban settings.

Sampling Selection

The approach taken in the interview component of this study can best be described as *purposeful sampling*. According to Patton (1990), most sampling in interview methods is neither probability sampling nor convenience sampling but falls into another category, *purposeful sampling*. Maxwell (1996) postulates that there are four main goals of purposeful sampling. Firstly, there should be representativeness of the settings,

individuals, or selected activities. According to Maxwell (1996):

A small sample that has been systematically selected for typicality and relative homogeneity provides far more confidence that the conclusions adequately represent the average members of the population than does a sample of the same size that incorporates substantial random or accidental variation, that the conclusions adequately represent the average members of the population. (p. 71)

The second goal that purposeful sampling can achieve is that it also can capture the heterogeneity in the population, which is opposite to the first goal. The purpose, then, is to ensure that the conclusions adequately represent the range of variation, rather than only the typical members or a subset of this range. The third goal is to select the sample to deliberately examine cases that are critical for the theories with which the study began or that have been subsequently developed. The fourth goal, which is less common, is to use purposeful sampling to identify differences between settings or individuals.

In this study, participants were invited to return a postcard (separately from the WHOLE Profile) indicating their willingness to be interviewed. From the returned postcards, 8 to 12 participants were to be contacted for both the interview and debriefing focus group session. It was recognized that, although the initial sample was randomly selected from a population of registered nurses, the interviewees essentially were self-selected for the interview component of the study. Due to the protocol established for the random selection of the participants, the researcher was not able to personally select nurses for this component of the study.

Setting

The qualitative data were obtained through personal interview. The interviews were conducted in a variety of settings to accommodate the preferences of the participants. For

instance, individuals were interviewed in their own private homes, in various offices within institutions, and in hotel rooms. A debriefing focus group session was held at an educational institution. All interviews were audio-taped with a cassette recorder and all tapes and transcripts were appropriately secured to ensure confidentiality.

Researcher-As-Instrument

The researcher is considered the instrument in the collection of qualitative data (Maxwell, 1996). The researcher and participants had a dialogue that was guided by a number of questions (see Appendix D) asked by the researcher. It is recognized that the researcher and the participants influenced each other. Researcher-as-instrument affords the opportunity to enhance the reciprocal relationship of the sharing of information. Such a discussion fosters an in-depth exploration of ideas that goes beyond the traditional survey method.

Procedure

While the survey Profiles were being returned, three nurses were interviewed to pilot the interview process. Feedback was received from the participants of the pilot study and it was ascertained that the questions were clear enough to provide a quality discussion. Minor changes were made to the questions to be used as a basis in the unstructured interviews. Moreover, after the interview, the three nurses were asked to comment further about the appropriateness of the questions for purposes of exploring, in-depth, specific issues emerging from the Profile. In their judgement, the interview questions appeared to satisfy the intended purpose. Face and content validity, therefore, were demonstrated through the feedback of the piloting process.

Each survey Profile package included an invitation to participate in personal interviews. The formal interviewing process was initiated in April, 1998 after the completion of the pilot study. Each participant signed a consent form indicating an informed decision and voluntary agreement to be interviewed. The participants were asked the same set of open-ended questions (see Appendix D) regarding their perceptions, opinions, intuitions, feelings, and beliefs about the experience of working as a registered nurse today and how work affects the whole person at various stages throughout the life-cycle. All participants were interviewed once and were invited to attend a debriefing focus group session. The debriefing focus group session provided an opportunity to discuss the researcher's interpretation of the data, to expand on major ideas presented, and to correct any misunderstandings. The unstructured interviews consisted of a one-to-three hour session plus a three and one-half hour debriefing focus group session. All interviews were audio-taped, transcribed verbatim, and then analyzed for themes. The content analysis undertaken in this study conformed to the guidelines outlined by Maxwell (1996) and Coffey and Atkinson (1996). The computerized transcripts were coded using fictitious names. Confidential information was separated from the data set and maintained in a locked drawer in the researcher's office. Moreover, all participant names, positions, and any other identifying markers have been changed in this thesis to ensure the complete confidentiality and anonymity of the eight participants.

Ethical Considerations

The research proposal outlining the proposed survey and interview methods received ethical approval by *The University of Lethbridge Human Subjects Research Committee*

and is consistent with the ethical guidelines published by the *Social Sciences and Humanities Research Council of Canada*.

Only aggregate information was used for the survey data. Individual consent was obtained from all participants in the interview component of this study and a consent of kind was acknowledged by those participants who returned the completed Profiles. Strict participant confidentiality and anonymity was respected in every aspect of this study. Confidentiality includes keeping private information that needs to remain private. This principle includes respecting the participants' confidence in the researcher's written and spoken word. Participants' anonymity was also honored by not disclosing the name of the participants or disclosing any unique characteristics that may identify that participant. Importantly, the ethical considerations pertaining to confidentiality and anonymity were reviewed with the few interviewees who met face-to-face during the debriefing focus group session. Each interview participant was identified in this thesis by a fictitious name. The three primary ethical principles upon which standards of ethical conduct in research are based: beneficence, respect for human dignity, and justice (Polit & Hungler, 1999, pp. 134-140), were followed throughout the research process.

Summary

Both survey and interview data collection methods were used in this study. The WHOLE Profile asked questions about demographics, health history, job involvement, burnout, and hardiness. The interview questions focused on information from nurses relevant to their values, beliefs, behaviors, and feelings, thereby, determining the meaning nurses give to their personal and professional life experiences. A complete presentation of

the results for both the survey and interview data follows in Chapter IV.

CHAPTER IV

Results

The findings of the study are reported as two distinct sections. Section I comprises data pertinent to the WHOLE Profile. Section II consists of information relevant to the interview data.

Section I - Survey Findings

At the time of the study all participants were actively registered within their professional nursing body in a province in western Canada. These registered nurses completed the eight-page, self-report, WHOLE Profile. A total number of 692 Profiles, of a possible 2000, were completed and returned, representing a 34.6% return rate. According to the postcard returns, a total of 348 nurses requested summary results of the survey findings.

Characteristics of the Sample

Table 4.1 presents the characteristics of the sample from the WHOLE Profile. The table includes the chronological and psychological age distribution of participants and the number of children currently living with each participant.

Responses to question one reflected the participants' marital status. Those individuals who were *married* ($n = 532$; 76.9%) or stated *other* ($n = 31$; 4.5%) were partnered in that relationship for 16.7 years on average, ranging between 0.5 to 43.0 years. Other results corresponding to the marital status question included: *never married*, 57 individuals (8.2%); *divorced*, 51 individuals (7.4%); *separated*, 10 individuals (1.4%); or *widowed*, 9 individuals (1.3%). Two participants did not respond to these questions. In all of the

Table 4.1***Participants' Age Distribution and Number of Children***

<i>Specific Descriptor</i>	<i>N</i>	<i>Range</i>	<i>M</i>	<i>Mdn</i>	<i>SD</i>
Chronological age	683	22 - 67	42.2	42	9.7
Psychological age	673	0 - 103	38.2	36	11.2
Number of children	537	0 - 5	1.6	2	1.1

Note. Percentages for this table and all tables in this chapter are calculated from the total number of nurses who answered a specific question, which was not necessarily 692 responses to every question in the Profile.

tables reported in this thesis, the numbers and percentages reported indicated the number of nurses responding to the Profile. These numbers may vary from the 692 returned Profiles.

The number and percentage of participants in each work category are listed in Table 4.2 along with minimum and maximum number of hours worked, on average, including unpaid overtime hours, in the week prior to answering the Profile. Each of the 692 participants responded to this question.

Health-Care History and Disease Screening Practices

Table 4.3 illustrates the nurses' responses to questions 5 to 10 in the Profile, which addressed their health-care history and their disease screening practices. Many (40.0%) of the nurses in this study implemented some aspect of health promotion (i.e., regular exercise) into their lifestyle. Also, they were conscientious with some aspects of disease detection practices (e.g., 69.4% had annual pelvic examinations). Compared to this

Table 4.2

***Participants' Employment and Minimum and Maximum Number of Hours Worked
in Week Prior to Completing Profile***

<i>Employment Area</i>	<i>N</i>	<i>% of Nurses Working in specific area</i>	<i>Min hours worked in past week</i>	<i>Max hours worked in past week</i>	<i>M</i>	<i>SD</i>
Staff/Community Health Nurse	465	67.2	2	60	28.9	11.4
Head Nurse	41	5.9	8	55	32.4	14
Clinical Nurse Specialist	15	2.2	3	50	30	13.1
Instructor/ Professor	34	4.9	2	50	20.5	17.2
Supervisor/ Coordinator	52	7.5	3	60	28.7	15
Assistant/ Associate Director	7	1	4	60	41.6	20.9
Chief Nursing Officer/ Director	16	2.3	30	65	48.6	9.6
Office/Industrial Nurse	33	4.8	5	60	30.4	14.6
Researcher	17	2.5	2	45	11.3	13
Consultant	24	3.5	2	50	14.5	16.5
Independent Nursing Practice	20	2.9	1	44	17.4	16.7

Note: For this question (Table 4.2), 692 participants responded and the percentages reflect this response rate (e.g., 465/692 = 67.2%).

Table 4.3***Health-Care History and Disease Screening Practices***

<i>Question</i>	<i>N</i>	<i>%</i>
Health-care Practices	<i>689/692</i>	<i>99.6</i>
5. I go for regular physical checkups	452	65.6
Hospitalization History	<i>134/688</i>	<i>19.5</i>
6. Hospitalization in past two years more than twice	8	6
Exercise History	<i>451/689</i>	<i>65.5</i>
7. Exercise three or four times a week	277	61.4
Disease Screening- Pap Smear	<i>690/692</i>	<i>99.7</i>
8. When was last pap smear?		
One year or less than one year ago	480	69.6
Never	10	1.4
Disease Screening- Self-breast exam	<i>691/692</i>	<i>99.9</i>
9. How often do you do self-breast examination?		
Once a month	174	25.2
Never	70	10.1
Comparison of Overall Health	<i>689/692</i>	<i>99.6</i>
10. Describe your overall health in comparison with others your age.		
Average Health	415	60.2
Above average health	246	35.7
Below average health	28	4.1

Note. For these questions (Table 4.3), only selected responses were indicated and the missing responses vary. The total number of nurses as well as the corresponding percentages were indicated in italics (i.e., 689/692, 99.6%). Non-italicized percentages reflect the response rate to each option within the specific question list (i.e., 452, 65.6%).

finding, only about 25% of individuals practiced monthly self-breast examinations for the early detection of breast lumps.

General Health Questions

Table 4.4 illustrates those individuals who responded *often* or *always* (out of the five-point scale *never, seldom, occasionally, often, and always*) to ailments that are generally associated with menopause. The results indicate that approximately 10% of the women from this study experienced menopausal ailments quite often.

Table 4.5 displays information about chronic illnesses. There was a choice of seven chronic illnesses plus a category for *other*. Fourteen percent of the sample stated *other* as a category, which was illustrative of two categories that were missing from the WHOLE Profile: *depression* and *musculo-skeletal injuries*. As noted in this Table, the incidence of chronic illnesses is generally quite small.

Table 4.6 presents a staggering total of 577 of the 690 nurses, or 83.6% of the survey sample, responded *yes* to having surgery at least once. Although tonsils tend to be removed during childhood, the remaining surgical procedures tend to be undertaken as adults. The number and percentages of participants who had experienced selected surgical procedures is given in detail. In addition, examples of the *other* surgical procedures were anything from dental surgery to major abdominal surgery.

Table 4.7 summarizes the number and percentage of participants who used medications and the reasons associated with this use. For instance, a total of 317 of the 690 nurses, or 45.9% of the sample, were taking prescription medication on a regular

Table 4.4***General Health—Menopausal Ailments***

<i>Ailments</i>	<i>N</i>	<i>%</i>
Heavy menstrual periods	<i>684/692</i>	<i>98.8</i>
Often	84	12.3
Always	23	3.4
Hot flushes/flushes	<i>685/692</i>	<i>99</i>
Often	50	7.3
Always	2	0.3
Night Sweats	<i>688/692</i>	<i>99.4</i>
Often	35	5.1
Always	1	0.1
Vaginal Dryness	<i>683/692</i>	<i>98.7</i>
Often	64	9.4
Always	20	2.9

Note. For this question (Table 4.4), only selected medical ailments and specific options were indicated and the missing responses vary. The total number of nurses as well as the corresponding percentages were indicated in italics (i.e., *684/692, 98.8%*). Non-italicized percentages reflect the response rate to each option within each question list (84, 12.3%).

basis in the six months prior to responding to the Profile. As noted in Table 4.7, approximately one-third of those responding to this question indicated that they were taking menopausal hormone therapy.

WHOLE Profile questions 16 and 17 asked questions about the individual's weight and height. The average weight of nurses was 152.1 pounds while the average height was five feet tall.

Table 4.5***Number and Percentages of Participants Experiencing Selected Chronic Illnesses***

<i>Chronic Illnesses</i>	<i>N</i>	<i>%</i>
Asthma	38	5.5
Emphysema	1	0.1
Diabetes	6	0.9
Cancer	9	1.3
Arthritis	51	7.4
High Blood Pressure	53	7.7
Heart Problems	15	2.2
Others	97	14.1
Total nurses responding <i>yes</i> to question 12	<i>212/687</i>	<i>30.9</i>

Note. For this question (Table 4.5), respondents checked all those chronic diseases that apply and more than one illness could be chosen. The total number of nurses responding *yes* to this question was indicated in italics (e. g., *212/687, 30.9%*). Each disease within the question is presented in this table as well as the corresponding percentages (i.e., *38/687, 5.5%*).

Life-Cycle Health Questions

WHOLE Profile Questions 18 to 23 dealt with life-cycle concerns (e.g., menstruation). The focus upon the three menopausal stages is appropriate given that all participants were working in their professional career and would typically fall within these three life-cycle stages. However, question 18 asked at what age menarche started. The mean age reported

Table 4.6***Number and Percentages of Participants Experiencing Selected Surgical Procedures***

<i>Removal of:</i>	<i>N</i>	<i>%</i>
Tonsils	312	45.2
Appendix	141	20.4
Gallbladder	77	11.2
Spleen	2	0.3
Uterus	95	13.8
One ovary	32	4.6
Both ovaries	26	3.8
Other	366	53
Total number of nurses responding yes to question 13	577/690	83.6

Note. For this question (Table 4.6), the responses to the list of surgeries varies. The total number of nurses as well as the corresponding percentages for each surgery was given (i.e., 312/690, 45.2%).

was 12.7 years. Table 4.8 shows the classification of individuals in the various menopausal life-cycle stages. Endogenous hormones refer to those hormones produced within one's own body, while exogenous hormones refer to hormones received in the form of menopausal or contraceptive hormone therapy. A specific category was created for those individuals who were not menstruating due to pregnancy, breast feeding, strenuous over-exercise, medications, or unknown causes. The vast majority of nurses in

Table 4.7***Number and Percentages of Participants Using Prescription Drugs by Category***

<i>Reasons</i>	<i>N</i>	<i>%</i>
Heart problems	6	0.9
High blood pressure	43	6.2
Headaches	24	3.5
Clinical depression	45	6.5
Arthritis	29	4.2
Breathing problems	18	2.6
Thyroid problems	53	7.7
Birth control	70	10.1
Menopausal hormone therapy	101	14.6
Other	19	2.8
Total number of nurses responding yes to question 14	317/690	45.9

Note. For this question (Table 4.7), the responses to the list of reasons for taking prescribed medication varies. The total number of nurses as well as the corresponding percentages for each reason is given (i.e., 6/690, 0.9%).

this study were in the combined pre- and peri- versus the post-menopausal life cycles (c.f., 69.6% versus 24.1%).

Table 4.9 displays information about attitudes toward menopause and the affects of

Table 4.8***Classification of Participants in the Various Menopausal Life-Cycle Stages***

<i>Life-Cycle Stages</i>	<i>N</i>	<i>%</i>
Pre-menopausal, due to:		
endogenous hormones	356	51.9
birth control therapy	53	7.7
menopausal therapy	31	4.5
Total pre-menopausal	440	64.1
Total peri-menopausal	38	5.5
Total combined pre- and peri-menopausal	478	69.6
Post-menopausal due to:		
natural menopause	69	10.1
surgical menopause	96	14
Total post-menopausal	165	24.1
Total secondary amenorrhea	43	6.3

Note. For this question (Table 4.8), 686 participants responded and the percentages reflect this response rate (e.g., $356/686 = 51.9\%$).

participants' menstrual cycle on how they approach, and how much they accomplish in, their work. According to the results of this study, slightly more than half of the participants responded that they had either a *positive* or *somewhat positive* attitude toward menopause. Only a small percentage (14 and 13%) of the nurses responded that their menstrual cycles affected how they approach their work or how much they accomplished in their work, respectively.

Table 4.9

Attitude Toward Menopause and Affects of Menstrual Cycle on Approach to Work and How Much Accomplished in Work

<i>Question</i>	<i>N</i>	<i>%</i>
21. Attitude toward menopause	686/692	99.1
Positive or somewhat positive	378	55.1
Negative or somewhat negative	84	12.2
Don't think about it	224	32.7
22. Affects of menstrual cycle		
How I approach my work	674/692	97.4
Yes	97	14.4
23. How much I accomplish in my work	673/692	97.3
Yes	90	13.4

Note. For this question (Table 4.9), varying number of participants responded and the percentages reflect this response rate (e.g., $686/692 = 99.1\%$).

Work Profile Questions

Part II of the Profile, questions 24 to 26, relates to the participants' work lives and the various roles they had during the week prior to answering the Profile. Question 24 asked if the participants were currently working and, if they were not, they were given a choice of responses such as being *retired*, *laid off*, or *unemployed*. If they stated that they were *unemployed* they were asked if they were currently looking for paid work inside or outside of the nursing profession or not looking for paid work. The results indicated that 658 (95.1%) individuals stated that they were working for pay and 0.6% were retired, 0.1%

laid off, 1.6% unemployed, 0.1% on leaves of absence, and 0.1% self-employed.

Question 25 asked the participants to indicate actual hours spent per week in each role, including unpaid overtime hours worked (see Table 4.2). The results illustrated that in every classification of employment area the maximum number of hours worked range between 44 and 65 hours. In addition to the total hours worked per week, question 26 asked the participants to indicate the setting(s) in which they worked: urban setting, described as having a population greater than 30,000, or rural setting, described as having a population less than 30,000, or were they working in both settings. Of the 641 responding to the question regarding setting, 454 (70.8%) indicated that they worked in an urban setting and 160 (25%) indicated that they worked in a rural setting. A few individuals ($n = 27$ or 4.2%) noted that they worked in both urban and rural settings.

Descriptive Statistics of the Occupational Measures Within WHOLE Profile

Table 4.10 illustrates the means, standard deviations, alpha reliabilites, and intercorrelations among the various occupational measures and their respective subscales. The reliability values obtained in this study are acceptable with those previously reported in the literature.

Scores from the Marlowe-Crowne Social Desirability Scale were correlated with the three occupational measures within the Profile. The correlations were statistically significant albeit fairly small in terms of the overall magnitude (-.13 to .13). The one exception depersonalization and social desirability had a correlation coefficient of -.25. The -.25 correlation can be explained in terms of the more one behaves in a depersonalized manner the less apt one is to please others or give a socially desirable

Table 4.10
Means, Standard Deviations, Alpha Reliabilities, and Intercorrelations of the Occupational Measures and Their Respective Subscales

<i>Measure/Subscale</i>	<i>M</i>	<i>Mdn</i>	<i>SD</i>	<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>	<i>6</i>	<i>7</i>	<i>8</i>	<i>9</i>	<i>10</i>
1. Phases of burnout	3.9	3.9	2.7										
2. Total job involvement score	32.4	33.0	5.5	-.38	<u>.76</u>								
3. Emotional Exhaustion	23.8	22.0	9.8	.82	-.37	<u>.88</u>							
4. Depersonalization	16.2	15.0	7.1	.58	-.31	.54	<u>.76</u>						
5. Personal Accomplishment (rev)	25.8	25.0	9.2	.53	-.34	.29	.33	<u>.73</u>					
6. Total Hardiness Score	75.5	76.8	9.2	-.46	.34	-.44	-.48	-.31	<u>.80</u>				
7. Commitment	39.7	41.0	5.6	-.50	.40	-.47	-.53	-.31	.88	<u>.63</u>			
8. Control	40.2	41.0	5.0	-.38	.24	-.35	-.43	-.27	.84	.71	<u>.50</u>		
9. Challenge	33.2	33.0	6.2	-.27	-.20	-.27	-.23	-.16	.80	.52	.46	<u>.59</u>	
10. Total Social Desirability Scale	15.2	15.0	2.1	-.13	.13	-.09*	-.25	-.11	.17	.16	.18	.08*	

Note. Correlations are significant at the 0.01 level unless marked with an (*) then significant at only the 0.05 level (2-tailed). Cronbach Alpha coefficients for each subscale/measure are underlined and shown in the diagonal.

response. One could say, overall, that the responses to job involvement, burnout, and hardiness do not appear to be influenced to any great degree by a social desirability response set.

Phases of Burnout

Using the median splits from a previous study (e.g., Golembieski et al., 1996) for the three subscales, depersonalization, personal accomplishment (reversed), and emotional exhaustion, participants were classified into one of the eight phases of burnout (see Table 4.11). Almost one-third (32.5%) of the nurses were classified in an advanced phase of burnout (Phases VI, VII, or VIII).

Table 4.11

Phase Model of Burnout

	<i>Phases of Burnout</i>							
	I	II	III	IV	V	VI	VII	VIII
Depersonalization	LO	HI	LO	HI	LO	HI	LO	HI
Personal Accomplishment (reversed)	LO	LO	HI	HI	LO	LO	HI	HI
Emotional Exhaustion	LO	LO	LO	LO	HI	HI	HI	HI
Participants by Phases in Percentages (N = 31,000)	21.7	5.8	12.6	9.7	6.3	12.5	7.3	24.1
Participants by Phases in Percentages (N = 678)	34.5	4.9	11.2	3.1	13.7	8.8	9.4	14.3
Numbers of Individuals	234	33	76	21	93	60	64	97

Note. The percentages reported on the second last line of this table were calculated from $n = 678$.

One-Way Analysis of Variance (ANOVA)

The one-way ANOVA of summary marker variables or organizational covariants were obtained to examine the progressive virulence of burnout as predicted by the Phase model (see Table 4.12). The one-way ANOVAs (i.e., *F* ratio) for job involvement, hardiness, and medical ailments, by phases of burnout were all significant at the .001 level of significance. Subsequent post-hoc comparisons were calculated to examine where the differences occurred. For example, in terms of medical ailments, means were compared with the means of each of the eight burnout phases. Interestingly, 26 of the 28 marker variables were in the expected direction according to the Phase Model of Burnout. Then, using the Sidak post-hoc option, 10 out of the 28 were in the expected direction according to the Phase Model of burnout and were statistically significant. Eta squared offered an estimate of the variance explained in the paired-comparisons for each marker variable by the eight phases of burnout. Over 90% of the paired comparisons for the three marker variables were in the expected direction according to the Phase Model of burnout and, of that total, over 35% were statistically significant.

Life-Cycle by Phases of Burnout

Figure 4.1 presents the three menopausal life-cycle stages and the category *secondary amenorrhea* across the eight phases of burnout. The percentages of individuals in the advanced phases of burnout do not appear to change as a result of menopausal life-cycle stages (i.e., pre-, peri-, post-menopausal including the category *secondary amenorrhea*). Crosstabulation results for life-cycle stages and secondary amenorrhea by advanced phases of burnout phases were 32.3%, 31.6%, 33.2%, and 30.2%, respectively. A

Table 4.12

One-Way ANOVAs: Summary of Marker Variables by Eight Burnout Phases for Selected Canadian Registered Nurses

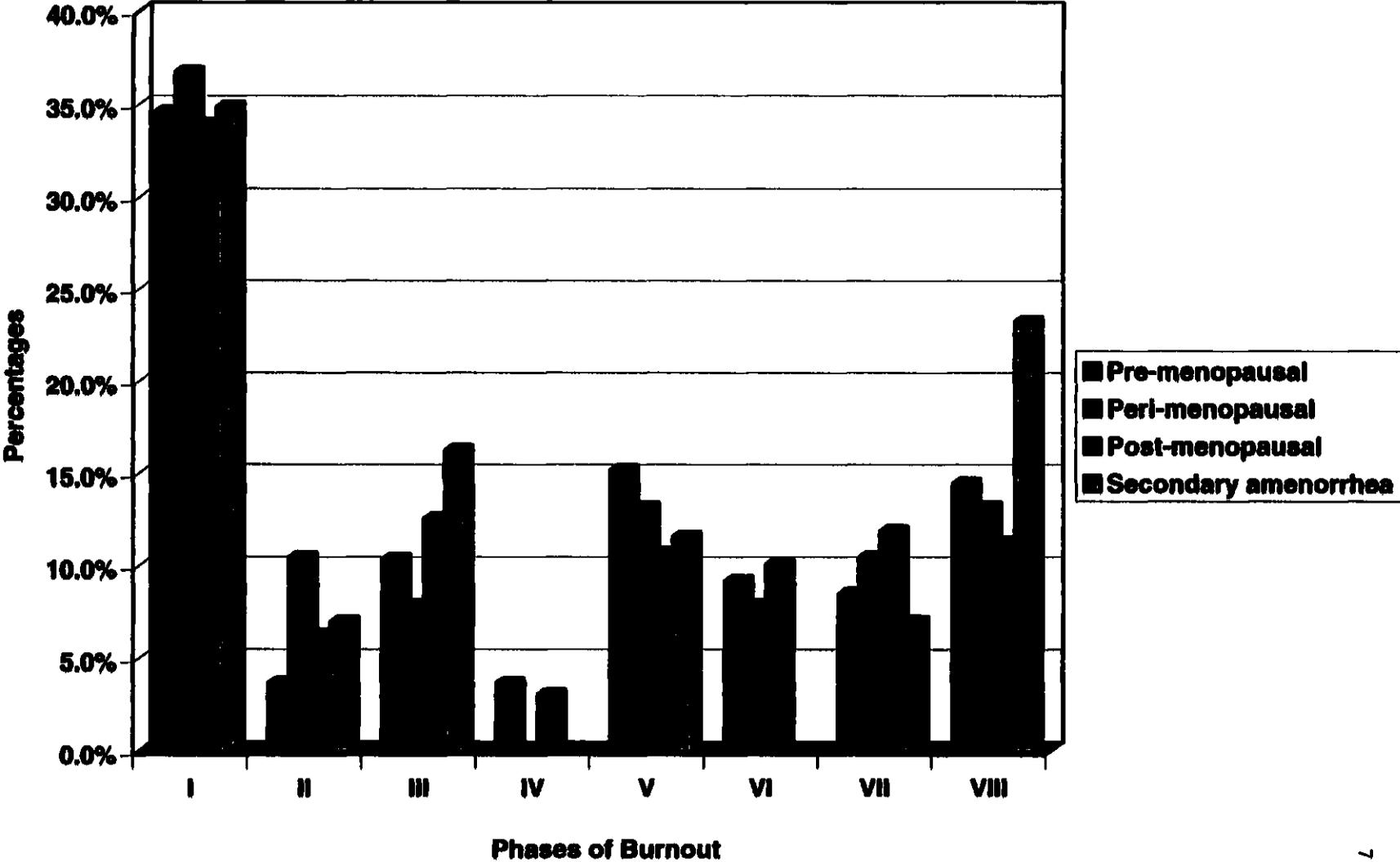
<i>Marker Variable</i>	<i>F-Ratio</i>	<i>F-Probability</i>	<i>η^2 Eta squared</i>	<i>Paired-comparisons in expected direction</i>	<i>Statistically significant & in expected direction</i>	<i>Paired-comparisons in contrary direction</i>
Job involvement	19.5	.001	0.17	24/28	10/28	4/28
Hardiness	33.7	.001	0.26	26/28	10/28	2/28
Medical Ailments	17.8	.001	0.17	26/28	10/28	2/28
Total sum of ratios	-	-	-	76/84	30/84	8/84
Percentages	-	-	-	90.5	35.7	9.5

Note. Sidak post-hoc comparisons were reported in this table. Sidak comparisons are the most conservative of the available post-hoc tests (SPSS, 1998).

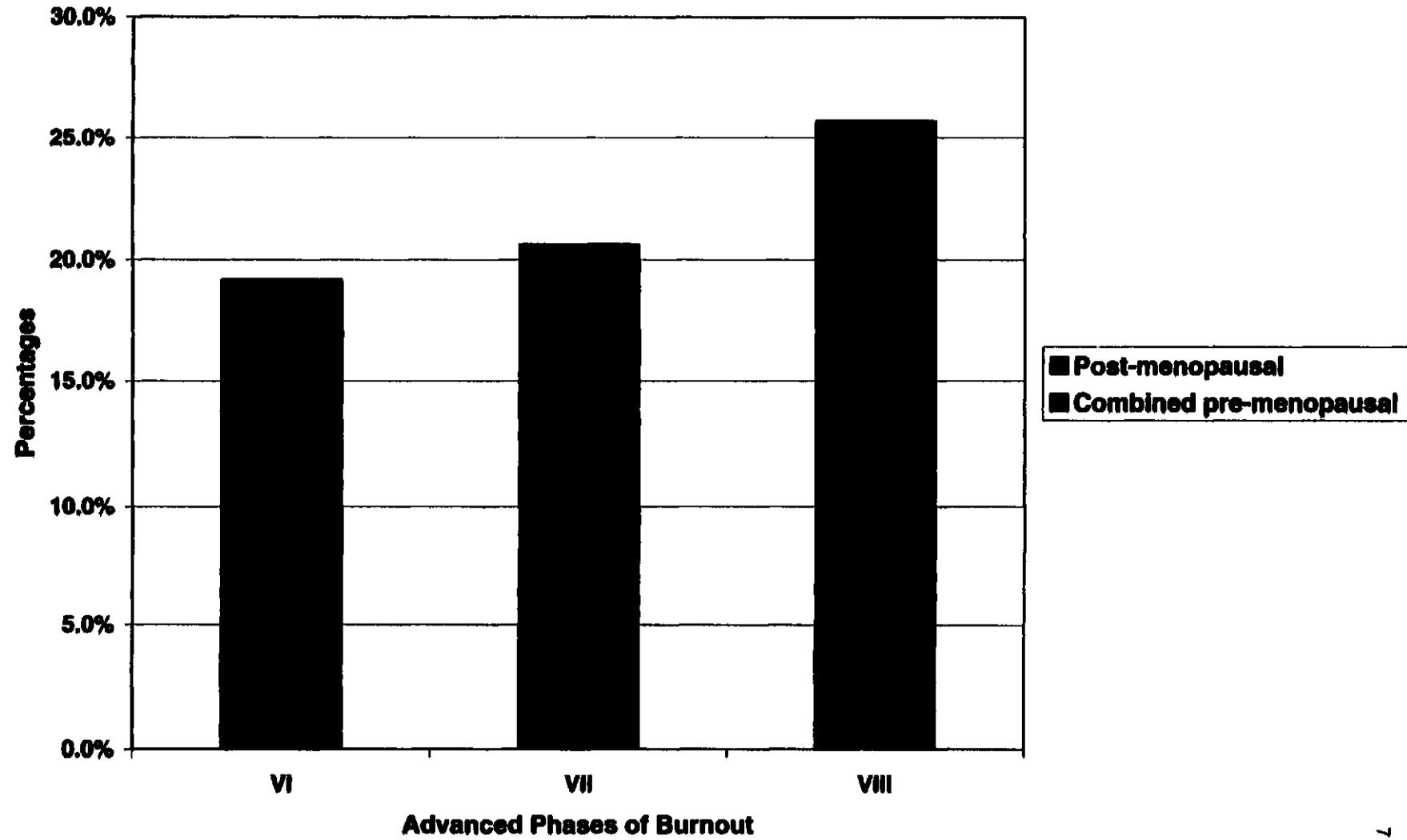
corresponding Chi-square test indicated no significant difference between the observed and expected frequency counts among life-cycle stages and secondary amenorrhea and the eight phases of burnout (i.e., Chi-square [21] = 17.7).

Figure 4.2 illustrates two life-cycle stages (i.e., combined pre-, and peri-menopausal, and post-menopausal groups; the secondary amenorrhea category was excluded here) by the three advanced phases of burnout (i.e., Phases VI, VII, and VIII). The peri-menopausal group was combined with the pre-menopausal category because of the low number in the peri-menopausal group (38). In order to do a chi-square a larger number provides a more

Figure 4.1 Menopausal Life-Cycle by Burnout Phase



4.2 Menopausal Life-Cycle by Advanced Burnout Phase



accurate calculation. The relative percentages of post-menopausal and combined menopausal women are consistent across the three advanced phases of burnout.

Burnout, Hardiness, and Job Involvement

As evidenced in Figure 4.3 (Chi-square [7] = 95.4 $p < .001$), a much larger percentage of *low hardy* individuals has been classified in the advanced phases of burnout. A similar pattern for those who are described as low in their job involvement or *passive* is presented in Figure 4.4 (Chi-square [7] = 72.9 $p < .001$).

Section II—Interview Findings

Interviews are a special form of interaction between people, the purpose of which is to elicit information by asking questions. The interview data were acquired so multiple realities could be described relating to the meaning that a small group of registered nurses give to their professional and occupational experiences, in particular, burnout, from their current menopausal life-cycle stage. An overview of the interviewees is presented in this section whereas an interpretation of their comments is presented in the next chapter.

Eight nurses were interviewed individually and at various locations. Seven of the eight interviewees were partnered. Six of the eight interviewees had at least two children living with them, one person had two children but they were living away from home and one nurse had no children. The average age of the participants was approximately 44 years of age. These nurses were from various nursing positions including staff nurse, educator, management, and independent practice, as well as a variety of settings (i.e., hospital and community). They had from 8 to 30 years of nursing practice experience. At least one nurse represented each of the menopausal life-cycle stages (i.e., pre-, peri-, and post-

Figure 4.3 Burnout Phase by Hardiness Level

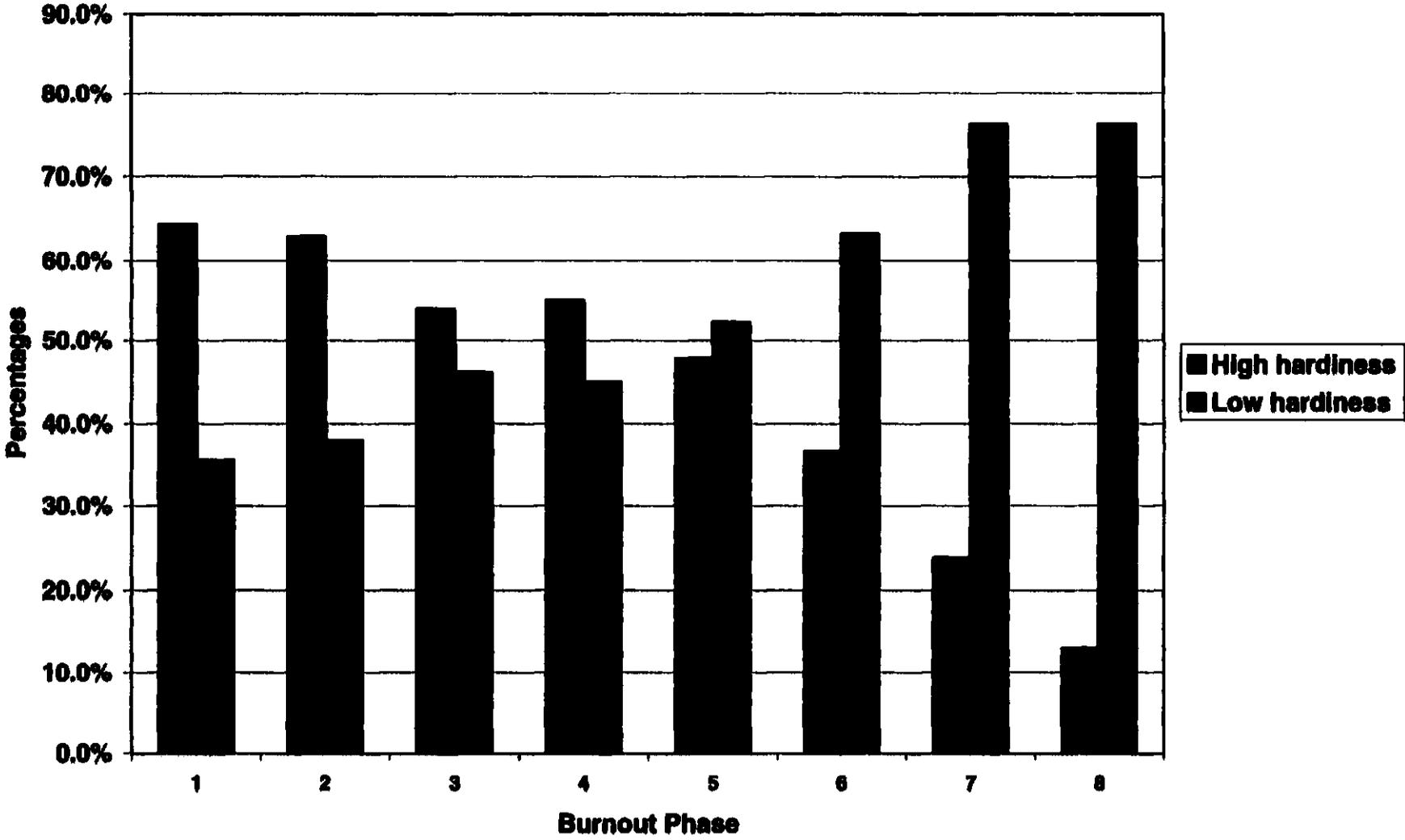
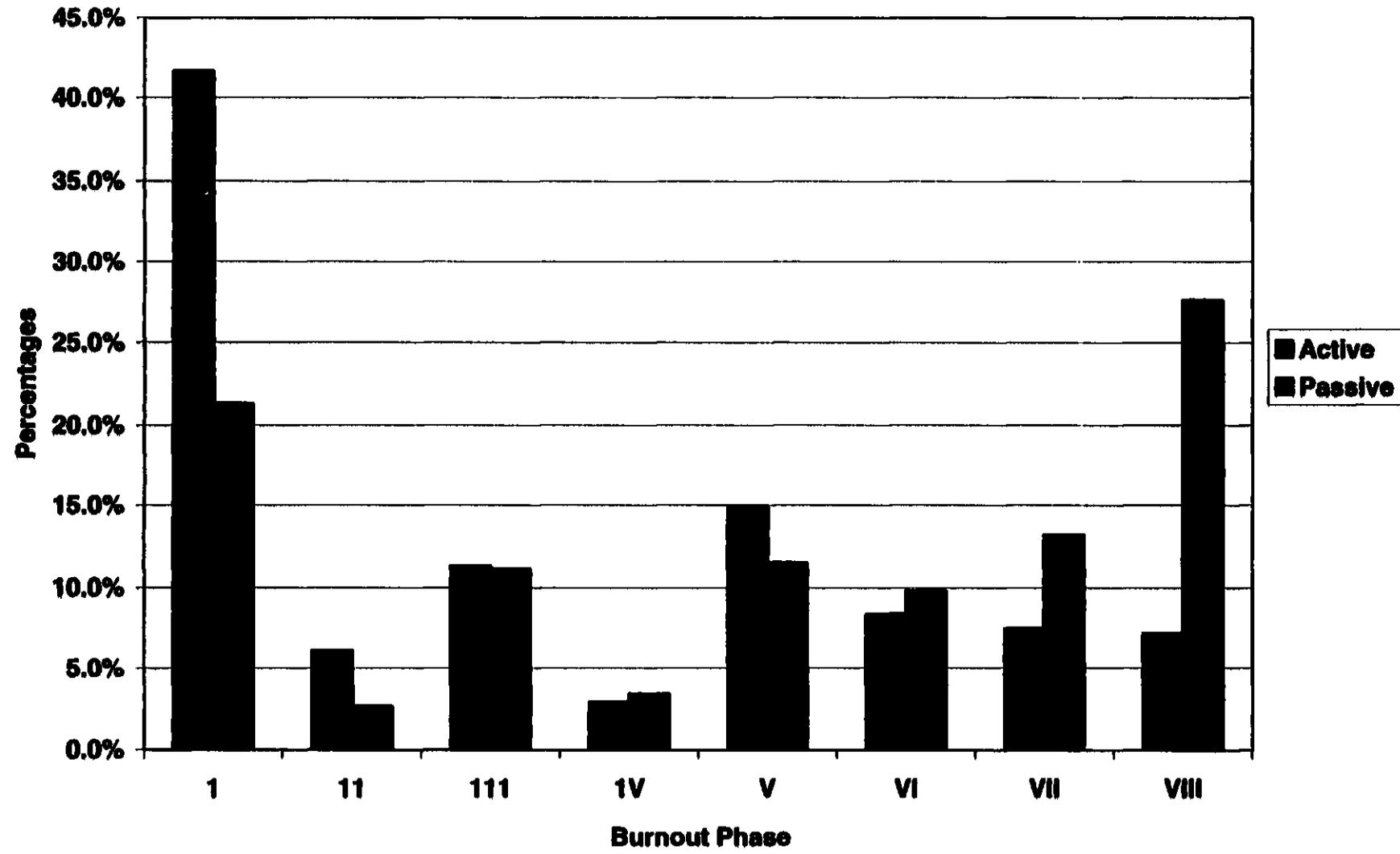


Figure 4.4 Burnout Phase by Job Involvement



menopausal). The interviews lasted from one to three hours and the transcripts consisted of 15 to 36 pages of text for each interview. In total, 197 pages of transcribed text were produced. The focus group debriefing session lasted three and one-half hours comprising 45 pages of transcribed data.

The first question provided an opportunity to get to know the nurse and for her to talk about herself in a general way. What I learned was that five nurses were diploma educated, two received their degree in nursing, and one had a master's degree in nursing. Those individuals who had their diploma wanted to return to university to obtain their degree and were waiting until their child-rearing responsibilities had diminished. All the interviewees revealed that they suffered from a multitude of medical ailments in the past and, currently, some of them were experiencing various chronic diseases such as high blood pressure and depression. Regardless of menopausal life-cycle stage, all the interviewees mentioned that there was some sort of struggle to balance their occupational and personal roles. As an outcome of this initial conversation, a discussion of stress ensued. Most of the interviewees were able to distinguish between the positives and negatives of stress without any prompting from me. The stressors they identified in their current nursing position were inadequate staffing, work overload, time pressures, strained interpersonal relations with peers and doctors, regionalization (i.e., a major restructuring of the health-care system), the bumping process (i.e., a nurse with more seniority, upon losing her/his position due to unit closure, redundancy, etc., may "take" the position of another nurse with less seniority, who in turn, may "bump" someone else or lose her/his position), and wasted money by administrators.

Many nurses stated throughout the course of the interview that policy makers need to address the issues of under-staffing so workloads can be more evenly distributed. They suggested that since regionalization was already in effect—some nurses did not agree with the decision to regionalize—that evidence-based decision-making would be a more organized manner in which to downsize. One nurse, in particular, mentioned that the amalgamation of services within hospital- and community-based settings and a decrease in administrative positions rather than decreasing front-line worker positions would be beneficial to both patients and health-care providers.

When asked what techniques they used to reduce distress in their lives, most interviewees shared that they used social support and regular exercise as a way of coping with distress. Some nurses stated that they had learned the hard way about the importance of looking after themselves first and, then, others later. These nurses mentioned that it wasn't until they had a major bout with depression or a major scare with their health at some point in their careers that they decided to slow down and look after themselves. When asked about how they rated their stress levels (i.e., on a scale of one to eight with one being the lesser amount of stress) in the week prior to being interviewed, two participants did not give an exact number but did describe their situation. Only two individuals indicated that they were at levels seven or eight, the other four stated they were in levels one to four. Importantly, it was determined through the conversations that four of those interviewed had taken time off work because of advanced burnout. One participant pointed out, so clearly, that it is really difficult to speak about burnout after the fact. Fortunately, all four nurses are currently back at work trying to adjust and maintain

balance in their lives. Most nurses spoke positively about their current menopausal life-cycle and stated that they basically had a positive outlook toward menopause. One person, who was post-menopausal, elected to go on hormone replacement therapy due to the various menopausal ailments she was experiencing. All participants stated they were excited to be involved in a study that pertained to women's health.

Summary

A triangulation of methods (i.e., survey and interview) approach was chosen for this study. Each method was carried out as a separate study and was evaluated according to a method specific rigor. Those respondents who were surveyed and who reported fewer medical ailments and obtained high job involvement and personality hardiness scores reported experiencing the lowest phases of burnout. The major conclusion from this study was that one in three women were burned out but, importantly, menopausal life-cycle stages were not related to the experience of burnout. The eight interviewees provided insight into what it means to be burned out, since four of the eight participants described personal experiences. Moreover, they spoke positively about their life-cycle stages, providing further support for the major conclusion of this study.

CHAPTER V

Discussion

A randomly selected sample of registered nurses in a western Canadian province was chosen for the survey component of this study. The research question that provided direction for the survey method asked how these nurses describe their professional and personal life experiences, in relation to health, job involvement, burnout, and hardiness, at various stages throughout the menopausal life-cycle. The hypotheses related to the survey research addressed these statements: nurses who rate high on the job involvement scale will experience lower phases of burnout, nurses with increased personality hardiness will experience lower phases of burnout, nurses with increased health ailments will experience more advanced phases of burnout levels, and there will be differences in the experiences of burnout as it relates to various menopausal life-cycle stages. Each hypothesis is addressed in this discussion. The interview research question involves how a purposefully selected sample of registered nurses describe the meaning of their occupational and personal experiences, in particular, burnout, from the perspective of their current life-cycle stage. The discussion also moves from a triangulation of methods to a triangulation of concepts.

The chapter is divided into three sections. Section I provides a discussion of the survey results. Section II speaks to the themes that emerged from the interview data, and Section III provides a triangulation of concepts in the form of a metaphor.

Section I–Survey

Characteristics of the Survey Participants

As previously stated, the typical respondent was in her early 40s, balancing family responsibilities with a professional career. Hence, women in the sample, on average, were at the age where they were moving into the second half of their lives; a time that Borysenko (1996) describes as the midlife metamorphosis (ages 42 to 49 years). This stage of life represents a time when women consciously reflect upon how they perceive themselves, their roles, and how they relate to others. Taken in another light, the demographics from this study reinforce the notion that the nursing population in Canada is aging, and is in crisis. Essentially, the nursing profession has been altered by the major health-care reforms in Canada. Consequences of these reforms include fewer women entering nursing, fewer nurses obtaining full-time employment upon completion of educational programs, and a cadre of nurses in the maintenance stage of their careers.

Health-Care History

Women in this study viewed themselves as being very healthy. For example, a majority of nurses (96%) rated their overall health as average or above average when compared to others their age. Consistent with this perception, only a small percentage of participants identified chronic illnesses (30.9%) and regular prescription medication use (45.9%), while 65.6% reported having regular physical checkups. Unfortunately, this positive perception toward their health does not necessarily translate to exercise and disease screening practices. Lee and his colleagues (1999) note that according to the 1996 American Surgeon General's Report on Physical Activity and Health, 60% (a finding

similar to this study) of Americans don't exercise regularly and of those 60%, 25% don't exercise at all. They also claim that exercise affects one's hormonal balance. Exercise sweeps excess cortisol (stress hormones) from the bloodstream and the body makes hormones called endorphins, which are natural painkillers and mood-enhancers. A positive outcome of exercise is that menstrual cramps and PMS are often soothed by a good workout.

Similarly, as the incidence of medical ailments (versus menopausal ailments) increases so does the incidence of burnout. Typical medical ailments include headaches, backaches, dizzy spells, and panicky feelings. Since 90.5% of the paired comparisons between medical ailments and burnout were in the expected direction, according to the Phase Model of burnout, hypothesis three was supported, that is, nurses with increased health ailments will also experience higher phases of burnout.

Moreover, one would expect nurses who are informed and primary health-care promoters, at home and in work settings, to practice prophylactic measures on their own behalf, without exception. There are different ways to view such statistics but it is surprising to find 10.1% of the sample not practicing self-breast examinations and 1.4% never having an annual Papanicolaou (cervical) smear. Northrup (1998) cites a report from the University of California that states 50% of all doctors do not have a personal physician—something that all doctors advocate for their patients, 20% don't exercise, and 50% of female physicians don't even do monthly breast self-examinations. One is left to wonder why health-care professionals, who typically promote health teaching with patients/clients, would avoid appropriate health promotion and disease screening practices

in terms of their own health. A rationale for this inaction could be that nurses are among the many professionals who do not always “practice what they preach,” perhaps, in part, due to their multiple roles and busy schedules. There is no mistaking the consequences of such inaction. For example, according to Northrup (1998), the cervical smear is the single most cost-effective disease screening test known to modern medicine. She cites estimates of 70% of cervical cancer deaths are actually preventable because of this inexpensive and noninvasive test.

Personal Life-Cycle Perspective

The single most important contribution of this study is its success in describing nurses’ personal and professional experiences. Essentially, this study features a menopausal life-cycle perspective—one that is holistic and positive versus singular and disease-oriented. On average, the 681 women responding to this question within the WHOLE Profile indicated they started the reproductive years (menarche) at 12.7 years of age. Of the 686 women responding to the menopausal life-cycle question, 440 (64.1%) reported, according to their monthly menstrual cycles, that they were at the pre-menopausal, 38 (5.5%) at the peri-menopausal, and 165 (24.1%) at the post-menopausal stages of the life-cycle. The distribution of nurses interviewed (i.e., five in pre-, two in peri-, and one in post-menopausal stages) reflect the distribution of the menopausal life-cycle stages of the nurses surveyed. Clearly, the majority of the women in the entire sample were in transition approaching the peri-menopausal stage and within ten years will be among the 47 million menopausal and post-menopausal entrants projected by Hill (1996).

About half the women classified themselves in their respective menopausal life-cycle

stages due to the natural production of their own hormones. Over 12% of the nurses were menstruating and were in the menopausal life-cycle categories due to exogenous hormones. Nurses (14%) in the post-menopausal group reported being in this category due to surgical intervention. Unfortunately, such a result reinforces the medical management approach (i.e., a disease orientation versus a more holistic and positive approach) to women's health.

Thirty-four percent of the nurses surveyed acknowledged they often suffered from menopausal ailments in the form of heavy menstrual periods, hot flushes/flushes, night sweats, or vaginal dryness. A further 7.7% of nurses from the survey research stated that they were menstruating due to birth control therapy and 4.5% of the nurses were menstruating due to menopausal hormone therapy. This latter finding is somewhat lower than what Northrup (1998) describes as 10 to 15% of women who typically choose hormone therapy. It is unclear, in this study and most others, how many women were on hormone therapy to relieve ailments of menopause or as a prophylactic measure for the prevention of osteoporosis, heart disease, or Alzheimer's disease. Ostensibly, placing women on hormone therapy for preventative reasons does not eliminate the increased risks of breast and cervical cancer that hormone therapy imposes. Disease trends now indicate that women on long-term synthetic hormone therapy may be dying of breast cancer instead of heart disease (Greenwood & Nunn, 1994). All we have done is replaced one disease with another.

Another interesting life-cycle finding from this study was that only 14.4% of the nurses stated that their menstrual cycle affected how they approached their work and only 13.4%

reported their menstrual period affected how much they accomplished in their work.

These findings are consistent with Northrup (1998) who reports that 10 to 15% of women are unfortunately incapacitated to varying degrees by menopausal ailments, which may affect their professional as well as personal lives.

Women do not win when it comes to discussing their biology. On the one hand, when they complain of biologically related ailments they are told it is all in their heads. On the other hand, their hormones are often assumed to control them to the extent that some people believe women are unfit for public life in high profile jobs. It will take time to change ingrained attitudes that the menstrual cycle and those hormones that regulate the reproductive cycles and transitions are not pathological; instead, we must accept that insight can be extracted from one's biology (Borysenko, 1996; Northrup, 1998).

On a positive note, many of the women's health authors cited in Chapter II point out the history of, and shame related to, the menstrual cycle. However, a trend is occurring that includes a more enlightened view of menopausal transitional stages. For instance, more than half (55.1%) of the women in the survey had a positive attitude or somewhat positive attitude toward menopause. Perhaps this finding reflects the positive influence various women's health authors are having in regards to changing attitudes within one occupational group of women at various stages of the menopausal life-cycle. The changing attitude will most likely increase as women, generally, are encouraged to share their experience of various life-cycle transitional stages in their personal and professional lives.

The menstrual cycle is a basic internal body rhythm. According to Northrup (1998) and

Borysenko (1996), the menstrual cycle governs the flow of not only fluids but also information and creativity. These two clinicians claim that women receive and process information differently at different times in the menstrual cycle. Janine (all names have been changed), along with other interviewees, noted: "I tend to think women [relate to one another and to life events] in rhythms or cycles." She recalls that women remember events in relation to periods of time in their life. She states women say such things as: "When I graduated from nursing, when I had my first child, or it [an event] happened after my daughter's birthday." According to several authors (Borysenko, 1996; Kamen, 1997; Northrup, 1998; Shuttle & Redgrove, 1994), women also recall events in relation to where they are in their menstrual cycles.

Occupational Life-Cycle Perspective

As stated previously, one in three nurses in the survey described herself as being in an advanced phase of burnout. Four of the eight participants in the interview component of the study were off work at some point in their careers due to burnout. Even though nurses, as health-care providers, are actually more at risk than non-health-care workers, the incidence of burnout from this study was slightly less than those reported in studies using similar populations (Golembiewski et al., 1996). The 32.5% of nurses in advanced burnout are in the mid range of samples (i.e., 17.9% to 47%) as cited by Boudreau, Leiter, Schaufeli, and Golembiewski (1999).

The results of the WHOLE Profile indicated those individuals reporting high job involvement scores (64.5%, actives) and those who indicated high personality hardiness scores (46.2%) also reported experiencing the lowest phases of burnout. Thus, hypothesis

one—nurses with increased personality hardiness will experience lower phases of burnout—and hypothesis two—nurses with increased personality hardiness will experience lower phases of burnout—were supported. At this point in time, there is uncertainty regarding what is cause and what is effect. Current writers describe that occupational health behaviors are associated with positive health outcomes in terms of lower burnout phases. For example, research outcomes consistently report that as involvement in one's job (Golembiewski & Munzenrider, 1988; White & Ruh, 1973) and personality hardiness (Kobasa, 1979; Simoni & Paterson, 1997) increases there is a corresponding decrease in burnout experienced on the job.

Finally, menopausal life-cycle stages did not covary with the burnout experience according to the analysis of the data. Therefore, the fourth hypothesis stating that there will be differences in the experiences of burnout as it related to various menopausal life-cycle phases was not supported. There were no differences.

Section II—Interview

As noted previously, this study intentionally incorporated a triangulation of methods—survey and interview. Specifically, this approach accommodates the benefits of going beyond traditional survey research by including interviews to explore in depth and develop related ideas. As such the next section provides a discussion of the participants and the three major themes emerging from the interviews. These themes included *Spirituality, Being Versus Doing, and Eustress Versus Distress*.

Characteristics of Interview Participants

Of the 692 nurses responding to the Profile, 138 individuals indicated an interest in

participating in the interview component of this study. Several attempts were made to contact individuals. Eventually, eight individuals—four each from urban and rural settings—participated in the interviews. When initial data analyses of the interviews were completed, participants were invited to attend a debriefing, focus group session. Only two people were able to attend the focus group.

A profile of the *average* participant in this component of the study indicated a female of approximately 44 years of age, married, with two children at home. The participants were from various stages of the menopausal life-cycle with at least one participant representing each life-cycle category (i.e., pre-, peri-, and post-menopausal). Also, participants were from hospital-based and community-based practices representing managers, administrators, and staff nurse positions.

Emerging Themes From the Interview Data

Each participant of the interview component of the study responded to the same series of general questions (see Appendix D) pertaining to various professional and personal life experiences. Nevertheless, the unstructured format of the interviews allowed the participants considerable freedom to explore and share whatever they wished (in response to the questions and other spontaneous questions). Probing questions followed their direction in each interview. It was anticipated that the participants would provide insights into the meaning that nurses give to their various roles, both personal and professional. Through their thoughts, feelings, and reflections about their experiences, it was possible to discuss how various menopausal life-cycle stages contributed to the meaning given to these roles. Three major themes emerged from a content analysis of the transcribed

interview data. These themes were labeled: *Spirituality, Being Versus Doing, and Eustress Versus Distress.*

Spirituality

In general terms, spirituality may be defined as one's inner guidance toward one's life purpose (reflecting one's values and beliefs). It represents a struggle with finding a balance in one's life through questioning and looking within oneself for answers to significant questions. It is also a recognition of a power greater than oneself with a need to reconcile one's life in terms of that greater power. Spirituality may also indicate a loss of dreams, a sense of regret, and a process of grieving. Spirituality represents our desire for interconnectedness to each other. Canfield and Miller (1998) state: "Concern and involvement with the bioenvironment also reflects an emerging sense of the spiritual" (p. 222). Participants provided insights into their spiritual reality in overt and covert comments. For instance, one participant, Margaret (all names have been changed), who is in her 40s suggested that she had been going through the questioning period. She remarked:

I think when you get to 40 [years of age], or whatever stage, you sit up and say, 'Okay, that's half my life, if I live to 80 [years of age]. Am I happy with that, and with us, where our kids are?' We are in transition anyway, first, they are going to leave home. So, along with the 40s comes the change in responsibility of child care and it is another stage that we consciously look at and think, 'Is this where I want to be, or, is this the track I want to stay in?'

Penny reflected upon her achievements in life and made the following comments:

The opportunities that have come along have not always been what any one of us thought would be our dream, but at the same time, taking that opportunity and running with it has been so rewarding. . . . I keep saying to people that I am only 50; I need another 50 years to try everything else. . . this is the time of my life that I am doing

fun things, it is work, but it is fun and you always look at what is the next challenge.

Penny goes on to explain the beauty of this time of reflection is allowing the spiritual self to emerge. "I have seen so many women in the media, whether it be entertainment or whether it be politics, or whatever, they are just getting started at 50." She describes a woman of 72 years who was her mentor, "Here is a lady of 72, full of life, living life and enjoying it." Further, Penny notes the importance of resuming a formal spiritual component of her life.

I am coming full circle, the area that I have got to look at more is my spirituality. That's the area I have to get more into balance. Not that I have lost the Catholic faith, but perhaps I have meandered away from the Church a little bit. I still very firmly believe in lots of things spiritual. I have prayed with patients and all the rest, but now I would like to get back into more formalized Church again. That is the part of the balance that has not been there.

Fay commented on her desire to make a career move toward parish nursing to integrate physical health with spiritual health. She stated: "I understand that it [parish nursing] involves applying your spiritual beliefs to the health and welfare of the people in your congregation, tying everything all together and working with them to maintain whole health rather than just physical health." She reflected on the interrelationship between the spiritual-emotional balance in people's lives and stated: "You have some people [who] are sick because their spiritual-emotional imbalance is not right and that is affecting their physical health." Also, relating to spirituality, Janine shared that she received a gift from both of her parents and disclosed:

Oh, yes, my parents were both professional people and they raised me with a faith. They were regular church going people so, some of those factors that build resilience in my life were already in my home. . . I know for myself it was my [religious]

upbringing and with my parent's professionalism that all got together and raised me with this idea of courage and community.

In essence, from the perspective of the eight interviewees, spirituality relates to an individual assessment of one's achievements in life, as seen through one's multiple roles. They sought direction from their inner voice and from a power greater than themselves. Typically, the outcome of this personal reflection provided guidance, and permission, for these nurses to fulfill their purpose in life. Spirituality fosters a caring for oneself as much as caring for others. There were no questions about spirituality included in the survey data, therefore, the theme spirituality can only be discussed in relation to the interview data.

Being Versus Doing

Being Versus Doing may be interpreted as the struggle or tension within women regarding whose needs to meet and when. For instance, *doing* indicates the natural response of women to invest their energies in doing things for others, to take on many roles and to be the nurturing person, particularly as a wife and mother. *Being* represents the essence of life. It means liking oneself, accepting oneself, and acknowledging that it is okay to care for oneself. Thus, the being versus doing theme may also represent a struggle within as women seek to understand themselves, to find their own voice, and to balance their own individual needs while they simultaneously endeavor to care for their families.

Penny described the typical scenario for women who wanted to work outside the home. Her description fits the young (pre-menopausal) wife and mother who is often wanting to be "the best she can be" in every role she pursues. Sometimes, there is a conflict between personal and professional roles, for numerous reasons. Often times,

today, the professional role is deemed necessary so the family can enjoy “the pleasures” of life—holidays or material goods. She said:

Looking back, [I was] probably running like the Road Runner in that I would work a three to eleven shift, but the house was clean, the supper was cooked, everything was all done before I would go in for my 3 o'clock shift. I would never ask my husband to do anything; he's always expected it of me. I guess I had a little joy in having to do this [housework], but to me, working was a privilege, it was almost like a reward after working hard at the house [work/chores], this was your privilege, you can go out to work.

Over the past several years, Penny realized the importance of consciously attending to her own needs. This perspective eventually emerged after many years of challenging and demanding career opportunities while simultaneously managing family and home responsibilities. She further stated:

About once a month or so, I will just have a ‘me day.’ I will have my coffee and if I want to read a book, if I want to do some gardening, I can do that without feeling guilty. At first, I used to feel very guilty. I always felt that I had to be doing something. Everything was done, work-wise, home-wise. . . . Go have a manicure, or go have a pedicure, that can be the start of a ‘me day.’

Fay, a participant in the peri-menopausal stage, offered a similar observation about recognizing the importance of self-care.

Yes, everyone [gets taken care of] except ourselves. So now this [exercise program] is a token of me taking care of myself. I started being more physically fit and I exercise pretty well everyday now. That takes a good chunk out of my day. Someone at work said, ‘when do you find time to clean house’ and I said ‘I don't care [about the housework as much as I did in the past].’

This same participant rationalized how taking care of herself also affected her family in a positive way. She explained:

My priority is being physically fit and mentally fit. . . . It is true, it is a recognition that he [her husband] recognizes if I am not exercising or doing something [for myself] then I am not going to be happy. If I am not happy, then no one is going to be happy.

Janine acknowledged the dilemma of finding balance and time for herself in her life.

She stated:

Yes, okay for balance . . . number one, my girls, because of their age, come first, so if I get called for overtime I feel guilt-free to be able to say 'no' to any extra work and I don't change shifts for that very reason. My kids know what the schedule is; they know that it repeats, they have the right to expect that I am available at those times [non-work]. Finding time for myself, like exercise and time for me and my [partner] is something that comes after the kids. Work commitments are a little harder because as a professional you need to make the time for study and that is getting more and more often. Once I walk away from the hospital I don't feel very much like going back for meetings and upgrading but we have a head nurse who believes in paying people for their time so we have an incentive for going back for important meetings and upgrading.

Janine went on to say:

I get up at 5:00 a.m. every morning and that is my reading time. I started doing that before I started [my university program] and it was a good thing too. So if there is reading or work to do I start at 5:00 a.m. . . . I have creative moments when I daydream and just look out the window before I go into the garden. I just look at my flowers and I look at my little patch of earth and I am just quiet for that hour and then I plan something else. Ideally, that is when I go for a walk, after my cup of tea.

Annette acknowledged how important it was to maintain some personal time:

I don't give it [her time] away quite as freely [as before] and maybe with the business of sort of establishing your own personal boundaries I did realize in the end that giving more didn't mean it was better. What it did mean, however, was I had no time left for me.

After some serious reflection Audrey described how a chronic illness allowed her to recognize the importance of making time for herself. She observed that she had to take responsibility if she truly wanted to make a change in her situation. These comments also demonstrate that focusing upon one's past and current circumstances is essential if one is to clarify, on an individual basis, what *really matters* in life and what one needs to do to achieve a level of self-satisfaction and self-actualization. In essence, Audrey described

moving from *doing for* others to also *doing for* self, in order to realize *being*.

I don't know whether it [thinking about change] was turning 40 [years of age] or thinking about dying [due to a chronic illness] . . . but I just thought, 'Really where am I? Do I feel really appreciated or do I feel used and abused?' Different days I felt different ways, you know. I just thought, 'Okay what bugs me and why?' Then, I looked and said, 'You know, I kind of did that [life circumstances] to myself' . . . I was always quite sure about everything and just took things in my stride and like I said [earlier], the only way I am going to undo it [my situation in life] is by letting people know how I feel. . . . I have always denied myself so I am going to make this [time in my life] for me. If my family doesn't like it [this change], it is okay, but it is going to be a time for me.

Throughout the dialogue the eight nurses spoke frequently about heeding the voice from within. In particular, these nurses developed insights and talked about the need to look after their own basic needs before overextending themselves to care for others. The interviewees expressed a consistent desire to be a human *being* rather than a human *doing*. Since no questions addressed personal views of this nature in the Profile, it was not surprising that the theme being versus doing was only available from the interview data.

Eustress Versus Distress

The terms eustress and distress were coined by Selye (1956) in his theory on stress. Eustress refers to the positive response to stress whereas distress is the negative response to stress. All of the participants acknowledged the presence of both positive and negative stress. Since they discussed the sources, effects, and potential resolutions to *stress* so openly and frequently, it seemed fitting to include a theme that accommodated the two elements of Selye's stress.

Interview participants were asked to rank their current burnout level on a scale of one to eight with eight being the highest burnout level experienced. Two participants did not give an exact number but did, however, describe their situation. Only two individuals

indicated that they were at levels seven or eight; the other four stated they were in levels one to four. The participants listed various stressors in their life such as: balancing work and family life, introduction of regionalization (i.e., restructuring of the health-care system), creating limited resources and extreme time pressures due to lack of adequate staffing of front-line-workers, conflict with nursing colleagues and doctors, patients and patients' families, the bumping process (a process whereby when a nurse is laid off she/he, according to her/his seniority and with the backing of the union, is able to bump or take an in-scope nursing position of a less senior nurse), lack of support from management, and wasted money by administrators with no input by front-line workers.

Importantly, four of the eight participants explained how serious health problems arose as a result of distress. These health problems necessitated time off work, rest, or counseling before they could resume a working role in their paid work environment. For instance, Ann reflected upon her situation:

Well, I know that there is good stress and bad stress. Stress is okay to have to a point as long as you can handle everything, but when you are to the point where . . . like now, I am at the point where I had to go off on sick leave because I had just had all that I could take. So stress is bad when it is affecting your health.

One of the four participants is currently working in a very challenging role and enjoying her work tremendously while another participant is continuing to seek the right position for herself in nursing. The third and fourth participants who have taken time off work returned to their previous place of employment and are trying to work through their situation by changing their perspective toward their paid work environment.

Several participants had experienced the loss of their nursing position due to the

provincial cutbacks or the bumping process. These experiences clearly brought about such a magnitude of distress that resulted in advanced burnout, and were especially difficult for those participants who believed that they had to work and had few choices in terms of work setting. Abby talked about the difficulty of being an experienced nurse and still being bumped out of the system. She stated:

That was really hard for me because when I was laid off, I had more than ten years of experience and I was getting bumped by somebody who had worked for a year and a half. That was really difficult for me. It was a sign of the times. I don't think that I ever felt any ill-will to the person personally who bumped me. I realized that she had a family to feed. . . . But, I was really angry at the system and the union for allowing nurses to have to do that to other nurses. That was really hard to take.

Even within this small sample, the negative influences of stress were significant enough that half of the sample (four of the eight participants) had to remove themselves from the work environment.

Annette, a participant in her mid 50s, summarized her experience with burnout and recognized the importance of seeking balance in life. She disclosed:

I mean I need to work, my husband had been in an [accident] and lost his ability to practice in his profession and, financially, we were in a jam and we were in a jam at the same time that health-care was really starting to put the thumb screws on [the profession of nursing]. So, I felt that I had absolutely no option at that time. . . . I just worked harder and harder and did everything I needed to do to survive. But, when that was over and we kind of climbed up the other side of that [situation], I actually was burned out. . . . I actually had to quit [my job], which I guess is also characteristic of what I learned about burnout. I had to get out of my situation in order to get well and it took me six months and I almost did not know how to do it [recover from burnout]. . . . There are some warning signs for me that I watch for now and I really am trying to balance so that I have a personal life, a professional life, a spiritual life, and a social life. So I think I am doing better than what I was but, it is not perfect yet. I think you never hit perfection but, at least, I am aware of what I am doing now and I just don't give it all at work.

Despite the difficulties many of the nurses experienced on the job, they also described

the positive effect of stress. Eustress provided the essential stimulus to do the work that needed to be done, to be especially productive. Penny recognized the importance of knowing her employees' strengths so that she could delegate extra work accordingly. As the manager, she would also ensure that the individual who took on this extra work was always compensated at a later time, so that one person wasn't always being overburdened. "That extra stress really got me going . . . I work well under stress. . . . Stress to me is very positive . . . I learned how to appreciate other people and what they could do." She believed in giving "people a little more control over their lives rather than somebody controlling their lives."

Janine, one participant in the peri-menopausal stage of the life-cycle, commented on the importance of believing in our ability to control our own destiny and the need to direct our energy in a positive direction. She added:

It [the balance between eustress versus distress] is always moving, it is not a static thing. . . . How you feel about it [eustress versus distress] is your own choice. If you want to go around with a down-turned mouth about things because things are not going your way, fine but you are not going to live long and you won't be happy. I think we choose our reactions to things and I believe when I have a positive attitude toward my peers they respond with a positive attitude in kind. Some of it [responding in a positive manner] takes more energy some days and some days it takes less.

The interviewees' responses to this issue stand as examples of resilience, hardiness, and determination. From the perspective of various menopausal life-cycle stages, these women have responded with energy and enthusiasm to find balance in their personal and professional roles. Ultimately, the notion of self-caring seems to come with midlife and these women provided insights into the meaning that they give to themselves as individual women and nurses. This theme, eustress versus distress, was supported in both the survey

and interview data. To end this discussion, Section III offers a melding of survey and interview data through the triangulation of concepts and metaphor.

Section III–Triangulation of Concepts

According to Foster (1997):

Triangulation of concepts alleviates concerns about combining numbers and text because both qualitative and quantitative results can be portrayed conceptually. The patterns and themes that emerge from qualitative research are clearly conceptual in nature. But the denominator works for quantitative results as well. Statistical values have meaning only to the extent that they describe characteristics of the phenomena under study. (p. 5)

One way to integrate the triangulation of concepts is through the use of a metaphor.

Coffey and Atkinson (1996) believe that

metaphorical statements enable the analyst to explore the linguistic devices used by social actors and how such devices reveal shared meanings and understanding. Metaphors also can be seen in a wider context of specialized vocabularies. Language is used in specific and particular ways. Cultural categories are organized through linguistic resources. Metaphors are therefore part of a wider use of linguistic symbols to convey (or create) shared cultural meanings. (p. 89)

A metaphorical display (see Figure 5.1) is offered as an example of conceptual triangulation that links both the survey and interview data findings. A woman's life was viewed by myself as analogous to an oak tree in a garden. The trunk of the tree is likened to a woman's core or soul and the branches depict the various menopausal life-cycle stages or paths of her life. The leaves and the branches of a tree go through processes of growth and rebirth according to the seasons. Similarly, women grow and develop through various menopausal life-cycle stages. The roots are symbolic of the three themes that emerged from the interview data, spirituality, being versus doing, and eustress versus distress. Many women are working toward balance. They metaphorically receive their

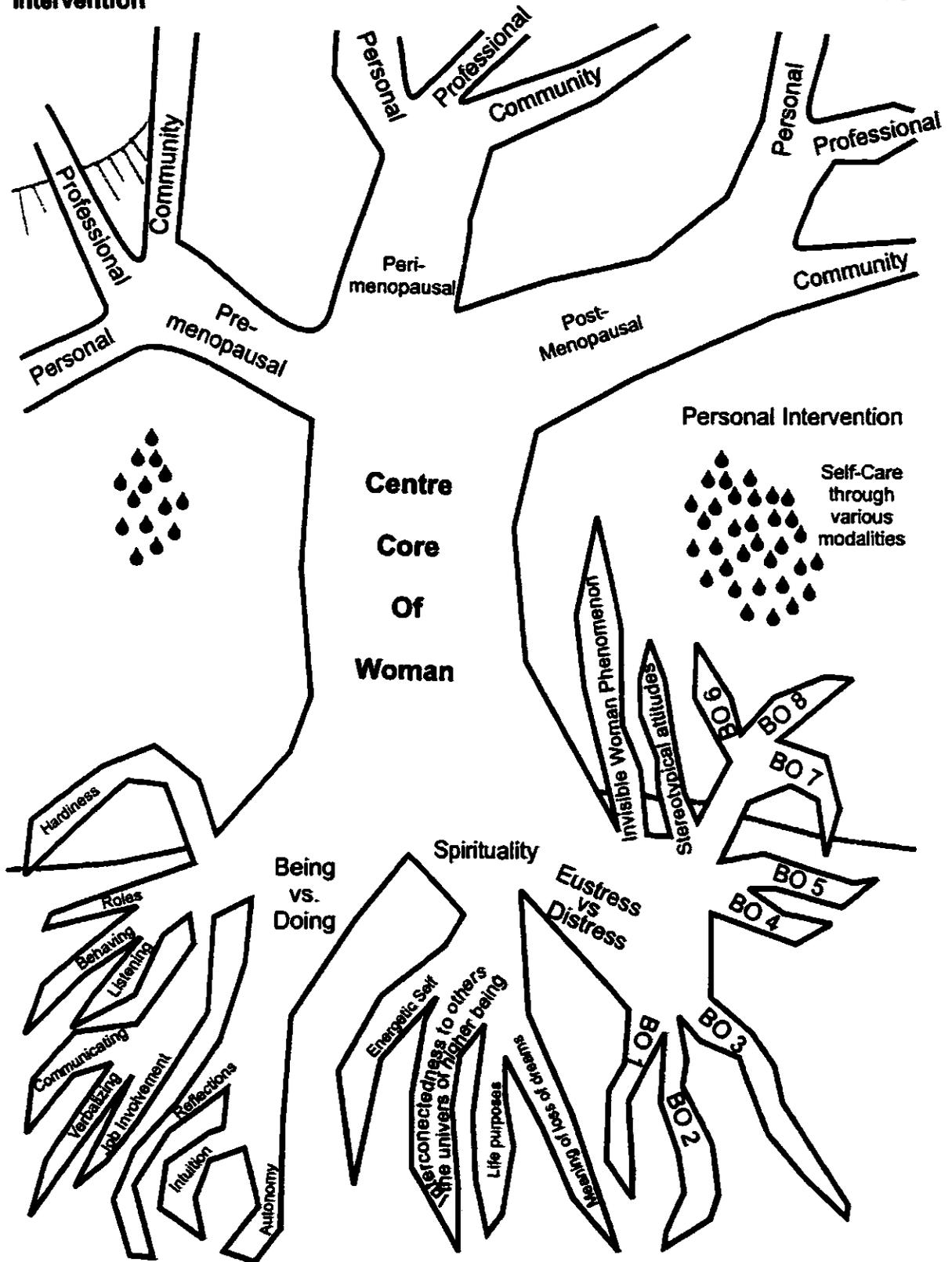


Figure 5.1. Wholeness of a Woman's Life Depicted Through a Metaphor

sustenance through the nourishment from the soil and the elements as portrayed in Figure 5.1 as organizational and personal interventions.

Limitations and Summary of Study

When reading research the results are to be considered in view of the overall limitations of the study. Maxwell (1996) states that internal generalizability refers to the generalizability of a conclusion within the setting or group and is a valuable contribution, consistent with the analysis of interview data. This study focused upon registered nurses in one province in western Canada. Only those nurses who were female, actively registered with the provincial nursing association, and working full- or part-time at the time of data collection were included in the study. The study was confined to those individuals who were invited and willing to participate in the study.

Another limitation pertained to the nature of the data collected, that is, perceptual data from a non-probability sample of nurses in one western Canadian province. To this end, Salancik (1979) believes, "Our reliance on other people's cooperation selects the knowledge we gather" (p. 641). In particular, the reliability of the data may be limited in that participants' perceptions of specific activities, events, and information may alter over time. Only nurses who work in one province in Canada were invited to participate, thereby limiting the findings to individuals who experience similar menopausal life-cycle stages and work in similar occupational settings.

In this study the participants provided valuable information regarding the relationships between health, job involvement, burnout, and hardiness in nurses' lives. The menopausal life-cycle perspective offers a positive view of women and can serve as a viable alternative

to the conventional medical model of health. If we are to accurately reflect the meaning that women give to their various life experiences, we must hear their voices throughout their life-cycle stages.

Epilogue

As I reflect upon the research process it becomes apparent to me that I have been on an interesting journey. I started on the outside looking in and it was my curiosity that brought me forward. I developed a need to approach women's health in a holistic manner. Clearly, I want to continue my research and work experience in the area of women's health with a specific focus on a menopausal life-cycle perspective. For example, I have reconsidered the labeling of the developmental process of women's lives as: pre-menarche, adolescence, pre-menopause, and post-menopause. My current thinking promotes the philosophy that women are responsible for their health. Transitions throughout life are gradual and progress not only through one's biology but also throughout one's psychology and spirituality. My research journey has led me to this end. I ask the reader to join me in the following reflections and recommendations:

Reflections

1. Tendency toward cross-sectional studies.
2. Multi-methods are not used, surveys proliferate.
3. Belief that medical science is omnipotent.
4. Biomedical model of health is dominant.

Recommendations

1. Support longitudinal studies in research.
2. Specifically, there is a need to take seriously those approaches that include some form of dialogue (i.e., interactive-, ethno-, or narrative-data).
3. Women as individuals need to reclaim their own knowledge and authority and develop a partnership within the context of the health-care provider relationship so women can move toward healing.
4. A variety of disciplines need to be involved and receptive to a positive, healing, and holistic view of women's health.

Reflections

5. Understanding women's health, occupational, and life experiences are multi-disciplinary in nature.
6. Need to focus future research efforts on investigating the possibility of increasing job involvement and personality hardiness through a learned response that may have the potential to control the effects of burnout manifested as disease and/or illness.
7. Burnout is more distress than eustress.
8. It is unlikely a universal pattern of adult development exists that would reflect diverse ethnic and educational backgrounds. Life-span developmentalists note the importance of understanding the developmental processes throughout adulthood across cultures.

Recommendations

5. Enable shared learning across the disciplines to enhance communication and health promoting practices through conferences, workshops, networks and other means.
6. Need a call to action for future research examining the role that hardiness and job involvement play as occupational covariants to burnout in nurses and other occupational groups.
7. Policy makers need to take action to lower the amount of distress in the workplace through organizational interventions on a global scale.
8. A life-cycle perspective to research and health has the potential to fill this identified gap (i.e., developmental processes).

This study offers an invitation to heed the voice from within. Women need to trust their insights supported by their body's messages and take personal responsibility for their own health. The menopausal life-cycle perspective, promoted within this study, is a holistic model promoting the philosophy that women are whole and valued at all stages throughout the process of their developmental life span, in work and in life.

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Appendix A
WHOLE Profile

**Women's Health:
Occupational and Life Experiences**

WHOLE PROFILE

After responding to the WHOLE Profile please take a moment to review all your responses.

ALL Profiles will be handled in a confidential and professional manner.

Thank you very much for your cooperation!

***Please return this completed Profile in the enclosed, self-addressed, envelope
by April 30, 1998, to:***

*Faculty of Management
University of Lethbridge
ATT: Jeannette Barsky, M.Sc. Candidate
4401 University Drive W.
Lethbridge, Alberta
T1K 3M4*

Part I

Demographics

(question 1-4)

1. What is your marital status?

- Married - I have been married to my current spouse for ___ year(s)
- Never married Widowed
- Divorced Separated
- Other - I have been living with my current partner for ___ year(s)

2. Do you have children?

- No
- Yes If yes, how many children are living with you? ___

3. Your year of birth is: 19 ___.

4. I am responding to this questionnaire on ...

Please circle the appropriate day of week, date, month, and year.

Day of Week	Date	Month	Year
Monday	1	January	1998
	2		
Tuesday	3	February	1999
	4		
Wednesday	5	March	
	6		
Thursday	7	April	
	8		
Friday	9	May	
	10		
Saturday	11	June	
	12		
Sunday	13	July	
	14		
	15	August	
	16		
	17	September	
	18		
	19	October	
	20		
	21	November	
	22		
	23	December	
	24		
	25		
	26		
	27		
	28		
	29		
	30		
	31		

Health Care History

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(questions 5-10)

5. Which statement BEST describes your health care practices?

- I go for regular physical checkups as a preventive health care measure.
- I see a health care professional only when I have a specific complaint.
- I have to be extremely ill before I will see a health care professional.

6. Have you been admitted to a hospital within the past two years?

Check (✓) either yes or no.

- No
- Yes If yes, how many times have you been hospitalized in the past two years?
- Once
- Twice
- More than twice

7. Do you exercise regularly?

Check (✓) either yes or no.

- No
- Yes If yes, how often do you usually exercise?
- Once a week
- Twice a week
- Three times a week
- Four times a week or more

On average, how often do you exercise at each session?

- Less than 30 minutes
- 30-60 minutes
- More than 60 minutes

8. When was your last pap smear?

- Never
- Less than one year ago
- One year ago
- Two years ago
- More than two years ago

9. How often do you do selfbreast examination?

- Once a month
- A few times a year
- Never

10. Overall, how would you describe your health in comparison with others your age?

- Above average health
- Average health
- Below average health

General Health

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(questions 11-23)

11. In the last six months, how often have you suffered from the following symptoms?

Early-morning awakenings

Never Seldom Occasionally Often Always

Difficulties in concentration

Never Seldom Occasionally Often Always

Loss of interest in sex

Never Seldom Occasionally Often Always

Dizzy Spells

Never Seldom Occasionally Often Always

Heavy menstrual periods

Never Seldom Occasionally Often Always

Loss of interest in life

Never Seldom Occasionally Often Always

Fluid retention prior to menstrual periods

Never Seldom Occasionally Often Always

Panicky feelings

Never Seldom Occasionally Often Always

Hot flushes/Hot flashes

Never Seldom Occasionally Often Always

Irritability prior to menstrual periods

Never Seldom Occasionally Often Always

Headaches

Never Seldom Occasionally Often Always

Backaches

Never Seldom Occasionally Often Always

Palpitations (fast heart beat)

Never Seldom Occasionally Often Always

Night sweats

Never Seldom Occasionally Often Always

Poor memory

Never Seldom Occasionally Often Always

Feeling tense

Never Seldom Occasionally Often Always

Breast tenderness prior to menstrual periods

Never Seldom Occasionally Often Always

General feelings of sadness

Never Seldom Occasionally Often Always

Vaginal dryness

Never Seldom Occasionally Often Always

12. Do you suffer from any of the following chronic illnesses as diagnosed by a physician?

Check (✓) either no or yes.

No

Yes If yes, check (✓) all that apply.

- Asthma
- Emphysema
- Diabetes
- Cancer
- Arthritis
- High blood pressure
- Heart Problems
- Others _____

13. Have you ever had surgery?

Check (✓) either no or yes.

No

Yes If yes, check (✓) all that apply.

- Removal of tonsils
- Removal of appendix
- Removal of gallbladder
- Removal of spleen
- Removal of uterus
- Removal of one ovary
- Removal of both ovaries
- Others _____

14. In the past *six months*, have you been taking prescribed medication on a regular basis?

Check (✓) either no or yes.

No

Yes If yes, check (✓) all reason(s) that apply.

- Heart Problems
- High blood pressure
- Headaches
- Clinical depression
- Arthritis
- Breathing problems
- Thyroid problems
- Birth Control
- Menopausal hormone therapy

15. In question 3, you indicated you are ___ years of age, but today you feel like about ___ years of age.

16. You weigh _____ pounds or _____ kilograms.

17. Your height is ___ feet ___ inches or _____ cm.

18. I started my menstrual periods at ___ years of age.

19. Which statement best describes your current life stage according to your hormonal status?

Please read all 7 statements before checking (✓) the single most appropriate response.

- Menstruating in a normal pattern **without** the aid of menopausal or contraceptive hormone therapy - cycle lengths of 24 to 35 days during the past 12 months
- Menstruating in a normal pattern **with** the aid of menopausal or contraceptive hormone therapy - cycle lengths of 24 to 35 days during the past 12 months
- Occasional irregularity in menstruation pattern due to unknown causes - on average cycle lengths of 24 to 35 days during the past 12 months
- Irregularity or changes in menstruation pattern and flow due to aging of the ovaries - several cycle lengths of greater than 42 days (six weeks) but have menstruated within the past 12 months
- Not menstruating for the past 12 months due to aging of ovaries
- Not menstruating due to surgical removal of uterus or ovaries
- Not menstruating due to one of the following causes: pregnancy, breast feeding, medication, heavy exercise, rapid weight loss, illness, or unknown cause

20. More specifically, have you had a menstrual period in the past *three months*?

Check (✓) either yes or no.

- Yes If yes, what is it due to?
 - Natural functioning of the ovaries
 - Contraceptive hormone therapy
 - Menopausal hormone therapy
- No If no, what is it due to?
 - Pregnancy
 - Breast feeding
 - Natural aging process of the ovaries
 - Medication
 - Heavy exercise
 - Rapid weight loss
 - Surgery
 - Illness
 - Unknown

21. Given your life stage indicated in question 19, today, what is your attitude towards menopause?

- Positive
- Somewhat positive
- Somewhat negative
- Negative
- Don't think about it

22. Today, where are you in your menstrual cycle?

- One week prior to period
- Currently having period
- One week after period
- Two weeks after period
- Periods have stopped

23. Please respond either yes, no, or no comment to the following 2 statements:

"My menstrual cycle affects how I approach my work."

- Yes
- No
- No comment

"My menstrual cycle affects how much I accomplish in my work."

- Yes
- No
- No comment

THE FOLLOWING QUESTIONS AND STATEMENTS DEAL WITH YOUR WORKDAY.

28. Put a check (✓) mark in the appropriate box that comes closest to describing your attitude or behavior.

1. For me, the first few hours of work really fly by.
 Never Seldom Occasionally Often Always
2. My job means a lot more to me than just a means to make money.
 I disagree strongly I disagree somewhat
 I'm undecided I agree somewhat I agree strongly
3. I'm really interested in my work.
 Never Seldom Occasionally Often Always
4. I would probably keep working even if I didn't need the extrinsic rewards.
 I disagree strongly I disagree somewhat
 I'm uncertain I agree somewhat I agree strongly
5. How much do you actually enjoy performing the day-to-day activities that make up your job?
 Very little Little Some Much Very much
6. The major satisfaction in my life comes from my job.
 I disagree strongly I disagree somewhat
 I'm uncertain I agree somewhat I agree strongly
7. The most important things that happen to me involve work.
 I disagree strongly I disagree somewhat
 I'm uncertain I agree somewhat I agree strongly
8. How much do you look forward to coming to work each day?
 Very little Little Some Much Very much
9. I'll stay overtime to finish a job even if I'm not extrinsically rewarded for it.
 Never Seldom Occasionally Often Always

29. Below are some items with which you may agree or disagree.

Please indicate how you feel about each one by circling a number from 0 to 3 in the space provided. A "0" indicates that you feel the item is not at all true; circling a "3" means that you feel the item is completely true.

As you will see, many of the items are worded very strongly. This is to help you decide the extent to which you agree or disagree.

Please read all the items carefully. Be sure to answer all on the basis of the way you feel now. Don't spend too much time on any one item.

- 0 = Not at all true
 1 = A little true
 2 = Quite a bit true
 3 = Completely true

1. I often wake up eager to take up my life where it left off the day before. 0 1 2 3
2. I like a lot of variety in my work. 0 1 2 3
3. Most of the time, my bosses or supervisors will listen to what I have to say. 0 1 2 3
4. Planning ahead can help avoid most future problems. 0 1 2 3
5. I usually feel that I can change what might happen tomorrow, by what I do today. 0 1 2 3
6. I feel uncomfortable if I have to make any changes in my everyday schedule. 0 1 2 3
7. No matter how hard I try, my efforts will accomplish nothing. 0 1 2 3
8. I find it difficult to imagine getting excited about working. 0 1 2 3
9. No matter what you do, the "tried and true" ways are always the best. 0 1 2 3
10. I feel that it's almost impossible to change my spouse's/partner's mind about something. 0 1 2 3
11. Most people who work for a living are just manipulated by their bosses. 0 1 2 3
12. New laws shouldn't be made if they hurt a person's income. 0 1 2 3
13. When you marry and have children you have lost freedom of choice. 0 1 2 3
14. No matter how hard you work, you never really seem to reach your goals. 0 1 2 3
15. A person whose mind seldom changes can usually be depended on to have reliable judgement. 0 1 2 3
16. I believe most of what happens in life is just meant to happen. 0 1 2 3

0 = Not at all true
 1 = A little true
 2 = Quite a bit true
 3 = Completely true

17. It doesn't matter if you work hard at your job, since only the bosses profit by it anyway. 0 1 2 3
18. I don't like conversations when others are confused about what they mean to say. 0 1 2 3
19. Most of the time it just doesn't pay to try hard, since things never turn out right anyway. 0 1 2 3
20. The most exciting thing for me is my own fantasies. 0 1 2 3
21. I won't answer a person's questions until I am very clear as to what s/he is asking. 0 1 2 3
22. When I make plans I'm certain I can make them work. 0 1 2 3
23. I really look forward to my work. 0 1 2 3
24. It doesn't bother me to step aside for a while from something I'm involved in, if I'm asked to do something else. 0 1 2 3
25. When I am at work performing a difficult task I know when I need to ask for help. 0 1 2 3
26. It's exciting for me to learn something about myself. 0 1 2 3
27. I enjoy being with people who are unpredictable. 0 1 2 3
28. I find it's usually very hard to change a friend's mind about something. 0 1 2 3
29. Thinking of yourself as a free person just makes you feel frustrated and unhappy. 0 1 2 3
30. It bothers me when something unexpected interrupts my daily routine. 0 1 2 3
31. When I make a mistake, there's very little I can do to make things right again. 0 1 2 3
32. I feel no need to try my best at work, since it makes no difference anyway. 0 1 2 3
33. I respect rules because they guide me. 0 1 2 3
34. One of the best ways to handle most problems is just not to think about them. 0 1 2 3
35. I believe that most athletes are just born good at sports. 0 1 2 3
36. I don't like things to be uncertain or unpredictable. 0 1 2 3
37. People who do their best should get full financial support from society. 0 1 2 3
38. Most of my life gets wasted doing things that don't mean anything. 0 1 2 3

0 = Not at all true
 1 = A little true
 2 = Quite a bit true
 3 = Completely true

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39. Lots of times I don't really know my own mind. 0 1 2 3
40. I have no use for theories that are not closely tied to facts. 0 1 2 3
41. Ordinary work is just too boring to be worth doing. 0 1 2 3
42. When other people get angry at me, it's usually for no good reason. 0 1 2 3
43. Changes in routine bother me. 0 1 2 3
44. I find it hard to believe people who tell me that the work they do is of value to society. 0 1 2 3
45. I feel that if someone tries to hurt me, there's usually not much I can do to try and stop him/her. 0 1 2 3
46. Most days, life just isn't very exciting for me. 0 1 2 3
47. I think people believe in individuality only to impress others. 0 1 2 3
48. When I'm reprimanded at work, it usually seems to be unjustified. 0 1 2 3
49. I want to be sure someone will take care of me when I get old. 0 1 2 3
50. Politicians run our lives. 0 1 2 3

30. Circle *T* (True) or *F* (False) for the following items.

1. I like to gossip at times. T F
2. There have been occasions when I took advantage of someone. T F
3. I'm always willing to admit when I make a mistake. T F
4. I always try to practice what I preach. T F
5. I sometimes try to get even, rather than forgive and forget. T F
6. At times I have really insisted on having things my own way. T F
7. There have been occasions when I felt like smashing things. T F
8. I never resent being asked to return a favor. T F
9. I have never been irked when people expressed ideas very different from my own. T F
10. I have never deliberately said something that hurt someone's feelings. T F

Thank you

The WHOLE Profile:**Questions 1 to 26:**

Jeannette Barsky (Copyright © 1998)

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(Question 11 - list of symptoms modified by Jeannette Barsky from a principal components factor analysis derived from the Women's Health Questionnaire (WHQ) used in a study by Myra S. Hunter and Malcolm I. Whitehead, 1989)

Question 27:

Christina Maslach and Susan Jackson, 1981

Maslach Burnout Inventory

(A modified version is used)

Question 28:

Kenneth White and Robert A. Ruh, 1973

Job Involvement Scale

Question 29:

Suzanne C. Quelling Kobasa, 1979

Personal Views Survey

Question 30:

David Marlowe and Douglas P. Crowne, 1960

Marlowe-Crowne Social Desirability Scale

Appendix B
Glossary of Terms

Glossary of Terms

Amenorrhea: absence of the menses. Primary amenorrhea refers to absence of the onset of menstruation at puberty. It may be caused by underdevelopment or malformation of the reproductive organs, or by glandular disturbances. When menstruation has begun and then ceases, the term *secondary amenorrhea* (italics and bolding added) is used. The most common cause is pregnancy. Breast feeding, general ill health, a change in climate or living conditions, emotional shock or frequently, either the hope or fear of becoming pregnant can sometimes stop the menstrual flow (Miller & Keane, 1983, p. 34).

Burnout: a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment which can lead to a deterioration in the quality of care or service provided by the staff; it appears to be a factor in job turnover, absenteeism, and low morale (Maslach & Jackson, 1981, p. 2).

Combined pre-menopausal: referred to pre-menopausal in Lee and Hopkins (1996); prior to menopause (Lee & Hopkins, 1996, p. 327).

Feminine life-cycle: Specific periods of time in the life span of a female that can be separated into seven year segments (Borysenko, 1996).

Menopause: is a three-stage process that ends a women's reproductive life: The first stage is pre-menopause which usually begins around the age of 40 years, denoting the decline of estrogen production by the ovaries; the second stage—peri-menopause follows pre-menopause and is a time where estrogen levels continue to decline and the consistency and regularity of the menstrual flow itself begins to change; eventually estrogen levels drop so low that the menses cease which is termed the actual menopause

which is from the last menstrual period to 12 full months without a period; the third stage—post-menopause is a term to describe the period of time after 12 full months without a menstrual period and beyond (Foley, Nechas, & Wallis, 1995, p. 331).

Menopause also refers to the cessation of menses—the term derives from the Greek *meno* (month, menses) and *pausis* (pause). This natural process is also known to many women as the ‘change of life’ or simply ‘the change.’ The years surrounding menopause and encompassing the gradual change in ovarian function constitute an entire stage of a woman’s life, lasting from six to thirteen years also known as the *climacteric* (Northrup, 1998, p. 515).

Peri-menopausal: referred to as pre-menopausal in this thesis—refers to the time preceding menopause when hormone changes are occurring (Lee & Hopkins 1996, p. 350).

Pre-menopausal: Prior to menopause, also called *peri-menopausal* (Lee, Hanley, & Hopkins, 1999, p. 351).

Middle-Life: A period of time in the life-cycle of a woman between the ages of mid-forties to mid-sixties (Sheehy, 1995, p. ix).

Registered Nurses: A predominantly female occupational group chosen as a sample from the population of women because of the diversity of role assignment throughout the nursing profession comprising, managers, educators, and clinicians.

Secondary amenorrhea: refer to amenorrhea.

Appendix C

Letter of Introduction



The
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FACULTY OF MANAGEMENT

March 2, 1998

Dear Participant,

We are conducting a study on women's occupational and life health issues. The data collected in this study will serve as the basis for a Master's Thesis.

The **Women's Health Occupational Life Experiences (WHOLE)** Profile consists of two parts. Part I includes questions about demographics, health care history, general health, menstrual cycle and menopause. Part II includes questions about your work experiences.

Some of the questions in the **WHOLE** Profile deal with topics that are personal. If, after looking through the Profile, you feel in any way uncomfortable about participating in this study, please **STOP!** Participation in this Profile is completely voluntary. If you agree to participate, answer the 30 questions as accurately and completely as possible. However, if you prefer to leave a specific question blank, do so and then move on to the next question. The Profile takes approximately 45 minutes to complete.

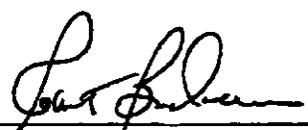
Your Profile responses will be kept in the strictest confidence. Please do **NOT** put your name on the Profile or the enclosed return envelope. **Absolutely no individual names** and only summary results will be reported in the findings from this study. This Profile has been reviewed and approved by *The University of Lethbridge Human Subjects Research Committee* and is consistent with ethical guidelines published by the *Social Sciences and Humanities Research Council of Canada*.

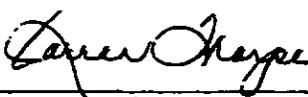
Your name has been selected randomly from a membership list from The Alberta Association of Registered Nurses. Return the enclosed response card **only** if you would like a brief description of the summary results. So you will **not** be identified in any way, please make certain that you mail the postcard **separately** from the completed Profile.

Thank you for taking the time to participate in this study of women's health. If you have any questions about this study, please do not hesitate to contact any one or all of us.

Sincerely,


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Appendix D
Interview Questions

Interview Questions

1. What is it like to be a nurse in your current work environment?
2. Tell me about your health history, including your life-cycle stage and any significant chronic illnesses.
3. Tell me about the balance between your paid work life and your various professional and personal roles in your present phase of life.
4. Since the term *stress* means so many different things to different people, describe what stress means to you?
5. What are the sources of stress in your paid work place?
6. If it were a given that the outcome of your advice would be acted upon what three suggestions would you give to policy makers to rectify the stressors in your workplace?
7. In your busy life what techniques do you use to reduce stress?
8. Discuss the level of burnout (on a scale of one to eight, with one being the lesser amount of stress) that you experienced in the past week at your current life stage (pre-, peri-, post-menopause).