

CALIFORNIA BAPTIST UNIVERSITY

Riverside, California

Burnout, Hardiness, and Intent to Turnover Among U.S. Healthcare Ancillary Managers

A Dissertation Submitted in partial fulfillment of the  
Requirements for the degree  
Doctor of Business Administration

Shua Joyce Moua

Division of Online and Professional Studies

Department of Business Administration

April 2020

Burnout, Hardiness, and Intent to Turnover Among U.S. Healthcare Ancillary Managers

Copyright © 2020

by Shua Joyce Moua

**This dissertation written by**

**Shua Joyce Moua**

**has been approved by the**

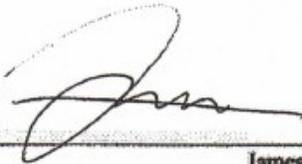
**Division of Online and Professional Studies at California Baptist University**

**in partial fulfillment of the requirements**

**for the degree Doctor of Business Administration**



Scott Dunbar, D.B.A., Committee Chair



James Yoo Ph.D., Committee Member



Kenneth Mingsmger, J.D., Committee Member



Dirk Davis, Ed.D., Associate Vice President of Academics

## ABSTRACT

The healthcare industry has many challenges that increases the likelihood of burnout among employees to include emotional fatigue because of caring for sick patients, long work hours, and the physical demands of the job. The purpose of this quantitative research study was to investigate hardiness, burnout, and intent to turnover among ancillary managers within a U.S. healthcare organization. Studies have focused on clinical staff burnout with research on burnout among nurse managers, nurses, and physicians. However, there have been limited research studies investigating burnout, hardiness, and intent to turnover among ancillary managers. There is a high demand for top talent, both on the clinical side with jobs such as nursing or physicians, as well as with ancillary managers who help to ensure operations and organizational goals are met. As managers play an important role in the organization, it is important to better understand the relationship between burnout, hardiness, and intent to turnover among ancillary managers in healthcare organizations.

*Keywords:* burnout, healthcare managers, ancillary managers, stress, healthcare, hardiness, intent to turnover

## ACKNOWLEDGEMENTS

This journey to completing this dissertation was only made possible in large part by the special people who have challenged, supported, and stuck with the researcher along the way. The researcher is tremendously fortunate to have had a wonderful dissertation chair, Dr. Scott Dunbar and is forever thankful for the prayers, support, and guidance from him, always aiming to moving her forward. The researcher would also like to extend her gratitude to the rest of her dissertation committee, Dr. James Yoo and Dr. Kenneth Minesinger for their continuous encouragement, feedback, and expertise. Additionally, the researcher would like to thank the CBU faculty and administration for their guidance and support to get the researcher to this point.

It is also important for the researcher to thank and acknowledge the support from her husband, Jun Yang, and six children, Lily, Nathan, Adelyn, London, Raegan, and Elijah. The encouragement, prayers, patience, and the many sacrifices made to allow the researcher to achieve her educational dreams were greatly appreciated. The researcher would also like to extend gratitude and thanks to her parents, siblings, and family who provided encouragement and instilled in her the desire to continue learning.

In addition to her committee, two other scholars and friends have been pivotal in the researcher's success: Dr. Douglas Hamilton and Dr. Phil Van Haaster. The researcher is grateful for their commitment to the program, encouragement, and prayers over the course of the years.

Lastly, without the grace and mercy of Jesus Christ, the researcher would not be where she is now. "Trust in the Lord with all your heart and lean not on your own

understanding; in all your ways submit to him, and he will make your paths straight”  
(Proverbs 3:5-6).

## TABLE OF CONTENTS

ABSTRACT.....	iv
ACKNOWLEDGEMENTS.....	v
LIST OF TABLES.....	x
LIST OF FIGURES.....	xi
CHAPTER 1: INTRODUCTION.....	1
Background.....	1
Statement of the Research Problem.....	2
Purpose Statement.....	3
Research Question.....	4
Significance of the Problem.....	6
Theoretical Framework.....	9
Maslach’s Conceptual Framework.....	10
Golembiewski Conceptual Framework.....	11
Demerouti et al. Theoretical Framework.....	13
Hardiness Scale Framework.....	14
Intent to Turnover Framework.....	15
Definitions.....	16
Organization of the Study.....	18
CHAPTER 2: REVIEW OF THE LITERATURE.....	19
Workplace Environmental Factors.....	19
Compensation.....	20
Spirituality.....	22
Work-Life Balance.....	24
Burnout Construct.....	27
History of Burnout Research.....	28
Industries.....	31
Burnout and Social Support.....	35
Burnout Construct in Healthcare Organizations.....	37
Burnout Research in Healthcare Organizations.....	38
Burnout Research Among Healthcare Managers.....	44
Nurse managers.....	45
Healthcare administrators.....	46
Healthcare managers.....	48
Hardiness.....	51
Hardiness Construct.....	51
Hardiness as a Predictor.....	53
Hardiness and Burnout Among Healthcare Workers.....	55
Intent to Turnover.....	58
Construct of Turnover.....	59
Organizational Commitment and Intent to Turnover.....	61

Intent to Turnover and Burnout Among Healthcare Workers .....	63
Summary .....	68
CHAPTER 3: METHODOLOGY .....	71
Purpose Statement.....	71
Research Question .....	72
Research Design.....	74
Population .....	75
Sample.....	75
Instrumentation .....	76
Burnout .....	76
Hardiness.....	78
Intent to Turnover .....	79
Demographics .....	79
Data Collection .....	79
Data Analysis .....	80
Limitations .....	81
Summary.....	81
CHAPTER 4: RESEARCH, DATA COLLECTION, AND FINDINGS.....	83
Overview.....	83
Purpose Statement.....	83
Research Questions.....	84
Research Methods and Data Collection Procedures .....	86
Sample.....	86
Participants.....	87
Data Collection .....	87
Presentation and Analysis of Data .....	88
Study Variables.....	88
Hypotheses Testing.....	89
Research Question 1 .....	89
Research Question 2 .....	90
Research Question 3 .....	91
Relationship Between Burnout, Hardiness, and Intent to Turnover .....	92
Moderating Relationships .....	94
Summary.....	97
CHAPTER 5: FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS .....	98
Major Findings.....	99
Research Question 1 .....	100
Research Question 2 .....	101
Research Question 3 .....	101
Unexpected Findings .....	102
Conclusions.....	104
Implications for Action.....	104
Recommendations for Further Research.....	106
Study Limitations.....	107

Concluding Remarks and Reflections.....	108
REFERENCES .....	110
APPENDICES .....	133
A. Participant Invitation Letter/Informed Consent .....	134
B. Survey Instrument .....	136
C. Reminder E-Mail to Participants/Informed Consent.....	140
D. Tables .....	142

LIST OF TABLES

Table 1. Average Hours Worked in the United States..... 25

Table 2. Golembiewski Eight-Sequence Model ..... 31

Table 3. Consequences of Turnover ..... 60

Table 4. MBI Version and Target Population..... 77

Table D1. Demographic Frequency ..... 142

Table D2. Distribution of Scores in the Study Variables..... 143

Table D3. Pearson Correlation Coefficients ( $n = 95$ ) ..... 143

Table D4. Correlations Matrix by Gender (Female:  $N = 51$ , Male:  $N = 44$ ) ..... 144

Table D5. Mean Scores of Burnout, Hardiness, and Intent to Turnover ..... 145

Table D6. Summary of Multiple Regression ..... 146

Table D7. Two-Sample  $t$  Test of Age Groups and Independent Variables ..... 147

Table D8. Moderating Relationships Between Study Variables ..... 148

Table D9. Hierarchical Regression Analysis for Intent to Turnover ..... 149

## LIST OF FIGURES

Figure 1. Annual total separation rate of healthcare and social assistance workers .....	8
Figure 2. Average hours worked in the United States comparison.....	26
Figure 3. Emotional exhaustion and age.....	95
Figure 4. Cynicism with age. ....	95
Figure 5. Inefficacy with age. ....	96
Figure 6. Hardiness with age .....	96
Figure 7. Intent to turnover with age .....	97

## CHAPTER 1: INTRODUCTION

The healthcare industry faces multiple challenges that increase the likelihood of burnout among employees, including emotional fatigue from caring for sick patients, long work hours, and physical demands of the job (Lin, Lin, Cheng, Wu, & Ou, 2016). Consequently, the healthcare industry has become a focus when it comes to burnout research. Burnout for the purpose of the study was defined as the emotional exhaustion and interpersonal stressors impacting employees because of their job or work environment (Maslach & Leiter, 2017). Past studies focused primarily on clinical staff burnout. Clinical staff consists of direct patient care positions such as nurse managers, nurses, and physicians (El-Ibiary, Yam, & Lee, 2017; Freitas, Vannuchi, Haddad, Silva, & Rossaneis, 2017). Although there are a variety of healthcare related studies on burnout, few investigate the relationship between burnout, hardiness, and intent to turnover among ancillary managers. For the purpose of the study, ancillary managers were defined as managers who work in a support department, also referred to as an ancillary department, that does not have direct patient care. Healthcare organizations are made up of ancillary departments that provide support services to clinical departments and are equally important to the organization. The purpose of this quantitative research study was to investigate the relationship between burnout, hardiness, and intent to turnover among ancillary managers within a U.S. healthcare organization.

### **Background**

Studies have indicated that burnout is an issue that touches many healthcare organizations regardless of size or location (Maslach & Leiter, 2017). The issue of burnout among healthcare workers remains a focus of research because of the high level

of emotional aptitude required when caring for others (Lu et al., 2016). When it comes to managers, burnout has been associated with their roles and responsibilities, which include remediation of patient and staff problems, dealing with employee retention, and job satisfaction (Maslach & Leiter, 2017). Managers are faced with many challenges that include, but are not limited to, managing daily operational needs, talent management, and employee retention, all of which require mental hardiness. Hardiness, for the purpose of the study, was defined as individuals' personality characteristics that comprise three dispositions of commitment, control, and challenge and affect how they view themselves and the situations around them (Ayala Calvo & García, 2018). Managers with a higher level of hardiness oftentimes are healthier and handle stressful situations better (Freitas et al., 2017). Hardiness and emotional aptitude required to complete the job as well as care for others have been associated with employees developing a negative outlook on job satisfaction and can lead to increased employee turnover (McPherson, Hiskey, & Alderson, 2016).

### **Statement of the Research Problem**

Employee retention and job satisfaction have been areas of focus for both managers and researchers alike (Reina, Rogers, Peterson, Byron, & Hom, 2018). Employee burnout in many different job roles such as nurses (Freitas et al., 2017), physicians and healthcare workers (van de Klundert, van Dongen-van den Broek, Yesuf, Vreugdenhil, & Yimer, 2018), construction managers and project managers (Yang, Li, Zhu, Li, & Wu, 2017), social workers (Wagaman, Geiger, Shockley, & Segal, 2015), and teachers (Szigeti, Balázs, Bikfalvi, & Urbán, 2017) has been linked to lower job retention and lower job satisfaction (Schutte, Toppinen, Kalimo, & Schaufeli, 2000). Healthcare

organizations are faced with challenges, specifically with patient care as the core business. Patient care requires a high level of mental aptitude and hardiness, which can lead to emotional fatigue (Jacobs, Hood, Nawaz, & Bae, 2012).

As such, the relationships built between manager and employee can influence their commitment to the organization. Shariro, Hom, Shen, and Agarwal (2016) found that there is a positive correlation between management turnover and employee turnover. Laschinger, Borgogni, Consiglio, and Read (2015) also found that management behavior is associated with healthy work environments and can promote positive work and outcomes among employees. Similar to other human services industries, the likelihood that healthcare managers experience burnout because of similar factors as their employees exist because managers are responsible for ensuring quality patient care is provided (Ayala Calvo & García, 2018). Although there have been many studies on clinical managers and staff, there are limited studies on ancillary managers in departments such as facility services, supply chain, finance, and environmental services. These departments support many of the operational functions of the healthcare organizations and offer valuable services to the organization.

### **Purpose Statement**

The purpose of this quantitative research study was to investigate the relationship between burnout, hardiness, and intent to turnover among ancillary managers within a U.S. healthcare organization. There has been a focus on clinical staff with research covering burnout and turnover among nurse managers, nurses, and physicians (Johansson, Sandahl, & Hasson, 2013). However, a gap exists in the research as there is limited research investigating the relationship between burnout, hardiness, and intent to

turnover among ancillary managers. This gap is important to note because ancillary managers support business operations to keep organizations running smoothly, while ensuring quality patient care is supported (Wells & Hejna, 2009). Because ancillary managers play an important role in organizations, the gap in the literature suggested that research needs to expand to include ancillary managers to give a more complete picture of organizational challenges when it comes to burnout, hardiness, and intent to turnover (Laschinger et al., 2015).

### **Research Question**

This study aimed to expand the field of burnout research to include ancillary managers within U.S. healthcare organizations by investigating the relationship between burnout, hardiness, and intent to turnover. Gaining insight into burnout among ancillary managers and understanding whether hardiness and burnout impact the intention to turnover fill a gap in the research that is seldom, if ever, studied. Utilizing the three dimensions of burnout, exhaustion, cynicism, and feelings of inefficacy, each hypothesis was developed to measure the relationship, if any, the variables had on intent to turnover among the employees (Maslach & Leiter, 2008, 2017). The first question addressed by the study was, “Is there a relationship between burnout and hardiness among ancillary managers within a U.S. healthcare organization?” Second, the research evaluated the relationship between burnout and the intent to turnover, addressing the second question: “Is there a relationship between burnout and intent to turnover among ancillary managers within a U.S. healthcare organization?” The third question the study evaluated pertains to the relationship between hardiness and intent to turnover: “Is there a relationship

between hardiness and intent to turnover among ancillary managers within a U.S. healthcare organization?”

Based on the questions addressed in the study, the hypotheses were as follows:

H<sub>0</sub>1: There is no relationship between emotional exhaustion and hardiness among ancillary managers working for a U.S. healthcare organization.

H<sub>A</sub>1: There is a relationship between emotional exhaustion and hardiness among ancillary managers working for a U.S. healthcare organization.

H<sub>0</sub>2: There is no relationship between cynicism and hardiness among ancillary managers working for a U.S. healthcare organization.

H<sub>A</sub>2: There is a relationship between cynicism and hardiness among ancillary managers working for a U.S. healthcare organization.

H<sub>0</sub>3: There is no relationship between feelings of inefficacy and hardiness among ancillary managers working for a U.S. healthcare organization.

H<sub>A</sub>3: There is a relationship between feelings of inefficacy and hardiness among ancillary managers working for a U.S. healthcare organization.

H<sub>0</sub>4: There is no relationship between emotional exhaustion and intent to turnover among ancillary managers working for a U.S. healthcare organization.

H<sub>A</sub>4: There is a relationship between emotional exhaustion and intent to turnover among ancillary managers working for a U.S. healthcare organization.

H<sub>0</sub>5: There is no relationship between cynicism and intent to turnover among ancillary managers working for a U.S. healthcare organization.

H<sub>A</sub>5: There is a relationship between cynicism and intent to turnover among ancillary managers working for a U.S. healthcare organization.

H<sub>0</sub>6: There is no relationship between feelings of inefficacy and intent to turnover among ancillary managers working for a U.S. healthcare organization.

H<sub>A</sub>6: There is a relationship between feelings of inefficacy and intent to turnover among ancillary managers working for a U.S. healthcare organization.

H<sub>0</sub>7: There is no relationship between hardiness and intent to turnover among ancillary managers working for a U.S. healthcare organization.

H<sub>A</sub>7: There is a relationship between hardiness and intent to turnover among ancillary managers working for a U.S. healthcare organization.

### **Significance of the Problem**

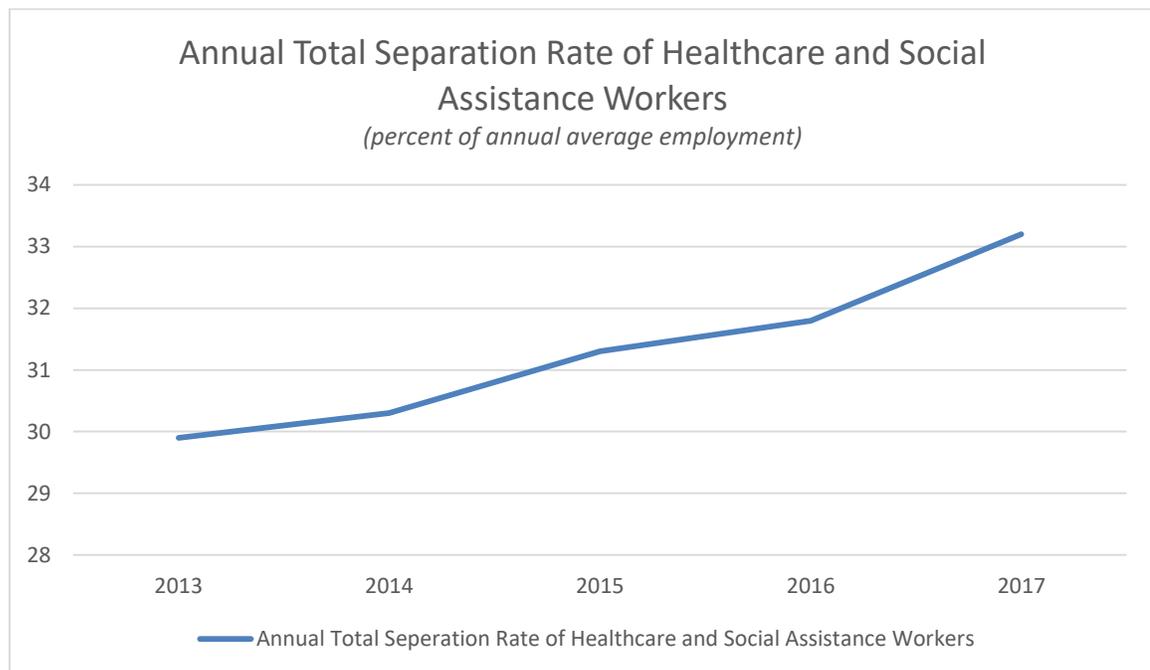
Healthcare professionals work in an environment that requires a high level of emotional aptitude and hardiness with higher levels of burnout (H. Li, Cheng, & Zhu, 2018). Burnout is associated with higher turnover and negative outlook on job satisfaction (Shanafelt et al., 2015). In some countries, burnout of healthcare professionals is associated with the lack of technology, poor outlook for patients, and being stationed in rural areas as seen in Tanzania and Ethiopia (Shemdoe et al., 2016; van de Klundert et al., 2018). In other countries, such as China, burnout among healthcare workers has been tied to the change in rules and regulations (Lu et al., 2016). In the United States, turnover and burnout among healthcare workers have been tied to higher demands of the job and longer work hours (Ayala Calvo & García, 2018). Maslach and Leiter (2017) indicated that burnout is an issue that impacts many healthcare organizations regardless of size and location. When it comes to managers, burnout is associated with their roles and responsibilities that include talent management, hiring

processes, training and development as well as meeting operational objectives (H. Lee et al., 2010).

In addition, studies have found that burnout can have a negative outcome on job performance and decreased quality of patient care (Covella, McCarthy, Kaifi, & Cocoran, 2017). Burnout can lead to increased injury rates, employee absenteeism, low team morale, increased cost for staff replacement because of turnover, and lower perceptions of work-life balance (Shariro et al., 2016). Overall, burnout can have the potential for monetary loss for the organization and can impact the quality of patient care (J. Johnson et al., 2017). In the United States, organizations such as the Joint Commission and the Department of Public Health measure poor quality of care, patient complaints, patient deaths, and other quality metrics (Centers for Medicare & Medicaid Services, 2018). Burnout among employees impacts a healthcare organization's brand when these metrics on quality are reported publicly (Salyers et al., 2017).

The Affordable Care Act (ACA) was signed into law in 2010 and aimed to provide affordable medical and health services for all U.S. citizens. The U.S. healthcare industry had to adjust to the higher volume of patients, which led to increased workloads for healthcare organizations (Gingold Pierre-Mathieu, Cole, Miller, & Khaldun, 2017; Mendoza, 2017). One study indicated that the cost of turnover in healthcare organizations represented 3.4-5.8% of the annual operating budget, totaling between \$17 million and \$29 million (Waldman, Kelly, Arora, & Smith, 2010). The cost of turnover included hiring and training employees and the loss in employee productivity. It is important to note that the U.S. Bureau of Labor Statistics (2018) reported an upward trend for healthcare and social assistance workers separating from their current employer.

Figure 1 shows the annual total separation rate of healthcare and social assistance workers. The most recent data indicated in 2017 that there was a rate of 33.2% of social assistance workers separating from their current employer in comparison to 2016 which had a rate of 31.8% (U.S. Bureau of Labor Statistics, 2018). This indicated an increase of 1.4% of employees separating from the previous year. The numbers do not identify what types of healthcare workers are separating or the type of separation from the organization, whether voluntary or involuntary. However, the trend is showing a consistent annual increase in the number of employees separating.



*Figure 1.* Annual total separation rate of healthcare and social assistance workers. From “Economic News Release,” U.S. Bureau of Labor Statistics, 2018 (<https://www.bls.gov/news.release/jolts.t16.htm>).

In addition, the U.S. Centers for Disease Control and Prevention ([CDC], 2015) reported the number of physician office visits increased from 955 billion in 2008 to 990 billion in 2015, a 35 billion visit increase over the course of 7 years. This indicated the

work had increased based on patient volume while more healthcare workers were leaving their employers at a faster rate. Based on the trend of increased patient volume and increased employee turnover, healthcare organizations have a significant problem with talent retention (Mendoza, 2017). As healthcare managers are faced with staffing and operational challenges, Romans 12:11-21 (NIV) is a reminder for Christian leaders to trust in God, practice hospitality, and bless those in need. The verse states, “Live in harmony with one another. Do not be proud but be willing to associate with people of low position” (Romans 12:16, NIV). This is the essence of a manager’s role and should not be overshadowed by burnout or other tasks.

### **Theoretical Framework**

Several theoretical frameworks have developed into models on burnout and have been utilized in studies pertaining to the clinical aspect of healthcare organizations and other human services industries. In this section, three influential frameworks are discussed and compared: Maslach (1982) conceptual framework, Golembiewski (1989) framework, and Demerouti, Bakker, Nachreiner, and Schaufeli (2001) framework. Maslach (1982) developed a conceptual framework that utilized a series of models to evaluate burnout among different industries and has become widely used in the study of burnout. The Golembiewski framework introduced in 1989 contains conceptual work on burnout dimensions that suggested employees move through phases of emotional exhaustion, depersonalization, and personal accomplishment (Golembiewski, 1989; Kilpatrick, Magnetti, & Mirvis, 1991). Unlike the first two frameworks, Demerouti et al.’s (2001) conceptual framework studied the relationship between job-related demands, the resources available, and how they impacted employee burnout.

## **Maslach's Conceptual Framework**

Currently, Maslach's (1982) conceptual framework has been used to conduct burnout research and is one of the more well-known burnout frameworks. The framework has been used in a variety of human service industries and revamped to address other industries. The three-component multidimensional theory examines unmet organization expectations that, coupled with poor job conditions, could potentially lead to employee burnout (Maslach, 1982). Burnout in this case has been defined as the emotional exhaustion and interpersonal stressors impacting employees because of their job or work environment (Maslach & Leiter, 2017). There are three dimensions or components of burnout that include exhaustion, cynicisms, and feelings of inefficacy. Based on this multidimensional theory, burnout develops over time through the experience of complex relationships and includes the manner in which an individual perceives his or her own state of accomplishment (Maslach, Jackson, Leiter, & Schaufeli, 1996). Maslach discovered this during interviews with healthcare employees and found parallel patterns between the employees' emotional response that implied or suggested that burnout was a syndrome of the workplace.

Based on the theory that burnout was a syndrome of the workplace, Maslach (1982) developed the Maslach Burnout Inventory (MBI) to address the individual experience to further investigate the phenomenon of burnout. Identifying burnout as a syndrome of the workplace, the MBI was used to standardize the collection of data. The survey assessed two variables that included the individual's emotional state and reaction to those around them. These variables helped determine whether there was a correlation of burnout to the workplace. Through time, the development of the MBI was adapted for

use in different industries outside of the human services industries and used to measure the burnout syndrome (Maslach & Leiter, 2008, 2017).

The MBI can be used to identify whether the burnout syndrome exists among healthcare managers using the specific dynamics of the survey that focus on exhaustion, cynicisms, and feelings of inefficacy (Lin et al., 2016; Shanafelt et al., 2015). The MBI contains three subscales with each subscale correlating to one of the three dimensions and can be used to determine which dimension is most significant based on the individual's response (Maslach, 1982). By identifying the dimension with the greatest impact, further studies and implications pertaining to the three dimensions can be examined and potential solutions can be made to better support the employees. Similar studies have been performed using the MBI; however, these studies have focused on clinical staff such as pharmacists (El-Ibiary et al., 2017), pediatric healthcare workers (Lin et al., 2016), physicians, and nurses (Leiter & Schaufeli, 1996; Lu et al., 2016).

### **Golembiewski Conceptual Framework**

The Golembiewski (1989) conceptual framework on burnout dimensions has similarities to Maslach's (1982) framework. However, it goes further into analyzing the three dimensions of exhaustion, cynicisms, and feelings of inefficacy by evaluating eight sequences of progressive virulence. Progressive virulence was defined as the harmful impact that exhaustion, cynicism, and feelings of inefficacy has on an employee (Golembiewski, 1989). To determine the impact each dimension had on one another, a phase model was developed. The phase model was defined as a high-lo criterion that suggested individuals moved through phases of exhaustion, cynicism, and feelings of inefficacy and experienced each dimension more or less depending on the employee's

environment (Golembiewski, 1989). Phases for the purpose of the study were defined as the different levels of emotions based on the three dimensions of burnout. The theoretical framework and model suggested that individuals move through the phases, although they may not hit every single phase, to full burnout (Golembiewski, 1989). In looking at the eight sequences and correlating them to one another, as well as within each dimension, the data would be more consistent over time. The results would show whether an individual is progressing through the sequences and what burnout dimension(s) are being impacted. For example, starting at Phase I, the individual would be low on all three dimensions. As the individual moves through Phases 2 and 3, he or she may score high on one of the three dimensions depending on his or her responses to the phase (Golembiewski, 1989).

The eight-sequence model can be utilized to give an in-depth understanding of the manner in which individuals move through the phases. The eight-sequences could be used to correlate with Maslach's (1982) burnout dimensions to understand the burnout syndrome. Similar studies such as Kilpatrick et al. (1991) utilized the model to study hospital administrators within Veterans Affairs (VA) hospitals. Kilpatrick et al. suggested that phases could only fall either on the low end (Phases I-III) or high burnout end (Phases VI-VIII; Kilpatrick et al., 1991). This suggested that individuals on the low end are less likely to feel burnout while those in the higher phases are more likely to experience burnout. Being able to utilize the high-low phases, correlating these phases with subscales, and looking at the total scores could give a more inclusive picture of the burnout syndrome. However, the challenge of the framework remains the progressive virulence, which can vary depending on the timeframe in which the method was utilized.

It would be best to use this framework and method across a longitudinal study as participants would go through phases and would therefore score differently over time.

### **Demerouti et al. Theoretical Framework**

Demerouti et al. (2001) proposed that higher job demands with limited job resources available could impact burnout among employees. When this occurs, it could create a negative work environment and impact employee motivation, productivity, and morale (Demerouti et al., 2001). This theoretical framework looked at expanding the rationale of burnout beyond the human services industries and focused on the phenomena of burnout through two main dimensions: exhaustion and disengagement from work.

Based on the theoretical framework, Demerouti et al. (2001) developed the job demands resource model (JD-R model), which studied the correlation between job demands and predictive feelings of exhaustion. The JD-R model also could be utilized to study the correlation between job resources, or lack thereof, compared to employee disengagement. Different studies such as Zis, Anagnostopoulos, and Sykioti's (2014) study have utilized the JD-R model to better understand burnout among medical residents. This model could have been used in the current study if the objective of the study had been to better understand how the demands of the job impact the employee. The model could also be utilized to do a comparison study to other industries to identify whether burnout is unique to the target population or whether it expands further. This would allow for a cross-functional study if the researcher wanted to compare the results to other industries.

The three frameworks and relevant models have many aspects that potentially could benefit this study. Based on the limitations and scope of the study, Maslach and

Jackson's (1981) MBI measurement tool, specifically the MBI-General Survey (MBI-GS), would benefit the study as previous studies have used this instrument in the healthcare industry and shown its validity (Cordes, Dougherty, & Blum, 1997; Leiter & Schaufeli, 1996; Schutte et al., 2000). Utilizing this model provided a benchmark to better understand which dimension of burnout most significantly impacted the target population studied. Although it may be one of many frameworks available in measuring burnout, the metrics and data provided helped to drive further discussion into burnout among ancillary managers. It is important to note that the MBI-GS was not utilized to determine causation; rather it was used to determine whether there was a level of burnout among the ancillary managers surveyed. Heinemann and Heinemann (2017) discussed the importance of addressing burnout by trying to identify the cause of burnout. Causation is still lacking in frameworks such as those of the MBI and Golembiewski. Utilizing variables such as hardiness and intent to turnover furthered the study of burnout to gain an understanding of how the personal characteristics of an individual could potentially impact burnout.

### **Hardiness Scale Framework**

Kobasa, Maddi, and Kahn (1982) proposed in their study of coping mechanisms that individuals with high levels of hardiness are more adept at dealing with stressful situations. Hardiness was defined as an individual's personality characteristics that comprised three dispositions of commitment, control, and challenge and affect how they view themselves and the situations around them (Ayala Calvo & García, 2018). Their study of submarine workers helped to develop the hardiness scale framework and eventually the hardiness scale model, which is one of the most widely used instruments.

The submarine workers provided a unique opportunity to better understand how they viewed themselves in stressful and oftentimes challenging situations. The mental aptitude in combination with stress and the confinement to a very tight workspace made the study more robust. The hardiness scale could be used to evaluate three dimensions of the employee: control, commitment, and challenge (Kadyan & Malik, 2017). This model has become widely used in measuring the level of hardiness among different groups and across many studies to include nurse managers (Freitas et al., 2017) and middle managers (Ayala Calvo & García, 2018).

### **Intent to Turnover Framework**

The intent to turnover develops over a period of time, usually associated with factors of the job or organization. Intent to turnover was defined as an employee's deliberate and conscious decision to resign or depart from his or her current employer or organization (O'Connor, 2018). March and Simon (1958) have been credited with developing much of the theoretical framework and conceptual model that suggested that intent to turnover is reduced by job satisfaction. Mobley (1977) contributed to the model by adding to the theory that an employee who experienced dissatisfaction on the job would take subsequent steps, after which would eventually lead to their intent to turnover. Similar to burnout, the employee would progress through stages of cynicism and eventually, if the perceived work environment did not improve, the employee would consciously choose to leave the job (Fasbender, Van der Heijden, & Grimshaw, 2019). For this reason, research suggested that the higher the turnover rate of employees, the higher the stress levels among the remaining employees (Erenstein & McCaffrey, 2007; K. B. Wright et al., 2014; J. Li, Lee, Mitchell, Hom, & Griffith, 2016). Cammann,

Fichman, Jenkins, and Klesh (1979) developed one of the more commonly used instruments to measure intent to turnover, widely known as the Michigan Organizational Assessment Questionnaire Job Satisfaction Subscale (MOAQ-JSS). Similar to the hardiness scale and MBI, the MOAQ-JSS could be used to assess five questions pertaining to the employee's turnover intentions (Bowling & Hammond, 2008).

### **Definitions**

Research on the construct of burnout has developed over the last 4 decades. Terms have been adapted over time based on studies and the discourse of burnout. The following were key terms and definitions used for this study:

**Ancillary manager.** For the purpose of this study, ancillary managers referred to all managers who work in a support department, also referred to as an ancillary department, that does not have direct patient care. These management positions included supervisors, assistant managers, managers, and directors. Examples of ancillary departments included supply chain, finance, staffing, environmental services, operator services, sterile processing, among other departments who support the healthcare organizations.

**Burnout.** Burnout was defined as the emotional exhaustion and interpersonal stressors because of the employee's job or work environment. Furthermore, the three dimensions of burnout comprised exhaustion, cynicisms, and feelings of inefficacy (Shanafelt et al., 2015). This definition relates to the MBI-GS subscales and was used in past studies as a common definition (Maslach & Leiter, 2017).

**Depersonalization.** Depersonalization was defined as the employee's emotional state where he or she knowingly withdrew from the relationship and could have a callous

response toward the individuals receiving services or toward their coworkers (Maslach, Schaufeli, & Leiter, 2001).

**Emotional exhaustion.** Emotional exhaustion was defined as an individual's personal feelings toward his or her job. These personal feelings were associated with being emotionally overextended from job tasks or interactions with others (Maslach & Leiter, 2017).

**Hardiness.** Hardiness was defined as an individual's personality characteristics comprised of three dispositions of commitment, control, and challenge that could affect how they view themselves and the situations around them (Ayala Calvo & García, 2018).

**Organizational commitment.** Organizational commitment was defined as the degree to which an employee identified and stayed involved with a specific organization (Wong & Laschinger, 2015).

**Reduced personal accomplishment.** Reduced personal accomplishment was defined as the negative feeling an employee could have toward achievements on the job (Maslach & Leiter, 2017). Different factors could impact the level of personal accomplishment to include productivity, teamwork, reliance on others, and relationships with coworkers.

**Social support.** Social support was defined as the support positively associated with the individual employee and organizational outcome that is given by others within an organization (Singh, Amish, & Singhi, 2015). This could include varying kinds of support such as emotional and informational support.

**Stress.** Stress was defined as the relationship an employee had with their environment in which they perceived it as taxing or exceeding their abilities or resources

(Lazarus & Folkman, 1984; Maslach & Leiter, 2017). Stress could impact the individual's wellbeing and be seen as a predecessor to burnout (Mohr & Wolfram, 2010).

**Turnover intent.** Defined as an employee's deliberate and conscious decision to resign or depart from his or her current employer or organization (O'Connor, 2018).

### **Organization of the Study**

Chapter 1 of the study presented the introduction, background of the problem, research questions, hypothesis, significance of the problem, theoretical framework, and definitions of key terms. Chapter 2 is a review of relevant literature and studies that addressed the following topics: burnout and stress, history of burnout research, history on social support, and burnout research in healthcare. Chapter 3 presents the methodology used for the study and details the research design, population and how the sampling was conducted, and finally the instrument used. A discussion on the validity, rationale, reliability and strengths as well as limitations of the design are included for each component. Chapter 4 is a presentation of the study results based on the methodology established in Chapter 3. Finally, Chapter 5 presents a discussion and analysis of the results, followed by recommendations and a conclusion.

## CHAPTER 2: REVIEW OF THE LITERATURE

The discourse on burnout is broad and encompasses a variety of industries and jobs; it continues to be an area of interest for researchers. This section discusses past research literature pertaining to burnout, hardiness, and intent to turnover as it exists today. This review includes burnout as it relates to stress, social support, burnout within healthcare organizations, hardiness as it relates to burnout, and intent to turnover as it relates to both burnout and hardiness. Burnout, hardiness, and intent to turnover are relatively large and broad topics that have been studied in varying aspects. Ambiguity still exists in understanding the relationship that burnout, hardiness, and intent to turnover have on employees in industries such as human services.

Within the healthcare industry, studies indicate that workplace burnout is much higher because of the nature of the work and expectations placed on employees (Lu et al., 2016; Shemdoe et al., 2016). Existing literature has focused on the clinical side of healthcare, looking at specific employee populations such as nurses, nurse managers, physicians, and pharmacists. Researchers and medical practitioners show great interest in studying burnout and hardiness, which is now more widely problematic within the present socio-economic environment (Heinemann & Heinemann, 2017). This chapter reviews existing literature to understand research into burnout, hardiness, and intent to turnover and potential gaps that may exist within the literature.

### **Workplace Environmental Factors**

The concept of burnout is said to be a phenomenon of the workplace environment (Freudenberger, 1974; Maslach & Leiter, 2017). There are contributing factors to the workplace that produce burnout. Job characteristics such as task demands and available

resources can be utilized to predict the well-being of employees. Job demands and job resources can determine how employees are coping with stress from the demands of their daily tasks (Bova, De Jonge, & Guglielmi, 2015). In the last 4 decades, moderating factors have been studied to determine whether a relationship exists between the differing variables associated with burnout. A few of the prevalent moderating factors include compensation, spirituality, and work-life balance. This section covers these three moderating factors and the relationship to burnout within existing literature.

### **Compensation**

Maslow's (1954) hierarchy of needs is a motivational theory that has been applied to the workplace environment to better understand how the five levels of the hierarchy impact the motivation of employees on the job. Maslow suggested that there are five basic human needs that must be met in order for an individual to be healthy and happy. The five needs are physiological needs, safety needs, belongingness and love needs, esteem needs, and finally, self-actualization. Employers who undermine any one of the five needs can potentially impact the employee in a negative way (Stewart, Nodoushani, & Stumpf, 2018). One of the first is physiological need, which is defined as basic needs to survive including food, clothing, monetary funds, and shelter. In the workplace, employers are responsible for compensating their employees to ensure this need is met. However, research into whether or not compensation impacts employment retention, happiness on the job, and whether it mitigates burnout among employees is inconclusive (Burmeister et al., 2019; Stewart et al., 2018).

Compensation was a common theme the researcher found in evaluating what factors or variables impact the levels of burnout among employees. Although it seems

that compensation is an important factor to employee retention and happiness on the job, it is not the most important. Fischer and Boer (2011) conducted a meta-analysis of well-being, burnout, and anxiety across 63 countries and found that individualism was a better predictor of the general well-being of those surveyed. Individualism is defined as the control of oneself or one's destiny and self-reliance. Well-being is defined as the subjective evaluation of an individual's life, to include their emotional state and perception of fulfillment in his or her life. Although still highly debated among researchers, it appears that individualism is positively correlated with happiness (Schwartz, 2000). Although Fischer and Boer's (2011) study was conducted at a societal level, the implications would suggest that increased compensation does not always equate to happiness or less stress. Increased compensation can actually promote a "keeping up with the Jones" mentality, which can actually negatively impact the well-being of individuals (Fischer & Boer, 2011, p. 178).

Van Beek, Hu, Schaufeli, Taris, and Schreurs (2012) found needs satisfactions, also referred to as extrinsic motivational factors, among nurses and physicians are negatively associated with burnout. The negative association would suggest that employees are not motivated by extrinsic factors such as money or fame. Rather, the study found the participants were less motivated by extrinsic factors. Less motivation caused the employee to act withdrawn and refrain from taking action on the job because of burnout. The findings of the study were similar to others and suggested that compensation was not the most important factor in reducing burnout or increasing employee engagement within the workforce (Fischer & Boer, 2011; Schwartz, 2000). Therefore, although compensation on the job helps fulfill an individual's physiological

need by allowing him or her to have the means to purchase food, clothing, and so forth, it does not mitigate burnout in the workplace.

## **Spirituality**

The workplace environment has evolved over the last few decades, and there are new challenges that organizations must address to remain competitive. Job demands have also changed and caused employees to feel more stress on the job as they face achieving goals while trying to balance work-life obligations (Mohr & Wolfram, 2010). Organizations are now tasked with finding ways to reduce stress and burnout levels among employees. If organizations choose to do nothing, there are negative implications to burnout such as lower productivity, absenteeism, and higher turnover among employees (Shemdoe et al., 2016). Spirituality is a job characteristic that has been studied as part of burnout research. There are factors to an individual's spirituality that influence the employee's contentment with his or her life and job satisfaction that can reduce the likelihood of burnout (Kumar & Kumar, 2014).

Varying factors impact the well-being and mental health of employees to include spirituality. Spirituality is defined as one's personal belief as it pertains to the end of life and the relationship to a sacred or transcendent deity or God (Carneiro, Navinchandra, Vento, Timóteo, & de Fátima Borges, 2019). Jones, Simpson, Briggs, and Dorsett (2016) conducted a meta-analysis of existing literature pertaining to spirituality and the work environment. The study found that spirituality had a positive association to resilience, mental health, and the overall quality of life for those surveyed. Liturgical support for these findings can be found in the Bible as Romans 8:6 (ESV) states, "For to set the mind on the flesh is death, but to set the mind on the Spirit is life and peace." This passage

would suggest that those who only focus on the physical aspect of life will have a much more difficult time coping during stressful situations. The opposite is true for those who are spiritually minded. Spiritual discernment provides an individual with a sense of grace, peace, and understanding that there are greater things than just the physical flesh and man-made needs. Spirituality, oftentimes, is engrained into an individual, and he or she carries it over from his or her home life into the workplace.

Karadag Arli, Bakan, and Erisik (2019) conducted a cross-sectional study on nurses who provide spiritual care as part of their job demands. The findings of the study suggested that there is a statistically significant relationship between burnout and spiritual care. As nurses provided more spiritual care to their patients, their levels of burnout also increased. The researchers attributed the statistical significance to lack of training on how to provide spiritual care, lack of management support, and personal conflict with the nurse's own spiritual beliefs. The study presented a unique aspect of spirituality and how it could negatively impact an individual. This is similar to other studies that indicated those who provided care requiring a high level of emotional aptitude were at higher risk of burnout (H. Lee et al., 2010). Kaur, Sambasivan, and Kumar (2013) suggested that a higher level of spiritual intelligence and emotional intelligence in employees would help mitigate burnout among the nursing population. Organizations should provide adequate training for those employees who provide spiritual care to mitigate the risk of burnout and positively impact the employee's attitude on the job (Rego, Godinho, McQueen, & Cunha, 2010).

In contrast, Carneiro et al. (2019) found in their cross-sectional study of a similar target population that there was a statistical significance between spirituality and the

association with resilience and burnout. The difference between the two studies was the focus of spirituality because Karadag Arli et al. (2019) looked at nurses who provided spiritual care to patients, while Carneiro et al. (2019) focused on how healthcare workers utilized spirituality to mitigate burnout. When utilized as a means to cope and to look at life events beyond just oneself, spirituality would be a mitigating factor for stress and burnout. However, there is still debate on whether or not those who teach spirituality or provide spiritual care receive the same positive association. This is an area that requires further study to determine preventative measures to reduce the impact of job demands associated with spiritual care. It would be of interest to determine how one's own spirituality positively or negatively impacts burnout among those who provide spiritual care.

### **Work-Life Balance**

The workplace environment has factors that influence and impact job satisfaction. Job satisfaction is defined as the positive emotional attitude toward the work an employee performs (Dwi Putranti, 2018). Commonalities of the three job characteristics, which are compensation, spirituality, and work-life balance, can be tied to Maslow's (2013) hierarchy of needs theory. Compensation fulfills the physiological need, and it could be said that spirituality fulfills the safety need and work-life balance fulfills the belongingness and love need of the hierarchy. In this case, work-life balance is defined as the balance between the demands and time allocated to an individual's social and family life as compared to the time allocated to his or her job or work (Cortese, Colombo, & Ghislieri, 2010). As with compensation and spirituality, work-life balance is equally important for organizations to understand as it impacts job satisfaction.

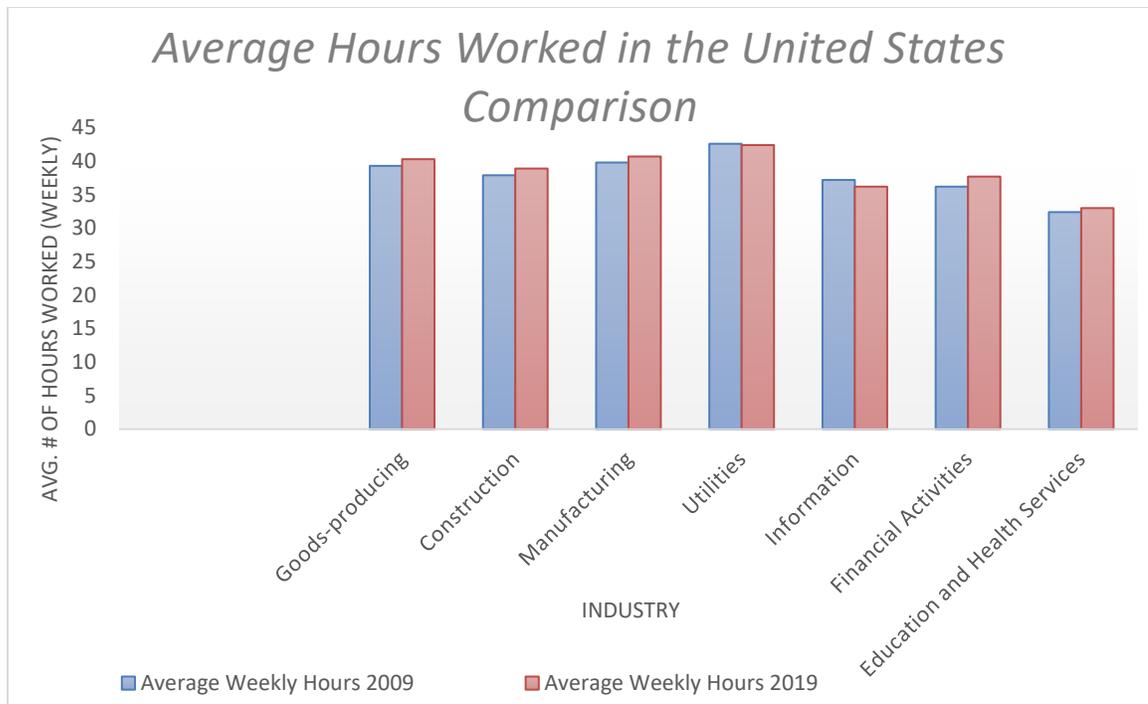
Achieving a work-life balance can be challenging in certain industries such as in healthcare (Bagley, Abubaker, & Sawyerr, 2018), construction management (Wu, Wu, Li, & Dan, 2018), and social services (Bae et al., 2019). There may be different reasons why work-life balance is hard to achieve. There are indications that long work hours, technological advancements, and physical travel or location of the work make it difficult to achieve a work-life balance (K. B. Wright et al., 2014). The U.S. Bureau of Labor Statistics (2009, 2019) reported the average number of hours worked in the United States has increased over the last decade. Table 1 and Figure 2 show the average weekly hours worked by U.S. employees in a 10-year span from 2009 to 2019. This supports studies that suggest there may be higher demands on the employee as indicated by the longer work hours among differing industries (Cortese et al., 2010; Dwi Putranti, 2018).

Table 1

*Average Hours Worked in the United States*

Industry	Average weekly hours Jan 2009 (seasonally adjusted)	Average weekly hours Feb 2019 (seasonally adjusted)
Goods-producing	39.3	40.3
Construction	37.9	38.9
Manufacturing	39.8	40.7
Utilities	42.6	42.4
Information	37.2	36.2
Financial activities	36.2	37.7
Education and health services	32.4	33.0

*Note.* From “Economic News Release,” U.S. Bureau of Labor Statistics, 2009 ([https://www.bls.gov/news.release/archives/empsit\\_02062009.pdf](https://www.bls.gov/news.release/archives/empsit_02062009.pdf)); “Economic News Release,” U.S. Bureau of Labor Statistics, 2019 (<https://www.bls.gov/news.release/pdf/empsit.pdf>).



*Figure 2.* Average hours worked in the United States comparison. From “Economic News Release,” U.S. Bureau of Labor Statistics, 2009 ([https://www.bls.gov/news.release/archives/empisit\\_02062009.pdf](https://www.bls.gov/news.release/archives/empisit_02062009.pdf)); “Economic News Release,” U.S. Bureau of Labor Statistics, 2019 (<https://www.bls.gov/news.release/pdf/empisit.pdf>).

As the global business market becomes more integrated, competitive, and fast paced, organizations are challenged with an increasingly higher number of employees experiencing stress, anxiety, and burnout because of higher job demands (Bova et al., 2015). Another recent challenge is the change in generational differences between the three largest cohorts: baby boomers, Generation X, and millennials. Researchers are interested in the emergence of the millennial generation as the largest cohort in the workforce, especially because their choices in employment, housing, and family decisions differ from past generations (Barbuto & Gottfredson, 2016; Britton, 2015; Clark & Mulder, 2000). Millennials are individuals born between 1981-1996 and are said to have shared characteristics that make the generation one of the most challenging

groups to work with in recent history. These characteristics include being one of the most educated generations, being highly technical, and no longer sticking with one company for their entire career as a norm (Becton, Walker, & Jones-Farmer, 2014).

The millennial generation has unique wants and needs associated with their employment, and there are indications that work-life balance is one of the most important job characteristics when job searching (Raina & Chauhan, 2016). Other important factors include career advancement and financial stability (Becton et al., 2014). As millennials start families, they are looking for work-life balance, both in regard to time spent with family and friends and enjoying time off to enjoy social activities (Barbuto & Gottfredson, 2016). This work-life balance will impact job satisfaction for many within the millennial cohort. Organizations are adjusting their policies and operations to be more attractive and retain talent (Gangawane, 2018; Glaser & Hecht, 2013; M. Johnson, 2015). Based on the literature, organizations will need to address work-life balance to improve job satisfaction and reduce burnout, specifically among the millennial generation. Although work-life balance is only one of many job characteristics, it has quickly risen to the top as a high priority because of the generational differences within the workforce.

### **Burnout Construct**

The term *burnout* is used for varying purposes in regard to the work environment. Freudenberger (1974) first conceptualized the phenomena as part of his research. He made observations of volunteers working in a healthcare setting and indicated that these individuals were impacted physically and emotionally with symptoms including exhaustion and the inability to cope with the stress of their jobs. The term burnout was

eventually coined and used to describe the consequence of a severe amount of stress within the helping professions.

In recent years, burnout is linked to the workplace and more clearly defined as the emotional exhaustion and interpersonal stressors caused by an employee's job or work environment. Furthermore, burnout is defined by three dimensions: exhaustion, cynicism, and feelings of inefficacy (Maslach & Leiter, 2008, 2017; Shanafelt et al., 2015). To better understand the burnout syndrome, it is important to understand how stress affects burnout as well as the difference between stress and the burnout syndrome. The next section covers burnout and its association with stress, the history of burnout research, theoretical frameworks, and the association of social support to burnout.

### **History of Burnout Research**

Freudenberger (1974) observed employees who became mentally exhausted on the job, and he referred to this mental state as "burned out." He conceptualized burnout and associated it with burnout symptoms and the phenomena of burnout in the workplace. Burnout symptoms negatively impact the cognitive, judgement, and emotional state of an employee. However, with measures in place, managers could possibly help reduce the impact or mitigate the damage done (Freudenberger, 1974; Maslach, 1982).

Freudenberger's observations at a clinic of the burnout syndrome in volunteers included physical symptoms such as exhaustion, sleeplessness, and fatigue. In addition to physical symptoms, observations of behavioral changes included increased frustration, cynicism, and depression.

Freudenberger's (1974) observations and conceptual framework became the grounds for Maslach (1982) and others regarding workplace burnout (Chiu & Tsai, 2006;

T. A. Wright & Hobfoll, 2004). Freudenberger (1974) argued, through his conceptual framework, that symptoms of burnout are job related and influenced by the situation. If burnout becomes a chronic state in the employee, there is a negative impact that is tied to absenteeism, reduced productivity, employee dissatisfaction, and increased turnover (Chiu & Tsai, 2006; Maslach, 1982; Maslach & Jackson, 1981; T. A. Wright & Hobfoll, 2004). Maslach and Jackson's (1981) research aimed to reduce the ambiguity that surrounded burnout symptoms and phenomena. Looking past the causes of burnout, the researchers began associating burnout through empirical research and established that burnout is the direct impact or result of prolonged stress because of the work environment.

Researchers such as Maslach (1982) helped to pioneer burnout research. More methodological tools, models, and frameworks now exist to measure burnout and to address how to mitigate the negative impact it could have on an organization. Better standardized measures exist to understand burnout using empirical data and include tools such as Maslach's Burnout Inventory (MBI), which is one of the most utilized burnout measurement tools to date (Maslach & Jackson, 1981). This standardized method of collecting empirical data used in human services industries helped validate findings pertaining to the burnout syndrome and advance research into preventing burnout. Using frameworks and models such as the MBI, research into burnout expanded into job fields such as pharmacists (El-Ibiary et al., 2017), nurses (Freitas et al., 2017; Liu et al., 2018), physicians and healthcare workers (Heinemann & Heinemann, 2017; Kilpatrick et al., 1991; Lin et al., 2016; Lu et al., 2016; Maslach & Leiter, 2017; Shanafelt et al., 2015; van de Klundert et al., 2018), managers (Ayala Calvo & García, 2018; Cordes et al., 1997;

Ou, Jungmin, Dongwon, & Hom, 2017; Rahim, 1995; Reina et al., 2018), construction managers and project managers (Yang et al., 2017), social workers (Wagaman et al., 2015), teachers (Szigeti et al., 2017), and other industries beyond human services (Leiter & Schaufeli, 1996; Schutte et al., 2000).

Golembiewski (1989) introduced a model similar to Maslach and Jackson's (1981). Golembiewski's model and research method analyzed the three dimensions of burnout by looking at eight sequences of progressive virulence. Progressive virulence in this methodology referenced the severity of each dimension of burnout as it related to one another and how the person perceived the severity of each dimension (Golembiewski, 1989). This furthered the burnout research by allowing researchers to dive deeper into the details of burnout and look at the stages of burnout that an individual may experience. The model indicated that an individual may not experience every phase and could progress up and down in phases depending on the environment or situation, as shown in Table 2. The three dimensions are scored on a high, medium, low scale with complete burnout indicated by Phase VIII in which all three dimensions are scored as high (Golembiewski, 1989).

Each phase is scored high or low based on the three dimensions of burnout with Phase I at a low level of burnout, depersonalization, and emotional exhaustion and high on personal accomplishment. The next two phases, Phase II and III, would begin to score higher, indicating the first signs of depersonalization and reduction of feelings toward personal accomplishments, but may not include high scores in both. Phase IV is typically where both symptoms are apparent, with Phase V showing emotional exhaustion along with high scores on depersonalization and continued reduction toward personal

Table 2

*Golembiewski Eight-Sequence Model*

Phase	Burnout dimension: Depersonalization	Burnout dimension: Personal accomplishment	Burnout dimension: Emotional exhaustion
I	Low	Low	Low
II	High	Low	Low
III	Low	High	Low
IV	High	High	Low
V	Low	Low	High
VI	High	Low	High
VII	Low	High	High
VIII	High	High	High

accomplishment. The final two phases would see higher scores in all three dimensions until Phase VIII indicated a high score in all three. Empirical data provided by this model have allowed researchers to tie the dimensions of burnout with levels of burnout. This model could potentially be used alongside the MBI to gain a deeper understanding and discussion based on individual perspective. Although not as widely used as Maslach and Jackson's (1981) MBI model, it is an instrument that researchers can utilize to better measure and understand the phases of burnout (Cordes et al., 1997; Golembiewski, 1999).

### **Industries**

Currently, limited studies are available pertaining to burnout among U.S. healthcare managers; however, studies exist in other industries. For example, Yang et al. (2017) studied burnout among construction project managers in China, which had similarities to healthcare managers based on duties and tasks. This population must deal with varying stakeholders, employees, and deadlines that add to the stressors of the job

and potentially turn into burnout. The scope of work for construction project managers can vary and be ambiguous at times, causing stress because of these responsibilities (Yang et al., 2017). Using the jobs demand resource (JD-R) model, the authors found that emotional exhaustion, lack of resources, and control of their job impacted the burnout rate of this population. The JD-R model measures working conditions based on job demands and job resources (Demerouti et al., 2001). Like healthcare managers, construction managers have a high level of responsibility and are the bridge between employees and the employer regarding communication (Yang et al., 2017).

Social work and education are other human service industries where burnout was heavily studied. Cordes et al. (1997) used both Maslach and Jackson's (1981) MBI and Golembiewski's (1989) model to study burnout among human resource employees and found that emotional exhaustion and depersonalization because of increased workloads were the stronger variables and indicators of burnout within the surveyed population. This population had added vulnerabilities to burnout as they experienced more interpersonal interactions with others, and in these situations, burnout is likely if the interactions are negative (Cordes et al., 1997).

Szigeti et al. (2017) used the MBI to measure burnout among teachers in Hungary and also found emotional exhaustion and depersonalization as a better predictor of burnout. Their study found that teachers who taught special needs children had a higher level of burnout, which indicates certain environmental factors of the job can impact different aspects of the burnout syndrome (Szigeti et al., 2017). Another variable that caused higher levels of burnout among teachers was the increased workload caused by overcommitment, in part to achieve students' development and academic experience

(Szigeti et al., 2017). In other words, teachers put a focus on students' outcomes and in so doing, push themselves to the brink of burnout.

Other research studied university level faculty, where burnout was also higher and had findings similar to that of Szigeti et al. (2017). El-Ibiary et al. (2017) used the MBI and found that the length of experience a faculty member had at a university had the worst scores for depersonalization and personal accomplishments. The study indicated scores that doubled the results of past studies with 43.3% of respondents indicating burnout. Although the scores suggested that pharmacy faculty members were more likely to experience burnout, other factors may have impacted the scores. For example, the sample size was much smaller, and the population was different than in similar studies. As with other studies in the human services industries outside of education, long work hours correlated with increased burnout among faculty, and having a social support system available could help reduce levels of burnout (El-Ibiary et al., 2017).

As with other human services industries, social workers spend much of their time caring for others and helping others in difficult situations. Wagaman et al. (2015) conducted a study of social workers, specifically looking at their level of empathy and how it impacted the burnout syndrome. Their findings suggested that there was a significant relationship between empathy skills in social workers and a negative correlation with burnout symptoms. Social workers are more prone to burnout because of the environment and job tasks they must perform.

Typically, burnout is slower to occur as situations arise and impact the social worker over a period of time. This implies that increasing coping strategies could better prepare human service workers, such as social workers, manage the inherent risk of

burnout. Burnout has gained increasingly more interest from academic researchers over the course of the years. Research has expanded over the last 40 years starting with research and discussions on psychological stress and how it impacts burnout (Heinemann & Heinemann, 2017). Burnout syndrome has been tied to the workplace although outside factors from an individual's personal life may be contributors. These factors are linked to psychological stressors that impact the individual (Maslach, 1982; Maslach & Leiter, 2008, 2017). For the purpose of this study, burnout was addressed based on the workplace environment; therefore, literature specific to workplace burnout was reviewed. Within the burnout syndrome, stress plays a major factor in the development of workplace burnout. Lazarus and Folkman (1984) defined stress as the relationship people have with their environment, which they perceive as taxing or exceeding their abilities or resources. This psychological perception could negatively impact an individual's wellbeing.

Maslach (1982) suggested that prolonged chronic stressors based on job requirements potentially create or cause employee burnout. Chronic stressors because of job requirements is an area where researchers have agreed that job burnout is a consequence of job stress and crucial for managers to understand in any industry (Maslach, 1982; Maslach & Leiter, 2017; Rahim, 1995; Yang et al., 2017). Based on Rahim's (1995) study on job stress and burnout, there were four dimensions that characterize job stressors: role conflict, role ambiguity, role overload, and role insufficiency. The findings suggested that employees who had more control of their job role, had more clarity and enough knowledge of their role were less impacted by job stressors, which in turn decreased the likelihood of burnout.

Psychological stress has both positive and negative consequences depending on the level and the control individuals perceive they have over their situation. When the level of stress goes beyond their control, an adverse reaction, such as that of burnout, could occur. Freitas et al. (2017) and Srivastava, Chandra, and Shirish (2015) suggested there are differences in people's personalities that give them different mechanisms for coping with stress. Therefore, stress levels can vary depending on individuals' position, their level of hardiness to cope with stress, and perceived control over their role.

Understanding how different individuals cope with job stress, the impact and cause of the stress, and how stress can develop into burnout over time is important for managers. This understanding enables managers to better support their employees (Srivastava et al., 2015). Without considering what causes job stress and failing to keep the stress at a manageable level, the likelihood that an employee experiences burnout increases as burnout is tied to the workplace environment. Maslach and Leiter (2017) pointed out that certain fields of work are more prone to stress, such as jobs within the human services industries. Human services industries include interdisciplinary fields that set out to meet human needs through prevention or remediation of problems (Maslach & Leiter, 2017). This includes, but is not limited to, industries of healthcare, education, social work, law enforcement, mental health, construction, and emergency management.

### **Burnout and Social Support**

The social support system within an organization has been linked to the increase or decrease in burnout syndrome among workers depending on how much support is provided to employees. There are two widely known conceptual frameworks associated with social support: perceived social support and received social support. Lindorff

(2000) defined these two frameworks; perceived social support is the belief and perception of acceptance and feeling loved by others with emotional support from others and received social support is defined as the behavioral aspect that occurs during interpersonal transactions.

The discourse of social support in the workplace is divided regarding whether there is a positive or negative impact on burnout based on perceived social support or received social support (Mohr & Wolfram, 2010). In Lindorff's (2000) study, she found that male managers were less likely to ask for social support in the workplace and saw an increase in levels of stress. The male managers also perceived little support available to them as opposed to their female counterparts. This study provided insight into the perception of managers. It suggested the importance for organizations to address social support among their managers and to ensure that perceived social support and received social support were adequate. The unique findings from this study provided insight into the differences among male versus female participants and how they react to stress in the workplace. In the future, it is worthwhile to study these differences because the typical roles for males and females are changing in evolving business environments.

Other areas of study have focused on many of the same human services industries, such as healthcare, and the impact of social support on employees that was based on the perceived support levels from supervisors or senior leadership. Singh et al. (2015) found that managers who received higher social support felt less job stress. Managers also had a positive correlation with job satisfaction and were less likely to leave their current role. This study ties into the burnout syndrome as prolonged stress can cause burnout among managers, increasing the likelihood that they would consider leaving the job because of

dissatisfaction, role ambiguity, role pressures, and lack of resources (Singh et al., 2015). Managers play a big role in organizations by bridging communications between the employers and the employees. With this role come added pressures because of work demands. It is therefore important for organizations to understand how social support can help to mitigate stress and burnout.

Social support is important as it shows employees and managers that they are supported by the organization regarding their role. The perceived support makes employees feel more motivated and satisfied with their job, which positively impacts the organizational performance through their commitment to succeed in their role (Singh et al., 2015). Similarly, Zhai, Lindorff, and Cooper (2013) suggested that social support and the feeling of being connected with an organization influenced employees to be more productive on the job. There were positive correlations between job satisfaction and supervisor-subordinate relationship based on social support. The study found that the relationships between supervisor and subordinates versus the relationship with direct coworkers were more important because supervisors seemed to have a stronger influence on job satisfaction. The study aligns with other studies in suggesting the importance of managers providing social support within the organization because it reduces stress and positively impacts job satisfaction in the long term.

### **Burnout Construct in Healthcare Organizations**

With new laws such as the 2010 Affordable Care Act (ACA), front line managers in U.S. healthcare organizations have had to adapt and expand upon their roles (Wong & Laschinger, 2015). Currently, research into burnout among U.S. healthcare managers is limited. It is focused primarily on clinical managers such as nurse managers. Limited

research is available pertaining to nonclinical (ancillary) managers. Increased requirements, tasks, and responsibilities placed on these individuals warrants further study to better understand how prevalent burnout is among U.S. healthcare managers. In this section, a systematic review of existing literature on burnout research in healthcare organizations and burnout research specific to healthcare managers is discussed.

### **Burnout Research in Healthcare Organizations**

It is widely agreed that human services industries such as healthcare, social work, and education see increased levels of burnout among employees. This is partly due to daily interaction with other people or having to care for other people on the job (Maslach & Leiter, 2017). Maslach and Jackson (1981) originally developed the MBI specific to the human services industry, which at the time was a large focus of burnout research. The MBI has been more widely used to provide empirical data on rates of burnout among healthcare workers. However, because of a lack of consistency with varying models, it is more difficult to do a cross comparison among the literature because not all studies utilized the MBI (Heinemann & Heinemann, 2017; Wong & Laschinger, 2015).

The history of burnout research has progressed over the last 4 decades and researchers now agree on the definition of burnout. Burnout is defined as the emotional exhaustion and interpersonal stressors because of the employee's job or work environment. Furthermore, burnout is comprised of three dimensions: exhaustion, cynicisms, and feelings of inefficacy (Shanafelt et al., 2015). However, fully understanding burnout is still distant because there are many variables that impact burnout. With differing surveys, models, conceptual frameworks, and instruments available to measure burnout, researchers have had a difficult time comparing findings

(Heinemann & Heinemann, 2017). With more research in different industries, jobs roles, and environments, the burnout discourse has expanded. Leading these efforts are researchers such as Maslach and Leiter (2017) and Demerouti et al. (2001) who developed frameworks and models that can be utilized to measure burnout among different types of employees. The instruments introduced by these researchers helped streamline the research process and allowed others to capture empirical data that were not previously available (Demerouti et al., 2001; Maslach & Leiter, 2017).

In the healthcare industry, burnout has been a topic of interest for healthcare organizations as well as for researchers. Much of the focus has been on clinical workers such as nurses, nurse managers, and physicians, as previously mentioned. These groups of individuals are prone to stressors as they deal directly with patient care daily and in some cases deal with highly emotional situations (Johansson et al., 2013). Adriaenssens, Hamelink, and Bogaert (2017) measured the burnout syndrome in healthcare workers and suggested it could be as high as 50%. This would indicate that burnout is a very real problem in the healthcare industry and should be a high priority for managers to understand in order to help their employees mitigate the likelihood that chronic stressors would eventually lead to burnout or burnout symptoms.

Wong and Laschinger (2015) conducted a cross-sectional study of front-line nurse managers to understand the impact of burnout. The results indicated that burnout among healthcare workers positively correlated with reduced levels of patient care and negatively impacted patient safety. This is an area of concern as patient care requires that healthcare workers interact with the patient and his or her families to provide the support needed to ensure quality of care. As the rate of burnout increases in healthcare workers,

cynicism, emotional exhaustion, and depersonalization increase. Therefore, the symptoms have the potential to cause the healthcare worker to disassociate himself or herself with the situation, thus negatively impacting the care experience (Wong & Laschinger, 2015). There remains ambiguity about how burnout can be addressed with the increasing workload on healthcare workers. Healthcare organizations are concerned for their workers because of new laws and regulations related to access to healthcare and increasing service demands because of aging baby boomers. However, research has provided a starting point on ways to mitigate burnout, such as providing a stronger social support system and ways to identify an employee experiencing burnout symptoms.

In addition, studies have found that burnout can have a negative outcome on job performance and decrease the level of patient care (Covella et al., 2017). Burnout can lead to increased injury rates, employee absenteeism, low team morale, increased cost for staff replacement because of turnover, and lower perceptions of work-life balance (Shariro et al., 2016). In the United States, organizations such as the Joint Commission and the Department of Public Health measure poor quality of care, patient complaints, patient deaths, and other quality metrics (Centers for Medicare & Medicaid Services, 2018). Burnout among employees impacts a healthcare organization's brand when these metrics on quality are reported publicly.

Salyers et al. (2017) found through a comprehensive review of healthcare studies that there is a lack of quantitative review across disciplines and domains within a healthcare setting. Therefore, it would indicate that studies on burnout within the healthcare industry have been siloed, and it would be difficult to recognize similarities across the different areas of healthcare. Healthcare organizations are made up of varying

support and clinical departments. Healthcare organizations utilize these multidisciplinary teams to achieve organizational goals. Furthermore, nurses and physicians have been among the most highly studied group regarding burnout within the healthcare industry. Shanafelt et al. (2015) found indications within survey results and other study methods that would suggest burnout rates among these populations are increasing. Although physician response suggests a higher level of burnout symptoms in this population, meta-analysis data suggest that nurses experienced even higher levels of burnout (Salyers et al., 2017). Empirical evidence linked burnout to safety risks in the healthcare environment, and these two populations are key players in the care of patients (Maslach & Leiter, 2017).

Historically, research into burnout in healthcare organizations has focused primarily on clinical staff such as pharmacists (El-Ibiary et al., 2017), nurses (Freitas et al., 2017; Liu et al., 2018), physicians, and frontline healthcare workers (Kilpatrick et al., 1991; Lin et al., 2016; Lu et al., 2016; Maslach & Leiter, 2017; Shanafelt et al., 2015; van de Klundert et al., 2018). Heinemann and Heinemann (2017) signaled the prevalence of studies on nurses, physicians, and healthcare students would indicate that burnout is a significant problem in the healthcare industry with numbers as high as 50% of those surveyed showing levels of perceived burnout. However, the study discussed the need to further research in the field regarding burnout and go beyond the identification of those who suffer from the burnout syndrome. There is a gap in research that goes beyond identification of those who suffer burnout, and questions remain as to what value identifying individuals has to organizations if little is done with the information. Identifying employees who suffer from burnout is one step in the right direction.

However, there is a need to clarify and remove the ambiguity behind the cause of burnout (Heinemann & Heinemann, 2017).

With that objective in mind, research has been conducted to better understand burnout among specific populations that care for patients daily. The main reasons why employees such as nurses are overly studied is the potential impact of burnout regarding exhaustion, cynicism, and feelings of inefficacy (Maslach & Leiter, 2017). In the healthcare environment this can have adverse effects on patient care with negative implications such as medical errors, lack of building relationship with patients, and withdrawal from work (Lin et al., 2016; Zis et al., 2014). In one of the larger studies conducted recently, Shanafelt et al. (2015) used the MBI to assess burnout among 6,880 physicians. The researchers found that 54.4% of those who responded to the survey indicated at least one burnout symptom. This was an increase from 2014, which at the time indicated 45.5% of physicians had at least one burnout symptom. Based on the study, there was an increase of 8.9% from 2014 to 2015, suggesting that more physicians are feeling burned out in their work environment compared to past surveys (Shanafelt et al., 2015). The survey results also indicated an increase in burnout rates among physicians that occurred after the ACA was enacted in 2010. This would be an area for further research to better understand the correlation, if any, between the ACA being signed into law and burnout rates among physicians. Laws and regulations are changing within the United States and limited studies have been conducted to better understand how these new laws impact healthcare workers.

As mentioned previously, another group of healthcare workers who are highly studied is nurses as they provide direct patient care daily. The nursing population has

been widely studied on a global scale, evaluating the impact of burnout on the job and the outcomes of patients (J. Johnson et al., 2017; Liu et al., 2018; van de Klundert et al., 2018). The outcomes of patients have been tied to nursing engagement, or lack thereof, with patient harm rates increasing when burnout is present (Lu et al., 2016).

H. Li et al. (2018) conducted a meta-analysis on emergency department nurses focused on the varying models of burnout. Instruments such as the MBI and JD-R were found to produce different results when measuring burnout. The research suggested evaluating studies that utilized the same models or instruments would be more ideal for comparison purposes. The meta-analysis of studies on nurses using the MBI instrument indicated that emergency nurses faced increased level of burnout. The highest-ranking stress factors were lack of control, perceived workload, lack of time for patient care, and teamwork (H. Li et al., 2018). The indications from that study highlight the challenges behind the ambiguity of the field of burnout because the factors vary greatly. Heinemann and Heinemann (2017) suggested burnout can be measured in different ways depending on the model, instrument, framework, or variables. Different models and frameworks allow researchers to utilize instruments that would best benefit their studies. However, using varying models and frameworks becomes problematic when trying to compare studies to gain a bigger picture of the overall issue of burnout in the healthcare industry and across different disciplines.

J. Johnson et al. (2017) furthered the research of burnout among nurses to include depressive symptoms and corroborated their results with past research. The study focused on how burnout and depressive symptoms are associated with patient safety. The study would suggest that burnout is the more impactful variable, as depressive symptoms

could be an adverse outcome of burnout (J. Johnson et al., 2017). Similar to other studies, J. Johnson et al. (2017) found that nurses experience higher levels of emotional exhaustion and depersonalization than other healthcare workers. Burnout in this case is associated with a positive correlation to working longer hours, which is common practice in a number of healthcare organizations.

Another recent study suggested that nurses are inherently predisposed to job burnout and stressors directly related to their roles as caretakers (van de Klundert et al., 2018). Many studies have focused on nurses who care for patients with terminal illnesses or challenging illnesses or who work in high stress environments such as the emergency department (H. Li et al., 2018; Lin et al., 2016; Liu et al., 2018). These studies suggest that nurses working in areas that are more stressful show higher burnout rates than nurses who work in less emotionally exhausting departments (Lu et al., 2016; Shemdoe et al., 2016). This has attracted a lot of attention to determining how to provide better social support and mitigate the burnout symptoms for the nursing population who are deemed more predisposed to burnout based on their work environment. The ability to identify high stress job roles based on patient demographics and outcomes can help organizations better support the clinical staff.

### **Burnout Research Among Healthcare Managers**

Burnout research has progressed greatly since the early 1970s in developing standardized methods and conceptualized frameworks that could be used to better understand burnout in varying industries. Currently, there is limited literature specific to burnout among U.S. healthcare managers working within the ancillary departments. Literature and studies pertaining to this area of burnout has focused on clinical managers

with job titles such as nurse managers as discussed previously (Wong & Laschinger, 2015). The ancillary managers are often responsible for the business side of healthcare organizations. For example, facility services managers are responsible for the upkeep of the hospitals, and environmental services managers are responsible for the cleanliness of the facilities. Without both roles, operations of the hospital would be very challenged.

**Nurse managers.** Although there are limited studies pertaining to ancillary managers, there are a number of studies that look at clinical healthcare managers. Adriaenssens et al. (2017) conducted a study in Belgium hospitals looking at the impact of nurse managers, burnout, and predictive measures to the nurse manager's well-being. Nurse managers have seen their roles increase over the last decade, supporting a broader range of activities. Not only do they support the functional aspects of the departments, they must also support different stakeholders such as the nurses, doctors, senior management, and patients (Johansson et al., 2013). This role is known to have a large set of responsibilities that may cause occupational stress. More nurse managers are reporting that they have some control of their job. However, this is not always the case, and the lack of control leads to burnout over time (Wong & Laschinger, 2015). Adriaenssens et al. (2017) also found that nurse managers were more likely to disengage from their work because of dissatisfaction and feelings of being overworked. In their study, 70% of the nurse managers reported that they felt they could not control the way they performed their daily tasks.

Another area of interest among this population based on Adriaenssens et al.'s (2017) study was the statistical results on the nurses' perception of social support provided by their nurse managers. The results indicated that a high percentage of nurses

felt their nurse managers were disengaged and did not support them on the job. This would suggest that there is room for improvement for nurse managers related to providing better social support to their nurses. This could be a direct result of increased workload and responsibilities, which could impact the nurse managers' ability to be more involved with their staff.

Wong and Laschinger (2015) found similar results in their study of nurse managers that indicated the role of a manager produced higher job strain, which leads to a higher rate of burnout among nurse managers. The study was conducted among nurse managers in Canada with findings similar to those of Adriaenssens et al. (2017). They found that nurse managers reported an increase in workload and less control of the decisions pertaining to their job tasks (Wong & Laschinger, 2015). Of interest with this study was the statistical finding that one out of every two nurse managers reported perceived levels of burnout. Specifically, nurse managers reported an increase in cynicism, low commitment to the organization, and high turnover intentions. This suggests that nurse managers are disengaging from the organizations in which they work because of higher demands and the higher emotional aptitude needed to deal with employees, patients, and senior managers. Nurse managers play an important role in the organization that ensures patients and staff remains safe. Therefore, it is no surprise that nurse managers have been a large target population for studies pertaining to burnout. Better support systems and preventative measures are needed to reduce the levels of burnout among nurse managers.

**Healthcare administrators.** Aside from nurse managers, there are studies that have focused on healthcare administrators although most did not identify job roles such

as supervisors, assistant managers, managers, directors, and executives (Kilpatrick et al., 1991). There is a lack of clarity when the job roles are not identified, preventing researchers from investigating whether there was a difference in perceived burnout among these roles. This is important to note as the gap in research would suggest that a large group of healthcare workers are not evaluated for burnout within healthcare organizations and that there is some ambiguity when it comes to research pertaining to healthcare managers. Healthcare managers often have responsibility in managing employees, achieving organizational goals, and ensuring quality patient care (Liu et al., 2018). These are tasks that would involve interacting with others, whether it is an employee, a customer, patient, family member, or another manager. The potential for burnout among managers is of relevant concerns given that their tasks are similar to those of clinical managers studied.

In looking closer at healthcare administrators, this particular population is typically associated with senior level management positions. Kilpatrick et al. (1991) conducted a study within the VA hospitals located in the United States and found that the healthcare administrators reported higher levels of burnout than other administrators when compared to other industries. There was a level of burnout among the healthcare administrators, with three of the ten respondents reporting burnout symptoms because of role conflict, ambiguity, and lack of resources. It is important to note that this study was limited to the VA hospital where healthcare administrators may have differing responsibilities from their counterparts in public or private healthcare organizations.

Kilpatrick et al.'s (1991) study posed unique insight into how the burnout syndrome impacts even those at the highest level of management. It would be of interest

to compare these healthcare administrators against other healthcare administrators in the public and private sector to gain a larger population for a study on burnout. It would also be helpful to understand the titles and levels of the healthcare administrators to see whether the level of management relates to the level of perceived burnout. Without this information, the gap in the literature remains because not all management levels are being captured within ancillary departments.

**Healthcare managers.** H. Lee et al. (2010) conducted their study focused on aspects of transformational leadership as part of an implementation of the Leadership Development Initiative (LDI) at the Alberta Cancer Board. The focus of the study was to determine whether there was a link between emotional health, the LDI, and burnout among managers in the healthcare setting (H. Lee et al., 2010). Their study looked at pre-LDI and post-LDI surveys to determine whether LDI would lower burnout among healthcare managers utilizing three different data collection instruments including the MBI and areas of work life survey. This study was unique in that it was conducted alongside LDI efforts during a period of change, growth, and expansion within the organization. It is unknown how much of that change related to the burnout rates with the managers both pre- and post-LDI. Although this was included as part of the literature review, H. Lee et al. (2010) focused more on the overall emotional health of managers through the use of the LDI and not solely on burnout. It was one of the few studies found that included varying levels of management within a healthcare organization to better understand the relationship at each level. However, this study was conducted in Canada and therefore does not reflect U.S.-based healthcare managers.

Burnout is a relatively large and broad research topic, spanning many industries and impacting different aspects of the workplace. There is still ambiguity when it comes to variances and understanding burnout as it is associated with the human services industries. Understanding how stressors impact burnout and the definition of burnout in the workplace has helped researchers redefine the scope of research (Maslach & Leiter, 2008). The topic of burnout is important for managers, employees, and business executives to understand as it can occur in any work environment (Maslach & Leiter, 2017). However, within the healthcare industry, which falls under the human services industry, workplace burnout is much higher because of the nature of the work and expectations placed on the employees, with much of their job focused on the care of others (El-Ibiary et al., 2017; Lu et al., 2016; Shemdoe et al., 2016). Because burnout is not a linear phenomenon and cyclical in nature, managers should be aware of the three dimensions. This will allow managers to identify ways to better support their staff.

The lack of research into burnout among U.S. healthcare managers, including clinical and nonclinical or ancillary managers, at all levels of management is of concern. This remains a gap in the research, in particular, focusing on ancillary managers who were not commonly addressed in past studies. With managers being the bridge between the employee, patient, and organization, it is very important to ensure the health of their emotional and physical well-being. Likewise, ancillary departments of healthcare organizations provide support services that are operationally needed to care for patients. These individuals help to drive the organization through support roles by being strategic thought partners for executive leaders. With that, their roles can become challenging as they must provide the services that support clinicians.

As indicated, to date a large focus has been mainly on nurse managers and those clinical managers that must deal with nursing staff or patients. Of course, these are important roles and roles that have an increased demand in workload (Wong & Laschinger, 2015). However, healthcare organizations are made up of many different departments, both support departments and clinical departments, that have managers and front-line supervisors who also must deal with the demands of patient care, whether directly or indirectly. Gaining insight into burnout among all levels of management and ancillary managers would provide a bigger picture of the prevalence, or lack thereof, of burnout in the U.S. healthcare organization and industry overall. It would also be of interest to compare clinical managers and ancillary managers to better understand similarities or differences among the populations.

Another gap exists in the literature in regard to the types of managers included in studies. Ancillary managers are not captured or broken out in studies to indicate whether burnout exists among this particular population of healthcare workers. It is worthwhile studying to gain a better idea into how different levels of management rate burnout, and whether there is a prevalence of burnout among ancillary managers. It would also help fill in the gap to understand how and whether ancillary managers are impacted by burnout as they often times do not deal with direct patient care. Ancillary departments are typically support services for the clinical departments. Support services are defined as departments that perform nonclinical job duties to maintain, clean, and upkeep the facility. However, as their jobs and roles support the clinical staff who are the internal customers, it is equally important to understand whether burnout impacts ancillary managers as it does their clinical manager counterparts. Finally, studies that include

ancillary managers would provide a comprehensive view of burnout within the population of healthcare managers and provide a broader understanding of the impact burnout may have on the individual roles within the organization.

### **Hardiness**

Kobasa (1979) conceptualized hardiness and described it as a personality trait that combined three attitudes: commitment, control, and challenge. These three attitudes became known as the 3Cs. Commitment referenced an individual's involvement with the activities occurring in and around them, and control was their ability to influence those activities (Sheard & Golby, 2007). Finally, challenge was defined as the perspective an individual has to change in his or her life. The 3Cs can impact an individual's overall hardiness level. Mental hardiness is scored based on three components of individuals: employees' commitment to their work or activity, employees' perception of how much influence they had on their work, and whether employees had a positive or negative outlook on change. In this section, a review of literature pertaining to hardiness and how it applies to burnout is discussed. For the purpose of this study, hardiness is defined as an individual's personality characteristics that are comprised of three dispositions of commitment, control, and challenge (Ayala Calvo & García, 2018). These personality characteristics affect how they view themselves and the situations around them.

### **Hardiness Construct**

Kobasa (1979) has been one of the key researchers into hardiness, conceptualizing psychological hardiness as a coping strategy to deal with tough situations. There is agreement that hardiness is learned and not something an individual is born with. The concept of individual hardiness is attributed through the 3Cs: commitment, control, and

challenge. Given a difficult situation, individuals have a mental or psychological choice to make and, depending on how they are able to utilize the 3Cs, determines their hardiness level. An individual with a high level of hardiness would be able to essentially motivate themselves to work hard at turning a stressful situation into a growth opportunity (Kobasa et al., 1982). The opposite is true as well; those with lower levels of hardiness would be less adept at motivating themselves during a stressful situation.

The original study on hardiness was conducted from 1975 to 1987 to test resilience of employees at Illinois Bell Telephone (IBT; Kobasa, 1979). Employees working in stressful conditions were followed for a number of years to determine whether there were individual characteristics that could explain differences in reactions to better understand the hardiness theory. During the longitudinal study, the organization went through a difficult time with many changes occurring. It was discovered that hardiness was a differentiator among the employees who were able to navigate successfully through the challenges of the company versus those who decided to leave (Maddi, 2006).

This was a notable study and launched hardiness into the forefront of resiliency applications for employees. Because the longitudinal study lasted 12 years, the outcome suggests that only a third of the employees showed high levels of hardiness. The employees with higher levels of hardiness were able to thrive in the high-stress environment, and the challenging environment had little effect on their health (Maddi, 2006). The other two thirds either left the company, experienced health problems or personal problems, or had work-related performance issues. The study indicated that hardiness played a role in an employee's success when stressful situations occurred. This validated the hardiness theory as employees' ability to commit to the situation, have input

and control of their work, and think positively during the changing work, which allowed them rise up in the organization. Using this study as the basis to hardiness, Kobasa (1979) was able to identify a personal trait that could be developed in employees to help them navigate stress and be successful in whatever role they were in.

Since then, hardiness studies have been done in many other industries such as the armed forces (Taylor, Pietrobon, Taverniers, Leon, & Fern, 2013), students (Sheard & Golby, 2007), athletes (Salim, Wadey, & Diss, 2016; Wieser & Thiel, 2014), and employees (Mazzetti, Vignoli, Petruzzello, & Palareti, 2019). In stressful environments and in the face of adversity as seen with students studying for difficult exams or patients diagnosed with cancer, these situations can lead people to dwell in their circumstances, causing burnout or depression. Studies have found that individuals can change their perception and reduce the levels of stress or burnout based on their hardiness attitudes, which in turn can lead to enhanced performance (Mazzetti, Guglielmi, Chiesa, & Mariani, 2016). There are moderating effects from hardiness that have shown mitigation of potential health problems and illness among workers through the reduction of stress.

### **Hardiness as a Predictor**

Hardiness has been utilized as a predictor to identify how an individual will deal with stress. Jamal, Zahra, Yaseen, and Nasreen (2017) studied the implications of hardiness and coping strategies and how these can be predictors of stress among rescue workers in Pakistan. Rescue workers deal with emergent situations daily. How well the individual rescue worker coped with stress was affected by their degree of hardiness. The study found that those with higher degrees of hardiness were more likely to adapt to the situation and in turn reduced their stress levels. In similar studies, findings among

rescue workers revealed that there is a negative relationship between hardiness and stress. The findings suggest a preventative measure for rescue workers would be to teach mental hardiness, which would then reduce stress and decrease the likelihood of negative affects to the organization (Ayala Calvo & García, 2018; Jamal et al., 2017; Saksvik, Bjorvatn, Magerøy, & Pallesen, 2016).

Abdollahi, Abu Talib, Yaacob, and Ismail (2015) conducted a cross-sectional study to identify whether hardiness in undergraduate students impacted their perceived levels of stress and suicidal ideation. Their findings suggest that hardiness can be utilized as a predictive factor with students scoring higher in hardiness less likely to have increased stress levels that would lead to suicidal ideation. Students scoring low on the hardiness scale were seen as more likely to report suicidal thoughts than those scoring higher. This study indicated that hardiness partially mediated perceived stress and suicidal ideation. Furthermore, these findings suggested that hardiness can be utilized to help students cope with their studies. The implications of the study led researchers to believe that hardiness can be used to screen for potential mental health challenges that may arise or to better identify those who may need more assistance related to managing stress (Maddi, Harvey, Khoshaba, Fazel, & Resurreccion, 2012).

Similar studies on resilience and mental toughness have commonalities with hardiness. These studies indicate that individuals who are more adapt at appraising stressful situations as challenges rather than as a threat to them were less likely to burn out (Arrogante & Aparicio-Zaldivar, 2017; Madigan & Nicholls, 2017). Fyhn, Fjell, and Johnsen (2016) conducted a study among police investigators and found hardiness as a predictor for the variances in burnout. The findings suggested that components of

hardiness were statistically significant regarding job commitment levels of the police investigators. Again, the study suggests that those individuals with higher scores in mental hardiness are less likely to experience burnout and less likely to turnover. The negative correlation of hardiness and burnout among high stress careers such as that of the police force, military, and healthcare professionals is an indicator that hardiness can be utilized as a means to predict burnout, screen for hardiness during the hiring process, and reduce the likelihood of turnover (Jamal et al., 2017; Saksvik et al., 2016; Westman, 1990).

Westman (1990) suggested that there was a relationship between the moderating effects of hardiness, stress, and job performance. In the study focused on cadets in the Israel Defense Force, personality factors such as hardiness were evaluated to identify whether characteristics of hardiness could act as a buffer to reduce the affect that stress had on the individual. The results of the study, like those mentioned previously, indicated that hardiness had a negative relationship to stress and a positive relationship to performance. Individuals scoring higher on the hardiness scale reported fewer negative effects of the job and less stress during critical events. The implications of the study suggest that in stressful career fields, finding individuals with higher hardiness levels would be ideal. If individuals scoring on the lower end of the hardiness scale are identified, providing stress management or coping skills would be beneficial to promote a higher level of hardiness (Bue et al., 2018; Maddi et al., 2012).

### **Hardiness and Burnout Among Healthcare Workers**

As researchers such as Maslach and Jackson (1981; Maslach, 1982) developed conceptual frameworks to measure burnout empirically, other researchers were

investigating how an employee's personality or hardiness level impacted burnout (Ayala Calvo & García, 2018). The term hardiness has been defined as the individual's personal beliefs on how he or she views self and world importance related to the level of commitment, control, and challenge to the workplace (Mazzetti et al., 2019). Ayala Calvo and García (2018) found that people who were better equipped and had higher hardiness levels were more successful at managing stress and reduced the likelihood of burnout. The findings were similar to original studies conducted by Kobasa (1979). The study looked at the prospective design, which measures one's perception of his or her commitment, control, and challenges in the workplace to determine whether individuals are equipped to handle stress and burnout (Ayala Calvo & García, 2018).

These studies suggested the need for preventative measures, which can be put in place to prevent burnout. Preventative measures, such as training managers to have a higher level of mental hardiness through mindfulness techniques, would be useful in high stress environments (Ayala Calvo & García, 2018). Paired with social support from senior leaders, training in mental hardiness could help prepare managers for their roles in the organization. Therefore, hardiness is a coping tool that can help managers build up resilience to deal with day-to-day tasks that may require a high level of emotional aptitude.

The gap in the research for hardiness is similar to that of burnout with limited research pertaining to ancillary managers within U.S. healthcare organizations. Measuring hardiness levels and burnout rates within all levels of management in a healthcare organization could be of interest because this industry is known for having employees with high stress levels. Similar to other healthcare related studies, hardiness

tends to be studied in individuals who work in stressful environments such as nurses and physicians working in the emergency department. Fyhn et al. (2016) conducted a study on nurse managers to identify whether hardiness mitigated burnout and stress among this population. Their findings suggested that stress was present among the majority of the nurse managers, with 56% indicating high levels of stress. Of those participants, only 40% of the nurse managers scored high on mental hardiness and indicated they felt in control of their work. With studies indicating that hardiness mitigates burnout and stress, it is of concern that people in roles such as nurse managers are scoring lower in mental hardiness. The lower scores on the mental hardiness scale could explain the increased burnout rate among the nurse managers.

Saksvik et al. (2016) conducted a longitudinal study of Norwegian nurses working shifts over a 2-year period and suggested that hardiness seemed to predict, to some degree, the tolerance of shift work. Shift work in this case is defined as a nurse who works from 7 p.m. to 6 a.m. The shift work makes this group of nurses more susceptible to negative aspects of the job such as health issues, nervousness, sleeplessness, fatigue, and burnout. The findings from the study support that hardiness could be a stronger predictive variable to burnout than psychological variables. Hardiness could reduce the negative consequences and impact of burnout in the nursing population by mediating the three dimensions of burnout as indicated by the empirical evidence (Arrogante & Aparicio-Zaldivar, 2017; Saksvik et al., 2016).

Managers, on the other hand, have a broad scope of work and oversight. Managers deal with taking care of daily operational needs, talent management, and employee retention to name a few, all of which require mental hardiness (Singh et al.,

2015). Managers with a higher level of hardiness often are healthier and handle stressful situations better (Freitas et al., 2017). Hardiness and emotional aptitude required to do the job tasks and take care of employees have been associated with managers developing negative outlooks on job satisfaction and increased employee turnover (McPherson et al., 2016). Similar to other groups of employees, managers can be positively affected by learning how to increase their hardiness levels to reduce stress and burnout.

### **Intent to Turnover**

The fast pace global marketplace poses many challenges for businesses around the globe. Organizations have had to change their work environment to adapt to the changes in generational differences among the four cohorts in the workforce: baby boomers, Generation X, millennials, and Generation Z (Becton et al., 2014). Turnover continues to be an area of concern as the cost of turnover can negatively affect the organization, and retaining talent has become a challenge with the generational differences (Luz, de Paula, & de Oliveira, 2018). Turnover intent is defined as employees' deliberate and conscious decision to resign or depart from their current employer or organization (O'Connor, 2018). Over the course of the last 100 years, at least 2,000 articles on employee turnover have been published (T. W. Lee, Hom, Eberly, Li, & Mitchell 2017). It is important to note that turnover intent is correlated to actual turnover. However, the percentage of those who reported intent to turnover versus those who do turn over are not the same. This section covers the construct of turnover, organizational commitment as it relates to intent to turnover, and intent to turnover and burnout among healthcare workers.

## **Construct of Turnover**

Intent to turnover develops over a period of time, usually associated with factors of the job or organization. March and Simon (1958) are credited with developing much of the theoretical framework and conceptual model suggesting that intent to turnover is reduced by job satisfaction. Job satisfaction is defined as the positive emotional attitude toward the work an individual is tasked with (Dwi Putranti, 2018). Mobley (1977) contributed to the idea by expanding upon the model and explaining how an employee experiences dissatisfaction on the job and that there are subsequent steps leading to the employee's intent to turnover. Similar to burnout, the employee progresses through stages of cynicism. Eventually, if the perceived work environment and job characteristics, such as compensation and work-life balance, do not improve, the employee will consciously choose to leave his or her job (Fasbender et al., 2019). Consequently, studies suggest that the higher the turnover rate of employees, the higher the stress levels among the remaining employees (Erenstein & McCaffrey, 2007; J. Li et al., 2016; K. B. Wright et al., 2014).

March and Simon (1958) introduced the theory on psychological variables that prompt employee turnover and specifically looked at the desirability and ease of movement. This theory is the basis for concepts and research on intent to turnover. Researchers lack agreement on the exact cause of turnover, with many turnover antecedents surfacing (Holtom, Mitchell, Lee, & Eberly, 2008). However, it is agreed that turnover, more often than not, has a negative effect on the organization and the remaining team members and causes financial loss to the business as well as society (Stater & Stater, 2019; Weng, Wu, McElroy, & Chen, 2018). Table 3 shows possible

Table 3

*Consequences of Turnover*

Organization	Individual who leaves	Individuals who remain
Cost associated with recruiting, training	Loss of knowledge on the job	Increased workload because of fewer resources in the form of manpower
Low morale and lower staff engagement	Regression in new role	Less commitment, low collective embeddedness
Loss of knowledge	Loss of status (starting off as the “new person”)	Less cohesion
Cost associated with loss in productivity	Loss in productivity (if moving to a new organization because of learning curve)	Low morale

*Note.* From “On the Next Decade of Research in Voluntary Employee Turnover,” by T. W. Lee, P. W. Hom, M. B. Eberly, J. Li, and T. R. Mitchell, 2017, *Academy of Management Perspectives*, 31(3), 201-221 (<https://doi.org/10.5465/amp.2016.0123>).

negative consequences as seen in the literature as they pertain to the organization, the individual who leaves, and those who remain. However, not all employee turnovers are negative as personal situations such as that of relocation, work-life balance, and family situations such as a birth or care of a loved one can affect an individual’s decision to leave (Luz et al., 2018). There are also individuals who choose to turnover internally within the organization. This practice has its own effect on the organization and could be both positive and negative. Examples of positive internal turnover can be an employee who takes on a promotion or chooses to accept a different position in which the workload is more in line with his or her expectations or relocates to another office (Fasbender et al., 2019). There can still be potential pitfalls to internal turnover similar to that of the employee leaving the organization completely. These can include low morale, loss of

knowledge and productivity, and associated costs to rehire or train (Grotto, Hyland, Caputo, & Semedo, 2017).

In regard to the workplace environment, aspects of the job potentially improve the experience and reduce the likelihood of an employee's intent to turnover. Herzberg, Mausner, and Snyderman (1967) proposed that work rewards, both extrinsic and intrinsic, motivate employees. Extrinsic rewards are associated with work completed and include compensation, reputation, peer relationship, and benefits (Van Beek et al., 2012).

Intrinsic rewards are benefits associated with the job that promote personal growth and self-motivation (Stater & Stater, 2019). Both extrinsic and intrinsic rewards can be associated with an employee's needs being met; when not met, the job satisfaction of the individual can decrease. Maslow's (2013) hierarchy of needs theory can be applied to the workplace environment in regard to the five levels of the needs hierarchy, which motivate employees to be productive on the job. Individuals are motivated by the hierarchy of needs, and as individuals achieve these needs, self-actualization is possible (Maslow, 2013). Employers who undermine any one of the five levels can negatively affect their employee. Undermining the needs of employees can also cause stressful situations to arise and in doing so, cause employees to disengage or consider leaving (Stewart et al., 2018).

### **Organizational Commitment and Intent to Turnover**

More recently, researchers suggested that organizational commitment is an employee attitude that better predicts turnover and is a driving antecedent to employee turnover (Lambert, Griffin, Hogan, & Kelley, 2015; Weng et al., 2018). For example, if an employee is committed to the job and the organization, he or she would be less likely

to turnover. In this case, organizational commitment is defined as the phenomena associated with the psychological attachment of an employee to the organization (Meyer & Allen, 1997).

Wombacher and Felfe (2017) furthered the research by adding that team commitment along with organizational commitment increases the citizenship behavior among employees, thus promoting positive workplace outcomes to include turnover intentions. Similarly, Neininger, Lehmann-Willenbrock, Kauffeld, and Henschel (2010) indicated that the effect of team commitment over time improves overall performance and commitment to the organization. Their longitudinal field study suggested there was a stronger relationship between organizational commitment, job satisfaction, and team commitment related to overall team performance and altruism. The implications of organizational commitment could then be said to have a negative correlation to intent to turnover among employees (Ng, 2015). This moves the research into a direction that is in alignment with the changing global market. As the millennial generation becomes the largest in the workforce, their preference in having meaningful work, being part of a team, and contributing to the organization are influenced by their commitment to the organization (Barbuto & Gottfredson, 2016; Grotto et al., 2017).

Additionally, organizational commitment is associated with the individual's feelings and perception toward his or her job, work, coworkers, supervisors, and the organization overall. This psychological attachment can be positive or negative and varies depending on how the individual feels at any given time (Rosso, Dekas, & Wrzesniewski, 2010). Depending on whether the employee has a positive or negative psychological attachment to the work could pose a challenge to overall organizational

commitment. There are multiple antecedents that can affect the commitment levels of an employee. Workplace variables such as equality in the workplace, contribution in the form of input in the decision-making process, social support, role conflict, and work-life balance or work-family conflict are stronger predictors of affective commitment than personal characteristics (Lambert et al., 2015). Currently, there is no consensus on which workplace antecedent is best at predicting intent to turnover as it applies to organizational commitment. The literature does provide reliable and credible quantitative support to suggest that organizational commitment is a good starting point to better understand retention of employees (Neininger et al., 2010). As stated, organizational commitment is only one of many employee attitudes used to predict driving antecedents to employee turnover.

### **Intent to Turnover and Burnout Among Healthcare Workers**

The U.S. healthcare industry has had to adjust to a higher volume of patients, which has led to increased workloads for healthcare organizations (Gingold et al., 2017; Mendoza, 2017). This in part was due to the ACA, which was signed into law in 2010 and aimed to provide affordable medical and health services for all U.S. citizens. A recent study indicated that the cost of turnover in healthcare organizations represented 3.4-5.8% of the annual operating budget, totaling between seventeen and twenty-nine million dollars annually (Waldman et al., 2010). The cost of turnover includes hiring and training employees and a loss of employee productivity. It is important to note that the U.S. Bureau of Labor Statistics (2018) reported an upward trend for healthcare and social assistance workers separating from their current employer. The most recent data indicated in 2017 that there was a rate of 33.2% of social assistance workers separating

from their current employer, in comparison to 2016 which had a rate of 31.8% (U.S. Bureau of Labor Statistics, 2018). This indicated an increase of 1.4% of employees separating from the previous year. The numbers do not identify what types of healthcare workers are separating or the type of separation from the organization, whether voluntary or involuntary. However, the trend shows a consistent annual increase in the number of employees separating year after year.

In addition, the U.S. Centers for Disease Control and Prevention ([CDC], 2015) reported the number of physician office visits increased from 955 billion in 2008 to 990 billion in 2015, a 35 billion visit increase over the course of 7 years. This indicates that the work increased based on patient volume while more healthcare workers were leaving their current employers at a faster rate. Based on the trend of increased patient volume and increase in employees separating, this suggests that there is a significant problem to address for healthcare organizations in how to retain employees to maintain the same service level (Mendoza, 2017).

Existing research on the topic of nurse turnover has been widely conducted as there are ongoing challenges over nurse shortages. Nursing shortages continues to be a widespread, global problem, making retention that much more imperative (Burmeister et al., 2019). As more of the baby boomer generation enter retirement, the need for qualified and trained nurses will increase to provide care for this aging population (Dabney & Kalisch, 2015). This will put an undue burden on the U.S. healthcare industry, on top of the already reported increase in number of office visits as indicated by the CDC (2015). Studies on intent to turnover and burnout among nurses have primarily looked at the job demands of nurses, suggesting that nurses are predisposed to stress and

burnout because of their job tasks (Hart & Warren, 2015; Van der Heijden, Peeters, Blanc, & Van Breukelen, 2018).

The nursing profession is unique because individuals working as nurses have reported that the job is a calling rather than just a means to an end (Arnold et al., 2006). The job calling indicates that nurses are more inclined to put themselves into job-related situations in which they risk their own personal safety and psychological health to care for their patients (Van der Heijden et al., 2018). The thought process can lead to unhealthy work-life balance and work-family conflict because of long hours on the job, emotional aptitude required, and physical labor needed to complete tasks. This situation can eventually lead to burnout. As burnout sets in, nurses are more likely to disengage from their work because of dissatisfaction and feelings of being overworked (Adriaenssens et al., 2017). These feelings can have a negative impact on patients, coworkers, and the organization.

Burmeister et al. (2019) conducted an international study on determinants of nurse absenteeism and intent to leave. Their findings suggested that as nurses got older and were more adjusted to the work, they were less likely to leave the job. One can accept based on this and other similar studies that the more confident and comfortable a nurse gets in his or her profession, the less stressed he or she becomes (Burmeister et al., 2019; Kuo, Lin, & Li, 2014). Another area of interest is the statistical significance from Burmeister et al.'s (2019) study, which indicated a positive correlation between the number of patients under the care of a nurse and his or her intent to turnover. This is of concern, particularly in the United States, where the numbers of patient visits are increasing as are the levels of burnout among employees (Hart & Warren, 2015; Van der

Heijden et al., 2018). Although intent to turnover does not equate to actual turnover, it does give an estimate on those considering leaving the job.

Although nurses make up a large number of the employees within the healthcare industry, front line managers in healthcare organizations are pivotal in the development of the workplace environment and ensuring healthy work conditions are in place for employees. Skagert, Dellve, and Ahlberg (2012) conducted a longitudinal study of managers within the Swedish healthcare system and found that turnover was as high as 40% over the 4-year period. Similarly, Hewko, Brown, Fraser, Wong, and Cummings (2014) found that 27% of acute and long-term clinical managers in the Alberta healthcare system reported intent to turnover within the next 2 years.

Furthermore, Wong and Laschinger (2015) found a positive relationship between job strain and burnout. In particular, cynicism, or psychological withdrawal from the work, was more statistically significant. The data indicated more of a positive effect between cynicism and intent to turnover as compared to commitment and intent to turnover. The results suggested that managers were disengaging from the work, which had negative implications to quality of patient care and low morale for staff. Mitigating factors found in Wong and Laschinger's (2015) study further implied that more control of the work and decision authority could have prevented burnout as well as increased the likelihood that the manager would become more committed to the organization.

This aligns with Maslach (1982) who suggested that prolonged chronic stressors based on job requirements of the employee potentially create burnout. This is an area in which researchers have agreed that job burnout is a consequence of job stress (Maslach & Leiter, 2017; Yang et al., 2017). Based on Rahim's (1995) study on job stress and

burnout, there are four dimensions that characterize job stressors: role conflict, role ambiguity, role overload, and role insufficiency. The finding suggests that as individuals have more control of their job role, more clarity and sufficient knowledge of the role, their outlook of the job improves. Overall, the dimensions that characterize job stressors will affect the stress level with burnout being a negative outcome. The workplace environment associated with the healthcare industry is known to be one of high stress because of the job tasks associated with the industry. As indicated in the studies, nurses, nurse managers, physicians, and other clinical managers are predisposed to burnout on the basis of their job tasks. These tasks include caring for sick patients, long work hours, and lack of resources, which increase the likelihood of job stress and could explain the high percentage of employee's intent to turnover. Healthcare organizations will be faced with the challenge of limited resources in the form of employees and increased demand from consumers for services. The organizations will need to implement changes in practice to improve the workplace environment. Improvements will need to come in the form of better employee support, increases in employees' perception of control related to their job task, and avoidance of overloading employees to attract and retain staff.

Currently, the existing literature covered intent to turnover of clinical staff to include nurses, nurse managers, physicians, and healthcare managers. Little research was found to address the intent to turnover of ancillary managers and the relationship to burnout among this group of healthcare workers. Although, ancillary managers make up a smaller number, the work they do is of importance to organizations. This gap in the research indicates that not all healthcare workers are accounted for, and it is not known to

what extent this population is impacted by burnout or their intent to turnover because of job stress.

### **Summary**

The existing literature on burnout, hardiness, and intent to turnover has been studied broadly across industries and multiple facets of business and psychology. With the vast research, there is still ambiguity related to understanding the relationship between burnout, hardiness, and intent to turnover among ancillary managers within U.S. healthcare organizations. As the global marketplace becomes more integrated and fast paced, organizations have to adapt to address larger workloads among their employees. These negative implications pose challenges for organizations, in particular within the healthcare industry where burnout, stress, and employee turnover are problematic.

Since Freudenberger (1974) first conceptualized the burnout framework, research into burnout has extended to a variety of industries. Maslach and Jackson (1981) added to the framework by developing the MBI, which has now become one of the most utilized instruments to measure burnout. The instrument has been utilized to measure burnout among human services industries, medical personnel, educational personnel, and other occupational groups. The healthcare industry has been a large focus of burnout research, with the largest number of studies focused on nurses and clinical staff (H. Lee et al., 2010; Shemdoe et al., 2016; Wong & Laschinger, 2015). The research has provided a starting point on ways to mitigate burnout such as providing a stronger social support system and ways to identify when an employee is experiencing burnout symptoms.

Kobasa (1979) conceptualized hardiness and described it as a personality trait that combined three attitudes: commitment, control, and challenge. Individuals with a high

level of hardiness would be able to essentially motivate themselves to work hard at turning a stressful situation into a growth opportunity (Kobasa et al., 1982). Recent studies have suggested that preventative measures, such as training managers to have a higher level of mental hardiness and resilience on the job, can be put into place to prevent burnout (Ayala Calvo & García, 2018). Hardiness is a trait that can be identified to determine managers and employees who would be better suited to handle job stress, providing organizations with a way to help employees better manage their stress in an effort to reduce stress.

March and Simon (1958) introduced the theory on psychological variables that prompt employee turnover, specifically looking at the desirability and ease of movement. This theory is the basis for concepts and research on intent to turnover. Researchers lack agreement on the exact cause of turnover, with many turnover antecedents surfacing (Holtom et al., 2008). However, it is agreed that turnover, more often than not, has a negative impact on the organization and the remaining team members and causes financial loss to the business as well as society (Stater & Stater, 2019; Weng et al., 2018). In the healthcare industry, this situation is becoming more problematic as workloads increase because of larger numbers of baby boomers retiring and changes in the law. Healthcare organizations in the United States will need to adjust their retention management strategy to remain competitive and attract qualified employees for jobs such as nursing and management.

Currently, gaps in the literature on burnout, hardiness, and intent to turnover exist as studies about ancillary managers within U.S. healthcare organizations were not found. This study addressed this gap in literature, focusing on ancillary managers to understand

any relationship burnout, hardiness, and intent to turnover may have on this population. The study utilized instruments that have been tested, validated, and found reliable. The findings could help healthcare organizations better understand the levels of burnout among ancillary managers and the effects of burnout in relation to hardiness and intent to turnover

## CHAPTER 3: METHODOLOGY

Studies have indicated that burnout is an ongoing issue that touches many healthcare organizations regardless of size or location (Maslach & Leiter, 2017). The issue of burnout among healthcare workers remains a focus for researchers because of the high level of emotional aptitude required when caring for others (Lu et al., 2016). When it comes to managers, burnout has been associated with their roles and responsibilities, which include remediation of patient and staff problems, dealing with employee retention, and job satisfaction (Maslach & Leiter, 2017). The design of this study was intended to expand the burnout discourse to include ancillary managers within U.S. healthcare organizations.

The researcher expanded on existing literature and research on burnout by investigating the relationship between burnout, hardiness, and intent to turnover among ancillary managers within a U.S. healthcare organization. This section includes the following: purpose statement, research questions, research design, population, sample, instrumentation, data collection, data analysis, limitations, and summary.

### **Purpose Statement**

The purpose of this quantitative research study was to investigate the relationship between burnout, hardiness, and intent to turnover among ancillary managers within a U.S. healthcare organization. There has been a focus on clinical staff with research covering burnout and turnover among nurse managers, nurses, and physicians (Johansson et al., 2013). However, a gap exists in the research, because there is limited research investigating the relationship between burnout, hardiness, and intent to turnover among ancillary managers. This gap is important to note as ancillary managers support business

operations to keep organizations running smoothly while ensuring quality patient care is supported (Wells & Hejna, 2009). Because ancillary managers play an important role in organizations, the gap in the literature suggested that research needs to expand to include ancillary managers to give a more complete picture of organizational challenges when it comes to burnout, hardiness, and intent to turnover (Laschinger et al., 2015).

### **Research Question**

This study aimed to expand the field of burnout research to include ancillary managers within U.S. healthcare organizations by investigating the relationship between burnout, hardiness, and intent to turnover. Gaining insight into burnout among ancillary managers and understanding whether hardiness and burnout impact the intention to turnover fill a gap in the research seldom, if ever, studied. Utilizing the three dimensions of burnout, exhaustion, cynicism and feelings of inefficacy, each hypothesis was developed to measure the relationship, if any, the variables had on intent to turnover among the employees (Maslach & Leiter, 2008, 2017). The first question addressed by the study was, “Is there a relationship between burnout and hardiness among ancillary managers within a U.S. healthcare organization?” Second, the research evaluated the relationship between burnout and the intent to turnover, addressing the second question, “Is there a relationship between burnout and intent to turnover among ancillary managers within a U.S. healthcare organization?” The third question the study evaluated pertains to the relationship between hardiness and intent to turnover: “Is there a relationship between hardiness and intent to turnover among ancillary managers within a U.S. healthcare organization?”

Based on the questions addressed in the study, the hypotheses were as follows:

H<sub>0</sub>1: There is no relationship between emotional exhaustion and hardiness among ancillary managers working for a U.S. healthcare organization.

H<sub>A</sub>1: There is a relationship between emotional exhaustion and hardiness among ancillary managers working for a U.S. healthcare organization.

H<sub>0</sub>2: There is no relationship between cynicism and hardiness among ancillary managers working for a U.S. healthcare organization.

H<sub>A</sub>2: There is a relationship between cynicism and hardiness among ancillary managers working for a U.S. healthcare organization.

H<sub>0</sub>3: There is no relationship between feelings of inefficacy and hardiness among ancillary managers working for a U.S. healthcare organization.

H<sub>A</sub>3: There is a relationship between feelings of inefficacy and hardiness among ancillary managers working for a U.S. healthcare organization.

H<sub>0</sub>4: There is no relationship between emotional exhaustion and intent to turnover among ancillary managers working for a U.S. healthcare organization.

H<sub>A</sub>4: There is a relationship between emotional exhaustion and intent to turnover among ancillary managers working for a U.S. healthcare organization.

H<sub>0</sub>5: There is no relationship between cynicism and intent to turnover among ancillary managers working for a U.S. healthcare organization.

H<sub>A</sub>5: There is a relationship between cynicism and intent to turnover among ancillary managers working for a U.S. healthcare organization.

H<sub>0</sub>6: There is no relationship between feelings of inefficacy and intent to turnover among ancillary managers working for a U.S. healthcare organization.

H<sub>A6</sub>: There is a relationship between feelings of inefficacy and intent to turnover among ancillary managers working for a U.S. healthcare organization.

H<sub>07</sub>: There is no relationship between hardiness and intent to turnover among ancillary managers working for a U.S. healthcare organization.

H<sub>A7</sub>: There is a relationship between hardiness and intent to turnover among ancillary managers working for a U.S. healthcare organization.

### **Research Design**

This study utilized the survey method, specifically using the Maslach Burnout Inventory-General Survey (MBI-GS) instrument to measure burnout, hardiness scale to measure the level of hardiness, and the Michigan Organizational Assessment Questionnaire Job Satisfaction Subscale (MOAQ-JSS) to measure intent to turnover.

This study was conducted as a nonexperimental design, and no variables were changed or manipulated during the course of the research. Because of the scope and time allotted for the research, a longitudinal study was not considered. Correlation and comparisons of means were computed among the variables. A set of demographic questions helped to pull information from the participants to utilize in identifying level of management and other information that could provide further insight.

The researcher selected the descriptive design as the investigation was not intended to find a correlation between the variables at the time of the study. The focus of the study, based on the hypotheses, was to determine whether there was any relationship between the dependent variable and the independent variables. The researcher did not intend to manipulate the independent variables; therefore, the experimental design was rejected.

## **Population**

This study was conducted within a healthcare system located in Northern California accessible to the researcher. Formal requests were made to the organization's senior leaders to establish approval to allow participation of their employees in the study. A power analysis was conducted with G\*Power 3.1.9.2 software. A result of 111 participants was solicited based on the following specifications of the power analysis specific to a Pearson's correlation: Type I error = .005; power = .95; detecting a medium size effect.

## **Sample**

Participants were both male and female 18 years of age or older who held any management level position within an ancillary department of the healthcare organization. Management, for the purpose of the study, included supervisors, assistant managers, managers, directors, and executives of the organization. The senior leadership of each medical center worked with the researcher to develop a list of 145 participants. The survey was made available during the month of September 2019 and received 95 responses for a 66% response rate. The sample was considered a convenience sampling technique as the researcher had access to the target population. Access to the participants was approved from California Baptist University's Institutional Review Board (IRB) and the healthcare organization's IRB. Although the researcher expected limited risk to the participants, the researcher did provide access to mental health contact information had it been needed.

## **Instrumentation**

The researcher's primary instruments utilized in the study were the MBI-GS to measure burnout (Maslach & Jackson, 1981), hardiness scale to measure the level of hardiness (Kobasa et al., 1982), and the MOAQ-JSS to measure intent to turnover (Cammann et al., 1979). This section details the three instruments, reliability, and validity of each.

### **Burnout**

The MBI is made up of 16 self-reported measures developed by Maslach et al. (1996). The version of the MBI was adapted from Maslach and Jackson's (1981) original version and is specific to human services industry as the survey has been adapted to be specific for the target population. The MBI-GS was chosen because it measures the level of burnout based on the core dimensions of the participants work experience and measured emotional exhaustion, cynicism and professional efficacy (Maslach et al., 1996). The scale used for the MBI-GS was the 7-point Likert type scale with 1 indicating *never* and 7 indicating *every day*. Each aspect of the three dimensions was measured by its own separate subscale. The emotional exhaustion subscale (EE) evaluated the participants' feelings of being exhausted or emotionally overextended in their job or work. The cynicism subscale (CY) evaluated the impersonal response toward others such as patients or those receiving care. The professional efficacy subscale (PE) evaluated the participants' feelings of success and personal accomplishment in their job or work, accounting for social and nonsocial accomplishments. The overall burnout score is reflected in high scores of EE and CY subscales and low scores on the PE subscale. Conversely, should the scores be low for EE and CY subscales but high in PE subscales,

it would indicate a lower level of burnout. The subscales were scored separately and not combined together.

The original MBI developed and updated by Maslach et al. in 1996 introduced five differing versions: MBI-Human Services Survey (MBI-HSS), MBI-Human Services Survey for Medical Personnel (MBI-HSS-MP), MBI-Educators Survey (MBI-ES), MBI-General Survey (MBI-GS), and MBI-General Survey for Students (MBI-GS-S). Table 4 shows the different versions of the MBI along with the target population for each survey. The MBI-GS instrument was chosen based on the target population being ancillary healthcare managers.

Table 4

*MBI Version and Target Population*

MBI version	Target population
MBI-HSS	Professionals working in human services industries such as social work, counseling, therapy, police and correctional officers, and clergy members.
MBI-HSS (MP)	Professionals working in human services, adapted specifically for medical personnel.
MBI-ES	Professionals working in the education industry such as teachers and volunteers in the educational environment.
MBI-GS	Professionals working in other occupational groups such as management, customer service, and manufacturing.
MBI-GS (S)	Designed for students in the college or university environment.

The researcher did not choose the MBI-HSS, because not all managers working within the healthcare organization fall under human services professionals such as nurses,

physicians, or pharmacists. The target population of managers included ancillary departments such as environmental services, supply chain, sterile processing, information technology, revenue cycle, clinical education, and finance. To avoid having to use multiple instruments, which could cause differing results as indicated by Heinemann and Heinemann (2017), the researcher chose to utilize the MBI-GS as the main survey instrument, which could be used with other occupational groups including managers. The MBI-GS fit the target population regardless of their role within the organization.

### **Hardiness**

Kobasa et al. (1982) developed the hardiness framework and in doing so created the hardiness scale as an instrument to measure hardiness. The hardiness scale was used to evaluate three dimensions of the employee: control, commitment, and challenge. The instrument also utilized the Likert scale to score hardiness (Kadyan & Malik, 2017). The survey contained fifteen self-reported measures used to identify the level of hardiness among the individual participants. The hardiness scale has been used in measuring the level of hardiness among varying groups and among studies to include nurse managers (Freitas et al., 2017) and middle managers (Ayala Calvo & García, 2018). The researcher chose the hardiness scale because it complements the MBI-GS and MOAQ-JSS instruments, with all three instruments utilizing a Likert scale, and a minimal number of questions to increase the likelihood for participation in the study. Individuals who score higher on the hardiness scale are hardier, making them more in control and able to adapt to challenging situations.

## **Intent to Turnover**

One of the models in measuring intent to turnover was developed by Cammann et al. (1979) and is known as the MOAQ-JSS. Similar to the hardiness scale and MBI, the MOAQ-JSS used the Likert scale and assessed five items pertaining to the employee's turnover intentions. The MOAQ-JSS has been shown to be a valid and reliable instrument to measure intent to turnover (Bowling & Hammond, 2008). Accounting for the limited time healthcare managers have, the researcher chose the MOAQ-JSS because the instrument contained five questions and would reduce the time a participant would have on taking the survey, therefore increasing the likelihood of a response from a greater number of participants.

## **Demographics**

Additional demographic questions were included to capture age, length of employment, gender, education level, employment type, job title, and average number of hours worked weekly. The information was presented at the end of the survey to gather relevant data pertaining to the participant and used to evaluate whether there was significance to the variables based on demographic segmentation.

## **Data Collection**

Upon receiving the names of all the managers from the healthcare organization, an e-mail communication was sent out from the researcher to each participant as seen in Appendix A. The e-mail contained a letter explaining the purpose and procedure for the study, looking at job-related attitudes in the healthcare environment. The survey was put into the online survey program SurveyGizmo for ease of access to the data and ease of distribution. The link was provided as part of the letter and statements on confidentiality

were guaranteed in the letter. Confidentiality was also mentioned on the welcome page of the survey with no identifying data collected as part of the study. By filling out the survey (Appendix B), the participant provided his or her consent to participate in the study. The survey was open for a 3-week period with a reminder e-mail, as seen in Appendix C, going out after Week 2 to ensure the largest number of respondents possible. The data were exported from the online survey tool and imported into SPSS for the purpose of data analysis. All data were stored on a password-protected USB only accessible to the researcher to ensure confidentiality.

### **Data Analysis**

Upon completion of the open survey period, the survey was closed out and all results were downloaded onto a password-protected USB. The data were uploaded into SPSS version 1.0.0.1126 for analysis. Utilizing Pearson's correlation to understand the relationship between the dependent variable and the independent variables, the researcher used the standard settings to include Type I error = .005; power = .95; detecting a medium size effect. Utilizing the MBI-GS, hardiness scale, and MOAQ-JSS instruments, the researcher categorized the responses to analyze the data. For the MBI-GS, the reporting values were 0 = *never*, 1 = *a few times a year or less*, 2 = *once a month or less*, 3 = *a few times a month*, 4 = *once a week*, 5 = *a few times a week*, and 6 = *every day*. The hardiness scale was categorized with 1 = *not at all true*, 2 = *a little true*, 3 = *often times true*, and 4 = *completely true*. The MOAQ-JSS was categorized as 1 = *strongly disagree*, 2 = *disagree*, 3 = *neither agree nor disagree*, 4 = *agree*, and 5 = *strongly agree*. The demographics questionnaire was categorized for example with 0 = *female*, 1 = *male* and employment with 1 = *full time* and 2 = *part time*. The data were then uploaded into

SPSS, running initially a Pearson's correlation to determine the levels of burnout, followed by a multiple regression analysis to determine whether there were variables within the model that were statistically significant.

### **Limitations**

The study was designed to answer the hypotheses and not draw causation conclusions but rather identify whether relationships existed among burnout, hardiness, and intent to turnover among the target population. This is important to note as the data analysis interpreted the results to determine whether relationships exist and not to find causation between the variables. The researcher identified a gap in existing literature and designed the study to account for burnout among ancillary healthcare managers and further study whether there are moderating effects of hardiness to burnout and intent to turnover. At the time, the researcher limited the study to the target population and did not include other managers within the healthcare organization, nor did the researcher compare burnout, hardiness, and intent to turnover among differing populations. Other limitations existed within the design of the study as the researcher conducted a cross-sectional, single one-time survey of the target population. The results of the study reflected only a point in time and were generalized to healthcare organizations in the United States. Because of time constraints and limited access to a larger sample population, a longitudinal study and experimental design were not considered.

### **Summary**

The researcher designed this study to contribute to the burnout discourse among U.S. healthcare managers. The study filled a gap in existing literature that provided insight into burnout among ancillary healthcare managers and investigated whether there

was a relationship between hardiness and burnout in predicting intent to turnover. The researcher selected the quantitative descriptive design, using the MBI-GS, hardiness scale, MOAQ-JSS, and demographics survey to address the hypotheses. The three instruments have been utilized in multiple studies and proven to be both valid and reliable.

The participants for the study included ancillary managers within a healthcare organization located in Northern California. The researcher acknowledged that these participants were drawn from a convenience population sample available to the researcher and followed all IRB processes to ensure the study was approved by California Baptist University and the healthcare organization. The data were collected using the online survey tool SurveyGizmo and imported into SPSS for analysis. The following chapters provide an overview of the study, a discussion of the findings based on the researcher's methodology as outlined, implications for action, recommendations for further study, concluding remarks, and the researcher's reflections on the study.

## CHAPTER 4: RESEARCH, DATA COLLECTION, AND FINDINGS

### **Overview**

Studies have indicated that burnout is an issue that touches many healthcare organizations regardless of size or location (Maslach & Leiter, 2017). The researcher expanded on the study of burnout by investigating the relationship between burnout, hardiness, and intent to turnover among ancillary managers within a healthcare organization, which currently remains a gap in research. The findings of this study contribute to the burnout discourse to include ancillary managers within U.S. healthcare organizations. The findings are presented in the following sections: purpose statement, research questions, research methods and data collection procedures, presentation and analysis of data, and section summary.

### **Purpose Statement**

The purpose of this quantitative research study was to investigate the relationship between burnout, hardiness, and intent to turnover among ancillary managers within a U.S. healthcare organization. There has been a focus on clinical staff with research covering burnout and turnover among nurse managers, nurses, and physicians (Johansson et al., 2013). However, a gap exists in the research as there is limited research investigating the relationship between burnout, hardiness, and intent to turnover among ancillary managers. This gap is important to note because ancillary managers support business operations to keep organizations running smoothly while ensuring quality patient care is supported (Wells & Hejna, 2009). As ancillary managers play an important role in organizations, the gap in the literature suggested that research needs to expand to include ancillary managers to give a more complete picture of organizational

challenges when it comes to burnout, hardiness, and intent to turnover (Laschinger et al., 2015).

### **Research Questions**

This study aimed to expand the field of burnout research to include ancillary managers within U.S. healthcare organizations by investigating the relationship between burnout, hardiness, and intent to turnover. Gaining insight into burnout among ancillary managers and understanding whether hardiness and burnout impact the intention to turnover fill a gap in the research seldom, if ever, studied. Utilizing the three dimensions of burnout, exhaustion, cynicism and feelings of inefficacy, each hypothesis was developed to measure the relationship, if any, the variables had on intent to turnover among the employees (Maslach & Leiter, 2008, 2017). The first question addressed by the study was, “Is there a relationship between burnout and hardiness among ancillary managers within a U.S. healthcare organization?” Second, the research evaluated the relationship between burnout and the intent to turnover, addressing the second question: “Is there a relationship between burnout and intent to turnover among ancillary managers within a U.S. healthcare organization?” The third question the study evaluated pertains to the relationship between hardiness and intent to turnover: “Is there a relationship between hardiness and intent to turnover among ancillary managers within a U.S. healthcare organization?”

Based on the questions addressed in the study, the hypotheses were as follows:

H<sub>0</sub>1: There is no relationship between emotional exhaustion and hardiness among ancillary managers working for a U.S. healthcare organization.

H<sub>A</sub>1: There is a relationship between emotional exhaustion and hardiness among ancillary managers working for a U.S. healthcare organization.

H<sub>0</sub>2: There is no relationship between cynicism and hardiness among ancillary managers working for a U.S. healthcare organization.

H<sub>A</sub>2: There is a relationship between cynicism and hardiness among ancillary managers working for a U.S. healthcare organization.

H<sub>0</sub>3: There is no relationship between feelings of inefficacy and hardiness among ancillary managers working for a U.S. healthcare organization.

H<sub>A</sub>3: There is a relationship between feelings of inefficacy and hardiness among ancillary managers working for a U.S. healthcare organization.

H<sub>0</sub>4: There is no relationship between emotional exhaustion and intent to turnover among ancillary managers working for a U.S. healthcare organization.

H<sub>A</sub>4: There is a relationship between emotional exhaustion and intent to turnover among ancillary managers working for a U.S. healthcare organization.

H<sub>0</sub>5: There is no relationship between cynicism and intent to turnover among ancillary managers working for a U.S. healthcare organization.

H<sub>A</sub>5: There is a relationship between cynicism and intent to turnover among ancillary managers working for a U.S. healthcare organization.

H<sub>0</sub>6: There is no relationship between feelings of inefficacy and intent to turnover among ancillary managers working for a U.S. healthcare organization.

H<sub>A</sub>6: There is a relationship between feelings of inefficacy and intent to turnover among ancillary managers working for a U.S. healthcare organization.

H<sub>0</sub>7: There is no relationship between hardiness and intent to turnover among ancillary managers working for a U.S. healthcare organization.

H<sub>A</sub>7: There is a relationship between hardiness and intent to turnover among ancillary managers working for a U.S. healthcare organization.

### **Research Methods and Data Collection Procedures**

This study utilized a survey method, specifically using the MBI-GS instrument to measure burnout (Maslach, 1982), hardiness scale to measure the level of hardiness (Kobasa et al., 1982), and the Michigan Organizational Assessment Questionnaire Job Satisfaction Subscale (MOAQ-JSS) to measure intent to turnover (Cammann et al., 1979). A set of demographic questions helped to pull information from the participants to utilize in identifying level of management and other information that could provide further insight.

The focus of the study, based on the hypotheses, was to determine whether there was any relationship between the dependent variable and the independent variables and was not intended to find causation between the variables. The researcher did not intend to manipulate the independent variables; therefore, the experimental design was rejected.

### **Sample**

Participants were both male and female who were 18 years of age or older and held a management position within an ancillary department of the healthcare organization. Management, for the purpose of the study, included supervisors, assistant managers, managers, directors, and executives of the organization. The senior leadership of each medical center worked with the researcher to develop a list of 145 participants. The survey was made available during the month of September 2019 and received 95

responses for a 66% response rate. After reviewing all responses for completeness, the final number of qualified participants was 95. The sample was considered a convenience sampling technique because the researcher had access to the target population. Access to the participants was approved from California Baptist University's Institutional Review Board (IRB) and the healthcare organization's IRB. Although the researcher expected limited risk to the participants, the researcher did provide participants access to mental health contact information.

### **Participants**

Table D1 represents the demographic and work profiles of the sample (see Appendix D). The population in the study consisted of employees working in an ancillary department within a U.S. healthcare organization. Ninety-five surveys were completed with both genders nearly equally represented with 51 females and 44 males. The age profiles of the sample indicated that 44.2% were between 36-45 years followed closely by 30.5% in the 46-55-year age group. All but one participant indicated he or she worked full time.

### **Data Collection**

Upon receiving the names of all the ancillary managers from the healthcare organization, an e-mail communication, as seen in Appendix A, was sent out from the researcher to each participant. An e-mail explaining the purpose and procedure for the study was sent to all participants. The survey was put into the online survey program SurveyGizmo for ease of access to the data and ease of distribution. The link was provided as part of the letter and statements on confidentiality were guaranteed in the letter. Confidentiality was also mentioned on the welcome page of the survey, with no

identifying data collected as part of the study. By filling out the survey, the participant provided his or her consent to participate in the study. The survey was open for a 3-week period from the start of September 2019 to the end of September 2019, with a reminder e-mail, as seen in Appendix C, going out after Week 2 to ensure the largest number of respondents possible. The data were exported from the online survey tool and imported into SPSS for the purpose of data analysis.

Ninety-five responses were received at the end of the survey period. All responses were screened for any missing values utilizing the frequency procedure in SPSS. Following the complete data analysis method, any missing values would have been excluded (Guan & Yusoff, 2011). The results found no missing values; therefore, all 95 responses were included in the study.

### **Presentation and Analysis of Data**

This section presents the findings related to each hypothesis. The researcher used Pearson's correlation to determine whether a relationship existed between the dependent variable and the independent variables. The researcher used the standard settings to include Type I error = .005; power = .95; detecting a medium size effect.

### **Study Variables**

The study measured gender, the three dimensions of burnout (exhaustion, cynicism, and feelings of inefficacy) and hardiness as the independent variables, predicting the dependent variable of turnover intention. Table D2 presents the descriptive statistics including the mean and standard deviation for all study variables. The research assumptions made were based on multivariate normality, which would suggest that the data should be normally distributed. The researcher utilized skewness

and kurtosis analysis to test the values for symmetry of the distribution of scores and the degree of distribution, respectively (Dorić, Nikolić-Dorić, Jevremović, & Mališić, 2009). Perfect values for both are considered to be one. Skewness values above 3.00 were considered to be outside the limits of normality for data distribution, and values of 8.00 and above were outliers in kurtosis (Kline, 2013). It is evident from Table D2 that all the study variables were within the limits of skewness and kurtosis.

Furthermore, the positive values for skewness show that scores were clustered left while negative values signify a distribution toward the right. For kurtosis, negative values reflect a flat distribution with outliers, and a positive value showed peakedness in the center. Therefore, all variables except overall cynicism were skewed toward the left, and all variables except the overall exhaustion were peaked in the center.

### **Hypotheses Testing**

To address the three questions, the study utilized Pearson's correlation to understand the relationship between the dependent variable and the independent variables. The results of the Pearson's correlation are outlined in the following sections.

**Research Question 1.** The first question addressed by the study was, "Is there a relationship between burnout and hardiness among ancillary managers within a U.S. healthcare organization?" The first three hypotheses were examined to determine whether a relationship existed with the findings as follows:

H<sub>0</sub>1: There is no relationship between emotional exhaustion and hardiness among ancillary managers working for a U.S. healthcare organization.

Emotional exhaustion and hardiness were found to have a negative correlation at  $r(95) = -.155, p = .134$ , such that higher reports of emotional exhaustion were related to reports of being less hardy. Therefore, the null hypothesis was accepted.

H<sub>0</sub>2: There is no relationship between cynicism and hardiness among ancillary managers working for a U.S. healthcare organization.

Cynicism and hardiness were found to have a moderately positive correlation ( $r(95) = .423, p = .000$ ). Therefore, the null hypothesis was rejected.

H<sub>0</sub>3: There is no relationship between feelings of inefficacy and hardiness among ancillary managers working for a U.S. healthcare organization.

Feelings of inefficacy and hardiness were found to have a moderately negative correlation ( $r(95) = .295, p = .004$ ). This finding would suggest that lower scores for feelings of inefficacy, which indicate higher levels of burnout, would relate to being less hardy. The null hypothesis was therefore rejected. Based on the Pearson's correlation, the researcher concluded that a relationship exists between burnout and hardiness; however, it was not statistically significant ( $p$  value > .05).

**Research Question 2.** The second research question evaluated the relationship between burnout and the intent to turnover with the question "Is there a relationship between burnout and intent to turnover among ancillary managers within a U.S. healthcare organization?" Hypotheses 4, 5, and 6 were analyzed utilizing Pearson's correlation with the findings as follows.

H<sub>0</sub>4: There is no relationship between emotional exhaustion and intent to turnover among ancillary managers working for a U.S. healthcare organization.

Emotional exhaustion and intent to turnover were found to have a moderately negative correlation ( $r(95) = -.216, p = .036$ ). Therefore, the null hypothesis was rejected.

H<sub>05</sub>: There is no relationship between cynicism and intent to turnover among ancillary managers working for a U.S. healthcare organization.

Cynicism and intent to turnover were found to have a weak and nonsignificant correlation ( $r(95) = -.185, p = .072$ ). Therefore, the null hypothesis was accepted.

H<sub>06</sub>: There is no relationship between feelings of inefficacy and intent to turnover among ancillary managers working for a U.S. healthcare organization.

The relationship between feelings of inefficacy and intent to turnover were found to have moderately negative correlation ( $r(95) = -.362, p = .000$ ). Therefore, the null hypothesis was rejected. Based on the Pearson's correlation, the researcher concluded that a relationship exists between burnout and intent to turnover, with emotional exhaustion and feelings of inefficacy being stronger predictive variables.

**Research Question 3.** The final research question examined the relationship between hardiness and intent to turnover with the question "Is there a relationship between hardiness and intent to turnover among ancillary managers within a U.S. healthcare organization?" Again, Pearson's correlation was utilized to examine Hypothesis 7 with the findings as follows.

H<sub>07</sub>: There is no relationship between hardiness and intent to turnover among ancillary managers working for a U.S. healthcare organization.

The relationship between hardiness and intent to turnover were found to have a weak negative correlation ( $r(95) = -.156, p = .130$ ). Therefore, the null hypothesis was

accepted. Therefore, it can be concluded that unlike burnout, hardiness had no relationship to intent to turnover.

### **Relationship Between Burnout, Hardiness, and Intent to Turnover**

Correlations, means, and standard deviations of key study constructs are presented in Table D2. The relationship between burnout (as measured by emotional exhaustion, cynicism, and feelings of inefficacy), hardiness, and intent to turnover among ancillary managers working for a U.S. healthcare organization were investigated using Pearson's correlation coefficient seen in Table D3. Further analyses examined the three dimensions of burnout, hardiness, and intent to turnover based on gender (Table D4).

Initial data analysis was conducted to determine the level of burnout among ancillary managers utilizing the MBI-GS (Table D5). Aggregate data from the response to Questions 1-16 of the survey were analyzed using measures of central tendency for each of the burnout subscales. The aggregate mean for the emotional exhaustion subscale (EE) was 13.37 and determined to be within the average category for exhaustion. The aggregate mean for the cynicism subscale (CY) was 30.57 and determined to be in the higher category for cynicism, which indicated a higher level of burnout. Finally, the aggregate mean for the professional efficacy subscale (PE) was 8.81 and determined to be in the lower category for feelings of inefficacy, which indicated a higher level of burnout. The overall burnout score is reflected in high scores of EE and CY subscales and low scores on the PE subscale, which the means of each subscale indicates that ancillary managers within the healthcare organization experience higher levels of burnout (Maslach et al., 2001).

A multiple regression was used to assess the ability of the three dimensions of burnout (exhaustion, cynicism, and feelings of inefficacy) and hardiness as the independent variables predicting the dependent variable of turnover intention (Table D6). Gender was also entered as an independent control variable. Within the model, feelings of inefficacy significantly predicted intent to turnover ( $p$  value  $< .05$ ), such that higher reports of feelings of inefficacy predicted higher reports of intent to turnover. Cynicism, exhaustion, and hardiness ( $p$  value  $> .05$ ) were not significant predictors of turnover intention. The researcher also introduced a dummy variable representing the educational levels, with participants indicating a bachelor's degree or lower set at 1 and those indicating a master's degree or higher set at 0. The inclusion of the dummy variable was found to be statistically insignificant in predicting the dependent variable of turnover intention with  $p$  value  $> .05$ .

To measure the strength of the relationships found statistically significant, effect sizes were estimated. According to Cohen (1988), an effect size measured through the value of Pearson's coefficient  $r$  from 0.1 to .29 is considered small, .3 to .49 is medium, and .5 to 1 is large. Therefore, based on the effect size, exhaustion had a medium effect size negative relationship with cynicism. Exhaustion also had a positive small effect relationship with intent to turnover and a strong positive relationship with feelings of inefficacy. Cynicism was strongly and negatively related to feelings of inefficacy and had a medium effect relationship with hardiness. Feelings of inefficacy were positively related to intent to turnover but negatively related to hardiness, both with medium effect. Emotional exhaustion was significantly and negatively related to cynicism, and positively related to feelings of inefficacy and intent to turnover. Cynicism was significantly and

negatively related to feelings of inefficacy and positively related to hardiness. Feelings of inefficacy were found to be negatively related to hardiness and positively related to intent to turnover.

### **Moderating Relationships**

There are implications in research that suggest age can be a moderating factor to burnout and intent to turnover among differing groups of professionals (Van der Heijden, Mahoney, & Xu, 2019). This is an area that has been previously studied among nurses and other professions. This analysis was conducted to determine whether age had a moderating relationship to burnout, hardiness, and intent to turnover. A two-sample *t* test was utilized to explore the impact of age on the three dimensions of burnout (exhaustion, cynicism, and feelings of inefficacy), hardiness, and intent to turnover.

Participants were divided into four groups according to their age with Group 1: 26-35, Group 2: 36-45, Group 3: 46-55, and Group 4: 56+ (Table D7). A post hoc comparison using Tukey HSD test indicated that only the mean hardiness score for Group 1 ( $M=39.64$ ,  $SD = 3.86$ ) was significantly different from Group 4 ( $M = 42.8$ ,  $SD = 4.37$ ), and Group 3 ( $M = 39.86$ ,  $SD = 3.86$ ) was also significantly different from Group 4 (Table D7). The remaining mean scores for burnout and intent to turnover were not statistically significant.

Additionally, emotional exhaustion seemed to increase with age and become stagnant with 46-55 and 56 and more age group. Figure 3 represents the mean values of exhaustion across different age groups. Emotional exhaustion was found to have no statistical significance with  $p$  value  $> .05$ . Similarly, cynicism increased with each age

group as seen in Figure 4, but the differences between mean values of the age groups were not statistically significant with  $p$  value  $> .05$ .

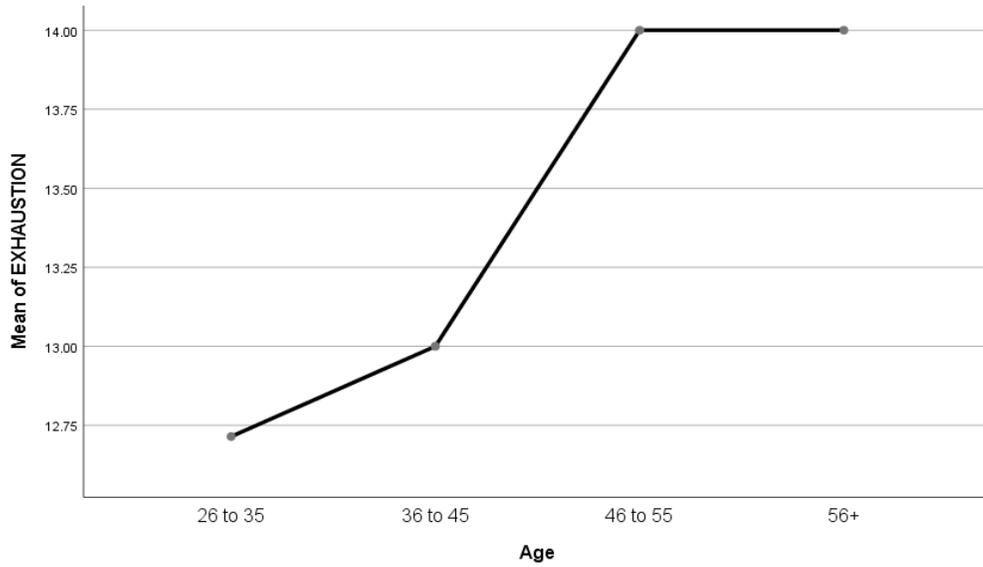


Figure 3. Emotional exhaustion and age.

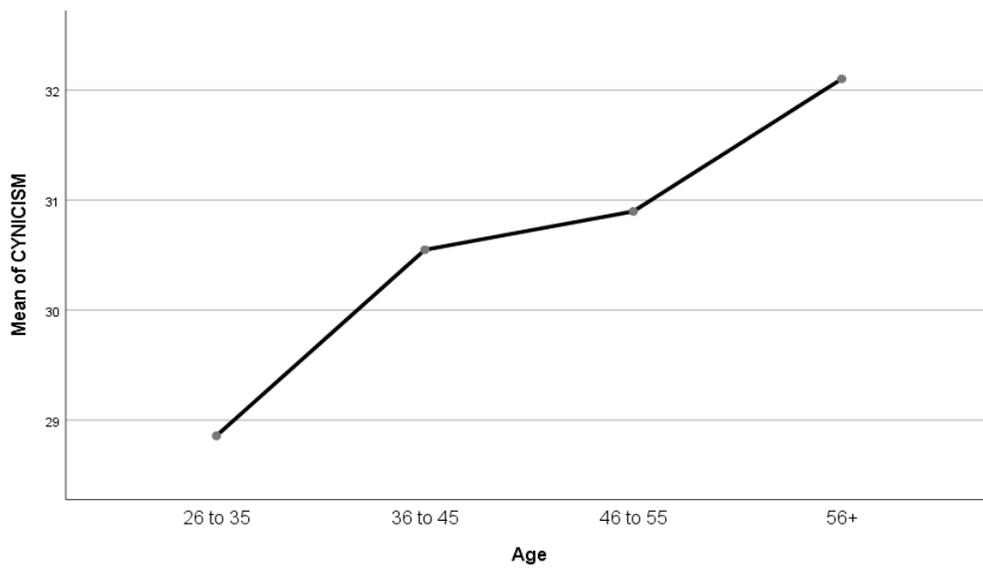


Figure 4. Cynicism with age.

Feelings of inefficacy decreased with increasing age as shown in Figure 5.

However, these differences between the mean values were not statistically significant with  $p$  value  $> .05$ .

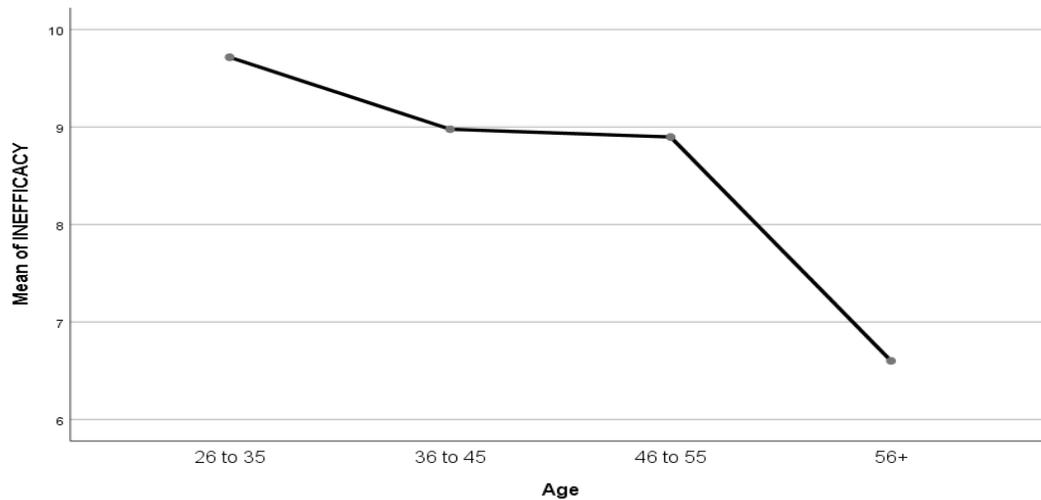


Figure 5. Inefficacy with age.

Hardiness increased from age groups 26 to 35 and 36 to 45 years, then dipped for the 46-55 years group after which it showed a dramatic increase for those 56 years or older as indicated in Figure 6. Additionally, this is the only difference between the mean values, which was statistically significant with  $p$  value  $< .05$ . Intent to turnover reduced with age but was not statistically significant with  $p$  value  $> .05$ , as shown in Figure 7.

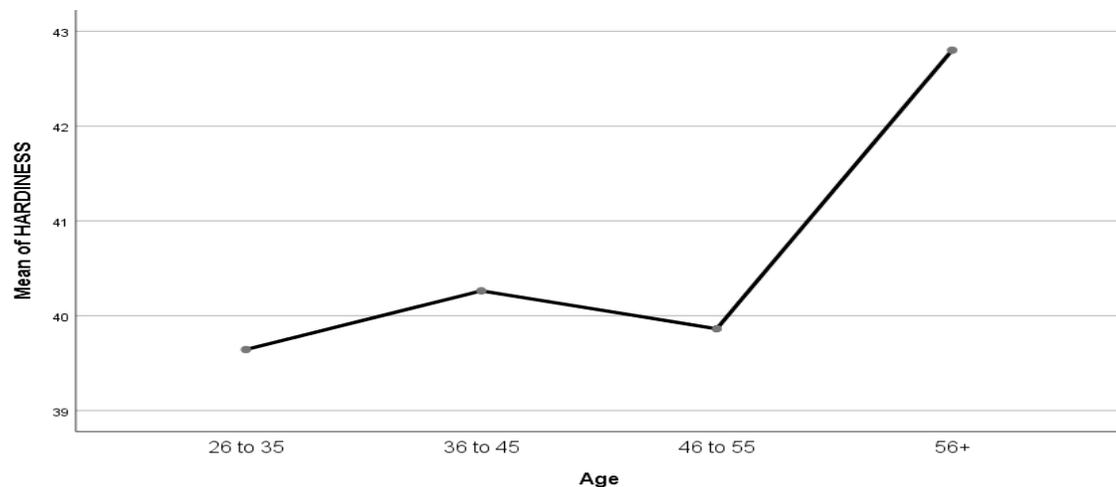


Figure 6. Hardiness with age.

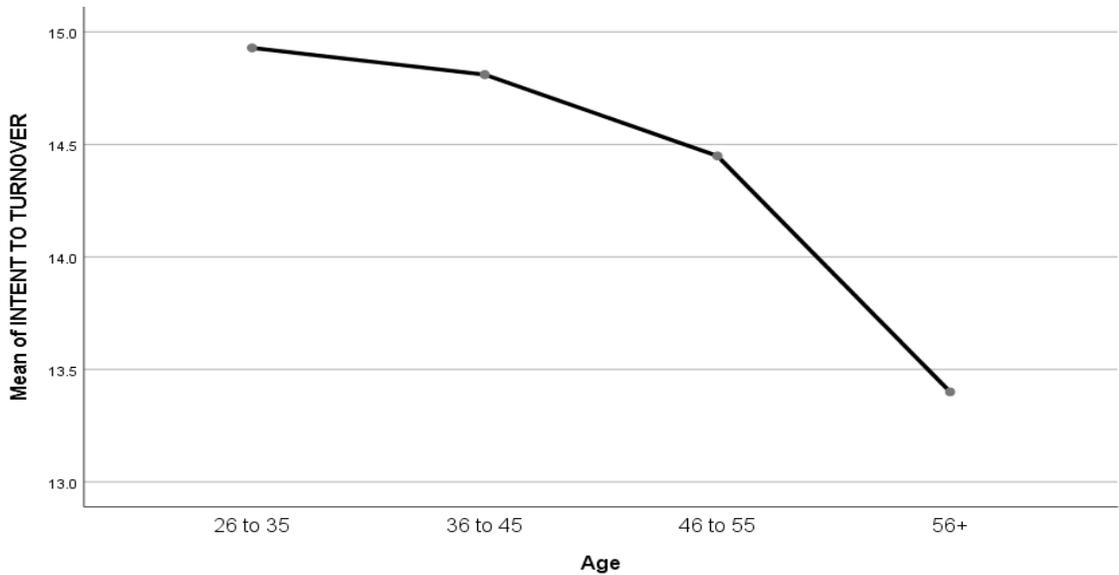


Figure 7. Intent to turnover with age.

### Summary

The results of this study indicate that the three dimensions of burnout, cynicism, emotional exhaustion, and feelings of inefficacy and hardiness are related in different ways to intent to turnover among ancillary managers within a U.S. healthcare organization. Utilizing Pearson's correlation as seen in Table D3, the model showed that emotional exhaustion was significantly and negatively related to cynicism. Furthermore, emotional exhaustion was positively related to feelings of inefficacy. Emotional exhaustion was shown to have a relationship that positively impacts intent to turnover. Feelings of inefficacy were found to be negatively related to hardiness and positively related to intent to turnover. Of all the variables tested, feelings of inefficacy had the strongest impact to intent to turnover among the population with a statistical significance ( $p$  value  $< .05$ ). Chapter 5 summarizes the key findings of the study, implications and recommendations, and final conclusion to the overall study.

## CHAPTER 5: FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

Healthcare organizations face many challenges with higher risks of burnout among healthcare professionals (Lin et al., 2016). The burnout discourse spans years of research within varying industries and target populations. The purpose of this quantitative research study was to investigate the relationship between burnout, hardiness, and intent to turnover among ancillary managers within a U.S. healthcare organization. The study focused on three research questions:

1. Is there a relationship between burnout and hardiness among ancillary managers within a U.S. healthcare organization?
2. Is there a relationship between burnout and intent to turnover among ancillary managers within a U.S. healthcare organization?
3. Is there a relationship between hardiness and intent to turnover among ancillary managers within a U.S. healthcare organization?

The quantitative data presented in this study facilitated a deeper understanding of the extent of burnout among healthcare managers by concentrating on ancillary managers. The population in the study consisted of managers working in an ancillary department within a U.S. healthcare organization. The survey was sent to 145 participants with 95 surveys completed for a 66% response rate. Both genders were nearly equally represented with 51 females and 44 males. The age profiles of the sample indicated that 44.2% were between 36-45 years followed closely by 30.5% in the 46-55-year age group. All but one participant indicated he or she worked full time.

The findings of the study are presented in the following sections: major findings, unexpected findings, implications for action, recommendations for further research, study limitations, reflections, and study conclusion.

### **Major Findings**

The major findings in this study are summarized in this section. Similar to studies on burnout, the researcher found that burnout does affect ancillary department managers with other variables such as hardiness impacting the levels of burnout (Danner, Hagemann, & Fiedler, 2015). With limited research found pertaining to ancillary managers, the researcher collected data from the target population utilizing the MBI-GS, hardiness scale, and MOAQ-JSS subscale, which indicated a higher level of burnout exists. Furthermore, the findings suggest ancillary managers experience higher levels of burnout, similar to those of clinical staff (Lin et al., 2016; Maslach et al., 2001).

The researcher started by determining whether burnout existed among ancillary managers, as this remained unclear based on previous research. The study found an aggregate mean for the emotional exhaustion subscale (EE) was 13.37, cynicism subscale (CY) was 30.57, and professional efficacy subscale (PE) was 8.81. The overall burnout score is reflected as high scores of EE and CY subscales and low scores on the PE subscale. Following scoring of the MBI-GS as outlined by Maslach and Leiter (2017), the means of each subscale were not combined and analyzed separately, indicating that ancillary managers within the healthcare organization scored at the average to higher levels of burnout across all three subscales.

The sample of the study had 95 ancillary managers within a healthcare organization who represented departments such as supply chain, environmental services,

operator services, information technology, and food services. The research questions outlined in the following sections utilized Pearson's correlation and multiple regression.

### **Research Question 1**

The first question addressed by the study was, "Is there a relationship between burnout and hardiness among ancillary managers within a U.S. healthcare organization?" The first three hypotheses were examined to determine whether a relationship existed utilizing Pearson's correlation, exploring the relationship between burnout, hardiness, and demographic variables such as age, gender, and tenure.

Based on the Pearson's correlation, the researcher concluded that a relationship exists between burnout and hardiness; however, it was not statistically significant ( $p$  value  $> .05$ ). Emotional exhaustion and hardiness were found to have a negative correlation at  $r(95) = -.155, p = .134$ , such that higher reports of emotional exhaustion were related to reports of being less hardy. As for cynicism and hardiness, the relationship was found to have a moderately positive correlation ( $r(95) = .423, p = .000$ ). Finally, the last burnout dimension of feelings of inefficacy and hardiness were found to have a moderately negative correlation ( $r(95) = .295, p = .004$ ). The findings suggest that lower scores for feelings of inefficacy, which indicate higher levels of burnout, relate to being less hardy. This is in line with literature that indicated hardy individuals are more adept and able to handle stressful situations whereas individuals with low hardiness levels do not have the coping mechanisms to handle stressful situations (Fyhn et al., 2016). The results support a rationale for a larger sampling to determine whether the generalizations of this study are valid and applicable to other U. S. healthcare organizations.

## **Research Question 2**

The second research question evaluated the relationship between burnout and the intent to turnover with the question “Is there a relationship between burnout and intent to turnover among ancillary managers within a U.S. healthcare organization?” Hypotheses 4, 5, and 6 were analyzed utilizing Pearson’s correlation with the findings as follows.

Based on the Pearson’s correlation, the researcher concluded that a relationship exists between burnout and intent to turnover, with emotional exhaustion and feelings of inefficacy being stronger predictive variables. Emotional exhaustion and intent to turnover were found to have a moderately negative correlation ( $r(95) = -.216, p = .036$ ). Of the three dimensions, cynicism was the only dimension that had a weak correlation to intent to turnover ( $r(95) = -.185, p = .072$ ); therefore, a relationship could not be established. Finally, the relationship between feelings of inefficacy and intent to turnover were found to have moderately negative correlation ( $r(95) = -.362, p = .000$ ). The researcher found that although only two of the three dimensions indicated a moderately negative correlation to intent to turnover, this would support past studies that also found that higher levels of burnout can predict turnover intentions (Morse, Salyers, Rollins, Monroe-DeVita, & Pfahler, 2012; Reina et al., 2018; Shanafelt et al., 2015).

## **Research Question 3**

The final research question examined the relationship between hardiness and intent to turnover with the question: “Is there a relationship between hardiness and intent to turnover among ancillary managers within a U.S. healthcare organization?” Again, Pearson’s correlation was utilized to examine Hypothesis 7. The relationship between hardiness and intent to turnover were found to have a weak negative correlation ( $r(95) = -$

.156,  $p = .130$ ). Therefore, the researcher concluded that unlike burnout, hardiness had no relationship to intent to turnover.

In evaluating the model, the researcher also utilized multiple regression to assess the three dimensions of burnout, hardiness, and gender in predicting intent to turnover. Within the model, only feelings of inefficacy had a statistical significance in predicting intent to turnover ( $p$  value  $< .05$ ). With only feelings of inefficacy statistically significant ( $p$  value  $< .05$ ), this suggests that personal accomplishments within the workplace as well as feeling effective on the job are important areas to focus on within this specific target population, and the findings are supported by previous studies (Wong & Laschinger, 2015).

### **Unexpected Findings**

The researcher initially started the study to determine whether a relationship existed between burnout, hardiness, gender and how it related to intent to turnover among ancillary managers. In further analyzing the data, unexpected findings were found when data were placed in subgroups based on age. There was a positive correlation between age and tenure, with older participants having longer lengths of tenure within the healthcare organization. Therefore, the researcher analyzed age as a generalization for the groups of participants, which was similar to past research (Toros, Dereceli, & Barut, 2017; Van der Heijden et al., 2019). In conducting the two-sample  $t$  test analysis between age groups, it was discovered that subgrouping by age produced some unexpected findings. Participants were divided into four groups according to their age, with Group 1: 26-35, Group 2: 36-45, Group 3: 46-55, and Group 4: 56+. A post hoc comparison using Tukey HSD test indicated that only the mean hardiness score for Group

1 ( $M = 39.64$ ,  $SD = 3.86$ ) was significantly different from Group 4 ( $M = 42.8$ ,  $SD = 4.37$ ), and Group 3 ( $M = 39.86$ ,  $SD = 3.86$ ) was also significantly different from Group 4 (Table D7). The remaining mean scores for burnout and intent to turnover were not statistically significant.

The Pearson's correlation found ancillary managers between the ages of 26-35 years old showed a strong negative relationship between emotional exhaustion and hardiness, suggesting individuals with higher emotional exhaustion had lower levels of hardiness. The strong negative relationship found between burnout (EE subscale) and hardiness appears to support the idea that hardiness may act as a buffer, specific to this age group, in the prevention of burnout (Kobasa, 1979; Taylor et al., 2013). Chaudhuri (2019) found in his study that millennials are intrinsically motivated differently from other age groups, and having one negative burnout dimension can impact the individual's learning (Lowe, Gakumo, & Patrician, 2016) or emotional well-being (Pape, Dong, & Horvath, 2018).

It was likewise interesting that no significant relationship was found in the overall model between all three subscales and hardiness. This indicates that within the ancillary management population, hardiness had no significant impact on how individuals experienced burnout with the exception of the 26-35-year-olds. The overall findings of this study did not support the findings of other research that have suggested hardiness can be a buffer to burnout and therefore predict intent to turnover (Fyhn et al., 2016; Kobasa et al., 1982). The aggregate mean for hardiness scale was 40.32, suggesting that ancillary managers were average on the scale for hardiness, which indicates that the overall

hardiness for ancillary managers could be an area for future study if hardiness levels could be increased.

### **Conclusions**

Studies of healthcare professionals have historically shown that healthcare professionals are more prone to stress, face challenging situations and workloads that put them at risk for burnout (Johansson et al., 2013). The findings of the study were in line with past studies as they indicate that ancillary managers experience higher levels of burnout as compared to other industries (Lin et al., 2016; Westman, 1990). The overall model proved to be statistically significant, which provides insight into burnout and how hardiness may buffer to an extent the levels of burnout among ancillary managers. At the same time, dimensions of burnout can be utilized as predictors of intentions to turnover as seen in Table D8.

### **Implications for Action**

The model presented in the study indicated some of the variables had a statistical significance, suggesting that dimensions of burnout can be utilized as predictors to intent to turnover. Past research has shown that hardiness can help protect or buffer against stress and burnout (Hystad, Eid, & Brevik, 2011). Healthcare organizations should determine how to build up hardiness within their management groups, encouraging and supporting policies or programs that will not only empower managers but also provide a sense of accomplishment to increase overall job satisfaction (Wombacher & Felfe, 2017). Based on the study findings, two implications for action are proposed: (a) emphasis on acknowledging accomplishments and helping employees feel that their work is valued and (b) building up hardiness levels among ancillary managers of all ages.

The study found statistical significance with feelings of inefficacy as the main predictive variable to turnover intentions among ancillary managers. As Maslach and Leiter (2017) described, these feelings are tied to past and present accomplishments. This can be explained by better understanding how ancillary departments are seen within the healthcare organization, not as just supporting departments, but as equals in the care of patients (Kunkel & Shmueli, 1994). Healthcare organizations should make it a point to include ancillary departments in celebrations or to acknowledge their contributions to the success of patient care, quality of care, and overall business success. This can provide positive affirmation to the ancillary managers to improve feelings of inefficacy ratings and thereby reduce intent to turnover.

Secondly, healthcare organizations should focus on programs or policies that support increasing training in resilience and hardiness. Similar to the first implication for action, hardiness and resilience training has been provided to clinical staff such as nurses (Saksvik et al., 2016); however, limited studies indicate the same is being done for ancillary managers or management (with the exception of nurse managers) in general within the healthcare setting. Although the study found no relationship between hardiness and intent to turnover, hardiness has been shown in other industries and studies to reduce burnout and reduce intent to turnover (Mazzetti et al., 2019; Taylor et al., 2013). The focus of the change should be on mental aptitude and coping mechanisms that would help managers better deal with stressful and challenging situations. The harder the individual, the more adept they will be at managing burnout, which will increase their joy in their work (Wieser & Thiel, 2014). A subfocus for the healthcare industry is to encourage training for younger managers who may lack hardiness or

experience. This was highlighted in the unexpected findings where managers between 26-35 years of age scored lower in hardiness. It makes sense to support newer managers who may feel overwhelmed and underappreciated because this will encourage commitment to the organization and better prepare them for the challenges ahead.

### **Recommendations for Further Research**

Based on the study findings that suggest ancillary managers experience higher levels of burnout, similar to that of their clinical counterparts, further research is necessary to compare just how different the levels are. Management should have a clear picture of the issue of burnout among all their managers to better support and retain these valued individuals. At this time, it is unknown how limited the supply and demand is on ancillary managers, unlike nursing shortages (Shemdoe et al., 2016; Udod & Care, 2012). However, as the global business market becomes more integrated, competitive, and fast paced, organizations are challenged with an increasingly higher number of employees experiencing stress, anxiety, and burnout because of higher job demands, which makes retention of employees a strategic priority (Bova et al., 2015). Variables such as resilience and hardiness levels would be a financial benefit for organizations as studies have shown hardiness can mitigate burnout rates.

Not only is it necessary to identify whether burnout exists, but there also continues to be a lack of understanding causation, focusing on the different dimensions and predictability factors of each in understanding how causation is related to intent to turnover (Waldman et al., 2010). Maslach and Leiter (2017) pointed out that many studies focus on identifying burnout; however, causation and preventative measures are rarely studied, in part because of the cost it would take to implement such a robust study.

However, being able to find causation and study variables that are the underlying issue to burnout will help many organizations plan and prepare strategies to help their employees, thus being able to reduce turnover.

The researcher found few longitudinal studies conducted in examining burnout among managers and intent to turnover. Studies such as Skagert et al., (2012) conducted a longitudinal study of managers within the Swedish healthcare system and found that turnover was as high as 40% over the 4-year period. Similarly, Hewko et al. (2014) found that 27% of acute and long-term clinical managers in the Alberta healthcare system reported intent to turnover within the next 2 years. However, further studies into factors that prevent burnout and intent to turnover are necessary, to include ancillary managers and supporting staff. It is also of interest to further the research based on subgroups of healthcare professionals utilizing age, tenure, wage, and number of hours worked as a variable. There is also a need for future studies to include generational differences as it is important to account for the unique situation that the global marketplace is undergoing as four different generations enter the workforce. Managers will ultimately need to put focus and emphasis on the generational differences to retain the talent they have (Aruna & Anitha, 2015).

### **Study Limitations**

The following study limitations were present based on the scope of the study. The study was conducted in a specific healthcare organization; therefore, the findings cannot be generalized to all ancillary managers across differing types of healthcare organizations (i.e., community hospital, for profit, private practice). The study relied on self-reported data from ancillary managers and was limited by the fact that self-reported

data cannot be independently verified. Self-reported data can also be impacted by fear of being identified, overemphasis, or selective memory; however, these limitations did not prevent the completion of the study. Lack of communication and restrictions pertaining to communication via e-mail by the healthcare organization also proved to limit the number of responses to the study. Finally, during the survey period, the healthcare organization was undergoing potential work stoppage, which could have impacted the response rate or increased the burnout levels among participants. This was a unique situation that occurred during the course of the study and potentially offers another area of future research to identify whether the findings would be the same in normal circumstances.

### **Concluding Remarks and Reflections**

The study was designed to analyze how burnout impacts other types of employees outside of the widely studied clinical groups such as nurses. Initially, the researcher had assumed that ancillary department managers would be impacted by burnout as they support the high stress, patient care environments even though they do not conduct direct patient care. This proved to be true with high scores in EE and CY subscales and lower scores on the PE subscale, suggesting ancillary managers were impacted by higher levels of burnout.

Additionally, the researcher expected managers who scored higher in hardiness to have significant differences in levels of burnout and thus have a lower level of turnover intent. Although the study proved the initial expectations to be unsubstantiated, the MBI-GS results on correlations between burnout and intent to turnover were consistent with theoretical frameworks by Maslach and Leiter (2017) and Kobasa (1979). The researcher

was surprised by the results, but the overall implications to the study would suggest that healthcare professionals overall, regardless of whether they are clinical or ancillary managers, experience higher than average burnout rates regardless of their levels of mental hardiness.

## REFERENCES

- Abdollahi, A., Abu Talib, M., Yaacob, S. N., & Ismail, Z. (2015). The role of hardiness in decreasing stress and suicidal ideation in a sample of undergraduate students. *Journal of Humanistic Psychology, 55*(2), 202-222. <https://doi.org/10.1177/0022167814543952>
- Adriaenssens, J., Hamelink, A., & Bogaert, P. (2017). Predictors of occupational stress and well-being in first-line nurse managers: A cross-sectional survey study. *International Journal of Nursing Studies, 73*(1), 85-92. <https://doi.org/10.1061/j.ijnurstu.2017.05.007>
- Arnold, J., Loan-Clarke, J., Coombs, C., Wilkinson, A., Park, J., & Preston, D. (2006). How well can the theory of planned behavior account for occupational intentions? *Journal of Vocational Behavior, 69*(3), 374-390. <https://doi.org/10.1016/j.jvb.2006.07.006>.
- Arrogante, O., & Aparicio-Zaldivar, E. (2017). Burnout and health among critical care professionals: The mediational role of resilience. *Intensive & Critical Care Nursing, 42*(1), 110-115. <https://doi.org/10.1016/j.iccn.2017.04.010>
- Aruna, M., & Anitha, J. (2015). Employee retention enablers: Generation Y employees. *SCMS Journal of Indian Management, 12*(3), 94-103.
- Ayala Calvo, J., & García, G. M. (2018). Hardiness as moderator of the relationship between structural and psychological empowerment on burnout in middle managers. *Journal of Occupational & Organizational Psychology, 91*(2), 362-384. <https://doi.org/10.1111/joop.12194>

- Bae, J., Jennings, P. F., Hardeman, C. P., Kim, E., Lee, M., Littleton, T., & Saasa, S. (2019). Compassion satisfaction among social work practitioners: The role of work–life balance. *Journal of Social Service Research*, 1-11. <https://doi.org/10.1080/01488376.2019.1566195>
- Bagley, C., Abubaker, M., & Sawyerr, A. (2018). Personality, work-life balance, hardiness, and vocation: A typology of nurses and nursing values in a special sample of English hospital nurses. *Administrative Sciences*, 8(4), 79. <https://doi.org/10.3390/admsci8040079>
- Barbuto, J., Jr., & Gottfredson, R. (2016). Human capital, the millennial’s reign, and the need for servant leadership. *Journal of Leadership Studies*, 10(2), 59-63. <https://doi.org/10.1002/jls.21474>
- Becton, J., Walker, H., & Jones-Farmer, A. (2014). Generational differences in workplace behavior. *Journal of Applied Social Psychology*, 44, 175-189. <https://doi.org/10.1111/jasp.12208>
- Bova, N., De Jonge, J., & Guglielmi, D. (2015). The demand-induced strain compensation questionnaire: A cross-national validation study. *Stress Health*, 31(1), 326-344. <https://doi.org/10.1002/smi.2550>
- Bowling, N. A., & Hammond, G. D. (2008). A meta-analytic examination of the construct validity of the Michigan organizational assessment questionnaire job satisfaction subscale. *Journal of Vocational Behavior*, 73(1), 63-77. <https://doi.org/10.1016/j.jvb.2008.01.004>
- Britton, M. (2015). *YouthNation: Building remarkable brands in a youth-driven culture*. Hoboken, NJ: John Wiley & Sons.

- Bue, S., Kintaert, S., Taverniers, J., Mylle, J., Delahaij, R., & Euwema, M. (2018). Hardiness differentiates military trainees on behavioural persistence and physical performance. *International Journal of Sport and Exercise Psychology*, 16(4), 354-364. <https://doi.org/10.1080/1612197x.2016.1232743>
- Burmeister, E. A., Kalisch, B. J., Xie, B., Doumit, M. A. A., Lee, E., Ferraresion, A., . . . Bragadóttir, H. (2019). Determinants of nurse absenteeism and intent to leave: An international study. *Journal of Nursing Management*, 27(1), 143-153. <https://doi.org/10.1111/jonm.12659>
- Cammann, C., Fichman, M., Jenkins, D., & Klesh, J. (1979). *The Michigan organizational assessment questionnaire*. Ann Arbor, MI: University of Michigan.
- Carneiro, É. M., Navinchandra, S. A., Vento, L., Timóteo, R. P., & de Fátima Borges, M. (2019). Religiousness/spirituality, resilience and burnout in employees of a public hospital in Brazil. *Journal of Religion & Health*, 58(2), 677-685. <https://doi.org/10.1007/s10943-018-0691-2>
- Centers for Medicare & Medicaid Services. (2018). HCAHPS: Patients' perspectives of care survey. Retrieved from <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalHCAHPS.html>
- Chaudhuri, J. D. (2019). Stimulating intrinsic motivation in millennial students: A new generation, a new approach. *Anatomical Sciences Education*, 13(2), 1-22. <https://doi.org/10.1002/ase.1884>

- Chiu, S. F., & Tsai, M. C. (2006). Relationships among burnout, job involvement, and organizational citizenship behavior. *Journal of Psychology, 140*(6), p. 517-530.  
<https://doi.org/10.3200/JRLP.140.6.517-530>
- Clark, W. V., & Mulder, C. H. (2000). Leaving home and entering the household market. *Environment & Planning A, 32*(9), 1657-1671. <https://doi.org/10.1068/a3315>
- Cohen, J. (1988). *Statistical power analysis for the behavioral sciences* (2nd ed.). Hillsdale, NJ: Lawrence Erlbaum Associates. <https://doi.org/10.4324/9780203771587>
- Cordes, C., Dougherty, T., & Blum, M. (1997). Patterns of burnout among managers and professionals: A comparison of models. *Journal of Organizational Behavior, 18*(6), 685-701. <https://doi.org/10.14264/uql.2016.836>.
- Cortese, C. G., Colombo, L., & Ghislieri, C. (2010). Determinants of nurses' job satisfaction: The role of work-family conflict, job demand, emotional charge and social support. *Journal of Nursing Management, 18*(1), 35-43.  
<https://doi.org/10.1111/j.1365-2834.2009.01064.x>
- Covella, G., McCarthy, V., Kaifi, B., & Cocoran, D. (2017). Leadership's role in employee retention. *Business Management Dynamics, 7*(5), 1-15.
- Dabney, B. W., & Kalisch, B. J. (2015). Nurse staffing levels and patient-reported missed nursing care. *Journal of Nursing Care Quality, 30*(4), 306-312. <https://doi.org/10.1097/NCQ.0000000000000123>
- Danner, D., Hagemann, D., & Fiedler, K. (2015). Mediation analysis with structural equation models: Combining theory, design, and statistics. *European Journal of Social Psychology, 45*(4), 460-481. <https://doi.org/10.1002/ejsp.2106>

- Demerouti, E., Bakker, A. B., Nachreiner, F., & Schaufeli, W. B. (2001). The job demands: Resource model of burnout. *Journal of Applied Psychology, 86*(3), 499-512. <https://doi.org/10.1037//0021-9010.86.3.499>
- Dorić, D., Nikolić-Dorić, E., Jevremović, V., & Mališić, J. (2009). On measuring skewness and kurtosis. *Quality and Quantity, 43*, 481-493. <https://doi.org/10.1007/s11135-007-9128-9>
- Dwi Putranti, H. R. (2018). Organizational commitment of hospital nurses: An empirical study on work-life balance and burnout management. *European Researcher, 9*(3), 235-248. <https://doi.org/10.13187/er.2018.3.235>
- El-Ibiary, S., Yam, L., & Lee, K. (2017). Assessment of burnout and associated risk factors among pharmacy practice faculty in the United States. *American Journal of Pharmaceutical Education, 81*(4), 1-10. <https://doi.org/10.5688/ajpe81475>
- Erenstein, C. F., & McCaffrey, R. (2007). How healthcare work environments influence nurse retention. *Holistic Nursing Practice, 21*, 303-307. <https://doi.org/10.1097/01.HNP.0000298615.25222.de>
- Fasbender, U., Van der Heijden, B. I. J. M., & Grimshaw, S. (2019). Job satisfaction, job stress and nurses' turnover intentions: The moderating roles of on-the-job and off-the-job embeddedness. *Journal of Advanced Nursing, 75*(2), 327-337. <https://doi.org/10.1111/jan.13842>
- Fischer, R., & Boer, D. (2011). What is more important for national well-being: Money or autonomy? A meta-analysis of well-being, burnout, and anxiety across 63 societies. *Journal of Personality and Social Psychology, 101*(1), 164-184. <https://doi.org/10.1037/a0023663.supp>

- Freitas, F., Vannuchi, M., Haddad, M., Silva, L., & Rossaneis, M. (2017). Hardiness and occupational stress in nurse managers of hospital institutions. *Journal of Nursing UFPE/Revista de Enfermagem UFPE*, *11*(10), 4199-4205. <https://doi.org/10.5205/reuol.10712-95194-3-SM.1110sup201725>
- Freudenberger, H. J. (1974). Staff burn-out. *Journal of Social Issues*, *30*(1), 159-165. <https://doi.org/10.1111/j.1540-4560.1974.tb00706.x>
- Fyhn, T., Fjell, K. K., & Johnsen, B. H. (2016). Resilience factors among police investigators: Hardiness-commitment a unique contributor. *Journal of Police and Criminal Psychology*, *31*(4), 261-269. <https://doi.org/10.1007/s11896-015-9181-6>
- Gangawane, S. (2018). Work-life balance: Why is everybody talking about it at all? *SSRN Electronic Journal*, 1-12. <https://doi.org/10.2139/ssrn.3224015>
- Gingold, D. B., Pierre-Mathieu, R., Cole, B., Miller, A. C., & Khaldun, J. S. (2017). Impact of the Affordable Care Act Medicaid expansion on emergency department high utilizers with ambulatory care sensitive conditions: A cross-sectional study. *American Journal of Emergency Medicine*, *35*(5), 737-742. <https://doi.org/10.1016/j.ajem.2017.01.014>
- Glaser, W., & Hecht, T. (2013). Work-family conflicts, threat-appraisal, self-efficacy and emotional exhaustion. *Journal of Managerial Psychology*, *28*(2), 164-182. <https://doi.org/10.1108/02683941311300685>
- Golembiewski, R. T. (1989). A note on Leiter's study: Highlighting two models of burnout. *Group & Organization Studies*, *14*(1), 5-13. <https://doi.org/10.1177/105960118901400102>

- Golembiewski, R. T. (1999). The phase model of burnout: Conceptual, theoretical, and practical issues. *Journal of Health and Human Services Administration, 21*(4), 490-501.
- Grotto, A. R., Hyland, P. K., Caputo, A. W., & Semedo, C. (2017). Employee turnover and strategies for retention. In H. W. Goldstein, E. D. Pulakos, J. Passmore, & C. Semedo, *The Wiley Blackwell handbook of the psychology of recruitment, selection and employee retention*. Chichester, United Kingdom: Wiley Blackwell.
- Guan, N., & Yusoff, M. S. (2011). Missing values in data analysis: Ignore or impute? *Education in Medicine Journal, 3*(1), e6-e11. <https://doi.org/10.5959/eimj.v3i1.87>
- Hart, S. M., & Warren, A. M. (2015). Understanding nurses' work: Exploring the links between changing work, labour relations, workload, stress, retention and recruitment. *Economic and Industrial Democracy, 36*(2), 305-329. <https://doi.org/10.1177/0143831X13505119>
- Heinemann, L., & Heinemann, T. (2017). Burnout research: Emergence and scientific investigation of a contested diagnosis. *SAGE Open, 7*(1), 1-12. <https://doi.org/10.1177/2158244017697154>
- Herzberg F., Mausner B., & Snyderman B. B. (1967). *The motivation to work* (2nd ed.). New York, NY: John Wiley.
- Hewko, S., Brown, P., Fraser, K., Wong, C., & Cummings, G. (2014). Factors influencing nurse managers' intent to stay or leave: A quantitative analysis. *Journal of Nursing Management, 23*(8), 1058-1066. <https://doi.org/10.1111/jonm.12252>

- Holtom, B. C., Mitchell, T. R., Lee, T. W., & Eberly, M. B. (2008). Turnover and retention research: A glance at the past, a closer review of the present, and a venture into the future. *Academy of Management Annals*, 2(1), 231-274. <https://doi.org/10.5465/19416520802211552>
- Hystad, S. W., Eid, J., & Brevik, J. I. (2011). Effects of psychological hardiness, job demands, and job control of sickness absence: A prospective study. *Journal of Occupational Health Psychology*, 16(1), 265-278. <https://doi.org/10.1037/a0022904>
- Jacobs, L. M., Hood, J. L., Nawaz, M. K., & Bae, S. (2012). Burnout among workers in a pediatric health care system. *Workplace Health and Safety*, 60(8), 335-344. <https://doi.org/10.3928/21650799-20120726-03>
- Jamal, Y., Zahra, S. T., Yaseen, F., & Nasreen, M. (2017). Coping strategies and hardiness as predictors of stress among rescue workers. *Pakistan Journal of Psychological Research*, 32(1), 141-154. <https://doi.org/10.1080/09735070.2017.1356033>
- Johansson, G., Sandahl, C., & Hasson, D. (2013). Role stress among first-line nurse managers and registered nurses—A comparative study. *Journal of Nursing Management*, 21(3), 449-458. <https://doi.org/10.1111/j.1365-2834.2011.01311.x>
- Johnson, M. (2015). Stop talking about work/life balance! TEQ and the millennial generation. *Workforce Solutions Review*, 6(2), 4-7.

- Johnson, J., Dunning, A., Johnson, O., Hall, L., Louch, G., Grange, A., . . . O'Hara, J. (2017). Burnout mediates the association between depression and patient safety perceptions: A cross-sectional study in hospital nurses. *Journal of Advanced Nursing*, 73(7), 1667-1680. <https://doi.org/10.1111/jan.13251>
- Jones, K., Simpson, G., Briggs, L., & Dorsett, P. (2016). Does spirituality facilitate adjustment and resilience among individuals and families after SCI? *Disability and Rehabilitation*, 38(10), 921-935. <https://doi.org/10.3109/09638288.2015.1066884>
- van de Klundert, J., van Dongen-van den Broek, J., Yesuf, E. B., Vreugdenhil, J., & Yimer, S. M. (2018). 'We are planning to leave, all of us'—a realist study of mechanisms explaining healthcare employee turnover in rural Ethiopia. *Human Resources for Health*, 16(1), 1-13. <https://doi.org/10.1186/s12960-018-0301-0>
- Kadyan, A., & Malik, S. (2017). Hardiness and self-esteem among female wrestlers: A correlational study. *Indian Journal of Health & Wellbeing*, 8(11), 1370-1373.
- Karadag Arli, S., Bakan, A. B., & Erisik, E. (2019). An investigation of the relationship between nurses' views on spirituality and spiritual care and their level of burnout. *Journal of Holistic Nursing*, 35(3), 214-220. <https://doi.org/10.1177/0898010116652974>
- Kaur, D., Sambasivan, M., & Kumar, N. (2013). Effect of spiritual intelligence, emotional intelligence, psychological ownership and burnout on caring behaviour of nurses: A cross-sectional study. *Journal of Clinical Nursing*, 22(21-22), 3192-3202. <https://doi.org/10.1111/jocn.12386>

- Kilpatrick, A., Magnetti, S., & Mirvis, D. (1991). Burnout and job satisfaction among public hospital administrators: Preliminary findings. *Journal of Health and Human Resources Administration, 13*(4), 470-482.
- Kline, R. B. (2013). *Beyond significance testing: Reforming data analysis methods in behavioral research*. Washington, DC: American Psychological Association.  
<https://doi.org/10.1037/10693-000>
- Kobasa, S. C. (1979). Stressful life events, personality and health: An inquiry into hardiness. *Journal of Personality and Social Psychology, 37*(1), 1-11.  
<https://doi.org/10.1037/0022-3514.37.1.1>
- Kobasa, S. C., Maddi, S. R., & Kahn, S. (1982). Hardiness and health: A prospective study. *Journal of Personality and Social Psychology, 42*(9), 168-177.  
<https://doi.org/10.1037/0022-3514.42.1.168>
- Kumar, V., & Kumar, S. (2014). Workplace spirituality as a moderator in relation between stress and health: An exploratory empirical assessment. *International Review of Psychiatry, 26*(3), 344-351. <https://doi.org/10.3109/09540261.2014.924909>
- Kunkel, E. J. S., & Shmuelly, Y. (1994). Sources of ancillary oncology staff stress in radiation oncology. *Psycho-Oncology, 3*(3), 241-243. <https://doi.org/10.1002/pon.2960030312>
- Kuo, H., Lin, K., & Li, I. (2014). The mediating effects of job satisfaction on turnover intention for long-term care nurses in Taiwan. *Journal of Nursing Management, 22*(2), 225-233. <https://doi.org/10.1111/jonm.12044>

- Lambert, E. G., Griffin, M. L., Hogan, N. L., & Kelley, T. (2015). The ties that bind: Organizational commitment and its effect on correctional orientation, absenteeism, and turnover intent. *Prison Journal, 95*(1), 135-156. <https://doi.org/10.1177/0032885514563293>
- Laschinger, H. K., Borgogni, L., Consiglio, C., & Read, E. (2015). The effects of authentic leadership, six areas of worklife, and occupational coping self-efficacy on new graduate nurses' burnout and mental health: A cross-sectional study. *International Journal of Nursing Studies, 52*(6), 1080-1089. <https://doi.org/10.1016/j.ijnurstu.2015.03.002>
- Lazarus, R. S. & Folkman, S. (1984). *Stress, appraisal and coping*. New York, NY: Springer.
- Lee, H., Spiers, J. A., Yurtseven, O., Cummings, G. G., Sharlow, J., Bhatti, A., & Germann, P. (2010). Impact of leadership development on emotional health in healthcare managers. *Journal of Nursing Management, 18*(8), 1027-1039. <https://doi.org/10.1111/j.1365-2834.2010.01178.x>
- Lee, T. W., Hom, P. W., Eberly, M. B., Li, J., & Mitchell, T. R. (2017). On the next decade of research in voluntary employee turnover. *Academy of Management Perspectives, 31*(3), 201-221. <https://doi.org/10.5465/amp.2016.0123>
- Leiter, M., & Schaufeli, W. (1996). Consistency of the burnout construct across occupations. *Anxiety, Stress, and Coping, 9*(3), 229-243. <https://doi.org/10.1080/10615809608249404>

- Li, H., Cheng, B., & Zhu, X. P. (2018). Review: Quantification of burnout in emergency nurses: A systematic review and meta-analysis. *International Emergency Nursing*, 39, 46-54. <https://doi.org/10.1016/j.ienj.2017.12.005>
- Li, J., Lee, T. W., Mitchell, T. R., Hom, P. W., & Griffeth, R. W. (2016). The effects of proximal withdrawal states on job attitudes, job searching, intent to leave, and employee turnover. *Journal of Applied Psychology*, 101(10), 1436-1456. <https://doi.org/10.1037/apl0000147>
- Lin, T., Lin, H., Cheng, S., Wu, L., & Ou, Y. M. (2016). Work stress, occupational burnout and depression levels: a clinical study of paediatric intensive care unit nurses in Taiwan. *Journal of Clinical Nursing*, 25(7/8), 1120-1130. <https://doi.org/10.1111/jocn.13119>
- Lindorff, M. (2000). Is it better to perceive than receive? Social support, stress and strain for managers. *Psychology, Health & Medicine*, 5(3), 271-286. <https://doi.org/10.1080/713690199>
- Liu, X., Zheng, J., Liu, K., Liu, J., Wu, Y., You, L., & Baggs, J. G. (2018). Hospital nursing organizational factors, nursing care left undone, and nurse burnout as predictors of patient safety: A structural equation modeling analysis. *International Journal of Nursing Studies*, 86, 82-89. <https://doi.org/10.1016/j.ijnurstu.2018.05.005>
- Lowes, M. A., Gakumo, C. A., & Patrician, P. A. (2016). Coping strategies of nurses in a palliative care unit. *Journal of National Black Nurses Association*, 27(1), 50-54.

- Lu, Y., Hu, X., Guo, P., Hao, Y., Huang, X., Feng, L., & Zhuang, X. (2016). Job satisfaction and associated factors among healthcare staff: A cross-sectional study in Guangdong Province, China. *BMJ Open*, *6*(7), 1-9. <https://doi.org/10.1136/bmjopen-2016-011388>
- Luz, C., de Paula, S., & de Oliveira, L. (2018). Organizational commitment, job satisfaction and their possible influences on intent to turnover. *REGE Revista de Gestão*, *1*(1), 84-101. <https://doi.org/10.1108/REGE-12-2017-008>
- Maddi, S. (2006). Hardiness: The courage to grow from stresses. *Journal of Positive Psychology*, *1*(3), 160-168. <https://doi.org/10.1080/17439760600619609>
- Maddi, S., Harvey, R., Khoshaba, D., Fazel, M., & Resurreccion, N. (2012). The relationship of hardiness and some other relevant variables to college performance. *Journal of Humanistic Psychology*, *52*(2), 190-205. <https://doi.org/10.1177/0022167811422497>
- Madigan, D. J., & Nicholls, A. R. (2017). Mental toughness and burnout in junior athletes: A longitudinal investigation. *Psychology of Sport & Exercise*, *32*, 138-142. <https://doi.org/10.1016/j.psychsport.2017.07.002>
- March, J. G., & Simon, H. A. (1958). *Organizations*. New York, NY: John Wiley.
- Maslach, C. (1982). Burnout and commitment: A theoretical alternative. *Personnel and Guidance Journal*, *61*(7), 390-393. <https://doi.org/10.1111/j.2164-4918.1983.tb00051.x>
- Maslach, C., & Jackson, S. (1981). The measurement of experienced burnout. *Journal of Occupational Behaviour*, *2*(2), 99-113. <https://doi.org/10.1002/job.4030020205>

- Maslach, C., Jackson, S. E., Leiter, P. M., & Schaufeli, W. B. (1996). *Maslach burnout inventory* (3rd ed.). Menlo Park, CA: Mind Garden.
- Maslach, C., & Leiter, M. P. (2008). Early predictors of job burnout and engagement. *Journal of Applied Psychology, 93*(3), 498-512. <https://doi.org/10.1037/2F0021-9010.93.3.498>
- Maslach, C., & Leiter, M. P. (2017). New insights into burnout and healthcare: Strategies for improving civility and alleviating burnout. *Medical Teacher, 39*(2), 160-163. <https://doi.org/10.1080/0142159X.2016.1248918>
- Maslach, C., Schaufeli, W. B., & Leiter, M. P. (2001). Job burnout. *Annual Review of Psychology, 52*, 397-422. <https://doi.org/10.1146/annurev.psych.52.1.397>
- Maslow, A. (2013). *A theory of human motivation*. Mansfield Centre, CT: Martino.
- Mazzetti, G., Guglielmi, D., Chiesa, R., & Mariani, M. G. (2016). Happy employees in a resourceful workplace: just a direct relationship? A study on the mediational role of psychological capital. *Career Development International, 21*(7), 682-696. <https://doi.org/10.1108/CDI-03-2016-0035>
- Mazzetti, G., Vignoli, M., Petruzzello, G., & Palareti, L. (2019). The harder you are, the healthier you become. May hardiness and engagement explain the relationship between leadership and employees' health? *Frontiers in Psychology, 9*(1), 1-9. <https://doi.org/10.3389/fpsyg.2018.02784>
- McPherson, S., Hiskey, S., & Alderson, Z. (2016). Distress in working on dementia wards—A threat to compassionate care: A grounded theory study. *International Journal of Nursing Studies, 53*, 95-104. <https://doi.org/10.1016/j.ijnurstu.2015.08.013>

- Mendoza, R. L. (2017). Information asymmetries and risk management in healthcare markets: The U.S. Affordable Care Act in retrospect. *Journal of Economic Issues*, 51(2), 520-540. <https://doi.org/10.1080/00213624.2017.1321451>
- Meyer, J. P., & Allen, N. J. (1997). *Commitment in the workplace: Theory, research and application*. Thousand Oaks, CA: Sage.
- Mobley, W. H. (1977). Intermediate linkages in the relationship between job satisfaction and employee turnover. *Journal of Applied Psychology*, 62(2), 237-240. <https://doi.org/10.1037/0021-9010.62.2.237>
- Mohr, G., & Wolfram, H.-J. (2010). Stress among managers: The importance of dynamic tasks, predictability, and social support in unpredictable times. *Journal of Occupational Health Psychology*, 15(2), 167-179. <https://doi.org/10.1037/a0018892>
- Morse, G., Salyers, M. P., Rollins, A. L., Monroe-DeVita, M., & Pfahler, C. (2012). Burnout in mental health services: A review of the problem and its remediation. *Administration and Policy and Mental Health Services Research*, 39(5), 341-352. <https://doi.org/10.1007/s10488-011-0352-1>
- Neininger, A., Lehmann-Willenbrock, N., Kauffeld, S., & Henschel, A. (2010). Effects of team and organizational commitment—A longitudinal study. *Journal of Vocational Behavior*, 76(1), 567-579. <https://doi.org/10.1016/j.vb.2010.01.009>
- Neuman, B. (1995). *The Neuman systems model* (3rd ed.). Stamford, CT: Appleton & Lange.

- Ng, T. (2015). The incremental validity of organizational commitment, organization trust, and organizational identification. *Journal of Vocational Behavior*, 88(1), 154-163. <https://doi.org/10.1016/j.jvb.2015.03.003>
- O'Connor, J. (2018). The impact of job satisfaction on the turnover intent of executive level central office administrators in Texas public school districts: A quantitative study of work related constructs. *Education Sciences*, 8(2), 69-82. <https://doi.org/10.3390/educsci8020069>
- Ou, A., Jungmin, S., Dongwon, C., & Hom, P. (2017). When can humble top executives retain middle managers? The moderating role of top management team faultiness. *Academy of Management Journal*, 60(5), 1915-1931. <https://doi.org/10.5465/amj.2015.1072>
- Pape, G., Dong, F., & Horvath, Z. (2018). Assessing the professional identify of dental school faculty: An exploratory study. *Journal of Dental Education*, 82(11), 1140-1145. <https://doi.org/10.21815.jde.018.117>
- Rahim, M. A. (1995). A comparative study of entrepreneurs and managers: Stress, burnout, locus of control, and social support. *Journal of Health and Human Services Administration*, 18(1), 68-89.
- Raina, R., & Chauhan, R. (2016). Organizational socialization & work related attitudes in India's uncertainty culture. *Indian Journal of Industrial Relations*, 52(2), 279-292.
- Rego, A., Godinho, L., McQueen, A., & Cunha, M. (2010). Emotional intelligence and caring behavior in nursing. *Service Industries Journal*, 30(9), 1419-1437. <https://doi.org/10.1080/02642060802621486>

- Reina, C., Rogers, K., Peterson, S., Byron, K., & Hom, P. (2018). Quitting the boss? The role of manager influence tactics and employee emotional engagement in voluntary turnover. *Journal of Leadership & Organizational Studies*, 25(1), 5-18. <https://doi.org/10.1177/1548051817709007>
- Rosso, B. D., Dekas, K. H., & Wrzesniewski, A. (2010). On the meaning of work: A theoretical integration and review. *Research in Organizational Behavior*, 30(1), 91-127. <https://doi.org/10.1016/j.riob.2010.09.001>
- Saksvik, L. I., Bjorvatn, B., Magerøy, N., & Pallesen, S. (2016). Hardiness, psychosocial factors and shift work tolerance among nurses—A 2-year follow-up study. *Journal of Advanced Nursing*, 72(8), 1800-1812. <https://doi.org/10.1111/jan.12951>
- Salim, J., Wadey, R., & Diss, C. (2016). Examining hardiness, coping and stress-related growth following sport injury. *Journal of Applied Sport Psychology*, 28(2), 154-169. <https://doi.org/10.1080/10413200.2015.1086448>
- Salyers, M. P., Bonfils, K. A., Luther, L., Firmin, R. L., White, D. A., Adams, E. L., & Rollins, A. L. (2017). The relationship between professional burnout and quality and safety in healthcare: A meta-analysis. *Journal of General Internal Medicine*, 32(4), 475-482. <https://doi.org/10.1007/s11606-016-3886-9>
- Schutte, N., Toppinen, S., Kalimo, R., & Schaufeli, W. (2000). The factorial validity of the Maslach burnout inventory-general survey (MBI-GS) across occupational groups and nations. *Journal of Occupational & Organizational Psychology*, 73(1), 53-66. <https://doi.org/10.1348/096317900166877>

- Schwartz, B. (2000). Self-determination: The tyranny of freedom. *American Psychologist*, 55(1), 79-88. <https://doi.org/10.1037/0003-066X.55.1.79>
- Shanafelt, T., Hasan O., Dyrbye L., Sinsky C., Satele D., Sloan J., & West C. (2015). Changes in burnout and satisfaction with work–life balance in physicians and the general US working population between 2011 and 2014. *Mayo Clinic Proceedings*, 90(12), 1600-1613. <https://doi.org/10.1016/j.mayocp.2015.08.023>
- Shariro, D., Hom, P., Shen, W., & Agarwal, R. (2016). How do leader departures affect subordinates' organization attachment? A 360-degree relational perspective. *Academy of Management Review*, 41(3), 479-502. <https://doi.org/10.5465/amr.2014.0233>
- Sheard, M., & Golby, J. (2007). Hardiness and undergraduate academic study: The moderating role of commitment. *Personality and Individual Differences*, 43(3), 579-588. <https://doi.org/10.1016/j.paid.2007.01.006>
- Shemdoe, A., Mbaruku, G., Dillip, A., Bradley, S., William, J., Wason, D., & Hildon, Z. J. (2016). Explaining retention of healthcare workers in Tanzania: Moving on, coming to 'look, see and go', or stay? *Human Resources for Health*, 14(2), 1-13. <https://doi.org/10.1186/s12960-016-0098-7>
- Singh, A. P., Amish, S., & Singhi, N. (2015). Organizational role stress and social support as predictors of job satisfaction among managerial personnel. *Journal of Psychosocial Research*, 10(1), 1-10.
- Skagert, K., Dellve, L., & Ahlborg, G. (2012). A prospective study of managers' turnover and health in a healthcare organization. *Journal of Nursing Management*, 20(7), 889-899. <https://doi.org/10.1111/j.1365-2834.2011.01347.x>

- Srivastava, S. C., Chandra, S., & Shirish, A. (2015). Technostress creators and job outcomes: Theorising the moderating influence of personality traits. *Information Systems Journal*, 25(4), 355-401. <https://doi.org/10.1111/isj.12067>
- Stater, K. J., & Stater, M. (2019). Is it “just work”? The impact of work rewards on job satisfaction and turnover intent in the nonprofit, for-profit, and public sectors. *American Review of Public Administration*, 49(4), 495-511. <https://doi.org/10.1177/0275074018815261>
- Stewart, C., Nodoushani, O., & Stumpf, J. (2018). Cultivating employees using Maslow’s hierarchy of needs. *Competition Forum*, 16(2), 67-75.
- Szigeti, R., Balázs, N., Bikfalvi, R., & Urbán, R. (2017). Burnout and depressive symptoms in teachers: Factor structure and construct validity of the Maslach burnout inventory-educators survey among elementary and secondary school teachers in Hungary. *Stress & Health: Journal of the International Society for the Investigation of Stress*, 33(5), 530-539. <https://doi.org/10.1002/smi.2737>
- Taylor, M., Pietrobon, R., Taverniers, J., Leon, M., & Fern, B. (2013). Relationships of hardiness to physical and mental health status in military men: A test of mediated effects. *Journal of Behavioral Medicine*, 36(1), 1-9. <https://doi.org/10.1007/s10865-011-9387-8>
- Toros, T., Dereceli, Ç., & Barut, A. I. (2017). Examination of the burnout levels of basketball players in terms of gender, age and experience. *Journal of Education and Training Studies*, 5(12), 155-161. <https://doi.org/10.11114/jets.v5i12.2817>

- Udod, S. & Care, W. (2012). Nurse managers' work stressors and coping experiences: unravelling the evidence. *Nursing Leadership, 24*(3), 57-72. <https://doi.org/10.12927/cjnl.2011.222601>
- U.S. Bureau of Labor Statistics. (2009). Economic news release. Retrieved from [https://www.bls.gov/news.release/archives/empsit\\_02062009.pdf](https://www.bls.gov/news.release/archives/empsit_02062009.pdf)
- U.S. Bureau of Labor Statistics. (2018). Economic news release. Retrieved from <https://www.bls.gov/news.release/jolts.t16.htm>
- U.S. Bureau of Labor Statistics. (2019). Economic news release. Retrieved from <https://www.bls.gov/news.release/pdf/empsit.pdf>
- U.S. Centers for Disease Control and Prevention. (2015). National ambulatory medical care survey: 2015 Summary tables. Retrieved from [https://www.cdc.gov/nchs/data/ahcd/namcs\\_summary/2015\\_namcs\\_web\\_tables.pdf](https://www.cdc.gov/nchs/data/ahcd/namcs_summary/2015_namcs_web_tables.pdf)
- Van Beek, I., Hu, Q., Schaufeli, W., Taris, T., & Schreurs, B. (2012). For fun, love, or money: What drives workaholic, engaged, and burned-out employees at work? *Applied Psychology: An International Review, 61*(1), 30-55. <https://doi.org/10.1111/j.1464-0597.2011.00454.x>
- Van der Heijden, B., Mahoney, C. B., & Xu, Y. (2019). Impact of job demands and resources on nurses' burnout and occupational turnover intention towards an age-moderated mediation model for the nursing profession. *International Journal of Environmental Research and Public Health, 16*(11), 1-22. <https://doi.org/10.3390/ijerph16112011>

- Van der Heijden, B., Peeters, M., Blanc, P., & Van Breukelen, J. (2018). Job characteristics and experience as predictors of occupational turnover intention and occupational turnover in the European nursing sector. *Journal of Vocational Behavior, 108*(1), 108-120. <https://doi.org/10.1016/j.jvb.2018.06.008>
- Wagaman, M. A., Geiger, J. M., Shockley, C., & Segal, E. A. (2015). The role of empathy in burnout, compassion satisfaction, and secondary traumatic stress among social workers. *Social Work, 60*(3), 201-209. <https://doi.org/sw/swv014>
- Waldman, J. D., Kelly, F., Arora, S., & Smith, H. L. (2010). The shocking cost of turnover in health care. *Health Care Management Review, 35*(3), 206-211. <https://doi.org/10.1097/HMR.0b013e3181e3940e>
- Wells, W., & Hejna, W. (2009). Developing leadership talent in healthcare organizations. *Healthcare Financial Management, 63*(1), 66-69.
- Weng, Q., Wu, S., McElroy, J. C., & Chen, L. (2018). Place attachment, intent to relocate and intent to quit: The moderating role of occupational commitment. *Journal of Vocational Behavior, 108*(1), 78-91. <https://doi.org/10.1016/j.jvb.2018.06.002>
- Westman, M. (1990). The relationship between stress and performance: The moderating effect of hardiness. *Human Performance, 3*(3), 141-155. [https://doi.org/10.1207/s15327043hup0303\\_1](https://doi.org/10.1207/s15327043hup0303_1)
- Wieser, R., & Thiel, H. (2014). A survey of “mental hardiness” and “mental toughness” in professional male football players. *Chiropractic & Manual Therapies, 22*(1), 1-14. <https://doi.org/10.1186/2045-709X-22-17>

- Wombacher, J. C., & Felfe, J. (2017). Dual commitment in the organization: Effects of the interplay of team and organizational commitment on employee citizenship behavior, efficacy beliefs, and turnover intentions. *Journal of Vocational Behavior, 102*, 1-14. <https://doi.org/10.1016/j.jvb.2017.05.004>
- Wong, C. A., & Laschinger, H. K. S. (2015). The influence of frontline manager job strain on burnout, commitment and turnover intention: A cross-sectional study. *International Journal of Nursing Studies, 52*(12), 1824-1833. <https://doi.org/10.1016/j.ijnurstu.2015.09.006>
- Wright, K. B., Abendschein, B., Wombacher, K., O'Connor, M., Hoffman, M., Dempsey, M., . . . Shelton, A. (2014). Work-related communication technology use outside of regular work hours and work life conflict: The influence of communication technologies on perceived work life conflict, burnout, job satisfaction, and turnover intentions. *Management Communication Quarterly, 28*(4), 507-530. <https://doi.org/10.1177/0893318914533332>
- Wright, T. A., & Hobfoll, S. E. (2004). Commitment, psychological well-being and job performance: An examination of conservation of resources (COR) theory and job burnout. *Journal of Business and Management, 9*(4), 389-406.
- Wu, G., Wu, Y., Li, H., & Dan, C. (2018). Job burnout, work-family conflict and project performance for construction professionals: The moderating role of organizational support. *International Journal of Environmental Research and Public Health, 15*(12), 1-20. <https://doi.org/10.3390/ijerph15122869>

- Yang, F., Li, X., Zhu, Y., Li, Y., & Wu, C. (2017). Job burnout of construction project managers in China: A cross-sectional analysis. *International Journal of Project Management*, 35(7), 1272-1287. <https://doi.org/10.1016/j.ijproman.2017.06.005>
- Zhai, Q., Lindorff, M., & Cooper, B. (2013). Workplace *guanxi*: Its dispositional antecedents and mediating role in the affectivity-job satisfaction relationship. *Journal of Business Ethics*, 117(3), 541-551. <https://doi.org/10.1007/s10551-012-1544-7>
- Zis, P., Anagnostopoulos, F., & Sykioti, P. (2014). Burnout in medical residents: A study based on the job demands-resources model. *Scientific World Journal*, 2014(1), 1-10. <https://doi.org/10.1155/2014/673279>

## APPENDICES

## APPENDIX A

### **Participant Invitation Letter/Informed Consent**

Dear Invitee,

My name is Shua Joyce Moua and I am a doctoral student at California Baptist University's Doctorate in Business Administration Program. I am kindly requesting your participation in a doctoral research study titled "Job Related Attitudes Among U.S. Healthcare Managers." This survey is independent of and not related to the healthcare organization in any way, participation is voluntary and should be completed off hours. Having said that, facility leaders and the healthcare organization's IRB has approved offering participation in the survey to this limited pool of individuals, consistent with other research studies.

The purpose of the research is to determine how managers perceive their role in the organization. Results of the study will be summarized and presented in a dissertation and may be presented in a journal for publication. Responses will be completely anonymous, and your identity will not be linked to this survey in any way.

If you decide to participate in the study, please click on the link to the survey here: <https://www.surveymzmo.com/s3/5203619/Job-Related-Attitudes-Among-U-S-Healthcare-Managers>. The survey should take you no more than 20 minutes to complete and contains a series of 35 questions along with 8 demographic questions. You will only need to take the survey once and it can be taken from any computer that has internet. If you do not wish to participate, simply discard this email. The survey will be available for the next 3 weeks upon which the survey period will close, and data will be sent to the researcher. The researcher will then analyze all responses for the purpose of the study.

There are no known major risks to your participation to this research study although it may inconvenience you to fill out the survey. Again, it should take about 20 minutes of your time. There are no major benefits to you for your participation, but a potential benefit would be to assist in the research to help better the understanding into the role of management in a healthcare organization.

Records of all information that you provide for the purpose of the research and identifying information will not be linked in any way. There are no possibilities to identify you as the person who provided specific information for the study. You are one of approximately 120 participants being contacted for the purpose of this research study.

You are encouraged to ask questions at any time, should it help you understand how this study will be performed and/or how it will affect you. You may contact the principal investigator, Shua Joyce Moua (xxxxx@xxxxx.xxx) or the investigator's faculty advisor, Dr. Dunbar (xxxxx@xxxxx.xxx) at any time. If you have questions or concerns about this study or your rights as a study participant, you may contact the University at 877-228-3615. If you should feel any discomfort, you may also call the Mental Health 24-Hour Crisis Line at 888-881-4881.

**Completing and returning the survey constitutes your consent to participate.**

**Please keep this letter for your records.**

Thank you for your assistance in this very important endeavor!

Kind Regards,

Shua Joyce Moua

## APPENDIX B

### Survey Instrument

#### MBI-General Survey Sample Survey

Instructions: On the following pages are 16 statements of job-related feelings. Please read each statement carefully and decide if you ever feel this way about your job. If you have never had this feeling, select the Never option. If you have had this feeling, indicate how often you feel it by selecting the phrase that best describes how frequently you feel that way.

---

	Almost never	Rarely	Sometimes	Often	Very Often	Always
0	1	2	3	4	5	6
Never	A few times a year or less	Once a month or less	A few times a month	Once a week	A few times a week	Everyday

---

1. I feel emotionally drained from my work.
2. I feel used up at the end of the workday.
3. I feel tired when I get up in the morning and have to face another day on the job.
4. Working all day is really a strain for me.
5. I can effectively solve the problems that arise in my work.
6. I feel burned out from my work.
7. I feel I am making an effective contribution to what this organization does.
8. I have become less interested in my work since I started this job.
9. I have become less enthusiastic about my work.
10. In my opinion, I am good at my job.
11. I feel exhilarated when I accomplish something at work.
12. I have accomplished many worthwhile things in this job.
13. I just want to do my job and not be bothered.
14. I have become more cynical about whether my work contributes anything.
15. I doubt the significance of my work.
16. At my work, I feel confident that I am effective at getting things done.

### Hardiness Scale

In this section, please answer each statement about your life. Read through each statement give your honest opinion with 1 being Not at all true and 4 being Completely true. There are no right or wrong answers.

---

1	2	3	4
Not at all true	A little true	Often times true	Completely True

---

17. Most of my life gets spent doing things that are worthwhile.
18. Planning ahead can help me avoid most future problems.
19. I do not like to make changes in my every day schedule.
20. Working hard does not matter since only the boss's profit by it.
21. Changes in my routine are interesting to me.
22. By working hard, you can always achieve your goals.
23. I look forward to my work.
24. If I am working on a difficult task, I know when to ask for help.
25. Most of the time people listen carefully to what I say.
26. Trying your best at work pays off in the end.
27. It bothers me when my daily routine gets interrupted.
28. Most days, my life is really interesting and exciting.
29. I enjoy the challenge when I have to multitask or do more than one thing a time.
30. I like having a schedule that does not change very much.
31. When I make a plan, I know I can make it work.

**Michigan Organizational Assessment Questionnaire Job Satisfaction Subscale**

Please use the following rating scale to indicate the extent to which you agree or disagree with the following statements with 1 being Strongly Disagree and 5 being Strongly Agree.

1	2	3	4	5
Strongly Disagree	<u>Disagree</u>	Neither agree nor disagree	Agree	Strongly Agree

32. All in all, I am satisfied with my job.

33. In general, I don't like my job.

34. In general, I like working here.

35. I will probably be looking for a new job in the next year.

36. I often think about quitting.

|

**Demographic Information**

Please let us know a little more about yourself.

Your Age:	1 – 18 to 25 2 – 26 to 35 3 – 36 to 45 4 – 46 to 55 5 – 56+
Your Gender:	1 – Female 2 – Male
Current Tenure in the company:	1 – Less than 6 months 2 – 6 months to 1 year 3 – 1 to 2 years 4 – 3 to 5 years 5 – 6 to 7 years 6 – 9 to 10 years 7 – More than 11 years +
Your Highest Educational Level:	1 – High School 2 – Associates Degree or Technical Degree 3 – Bachelor's Degree 4 – Master's Degree 5 – Post-Graduate Degree 6 – Doctorate Degree
Your Employment Status:	1 – Full Time 2 – Part Time

Your Position Title:	1 – Supervisor 2 – Assistant Manager 3 – Manager 4 – Director 5 – Executive
The Average Number of Hours worked weekly:	1 – 20 hours or less 2 – 21 hours to 30 hours 3 – 31 hours to 40 hours 4 – 41 hours to 50 hours 5 – 51 hours +

## APPENDIX C

### **Reminder E-Mail to Participants/Informed Consent**

Dear Invitee,

My name is Shua Joyce Moua and I am a doctoral student at California Baptist University's Doctorate in Business Administration Program. I previously sent an email requesting your participation in a doctoral research study titled "Job Related Attitudes Among U.S. Healthcare Managers." This survey is independent of and not related to the healthcare organization in any way, participation is voluntary and should be completed off hours. Having said that, facility leaders and the healthcare organizations' IRB has approved offering participation in the survey to this limited pool of individuals, consistent with other research studies.

The survey is open for another week and I am kindly requesting your consideration to participate in this study. The purpose of the research is to determine how managers perceive their role in the organization Results of the study will be summarized and presented in a dissertation and may be presented in a journal for publication. Responses will be completely anonymous, and your identity will not be linked to this survey in any way.

If you decide to participate in the study, please click on the link to the survey here: <https://www.surveymzmo.com/s3/5203619/Job-Related-Attitudes-Among-U-S-Healthcare-Managers>. The survey should take you no more than 20 minutes to complete and contains a series of 35 questions along with 8 demographic questions. You will only need to take the survey once and it can be taken from any computer that has internet. If you do not wish to participate, simply discard this email. The survey will be available for

the next 2 weeks upon which the survey period will close, and data will be sent to the researcher. The researcher will then analyze all responses for the purpose of the study.

There are no known major risks to your participation to this research study although it may inconvenience you to fill out the survey. Again, it should take about 20 minutes of your time. There are no major benefits to you for your participation, but a potential benefit would be to assist in the research to help better the understanding into the role of management in a healthcare organization.

Records of all information that you provide for the purpose of the research and identifying information will not be linked in any way. There are no possibilities to identify you as the person who provided specific information for the study. You are one of approximately 120 participants being contacted for the purpose of this research study.

You are encouraged to ask questions at any time, should it help you understand how this study will be performed and/or how it will affect you. You may contact the principal investigator, Shua Joyce Moua (xxxxx@xxxxx.xxx) or the investigator's faculty advisor, Dr. Dunbar (xxxxx@xxxxx.xxx) at any time. If you have questions or concerns about this study or your rights as a study participant, you may contact the University at 877-228-3615. If you should feel any discomfort, you may also call the Mental Health 24-Hour Crisis Line at 888-881-4881.

**Completing and returning the survey constitutes your consent to participate.**

**Please keep this letter for your records.**

Thank you for your assistance in this very important endeavor!

Kind Regards,

Shua Joyce Moua

APPENDIX D

Tables

Table D1

*Demographic Frequency*

Variable <sup>a</sup>	<i>N</i>	Percentage
Age		
18 to 25	0	0
26 to 35	14	14.7
36 to 45	42	44.2
46 to 55	29	30.5
56+	10	10.5
Gender		
Females	51	53.7
Males	44	46.3
Tenure		
Less than 6 months	2	2.1
1 to 2 years	7	7.4
3 to 5 years	30	31.6
6 to 8 years	21	22.1
9 to 10 years	11	11.6
11+years	24	25.3
Education		
High School	9	9.5
Associates degree	16	16.8
Bachelor's degree	41	43.2
Master's degree	25	26.3
Postgraduate degree	3	3.2
Doctoral degree	1	1.1
Employment		
Full time	94	98.9
Part time	1	1.1
Position		
Supervisor	44	46.3
Assistant manager	10	10.5
Manager	30	31.6
Director	6	6.3
Executive	5	5.3
Hours worked		
31 hours to 40 hours	15	15.8
41 hours to 50 hours	50	52.6
51 hours +	30	31.6

<sup>a</sup> (*N* = 95).

Table D2

*Distribution of Scores in the Study Variables*

Variable	Minimum Feb 2019 (seasonally adjusted)	Maximum	SD mean	Skewness		Kurtosis	
				Statistic	Std. error	Statistic	Std. error
Overall exhaustion	0	27	13.37	.17	.25	-.50	.49
Overall cynicism	17	36	30.57	-1.1	.25	1.53	.49
Overall feelings of inefficacy	0	27	8.81	.81	.25	1.14	.49
Overall burnout	35	76	52.75	.50	.25	.02	.49
Overall hardiness	33	51	40.32	.69	.25	1.7	.49
Overall intent to turnover	11	20	14.57	.50	.25	.15	.49

Table D3

*Pearson Correlation Coefficients (n = 95)*

	1	2	3	4	5
1. Exhaustion	-	-.302**	.539**	-.155	.216*
2. Cynicism		-	-.557**	.423**	-.185
3. Inefficacy			-	-.295**	.362**
4. Hardiness				-	-.156
5. Intent to turnover					-

\*\* . Correlation is significant at the 0.01 level (2-tailed).

\* . Correlation is significant at the 0.05 level (2-tailed).

Table D4

*Correlations Matrix by Gender (Female: N = 51, Male: N = 44)*

	Exhaustion	Cynicism	Inefficacy	Hardiness	Turnover
FEMALE Exhaustion	-	-.479**	.661**	-.316*	.202
Cynicism		-	-.620**	.423**	-.145
Inefficacy			-	-.323*	.450**
Hardiness				-	-.086
Intent to turnover					-
MALE Exhaustion	-	-.058	.337*	.070	.242
Cynicism		-	-.475**	.419**	-.236
Inefficacy			-	-.258	.233
Hardiness				-	-.242
Intent to turnover					-

\*\* . Correlation is significant at the 0.01 level (2-tailed).

\* . Correlation is significant at the 0.05 level (2-tailed).

Table D5

*Mean Scores of Burnout, Hardiness, and Intent to Turnover*

	<i>N</i>	Minimum	Maximum	Mean	Std. deviation
Overall exhaustion	95	0	27	13.37	5.918
Overall cynicism	95	17	36	30.57	3.744
Overall inefficacy	95	0	27	8.81	5.219
Overall mental hardiness	95	33	51	40.32	2.997
Intent to turnover	95	11	20	14.57	1.635

Table D6

*Summary of Multiple Regression*

<b>Model Summary</b>									
Model	<i>R</i>	<i>R</i> <sup>2</sup>	Adjusted <i>R</i> <sup>2</sup>	Std. error of the estimate	Change statistics				
					<i>R</i> <sup>2</sup> change	<i>F</i> change	<i>df</i> 1	<i>df</i> 2	Sig. <i>F</i> change
1	.244 <sup>a</sup>	.059	.028	1.612	.059	1.915	3	91	.133
2	.422 <sup>c</sup>	.178	.112	1.541	.108	3.799	3	87	.013

<b>ANOVA<sup>a</sup></b>						
Model		Sum of squares	<i>df</i>	Mean square	<i>F</i>	Sig.
1	Regression	14.920	3	4.973	1.915	.133 <sup>b</sup>
	Residual	236.385	91	2.598		
	Total	251.305	94			
2	Regression	44.821	7	6.403	2.698	.014 <sup>c</sup>
	Residual	206.484	87	2.373		
	Total	251.305	94			

Model		<i>B</i>	<i>SE</i>	$\beta$	<i>t</i>	Sig.
1	Gender	.071	.335	.022	.213	.832
	2	Gender	.022	.324	.007	.068
2	Hardiness	-.026	.060	-.048	-.440	.661
	Exhaustion	.021	.033	.076	.645	.521
	Cynicism	.034	.055	.079	.625	.534
	Feelings of Inefficacy	.103	.042	.329	2.458	.016

a. Dependent variable: Intent to turnover.

b. Predictors in the model: (Constant), gender.

c. Predictors in the model: (Constant), gender, hardiness, exhaustion, cynicism, feelings of inefficacy.

Table D7

*Two-Sample t Test of Age Groups and Independent Variables*

Dependent variable	(I) Age	(J) Age	Mean difference (I-J)	Std. error	Sig.	95% confidence interval	
						Lower bound	Upper bound
EXHAUSTION	26 to 35	36 to 45	-.286	1.848	.999	-5.12	4.55
		46 to 55	-1.286	1.949	.912	-6.39	3.82
		56+	-1.286	2.480	.954	-7.78	5.20
	36 to 45	46 to 55	-1.000	1.446	.900	-4.78	2.78
		56+	-1.000	2.108	.965	-6.52	4.52
		46 to 55	56+	.000	2.197	1.000	-5.75
CYNICISM	26 to 35	36 to 45	-1.690	1.144	.455	-4.68	1.30
		46 to 55	-2.039	1.206	.334	-5.20	1.12
		56+	-3.243	1.534	.157	-7.26	.77
	36 to 45	46 to 55	-.349	.895	.980	-2.69	1.99
		56+	-1.552	1.304	.634	-4.97	1.86
		46 to 55	56+	-1.203	1.359	.812	-4.76
INEFFICACY	26 to 35	36 to 45	.738	1.617	.968	-3.49	4.97
		46 to 55	.818	1.705	.963	-3.65	5.28
		56+	3.114	2.170	.481	-2.56	8.79
	36 to 45	46 to 55	.080	1.265	1.000	-3.23	3.39
		56+	2.376	1.844	.572	-2.45	7.20
		46 to 55	56+	2.297	1.922	.632	-2.73
HARDINESS	26 to 35	36 to 45	-.619	.898	.901	-2.97	1.73
		46 to 55	-.219	.947	.996	-2.70	2.26
		56+	-3.157	1.205	.050*	-6.31	.00
	36 to 45	46 to 55	.400	.702	.941	-1.44	2.24
		56+	-2.538	1.024	.070	-5.22	.14
		46 to 55	56+	-2.938	1.067	.035*	-5.73
INTENT TO TURNOVER	26 to 35	36 to 45	.119	.494	.995	-1.17	1.41
		46 to 55	.480	.521	.793	-.88	1.84
		56+	1.529	.662	.104	-.21	3.26
	36 to 45	46 to 55	.361	.386	.786	-.65	1.37
		56+	1.410	.563	.066	-.06	2.88
		46 to 55	56+	1.048	.587	.286	-.49

<sup>a</sup>(N = 95).

\*Correlation is significant at the 0.05 level.

Table D8

*Moderating Relationships Between Study Variables*

Variable	Pearson's coefficient	Strength Feb 2019 (seasonally adjusted)
<b>Age</b>		
Emotional exhaustion and hardiness among ancillary managers aged 26-35 is related.	-.620	Strong
Cynicism and hardiness for ancillary managers aged 46-55 years is related.	.573	Strong
Feelings of inefficacy and hardiness for ancillary managers aged 46-55 years is related.	.540	Strong
Emotional exhaustion and intent to turnover for ancillary managers aged 46-55 years is related.	.384	Medium
Cynicism and intent to turnover for ancillary managers aged 36-45 years is related.	.454	Medium
Feelings of inefficacy and intent to turnover for ancillary managers aged 36-45 years is related	.512	Strong
<b>Gender</b>		
Emotional exhaustion and hardiness of female ancillary managers are related.	-.155	Weak
Feelings of inefficacy and hardiness are related for female ancillary managers.	-.323	Medium
Emotional exhaustion and intent to turnover are related directly, they do not differ based on gender.	.000	Weak
Feelings of inefficacy and intent to turnover are significantly related only for females.	.450	Medium

Table D9

*Hierarchical Regression Analysis for Intent to Turnover*

Variables	Model 1		Model 2	
	<i>B</i>	<i>SE B</i>	<i>B</i>	<i>SE B</i>
<i>Block 1</i>				
Gender	.071	.335	.022	.324
<i>Block 2</i>				
Hardiness	-	-	-.026	.060
Exhaustion	-	-	.021	.033
Cynicism	-	-	.034	.055
Feelings of inefficacy	-	-	.103*	.042
<i>Block 3</i>				
Constant	.244		.422	
Adjusted R <sup>2</sup>	.028		.112	
<i>F</i> change	1.915		3.799	

\* $p \leq .05$ .