Nurses as Caregivers:
Identifying some Negative Aspects of Caregiving

by

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Honors Project

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Abstract

Communion is a focus on others and involves helping and caring for others and being attuned to others' feelings. By contrast, unmitigated communion is an extreme focus on others to the neglect of the self. The goal of the present study was to explore communion and unmitigated communion in a caregiving population where the benefits and hazards of an orientation towards others might be observed. A total of 61 nurses, 56 of whom were women, were interviewed for 30 minutes by phone or in person. The following traits were measured: unmitigated communion, communion, agency, self-esteem, externalized self-perception, feelings when help is rejected, anger, depression, and job distress. It was hypothesized that unmitigated communion would be associated with low self-esteem, externalized self perception, negative feelings about the self when others rejected help, holding anger in, depression, job distress, and intrusive thoughts about patients. Communion was not expected to be related to any of these outcomes. Results largely confirmed these hypotheses. Unmitigated communion was related to more distress in general, but not necessarily job distress. By contrast, communion was related to reduced job distress. Both unmitigated communion and communion were related to being distressed by intrusive thoughts about a specific patient, but only unmitigated communion was associated with having intrusive thoughts about patients in general. Thus, communion is associated with a concern for others, but not an involvement with others that causes negative effects on nurses' well-being. The degree of overinvolvement and self-sacrifice that is characteristic of unmitigated communion appears to be the root of the negative health effects experienced by these people.

Nurses as caregivers:

Identifying some negative aspects of caregiving

In general, people associate positive consequences with helping and caregiving behavior. However, research has shown that there can be both positive and negative consequences to helping that are reflective of personality traits that the helper possesses. There are two basic personality traits that reflect a concern for others. The first of these is communion, a term introduced by Bakan (1966) that focuses on a connection with others. Communion is a focus on others and involves helping and caring for others and being attuned to others' feelings. Communion is considered a positive focus on others because it has been linked to many positive outcomes reflecting people's ability to connect with others, such as increased marital satisfaction (Antill, 1983), satisfying relationships (Helgeson, 1993), and reduced loneliness (Wheeler, Reis, & Nezlek, 1983). In addition to communion, agency, or a focus on the self, is required for optimal well-being (Bakan, 1966). Bakan (1966) suggested that the communal orientation should be mitigated by some focus on the self. Communion in the absence of agency may result in unmitigated communion. Unmitigated communion is a focus on others to the neglect of the self and is associated with negative health outcomes. Those possessing unmitigated communion tend to help others at their own expense (Helgeson, 1994).

Although unmitigated communion and communion both reflect a concern for and focus on others and are modestly positively correlated (Helgeson, 1994; Helgeson & Fritz, 1996), there are several characteristics that distinguish the two. Unmitigated communion is associated with a negative view of the self and is characterized by an overinvolvement in others' problems to enhance others' views of themselves. Unmitigated communion is also associated with discomfort upon receiving support from others and a desire for others to take one's advice (Fritz & Helgeson, in press).

More specifically, unmitigated communion is associated with low self esteem (Helgeson & Fritz, in press). Fritz and Helgeson (in press) suggest that people high in

unmitigated communion have a low regard for the self and turn to their social environment for self-esteem. Helgeson, Richardson, and Fritz (1997) found that unmitigated communion was associated with a high fear of negative evaluation. A combination of basing one's self perception on others, known as an externalized self perception, and perceiving that others do not value the self suggests why unmitigated communion is related to low self-esteem (Helgeson & Fritz, in press; Fritz & Helgeson, in press).

Those high in unmitigated communion engage in maladaptive behaviors in order to enhance their self-worth in the eyes of others (Fritz & Helgeson, in press). Unmitigated communion is associated with feeling uncomfortable receiving support and feeling bad about the self when others reject one's advice or support (Helgeson & Fritz, in press). These individuals help to an extreme and are not only overly nurturant , but have intrusive thoughts about others' problems. In two studies, Fritz and Helgeson (in press) showed that those high in unmitigated communion have intrusive thoughts not only about a close friend's problems, but about a stranger's problems as well. In the first study, female college students were exposed to a stranger (confederate) discussing a problem and then contacted two days later to see if they were distressed about the problem. Unmitigated communion was associated with greater distress upon hearing a stranger disclose a problem as well as more intrusive thoughts about that stranger's problem two days later (Fritz & Helgeson, Study 3, in press). In a replication of that study with friends, unmitigated communion was again associated with intrusive thoughts about a friend's problem two days later (Fritz & Helgeson, Study 4, in press).

Even more compelling are findings which show that unmitigated communion is associated with poor health. A study of cardiac patients demonstrated that unmitigated communion was associated with increased psychological distress and poor health outcomes (Helgeson, 1993). Similarly, in a study of adolescents with diabetes, unmitigated communion was associated with increased psychological distress and poor metabolic control (Helgeson & Fritz, 1996). In a study of adolescents, Gore, Aseltine, and Colten

(1993) found that a tendency to get overinvolved in others' problems, a feature of unmitigated communion, was associated with greater depression. Those characterized by unmitigated communion may be more susceptible to depression and despair (Malley & Stewart, 1988; Stewart & Malley, 1987; Stewart & Salt, 1981). None of these views or behaviors are reflective of communion. Therefore, unmitigated communion can be considered an unhealthy focus on others to the exclusion of the self (Helgeson & Fritz, 1996).

An interesting population in which to study unmitigated communion is nursing. Nursing is a profession in which helping behavior plays a prominent role. Compared to other professions, it may attract a high number of unmitigated communion individuals. This study examines the nursing population in order to examine the negative as well as the positive aspects of caregiving.

Some negative aspects of caregiving are job burnout and job distress. Nurses are especially vulnerable to burnout (Maslach & Jackson, 1982) because of a variety of stressors such as work overload, low job status, lack of control within the job setting, lack of criteria for measuring accomplishment, lack of feedback and support, and ambiguity and uncertainty about professional roles (Cherniss, 1980; Jayaratne & Chess, 1983; Maslach, 1978; Maslach & Jackson, 1981; Motowildo, Packard, & Manning, 1986; Wills, 1978).

In addition, the emotional burden of nurses is high, including feelings of failure to respond to patients' needs and frustration to be of real help to the patient (Berlin, Ray, Nichols, & Perritt, 1987). There have been studies on nurses that show that those low in communal orientation tend to have burnout symptoms more often than those high in communal orientation (VanYperen, et al., 1992). That study defined a communal orientation as the desire to give and receive benefits in response to others' needs. Unmitigated communion was not examined in that study. We hypothesize that nurses high in unmitigated communion will experience burnout more often than those low in

unmitigated communion because such people have one-sided relationships. They give without desiring receipt. In addition, they are vulnerable to distress when exposed to others' problems. We expect nurses high in unmitigated communion to experience intrusive thoughts about their patients, which could be related to burnout syndrome.

This study focuses on the differences between communion and unmitigated communion in regard to personality traits, depression, and job stress. It is expected that those high in unmitigated communion will have lower self-esteem, an externalized self-perception, negative feelings about the self when others reject help, internalize anger, higher depressive symptoms, and increased job stress compared to those low in unmitigated communion.

To test more specific ideas about unmitigated communion and caregiving, we considered who these people would help, if they would ever avoid helping, and what type of helping situation would be most distressing. We created scenarios about patients who needed help and manipulated two variables, whether the nurse could help or not and whether their help was recognized or not. The ability to help was manipulated by whether medication was available to reduce the patient's pain. Help recognition was manipulated by whether the patient, a stroke victim, could still recognize people. We predicted that those high in unmitigated communion would be more likely to help when their help was recognized and that they would avoid situations and experience distress when their help was not recognized. We predicted that both high unmitigated communion and high communion individuals would be more distressed and more likely to avoid situations when they could not help the patient.

Method

Participants

A total of 61 nurses were interviewed, 56 of whom were women (91.8%). The mean age of participants was 39 years old, and the age range was from 23 to 58 years old.

The marital status of the participants was as follows: 42.6% married, 29.5% single, 21.3% divorced, 4.9% separated, and 1.6% widowed.

Participants were recruited by mailing fliers to 500 nurses at Shadyside Hospital in Pittsburgh, Pennsylvania. The incentive to participate in the study included a lottery with cash prizes (one $100 prize and two $50 prizes). Initial response to the mailing was extremely low. Flyers and sign-up sheets were then placed in several nurse lounges at Shadyside Hospital. Subsequently, bagels were also provided and accompanied by a sign-up sheet. These efforts were more successful and yielded 61 total nurses who volunteered to be participants.

Procedure

Nurses were told that this was a study on nurses as caregivers and that the positive and negative aspects of caregiving would be assessed through an interview by phone or in person. They were told that all answers would remain confidential and that they did not have to answer any question that made them feel uncomfortable. The majority of participants (95%) agreed to be interviewed by phone rather than in person. In these cases, verbal consent was attained over the phone. Two consent forms were mailed to the participant at the end of the interview, one to return and one to be kept by the participant . Each interview lasted approximately 30 minutes. The following variables were assessed: personality traits (unmitigated communion, communion, agency, self-esteem, externalized self-perception, feelings when help rejected), anger, distress (both in general and job-related), and feelings towards patients.

Instruments

Unmitigated communion. Unmitigated communion is defined as the extent to which someone is so focused on helping others that he/she neglects his/her own needs. A 9-item scale devised by Helgeson (1993) was used. Items on the instrument include "I always place the needs of others above my own" and "I can't say no when someone asks me for help." Participants indicated the extent to which they agreed or disagreed with each

statement on a 5-point scale. The internal consistency for the unmitigated communion scale was .72.

Communion. Communion was measured with a subscale from the Personal Attributes Questionnaire (PAQ; Spence et al., 1974). The subscale consisted of 8 items reflecting a positive orientation towards others, such as "kind," "understanding of others," and "aware of others." Each item was rated on a 5-point bipolar scale ranging from "not at all" having the attribute to "very much" having the attribute. The internal consistency in this study was .76.

Agency. Agency was measured with a subscale from the PAQ (Spence et al., 1974). The subscale consisted of 8 items reflecting a positive self-orientation, such as "independent," "competitive," and "self-confident." Each item was rated on a 5-point bipolar scale ranging from "not at all" having the attribute to "very much" having the attribute. The internal consistency in this study was .73.

Self-esteem. The 10-item Rosenberg Self-Esteem (1965) scale was used to measure self-esteem. The internal consistency in this study was .81.

Externalized self-perception. The externalized self-perception subscale from Jack and Dill's (1992) Silencing the Self Scale was used to measure the extent to which one judges the self by external standards. The 6-item scale included items such as "I tend to judge myself by how I think other people see me" and "When I make decisions, other people's thoughts and opinions influence me more than my own thoughts and opinions." Participants indicated the extent to which they agreed or disagreed with each statement on a 5-point scale. The internal consistency in this study was .82.

Feelings when help is rejected. We developed a scale to measure the extent of shame that participants felt when their help was rejected. Sample items from this 7-item scale include "How do you feel when someone ignores your advice?" and "How do you feel when a close friend or family member goes to someone else for help?" Each item was

rated on a 5-point scale ranging from 1 "does not affect how I feel" to 5 "extremely ashamed." The internal consistency for this scale was .88.

Anger. Haynes, Levine, Scotch, Feinleib, and Kannel's (1978) anger scales were used to measure how people respond to anger. This scale included three subscales: symptoms of anger, internalizing anger, and letting anger out. The anger symptoms subscale consisted of 6 items, such as "When really angry or annoyed I get a headache." The anger-in and anger-out subscales each consisted of 4 items. Sample items from these scales are, respectively, "When really angry or annoyed I try to hold it inside" and "When really angry or annoyed I yell at someone." Each item was rated on a 5-point scale ranging from 1 "not at all likely" to 5 "very likely." The internal consistency for anger symptoms was .76, for anger-in was .72, and for anger-out was .80.

Depression. The Center for Epidemiological Studies Depression (CES-D) scale was included as a measure of depression over the past week (Radloff, 1977). It consists of 20 items, each of which is rated on a scale from 0 " none of the time" to 3 "most of the time." The internal consistency was .90.

Job Distress. Job distress was measured in three ways. First, perceived job stress was measured over the past month. We used an abbreviated four-item version of Cohen, Kamarck, and Mermelstein's (1983) Perceived Stress Scale. We tailored the individual items to reflect job stress. For example, a sample item was "In the last month, how often did you feel confident about your ability to handle problems at work?" Participants responded on a 5-point scale ranging from 1 "never" to 5 "very often." The internal consistency was .65.

Second, participants were also asked about their attitudes towards their job. Participants rated how relaxed, worried, tense, content, upset, fulfilled, unhappy, and frustrated they were with their job in general. Items were rated on scales from 1 "not at all" to 5 "extremely." The internal consistency of this scale was .77. Third, participants were also asked whether they had ever felt burnt out at work and responded "yes" or "no."

Feelings toward patients. Intrusive thoughts about patients' problems in general were measured over the past few days with the 7-item subscale from the Impact of Event Scale (Horowitz, Wilner, & Alzarez, 1979). This scale measured the amount nurses thought about their patients when they did not mean to. A sample item is "Pictures about my patients and their problems popped into my mind." Items were rated on scales from 0 "not at all" to 5 "often." The internal consistency was .74.

Nurses were also asked to identify a specific patient that currently had an extremely distressing problem. Four questions were used to tap how distressed nurses were by intrusive thoughts about this specific patient. A sample question was: "How much do thoughts about Patient X interfere with your ability to think about or do other things?" Participants responded on a 5-point scale ranging from 1 "not at all" to 5 "extremely." The internal consistency was .70.

Scenarios were formulated to assess nurses' responses to different caregiving situations. There were four scenarios, each of which dealt with a patient who recently had a stroke. The extent to which the nurse could help the patient was manipulated by telling the nurse whether medication was available for the patient or not. Whether the help was recognized was manipulated by telling the nurse whether or not the patient could still recognize people due to the stroke. Thus, four scenarios were created: 1) the nurse has the ability to help the patient and their help can be recognized by the patient ; 2) the nurse does not have the ability to help the patient but their attempts to help can be recognized by the patient; 3) the nurse has the ability to help the patient and their help cannot be recognized by the patient; and 4) the nurse does not have the ability to help the patient and their attempts to help cannot be recognized by the patient. For each scenario, four questions were asked. Two questions measured distress: "How distressed would you feel about the situation?" and "How comfortable would you feel around this patient? (reverse coded)" These two questions were highly correlated within each scenario (r's = .47 to .66) and thus combined to form a single distress measure. Two additional questions were: "Given that this is a

busy day for you, how likely would you be to volunteer to take care of this patient?" and "How likely would you be to avoid the situation?" Participants responded to each question on a 5-point scale ranging from 1 "not at all" to 5 "extremely." The four scenarios were interspersed throughout the entire interview.

Results

Correlations among Personality Traits

As expected, unmitigated communion was marginally positively related to communion, $r = .23$, $p = .07$. The correlations of unmitigated communion and communion to all of the other personality traits are shown in Table 1. Unmitigated communion was not related to agency, whereas communion was positively related to agency. Unmitigated communion was negatively related to self esteem, whereas communion was marginally positively related to self esteem. Unmitigated communion was associated with an externalized self perception, whereas communion was unrelated to an externalized self perception. Unmitigated communion was related to negative feelings about the self when others rejected help, however, communion was unrelated to such negative feelings. All of these results are consistent with previous findings.

Insert Table 1 about here

Correlations of Unmitigated Communion and Communion to Anger and Depression

Three categories of anger were evaluated: symptomatic anger, internalization of anger, and externalization of anger. As shown in Table 1, unmitigated communion was related to internalization of anger and marginally related to symptomatic anger. Communion was negatively related to the externalization of anger.

As predicted, unmitigated communion was associated with depression, whereas communion was unrelated to depression (see Table 1).

Correlations of Unmitigated Communion and Communion to Job Distress

The correlations of unmitigated communion and communion to job specific stress are shown in Table 2. It was expected that unmitigated communion would be positively related to perceived job stress and burnout. Unmitigated communion was unrelated to perceived job stress, but communion was marginally related to less perceived job stress. There was a weak trend for unmitigated communion to be related to burn out ($p = .12$) in regard to work, whereas communion was unrelated to burn out. Unmitigated communion was unrelated to attitudes regarding the job, whereas communion was related to fewer negative feelings regarding the job.

Insert Table 2 about here

Unmitigated communion was related to intrusive thoughts about patients in general and distress by intrusive thoughts about a specific patient. However, communion was related only to distress by intrusive thoughts regarding a specific patient.

Explanations for the Relation of Unmitigated Communion to General and Patient-Specific Distress

We sought to determine whether other personality characteristics or ways of coping with anger would account for the relation between unmitigated communion and distress--general depression and patient-specific distress. We considered the possibility that unmitigated communion individuals have greater depression because they have intrusive thoughts about their patients, they hold anger in when upset about patients, they feel symptoms of anger when upset about patients, they have a view of the self that is dependent on others, and/or they feel bad about themselves when others reject their help. Thus, we examined the extent to which the relation between unmitigated communion and depression was reduced when statistically controlling for: intrusive thoughts (general), distress by intrusive thoughts about a specific patient, internalized anger, anger symptoms,

externalized self-perception, and feelings of rejection. As shown in Table 3, internalization of anger accounted for part of the relation, but externalized self perception accounted for the entire relation.

Insert Table 3 about here

We sought to determine whether other personality characteristics or ways of coping with anger would account for the relation between unmitigated communion and intrusive thoughts about patients in general. We considered the possibility that unmitigated communion individuals have greater intrusive thoughts about their patients because they hold anger in when upset about patients, they feel symptoms of anger when upset about patients, they have a view of the self that is dependent on others, and they feel bad about themselves when others reject their help. The latter two explanations have to do with their self-esteem being dependent on helping. As shown in Table 4, the relation between unmitigated communion and intrusive thoughts about patients in general was most dramatically reduced when controlling for the internalization of anger or externalized self perception.

The relation between unmitigated communion and distress by intrusive thoughts about a specific patient could not be explained when statistically controlling for internalized anger, symptomatic anger, externalized self-perception, or feelings of rejection (see Table 5).

Insert Tables 4 & 5 about here

The Relations of Unmitigated Communion to Caregiving Scenarios

First, we examined the relation of unmitigated communion and communion to willingness to volunteer to help the patient, distress around the patient, and avoidance of

the patient, averaging across the four scenarios. Neither unmitigated communion nor communion were related to volunteering to help patients. In addition, neither unmitigated communion nor communion were related to avoiding these situations. However, unmitigated communion was related to feeling greater distress around these patients, $r = .29$, $p < .05$. Communion was not related to distress about the situations.

Two independent variables were manipulated in these scenarios, ability to help and whether help was recognized. A two-way ANOVA (help by recognition) was performed separately for people high and low in unmitigated communion to determine whether the ability to help and the recognition of help would affect high and low unmitigated communion individuals' motivation to help other people. High and low unmitigated communion groups were created by a median split on the unmitigated communion score. There was no effect of help or recognition for either high or low unmitigated communion individuals on volunteering to help the patient. For distress, there was no effect for help or recognition for low unmitigated communion individuals. However, for high unmitigated communion individuals, there was an effect of help on distress, $F(1, 31) = 4.63$, $p < .05$. As shown in Figure 1, high unmitigated communion individuals showed greater distress when they could not help than when they could help the patient. In regard to the avoidance question, no effect was found for help or recognition for low unmitigated communion individuals. For high unmitigated communion individuals, there was an interaction between help and recognition on avoidance, $F(1, 31) = 7.15$, $p < .05$. As shown in Figure 2, if help was recognized, there was little difference in high unmitigated communion individuals' avoidance of the situation whether they could help or not. However, if help could not be recognized, high unmitigated communion individuals were more likely to avoid the situation if they could not help than if they could help the patient.

Discussion

Interpersonal relationship variables are rarely studied in association with caregiver distress. This study examined the positive and negative aspects of caregiving. We have

distinguished unmitigated communion from communion in terms of personality traits, anger, depression, and job distress.

The Link of Unmitigated Communion to Specific Personality Traits

Unmitigated communion was associated with low self-esteem, externalized self-perception, and feelings of rejection, whereas communion was associated with agency and high self-esteem. People high in unmitigated communion may focus on others as a way to enhance others' views of themselves and ultimately their own view of themselves. If one's view of the self depends on others and one believes others regard the self unfavorably, the logical result is for one to regard the self unfavorably.

It is unclear whether the unmitigated communion individual's low self-esteem is what causes them to focus on others. The relation is likely to be reciprocal. A negative view of the self combined with an orientation towards others could lead to a focus on others for approval. This could, in effect, keep these individuals from developing a positive view of the self. Similarly, individuals characterized by unmitigated communion base their perception of themselves on others and perceive that others view them negatively, both of which could contribute to low self-esteem and subsequent depression.

The Link of Unmitigated Communion to Anger and Depression

Because unmitigated communion individuals focus on others for their self-worth, then it follows that they would internalize their anger so that others would not view them negatively. Unmitigated communion was not only related to internalizing anger, but also to experiencing somatic distress (e.g. headaches) when angry, which is further evidence that these individuals hold anger in. Communion, by contrast, was not related to holding anger in or having anger symptoms, but was related to less externalization of anger.

This study supports the idea that unmitigated communion individuals experience poor health effects due to their extreme focus on others. The relation between unmitigated communion and depression is consistent with previous research. When controlling for externalized self-perception the relation between unmitigated communion and depression

disappeared. When controlling for internalization of anger, the relation of unmitigated communion to depression was reduced. Thus, unmitigated communion individuals appear to be depressed because these individuals have a high concern for how others view them. Also, unmitigated communion individuals avoid expressing their anger which could lead to depression.

The Link of Unmitigated Communion to Job Distress and Intrusive Thoughts

The findings for job distress were not directly consistent with our hypotheses. There was more evidence that communion was related to less job distress and more positive attitudes about the job than there was that unmitigated communion was related to greater job distress and negative attitudes about the job. Because communion individuals have created a healthy balance between helping others and tending to their own needs, it is not surprising that they would have less job stress and be more likely to have positive attitudes towards their job than unmitigated communion individuals. In the future, it would be useful to investigate job burnout more thoroughly. Instead of using a simple "yes" or "no" question for job burnout, it might be more beneficial to develop a multi-item scale that taps burnout. A more reliable measure might yield a significant relation between unmitigated communion and job burnout.

Unmitigated communion was linked to having intrusive thoughts about patients in general, but communion was not. We know from previous research that unmitigated communion individuals take on others' problems as their own (Fritz & Helgeson, in press). When controlling for the internalization of anger and externalized self-perception the relation between unmitigated communion and intrusive thoughts about patients in general was diminished. Unmitigated communion individuals may be having intrusive thoughts about patients because they are concerned that they did not live up to the standards of others and offer enough help. Intrusive thoughts may reflect an esteem-enhancing process that unmitigated communion individuals engage in as a means of reaffirming their identity of being helpful and important to others. Alternatively, unmitigated communion

individuals might ruminate about their patients because they are frustrated by the situation and unable to express their anger. Their anger may be related to their job in general or the specific treatment of patients.

Both unmitigated communion and communion were related to distress by intrusive thoughts about a specific patient. None of the variables we assessed could account for this relation, which is not surprising because communion individuals, as well as unmitigated communion individuals, reported experiencing this kind of distress. The fact that communion and unmitigated communion individuals have intrusive thoughts about patients with particular problems is not surprising because both individuals are concerned about the well-being of others. Recall that participants were asked to think about a specific patient who had a problem that was most distressing to them at that particular time.

The scenarios used in this study suggest that individuals may have different motives for helping. Both unmitigated communion and communion individuals were equally as likely to volunteer to take care of the patients. Thus, the quantity of help that unmitigated communion and communion individuals provide may be comparable. The quality of help given, however, may differ. Unmitigated communion individuals experienced greater distress when they could not help the patient than when they could help the patient. The distress may have to do with a concern with how the inability to help appears to patients or their self-esteem being contingent on being able to actually meet others' needs. Unmitigated communion individuals also reported being more likely to avoid patients when they could not help and their attempts to help the patient were not recognized. Because they rely so much on what others think of them, it may be essential that their help is recognized.

Implications for the Nursing Profession

The results of this study show that it is possible that the unmitigated communion individual's concern for what others think can cause them problems in the workplace. Not only was unmitigated communion associated with low self-esteem and depression, but the possible relation to job burnout is intriguing and should foster further research in this area.

Also, this study suggests that unmitigated communion individuals might spend a great deal of their time thinking about their patients' problems and taking them on as their own. This has psychological consequences that could have negative effects on the nurse's well-being.

In order to decrease the likelihood of burnout among nurses, these results suggest that the presence of unmitigated communion should be taken into consideration when selecting young adults for nursing. It might prove fruitful to organize some type of support group where nurses could talk out their problems and try to express their anger.

Our results make it clear that communion individuals find their jobs to be less stressful and have more positive attitudes toward their jobs. Therefore, the importance of considering the presence of both communion and unmitigated communion when investigating the positive and negative aspects of caregiving is evident. The results from the scenarios suggest that individuals may have different motives for caregiving.

Limitations and Future Directions

There are some limitations to the present study. It must be noted that self-selection is taking place. Individuals with a particularly strong need to serve, care, and nurture aspire to be nurses. By studying nurses who participated on a volunteer basis, there is clearly a selection bias. Perhaps those nurses who were experiencing the greatest amount of stress did not participate in this study. This could have an effect on the results of the job distress measures. Maybe there would be a stronger relation between unmitigated communion and job distress if there was more variability on the job distress measures. Also, a major limitation of this study was that all information was obtained by self-report. Future research could employ an observational methodology which would include a more representative sample of the nursing population. An observational study would also be effective in assessing whether unmitigated communion nurses provide a different overall quantity or quality of help to their patients than communion nurses. It appeared that the quantity of help given by unmitigated communion and communion individuals in this study was similar, but these results were obtained by self-report. This study did not investigate

the quality of help that was given to patients and could be measured by looking at how time is spent with patients. It would also be useful to obtain peer reports to see how coworkers view unmitigated communion nurses' behavior toward patients.

Another limitation of this study was its cross-sectional nature. A longitudinal study could examine how burnout develops over time and examine the implications of unmitigated communion and communion for nurses' physical and psychological well-being over time. The results of future studies would enable health institutions to deal more effectively with some fundamental causes of depression, burnout, and possible health issues.

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Table 1

Correlations of Unmitigated Communion and Communion to Personality Traits, Anger, and Depression

	Unmitigated Communion	Communion
Personality Trait		
Agency	-.18	.26*
Self Esteem	-.31*	.23+
Externalized Self Perception	.50***	-.00
Feelings of Rejection	.35**	.11
Symptomatic Anger	.23+	.03
Internalized Anger	.32*	.09
Externalized Anger	.02	-.28*
Depression	.33**	-.03

+$p < .10$; *$p < .05$; **$p < .01$; ***$p < .001$.

Table 2

Correlations of Unmitigated Communion and Communion to Job Distress

	Unmitigated Communion	Communion
Distress Type		
Perceived Job Stress	-.10	-.24*
Burn Out (Job)	.20	-.08
Attitudes Toward Job	.12	-.27**
Intrusive Thoughts (general)	.30**	.02
Intrusive Thoughts (patient specific)	.37***	.28**

*$p < .10$; **$p < .05$; ***$p < .01$.

Table 3

Partial Correlations of Unmitigated Communion to Depression

Correlation between unmitigated communion and depression	.33***
Control Variable	
Intrusive Thoughts (general)	.25*
Distress by Intrusive Thoughts	.31**
Internalized Anger	.21
Anger Symptoms	.26**
Feelings of Rejection	.36***
Externalized Self Perception	.00

*$p < .10$; **$p < .05$; ***$p < .01$.

Table 4

Partial Correlations of Unmitigated Communion to General Intrusive Thoughts

Unmitigated Communion and General Intrusive Thoughts	.33***
Control Variable	
Internalized Anger	.18
Anger Symptoms	.24*
Externalized Self Perception	.13
Feelings of Rejection	.32**

*p < .10; **p < .05; ***p < .01.

Table 5

Partial Correlations of Unmitigated Communion to Distress by Intrusive Thoughts

Unmitigated Communion and Distress by Intrusive Thoughts about a Specific Patient	.37***
Control Variable	
Internalized Anger	.35***
Anger Symptoms	.34**
Externalized Self Perception	.35***
Feelings of Rejection	.34**

*$p < .10$; **$p < .05$; ***$p < .01$.

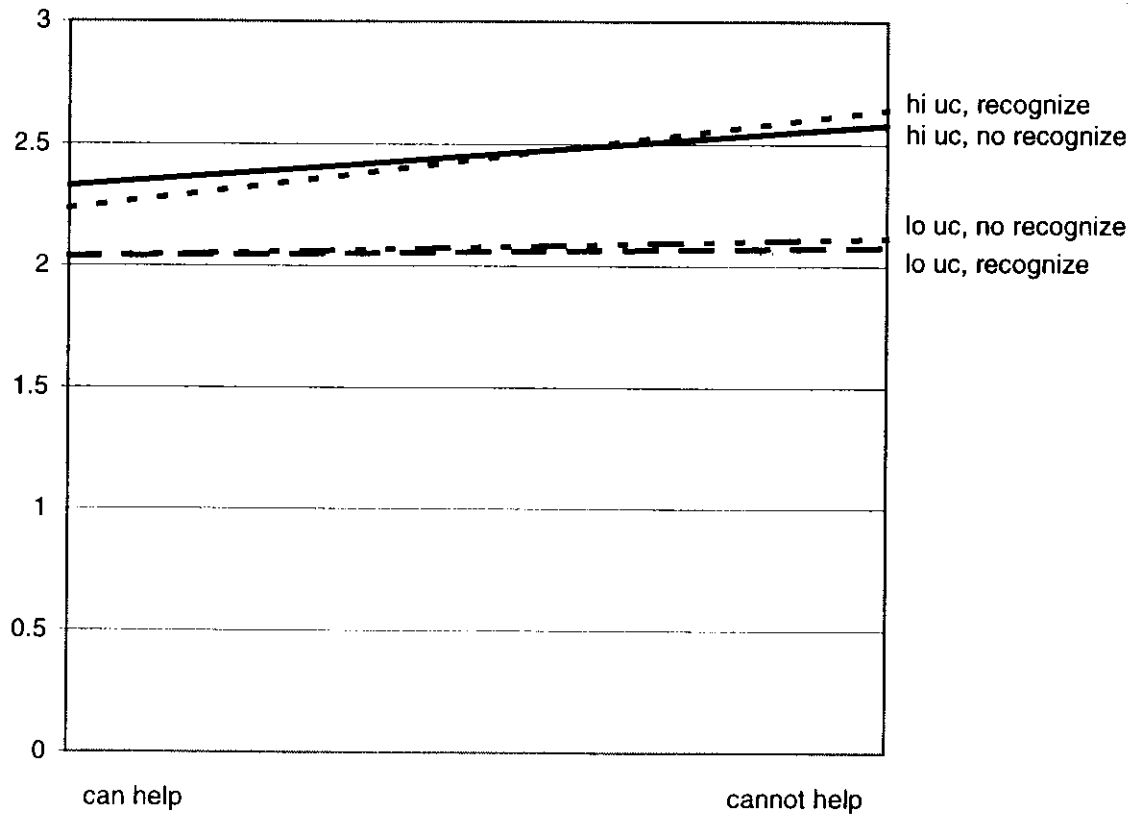
3
2.5
2
1.5
1
0.5
0
hi uc, recognize
hi uc, no recognize
lo uc, no recognize
lo uc, recognize
can help
cannot help

Figure 1

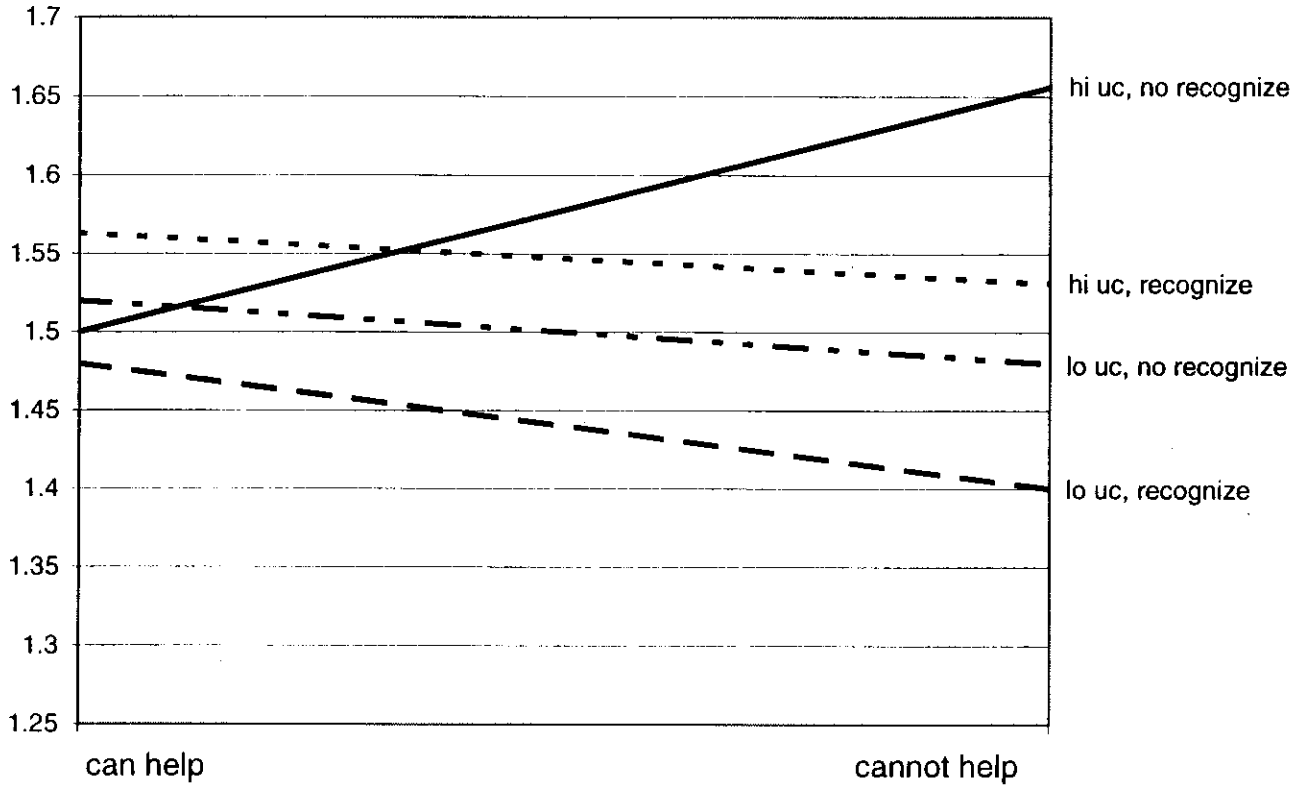
1.7
1.65
1.6
1.55
1.5
1.45
1.4
1.35
1.3
1.25
can help
cannot help
hi uc, no recognize
hi uc, recognize
lo uc, no recognize
lo uc, recognize

Figure 2