The grief reactions that nursing personnel may experience following the deaths of patients have been well documented in the literature. For many, these grief reactions can have serious and problematic implications, including feelings of helplessness and moral distress (Davies et al., 1996; Papadatou, Bellali, Papazoglou, & Petraki, 2002), chronic and compounded grief (Adams, Hershatter, & Moritz, 1991; Feldstein & Gemma, 1995), and feelings of overwhelming stress and burnout (Vachon, 2000). The negative aspects of grief tend to be the primary focus of research, but positive outcomes from grief have also been reported, such as emotional and professional growth (Adams et al., 1991; Papadatou et al., 2002). Although past research has shed some light on the effects of grief on nursing personnel, studies have yet to consider the role of grief in burnout and turnover, two significant problems that can affect quality of care. This study considers both the problematic and the more positive outcomes of grief in relation to burnout and turnover in certified nursing assistants (CNAs) working in nursing home settings.

**LITERATURE REVIEW**

A considerable body of research exists on the grief experiences of nursing personnel; however, few studies have focused specifically on the grief experiences of CNAs in nursing home settings. Ironically, several factors seem to indicate that CNAs in these settings would be at greatest risk of experiencing complications with grief. First, CNAs in nursing homes tend to have close relationships with residents, forged during years of intimate care. CNAs often characterize these relationships as tantamount to relationships with their own family members (Chichin, Burack, Olson, & Likourezos, 2000; Moss, Moss, Rubinstein, & Black, 2003). Second, the environment of nursing homes may effectively disenfranchise the grief experiences of CNAs. CNAs are exposed to death on a regular basis and are typically provided with little in terms of supportive services. The business nature of the nursing home and the focus on bathing and body care tasks preclude CNAs from taking time to grieve residents’ deaths (Gubrium, 1975; Moss & Moss, 2002). In addition, few nursing homes have any form of memorial for deceased residents, and CNAs are rarely provided with the time, space, or professional assistance to help promote healthy grieving (Moss & Moss, 2002; Sumaya-Smith, 1995). Finally, CNAs are provided with scant training on how to address their grief and how to prevent problematic or chronic grief (Downe-Wamboldt & Tamlyn, 1997; Ferrell, Virani, & Grant, 1999). These factors combined place CNAs working in nursing homes at high risk of enduring the more negative aspects of grief.
of grief, such as burnout, without receiving the benefits associated with healthy grieving.

**Burnout**

Two potential outcomes related to grief were examined in this study: burnout and the potential for turnover. Burnout is a stress-related syndrome in which individuals experience emotional exhaustion, depersonalization (an emotional hardening and impersonal response toward nursing home residents), and a reduction in feelings of personal accomplishment (Maslach, 1976). Burnout is an important phenomenon to consider, as the symptoms can affect the physical and emotional well-being of nursing personnel, their ability to perform their work, and the quality of care received by patients and residents. Across health care settings (e.g., hospice organizations, oncology units, long-term care facilities, hospitals), past research has consistently linked burnout in nursing personnel to dissatisfaction with organizational factors, such as high workloads and high patient-to-staff ratios (Brannon, Zinn, Mor, & Davis, 2002; Duquette, Sandhu, & Beaudet, 1994). Support from coworkers, support from the institution, and the development of coping skills have also been correlated to burnout in nursing staff (Payne, 2001). Other studies (Tai, Bame, & Robinson, 1998) have found that nurses who are younger, from minority backgrounds, or in lower-level job categories (e.g., CNAs) tended to experience higher levels of burnout.

**Turnover**

Along with burnout, turnover in nursing staff is a serious problem with many ramifications, including financial costs to the institution (e.g.,
recruiting, retraining), disruption of services and organization, and decreased consumer satisfaction (Tai et al., 1998). Turnover of CNAs has proven to be especially problematic, with annual rates estimated to be between 49% and 143% across regions and facilities; nationwide, shortages of CNAs are estimated to be 200,000 and anticipated to increase (National Citizens Coalition for Nursing Home Reform, 2001). Turnover has been attributed to several factors, including dissatisfaction with job characteristics (e.g., higher workload with lower pay); mediating factors (e.g., less social support); and demographic factors (e.g., younger age and less education) (Bowers, Esmond, & Jacobson, 2003; Brannon et al., 2002; Parsons, Simmons, Penn, & Furlough, 2003).

HYPOTHESES
To date, no research has been conducted examining the relationship between the grief experienced by CNAs and burnout and turnover. To address this gap in the literature, the following hypotheses were developed:

1. CNAs who report higher levels of personal growth from their grief, lower levels of complications from their grief, and greater pay and job satisfaction will report lower levels of burnout.

2. CNAs who report higher levels of personal growth from their grief, lower levels of complications from their grief, and greater pay and job satisfaction will report less desire to leave their current facility or the vocation altogether.

METHOD
Sample
The convenience sample consisted of 136 CNAs (N = 136) working in 12 nursing homes randomly selected from across Kentucky (Table 1). A total of 270 self-administered surveys were distributed; 136 were completed and returned by mail to the researcher (K.A.), indicating a return rate of 50.4%. The nursing homes tended to be fairly large (mean = 90.40 beds), located in rural areas (75.0%), and not religiously affiliated (78.7%). Participants tended to be women (92.6%), Caucasian (83.1%), Christian (78.7%), high school graduates (mean = 12.17 years of schooling), and with a mean age of 37. However, the racial distribution of the sample is significantly different from that of CNAs across the United States, which has been estimated to be 57% Caucasian, 32% African American, 4%

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean (SD)</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>35.22 (13.46)</td>
<td>17 to 68</td>
</tr>
<tr>
<td>Education (years)</td>
<td>12.17 (1.15)</td>
<td>8 to 16</td>
</tr>
<tr>
<td>Time in nursing profession (months)</td>
<td>108.10 (91.60)</td>
<td>2 to 360</td>
</tr>
<tr>
<td>Time in current facility (months)</td>
<td>57.24 (77.03)</td>
<td>1 to 296</td>
</tr>
<tr>
<td>Facility size (beds)</td>
<td>90.40 (27.25)</td>
<td>58 to 148</td>
</tr>
<tr>
<td>Number of deaths experienced in the facility during the past year</td>
<td>15.54 (8.79)</td>
<td>0 to 43</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Variable</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Women</td>
<td>126 (92.6)</td>
</tr>
<tr>
<td>Men</td>
<td>10 (7.4)</td>
</tr>
<tr>
<td>Race</td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>113 (83.1)</td>
</tr>
<tr>
<td>Non-Caucasian</td>
<td>23 (16.9)</td>
</tr>
<tr>
<td>Marital status</td>
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</tr>
<tr>
<td>Married/living with partner</td>
<td>81 (59.6)</td>
</tr>
<tr>
<td>Widowed</td>
<td>3 (2.2)</td>
</tr>
<tr>
<td>Divorced</td>
<td>18 (13.2)</td>
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<tr>
<td>Separated</td>
<td>7 (5.1)</td>
</tr>
<tr>
<td>Never married</td>
<td>27 (19.9)</td>
</tr>
<tr>
<td>Religion</td>
<td></td>
</tr>
<tr>
<td>Protestant</td>
<td>90 (66.2)</td>
</tr>
<tr>
<td>Catholic</td>
<td>17 (12.5)</td>
</tr>
<tr>
<td>Other</td>
<td>29 (21.3)</td>
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<tr>
<td>Employment status</td>
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</tr>
<tr>
<td>Full time</td>
<td>119 (87.5)</td>
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<tr>
<td>Part time</td>
<td>17 (12.5)</td>
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<tr>
<td>Facility location</td>
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<tr>
<td>Urban</td>
<td>34 (25.0)</td>
</tr>
<tr>
<td>Rural</td>
<td>102 (75.0)</td>
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<tr>
<td>Religious affiliation of the facility</td>
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</tr>
<tr>
<td>Affiliated</td>
<td>29 (21.3)</td>
</tr>
<tr>
<td>Non-affiliated</td>
<td>107 (78.7)</td>
</tr>
</tbody>
</table>

Table 1: Contextual and Demographic Characteristics of Facilities and Participants (N = 136)
and 11% Hispanic (Scanlon, 2001). However, the racial distribution of the sample is significantly different from that of CNAs across the United States, which has been estimated to be 51% Caucasian, 35% African American, and 10% Hispanic (Scanlon, 2001).

Measures

**Independent Variables.** Drawn from past research on grief, burnout, and turnover, a select group of independent variables were included in the current study. A positive outcome of grief (personal growth) and a problematic outcome of grief (complicated grief) were included to determine their relationship with burnout and turnover. Pay and job satisfaction were also included as independent variables, as these two factors have previously been shown to have significant associations with burnout and turnover in CNAs. Details about these variables are listed below:

- Personal growth. Defined as gains in tolerance, compassion, for-giveness, and hope, personal growth is a possible positive outcome of grief. The Personal Growth (PG) subscale from the Hogan Grief Reaction Checklist (Hogan, Greenfield, & Schmidt, 2001) was used to measure personal and emotional growth. The PG subscale consists of 12 items that examine the positive sequelae of grief. Using Cronbach’s alpha, Hogan et al. (2001) reported internal consistency for the subscale to be 0.82 and test-retest reliability to be 0.81. Internal consistency in the current study was high (0.94).

- Complicated grief. The Inventory of Complicated Grief (ICG) scale was used to measure the presence of maladaptive and problematic outcomes from grief (Prigerson et al., 1995). The ICG consists of 19 items that yield an overall score indicating the prevalence and severity of the symptoms of complicated grief. Using Cronbach’s alpha, Prigerson et al. (1995) reported internal consistency for the scale to be 0.94 and test-retest reliability to be 0.80. Internal consistency in the current study was high (0.92).

- Job satisfaction. Job satisfaction (e.g., feelings of accomplishment, satisfaction with supervision) can affect feelings of burnout and affect individuals’ decisions to stay on the job. The Minnesota Satisfaction Questionnaire (MSQ) Short Form (Weiss, Davis, England, & Lofquist, 1981) was used to measure overall job satisfaction. The short-form MSQ is a 20-item scale that relates intrinsic and extrinsic job satisfaction with various elements of the work environment and the work experience. Using Hoyt reliability, Weiss et al. (1981) reported internal consistency for the scale to be 0.87 and test-retest reliability within an acceptable range of 0.70 to 0.89. Internal consistency in the current study was high (Cronbach’s alpha = 0.92).

- Pay satisfaction. Although CNAs’ average pay ($9.86 per hour) is well above minimum wage, it merits investigation as to whether the pay that CNAs receive is high enough to offset the challenges of the job and whether pay is a factor in deciding to leave one facility for another or the vocation altogether (U.S. Department of Labor, 2006). Satisfaction with pay in this study was determined by asking participants the following single question: “How satisfied are you with the pay that you receive?”

A number of contextual and demographic factors were considered in this study on the basis of past research on grief, burnout, and turnover. Covariates included age, race and ethnicity, gender, marital status, religion, years in the profession, facility size, and number of deaths experienced on the job in the past year.

**Dependent Variables.** The Maslach Burnout Inventory (MBI) was used to measure the presence and strength of feelings of burnout (Maslach & Jackson, 1986). The MBI consists of 25 items that measure burnout across three subscales: emotional exhaustion, depersonalization, and personal accomplishment. Using Cronbach’s alpha, Maslach and Jackson (1986) reported internal consistency for the subscales ranging from 0.71 to 0.90 and test-retest reliability within an acceptable range of 0.60 to 0.82. Internal consistency in the current study was moderate (0.82 to 0.83).

Because the current study focuses on CNAs currently employed, the potential for turnover, rather than turnover itself, was used as an outcome measure. Potential for turnover, defined as the desire to leave either one’s current facility or the vocation altogether, was measured using a 2-item scale specifically designed for this study. Items included the following questions: “If you could, would you leave this facility for another facility?” and “If you could, would you leave the nursing profession?”

**RESULTS**

Four regression models were constructed to test the hypotheses for this study. In each model, independent variables included personal growth, complicated grief, job satisfaction, and pay satisfaction. Contextual and demographic variables that were found to be significantly correlated (p < 0.05) with the outcome variables were also included as covariates in each model.

Hypothesis #1: Burnout

Three regression models were constructed to test the first hypothesis, one for each element of burnout (Table 2). In the first model, emotional exhaustion served as the dependent variable. None of the covariates were found to be significantly correlated with emotional exhaustion and therefore were not included in the model. None of the independent variables included in this model were found to be significantly related to emotional exhaustion.

The second regression model used depersonalization as the dependent
variable. Race was included as a covariate, as it was found to have a significant correlation with depersonalization. Of the independent variables considered, only complicated grief was found to be significantly related to depersonalization ($\beta = 0.224; p < 0.01$). The covariate, race, was also found to have a significant relationship with depersonalization ($\beta = 0.181; p < 0.05$). These findings indicate that participants who reported higher levels of complicated grief and who were Caucasian were more likely to experience higher levels of depersonalization.

In the third regression model, personal accomplishment served as the dependent variable. Religious affiliation of the facility and the number of years the CNAs had worked in their current facility were considered as covariates. Two of the independent variables considered in this model—personal growth ($\beta = 0.276; p < 0.01$) and job satisfaction ($\beta = 0.292; p < 0.01$)—were found to have significant relationships with personal accomplishment. Religious affiliation of the facility ($\beta = 0.163; p < 0.05$) and number of years working in the facility ($\beta = -0.270; p < 0.001$) were also found to have significant relationships with personal accomplishment. Specifically, CNAs who experienced greater personal growth from their grief, who were more satisfied with their jobs, who worked in religiously affiliated facilities, and who had less seniority in their current facility experienced significantly higher levels of personal accomplishment.

**Hypothesis #2: Turnover**

To test the second hypothesis, one regression model was constructed, with potential for turnover serving as the dependent variable. Age and education level were found to have significant correlations with potential for turnover and were included as covariates in the model. Of the independent variables considered, only job satisfaction ($\beta = -0.350; p < 0.01$) was found to have a significant relationship with potential for turnover. The covariate, age ($\beta = -0.178; p < 0.05$), was also found to have a significant relationship with potential for turnover. Therefore, CNAs who reported less job satisfaction and who were younger showed a significantly higher potential for turnover.

**DISCUSSION**

Several factors considered in this study were found to be significant predictors of burnout. CNAs who experienced higher levels of complicated grief reported higher levels of depersonalization, an emotional hardening that results in the objectification of nursing home residents. Although CNAs may view the nursing home residents under their care as family (Moss et al., 2003), CNAs who have difficulty emotionally processing death may begin to view residents as room numbers rather than people (Gubrium, 1975). Complications with grief may actually accentuate and perpetuate the impersonal care that has been reported as a primary concern of nursing home residents and their families (Edwards et al., 2003).

Depersonalization is certainly a concern in terms of quality of care; however, this personal distancing may provide prophylactic benefits to CNAs, allowing them to endure the multiple deaths experienced on the job. It was also found that Caucasian CNAs reported higher levels of depersonalization. This finding was not anticipated, nor does it reflect past research in which nurses from minority backgrounds experienced higher levels of burnout and subsequently left their jobs with greater frequency (Tai et al., 1998). The findings from the current study suggest that CNAs from minority backgrounds may have better coping skills or greater resiliency in the face of grief, which enables them to remain emotionally attached to nursing home residents despite repeated losses. Further research is warranted to clarify the role of race in this complex process.

CNAs who experienced higher personal growth from their grief and higher job satisfaction reported higher levels of personal accomplishment, the lack of which is the third component of burnout. This finding indicates the importance of growth through grief in the personal and professional lives of CNAs. Those
CNAs who were able to view grief as a positive, enriching experience indicated that they felt more positively about the work they perform and their ability to handle the emotional challenges of that work. This finding also validates grief theory, in which the healthy resolution of grief is associated with gains in self-efficacy, positive memories, and inner peace.

Job satisfaction was also found to be a significant predictor of personal accomplishment among study participants. Again, this finding was anticipated from the literature on burnout and from the congruence of the positive aspects of both measures (Brannon et al., 2002; Tai et al., 1998). Two contextual factors, length of time in the current facility and religious affiliation of the facility, were also found to be significant predictors of personal accomplishment among participants. Specifically, CNAs with less time in their current facility reported higher levels of personal accomplishment. It may be the case that CNAs experience less personal accomplishment from their work when they remain for longer periods of time in one facility, whereas periodically changing facilities may provide CNAs with new opportunities to experience growth and satisfaction in their work. CNAs who worked in facilities that were religiously affiliated also reported higher levels of personal accomplishment. CNAs in religiously affiliated facilities may find enhanced meaning in their work, as they may feel they are doing God’s work (Counsel & Care, 1995). Religiously affiliated facilities typically foster environments in which the notion of doing God’s work is reinforced by the presence of chapels, nursing home chaplains, and religious services. This environment may provide some protection against burnout.

Several factors were found to be significant predictors of potential for turnover. CNAs who reported lower levels of job satisfaction indicated a greater potential for leaving their current facility or the vocation altogether. This finding was anticipated on the basis of recent research on turnover in the general nursing profession and in CNAs in nursing homes (Bowers et al., 2003; Brannon et al., 2002; Parsons et al., 2003). Age was also found to be a significant predictor, with younger CNAs reporting higher levels of potential for turnover. Again, this reflects much of the literature on turnover (Neumark, 2000; Tai et al., 1998). Younger CNAs may have higher mobility, less desire to make nursing a profession, and greater opportunity to pursue alternate avenues of employment.

Unexpectedly, the grief experiences of CNAs were not found to have a significant relationship with turnover among the participants in this study. However, dismissing the importance of grief in predicting turnover may not be wholly warranted. In this study, personal growth from grief was strongly correlated with job satisfaction (Cronbach’s alpha = 0.62). This indicates that the grief experiences of CNAs do affect the level of satisfaction they derive from their work; therefore, items focusing on grief should perhaps be incorporated into a proprietary measure of job satisfaction for health care workers. The findings from this study indicate that grief is a significant predictor of burnout, which may be a condition or state that precipitates turnover. Although this study failed to find a direct connection between grief and turnover, future studies should consider the indirect relationships that may exist between grief, job satisfaction, burnout, and turnover.

**LIMITATIONS**

Several limitations exist, most notably in the sampling procedure and the prospective nature of the study. Convenience sampling was used; therefore, the sample included only those CNAs who were most willing to participate. The resulting sample may overrepresent CNAs who were more willing to discuss their grief experiences or who were more satisfied with their work. There was also a potential for sampling bias, as this study relied on selected senior facility staff members (e.g., social workers, chaplains) to recruit participants and distribute the surveys. Because this was a study of CNAs currently employed, potential for turnover, rather than actual turnover, was measured. CNAs’ desire to leave the job may differ from the actual motives that prompt them to leave, and the findings from this study should be interpreted and generalized with this notion in mind.

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**KEYPOINTS**

**GRIEF EXPERIENCES OF CNAs**


1. Certified nursing assistants (CNAs) who experienced more problematic grief reactions reported higher levels of depersonalization in their work with nursing home residents.

2. CNAs who reported more growth from their grief experiences reported higher levels of personal accomplishment in their work.

3. Job satisfaction was a strong predictor of turnover in CNAs, but grief reactions did not have a significant relationship with turnover.

4. Enfranchising grief through support and education may help reduce the negative consequences of grief for CNAs in nursing home settings.
NURSING IMPLICATIONS

The findings from this study help to identify several possible interventions that may aid in facilitating healthy grief experiences for CNAs and reducing burnout and the potential for turnover. On the basis of these findings, interventions that enfranchise healthy grieving may benefit CNAs as they endure the deaths of nursing home residents. Enfranchising grief involves recognizing the importance of the relationships between CNAs and nursing home residents, acknowledging their losses, and including CNAs in therapeutic rituals, such as funeral services (Doka, 2002a). For example, it may be beneficial to provide a short pause in daily activities when a resident dies (e.g., a moment of silence) or to maintain memorial boards to mark the lives and deaths of residents (Bonifazi, 1998). Funeral rituals can also have therapeutic effects for the bereaved and are commonly viewed as important elements in the grief process (Doka, 2002b). Although most staff members are typically unable to attend services outside of the facility, periodic facility-based or unit-based memorial services may accord staff the opportunity to remember and reflect on residents who have passed away. Through such simple and cost-effective measures, facilities may be able to accentuate the positive aspects of grief and add to the well-being of their frontline staff.

Educational interventions may also be effective in promoting healthy grief experiences. CNAs typically receive little, if any, death education, and studies have found deficiencies in the training RNs receive regarding end-of-life issues (Downe-Wamboldt & Tamlyn, 1997; Ferrell et al., 1999). In response to this need, educational programs have been developed for both RNs and CNAs. The End-of-Life Nursing Education Consortium has developed a training program for RNs that includes attention to grief, loss, and bereavement issues (Ferrell et al., 2005; Matzo et al., 2003). This additional training may allow RNs to assume leadership and mentoring roles by training CNAs in their facilities. Training programs specifically designed for CNAs, such as the Good Endings program, may also serve as resources for in-service death education programs (Gross, 2007). Ideally, facility RNs could lead periodic in-service trainings augmented by either training videos or facility personnel with bereavement training (e.g., social workers, chaplains) and provide informal support and counseling to CNAs as grief experiences arise. Although these educational interventions appear to have great promise, additional evaluative research is warranted to determine the effects of these programs on grief in nursing home settings.

CONCLUSION

The findings from this study help illuminate the relationship between grief, burnout, and turnover. In addition, the findings indicate several areas where interventions may be effective in promoting healthy grief experiences, which may, in turn, enhance the well-being and job stability of CNAs. CNAs are the primary providers of care in nursing home settings; therefore, maintaining their emotional health and promoting job satisfaction is essential to the overall quality of life for nursing home residents. Future research should consider the use of larger, more diverse, and more representative samples, the development of different measures (e.g., measuring actual turnover), and the implementation of different analytical techniques (e.g., Cox proportional hazard modeling) to further illuminate the role of grief in burnout and turnover and to expand theoretical and conceptual understanding.

REFERENCES


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