

## CHAPTER II

### LITERATURE REVIEW

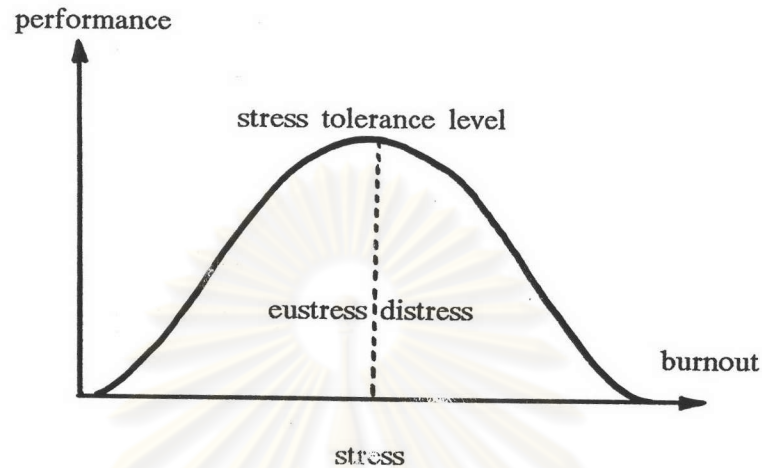
The study of influential factors of burnout among professional nurses was done before by some researchers. The study was different in the purpose, the method of study and the benefit from the results.

#### THEORETICAL BACKGROUND

Hans Selye, a Canadian physician who has studied stress responses in the human being over a number of years, presents a model that can be used as a base from which to view stress. Through his studies of individual responses to stress, Selye realized that not all stress is bad. Selye is credited with describing the positive, motivating force of stress, which he named eustress, separating it from the common definition of stress as a negative, debilitating force or distress. This latter force is a familiar term to all of us.

In Selye's model, stress is placed on the horizontal axis and performance on the vertical axis (see figure 2.1). It takes a certain amount of stress to get you out of bed, off to work, and functioning in your job. This is eustress. It energizes you, and its constant and/or increasing presence allows you to approach your peak performance. In the eustress phase many things are possible. You can approach life and its numerous, varied facets with enthusiasm and zeal. Work, play, educational pursuits, and a gratifying family life can coexist, complementing each other for optimal living.

## SELYE MODEL



**Figure 2.1** : Hans Selye' model provides a way to view the negative and positive kinds of stress in a person's life.

Human beings are interesting creatures. In any physical illness, they exhibit the same or similar symptoms. However when they are stressed or experiencing stressful situations beyond their stress tolerance level, they react in a wide range of -sometimes opposite- ways.

These reactions generally can be placed in three categories: physiological, behavioral, and emotional. Symptoms or responses indicating that individuals have reached or passed their stress tolerance level and are in the distress phase are outlined below.

### *Physiological:*

Symptoms or responses that are physiological include increased pulse rate (heart pounding), cold, clammy hands, headaches, abdominal pain, backaches, stiffness of the neck and shoulders, elevated blood pressure, fatigue, dryness of the mouth, nausea, vomiting, diarrhea, excessive urination, and profuse perspiration.

*Behavioral:*

Symptoms or responses that are behavioral include overactivity, crying, forgetfulness, yelling, blaming, bossiness, quiet (not talking), compulsive eating, short temperness, compulsive smoking, grinding teeth, driving too fast, inability to eat, sleeplessness, sleeping long period without feeling rested, restless pacing, and endless chattering,

*Emotional:*

Symptoms or responses that are emotional include feelings of isolation, feeling that others don't like you, fear, anxiety, frustration, feelings of powerlessness, inflexibility, impotence, worry, depression, loneliness, overwhelming quiet, almost unbearable grief, feelings of worthlessness, and rage.

This is not to say that your symptoms are coming only from distress. However, if gastric upset is your common reaction to distress, then consider the possibility that you may be experiencing overwhelming stress.

Research has shown that individuals experiencing high, intolerable, unmanaged stress are at risk of contagious diseases in the environment. In other words, if a disease-causing organism is marching through town, the likelihood of contracting the disease is high if you are distressed or overwhelmed.

## **BURNOUT DEFINITION**

Burnout initially was described by Herbert Freudenberger as always happening in the workplace and as experienced mostly by members of the helping professions: nurses, doctors, school teachers, counselors, policeman, etc.

In the allied health literature burnout is sometimes equated with job stress (Bailey, 1980). Job stress is generally viewed in relation to factors in the work environment that interact with a worker's personality in such a way as to disrupt the worker's psychological or physical functioning (Margolis and Kroes, 1974). Although intrinsically related, burnout and job stress are not synonymous. Burnout is typically considered as on consequence of job stress. Job stress appears to be a necessary

condition for burnout to occur. Many workers experience job stress and do not burnout, but none burn out without experiencing job stress.

Among the formal definitions of burnout there are direct implied links to the stress experienced in one's work. For example, Veninga and Spradley (1981) made an explicit connection with job stress in their definition of burnout as "a debilitating psychological condition brought about by unrelieved work stress." They maintained that this work-related condition results in "(1) depleted energy reserves, (2) lowered resistance to illness, (3) increased dissatisfaction and pessimism, (4) increased absenteeism and inefficiency at work". Edelwich and Brodsky (1980) emphasized the stressful aspects of one's job in defining burnout as "a progressive loss of idealism, energy, and purpose experienced by people in the helping professions as a result of the conditions of their work".

Edelwich and Brodsky restricted their use of the term burnout to the helping professions. Although they did acknowledge that burnout can occur in virtually any profession, they maintained that it tends to occur with more regularity, carry higher social costs, and assume special intensity and character in the human service professions.

Pines and Aronson (1981) highlighted the applicability of the burnout concept to the helping professions. They defined burnout as "the result of constant or repeated emotional pressure associated with intense involvement with people over long periods of time". The authors further viewed burnout as a "state of mind that frequently afflicts individuals who work with other people...and who pour in much more than they get back from their clients, supervisors, and colleagues". These investigators suggested that burnout is a syndrome that includes physical, emotional, and mental fatigue; feelings of helplessness and hopelessness; and a lack of interest and enthusiasm for work and life in general. As an erosion of spirit, burnout affects precisely those professionals who had once been the most idealistic and enthusiastic. According to Pines and Aronson, these are the professionals who had at one time been "on fire."

Cherniss (1980) implied this erosion of spirit in his definition of burnout as a "process in which a previously committed professional disengages from his or her work in response to stress and strain experienced on the job". It appears that a prerequisite condition for burnout among health professionals is an initially strong humanitarian commitment to helping the less fortunate. This commitment is grounded in altruistic values and entails an investment of one's whole self in the purpose of one's work. Burnout robs health professionals of that investment and leaves them bankrupt of enthusiasm and purposes. Helping becomes either just another job or more of a problem than it is worth. The fire and sense of mission in one's calling fades and dies.

Perhaps the most widely cited definition of burnout is not proposed by Maslach. She defined burnout as "The loss of concern for the people with whom one is working including physical exhaustion and characterized by an emotional exhaustion in which the professional no longer has any positive feelings, sympathy, or respect for clients or patients. (Maslach and Jackson, 1977)" Maslach's definition characterizes burnout as a phenomenon common to personnel in human services. Subsumed under this definition is an attitude of detachment resulting from continual demands on emotional resources and a tendency to become rigidly technical in the performance of job duties. Thus, a salient feature of burnout appears to be a disruption of previously satisfactory relationships between professionals and their work environments.

These definitions reflect certain generally accepted dimensions of burnout. First, burnout is one response to a stressful work environment. It is not synonymous with stress. Rather, it is a consequence of unrelieved work stress. Second, although burnout may occur in any occupation, it is especially prominent among health professionals who come into repeated emotional contact with people in need of services. The type of work-related interactions that take place between providers and recipients is distinct from the kind of interactions between persons in business and industry. Providers of human services are typically inspired by altruistic values, with helping being a value in itself. Third, burnout typically manifests itself as a combination of physical, mental, and emotional exhaustion; loss of commitment; disengagement from one's work; and a general inefficiency in adapting to the unique demands of one's relationship with the environment that surrounds the delivery of human services.

## DEGREES OF BURNOUT

There are many levels of personal burnout caused by various behaviors and circumstances. These levels can be classified as first, second, and third degrees of burnout in order of severity (i.e., the form causing the least physiological or psychological harm as the first degree); the next more severe, second degree; and the worst form of burnout being third degree. Figure 2.2 outlines these types of burnout.

### First Degree Burnout

A particularly insidious form of first degree burnout is caused by the failure to keep up-to-date. Whether a manager or a technician, an individual with this trait can suffer the loss of position. Even though its consequences can be disastrous, first degree burnout manifests itself in relatively inconspicuous forms.

The failure to keep up-to-date is not restricted to older people. McCarthy indicated that age is not the important factor. Rather, it is the tendency of some individuals at any age to feel comfortable with the status quo. They not only resist new techniques, but also are often totally unaware of the existence of innovations.

There are also individuals who never reach their full potential. In this age of constant technological and professional breakthroughs, no person who fails to stay up-to-date can hope to advance. Too many managers are quite satisfied with remaining where they are, however. Their material needs are met; they become complacent, lulled into a false sense of security; and they see no need for improving their organization. If an organization has a large number of such individuals, particularly if they are in managerial positions, organizational failure is assured.

**Figure 2.2 : "Degrees" of Personal Burnout**

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1st Degree Burnout	Failure to keep up-to-date Complacency Gradual loss of reality
2nd Degree Burnout	Accelerated physical deterioration * Loss of sleep * Loss of energy * Weight Gain Graduated indifference to work situation
3rd Degree Burnout	Major physical and/or psychological breakdown * Heart attack * Ulcer * Mental Illness

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### **Second Degree Burnout**

The accelerated physiological, psychological deterioration of an individual with second degree burnout may be caused by some of the factors. Many of these factors, particularly the physical aspects of burnout, can be controlled by the individual - smoking, exercise, eating habits, sleep, work. Other such as a gradual deterioration of morale and other work-related stress factors, are external. Anxiety is one of the first and most important signs of an individual who feels unable to cope. Wareham suggested that incompetent executives often cope by developing a psychogenic illness, such as an ear condition, blinding migraine headaches, or ulcers. One of the most important stressors for managers is work overload. There is both quantitative (i.e., having too much to do) and qualitative (i.e., having work that is too difficult) overload. Neither these factors nor their effects have been fully explored in health care executives.

### Third Degree Burnout

Illness associated with the pressure of work is so commonplace that it is almost an accepted part of corporate life. The classic result of major stress is myocardial infarction.

Each year, over 400,000 individuals who have survived a myocardial infarction are discharged from hospitals. At least half of these patients have had uncomplicated, mild infarctions. More than 85 percent of previously employed patients under age 65 return to work within two to four months after a heart attack, but one quarter of these do not return to prior levels of activity. A considerable number of survivors remain on the disabled list for physical and/or emotional reasons.

The most extreme form of burnout is, of course, suicide.

### IMPACT ON HEALTH CARE

Contemporary health care practices are more technically efficient, sophisticated, and complex than ever before. As a result, the chances of producing positive changes in the health and well-being of patients are much more favorable than they were in the past. However, the stress and strain associated with delivering health care services can have various adverse effects on providers and ultimately on the overall quality of medical and nursing practice. It is certainly possible that iatrogenic effects of treatment may occur.

*For one thing*, chronic stress can gradually produce a state of tension and irritability that is incompatible with performance efficiency. A chronically aroused, tense, and irritable health professional is a person with an impaired ability to respond to continually changing conditions and demands. Such a professional may not adequately meet the treatment needs of patients, and, therefore, patient neglect becomes an increasingly probable outcome.



*Second*, as enthusiasm and commitment wane, there is a decline in overall motivation to provide quality health care. Health care becomes just a job—one that is performed grudgingly by a demoralized health professional and only well enough to get by without any seriously adverse consequences.

*Third*, under prolonged stress the burnout syndrome may come to include an impairment of the ability to attend, concentrate, and engage in complex thinking and problem solving. Because medical and nursing practices are so complex, they require critical thinking, problem solving, and decision making on a regular basis. When these functions are impaired in the provider, the outcome of work performance can be disastrous for patients.

*Fourth*, with a decline in enthusiasm and liking for one's work, there may also develop a loss of empathy, caring, and respect for patients. It is much easier to neglect—and in some cases even consciously harm—people whom we do not understand, care about, or respect. They become medical or surgical entities, stripped of humanity and deserving of no more concern than one would show for the cleanliness of one's uniform.

*Fifth*, as health professionals burn out, they tend to become more concerned with their own well-being and less about the welfare of others. "I've got to take care of myself before I can be effective in taking care of others" becomes more than a sensible piece of advice. Burned-out health professionals may protect and defend against any perceived imposition on their time and energy. They may become unwilling to help a colleague ("It's not my job," "I don't ask for help, so don't ask me," or "If you can't do your own job, then maybe you shouldn't be here"). If several members of the same staff are experiencing burnout, frequent conflicts over duties may occur. Staff members may withdraw from interactions with one another, breaking the cohesiveness of the staff, closing off channels of communication and disrupting team functioning.

*Sixth*, burned-out health professionals who cope with the stress of their jobs by heavy drinking or drug use or both are more than a liability—they are dangerous. They represent accidents waiting to happen. They are the most serious threat to the well-being of patients.

*Finally*, every year health care organizations lose hundreds of their most competent and committed practitioners to burnout. The effects of this turnover ripple through all levels of these organizations. High turnover is associated with increased expenditures for training new personnel to replace those who have left. It is also associated with lowered morale and the disruption of patient services (Edelwich and Brodsky, 1980). As morale falls and staff-patient relations are disrupted, other staff members become disposed toward burnout, and the cycle repeats itself.

## RESEARCH ON NURSING STRESS

In recent years, researchers have documented the elevated stress levels existing in hospital systems. Vachon found that nurses working in hospital units with terminal patients had only slightly lower stress levels than did new widows, and considerably higher levels than women beginning radiation treatment for cancer (Vachon, Lyall and Freeman, 1978). Intensive care units are also becoming known as notoriously difficult work environments, and many nurses are leaving such units because of their highly stressful nature (Bailey, Steffen and Grant, 1980).

Unfortunately, while nursing personnel continue to experience high levels of stress, they have few resources to protect themselves and little power to alter external pressures. By its nature, the nursing role entails constant response to either patient or institutional demands, yet these pressures can have detrimental effects if continued over extended time periods.

From early research conducted by Selye (1956), it is known that during emergency situations, the body reacts with a stress - alarm response by increasing the heart rate, muscle tension, blood pressure, and other physiological changes which rally the body preparedness for action.

While these reactions are necessary in crisis situations, when the alarm response is maintained over long time frames, a person's health can deteriorate. It is this constant elevation of tension over time that creates the burnout syndrome.

## MASLACH BURNOUT INVENTORY

The Maslach Burnout Inventory (MBI) (Maslach and Jackson, 1981) will be used to measure burnout. This questionnaire assesses the three components of burnout syndrome: emotional exhaustion, depersonalization, and decreased personal accomplishment. In each component, the scores are calculated separately (i.e. are not combined into a single, total score). Although, the original inventory measured both frequency and intensity of burnout, recent studies preferred to use the frequency scale (Firth, McIntee, McKeown, and Britton, 1985). Since a second scale on "how strong" (intensity) was criticized (Mitchell, 1985) as a poor fit for some items such as "I can easily understand how my patients feel about thing." So this study will use the frequency scale only.

The Emotional Exhaustion subscale assesses the feelings of being emotionally overextended and exhausted by one's work. The Depersonalization subscale measures an unfeeling and impersonal response toward patients of one's care or service. The Personal Accomplishment subscale assesses feelings of competence and successful achievement in one's work with people. A greater degree of burnout is reflected in high scores for emotional exhaustion and depersonalization and low scores for personal accomplishment.

The Maslach Burnout Inventory is composed of 22 self-descriptive statements; nine assess emotional exhaustion, five assess depersonalization, and eight assess personal accomplishment. The respondent rates each statement using a Likert-type continuum to indicate how frequently he or she has the feeling (range 0-6). The Maslach Burnout Inventory is self-administered and takes 20-30 minutes to complete.

High, moderate, and low burnout are categorized according to the scores for each of the three components of burnout. For example, moderate burnout is demonstrated by scores of 18-29 for frequency of emotional exhaustion, 6-11 for frequency of depersonalization, and 34-49 for frequency of personal accomplishment.

*Reliability:*

The internal consistency of the Maslach Burnout Inventory was estimated by Cronbach's coefficient alpha ( $n = 1,316$ ). The reliability coefficients for the subscales were: emotional exhaustion, 0.90; depersonalization, 0.79; and personal accomplishment, 0.71. Two to four week test-retest reliability coefficients of the Maslach Burnout Inventory ( $n = 53$ ) were: emotional exhaustion, 0.82; depersonalization, 0.60; and personal accomplishment, 0.80 (Maslach and Jackson, 1981).

*Validity:*

Convergent validity was demonstrated in three ways. First, an individual's score were correlated with behavioral ratings made independently by a person who knew the individual well. Second, scores were correlated with the presence of certain job characteristics that were expected to contribute to experienced burnout. Third, scores were correlated with measures of various outcomes that had been hypothesized to be related to burnout. Forty-two of the 51 correlations for validity of the frequency dimension (range = 0.16-0.56) were significant ( $p < 0.05$ ) (Maslach and Jackson, 1981).

Discriminant validity of the Maslach Burnout Inventory was estimated by distinguishing it from measures of other psychological constructs presumed to be confounded with burnout. Maslach and Jackson (1981) compared subject scores on the Maslach Burnout Inventory with scores on the job Diagnostic Survey ( $n = 91$ ) and found that the correlations were not so high as to suggest that job dissatisfaction and burnout were synonymous. Job satisfaction correlated negatively with emotional exhaustion ( $r = -0.23$ ,  $p < 0.05$ ) and frequency of depersonalization ( $r = -0.22$ ,  $p < 0.02$ ), and positively with frequency of personal accomplishment ( $r = 0.17$ ,  $p < 0.06$ ). They also considered the possibility of subject score distortion due to a social desirability response set since many items dealt with feelings contrary to professional ideals. However, subject scores on the Maslach Burnout Inventory and the Crowne-Marlowe Social Desirability Scale were not significantly correlated (Maslach and Jackson, 1981).

## **NURSING STRESS SCALE**

Gray-Toft and Anderson's (1981) Nursing Stress Scale will be used to measure occupational stress. It consists of 34 items that describe situations that have been identified as causing stress for nurses in the performance of their duties. It provides a total stress score as well as scores on each of seven subscales that measure the frequency of stress experienced by nurses in the hospital environment. The seven subscales are 1) death and dying 2) conflict with physicians 3) inadequate preparation 4) lack of support 5) conflict with other nurses 6) workload and 7) uncertainty concerning treatment.

### **Factor I: Death and dying.**

This factor appears largely to measure stressful situations resulting from the suffering and death of patients. Four of the seven items that load on this factor are related to the death of a patient. Two other items are associated with patients who fail to improve or who suffer. The performance of painful procedures on patients is also potentially stressful.

### **Factor II: Conflict with Physicians.**

This factor consists of stressful situations that arise from the nurse's interactions with physicians.

### **Factor III: Inadequate preparation to deal with the emotional needs of patients and their families.**

The three items that load heavily on this factor concern nurses' attempts to meet the emotional needs of patients and their families. Feeling inadequately prepared to deal with these psychological and emotional needs may lead to stress.

**Factor IV: Lack of staff support.**

This fourth subscale measures the nurse's assessment of the extent to which opportunities are available to share experiences with other nurses and to vent negative feeling of anger and frustration. The lack of such opportunities may result in stress for nurses.

**Factor V: Conflict with other nurses and supervisors.**

The items that load on this factor are associated with conflictual situations that arise between nurses and supervisors. Two of the items involve conflict with or criticism by a supervisor; the other three items have to do with conflict with nurses on the same or other hospital units.

**Factor VI: Workload.**

This factor includes stressful situations that arise from the nurse's work load, staffing and scheduling problems, and inadequate time to complete nursing tasks and to support patients emotionally.

**Factor VII: Uncertainty concerning treatment.**

Stressful situations also arise where there is uncertainty concerning the treatment of patients. This may develop when the physician fails to adequately communicate to the nurse information concerning a patient's medical condition. When this occurs the nurse does not know what to tell a patient or the patient's family about the medical condition and its treatment. A potentially stressful situation occurs when a physician is not present in a medical emergency.

The Nursing Stress Scale is composed of 34 self-descriptive statements; seven assess death and dying, five assess conflict with physicians, three assess inadequate preparation to deal with the emotional needs of patients and their families, three assess lack of staff support, five assess conflict with other nurses and supervisors, six assess work load, and five assess uncertainty concerning treatment. Four response categories will provided for each item: never (0), occasionally (1), frequently (2), and very frequently (3).

*Reliability:*

Two estimates of the reliability of the Nursing Stress Scale were determined: test-retest and internal consistency. The scale was readministered to a sample of 31 nurses after 2 weeks. The sample was taken proportionately from the five units originally studied. The test-retest coefficient for the total scale was 0.81. Four measures of internal consistency were obtained: a Guttman split-half coefficient of 0.79, a coefficient alpha of 0.89, and a standardized item alpha of 0.89. All four measures indicated a satisfactory level of consistency among items.

The factor analysis described earlier revealed seven subscales that measure different sources of stress. Test-retest reliability coefficients for four of the seven subscales exceeded 0.70. Internal consistency measures exceeded 0.70 for all components with the exception of two subscales.

*Validity:*

Validity of the Nursing Stress Scale was determined by empirically investigating its relationship to other important criteria to which stress is theoretically related, namely, trait anxiety, job satisfaction, and turnover. The ability of the scale to differentiate hospital units and groups of nurses known to experience high level of stress and turnover was also investigated (Gray-Toft and Anderson, 1981).

It was hypothesized that nurses with high levels of anxiety would experience more frequent stress in the performance of their nursing duties than other nurses (Appley and Trumbull, 1967; Lazarus, 1966). In order to test this hypothesis, trait anxiety with the IPAT Anxiety Scale Questionnaire (Krug et al., 1976) and state anxiety with the potent negative affect component of the Affect Rating Scale (Sippelle et al., 1976). The IPAT is a 40-item scale that includes indicators of worry, tension, low self-control, emotionality, and suspiciousness. The affect Rating Scale consists of 30 bipolar adjectives designed to measure transitory changes in anxiety. Nursing Stress Scale scores significantly correlated with state (0.35) and trait (0.39) anxiety in a sample of 122 nurses ( $p < 0.01$ ), indicating support for the criterion-related validity of the scale.



Furthermore, it was hypothesized that nurses who experienced high levels of stress in their work report significantly less job satisfaction (Davis, 1974; Kramer, 1974). The Work Subscale of the Job Description Index was used to test this hypothesis (Smith et al., 1969). Respondents indicated their degree of satisfaction with their work by responding to 18 adjectives that describe jobs in general. The Nursing Stress Scores was found to be inversely correlated with job satisfaction (-0.15).

Validity also was determined by examining turnover among the nursing staff of the five units. Turnover was considered to be an important indicator of staff burnout resulting from high level of stress. Consequently, it was hypothesized that nurses in units experiencing high rate of turnover score significantly higher on the Nursing Stress Scale. Finally, it was hypothesized that registered nurses would score highest on the Nursing Stress Scale and nursing assistants would score lowest. This hypothesis was based on the fact that registered nurses have the major responsibility for implementing physicians' orders and for supervising licensed practical nurses and nursing assistants. Nursing assistants' primary responsibility is bedside care. Moreover, hospitals are experiencing significant problems in recruiting and retaining registered nurses (Kramer, 1974; National Commission on Nursing and Nursing Education, 1970). As hypothesized, a two-way analysis of variance controlling for race found significant differences among the three groups of nurses ( $p < 0.03$ ). The highest stress scores and turnover rates were among registered nurses. Nursing assistants appeared to experience the least stress and evidenced the lowest turnover rates.

## MOTIVATION QUESTIONNAIRE

The Motivation Questionnaire (WHO, 1988) has been designed to help supervisors, faced with poorly-motivated staff, to define the causes precisely.

There is reasonable support for the theory that some aspects of work serve to prevent people leaving their jobs (hygiene factors) but do not of themselves promote good work. Other aspects are required to do this. Nevertheless, if hygiene factors are neglected, staff will become disaffected. The questionnaire therefore includes hygiene factors and factors associated with good work.



## THE HIERARCHY OF NEEDS THEORY

One of the most widely mentioned theories of motivation is the hierarchy of needs theory put forth by psychologist Abraham Maslow. Maslow saw human needs in the form of a hierarchy, ascending from the lowest to the highest, and he concluded that when one set of needs was satisfied, this kind of need ceased to be a motivator.

The basic human needs placed by Maslow in an ascending order of importance and shown in Figure 2.3 are these:

### 1. Physiological needs:

These are the basic needs for sustaining human life itself, such as food, water, shelter, and sleep. Maslow took the position that until these needs are satisfied to the degree necessary to maintain life, other needs will not motivate people.

### 2. Security, or safety, needs:

These are the needs to be free of physical danger and the fear of loss of a job, property, food, of shelter.

### 3. Affiliation, or acceptance, needs:

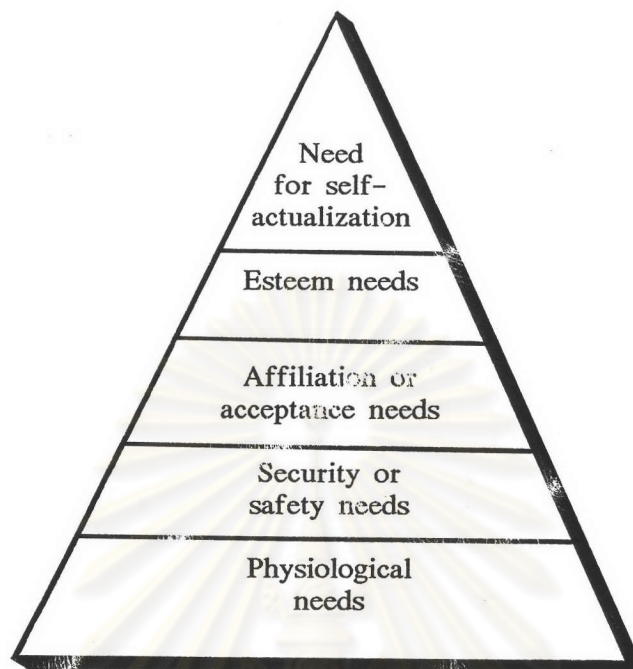
Since people are social beings, they need to belong, to be accepted by others.

### 4. Esteem needs:

According to Maslow, once people begin to satisfy their need to belong, they tend to want to be held in esteem both by themselves and by others. This kind of need produces such satisfactions as power, prestige, status, and self-confidence.

### 5. Need for self-actualization:

Maslow regards this as the highest need in his hierarchy. It is the desire to become what one is capable of becoming—to maximize one's potential and to accomplish something.



*Figure 2.3* : Maslow's Hierarchy of Needs

## THE MOTIVATION-HYGIENE APPROACH TO MOTIVATION

Maslow's need approach has been considerably modified by Frederick Herzberg and his associates. Their research purports to find a **two-factor theory** of motivation. In one group of needs are such things as company policy and administration, supervision, working conditions, interpersonal relations, salary, status, job security, and personal life. These were found by Herzberg and his associates to be only 'dissatisfiers and not motivators. In other words, if they exist in a work environment in high quantity and quality, they yield no dissatisfaction. Their existence does not motivate in the sense of yielding satisfaction; their lack of existence would, however, result in dissatisfaction. They were consequently referred to as "hygiene" factors.

In the second group, Herzberg listed certain satisfiers and therefore motivators are related to job content. They included achievement, recognition, challenging work, advancement, and growth in the job, Their existence will yield feelings of satisfaction or no satisfaction (not satisfaction). As we can see from Figure 2.4, the factors identified by Herzberg are similar to those suggested by Maslow.

**Figure 2.4** : Comparison of Maslow's and Herzberg's theories of motivation

Maslow's need hierarchy	Herzberg's two-factor theory
Self-actualization	Challenging work Achievement Growth in the job Responsibility
Esteem or status	Advancement Recognition
Affiliation or acceptance	Status Interpersonal relations Quality of supervision
Company policy and administration	Working conditions
Security or safety	Job security Salary
Physiological needs	

The first group of factors (the dissatisfiers) Herzberg called maintenance, hygiene, or job context factors. Their presence will not motivate people in an organization; yet they must be present, or dissatisfaction will arise. The second group or the job-content factors, he found to be the real motivators because they have the potential of yielding a sense of satisfaction. Clearly, if this theory of motivation is sound, managers must give considerable attention to upgrading job content.

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