Work Setting, Community Attachment and Satisfaction among Rural and Remote Nurses

Abstract

Objective: To describe community satisfaction and attachment among rural and remote Registered Nurses (RNs) in Canada.

Design: Cross-sectional survey of rural and remote RNs in Canada as part of a multi-method study.

Sample: A stratified random sample of RNs living in rural areas of the western country and the total population of RNs who worked in three northern regional areas and those in outpost settings. A subset of 3331 rural and remote RNs who worked mainly in acute care, long-term care, community health, home care and primary care, comprised the sample.

Measurements: The Home Community Satisfaction Scale measured community satisfaction, whereas single item questions measured work community satisfaction and overall job satisfaction. Community variables were compared across practice areas using ANOVA whereas thematic analysis was conducted of the open-ended questions.

Results: Home care and community health RNs were significantly more satisfied with their work community than RNs from other practice areas. RNs who grew up in rural communities were more satisfied with their current home community. Four themes emerged from the open-ended responses that describe community satisfaction and community attachment.

Conclusions: Recruitment and retention strategies need to include mechanisms that focus on community satisfaction which will enhance job satisfaction.

Key Words: community satisfaction, rural nursing, public health nurses, home care nurses, community attachment

Work Setting, Community Attachment and Satisfaction among Rural and Remote Nurses

Recruiting and retaining health professionals for rural areas is increasingly challenging (CACC & CHCA, 2003). Understanding the dynamics that influence community health and home care nurses' decisions to seek employment and remain in rural communities is therefore essential. The main focus of this paper is to provide information about community attachment and satisfaction and the links to work satisfaction among a sample of rural and remote RNs. Comparisons are made between acute care, long-term care, community health, home care and primary care nurses to illustrate the uniqueness of community health and home care nurses regarding the topic under study. All analyses are from the survey component (Stewart et al, 2005) of a multi-method study of nursing practice in rural and remote areas of Canada (MacLeod, Kulig, Stewart, Pitblado & Knock, 2004).

Background

In this study, rural refers to "individuals in towns or municipalities outside the commuting zone of larger urban centres (with 10,000 or more population)" (duPlessis, Beshiri, Bollman & Clemenson, 2001, p 6). Rural communities have many assets (i.e., friendliness, sense of belonging, sense of security) that attract individuals to them but they also face challenges including loss of youth (Tremblay, 2001), loss of services and urban centric policies that do not consider the uniqueness of rural settings (Kulig, Nahachewsky, Thomlinson, MacLeod & Curran, 2004).

Community refers to a multi-dynamic setting with internal and external relationships to meet the collective goals of the residents (Walter, 1997). It also represents a type of social institution that meets personal or social needs such as a sense of belonging (Toth Brown & Xu, 2002). This emphasizes social processes (Brown, 1993) rather than geographic components but

acknowledges that there are inter-relationships between these two dimensions. In other words, geography of place can enhance or detract from the development of social processes. In this article, community and rural community are used interchangeably.

It is becoming increasingly difficult to successfully recruit and retain health professionals, including RNs for rural communities (Halseth & Ryser, 2006). Given the global nursing shortage, there is a pressing need to identify relevant factors which may influence community attachment and satisfaction with potential impact on decisions to choose rural nursing or remain employed in nursing in rural areas.

Community Attachment

Community attachment includes the local social bonds and the sentiments towards one's community (Goudy, 1990). The extensiveness of social connections in the community determines the level of community attachment or commitment to one's community (Liu, Ryan, Aurbach & Besser, 1998). Affective community attachment refers to a "sense of community" (Liu, et al, 1998) which is demonstrated by factors such as a sense of belonging to the community and having expressions of emotional connection to the community (McMillan & Chavis, 1986).

The systemic model of community attachment includes three dimensions that explain commitment to rural communities (Beggs, Hurlbert & Haines, 1996). The sentiment dimension focuses on positive feelings toward the community, the participation dimension includes involvement in formal community organizations, and the interpersonal dimension refers to ties to friends and family in the local community (Beggs et al, 1996). Length of residence, social position and stage of life cycle (Goudy, 1990) and social networks (Beggs, et al, 1996) have all been studied to clarify the significance of these dimensions. One conclusion is that people attach

in different ways to communities and that different types of people attach to communities in different ways (Goudy, 1990). This is confirmed by a more recent study in which the participants indicated their attachments were related to the natural environment, built environment or social environment of their community (Cross, 2003).

Community Satisfaction

Community satisfaction is dependent upon both structural and social supports. Structural supports include economic security, opportunities for personal advancement in employment and education and local availability of services (Pretty, Bramston, Patrick & Pannach, 2006). Social supports (e.g., family and friends) include one's sense of belonging and sense of community. There is some indication that community satisfaction is more important for rural residents due to the types of relationships developed and maintained in these smaller communities (Toth, Brown & Xu, 2002). Furthermore, rural residents have reported higher community satisfaction than their urban counterparts (Theodori, 2001; Toth et al, 2002). Theodori noted that community satisfaction and attachment have been positively associated with individual well-being.

There are numerous studies that focus on aspects of satisfaction but none formally address this concept to explain why individuals leave rural communities. One exception is an Australian study with rural youth which examined the "push and pull factors" contributing to youths' decision about moving. These factors were then related to concepts such as sense of belonging and sense of community which contribute to community satisfaction (Pretty, Bramston, Patrick & Pannach, 2006).

There is scant literature available that addresses community satisfaction among rural nurses in general, or specifically among rural community health and home care nurses. Most of the research has focused on work satisfaction as a separate entity (Bushy & Banik, 1991; Stewart

& Arklie, 1994) or focuses on work satisfaction and in passing refers to community satisfaction (MacPhee & Scott, 2002).

The exceptions to the paucity of literature on community satisfaction among nurses are as follows. A study in the early 1990's examined the likelihood of RNs leaving rural settings (Pan, Dunkin, Muus, Harris & Geller, 1995). The RNs in this study worked in community hospitals, skilled nursing facilities and public health agencies. The RNs' perceptions of their jobs and communities played significant roles in their decision to remain in their current position. A second study included both urban and rural nurse practitioners and examined their satisfaction with practice and community satisfaction (Keith, Coburn, Mahoney, 1998). Among the rural nurse practitioners (55.9%, $n = 40$), there were higher scores for satisfaction with home community.

Retention of public health nurses in rural British Columbia, Canada was examined by conducting a survey about job and community satisfaction (Henderson Betkus & MacLeod, 2004). Two scales were used: a 12-item community satisfaction developed by the first author of the article and an adaptation of a 37 item job satisfaction scale from the University of North Dakota Rural Health Centre Questionnaire (Dunkin, Juhl, Geller, & Ludke, 2004). There were no clear relationships between job or community satisfaction and retention but job and community satisfaction were correlated. The authors postulated that beyond job or community satisfaction, "filter factors" such as the closure of local schools or lack of available spousal employment were important factors that influenced their ability to remain as a public health nurse in the rural community. Further research that examines community satisfaction and the filter factors in more depth is needed to increase our understanding of the decision-making employed by rural-based community health nurses to remain in their positions.

Community attachment and satisfaction is a complex relationship of social network bonds. One assumption is that RNs who work in rural communities, regardless of work setting, are attracted to living in a small community. For the purposes of this article, we explore the differences between RNs who work in community health and home care and other types of work settings regarding community attachment and satisfaction and work satisfaction in rural communities.

Methods

Design

The data examined in this paper were drawn from a cross-sectional survey of rural and remote RNs in Canada (details of method in Stewart et al, 2005). Ethical approval was received from the second author's institution. The survey method was a modified version of Dillman's (2000) Tailored Design Method with persistent follow-up. Survey participants were asked to complete the mailed questionnaire which included the content areas of demographics, work environment characteristics, nursing practice roles, the context of their practice, and issues related to nursing worklife. The participants also responded to five open-ended questions at the end of the survey. The questions included their reason(s) for accepting their current position, how rural and remote nursing differed from other nursing roles and how their education prepared them for rural or remote nursing. Importantly for this article, the participants responded to these questions with comments about *living* in rural communities, including what they liked about them and how this influenced their decision to accept their current position. A limitation is that some participants may not have included all comments related to the questions or may not have elaborated as much as they had desired.

Participants

The national survey included the total population of RNs who were licensed to work in the Yukon, Nunavut and Northwest Territories, and nursing stations or outpost settings, as well as a stratified random sample of RNs living in rural areas in all of Canada's provinces. A total of 3933 usable questionnaires were returned between October 2001 and July 2002, resulting in a 68% response rate. The subset of 3331 rural and remote RNs analyzed in this paper, were those participants who reported that most of their work time was spent in one of the five main areas of

nursing practice, acute care, long-term care, community health, home care and primary care. This analysis excluded those RNs who reported practicing in administration, education, research and other areas (e.g., mental health, corrections, addictions). A limitation of the questionnaire approach was that the RN respondents were provided with the five categories of work and each RN used their own definition to decide which category to attribute their work.

Measures

The Community Satisfaction Scale (Henderson Betkus & MacLeod, 2003) includes items related to satisfaction with aspects of the home community such as friendliness and safety, social and recreational opportunities, and rural/remote specific items such as community size, and distance from major centres. For the current analysis, we used the 11-item 5-point Likert scale (excluding the overall community satisfaction item), with summated scores ranging from 11 to 55 and a Cronbach's alpha of .86. A previous study (Henderson Betkus & MacLeod, 2003) reported an alpha of .84 for 12 items including overall community satisfaction. Work community satisfaction was measured using a single 4-point item: "I am happy with the community in which I work" (scores ranging from 1 to 4). Overall job satisfaction was also measured using a single 7-point item: "Overall, I am very satisfied with my job" (scores ranging from 1 to 7). For all measures, a higher score was related to higher satisfaction. Means and standard deviations for these continuous measures, along with age in years, are found at the bottom of Table 1 in relation to the five main practice areas. Frequencies of dichotomous demographic variables relative to practice area can be found at the top of Table 1.

Survey questions about the populations of communities where the RN lived, worked, and grew up, were dichotomized into ‘10,000 and less’ versus ‘over 10,000’ based on the definition of rural used in this study. Table 2 presents means and standard deviations for satisfaction with

home community and work community in relation to reports of the size of these communities (childhood, home and work).

Data Analysis

Descriptive comparisons of the sample of rural and remote RNs from the five main practice areas were conducted. One-way Analysis of Variance (ANOVA) was used to determine differences in satisfaction across the five practice groups, with significant findings followed by Tukey tests to make pairwise comparisons of means and detect the specific differences within the five groups. Separate ANOVAs were used for satisfaction with work community and home community (Table 2) in relation to size of community (childhood, home and work). A Pearson correlation was conducted between satisfaction with work community and overall job satisfaction for the entire sample.

The responses to the open-ended questions for all the participants (n = 3331) were analyzed within subgroups of current area of practice (i.e., acute, long-term care, community health, home care, and primary). The RNs were not specifically asked about community attachment or satisfaction but they spontaneously included comments about what it was like to live in a rural community, why they chose to live and work in a rural community and how the rural characteristics impacted their decision to remain in a rural community or to move from one rural community to another. Their responses were read by the lead and last authors, categorized and developed into four major themes. These themes were then discussed and clarified with the other authors who individually read selected pages from the transcripts. Comparisons were made between the five practice areas to determine similarities and differences regarding community attachment, community satisfaction and work satisfaction.

Results

Sample Characteristics

Table 1 describes the demographic characteristics, home community satisfaction, work community satisfaction and overall job satisfaction of the 3331 rural and remote RNs from the five main practice areas. The majority of RNs reported working in acute care (n =1552, 47%) with the lowest proportion of RNs working in primary care (n =291, 9%). Over ninety-percent of RNs were female across all five practice areas. Only 0.7% of home care RNs were males with the largest proportion of males (9.7%) working in the primary care area of practice. The rural and remote RNs from the five main practice areas represent an aging population with a mean age of 44.1 (range 42.6 - 46.6). Although mean age differences were small, there was a significant difference in age across the practice areas [$F(4, 3291) = 23.25$, $p < .001$].The Tukey multiple comparisons of means revealed that acute care RNs were significantly younger than RNs from each of the other practice areas ($p < .001$). The home care RNs reported the highest mean age and were significantly older than both the acute care RNs ($p < .001$) and the community health RNs ($p < .01$).

The majority of RNs from the five practice areas were married, however a lower proportion of the primary care RNs reported being with a partner (67.7%). Approximately the same proportion (56-61%) of RNs from 4 of the practice areas reported having dependent children or relatives; with a lower proportion of primary care RNs having dependents (44.3%). A diploma in nursing was the highest attained nursing education reported by the majority of acute care, long-term care, and home care RNs. A higher proportion of the community health (51%) and primary care (39.5%) RNs had attained a degree in nursing (Bachelors, Masters or PhD).

The sample of RNs from the five main practice areas represent rural and remote RNs; with over 80% of all groups reporting that they were living in communities with a population of 10,000 people or less. The majority from the five main practice areas were also working in communities with a population of 10,000 or less with the lower majority of acute care RNs (70%) working rurally. The greater part of the sample also grew up in smaller communities, with the smallest proportions of community health (64.4%) and primary care RNs (63%) growing up in smaller rural communities.

Community and job satisfaction among five main practice areas

Significant differences were found between the five main practice areas of acute care, long-term care, community health, home care and primary care for Home Community Satisfaction [$F (4, 3220) = 7.27$, $p < .001$], Work Community Satisfaction [$F (4, 3261) = 6.76$, $p < 0.001$], and Overall Job Satisfaction [$F (4, 3241) = 17.56$, $p < 0.001$]. Post hoc Tukey tests for the Home Community Satisfaction scale revealed that the primary care RNs had significantly lower satisfaction with their home community than the RNs who worked in acute care ($p <.001$), long-term care ($p <.01$), community health ($p <.01$), and home care ($p <.001$). Post hoc analysis for the Work Community Satisfaction item revealed that the home care RNs were significantly more satisfied with their work community than the RNs who worked in long-term care ($p <.05$), acute care ($p <.01$), and primary care ($p <.001$). As well, community health RNs were significantly more satisfied with their work community than the primary care RNs ($p <.05$). Post hoc tests revealed that the RNs in community health, home care, and primary care had significantly higher levels of overall job satisfaction than the RNs in acute care ($p <.001$) and long-term care ($p <.01$). Across the entire sample there was a moderate correlation ($\underline{r} = .41$; $p < .001$) between satisfaction with work community and overall job satisfaction.

Community satisfaction among size of community

Table 2 outlines the significant differences that were observed based on survey questions that differentiated between the three sizes of community categories (childhood, home and work) and community satisfaction (home and work). Registered nurses from the five main practice areas that grew up in rural communities with a population of 10,000 people or less were significantly more satisfied with their home community [$F (1, 3189) = 14.06$, $p < .001$] than RNs from larger communities. In contrast, the RNs who lived in larger rural communities were significantly more satisfied with their home community [$F (1, 3189) = 34.28$, $p < .001$] than the RNs who lived in the smaller communities. Similarly, the RNs who worked in communities with a population over 10,000 people were significantly more satisfied with their home community [$F (1, 3160)$, $p < .001$] than the RNs who worked in smaller rural communities. There were no significant differences noted based on size of childhood and home community and satisfaction with the work community. However, those RNs who worked in communities with a population over 10,000 were significantly more satisfied with their work community [$F (1, 3202) = 3.94$, $p < .01$] than the RNs who worked in the smaller rural communities.

Community Attachment & Satisfaction: Open-Ended Responses

Community attachment. There were two themes in relation to Community Attachment: *Going Home* and *Becoming Home*. Nurses who go home to rural communities (either their original community or a similar one) do so because they are attached and therefore satisfied. An acute care RN said: “It’s what I chose because it’s my home”. A home care RN said: “I grew up in this community and I love rural life. I can’t imagine living anywhere else.” A community health RN said: “Location is near my home; it allows me more time at home with family.” whereas a long-term care RN said: “Like small towns. Born and raised in a small town.” A

primary care RN said: “This is my home community, a nurse was needed and I knew what outpost nursing entailed as my mother was one.” Aboriginal participants more often responded about a personal commitment to go home and work with their people. In these instances they more often worked in community health or primary care because of the lack of other nursing positions in their home communities. These participants often simply responded that they chose their current employment :”To work with my people.”

Becoming Home was also a common theme and usually occurred for one of three reasons: the nurse: (1) chose the rural community as their home; (2) “married in” (i.e., married a local individual); or, (3) followed their spouse and together they made their chosen community home. In the latter example it was more often female nurses relocating with their husbands who worked as police personnel or in natural resources such as mining, farming, or fishing. One primary RN said: “I chose to live in this small community, built a home and started a family due to lifestyle, scenery and vicinity to larger center….I really think there are certain personalities that suit this lifestyle better than others. My upbringing in a small town in rural Canada has made me more comfortable in similar settings.”

One home care RN noted: “My husband is from this community. All of my experience has been in rural/remote communities. I like the autonomy, independence and being part of the community.” Another home care RN said: “I came here to work fall of 1963, met and married a farmer and have lived here since.” One community health RN said: “I enjoy small town nursing because of the way it makes me feel part of the community” while another said: “Rural nursing is very rewarding, in that there is a sense of community, clients are not seen in isolation, but as part of the community. Nurses are also seen and appreciated for their contribution.”

There were two themes related to Community Satisfaction: Being Rural and Becoming Rural. Being rural refers to a RN who is a rural person and wants to continue living rural and being close to family; their chosen career of nursing helps them achieve that. A long-term care RN said: "All my extended family live here. Better for children growing up." One acute RN responded to why she was working in a rural community by saying: "It is my hometown and I was offered my first job here." One home care RN shared a similar sentiment: "Because I love the life in the country where I can live with my family," while a community health RN said: "I returned to a community I knew and enjoyed." One other community health RN related: "Grew up in the area and received a northern development bursary and had obligations to work in a remote area," and still another said: "My home—and my family—is here." Another community health nurse noted: "I'm originally from a northern small community and felt very comfortable leaving the city to move back to one and live."

Becoming rural refers to RNs who have chosen to move to a rural location for adventure or the opportunity to nurse in a different setting. Specific factors such as the geography of the place or the lifestyle it offers also attracts them to a rural community. They then adapt to the rural environment and make it their chosen home. In this instance, specific positive characteristics of rural become apparent to them such as the closeness of the people, the lifestyle including the slow pace and an ideal setting to raise children. In some instances, the RN arrived with a spouse but often they came by themselves.

One example from an acute care RN is: "I was a 'city girl,' and certainly never expected to find myself in 'small town Saskatchewan.' But I grew to love the town and the job. I grew confident in my abilities as a nurse and grew to enjoy the level of independence involved in working here." Another acute care RN said: "I followed my husband to his new job in the north.

I subsequently took work at the hospital here. I came to the north in the 1970s to escape the regional population explosion and have been slowly migrating further and further north. The land, the solitude, the independence, the vigor, the contrasts, the harsh realities, the sublime beauty." One other acute care RN said: "My life in the North began at age 24 (I came for 3 months). I'll be 50 this year—what a great life! Fantastic people and community. Rewarding work experience—I'm not sorry I stayed. We are raising our family here." Most primary care RNs came from southern parts of the country under study and adopted rural or remote communities as their homes, if only temporarily. One primary care RN described her work as: "More genuine, more personal in Aboriginal community. I love the direct relationship with people in their own community where I can see whole relationships."

A home care RN stated: "Lifestyle, slower pace, recreation and boating," were the reasons rural living was attractive. Another related: "I enjoy the smaller setting as opposed to a more impersonal city setting." A community health RN said: "I love the small community. We are so very lucky to live and work in a small Northern community," while another epitomizes why rural settings are sought by some nurses: "I was young and single and looking for adventure—28 years ago!"

The following quote from a primary care RN reflects the relationship between work and lifestyle: "I have often said that northern nursing is not a job; it is a lifestyle. You are rarely able to separate yourself from your role as a nurse. It is an exhausting, challenging, rewarding, frustrating and sometimes frightening opportunity to learn about yourself in a cross-cultural context. It's been a 'trip'." This is reinforced by the following quotes, the first from a home care RN: "I enjoy it. I think people in my community feel more at ease when they know the person knocking on the door." The following quote from a community health RN also supports the

importance of familiarity in rural settings: “Rural nursing is different because of the long-term relationships you develop with people, caring for them over the years.” These ideas are also reinforced by the following quote from a community health nurse: “I believe a rural nurse has a higher, more personal level of involvement with clients, especially if you happen to live in that community.”

Some of the responses acknowledged the relationship between community and job satisfaction. For example, a primary care RN said: “When a nurse becomes “part” of a community, the job satisfaction increases. I have worked in very remote nursing stations and keeping a “balance” or playing sports and attending social events is so important. The nurses I see with poor job satisfaction isolate themselves from the community or socialize in select cliques.” A long-term care nurse said: “Have always worked in rural area. I feel there is greater emotional support from colleagues and more intense community support for nursing in rural areas.” Another long-term care RN stated: “Last year I came back to the community I grew up in to be the support person of my aging father who lived alone. I very much love rural nursing and the people found in small communities. It is much more personable and the job satisfaction is the best I have had.”

Discussion

The quantitative survey results indicate that there are differences in both community satisfaction and job satisfaction across the five categories of practice. RNs in this study who were raised in rural communities demonstrated greater levels of satisfaction with their home community than RNs who grew up in larger communities (population › 10,000), but there was no difference between these groups in satisfaction with their work community (Table 2). Home care and long-term care RNs were more likely to have rural childhood communities, whereas community health and acute care RNs in this sample (Table 1) were more often from larger communities.

In the thematic analysis of open-ended questions, community health and home care RNs who were from rural communities consciously chose to 'go home' and work in these communities. The acute care, primary care, and long-term care RNs were more often from urban areas and adopted rural living for adventure or to be with their partner. These RNs often became engrained in rural values and lifestyle. These findings support the Keith, Coburn and Mahoney (1998) study which also demonstrated that more often RNs returned to work in rural areas where they were raised.

In the current study, RNs in community health, home care and primary care had significantly higher job satisfaction than those in acute or long-term care. In addition, the open-ended responses from these groups provide some indication that there is a relationship between job and community satisfaction. In the findings reported here, rural RNs commented about their attachment to community and how that factored into their job satisfaction. If community attachment and satisfaction are related to individual well-being, as Theodori (2001) notes, then health regions need to be concerned about these factors when they recruit RNs.

The open-ended responses within the surveys (i.e., ties to family and friends and positive feelings toward the communities in which they live and work) demonstrate support for two of the dimensions (i.e., interpersonal and sentiment dimensions respectively) of the systemic model of community attachment (Beggs, Hurlbert & Haines, 1996). Goudy postulated that different people attach to communities in different ways—the data provided here demonstrates that for some of the RNs, their attachment to rural settings was related to physical features while for others it was the social characteristics (i.e., closeness of the people). Brehm, Eisenhauer and Krannich (2004) have also noted the significance of community attachment based upon the natural environment which requires further examination among rural nurses. Community satisfaction was also shown in the open-ended responses. There are a number of examples of the sense of belonging and sense of community discussed by the RNs who described the community context within which they provided care.

Examining community attachment and satisfaction and their relationship to job satisfaction may be part of the puzzle of successful recruitment and retention. Given the current nursing shortage, identifying and implementing successful recruitment and retention strategies for rural-based community health and home care RNs is a high priority. One solution may be for rural communities to be more closely involved in helping to ensure that RNs experience a sense of belonging in order to develop attachment to the community. For example, providing opportunities for newly arrived RNs to be involved in voluntary organizations or local celebratory events may be one way for them to develop local bonds. However, recruitment of RNs also starts in high school when students are choosing their careers; rural communities need to consider incentives to enhance reasons for RNs to return to their home communities for employment.

Conclusions

The links between satisfaction with one's home and/or work community and job satisfaction are important concepts to examine when recruiting and retaining all rural RNs but particularly those who work in community health and home care. This study showed that rural-based community health and home care nurses were more often originally from rural communities and chose to return to there to pursue their careers. Working with employed community health and home care nurses and community residents to assist newly recruited nurses to develop a sense of belonging and attachment may be an important retention strategy. Emphasizing the opportunity for rural settings to become one's home while also focusing on their unique geography and lifestyle are other aspects that need addressing.

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TABLE 1
CHARACTERISTICS AND COMMUNITY SATISFACTION OF RURAL AND REMOTE RNS IN FIVE MAIN PRACTICE AREAS N=3331†

Characteristic	Practice Areas n (%)				
	Acute Care	**Long-term Care**	**Community Health**	**Home Care**	**Primary Care**
	(n=1552)	(n=620)	(n=564)	(n=304)	(n=291)
Gender					
Female	1460 (94.1)	604 (97.6)	537 (95.6)	301 (99.3)	262 (90.3)
Male	91 (5.9)	15 (2.4)	25 (4.4)	2 (0.7)	28 (9.7)
Highest Attained Nursing Education					
Diploma	1238 (80.7)	537 (88.5)	273 (49)	226 (74.3)	176 (60.5)
Degree	297 (19.3)	70 (11.5)	284 (51)	78 (25.7)	115 (39.5)
Marital Status					
Married/ Common-law	1274 (82.4)	515 (84)	435 (77.7)	262 (86.8)	197 (67.7)
Single/divorced/ widowed	272 (17.6)	98 (16)	125 (22.3)	40 (13.2)	94 (32.3)
Dependents					
Yes	947 (61.4)	348 (56.8)	316 (56.8)	182 (60.3)	129 (44.3)
No	595 (38.6)	265 (43.2)	240 (43.2)	120 (39.7)	162 (55.7)
Population of Home					

Community					
10,000 or less	1252 (81.9)	540 (89)	442 (80.1)	291 (90.6)	235 (81.9)
Over 10,000	276 (18.1)	67 (11)	110 (19.9)	28 (9.4)	52 (18.1)
Population of Childhood Community					
10,000 or less	1095 (71.6)	470 (77.9)	357 (64.4)	234 (78.3)	182 (63)
Over 10,000	435 (28.4)	133 (22.1)	197 (35.6)	65 (21.7)	107 (37)
Population of Working Community					
10,000 or less	1059 (70)	492 (81.6)	463 (84.2)	243 (81.5)	253 (90.4)
Over 10,000	454 (30)	111 (18.4)	87 (15.8)	55 (18.5)	27 (9.6)
	M (SD)	M (SD)	M (SD)	M (SD)	M (SD)
Age (years)*	42.6 (9.3)	46.1 (9.9)	44.3 (9.7)	46.6 (8.6)	45.3 (9.8)
Satisfaction with Home Community*	39.6 (7.4)	39.5 (7.7)	39.2 (7.5)	40.4 (6.7)	37.3 (8.6)
Satisfaction with Work Community*	3.6 (0.6)	3.6 (0.7)	3.7 (0.6)	3.8 (0.5)	3.5 (0.6)
Overall Satisfaction with Job*	5.3 (1.4)	5.3 (1.3)	5.8 (1.2)	5.7 (1.2)	5.7 (1.1)

* Continuous variables, results displayed are Mean and Standard Deviation

† Sum may not equal total sample size owing to missing values

TABLE 2
COMPARISONS OF COMMUNITY SATISFACTION BASED UPON SIZE OF COMMUNITY (CHILDHOOD, HOME AND WORK) N=3331

	Satisfaction with Home Community†			Satisfaction with Work Community††		
Size of Community	M (SD)	F	*p*	M (SD)	F	*p*
Childhood Community						
10,000 or less	39.7 (7.5)			3.64 (0.6)		
Over 10,000	38.5 (7.8)	14.06	.000*	3.60 (0.6)	2.25	.134
Home Community						
10,000 or less	39.0 (7.5)			3.64 (0.6)		
Over 10,000	41.1 (7.5)	34.28	.000*	3.62 (0.6)	0.29	.587
Work Community						
10,000 or less	38.9 (7.7)			3.63 (0.6)		
Over 10,000	40.9 (6.8)	43.00	.000*	3.68 (0.6)	3.94	.047**

† Satisfaction with home community scale (range in scores from 11-55)

†† Satisfaction with work community single item (range in scores from 1-4)

*Statistically significant $p<0.001$

**Statistically significant $p<0.05$