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ASPECTS OF PROFESSIONAL BURNOUT AMONG NURSES

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Abstract: *This paper focuses on the job-related burnout among nurses working in Romanian public hospitals. The correlational study conducted on a convenience sample of 106 nurses working in two public hospitals aimed at highlighting aspects related to the perceived intensity of specific burnout emotional and behavioral manifestations among nurses and their relationships with other variables, i.e. age, length of service as nurse, family status, and emotional intelligence – an individual ability that plays an important role in optimal adjustment to specific nursing demands. Even though in the current sample the level of burnout dimensions was moderate, comparative data revealed significant differences between nurses differentiated by the hospital they worked in. For the whole sample the emotional intelligence score was a negative predictor of the sense of professional failure accounting for 12.6% of the variance in this dimension of burnout. This result suggests that nurses who show a lower ability to manage their own emotions are at higher risk to experience a sense of professional failure and dissatisfaction.*

Keywords: *nursing, burnout, emotional intelligence, correlational study*

1. INTRODUCTION

The topic of burnout has emerged in the literature over three decades ago [9, 12, 14]. Job-related burnout was conceptualized as one of the negative consequences of prolonged occupational stress, which occurs when an employee is no longer able to cope with stress at work (Pezet-Langevin, 2001). Job burnout is not a disease and should not be confused with depression.

Burnout and its organizational implications have their roots in people-oriented, helping professions in which workers continuously deal with people and their problems: nurses, doctors, educators, social workers, psychologists, firefighters, policemen, rapid intervention teams etc. Subsequently, the concept was extended to other occupations

considered to be demanding and requiring a high level of professional commitment. The most common operational definition of burnout has been suggested by C. Maslach and S. E. Jackson [9] to describe this psychological condition among professionals in fields involving the delivery of immediate aid. According to this definition, burnout is characterized by three related dimensions: a) emotional exhaustion which is the feeling experienced by some employees that they do no longer have any emotional resource to cope with professional demands; from this point of view, emotional exhaustion must be distinguished from physical or mental exhaustion; both physical and emotional exhaustion are facets of chronic fatigue syndrome; b) depersonalization (cynicism) is the negative attitude (i.e., indifference,

coldness) towards the beneficiaries of their professional service; c) sense of professional failure (the employee feels to be unproductive and having a low professional efficacy). *Maslach Burnout Inventory/MBI* [9] is the most widely validated instrument which assesses the frequency and/or intensity of burnout dimensions.

Empirical studies have been focused on the effects of job-related burnout in relation to a number of indicators related to organizational efficiency, employee performance and attitudes towards work [7, 14]. There is also substantial empirical evidence on the relationship between burnout and indicators of physical and mental health in employees [3].

In addition to a number of factors related to certain characteristics of the nursing (e.g., role conflict, role ambiguity, supervision and control, work overload) a very important role in the genesis of burnout among nurses is played by interpersonal factors, i.e. emotional exigencies which are specific to nurse-patient relationship [4]. Thus, feeling emotionally overburden in the relationships with patients seems to play a crucial role in the emergence and intensification of professional burnout among nurses. Other variables found to have consistent relationships with the intensity of specific burnout manifestations among nurses were: the amount of time spent with patients and working with patients with poor survival prognosis [4], frequent exposure to pain experience and patient death [6], age [1, 5] – this factor shows the most consistent relationship with burnout [cf. 7] or emotional intelligence [2, 11, 13].

2. THE PRESENT STUDY

2.1 Aim. Starting from the operational definition proposed by Maslach and Jackson [see 9] and empirical evidence reported in the literature, this study aimed to deal with issues related to: a) perception of the intensity of burnout manifestations among nurses working in various public hospital unit or clinics; b) some variables that are related to burnout among nurses. The current study was both comparative and correlational.

2.2 Participants and procedure. Data were collected through a self-administered standardized protocol. One hundred and six nurses (16 men and 90 women) responded in this study. Of participants, 40 were working at the “Sf. Ioan cel Nou” County Emergency Hospital in Suceava and 66 at the “I. M. Georgescu” Institute of Cardiovascular Diseases (ICVD). The average length of service as a nurse was 12.95 years (SD = 7.86; range: 0.33-39 years). The average length of service in the job held at the time of data collection was 10.74 years (SD = 7.44 years; range: 0.25-36 years). The units or clinics the participants worked in as nurses were: medical therapy for patients with cardiovascular disease (33% of participants), cardiovascular surgery (31.1%), general or pediatric surgery, internal medicine, pediatrics or ophthalmology (2.8% of participants each), other medical specialties (e.g., plastic surgery, diabetology and metabolic syndrome, gastroenterology, orthopedics, obstetrics and gynecology, etc. – 17% of participants). The mean age of participants was 36.91 years (SD = 6.76). Over three quarters of participants were married, the remainder being unmarried (18.9%), divorced (3.8%) or having other relational statuses. Almost a third of respondents (32.1%) had no children in care, while 37.7% had one child, 27.4% - two children, and the remaining - 3 children.

Participants were recruited through convenience sampling of the medical staff at two public hospitals. Nurses completed the protocol with questionnaires at work or at home, after giving a verbal agreement to participate in the study. Responses were anonymous to encourage honesty.

2.3 Measures. For data collection nurses completed three standardized questionnaires. The first questionnaire covered a range of demographic and occupational characteristics. The second questionnaire [MBI; see 9] operationalized the dimensions of burnout. In this study we used a translated and adapted version of the *Maslach Burnout Inventory-General Survey* (MBI-GS). Nurses were asked to respond to a pool of 20 items scored on a seven-point Likert-type scale as follows: 1 – very little intense; 2 – little intense, 3 – quite



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little intense, 4 – moderately intense, 5 – quite intense, 6 – intense and 7 – very intense. For each dimension, a total score was computed as the average scores of the corresponding items. High (between 5 and 6.50) or very high (between 6.51 and 7) scores were interpreted as increased subjective feeling of emotional exhaustion, depersonalization, and sense of professional failure. Investigations conducted by Maslach and Jackson [9] showed a good reliability (internal consistency and test-retest correlation), concurrent, discriminant, and criterion-related validity of MBI [see also 8]. For the sample of nurses who participated in this study, the internal consistencies (estimated with Cronbach’s alpha coefficient) were: 0.83 (emotional exhaustion), 0.78 (sense of professional failure), and 0.62 (depersonalization).

Emotional intelligence self-assessment was performed by using the *Self-Reported Emotional Intelligence Test/SREIT* [15]. This measure is based on the conceptual model proposed by J. D. Mayer and P. Salovey [see 10] and includes 33 items scaled on a five-point Likert-type scale: 1 – strongly disagree, 2 – disagree, 3 – neutral (neither disagree nor agree), 4 – agree and 5 – strongly agree. For each participant, a total score was computed (by summing the scores for the 33 items) which indicated the level of emotional intelligence (possible range: 33-165). A high score was interpreted as a high level of emotional intelligence. In this study, $\alpha = 0.77$.

2.4 Results and discussion. Considering the possible range for score variation on the questionnaires administered to nurses, we obtained: a) a moderate level of emotional exhaustion ($M = 3.56$, $SD = 1.14$; lowest score = 1; highest score = 6.33); b) a low sense of depersonalization ($M = 2.29$, $SD = 1.14$; lowest score = 0.75; highest score = 5.25); c) a moderate to low sense of professional failure ($M = 3.14$, $SD = 1.16$; lowest score = 1;

highest score = 6.57); d) a moderate to high level of emotional intelligence ($M = 125.33$; $SD = 10.55$; lowest score = 90; highest score = 150). The distributions of scores on burnout dimensions and emotional intelligence were quasi-normal, because: a) the absolute values of skewness (asymmetry) ranged from 0.27 to 0.57 (they were not significantly deviated from the zero value which is specific to a normal distribution); b) absolute values of kurtosis were between 0.21 and 0.75; c) values for the Kolmogorov-Smirnov (z) test used to estimate the normality of distributions were not statistically significant (range of z : 0.74-1.50; range of associated statistical significance thresholds: 0.052-0.633).

Gender-based comparisons of the study participants were not performed due to the small number of males and significant discrepancy between male and female subsample sizes. However, starting from the premise that, among nurses, to the high-level job duties and strain the family responsibilities are added, resulting in an increased vulnerability to stress symptoms, we compared the scores on burnout dimensions according to marital status and number of children. None of the demographic characteristics had a significant effect on burnout scores. Thus, married nurses ($N = 80$) had slightly lower mean scores on emotional exhaustion ($M = 3.49$, $SD = 1.20$) and depersonalization ($M = 2.20$, $SD = 1.13$), and a higher mean score on the sense of professional failure ($M = 3.22$, $SD = 1.22$) compared to unmarried nurses ($N = 20$) – $M = 3.90$ and $SD = 1.01$ on emotional exhaustion, $M = 2.42$ and $SD = 1.20$ on depersonalization, $M = 2.87$ and $SD = 0.94$ on sense of professional failure. However, differences between means were not statistically significant: $t = -1.37$ and $p = 0.172$ on emotional exhaustion; $t = -0.78$ and $p = 0.435$ on depersonalization; $t = 1.20$ and $p = 0.231$ on sense of professional failure.

Moreover, the values of one-way ANOVA F-test were not statistically significant (the independent variable was the number of children: N = 34 – no children, N = 40 – one child, and N = 32 – two or three children): F = 0.23 and p = 0.792 on emotional exhaustion, F = 2.57 and p = 0.081 on depersonalization, and F = 0.90 and p = 0.408 on the sense of professional failure.

However, the scores on emotional exhaustion and depersonalization were significantly related to the hospital nurses worked in. Thus, compared with nurses working in Suceava County Hospital, those who were employed at the “I. M. Georgescu” ICVD had significantly higher mean scores on these two burnout dimensions: t = 5.03 and p < 0.001 on emotional exhaustion, t = 3.26 and p < 0.01 on depersonalization. Nurses working in ICVD also had a slightly higher mean score on sense of professional failure, but the difference was not statistically significant (t = 0.69; p = 0.489). In addition of general nursing care, nurses working in cardiovascular surgery and medical treatment units of ICVD (a renowned health care facility that serves a large number of patients in the Moldavia region) also perform other specific activities depending on the nature and level of demands [13]. Thus, the staff working with cardiovascular patients provides preoperative nursing care to patients undergoing cardiac surgery. Specific to these patients is the risk (often potentially fatal) of cardiovascular disease symptoms, requiring permanent vigilance from medical staff and a high level of professional responsibility. The nurses are employed at the “I. M. Georgescu” ICVD have to perform a large volume of medical procedures according to strict clinical protocols, requiring quick reaction, good professional knowledge and an implicit assumption of the consequences of their actions. On the other hand, the clinical sensitivity of cardiovascular patients who are to receive a very strict protocol before surgery may be an additional source of pressure and stress. The peculiarities of nursing-related activities carried out in “I. M. Georgescu” ICVD may partially explain the results we obtained.

For whole sample of nurses, the correlations among scores on burnout dimensions and age and length of service were not statistically significant: r = - 0.02 and p = 0.815 (age), r = 0.02 and p = 0.836 (total length of service as a nurse), r = 0.01 and p = 0.875 (length of service in the current job) – emotional exhaustion; r = 0.05 and p = 0.558 (age), r = 0.003 and p = 0.997 (total length of service as a nurse), r = - 0.03 and p = 0.688 (length of service in the current job) – depersonalization; r = 0.01 and p = 0.922 (age), r = 0.08 and p = 0.387 (total length of service as a nurse), r = 0.07 and p = 0.432 (length of service in the current job) – sense of professional failure.

Of three burnout dimensions, only the sense of professional failure showed a significant correlation (negative, as expected) with emotional intelligence score (r = - 0.35; p < 0.001). For the other two dimensions of burnout, the statistical significance of correlation with emotional intelligence was marginal. Data of a bivariate linear regression analysis (which included the constant in the equation) revealed a statistically significant model (R = 0.35; F = 14.96; p < 0.001). Emotional intelligence was a significant predictor of the sense of professional failure score (b = - 0.03; SE = 0.01; β = - 0.35; p < 0.001) accounting for 12.6% of variance in this burnout dimension. Data were convergent with those reported by T. Brand [2] who, in a large sample of nurses, found consistent correlations between the sense of professional failure and three dimensions of emotional intelligence: recognition and expression of emotions, understanding emotions, and managing emotions. In the research conducted by Brand the scores on the dimensions of emotional intelligence explained together 18.1% of the variance in the sense of professional failure.

The result we obtained in this study can be explained by the importance of emotional intelligence in the adjustment to the emotional demands that are specific to nursing work. Thus, many nurses perceive their own work as invisible to others, undervalued and very complex [11]. Often, nurses believe they successfully overcome the negative emotional



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states, but they feel emotionally exhausted. Some empirical evidence suggests that nurses with high levels of emotional intelligence more easily adapt to specific occupational stress. Emotional intelligence allows nurses to prevent the specific manifestations of burnout and other negative ideations [11]. Le Blanc et al. [6] showed that oncology nurses with a low level of emotional intelligence are more likely to experience burnout when faced with job-related emotional demands and do not have adequate coping resources. Therefore, nurses need specialized training to develop skills for managing their own emotions and to improve the ability to help patients to cope with their own negative emotions.

3. CONCLUSIONS

One of the most important result of our study is the negative relationship between the sense of professional failure and emotional intelligence. According to Mayer and Salovey, emotional intelligence is an individual ability that involves both cognitive as well as emotional domains [10]. Emotional intelligence is composed of four abilities that are dynamically interconnected in the daily human functioning: a) the ability to perceive and identify emotions in oneself and others; the ability to express emotions in different interpersonal contexts; b) integration of emotions into the cognitive system and of their influences on knowledge that an individual has already gained through experience; c) the ability to understand the significance of emotions, the relationships among various emotions, and their implications in personal and interpersonal functioning, and d) the ability to manage the emotions in different interaction situations, in solving various life-related problems or in coping with stressful demands. Mayer and Salovey suggest that the four facets of emotional intelligence operate in

an integrative manner. Thus, the perception and identification of emotions require the emotional information processing, while the emotional facet implies the use of emotions to improve cognitive processes. The fourth facet implies the self-regulation of emotions according to the specific tasks which the individual has to solve or life situations he/she goes through. By its integrative nature, emotional intelligence contributes to cognitive and emotional adjustment as well as to personal development. In nurses experiencing high levels of cognitive, social and emotional strains, emotional intelligence can be of important instrumental value.

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