

2021

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Recommended Citation

LaBelle, S. (2021). Burnout in the Nursing Profession: Extant Knowledge and Future Directions for Research and Practice. *Nursing Communication*, 1 (1). Retrieved from <https://repository.usfca.edu/nursingcommunication/vol1/iss1/8>

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Burnout in the Nursing Profession: Extant Knowledge and Future Directions for Research and Practice

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Abstract

Burnout is a psychological state resulting from prolonged psychological or emotional job stress, and is a culmination of three factors: emotional exhaustion, depersonalization, and reduced personal accomplishment. Due to the nature of the “people-work” they must constantly perform, along with a highly stressful and unpredictable work environment, nurses have alarmingly high rates of burnout among members of their profession. Given the importance of research on burnout to understanding the context-specific stressors and challenges of nursing, this review offers a synthesis of research published in the last decade in both nursing and communication journals, with an emphasis on discussing opportunities for further research in this area of study. As such, an overview of the extant research on the predictors, outcomes, and means of coping with and preventing burnout among nurses will be discussed. Finally, this article concludes by forwarding a series of directions for both research and practice in the fields of nursing and communication.

Keywords: nursing, communication, burnout, nurse job stress

Introduction

Clinical psychologist Herbert Freudenberger (1974) first used the term “burnout” to describe the stress responses of employees of halfway houses and free clinics. Four decades later, in May 2019, the World Health Organization (WHO) officially recognized burnout as an “occupational phenomenon” in the International Classification of Diseases (ICD-11). Understood as a psychological state resulting from prolonged psychological or emotional job stress, burnout is an internal emotional reaction that results in a lack of personal and/or social resources (Maslach & Jackson, 1981). More emphatically, Maslach and Leiter (1997) term burnout as “the index of the dislocation between what people are and what they have to do. It represents an erosion in values, dignity, spirit, and will—an erosion of the human soul. It is a malady that spreads gradually and continuously over time, putting people into a downward spiral from which it’s hard to recover” (Maslach & Leiter, 1997, p. 17). Burnout is a culmination of three factors: emotional exhaustion, depersonalization, and reduced personal accomplishment (Maslach, 2003). That is, individuals experiencing burnout feel emotionally depleted, cynical about their job, and less capable of performing their occupational duties (WHO, 2019). A syndrome occurring often in those professions that involve a significant amount of “people-work,” burnout is unique from other job stress responses as it results specifically from the social interactions

between individuals and recipients of their help (Maslach, 2003, p. 2). As described by Miller, Stiff, and Ellis (1988), burnout is “a reaction to constant, emotional, communicative contact with individuals in need of help” (p. 250).

Nursing is a profession that stands at particularly high-risk for burnout symptoms (Maslach, 2003). The emotional and psychological resources necessary for nursing, along with the unpredictability, responsibility, and exposure to traumatic situations characteristic of nurses’ work environment (Chang, 2012; Leiter, Jackson, & Shaugnessy, 2009; Piko, 2006), are all potential causes for the alarmingly high rates of burnout in this population. In fact, as many as 30-50% of nurses reach clinical levels of burnout (see Cañadas-De la Fuente et al., 2015; Jesse, Abouljoud, Hogan, & Eshelman, 2015), with one in four emergency room nurses in particular demonstrating multiple components of burnout syndrome (Adriaenssens, de Gucht, & Maes, 2015). Many have recognized burnout’s ability to impact the working professionals and investigated signs and symptoms of burnout in order to attempt to curtail its negative effects (e.g., Maslach, 2003).

In her extensive research on the causes of burnout among caregiving professionals, Maslach (2003) established three distinct components of this syndrome: emotional exhaustion, depersonalization, and reduced personal accomplishment. *Emotional exhaustion* results from a person getting over involved emotionally, overextending him or herself, and then feeling overwhelmed by the emotional demands of others. Eventually, this

pattern leads individuals to feel as though they cannot exert any further emotion, or provide an emotional response to situations or people. This psychological detachment can be protective, but it can also lead to problematic feelings of indifference and disregard for others leading to the second component of burnout, depersonalization. *Depersonalization* is characterized by a detached, callous, and pessimistic approach to other people. This negativity can, of course, eventually lead to a sense of negatively and guilt toward oneself. Thus, the third and final component of burnout is a *reduced sense of personal accomplishment*, in which individuals have “a gnawing sense of inadequacy about their ability to relate to recipients” and a growing sense that one is a failure in his or her profession (p. 7). Although these three components tend to occur simultaneously, the sense of reduced efficacy characteristic of lessened personal accomplishment appears to develop in parallel with emotional exhaustion and depersonalization, as opposed to sequentially (Maslach, Schaufeli, & Leiter, 2001). Whereas emotional exhaustion and depersonalization arise from emotional and work overload, reduced personal accomplishment is more often associated with reduced resources (Maslach et al., 2001). These three factors are clearly related and influence one another in the workplace: if individuals feel detached and emotionally drained, they are less likely to feel they have the resources to do their job well, and vice versa. Encompassing evaluations of both the self and others as well as the impact of human-work on the worker (Maslach & Leiter, 2008), this three-factor model of burnout has been the dominant conceptual and methodological framework for burnout research in the past few decades.

As others have summarized the extant and historic research on nursing burnout across multiple disciplines (see Adriaenssens et al., 2015; Khamisa, Peltzer, & Oldenburg, 2013; Maslach et al., 2001), this review prioritizes research published in nursing and communication journals within the past decade. As such, an overview of the extant research on the predictors, outcomes, and means of coping with and preventing burnout among nurses will be discussed. Finally, this article concludes by forwarding a series of directions for both research and practice in the fields of nursing and communication.

Predictors of Burnout

To date, much of the research on burnout in the nursing profession has focused on predictors of burnout's three components (i.e., emotional exhaustion, depersonalization, and reduced personal accomplishment). This existing literature can be categorized into three overall types of predictive factors: demographic predictors, personality predictors, and profession-related (e.g., contextual or structural) factors. Notably, a fourth category emerges when considering predictors of burnout through a communicative lens: communicative predictors of burnout.

Demographic Predictors

Various studies have examined predictors of nursing burnout at the individual level, finding associations with demographic variables such as age, gender, marital status, and having children (Cañadas-De la Fuente et al., 2015). However, it is worthy of note that the results of demographic influences on burnout have largely been inconsistent. Although there is evidence to suggest that female nurses experience higher levels of stress than male nurses (Yada et al., 2014), and that male nurses experience higher levels of depersonalization (Cañadas-De la Fuente et al. 2015), many of the investigations of gender differences in burnout fail to yield significant differences across the three burnout dimensions (see Cañadas-De la Fuente et al., 2015; Hooper, Craig, Janvrin, Wetsel, & Reimels, 2010; Sorour & El-Maksoud, 2012). Similarly, the relationship between age and burnout has not been consistent across studies (Alcacioglu, Yavuzsen, Dirioz, Oztop, & Yilmaz, 2009; Cañadas-De la Fuente et al., 2015). Although there is some evidence to suggest that burnout decreases with age (Adali & Priami, 2002), this might be due to increased experience and resources for coping with the symptoms of burnout. It is evident from systematic reviews on nursing burnout that efforts to pursue demographic differences as a means of characterizing burnout is insufficient (see Adriaenssens et al., 2015; Cañadas-De la Fuente et al., 2015). Rather, researchers should continue to investigate more complex determinants of this phenomenon.

Personality Predictors

Indeed, there appears to be a much stronger connection between a variety of nuanced personality constructs and burnout than surface in more simplified demographic factors. A nurse's level of neuroticism, for instance, is associated with higher levels of emotional exhaustion, whereas conscientiousness, agreeableness, extraversion, and openness are negatively related to this aspect of burnout (Cañadas-De la Fuente et al., 2015). Further, a nurse who has higher levels of neuroticism experiences more depersonalization and less personal accomplishment, whereas a nurse high in conscientiousness, extraversion, agreeableness, and openness is less likely to experience depersonalization and more likely to have a sense of personal accomplishment. Relatedly, in a study of geriatric care employees, Rouxel, Michinov, and Dodeler (2016) found that negative affectivity, a personality level variable, was predictive of burnout through its impact on perceived negative emotional display rules and job demands; positive affectivity, on the other hand, is a negative predictor of burnout through its impact on perceived positive display rules and job control (Rouxel et al., 2016).

Another personality trait, self-efficacy, has been found to be associated with nurses' sense of emotional

exhaustion and personal accomplishment (Chana, Kennedy, & Chessell, 2015); as “the self-evaluation aspect” of burnout, it makes sense that nurses who have stronger senses of self-efficacy can more easily strengthen and maintain their mental health in the workplace (Wang, Liu, & Wang, 2015, p. 84). In addition to these personality variables, personal stresses such as familial difficulties outside of the workplace have been associated with high burnout (Woodhead, Northrop, & Edelstein, 2016). These results suggest that further research should be done to investigate the relationship between more stable personality traits and the choices that nurses make in their daily lives that might impact their sense of emotional exhaustion, depersonalization, and personal accomplishment.

Profession-Related Predictors

Unsurprisingly, an array of job-related factors has been associated with nurse burnout. Job satisfaction has been investigated for its relation to burnout across several studies, and appears to have both direct and indirect effects on nurse’s emotional exhaustion and depersonalization (Kalliath & Morris, 2002). Interestingly, however, examinations of nurses in haemodialysis units have revealed that high burnout can exist even among highly satisfied nursing staff (Hayes, Douglas, & Bonner, 2015), suggesting a complex relationship between an individual’s job satisfaction and burnout. Contextual and structural elements (e.g., community healthcare as opposed to hospital care) have also been examined in relation to nurse self-reports of burnout, including the type of work shift, healthcare service area, and conducting administrative tasks (Cañadas-De la Fuente et al., 2015; Hsu, Chen, Yu, & Lou, 2010; McTiernan & McDonald, 2015; Woodhead et al., 2016). Hospitals with poorer care environments, for instance, have higher rates of both work dissatisfaction and burnout levels among nursing staff (Aiken, Clarke, Sloane, Lake, & Cheney, 2008); and for such reasons burnout can also be examined as a syndrome of an entire nursing unit, as opposed to just an individual experience (Garman, Corrigan, & Morris, 2002).

The ways in which nurses manage job-related factors also play a significant role in how they experience burnout. For example, emotional annoyance—a sense of uncertainty at work including feelings of insecurity, alertness, and inconvenience—has been associated with increased levels of emotional exhaustion among nursing staff (García & Calvo, 2011); this level of annoyance likely occurs and exists differently for nurses in different settings. Further, the impact of role ambiguity, work overload, and role tension in the workplace—which undoubtedly occur differently based on nursing context—have strong relationships to burnout, regardless of a nurse’s

optimism, emotional competence, and personality (Garrosa, Moreno-Jiménez, Rodríguez-Muñoz, & Rodríguez-Carvajal, 2011). Role stress, in particular, has been shown to be predictive of burnout even after controlling for personal resources (Garrosa et al., 2011). Extended work hours and lack of sleep, likely the result of many stress factors in the workplace, are also associated with increased burnout levels (Chin, Guo, Hung, Yang, & Shiao, 2015; Kunaviktikul et al., 2015). Overall, when coupled with demographic and personality considerations, contextual and structural elements within the nursing profession could provide more nuanced and telling explanations of why burnout occurs than any of these elements on their own.

Communicative Predictors

The aforementioned findings strongly suggest that burnout is a communicative process. That is, communication appears to be an important factor in how burnout symptoms emerge, how burnout is experienced, and how workplace stress is (or is not) managed. In fact, environmental factors, such as job stress and professional nursing practice environment, appear to be the strongest predictors of emotional exhaustion (Wang et al., 2015). More specifically, stress from professional interactions such as those between nurses and management, between nurses and patients when administering care, and overall nurse environment (e.g., nurse-physician relations, staffing and resource adequacy) are predictors of depersonalization, or the interpersonal element of burnout (Wang et al., 2015). Even more telling is the notion that the interactions outlined above, specifically those between nurses and management, nurses and patients, and even among nurses themselves, do not happen independently of one another; indeed, supervisor and coworker support and discomfort with difficult patient interactions have also been associated with increased levels of burnout (Chana et al., 2015; Jenkins & Elliott, 2004; Jesse et al., 2015; Jourdain & Chenevert, 2010). Job resources in the form of support from supervisors, on the other hand, are associated with less emotional exhaustion and higher levels of personal accomplishment (Woodhead et al., 2016). Relatedly, interpersonal violence with patients is also positively associated with aspects of burnout, most notably emotional exhaustion and cynicism (Galián-Muñoz, Ruiz-Hernández, Llor-Esteban, & López-García, 2016). Notably, support from family and friends were also associated with more positive outcomes, suggesting that efforts to reduce nurse burnout might focus on increasing social support outside of the workplace. Together, these findings suggest multiple communicative “interface” points that nurses experience on a daily basis, that might be used in preventative strategies to reduce burnout. Such an intervention, for example, could target those who communicate *with* nurses each day to encourage forms of communication

that are more supportive and encouraging, thus reducing the interpersonal components of this epidemic among overworked nursing professionals.

In addition to the literature on the demographic, personality, profession-related, and communicative predictors of burnout, there has also been a substantial amount of research in nursing and communication on the outcomes associated with burnout's three dimensions.

Outcomes of Burnout

As discussed by Maslach and colleagues (2001), burnout affects individuals at the personal level (emotional exhaustion), the social level (cynicism), and at the professional level (professional inefficacy). Likewise, research examining the effects of nurse burnout has uncovered consequences at three levels: the health nurse, the patient, and the health care system. For the nurse, higher levels of burnout are associated with a number of implications for work, including increased absenteeism, intentions to leave, and turnover rates (Meng et al., 2015). In fact, in a cross-cultural study by Estry-Béhar and colleagues (2007), nearly 30 percent of nurses experiencing burnout had thought about leaving the nursing profession in the past year. A disheartening finding of Estry-Béhar et al.'s review was the paucity of work discussing the impact of burnout on nurse's outcomes beyond their profession. Perhaps in a reflection of the larger issue at hand, it appears that the fact that nurses are *people* has largely been neglected in this work. In an effort to bolster arguments regarding the importance of burnout—as suggested previously with regards to the predictors of burnout—future research should seek to uncover the ways in which burnout affects the individual *person* in the nursing uniform. The breadth of research knowledge on such outcomes to date is incredibly scant.

For patients, the consequences of nurse burnout can be severe. In a study examining burnout's relationship to patient outcomes in community hospitals across Thailand, Nantsupawat, Nantsupawat, Kunaviktikul, Turale, and Poghosyan (2015) found all three components of burnout to be significantly related to nurses' reports of poorer quality care, patient falls, medication errors, and infections. These relationships were so significant, in fact, that increases in emotional exhaustion were associated with 2.53 times the likelihood of nurse's reporting fair or poor quality care, a 30% increase in patient falls, 47% increase in medication errors, and 32% increase in infections. Although it may be tempting to constrain the interpretability of Nantsupawat et al.'s (2015) results to the sample from which they were drawn (i.e., community hospitals in Thailand), survey data collected from 53,846 nurses across six countries (i.e., United States, Canada, United Kingdom,

Germany, New Zealand, and Japan) provide continued evidence that nurse burnout levels are associated with appraisals of their quality of care, independent of nurse environment, job satisfaction, and other relevant characteristics (see Poghosyan, Clarke, Finlayson, & Aiken, 2010). These relationships have been supported in other studies as well (Van Bogaert et al., 2014).

Notably, these examinations relied on nurse reports of their own quality of care. While discussed as a limitation by the authors (Nantsupawat et al., 2015; Poghosyan et al., 2010), it is concerning that nurses recognize and acknowledge that they are not providing optimal care to their patients. Given the altruistic motives of individuals in the nursing profession (Thorpe & Loo, 2003), and the previously mentioned associations between decreased efficacy and burnout (Chana et al., 2015), there appears to be a dangerous mental cycle of poor performance and poor self-evaluation for nurses experiencing burnout symptoms. These self-evaluations unfortunately do translate to patient perceptions of decreased quality of care; overall, patient and family complaints and verbal abuse toward nurses rise with increased reports of burnout (Van Bogaert et al., 2014). Similarly, team-level burnout is associated with decreased levels of patient satisfaction (Garman et al., 2002).

A curious and troubling observation of reviewing the work on nurse burnout, however, is the underrepresentation of the patients' perspective in this research. Perhaps due to difficulties in methodology, the patient is very rarely asked to comment on the impact of nurse burnout on their satisfaction, safety, comfort, or countless other perceptions. This is concerning at a financial level for hospitals, as healthcare has undoubtedly moved toward a consumer-based model (see Herrick, 2005), but is also troubling that in a discipline which is so person-centered, the research seems to have left one (very important) person in the nurse-patient dyad behind.

Coping with and Prevention of Burnout

In response to decades of research establishing an association between burnout and negative nurse, patient, and hospital outcomes discussed above, researchers have begun to examine strategies for coping and preventing burnout among those in the nursing profession. These emergent findings are turned to next.

Coping with Burnout

Chang and Chan (2015) found that nurse's higher levels of optimism and coping were associated with lower levels of burnout, particularly in regard to decreased personal accomplishment. Specifically, increased levels of optimism both directly and indirectly affected reduced burnout by encouraging proactive coping strategies, such as self-determined goal setting

(Chang & Chan, 2015). These findings are echoed in a study by Garrosa and colleagues (2011), in which the researchers found that optimism moderated the effect of nurse exhaustion on levels of engagement. Such coping strategies can reduce nurse burnout for extended periods of time, from six months to one year following educational interventions (see Lee, Kuo, Chien, & Wang, 2016, for a review of coping strategies and nurse burnout outcomes). Future research should be done which considers the cognitive, emotional, and situational factors that contribute and potentially constrain nurses' efforts to cope with burnout.

Notably, there is promise for communication-specific means of coping with the job stressors that nurses face each day. Wanzer, Booth-Butterfield, and Booth-Butterfield (2005) found that nurses use a variety of humorous attempts to cope with stressors in the workplace, including but not limited to "silly" or physical humor, impersonations, laughing, and word play. These strategies were used to deal with a wide variety of situations, including death, difficult patients, day-to-day interactions with coworkers, and to simply overcome "a bad day" (Wanzer et al., 2005, p. 117). Importantly, these humorous enactments led to increased coping efficacy that, in turn, affected nurses' job satisfaction. Although there are certainly situations where humor may not be appropriate, as argued by Wanzer and colleagues, educating nurses on humorous communication behaviors that they can use to deal with the everyday stressful situations they face might be a proactive means of preventing burnout.

Another potential avenue for communication training lies in the way that nurses choose to express their emotions to patients. As examined by Goussinsky and Livne (2016), emotion regulation strategies in which nurses attempt to genuinely experience and handle emotion, versus suppressing emotion or faking emotion in response to an adverse event (e.g., patient violence), lead to less depersonalization among nurses. Cognitive reappraisal in particular, or the reframing of a negative event to alter one's emotional response to it, was significantly associated with decreased depersonalization among nurses in their study. On the other hand, "surface acting" in which nurses do not allow for the full experience of emotion following a negative patient event and self-regulate to a much greater extent, was associated with increased burnout (Goussinky & Livne). Importantly, the emotion regulation strategies that nurses selected were related to supervisor support; with increases in supervisor support, nurses selected more effective and genuine means of handling emotion. Thus, the involvement of management and administration in the encouraged use of specific communication strategies is critical. As Goussinky and Livne (2016) argue, communication training to help nurses in their ability

to effectively handle emotions in the face of negative, and even violent, events has tremendous potential to reduce the facets of burnout associated with emotional fatigue.

Preventing Burnout

In addition to the research on coping with burnout, there has also been work attempting to prevent symptoms of its three components (i.e., emotional exhaustion, depersonalization, and reduced personal accomplishment) among nurses. These prevention programs range from educational and training initiatives regarding work-related stressors to meditation and mindfulness training meant to help nurses deal with burnout and related concepts (e.g., anxiety) internally.

One intervention aimed to reduce death anxiety and burnout among outpatient hemodialysis staff members, including nurses. Lee and King (2014) found that educational courses providing content on death anxiety, the process of grieving, and coping and self-care practices had a significant impact on posttest emotional exhaustion. As the authors argue, end-of-life education is not a routine part of the hiring process for nurses, in this case dialysis caregivers, which leaves these individuals emotionally and otherwise unprepared for the number of patient losses they will experience (Lee & King, 2014). The results of this study suggest that educational interventions can not only decrease the emotional exhaustion these caregivers face by providing them with the resources to cope effectively, but also improve the quality of care provided to patients in these units.

There is also promise for mindfulness, meditation, and stress reduction programs to reduce stress and burnout among nursing professionals. Specifically, in a pre-post test design dos Santos et al. (2016) found that a six-week stress reduction program focused on mindfulness and meditation significantly reduced burnout, stress, and other physical and psychological indicators of work stress among nurses. Importantly, the impact of this program on participants' stress and burnout levels remained stable at a follow up assessment six weeks after the conclusion of the program (dos Santos et al., 2016). Similarly, intensive trainings in mindfulness-based stress reduction (MBSR) reduce stress, anxiety, and burnout, while improving focus and increasing empathy among healthcare professionals (Smith, 2014). Perhaps such programs help nurses to build resilience, which has been associated with decreased levels of emotional exhaustion (García & Calvo, 2011).

Importantly, burnout in nursing education has been associated with lower mastery of nurse-specific tasks and lower use of evidence-based practice in follow-up examinations one year post-graduation (Rudman & Gustavsson, 2012), suggesting that strategies to cope with stress and burnout should be incorporated into the nursing education curriculum. In fact, the importance of

studying nurses early in their career cannot be understated. An examination of nurses across the career spectrum in haemodialysis units by Hayes and colleagues (2015) revealed that younger nurses were less satisfied and reported more burnout than their older (and therefore, more experienced) colleagues. As suggested by the authors, further examinations of why these younger nurses are less satisfied and more stressed in the workplace might lead to changes in how nurse educators and supervisors approach mentorship and professional development programs in order to curtail burnout.

In addition to nursing education and professional mentorship, nurses' personal networks may serve an important function in helping to prevent burnout. As mentioned previously, the personal stress of nurses has been positively associated with burnout, while social support from family and friends provides a negative association (Woodhead et al., 2016). This research suggests that strategies to reduce burnout provided to nursing staff might include "outside of the workplace" efforts to reduce myriad forms of stress and spillover effects, thereby decreasing occupational burnout.

Overall, burnout is not only an individual problem, as Maslach (2003) noted that burnout is often a result of the environment in which nurses work. Interventions that focus on individuals (dos Santos et al., 2016; Lee & King, 2014), as well as unit- or department-wide change, although rare, show promise (Jesse et al., 2015). For example, the Civility, Respect, and Engagement at Work (CREW) intervention has been implemented nationally in large hospital settings with improvements and provides evidence for creating sustained change (Leiter, Day, Oore, & Spence Laschinger, 2012; Leiter, Spence Laschinger, Day, & Oore, 2011; Spence Laschinger, Leiter, Day, Gilin-Oore, & Mackinnon, 2012; for a more in depth discussion of burnout intervention studies, particularly in the context of staff providing care to elderly or geriatric patients, please see Westermann, Kozak, Harling, & Neinhaus, 2014).

Directions for Future Research

The current body of work on nurse burnout does much to stress the importance of examining this construct further; to date, research on the predictors and outcomes of burnout have established that this is an interdisciplinary area of research and practice that is critically important. However, as with all areas of study, there are significant gaps that must be addressed in order for the practical and theoretical utility of the research to reach its full potential. Toward this, three overall suggestions are provided in this article to encourage and provide direction to scholars in nursing and communication who pursue the understanding, prevention, and coping of burnout

in the nursing profession. These are: (a) to incorporate the use of communication theory, (b) to continue to examine evidence-driven and effective means of preventing and coping with burnout, and (c) to pursue more global, cross-cultural understandings of burnout's predictors, outcomes, and strategies for prevention.

The most notable exception from the extant literature on nurse burnout, in both the fields of communication and outside of it, is the general absence of theory. Although some research has employed models to examine more complex associations among predictors of burnout and its three components (see Gandi, Wai, Karick, & Dagona, 2011; Snyder, 2012), there is an almost complete lack of communication theory-driven work in this field. The Empathic Communication Model of Burnout (Miller et al., 1988) offers promise in this regard; the model predicts that individuals' other-oriented responses to stress, the *contagion of negative affect* and *empathic concern*, affect one's communicative responsiveness to others' negative emotional state which, in turn, impacts their experiences of burnout. Specifically, the contagion of negative emotions is predicted to negatively affect communication responsiveness, whereas empathic concern is predicted to increase it. Fluctuations in communication responsiveness are then predicted to affect the onset of burnout's three dimensions. The successful use of the ECM in healthcare contexts (e.g., Omdahl & O'Donnell, 1999) has been cause for some to urge the training of empathic concern in healthcare organizations (see Dollard, Dormann, Boyd, Winefield, & Winefield, 2003). Future research should seek to establish strategies for nurses to express enough emotion to show they *feel* for their patients, but do not parallel the patient's emotions and therefore become overwhelmed. Importantly, the demonstration of empathic concern recognizes that nurses can have emotional reactions to patients. This recognition could have a fairly significant impact on the depersonalization characteristic of burnout syndrome.

Although slightly more prevalent than those that employ theory, studies examining ways to prevent nurse burnout remain relatively scarce. As suggested by Cañadas-De la Fuente and colleagues (2015), it might behoove researchers to develop profiles of not only the nurses most at risk for burnout, but also those most capable of preventing it. By examining those nurses who cope with burnout successfully, it may be possible to derive effective coping strategies, personal resources, and methods of communication that prevent this syndrome. Much of the research to date on nursing burnout has assumed a passive and reactive actor (i.e., the nurse) who responds to organizational and external stressors; what if instead, as Chang and Chan (2015) argue, we begin to examine nurses as proactive agents, armed with the resources to actively prevent burnout before it occurs? This conceptual and methodological perspective could be incredibly crucial in the

development of this field of study beyond pure descriptive research to more explanatory and predictive frameworks.

Also, although there is a fair amount of intercultural work in this area of study that examines nursing units within Europe (Galián-Muñoz et al., 2016; Rouxel et al., 2016), Asia (Chang & Chan, 2015; Meng et al., 2015), the Americas (Dalmolin, Lunardi, Lunardi, Barlem, & Silveira, 2014), there is less cross-cultural work that seeks to make comparisons and contrasts of nursing units in order to establish larger, more fundamental claims in this area of work. One notable exception is the work of Pogosyan and colleagues (2010), which sought to make broader connections between nurse burnout and quality of care across six countries. The results of their efforts allow for a wider, more comprehensive understanding of how nursing impacts nurses, patients, and hospital systems. Although it is certainly true that cultural elements must be taken into consideration when it comes to prevention and coping with burnout, there may be important lessons to learn by examining how nurses experience similar trials and challenges in their work at the global level. Researchers should seek to make connections across cultures to strengthen our understanding of the nuances and similarities of nursing, burnout, and coping across continents.

In reviewing the literature on nurse burnout, and its myriad predictors and outcomes, it is apparent that this is a phenomenon influenced by communicative factors. The way that patients communicate, that social support is or is not expressed, and the means through which job duties are assigned and maintained have been discussed in this essay as crucially important factors in nurse's perceptions of stress and burnout. Further, and in a more promising way, research suggests that the means of coping and preventing burnout lie in communication; education, social support, and humor are evidence-based means of reducing this syndrome among the nursing population (Jesse et al., 2015; Westermann et al., 2014). As such, it is imperative that more interdisciplinary work be conducted on nurse burnout, as opposed to researchers operating within the silos of "nursing" and "communication." A notable example of such research is the work of Nicotera and colleagues (2015), who used structural divergence (SD) theory to examine the root causes of negative nursing outcomes, such as intention to leave and low job satisfaction. In their work, Nicotera et al. discovered that structural divergence, caused by perceived unresolvable conflicts in which individuals feel compelled by multiple systems of social rules, was contributing to feelings of role conflict, depression, and burnout (among other outcomes) among nurses in their study. As the researchers argue, "SD theory provides a fruitful avenue of study to

understand more deeply, from a communication theory perspective, perplexing problems in the nursing workplace," and allows for a more nuanced understanding of the myriad influences of burnout (and likewise, the means of prevention) (Nicotera et al., 2015, p. 382). For instance, the research on emotional labor in healthcare settings (see Riley & Weiss, 2016 for a review), might be used to understand the multifaceted skills that nurses are expected to use in their everyday roles, and how these skills might be better supported by the healthcare system.

Conclusion

The implications and outcomes of burnout are well understood in the literature, as are its myriad associations and influences. What remains to be fully captured in the research literature, however, is a theoretical understanding of how burnout and its three related components (emotional exhaustion, depersonalization, and reduced personal accomplishment) can be predicted and coped with. Researchers in communication and nursing have a distinct and important opportunity to offer evidence- and research-based strategies to mitigate nurse burnout. It is hoped that the establishment of this new journal, *Nursing Communication*, will not only encourage these efforts but also provide a platform for such interdisciplinary conversations.

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