



Burnout and its relationship with personality factors in oncology nurses



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ABSTRACT

Purpose: To assess burnout levels in oncology nurses, to evaluate at what stage of burnout suffering they are and to analyze the relationship between burnout with personality factors.

Method: A quantitative, observational, cross-sectional multicenter study was done. Oncology nurses ($n = 101$) from the Andalusian Health Service (Andalusia, Spain) were included. The main variables were personality factors, assessed with the NEO-FFI questionnaire, anxiety and depression, assessed with the Educational-Clinical Questionnaire: Anxiety and Depression, and burnout, evaluated with the Maslach Burnout Inventory. Student t -statistic was used for hypothesis contrasts and Pearson's correlation coefficient was used to establish the association between personality factors and burnout.

Results: According to the burnout phases model, 29.6% of the sample is in the most severe phases. Emotional exhaustion and depersonalization are positively correlated with neuroticism and negatively correlated with agreeableness, conscientiousness, extraversion and openness. Personal accomplishment has a negative correlation with neuroticism and negative correlations with agreeableness, conscientiousness, extraversion and openness. Finally, emotional exhaustion and depersonalization have a positive correlation with anxiety and depression, while personal accomplishment has a negative correlation with anxiety and depression.

Conclusions: A significant number of oncology nurses are in the most severe stages of burnout suffering. Personality factors have a key role in burnout development. The importance of personality factors in burnout development should be taken into account.

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1. Introduction

Burnout is a syndrome that mostly affects professionals working in contact with the beneficiaries of their services (Schaufeli et al., 2009). Maslach and Jackson (1981) defined burnout as a three-

dimensional syndrome in which the affected person presents depersonalization (D) or cynicism in dealing with patients, emotional exhaustion (EE) and low personal accomplishment (PA). Burnout construct has been widely studied throughout the four decades it has been recognized; it has negative consequences for the professionals who suffer from it, the organization in which they work and the patients that they care for. The professional with burnout can show diverse symptoms such as chronic fatigue, headaches, insomnia, impaired concentration, nightmares and hypervigilance (Embriaco et al., 2007; Potter et al., 2010). In the case of health institutions, burnout has been linked to increased absenteeism, the abandonment of jobs, a reduction in health care

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quality, an increase in errors and a reduced level of patient safety (Gasparino, 2014; Hall et al., 2016; Teng et al., 2010).

Healthcare workers are one of the groups affected by the syndrome due to, among other causes, the workload, the length of the shifts, patients' complaints and claims and the imbalance between work and personal life (Biksegn et al., 2016; Suñer-Soler et al., 2014). Within the healthcare professions nursing has been identified as one of those with a higher prevalence of burnout (Cañadas-De la Fuente et al., 2015; Gómez-Urquiza et al., in press). However, the burnout study in nursing is focused on specific units or services. Nurse practice, the type of patients and therefore the risk for the development of burnout, can vary greatly between an emergency nurse (Adriaenssens et al., 2015; Albendín et al., 2016) a primary care nurse (Gómez-Urquiza et al., 2017) and an oncology nurse (Russell, 2016; Wu et al., 2016).

Oncology nurses treat patients with specific characteristics compared to other units. During the illness, oncology patients often experience psychological problems, feelings of vulnerability, anxiety, fear and depression, which has been associated with an increased stress in nurses (Kubota et al., 2016). Furthermore, oncology nurses have to deal with ethically complex clinical decision-making situations (Pavlish et al., 2015), lack of training for end of life care in novice nurses, the complexity of cancer treatments, grief, bad news communication and the death of patients (Ko and Kiser-Larson, 2016; Romeo-Ratliff, 2014). These situations may not be present in other services with chronic patients such as primary care (Gómez-Urquiza et al., 2017), in emergency services where the time in contact with the patients is shorter (Albendín et al., 2016) or in services where the patient spends much of the time under sedative effects like the operating room (Arnal Velasco et al., 2016). For these reasons, it is expected that oncology nurses' burnout varies with nurses from others units.

The concrete characteristics of oncology units and their relationship with burnout in nurses have been studied in recent years, with moderate and high prevalence rates in each dimension being found (Gómez-Urquiza et al., 2016a; Wu et al., 2016). In addition, different burnout risk factors in oncology nurses have been studied. For example, sociodemographic variables such as age and marital status (Alacacioglu et al., 2009; Davis et al., 2013), occupational variables such as professional experience, workload, shift, support at work, the difference between ambulatory or hospitalization units (Davis et al., 2013; Gallagher and Gormley, 2009; McMillan et al., 2016; Quattrin et al., 2006) and psychological variables, such as the need for approval, trust and compassion fatigue (Ostacoli et al., 2010; Wu et al., 2016).

Despite all the above points, it is necessary to advance the study of the syndrome. The estimation of the prevalence of the disorder in each dimension in oncology nurses (Gómez-Urquiza et al., 2016a) could be complemented with a classification of the professionals depending on the gravity phase or stage of global burnout development in which they are, taking into account Golembiewski and Munzenrider (1988) phase model. According to this model, professionals who score low in the three dimensions are in phase 1. In phases 2 to 7 there are those that are progressively increasing their burnout levels and in phase 8, those that score high in the three burnout dimensions.

This model can be used to estimate the prevalence of global burnout in these professionals. Studies have been done in other services that report significant relationships between some psychological variables and burnout syndrome, informing of significant relationships between nurses' personality factors and burnout (Ang et al., 2016; Cañadas-De la Fuente et al., 2015; Ganjeh et al., 2009; Hudek-Knežević et al., 2011). However, to our knowledge, there is no research in oncology nursing, where burnout risk profiles include personality characteristics and other psychological

variables (Gómez-Urquiza et al., 2016a).

This study has three objectives: a) to assess burnout levels in oncology nurses (low, medium or high EE, D and PA), b) to know at what stage of global burnout suffering oncology nurses are (Phases 1 to 8 from Golembiewski's burnout phase model) and c) to analyze the relationship between burnout with personality factors and other psychological disorders.

2. Method

2.1. Sample

The sample consisted of $n = 101$ professionals from the Andalusian Health Service (Andalusia, Spain). A convenience sampling of contracted nurses belonging to oncology units was carried out. Nursing students were excluded. According to the Andalusian Oncological Plan, it is estimated that there are between 600 and 800 nurses in oncology services. For a 95% confidence and an assumed error of 5%, using the higher score of the oncology nurses estimated population, a sample of approximately 110 nurses was needed. In 2015, 170 questionnaires were delivered and 101 were collected with information from nurses from all Andalusian provinces.

2.2. Outcome measures

A paper copy booklet was given to the participants for data collection.

- 1 Demographic data. The studied variables were socio-demographic (age, gender, marital status and number of children) and occupational (fixed or rotating shift, seniority or years of experience in the profession and seniority or years of experience in the workplace).
- 2 Neo Five Factors questionnaire (NEO-FFI). To assess the five personality factors (neuroticism, extraversion, agreeableness, conscientiousness and openness) an adapted reduced version of NEO-FFI (McCrae and Costa, 1999) was used for the Spanish population (Costa and McCrae, 2002). The questionnaire has 60 items, 12 items for each dimension with a Likert scale of 5 points. The Cronbach alpha for neuroticism is 0.92, 0.89 for extraversion, 0.86 for agreeableness, 0.90 for conscientiousness and 0.87 for openness.
- 3 Educational-Clinical Questionnaire: Anxiety and Depression (CECAD) (Lozano et al., 2007) was used to measure anxiety and depression symptoms, following DSM-IV Criteria. It has 45 items with a Likert scale of 5 points, 19 items for anxiety and 26 items for depression. The Cronbach alpha for anxiety is 0.85 and 0.90 for depression.
- 4 Maslach Burnout Inventory (MBI). The three burnout dimensions (emotional exhaustion, depersonalization and personal accomplishment) were measured with the Spanish adaptation of the MBI which has 22 items with a Likert scale of 7 points (Maslach and Jackson, 1981; Seisdedos, 1997). The EE dimension has 9 items, D has 5 items and PA has 8 items. The Cronbach alpha for EE is 0.89, 0.77 for D and 0.78 for PA. The diagnostic values used to establish high, medium or low levels of each dimension, EE (low: <19, medium: 19–26, high: >26), D (low: <6, medium: 6–9, high: >9) and PA (low: <34, medium: 34–39, high: >39), were those proposed by manual test (Seisdedos, 1997).
- 5 Stage of global burnout was assessed using the Golembiewski and Munzenrider (1988) phase model. This model categorizes the score of each burnout dimension into low or high levels and,

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