Institute for Clinical Social Work

EMPATHY AND BURNOUT IN NURSES

A Dissertation Submitted to the Faculty of the Institute for Clinical Social Work in Partial Fulfillment For the Degree of Doctor of Philosophy

BY

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March 2008
ABSTRACT

In a sequential, mixed-method study designed to gain understanding of the role of empathy in nurses not experiencing burnout, the Maslach Burnout Inventory (MBI) was administered to female nurses at a small hospital. No significant correlations indicating possible psychological factors as opposed to occupational factors were found. Potential interview candidates were identified using MBI scores \((n=162)\). Twenty-two Caucasian female nurses (ages 25-59) from a cross-section of units were interviewed.

Grounded theory was used to analyze interviews, and findings were interpreted from a self psychology perspective. All of the interviewees recognized compassion and empathy as key characteristics of nurses. Each nurse had her own theory of the nurse/patient relationship; thorough examination revealed that many facets were involved, with empathy as an assumed ingredient. Examples of ways of demonstrating empathy were found throughout the interview narratives.

Qualitative data analysis revealed that several of the nurses had been burned out in the past and had learned mechanisms for managing it. Some nurses described their experiences of burnout as being related to the whole person and stressful life events, not limited to workplace stressors, suggesting burnout can be a normative experience.

The nurses interviewed reported that burnout as well as other factors, such as difficult patients, could create impediments to empathy. This study highlights the importance of the nurse’s own psychological self as a key element in both resiliency to burnout and the capacity for empathy. Implications for nursing education and clinical implications are discussed. Areas of future research are recommended.
For my parents, Herman and Gayle Kurrelmeier

and my daughters, Kari and Heather
I wish to acknowledge Carle Foundation Hospital, Urbana, IL for sponsoring this study. I am thankful to all the nurses who took time to fill out and send in the surveys. I am indebted to those nurses who gave their precious time to this study and gave me the gift of reawakening my identification with nursing.

I wish to thank my Chair, R. Dennis Shelby, Ph.D., whose steadiness guided me and for demonstrating the true meaning of empathic attunement; my committee members Constance O. Goldberg, M.S., whose containment and wisdom has enriched me personally and professionally throughout my entire education at ICSW, and Sidney Miller, PhD, LCSW, RN, a kindred spirit, whose knowledge of both the nursing and social work professions were invaluable. I also appreciate my readers Joseph Palombo, M.A., for our early discussions that helped me conceptualize this project, and Miriam Reitz Ph.D., for her thoughtful comments.

Many others who are unnamed, but not forgotten, have contributed to my learning and my efforts. I am grateful to all those people who I know in my heart made this whole endeavor possible. Finally, I could not have completed this project without the loving support of my husband, Quinn Brewster.

This project has been written in loving memory of Mack, who affected my life in so many profound ways. 
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CHAPTER I

INTRODUCTION

History of the Problem

People who become hospital bedside nurses are not the faint of heart. Nurses see people (patients) at their worst, both physically and emotionally. Most nurses choose their profession because they want to help other people. However, there is a serious shortage of nurses and one of the major reasons cited is burnout.

The American Association of Colleges of Nursing (AACN) cites the growing shortage of nurses. The AACN cites the 2004 US Bureau of Labor Statistics (as cited in AACN Media Relations, 2004), which reports that in 2012 more than 1,000,000 new and replacement nurses will be needed. Job burnout and dissatisfaction are the primary reasons registered nurses (RN) leave the profession (Aiken et al., 2002, as cited in AACN Media Relations, 2004). Forty percent of nurses who work in hospitals are dissatisfied with their jobs, and one in three nurses under thirty plans to leave the profession (Aiken et al., 2001, as cited in AACN Media Relations, 2004).

The ability to be empathic, or the ability to put oneself in the other’s place psychologically, is a crucial ingredient in the nurse/patient relationship. The nurse’s ability to understand her patient’s experience helps her to give “good patient care.” Pines
and Maslach (1978) suggest that the nature of the helping relationship may itself be a cause of stress and burnout.

Kohut’s (1959) definition of empathy, “vicarious introspection,” a value-neutral mode of observation, is a tool for observing another person’s internal world. However, toward the end of his life, Kohut expanded his definition of empathy to include “a powerful emotional bond between people” (Kohut, 1982, p. 3). He adds that “the mere presence of empathy, has also a beneficial, in a broad sense, a therapeutic effect—both in the clinical setting and in human life, in general” (1982, p. 3).

The capacity for empathy is related to the ability to give “good patient care.” Empathy involves the ability to temporarily identify or merge with the other. According to Emde, “transient identifications occurring in the midst of empathy require a temporary sense of oneness with the other, followed by a sense of separateness in order to be helpful” (1990, p. 3). The delicate balance between “temporary oneness” (Emde, 1990) and separateness allows for optimal empathy. For example, in over identifying with the patient, a nurse loses connection with the experience of the patient and reacts in a way that reflects her own feelings or experience and may no longer be helpful to the patient.

This study explored the role of empathy in bedside nurses who did not experience burnout, with the assumption that nurses who are burned out have less capacity for empathy. Specifically, the focus of this study was on the subjective experience of nurses and their commentary on the role of empathy and burnout in a mixed method approach to this consequence-centered issue. This study analyzed the subjective data from interviews with the nurses through the theoretical lens of self psychology, thus bringing together two
different disciplines, nursing and psychoanalytically oriented social work, both of which involve helping people.

The focus of this study was on nurses and the information gained will help clinical social workers in their clinical practice as well. The knowledge gained in this study applies to social workers who also work in a hospital setting. In addition, for social workers who are psychotherapists, this study contributes to their clinical practice by increasing their understanding of the nurses they treat in psychotherapy. Moreover, understanding gained from the exploration of the role of empathy in nurses who were not burned out may be generalized to the social worker, contributing to understanding the role of empathy in their ranks as well.
CHAPTER II

LITERATURE REVIEW

Introduction

Generally, nurses begin their careers with the motivation of helping people. However, nurses often experience emotional and physical problems such as exhaustion, increased absenteeism, depersonalization, poor work performance, interpersonal problems with family and coworkers, frustration, anger, cynicism, guilt, disturbances in sleep, depression, and substance abuse (Collins & Long, 2003; Maslach & Goldberg, 1998; Sabo, 2006; Sadovich, 2005). Nurses also report feeling depleted (Wright, 2004), dissatisfaction in not being able to attend to the patient as a whole person (Reynolds, Scott, & Austin, 2000), increased patient caseloads, increased paperwork, less time for direct patient care (Gordon, 2005), and less connection to the patient and their family (Finke, 2006).

Burnout in nurses has been studied for several decades. Scholarly investigations of burnout (Maslach, 1981) have named three agreed-upon dimensions: emotional exhaustion, depersonalization (or cynicism), and a feeling of a lack of personal accomplishment. Some studies have shown the environmental factors that contribute to job dissatisfaction and burnout are increased workload, decrease in contact with patients, and lack of administrative support.
Despite stressful work environments, some nurses do not burnout. Anxiety, depression, low self-esteem, passive personalities, and those who are resistant to change have been identified as characteristics of those more prone to burnout. Some studies have suggested that excitement about their work, professional autonomy, altruism, and intellectual satisfaction are factors that seem to contribute to the prevention of burnout in nurses.

Four quantitative studies of nurses (Astrom, Nilsson, Norberg, & Winbald, 1990; Baxter, 1993; Omdahl & O’Donnell, 1999; Lee, Song, Cho, Lee & Daly, 2003) found that burnout and empathy are correlated in the nurse. Empathy, as measured, for example, on the Barrett-Leonard Empathy Scale, is found to be lower in nurses who measure as burned out on the Maslach Burnout Inventory and higher in those who do not. Each study has its own definition of empathy. Most of the definitions overlap. However, there are limitations to these studies that suggest that further investigation is warranted. For example, no qualitative studies on burnout and empathy in nurses were found. The advantage of qualitative studies is that the data are derived from the subjective voices of the participants; therefore, the data are closer to the experience of the participant than the data gathered in quantitative studies.

Empathy is indicated in the literature as key in nurse-patient interactions and relations. However, the concept of empathy is not used consistently in the literature and needs to be clarified. “Good-enough” empathy allows the nurse to put herself in the patient’s place long enough to understand what the patient may feel or need. While doing this, the nurse is also able to retain her own feeling experience and remain her own separate person. When the nurse over identifies with her patient, she loses her

1 The pronoun ‘her’ will be used to simplify writing and reading since all subjects were female nurses.
objectivity. Empathy is understood through Heinz Kohut’s definition, which is “vicarious introspection.” The idea of good-enough empathy is thus elaborated within the context of Kohut’s theory, and this understanding may have implications for the training and retaining of nurses.

Theoretical Literature on Burnout

The origin of the term “burnout” emerged as Freudenberger (1974), a psychiatrist in a free clinic, wrote about his observations of himself and his staff. He noted, “that the dictionary defines the verb ‘burnout’ as ‘to fail, wear out or become exhausted by making excessive demands on energy, strength, or resources’” (p. 159). In contrast to other research about working conditions, burnout was described as a phenomenon by those who experienced it in their own work environment. Scholarly research has since followed. Maslach first conceptualized burnout as a psychological syndrome in 1976. Maslach has had a prominent place in the study of burnout in general. Chronic emotional and interpersonal stress is the hallmark of burnout (Maslach & Goldberg, 1998). Maslach (1981) interviewed many people across disciplines and eventually used quantitative measures to name three dimensions of burnout that have become widely accepted:

1. Emotional Exhaustion: People who burnout feel used up emotionally. For example, the nurse feels overextended and depleted. Nurses can feel unable to recharge their emotional batteries. Emotional exhaustion is the hallmark of burnout and the first sign of the burnout syndrome (Maslach, 1981).
2. Depersonalization (=cynicism): Emotional exhaustion may lead to depersonalization, a feeling of distance, disconnection, or detachment in which the worker (i.e., nurse) withdraws and may develop a callous attitude toward another person (i.e., patient). According to Maslach, the balance between the closeness and distance in the relationship is difficult to find. “Much like oil and water, detachment and concern do not mix easily” (Maslach, 2003, p. 4). Often workers (nurses) feel a pull toward one end of that balance or another. The emotional stance that one takes is an attempt to protect oneself emotionally. Detachment may lead one to dehumanize the other, or to feel callous toward the other, both of which are signs of burnout (Maslach, 1981).

3. Reduced sense of personal accomplishment: The sense of guilt, associated with giving poor care decreases a person’s sense of accomplishment. Workers (i.e., nurses) may feel bad about the way they have treated someone and may feel inadequate in their ability to help others. With a sense of failure, their self-esteem drops. They do not want to be the person they have turned into.

Burnout and its developmental course have been identified as emotional exhaustion leading to depersonalization (=cynicism, according to Maslach et al., 2001). The course of the sense of lack of accomplishment is less clear. Most research supports the dimension of inefficacy as a simultaneous development rather than following from either of the other two dimensions (Maslach et al., 2001). Research confirms that burnout happens over time and is the result of chronic stress at work.

In addition to the three dimensions of burnout, there are four aspects of the care giving relationship that contribute to burnout (Maslach, 1981):
1. Problem focused: Maslach (1981) reports that the very nature of the helping relationship is based on focusing on recipient’s (i.e., patient’s) problems. The nurse rarely gets to know the patient in any other way.

2. Lack of positive feedback: According to Maslach (1981) it is natural for people (i.e., nurses) to want to be recognized for one’s accomplishments. The recipient expects that things go right. When things do go right, it does not occur to some recipients (i.e., patients) to give positive feedback. In fact, nurses are often on the receiving end of the patient’s strong feelings of anger, frustration, and fear, which in turn may be absorbed by the nurse. She may displace these feelings onto other people as a way of dealing with the strong emotions. This only leads to further problems in her other relationships.

3. Possibility of Change or Improvement: It is very challenging to work with patients who do not respond to nursing care. For example, the patient who refuses to learn the needed balance in his/her diet for his/her diabetic condition due to denial may lead to serious health consequences. As a result, the nurse can feel ineffective. “People who do not acknowledge our presence, do not provide feedback, or fail to follow our advice or guidance are ‘dehumanizing’ to us, and it becomes easier, in turn, to dehumanize them and hold negative attitudes about them” (Maslach, 2003, p. 37).

4. Emotional stress: The very nature of working with people in some professions is stressful (Maslach, 1981). Nursing is very emotionally demanding because it puts nurses in constant contact with pain, illness, trauma, or death.
Burnout and the Work Environment

There is a vast body of literature that ties burnout to aspects of the work environment (Duquette, Kerouac, Sandhi, & Beaudet, 1994; Maslach & Leiter, 1997; Pines & Kanner, 1982; Atencio et al., 2003; Raiger, 2005; Sadovich, 2005). Some studies link burnout and job dissatisfaction (Jansen, Kerkstra, Abu-Saad, & Van Der Zee, 1996; Haddad, 2002; Atencio, Cohen, & Gorenberg, 2003), others have tied job stress with burnout (Hillhouse & Adler, 1997; Maslach & Goldberg, 1998; Pines, 2000; Atencio et al., 2003; Billeter-Koponen & Freden, 2005; Rowe & Sherlock, 2005). Rowe and Sherlock (2005) tie burnout to the verbal abuse that nurses feel they receive from other nurses. Duquette et al. reviewed 300 articles or studies on nurses and burnout. Their review of the literature indicates that role ambiguity, workload, age, hardiness, active coping, and social support are factors related to nursing burnout.

Certain kinds of organizational structures and cultures may help prevent the chances of burnout in employees (Maslach, Schaufeli, & Leiter, 2001). Raiger (2005), in developing a cultural care theory, argues that organizational cultures that foster trust, support, open communication and respect can ameliorate burnout in nurses. “Magnet hospitals,” a concept initiated in the 1980s, provide such a culture. According to Scott et al. (as cited in Raiger, 2005), magnet hospitals have a nursing administration that is supportive of nurses, that values the professional development of the nurse, and maintains open lines of communication. Raiger (2005) argues that when organizations do not foster this kind of supportive work culture, high rates of absenteeism and turnover are seen. People who stay on the job and are burned out have markedly lower levels of productivity and are less committed to their job or their employer.
Burnout and the Individual Nurse

Even within the same stressful environment, some nurses burn out while others manage not to, suggesting that individual factors or attributes may also contribute to burnout. Maslach (2003) has studied many professionals over many years. Maslach et al. (2001) note that in general, people who are less experienced, more educated, and are unmarried tend to have higher scores for burnout. Women tend to rate higher on exhaustion, while men rate slightly higher on cynicism (Maslach et al., 2001).

According to Dr. Storlie of the University of Nevada School of Nursing (as cited in Maslach, 2003), “the seeds of burnout lie in this conflict between the real and the ideal:

Burnout requires a susceptible host—that host being the highly idealist nurse…. When a student is graduated, she reads ads that invite her to work at the “hospital that really cares”...the young nurse believes that caring really matters, that loving and respecting others is what nursing is all about. She hopes to help people to heal, to cure...But often she finds in the hospital setting, “what I was taught” and “what I want to believe” clash with “what really is”(p. 222).

In reference to these comments, Maslach (2003) notes that training programs often refuse to address the issue of burnout because it is not considered a professional ideal. “One is not supposed to be emotionally depleted by the work or feel negatively about people” (p. 222). Yet in reality we can be depleted and feel negatively, especially when burned out. That is, that working with people can be stressful and understanding how to inoculate ourselves against burnout is part of taking care of ourselves in order to take care of the other.

Maslach et al. (2001) found that personality factors play a role in burnout. Those who are less hardy (i.e., less open to change, have less of a sense of control over events) rate higher on exhaustion dimensions. In general, those who are passive, and have a
defensive personality are more prone to burnout than those who are more active and confrontive (Maslach et al., 2001). Lower self-esteem also is correlated with burnout. Neuroticism, as a personality trait, contributes to a risk for burnout. Neuroticism includes traits like anxiety, hostility, depression, self-consciousness, and vulnerability. People who bring high expectations to their job may work too hard and become cynical when they become disappointed (Maslach et al., 2001). Those people who are burned out complain more of stress-related ailments and more conflict at home (Maslach et al., 2001).

Nurses studied over the world have been identified as a population that can suffer from burnout. In studying nurses in Greece, Tselebis, Moulou, and Ilias (2001) found there is a relationship between burnout and depression. In Germany, Buhler and Land (2003) found the same link. In addition, they found that the nurse who exhibits personality traits of neuroticism (which includes depression), who are unable to distance themselves from their job, who experience an external locus of control, and who experience existential frustration are at risk for burnout. Ekstedt and Fagerberg (2005) studied nurses in Sweden. In their interviews they tracked the transition time before burnout occurred and found that nurses reported a sense of being trapped between positive challenges and overwhelming demands. Once the nurses reached bottom emotionally, they cut themselves off from their feelings. This cutting off from feelings is associated with burnout.

Altun (2002) studied nurses in Turkey and found that personal and professional values like altruism, freedom, and truth helped inoculate the nurses against burnout. These values are reflected in individual attitudes. Browning, Ryan, Greenberg, and
Rolniak (2006) found that those nurses who had the quality of cognitive adaptation, as defined by mastery, optimism, and self-esteem, measured lower on the burnout inventory.

In studying Norwegian nurses, Jansen et al. (1996) found that job satisfaction is more related to job characteristics, whereas individual characteristics have more of an impact on burnout. Individual characteristics of nurses who prefer autonomy, have a preference for prestige, or support from nurses in administrative roles, are less likely to burnout if they feel these preferences are met.

Bakker, LeBlanc, and Schaufeli (2005) studied a large number of Intensive Care nurses (n=3000) across Europe and found that burnout was contagious between colleagues, that is, nurses who work closely enough together ‘catch’ the emotions of one another. They found that nurses who reported the highest amount of burnout in their colleagues were also the most likely to experience high levels of burnout themselves.

Pines (2000) argued that it is not only the physical workload, or long hours that cause a nurse to burnout, which has been the focus of many studies. “The root cause of burnout lies in people’s need to believe that their lives are meaningful, that the things they do are useful, important” (Pines, 2000, p. 24). Pines (2000) found in her mixed methods design that Israeli nurses felt the most stress came from frustrated hopes, goals, and expectations. Those who originally sought nursing as a career in order to help another person, felt frustrated and eventually helpless when conditions existed that prevented the outcome of effective helping. It is the individual attribute of meaning in life derived from work that contributes to the nurse’s experience of burnout, not the stressful work (Pines, 2000).
Empathy in the Nursing Literature

Empathy in nurses has been studied over decades; however, the concept of empathy has not been used consistently in the nursing literature and needs clarification.

Empathy, as defined by Webster’s Dictionary (Merriam-Webster Online, 2007) is:

1. The imaginative projection of a subjective state into an object so that the object appears to be infused with it.

2. The action of understanding, being aware of, being sensitive to, and vicariously experiencing the feelings, thoughts and experience of another of either the past or present without having the feelings, thoughts, experience fully communicated in an objective explicit manner.

This definition of empathy shows that while the capacity for empathy requires ultimately the ability to be separate, it should not be confused with sympathy, where the capacity to merge is prominent.

Compare the definition of sympathy (Merriam-Webster Online, 2007):

1. An affinity, association, or relationship between persons or things wherein whatever affects the one similarly affects the other.

2. Inclination to think or feel alike.

3. The act or capacity of entering into or sharing the feelings or interests of another. This definition of sympathy reflects an identification that does not allow for separateness in experience.

Empathy has historically been considered a characteristic of nursing. From Florence Nightingale to contemporary theorists, much of the nursing literature
emphasizes empathy as a crucial ingredient in the nurse-patient relationship (Nightingale, 1946; Peplau, 1952; Katz, 1963; Zderad, 1969; LaMonica, 1981; Gould, 1990; Baillie, 1996; Reynolds, 1999; Walker & Alligood, 2001). It is generally agreed upon, in the nursing literature, that empathy is the ability to enter objectively into another person’s feelings in order to understand what he/she is feeling or perceiving (Peplau, 1952; Kalisch, 1973; Gagan, 1983; Gould, 1990; Reynolds & Scott, 1999).

The definition of empathy may include understanding current feelings (Kalisch, 1973). Reynolds and Scott (1999) noted that empathy involves communicating the understanding one has to the patient. Much of the nursing literature fails to distinguish between empathy and sympathy (Gagan, 1983; Gould, 1990; Alligood, 1992; Reynolds et al., 2000). Some researchers have included sympathy as part of empathy (Morse, Bottorff, Anderson, O’Brien & Solberg, 1992).

Brems (2001) reported two dimensions of empathy through the use of seven quantitative measures. The two dimensions include cognitive and affective empathy. The cognitive aspect requires cognitive understanding of another person. The affective dimension requires only that the person can put him/herself in the other person’s feelings.

Morse et al. (1992) identified four components of empathy. They are emotive, moral, cognitive, and behavioral empathy. Williams (1990) noted cognitive empathy, emotional empathy, communicative empathy, and relational empathy as all elements of empathy. Barrett-Lennard (1981) formulated a multidimensional model of empathy that denotes phases of empathy rather than dimensions or types of empathy. These phases explain the circular fashion of listening to the other, communicating the feelings perceived, and acknowledging the clients’ awareness of the communication. Alligood
identified two types of empathy based on related disciplines to nursing. The first type is basic empathy, which is defined as a basic human characteristic. The other type is trained empathy, in which education can serve to increase empathy in the clinical setting. Types of empathy, components of empathy, elements of empathy, or phases of empathy as suggested in the above literature, confirm the lack of consistent conceptualization of empathy.

Empathy in Nurses

Baillie (1996) interviewed nurses to understand their perspective on empathy. Nurses agreed that to be empathic is to understand how another person feels. However, they distinguished this from sympathy, which includes feeling sorry for someone. In addition, nurses felt that getting to know a patient helped them to be empathic. On the other hand, some nurses intentionally tried not to get too close to patients, because they felt it blurred their objectivity. Furthermore, the nurses felt experience, personal and professional, helps with developing empathy. Some nurses reported that patients who have very different experiences than their own are hard to empathize with.

Maatta (2006) outlines a clear theory of empathy for nursing based on the German philosopher Edith Stein. Stein’s conception of empathy includes three levels. The first level is active listening in which there are two separate human beings. At the second level, the listener temporarily merges with the other in order to understand what the other is feeling. The third level requires separating the two individuals in the mind of the listener but remaining close to the feeling of the other.
Stein’s theory gives a solid explanation for what happens intrapsychically and defines the emotional distance required to be empathic. For example, a nurse answers a call light and observes the patient in the bed with a contorted face and writhing in the bed. She already knows this patient is recovering from a fresh major surgery. The patient is not able to talk because of a tracheotomy tube. She takes in with her eyes the facial expressions, along with the body language, and she imagines that if she were in his position, she might be in pain, since she knows it has been 5 hours since the last pain medication was administered. She asks him to confirm what she might suspect. She has identified with the patient in her listening stance in order to ask the appropriate nursing assessment question. However, she does not over identify with his pain and feel the pain as her own. She immediately gives him the pain medication that he asks for and needs, given that the timing is appropriate. This nurse has been empathic with this patient in a way that is helpful to him and not harmful to her.

Stein’s theory of empathy helps us to understand how nurses use themselves in the assessment and care of their patients. For example, it does not require empathy, per se, to deliver pills to the patient at the bedside. However, the nurse may use empathy by delivering the pills, by encouraging the patient to take them, and by explaining what they are for and how they might help; thus the patient is respected as an informed participant rather than a passive recipient. Empathy is a critical ingredient in this example of a nurse-patient interaction in the simple delivery of pills. This use of empathy can make all the difference in the level of care that the patient experiences.
Burnout and Empathy

One study reviewed investigates the hypothesis that burnout and empathy measures could be redundant for the same underlying conceptual phenomenon in the helping professionals (Williams, 1989). Another study postulates a causal model regarding empathy and burnout in human service workers (Miller et al., 1988). Four studies (Astrom et al., 1990; Baxter, 1993; Omdahl & O’Donnell, 1999; Lee et al., 2003) have shown an inverse correlation between the level of empathy a nurse provides in caring for her patients and the burnout she experiences. One study is reviewed because of the concept of closeness and distance in the care giving role as it relates to burnout (Blomberg & Sahlberg-Blom, 2007). It is felt that the proximity of the terms ‘closeness and distance’ is very close to the concept of empathy. In the following paragraphs each of these studies will be examined in more detail.

Blomberg and Sahlberg-Blom (2007) looked at care team members (including nurses) for terminally ill cancer patients. A qualitative study was done based on focus groups in a care team in Sweden. The members disclosed the different ways they consciously think about closeness and distance in different aspects of caring for patients. In order to protect themselves, members of the team distanced themselves from the patient. However, the members felt closest when they allowed themselves to touch and be touched by the patients. At times, the members were task oriented vs. person oriented as a way to manage feelings. It appears that there was a balance between being close and distancing themselves emotionally that which allowed them to care for patients in the most effective way and not burnout. Their description of closeness and distance is related closely to the concept of empathy, though empathy as a concept is not mentioned.
Williams (1989) tested the hypothesis that burnout and empathy instruments may be redundant, because they appeared to describe the same underlying phenomenon from opposite ends of the continuum. Williams likened this idea to measuring low and high self-esteem by two different instruments, thus measuring the same underlying concept of self-esteem. The underlying concept that Williams tested was not named; however, she described it by stating that both burnout and empathy are linked with professional helping behaviors. In other words, burnout represents a decline or absence of professional helping behavior and empathy is linked with more effective professional functioning.

Her findings show no support for the hypothesis. Williams (1989) used two instruments on empathy and one instrument on burnout (MBI) on nurses, social workers, and school-teachers to quantitatively show no significance in the conceptualization that burnout and empathy may be redundant measures. Burnout is defined according to Maslach’s three dimensions of emotional exhaustion, depersonalization, and lack of personal accomplishment (1981). Empathy is reviewed in the literature, and the basic definition is the ability to respond to another emotionally without loss of objectivity. A definition of empathy for this study is not given, but is implied by the two instruments chosen to measure empathy. She suggests “burnout and empathy are both critically important concepts for study” and states that her research warrants further investigation into their relationship (p. 177).

Miller et al. (1988) suggest a causal model of burnout. The concept of empathy is formulated around the idea that communication is a mediator for burnout. In their model empathy is defined by two dimensions:
1. Emotional contagion, in which the caregiver has parallel affective experiences.

2. Empathic concern, in which there is a concern for the welfare of the other, however the caregiver does not have a parallel affect with the other.

These two dimensions are designated as positive (empathic concern) and negative (emotional contagion). The dimension of empathy that dominates a caregiver will indicate the type of communication the caregiver delivers. Whether the communication comes from someone whose empathy is driven by emotional contagion or empathic concern will predict the likelihood and/or the path of burnout as measured by Maslach’s (1981) three dimensions of burnout: depersonalization, lack of personal accomplishment, and emotional exhaustion. In Miller et al. quantitative study several measures were given to human service workers in a hospital setting to test the causal model suggested. Findings suggest a positive correlation between empathic concern and the caregiver’s belief in their ability to communicate care effectively and a negative correlation between emotional contagion and communicative responsiveness, indicating sharing the other’s emotions detours one from helping effectively. They suggest further research on the interpersonal relationship between the caregiver and the care recipient.

Astrom et al. (1990) studied 557 nurses (RNs and LPNs) in a geriatric care facility in Sweden. The quantitative study measured empathy as a variable in burnout. They found the higher the scores for empathy, the lower the burnout scores were for nurses, or in other words a negative correlation between empathy and burnout. While empathy was used as a variable, this study focused their recommendations on changes in the work environment rather than addressing individual factors. The definition of
empathy for this study is “using La Monica’s definition (1981) that states that empathy is an ‘ability in the nursing staff to place himself mentally and emotionally into the world of the patient with whom he is interacting, to communicate his understanding to the patient and the patient’s perception of the helper’s understanding’” (Astrom et al., p. 1237).

Lee et al. (2003) studied 178 Korean nurses. Korean nurses rate a higher degree of burnout than nurses in other countries. Empathy, as one of several individual characteristics examined, was subdivided into cognitive empathy and emotional empathy. The Barrett-Lennard Empathy Scale (BLES) used in this study defines cognitive empathy in terms of being related to the interactions with patients, whereas the same scale defines emotional empathy as related to general characteristics of the nurse, not the interaction with the patient. This quantitative study found that cognitive empathy is the most important predictor of depersonalization and lack of personal accomplishment as measured by the Maslach Burnout Inventory. According to Lee et al. (2003), with too little cognitive empathy the nurse can over-extend herself in providing emotional and physical care. The nurses reported high levels of emotional empathy and the authors suggested that this increases the chance of problems in detaching from patients. Low levels of cognitive empathy were also found, which the authors reported did not then give the nurse the ability to have a more objective stance with her patients. Lee et al. (2003) argue that this imbalance between kinds of empathy can result in burnout. In general, this study (Lee et al., 2003, p. 538) defined empathy as “‘the ability to understand another’s thoughts and feelings’” as cited by Barrett-Lennard (1981).

Baxter (1993) examined the relationship between empathy and burnout in registered nurses working in acute care settings in New Hampshire. Through two survey
methods, findings suggest nurses have an inverse relationship between empathy and two of the dimensions on the Maslach Burnout Inventory, emotional exhaustion and depersonalization. In other words, nurses who have a high degree of empathy do not rate burned out, and nurses who rate as highly burned out have a low degree of empathy. Experienced nurses are more likely to rate higher on empathy and lower on burnout, presumably because they have learned how to help patients effectively, without blurring their objectivity. Empathy is defined by Baxter (1993, p. 11 as cited by Barrett-Lennard, 1978) as “‘experiencing the process and content of another’s awareness in all its aspects. In particular, it includes sensing the immediate affective quality and intensity of the other’s experience, as well as recognizing its particular context.’”

Omdahl and O’Donnell (1999) studied registered nurses from two hospitals in the Northeastern United States. From a sampling of 164 nurses, this quantitative study identifies three variables along the continuum of empathy. The variables identified are emotional contagion, empathic concern, and communicative responsiveness. Emotional contagion is sharing another person’s feelings. Empathic concern is defined as “concern for the well-being of another that does not require sharing emotion” (p. 1357). Communicative responsiveness is defined as being able to communicate to another person material that is sensitive or emotional. Nurses who report higher levels of emotional empathy are more likely to depersonalize patients and are more exhausted and feel a lack of personal accomplishment. Emotional contagion predicts emotional exhaustion. Their recommendations include education for nurses on maintaining their own identity. In addition, they recommend that nurses not take on the feelings of another
person in order to remain objective, an emotional stance that will help prevent burnout in nurses. Their recommendations include both environmental and individual suggestions.

Conclusions

A large number of nursing studies on the burnout syndrome reveal various explanations for the causes of burnout that range from the work environment to the attributes of the individual nurse. The role of empathy, a crucial aspect of the nurse-patient interaction, has been widely studied in the nursing literature as well. There is little agreement on the concept of empathy in the nursing profession, despite its importance in the nurse-patient relationship. Moreover, there have been very few studies in the nursing literature to date that have examined the relationship between burnout and empathy. No qualitative studies of nurses were found that examined burnout and empathy.

This study investigated the emotional stance, as it relates to closeness vs. distance, that is necessary in order for the female nurse to be empathic and feel she has provided her patients with good care, without over identifying and losing herself in the process. It was assumed that the empathy a nurse is able to give to her patients is an expression of a cohesive self. It contributes to maintaining her well-being as well. In other words, the quality of empathy or the nature of the emotional stance a nurse takes with her patients contributes to her resilience.
Theoretical and Conceptual Framework

History of Empathy

Empathy, first conceived by Robert Vischer in 1873, was used to describe the human feelings that are projected onto the natural world (Pigman, 1995). The German word for empathy is *einfühlung*. *Einfühlung*, originally used to describe aesthetics, is a term originally derived from Greek meaning “to perceive.” However, Kant used “aesthetics” to delineate a branch of philosophy having to do with beauty. Theodor Lipps, a philosopher, used *einfühlung* to describe how people become aware of others as separate beings. Sigmund Freud admired Lipps for over 40 years. Lipps wrote prolifically on the topic of *einfühlung* and used the word in a psychological sense. Freud wrote in German, his native language, and Pigman (1995) asserts that when Strachey translated Freud’s work into English in the Standard Edition, *einfühlung* was not always translated as empathy. As one example of the various translations of empathy by Strachey, Pigman (1995) cites the translation of “On the beginning of treatment” (1913) as misleading in translating *einfühlung* to mean “sympathetic understanding.” As a result, empathy in Freud’s work has been under-emphasized.

Freud first used *einfühlung* in “Jokes and their Relation to the Unconscious” published in 1905. Freud used this term to describe how we put ourselves into others’ shoes in order to understand them. Pigman (1995) cites Montaigne’s essay “On experience” (1588) as anticipating the connection Kohut (1959) would later make between introspection and empathy. According to Pigman (1995), Lipps had such a
profound influence on Freud that he is likely Freud’s source for his thoughts about the unconscious. All of Freud’s references to *einfühlung* are intellectual. In addition, he assumes *einfühlung* to be such an obvious underlying part of the patient/doctor relationship that Freud does not mention it often in his work. Freud always used *einfühlung* to mean putting oneself into another’s place.

*Kohut’s Definition of Empathy*

Kohut states (1959) that the only way to know another psychologically is through vicarious introspection, which is his definition of empathy. We search ourselves for experiences that are analogous to those described by our patients. Kohut (1959) gives an example:

We see a person who is unusually tall. It is not to be disputed that this person’s unusual size is an important fact for our psychological assessment without introspection and empathy, however, his size remains simply a physical attribute. Only when we think ourselves into his place, only when we, by vicarious introspection, begin to feel his unusual size as if it were our own and thus revive our inner experiences in which we had been unusual or conspicuous, only then begins there for us an appreciation of the meaning that the unusual size may have for this person and only then have we observed a psychological fact (1959, p. 2).

Kohut (1982) stresses that empathy, as viewed from an epistemological viewpoint, is a value-neutral mode of observation. Kohut notes that extrospection is the tool of observation for the external world, while introspection is the tool of observation for the internal world of another person.

Kohut, like Freud, describes empathy from an intellectual, objective stance. It is certainly possible to err in one’s assessment using vicarious introspection (1959). In fact, Kohut (1982) notes that the more dissimilar someone is from one’s self, the more
difficult it is to empathize. Kohut gives credit to Freud for Freud’s understanding and scientific use of introspection and empathy (Pigman, 1995).

In Kohut’s final words before his death (1982), he broadened his definition of empathy to include empathy “as a powerful emotional bond between people” (p. 3). He adds, “the mere presence of empathy, has also a beneficial, in a broad sense, a therapeutic effect - both in the clinical setting and in human life, in general.” (1982, p. 3). The distinction between the two levels of empathy is important for Kohut. One involves information gathering, and the other describes the beneficial effect of being in the presence of one whose intent is to understand one’s experience. Empathy, for Kohut, comes from more than emotion. It requires cognitive and perspective-taking abilities.

Empathy has a developmental trajectory. Like other developmental achievements, it can be underdeveloped or nurtured. The developmental process of empathy is fostered in relationships with other people. Emde (1990) notes the developmental aspects of empathy are based on principles of understanding lifespan development in general. The development of the self is continuous and ongoing. However, we begin our first look at the ability to empathize with the early care giving relationship between the infant and parent. Current research supports the idea that early care influences the future care giving abilities of the child (Fraiberg, 1975). In other words, those who have been given to in an empathic way are more likely to be able to give back to others in an empathic way. However, there are times in life when regression to an earlier state (i.e., in physical illness) may leave one unable to maintain the same capacity for empathy.
Related to care giving is the capacity for “developmental empathy” (Emde, 1990). This requires a mature ego. The increasing ability to empathize comes with age and experience. According to Emde, “transient identifications occurring in the midst of empathy require a temporary sense of oneness with the other, followed by a sense of separateness in order to be helpful” (1990, p. 3).

Greenson (1960) notes two extremes that can be problematic in the process of merging and separating from another. The first is the person who is inhibited in his capacity to empathize. This person is afraid to get involved with other people. On the other end of the continuum is the person who exhibits what Greenson (1960) refers to as a loss of control of empathy. In other words, the person can empathize, but he remains in the “temporary oneness” that Emde (1995) describes as the process of empathy. In over identifying with the other person, a person loses connection with the experience of the other and reacts in a way that reflects his own feelings or experience. They can not slip out of the “temporary oneness” (Emde, 1990) into separateness. Greenson (1960) stresses that one needs to be able to be both involved and detached, subjective and objective, and be able to move between “temporary oneness” and separateness in order to achieve the optimum capacity for empathy.

Basch (1983) notes that the ability to be sensitive to another person can only be called empathy when it is in the service of a mature ego. Misunderstanding has abounded in the lack of distinction between the value-neutral mode of observation called empathy and the altruistic goal of mature empathy. Confusing these two has led to blurring feelings like love, compassion, and sympathy with empathy.
Basch writes “empathy, as all who have concerned themselves with the topic seem to agree, depends on the transmission of affect” (1983, p. 4). Basch maintains that the word “affect” is often used interchangeably with the words “feeling” or “emotion.” However, he points out that affect is more of a somatic response: “emotions are complex states in which several feelings are experienced as a unity in a relationship to the self and its goals” (1983, p. 10). There is a clear progressive of developmental stages in the affective life, which Basch names as “affect, feeling, emotion and empathic understanding.” Each developmental stage includes the previous stage and adds a dimension when progressing to the next stage. In other words, affective communication includes all of these stages, integrating the previous stage with the next stage along the developmental path. Basch also points to an important distinction between empathy and affective communication:

Sensitivity to the affective communication of others is present from the beginning of life, has its own development, and can be used in the service of a variety of goals, empathic understanding being only one of these. For example, infants and children who either have no sense of self as yet or cannot take distance from it, cannot be empathic; they are, nevertheless, clearly sensitive to the affect of others and guide their behavior accordingly. To be empathic an individual must be able to separate himself sufficiently from his feelings and emotions so that instead of simply reacting to them he can establish their genesis and the significance they have in the context in which they are experienced (1983, p. 11).

Basch’s clarification differentiates between someone who is responding to another out of mature empathy and one who is responding from their own feelings or needs.

In order to further the understanding of the role of empathy in nurses who do not burnout, this study utilized the psychoanalytic theory of the self formulated by Kohut.
Rather than define empathy as an isolated concept, the Kohutian theory of the self defines empathy as grounded in a theory of the whole person.

**Overall Questions Explored**

This study was designed to answer the following questions:

1. How do nurses, who measure not burned out, articulate their experience of the role of sustained empathy with their patients?
2. How do nurses articulate and describe, in depth, the emotional stance they find effective with their patients and themselves overtime?

**Theoretical and Operational Definitions of Major Concepts**

Registered Nurse (RN): One who has passed the National Council for Licensing Examination for Registered Nurses (NCLEX-RN) and is currently licensed in the state of Illinois. A person must have an Associates Degree in Nursing (two years of education), a Diploma in Nursing (three years of education through a hospital), or a Bachelor of Science in Nursing (four years of education) in order to be eligible to sit for the NCLEX-RN.

Burnout: The three widely agreed upon dimensions of burnout are: emotional exhaustion, depersonalization, and lack of personal accomplishment (Maslach, 1981).

Empathy: ‘Vicarious introspection’ as defined by Kohut (1959). Empathy is the ability to find within oneself feelings and experiences that are similar to those of another; however, the objectivity of the observer is not lost. The feelings of the observer remain his or her own. From this value-neutral position, information may be learned that aids in the understanding of the needs of the other person. For example, a nurse may understand
what a patient needs through vicarious introspection, and this will help her give effective care.

Emotional stance: The emotional closeness vs. distance that a nurse maintains between herself and a patient.

Cohesive Self: The healthy state of the self in which there is a genuine feeling of well-being. As defined by Kohut (as cited in Siegel, 1996), when one has a feeling of well-being or has a cohesive self, she has the ego strength to not only give to help another but also the ability to hold onto herself in the process, not merge with another or lose herself in another. In other words, she can effectively help someone but also recognize and pay attention to her own feelings and needs.

Over-identification: The emotional merger of the observer, to the extent that the response comes from one’s own feelings and needs rather than the feelings and needs of the other.

Statement of Assumptions

1. Empathy is one of several traits that are inherent in the wish to help others.
2. The ability to empathize comes from a cohesive self.
3. Nurses originally became interested in the nursing profession as a result of wanting to help others; this desire to help others may stem from many aspects of the nurse’s personality, some of which may be defensive.
4. The cohesive self allows nurses to establish a professional stance that supports high professional functioning.
5. Empathy informs how nurses carry out patient care. This includes the full continuum of care, from explaining a procedure in a way that a patient can
understand to performing a technique in a manner that is compassionate with the patient’s needs.

6. The fields of nursing and analytically informed social work assume that empathy is a basic human function even though the application of empathy in the two disciplines may be different.

7. This study will build a bridge between two worlds--nursing and analytically informed social work in such a way that one may help to inform the other.

8. The burnout scale is reliable and valid and will identify RNs who are not burned out.

9. The nurses will be able to articulate how they think of empathy and its role in many facets of patient care.
CHAPTER III

METHODOLOGY

Introduction

This study was based on pragmatism, which includes the following knowledge claims as cited in Creswell (2003). “Pragmatism is not committed to any one system of philosophy and reality. Individual researchers are free to choose methods, techniques, and procedures of research that best meet their needs and purposes” (p. 12). This allows the researcher to use both quantitative and qualitative approaches in order to best understand the research problem. “Truth is what works at the time” (Creswell, 2003, p. 12). Pragmatists follow their personal value system, and this in turn represents a practical philosophy to research design (Tashakkori & Teddlie, 1998). The pragmatic knowledge base was chosen to support research that is designed for a consequence-centered issue like the role of empathy in nurses who do not burnout.

This was an exploratory study, using a convenient sample that utilized a mixed methods design. Both quantitative and qualitative approaches were used. A survey to measure burnout was used to gather quantitative data and to provide the sample of nurses for the interviews. Since other investigators have previously tested the survey for reliability and validity, it was assumed that its use here would reliably identify nurses who were not burned out. The quantitative data yielded frequencies, distribution of
scores and correlations. Interviews with the nurses who did not measure as burned out yielded rich subjective data. This sequential, mixed method exploratory study yielded descriptive data that helped to conceptualize a theory of the emotional stance that nurses who are not burned out use to approach their patients.

Previous research is limited, since there are no qualitative studies on burnout and empathy in nurses. Qualitative research uses in-depth interviews, in which the individual voice of each nurse is heard. Grounded theory (Strauss & Corbin, 1998), a qualitative method of inquiry, calls for the researcher to put all the subjective data from the interviews into a coded format. This type of coding is an intuitive and creative process. It is an effort to understand what is underneath the words that the nurses use. The process involves multiple stages of data collection in which the data are put into categories of information, finding themes and sub-themes in the data until there is redundancy. These categories were used to generate a framework of a process that can be tested in further research.

Participant Recruitment

The study consisted of female registered nurses (RN) who were employed at Carle Foundation Hospital (CFH), a 305-bed, not-for-profit hospital located in central Illinois. To control for variability in responses due to gender, the study was limited to female RNs. The RNs chosen had worked at the bedside in acute nursing hospital departments for at least two years. All RNs in the CFH database who met these criteria received a survey in their CFH mailbox.
The Maslach Burnout Inventory-Human Services Survey (MBI-HSS) (Appendix A), described below, was given to RNs who were female and who had worked at the bedside two years or more to measure degrees, if any, of burnout. In addition to the survey, demographic information was acquired (Appendix B). Packets were sent to the 486 eligible participants. A sample size of 162 female RNs responded to the survey.

Following quantitative data analysis of the survey, 22 nurses were interviewed. None of the nurses were burned out at the time of the interviews. In interviews nurses were asked about their experiences and about the role of empathy in their caregiving.

In the beginning phases of the study a meeting was arranged with the CFH research team in charge of nursing staff. In the introductory meeting, a two-page summary of the study proposal was discussed. During this first meeting, members of the research team said that in previous research, nurses had been reluctant to participate in research conducted at CFH. It had been reported that the nurses feared being identified and retaliated against. In an attempt to make the nurses feel as comfortable as possible, the PI incorporated several measures designed to assure them that confidentiality would be maintained. One of these measures was to have the survey returned directly to the PI rather than to the HSRC, as had been done in previous studies conducted at the hospital. Another was to reassure the nurses that confidentiality would be practiced and maintained in every step of the process. The PI is not affiliated with CFH and made a point of letting the nurses know this in the cover letter. Finally, the interviews were conducted at a time and in a place that was selected by the nurse.

The study proposal for this study went through a rigorous review by the CFH Institutional Review Board (IRB). The letter of approval from that process is attached to
this document (Appendix K). In addition, the IRB for The Institute for Clinical Social Work approved the study.

Data Collection Methods and Instruments

Prior to the distribution of the MBI-HSS packet, the study was announced to all nurses by the following methods:

1. An email message was sent to all the bedside nurses by the head of Health Systems Research Center (HSRC). This message introduced the study, encouraged nurses to participate in it, and alerting them that a survey packet would be to the arriving in their mailboxes (Appendix C).

2. Each nurse manager was asked to verbally notify staff at their monthly meetings and also to post a notice announcing the survey on their units (Appendix D). Nurse managers were asked to encourage all staff to participate in the study by completing and returning their packets promptly.

A cover letter (Appendix F), the MBI-HSS form (Appendix A), a demographic questionnaire (Appendix B), informed consent (Appendix G), and a pre-addressed stamped envelope were distributed to the mailboxes of all female RNs that meet the study criteria. A second mailing was delivered to the mailboxes six weeks after the first mailing. The cover letter of the second mailing was slightly different (Appendix H) than the first letter, given those who had not responded to the first invitation another opportunity to participate. In addition a notice was included in the second mailing informing the nurses that if they had not already filled out their surveys, they could
respond anonymously (Appendix I). All completed questionnaires were returned to the Principal Investigator (PI), located at 7 Dunlap Court in Savoy, IL 61874.

All of the surveys were stored at the office of the PI. Only the PI knew the identity of the nurses who agreed to participate in the study. All data had remained confidential; all of these details concerning the protection of confidentiality were clearly communicated to the participants.

The instrument to be used for the survey was the Maslach Burnout Inventory-Human Services Survey (MBI-HSS, Maslach, Jackson, & Leiter, 1996). The MBI contains three subscales. The MBI-HSS has 22 items that are measured on the Likert scale by the respondent, and takes about 10 minutes to complete. This is a self-administered survey that includes complete instructions for the respondent. The three subscales that are measured are emotional exhaustion, depersonalization, and lack of personal accomplishment. The Emotional Exhaustion (EE) subscale assesses feelings of being emotionally overextended and exhausted by one’s work. The Depersonalization (Dp) subscale measures an unfeeling and impersonal response toward recipients. The Personal Accomplishment (PA) subscale measures feelings of competence and successful achievement in one’s work with people. A high degree of burnout is reflected in high scores across the emotional exhaustion (≥27) and depersonalization (≥10) subscales and low scores on the personal accomplishment (≤33) subscale (Maslach et al., 1996). The scores are considered separately and not combined into a single, total score.

The MBI-HSS was first designed for human service workers and has been expanded to other versions for other professions, demonstrating it is the most widely used measure of burnout. The reliability of the subscales is reported as .90 for the emotional
exhaustion subscale, .79 for the depersonalization subscale, and .71 for the personal accomplishment subscale using Cronbach’s coefficient alpha (Maslach et al., 1996). The MBI-HSS has been shown to exhibit good internal and external validity in the human service professions (Maslach et al., 1996).

The MBI-HSS and demographic surveys were coded by number to insure confidentiality and the code remain locked in the office of the PI. The MBI-HSS and demographic information were entered into a secured database developed by Health Systems Research Center (HSRC) staff that was used for the statistical analysis.

Nurses who scored low on the emotional exhaustion and depersonalization subscales and high on the personal accomplishment subscale were contacted by email extending an invitation to be interviewed face-to-face. A $10.00 coupon, from Bath and Body Works, was given to those who completed the interview as a thank you for their participation. The PI conducted all the interviews. The interviews were semi-structured, containing open-ended questions (Appendix J), and lasted approximately one hour. The interviews were recorded and transcribed verbatim. After transcription the recording was destroyed. The transcription was coded so that only the PI knew the identity of the interviewee during data analysis. An out-of-area transcriptionist was hired, and she heard only the voices of the interviewees. She did not have access to the names or identities of the participants. The transcriptionist was educated and bound by confidentiality. During member-checking interviews nurse participants had the opportunity to review the final document to be sure they agreed with the material or to clarify any points they might wish to clarify. The PI was responsible for the data analysis of the interviews.
HSRC and the PI took every measure to ensure that the confidentiality of the information received during this study was maintained. The raw data was used only for the purpose of this study and will not be available to anyone else.

Data collection, including the interviews, took a total of five months.

Description of Interview Participants

The original proposal called for 20 nurses who did not rate as burned out on the MBI-HSS to be interviewed. In the end, 22 nurses were interviewed. All of the subjects completed the interview process. Due to time constraints artificially imposed by the hospital (see Chapter VI) only four of the nurses were interviewed twice. Six subjects participated in the member checking interviews.

Participants ranged in ages from 25 to 69 years old. Forty-one percent of the nurses interviewed were in their 50s, 27% were in their 40s, 15% were in their 30s, and 20% were in their 20s. All of the nurses interviewed were Caucasian. A more extensive breakdown of the demographics of the survey sample and interview sample are reviewed in the Quantitative Chapter.

Interview Process

The PI intentionally identified herself in the cover letter to the nurses as an RN, hoping that this information might help to establish trust. Trusting the research process in this particular institution had proven challenging with the nurses involved in previous nursing studies. Since this research proposed asking more personal and potentially more sensitive questions than those that had been asked in previous research, every effort was
made to assure the nurses that their privacy would be respected, and confidentiality maintained. It was hoped that the nurses would feel as comfortable as possible, and that they would be assured that this was a non-judgmental process.

The PI’s first professional career was as a bedside nurse. This background experience proved to be helpful during the interviews with the nurses. First, there was a discussion with several of the nurses about common experiences that seemed to facilitate a gradual and comfortable easing into the interview. The nurses understood that they shared a common language and experience with the PI, and that they could talk “nurse to nurse,” even though they also knew that the researchers current professional role is as a social worker. Secondly, the nurses knew that the PI had worked as a bedside nurse: interviewees were able to make assumptions about the researcher’s ability to understand various components of their working environment. Thirdly, while it had been many years since the PI was employed in a hospital setting, she has retained a common basic understanding of medical language, the frequent acronyms used by nurses in conversation, and a fundamental understanding of many of the disease processes and procedures. Finally, the PI experienced a renewed identification with the nursing profession in the process of the interviews.

The fact that the PI was able to identify with the nurses helped during the interviews. However, when it came time to analyze the data and especially to write it up, there were difficulties in taking off the ‘nursing hat’ and re-engaging the clinical social work/researcher role. With the aid and supervision of the chair, a process of de-identification with the nursing self took place in a way that was helpful to writing up the research. The PI’s ability to use her nursing background as an aid to understanding the
data was helpful; however, not having that background interfere with the research process and analyzing the data called for a delicate balance.

Upon reflection, the PI realized that she was identifying with the subjects of her study much the way nurses empathize with their patients. Identification with the nurses facilitated an empathic inquiry with them during the interviews; however, at some point becoming over-identified with the nurses was interfering with the PI’s ability to think clearly as a clinician. Her chair proved invaluable in facilitating the clinician part of her brain to re-engage with the data.

Data Analysis

Statistical analysis provided frequencies for each of the items on the MBI-HSS. Patterns of the scores were analyzed. There is not a total score given for the MBI-HSS, only scores for each of the previously identified subscales. The three subscale scores determine, as a group, whether the subject is burned out or not. Correlation of each of the demographic questions and each subscale score was compared. Of specific interest was the correlation between burnout and each measure of the demographic survey. This might help ascertain, for example, whether there was a correlation between years of education and burnout. This also provided a basis for comparing quantitative measures with the qualitative information obtained in the interviews. The primary interest of the survey was the subscale scores, which determined who was invited to be interviewed. Comparisons between the data from the quantitative measures and the interviews were used to check for consistency in the overall data gathered. This in turn assisted in the
interpretation of the data. Characteristics of the RNs whose scores reflected low burnout were the focus of this study.

In order to obtain the most data possible, a semi-structured interview protocol with open-ended questions was utilized. Some of the questions that guided the one-hour interview included: 1) Tell me what influenced you to become a registered nurse. 2) Tell me of an experience when you felt you could not give your best care because it was a difficult patient. 3) Tell me of an experience when you felt good about the care you were able to give a patient (Appendix J). While the prepared questions were used in the interview, additional questions also evolved in the process of the interviews. The interview questions were based on Rubin and Babbie’s (2001) interview guide.

Grounded theory, one method of analysis for qualitative data, was used to analyze the interviews. “Grounded theories, because they are drawn from data, are likely to offer insight, enhance understanding, and provide a meaningful guide to action” (Strauss & Corbin, 1998, p.12). In this method of analysis, descriptions given by the participants conveyed their feelings and perceptions. From these descriptions, the PI looked for the conceptual organization of data; that is, the raw data were placed into categories. Categories were then broken down further, into properties and dimensions. Once the categories were established, the researcher began to put them into a formulation or began to theorize what the data meant. “At the heart of theorizing lies the interplay of making inductions (deriving concepts, their properties, and dimensions from data) and deductions (hypothesizing about the relationships between concepts, the relationships also are derived from the data, but the data that have been abstracted by the analyst from the raw data)” (Strauss & Corbin, 1998, p. 22). It was hoped that the creative and analytic
process of this method of data analysis would contribute a framework that would be helpful in conceptualizing the role of empathy in nurses who do not burnout.

The PI conducted all the interviews. However, to increase the reliability and validity of the interview data analysis, at least one other master’s prepared social worker was asked to sample some of the coding for inter-rater reliability. This ensured that the same codes were being applied to the same data by two different raters.

Member Checking

Member checking “occurs when researchers ask the subjects of their research to confirm or disconfirm the accuracy of the research observations and interpretation” (Rubin & Babbie, 2001, p. 432). Six nurses who participated in the interviews were asked to read and respond to the six chapters of qualitative results. The six nurses represented a cross section of age and work settings of the nurses who were interviewed. The PI met with each of these nurses either face-to-face, or spoke to them individually in telephone interviews to ascertain their reactions to the results, and collect their feedback.

All of the nurses felt that the narratives gave an accurate portrayal of nurses. All of the nurses commented on the breadth and thoroughness of the picture of nurses that emerged in the results. One nurse said, “I thought it covered everything about nurses, which is a lot, and I found it to be very thorough. Not everyone has a clear picture of what we do. I was amazed when I asked myself if anything was left out, that I couldn’t think of anything!”

One nurse opened the member-checking interview with this statement. “I was surprised to think back and realize I have had more bouts of burnout than I realized, when
I thought about family stressors and stuff like that. I think it is easier to think of work as the stressor in your life.” Another nurse said, “It was funny to be reading along and read a quote and think, ‘I think I am the one who said that.’”

One nurse said,

I just came from a meeting on my unit where we talking about over-time. The [administration] is wanting us to not [do it]…one nurse was saying that her priority was taking care of her patient, and if that meant she had to do her documentation and work over-time, then that is what she felt was required. So it made me think of what nurses had told you in the interviews about that.

One nurse commented on how some nurses had talked about feeling as though they need to advocate for the patient with other nurses. She said, “I never thought of that as patient advocacy, but I realize I do that all the time. I make sure I pass on something personal that helps with patient care.”

One nurse took the opportunity in the member-checking interview to tell additional stories of what had happened recently on her unit. These new stories were told as a way of illustrating what we had been talking about in the results; however, it also seemed that telling these stories at that point in time was helpful to the nurse in processing recent events.

One nurse commented on the general impression of nurses she had gained in reading the document. “I was surprised at how different we nurses are. My goodness, I have never felt like some of the nurses that I read about, but it wasn’t, like, unheard of either.”

Other comments from the member checking interviews have been woven into the results.
Limitations and Generalizability

One limitation in this study is that all the nurses who elected to participate in it work at one Midwestern hospital, thereby limiting its generalizability to nurses in other institutions. Secondly, there were only female participants. This limitation was deliberately maintained to control for gender variables; however it also reduced the generalizability of the study, even to some degree within this hospital. However, since nursing remains a female dominated profession, and most of the nurses in this hospital are female, the possible limitation of the study in this regard was reduced. Third, the PI chose to interview only nurses who were not burned out at the time of the interview. This may have limited the findings in other ways that reduces generalizability. Further research will help to fill in some of these questions about nurses, burnout and the question of the emotional stance necessary for nurses to maintain with their patients in order to serve their patients and themselves well.

Another limitation was the fact that, the success of the interviews depended on the nurses’ abilities to accurately describe their own experiences. There is always a risk that participants do not disclose important subjective information or that memory distorts perceptions. A variety of human errors, either intentional or unintentional, conscious or unconscious, could potentially affect what each nurse had reported.

Moreover, the PI chose Kohut’s theory of the self to use as a theoretical lens with which to view the interview data. The use of this theory may have posed some limitations, whereas using another theory might cause the same raw data to yield different findings. Despite the limitations, the hope was to build another step in the understanding of the role of empathy in nurses who do not burnout.
Statement on Protecting the Rights of Human Subjects

*Risks/Benefits*

Risk for harm to the participants of this study was minimal. The interviewer is trained in observing emotional responses that may have required further consultation. If necessary, the PI could have referred participants to the Employee Assistance Program or another professional of the participant’s choosing for further treatment. However, none of the participants appeared distressed at any time during the interviews. There were no material benefits to the individual nurses beyond the $10.00 gift certificate. In general, benefits of the research included helping others better understand the feelings nurses have about their work, and specifically in understanding the role of empathy in nurses who are not burned out. Findings of this study could have implications for the training of nurses. Nurses also had the opportunity to learn about the outcome of the study. Potential benefits outweighed the participants’ risks in this study.

*Informed Consent*

All participants were provided with the informed consent form in the initial packet. This consent form was written by the HSRC of CFH in order to comply with their institutional standards. The consent form includes the purpose and descriptions of the study, its costs and benefits, and how the participant’s privacy and confidentiality would be safeguarded. It also explained the voluntary nature of the research. A copy of the informed consent form was given to each participant. All the nurses who agreed to be interviewed signed the consent form, and their consent was reviewed at the beginning of
each interview. Some of the nurses in the survey sample chose not to return the consent form, but did participate anonymously by returning their two surveys.

Use of Data

The PI is the only one who knows the identities of the interviewees. The identities of the interviewees were kept in a numbered code in a locked cabinet in her office. The data from the interviews did not contain names or any other identifying information. To further ensure confidentiality, the interviews were held at the office of the PI or at another place of the participant’s choosing in order to maintain confidentiality. The interview was transcribed as soon as possible after the interview, and the digital recording of the interview was destroyed immediately after transcription. The subjects were identified by number code only on the typewritten document. Quotes from the interviews were used in the final document, but only to help in understanding of the data, and no identifying information was included. The gross data gathered from the MBI-HSS was entered into the confidential database at HSRC. All efforts to maintain confidentiality were given priority by both the PI and the HSRC. The final use of the quantitative data was given in the aggregate form only. All of the data will be destroyed five years after the dissertation has been approved.
CHAPTER IV

INTRODUCTION TO THE RESULTS

The initial purpose of this study was to explore the role of empathy in nurses who do not burn out. The results of the MBI-HSS yielded a pool of interview candidates who did not measure as burned out. However, qualitative analysis revealed that even though the nurses were not burned out at the time of the interviews, several of the nurses reported they had been burned out in the past. Therefore, the interviews included discussion of both the experience of burnout and the role of empathy in the nurse/patient relationship.

In the interviews, empathy was described by the nurses through exquisite examples they shared from their experiences in clinical practice as they talked about the nurse/patient relationship. Some of the nurses spoke about past experiences with burnout, shedding light on this subject as well. Almost all of the nurses confirmed the study’s assumption that when nurses feel burned out they have less capacity for empathy.

The study results begin with Chapter V, the quantitative chapter, which illustrates the statistical analysis of the frequencies and correlations compiled from the MBI-HSS and the demographic survey. There were no correlations found between any of the demographic variables and any of the three subscale scores from the MBI-HSS.
Following the discussion of quantitative results Chapter VI introduces the qualitative results, to aid in setting a framework for the study. The subsequent six qualitative chapters discuss the experiences of bedside nurses who were not burned out, as determined from by the MBI-HSS scores and self-report, from one Midwestern hospital. These chapters detail the stories these nurses shared about their experiences of the role of empathy in their work, as demonstrated largely through examples they offered from their everyday lives. The interviews were analyzed using grounded theory, as conceptualized by Strauss and Corbin (1998). Each of these six chapters discusses a category, and each of the chapters further elaborates the properties and dimensions within that category.

The first category, Routes to the Profession, has three distinct, yet overlapping, properties that demonstrate how the nurses chose their profession. Calling was the most commonly stated reason for becoming a nurse. Many of the nurses knew from an early age that they wanted to be nurses. Some described it as a Calling; others talked about how they had an Idealization of nursing because of a nurse they had known or observed in their early life. Financial Compensation was another route to the profession, though it often overlapped with Calling or Idealization.

The second category, Professional Pride, illustrates the complexity and variety of feelings nurses have about their profession. All of the nurses felt that Compassion was an integral part of the nursing profession, and they spoke of this property with pride. Some of the nurses felt Protective of Disclosure regarding information, especially as it pertained to other nurses. Some of the nurses spoke somewhat reluctantly during the interviews; most said that they did not feel that they could speak for another person; these
nurses stated that their hesitance about speaking was based in not knowing enough to speak for another person, rather than out of a sense of protection.

Another property of Professional Pride is the Unique Personal Qualities that the nurses were pleased to say that they brought to the profession. Regarding the property of Self-Evaluation, many of the nurses spoke of the many ways they evaluate themselves and the work they have done at the end of a task or at the end of a shift. Some of the nurses talked about how they often consider how they could do things differently next time. Most spoke of wanting to provide good patient care and said that what contributed to their sense they had “failed” was determined by their own personal standards. In the last property, A Profession With Many Opportunities, all of the nurses were proud of and pleased about the many avenues that are open to them because of their nursing expertise.

The third category, Theories of the Nurse/Patient Relationship, describes the many ways that nurses see their role in relation to their patients. In the property of Facilitation, there are three dimensions that explore the descriptions and characteristics that nurses felt they brought or ought to have in order to be a good nurse. Among the dimensions of Facilitation are: Engagement, Patient Advocacy, and Education.

In this category, the property of Experience illustrates how the nurses felt that both life and professional experience helped them to know what to do for their patients. Nurses depicted their own sense of Self-Awareness in the next property of this category. They were aware of what made them happy in their jobs: this included the types of patients they chose to work with, the types of unit that were good matches for them, and their ability to speak up for themselves to ensure that they got what they needed in order
to feel professional satisfaction. Intellectual engagement was also important to many of the nurses, and helped to keep them engaged in their profession.

Finally, the property of The Function of Others describes the other people with whom the nurses interfaced with and the effect it had on them. For example, patients’ families presented extra challenges that often took more time and energy than the nurses felt they had to give, not to mention the complications that could potentially arise in these relationships. Throughout this category, in every property and dimension the nurses gave exquisite examples of how they had demonstrated empathy in their interactions with their patients.

The fourth category, Empathy, is an extension of the previous category, Theories of the Nurse/Patient Relationship. Empathy is a key ingredient in the nurse/patient relationship and a crucial requirement in the nursing profession. The properties of Empathy include the Definition nurses gave regarding their understanding of empathy. In the second property, empathy was described as a delicate Balancing Act, involving the way nurses “felt” themselves into understanding the positions of their patients; but they also talked about the balance each of them maintained in the emotional closeness vs. distance aspect of their care.

The final property, the Limits to Empathy, describes ways in which there are limits to empathic attunement. Sometimes the ability to empathize was interfered with by the nurse’s own life experiences, most notably when she felt the loss of objectivity with a patient or a family member of a patient. Other times the affective state of the patient influenced the affective state of the nurse, as in countertransference, and her objectivity was compromised. Other times there were limits to empathy simply based on the fact
that the nurse could not relate to the patient; she could not put herself in her patient’s shoes, perhaps because the patient’s experience was too foreign for the nurse to imagine.

In Burnout, the fifth category, nurses described the Descriptors and the Contributors to the phenomenon of burnout. None of the nurses interviewed were burned out at the time of the interview; however, most said they had experienced phases of burnout in the past. The interviews led to the discovery of the Progression of burnout. Specifically, burnout was described by some of the nurses as a progression of events that burdens the self over time and converges with an end result that we call “burnout.” The progression is so subtle that even with hindsight it was difficult for some of the nurses to identify all the contributors to the phase of burnout.

In addition to the Progression of burnout, the nurses who were able to talk about their experiences with burnout felt that it was a phase rather than a discrete event, and that it was something to be dealt with, a predictable challenge in the career of a nurse. The experience of burnout and the vicarious experience of watching other nurses experience it gave the nurses who were interviewed several ideas about what they felt the Inoculators against burnout might be.

Finally, most of the nurses felt there was a link between the feeling of burnout and the limits of empathy. Specifically, they felt that when a nurse was burned out, it was more difficult, if not impossible, to be empathic with their patients. Most of the nurses seemed to feel that both burnout and empathy are endemic to the profession. Burnout was a phase that most nurses felt they had managed and worked through, and was a natural part of the experience of being a nurse. It is in the nature of being human, and is not specific to the nature of their work. Burnout comes and goes in a lifetime or career,
and while there are many things one can do to take care of oneself, and try to minimize it, it may not be possible to avoid it altogether.

Empathy, on the other hand, is not only a desired quality in nurses; it is a key component of the nurse/patient relationship. If the nurse feels stressed or burned out, her capacity for empathy is limited. Nevertheless, the nurses interviewed spoke honestly about their experiences with burnout and their limits of empathy; however, woven throughout all the interviews were examples of the mature empathy they had shown toward their patients.

The final category, Generational Differences, was discovered as the interviews progressed over time. The nurses consistently talked about generational differences among nurses. Sometimes they spoke with appreciation of the qualities of the generation of the “other” generation. Sometimes they expressed complaints. The discovery of these Generational Differences led to an unexpected interview with an RN who is employed by the hospital and is also an inspirational speaker who travels the country giving talks on Generational Differences.
CHAPTER V

QUANTITATIVE RESULTS

Introduction

In the quantitative section of this sequential mixed method study, the Maslach Burnout Inventory-Human Services Survey (MBI-HSS, Maslach, Jackson, & Leiter, 1996) (Appendix A), and a demographic survey (Appendix B) were sent out to all the bedside nurses (RNs) by hospital courier. The MBI-HSS was administered for two reasons: 1) to ascertain the frequencies, patterns, and correlation scores and 2) to identify a set of nurses who were possible interview candidates, based on their MBI-HSS scores. The demographic variables (age, education, years as a hospital RN, average hours worked, and medical setting) were chosen to see if there was any correlation between any of the demographics and the subscale scores of the MBI-HSS. Frequencies of the demographic variables also helped to determine how representative the interview sample was of the larger survey sample.

In addition to the MBI-HSS and the demographic survey, two copies of the informed consent form, (one stamped ‘copy’ in red for the participant to keep) (Appendix G), a cover letter (Appendix F), and a pre-addressed, stamped envelope addressed to the private office of the PI were included in the packet that was distributed to the nurses by the hospital courier. An e-mail alert was sent out to announce the study a few days prior
to the mailing by the head of the research department at CFH (Appendix C). There was also a second mailing six weeks after the first mailing in an attempt to increase the return rate.

The sample size of nurses who were mailed packets was 486. The final sample size of nurses who responded to the survey was 162 (a return rate of 34%). Since other investigators have previously tested the survey for reliability and validity, it was assumed that its use would identify nurses who were not burned out. The purpose of the survey was twofold: 1) to identify nurses who were not burned out that would be possible interview candidates and 2) to measure correlations between the demographic variables and each of the subscale scores of the MBI-HSS that measure burnout.

The interview sample was derived from survey participants who 1) turned in signed consent forms, thus identifying themselves, 2) scored low on the three subscales of the MBI-HSS (64% of those interviewed) and agreed to be interviewed, and 3) those who scored on the low end of moderate in at least one subscale of the MBI-HSS and agreed to be interviewed (36% of those interviewed). Candidates in the third category were considered as subjects when it became clear that the pool of possible interviewees was limited. None of the nurses interviewed felt burned out at the time of the interviews.

The MBI-HSS statistical data will be reviewed. The interview sample will be discussed with regards to representation of the larger sample and the differences noted and commented upon.
Demographic Survey Results

While the primary purpose of using the MBI-HSS was to identify a set of interview candidates, compilation of the frequencies of the demographic survey also helped to determine how representative the interview sample was compared to the survey sample. In addition, correlations for each demographic item and each subscale on the MBI-HSS were measured. Statistical results were compiled on SPSS by the CFH research department.

Age category frequencies are displayed in Table 1. Overall, the survey sample reflected a uniform distribution over the ages between 20-60, with approximately 25% of the respondents falling into each of the four age group categories (21-30, 31-40, 41-50, 51-60). Of 162 respondents, 7.4% did not answer the question about age.

Educations category frequencies are displayed in Table 2. The education category was grouped together for statistical purposes. ADN and Diploma degrees were grouped into one category, and BSN and BS and BA degrees were grouped in the other major category. The rationale for grouping the nurses was as follows: ADN is a two-year associate degree, while Diploma nurses have three years of education through a hospital-sponsored training program. Neither the associate degree nor the Diploma nurses are exposed to research in their curricula. The BSN (Bachelor of Science in Nursing), like any BS or BA degree, requires four years of college education. The MSN (Master of Science in Nursing) or any other higher degree requires education beyond the bachelor's level. Therefore the education degrees were combined, based on number of years and type of education. Most of the sample of nurses (95%) fell into the categories of ADN/Diploma and BSN/BS; the split between those two categories was almost even.
The third category, nurses who had completed a master’s degree or beyond, accounted for less than 5% of the total sample. The column labeled “Missing” in Table 2 represents the respondents who elected to send in only the MBI-HSS, leaving out the demographic survey.

Years of experience as a hospital RN category frequencies are displayed in Table 3. There was a larger representation of nurses who had worked for less than 15 years than nurses who had worked more than 16 years. Sixty-three percent of the sample had from 1-15 years of hospital service as an RN.

Hours worked per week category frequencies are displayed in Table 4. Most of the sample (more than 60%) worked 36-40 hours per week. The likely reason for a high response at the 36-40 hour level is that 36 hours a week confers full-time status and therefore qualifies such nurses for the full benefits package.

Work setting category frequencies are displayed in Table 5. The largest portion of the survey sample was from the ‘other’ category (33.1%): this is the category that was marked by the nurses whose units did not clearly fit into any of the other categories. Nurses who worked on medical/surgical units, may have marked both medical and surgical on the demographic survey, perhaps in an effort to be accurate. In addition, the PI also discovered by comparing their name with the unit the hospital listed them in, that some of the nurses chose to elect ‘other’ as a way of remaining more anonymous with CFH. Although only the PI has the names of the participants coded with the survey and the demographic survey, both forms were inputted in the CFH database. Identification of the subjects might have been possible to deduct therefore by using the demographic information. For example, there might be only one nurse who was 45 years old that had a
BSN, and 10 years of experience on the maternal/child unit. Perhaps for this reason some of the nurses chose to provide an additional level of protection of their identities by not revealing some of those demographic factors. Remaining anonymous appeared to be important to many of the nurses.

The critical care category includes all the intensive care units. They comprised the second largest representation of the sample at 21.4%. The medical and surgical units measured 14.9% and 16.9% respectively. Maternal/child, pediatrics, and emergency room measured the smallest representation with 5.8%, 2.6%, and 5.2% respectively. In retrospect, the work setting choice list could have been developed to more accurately reflect the names of the units in the hospital.

Table 1

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</tr>
<tr>
<td>Missing</td>
<td>12</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>162</td>
<td>-</td>
</tr>
<tr>
<td>Education</td>
<td>Frequency</td>
<td>Percent</td>
</tr>
<tr>
<td>-----------</td>
<td>-----------</td>
<td>---------</td>
</tr>
<tr>
<td>Dip/AND</td>
<td>70</td>
<td>45.5</td>
</tr>
<tr>
<td>BSN/BS</td>
<td>77</td>
<td>50.0</td>
</tr>
<tr>
<td>MSN+</td>
<td>7</td>
<td>4.5</td>
</tr>
<tr>
<td>Total</td>
<td>154</td>
<td>100.0</td>
</tr>
<tr>
<td>Missing</td>
<td>8</td>
<td>—</td>
</tr>
<tr>
<td>Total</td>
<td>162</td>
<td>—</td>
</tr>
</tbody>
</table>
Table 3

*Years as a Hospital RN Category Frequencies*

<table>
<thead>
<tr>
<th>Years Hosp RN</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-5</td>
<td>48</td>
<td>31.2</td>
</tr>
<tr>
<td>6-10</td>
<td>33</td>
<td>21.4</td>
</tr>
<tr>
<td>11-15</td>
<td>17</td>
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<tr>
<td>16-20</td>
<td>12</td>
<td>7.8</td>
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<tr>
<td>21-25</td>
<td>15</td>
<td>9.7</td>
</tr>
<tr>
<td>26-30</td>
<td>11</td>
<td>7.1</td>
</tr>
<tr>
<td>31-35</td>
<td>14</td>
<td>9.1</td>
</tr>
<tr>
<td>36-40</td>
<td>4</td>
<td>2.6</td>
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<tr>
<td>Total</td>
<td>154</td>
<td>100.0</td>
</tr>
<tr>
<td>Missing</td>
<td>8</td>
<td>—</td>
</tr>
<tr>
<td>Total</td>
<td>162</td>
<td>—</td>
</tr>
</tbody>
</table>
Table 4

*Average Hours Worked Per Week Category Frequencies*

<table>
<thead>
<tr>
<th>Avg. Hrs. Wk.</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.0</td>
<td>1</td>
<td>.6</td>
</tr>
<tr>
<td>12.0</td>
<td>3</td>
<td>1.9</td>
</tr>
<tr>
<td>20.0</td>
<td>2</td>
<td>1.3</td>
</tr>
<tr>
<td>24.0</td>
<td>7</td>
<td>4.5</td>
</tr>
<tr>
<td>26.0</td>
<td>2</td>
<td>1.3</td>
</tr>
<tr>
<td>27.0</td>
<td>1</td>
<td>0.6</td>
</tr>
<tr>
<td>28.0</td>
<td>3</td>
<td>1.9</td>
</tr>
<tr>
<td>30.0</td>
<td>4</td>
<td>2.6</td>
</tr>
<tr>
<td>32.0</td>
<td>4</td>
<td>2.6</td>
</tr>
<tr>
<td>35.0</td>
<td>1</td>
<td>0.6</td>
</tr>
<tr>
<td>36.0</td>
<td>31</td>
<td>20.1</td>
</tr>
<tr>
<td>37.0</td>
<td>2</td>
<td>1.3</td>
</tr>
<tr>
<td>38.0</td>
<td>15</td>
<td>9.7</td>
</tr>
<tr>
<td>39.0</td>
<td>3</td>
<td>1.9</td>
</tr>
<tr>
<td>40.0</td>
<td>46</td>
<td>29.9</td>
</tr>
<tr>
<td>41.0</td>
<td>3</td>
<td>1.9</td>
</tr>
<tr>
<td>42.0</td>
<td>4</td>
<td>2.6</td>
</tr>
<tr>
<td>44.0</td>
<td>2</td>
<td>1.3</td>
</tr>
<tr>
<td>45.0</td>
<td>2</td>
<td>1.3</td>
</tr>
<tr>
<td>48.0</td>
<td>3</td>
<td>1.9</td>
</tr>
<tr>
<td>50.0</td>
<td>8</td>
<td>5.2</td>
</tr>
<tr>
<td>55.0</td>
<td>1</td>
<td>0.6</td>
</tr>
<tr>
<td>60.0</td>
<td>3</td>
<td>1.9</td>
</tr>
<tr>
<td>72.0</td>
<td>1</td>
<td>0.6</td>
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<tr>
<td>76.0</td>
<td>1</td>
<td>0.6</td>
</tr>
<tr>
<td>86.0</td>
<td>1</td>
<td>0.6</td>
</tr>
<tr>
<td>Total</td>
<td>154</td>
<td>100.0</td>
</tr>
<tr>
<td>Missing</td>
<td>8</td>
<td>—</td>
</tr>
<tr>
<td>Total</td>
<td>162</td>
<td>—</td>
</tr>
</tbody>
</table>
Table 5

Work Setting Category Frequencies

<table>
<thead>
<tr>
<th>Work Setting</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>23</td>
<td>14.9</td>
</tr>
<tr>
<td>Surgical</td>
<td>26</td>
<td>16.9</td>
</tr>
<tr>
<td>Maternal/child</td>
<td>9</td>
<td>5.8</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>4</td>
<td>2.6</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>8</td>
<td>5.2</td>
</tr>
<tr>
<td>Critical Care</td>
<td>33</td>
<td>21.4</td>
</tr>
<tr>
<td>Other</td>
<td>51</td>
<td>33.1</td>
</tr>
<tr>
<td>Total</td>
<td>154</td>
<td>100.0</td>
</tr>
<tr>
<td>Missing</td>
<td>8</td>
<td>—</td>
</tr>
<tr>
<td>Total</td>
<td>162</td>
<td>—</td>
</tr>
</tbody>
</table>

MBI-HSS Subscale Scores

The Emotional Exhaustion (EE) subscale from the MBI-HSS showed a fairly even representation across the three subscales (low, moderate, and high), each having a frequency of about 33%. Nurses who rate low are considered not burned out. See Table 6.

The Depersonalization (Dp) subscale reflected a different pattern with the highest representation in the low range (62.1%) followed by 23.6% in the moderate range and 14.3% in the high range. This means that more than half of the nurses in the survey
sample rated low on the depersonalization syndrome. Those who rated low are considered not to depersonalize their patients. See Table 7.

The Sense of Personal Accomplishment (PA) subscale showed that most of the survey sample rated low (53.4%). This means that more than half of the nurses do feel a sense of personal accomplishment in their jobs. The moderate range included 31.1% of the nurses, and the high range measured 13.0%. Those who rate low are considered to have a sense of personal accomplishment in their work. This score was turned around for scoring purposes by the developer of the scale for easier reading of scores; those who have a high total raw score rate low. Thus, someone who rates “not burned out” will have a low score on all three of the subscales. See Table 8.
Table 6

*Emotional Exhaustion Subscale Category Frequencies*

<table>
<thead>
<tr>
<th>EE category</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>53</td>
<td>32.9</td>
</tr>
<tr>
<td>Moderate</td>
<td>55</td>
<td>34.2</td>
</tr>
<tr>
<td>High</td>
<td>52</td>
<td>32.3</td>
</tr>
<tr>
<td>Unable to Score</td>
<td>1</td>
<td>.6</td>
</tr>
<tr>
<td>Total</td>
<td>161</td>
<td>100.0</td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td>—</td>
</tr>
<tr>
<td>Total</td>
<td>162</td>
<td>—</td>
</tr>
</tbody>
</table>

Table 7

*Depersonalization Subscale Category Frequencies*

<table>
<thead>
<tr>
<th>Dp category</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>100</td>
<td>62.1</td>
</tr>
<tr>
<td>Moderate</td>
<td>38</td>
<td>23.6</td>
</tr>
<tr>
<td>High</td>
<td>23</td>
<td>14.3</td>
</tr>
<tr>
<td>Total</td>
<td>161</td>
<td>100.0</td>
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<td>1</td>
<td>—</td>
</tr>
<tr>
<td>Total</td>
<td>162</td>
<td>—</td>
</tr>
</tbody>
</table>
Table 8

*Personal Accomplishment Subscale Category Frequencies*

<table>
<thead>
<tr>
<th>PA category</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>86</td>
<td>53.4</td>
</tr>
<tr>
<td>Moderate</td>
<td>50</td>
<td>31.1</td>
</tr>
<tr>
<td>High</td>
<td>21</td>
<td>13.0</td>
</tr>
<tr>
<td>Unable to Score</td>
<td>4</td>
<td>2.5</td>
</tr>
<tr>
<td>Total</td>
<td>161</td>
<td>100.0</td>
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<tr>
<td>Missing</td>
<td>1</td>
<td>—</td>
</tr>
<tr>
<td>Total</td>
<td>162</td>
<td>—</td>
</tr>
</tbody>
</table>

Correlations

Correlations for the demographics and each subscale of the MBI-HSS were compiled. Spearman’s rho correlation coefficient was computed for age, education, years as a hospital RN, average hours worked, and work setting in the demographic variables with each of the subscale scores, Emotional Exhaustion (EE), Depersonalization (Dp), and Personal Accomplishment (PA). Significant correlations were determined by comparing the correlation coefficient to the significance number (two-tailed) designated by a mathematical formula. If the correlation coefficient number were higher than the significance number, then the finding would have been significant. There were no significant correlations found between any of the demographic variables and any of the subscale scores of the MBI-HSS. See Tables 9-13.
Table 9

*Age Spearman’s rho Correlation*

<table>
<thead>
<tr>
<th>Category</th>
<th>Correlation Coefficient</th>
<th>Sig. (two-tailed)</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>EE</td>
<td>0.029</td>
<td>0.725</td>
<td>150</td>
</tr>
<tr>
<td>Dp</td>
<td>-0.019</td>
<td>0.814</td>
<td>150</td>
</tr>
<tr>
<td>PA</td>
<td>0.032</td>
<td>0.704</td>
<td>146</td>
</tr>
</tbody>
</table>

*p < .05, two-tailed.*
Table 10

*Education Spearman’s rho Correlation*

<table>
<thead>
<tr>
<th>Category</th>
<th>Correlation Coefficient</th>
<th>Sig. (2 tailed)</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>EE</td>
<td>.014</td>
<td>.864</td>
<td>154</td>
</tr>
<tr>
<td>Dp</td>
<td>.062</td>
<td>.445</td>
<td>154</td>
</tr>
<tr>
<td>PA</td>
<td>.082</td>
<td>.318</td>
<td>150</td>
</tr>
</tbody>
</table>

*p < .05, two-tailed.*
Table 11

_Years as a Hospital RN Spearman’s rho Correlation_

<table>
<thead>
<tr>
<th>Category</th>
<th>Correlation Coefficient</th>
<th>Sig. (2 tailed)</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>EE</td>
<td>-0.066</td>
<td>0.417</td>
<td>154</td>
</tr>
<tr>
<td>Dp</td>
<td>-0.033</td>
<td>0.682</td>
<td>154</td>
</tr>
<tr>
<td>PA</td>
<td>0.048</td>
<td>0.557</td>
<td>150</td>
</tr>
</tbody>
</table>

*p < .05, two-tailed.*
Table 12

*Average Hours Worked Per Week Spearman’s rho Correlation*

<table>
<thead>
<tr>
<th>Category</th>
<th>Correlation Coefficient</th>
<th>Sig. (2 tailed)</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>EE Category</td>
<td>-.072</td>
<td>.372</td>
<td>154</td>
</tr>
<tr>
<td>Dp Category</td>
<td>.070</td>
<td>.390</td>
<td>154</td>
</tr>
<tr>
<td>PA Category</td>
<td>-.026</td>
<td>.752</td>
<td>150</td>
</tr>
</tbody>
</table>

*p < .05, two-tailed.*
Table 13

*Work Setting Spearman's rho Correlation*

<table>
<thead>
<tr>
<th>EE Category</th>
<th>Correlation Coefficient</th>
<th>Sig. (2 tailed)</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>-.046</td>
<td>.571</td>
<td>154</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dp Category</th>
<th>Correlation Coefficient</th>
<th>Sig. (2 tailed)</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>.002</td>
<td>.979</td>
<td>154</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PA Category</th>
<th>Correlation Coefficient</th>
<th>Sig. (2 tailed)</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>-.034</td>
<td>.677</td>
<td>150</td>
</tr>
</tbody>
</table>

*p < .05, two-tailed.

The lack of significant correlations between any of the demographics and the MBI-HSS subscales indicate that burnout is not related to age, education, work experience or work setting. This appears to indicate that other factors, perhaps more purely psychological or emotional factors may be contributing to or inoculating nurses from the phenomenon we call burnout.

Interview Sample

Of the nurses interviewed, 14 rated low on the MBI across all the subscales. The remaining eight nurses rated moderate in at least one subscale, with three of them rating low on two out of three subscales, and five of them rating moderate on two of the
subscales and low on the other. Five of the nurses interviewed rated moderate on the Emotional Exhaustion scale, one rated moderate on the Depersonalization subscale, and five rated moderate on the Sense of Personal Accomplishment subscale. Moderate on all accounts were towards the lower end of the rating scale. For example, one nurse rated 20 on the Emotional Exhaustion subscale where the range was 17-26 for the moderate rating scale.

There appeared to be some individual variation among the nurses interviewed regarding their ability to talk about their jobs, or their level of comfort in doing so. Perhaps coincidentally, those nurses who scored moderate on at least one category of the subscales of the MBI-HSS seemed to be the most comfortable in talking about their experiences. These nurses were quite forthcoming and honest in sharing their descriptions of past experiences with burnout. No one reported feeling burned out at the time of the interview. The MBI-HSS measures burnout for a person at one point in time. The time difference between filling out the survey and being interviewed, while not long in the grand scheme of things, may have been enough time that those who rated moderate on one of the subscales may have rated low at the time of the interviews. Implications of the results will be discussed in the Theoretical Implications Chapter.

Survey Sample versus Interview Sample

Based on the scores of the MBI-HSS, out of 32 survey participants invited to be interviewed, 22 survey participants were actually interviewed. The interview sample tended to be older and had served more years as a hospital RN than the survey sample overall.
The interview sample did not represent the medical settings category, since more equal representation across hospital units was desired. The other categories were more representative of the larger sample. The following paragraphs break down the differences between the survey sample and the interview sample in detail.

Forty one percent of the nurses interviewed were in their 50s as compared to 23% of nurses who filled out the survey. On the other end of the spectrum, 20% of the nurses in their 20s were interviewed as compared to 26% who returned the survey. Fifteen percent of the nurses in their 30s were interviewed as compared to a 22% rate of return on the survey, and 27% of the nurses interviewed were in their 40s as compared to 28% of the nurses who responded to the survey. The middle years are more representative of the larger sample size.

Differences in the participation rates between the youngest and oldest age categories may be related to time constraints of younger nurses in their personal lives. Estimation of the motivation to be interviewed was derived from the experience of attempting to set up interview times with the younger nurses. Though the PI was very flexible in making herself available for time and place for interviews, younger nurses had many outside commitments, either school or family or both, making it more difficult to schedule interviews with them. It seems that for nurses in their 20s and 30s that this stage of life was more difficult for them to commit to an interview. Those who were unwilling to be interviewed were self-selected out by not agreeing to be interviewed in the first place. There was no statistical significance that correlated with age and burn out.

The educational level completed by the nurses interviewed does represent the larger sample more closely. When the categories of education are collapsed, those
interviewed who had an ADN (Associates Degree in Nursing) or a Diploma (a three-year diploma from a hospital-based program) reflected 42% of the interview sample versus 46% of the survey sample. Those nurses interviewed who had either a BSN (Bachelor of Science in Nursing) or a BS or BA (Bachelor of Science or Bachelor of Arts degree in another field) was 55% of the interview sample versus 50% of the total survey sample. Those interviewed who had an MSN (Master of Science in Nursing) or MS (Master’s degree in another field) reflected 0.50% of the sample, versus 5% of the survey sample.

The sample of nurses interviewed did not represent the sample of the nurses surveyed in the total sample in the category of years worked as a hospital RN. Of those interviewed, 37% had worked in the hospital one to five years as compared to 31% of the larger survey sample. The middle years of experience as a nurse were the least representative, with six to ten years representing 0.50% of the nurses interviewed, whereas there was a 21% rate of return on the survey in these years of service group. One half of a percent also reflected the years as a hospital RN for the categories of 11-15 years and 16-20 years in the interview sample, whereas the larger survey returns reflected 11% return for 11-15 years and 8% return of 16-20 years.

In the years of hospital service as an RN category the nurses interviewed in the 21-25 years category comprised 20% of the interview sample, while the survey sample reflected 10%. Nurses who had worked in the hospital for 26-30 years comprised 20% of the interview sample versus 7% of the survey sample. Nurses who were interviewed in the category of 31-35 years worked as a hospital RN made up 15% of the interviewees, while 9% of the nurses who returned the survey were from this category. This discrepancy may reflect the same explanation as the age differences in the representation
of the sample of interviewees. Age in years did not match years of hospital service one-to-one in each of the samples, however the larger portion of nurses who were older had practiced longer overall.

In the hours worked per week category of the demographic form, nurses in the interview sample measured 64% in the 36-40 hours per week category, whereas the larger sample of survey respondents measured 78%. While 27% of the nurses in the interview sample worked 0-36 hours per week, 18% of the survey respondents worked 0-36 hours per week. Ten percent of the interviewees worked 50-60 hours per week, whereas 17% and 2% of the survey respondents represented the 41-60 and 61-86 hours per week respectively.

In the work setting category the two samples compare as reflected in Table 14.
Table 14

*Work Setting Comparison of Survey and Interview Samples*

<table>
<thead>
<tr>
<th>Setting</th>
<th>Survey Sample</th>
<th>Interview Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>15%</td>
<td>33%</td>
</tr>
<tr>
<td>Surgical</td>
<td>17%</td>
<td>23%</td>
</tr>
<tr>
<td>Maternal/child</td>
<td>06%</td>
<td>01%</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>03%</td>
<td>01%</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>03%</td>
<td>14%</td>
</tr>
<tr>
<td>Critical Care</td>
<td>05%</td>
<td>27%</td>
</tr>
<tr>
<td>Other</td>
<td>33%</td>
<td>01%</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Summary of the Survey Sample versus the Interview Sample

The age and years of service as a hospital RN categories do not represent the larger survey sample. As previously mentioned, it seems that older nurses had more time and more flexibility in their schedules at this stage of life.

The education and hours worked categories are representative of the larger survey sample.

With regard to the work setting, and the other categories in general, those in the interview sample were selected not only for their scores, but to attain a representative sample of nurses across hospital units and ages. This would naturally tend to move the numbers away from being representative of the survey sample population. The different
units differ dramatically not only in the type of work required, but also in the nature of the working environment, (collegial, social, patient population, including type of patient and duration of hospital stay, physician temperaments, etc.) A representation of as many different units as possible was desired in order to attain better understand of the hospital population of nurses as a whole.

Conclusions

The frequencies of the survey sample versus the interview sample varied according to categories. It is hypothesized that the difference in the survey sample and the interview sample were due primarily to two reasons: 1) the older nurses were represented more heavily in the interview sample. This may have been due to stage of life and time available to be interviewed, and 2) a representative sampling of ages and hospital units was desired, as much as possible, which meant asking nurses from some units to be interviewed over nurses from other units. This affected the interview sample representation. The main reason for using the survey was to obtain a pool of candidates to interview.

There were no statistically significant correlations between any of the demographic variables and any of the subscale scores on the MBI-HSS. Burnout is a complicated phenomenon that did not correlate to any demographic data in this study; hence, it may be more of a psychological or mental phenomenon. Implications of these results will be covered in the Theoretical Implications Chapter.
CHAPTER VI

INTRODUCTION TO THE QUALITATIVE RESULTS

It is important to note a series of unforeseen complications that occurred during the course of this study. This explanatory section has been added so that readers understand the context for certain constraints of the study and why they occurred.

The first round of surveys measured burnout. A survey was sent out to all bedside nurses and in an effort to maximize the return rate, the PI sent the same mailing a second time. The original plan was to send the two mailings about two weeks apart. However, as it turned out, there was about six weeks between the two mailings. This was due in part to very slow responses from the nurses. After some investigation it was learned that some of the nurses did not check their mailboxes very often (though an e-mail had been sent out, alerting them to the upcoming study, and telling them to look for the survey in their mailboxes).

HSRC said that the nurses are not able to check their mailboxes very often and they do not check their e-mail very often either, since they are generally busy on their units. In addition, the nurses work 12-hour shifts, which gives them the flexibility to work three days in a row; this means that they often have seven days consecutive days off, so in some cases it took quite a while for the nurses to receive the survey. Also, in
one unit, the manager notified the PI that someone had taken all the surveys out of the nurses’ mailboxes.

In June of 2007, 625 survey packets were sent out via the courier system of the hospital to all the bedside nurses in the hospital. After filtering through the names and eliminating all the males and the names of nurses who were no longer at the institution, the sample size was 486. The final sample size of respondents was 162, or 34% of nurses who were sent the original mailing.

The original packets contained the MBI-HSS survey (Appendix A), a demographic form (Appendix B), two copies of the informed consent form, one marked ‘copy’ in red for the participant to keep (Appendix G), a cover letter explaining the study (Appendix F), and a pre-addressed stamped envelope to be mailed to the PI at her office. Mailing the survey to the PI’s office was a departure from the method of data collection used in other nursing surveys done at the hospital (they had previously used their courier service to mail surveys back to HSRC). This was not the method chosen, since previous researchers had had difficulty in getting nurses at this institution to respond, because they lacked trust in the confidentiality of their responses. (The HSRC research team referred to nurses at this hospital as “paranoid.”) In an attempt to make the nurses feel as safe as possible in the process, therefore, respondents were provided with envelopes in which they could mail their forms to the PI at her office, which was not at the hospital.

The PI had planned to number the backs of the envelopes so there would be a way to know who had responded and who had not (for purposes of the second mailing). This plan however, was jettisoned to add another additional measure of confidentiality.
One thing that the PI did not anticipate is that some of the nurses would find their own ways to remain anonymous--by not returning their consent forms. One nurse sent all her information back to the PI, saying she would never fill out anything unless it was totally anonymous.

The second mailing went to all the nurses again with a large print cover note (Appendix I) that stated that if the nurses had already filled out the survey, they should not respond a second time; and that they could choose to stay anonymous by not returning the consent form. It was hoped that they would send the PI the MBI, the demographic form, and their signed consent form.

In the final analysis, those who chose to not be identified did not necessarily rate as burned out. Those who did identify themselves represented the whole range of possible answers from burned out to not burned out.

After the surveys were received, the PI began the interviewing process as planned. She had initially sent out e-mails via the CFH e-mail system, inviting three of the nurses who rated low on the three subscales, thus “not burned out,” to be interviewed. One nurse responded immediately and a date was set for the interview. As it turned out, it would take three attempts (including one no-show), and three weeks would go by before the first interview took place. Another one of the original three nurses wrote to the PI after three weeks, saying that she had been on vacation and did not often check her e-mail, but that if she was still needed, she would be glad to be interviewed. The third one never responded.

The second interview took place after the transcript of the first interview had been coded. After each interview, the interview was transcribed, coded, and then, from the
emerging data the PI proceeded with more interviews and continued to formulate the subsequent interview questions (which were being shaped by the emerging data), according to the grounded theory data analysis process (Strauss & Corbin, 1998).

Unfortunately, only two interviews had been completed when the PI received a call from HSRC of CFH stating that she “needed to wrap up the project.” When the PI explained that she would need much longer to complete the interview process, the answer was a definitive “No.” The administration was not open to re-negotiating the timeframe agreed upon in the original discussions. The PI was told that she was “lucky” because they had wanted to end the study earlier, but had decided to extend the time.

In addition, there had been a sudden reorganization of the original research team the PI was to work with. She now had six weeks to gather all the data she needed and be out of the hospital. She was allowed a little longer to write up her findings, but was told that after December 1, 2007, she should not have any additional contact with the nurses interviewed, and that she would no longer have a Co-PI (a hospital employee) working with her on the project. In other words, the sponsorship was quite abruptly pulled from the project.

At least 18 more interviews were needed in order to complete the study. The PI did manage to get permission to do the member-checking process; however, she was told it needed to be complete during the month of January 2008.

At this point the PI realized that contacting and getting nurses to agree to be interviewed was more time consuming than she had predicted and that there was no longer enough time. Of the 162 nurses who had responded to the surveys, 66 (41%) were anonymous responses and therefore not possible interview candidates. Of the remaining
nurses who had identified themselves, the PI needed nurses who did not rate burned out for the interviews.

On first glance there appeared to be about 17 such candidates. The PI knew that not all of these nurses would agree to be interviewed. In addition, she wanted the sample of nurses interviewed to represent diverse units across the hospital and to have a range of ages. This began to look like a tall order to fill in a very short period of time.

The analysis of the surveys had not been run yet, so the selection of the nurses was done by manually scoring the survey. The PI decided she would have to change the standards for interview subjects. She still wanted nurses who did not rate burned out. With the manual system of scoring, she chose nurses who did not necessarily rate low across the three subscales, but decided to also accept a few who were in the moderate range, but only by a couple of points, and on only one of the scales. In a state of anxiety, her preliminary look was influenced by a desire to have representation of most of the units across the hospital and across ages.

The first several nurses interviewed were all in their 50s. Not as many of the younger ones were appropriate candidates to be interviewed because of their scores, but also the few younger nurses who were invited to be interviewed were not stepping forward.

After scanning the sample, the PI sent out another wave of e-mails inviting certain nurses to be interviewed. This time after scoring the surveys the PI chose nurses who rated moderate (by only a couple of points) on one of the subscales of the MBI-HSS. Again it took some time to hear from the nurses. In the end, of the 32 invited for an interview, 22 agreed (70%).
All of the nurses who agreed to be interviewed showed up at their appointed times, dutifully, either on time or early; and none of the nurses dropped out of the study after being interviewed.

By the end of the interviewing process the PI had conducted a total of 26 one-hour face-to-face interviews with 22 nurses (four nurses were interviewed twice). A total of 24 interviews were conducted over a six-week period of time. The original plan had been to interview, transcribe, digest, and re-formulate interview questions as the data emerged over time. Given the circumstances, the PI tried to listen as carefully as she could during the interviews, making mental notes about emerging themes and areas to be further explored. She met frequently with her chair during this time. From these conversations she developed interview questions.

While the PI would have preferred to have had more time and to have been able to interview the nurses a second time, analysis of the interviews yielded rich data that it is hoped will contribute further to understanding the role of empathy in nurses who are not burned out.
CHAPTER VII

ROUTES TO THE PROFESSION

“Once you are a nurse, you are always a nurse.”

Introduction

There are three distinct routes to the profession of nursing as described by the nurses: Calling, Idealization, and Financial Compensation, the three properties of this category. The reasons the nurses interviewed gave for choosing nursing were complex; often there were multiple reasons. Some felt it was not so much a choice as a “calling.” Others wanted to do something in the helping field and felt that nursing was a good choice. Several of the nurses had been inspired early in their lives by experiences that had influenced their choice of profession. Some had relatives or acquaintances that were nurses whom they admired, while others had watched as nurses had cared for their loved ones. Some nurses chose the profession for more practical reasons, such as money or job security.
Calling

“I think I have a servant’s heart…I think nursing is a calling—because I think that I am called to serve.”

This property includes the dimensions of faith or other religious beliefs, and altruism, which influenced most of the nurses in the study. Helping others was either seen as a personal value or important because of religious beliefs. These were by far the strongest reasons for choosing nursing as a profession for most of the nurses in this study. Some who chose the profession for the practical reasons of money or job security also stated that they wanted to help others.

For those who referred to nursing as a calling, most said they had wanted to be a nurse since a young age. There was some overlap between those who chose nursing because of an inspirational person early in life and those who said they had a romantic idea of what nurses did from an early age. One nurse stated a sentiment that was a theme for several of the nurses.

Between the ages of five and seven I wanted to be a doctor, and just the thought of that much school…even at such a young age I realized that the doctors don’t get to spend as much time with the patients as nurses did.

For some this choosing nursing was not an easy decision. A few were told by family members that they should “use their brains to go to medical school.” Others knew they had good enough grades to become a doctor, but felt the pull to become a nurse because they wanted to provide more hands on patient care and felt that the doctor was “only a diagnostician.”

Reflective of many of the nurses’ sentiments, one nurse said, “I feel like it was a calling of some sort. I just never considered anything else.” Several of the nurses
referred to their passion for nursing. They felt that the belief in a calling was necessary in order to help them keep perspective on their work and not burn out.

I guess I have always tried to have faith that there is someone, that God has a path for all of us. I think His path for me is nursing, because I have such a love for it, such a passion for it.

Those who felt called to nursing by their faith felt it fit both their faith system and their personality.

I think my faith is a big deal in that I feel like God has called me to nursing and so it is something that I feel fulfilled in and I know that it is the right area for me, I feel I can be myself as I am doing this job.

Another nurse said:

Knowing that I make a difference is what is important for me. Knowing that God created me for a purpose and I ask Him to live in His will and to fulfill the purpose that he has created me to do.

Idealization

“There were a couple of nurses that I worked with that—this is going to sound crazy—but they just like seemed so smart, very confident with who they were, and they loved their jobs.”

This property has several dimensions. Some nurses had romantic ideas about what nurses did; others were inspired by direct experiences with nursing care provided for either family members or themselves. Several of the nurses had close family members, including mothers, who were nurses.

About half of the nurses felt that the decision to become a nurse was influenced by personal experiences they had had with nurses. For some, these experiences came at an early age, by observing a relative or a neighbor who was a nurse, or imagining what they did at work. One nurse said,
I think I was just very impressed with her demeanor and her outfit, the fact that the job she did, you know. I always felt that nurses had a place and most people if they find out that you are a nurse, the first thing they say is, “Oh my God, how do you do that? I could never do that kind of work.”

Some were motivated by the experience of helping to care for an elderly person in their family or neighborhood early in life.

For a few, an experience of direct nursing care touched their lives forever.

I was just fascinated with how the human body works, and people who work in that [field]. When I was seven years old and had my appendix out, the nurse would let me play with the syringes that they used to give me shots. I got to play with the medical stuff and that was cool.

Another nurse explained,

I was in the hospital and you know how they do the EEG and my hair was just like, you know it had all this stuff in it from the paste and [the nurse] came up to me and she goes, “Do you want to wash your hair?” and I said “Oh, yeah,” and so then we put on the [isolation] mask, you know, and technically we probably should not have been out of the room, and so she went and she washed my hair. I mean what a difference I felt! I could not believe it, night and day, and I thought--that just really made an impact on me.

This young lady felt so cared for that she became a nurse who could offer that same kind of care to others.

A couple of nurses felt touched by early experiences of observing nurses who cared for their loved ones. One woman had watched nurses care for her loved one over a period of time and take “really good care of him.” Another spoke about watching elderly family members who could not care for themselves and “feeling like I never wanted to be in a position of where I don’t know what to do to help somebody.” She added that nurses “always seemed to know how to care for someone.” Some reported early feelings about animals they cared for. “I can remember being very young and feeling really badly about an injured animal.”
A couple of the nurses had lost very close relatives and had spent a lot of time in the hospital watching nurses care for their loved ones. The sadness of that loss was palpable during their interviews and my sense was that this was not a topic to be spoken of any further. After all, the nurses had signed up for an interview with me, not an emotional/psychological assessment. These nurses spoke about the time spent in the hospital with the family member; however, they did not name watching the nurses as being the reason they became motivated to be nurses. Rather, they demonstrated their feelings in actions, perhaps sublimating their painful feelings of watching their loved ones suffer into their choice of profession.

Financial Compensation

“I think that money and job security is what are bringing people now into nursing more than before.”

Though this was the property with the fewest number of nurses who named it as a professional motivation, financial compensation was mentioned often. Sometimes the importance of financial compensation was referred to with a negative connotation.

“Noon, night, and payday nurses, in other words they live for lunch, they live to clock out and they live for their paycheck.” One nurse said, “Sometimes I wonder if people just roll out of bed, go to work, and come home. In nursing you just can’t do that.” These comments were in reference to nurses who the interviewees did not feel were in the profession for the right reasons.

Naming money or job security as a reason for choosing the profession had as much affect associated with it as those who chose the profession for altruistic reasons. But the type of affect depended on who was telling the story and whom they were talking
about. When the comments referred to other nurses, the implication was that those nurses were not quite as dedicated as they might be. If they were referring to themselves, the matter of financial compensation was spoken about more matter-of-factly.

Some felt financial motivation was associated with not caring as much, or choosing nursing for the wrong reasons.

A lot of times people don’t really know what they want or who they are. I hear people say they joined nursing because it is a high demand job, where you know everybody needs them, there is job security, and it is a fairly decent amount of pay and so you have these people joining the profession that pays fairly well and has a high demand, but I think if someone were to do a statistic somewhere that they would find that could be related to dissatisfaction on the job, because they’re [in the profession] for the wrong reason.

Financial remuneration and job security were significant factors for those who came to nursing as a second career. Many of those who chose nursing as a second career considered carefully what the pay and benefits would be. Many had chosen first careers which for a variety of reasons that had not worked out, so their approach to the choice of nursing as a profession was more pragmatic. They had already invested time and money in one career, had been disappointed, and did not want that to happen again. One nurse said,

I graduated from the University of Illinois, and that and 50 cents could get me a cup of coffee at a cheap place. I was working itsy-bitsy jobs, so I sat down with myself and said what can I do that is social service oriented that I can get a job in? And that is what brought me to nursing.

This nurse’s statement is both pragmatic and altruistic. One nurse simply stated, “No one stays in nursing for the money.” While financial reasons might bring some into the field, most nurses felt that the pay-off must be more than financial to keep them in the profession.
Some chose nursing as their first profession for practical reasons. “I picked nursing because, as a woman, the pay was good and the hours were unbelievably flexible and you can get a job anywhere.” Even with pragmatic reasons they approached their profession with the same commitment as those who had chosen nursing for other reasons. They, too, stated the desire to care for others.

Conclusion

Though there are three discrete properties, Calling, Idealization, and Financial Compensation in this category, most interviewees had overlapping reasons for choosing nursing as a profession. Those nurses who came to nursing for practical reasons also stated that they wanted to help others. While the desire to help others was the most frequently cited reason for choosing nursing, often it was coupled with a faith value or reference to a religious belief system.

All of the nurses in the properties of Calling, Idealization and Financial Compensation appreciated the “decent pay” that they felt nurses can now command. In addition, all the nurses indicated feelings of caring and concern for their patients, whether they came to the profession because of a calling, or for the money. Those nurses who admired or idealized nurses from a-far, or because of early relationships felt that they had been influenced to become a nurse by other nurses. Some had romantic ideas of what nurses did, like helping the elderly or frail, while others had had direct experiences with nurses that influenced them to want to be like the nurses they had come into contact with personally.
No matter what the motivation for becoming a nurse, all of the nurses were comfortable with their own motivations for their choice of profession.
CHAPTER VIII

PROFESSIONAL PRIDE

“You know the fact is that we perceive ourselves as holding that light for people, we are holding the hope, we are holding their health, their well being, their recovery in our hands.”

Introduction

There are many facets to this category, summarized in these five properties: Compassion, Protective of Disclosure, Unique Personal Qualities, Self-Evaluation, and A Profession With Many Opportunities. This category has to do with the individual nurse’s sense of self, both personally and professionally.

Most of the nurses felt that compassion and empathy are the key qualities nurses need in order to fulfill their role. However, the emphasis varies from individual to individual. One nurse may focus her energy on tasks, while another may focus on the relationship with the patient; but all the nurses interviewed agreed that compassion and empathy are key in the nursing profession.

Because compassion and empathy were viewed as such crucial ingredients, those interviewees may have been reticent to speak about the downside of nursing, specifically burnout and the limits on empathy. However, several of the nurses interviewed felt that they brought something unique to their role as a nurse, and were proud of what they had to offer to patients. Because of the high value placed on compassion and altruism, these
nurses held themselves to high standards. They wanted to do a good job, both for
themselves and for their patients. They were constantly evaluating their own
performance, and this impacted how they felt about themselves. Lastly, all the nurses
were proud of the many opportunities that nursing has to offer, especially the freedom of
choice that the profession makes possible. The five properties of this category are:
Compassion, Protective of Disclosure, Unique Personal Qualities, Self-Evaluation, and A
Profession With Many Opportunities.

**Compassion**

“I think I am a compassionate person, I think every nurse is. I would probably put
‘compassionate’ in the top three words to describe nurses. If you are not compassionate,
then you do not love your job.”

Professional pride was palpable with almost all the nurses interviewed. It was as
if there was a glow that radiated from the nurses when they spoke about their profession.
Some of their comments were general: “I think this hospital would not run with out
nurses,” or “Because that is what we do as nurses, we fix things.”

One unspoken assumption permeated all the interviews, as expressed by this
nurse:

It is very tough. It is mentally tough, emotionally tough; it is physically tough. I
mean, my goodness, I work out at the gym every day that I don’t work, and I
think I work out more at work than I do on the treadmill and at the gym any day.
At least on the treadmill I can put my earphones on and think about nothing but
the next song! But at work I am running mentally and physically.

Most of the nurses, regardless of age, spoke of the physical demands of the job. The
most frequent comment or complaint had to do with 12-hour shifts. The sentiments
ranged from “I want my 8-hour shifts back” to “I love my 12’s.” Most of the nurses
accepted the longer working hours, and some liked them, since they allowed them to have three or four days off every week. However, there was a physical price to pay. All the nurses agreed that 12-hour shifts were hard on them physically and some said that it took most of their first day off to recover, especially if they had worked three days in a row.

Crucial traits for a nurse are compassion and empathy. The nurses interviewed felt that this quality is not only a defining profession quality, but is critical to their job performance. One said,

The emotional/spiritual needs are common in all of humanity. I think that if you forget that—that is a large part of nursing—then you are missing out on an entire aspect of someone. It is like taking care of their heart, but not their lungs. So I think when people forget that, they are trying to take care of their physical needs and not their emotional needs—then something is missing.

Nurses often see patients at the most critical times of their lives.

We’re there in the craziest moments of their life, when sometimes not even their families or friends stick around. If you can meet someone in that place and be there for them in a way that you would want someone to be there for you in a caring, compassionate, non-judgmental way—then I think that sometimes speaks wonders.

The nurses I spoke to saw their position as one of not only being crucial, but special. They regarded it as a privilege to be a part of someone’s life in this capacity. There was honor in this role, as well as pride.

While it was not the overall attitude, some of the nurses mentioned a downside to the importance of compassion in nursing. For many years, nurses have struggled to have their work recognized as a profession. There was a sense in which the very topic of this study elicited protectiveness about the profession with a few of the nurses.

There are a lot of stigmas [connected] with nursing. One is that we are not critical thinkers. I think as successful, educated women we have recently realized that if we plan on the emotional component of successes...we will be categorized as women, not as players in the professional field. So the emotional components
can’t be played up as much now. We say that caring is the number-one component in nursing, but we know that caring isn’t going to get us recognized as a profession. It needs to be caring in addition to all the other things we do.

It is true that nurses have an impressive arsenal of knowledge. They manage very complicated, technologically difficult equipment; they understand the human body and are knowledgeable about the tests that a patient goes through; they understand medications and possible drug interactions. They often juggle technological and human challenges simultaneously without blinking an eye. This flexibility is an assumed part of the job. With out a doubt, nursing uses both the right side and the left side of the brain. Nurses need to be technologically savvy as well as compassionate.

Protective of Disclosure

“I don’t want to speak for or about anyone else.”

A sense of protectiveness characterized parts of many interviews. There are probably a variety of reasons for this. One nurse said, “I would defend my nurse, even if I agree with what the other person said. I would try to down play it. I don’t want it to reflect badly on my unit.” There may be complaints aired within a unit, but nurses protect their own, this nurse implied. Suggestive of a sisterhood, what prevails ultimately is protecting what happens on the units, making it private business for only those who are part of the unit.

Some nurses sensed that I was an understanding party because I am a nurse; nevertheless, burnout and empathy were topics that some of the nurses hesitated to speak about, even with a sympathetic stranger who is also a nurse. Other nurses spoke freely about burnout and empathy as exemplified by examples or stories about their own
experiences. Nurses who came to the profession for practical reasons, like money, or who had been nurses for a long time could speak about nursing more easily than those nurses who were younger or who came to the profession for more altruistic reasons. However, those nurses who came to the profession for more altruistic reasons spoke with more affect when they talked about their feelings about nursing in general.

Another reason for not wanting to speak about colleagues was that nurses do not like to speak for other nurses. Is this a personal or a professional ideal? The ideals may have blended together; in any case, more than a few of the nurses I spoke to said they did not want to speak about others. They considered it an important value to “stay away from gossip.” They would allude to what they thought about some things, with great discretion, stating for example, “I don’t want to go into the details, but….”

Some nurses did not refuse to speculate about other nurses; however they said they honestly did not know how to answer some of the questions. This may be because the work that nurses do is in some ways somewhat solitary. One comment was, “I may not be a good resource for that because I am fairly isolated in my department.” During a member-checking interview, one nurse said, “I think this would be really good for nurses to read, because we really don’t know how each other feels. There just isn’t enough time. And also we see each other at work, but that’s it.” Another nurse during member checking said that reading the document gave her “a chance to step out of her world and see what’s happening in the rest of the hospital.” She, too, felt somewhat isolated because she did not have a chance to talk with her co-workers. Many nurses said they did not know how other nurses interacted with their patients. What they were willing to talk
about were the comments that they had heard the other nurses make in the nurses’ station. Or they commented on behaviors they had observed outside of patients’ rooms.

To a large degree, the nurses could not speak about nurses on other units in the hospital. They were most familiar with nurses on their own units and especially on their own shifts. To know what goes on during a different shift is difficult enough. To know what is going on in other units is an even bigger mystery, since there is so little interaction between units, and some of the units perform very different functions.

In the quiet spaces of their conference rooms nurses may talk about colleagues they do not get along with or problems within a unit with a trusted colleague or two, but even amongst themselves they keep quiet about some of their feelings. “I stay away from gossip. I just leave the room when that begins,” one said. Sometimes they would say they were too busy to have time to chat. Other times they may have secretly felt that they were not supposed to feel the way they did. Nurses who were older, more experienced, and/or who had had the good fortune to have had colleagues with whom they could share some of their misgivings were able to speak more openly about the difficulties associated with burnout and the lack of empathy they had felt at times.

Unique Personal Qualities

“She is definitely not like I am, I am excited when I am at work and I carry that [excitement] with me for 13 hours, which is probably why I am so tired when I get home.”

Many of the nurses I interviewed spoke about the unique qualities they felt they brought to the profession. One nurse expressed it in broad terms: “I truly think that there
is no other person like myself… I see the impact that I have not only on my patients but on my co-workers, I see it everyday that I go to work.” Another nurse said,

I know that no matter what I can make it. For me, it’s self-efficacy; it is not just confidence; I really feel like it is resilience. I know that no matter what, I am going to be able to make it. I may not want to encounter some challenges, but I know that I will be okay with them.

Another nurse was more specific about her unique qualities.

I think that the thing that lots of people don’t understand is that we have to be as factual and direct and non-emotional as possible. People who are emotionally upset have got so much chaos on the inside they need those boundaries, and so people in my department crack me up because they are so afraid of, like, psychiatric patients.

Several nurses in this study felt that they brought something special to their nursing careers. Whether it was their personalities or their faith, or what they had learned from their past experiences they felt confident that their contribution was unique and they liked that about themselves.

Self-Evaluation

“I have a long drive home so I have time alone to think about what might have happened or what I think I did well, or what I could have done differently, what I am going to do tomorrow.”

All of the nurses in this study expressed a desire to do the best they can at their jobs. This desire overlaps with the frustration they feel gets in the way of doing what they want to, or feel they need to, do with their patients. One nurse summed by saying, “Most nurses would rather spend more time with their patients than sit with a computer, or with a chart in front of them.” The frustrations that get in the way will be discussed in greater length in the Chapter IX, Theories of the Nurse/Patient Relationship.
Despite frustrations about not being able to get their work done, nurses thought about how well they did at work and how this affected the way they feel about themselves. Nurses in this study did not tend to talk directly about how they felt about themselves in general; however, they did talk about they evaluated themselves at the end of a task or the end of the day.

I don’t lose sleep over [not meeting patient’s needs] because of course you can’t make everyone happy. But I do feel bad that I couldn’t have been maybe a little bit more attentive or a little bit more empathic. I don’t know. Nurses beat up on themselves a lot.

Some of the statements were more general. “I have to be able to look at myself in the mirror and like who I see. If I can’t come to work and smile, be someone who is respected and respects everyone else, then I need to get out.” Another nurse echoed a common feeling: “The better I can make people’s visits--or if I can make them feel good-then that is rewarding to me as well.” In general, the nurses wanted to help people and they got something back when they were able to do so. This enhanced their sense of self.

Some of the nurses spoke about how they felt when the patient did not do well.

I think you reflect on yourself. You think, was there something I missed? Did I call the doctor fast enough? Did I wean the drip a little faster than I should have? You know, there are lots of things that fall into it.

Another said, “You want to know that you did all you could. Otherwise I will keep wondering what else I should have done to make it better.”

In addition to their own self-evaluation, nurses cared about what others thought of them as well. They wanted to be seen as good caregivers, and competent professionals who gave their patients the kind of care they themselves would like to receive. Some days the reality of being busy and pulled in several directions collided with the
professional ideals they believed in. One nurse walked me through her day and the feelings she had had and ultimately, her regret at the end of the day:

I’ve had patients where at the end of the day I look back and think, “Wow, I wish I could do it again” because I have been in a bad mood, or really tired, or not feeling well, or incredibly rushed. Beyond things that I can control, like dealing with ancillary departments or doctors, or trying to get other people home, and dealing with new people coming from the emergency room, and just remembering or thinking back at the end of the day sometimes I think, “Wow, you know if I had been able to see how busy I was I could have turned their day around.” Because I’ve had people say “You really made a difference for my mom,” or whatever, at the end of the day. Well, all I really did was try to be compassionate and caring to them and it wasn’t necessarily any one big thing that I did. As a nurse you are doing a series of small things most of the time. So in my disappointment, when I feel like I have failed at the end of the day, to me being aware of what is going on with me and my patients is really important. To me it makes a huge difference at the end of the day. Not necessarily in how those people perceive me, because who really cares? I mean, I don’t know that I’ll ever see them again, so it’s not like I want them to think I am the best nurse ever. But you can really make a difference in peoples’ perception of their illness and their recovery, or their hospital stay, or nursing in general.

This nurse expressed several key sentiments. She talked about wanting to be helpful; however, she also explained how the busyness of the job or demands of others got in her way of attending to her patients, and how that may have affected how she felt (“tired,” or in a “bad mood”). She also said she does a “series of small things,” which is perhaps overly modest. The ambivalence of wanting to do well by the patients, but also having difficulty in acknowledging the value of one’s contribution was a sentiment that many of the nurses implied in their interviews.

Nurses were not only concerned for their patients and for how they felt about themselves as nurses; they were also aware of the investment of time and energy in their work.

I think about the idea that you invest your time in recovering them, or admitting them, and I am doing all this stuff. And when I go home it is like, I want to
know, did I miss something? Did something slip by me? Did he do okay through the night?

Many of the nurses talked about how they took great care to give a thorough report to the nurse on the next shift so that the patient would continue to do well.

Some of the nurses spoke about the kinds of rewards they received from patients or the families of patients. Many of the nurses said that knowing they made a difference in someone’s life was important to them.

Not only is nursing a calling for me, but I really enjoy it if I can see that I made a difference in someone’s day. And a lot of times the great thing about nursing is that you are so blessed by the people that you meet. They end up affecting you more than you think that you will ever affect anyone else.

“Making a difference” influenced the way the nurses felt about themselves and helped them to get through difficult days. They felt that helping people was one of the personal rewards in the nursing profession. This demonstrates a feedback loop whereby those who give to others not only feel good about the giving, but feel they are receiving as well. This enhances the way they feel about themselves, which encourages them to keep giving.

A Profession With Many Opportunities

“I love the fact that you can do so many things under the umbrella of nursing.”

The nurses I spoke to were unanimously proud of all the opportunities that the profession offers them. They felt that it gave them flexibility in offering a variety of working environments, schedules, or the opportunity to learn new skills and specialties. One nurse said,

The key is to find the place that fits for you.” That is one of the most beautiful things about nursing, there are so many different facets...you can do hospital
nursing, clinic nursing, home health nursing. There are millions of things that you can do with it, and as you build your education you can do more and more things. But there is also the aspect of not only finding what you love to do, but also finding the people you love to do it with.

One nurse said, “I think that is one of the reasons that I am very happy and I haven’t burned out in nursing. I really feel I have so many options.” Her sentiment was echoed in many of the interviews. If one job did not work or match for a nurse, she could change and even still stay with in the same hospital or clinic system, which many felt was an advantage as well. Particularly the older nurses named retirement packages as one of the reasons that they would stay at an institution. They pointed out that if they were unhappy in one department they could always find a different department to work in and be happy there. Even the younger nurses felt good about staying at the same institution. There was an institutional pride as well as professional pride expressed by several of the nurses.

A of the few nurses felt that nurses who do not see that they have these abundant opportunities can end up feeling “stuck.” “I think sometimes when those alarm bells go off, when people don’t really think that they have choices, they don’t see that they have options they [feel they] just have to stick it out.” The many opportunities that nursing as a profession offers felt encouraging to nurses in general. This aspect of the profession allowed each nurse to find the match that best fit her personality or lifestyle and did not compromise her professional or personal ideals.

Conclusion

This category demonstrates the many aspects to Professional Pride. The properties of Compassion, Protective of Disclosure, Unique Personal Qualities, Self-Evaluation, and A Profession With Many Opportunities reflect the many facets of nursing
as a profession. The nurses felt that compassion and empathy were key ingredients in their relationships with patients. However, some seemed to feel protective of disclosing what might be perceived as negative attributes of other nurses.

Several of the nurses were pleased with the unique qualities that they brought to the profession individually. Nonetheless, nurses are constantly evaluating themselves and the job they have done. Did they do the right thing by this patient? Could they have done something differently if the outcome was not desired?

Regardless of whatever dissatisfaction or frustration they might encounter in the course of their careers, all the nurses were proud of the many opportunities their profession offers. They did not feel “stuck” in a role they did not want to be in.
“If the patient calms down, the patient’s pain is relieved, you know you are accomplishing your goals. If they are calm, they are quiet, they are relaxed, then you know you’ve done what you feel is good for that patient. Which I think is the ultimate goal.”

Introduction

The quotation above explains how one nurse knows when she has provided a patient with good care. This capacity is based on her ability to imagine herself in the patient’s position: what might provide relief from the pain she imagines that person feels? What would feeling relaxed be like for that person? The nurse temporarily merges with her patient, putting herself in his or her position to discover what the pain feels like or which position would be most comfortable for a person in this kind of pain. Then she has to move out of the temporary merger in order to act.

Nurses develop keen observational skills in order to notice when patients need physical care, such as repositioning for greater comfort. In the quote above, the nurse expresses her acuity to psychological states by reading bodily signs.

Nurses must be able to mentally slide between the sheets with their patients and imagine what the experience of the patient is like. They must be empathically attuned to both the psychological and somatic states of their patients in order to give them
“good patient care.” Thus, empathy has an assumed role in the nurse/patient relationship.

Nurses must be able to imagine bodily states that would make most of the rest of the world shudder. For example, a nurse sees a one-inch diameter tube stitched into the skin of a patient’s rib cage, for the purpose of draining fluid away from the lungs. She imagines what it must be like to have a few stitches holding in a tube that tugs at his skin, gravity pulling against the stitches. She understands what she must do to make the patient more comfortable, to take care of the site so that no infection develops, and to help him understand what to expect and how to live, albeit temporarily, with this tube that feels like an assault to him.

In addition to imagining what it feels like to be in the patient’s position, she must manage her own feelings. Rather than becoming overwhelmed with the feeling of the pain she imagines, she must retain her own self so that she can think about what she might do to alleviate the patient’s pain. She has to be able to imagine physical states that could overwhelm most of us. However, her feelings must also remain fluid enough to slip into the “as if” state of the other’s feelings, and then move away from that state of merger with the patient, in order to be helpful. The “as if” state of mind is not the same as the “that could be me” state of mind. There is an important, though subtle, distinction here. Perhaps there is thin layer of denial in the “not me” state which allows the delicate balance in the temporarily merged state, a psychological split of sorts. All of this is a very complicated psychological balancing act, not easy to achieve.

Simultaneously with all the technological and physical tasks the nurse must master, she must also relate to the patient’s constantly changing psychological, as well as, physical needs. In other words, she manages multiple psychological states while she is
giving physical care. Even while the nurse is repositioning the patient who is in pain, or covering the patient she imagines is cold, or comforting the patient who is anxious, or reassuring the patient who is afraid, the nurse is also constantly performing this complex, subtle act of shifting between awareness of the psychological state of the patient and ideas about how she can help him.

All the nurses interviewed practiced empathy, but it was always referred to as something else, such as “patient advocacy” or “patient education.” Though empathy became its own category in this study, and will be explored more directly in the next chapter, in fact empathy is found in all the dimensions discussed in this chapter. In addition, the nurses describe the importance of other people, especially other nurses, to their own well-being.

The desire to become a nurse, combined with elements of her education, sets the stage for each nurse’s theory of the nurse/patient relationship. Some brought pre-conceived ideas with them to nursing school; others developed their ideas as they moved through their training. For some, ideas about the nurse/patient relationship came about as a result of experiences with patients.

Nursing schools have a large influence on what nurses value in the nurse/patient relationship. However, each nurse also had her own theory of that relationship, and her own areas of emphasis, apart from the influence of her education. Every nurse brings a part of herself to the profession, just as the self of the nurse is influenced by the profession and her experiences in it. What she values personally, as well as professionally, comes together in the category of the Theories of the Nurse/Patient Relationship.
The properties in this category include: Facilitation, Experience, Self-Awareness, and The Function of Others. There are three dimensions within the property of Facilitation: Engagement, Education, and Patient Advocacy. Within the dimension of Patient Advocacy, the nurses named several types of advocacy, such as helping a patient through the system, assisting them with family issues, helping with communication, and looking at the patient holistically. In the property of Experience, the nurses felt that both life experience and nursing experience help to make a nurse more seasoned. Almost all of the nurses felt that more experience was helpful in improving the nurse/patient relationship.

While the focus of the relationship is largely on the patient’s physical needs, the nurse’s ability to know her own needs and limits are also an important part what makes the nurse/patient relationship work. Even though self-awareness is an important function of having a good nurse/patient relationship, other people have a direct influence on how well the nurse can proceed, or how her attempts to fulfill her role can be frustrated by others. Other aspects of what affects a nurse’s personal theory are described and include the kinds of patients they are dealing with, and the technology that the nurse must master in order to do her job effectively.

Facilitation

“I always use the phrase, ‘You got to let me know if you need something. Because if I don’t know about it, I can’t fix it.’”

All the nurses agreed that their role is to facilitate. “I facilitate by knowing what medicine to give them, what position to help them into, by helping them to relax, letting
them talk about their troubles.” There are several dimensions along this property of Facilitation: Engagement, Education, and the many facets of being a Patient Advocate.

Facilitation was seen as enlisting patient cooperation, the promotion of healing, or helping to expedite matters within the medical system. Most of the nurses wanted to help facilitate in the healing process, but for some the facilitation was involved with the process of dying. Facilitation depends on the patient’s needs and the nurse.

In order to effectively perform their role as facilitators, nurses need the patients’ and/or families’ cooperation. Some nurses think about how to engage the patient in the process and actively do so.

You know, by engaging them in the process and making them aware of why it is happening, why you are doing what you are doing, that comfort level comes. Because they are informed and they are actually making the decisions for themselves, not you.

This nurse is attuned to patients needs to feel some control over their healthcare choices.

In attempting to gain cooperation, sometimes the nurses run into resistance. One nurse tells how she engaged a patient to share information with her about his alcohol intake, which he wanted to keep to himself.

[I told him] it is so important to know because when you can’t have any of [alcohol] then you look for the DT’s, you know, the Delirium Tremens, and the alcohol withdrawal. I would say to him, “This is important that we know,” and explain it to him. And he was like “Okay.”

This nurse allayed the patient’s anxiety about being judged, or experiencing shame, or possibly punishment, by telling him the truth about why knowing about the details of his behavior was important for his health and well-being. In so doing, she enlisted his cooperation in managing his own healthcare.
Some nurses used humor to cajole or enlist the patients’ cooperation. “I kind of use humor with my patients, I try to get them to laugh by saying something funny,” one nurse said. Particularly with difficult patients, cajoling humor may be attempted in an effort to build a relationship with a patient and enlist his cooperation.

I just sort of said teasingly, “Oh, I think I might’ve seen a smile there,” and, you know, before the end of the shift, he was a little more cooperative with me. But he was a difficult one, I tell you.

Teasing humor also helps sometimes, to decrease the patient’s anxiety. One nurse said,

I tell my patients, the ones you know you can kid around with, I will say “Do you know what the number-one rule in healthcare is, really?” And they will say “No.” And I tell them “Never, under any circumstances, piss off your caregiver.” And they will say “Why?” I say, “Because we could hurt you.” And they always laugh at that.

This nurse uses dark humor not only to enlist patients’ cooperation; she understands the fear that patients feel and tries to help them focus on it in a lighthearted way that will be helpful to them.

This strategy is not something everyone would confess to using. And yet, what this nurse is telling the patient is similar to the strategies that a lot of the nurses talked about using in their dealing with patients. They said over and over, and in many different ways, that if patients are nice to them, it makes it easier to take care of them and may even in some cases affect the quality of care that the patients receive. So while this nurse’s statement might seem to some a bit inappropriate, her advice, though dressed in dark humor, is honest and is meant to be helpful to the patient.

Some nurses see their facilitator role as a more active one than other nurses do.

If you join the profession and want to make a difference, well then you have to be the one who initiates that, you just can’t expect it to happen. Like, on Monday I called myself the “oxygen Nazi” because I had patients who,…I wanted them to go home and they were both on high oxygen levels. One I had on six [liters of
oxygen], and I had one on four [liters of oxygen] and I turned them both down to two [liters] and they both did extremely well, and I just ended up taking them off, and that was all before noon. Because like I said, if you want to make a difference, that’s great, but you have to initiate it. You can’t expect your patient to know.

This nurse saw that it was possible to take an action in order to expedite the discharge date or time of the patient from the hospital. Part of her point is that her intervention was timely. She felt that without her proactive intervention the patients would not have progressed as quickly and as a result would not have gotten to go home as soon. She is working from the assumption that the patients want to go home sooner, rather than later; however, as she alludes to in the end, patients do not know how to expedite their own discharge through medical interventions. Nurses do.

Most of the nurses saw themselves as fulfilling an important role as educators with their patients. Patient education is emphasized in nursing schools and has been seen for years as an integral part of the nurse’s role. “One of the things that I love doing with people is educating them, so that is why I think it comes so easily for me,” one nurse commented. What may make the teaching ‘easy’ for this nurse is her feeling of helpfulness when she does it. However, the amount of teaching needed, or the pressure to teach patients depends heavily on which unit the patient is on, and the reason they are in the hospital.

Patients who are in for short stays need quicker action and sometimes are approached more actively by nurses. One nurse said,

You have one chance to make a first impression. That’s a very old saying, but it’s true. You have the first chance to get that patient to feel secure, to feel safe, to feel they are in the right place. Because from the very first time they come to you, you start educating them on their plan, you start educating the family on the plan. The family is very important because these days families are a lot more
present at the bedside than what they used to be. Sometimes that is a good thing and sometimes, unfortunately, it really causes problems.

This nurse works on a unit where she knows that she will not have her patients for a long time and she must move swiftly to engage the patient and/or family in a cooperative relationship. Part of the education process includes empowering the patient in the areas where they have control.

The nurse may find herself in the position of being not only an educator, but also a cheerleader, or one who encourages the patient. This nurse explains her view about that kind of role.

I know what they can be, and I know what physical condition they are in right now. I don’t know what they are wanting, but by listening and telling them what I know and giving them knowledge, then I am giving them what they need to make decisions. I always say, “I am not going to help you do something, I am going to help you to help yourself.” They need a cheerleader. I say “I am your cheerleader, I am going to give you the tools that you need to get you where you are, but your skills and desire to do it has to come from you. But I am going to help you get there.”

This nurse is working hard to help her patients avoid the regressed state that they easily can slip into. It is as if she holds hope for the patient temporarily as their cheerleader, until they can feel hope themselves.

Another nurse put it this way:

Ninety-nine percent of the time, when [patients] are in the hospital [they] want to leave. I flat out ask them “Do you want to go home?” “Yes, I do,” they say. [Then I say] “I will tell you what you need to do to get there and if you want to get there quick, this is the way you need to do it.”

The reality is that today many hospital stays are quite short. It is a system that is payer-driven and it does not pay to have patients stay in the hospital very long, especially when they can receive home health services or may have family members who can care for them. In this climate, nurses feel the time crunch of the facilitation process. Most of
them spoke about trying to enlist the patient’s cooperation in taking charge of their healing so they would be in better shape when they were discharged.

While nurses may value and enjoy patient education, the pressure to get many other tasks accomplished is always pressing in on them. I sometimes heard about patient education being overlooked, in the context of frustrations with other nurses. Nurses may make every effort to educate patients in the time they have with them, but some days are more hectic and busier than others, and on such days patient education may be neglected in the interest of attending to the more basic needs of many patients.

Sometimes, the education part, I think this is lacking a lot these days, more than I would like. The education piece to our job is one of the most important and a lot of times it is blown off, you know, people get so busy. They think of all the tasky things that they have to do and sometimes our patient education goes by the wayside. But I am one of those people who really believes in educating the patients as much as possible and educating other nurses to educate the patients as much as possible.

Another nurse said, “I see all of nursing as caring. If you care enough then you are helping the healing process just by educating patients.”

The nurses who spoke about education did so with a lot of feeling. “I really like patient education,” said one. She added,

I’ve always believed as a nurse that my job is to work myself out of a job by education…if people can learn well enough how to care for themselves, then they would have health. I hate our system; we don’t do enough preventative stuff.

Another said, “If everyone educates [the patient] then people won’t fall through the cracks as easily. I think that is one of the most important things that we do and I think that we drop the ball a lot.”

Patient advocacy is another dimension in this property. Most of the nurses spoke about being an advocate for patients in one sense or another. The way they advocate or
what they advocate for may differ, but the theme of patient advocacy ran strongly throughout all of the interviews with the nurses. Nurses feel, in varying degrees and in different ways, protective of their patients. Sometimes they expressed generalized frustration with the system. For example, one nurse said, “I see patients all the time that I think, this could have been done differently. Or, the process of getting a diagnosis and getting to a point of getting definitive treatment plan just was not easy for them.”

Some nurses spoke of advocacy in more general terms:

If my patient does not have a good airway, there is no way that I am going to have my hands on that computer documenting anything. So, [the computer] is a frustration but in some ways it’s another way that just really drives my advocacy and I think now more than ever.

Another said, “My patient needs this or that, and I will have to deal with the charting or documentation of it after those needs are met.” So while the role of patient advocate was a priority for all the nurses, one can hear in the background of their words the pressure they often feel to get the paperwork part of their job done as well. It is as if they are having an argument not only with the pressures of the job, but also are arguing with themselves, because at the end of the day, they are still required to have done their documentation. This seemed to be source of constant conflict for all of the nurses I talked to.

Unfortunately, nurses do not always feel that their efforts in patient advocacy are appreciated. Sometimes being an advocate means engaging in conflict with others, like the family members of the patient. One nurse told me how she approaches the patient and family:

It can really spiral downhill quickly, and medicine is a very emotional business. When emotions run high and families feel that they are out of control, they want the best for their family member and they don’t know what to do. What they
think they need to do is speak up for that family member, when in actuality the nurse is the advocate as well, so there is that teamwork that could happen between the nurse and the family member. We have to let them understand that yes, we are going to be that patient’s advocate too.

It is sometimes delicate for nurses to convey to the family that they are on the same team. But nurses are not only advocating for the patients; they are advocating for themselves as professional nurses as well. A nurse may often feel the family’s anxiety and anger projected onto her. Then she must not only manage the patient’s anxiety; she must also see the family as an extension of the patient, and manage or understand their feelings as well.

Some of the nurses talked about how they need to advocate for the patients with the patients themselves. “Sometimes you guilt the patient into doing something, you know, you say ‘This is for your benefit, you are not going to get any better if you do not get this done.’” Or,

Sometimes you are so wanting to help that person get better that you are like begging them “Please, we are just going to sit on the side of the bed. That is all we are going to do. We need two minutes, that is all I am asking.” Sometimes it is different tactics with different patients.

Another said, “I think there are times when if you can provide hope for people, they will do the things that you are asking of them.” Yet another said,

I have seen it make a difference for people if I can meet them where they are, instead of demanding that they act differently than they are. Then sometimes they have done exactly what you are hoping that they will do and in terms of physical outcomes, this can help people heal faster.

In facing a difficult patient with an end-of-life issue one nurse told this story:

[The doctor] had tried to tell her [the truth] while she just pulled the covers over her head. Because she was just shutting him out, you know, that her cancer had gotten worse. And I said [to her], “Do you want to live on a machine?” and she was like, “No.” And so she signed the paper.
This nurse was acutely tuned into the patient’s denial, and was trying to help her deal with an end-of-life decision by asking a well-timed question. In so doing, she took an active role with the patient, advocating for her in one of the most delicate times of her life. If the patient had not signed the paper allowing her to die, she would have been connected to machines to be kept alive. What this nurse calls advocacy in this case is a beautiful example of empathic attunement to the patient’s needs in the correct dosage, at the right time.

Sometimes being an advocate for patients means assisting in the communication between the doctor and the patient. Nurses often understand what the doctor wants and why, or they understand the rationale for a medical procedure or decision that the patient does not want, as in the example above. One nurse said, “Different doctors that you work with--some are personable to patients and some aren’t. So, I think a lot of times you’re trying to make up for their lacking of personal, or people skills.”

In the example above, the nurse advocated for the patient by trying to get her to listen to the doctor. Sometimes the nurse is advocating for the patient by trying to get the doctor to listen to the patient, as in this story:

You know, not everyone is going to get well. I remember one patient we had, he had end-stage cancer and the doctor had come in and he was talking about going for some fancy procedure in another hospital away from here with the daughter and the son. The gentleman, I think he was around 80, he sat there and listened, you know he just sat there and he just looked at [the doctor], and he wasn’t really being included in the conversation. I made it a point to be there because I knew the kinds of things they were talking about. And the doctor was telling [the son] that the chances were really slim, that even if it did work it wasn’t going to be long-term, you know it would be just a short fix, and it wasn’t going to cure him of his cancer. It would just help him breathe easier if it worked. And so I finally I looked at [the patient], and he was just kind of staring off into space. I took that moment to go over and sit down next to him, and I got a hold of his hand, and I asked him quietly, “What do you want to do?” And he said, “Die, I just want to be done with it.” Well, that is a sad thing. But then when I did that, everybody quit
talking, and then the daughter said, “What did you say, Dad?” and he said, “I want to be done with it.” He said, “I am tired,” he said “I have fought it and I am tired and I want to be done with it.” So, you know, decisions were being made about him, and probably if they had gone ahead and said, “Well, Dad, why don’t you go ahead and do this, it might give you another four to five months?” he probably would have done it if nobody would have asked him directly what he wanted to do.

This nurse’s empathic attunement to the patient’s needs, and the tenderness with which she conveyed this story to me brought tears to my eyes as I listened to her.

A few of the nurses talked about needing to advocate for their patients in order to protect them from other nurses. They might not like the way other nurses treated patients, and this caused them to feel protective of the patients.

I think there are a couple of nurses, but this one in particular, she used to really irritate me because she was just not nice. I had said things to the manager and the patients were complaining so that you have to really protect the patient. I really felt like I had to be on my guard if she was going to be taking over for my patient because I am very protective of them and I feel that you’ve come a long way that day and you don’t want something to happen that is going to really compromise your relationship between the nurse and the patient care. I would try to tell her in particular as much about the patient’s personal history so that she felt she knew the patient.

Nurses also advocate for their patients is while giving the report to nurses on the next shift.

I was telling the night nurse, who has kind of a very short [terse] way of interaction with patients, and doesn’t like it when they have these outbursts. I know her personality and I know the patient’s personality, and so I was telling her, “Be aware, she’ll have these outbursts.” And I said, “If you just talk to her and re-orient her, tell her what procedure she had done, then that will calm her down.” And I said, “If she needs extra medication, you know, you can give her some.” But I said, “This is just the way that it has been today and she has done fine.”

Several nurses said that they feel were able to see “the whole picture,” a perspective that they feel sometimes gets lost sight of in the patient’s care. Sometimes in order to see that whole picture they may need to do some problem-solving or ask
questions that others may not feel are pertinent in the moment. Advocating for patients takes extra time and energy; however, the nurses felt strongly about the importance of their role as advocates for their patients.

One nurse gave several examples of what she saw as problem solving:

Sometimes they are being over-medicated. Sometimes they just might need, if you talk to them, you talk to their family, you can find out so much more. My theory is there is always a reason for everything, it is very difficult to find, but so many times nurses just say, “Well, that is just because that is the way they are, or that’s just because you know blah, blah, blah.” But there’s always a reason for everything. Like this one lady, I mean, if you look back in her history she had a history of depression, but people don’t talk to them [patients] to find out that information. And a lot of times they [other nurses or caregivers] come in and the focus is on the main problem and everything else gets put on the back burner. It is like, if you are treating the whole patient, you have to look at everything instead of just that initial problem.

Several of the nurses felt that nurses are in the unique position of treating patients holistically, and they try to keep this in mind while they juggle many different aspects of their role. The traditional role and the importance of bedside care is a central element in the nurse’s role. Nurses are almost de facto more aware of the whole picture than either doctors or members of the family. They are in the unique position of having both extensive medical knowledge and human awareness of “the human factor,” and as such they are a bridge between overly clinical doctors and naïve family members.

Experience

“Lots of peoples’ personalities change with experience and with education.”

Most of the nurses, no matter what age they were, expressed feelings about the role of experience in helping nurses to mature in their professional role. Some specifically talked about life experience as providing an advantage. Most of the older
nurses, regardless of the amount of nursing experience they had had, felt strongly that their life’s experiences had helped them to become better nurses. “I think it’s helpful having had the life experience leading up to where I am at now,” one nurse said. A younger nurse said, “The nurses that work there are just awesome, you just wish you had some of their qualities, but believe me it comes with maturity.” This young nurse expounded on her youth and how she felt it affects her patients, as well as herself.

When I was in, like, OB clinicals, you know, I was taking care of people maybe 10 years older than me, [and I’m] like, “I never had a kid, why are they going to listen to me?” kind of thing. Same thing with cancer patients; I don’t know how bad they feel.

The dimensions of life experience and nursing experience overlap considerably with the ability, or lack thereof, to empathize and will be explored more closely in the category of Empathy, in the next chapter.

One nurse commented on how the ability to combine the “task” part of the job with the “people” part of her job had developed over time. “The more experience I have and the more confidence I have in my competence, you can just kind of make it flow.” Another experienced nurse talked about how her ability to “leave work at work” continued to develop the longer she was a nurse.

I don’t carry baggage. It is not like I felt like years ago being a new grad or whatever. I used to take baggage home with me like, “I hope I made the right decision, I hope I did this okay.” I don’t usually do that now.

This was a sentiment that several of the more experienced older nurses expressed. They also commented that this is one of the things that is especially hard about the job for new nurses, until they have had enough experience.

The hospital tries to help in this process by pairing experienced nurses with new graduates in a mentoring program that all the nurses feel is important in helping the
younger nurses make it through in the beginning. However, there is nothing like just
plain experience to teach someone, as expressed in this nurse’s statement:

Back when I graduated you couldn’t go straight to ICU. Of course now we have
them coming right from school, and I say “No, they really need that experience.”
I worked two years on a med-surg floor, and then I went and worked at an ICU. I
felt that if I didn’t have that history I would just feel so frustrated. Knowing what
I had learned in those two years helped me tremendously.

One nurse summed up the dimension of this property nicely.

It is the little tricks that you learn along the way; it may be helping your patient’s
pain to be better [managed], or teaching people. The way that you educate them
with different media, like you may educate somebody who is more hands on this
way; it is just little things like that. It’s also bouncing things off of colleagues that
have been there 30 years. You might have never seen a patient that’s behaving
this way, or seen a disease process that is manifesting this way, or something like
that. So it is also about collaboration, about getting opinions from others to try to
find a formula that you plug right into the problem to fix it. Thinking outside the
box is taking experience, plus your technical skills, and putting them all together.

Self-Awareness

“If I were in a position where I couldn’t see making a difference as easily I would not be
as satisfied.”

There are several dimensions in this property, including the type of unit, type of
patient, the ability to advocate for oneself, and intellectual engagement. Whether a nurse
feels that she is contributing to the patient’s well-being affects not only the way she feels
about herself, but her job satisfaction as well. Once someone has chosen nursing as a
profession, there are many different kinds of experiences that nursing can offer. For most
nurses the trick is finding the right match for themselves. The type of patient they like to
work with and the right unit to work in both contribute to a good fit. One nurse said,
“One thing I have found is that coming out of nursing school, most nurses knew what it is they don’t want to do. It takes time to find what you do want.”

A couple of nurses told me that they liked a certain type of patient, but they ended up choosing a different kind of unit to work on based on the nurses they would have an opportunity to work with there. “I did my first clinical there and I was so captivated by someone there; there was a nurse who made me want to come to work on that unit.” Or “She has the biggest heart, that type of person that just really makes you believe that you are a really good person and that you can do things for other people.” Another nurse described her decision-making process when choosing a unit just out of school:

"The only reason I didn’t end up going to that unit right out of school was because the manager and the staff on this unit were my favorite, because I had worked there as an intern and as a tech and I have floated all over the hospital. So when it came down to picking who I was going to spend my daily time with, the manager on the other floor was just phenomenal and she’s amazing. Even though I thought that it would be a little more scary than the other unit, I tried it anyway because of her.

This nurse’s statement reveals the way nurses need essential others for psychological as well as other kinds of collegial support.

Different units within a hospital function in such different ways that where a nurse works can make a significant difference in the way she feels about her work. Nurses like working with colleagues that they feel they can, at the very least, get along with or, ideally, experience working together as a team.

However, other factors can also determine whether a unit is a good fit for a nurse. A nurse might like her colleagues or manager, but may feel that the pace of work on the unit is not right for her, or that her best skills are not compatible with it. This dimension
overlaps considerably with the type of patient that is on the floor, but not entirely. The pace of work on the unit is important to this nurse.

So you really keep your skills sharp. Some days you feel like you are on a roller-coaster, you know you’re up with your patients, you’re down with your patients, you never know what is going to happen on that floor. So it is really a good fit for my personality because I am a constant go’er, I go, go, go, all the time.

Another nurse said of her unit, “It is a very good match. I love it. It is perfect. I learn something new almost every day, which I think is great. It is very intense, it is extremely intense for short periods of time; it is perfect.”

Some nurses like the use of high technology that some units offer. One nurse said,

Those nurses that come to the ICU are looking for the high tech, they are looking for those challenges, so I think they are maybe more focused on that, than on the actual taking care, putting the patient on the bedpan, doing baths or that type of thing.

Others nurses prefer a completely different kind of unit for different reasons, as this nurse reveals in her refection about a nurse friend.

She actually just left the bedside and went to more of a surgi-center outpatient unit, and she said she doesn’t miss it. She doesn’t miss having to shut everything off at 7:30 or 8:00 when she is going home; she has a more fluid personality. She is not A type person from 7-7 and B type person from the other 7-7. She is more herself all the time.

In shifting gears from work to home life, this nurse wanted more continuity of pace. She did not like the challenge of having to leave everything behind psychologically at work in order to be at home.

Another nurse reported that she became depressed when she worked on a rehabilitation unit.

That was the other thing on rehab that I couldn’t take. The progress that happened, it was like miniscule and it took like three months, which is really
amazing that they could get that far, but it was just not fulfilling to me to do that, it really wasn’t.

This nurse may have been distressed by the enormity of the tasks at hand, and flooded with feelings about the slow pace of progress by the patients.

Some of the nurses liked their units because of the variety of patients that they cared for.

The kind of patients that I have on my floor, the biggest reason why I love my floor is because I have had everything from a fetal demise patient who was post-partum, to traumas, to basic ortho surgeries. I do stable open hearts who are two days out of their open heart surgery, I do vascular patients, I do basic medical, stuff like pneumonia or COPD, I’ve had pregnant patients who were just there because they were having like hyperemesis, or whatever, I have them. I see everything, I deal with everything, and that is why I love it.

One interesting theme that emerged during the course of the interviews was particularly in regard to the nurses’ feelings about the mothers of patients. Many of the nurses did not want to work with pediatric patients; their feelings seemed to have been based on over-identification with the child and/or the parents, as this nurse described:

When we have a patient who’s been beaten, or a shaken baby, or one who is deathly ill and the parents aren’t around, they just dropped the kid off and left, it moves me to tears. But also I was just thinking of when we were suctioning this baby and the mom just started crying. I was tearing up because I could imagine how hard it would be for me to have to hold my son while he was being suctioned, even though I would know he needs it.

This same nurse continued, “Now that I am a mom, it is like I can honestly see what it is like. Before I tried to understand what it was like, but it is amplified now.” Now that this nurse is a mother, her feelings are even more intense than before, as she takes care of children and sees their mothers struggle with their feelings. This nurse had not only found herself over-identifying with a child who had been shaken, she found herself over-identifying with the mother of a child who needed suctioning. In this case, as with some
of the other nurses, it was not only the patient that was hard to care for, but also members of the family, in this case the mother.

Another nurse told about an experience one of her nurse friends had shared with her.

I was talking to a cancer nurse the other day who said that while she knew she had a calling for that unit [oncology], she said she had never gotten hardened to the mothers of cancer patients. She said, “It doesn’t matter if the mothers were the age of my mom when she was in her 80s or the age of a young person, it is the moms who always get to me.”

On both pediatric and oncology units, nurses seemed to have had more difficulty managing their feelings about the mothers of patients. They found themselves having to manage their affects about the family member’s position in relation to the patient, sometimes even more than with the type of patient they were caring for. They over-identified with the family member to the point of their own painful affective states that sometimes felt unmanageable.

All of the nurses were clear about the kind of patients they could not work with, and there was a lot of affect when they spoke about those types of patients. Whether it had to do with the kind of disease they were suffering from, or their type of personality, nurses had their lists of what kinds of patients and conditions they did not want to take care of. Pediatrics was the most commonly mentioned unit that nurses did not want to work on, with oncology running a close second. One nurse said,

You know, during nursing school they say that you’ll find your niche, you’ll know it when you see it, you’ll know that that is the one for you. Pediatrics just wasn’t something I could do. I can take care of my own children and I can take care of my friends’ kids but there is that special kind of nurse [who can] take care of children, and oncology as well. I have a lot of cancer in my family and I can take care of my family, but going to work and seeing that and being positive, productive, you know [to be] a proactive nurse in that kind of environment would be a little tougher for me. It’s too close.
This nurse’s statement hints at the kinds of feelings that can occur when she takes care of children or oncology patients. The opposite of “positive and productive” may be sad and immobilized. Nurses are affected emotionally.

When psychiatric patients were mentioned as being an undesirable type of patient to deal with, it was expressed in strong affective stances. One nurse said, “I hate psych patients.” A surprising number of nurses did not like working with psychiatric patients. Their emotional complaints seemed hard for the nurses to interpret, or to understand, since the complaints were not in the form of physical, somatic states. These nurses may have found themselves feeling helpless with this kind of patient.

Some nurses liked working with short-term patients; others preferred long-term patients. Short-term patients tend to be patients that are healthier, and their needs are very different than those of the long-term patient. “It seems easier to take care of somebody that, they come in tonight and they leave tomorrow. I mean, that is pretty easy because you know they are going to be more motivated and stuff.” There are also less regressed psychological states in patients who are relatively healthy. One nurse said,

I take care of them in acute situations and you get to see them excel, and you get to see them come in for the surgery that they haven’t been expecting, or that they have been waiting to have for a very long time, and then you get to go and push them to their limits, which you know that they can do. You help them to help themselves, to get back there and get well again.

While the regressed emotional states of these patients are temporary, this nurse feels that she can help them get into a more normal state of caring for themselves.

Contrast her perspective to that of this nurse, who preferred working with long-term patients.
So there is high acuity to keep you learning and interested and busy, but you still have the contact with the patients and their families, and you get to know people. There is still that teamwork too, which is what I really liked about rehab. And I found over the years that I like a slower pace, I don’t like emergencies. I can handle them, but I don’t like them.

This nurse felt that she could manage the patients,’ as well as the families’ feelings, and she liked the relationships that developed out of helping them through their struggles.

Most of the nurses spoke about not wanting to take care of ‘difficult’ patients. What was meant by ‘difficult’ varied from nurse to nurse, and will be explored further in the chapter on Empathy. However, there were also nurses who said they did not mind working with difficult patients.

I know a lot of people I work with, they will have a difficult patient and they are just somebody that nobody wants to go into the room because it is going to be a bad day. And they will say, “Oh, please, I don’t want that patient back tomorrow, give me a different patient.” But I have found that nine times out of ten, if you do that, you are going to get somebody just as bad the next day. Everyone has their problems.

The term “difficult” meant something different concretely to each nurse. However, in general, nurses who spoke about difficult patients were managing regressed psychological states in their patients, and were feeling the regressive pull themselves. The nurse quoted above was able to not become overwhelmed with her own feelings when dealing with these kinds of patients. Perhaps that is why changing patients did not seem like the answer to her.

A few nurses spoke about the need to set limits on what they thought they could tolerate from patients. One said,

I had this one patient and he was kind of, you know, gross, or saying derogatory things. I just said, “Well, that is your opinion, and I would prefer that you not talk that way.” Then [the patient] may stop, but you know, sometimes, [the patient] knows that they are getting a charge out of [the nurses], and then they will
continue with it, so you just stop it. You stop that behavior and you don’t feed into it.

This nurse dealt with a patient who was misbehaving like a child and said ‘no’ as a container for unprocessed primitive feelings.

Another nurse gave an example of yet another kind of patient who needed to be contained in order to move forward with the healing process. “You are either going to sit up and cough and get this [phlegm] out, or you are going to be intubated again,” she told him. “I think with them the line is clear and so definite, and you need to tell them. “What I need you to do is something I need you to do right now!”

“I feel as if really I learn something everyday.” This sentiment was echoed in many of the interviews with the nurses. Part of what they liked about nursing was their intellectual engagement with their work.

Having said that, different kinds of challenges engaged different nurses. Sometimes a nurse would describe the problem-solving aspect of the nurse/patient relationship she was trying to forge.

I try to find out what it is. Sometimes it is just something little that set them off. And if you could kind of clear that up, then that helps your relationship, and then you can talk about some of the other things, but it takes a while to figure out what it is.

Another described her very direct approach,

I see that as a challenge and I want to figure out why. And I will flat-out ask the patient what it is. I don’t hold back anything because I see them as people, not somebody who is there to be sick. If they are having a true issue I want to resolve it…because if you keep jumping over the issue they are just going to build up and the next thing you know it is like a bomb waiting to go off.

Nurses do only want to help their patients; they also want the relationship they have with the patient to feel good to the patient. Sometimes the relationship is the
hardest part of the work. As one nurse put it, “I ended up playing a game with her, you have to get down to where they are and just kind of be a little rough and tough, like with her, and joke. And pretty soon she came around.”

Of course figuring out what works with one patient may or may not work with the next. This nurse’s willingness to figure out this kind of interaction with her patient represents her state of mind. She does not feel this challenge as something to avoid. Instead, in her steady state, it is simply a problem to be solved.

Some of the nurses appreciated the challenges of problem-solving when they saw a medical issue arise.

I like it because [it] makes me think. It is that idea when something is going wrong and I have to guess, like it is a puzzle, and I like it. Or sometimes when I have to call the doctor I will say something like “Do you want me to increase the [medication]?”

Intellectual stimulation, if it is invigorating for the nurse, may override the challenging affective states of dealing with critically ill patients. It allows the nurse to engage with her patient in a way that is helpful to both of them.

Most of the nurses felt it is the nurse’s individual responsibility to be aware of what does and does not work for her. One nurse said, “I think that part of the nurse retention [issue] has to be from the nurse herself. What is making you happy? And if you’re not happy, why aren’t you trying something else?” Part of what makes the nurse/patient relationship work is when the nurse likes what she is doing, whether she is with people she enjoys working with, on a unit that is a good fit for her, or dealing with technological challenges that are enjoyable to solve, and not overwhelming. When nurses know their own preferences, personalities, and tolerance levels, they can play a part in making
the nurse/patient relationship effective by making sure that they are in a work situation that matches their abilities and preferences.

The Function of Others

“I attribute that to why I love my job so much--it is the people I work with.”

Other people affect the lives and work of nurses. The “others” range from other nurses, to administrators, to God. The role of technology has also been included in this section. While technology is not really an “other,” the nurses mentioned the role of technology in affecting the nurse/patient relationship so often that it has been included in this discussion.

In many of the interviews I heard comments about other people, from the very personal--for example, comments specifically about a coworker--to more diffuse ones, such as general comments about the administration. Whatever the context, both other people and the demands of technology directly affect the working lives, and thus the feeling states, of each nurse, though each nurse also had individual experiences, tolerances, and preferences for the ways in which others affected their lives.

Feeling appreciated by patients and their families could make or break a nurse’s day, and could even make or break the whole job for many of the nurses. While nurses have, in general, an altruistic spirit that they carry into their profession, they also want to feel appreciated. For some this is the most important inherent reward in being a nurse. One nurse said, “If we could get that message to patients--of course they are sick and they are not at their best--but just a ‘thank you’ goes a long way.” Another said, “I am getting something back if they smile or say ‘Thank you.’ That is all it takes, is a ‘Thank
you.”’’ One nurse said, “They tell me, ‘Your mom should be glad, you are a great nurse,’ or whatever. That is always gratifying to hear. It makes you want to come back the next day.” Nurses have their own natural need for some narcissistic gratification from others. It is clear from these statements that, for many nurses, not much is required to fulfill that need.

The nurses spoke with a good deal of ambivalence about dealing with the families of patients. Many a nurse said she felt as if dealing with the families was the most stressful part of her job. The nurses juggle not only with technology, and with the patients and their feelings, but also with the anxieties and feelings of the families.

The nurses interviewed often spoke of how managing all of this was a delicate balance.

Sometimes you just can’t help wondering how someone is going to take you. So with my patients, I feel I can be honest and up front with them, but my family members I feel like I need to baby them a little bit more and keep the line of communication open and soften what I say to them.

Another nurse compared her experience in pediatrics with adult units.

I think all nurses tend to care for the patient and the family as well. But families come and go on adult floors. On peds, the client isn’t really the patient, it is the entire family. Lots of times the babies are easy to take care of, it is the parents that are the most work, so, oh yeah, with out a doubt it takes a toll.

The families are full of anxiety and fear, and especially on a pediatric unit the nurse must understand and manage their feelings as well as the patient’s feelings and her own.

Sometimes families can make it easier for nurses to attend to difficult patients; and some nurses appreciate the family’s support when they feel it is appropriate. In general, nurses would rather have a supportive family member present for the sake of the patient; however, this does not mean that having them there is easy on the nurse.
Even though I say families can be difficult to deal with, I think that patients that
don’t have families are hard to deal with too because they don’t have any support
systems. So I really prefer to have a patient who has people who care about them.
But they can cause trouble sometimes.

This nurse is talking about a delicate balance sometimes between what is good for the
patient--a supportive family--and what is good for the nurse--a family that does not
project their anxieties onto her.

Difficult families or patients can demand a great deal of time and energy from the
nurse, as well as from the system in general, as this nurse described.

Our system is not set up to really handle those kinds of issues like that,” one nurse
said, “We try to think, is it a discharge planning thing? Do they need knowledge
or something? It may not be the job of pastoral care either, which are wonderful,
but sometimes it is not a religious or spiritual need either, and we don’t have time
to just handle that the daughter is giving everybody a problem.

This nurse is basically expressing a plea for help with a regressed or distressed person.

While the daughter she refers to may be “giving every one a problem,” no one is prepared
to manage her difficult psychological state, and therefore her anxiety becomes
contagious.

Another nurse told the story of a patient who was difficult, who was projecting
her anger onto the nurse, and how the nurse had tried to understand why the patient was
so difficult.

Well, they are just mad in general, so you want to try and help. I was thinking
about having a gal in her 30s who just didn’t feel like she was getting what she
needed. Every time she came in they just couldn’t figure out what was wrong
with her. And that frustrates the patients, especially when the doctors don’t know.
And so they make threats, but you get other people involved, like a new nurse, the
manager, there are a lot of teams that you can bring in.

Managers and administration play no small role in the quality of the nurse/patient
relationship on their units. Several nurses expressed appreciation for the support they felt
they had from their managers. Good managers can help a nurse solve a wide range of problems, from clinical to personal. They can help out when staffing is low, listen supportively to the nurses when they are stressed out, alleviate problems on the unit to the best of their ability, and support them in conflicts with other departments or doctors. Bad managers, on the other hand, can make life miserable for nurses. Bad managers show preferential treatment, do not attend to staffing issues, and in general do not support their nursing staff. A bad manager is often the reason a nurse asks to transfer to another unit.

For this study, nurses from a wide range of units within the hospital were interviewed; and the consensus of this group of interviewees was that they had good managers. Only a couple of the nurses felt that they had problems with their managers. Some of the nurses felt that bad managers had contributed to their not feeling understood at critical times, either in their lives or careers.

For the most part, this group of nurses appreciated their hospital’s administration. Some of the nurses felt that favorable relations were due to the hospital’s application for magnet status; however, most of them were simply grateful to have the support. Several felt that administration was doing a much better job of listening to the nurses and appreciating the nurses than in the past, in various ways. One nurse recognized a change from times past by stating,

I think that is one thing that hasn’t burned me out quite as bad is that Carle has finally realized that you can hire all the new nurses that you want, but unless you keep the old nurses, they are not worth a shit.

Another nurse said, “There is a mentoring program, Carle has really put a lot into the mentoring program of the new nurses, to help keep them.” Another noted, “I think the administration is trying. I think they listen more here than at other hospitals I have
been at.” Some of the nurses appreciated a recent $1.00 an hour, across-the-board raise, because they have been working more hours due to a severe nursing shortage. All of the nurses spoke about the severity of the shortage; however, the administration’s attention to the shortage, and the appreciation they have shown for their nurses by paying them more and giving them more shift flexibility echoed so loudly in the interviews that the severity of the shortage was minimized, even when they were talking about how many extra hours they were working.

While patients and their families were the first and most commonly discussed subject in part of the interviews, also near the top of the list was the importance of relationships with other nurses. Overall, the nurses felt that having a good working environment included working with a group of colleagues they felt that they could depend on. How they defined “depending on another nurse” varied from nurse to nurse. The older nurses tended to evaluate their colleagues based on whether they showed up for work consistently and “pulled their weight” while at work. Younger nurses tended to see their colleagues as dependable not only on the work front, but as friends outside of work. Younger nurses were less likely to be bothered if other nurses called in sick. These and other age-related differences overlap with the category Generational Differences and will be covered in more depth in that chapter.

Some nurses told stories about the closeness they felt with other nurses. One said,

There is a core group, even though I have not been there that long, that you just feel that if you have an issue, that you have to talk to somebody about something, or problem solve, like if you are having trouble with a clinical thing or we can’t get along with someone then they are helpful.

Another said, “That’s where you know that there’s people and you will bounce it off of each other, you are never alone, you can always go to somebody else.” One nurse
expressed another significant effect of the nature of relationships between colleagues on a unit by stating, “If you are closer to the other nurses on your floor you are more apt to be able to connect more and be closer to your patients, I think.” This comment overlaps with the category of Empathy, which will be covered in more detail in the next chapter.

Other nurses spoke of relationships with colleagues in more personal terms.

It is our own little family and on each unit you can tell the dynamics. You know in the unit when you walk onto it. And there are some units, oh yeah, there are some units that I wouldn’t work on it if you paid me a million dollars a year. Because they don’t have that camaraderie and they don’t have that cohesiveness. It is not a touch feely family here, where you always have to be in each other’s business, it is not like that at all. I mean there are some girls that are better friends with each other than others, but we all have mutual respect as professionals and human beings that we all feel that we are all here for the greater good of our patients.

One nurse said, of her unit,

When I took the job, I immediately felt like they really brought you into a group that was really going to watch out for you and nurture you, since nursing is known for eating its own. We really have made a conscious effort, especially on our unit, and I know other units in our hospital as well, have really made a conscious effort to take in new gals and to really help them out.

Not all nurses sang the praises of other nurses. For some of the nurses, other nurses were cited as one of the biggest stressors in their job. Some gave examples of how other nurses have been either hurtful, or not respectful, or outright mean to them.

“Nurses eat their young” was a phrase that came up in several interviews, either as a way of saying that nursing had gotten better as a profession, or to say that the problem still exists.

I don’t know if I ever thought it was punitive, but when I asked for her help, she was like, “Do it yourself.” That was pretty much her attitude. You know, her attitude was, “If I had to do it myself, you find a way to do it.” Or she would say “I can help you in ten minutes” and fifteen minutes later she would still be working on her stuff and not be able to come and help me do what I asked her to do, or [she would say] “Find somebody else to help.” So I found that frustrating.
Another nurse who talked about the difficulty of dealing with an uncooperative colleague:

I didn’t trust her clinically, and she made me so irate that everything started irritating me. And when I would call her, she would say “Oh, well, I have plans, I can’t come for that shift,” I would be like, “You know, we need you” and she would be like, “Well, sorry, I am not coming.”

Another nurse showed another side of the coin by talking about how sometimes more experienced nurses might be too impatient, or not supportive enough, with younger nurses.

They are very judgmental, I mean judging this one should have never been allowed to happen, instead of supporting her, like “you have been given this assignment, we know you don’t have a lot of experience, but we can do what we can to help you.” Eating our young so to speak.

This phrase ‘nurses eating their young’ reflects the aggression that some nurses act out.

Some nurses spoke about the importance of “collaborative medicine.” Some of them talked about feeling supported by the doctors; others about feeling disrespected by them. This is a variable that seems to vary widely from unit to unit, if not from doctor to doctor. I seemed to hear about the extreme cases and not much about the middle ground.

What was clear from all of these stories is that when collaborative medicine is practiced, when the nurses feel respected as part of the healthcare team, they feel better about their work and their unit. One nurse said,

The physicians here really believe in collaborative medicine with the nursing staff, which makes a huge difference. Because you can sit and bat something around with someone, as opposed to somebody who is going to tell you what they think is going on, and “Don’t you dare tell me that you have an opinion on this.”
Another nurse said, “You know you can go to that doctor and air a grievance and if he or she can, they will take it to whomever they will need to take it or they will stand behind you. You are not alone.”

At the time of this study, Carle Foundation Hospital was going ‘live,’ instituting electronic charting. They had been involved in this process over a period of time, so that some of the units had been doing electronic charting for almost a year while others were just being trained. Electronic charting provided a predominant example of the technological aspect of the job. While nurses learn to manage complicated equipment of all sorts, they had ambivalent feelings, at best, about the electronic charting. Of course they would expect to learn how to operate a ventilator, for example, a complicated machine that helps patients breathe. Their feeling seemed to be that learning technology in the service of patient care should be unquestioned.

However, even before electronic charting was introduced, nurses have been disturbed by the amount of paperwork they are required to do as part of their job. Most nurses want to spend most of their time with their patients, and they often see the paperwork they are required to do as keeping them from the most important part of their job.

Some of the nurses were more resistant to using computers than others. Not surprisingly, I heard more complaints about the electronic charting from older nurses. This may be the effect of the computer age on different generations. The younger generation has grown up with computers in school, while the older generation has had to learn them as the technology has developed. One nurse in her 50s said,

I think it is really hard to assimilate it all, coming from being an old nurse, and now we are getting into electronic charts. And so it is like, I am not a computer
nerd, I am comfortable with computers, but every layer they give us, I feel like there is just another ball and chain wrapped around my neck. To focus, and to have the patient be the focus is harder and harder.

Another nurse said, “It’s a lot of paper work time even on the computer. The computer isn’t saving nurses any time.” One nurse said that using the computer at the bedside, as they have been set up to do, is not workable because the computer terminal is in the space where the family congregates, and often the nurses cannot get to the terminal for all the congestion in the room. This nurse’s complaint was that the administration had had the terminals installed without listening to the nurses’ comments about where should be placed.

One of the younger nurses who was comfortable using the computer, also expressed frustration with her ability to provide patients with the kind of bedside care they need.

Yeah, it is the technology you like, it is the high level of care you are giving, but I think we all just wish that we all just had another free hour in the day to give patient care. Even though there are restrictions, patient care is the biggest thing that nurses do and they have given us computers so we could do more bedside nursing, but we actually do not feel that has been the outcome. Because they have given us this computer system and that at the same time, I feel like there are other requirements that they would like us to do. Just because what the computer has slimmed down for us in time, these other things have just filled up that space.

Another nurse commented on the awkward social feeling that using the computer set up between her and her patients, and the difficulty she experiences in not being able to attend to her patients in the ways she is accustomed to doing.

To have that one-on-one eye contact is part of patient care, so now I can’t. [The patients] are talking away, and I’m looking at the computer. I just feel like it is kind of, normally what wouldn’t happen, you know, when you come into that room you’re focused on your patient. And now you’re kind of like distracted, and needing to concentrate on something else.
Some of the nurses, while generally disapproving of computers, did say that they liked the fact that with the computer system they were less likely to make an error with medications. “I love the medicine administration part of the computer, I mean it just decreases error by who knows how much. Because you just can’t, unless you are not using the system, you can’t give them medicine incorrectly.” Computers are here to stay, and the nurses all accept this reality; but they also said they felt pulled in yet one more direction, and not in a way that they feel was helping them to provide good patient care.

A few nurses spoke about their faith or religious beliefs, or God, as helping them in their role as a professional with their patients. One nurse said that people in general are reticent to speak about their faith, but she felt that it plays a role in the nurse/patient relationship, beyond what many nurses may be willing to say. During a member checking interview one nurse stated her surprise at the amount of conversations that include the expression of religious attitudes. She said, “I think it is really important and I know it affects how a lot of nurses give care, but you just never hear anyone talk about it.” One nurse said, “Faith has certainly gotten me through a lot of situations.” Faith and religion were spoken of in conversations about choosing the profession by several of the nurses, and some spoke of their faith or religion as also playing a role in the nurse/patient relationship. However, religious beliefs were mostly discussed in the context of empathy.

Empathy has an assumed role in the nurse/patient relationship. They go together like a hand and glove. Empathy is such a prominent part of the nurse/patient relationship that it became it’s own category, and will be expanded upon in the next chapter.
Conclusion

While the properties of Facilitation, Experience, Self-Awareness, and The Function of Others describe the various parts of a theory that a nurse may hold, each nurse’s individual theory of the nurse/patient relationship is as unique as each nurse’s personality and temperament. Nurses come to the profession for a variety of reasons and with their education and their own personal value systems they develop their own personal theories of the nurse/patient relationship. What may work for one nurse will not necessarily work for another. What one nurse may value, may differ from what another nurse values. This is part of the unique strengths that individual nurses bring to their profession. They each have their own personal strengths, and their own individual ways that give them their own personal touch with patients. And this is good, because what works for one patient may not work for another patient. After all, patients are as different and unique in their needs and personalities as nurses are. A “successful” nurse/patient relationship has been forged when there is a good match between nurse and patient. All of the nurses had definite and strong feelings about what they felt helped and harmed a nurse/patient relationship.
CHAPTER X

EMPATHY

“If this was me or my loved one lying in this bed, what treatment would I want? That is the bottom line. There are lots of other things that come into play as far as how much can I connect with or relate to that person or not, or, you know, how much I know about the etiology, the surgical process, the anesthesia process, but it all boils down to what would I prefer? How would I prefer to be treated if it were me on the other side of it?”

Introduction

When a nurse asks herself “What treatment would I want?” she temporarily merges with her patients to understand what they might be experiencing. This is a complicated psychological process in which she must not only put herself in the patient’s position; she must also be able to imagine old age, sickness, and even death, the inevitable end of life.

Most of us do not encounter these situations in our daily lives. We may even make it a point to stay away from them. For some, visiting a friend in the hospital may cause feelings of vulnerability.

The truth is that suffering, while a normal part of life, is also a narcissistic injury. The mere thought of serious illness can be so frightening to some people that imagining what it feels like to be that person is too painful, so painful that they refuse to engage in that imaginative act and find ways to avoid it. However, when the nurse temporarily merges with her patient, she needs to be able to imagine all the physical assaults that life,
death, and modern medicine offer. She must be able to imagine various kinds of pain, the panic-stricken state of gasping for air, the discomfort caused by tubes protruding from the body, liquids of various colors that smell “funny,” or bad, and drain from anywhere possible.

Empathy allows the nurse to figure out the nursing action she needs to take for her patients in these situations. Empathy is employed by nurses in different ways and for different reasons. In addition to imagining what the patient’s physiological states might be, nurses must also be attuned to their patient’s psychological states. Many patients are anxious, scared, angry, or lonely. People who do not feel well are not at their best psychologically. Often they have entered into a regressed psychological state that has a regressive pull for the nurse. Nurses must be able to be attuned to the patient’s emotional states and be able to merge temporarily with them in order to understand what the patient is experiencing. The regressive pull informs the nurse about the patient’s feelings and requires that she manage her own feelings even as she experiences that regressive pull.

If the patient is short-tempered and uncooperative, it may be because he is afraid and needs reassurance or explanation. To calm an anxious patient the nurse soothes; she reassures the frightened patient, provides a container for the displaced anger of another patient, gives explanations to calm the confused patient, and tries to help re-orient the patient whose mind is temporarily visiting another realm. She temporarily merges with her patients to imagine what they are feeling emotionally and physically. Throughout that process she must remain her own person. Sometimes this means providing patients with emotional support. At other times it requires performing a task that requires a
special set of skills for providing physical care. Nurses show how they give life to the concept of empathy from the nursing perspective.

The category of Empathy has three properties: Definition, Balancing Act, and Limits to Empathy. All the nurses interviewed assumed a working definition of empathy. While empathy has an assumed role in nursing, the nurses spoke about empathy by giving examples of how it is demonstrated in a nurse’s everyday life.

There are several dimensions to the Balancing Act property. The dimension of emotional closeness and distance is explored at length. Some nurses found themselves feeling close to their patients and liked it that way. Some were guarded about how close they became to their patients, and others felt that retaining some distance was helpful to both them and the patients. All of the nurses had their own comfort zone in this regard. All of the nurses said they must balance the technological aspect of their jobs with the “people skills” part. They talked about how they managed difficult patients and especially the aggressive feelings that were elicited in them when working with such patients.

The Limits to Empathy property refers mainly to dealing with patients with whom nurses have trouble empathizing. In some cases the patient’s situation was uncomfortably close to something in the nurse’s own life situation. In other cases it was simply a case of not being able to relate well to the other person. Some nurses talked about types of patients that they had trouble being empathic with, such as patients who do not participate in their own health care.
Definition

“It is like the Golden Rule, you know, where you treat others as you want to be treated.”

The Golden Rule was referred to by many of the nurses interviewed, as a working definition of empathy. The definitions they gave were casual and were not asked for specifically, but were taken from parts of interviews in which the nurses had spoken about the concept of empathy. Most of them did not mention the Golden Rule by name, but often a nurse would say something like this: “I think about if I was in this position, I would want the nurse to treat me this way, or make sure this was done.” Such a comment was a guiding principle that the nurses kept in their minds as they dealt with patients, and also served as an operational definition of empathy. One nurse said, “To me the bottom line is looking at an individual or a situation and thinking, How would I want to be treated? How would I want this outcome? You know, what would I prefer?”

The definition of empathy and the nurses’ descriptions of it came in the form of eloquent, sometimes touching examples that nurses shared with me from their working lives. Empathy plays an assumed role in the nursing profession. “I think just being a nurse you have to have empathy, I mean this isn’t a job you can go in for a paycheck, you know,” one said.

Several of the nurses said they had been told in school to have empathy, but even in school the discussion did not go beyond this rather vague discussion. Although empathy is recognized as an important aspect of nursing, it appears to be a difficult concept to teach. Referring to the educational process, one nurse said, “Well, that’s fine, you’re telling me everything about nursing, but you are not telling me how to do it.” Another nurse echoed this sentiment.
I just don’t think that [empathy] is really talked about, or you are given situations, “If you have this, what would you do?” I think that we are so focused on the hard facts, okay, so your patient has a low blood pressure, so this is what you are going to do. You know, “What things you are going to use?” But you don’t really talk about the emotional things you do that really make a big difference.

Another nurse talked about the difficulty of truly understanding the concept of empathy.

The problem is, if you are sending somebody out into the world who has absolutely no idea how to talk to people or if they think that they are being empathic…I think sympathy and empathy get blurred often. In school, when we first met with a patient, we were supposed to devise a plan of care and goal for that patient by the time our visits were done. Well, that right there tells the patient that we are here for that purpose only [the care plan]. We are not really here to be here with them. And I think before they do things like that they really need to educate students, because most of the people that go into the program, are people right out of high school. How many high schoolers know how to talk to people?

One nurse said, “I don’t know if empathy is something that you can teach. You can teach them to critically examine each situation, but I think that differs from empathy in the sense of the emotional involvement.”

These comments convey a sense of frustration. Nurses want to be as empathic as they are able to be; however, they also want all the tools they need to do so, and they are aware that they need help in learning what they do not know. While they assumed that nurses have empathy in general, they wanted help understanding how others feel in various situations, or how to deal with some of the situations they face.

Many a scholar has had difficulty discussing empathy. If nursing schools struggle with how to teach empathy, it follows that nurses will struggle in figuring out how to apply it in their work. However, this does not mean that the nurses do not have any ideas about it, or that they lack empathy.
Much of the direct discussion of the concept of empathy in the interviews was intellectual. The definition was in the background of the words. Some of the nurses made value-laden statements about empathy. For example, “I think that people who don’t realize that [empathy] is something that they are going to have to deal with in the profession of nursing,…are missing out on an entire aspect of what the job is.”

Another nurse said,

It’s the personal touch that we bring that I think is the most important thing. I do not think all nurses realize that. They do not realize the impact they have. Whatever little contact they have [with patients] is so important.

Some of the nurses tried to describe empathy. “You are putting an emotional aspect on it,” one nurse and added,

Medicine is a very emotional business. When people don’t feel good they are not at their best, and when you do not feel good it is hard to understand things. When it is a stressful situation, and a lot of times when they are with us, it is the most stressful situation that they have dealt with for awhile.

Hinting at the regressive state that illness imposes on people, this nurse recognized that she needed to help mediate that state with her patients.

One theme that was present in many of the interviews was that empathy develops with experience, either life experience or nursing experience. This may partially explain why it is so difficult to teach. Both older and younger nurses felt that nursing experience was helpful in developing empathy; however, more often than not the older nurses felt that life experience was the best teacher. One nurse described her thoughts eloquently:

I guess I have always kind of put myself in their position and to me, even though everyone perceives things differently, there is a kind of basic role you play. We are all human beings and we all experience pain and suffering and depression and the stresses in life. As you are older you have more experiences and that is how you acquire a lot more empathy, as if you have been through it yourself, so you kind of know that other side.
This can be helpful to the nurse because it helps her relate to the patient; or the experience may help to build her confidence, to understand what a patient is undergoing.

However, this same nurse went on to describe how empathy can be interfered with increasing maturity as well.

My perception of what is important [in life], and not important, [is] so totally different than before I had a child. Especially taking care of kids. Right after I had my son I was taking care of a very traumatic car accident, a child, and it was very hard… whereas, before I had a child…this never really bothered me. But it just had so much more of an impact on me personally after having a child.

In this case, the nurse’s over-identification with the mother’s position actually interfered with her ability to empathize with her patient.

Some nurses felt that empathy is a personality trait and either you do have it or you do not. “I think it is more personality, just ingrained personality, more than anything else,” one said. She explained that she felt that personality is formed by early experiences that affect the ability to empathize, that it is not necessarily something that is formed with continuing life experiences. Another nurse expressed a similar developmental approach to thinking about empathy.

I think it was the molding and the growing of [the nurse’s] personality, like the surroundings that they were in as they developed their personality. I think it says a lot about the type of family environment and how much time you spent together receiving and giving that feedback from one another, kind of those behavior checks that some of us do.

As nurses strive to be recognized as professionals, some of the more traditional concepts of nursing linger in the minds at least of some of the nurses. One nurse explained,

With nursing becoming more of a profession, and with feminism’s influence and that bringing more freedoms for women and things like that, I think that there has been a push for it to be more than it used to be, and I think that it is good. That if nurses could be more informed, have more knowledge and know more about
pathophysiology, and body systems, and medications, and things like that, then the tasks that we are asked to do daily you are doing with much more information and you can do in a better way. I am certainly not saying that I wish I was going back to the days of wrapping ripped sheets around someone’s arm, but I think that [tending to the emotional aspect of nursing] is also very important and when you take it out of the scenario, when you are just there to do a job, and that is how you see it, like, “This task is my job and that task is not”…I just think you lose a part of what nursing can be when you leave behind some of that older concept of nursing.

The nurse’s sole job, in fact, many years past, was to attend to the emotional suffering of the patient since there was not much else that could be done for them.

A few nurses talked about empathy and how it related to their faith or religious beliefs. One nurse talked about the non-judgmental attitude that her religion helped her maintain.

I have a Christ-like attitude with people, and [try] to remember that I’ve done things that I don’t like. Just because you smoked for 45 years and now you have lung cancer and now we had to do a thoracotomy and remove part of your lung, and other people are thinking “Well, you might as well be quiet and hush up and do your therapy because you caused this.”

Other nurses may deal with the painful experience of seeing a patient suffering from a health condition that has been caused by their lifestyle, and one way the nurse manages her own painful feelings is by blaming the patient and feeling angry.

Another nurse explained her views concerning letting people die “when their time comes” by talking about her religious beliefs.

I am a Christian so I am going to heaven when I pass away and my family members will too, as long as they are believers. I think if that was me laying there, my husband would know, “I can let her go because I will see her when I pass.” And you got family members [that] I don’t think have that, which a lot of people don’t, but I think that you don’t feel like that is what happens when [the patient] dies if you aren’t a Christian.

This nurse’s own feelings of distress seeing someone suffer, when death was imminent, were mitigated by her religious beliefs.
Balancing Act

“But then I sit back and for a split second I wonder, Why am I having that emotional response to you, what is it about you or your situation that is really just torqueing my screws? And if I can figure it out and then be okay with not being okay with that one aspect then I am usually alright. But if I can’t, if I am just uncomfortable with the patient or the family here, or if I can’t resolve it, if they are continually making me frustrated for whatever reason, then I struggle with that patient all day long. And you just do the best you can then.”

There is a very fine distinction between the properties of Balancing Act and the Limits of Empathy. There is considerable overlap between the two, and another researcher might have chosen to put them together; however, I felt that there was a difference between what the nurses needed to do to find balance in their feelings and actions, and dealing with the type of patient with whom it was difficult to empathize. In the property of Balancing Act, the nurses talked about the difficulties they encountered when they wanted to be or were required to be empathic, and they noted ways in which they managed difficult feelings or situations.

One dimension of the Balancing Act is along the continuum of how close or how distant emotionally a nurse felt toward her patients. Some nurses took this emotional stance for granted, assuming that the balance between closeness and distance was not a choice. In other words, they had never considered their emotional stance, nor would they have wanted to.

“You immediately attach to, I think, the ones that are sicker and are a little more vulnerable and are not able to take care of themselves,” one said. Another said, “I think you do bond in a strange way when you see [the patient] all peaceful.” “Attach,” “bond,” “connect,” and “click” are all words the nurses used interchangeably to refer to the
emotional stance vis-à-vis their patients. The nurses used these same words when they were describing empathy. One nurse said,

I think it depends on the personality. Because I click with some. If you feel more comfortable with somebody, then I think you are apt, I don’t want to say to give special treatment, but you want to make sure that you do well for them.

The empathic response of the nurse, in other words, is more easily elicited when there is an emotional bond with a patient.

Most of the nurses felt that some degree of closeness with their patients helped them personally and helped them provide good patient care. “Getting connected with my patients helps me from getting burned out, because I know that I am making a difference. On the other hand, if I don’t connect with my patients, I don’t feel good.” One nurse summed it up by stating, “Getting closer is better. It allows you to understand more what they need.” Another nurse explained her approach, “Emotionally, I pretty much open up everything.”

So what does “close” really mean? The implication in many of the nurses’ narratives is that feeling close to the patient means finding the emotional stance that allows them to merge with the patient temporarily. Closeness represents a desire to get inside the patient’s mind, or to merge and know more about their psychological and/or physical state. Nurses felt that achieving this kind of closeness helped them feel more empathic toward their patients.

Emotional distance implies that the nurse is not able to empathize as well. Some nurses felt, however, that emotional distance actually helped them with their patients. This may have to do with the individual temperament of the nurse and how she tolerates closeness and distance in any of her relationships. One nurse may want more emotional
closeness in order to feel that temporary merger, while another nurse may prefer to refrain from emotional closeness and be better able to think about what the patient’s experience might be.

Detachment, the extreme end of distance, would not allow for merger states or empathic attunement. When empathy is limited, one could conjecture that it is because something has interfered with the ability to empathize. The reasons for this vary with each nurse. For some it may be that the patient’s situation is too close their own life circumstances; or the nurse may become flooded with affect that relates to early childhood experiences. She may have a transference response that interferes with her ability to be empathic with certain patients.

One nurse reflected on not only the balance, but also the degree to which she felt a nurse was good or not based on how close she would get to a patient.

I still think that, you know, you have to have some attachment or you are not a very good nurse. I mean, I think that there is a kind of gray area where I can’t be friends with everybody who comes through the unit.

Another nurse said:

I think that it is a good thing, to an extent, to really be genuinely attached to your patient as far as having a common goal, wanting to get to a common place, whether that is out of the hospital or just over this brief sickness or whatever. But it is certainly very unhealthy to be constantly just consumed by your patient.

The degree of closeness and distance that was judged as good for a particular nurse varied from individual to individual.

Measures of emotional closeness and distance may have to do with the nurses’ own feelings about what is overwhelming. If a nurse is overwhelmed by her own feelings, it is better to stay at more of a distance emotionally. However, the phrase “consumed by your patient” implies that the merger has become more of a permanent
state. In this situation the nurse no longer has her own independent feelings; she has lost herself. And both closeness and distance may interfere with empathy. When the emotional stance is “too close,” it interferes with empathy. When it is “too distant” her own feelings may remain intact, but empathy may be interfered with in this case because the nurse cannot temporarily merge with her patient in order to gain the information needed to provide good nursing care. The balance is both delicate, and very individual.

Several of the nurses stated they felt that getting close to their patients was not something that they could choose not to do.

I worry about patients when I am not here and I wish I could not do that but I just worry about how people are doing. I thought I wouldn’t do that still, but I had trouble with that earlier when I was a new nurse. I thought that it would get easier. And it has a little bit. But I still have certain patients in my past that I will never forget and you get, you know, where you don’t want to, but you do get connected to people.

The longevity of the nursing career or the age of the nurse did not appear to make a difference in the closeness/distance dimension. It seemed to be a function of the individual nurse, her coping mechanisms, and her personality.

One nurse said, “It is hard to just drop it and go home and just say, ‘So be it, whatever happens, happens.’ There are lots of times that I call in the evening and I will say ‘Is he doing okay?’” Another nurse said, “It seems like unfinished business if you do not know. It is like a story and you want to know the end of the story.” Many nurses never see their patients again, so “knowing what happened” is a form of closure for them.

Some of the nurses changed over time in how close they were willing to get to their patients, as expressed by this nurse.

I used to think [about the patient], especially about trauma patients, I would call when I got home, you know and say “How are they doing?” Especially when they were right on the edge. I don’t call anymore.
This nurse felt that when she called to follow up with patients, she did not get the emotional break she needed during her time off from work.

Some of the nurses were very aware of drawing their own internal boundaries; they were willing to do some things and not others in the nurse/patient emotional relationship.

For me it’s not a hard transition because I have another life outside of my work. Even with patients that I don’t really get along with or that are a little cranky, I still think about them. You always go home and think about them. “I wonder how they did today” and “I wonder if they cooperated. I wonder if they are able to get out and move around.” You go through the whole thing. But I don’t think that it interrupts my daily life. The thoughts will come and go sometimes, depending upon the patient.

Another nurse spoke of how she manages to let the interactions at work not take over her feelings,

I guess my philosophy in life is if there were something I could do to fix the situation or change the course, then I would do that. But if I do not think that I could do anything to change the course of the situation, then I just let the situation go its own way. I don’t beat myself up over a situation that I have no control over.

Another nurse talked about her mechanism for dealing with painful situations and then moving on.

I just go into a room and cry a little bit and let it out. I debrief sometimes when the chaplains come in, I stay in the room, and I say a prayer with them. I let them [the patient or family] know how I am sorry. It’s a skill that you have to develop, but it is hard not to take it home with you. But if you take that home with you every night that would be hard on your family as well.

As this nurse describes so well, the psychological balancing act required is not only delicate for the nurse, it is extremely complex.

A few nurses felt that maintaining some psychological distance was beneficial for the patient. It was also implied that this was helpful to the nurse as well. One nurse said,
I think that they need somebody too that can distance herself a little bit and kind of help guide and direct them. Because if you don’t know the answers, maybe the social worker does, so you need to just keep thinking “Who do I need to bring into this? Do I need to bring in other services?” So you just kind of take your focus off yourself for a little bit, but… you don’t totally detach.

The balancing act is different for each nurse and it does not have to do with the medical condition or the patient’s personality as much as with the nurse’s emotional needs. Some nurses need to feel more closeness in order to feel good about the care they have given; others need more distance to feel good about their caregiving role. Individual responses allow nurses to manage their individual affective states and their jobs in ways that they find satisfying without crossing the line of “too much.” In turn, this allows individual nurses to provide their own style of patient care, and to “be a good nurse” each in their own personal way.

The psychological balancing act that the nurses have to manage is considerable given the number of patients they have, as well as the unique and different story that each patient presents. This nurse reflected on the balancing act and how she felt a nurse needs to conduct herself.

I know that [the nurses] are frustrated by what happened yesterday, but you need to take a breath, or go cry, and then come back and take care of people the way that you would want to be treated. I don’t know where to say it is stepping across the line.

This nurse had a philosophy that guided her, but it was not always easy to sustain.

Feeling too close to patients, however noble it may seem, may have a price for some nurses, as this nurse observed.

I think those nurses that do really have, like someone who has been in a car accident, and they are there for a long time…you see that with certain nurses, I do not think they are able to unhinge from work. I do not think they are ever not there [at work] and I think that would burn you out. I think it would wear you
down. If I went from one patient to the next internalizing and living their pain and suffering, I think that would just make me tired.

This nurse was describing the loss of objectivity in the name of empathy.

More than a few nurses felt that the boundary of closeness was breached when nurses became friends, or personally involved, with patients after their hospitalization. Only one nurse I spoke with said she had become involved with patients after discharge and for her it was a rewarding experience, though not one she referred to as a friendship.

There was a range of opinions on this matter. One nurse said,

In order for me to give good health care, I don’t feel that it’s necessary for me to be the friend of the family and know everything about everything in their lives...I could give really good health care. I could be a great nurse and very sympathetic, and love the patient and take care of them and give them great emotional support with out spending 30 minutes of my night just chit-chatting with the family.

Another said,

I think your patient is your number-one priority and if you are consistently turning the conversation onto yourself and not listening to your patient, that is a problem. I’m sure there are some nurses who find an emotional outlet with their patients instead of getting it from them. You know, feeling like they are getting too close to their patients, sure, I mean, I don’t think that’s healthy, that is not healthy for them and foremost not healthy for their patients.

One nurse commented that she had known more than a few nurses over the years that had married their patients.

Far from being friends with patients, a few nurses said they considered what they thought the patient wanted in terms of closeness.

I try not to push people into their emotions, not because I don’t know those kinds of relationships, but I know other nurses might try to break down that barrier. If someone doesn’t want to be that personal with me I am not going to push them to be that personal.

Another nurse stated, “There are some [patients] who need/want that close of an interaction, or some who are not that comfortable with it,” echoing the previous nurse’s
statement. Both of these nurses are taking the position that the emotional stance should be determined by the patient’s desire to be close or distant.

Another dimension in the category of Balancing Act is the attempt to balance the nurse’s technological and physical duties with their people skills. This is a different kind of balancing act. Many of the nurses gave examples of trying to strike this delicate balance. One nurse said,

I feel that if [the patients] are talking to me and I am concentrating on my work so I have to ask them to repeat what they said, it is not really registering with me what they said. So I get frustrated and I am mad at myself because I just really have to focus on that part, on not getting short with them, or answering their questions and talking. It might be that they just want to have a conversation, so I don’t want them to feel like they are being ignored.

This is a very difficult balancing act: paying attention to the psychological needs of another person, while at the same time juggling technology, which requires operating from a different part of the brain. Another nurse explained how she found this balance.

What would be really easy is to let technology take over. You can just focus so much on that that you lose sight of what’s going on with the patient. Sometimes I have just told the patient, “I have to really concentrate on this and when I am done doing that then we can talk about this or we will do this thing.” So you have to separate it.

This nurse spoke about the anxiety she understood could be elicited in her patients when her focus was only on the technology,

I might look them over quick because I think that if you are ignoring something really important you are in big trouble. But I want to not walk in the room and spend 15 minutes on the computer before I even say hi to someone. To me that is like “Who are you, and what are you doing in my room, and why are you not talking to me? What are you looking at that I can’t hear about?” I mean, how people go about their tasks can really say things to people that you are not meaning to communicate at all. So if you are busy and hurriedly moving around the room, scribbling down numbers and writing things down or being concerned about that beeping and not telling someone that it is just beeping because they need to change your IV fluids because it is almost empty, then they are wondering
“Why is that beeping, and how come you are not telling me about it?” and you can create a sense of anxiety in people for no big reason.

Attuned to her patient’s emotional response to her activity in the room, this nurse juggled imagining the emotional responses of her patient with the technical demands of her job.

Another nurse talked about the balance she tries to find when her own feelings are stirred up.

Yeah, it is really hard to do. If you find yourself being too emotionally involved with the patient and you notice that you are being more and more emotionally reactive, then if you are able to think it through, then it is an issue you need to examine on the inside.

There is a delicate balance between what is being stirred emotionally in the patient and what is being stirred in the nurse. She may be having a countertransference reaction to the patient’s affective state that is hard to recognize in the moment. Some of the empathic attunement needs to be inwardly focused for the nurse’s introspection.

Some of the balancing act came when dealing with difficult people or delicate situations. One nurse explained.

For communication and effective listening it is so hard when someone is attacking you personally and sometimes you get defensive, you can’t help but get defensive. For the most part I try to stay calm and explain the situation to them. If they want to leave because they are unhappy, then that is their prerogative.

This nurse gave another example.

Most of [the nurses’] issues come when we are sustaining life and our opinion is that we are hurting the patient, we are hurting that person. Anything that we are doing to the person is uncomfortable, and it’s got to be painful, and we know the outcome is not a good quality of life. They may be mentally comatose and not know their existence, and we keep being pushed by family members who find it hard to let go, which I understand. But I think being there day in and day out you do become more like, “Ahh, if they just knew what we do to this person day in and day out and hour after hour,” and I think that is when I become jaded. That is when you kind of drag when going into that patient’s room.
This nurse is reaching her emotional limit and the warning sign is her acknowledgement of the “drag when going into that patient’s room.” Her affect is beginning to determine her actions, rather than her empathy.

Another balancing act that the nurse must consider is how she will deal with difficult patients and how that sometimes affects her feelings towards the patients. This overlaps with the property of Limits to Empathy and will be discussed at greater length in the following section. However, one nurse noted,

No, no, I will meet everybody’s little needs and I don’t distinguish how I feel or how much energy I give to you if I like you or if I don’t like you. I’ll get you a cup of coffee if I hate you or if I don’t like you, I will get you a blanket, I’ll get you what you need, I’ll get you a glass of water, I’ll get whatever, but I may not have joy in it. If I like you, I will have my joy in it. I don’t even know if the patient would know the difference, to tell you the truth.

Another nurse simply said, “I may find myself maybe going more through the motions as opposed to making a little bit of small talk.” Several of the nurses could talk about having these feelings; however, as implied by these nurses, they did not feel that their basic ability to provide patient care is affected by not liking the patient. They try to keep the way they feel about the patient to themselves. They are working hard in the moment to manage their own affective states and that is the balancing act at that moment.

Other nurses recognized having the same kinds of difficult feelings; however, their response to them was a little different. “I mean you have to make yourself sometimes go back [in the room] because it’s like I said, you can find other things to do. It’s not like you are sitting in back room doing nothing.” This nurse is aware of her wish to ignore the patient and her difficulty giving the care the patient may need at times. Avoidance is a way of dealing with her own affective state. Another nurse talked about working with a difficult patient.
I tried what I could and she said, “You’re hurting me,” and I was trying not to. Well, I said, “Be patient with me and let me see if I could just kind of find it for a minute and we will work around your comfort.” Oh, she was just so vile. I just gave up and I walked out the door and I told the nurse “You can have her!”

For this nurse it was too difficult to process the narcissistic rage of the patient. She had reached her personal limits.

There is another kind of balancing act that several of the nurses found difficult to talk about or even approach as a topic. That is how a nurse managed her aggressive feelings toward her patients. Aggressive feelings are normal; however, if the nurse felt she was not allowed to have them, much less acknowledge them, then she may have had trouble dealing with them. Some of the nurses did speak about their aggressive feelings and how they balanced them. One nurse simply said, “You have to watch what you say, because I would just as soon tell her to get up and do it herself, but you can’t do this.”

One nurse said,

I find that there are patients who either won’t listen to you or they think they might be right, but really, I am sure I have never had abdominal surgery myself, but being trained to take care of these patients is like, I think I know something.

It is hard for some nurses to understand why patients do what they do, which makes them frustrating to work with or at least not gratifying to care for. This nurse implied that she took it personally when patients did not listen to her. She was offended, and that made it difficult to care for the patient. Another nurse echoed this frustration, but found a way to overcome it. “Part of me is like, ‘Okay, well then, suffer the consequences,’ but the other part of me is like, ‘No. I don’t want you stuck here longer because you are not listening to anybody.’” This nurse was ambivalent: she wanted the patient to pay a price for not listening, but at the same time she also felt compassion for the patient, as well as the desire to provide good nursing care despite the difficulty of doing so.
Sometimes aggressive feelings came out in ways the nurses felt were not harmful to the patient. One nurse had an inner dialogue with herself that gave her some relief.

I go in and say, “Do you know what my goal is for this shift?” She will say “No,” and I will say, “To get you some sleep, to get you to rest.” But really in my mind I am saying, “I want your ass to quit calling me on the call light.” So, “I want you to get a good night’s rest.”

Another nurse said, “For me, I don’t give my honest answer, I mean this is going to sound terrible to say, I guess, but I have an incredible ability to put somebody down and they don’t even realize I am putting them down.” Whatever the outlet, aggressive feelings have little place in the lives of the nurses and it may be helpful to them if they were to have effective ways to help them manage the normal, but troublesome, feelings that arise in such a high intensity job. Often, when patients are difficult the nurses feel at a loss with how to respond.

Another nurse told the story of a patient who was ringing the call light a lot, and how she dealt with it.

So the call light is going constantly. So, I went in one time and I said “What do you need, what can I do for you?” “I’m thirsty.” I said, “Well, your water glass is right there.” She said, “Well, I can’t see it,” and I said, “Well, open your eyes!” “I can’t because there is a washcloth on my eyes,” and I said, “Then move it.” I mean by that time I was not empathic, I was not sympathetic. I had [other] patients that needed help and she could have very well have taken that washcloth off her face herself. So, as the night progresses, you know, the call light continues and you start getting shorter and shorter or you don’t answer the call light, and you know you can’t do that, so you go in, you do what you need to do, like the tough love thing with the washcloth. Sometimes you actually have to have the discussion that “I am not a servant. I am here to help you get better but the things that you can do, you need to do.”

While this nurse set a limit with the patient, it was difficult for her to contain anxiety that had turned into excessive demands. This nurse had difficulty seeing the regressive feelings of the patient.
One nurse told the story of how she felt when she was angry with a patient and why she needed to have her anger under control.

If you are angry with that patient for whatever reason and you walk in there and you need to get a job done, like getting that person out of bed, you are going to be impatient and want to pull on their arm and, you know, you are not even going to do a good job anymore at just the physical stuff, much less everything else.

Another part-time nurse talked about how being angry with her patients made her feel about herself.

Sometimes I find myself getting so short, almost too short with my patients. And then I get upset with myself because I let myself be angry, instead of making it controlled. That is when I pull back and go, okay, it is a good thing I am not here all that often.

A common way to manage aggressive feelings is to not agree to work with the patient on a subsequent shift. One nurse said openly,

The other thing that I like to do is sometimes I’ll keep the same patient for those three days, if they are not crazy. If they are crazy one day, that’s it! I don’t get them a second day. The first thing you will hear nurses say is “No, I had that crazy fool yesterday. I am not taking him today.”

Sometimes it is a matter of nurses balancing their own feelings and knowing when and how to turn them off for a while if they are getting to be difficult to manage. Some of the nurses said they watch out for each other in this regard as well. One nurse spoke of noticing the feelings of a colleague and then respecting the other nurse’s wish to move away from the feelings.

I went to work that day and I told a nurse that cared for [a patient who had died] that day she went home. I said, “She died.” She said, “Well, at least she got to spend some time with her kids.” We sat there for a minute and then she said, “I don’t want to talk about that anymore.” And so, kind of we ended that. She just needed to flip the button off, because she knew she was going to cry again.

Managing their own affective states, whether they are tender or aggressive feelings, is just one of the many aspects that nurses must balance in the course of their daily lives.
Limits to Empathy

“At a certain point you really can’t put yourself in another person’s place.”

The broadest limit to empathy reported by the nurses was not being able to relate to another person.

Because you have the experience of taking care of maybe somebody like that type before, but if you haven’t been through it, I don’t think you really know. And taking care of somebody doesn’t mean that you know what they are going through.

Another nurse said,

I will say that if there are some people that are harder to relate to I don’t change the way that I approach them or the standards of care that I give, but I certainly don’t engage with them as easily. The treatment they receive is always the same standard. It is just that I may not openly engage them in a conversation after I give them their morphine or whatever it is.

One nurse recognized her own limitations. She said, “I have a kind of adolescent point of view sometimes that I can fall into, where we are all the same, and so if I can do this, you can do this, which I realize is not very mature.” Another nurse said she had a limitation in empathy for patients when she had a strong disagreement with a moral choice they had made. She gave an example:

A patient who is suffering after having an abortion and she is in a lot of pain, it’s like, I do feel badly that she is hurting, but I can’t empathically join with her. I just don’t engage with her as much as I would a patient who hasn’t made that choice in their life.

By their own admission, it was hard for nurses to engage with patients when they felt negatively about the patient’s choices in life. Most nurses try to be as objective as possible; however, their own feelings and biases affect them, just like anyone else’s do. The difference is that when it is a nurse, it can affect the level of care a patient in a
dependent position receives. One can hear in the background of the nurses’ comments the wish not to withhold care, but in the foreground is the fact it does happen, even if the nurse works against the impulse.

At the opposite end of the spectrum are those nurses who have had personal experiences that made it difficult, if not impossible, to care for certain kinds of patients. It was simply too close to them. Some felt that their ability to be empathic was impaired by the feelings that were triggered in them by the patient’s illness or situation. One nurse said,

I would rather not take care of [children] and the only reason is, I can take care of a sick child, but my issue would be every time I had to deal with a trauma on a child I would be so involved with that patient that I would be afraid that I would neglect my other responsibilities.

Another nurse looked away from me as she said, “I had a family member die who was close to me, and when I see an oncology patient I would see my family member, so I needed to step away.” Another nurse said that after the death of a close family member it had affected her judgment about end-of-life decisions:

I found that I was ready to shut people off faster. Somebody would be sick and I would say, “Why are we doing this?” I was like, okay, “Why are we doing this? Just stop this and let him die.”

In retrospect, this nurse’s personal experience had colored her feelings about the treatment of patients for a time after the death of her loved one. Sometimes close personal experiences interfere with the nurse’s ability to be empathic for a time. The key here is that empathy is not a static state, and it is fluid. The capacity to empathize is closely related to the state of cohesion that the nurse feels internally and that may be affected by things that are currently happening in her life.
It did not take having a family member or someone close to them die to have patient’s experiences feel too close. Sometimes the patients were just simply too close in age to the nurse. One nurse said,

I loved that floor, but after a year of doing that, I got tired of seeing people my own age end up paraplegic or quadriplegic, and I was so young then. It was going to be a lifetime of a wheelchair for those people.

This nurse may have over-identified with her patients. However, she may have also become overwhelmed with the chronic nature of the patients’ condition.

Some of the nurses told of limitations that were imposed upon them by the system.

I think a lot of nurses would like to be more empathic but feel like they are bound by the system they are in. They can’t spend another 30 minutes going over instructions with this patient. It is like, “I would like to make sure that this patient’s Aunt Susie knows that these are the phone numbers and blah, blah, but I really can’t do that right now. I can’t let that be a priority now.”

Difficult patients were a topic of discussion with all the nurses I spoke to. Taking care of patients who elicited their own regressed feelings was not only easily misunderstood, it was confusing and interfered even further in their ability to empathize with their patients. “It is hard to be nice to someone who is mean to you,” one said, and another, ”You only do the minimal care” and still another “I am saying to myself I wish I could get out of this room as soon as possible.”

Nurses did not like the contagion of anxiety, the projection of anger, or the anxiety that was manifested by patients’ demanding behaviors. This is often what they meant when they talked about a “difficult patient.” Regressive states in patients were the least tolerated. The nurses said they felt that if some patients could change their attitudes, then their stay could have been better. One nurse said, mimicking a patient’s whiny
voice, “We had this one patient who just said, ‘The only nurse who has been nice to me is Z, my whole stay here,’ and this other nurse said [to her], ‘You never said please, you never said thank you once.’”

Nurses do not like to interact this way with patients. The nurses want to get along with patients and have good feelings towards them, but when faced with a challenging situation they cope the best way they know how. “It is hard, but I think what I normally do is, do what I have to do, and if they don’t want to talk, then I just do the minimum.” Not knowing what else to do, this nurse withdrew from her patient. Withdrawal helps protect her from further rejection or feelings of helplessness.

Several of the nurses spoke about ways in which they could monitor and deal with challenging patients as a unit.

I have done the whole thing where you take on your work one night and you will come back the next and you will take the same patients, you will have some continuity that way. Then the third night, if they have been a difficult patient or if you have had problems, you pass the patient off. And I think that is what is great, that we recognize in ourselves, I just can’t do that patient tonight. You realize that you are not giving him good patient care. And you may not even loathe your patient, but you are not giving good emotional support. That is what you are not giving anymore. And that bothers us.

The nurses on this unit felt free to take care of themselves, and each other, while recognizing their own limitations.

Different nurses reported different kinds of patients they had trouble empathizing with, though there were several common types of patients that the nurses spoke about. Patients who did not help themselves in their care, or who had contributed to their decline in health were the most common kind of patient the nurses named as being difficult to empathize with.
Something that I struggle with is the huge, morbidly obese people who have, by the time they get to be 60 and they get sick and it is not just muscle atrophy, they can’t lift that weight anymore. They can’t lift their leg to move it over on the bed and I really don’t have empathy for those people as much as I do others. You know when you get a 40 something-year-old person in there that is five foot whatever and 460 pounds and they are short of breath. Well, yeah, “Did you think that you can keep doing this and not have problems?” I mean, I feel for what they are going through at this time…[but]…

Another nurse spoke of patients who are hard to care for:

Because they demand a lot of time and physical labor and the patient expects you to do so much for them even physically, demanding lifting and moving them. Those are the ones that get to me.

Some patients tried the nurses’ last empathic nerves when they had expectations beyond what the nurses felt was reasonable. One nurse named a type of patient she had trouble dealing with. “People who take advantage of the system are the ones that bother me more than anything. Rarely do I have empathy for that. These people walk around with a sense of entitlement.” Another nurse told of a kind of patient that engendered similar feelings.

I’ve always gotten frustrated with repeaters or people who aren’t willing to take responsibility for their own healthcare or their own bodies, people who would rather put more time and energy into their car than understand how to take care of themselves. And then they come in, and I have this sense of well, “You totally disregarded your own body, your own healthcare, and now you expect me to fix it.” That really rubs me the wrong way.

One nurse said,

The people that drive me most nuts, I know this is going to sound terrible, but the people who are extraordinarily whiny, whiny voices, I don’t know what it is. I can deal with people who are hurting, I can deal with people who are needy, but if they say …[mimicking a whiny-sounding voice] and they do that all the time, I’m sorry, I know I should have more empathy for them, but I can’t. I think I feel like they are playing me.

This level of regression in the patient interferes with this nurse’s being able to be empathic. Another nurse talked about having to give pain medication to patients she felt
were not in either enough pain or “true pain” but were instead “drug seeking.” She said, “It’s frustrating because we were always taught that pain is what the patient says it is.” The common theme here is being taken advantage of, whether it is the system or the individual nurse being taken advantage of. Many of the nurses had little tolerance for that. One nurse summed up patients who were unwilling to help themselves in these words. “If you are not willing to help yourself, how much of my time and effort should I put into it?”

One thing that nurses did not mention often even though it was in the background of their complaints about patients who did not care for themselves, was the physical toll that lifting takes on nurses’ bodies. Lifting heavy patients in the bed, or helping someone who is dead weight out of bed is an occupational hazard that the nurses take on willingly. But there is a quiet resentment when their bodies pay a price for the labor put into lifting and caring for patients who do not care for themselves. It is interesting to note that a few nurses mentioned having had job-related injuries; however, there were no outward complaints.

Conclusion

The properties of Definition, Balancing Act, and Limits to Empathy were explored in this chapter. The definition of empathy was demonstrated throughout the chapter in examples given by the nurses. There were several dimensions to the property of Balancing Act, including the individual differences in the nurses regarding the degree of emotional closeness and distance that nurses felt with their patients, balancing challenging patients and delicate situations, and finally, balancing their own aggressive
feelings that are sometimes elicited in dealing with some patients. The Limits to
Empathy were mainly the nurses’ difficulties with particular kinds of patients. The most
common kind of patient that was difficult for nurses to empathize with were patients who
did not help themselves.
CHAPTER XI

BURNOUT

“I had all the classic symptoms. I didn’t like my job, I’d wake up in the morning and try to figure out what I could call in for, aches and pains started up, all that type of stuff.”

Introduction

The category of Burnout describes what can happen to nurses when a combination of personal and professional stressors make it difficult for them to perform their jobs as well as they might otherwise. The properties of Descriptors, Contributors, Progression, and Inoculators offer many different descriptions of burnout, detail the nurses’ ideas about what the contributors to burnout are, and describe the emergence of a series of events that converge over time, resulting eventually in what we call burnout. Inoculators are personal strategies that nurses have developed for either preventing or recovering from burnout. The last property, Burnout and Empathy, describes the nurses’ thoughts about the relationship between burnout and empathy.

Descriptors

“IT is very sad. She has always been someone that I admired when she was ‘on.’”

None of the nurses interviewed felt burned out at the time of the interview. Some of the nurses I talked to said they had experienced burnout in the past and were willing to talk about their experiences. A few said that they had never felt burned out.
The nurses used short descriptors to talk about other nurses they knew who were burned out. However, the term “burnout” was used to describe a variety of symptoms, feelings, or phenomena. There did not seem to be a clear and consistent definition of burnout among the nurses interviewed. Their descriptions ranged from vague comments about the general nature of burnout to observations of other nurses and also to some accounts of experiencing burnout themselves. Some nurses said, “They don’t really use the word ‘burnout,’ but, boy you can see it in their attitudes.” Another said, “When someone is stressed out you can clearly see it and they carry that all day. And if they come back to work the next day and they haven’t fixed the stress, then it is the same thing again.”

The first and most common word that the nurses used to describe a nurse who was burned out was “angry.” “She is angry, very angry, and unfortunately she hasn’t learned. I mean you can tell her, but until you learn that your happiness comes from yourself, then she will stay angry.” Another said, “The first description that comes to my mind is angry. Just frustrated. Not wanting to be there. Very judgmental.”

“They are tired and they complain,” one nurse said, and another noted, “Some people--you’ve seen them--some people can’t smile and I don’t know what happened to them.” One nurse noted that the behavior of a burned out nurse was not necessarily consistent:

You know, sometimes they are compassionate, other times they are very, I don’t want to say like a drill sergeant, but they say things like, “We are going to do this, we’re going to do that,” and they don’t really listen to the patient. They get their work done and get out as fast as they can.

Another nurse noted,
I think they are just kind of removed from dealing with the situation, they are stressed out, they don’t want to deal with it. It is like, ‘Let’s just medicate him and then I wont have to deal with it. I don’t have to stand and talk to them and try to do that part.’ You know sometimes that is all it takes.

Another nurse’s statement described a characteristic pattern of burnout.

They may start calling in a little bit more often, not smiling and socializing with the staff the way they usually do, be withdrawn. I have seen some errors or complaints that are very atypical of the person, I mean like performance things.

One nurse said of a coworker,

She calls in a lot, when people are burned out they call in because they don’t worry about how their coworkers are doing. I have gone to work not feeling well because I know that my unit will suffer if I am not there or someone else is not there.

Another said, “She’s not productive, she is not a team player, I know she does not get along with the others very well, both from her standpoint and from theirs.” Another said, of a colleague, “She is not doing [her job] well, even though she keeps working all these extra hours, she is messing up.”

Several nurses noted that a burned out nurse does not have the same attitude or outlook that she once did. She withdraws from coworkers and patients alike. She makes more clinical errors, perhaps due to decreased concentration. She is irritable at best, outright angry in other cases. She takes her anger out on both her colleagues and her patients.

Most of the nurses had not had personal conversations with the nurses who they had observed were burned out; instead they tended to try to stay away from them. They did not feel that they could say anything helpful to the burned out nurse. Perhaps as a result of the other nurse’s irritability or withdrawal, common symptoms of burnout, most nurses did not feel that they could approach burned out nurses. Some nurses felt badly
for them; others were irritated with them because their poor work performance was negatively affecting their already stressful workload. These nurses did not feel badly for the burned out nurse at all, but felt she should get help, make a change, or get out of the job.

One nurse described the progression of a worsening pattern with a burned out nurse.

She will say “I don’t have time to talk to you about this right now.” She doesn’t tell you “I’m sorry, I’ll be back later and we can talk about this in detail.” There is this hurried sense. This sense of “This is not important enough for me to stop and hear you.”

This nurse went on to describe the effect of this kind of behavior on the other nurses.

People automatically put a wall up and then the rest of the day you are fighting that. I think when nurses start to feel burned out and they start to act short with people or curt, they communicate that. People can tell when you just really don’t care about what they are saying.

This nurse described the defense mechanisms that others construct in response to a burned out nurse’s behavior (“a wall going up”), and alludes to the negative chain of events one can imagine might be triggered in response to that: for example, the less cooperative patients being provoked, or patients lodging complaints against the nurse.

Some nurses seem to be aware that they are feeling burned out.

The reason I am thinking of this person as burned out is because I am not the only one who is wondering if she is burned out. And those are actually the words she has said to me, “I wonder if I am starting to get burned out.”

This kind of open acknowledgement of burnout on the unit was a rare occurrence in the interviews. If there were nurses on the unit who knew they were burned out, they did not seem to be talking about it openly. The nurses who described burned out nurses described behaviors they observed, or mentioned what others were talking about. It was
significant that no one was talking to the nurses who were described as being burned out, unless the burned out nurse initiated the conversation herself. Perhaps the nurses feel it is “off limits” to speak about burnout to a colleague.

Contributors

“I understand the reason why people work 12 hour shifts, but I think that’s a major reason for burnout.”

Everyone interviewed had a theory about the causes of burnout. A few of the nurses felt it was caused by a single thing, while others felt it was brought on by a combination of stressors. Different nurses named different stressors. The nurses’ descriptions of the contributors were often voiced in terms of imagining themselves in the other’s place. Sometimes they described burnout in terms of behaviors or attitudes they observed in other nurses.

It was in this part of the interviews that a picture of burnout emerged through personal stories, but burnout was only hinted at in most of the interviews at this point, and voluntarily acknowledged as such in only a couple of the interviews. Most nurses felt reluctant to disclose this kind of information. Some felt self-conscious about their own experiences with burnout, and seemed to feel a sense of shame. After they felt more comfortable with the interviewer, some of the nurses began to talk about their personal experiences. Four of the nurses were interviewed twice, and in each case in the second interview the nurses felt more comfortable and began to speak a little more freely. A few of the older nurses seemed to feel more comfortable talking about burnout. These nurses seemed to view burnout as a natural developmental phase in a nurse’s career, or a reality they had learned how to manage.
One nurse named her own anxiety about her work as a contributor to burnout.

Oh, it would make me so anxious! Some people don’t care, where [the demands] would be so wearing on me. I couldn’t get to every patient fast enough, or I couldn’t give the kind of care to each patient [that I wanted to] and that wore me out like you have no idea.

Another nurse spoke more globally, but also acknowledged the importance of personality type in managing burnout. “You have to like people. You can see pretty quickly when a nurse doesn’t like himself or herself, because they don’t treat others well.” For this nurse, “liking oneself” translated into providing good treatment of others and therefore being a happier person and not burned out. Another said simply, “I do think there are different reasons why people burnout and I think a lot of it has to do with personality.” She implied that there is something not quite right with the personality of someone who burns out. With many of the nurses there did seem to be an unspoken assumption that if a person is strong enough, they will not burnout.

Talking about burnout was not a difficult topic if we discussed it in the third person. The discussion became more difficult, more vague, and less fluid when it became more personal. One nurse spoke about personal characteristics from a different perspective.

If you allow people to cross your boundaries, whatever they are, and you don’t stick up for yourself, or you don’t attempt to change the situation then that is bad. But anytime anyone crosses your boundaries and you aren’t able to fix it so that it doesn’t happen again, you get defensive and angry with that person. So I think not letting others walk all over you is extremely important. Because I’ve had days where I was very frustrated and angry with a patient and their family thinking, “What in the world?” And just that they stepped on whatever boundary and continued to do so and I felt I like I couldn’t say anything. I left the situation feeling angry with that person. If you don’t have boundaries and limits that will totally make you burnout. Because then the one thing that you are hoping you are being good at during the day is the one thing that is making you angry and drained.
Another nurse felt that multiple factors lead to burnout and that it is a natural phenomenon for nurses, especially for nurses who may not be passionately committed to their work.

Certainly in any service industry, but particularly in nursing, if you don’t have a passion or a heart for it, there are lots of things you can look at, but it just all piles up and you end up burned out.

Another nurse pointed to colleagues as a stressor. “For the most part people getting burned out doesn’t have to do with the patients you are working with, it has to do with the nurses that you are working with.” Another nurse alluded to the same problem a bit more specifically.

You give everything you can possibly give and hope that it is enough and the ones that don’t, you try to make up for them. And I think that is a way people get burned out as well, when they are pulling up the slack of others.

One nurse named the many external stressors that affect nurses and contribute to burnout.

I think that people get burned out when the other things that control the situation, like staffing, or coworkers, or scheduling, or your outside life just get in the way of who you normally are. I think a lot of really good nurses get burned out and frustrated and that is too bad, with the nursing shortage. It is tough to keep people in a place where they are able to do their jobs.

One nurse implied that the personal rewards of the job are necessary to help the nurses keep going.

I think for me it was that you just don’t feel like you were doing any good. Once you are burned out, you don’t have anything left to give. You have to get something back. If you don’t, you just can’t keep doing that work.

This nurse seems to suggest that implied that without this intrinsic reward, which is defined differently by different people, the more susceptible to burn out one becomes.
Many of the older nurses commented that they thought that nursing experience helped in managing burnout. One nurse pointed out that this same phenomenon might contribute to burnout in younger nurses. “When you are older I think you are comfortable with your care, you are comfortable with your knowledge base, and I think that makes it harder on the younger nurses.” She was implying that because they are less confident about their skills and experience, less experienced nurses are more susceptible to burnout.

**Progression of Burnout**

“I was talking to my girlfriend who works with me, and she said ‘You know, the last couple of weeks I have been saying that I’m burned out.’ But she doesn’t think she is really burned out. She just needs a vacation, she needs a break from her life, it is not work. It is everything together, I think, because the gals that I know that are miserable at work are also miserable at home. It is not just work.”

Once the nurses began talking about their own experiences with burnout, an interesting theme emerged. Burnout is a complex phenomenon and part of what makes it complex is not only the difference in how it is defined, but also the fact that it takes place over time and involves many different aspects of a person’s life.

Over the course of the interviews some of the nurses described a progression of events that led, over time, to the feeling of what they called burnout. The descriptors and contributors are part of the story; however, in many cases the story involved a series of events culminating with, as one nurse put it, “the straw that broke the camel’s back.”

Most of the nurses interviewed did not feel that it was just one thing caused burnout for everyone. They felt there were individual differences in why it came about. One nurse talked about this phenomenon:
Depending on the person, it is because of different things. It depends on the nurse. Different people have different baggage. For me it had to do with things that were happening at work. For someone else it may be things happening at home. For some other people it may just be their personality.

One individual difference might be that for some nurses, nursing was an unfortunate, or inappropriate choice of profession. One nurse talked about a young nurse she felt was burned out. “She is like 22 or 23, and the other day she made the comment ‘This isn’t what I thought it would be.’” Another said, “We’ve had new grads come that we knew were not happy, you know they were just not happy doing this work.” This contributor to burnout is a feeling of disappointment in the nature of the work.

Different nurses named different stressors they felt contributed to the progression of burnout. One said speaking of a younger colleague,

She has only been there not too much over a year, and she asked me the other day, “How do you keep from getting burned out? I am so burned out.” But she has a baby at home and her husband is in school and so I think it is more than nursing burnout, I think it has to do with her whole life.

This nurse did not feel that it was the job per se that was causing her coworker to burnout, but all the additional stressors in her life. Another nurse said, “There is one person who comes to my mind. She was going through a divorce and I think her personal life was affecting her professionally. She ended up leaving.”

Another nurse talked about how it was easy to be confused about which stressors in a nurse’s life were causing burnout.

When you are spending 12 hours with [a patient] one-on-one time, you don’t realize what you are really mad about is that fight you had with your husband last night and the fact that you really haven’t given that anger up yet, but you are not emotionally/spiritually okay yourself.

This displacement of feelings may blur the picture for some nurses.

Another nurse who is a working mom described a common sentiment this way:
I was with my kids and worrying about work, or at work and thinking about my kids, and I wasn’t functioning well. So I would just hit the door and think, “It’s done and I don’t have to think about [work now],” and go to the next thing. Now, the down side is, and I have had this happen multiple times, I wake up in the middle of the night thinking, like it wakes me up and I will think through like, “Oh did I give that drug?!” Stuff like that.

This nurse tried to keep work and home separated in order to cope with the multiple demands of her life; however, she was not really able to achieve the separation. In her case, anxiety about her performance was even interfering with her ability to sleep, creating yet another stressor, fatigue.

Another nurse felt that burnout was sometimes due to the lack of challenge in the job. “There are a lot of ways I see burnout, but sometimes work becomes so mundane and routine. Some nurses are ready for bigger challenges.”

Some of the descriptions came in little vignettes, stories that emerged over the course of the interview and were not always told all at once. One nurse felt that she had been burned out for a while about four years earlier, due to job pressures. But as the interviews progressed, a more complete and complex picture of the causes for the burnout became apparent.

Okay, one time that I can think of I was just fed up with it, but I don’t know if it was just nursing. I don’t know, I had been sick, my boyfriend was very ill, and I was trying to care for him. I had just finished some classes and I was trying to work extra hours, since money was tight.

This nurse ended up quitting her job after she was required to work what she felt were unreasonable hours. And while many other stressors were happening in her life at the time of feeling burned out, she attributed her period of burnout to pressures on the job.

Another nurse did not put the whole picture together all at once, but as she recalled her experiences she realized there were many stressors that had contributed to
her burnout. This phenomenon may be due to the fact that burnout occurs over the

course of time. Often the reasons for burnout are not clear, even after time has passed. It

appears that hindsight is not necessarily 20/20 with burnout. This nurse said,

It wasn’t just one thing, it was a whole bunch of things. Honestly, I didn’t recognize it until I woke up that one day crying. Later my doctor said “You went a year and a half where you should have gotten help for stress,” but I thought I was dealing with it just fine.

Another nurse commented that she did not know what was happening to her until it was too late.

I got angrier and angrier and I was not nice to work with because I was angry about a number of things. I ended up in the disciplinary process. I knew I was having issues, but I didn’t know how bad the issues were until after it was all over and when I looked back, I was really nasty. It all lasted probably about a year.

One nurse who spoke openly about her experience with burnout also alluded to stress in her personal life that may have led to burnout.

I think my burnout was worst when my husband died. It lasted about two years. But I just got where I was snippy, in general just kind of mad. I was tired. I was not sleeping well. I lost a lot of weight and I wasn’t eating because my schedule was different. And then I had aches and pains that you get from stress. My husband had been ill for a couple of years and before he got sick, I was sick.

This nurse’s symptoms suggest a depressive episode, and when she was asked to comment on the possibility that she had been depressed, she emphatically agreed; that what she had called burnout was actually depression.

Another nurse attributed her burnout to both personal and professional stressors.

I went through this long period of two years where I had a bad manager and that was just awful for me. And then I was having marital problems. We worked through that, and then my dad ended up dying. Plus we were raising kids.
This nurse was very clearly aware, at least in retrospect, that there was a build up to her experience of burnout; however, her comment at the end of her story was that she had not seen it coming.

One seasoned nurse’s account of her experience with burnout emerged over the course of the interview. At first she named the type of patients she was dealing with as the cause of her burnout. “I think it was more the type of patients that I was taking care of. They were traumas; it was very depressing. It was like you didn’t see them getting really much better, especially the head injuries.” Later in the interview she reflected on another reason for the burnout.

You know, I was frustrated with the nurses that I worked with because they weren’t very nice to their patients. I think I was burned out on the other nurses. So I guess it was a combination of both the patients and the other nurses.

When I asked her about what was going on her personal life at the time, she named several stressors, including having a young baby that wasn’t sleeping through the night, which meant she wasn’t getting much sleep either. But she had not connected the personal stressors with her story of burnout, though they were occurring at the same time. She felt that the feelings associated with burnout came solely from her job, when in reality there were stressors in other areas of her life as well.

Of the nurses who were willing to talk about their experiences of burnout, all had one theory in common. “It’s not a terminal state, although some people make it seem that way.” Another said, “Here is the thing, unless you do something positive to help yourself, to turn it around, you do slide down to that burnout phase and you are done.” In general, these nurses felt that burnout is a state that comes and goes; it is a phase that nurses can go through and emerge from again. One nurse said,
I think a lot of it with burnout is identifying it and doing something about it. I catch myself at times—I have had peaks and valleys through my career where I am just done, you know, it’s a struggle to come in [to work]—and I just don’t think that I have anymore to give. Then I have to pull back. First of all, I have been a nurse for a long time, so I know when I have nothing left to give it is not good for me to be there. It’s not good for [the patients] and it is not good for me. I try to identify what is bogging me down and what it is I am worried about.

One nurse told me that one of her coping mechanisms was prayer. “I think I go in and out of burnout. And I literally pray. I pray the Lord’s Prayer and I ask the Holy Spirit to infuse every cell of my body.” This same nurse, who was working on a very stressful unit, also sang a religious song (during the interview) that she sings on her way to work to fortify herself for the day ahead. Another seasoned nurse calmly said, “I am sure I am like all the other nurses that work here, I have times when I feel that I am burned out or I am getting burned out. I have been a nurse for over 30 years.” This nurse considered what she had seen over the years as happening to many of her colleagues as well as to herself as a normal phenomenon. To her, burnout, or the feelings associated with it, is a professional challenge to meet and overcome, not unlike other challenges on the job or in life.

The picture of burnout is not always clear. It is like looking at a Monet watercolor, an impressionistic view, where from a distance an overall picture is formed, but up close the painting looks like a lot of fuzzy little dots of color, seemingly unrelated to one another. This fuzziness makes it difficult to clearly, remember, much less clearly describe the experience of burnout. It is as if the nurse is too close to herself to be able to see the full picture. With the distance of time, some of the nurses were able to see that they had experienced burnout.
Inoculators

“I think what has kept me happy all these years is the fact that you are constantly learning, growing, expanding. When you become an expert in the field you know you have some kind of vested interest in it.”

One of the easier topics for the nurses to discuss was “inoculators” for burnout. These are the coping mechanisms that helped the nurses avoid burnout. Each of the nurses had ideas about what had helped them to, either avoid, or get out of a state of burnout. Most of the nurses agreed that taking care of themselves is a priority. “When I think back, even though it was very busy and stressful at work, I figured out I just have to take care of myself.” Another nurse spoke about needing to take care of oneself and not expecting others to do it for you. “It took me a long, long time to figure out a couple of different things. One, no one here at Carle is ever going to take care of me. Nor should they have to. I should take care of myself.”

One nurse said of nursing in general,

You have to be hardened. You have to be able to take a lot. It is physically hard. It is emotionally draining. You see a lot of sad things and depressing things, but you see a lot of really wonderful things too.

Later in the interview this nurse mused that she thought the more tenderhearted nurses were the ones she had seen burnout.

It does, in fact, take a certain personality to be able to cope with managing so many difficult situations and feelings on the job, others as well as one’s own. One salient comment that occurred throughout the interviews is that nurses often have others say to them, “I don’t know how you do what you do.” Most nurses would agree that not just anyone is cut out for the nursing profession.
However, even nurses who are well suited to the demands of the job need to have coping mechanisms to deal with difficult times. They are human and they have feelings. They need to find ways to protect and process those feelings. Some spoke of their coping mechanisms, others called them defense mechanisms; some simply described the things they do to manage stress. Nevertheless, each nurse understood quite well that she had to find ways to manage the demands of her career. One nurse said it well.

To be an efficient nurse you have to have really good coping mechanisms. You have to be able to cope with it and know that you have to deal with that another time, not to say that doesn’t exist, but you need to kind of put it on the back burner.

For this nurse, the defense of suppression helped get her through stressful moments. She was not talking about denial, and she makes this very clear; but about a temporary state of suppressing her feelings in order to do her job.

“I am like a light switch, I think,” another nurse said. “I can transition, because I feel the stress, but I can also handle it a lot better than I’ve seen other people deal with it.” Another said, “I think one way not to be burned out is not to take it home with you. It is a conscious decision when you leave the building that you don’t bring it home.”

The importance of “leaving work at work,” or being able to compartmentalize feelings about work, was a common theme throughout the interviews. Most nurses felt that to some degree it was necessary to do this in order not to burn out. One nurse described this as a coping mechanism she used. “For me, I am very good at compartmentalizing, so when I am at work I think about work and when I am at home, I think about home. I have always kept them very separate.” Another nurse described the same mechanism.

It is like you have to put everything aside. You know, my daughter is four years old and she doesn’t understand what I have seen all day or dealt with. I will come home and she will be whining or something and I find myself feeling, “I just
dealt with that all day and I don’t need to hear it at home.” But she doesn’t understand that.

Another common theme was that several of the nurses were able to not take what patients, families, or colleagues said to them personally. “I think it is really important that you not take things personally.” One nurse explained how a situation could develop, and how she managed it for herself.

You have to kind of know what [patients] need. And if they will trust you and feel okay with what you are suggesting, then that is helpful. But with some people you just have a feeling right away that they are not going to be open to suggestions. They kind of know what they want and that is how it is going to be and you just have to work around it.

This nurse prefers that patients take her suggestions; however, she does not get mad or upset when they do not. She does not take it to mean that she is doing something wrong. In other words, being less vulnerable to narcissistic injury helps to inoculate against burnout.

Some of the nurses named humor as a way of helping them to not burnout. “I get it all the time, and I don’t always realize that I am doing it, but people will say, ‘You are so funny.’ I think that is because it is part of my personality.” Another nurse said, “I think that you have to have a number-one sense of humor. You know, people always said that nurses have a morbid sense of humor, but that is just because it is a coping method.”

Another commonly named mechanism for either helping deal with burnout, or preventing, it was learning, either by changing jobs or by going back to school for more training. One nurse said,

I don’t have tolerance for things not being what I would like them to be. To a degree you have choices and options, you can make things work better for you. If I am in an intolerable situation, I am looking for something else. I am thinking “Okay, this can’t work, so there must be another way.”
Another said, “I think that for me certainly getting out of it sometimes, changing jobs and learning a new skill is helpful.” And yet another said, “I think at one point I did have a burnout and when I went back to school that helped tremendously. I really enjoyed that and so I am glad I that I did that.”

Other nurses talked about the importance of adaptation. One older nurse commented on what for some nurses was a necessary period of disillusionment after nursing school. “I think that we all come out with rose-colored glasses, then we all figure out that nursing is not all that it is cracked up to be.” Being able to overcome the disappointment and adapt to the reality of the situation helped to prevent a certain kind of burnout, related to disappointed expectations.

Another form of adaptation mentioned was the necessity of adapting to the ever-changing demands of new technology. One nurse described how she had found a way to meet the new demands, while maintaining what she felt was important in the nurse/patient relationship.

I would sit down [with the patient] normally when I did my assessment. I just brought the chart with me, so that kind of helped me when we went to the computer because I would sit there and talk to [the patient] while I was entering the data.

Another nurse talked not only about adapting to the computer herself, but sharing a successful strategy with other nurses.

You just have to develop a technique. I was just telling a new nurse today. She said, “Do you take your laptop and get the history and do your assessment and document right there?” And I said “I did that for a while, but then I felt I was too focused on the computer.” So now I told her I just do exactly what I have done for years. I go in and do a head-to-toe assessment and ask [the patient] whatever questions I need to, and then I go out and document it. That way [the patient] doesn’t have to see me focused on the computer all the time.
Not only did this nurse find a technique that worked for her, she was able to share it with a younger nurse. This helped both of them.

One younger nurse felt that one thing that helps keep nurses from getting burned out was sharing information with other nurses.

You can listen to 1,000 lungs and you might have heard one of them one time, but you go to a colleague that has been there two years and they might have heard it ten times. So it is taking all of the experience of everyone and giving it to that new grad. It is bringing him or her into your world and showing them what makes it fantastic, what makes it fascinating, what makes it negative, how to get around that so you know how to bring them to be the best they can be. I think that is one of the things we do best for these new grads to prevent burnout.

The desire to share the knowledge that they have gained with the younger generation not only helps younger nurses to avoid burnout; it helps the more experienced nurses, as well, by giving them the satisfaction of sharing their expertise. This generative feeling helps younger nurses feel supported, and older nurses feel valuable and respected.

A few nurses felt that distancing themselves from negative talk was also helpful. I don’t gossip, I don’t listen to stories, and I don’t tell stories about people. And I don’t linger on the day. You know, if a nurse does me bad or somebody in the department does, like all of a sudden I have ten patients and someone else has two, I don’t pay attention to that kind of stuff, I just do my job.

Another nurse said, “I just concentrate on my patients. You have more time [for them] if you don’t get caught up in the complaining about other nurses.” Both of these nurses felt that complaining brought them down and that one way to stay more satisfied in their jobs was to distance themselves from that kind of negativity.

Burnout and Empathy

“When I am burned out I find it is harder for me to tolerate people. It is the little things that get underneath my skin. Normally if I have a confused patient, it wouldn’t bother me, but that particular day they drive me up the wall and I am ready to get the hell out of there!”
Most of the nurses, though not all, felt that there was an inverse relationship between burnout and empathy. One said,

You can only be as empathic as your emotions will allow you to be. If you are so burned out or so stressed out because of something at home you can only give so much because you are so weighed down already.

Another said, “I think that for me it would be very hard to be empathic towards patients if I was really, really burned out. Or maybe I could be, but I think that my family life would suffer. Something would suffer.”

Another nurse said,

I do think that nurses that are burned out have certainly--I don’t want to say they are mean to their patients. But they don’t maybe have just that extra “oomph” that you need sometimes to take care of a patient. Like they will not look after the patient, make sure they are covered, make sure they are comfortable, make sure that they get hydration, or a drink, or some juice and crackers, or that kind of thing. And certainly if you are taking care of a person who is not very grateful, or kind of mean, you know, it makes it even harder.

To be empathic requires that the nurse feel at her best, or at least good enough. This is necessary in order to be able to have the ability to put oneself in another’s shoes. If the nurse is preoccupied with her own stressors, she is less likely to be available emotionally to her patients.

Some of the nurses described the behaviors of other nurses who they felt were burned out.

I think they are thinking of what they would rather do, what they are going to do tomorrow on their day off. Whereas, an attitude of “Let’s get the work done here and make sure the patient’s needs are taken care of.”
Another nurse said, “You might not get the whole story from them [about a patient]. You just lose that listening skill a little bit, just wanting to get things done and get home. It’s like you just hurry through your day.”

Reflecting on what it might feel like to be patients who have burned out nurses caring for them, one nurse said, “They might not feel they are getting the care they need, or they just don’t feel like they are being understood.”

One nurse said,

I think it is very tough because I know people in both groups. I know those who really empathize with their patients and then have nothing else to give; and then I see the ones who I don’t think are that empathic, at least you don’t see their empathy, and they burn out [too]. I don’t know if it is maybe because they chose the wrong profession.

This nurse was not sure that being burned out made a nurse less empathic. Her feelings were mixed. All the other nurses I spoke to felt that empathy decreases when someone is burned out.

Conclusion

As the nurses described symptoms of burnout, contributors of burnout, or factors that lead up to the phase of burnout, the final conclusion of most of the nurses was that burnout was something they had to contend with in their lives. Most felt that it is not necessarily always preventable; that in certain circumstances, especially when personal and professional pressures combine simultaneously, it is almost inevitable, and that the burnout is the result of a progression of events over time.

None of the nurses interviewed were burned out at the time of the interviews, though most had been through a period of what they called “burnout.” Some of the
nurses were very open in sharing memories and thoughts about their past experiences of burnout. Most of the nurses felt that burnout is treatable and it is not, as one nurse said, “terminal.” Seasoned nurses who have lived through bouts of burnout shared what they felt were the most helpful strategies in dealing with it. For some nurses it was hard, even in retrospect, to see the picture of burnout clearly.

What is clear from the interviews is that what happens over time is a series of events, personal and/or professional, culminating into various levels of burdens on the self that they all called “burnout.” Burnout is a complex phenomenon that comes and goes in the life of a nurse, a predictable, phase-like experience that nurses are aware of, pay attention to, and find ways to treat.

Finally, the general consensus of the nurses interviewed was that when a nurse is burned out, she has less capacity for empathy because her emotional reserves are used up, or because she has turned inward in order to manage her own feelings and stressors.
CHAPTER XII

GENERATIONAL DIFFERENCES

“These younger nurses don’t know how to work.”

Introduction

Generational Differences is a theme that emerged and became a story of its own. Most of the nurses agreed that there were generational differences. Nearly all agreed there were generational differences.

There are no designated properties in the category Generational Differences. The comments from the younger and older nurses have been dispersed throughout this category rather than separated. Younger nurses are 20-30 year old age group and 40-60 year olds are older age group approximately.

“There are interesting generational differences in nurses. A few of the older nurses, who prided themselves on their loyalty, said that the younger nurses were not as loyal to the institution as the older ones were. The comments of the younger generation were more positive: they said that they looked to the older nurses to help them out..."
clinically, and that they valued what the older nurses had to bring to the profession with their nursing experience.

Faith Roberts, who is an RN at the hospital and who is also an inspirational speaker, had been mentioned by several of the nurses in their interviews. Roberts travels the nation talking to many different professionals. The name of her talk is “From wedding rings to nose rings…generational differences in the workplace and in the practice setting” (Roberts, 2007). Ms. Roberts spoke about the nature of the generational differences that she discusses in her talks. She gives her talk at least once a year at the hospital, where she is clearly well respected. Ms. Roberts is engaging and enthusiastic.

Ms Roberts observations of generational differences are meant to help the generations understand one another in order to work better together, but may have had the opposite affect. She has categorized several generational groups for the purpose of discussing generational differences in attitudes toward work. She compares work values and attitudes of Pre-Boomers (people born before 1945), to Baby Boomers (born 1946-1959), Cuspers (born 1960-1978), Generation Xers (born 1968-1978), and finally the Millennials (born after 1979). Each of these groups is illustrated through characteristic statements in Ms. Roberts talk (published as an article by the same title) (Roberts, 2007).

While Generational Differences have been added as a category because of the frequency with which the topic came up in the interviews, this researcher wondered if Ms. Robert’s influence might have affected the interviewees, or if the nurses had picked out points of her talk that they had related to and then passed on in the interviews. Although Ms. Roberts’s talk is intended to bring people together, it appears to have
highlighted generational differences in such a way that some of the nurses felt justified in
naming the differences as complaints.

Among the nurses interviewed, the older nurses observed more differences than
the younger ones. One older nurse said.

[Younger nurses] are not looking for bedside nursing, they are looking for other
spots. They will go into bedside nursing until they sit there awhile and then make
their move. They also come out with the idea that, “Hey, I am a bachelor’s,” “I
am a master’s degree nurse.” “I don’t want to work weekends, I don’t want to
work holidays, and I don’t want to do rotating shifts. I want straight days.”

Some of the older nurses complained that this attitude of the younger nurses not wanting
to “put in their time” in order to “earn” the coveted shifts or jobs. The ones who
expressed these concerns felt that the younger nurses should have to “pay their dues” as
they had done when they were younger. One nurse ventured an explanation for their
attitude, by stating, “I think that [younger nurses] burn out a little easier. This is the
generation of my children, and they have had everything at their fingertips, they have had
everything given to them.”

Both older and younger nurses agreed that the older nurses brought a certain kind
of knowledge to their work that only experience could give them. This overlaps with the
Experience property in the Theories of the Nurse/Patient Relationship category. One
older nurse talked about “knowing when to worry.”

If a patient’s blood pressure is 85/60, 85/50 even, and they are awake, alert, and
talking to you, you are not going to worry. If they were hard to rise and their
blood pressure was 90/60, you would worry. It is the younger nurse who says,
“That patient has a BP of 85/60,” and I say, “Wait a minute, have they been
talking to you? Did they get up and pee? Yeah? Then don’t worry.”

This nurse was not only drawing on her nursing experience, she was also sharing it with
the younger nurse. Her comment reflects the kind of learning that only experience can
teach, and is difficult to learn from a textbook. It is stressful for younger nurses to not know the difference between what needs medical attention and what does not in a situation like this one, and it is in this kind of situation that having more experienced nurses around can be very helpful.

Another nurse, this one from the in-between generation (late 30s), observed a generational difference in the way nurses work together.

I think there is a different definition of team. Here is what I mean by that. When I worked with the older nurses they didn’t seem to be as close with each other, but they did work together to make sure that the floor was covered. On the floor right now, these [young] nurses go out together afterwards, they know what is going on in each other’s lives. [Younger nurses] do things together outside of work much more.

One younger nurse observed a generational difference in nurses’ willingness to approach doctors.

The older nurses are used to [going up to the] doctor, and saying “What can I do for you? I am here to serve the physician.” Whereas, younger nurses, we are different. I have the utmost respect for the physicians that I work for. However, I believe I am an equal, I believe that I am there with him or her as a care provider on a team to take care of this patient. I am their eyes, I am their ears, their nose, their mouth, their everything, when they are not at the bedside. I am there 24/7, they are not. So that relationship that I have with that doctor needs to be good, it needs to be respectful, it needs to be positive, and it needs to be that the patient can see, that I am with, you know, him or her…to make them better. And I know that patients have said, “You can tell that you have a good relationship with Doctor So-and-So, he really likes you, or she really likes you. And that makes me feel good because I know you guys are working together to help me out to make me better.” And we are. I think that the older nurses don’t feel they can be as personal with the physicians as the younger generation does. And I have heard several of the other older nurses say that. “I can’t believe you went up there and slapped him on the back and told him a joke, or, you know, asked him about his kids.” But there is a definite difference between the generations, and the way that you conduct yourself not only as professionals, but maybe at the bedside as well.
During the member checking interviews a nurse in her 50s said, “I can’t believe what I hear some of the younger nurses say to doctors, that part is so true about those differences in the generations.”

Another younger nurse spoke about the advantages of having different generations available on the unit. She felt that if she was having trouble with a patient she could give that patient to an older nurse and the older nurse would be given the respect that younger nurses were not.

[Patients] don’t show disrespect [to older nurses] because they feel it is an authority figure, they feel like it is one of their older family members, they would never talk to them like they would talk to us. So, it is kind of...that’s one thing when your nurse and your patient fit, it makes a good match and this is just one of the things that we can do to kind of make things work a little bit better. But the difference between the generations, I think that there is definitely one for sure.

A couple of nurses did not feel that there was a difference in the generations. One stated, “I don’t see the generations as a factor at all, I just think that there is a difference in attitudes between people.” Another said,

I think that the younger ones…are only going to give what they have to give, but really it depends on their different levels and commitment to the profession because there are some that just give, give, give that are younger ones, and there are ones that, you know, what it is to three days a week that’s it, not giving more than that. So, I think that it really depends on what their outside interests are, also what their financial needs are. I think that there are so many variables that really drive that, that I don’t see that with just because they’re younger that they don’t give as much.

Conclusion

The category Generational Differences not only characterized some of the differences that the nurses spoke about in the interviews; it also was a commentary on the powerful influence that an annual speaker can have on a staff. Nurses may feel an identification with Faith Roberts because they feel her as ‘one of their own.’ Clearly
Faith Roberts’s annual talk had struck a familiar chord in many of her listeners and resonated with many of them. Whether the nurses’ ideas about generational differences had been influenced by Ms. Roberts’s talk, or she had simply expressed something the nurses had already noticed on their own was an interesting side-note to the conversations with the nurses.
CHAPTER XIII

SUMMARY OF THE RESULTS

The initial purpose of this study was to explore the role of empathy in nurses who were not burned out. This researcher assumed that nurses who were burned out had less capacity for empathy. Using this assumption, it was necessary to obtain a set of interview candidates who were not burned out. The nurses were not burned out at the time of the interviews, but reported phases of burnout in the past.

The MBI-HSS was administered to determine the frequency of burnout in one nursing population, analyze for correlations, and ultimately to define the parameters for a pool of nurses who did not rate burned out to be interviewed. The interview sample was representative of the survey sample in the education and average hours worked per week categories of the demographic survey. The interview sample did not represent the survey sample in the age, years of hospital RN service, or medical setting categories of the demographic variables. A larger percentage of older nurses with more experience were interviewed than was represented in the survey sample. There were no correlations found between any of the demographics and the MBI-HSS, indicating that burnout may be more of purely a psychological or emotional phenomenon.

None of the nurses who were interviewed were burned out at the time of the interviews. The nurses who were interviewed shared their reasons for choosing their
profession, the various reasons they feel pride in their chosen profession, their own individual theories of what characterizes the nurse/patient relationship, and how the crucial ingredient of empathy in that relationship is defined, balanced, and limited at times.

Burnout was described as the result of a convergence of personal and professional stressors that happen over time. Most of the nurses felt that there was an inverse relationship between burnout and empathy, based on the idea that when people are stressed they are more limited in what they have to give emotionally. A difference in generations emerged as a theme, and while it is woven into the entire story about the nurses, there was also a separate story about the generational differences that developed as the interviews progressed. The observations of generational differences noticed by the nurses may have been influenced by an inspirational speaker who delivers a talk on generational differences to them every year as a way to learn about the different strengths each generation possesses.

The results of the qualitative portion of the study (the interviews) are organized into six categories: Routes to the Profession, Professional Pride, Theories of the Nurse/Patient Relationship, Empathy, Burnout, and Generational Differences. Each category is briefly reviewed below.

In the category Routes to the Profession, nurses described how they came to choose the profession of nursing. Many of the nurses felt it was a Calling related to religious beliefs or a feeling of altruism. Some said they had identified experiences with nurses early in their lives that had influenced them to become nurses. Several of them had either had direct experience with nurses themselves, or had witnessed nurses giving
care to loved ones that they had been emotionally touched by. This developed into an Idealization of nurses and what they do for others. Others chose the profession for more pragmatic reasons, such as Financial Compensation or job security. There was a fluidity of these categories, whereby those who felt called to nursing were also appreciative of the decent pay that nurses commend. All of the nurses expressed an interest in helping people even if they did not list it as their main motivation for choosing the profession.

As the nurses spoke, regardless of what Route to the Profession they had taken, there was a palpable sense of Professional Pride. All the nurses expressed the need for nurses to feel Compassion for their patients and were pleased that they were associated with a profession with such a noble ingredient. Several of the nurses were Protective of Disclosure when it came to other nurses or sometimes themselves. There was a sense of a sisterhood in which nurses may sometimes have negative feelings about other nurses, but believe that such information is private, to be kept within the unit and discussed quietly. There was also a sense among the nurses of not being able to speak about other nurses because they simply do not have enough contact with other nurses to have valid observations. This was especially true of nurses from other units, which may function very differently. There seems to be little known about the nurses on other units since there is little interaction between units. Some of the nurses were pleased with the Unique Personal Qualities that they bring to the profession. All the nurses described ways in which they undergo Self-Evaluation, always monitoring what kind of care they were able to give patients, and going over in their minds if they had done all that they could do in various situations. All the nurses were proud of the fact that they are in a Profession
With Many Opportunities. They are pleased to have so many professional choices in their careers.

All of the nurses described their own personal Theories of the Nurse/Patient Relationship. Which aspects of the relationship the nurses chose to emphasize varied from nurse to nurse, and seemed to be dependent on factors such as personality, the unit they worked on, or what type of patient they worked with. There are several dimensions to the property of Facilitation: engagement with patients and their families, patient education, and patient advocacy were at the top of the list of what nurses do with their patients, the emphasis on each depending on the type of work required in the individual units.

All the nurses interviewed felt that both life and nursing experience helped with their ability to develop the nurse/patient relationship, especially their ability to understand what patients are going through. In order to be happy personally and professionally nurses felt that they needed to know for themselves what made their job work or not work for them, as discussed in the property of Know Thy Self. In addition, The Function of Others plays an important role in how the nurses view their jobs. “Others” ranged from other nurses to God. The role of technology was mentioned in many of the interviews and incorporated into the The Function of Others property.

The nurses gave examples of mature Empathy in their stories about The Theories of the Nurse/Patient Relationship. Empathy was so important that it became its own category, and while a clinician can hear examples of empathy being described between the lines of the stories of patient advocacy or education, additional dimensions of Empathy are elaborated on in the following chapter.
The fourth category, Empathy, is broken into the properties of Definition, Balancing Act, and The Limits of Empathy. Most of the nurses referred to the “Golden Rule” in one form or another as a way of thinking about Empathy. The definition of Empathy came through examples rather than intellectual definitions. There are many aspects that the nurses felt they must be in balance in relationship to their patients, specifically the emotional stance, or the emotional closeness or distance that each nurse requires in order to feel that empathy with a patient is at an optimum level. Most of the nurses felt that some degree of emotional closeness helped them to empathize with their patients. The degree of emotional closeness or distance that was considered optimal depended on the nurse and/or the circumstances.

Other roles the nurses must balance include moving between the technological and the psychological tending of patients. The balancing act that is required of them is a complex psychological phenomenon. Despite their best efforts to remain empathically attuned to their patients, most of the nurses had Limits to Empathy. They each described what personally what felt challenging to them as nurses in regard to maintaining empathic attunement. One common theme reflected in the examples they gave was about patients who exhibited regressive behaviors that could in turn elicit the nurse’s own regressive pull. The nurses find this phenomenon confusing and disturbing, and generally try to avoid those situations, though it is not always possible. Dealing with patients’ families was named by several of the nurses as one of the most stressful aspects of their jobs. They want their patients to have the benefit of family support; however, they said that family members often behave in ways that interfere with their role as nurses. More education in the affective states that patients and families can experience
during illness or hospitalization may help facilitate better understanding of patient’s needs, and aid nurses in maintaining the empathic attunement in difficult circumstances.

The fifth category, Burnout, was most easily discussed in the third person for most of the nurses. Most of the nurses had experienced burnout, though a few nurses said they had never felt burned out. Nurses who were older, more experienced, or had the good fortune to have colleagues with whom they could openly share their feelings, seemed to be more willing to share their experiences of past phases of burnout. All the nurses named descriptions or contributors of burnout, whether they had personal experience with burnout or not. Most of the nurses felt that burnout was not attributable to just one stressor, and was very individualized. Most of the nurses felt that stressors in personal and professional lives could combine to create feelings of burnout. Of the nurses who spoke of their own experiences with burnout, a theme emerged around the progression of life events that burdened the self, were personal and/or professional and converged over time to result in an end description of what most nurses thought of as a phase of “burnout.”

The last category, Generational Differences, is an incidental theme that emerged in the course of the interviews. Some of the older nurses commented on characteristics of the younger nurses and vice versa. While their reflections were interesting it seemed that they may have been influenced in their thinking about these differences by a talk they all hear every year by an inspirational speaker they admire.

In addition to the many other challenging aspects of their jobs, nurses must function within a very complex, often intense psychological arena. They are continually working with patients who require psychological attention, physical demands, and
ongoing nursing assessment, and intervention. This requires the ability to read both psychological and somatic states. The acuity of attunement that these nurses have developed is impressive and yet they often manage it all without seeming to be aware of what they are doing.

Empathy was not only an assumed role in the nurse/patient relationship, it was demonstrated through the examples the nurses gave in the interviews. Overall, the nurses felt good about their professional abilities, and satisfaction in being able to help other people, when stressors that accompany the role of caregiver made their jobs more difficult.
CHAPTER XIV

THEORETICAL IMPLICATIONS

Introduction

This study yielded several important findings, which are detailed in this chapter. Clinical implications and areas for future research follow the discussion and conclude the study.

Brief Summary of the Findings

The initial focus of this study was on the role of empathy in nurses who do not experience burnout. However, qualitative data analysis revealed that even though the nurses interviewed had scored low to moderate on the MBI-HSS, indicating that they were not burned out at the time of the interviews, several of them reported they had been burned out in the past, had learned mechanisms for managing burnout, and considered occasional periods of burnout to be a normal part of their careers. Therefore, the findings of this study are related to burnout as well as the role of empathy. The results of the study demonstrate five major findings and are related to the quantitative results as well as the narratives of the nurses.
Finding #1 is drawn from the quantitative portion of this sequential, mixed method study. There were no statistically significant correlations found between any of the identified demographic variables and any of the subscale scores on the MBI-HSS.

Finding #2 relates to the phenomenon of burnout. As described by the nurses interviewed, burnout is not a singular, discrete phenomenon, but appears to be a series of events that over a period of time converge to create a phase or condition that periodically comes and goes in a nurse’s career. This seems to be a normative occurrence in the careers of most nurses. Several of the nurses interviewed reported past experiences with burnout; however, none of the nurses described themselves as being burned out at the time of the interviews, nor did they appear to be burned out.

Finding #3 discusses various coping mechanisms that nurses described as ways for inoculating themselves from or managing burnout. The defense mechanisms discussed are: sublimation, humor, altruism, and suppression. The nurses also discussed how developing the ability not to personalize comments or criticisms expressed by patients, families, or their colleagues helped them feel less stressed.

Finding #4 focuses on comments made by several of the nurses that patients’ families were a source of stress, as well as their comments concerning the challenges associated with working with “difficult patients.” It appears that nurses sometimes feel unprepared to deal with the emotions of some patients and family members.

Finding #5 describes how empathy can be compromised when nurses over-identify with patients, or with the family members of patients. Some of the nurses cited their difficulty in maintaining clinical objectivity when they observed the suffering of
family members of patients, and identified this as a reason they could not work with pediatric and/or oncology patients.

Finding #1

*There were no statistically significant correlations found between any of the identified demographic variables and any of the three subscale scores from the MBI-HSS.*

Burnout was first conceptualized as a psychological syndrome by Maslach in 1976, and it was Maslach who defined the three widely accepted dimensions of burnout: emotional exhaustion, depersonalization, and reduced sense of personal accomplishment. These three dimensions make up the subscales of the MBI-HSS (Maslach, 1981).

The quantitative results of the correlations compiled showed no statistical significance between any of the demographic variables (age, education, years as a hospital RN, hours worked per week, work setting) and any of the three subscale scores of the MBI-HSS.

Maslach and Leiter (1997) emphasize the importance of the work environment in creating burnout by stating, “burnout is not a problem of the people themselves but of the social environment in which people work” (p. 18). Maslach and Leiter (1997) go on to say, “We argue that burnout in individual workers says more about the conditions of their job than it does about them. Contrary to popular opinion, it’s not the individual but the organization that needs to change” (p. 21). There is a vast body of literature that supports Maslach and Leiter’s research findings that burnout is tied to aspects of the work environment (Duquette, Kerouac, Sandhi, & Beaudet, 1994; Pines & Kanner, 1982; Atencio et al., 2003; Raiger, 2005; Sadovich, 2005).
However, even Maslach et al. (2001) note that individual factors or attributes can also contribute to burnout. It appears that while their emphasis is on the work environment, Maslach and Leiter (1997) are not dismissing the relevance of individual characteristics in the development of burnout. As compiled in the literature review of this document, many studies, especially studies conducted outside of the U.S., make a connection between burnout and individual factors (Tselebis, Moulou, & Iias, 2001; Altun, 2002; Buhler & Land, 2003; Bakker, LeBlanc, & Schaufeli, 2005; Ekstedt & Fagerberg, 2005; Browning, Ryan, Greenberg, & Rolinak, 2006). Each of these studies chose different individual attributes to investigate.

It is notable that on the whole the nurses in this study were happy with their employer and felt appreciated by their hospital’s administration. This had not always been the case, but at the time of these interviews, this set of nurses, by and large, felt that the administration of the hospital was respectful of their nurses and was actively listening and responding to their needs. Current efforts by the administration to apply for magnet status may have been part of the reason for the positive change in the nurses’ relationship with administration. In any case, comments about the administration came up minimally in the interviews and when they did, the administration was referred to positively by most of the nurses. Two nurses had general complaints about the administration; however, their complaints were not the focus of their interviews, but were expressed in passing comments.

Even though there were complaints or worries about workplace issues related to relationships with other nurses, this was not reflected in the work-setting demographic correlation-coefficient to any of the three subscale scores on the MBI-HSS. Nurses from
units across the hospital were interviewed; on a couple of units, morale was low and there were “staffing problems.” This was not reflected in the larger survey results when the correlations were compiled.

This study supports the findings of other research (Tselebis, Moulou, & Iias, 2001; Altun, 2002; Buhler & Land, 2003; Bakker, LeBlanc, & Schaufeli, 2005; Ekstedt & Fagerberg, 2005; Browning, Ryan, Greenberg, & Rolinak, 2006) that suggest that burnout is related to individual factors. The fact that there were no statistical correlations between the demographic variables and any of the subscale scores suggests that burnout is more related to psychological or mental phenomena than to workplace issues.

Most researchers agree that burnout is a complex phenomenon; and while it has been widely studied for more than thirty years, there is much that is not yet clearly understood. Burnout continues to be a focus of study and concern. While there is widespread agreement that burnout is a complex multi-dimensional syndrome, “it has been hard to find any strong, consistent statistical relationships regarding burnout” (Skovholt, 2001, p. 107).

**Finding #2**

*Burnout is not a singular phenomenon. It seems, rather, to be related to a series of events in a nurse’s life, personal and professional, that converge over a period of time. Burnout comes and goes as a matter of course in a nurse’s career. The nurses in this study did not describe themselves as being burned out at the time of the interviews; however, several reported experiencing periods of burnout in the past.*
The literature on burnout consistently speaks of burnout prevention, inoculation, or treatment (Maslach & Leiter, 1997; Skovholt, 2001; Maslach, 2003). But is it possible to completely prevent burnout? Is this a realistic goal?

There are many coping methods, both personal and professional, that can help minimize the occurrence of burnout, and can help mitigate its effects when it occurs; however, perhaps burnout is a normal phenomenon that occurs from time to time over the course of a nurse’s career. As a normal part of life, we live through many stressors, such as the illness of a close family member, the care of aging parents, divorce, workplace difficulties, etc. These stressors can have an effect on the professional life of a nurse. Nonetheless, these stressors usually do not last forever. Perhaps burnout occurs during the normal, transient phases of life that are especially personally or professionally challenging.

Burnout is particularly noticeable when it is related to several stressful events happening over a period of time. When this series of events or stressors converges, symptoms of burnout may show up in the workplace; or they may be felt in the workplace in response to other stressors in life that sap the energy and vitality from the self.

Most of the nurses in this study commented that they felt burnout was related to the overall functioning of the whole person, rather than just caused by workplace issues. One nurse said, “I think [burnout] is everything together, because the gals that I know that are miserable at work, are also miserable at home. It’s not just work.” Another commented, “She has a baby at home and her husband is in school and so I think it is more...than nursing burnout, it has to do with her whole life.”
Nurses who had experienced burnout in the past reflected on what they thought had contributed to it, and what they thought had helped them to overcome it. Several nurses painted pictures of multiple stressors that were happening in their lives at the same time as work stressors; or said they felt that work seemed stressful as a result of life stressors. According to the nurses in this study’s description, the period of burnout lasted from one to two years. A few nurses had some difficulty in putting their own stories together, since there was such a wide span of time involved, and so many stressors had been happening at once. For some of the nurses, telling their stories during the interview seemed to help them clarify their experiences with burnout. Several of them commented, “I never thought of it that way before.” As their stories emerged in the interviews, some of the nurses reflected on the build up of events that had led to burnout as it was discussed; other nurses had thought about all the events, personal and professional, that had contributed to burnout and were able to name the events that had led up to their phase of burnout. Most of the nurses had a better view of burnout in hindsight, though often even looking back, not all of the factors that contributed to burnout were taken into account, especially personal stressors.

As Maslach (2003) has noted, in general, training programs do not address the possibility of burnout. Perhaps if burnout was viewed as just another normal workplace challenge to be dealt with, and nurses were educated about it, they would recognize the symptoms of burnout, and would be able to manage it more effectively. It would be helpful if nurses were able to understand, rather than be expected to avoid, the factors involved in burnout. For example, when a nurse finds herself feeling irritable, fatigued, or unmotivated at times she would understand that there are stressors in her personal life,
in addition to work stressors, that may be contributing to her symptoms and that it is important to pay attention to them in order to care for herself and maintain optimal functioning in her work. Rather than being viewed as a sign of personal weakness, burnout could be seen as a normal phase in the professional life of a nurse that comes and goes, and nurses could be taught that learning ways to manage it is an important professional skill to develop.

While much has been written about ways to treat or prevent burnout in the literature (Maslach & Leiter, 1997; Skovholt, 2001; Maslach, 2003; Leiter & Maslach, 2005), no studies were found that portray burnout as a normal part of professional life. Maslach herself hints at this by noting the lack of mention of burnout in training programs. However, the more seasoned nurses in this study spoke about burnout without apparent shame or worry that there was something wrong with them. They described it somewhat matter-of-factly as something they had lived through, survived, and learned how to manage when it occurred. One nurse calmly said, “I am sure I am like all the other nurses that work here, I have times when I feel burned out or I am getting burned out.” During the member-checking interviews one nurse said that she realized after reading the draft of the study that she had been burned out more times than she had thought. She said she had never taken into account personal stressors that had affected her ability to work efficiently at times.

One nurse described her most recent experience of burnout in terms that clinicians would categorize as a depressive episode. This nurse also said, when asked if she thought that depression was a possible explanation of her symptoms, that she thought she had been depressed at the time. Buhler and Land (2003), who studied nurses in ten
German hospitals to test for personality variables that may have an impact on burnout stated, in their opening paragraph, “We consider burnout syndrome to be a subclass of affective disorders, either as an abortive form of minor depression or as dysthymia, depending on the duration. In severe cases, a burnout syndrome can become a major depression.” (p. 5). Buhler and Land also comment that the burnout research in America favors viewing it from a sociological perspective, looking mainly at external triggers. Given their findings, as well as the findings of this study, further investigation into the correlation between depression and burnout is warranted, both in the U.S. and abroad.

Finding #3

Nurses in this study described coping mechanisms that aided them in feeling more resilient to stressors. Some of the nurses also noted the importance of not personalizing criticism or negative comments from others.

As the interviews proceeded it became clear that there was a set of healthy defense mechanisms that the nurses had developed either in their personal lives or over time as a professional that helped them to deal with stress and be less prone to burnout. As the nurses described their own prescriptions for dealing with burnout, what emerged was a set of coping mechanisms that they found most helpful. These coping mechanisms had become part of their own practice wisdom and their set of tools for dealing effectively with the demands of their jobs.

In his book Aging Well, Vaillant (2002) describes the longitudinal Study of Adult Development at Harvard University, which continues to look at the development of three cohorts from adolescence through old age. The findings of this study include “mature
defense mechanisms,” which Vaillant reports to be sublimation, humor, altruism, and suppression. The maturity of these defenses requires emotional development as well as life experience. Like subjects in Vaillant’s study, the nurses in this study spoke of their ability to use mature coping mechanisms that allowed them to function at a high level of professional performance.

According to Vaillant, sublimation “involves a kind of psychic alchemy; the pain of childhood becomes transmuted in the mature artist’s masterpiece” (Vaillant, 2002, p. 63). In other words, the early instincts of life are transformed into socially acceptable forms of contributions to society. For example, one could say that a brilliant surgeon’s technique is based in the sublimation of murderous wishes from childhood. One nurse in the study stated that one of her reasons for choosing nursing as a profession was because of a memorable childhood experience. “The nurse would let me play with the syringes that they used to give me shots.” One could interpret her behavior at a young age as identification with the aggressor; however, through the process of sublimation, she became a nurse.

Humor is also an important coping mechanism. “Mature humor allows us to look directly at what is painful. Humor permits the expression of emotion without individual discomfort and without unpleasant effects upon others” (Vaillant, 2002, p. 63). Humor allows the pain to be transformed into something that is more bearable, or even funny. Members of the medical professions are known for their “dark humor.” Using humor, nurses can help transform their own pain as well as that of their patients, at least sometimes, creating a manageable means for dealing with painful realities. One nurse said, “I think that you have to have a number-one sense of humor. You know, people
always said that nurses have a morbid sense of humor, but that is just because it is a coping method.” Kohut referred to the attributes such as humor as “transformations in narcissism” (Seigel, 1996, p. 62).

“Altruism involves getting pleasure from giving others what we ourselves would like to receive” (Vaillant, 2002, p. 63). Most of the nurses in this study spoke of their wish to give to others and talked about how they themselves received psychological benefits from giving to their patients. One nurse said, “I think my faith is a big deal in that I feel like God has called me to nursing and so that it is something that I feel fulfilled in, and I know that it is right for me.” Another nurse said, “I think about [how], if I was in this position, I would want the nurse to treat me this way, or make sure this was done.”

Suppression involves putting something that may be bothersome or may need to be attended to at a later time out of mind temporarily. Most of the nurses referred in one way or another to their ability to suppress either their thoughts or their feelings in order to care for a patient or to keep doing their job. One nurse said it well:

To be an efficient nurse you have to have really good coping mechanisms. You have to know that you have to deal with that another time, not to say that doesn’t exist, but you need to kind of put it on the back burner.

Both repression and suppression are ways of putting present challenges or stressors out of mind. However, there is an important distinction between the two: suppression is only a temporary state, and not a state of denial. Repression is forgetting and then never resolving a problem or feeling. “Thus, Freud regarded the postponement (suppression), but not forgetting (repression), of gratification as the ‘hallmark of maturity’” (Vaillant, 2002, p. 63).
Nurses in this study who did not personalize people’s criticism or other negative words or behaviors did not feel the stress of working with people to the same degree as those who felt “defensive,” or stressed by what other people did or said. One nurse said, “I think it is really important that you not take things personally.” Nurses who are able to maintain this position are less prone to experience narcissistic injury. The ability to be less vulnerable to narcissistic injury comes from a cohesive self, one that is intact and resilient to the normal, everyday actions or words of others. Self-cohesion can be somewhat fluid, meaning that it can shift somewhat from day to day, depending on what is going on in our lives. However, over time cohesion of the self is usually fairly consistent and is a result of our experiences with important others in our lives who have contributed toward optimal psychological development.

**Finding #4**

Many of the nurses in this study cited dealing with the families of patients as one of their biggest stressors. In addition, several nurses spoke about the challenges of dealing with “difficult patients.” It appears that nurses sometimes feel unprepared to deal with the feelings of some of their patients and members of their families.

Nurses need training in multiple areas. Learning the myriad tasks required to perform their work is paramount. Effective managing of the nurse/patient relationship is also a priority in their training. Nurses are often acutely attuned empathically with their patients and can understand their feelings of anxiety, fear, sadness, anger, frustration, etc., as well as the behaviors that arise out of these feelings.
Nurses may also find themselves setting limits with patients that arise more from their own attempts “to cope with [their] own annoyance, irritation and frustration than for the benefit of the patient” (Berkowitz, 1977, p. 7). Naturally, patients may not experience this kind of limit setting as empathic. During a member-checking interview one older nurse said she remembered the days when patients were limited to two visitors at a time, and the limited visiting hours were strictly enforced. Today families often gather in large groups around the patient’s bedside, and sometimes remain there 24 hours a day: this can set the stage for regression, which may have been more easily contained with less family in the room and fewer opportunities for them to visit patients.

Patients may act out their feelings in ways that nurses may find confusing or annoying. Freud noted that the ill person has less capacity to love, since the libido has turned inward toward the self. In this regard, Kohut’s self psychology may help nurses understand what may be occurring intrapsychically with their patients. “Narcissistic injuries or injuries to the self occur at points of vulnerability…and this vulnerability is present at points of narcissistic imbalance.” (Goldberg, 1973, p. 723). Illness is a narcissistic injury. For example, rather than show their fear or anxiety, some patients may instead act like a demanding child, in an attempt to prevent the fragmenting of the self, the other end of the continuum of self cohesion. It may help nurses better understand patients’ demanding behaviors as the expression of fear, if they have a basic understanding of Kohut’s concepts of selfobject functions, the selfobject matrix, and the developmental path of the concept of self-cohesion.

One of the most important contributions of Kohut’s theory of the self is the concept of the selfobject, which he first introduced in 1971. “Selfobjects may then be
defined as the set of experiences that, when present, lead to an experience of cohesion and stability; but which, when absent, lead to disruption and fragmentation” (Palombo, 2004, p. 18). There are two basic types of selfobjects: 1) the grandiose or mirroring selfobject and 2) the idealized parental imago.

Experiences that affirm or mirror another person’s internal state and enhance the state of the self are associated with the grandiose self. For example, those nurses who gave their patients encouragement or cheered them on to master new skills (e.g. learning to walk with a walker), or who pushed their patients to get better provided the selfobject function of affirming the capacity to do a physical task that the patients felt unsure or fearful of attempting. These nurses were able to help bolster their patients’ sense of self. They were thus able to help the patients maintain a state of self-cohesion, and to limit or prevent fragmentation or regression.

When they experience a sense of calmness and protection emanating from nurses, patients may be encouraged to stretch their physical limits and, feeling as though they are in safe hands, may be better able to help themselves toward an improved state of physical health. In this case, the experience of the calmness and sense of protection the nurse provides functions as a selfobject for the patient. This selfobject function is an example of the idealized parental imago. It contributes to maintaining the sense of cohesion the patient experiences, in addition to reassuring them that they will get better.

A cohesive self develops over a lifetime of selfobject experiences that other people provide for us. While the functions of selfobjects become internalized along the normal developmental path, the presence of selfobjects in our world continues to be a life-long need. The more that a sense of cohesion is felt by a patient before illness, the
more likely that their coping mechanisms will enable healing when they are ill. However, illness is experienced as a narcissistic injury to the self and therefore it is normal to have the sense of cohesion slide into a more regressed state, or even temporarily into fragmentation during illness.

Self-awareness, self-esteem, and the myriad coping skills that one develops over a lifetime are all part of a cohesive self. Illness is a narcissistic insult to the self, or even a threat to life. By definition hospital nurses do not see patients at their best either physically or psychologically; and they are also not likely to have a sense of the baseline psychological level of functioning of their patients. This makes it difficult to assess and to understand patients.

Pattison (as cited by Tasman, 1982) outlines the fears of patients:

Fear of the unknown, of loneliness, of loss of body and body function, loss of self-control, of loss of identity, and of regression to primitive levels of functioning [are patients’ fears]. Regulation of and coping with these fears and their impact are functions of a cohesive self. Although vulnerability of the cohesive self varies individually, these stresses are present in all patients (Tasman, 1982, p. 1).

Patients may therefore be at risk for self-fragmentation during their illness and need the selfobject function of the nurse to help bolster their sense of self-cohesion. Of course, some patients are harder to for nurses to deal with than others. Many of the nurses spoke of the types of patients who do not participate in their own health care, or who have ended up in the hospital as a result of decisions or behavior that the nurses find personally objectionable.

Members of the families of patients are also individuals, each with their own psychic makeup, all also unknown to the nurse prior to the hospitalization of the patient. Family members do not only provide selfobject functions for the patient; it is also likely
that the patient may, at least historically, have provided selfobject functions for family members. The disruption of a needed selfobject’s health may thus elicit many difficult or potentially overwhelming uncomfortable feelings in various members of the family. So, in addition to seeing their loved ones in a compromised state of physical health, they may also feel threatened by the fear of loss of needed selfobject functions the patient normally provides them with. Such changes in the roles of family members may create stress in maintaining the self-cohesion of all family members, not just the patient, to varying degrees. The degree to which this is disruptive to the overall functioning of the family is determined by the cohesiveness normally experienced by each individual, as well as changes in their relationships with the patient, and the meaning of those changes to each person.

In addition to the difficulty of adjusting to the patient’s illness, family members may have their own sets of feelings and reactions to deal with concerning other matters. They may be frustrated with the doctor as they wait to hear the results of a procedure, or put off by the doctor’s bedside manner; or they may simply feel out of control emotionally because the state of their loved one’s health is variable and/or uncertain. They may feel anger, which may be projected onto the nurse, or they may feel an intolerable sadness or feeling of helplessness. They may want to do something in order to feel more potent and to manage their feelings of helplessness. And the things they choose to do may or may not be perceived as helpful by the nurse.

In an article about death and dying, Tasman (1982) interprets the stages of dying named by Kubler-Ross (as cited by Tasman, 1982) from a self psychological perspective.
The feelings elicited during the dying process may also be elicited during illness, in both patients and family members. According to Tasman:

Thus, it can be seen that vulnerabilities to self-disruption previously compensated by both internal and familial process may emerge... The stage of denial can be seen as a revival of a primitive, grandiose self-experience of invincibility. The second stage, anger, can be seen as the rage at the perceived injury to the invincible, omnipotent self as reality challenges the grandiose stance. Kubler-Ross states that the bargaining phase may reflect an attempt to postpone or avert the eventual outcome. Another possibility is that this phenomenon is a signal of a reemergence of the idealized parental imago in which resides the infantile wish for a guarantee of self-cohesion through merger or identification with traits of the idealized other. The depressive phase may represent the reaction to an injury to the self, following failure of attempts to reestablish self-equilibrium (p. 4).

In other words, these affective states may be experienced by patients or families along the path of any illness. Therefore, the inclination for a decrease in self-cohesion is not only normal, but must be expected. How well the nurse understands these states comes from not only her capacity to empathize, but also her knowledge of the complex psychological states that are elicited in her patients and the families of patients under the stress of illness.

Given the complexity of the psychological states that can be potentially elicited in patients, families and nurses, it seems that it would be helpful to both nurses and patients if nurses had more training in the psychology of patients and their families and the countertransference feelings that may develop during illness.

Finding #5

_The capacity to empathize may be compromised when nurses over-identify not only with patients, but also with family members of patients. Some of the nurses cited family_
members of patients as the reason they could not work with pediatric and/or oncology patients.

One nurse said that she had to leave the oncology unit she worked on after a close family member died of cancer. She would see a patient that reminded her of her own family member; she described observing the family of the patient and remembering what it had felt like to be in that position. As she talked about this during the interview, she looked downward, and her affect changed. She shifted in her chair, changed positions, cleared her throat and then changed the subject. She went on to name the many aspects she had liked about working on the oncology unit, until she had decided she needed to change units.

The ability to sense what another person is experiencing defines the very nature of empathic attunement. Deutsch (as cited by Basch, 1983) stated:

Intuitive empathy is precisely the gift of being able to experience the object by means of identification made possible by the fact that the psychic structure of the analyst is a product of developmental processes similar to those which the patient himself had also experienced (p.3).

The nurse who had to leave the oncology unit found herself experiencing the family members’ feelings, and remembering how she had felt when her own family member was ill. While she was able to be empathically attuned with the patient, it was the family members of the patient with whom she over-identified.

Over-identification is defined, for the purposes of this study, as the emotional merger of the observer with the observed, to the extent that the responses come from one’s own feelings and needs rather than the feelings and needs of the other. The nurse whose family member had suffered from cancer was not able to disengage from the “temporary oneness” Emde describes (1990). The self of the nurse remained intact while
she empathized with the patient; however, she felt her own distress reignited when she identified with the family members’ imagined pain.

Another nurse spoke of the emotions she had felt as she helped suction a baby, and the baby’s mom had started to cry. “I was tearing up because I could imagine how hard it would be for me to have to hold my son while he was being suctioned.” This nurse is describing her loss of connection with the experience of the mother, and her reacting in a way that reflected her own feelings. “The identification that takes place in an empathic encounter is not with the other person per se, but with what he is experiencing” (Basch, 1983, p. 3). It is assumed that nurses are empathic with their patients. However, what emerged in the interviews was that there may actually be a disruption of empathy when nurses experience a loss of clinical objectivity toward family members of the patient.

The mothers of patients seem to present a particular challenge for some nurses, especially if they themselves are mothers. There was almost a feeling of hushed reverence when a few of the nurses spoke about the mothers of patients. One nurse commented on the difficulty in caring for pediatric patients after she became a mother herself. Another nurse referred to a conversation with a nurse friend who worked in oncology. “My friend said she had never gotten ‘hardened’ to the mothers of cancer patients, regardless of the age of the patient.” Another nurse said, “Now that I am a mom, it is like I can honestly see what it is like [to be the mother of a child in the hospital].” This same nurse went on to tell of her own recent struggle with watching her daughter experience the symptoms of the common cold. She described, with great affect, all the different measures she took to try to help her child, including calling her nurse
friends multiple times and calling the doctor a few times for reassurance that she was not missing anything. Her description was meant to illustrate how she could understand the way mothers of young children who are sick feel, and how even she, with her extensive nursing education, had trouble containing her anxiety when her own child was ill with something as simple as a cold.

Empathy is not a static state, as the nurses’ stories illustrated. Temporary loss of objectivity is also not a comment on a nurse’s general ability to empathize. In other words, the examples shared by the nurses show that there was a loss of objectivity or an over-identification, for a certain period of time with certain family members. However, in other circumstances the same nurses were quite capable of remaining empathic without disruption, as demonstrated by the stories they shared with respect to other patients or family members. The difficulty in losing their empathic objectivity in relation to the mother of a patient or another family member of a patient seemed to be one of the most distressing experiences for some of the nurses.

Basch (1983) states, “Many a mother cannot describe how she came to understand what her child conveyed to her or why she behaved as she did with that child; she ‘just knew’ it was the right thing to do” (p.12). This quotation is almost a verbatim echo of what nurses reported in the interviews as they described how they cared for their patients. While it was more difficult to describe what they did emotionally with patients, they could describe, with much affect, the interference in their ability to empathize or their inability to remain objective enough with the mothers of patients, especially the mothers of young children, after they had become mothers themselves. Basch continues:

There is nothing primitive about empathy. That empathic understanding, like any other form of understanding, proceeds on the unconscious level only attests to
Freud’s discovery that whatever can be done with the participation of consciousness can also be done without it (p. 12).

Conclusion

Taken together, these findings create a framework for understanding more about the phenomenon of burnout and the defense mechanisms that help nurses maintain the kind of self-cohesion that can contribute to her sense of resilience. Even among nurses who are not burned out, there are factors that interfere with the ability to empathize with patients. These include dealing with “difficult” patients, the families of patients, and over-identification with family members of patients. These sources of stress may cause nurses to want to retreat from their patients, rather than to engage, much less empathize, with them.

Clinical Implications

The five major findings of this study are as follows:

1. There were no statistically significant correlations between any of the demographic variables and any of the three subscale scores from the MBI-HSS.
2. Burnout is not a singular phenomenon. Burnout seems, rather, to be related to a series of events that converge over time and is a condition that comes and goes in the career of a nurse. Nurses in this study were not burned out at the time of the interviews; however, several reported phases of burnout in the past.
3. Nurses in this study named coping mechanisms that helped them to feel more resilient. These defense mechanisms included sublimation, humor, altruism, and
suppression. In addition, nurses felt that not personalizing what others say or do helped to inoculate them from stress.

4. Many of the nurses in this study named dealing with the families of patients as one of their biggest sources of stress. In addition, several nurses spoke about the challenges of managing “difficult” patients and how they felt about them. It appears that nurses can feel unprepared to deal with the feelings of some patients and families of patients.

5. The capacity to empathize may be compromised when nurses over-identify not only with patients, but also with family members of patients. Some of the nurses cited family members of patients as the reason they could not work with pediatric and/or oncology patients.

The clinical implications follow from the findings. Since there were no correlations between the demographic variables and the subscale scores of the MBI-HSS, it appears that burnout is more likely psychological than sociological in nature. In other words, burnout is more of an internal response to a series of external stressors. The nurses who talked about their experiences with burnout described it as a condition that comes and goes throughout their careers. These nurses viewed burnout as a dynamic, ongoing challenge of the profession. While the nurses described ways in which they managed burnout or strategies and techniques that kept them more resilient, it appears that when enough stressors converge over a period of time the self of the nurse becomes over-burdened and her ability to remain cohesive is threatened. When self-cohesion is
lessened, the nurse is more vulnerable to other stressors that may then compound already existing stressors.

Since much of the research on burnout in this country has focused on the effect of the work environment, it is critical for clinicians to be attentive to workplace complaints or stressors as less externally driven and to explore further to create a more complete picture of how burnout develops. While workplace issues may present problems for nurses, when burnout occurs it is not fair to place the blame solely on the institution, or to expect that the solution will only come from the employers. Assessing the internal landscape of the person who is burned out, just as a psychodynamically trained clinician would do with any other presenting problem, is necessary. Burnout may be listed as a complaint in any workplace, and the findings of this study may be generalized to apply to other professions. When a nurse or other professionals present with the complaint of “burnout,” clinicians should listen for symptoms of depression, or other life stressors that may be impinging on the self and may perhaps be projected onto the workplace.

However, particularly when nurses present for treatment, it will be helpful for clinicians to have an understanding of the nature of the demands that are placed upon the self of the nurse in order for her to operate within her professional realm. Helping nurses and others who complain of burnout to form a narrative describing the last couple of years of their lives will help them to see what factors may be contributing to burnout, and understand more fully the burdens that they are experiencing. Developing their own narratives of what the contributors to burnout may be, as well as the symptoms of it, can help clients see the various factors that are impinging on their ability to function effectively in their jobs, and what is driving their choices in managing stress.
It was assumed at the outset of this study that when nurses feel burned out they will have a diminished capacity for empathy. It was also assumed that the ability to empathize comes from a cohesive self. Nurses who seek treatment may find it difficult to access some of their feelings, since in the normal course of their work they must compartmentalize so many different feelings or emotions. Helping nurses to identify their own narratives can help them locate necessary selfobject functions available to them. This will help them to shore up the self and move in the direction of self-cohesions. In doing so, the nurse will feel her self to be more intact and better able to manage the emotional and psychological demands of her professional role. This in turn, will enable her to be more empathically attuned to her patients, to the best of her internal capacity.

In clinical work with nurses, it is helpful to understand the processes of identification that may lead to their career choice and to their identity as nurses who are functioning professionally. In addition, further understanding of the processes that can interfere with empathy, even when the nurse is not burned out is warranted. Nurses who are also mothers, especially if they are the mothers of young children, may be more likely to feel stressed by working with people with whom they are likely to lose their objectivity, such as other mothers of young children. This does not reflect an emotional deficit, but merely an understandable limit in the nurse’s ability to empathize with this kind of patient at this stage in her life. It is important to remember that empathy is a fluid capacity that ebbs and flows in different stages of life. Family members of patients may present nurses with the challenge of over-identification, which they may find distressing. For nurses who are in treatment, there is a window of opportunity in which to explore what these feelings may represent to them in their personal lives.
Finally, based on the findings of this study, professional development by means of further education, and additions to the nursing curriculum are recommended. Not only would it be helpful to treat the likelihood of burnout as a normal phenomenon in the professional development of nurses, it is recommended that this training would include practical tips for managing burnout as well as recognizing early symptoms when it occurs.

It is recommended that a more full understanding of the psychological phenomena that nurses manage on a daily basis with their patients, families, and themselves also be worked into the curriculum for training nurses. Specifically, in-depth training in regression and the propensity for the regressive pull in nurses is recommended. Most nurses seem to have some understanding of this phenomenon; however, further elucidation in the nature of regression will help nurses understand both their patients and themselves better, and will give them the perspective they need to better manage the difficult emotions that arise as a matter of course for both patients and nurses. This will help nurses in dealing with families as well as patients.

Training that helps nurses understand the selfobject functions that they provide to their patients and the families of patients may aid also in their understanding of how they can be most helpful to patients and their families.

It is further recommended that hospital administrators develop a clearer and more complete picture of both the psychological and physical aspects and challenges of the services nurses provide their patients with every day. This will help them provide better support for their nurses. For example, a better understanding of the psychological demands placed on nurses as a result of patient-visitor policies may invite reconsideration
of those policies to make sure that they are serving the best interests of both the patients and the nurses who care for them.

Areas for Further Research

Much of the literature on burnout has been researched by social psychologists rather than psychodynamically informed researchers and clinicians. Further research that investigates the many facets of burnout viewed through a psychodynamic lens is warranted. This would help to inform nurses, nurse educators, and hospital administrators of the psychological aspects of the role that nurses play for patients and families and the way in which this role affects the healing process.

Burnout has been cited in previous research as an affective disorder (Buhler & Land, 2003). Further investigation into the burnout syndrome and its relationship to depression is warranted for further clarification of the currently vague and ambiguous definition of “burnout.” It is possible that some phases of burnout are actually symptoms of depressive episodes. If understood through the lens of psychodynamically informed research, the treatment of burnout may vary from person to person, depending on whether the burnout is a symptom of a major depressive episode, or simply a normal phase in a nurse’s career.

Several nurses stated that knowing what kind of unit is a good match is important for nurses in finding and maintaining job satisfaction, and not burning out; however, they were also pleased to have a wide variety of choices available to them if and when they choose to change directions. Further investigation into how nurses go about making the
decision to change units or directions in their career would lend further understanding of how nurses deal with the challenges and opportunities specific to nursing.

Some of the nurses spoke about the difficulty of caring for patients, especially pediatric patients, once they themselves had become mothers, and the profound internal affect this had on them emotionally. Further qualitative investigation into the dynamics of what makes nurses who are also mothers lose objectivity when they encounter the mothers of certain patients is warranted. This could be an area of fruitful research to help further understanding of internal object relations as well as selfobject functions. Such research could include looking into the phenomenon of nurses who over-identify with family members, lose their ability to stay empathically attuned to patients, and feel the need to retreat in order to manage their own affective states. Further investigation is also warranted in examining gender differences of nurses in the manner of response to patients and family members.

There is still much to be learned about the subject of burnout, the definition of which remains elusive. There is a complexity of research that has not yet created a unified, universal understanding of what burnout truly is. The role of empathy is no less ambiguous. As Basch (1983) said, “Is empathy an end result, a tool, a skill, a kind of communication, a listening stance, a type of introspection, a capacity, a power, a form of perception or observation, a disposition, an activity or a feeling?” (p. 2). The fact that nurses employ empathy in different ways than analysts may contribute to the ambiguity of this concept. While there is an assumed role of empathy in the nurse/patient relationship, further understanding of the concept of empathy, as employed by nurses could help nurses improve their professional functioning.
Final Thoughts

The purpose of this study was to understand the role of empathy in nurses who are currently not burned out, with the assumption that burnout compromises the capacity for empathy. During the course of the study unexpected findings were discovered. It was confirmed that burnout compromises the capacity for empathy; but this study found that there are other impediments to empathy as well. Since many other factors were found that compromise empathy, further inquiry into the role of empathy and how it can be interfered with in nurses who are currently not burned out needs further investigation.

Further research is needed in the area of burnout, from the standpoint of burnout not as an anomaly, but as predictable phenomenon in the average nursing career. A better understanding of the relationship between burnout and depression is also warranted.

Finally, further understanding of empathy and how it is employed in the role of the professional nurse will contribute to a better understanding of the intrapsychic world of the nurse. This needs to be woven into the training and in-services offered to nurses. Continued research will also help clinicians who work with nurses in treatment better understand why nurses become upset with themselves for not being empathic; and how this affects not only their sense of self, but their ability to perform their important work as well as they can.
APPENDIX A

MASLACH BURNOUT INVENTORY (MBI-HSS)
MBI—Human Services Survey

The purpose of this survey is to discover how various persons in the human services or helping professionals view their jobs and the people with whom they work closely.

Because persons in a wide variety of occupations will answer this survey, it uses the term recipients to refer to the people for whom you provide your service, care, treatment, or instruction. When answering this survey please think of these people as recipients of the service you provide, even though you may use another term in your work.

On the following page there are 22 statements of job-related feelings. Please read each statement carefully and decide if you ever feel this way about your job. If you have never had this feeling, write a “0” (zero) in the space before the statement. If you have had this feeling, indicate how often you feel it by writing the number (from 1 to 6) that best describes how frequently you feel that way. An example is shown below.

Example

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How Often

0–6

Statements:

1. _________ I feel depressed at work.

If you never feel depressed at work, you would write the number “0” (zero) under then heading “How often.” If you rarely feel depressed at work (a few times a year or less), you would write the number “1.” If your feelings of depression are fairly frequent (a few times a week, but not daily) you would write a “5.”
## Appendix A

**MBI–Human Services Survey**

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### How Often 0–6 Statements:

1. I feel emotionally drained from my work.
2. I feel used up at the end of the workday.
3. I feel fatigued when I get up in the morning and have to face another day on the job.
4. I can easily understand how my recipients feel about things.
5. I feel I treat some recipients as if they were impersonal objects.
6. Working with people all day is really a strain for me.
7. I deal very effectively with the problems of my recipients.
8. I feel burned out from my work.
9. I feel I'm positively influencing other people's lives through my work.
10. I've become more callous toward people since I took this job.
11. I worry that this job is hardening me emotionally.
12. I feel very energetic.
13. I feel frustrated by my job.
14. I feel I'm working too hard on my job.
15. I don't really care what happens to some recipients.
16. Working with people directly puts too much stress on me.
17. I can easily create a relaxed atmosphere with my recipients.
18. I feel exhilarated after working closely with my recipients.
19. I have accomplished many worthwhile things in this job.
20. I feel like I'm at the end of my rope.
21. In my work, I deal with emotional problems very calmly.
22. I feel recipients blame me for some of their problems.

(Administrative use only)

APPENDIX B

DEMOGRAPHIC SURVEY
Demographic Survey

Please fill out the demographic information listed below. This information will assist in understanding nurses and their perceptions of their work and will ONLY be used for the purposes of this research. This information will be kept confidential.

1. Age (in years) _______

2. Marital Status
   ____ single
   ____ married
   ____ divorced
   ____ living with partner
   ____ widowed

3. Level of Nursing Education
   ____ diploma in nursing
   ____ ADN
   ____ BSN
   ____ bachelor degree, other (specify)___________
   ____ MSN
   ____ master degree, other (specify)___________
   ____ doctoral degree (specify)___________

4. Years you have been a registered nurse _______

5. Years practicing as a hospital nurse _______

6. Years practicing as a nurse _______

7. Employment status
   ____ Full-time
   ____ Part-time/flex
   ____ PRN

8. Average number of hours worked per week _______

9. Setting you work in
   ____ Medical
   ____ Surgical
   ____ Maternal/child
   ____ Pediatrics
   ____ Emergency Room
   ____ Critical Care
   ____ other
APPENDIX C

EMAIL ALERT
To: NURSSTAFF
From: cheryl.schraeder@carle.com, James.leonard@carle.com
Subject: New Nursing Research Studies

Dear Colleagues,

We would like to alert you to an interesting new nursing research study that you may have an opportunity to participate in. The nursing study conducted by Kelly Bradham, RN, LCSW from the Institute for Clinical Social Work in Chicago will explore the role of empathy in nurses who do not experience burnout by surveying and interviewing registered nurses employed at Carle Foundation Hospital.

Participation in this project will be beneficial not only for the potential knowledge to be gained, but also because it is an important part of our on-going effort to gain Magnet status through heightened participation in research activities.

You will receive a packet in your unit mailbox in the next few days. Please take time to fill out the questionnaire and return it to Kelly in the enclosed stamped envelope.

Thank you in advance.

Sincerely,

Cheryl Schraeder, PhD, RN, FAAN, Head of HSRC
James Leonard, MD, President/CEO Carle Foundation Hospital
APPENDIX D

NURSE MANAGERS NOTE
NURSE MANAGERS:

Please POST the attached notice where your nursing staff will see it

There is a NEW research study beginning for female registered nurses

The goal of this research is to investigate what nurses need in order to feel more engaged or excited with their work. This study will be looking at the attitudes of female registered nurses who have worked at bedside nursing for two years or longer.

It is hoped that you will encourage your nurses to participate, however they will need to understand from you that it is voluntary.

WE VALUE THE NURSES INPUT! THEIR INPUT CAN MAKE A DIFFERENCE!

IF YOU HAVE ANY QUESTIONS, PLEASE FEEL FREE TO CONTACT:
KELLY M. BRADHAM
EMAIL: RNRESEARCH@INSIGHTBB.COM OR
(217) 378-4435
APPENDIX E

REGISTERED NURSE NOTE
REGISTERED NURSES:

How do you feel about your work?

YOUR INPUT IS NEEDED IN THIS NEW RESEARCH STUDY

What can we do to facilitate nurses feeling good about their work?

If you are a female Registered Nurse who has worked at the bedside in the hospital for two or more years, you will receive a packet in your mailbox. The survey will only take 10 minutes of your time and your input is valuable. Your participation is voluntary. This research has been approved by Carle’s Institutional Review Board.

THIS RESEARCH IS BEING CONDUCTED BY A REGISTERED NURSE WHO DOES NOT WORK FOR CARLE OR ANY OF ITS AFFILIATES. YOUR INPUT IS STRICTLY CONFIDENTIAL.

IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT:

KELLY M. BRADHAM
EMAIL: RNRESEARCH@INSIGHTBB.COM OR
(217) 378-4435
APPENDIX F

COVER LETTER TO NURSES
Dear Registered Nurse,

My name is Kelly Bradham. I am a nurse and a social worker, conducting a confidential study on hospital nurses and their work, and I’d like to invite you to participate. Specifically, I am researching nurses who do not experience burn out and how we can use that information to help all nurses. It is hoped that my study will contribute to the education of nurses, their job retention, and satisfaction. All individual data collected will be kept confidential; information will be used only in the aggregate. No individual will be identified in my study.

I am not an employee of the Carle Foundation Hospital or any of its affiliates. This research is being conducted in partial fulfillment of my doctoral program at the Institute for Clinical Social Work, Chicago, IL. For your protection, this study has gone through a rigorous review process, by an Institutional Review Board (IRB). All participation is completely voluntary.

If you are interested in participating in this study, please complete and return the enclosed informed consent form, the demographic form, and the short survey, which should take about 10 minutes. An pre-addressed stamped envelope is included.

A small number of those nurses surveyed will have the opportunity to be interviewed for an hour at a time and place set at each nurse’s convenience. Your completing the enclosed survey will greatly assist me in my research even if you don’t wish to be interviewed at a later date.

If you have any questions, please feel free to contact me by email at Rnresearch@insightbb.com or by phone at (217) 378-4435 at anytime. Thank you very much for your consideration.

Sincerely,

Kelly M. Bradham, RN,  
Licensed Clinical Social Worker (LCSW)
7 Dunlap Court
Savoy, IL 61874
(217) 378-4435
APPENDIX G

CONSENT FORM
Informed Consent

**Title of Project:** An Exploration of the Role of Empathy in Nurses Who Do Not Experience Burnout

You are invited to participate in a research study conducted by Kelly M. Bradham, RN, LCSW at the Institute for Clinical Social Work, Chicago, IL. The goal of this study is to determine the emotional characteristics necessary for a nurse to be effective and not experience burnout. The study also hopes to determine the role of empathy in nurses who do not experience burnout.

**Description:** You are being asked to fill out the survey sent to all RN’s who have worked at the bedside in acute nursing hospital departments for at least 2 years. Some demographic information will also be acquired. Following data analysis of the surveys, if you rate low on the survey for burnout, some participants will be asked if they are willing to be interviewed by the Principal Investigator (PI). If you participate in the interview, this will serve as your consent. Interviews will be about one hour long. Surveys will be entered into a database and 10-20 RNs will be interviewed.

**Participation:** Your participation in this study is voluntary. Your involvement throughout the study is important, however, you have the right to refuse to answer questions or withdraw at any time. Your decision to participate, decline or withdraw will have no effect on your current status or future relations with Carle Hospital. If you participate in the interview, you will receive a $10.00 coupon for use in Carle facilities for your time.

**Confidentiality:** All efforts will be made to keep your information confidential. Only the PI and Health Systems Research Center (HSRC) data management staff will know your identity. All surveys will be stored at the office of the PI. Survey and demographic information will be coded and stored in a secure data base at HSRC. Interviews will be recorded and transcribed verbatim. The recording will be destroyed and a copy of the transcription will be given to you to correct, clarify or eliminate any statements. The transcriptionist will be someone from out of the area, who has signed a confidentiality agreement and will hear only your voice. She/He will not know your name. Only the PI will interview you and be responsible for the data analysis of the interviews. The transcription will be coded so the PI will not know the identity of the interviewee during data analysis. Your anonymity will be carefully protected in any reports of the results of the study.

**Benefits and risks:** By participating in this study you have the opportunity to contribute to scholarly research concerning nursing and burnout. Further, participation in this study may be beneficial to you because this study aims to develop knowledge about ways your organization can help better meet your needs.

**Contact:** If you have questions about this project, you may contact the investigator, Kelly Bradham at (217) 378-4435 or RNResearch@insightbb.com. You may also contact the Carle Institutional Review Board Office at (217) 383-4366. An Institutional Review Board is a group of people who review research to protect your rights.
**Consent:** I have read and understood the above information and consent to participate in the study. A copy of this form will be provided to me.

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APPENDIX H

SECOND COVER LETTER
Dear Registered Nurse,

A few weeks ago you were sent a survey packet in your mailbox. I would like to invite and encourage you again to participate in this research study that I hope will contribute to the education of nurses, their job satisfaction, and retention. Specifically, I am researching nurses who do not burn out and how we can use that information to help all nurses. All data will be kept confidential and will be used only in the aggregate. No individual will be identified. Your input is needed.

I am not an employee of the Carle Foundation Hospital or any of its affiliates. This research is being conducted for partial fulfillment of my doctoral program at the Institute for Clinical Social Work in Chicago, IL. For your protection this study has gone through a rigorous review process by an Institutional Review Board (IRB). Your choice to participate is voluntary.

If you are interested in participating in this study, please complete and return the enclosed informed consent form, the demographic form, and the short survey, which should take you about 10 minutes. An pre-addressed stamped envelope is included.

A small number of the nurses surveyed will have the opportunity to be interviewed for an hour at the time and place of determined by each nurse’s convenience. Your completing this survey will greatly assist in my research, even if you do not wish to be interviewed at a later date.

If you have any questions, please feel free to contact me by email at Rnresearch@insightbb.com or by phone at (217) 378-4435 at anytime. Thank you for your consideration.

Sincerely,

Kelly M. Bradham RN,
Licensed Clinical Social Worker (LCSW)
7 Dunlap Court
Savoy, IL 61874
(217) 378-4435
APPENDIX I

SECOND MAILING NOTICE
NOTE:

You can participate and remain ANONYMOUS

By sending in only the two survey forms and NOT the consent form

However, your signed consent is confidential and most appreciated

**** Thank you, if you have already returned your survey from the first mailing. If you did not, I appreciate your taking time to do it now.
APPENDIX J

INTERVIEW QUESTIONS
Interview Questions

Developmental aspects of becoming a nurse
Tell me what influenced you to become a registered nurse.

Phenomena of empathy:
Tell me how and/or what you learned about empathy in your training.
What do you feel are some of the characteristics involved in empathy?
How do you feel you were able to gain empathy in your life?
Do you feel there are different kinds of empathy?

Nurses’ experience of empathy:
Does it ever seem you empathy for a patient has gotten blurred, like feeling their situation too much?
Are you ever so tired or feeling something else that you can’t see anything from a patient’s point of view?
Tell me of a time when you felt like you had the right amount of empathy for the patient and it felt like a good experience for you too.

Emotional stance of nurse:
How do you think about how close vs. distant, emotionally, you become with a patient?
Does it depend on the patient? How close is good, how distant is not good?
How emotionally involved do you think is helpful to get with your patients?
Think of a time when you or another nurse became over-involved with a patient. What was that like for you? Do you think it was beneficial to you or the other nurse? To the patient?

Burnout:
Is there a relationship between feelings of being burned out and your feelings about yourself and your feeling that you can empathize with your patient?
Think of a nurse who is burned out. What is the difference between them and you?
What keeps you from getting burned out?
What is your experience of being burned out?

Burnout and Empathy:
What, if any, is the relationship of empathy and burnout for you?
Do you think empathy is related to burnout?
……too much empathy leads to burnout? If so, how so?
……too little empathy leads to burnout? If so, how so?

Anything come to mind that I have not asked?
APPENDIX K

APPROVAL LETTER FROM CARLE IRB
DATE: April 18, 2007

TO: Kelly Bradham, RN, LCSW

FROM: David M. Main, MD
Chair, Carle Institutional Review Board

SUBJECT: 07-17 An Exploration of the Role of Empathy in Nurses Who Do Not Experience Burnout

Thank you for submitting the above study to the Institutional Review Board. The study was reviewed and approved at the Institutional Review Board committee's last meeting on April 18, 2007. The protocol has been approved at minimal risk. The following were also approved: Appendix A: “MBI-Human Services Survey”, Appendix B: demographic information, Appendix C: letter to “NURSSTAFF”, Appendix D: (a) recruitment flyer addressed to “Nurse Managers” and (b) recruitment flyer addressed to “Registered Nurses”, Appendix E: letter to “Registered Nurse”, Appendix F: Informed Consent, Appendix G: follow-up letter to “Registered Nurse”, Appendix H: information flyer addressed to “Registered Nurses”, and Appendix I: “Interview Questions”. There is no HIPAA documentation required with this research. Research on this project may begin at any time.

• The original signed copy of the consent form should be kept with your study records. A copy should go in the patient’s chart, and another copy should be given to the patient for their records.

• If changes in procedure become advisable, these changes must be submitted to the Office of the Institutional Review Board and approved by the Institutional Review Board prior to initiating the changes.

• If any problems involving human subjects occur, the Carle Institutional Review Board needs to be notified within 24 hours. The phone number is 217/383-4366.

• If a research participant becomes incarcerated during the course of the study, the Carle Institutional Review Board needs to be contacted and approval must be obtained before research can continue with that participant.

• Materials submitted to the Carle Institutional Review Board should not contain participant names, clinic numbers, or other identifying factors.

• You will be asked to make periodic reports on this research to the Carle Institutional Review Board.

Thank you for your interest in research at Carle.

sw

cc: Barbara Hall, BS/MERC
REFERENCES


Altun, I. (2002). Burnout and nurses' personal and professional values. *Nursing Ethics, 9*(3), 269-278.


