Communal Orientation and the Burnout Syndrome Among Nurses[1]

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In the present study, burnout symptoms (emotional exhaustion, depersonalization, and reduced personal accomplishment) were hypothesized to occur among male and female nurses who are low in communal orientation and feel they invest more in their relationships with patients than they receive in return. Communal orientation refers to the desire to give and receive benefits in response to the needs of and out of concern for others. Furthermore, it was expected that the perception of imbalance would be more strongly related to depersonalization and reduced personal accomplishment among women than among men. The sample consisted of 194 full time working nurses (48 5% males, 51.5% females). Burnout was measured with the Maslach Burnout Inventory (MBI). The results show that the burnout syndrome is more widespread among: (a) subjects, particularly women, who perceive an imbalance in their relationships with patients; (b) subjects low in communal orientation; and (c) subjects who both perceive an imbalance and are low in communal orientation. The results are discussed in the context of theoretical and practical implications.

In the human service professions, the burnout syndrome is generally viewed as a response to job-related stress and as a crucial determinant of illness, absenteeism, and job turnover. Although research on burnout is characterized by a diversity in operationalization of the concept in question (e.g., Farber, 1983; Freudenberger, 1983; Maslach & Jackson, 1981; Pines & Aronson, 1981; Savicki & Cooley, 1983), feelings of emotional exhaustion or energy depletion are generally considered a core

[1] The authors are grateful to Esther Groenestijn for her help in data collection.

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Journal of Applied Social Psychology, 1992, **22**, 3, pp 173-189

symptom of the burnout-syndrome (Garden, 1989; Maslach & Jackson, 1981; Pines & Aronson, 1981; Schaufeli, 1990; Shirom, 1989). Additionally, two characteristics of burnout have been described in the literature: the development of negative, cynical attitudes and feelings about recipients (depersonalization), and the tendency to evaluate oneself negatively, especially with regard to one's work with recipients (reduced personal accomplishment) (cf. Maslach & Jackson, 1981). These two characteristics of burnout reflect the relation between burnout and working with people. Thus, this multidimensional description of burnout is restricted to human service occupations, including nursing, teaching, police, and social work.

It is widely acknowledged that nurses, who are the subjects in this study, are especially vulnerable to the burnout syndrome (Maslach & Jackson, 1982). Nursing positions are characterized by a variety of stressors, including work overload, low job status, lack of control within the job setting, lack of criteria for measuring accomplishment, lack of feedback and social support from co-workers and supervisors, and ambiguity and uncertainty about professional roles (cf. Cherniss, 1980; Jayaratne & Chess, 1983; Maslach, 1978; Maslach & Jackson, 1981; Motowidlo, Packard, & Manning, 1986; Wills, 1978). The present study focuses upon an additional important factor that might contribute to the development of burnout among nurses, that is, the nature of the exchange process with patients. Social exchange theories basically assume that subjects involved in personal relationships evaluate such associations in terms of rewards, costs, investments, and profit (cf. La Gaipa, 1977). For example, according to equity theory (Adams, 1965), individuals are less satisfied with a relationship when they perceive their investments not proportional to their outcomes. Indeed, among high school teachers, Blase (1982) showed that a discrepancy between effort and outcomes was negatively related to satisfaction. He suggested that one of the predictors of the burnout syndrome is the absence of rewards, including verbal and nonverbal expressions of enthusiasm and gratitude by students, in relation to the demands of work-related stressors.

A characteristic feature of the relationships between nurses and patients is that they are basically complementary: nurses are supposed to *give*, while patients are supposed to *receive* (cf. Heifetz & Bersani, 1983; Pines & Aronson, 1981). Hence, nurses may feel underbenefitted in their relationships with patients, because they put more into these relationships than they receive. Intrinsic rewards, including positive feedback from patients, health improvement of the patient, and

appreciation and gratitude are variable and unpredictable (cf. Eisenstat & Felner, 1983; Heifetz & Bersani, 1983; Pines & Aronson, 1981; Sakharov & Farber, 1983). In addition, extrinsic rewards, including career advancement, salary, and administrative approval, are meager at the lower level of health profession positions. The inclusion of reward variables appears to be useful in understanding development of burnout. For example, Turnipseed (1987) suggested that the low levels of burnout among hospice nurses could be explained by, among others, feelings of freedom and autonomy and immediate positive feedback. A study of Jayaratne and Chess (1983) among social workers showed that perceptions of financial rewards, promotional opportunities, and promotional fairness were strongly related to job satisfaction, which was negatively related to depersonalization and emotional exhaustion. Cherniss (1980) suggested that material rewards may become more important for health workers over time, to replace the nonmaterial rewards they had hoped for in the early phase of their careers.

In contrast to the moderate level of rewards generally found in the human health professions, the emotional burden of nurses is high, including feelings of failure to respond to patients' needs and frustration to be of real help to the patient. This is particularly true for those who are working with the terminally ill (Berlin Ray, Nichols, & Perritt, 1987). Furthermore, being abused or manipulated by patients, and dealing with worried, complaining, impatient, and unreasonable patients can be considered as primary costs and can be very distressing for professionals, particularly for novices, who naively assume that patients are honest and cooperative under all circumstances (Cherniss, 1980).

Thus, there is evidence to assume that nurses may experience a lack of reciprocity in their relationships with patients. Among the various theories that have dealt with the consequences of a lack of reciprocity in interpersonal relationships (La Gaipa, 1977), equity theory probably offers the best developed theoretical framework. This theory would suggest several options to cope with such a lack of reciprocity, including restoration of actual or psychological equity, altering the comparison other, and leaving the profession. Nurses perceiving disequilibrium may attempt restoration of equity by reducing their patients' outcomes (restoration of actual equity; Walster, Berscheid & Walster, 1973). Patients' outcomes are lowered by responding to them in an impersonal way. Indeed, Garden (1987, 1989) pointed out that especially among full time workers who are frequently in contact with clients, depersonalization is likely to occur.

However, nurses may not always be characterized by the pursuit of reciprocity in their interactions with patients. Instead, many of them may be distinguished by their altruistic motivations, and their need for helping troubled people (cf. Cherniss, 1980; Farber, 1983; Pines & Aronson, 1981; Ratliff, 1988; Sakharov & Farber, 1983; Savicki & Cooley, 1983). For example, Garden (1989) showed that more than 70% of the nurses in her sample could be categorized as "feeling types." These persons are distinguished from another Jungian type, that is, the "thinking type," by, among others, their concern for people. Accordingly, it can be assumed that many nurses are high in *communal orientation*, an individual difference characteristic that refers to the desire to give and receive benefits in response to the needs of and out of concern for others (Clark, Ouellette, Powell, & Milberg, 1987; VanYperen & Buunk, 1991). Clark et al. (1987) demonstrated that a communal orientation leads to greater helping and greater responsiveness to other's needs. Furthermore, they cautiously suggested that people low in communal orientation may react negatively to others' emotional indications of need. Therefore, it may be expected that nurses low in communal orientation will be more vulnerable to burnout than high communally oriented nurses.

It has to be noted, however, that even though the nurse-patient relationship is, by definition, not reciprocal, nurses will not necessarily *experience* inequity. Some will consider their intrinsic rewards from their relationships with patients sufficiently compensatory for the lack of extrinsic rewards, the emotional burden, and the stressors that are prevalent in the health professions (which can be considered as restoration of equity psychologically). When nurses do not perceive their relationships with their patients as inequitable, they may not develop burnout symptoms, even when they are low in communal orientation.

In sum, in this study it is expected that burnout symptoms will occur primarily among nurses who are *low* in communal orientation and who simultaneously perceive their relationships with patients as generally *imbalanced* in terms of inputs and outcomes. Apparently, these individuals do not choose to leave the health profession field. They are expected to cope with the imbalanced situation by restoring actual equity. The most obvious way to do so is by depersonalizing the patients. However, considering the occupational identity of nurses, dealing with patients in an impersonal manner may lead to feelings of reduced personal accomplishment and, next, to emotional exhaustion (cf. Golembiewski, Munzenrider, & Carter, 1983).

Additionally, some gender differences are expected. It is generally found that men score higher in depersonalization than women (cf. Cahoon & Rowney, 1984; Gold, 1985; Greenglass & Burke, 1988; Greenglass, Burke, & Ondrack, 1990; Maslach & Jackson, 1985; Schwab & Iwanicky, 1982; Williams, 1989). This finding can be explained by sex-role socialization; girls are traditionally taught to be nurturant, responsible, and empathic, whereas boys are encouraged to be achieving, objective, and nonemotional (Greenglass et al., 1990; Kidder, Fagan, & Cohn, 1981; Maslach & Jackson, 1985). Maslach and Jackson (1985) suggested that men may be therefore somewhat more likely than women to respond to other people in an impersonal manner. Because the level of depersonalization is in general higher among men, this behavior will not easily be recognized as an equity-restoring mechanism or a coping technique among men who perceive themselves as underbenefitted. Furthermore, depersonalized behavior among men may not be perceived as reduced personal accomplishment. Among men, the burnout syndrome may manifest itself exclusively by its core symptom, namely emotional exhaustion. On the other hand, for women, considering other individuals as things or objects is likely to violate the female sex-role conception. If women who perceive themselves as underbenefitted restore equity by depersonalizing patients, this behavior may result in perceptions of reduced personal accomplishment among them, and next, lead to emotional exhaustion. Thus, gender differences are expected to occur on depersonalization and reduced personal accomplishment, but not on emotional exhaustion.

Method

Subjects

The sample consisted of 194 nurses with a full-time job. These subjects were selected from a sample of 351 respondents (48.5% males, 51.5% females) on the basis of the number of hours they were employed (full time, that is 38 or more hours per week), as well as the percentage of the time they were actually in contact with patients (50% or more). This selection was made on the assumption that the number of contact hours with patients is related to burnout among full time workers (cf. Jayaratne & Chess, 1983; Savicki & Cooley, 1987). Much more than in a part-time job, a full-time job requires an almost total involvement in work (Cherniss, 1980). The mean age of the selected subjects was 30.6 years, and the mean length of their professional career as a nurse was

10.6 years. Some 41.6% worked with physically ill, 20.8% with mentally ill, and 37.6% with mentally retarded patients.[3]

Procedure

The subjects were participants in a part-time head-nursing training program and were contacted during the course of the program. They filled out the questionnaire immediately, or took it home and delivered it at a later date. The response-percentage was 86%. The numbers of subjects in the following analyses vary due to occasional missing data.

Measures

Burnout was measured by the Maslach Burnout Inventory (Maslach & Jackson, 1986). Coefficients alphas were adequate (N = 351): for the emotional exhaustion scale (EE) .88, depersonalization (D) .71, and personal accomplishment (PA) .80. The correlation between EE and D was .56 ($p \leq .001$), between EE and PA -.49 ($p \leq .001$), and between D and PA -.55 ($p \leq .001$).

Communal orientation was assessed by the scale of Clark and her colleagues (see Clark et al., 1987, for all 14 items of the scale; cf. VanYperen & Buunk, 1991). The 14 items are each followed by a five-point scale, ranging from "definitely does *not* sound like me" to "definitely sounds like me." Some examples of items fo the communal orientation scale are: When making a decision, I take other people's needs and feelings into account; I don't especially enjoy giving others aid; When I have a need, I turn to others I know for help. Coefficient alpha was .66 (N = 351).

Perception of imbalance. The balance of investments and outcomes was measured by the following item: "How often do you feel you invest more in the relationships with patients than you receive in return?" Similar global measures of imbalance have often been employed in research on equity in interpersonal relationships (Buunk & VanYperen, 1990). Pearson's correlation with communal orientation is r = -.08 (n.s., n = 191). Subjects who never or next to never perceived an imbalance between investments and outcomes in their relationships with patients were grouped together (63%), as well as subjects who sometimes, regularly, or often perceived such an imbalance (37%). Thus, a majority did not perceive a substantial imbalance in their relationships with patients.

[3] Physically ill, mentally retarded patients may respond in different ways to treatment and to the caregiver. Also, there could be differences in the treatment setting and the nurses' interaction with significant others to the patients (family, spouse, etc); which would differ among the groups and which could affect the caregivers' perception of imbalance. For example, one would expect more family contact and expression of support from the family of an individual suffering from an illness from which he/she may recover, and who is being treated in a hospital, than from the family of a mentally ill or retarded individual who is institutionalized. Indeed, an analysis of variance revealed significant differences with respect to the perception of imbalance between nurses who worked with physically ill, with mentally ill, or with mentally retarded patients ($F(2, 170) = 7.77$, $p \leq .001$). More than nurses who worked with physically ill (M = 2.1), those who worked with mentally ill (M = 2.9; $t(106) = 3.96$, $p \leq .001$) or mentally retarded patients (M = 2.5; $t(135) = 2\ 51$, $p \leq .01$) perceived an imbalance between investments and outcomes in their relationships with patients. The difference between the two latter groups was not significant ($t(99) = 1.60$, n.s.).

Results

To examine the relationship between perceived imbalance, gender, communal orientation and burnout, a multivariate analysis of variance (MANOVA) was executed, with the perception of imbalance, gender, and communal orientation as the independent variables, and the three subscales of the MBI as dependent variables. First of all however, a median split was conducted to create subjects high and low in communal orientation.

As shown in Table 1, the MANOVA revealed that the effect of gender was not significant.[4] In contrast, two main effects of imbalance and communal orientation were found. Burnout symptoms were more widespread among subjects who perceived an imbalance, and among those who were low in communal orientation. Univariate analyses revealed that there was no difference between high and low communally oriented subjects on emotional exhaustion. Additionally, the two-way interaction effects between the perception of imbalance and communal orientation, and between gender and communal orientation appeared to be significant.

As expected, nurses low in communal orientation who felt they invested more in their relationships with their patients than they received in return were particularly vulnerable to the burnout syndrome. Univariate analyses showed that the interaction effect between the perception of imbalance and communal orientation was significant for all three dimensions of burnout. Thus, especially the combination of a low communal orientation and a perceived imbalance in the relationships with patients is accompanied by more negative, cynical attitudes and

[4] A simple t-test revealed that men scored higher on depersonalization than women (respectively M = 6.46 and M = 5.08; $t(188) = 2.59$; $p \leq .01$), a result that is in line with several other studies (Cahoon & Rowney, 1984; Gold, 1985, Greenglass & Burke, 1988; Greenglass et al., 1990; Maslach & Jackson, 1985; Schwab & Iwanicky, 1982, Williams, 1989).

Table 1

MANOVA Results with the Perceived Imbalance, Gender, and Communal Orientation as Independent Variables, and Burnout as Dependent Variable, Characterized by Depersonalization (D), Reduced Personal Accomplishment (RPA), and Emotional Exhaustion (EE)

	Multivariate $F(3, 167)$		Univariate $F(1, 169)$
Imbalance	3.30*	D	4.44*
		RPA	6.96**
		EE	6.97**
Communal	5.83***	D	12.39***
		RPA	12.36***
		EE	1.94
Gender	1.91		
Imbalance × communal	5.01**	D	12.94***
		RPA	7.27**
		EE	8.97**
Imbalance × gender	2.86*	D	4.78*
		RPA	4.57*
		EE	.01
Gender × communal	1.00		
Imbalance × gender × communal	.30		

* $p \leq .05$; ** $p \leq .01$; *** $p \leq .001$.

feelings about one's patients (see Figure 1), the tendency to evaluate oneself negatively, especially with regard to one's work with patients (see Figure 2), and emotional exhaustion (see Figure 3).

The perceptions of imbalance was related to depersonalization and personal accomplishment only among women (see Table 1 and Figures 4 and 5). Such a relationship was not found with regard to emotional exhaustion.

Discussion

This study suggests that equity theory is a fruitful approach to improve our understanding of the burnout syndrome among nurses. Nursing is generally considered as emotionally burdensome and

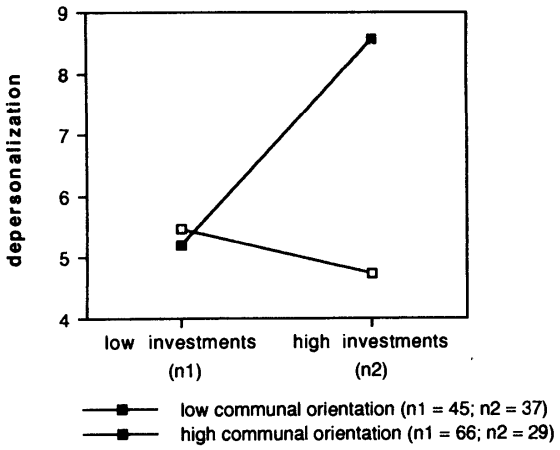

Figure 1. Relationship between the perception of imbalance, communal orientation, and depersonalization.

stressful, while appropriate extrinsic rewards are minimally available. Some 37% of the nurses in the present sample felt they invested more in the relationships with patients than they received in return. In this study, it was reasoned that low communally oriented nurses who perceive an imbalance in their relationships with patients would be relatively susceptible to the burnout syndrome. In contrast to individuals high in communal orientation, these subjects respond to needs of others to a lesser extent, and operate less out of concern for others. Indeed, the results clearly showed that depersonalization, reduced personal accomplishment, and emotional exhaustion were more prevalent among nurses low in communal orientation who considered their relationships with their patients imbalanced.

In order to decrease the likelihood of burnout among nurses, these results suggest that the degree of communal orientation should be taken into account when selecting young adults for nursing. It has to be noted however, that self-selection is already taking place here, considering the

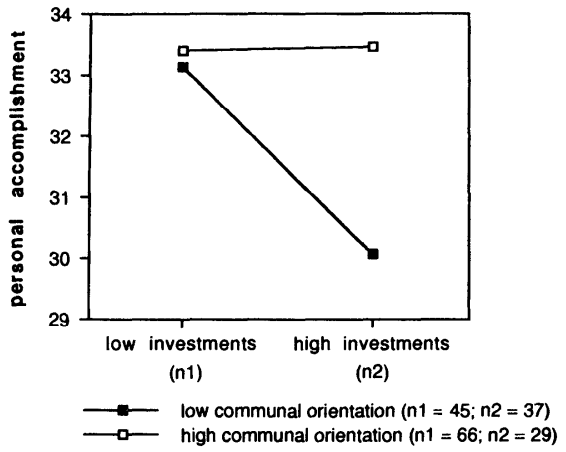

Figure 2. Relationship between the perception of imbalance, communal orientation, and personal accomplishment.

majority of nurses who do not feel underbenefitted in their relationships with patients. Evidently, individuals with a particularly strong need to serve, care, and nurture aspire to nursing careers. Others point out the role of an explicit moral-religious ideology (Cherniss & Krantz, 1983). A formal, moral-religious (i.e., communal oriented) ideology may promote commitment and enhance social support and may accordingly operate as a buffering effect upon burnout. Commitment and support can counteract the negative consequences of stressors upon health and well-being (Buunk, Janssen, & VanYperen, 1989).

Furthermore, realistic job expectations seem to be an additional condition for preventing burnout among novices. Various authors have suggested that a lack of rewards and the concomitant perceptions of imbalance may primarily originate from unrealistic job expectations, which may next result in feelings of frustration and social incompetence, and burnout (cf. Cherniss, 1980; Harrison, 1983; Sakharov & Farber, 1983). It must be noted that this assumption was not supported by a

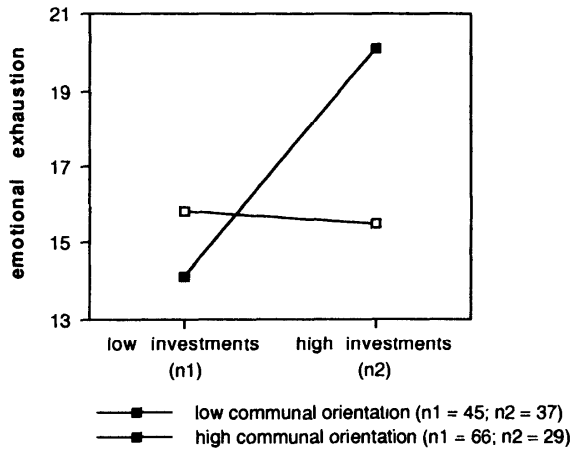

Figure 3. Relationship between the perception of imbalance, communal orientation, and emotional exhaustion.

study of Jackson, Schwab, and Schuler (1986), but they pointed out that there is some doubt about the validity of the utilized measures regarding the expectations their subjects had several years previously. In any event, it seems to be important for individuals to recognize their motives for being or becoming a professional health worker as well as the type of rewards they expect: money, experience, glory, or philosophical rewards (cf. Patrick, 1987; Ratliff, 1988). Consequently, young people who want to become health professionals should be adequately informed about the profession, which may result in more realistic job expectations, and this in turn may have a positive impact on job performance and reduce the likelihood of frustration, stress, and burnout symptoms. Besides improvements in selection and training of nurses, attention has to be paid to interventions in the work setting to reduce burnout (Cherniss, 1980).

Another important finding of the present study was that only among women, the perception of imbalance per se was related to depersonalization and reduced personal accomplishment. These findings

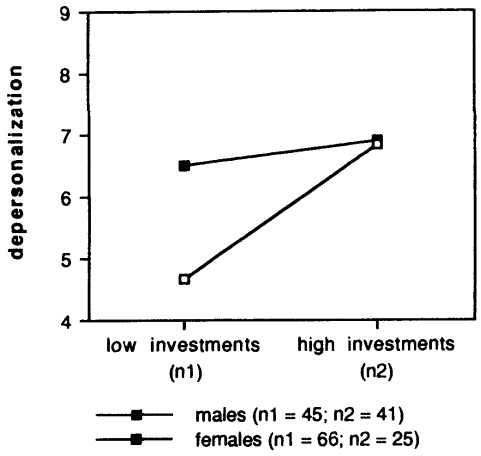

Figure 4. Relationship between the perception of imbalance, gender, and depersonalization.

support our contention that depersonalization has a different meaning for men than for women. As Lemkau, Rafferty, Purdy, and Rudisill (1987) suggested, depersonalization among men may reflect a more task-oriented self-concept. Therefore, men may be, more often than women, inclined to respond to patients in a nonpersonal, objective way, independent of the degree of stress experienced, and it may not occur to them to resort to depersonalization as a coping strategy. In contrast, among women a depersonalizing style may serve as a coping mechanism (Lemkau et al., 1987). Because this way of responding to people strains the female self-concept, it may result in reduced personal accomplishment.

Only the so-called core symptom of the burnout-syndrome, emotional exhaustion, did not differentiate between men and women. Men and women who perceived an imbalance in their relationships with patients scored higher on emotional exhaustion than those who did not perceive such an imbalance. Hence, the question emerges of whether

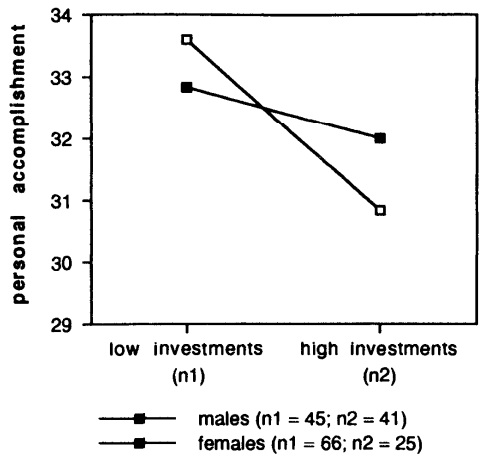

Figure 5. Relationship between the perception of imbalance, gender, and personal accomplishment.

only the emotional exhaustion scale of the MBI is an adequate measure for burnout among men. Garden (1987) also discusses the validity of depersonalization as a dimension of burnout, and suggests that the concept might be type-specific. In line with earlier studies, the results of the present study suggest that depersonalization is gender-specific (cf. Cahoon & Rowney, 1984; Gold, 1985; Greenglass & Burke, 1988; Greenglass et al., 1990; Maslach & Jackson, 1985; Schwab & Iwanicky, 1982; Williams, 1989). Apparently, to study the phenomenon of burnout, it is necessary to take into account individual difference variables, including gender and communal orientation.

The perception of imbalance between investments and outcomes appears to play a crucial role with regard to the occurrence of burnout among low communally oriented nurses with a full time job who spent at least 50% of their time in patient contact. However, a limitation of the present study is that it is difficult to distinguish perceived imbalance as a cause or effect of burnout. It has been hypothesized that imbalance

leads to burnout symptoms. On the other hand, it can also be argued that the burnout syndrome produces perceptions of imbalance. Arguing against this reverse relationship are the results of an earlier longitudinal study on equity (VanYperen & Buunk, 1990). In that study, it was shown that the perception of inequity among married women can be considered as a cause of relationship dissatisfaction. It remains an open question, however, whether nurses' perceptions of imbalanced relationships with patients and the occurrence of burnout should be interpreted as, respectively, cause and effect. Longitudinal studies should be employed to provide more clarity about this point.

In the present study, the operationalization of the perception of imbalance has a limited scope. Investments and rewards can be specified in, for example, time investments, involvement, sense of success and control, and pleasantness experienced in the relationships with clients. The exchange relationship with the *organization* can also be considered by assessing organizational stressors, including work overload, frequency of staff meetings, role ambiguity, relationships with supervisors, autonomy, skill variety, and work-sharing (cf. Leiter & Maslach, 1988; Pines & Maslach, 1978). Consequently, the results of future studies on burnout that take specified investments and rewards into account may advance our understanding of the phenomenon of burnout, and enable health institutions to deal effectively with some fundamental causes of absenteeism, illness, and job turnover.

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