

# ASSESSMENT OF BURNOUT AND PSYCHOLOGICAL WELLBEING AMONG HEALTH PROFESSIONALS IN THE BASQUE COUNTRY

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A sample of 1275 health professionals in the Basque Country (Spain) were assessed (619 doctors, 430 nurses, and 208 auxiliary nurses). Assessment of burnout levels by means of a questionnaire (CDPE) yielded average levels of burnout. However, 28.8 percent of the sample showed high levels of emotional exhaustion. Wellbeing at work assessed by means of the Smith Work Dispositions Inventory and resulted in average levels – only 8 percent of our sample presented high levels of psychological well-being.

Correlation and multiple regression analyses indicated that sociodemographic and work variables such as work overload, lack of recognition and lack of career development were significantly related to high levels of burnout and low wellbeing levels, respectively. As expected, psychological wellbeing and emotional hardiness were negatively related to burnout. Also, burnout significantly predicted negative consequences at various levels (physical, psychological, professional, family, and social), whereas psychological wellbeing, and more specifically emotional hardiness, reduced these negative consequences. The need for intervention programmes at both the organizational and personal level is emphasized. Sampling error was 2.6 percent, and confidence level was 95 percent.

**Keywords:** Burnout syndrome. Psychological wellbeing. Emotional hardiness. Consequences. "Ex postfacto" study.

Se evaluaron los niveles del Síndrome de Quemarse por el Trabajo (SQT) y bienestar psicológico en el trabajo de 1275 profesionales sanitarios (619 Médicos, 430 ATS/DUE, y 208 Auxiliares) en el País Vasco. Los niveles generales del SQT y bienestar presentaron niveles medios. El 28.8% de la muestra estudiada presenta niveles altos de cansancio emocional, y solamente un 8% presenta niveles altos de bienestar psicológico. Los análisis correlacionales y de regresión mostraron que hay una serie de variables sociodemográficas y laborales como la sobrecarga, la falta de reconocimiento y desarrollo profesional, entre otras, que se relacionan significativamente con altos niveles del síndrome y bajos niveles de bienestar. El bienestar psicológico y la dureza emocional se relacionan con el SQT de forma inversa. Así mismo, el SQT predice significativamente una serie de consecuencias negativas a varios niveles: físico, psicológico, socio-familiar, y profesional. Por su parte, el bienestar psicológico y, especialmente, la dureza emocional amortiguan dichas consecuencias en diferentes proporciones. Se resalta la necesidad de que las organizaciones de salud pongan en marcha programas de intervención a nivel organizacional y personal. Error muestral 2.6%, nivel de confianza de 95%.

**Palabras clave:** Síndrome de quemarse por el trabajo (SQT). Bienestar Psicológico. Dureza Emocional. Consecuencias. Estudio "Ex postfacto".

The main purpose of the present study was to assess levels of burnout and psychological wellbeing at work in a sample of health professionals from various hospitals, health centres and public and private clinics in the Basque Country, as well as their consequences at a physical, psychological, socio-familial and professional level. In addition, we studied a series of mediating variables including emotional hardiness and coping.

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In Spain, although different terminologies are used, the most common is that proposed by Gil-Monte (2003) (*Síndrome de Quemarse por el Trabajo*), while the most widely accepted definition of this syndrome among researchers is its conceptualization as emotional exhaustion (Maslach, Schaufeli & Leiter, 2001; Ortega & López, 2004).

A considerable amount of research has been carried out to determine the prevalence of burnout and the sociodemographic and work-related variables associated with it among healthcare personnel at health centres and hospitals from several of Spain's Autonomous Regions: Madrid, Barcelona, Asturias, Extremadura, and so on. Many of these studies agree that its prevalence is high (Caballero, Bermejo, Nieto & Caballero, 2001; Martínez

de la Casa et al., 2003; Molina, García, Alonso & Cecilia, 2003). However, there are also studies that found more moderate levels (Prieto, Robles, Salazar & Daniel, 2002; Recio & Reig, 2003; Bernardo & Labrador, 2007).

As regards the causes of burnout, health professionals are continually exposed to specific stressors related to high emotional involvement (e.g., continuous contact with patients' suffering and death), which combine with those deriving from the organization of the work itself (e.g., work overload) and personal factors. As far as this last type of factor is concerned, the different studies carried out have found that the professionals most prone to suffer from burnout syndrome are those with low levels of emotional hardiness, with feelings of low personal control over situations, with high trait anxiety and who use inadequate coping strategies (Moreno, González & Garrosa, 2002; Luceño, Martín, Jaén & Díaz, 2006; Jenaro-Río, Flores-Robaina & González-Gil, 2007).

A range of negative consequences have been identified in relation to this syndrome, affecting physical, psychological, work-related and socio-familial wellbeing (García-Izquierdo, Sáez & LLor, 2000; González et al., 2003). In sum, burnout constitutes a personal reaction to chronic work stress in response to the demands and characteristics of the occupation. This syndrome, while common in human services professions, is not confined to them.

An important contribution of our work is the measurement of employees' psychological wellbeing. Psychological wellbeing is conceptualized as effectiveness in the overall psychosocial functioning of the individual, and includes positive emotional states in a high and a low dimension (happiness vs. sadness or depression). The variables related to psychological wellbeing include satisfaction with life (including one's job) and emotional hardiness (Wright & Cropanzano, 2000, Lambert, Lambert & Yamase, 2003). Thus, individuals scoring high on these variables tend to rate contradictory or stressful situations in a positive way, believe they can control them, and use active coping strategies, such as problem-solving and/or cognitive reappraisal (Losiak, 2002; Fredrickson, Tugade, Waugh & Larkin, 2003). Such people have lower vulnerability to stress.

Some authors (Wright & Cropanzano, 2000; Wright et al., 2002) consider psychological wellbeing and emotional hardiness (commitment, and feelings of challenge and control at work) to be the variables that

predict job performance, rather than job satisfaction. However, on this matter the results are contradictory (Sobrequés et al., 2003; Mañas, Salvador, Boada, González & Agullo, 2007).

In the present study we shall assess the level of psychological wellbeing of healthcare employees in the Basque Country and identify its relationships with burnout, dissatisfaction and emotional hardiness. Another of the contributions of this work is the fact that it analyzes jointly different types of health professionals (doctors, nurses and auxiliary nurses), since the majority of previous research has concentrated on one type of professional.

The need to study both burnout and psychological wellbeing is in line with the expressed objectives of organizations, among which are those of improving their employees' quality of life and increasing efficiency. As pointed out by large numbers of studies both in Spain and internationally (Wright & Cropanzano, 2000; Wright et al., 2002; Mañas et al., 2007), increased personal wellbeing in employees results in greater motivation and commitment to the organization, higher job satisfaction and productivity, and a reduction in the psychosocial risks and costs associated with high levels of burnout. In contrast, workers with low levels of wellbeing will tend not to experience positive emotions, and their job performance will be lower.

The objectives of the present study were as follows: a) to determine the prevalence of burnout and level of psychological wellbeing among health professionals in the Basque Country; b) to determine the syndrome's relationship with sociodemographic and work variables, as well as with psychological wellbeing; c) to assess levels of emotional hardiness, the coping strategies used by this group and the influence of these variables on levels of burnout and psychological wellbeing; and d) to determine the effects of burnout on a series of personal, organizational and socio-familial variables.

In accordance with these objectives, we propose the following hypotheses: 1) there are sociodemographic and work variables such as age, lack of career development and recognition, and work overload, which have a significant effect on levels of burnout and psychological wellbeing. 2) professionals with low levels of psychological wellbeing and emotional hardiness (commitment, and feelings of challenge and control at work) will more frequently experience burnout. 3) professionals who use adaptive coping strategies (focused on problem-solving or seeking

support) will show greater psychological wellbeing and lower levels of burnout; likewise, professionals with low levels of wellbeing and emotional hardiness will tend to more frequently use maladaptive coping strategies (denial, flight from the problem, etc.). 4) Burnout predicts a series of negative consequences at a personal level (physical and psychological), a professional level (desire to change profession) and a socio-familial level (negative interpersonal relations), and psychological wellbeing and emotional hardiness cushion such consequences.

## METHOD

### Participants

A total of 1275 health professionals (619 doctors, 430 nurses, 208 auxiliary nurses and 18 undisclosed) from different hospitals, health centres and clinics (public and private) in the Basque Country (Spain). The sample was made up of 357 men, 903 women and 15 people who did not disclose their sex. Over-45s accounted for 41.1% of the sample, and 67% worked in the public sector. By provinces, the distribution was as follows: Vizcaya (N=498), Guipúzcoa (N= 561) and Álava (N= 216).

### Instruments

- Questionnaire for the collection of sociodemographic (age, sex, marital status, number of children, etc.) and job-related data (years of experience, job category, number of patients per day, etc.), drawn up by the authors themselves.
- Questionnaire on Professional Burnout for Nursing Professionals (*Cuestionario de Desgaste Profesional para los Profesionales de la Enfermería*; CDPE-R; Moreno, Garrosa & González, 2000). We used an abbreviated and adapted version comprising 63 items. Internal consistency of its scales in our sample were satisfactory. The construct validity, initially assessed by means of the factorial structure of the instrument, replicated the factorial structure in its original dimensions. Below we describe the number of items, the internal consistency index and the percentage of variance explained (explained variance, Ev) by the factors of each dimension: Professional Burnout (Emotional Exhaustion, Depersonalization and Lack of Personal Realization – 12 items; Cronbach's alpha = 0.86, Ev = 62.48%), Consequences (Physical, Psychological, Organizational and Socio-Familial – 16 items;  $\alpha$  = 0.92, Ev = 64.50%), Emotional hardiness (Commitment, and feelings of Challenge and Control at work – 12 items;  $\alpha$  = 0.83, Ev =

57.66%), and Coping strategies (Direct Coping, Social Support Seeking and Avoidance – 9 items;  $\alpha$  = 0.57, Ev = 61.28%). Likewise, this instrument permits the collection of data on certain variables of a work-related nature. We called this dimension Job Dissatisfaction (Overload, Monotony and Dissatisfaction – 14 items;  $\alpha$  = 0.83, Ev = 59.70%). The CDPE is a reliable, validated and widely used instrument (Moreno, Garrosa & González, 2000; Garrosa, Moreno, Liang & González, 2006).

- Smith Work/School Dispositions Inventory (SW/SDI). This instrument assesses psychological wellbeing in the form of positive affective states commonly experienced at work (Smith, 2001). The Spanish version is made up of 19 items and shows high internal consistency (Cronbach's alpha = 0.90). In addition, we carried out different factorial analyses on this inventory. Positive emotional states associated with psychological wellbeing present a factorial structure made up of 3 factors that explain 72.95% of the variance: F1-Relaxation/Energy/Happiness (11 items); F2-Love/Spirituality (6 items); and F3-Disconnection (2 items). The factorial solution obtained constitutes an element in support of the instrument's construct validity.

### Procedure

Application of the questionnaires was carried out through the different doctors' and nurses' professional associations in the Basque Country. We contacted the directors of these associations (*colegios oficiales*), briefly informed them of the aims of the study and requested their cooperation with the application and collection of the questionnaires. The questionnaires were presented in booklet form to facilitate their distribution.

## RESULTS

The data were analyzed by means of the SPSS 14.0 program for Windows. Table 1 shows the levels of prevalence and mean values obtained in each component of burnout and psychological wellbeing. Although on a general level the prevalence of the syndrome is not high (4.1% of the professionals present high levels and 52.1% present moderate levels), there is a considerable prevalence of health professionals with high levels of emotional exhaustion (28.8%), especially among doctors (32.8%). Some of the items measuring emotional exhaustion were: "*I feel burnt out at work*", "*I feel that my daily work at the health*

*centre/hospital/clinic wears me out*", etc. This result concurs with those obtained in other studies (Cebriá et al., 2001; Martínez de la Casa et al., 2003; Bernardo & Labrador, 2007). As far as wellbeing is concerned, just 8% of the sample studied presented high levels.

In order to verify our first hypothesis we applied the Mann-Whitney U and Kruskal-Wallis non-parametric tests. Thus, we found that a large number of sociodemographic and work-related variables are significantly related to levels of burnout and psychological wellbeing at work: *sex* (higher levels of burnout in men); *age* (professionals aged over 45 experience higher levels of burnout and lower levels of psychological wellbeing), *number of years worked* (the longer the time, the higher the levels of burnout and the lower the wellbeing); *job situation* (locums are those

with the highest levels of burnout and the lowest wellbeing, and significantly so compared to substitutes); *number of patients attended* (the higher the quotas and numbers of patients attended per day, the higher the

**Table 1**  
Prevalence and mean scores for burnout and psychological wellbeing at work in health professionals in the Basque Country

	Burnout	EE	DP	LPR	PW			
	%	$\bar{X}$	%	$\bar{X}$	%	$\bar{X}$	%	$\bar{X}$
DOCTOR	5.7%	2.15	32.8%	2.59	6.2%	1.92	6.1%	1.94
NURSE	2.3%	2.01	24.7%	2.42	2.8%	2.42	3%	1.76
AUXILIARY	2.9%	2.10	25.5%	2.47	4.4%	2.47	5.3%	1.92
NURSE								
TOTAL	4.1%	2.10	28.8%	2.51	4.7%	1.9	4.9%	1.88
								8.0%
								2.26

Note: Prevalence (%) = Percentage of high scores (minimum of 3 and maximum of 4). Range of mean scores ( $X$ ) from 1 to 4. EE = Emotional exhaustion; DP = Depersonalization; LPR = Lack

**Table 2**  
Sociodemographic and job-related variables that present significant interactions with burnout and/or psychological wellbeing: level of prevalence, mean scores and significance levels

	Categories	%	Significance level for group comparisons
SEX*	man	28.0	BURNOUT 0.026 WELLBEING ns
	woman	70.8	2.14 (0.51) 2.08 (0.49) 0.000 0.000
AGE*	$\leq 45$	54.0	2.04 (0.47) 2.16 (0.52)
	$> 45$	41.1	0.000 0.000 0.001
YEARS WORKED**	< 3 years	25.2	2.01 (0.45) 2.07 (0.51)
	3-5 years	13.2	2.10 (0.49)
	5-10 years	15.5	2.15 (0.51)
	> 10 years	44.2	0.019 0.000
JOB SITUATION**	Permanent	58.6	2.11 (0.50) 2.14 (0.50)
	Locum	17.6	2.03 (0.46)
	Substitute	21.3	0.001 0.000
NUMBER OF PATIENTS QUOTA**	< 1000	20.8	2.00 (0.45) 2.11 (0.52)
	1000-1500	7.5	2.11 (0.51)
	1500-2000	17.2	2.11 (0.51)
	> 2000	17.6	2.18 (0.48)
NUMBER OF PATIENTS PER DAY**	< 20	29.1	0.003 0.001
	20-30	28.9	2.06 (0.47) 2.07 (0.51)
	30-40	22.4	2.18 (0.47)
	> 40	9.6	2.12 (0.48)
MEAN TIME PER PATIENT**	< de 3 minutes	1.6	0.006 ns
	3-5 minutes	9.8	2.14 (0.48)
	5-10 minutes	38.4	2.17 (0.51)
	> 10 minutes	33.3	2.14 (0.48)
TEACHING AND/OR RESEARCH ACTIVITY*	yes	20.1	0.048 0.006
	No	74.7	2.06 (0.49) 2.11 (0.49)
PRINCIPAL ACTIVITY*	private	20.5	0.003 ns
	public	67.0	2.02 (0.50) 2.13 (0.49)
JOB LOCATION**	urban	79.4	2.09 (0.49) 2.15 (0.50)
	suburban	9.1	2.14 (0.48)
	rural	6.5	2.40 (0.58)

Note 1: Prevalence (%) and mean scores (range 1-4)

levels of burnout and the lower the wellbeing); *mean time per patient* (lower levels of burnout in professionals who devote more than 10 minutes to each patient); *teaching-research activity* (professionals involved in teaching and/or research present lower levels of burnout and higher wellbeing); *principal activity* (professionals working principally in the public sector present higher levels of burnout and lower levels of wellbeing compared to those working mainly in the private sector); and *job location* (professionals working in rural areas present higher levels of wellbeing). Prevalence levels and mean scores on the variables significantly related to burnout and wellbeing are shown in Table 2.

Additionally, the Mann-Whitney U test shows that there are a series of variables related to negative working conditions that may produce job dissatisfaction and which have a significant effect on levels of burnout and psychological wellbeing, so that the higher the score on these variables, the higher the level of burnout and the lower the psychological wellbeing at work. These variables are: overload, monotony, lack of career development, lack of professional recognition, deficient supervision, lack of participation, insufficient retribution and lack of cohesion. Mean scores obtained in these job dissatisfaction variables and the prevalence levels are

considerably high (Table 3).

With the aim of determining the predictor variables for burnout and wellbeing, we carried out a first stepwise multivariate regression analysis of the dissatisfaction variables on burnout. As a result of this, we observed that four of these variables enter the equation and predict burnout significantly, with good fit ( $R = 0.660$ ;  $\beta_0=0.444$ ,  $p=0.00$ ; *Monotony*,  $\beta_1=0.281$ ,  $p=0.00$ ; *Lack of recognition*,  $\beta_2 = 0.141$ ;  $p=0.00$ ; *Overload*,  $\beta_3 = 0.193$ ,  $p=0.00$ ; *Lack of career development*,  $\beta_4=0.045$ ,  $p=0.002$ ). Also, and in particular fashion, work overload or excessive demand predicts, above all, emotional exhaustion ( $R = 0.538$ ,  $\beta_0=0.952$ ;  $\beta_1=0.552$ ,  $p=0.00$ ), with moderate fit. Overload is significantly related to number of patients assigned to the professional (greatest overload is found in professionals with 1500-2000 patients), number of patients attended per day (more than 40) and number of hours per week devoted to bureaucratic work. For its part, monotony at work is significantly associated with number of patients attended per day. Thus, professionals with higher quotas of patients and those who attend most patients per day present higher levels of burnout and lower wellbeing.

Likewise, the stepwise multivariate regression analysis shows that the dissatisfaction variables predict

**Table 3**  
Variables indicative of job dissatisfaction that present significant interactions with burnout and/or psychological wellbeing:  
level of prevalence, mean scores and significance levels

		%	$\bar{X}$	Significance level for group comparisons	
LACK OF PARTICIPATION	YES	79.9	3.13	BURNOUT	WELLBEING
	NO	20.1		0.000 2.14 (0.48)	0.000 2.22 (0.51)
LACK OF CAREER DEVELOPMENT	YES	65.7	2.86	1.91 (0.53)	2.44 (0.55)
	NO	34.4		0.000	0.000
INSUFFICIENT RETRIBUTION	YES	72.4	3.02	2.21 (0.47)	2.17 (0.51)
	NO	27.6		1.89 (0.47)	2.45 (0.50)
LACK OF COHESION	YES	49.0	2.56	0.000	0.000
	NO	51.0		2.15 (0.48) 1.95 (0.49)	2.22 (0.52) 2.38 (0.52)
LACK OF RECOGNITION	YES	51.3	2.58	0.000	0.000
	NO	48.7		2.29 (0.48) 1.89 (0.43)	2.11 (0.49) 2.43 (0.50)
DEFICIENT SUPERVISION	YES	78.3	3.12	0.000	0.000
	NO	21.7		2.16 (0.49) 1.89 (0.47)	2.49 (0.52) 2.20 (0.51)
OVERLOAD	YES	33.5	2.82	0.000	0.000
	NO	66.5		2.31 (0.46) 1.99 (0.48)	2.09 (0.52) 2.35 (0.50)
MONOTONY	YES	7.4	2.19	0.000	0.000
	NO	92.6		2.58 (0.47) 2.06 (0.48)	1.99 (0.53) 2.28 (0.52)

Note 1: Prevalence (%) and mean scores (range 1-4)

wellbeing at work inversely with moderate fit, so that the higher the dissatisfaction levels, the lower the wellbeing ( $R=0.463$ ;  $\beta_0=3.515$ ,  $p=0.00$ ; *Lack of recognition*,  $\beta_1= -0.136$ ,  $p=0.00$ ; *Monotony*,  $\beta_2 = -0.130$ ,  $p=0.00$ ; *Overload*,  $\beta_3 = -0.103$ ,  $p=0.00$ ; *Deficient supervision*,  $\beta_4= -0.060$ ,  $p=0.002$ ; *Lack of career development*,  $\beta_5= -0.049$ ,  $p=0.012$ ). Thus, we can consider the first of our hypothesis confirmed.

In order to verify our second and third hypotheses, we carried out correlational and regression analyses between burnout and psychological wellbeing, as well as with emotional hardiness and the coping strategies used by these professionals. As regards wellbeing, this correlates negatively with burnout (-0.47,  $p=0.00$ ) and, particularly, with emotional exhaustion (-0.50,  $p=0.00$ ) (Table 4).

The levels of emotional hardiness at work in the sample studied are moderately high (Table 5). Some of the items related to emotional hardiness were: “*I consider that the work I do is of value for society, and I don't mind devoting all my efforts to it*” (commitment), “*What particularly attracts me about my work are the innovations and novelties in procedures*” (challenge), “*I don't make too much of an effort at work, since the result is the same in any case*” (control). Emotional hardiness emerges as negatively associated with burnout ( $r = -$

$0.55$ ,  $p=0.00$ ), and positively and significantly with wellbeing at work ( $r = 0.44$ ,  $p=0.00$ ). The multiple regression analyses show that psychological wellbeing and emotional hardiness (commitment, challenge and control at work) predict burnout inversely with good fit ( $R=0.606$ ;  $\beta_0=4.226$ ,  $p=0.00$ ; *Emotional hardiness*,  $\beta_1=-0.524$ ,  $p=0.00$ ; *Psychological wellbeing*,  $\beta_2 = -0.263$ ,  $p=0.00$ ), both factors emerging as protecting against or moderating the syndrome.

As it can be appreciated, emotional hardiness displays greater predictive power for burnout than wellbeing. However, psychological wellbeing more strongly

**Table 5**  
Prevalence and mean scores for emotional hardiness and for the coping strategies used by the sample of health professionals studied

	EMOTIONAL HARDINESS		COPING STRATEGIES					
			Direct coping		Support		Avoidance	
	%	$\bar{X}$	%	$\bar{X}$	%	$\bar{X}$	%	$\bar{X}$
DOCTOR	32.7	2.90	20.1	2.88	20.1	2.92	1.8	2.24
NURSE	42.3	2.99	17	2.89	29.5	3.08	1.9	2.23
AUXILIARY NURSE	35.1	2.92	25	2.90	27.9	3.01	3.4	2.32
TOTAL	<b>36.4</b>	<b>2.93</b>	<b>19.8</b>	<b>2.89</b>	<b>24.6</b>	<b>3.00</b>	<b>2.1</b>	<b>2.25</b>

**Table 4**  
Correlational analysis between principal variables

	BURNOUT	EMOTIONAL EXHAUSTION	LACK OF REALIZATION	DEPERSONALIZATION	WELLBEING	HARDINESS	DISSATISFACTION
BURNOUT	1,00	0,82	0,86	0,75	-0,47	-0,55	0,53
EMOTIONAL EXHAUSTION	0,82	1,00	0,58	0,36	-0,50	-0,38	0,58
LACK OF REALIZATION	0,86	0,58	1,00	0,51	-0,37	-0,54	0,43
DEPERSONALIZATION	0,75	0,36	0,51	1,00	-0,24	-0,44	0,26
WELLBEING	-0,47	-0,50	-0,37	-0,24	1,00	0,44	-0,42
HARDINESS	-0,55	-0,38	-0,54	-0,44	0,44	1,00	-0,34
DIRECT COPING	-0,07	-0,02*	-0,10	-0,08	0,16	0,32	0,04*
SUPPORT	-0,18	-0,09	-0,19	-0,17	0,17	0,28	-0,09
AVOIDANCE	0,14	0,01*	0,13	0,21	0,05*	-0,05*	-0,04*
PROFESSIONAL CONSEQUENCES	0,51	0,47	0,45	0,32	-0,35	-0,41	0,41
FAMILY CONSEQUENCES	0,47	0,49	0,37	0,28	-0,35	-0,27	0,38
PHYSICAL CONSEQUENCES	0,53	0,56	0,43	0,26	-0,41	-0,28	0,42
MENTAL CONSEQUENCES	0,61	0,58	0,53	0,34	-0,44	-0,39	0,43
DISSATISFACTION	0,53	0,58	0,43	0,26	-0,42	-0,34	1,00
LACK OF PARTICIPATION	0,27	0,33	0,22	0,07	-0,18	-0,23	0,75
LACK OF CAREER DEVELOPMENT	0,35	0,38	0,30	0,15	-0,31	-0,29	0,77
INSUFFICIENT RETRIBUTION	0,21	0,27	0,12	0,10	-0,18	-0,07	0,59
LACK OF COHESION	0,30	0,30	0,26	0,15	-0,25	-0,23	0,66
LACK OF RECOGNITION	0,46	0,45	0,43	0,21	-0,37	-0,33	0,73
DEFICIENT SUPERVISION	0,28	0,34	0,23	0,11	-0,27	-0,16	0,74
OVERLOAD	0,41	0,54	0,24	0,19	-0,26	-0,11	0,34
MONOTONY	0,57	0,42	0,43	0,40	-0,30	-0,38	0,29

predicts emotional exhaustion than emotional hardiness ( $R=0.530$ ;  $\beta_0=4.662$ ,  $p=0.00$ ; *psychological wellbeing*,  $\beta_1=-0.534$ ,  $p=0.00$ ; *emotional hardiness*,  $\beta_2=-0.323$ ,  $p=0.00$ ). We thus confirm our second hypothesis, whereby professionals with low levels of psychological wellbeing and emotional hardiness more commonly experience burnout. Additionally, we find that emotional hardiness predicts psychological wellbeing at work with moderate fit ( $R=0.444$ ;  $\beta_0= 0.577$ ,  $p=0.00$ ;  $\beta_1= 0.574$ ,  $p=0.00$ ).

As regards coping strategies, those most widely used were direct coping with the problems and seeking social support (see Table 5), the use of social support being significantly greater in women ( $p=0.00$ ), and in nurses compared to doctors ( $p=0.00$ ). However, very few significant relationships were found between burnout and wellbeing levels and type of strategies used, and the correlations obtained were very low (see Table 4). Therefore, we cannot conclude that health professionals with high levels of burnout and low levels of wellbeing more commonly use maladaptive coping strategies (denial and flight from the problem). We reject the third hypothesis.

As far as our final hypothesis is concerned, the results obtained permit us to confirm that burnout predicts a series of negative consequences at several levels: physical, psychological, socio-familial and professional. In parallel, psychological wellbeing and emotional hardiness reduce the negative consequences of burnout (Table 6). A more detailed analysis of the results reveals that emotional hardiness moderates more than wellbeing the professional consequences of burnout; however, with respect to the rest of the consequences – physical, mental and familial – the mental wellbeing variable has more cushioning weight.

In addition, and with the aim of comparing the

predictive value of emotional hardiness and wellbeing at work with respect to that of dissatisfaction variables in relation to the professional consequences of burnout, we carried out a final stepwise multivariate regression analysis, introducing as independent variables burnout, the dissatisfaction variables, hardiness and wellbeing, and professional consequences as dependent variable. As a result, we found that emotional hardiness and psychological wellbeing at work mitigate the negative professional consequences of burnout and those of the variables related to job dissatisfaction ( $R=0.555$ ;  $\beta_0=1.591$ ,  $p=0.00$ ; *Burnout*,  $\beta_1= 0.488$ ,  $p=0.00$ ; *Dissatisfaction*,  $\beta_2= 0.256$ ,  $p=0.00$ ; *Emotional hardiness*,  $\beta_3 = -0.305$ ,  $p=0.00$ ; *Psychological wellbeing*,  $\beta_4= -0.116$ ,  $p=0.008$ ). The results obtained indicate that the strongest predictor variables of negative professional consequences were burnout and emotional hardiness. That is, the degree of commitment, of a sense of challenge and of a feeling of control in relation to the person's job have greater predictive strength than the job variables of dissatisfaction, and moderate the negative professional consequences of burnout. Such professional consequences are expressed above all in thoughts about or desire for a change of profession, and in lack of motivation.

Finally, we asked the healthcare employees in the sample studied to make suggestions for mitigating job stress. Among the needs highlighted were those for a better balance between time and tasks (27% of the sample), for recognition and promotion (13%), for more extensive training (12%) and for better salaries (12%).

## DISCUSSION

Even though the prevalence of burnout in the sample of health professionals studied is not high, the percentage that report emotional exhaustion is considerable,

**Table 6**  
Results of multiple regression analyses on the professional, family, physical and mental consequences, taking as predictor variables burnout, psychological wellbeing and emotional hardiness

	$\bar{X}$	PREDICTOR VARIABLES						R	Adjusted R <sup>2</sup>	F	Sig
		CTE	BURNOUT	HARDINESS	WELLBEING	Beta0 (sig)	Beta1 (sig)	Beta2 (sig)	Beta3 (sig)		
PROFESSIONAL CONSEQUENCES	2.17	2.197 (0.00)	0.603 (0.00)	-0.309 (0.00)	-0.170 (0.00)	0.538	0.288	167.709	0.00		
FAMILY CONSEQUENCES	2.27	1.508 (0.00)	0.540 (0.00)	0.047 (0.35)	-0.228 (0.00)	0.495	0.243	133.082	0.00		
PHYSICAL CONSEQUENCES	2.24	1.222 (0.00)	0.619 (0.00)	0.122 (0.11)	-0.282 (0.00)	0.560	0.312	187.836	0.00		
PSYCHOLOGICAL CONSEQUENCES	2.11	1.385 (0.00)	0.670 (0.00)	-0.037 (0.41)	-0.255 (0.00)	0.630	0.396	270.481	0.00		

especially among doctors, who emerge as particularly vulnerable to this disorder. In line with this, the sample shows moderate levels of psychological wellbeing at work, with only a small percentage of professionals who experience high levels.

We obtained significant interactions of burnout and psychological wellbeing with sociodemographic and work-related variables. Thus, for example, the number of patients in the professional's quota and attended per day, and the hours per week devoted to bureaucratic tasks are significantly related to the variables of overload and monotony, and to high levels of burnout and low psychological wellbeing. Specifically, overload emerges as an important work-related variable that predicts high levels of emotional exhaustion and low psychological wellbeing. It seems evident that, on the one hand, these professionals are overworked due to excessive patient numbers, and under pressure given the lack of time to devote to each one, and on the other, they have too many bureaucratic demands (filling out forms, writing prescriptions, writing reports, etc.). This finding is related to one of the fundamental proposals for mitigating or preventing burnout and improving the degree of wellbeing at work, as mentioned by around 30% of the sample: a better balance between time and tasks. These results concur with those obtained in previous research (Caballero et al., 2000; Prieto et al., 2002; Molina et al., 2003; Sobrequés et al., 2003; Jenaro-Río et al., 2007).

In addition, there are another series of variables that predict high levels of burnout and low psychological wellbeing, such as lack of expectations of career development and recognition, or deficient supervision, which reflect the significant relations between job dissatisfaction, burnout and wellbeing. Thus, for example, professionals who do not carry out activities related to teaching and/or research present significantly lower levels of wellbeing and higher burnout. Likewise, professionals who are not involved in supervisory or coordinatory duties present higher levels of lack of realization in their job. These data are in the line as previous results obtained and are coherent with the suggestions made by the study participants themselves for mitigating stress and improving the degree of wellbeing at work: better training and promotion possibilities, more recognition, improvements in teamwork and better coordination of professional groups, among others. Burnout, then, emerges as associated with factors that could easily be modified through organizational interventions aimed at improving

the quality of life of health professionals.

Secondly, low levels of psychological wellbeing at work predict high scores in emotional exhaustion and, in general, in burnout. Therefore, we consider that interventions aimed at improving wellbeing levels would be highly effective in the prevention and treatment of the burnout syndrome. In the same line, emotional hardiness emerges as negatively associated with burnout, and positively and significantly associated with wellbeing, both variables appearing to be protective against burnout. In this regard, the finding that emotional hardiness predicts psychological wellbeing at work is an important one, and which supports our belief that it may have a positive influence on employees' performance, even in the absence of satisfactory working conditions.

As regards coping strategies, and in contrast to the results obtained by other researchers (Manzano & Ramos, 2001; Ortega & López, 2004), we cannot conclude that health professionals affected by burnout more frequently use escape or avoidance. In general, the group studied uses adaptive coping styles, such as direct coping with problems and seeking social support. This result is in consonance with those obtained in other studies (Maslach, 2001; Hernández, Olmedo & Ibáñez, 2004; Jenaro-Río, et al., 2007), which found scarce relationships between burnout and coping.

Finally, burnout produces a series of negative consequences at a professional level (e.g., *thoughts of giving up the profession*), a socio-familial level (e.g., *my job restricts my social life*), a physical level (e.g., *my job is negatively affecting my health*) and a psychological level (e.g., *I constantly feel like I'm about to explode*). These results are in the line of other authors' findings (González et al., 2003; Ortega & López, 2004; Mañas et al., 2007). All of these consequences, in turn, negatively affect job performance.

For their part, emotional hardiness and psychological wellbeing cushion the consequences of burnout and dissatisfaction, counteracting their negative effects. Thus, individuals who score high in emotional hardiness at work, that is, show a sense of commitment in their job, feel control over it and respond to problems as challenges (as well as feeling wellbeing at work), will experience fewer negative consequences of burnout than those who score low on these variables, even though they may feel emotionally tired and subjected to unsatisfactory working conditions. Consequently, we consider job satisfaction to be an important variable, but insufficient to predict good performance. Indeed, to

improve performance it would be necessary to increase the worker's job commitment, which should receive a boost as levels of emotional exhaustion/burnout decrease and those of psychological wellbeing and emotional hardiness rise. Increased commitment will have positive repercussions for the organization, such as improvements in efficiency and quality, among others.

With regard to the implications of the results obtained, there is clearly a need to develop short-term health policy initiatives with a view to palliating and preventing the negative consequences of burnout syndrome and, at the same time, boosting levels of commitment and psychological wellbeing in the workplace. More specifically, there is a need for urgent organizational intervention by the relevant authorities, especially in the field of public health, for preventing the development of psychological and physical disorders related to burnout and organizational problems in the form of absenteeism or reduced performance. Intervention should focus on reducing work overload and monotony (cutting quotas, reducing red tape), enhancing personal recognition for work done, facilitating the development of professional careers, enriching jobs (providing opportunities for coordination, supervision, teaching and research), and facilitating participation in decision-making, as well as improving management and leadership at the administrative level (improving supervision, coordination and communication).

In line with the above, and with a view to boosting the effectiveness of organizational interventions, we recommend the implementation of preventive initiatives at the personal level (individuals and/or groups), including training in self-control techniques (relaxation), so as to alleviate the negative emotional experiences of these professionals deriving from their job and to increase levels of psychological wellbeing and emotional hardiness in those who need it. It should be borne in mind that the experience of positive emotions constitutes an important predictor of coping efforts, health and quality of life (Amutio, 2004; Lozano, Montalbán & Durán, 2002; Smith, 2001). Likewise, emotional hardiness can be a tool for effective coping that may be developed as part of a programme of intervention in the management of job stress (Maddi, Kahn & Maddi, 1998; Lambert, Lambert & Yamase, 2003; Garroso et al., 2006).

Management-related measures aimed at improving the quality of healthcare may be hampered by failing to account of burnout and the principal variables involved in its development and maintenance. Organizations must

be aware that the costs of initiatives to deal with such aspects constitute an investment in the future, to the benefit of efficacy and competitiveness. We feel the results presented here to be of real importance, given the practical non-existence of studies designed for the joint assessment of burnout, wellbeing and emotional hardiness.

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