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Rehabilitate in psychiatry, Does it burn nursing staff out?

Rehabilitar en psiquiatría ¿quema al personal de enfermería?

*Leal Docampo, Purificación *De Pablo Jarque, Isabel

*Nurse in the Psychiatric Rehabilitation Service (Xerencia de Xestión Integrada de Vigo). Pontevedra.
E-mail: purificacion.leal.docampo@sergas.es

Keywords: Wear Professional (burnout); nurses psychiatric rehabilitation; CDPE-A; socio-demographic variables; hardiness.

Palabras clave: Desgaste profesional (burnout); personal de enfermería de rehabilitación psiquiátrica; CDPE-A; variables sociodemográficas; personalidad resistente

ABSTRACT

The aim of this study was to analyze the burnout on nurses dedicated to inpatient psychiatric rehabilitation. This took into account the three specific dimensions of the syndrome (emotional exhaustion, depersonalization and lack of professional accomplishment), organizational type variables as potential sources of stress, the consequences for the physical, psychological, social and family labor and the role played in the development of this process of socio-demographic variables and personality. These data, which includes the questionnaire CDPE-A Moreno Jiménez, on a sample of 42 nurses Psychiatric Rehabilitation Hospital O Rebullón of Vigo (Spain), were analyzed by descriptive and inferential statistics.

The results indicate a low presence of burnout syndrome in the study population. Low relevance of sociodemographic and work variables with significant bivariate level effects only in terms of age and children, and no main effects multivariate level. However we show high levels in all dimensions of the scale of hardiness, and strong coping mechanisms both directly and in the perception of social support, which makes it possible to interpret these variables may be intervening as protective factors against development of the syndrome and thus may serve as indicators of occupational health and quality of care.

RESUMEN

El **objetivo** de este estudio fue analizar el desgaste profesional en el personal de enfermería dedicado a la rehabilitación psiquiátrica hospitalaria. Para ello se tuvieron en cuenta tanto las tres dimensiones específicas de este síndrome, es decir, agotamiento emocional, despersonalización y falta de realización profesional, además de otras variables organizacionales como posibles fuentes de estrés y las consecuencias para la salud física, psicológica, sociofamiliar y laboral; así como el papel desempeñado en el desarrollo de este proceso de algunas variables sociodemográficas y de personalidad. Estos datos, que recoge el cuestionario CDPE-A de Moreno Jiménez, sobre una muestra

de 42 profesionales de enfermería del Hospital de Rehabilitación Psiquiátrica O Rebullón de Vigo (España), fueron analizados a través de estadística descriptiva e inferencial.

Los **resultados** evidencian una baja presencia del síndrome de desgaste profesional en esta población de estudio, con poca relevancia de las variables sociodemográficas y laborales estudiadas, encontrando efectos significativos a nivel bivariado sólo en función de edad e hijos, y sin efectos principales a nivel multivariante; sin embargo, nos muestran unos niveles altos en todas las dimensiones de la escala de la personalidad resistente, así como fuertes mecanismos de afrontamiento tanto directo como en la percepción de apoyo social, lo que posibilita interpretar que estas variables pudieran estar interviniendo como factores preventivos ante el desarrollo del síndrome y por tanto podrían servir de indicadores de salud laboral y calidad asistencial

INTRODUCTION

The concept of stress is already introduced in the field of health in 1926 by Hans Seleyec as a body's response to any stressor stimulus or stressful situation [(1)]. The first approach to the process of burnout, defined as an advanced stage of work stress, is found in 1974, when the psychiatrist Herbert Freudenberger defined "burnout" as failing, getting exhausted, or getting to wear out because of excessive force, excessive energy or resources claims [(2)]. Meanwhile, Maslach and Jackons focused on emotional stress arising from interpersonal relationships with clients and in the 80s they developed the questionnaire "Maslach Burnout Inventory" (MBI) as an instrument to assess burnout, considering it as a gradual process of emotional exhaustion, progressive cynicism and depersonalization and progressive decrease in effectiveness or professional conduct [(3)]. Emotional exhaustion would refer to feelings of not being able to give more of themselves emotionally; depersonalization would mean a response to the emergence of negative distance as the cynical attitudes towards others who are usually the recipients of the service or care; and low professional satisfaction would correspond to a negative self-evaluation of competence and achievement at work. The etiology and development of this process could also be explained, in general, by the presence of high task demands and scarce resources or individual capacities. And in the case of people devoted to helping professions arguably interpersonal lawsuits are consuming so much emotional capital that depersonalization as a coping strategy is adopted to avoid contact with the original source of discomfort, which would ultimately lead to reduced professional accomplishment[(4)].

Although burnout as an advanced stage of chronic stress was produced after the imbalance of expectations between the professional field and the reality of daily work [(5)], cannot be restricted to professionals in the social and health services, it is in these fields where more evidence has been found, especially in the staff caring for critically and terminally ill patients [(6)]. In turn, within the health professions, the nursing staff has been identified as a group of professionals with a high risk of burnout and stress, as shown by various studies worldwide [(7, 8)].This is due to the large number of stressors inherent in the work they face daily, and their direct relationship with sick people, characterized by continuous and intense emotional and physical demands for extended periods of time which constantly face poor prognosis, human suffering, disability and death [(9)]. Or, as in the area of mental health, where the management of the psychiatric patient is highly stressful if they lack certain skills[(10)]. In addition to work overload, other occupational factors both organizational and administrative that increase vulnerability to burnout could be added: insufficient recognition and support from management, lack of companionship, as well as conflict and role ambiguity by limits unclear on the responsibility of roles and duties, lack of communication or limited

participation in decision-making. There is some research that corroborate that high levels of cohesion often reduce occupational stress, while the management support and companionship protect the additional obligations that patients create[11].

The literature confirms the inverse relationship between burnout and job satisfaction[12], and it also demonstrates the lack of consensus when developing a risk profile given the disparity of results in different investigations for the purpose [13]. While it is customary to consider the relationship of some sociodemographic variables as facilitators or inhibitors of the development of the syndrome, some authors have noted little or no relationship between sociodemographic characteristics and burnout. On the other hand there is increasing work showing that individual factors such as hardiness or any of its dimensions may act directly or indirectly reducing the chance of experiencing this burnout.

The strength or hardiness was a constructo proposed by Kobasa in 1979. It consists of three variables: commitment, control and challenge or dare. While the first two are specifically associated to protection from burnout , the challenge would be negatively related to the lack of realization [7] to develop a resistance function before the occurrence of a stressful stimulus, which would mean that before being avoided or evaluated it would be understood as an opportunity and an incentive for personal growth [14]. Results of several studies in this line confirm the relationship between hardiness and health or psychological well-being [15].

The need to study job stress as one of the forerunners of deteriorating mental health stems, and especially in Spain, from the emphasis made by the appearance of the new Law on Prevention of Occupational Risks (Law 31/1995 of 8 November BOE 10-11-1995) "to recognize the organization and management of work as working conditions that are likely to produce occupational hazards" (Article 4, paragraph 7.d) The reasons that recommend paying attention to mental health problems range from those responsible for absenteeism and sick leave, to abandonment of the profession, as well as the impact that the welfare and occupational health have on the effectiveness of an organization given the existing feedback between quality of life, state of physical and mental health and organization. In the conclusions of the WHO Ministerial Conference on Mental Health in Helsinki in 2005, WHO established measures to prevent absenteeism and mental illness resulting from occupational stress situations [16].

Given that burnout is a composite of cognitions, emotions and negative attitudes towards work, towards people you work with, towards the professional role and own experience that this will be accompanied by dysfunctional consequences at physiological, psychological and behavioral level, which will have harmful consequences for the individuals and the organization, and they usually show up for the use of inadequate coping with work stress generated by the relations customer and organization [2]. And not forgetting that some studies also confirm the high prevalence of burnout and suicidal behavior [17]. There is no doubt that the study of this syndrome becomes a social necessity must focused on improving the health and quality of life of people.

Based on the hypothesis that the nursing staff is capable of developing burnout syndrome, and this is a strong indicator of loss of health, which affects both job satisfaction and quality of service of the organization, this study was developed with the aim of checking the burnout levels in nurses who work in a psychiatric

rehabilitation hospital, as well as the consequences and some organizational, demographic and personal factors that might be involved in this process, to promote interventions aimed at prevention within the context of Occupational Health and Occupational Risk Prevention.

MATERIAL AND METHOD

Design: This is a descriptive cross-sectional study carried out in a psychiatric rehabilitation hospital in Vigo.

Sample and procedure: The study population was the total nursing staff of the hospital O Rebullón (N = 69), divided into four units The procedure, after nursing management approval of CHUVI was sharing nominally sealed envelopes addressed to each professional. These envelopes contained a questionnaire with a cover letter, a thank you letter and information about the study and the confidentiality of the data, as well as an envelope to save the questionnaire once completed and led to the unity of teaching to ensure anonymity of respondents. Participation was voluntary, with the response rate for the entire month of May 2012 (timetabled for this period) of 65%; although the total 45 questionnaires collected and analyzed in a new revision 42 were considered valid, reducing the sample analyzed here 61% of the total population.

Measuring instruments: the CDPE-A shortened version of the Survey of Professional Burnout of Nursing (CDPE), which was built for the specific assessment of burnout among nursing staff was used. This questionnaire had already been used for this purpose in other studies and this time it was given and authorized by Moreno-Jiménez, author with Garrosa and González of the questionnaire. The CDPE, with 174 items, is based on a transactional and interactive theoretical model, which considers the emergence of nursing burnout as a result of the work context of this profession, individual characteristics and the type of coping adopted. The CDPE-A format now reduced, maintains the same initial characteristics of the structure of CDPE (18) and contains not only sociodemographic variables, but also 65 items that are answered using a Likert scale ranging from 1 to 4 , where 1 means strong disagreement and 4 strong agreement. This questionnaire includes measures of background variables which are characteristic of the hospital organizational environment such as role ambiguity, contact with pain and death, conflictive interaction and overwork (background level); measures of burnout syndrome itself given the three classical dimensions proposed by Maslach and Jackson inventory MBI, emotional exhaustion, depersonalization and personal accomplishment, the latter being changed by the analog reverse "lack of personal fulfillment" (scale syndrome burnout); and finally, it collects information on the various consequences of the syndrome at physical, psychological, social and family and work (scale effects) level, as well as other variables that may be involved in the genesis and development of burnout as the "hardy personality" and coping strategies, through the dimensions commitment, challenge, control (inverted), social support, avoidance and direct coping (scale of personality and coping)

Data Processing: The data analysis was made statistically, using SPSS 15 for Windows software. Descriptive statistics mean percentage, maximum, minimum and standard deviations for the variable scales CDPE-A; were used and inferential statistics (with confidence intervals of 95%) to find the influence of sociodemographic and occupational variables, through bivariate analysis, using the Student t test for independent samples into dichotomous variables, and ANOVA and Bonferroni

contrasts in polytomous variables; finally multivariate analysis of variance (MANOVA) were performed.

RESULTS

Regarding the characteristics of the sample, it involved 76.2% women vs. 23.8% men, being 83.3% over 41 years old. A high percentage had a stable partner (78.5%) and with a fairly similar distribution among staff who had no children and having one or two. Being 21.4% staff RNs, 35.7% technical staff nursing assistants and 42.8% support staff of psychiatry; the majority (80.9%) have fixed place and 54.7% over 16 years experience in the field of psychiatry. As for working hours, 88.1% work full time and 83.3% work in a complex rotation system. The interaction time (in this case continuous and direct contact) with the psychiatric population assisted is similar, as well as the number of patients.

Table 1. Distribution of the sample according to sociodemographic variables

		n	%
Sex			
	women	32	76,19
	men	10	23,81
Age			
	20 to 30 years	4	9,52
	31 to 40 years	3	7,14
	41 to 50 years	17	40,47
	More than 51 years	18	42,86
Personal relationship			
	with regular partner	33	78,57
	with sporadic partner	2	4,78
	without a partner	7	16,66
Children-daughters			
	0	11	26,20
	1	14	33,32
	2 or more	17	40,49

Table 2. Distribution of the sample according to the working variables

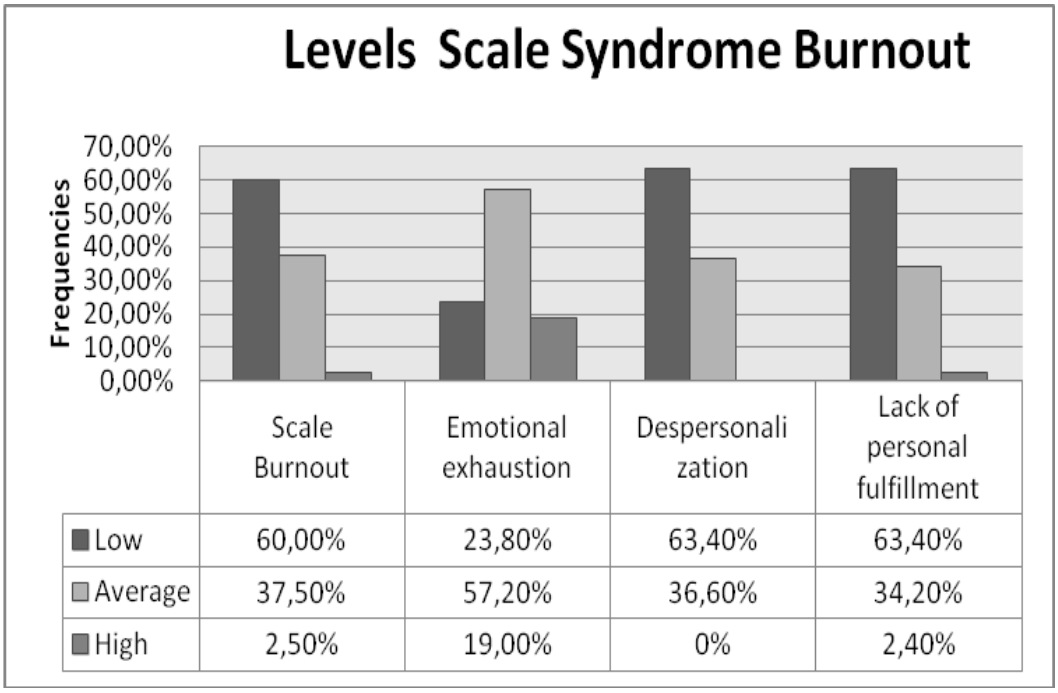
		n	%
Proffesional category			
	DUE	9	21,43
	TCAE	15	35,70
	APS	18	42,86
Employment situation			
	Fixed square	34	80,95
	Contract	6	14,29
	Interim	2	4,76
Antiquity in the hospital			
	0 to 5 years	12	28,57
	6 to 15 years	7	16,61
	16 to 30 years	15	35,70

	31 or more	8	19,05
Workday			
	Full-time	37	88,10
	1/3 of working hours	3	7,14
	2/3 of working hours	2	4,76
Work shift			
	Fixed morning	2	4,76
	Rotary simple	5	11,90
	Rotary complex	35	83,30

The results for the four scales CDPE-A obtained in this sample of 42 nurses were:

On the scale of burnout syndrome (see Figure I) 60% are at low levels, 37.5% at average levels, and only 2.5% at high levels, highlighting the average levels achieved only for the fatigue dimension (57.2%).

Figure I



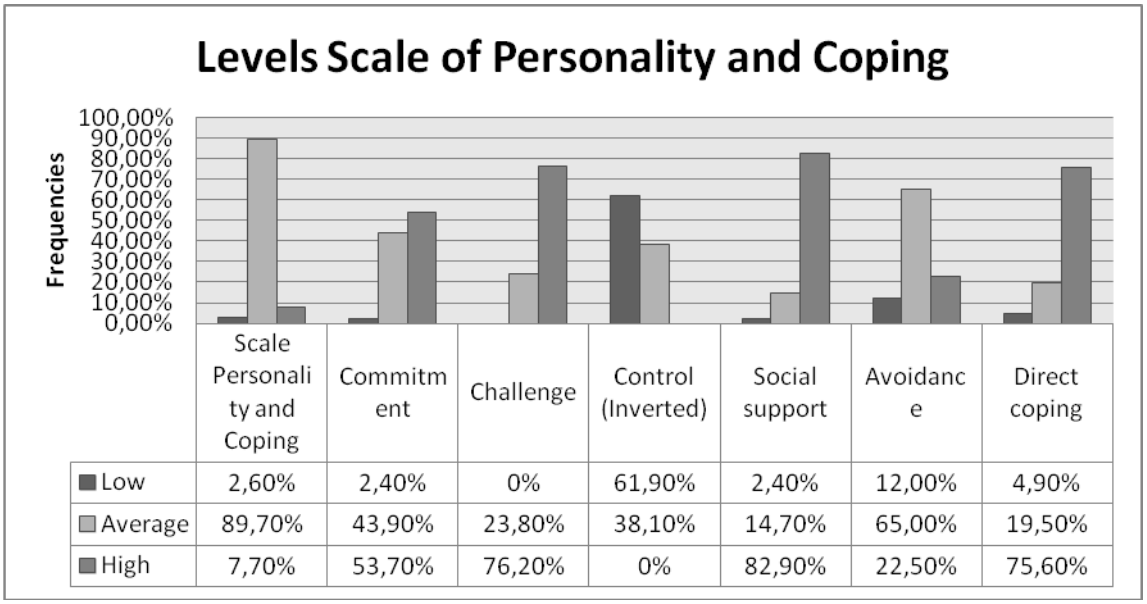
Regarding the professional burnout background scale, characteristic of the hospital organizational field, inherent and interpersonal to work, average levels (85.3%) for the scale in general were found, as for the role ambiguity dimension (73 ,8%), conflictual interaction (64.3%) and overhead (58.5%), while for contact with pain and death dimension the levels were high (66.7%)

On the scale of consequences of the syndrome low levels (53.7%) are also appreciated, especially in the professional consequences (47.6%), and reaching average levels in the psychological effects (59.5%), social and family (50.0%) and physical (61.0%).

The personality scale includes measures for the three dimensions of hardiness: commitment, challenge and control, and measures for three coping mechanisms:

social support, avoidance and direct coping. In Figure II the levels for this scale and for each of its dimensions can be seen, being average levels to the scale of personality and coping and highlighting the high levels in commitment, challenge, control, perception of social support and direct coping.

Figure II



	Scale Personality and Coping	Commitment	Challenge	Control (Inverted)	Social support	Avoidance	Direct coping
Low	2,60%	2,40%	0%	61,90%	2,40%	12,00%	4,90%
Average	89,70%	43,90%	23,80%	38,10%	14,70%	65,00%	19,50%
High	7,70%	53,70%	76,20%	0%	82,90%	22,50%	75,60%

Taking the sociodemographic and occupational variables as independent variables (see Tables 1 and 2) and the scores on the scales of burnout as dependent variables, no multivariate main effects were found among them, appreciating only significant effects at bivariate level depending on the age and number of children. In terms of age, although at a personality scale level all age groups reached average levels, the variable that contributed most to the overall difference between the age group under 30 and over 41 was the group that presents social support ($F = 4.367$, $p = 0.034$); being the youngest staff the group that presents greater perception of social support ($M = 3.92$, $s = 0.16$) and decreasing as the age increases to the average levels achieved by the group of over 51 ($M = 2.91$, $s = 0.59$). While the results in the dimensions of the scale of the syndrome are at the same levels and no main effects were found, less overall wear on the younger staff is observed although it gets higher average in the fatigue dimension. The same happens with the background scale where the group under 30 reaches higher levels in contact with pain and death, and also at a psychological level in the scale of consequences.

In relation to the number of children main effects on the background scale appear, finding these among staff who has no children or has only one child ($F = 4.152$, $p = 0.041$). Even though both groups present average level, the staff who has no children reaches upper middle in the background level, highlighting the overhead dimension, where they reach average levels ($M = 2.52$, $s = 0.74$) compared to low levels obtained by the staff who have one child ($M = 1.96$ $s = 0.29$). Although the levels in the syndrome scale were low in both groups, they reached average levels staff who have two or more children, and more particularly accusing difference in the dimension of fatigue.

DISCUSSION

The analyzed sample represents 61% of the studied population, therefore it can be considered representative. Analyses in this paper show that burnout of the nursing staff in the Psychiatric Rehabilitation Hospital ORebullón is within a low range and only 2.5% reaches high levels in the scale of the syndrome. While these levels of burnout were significantly lower than some national studies [7, 19], similar results were also found in others [20]. On the other hand, the results on the scale of the syndrome are consistent with those found in the scale of consequences, where low impact on the employment and moderate impact at physical, psychological, social and family level were found.

Given the potential predictors of this syndrome, related to background and organizational work factors, average levels in role ambiguity, conflict and overload interaction have been achieved, and only the high scores on the dimension of touch with the pain and death are highlighted, which is usually one of the most frequently stressors found in nurses [21].

When analyzing what factors might be modulating the results, it could be confirmed that in this study the sociodemographic variables classically studied have little relation to the occurrence of burnout, as no significant effects came to be found on the scale of the syndrome, and only significant effects in terms of the age variable in the personality scale and the number of children variable in the background level appear. As for age, the literature disagrees to associate years of experience with the development of the syndrome, and sometimes it shows an inverse relationship between this and age, either by the learning of effective coping strategies or own survival, assuming that it is the burnt staff which mostly leaves the job [22]. Here we find that despite finding no major effects on the dimensions of the syndrome, and being all age groups at an equal level, less general burnout is observed in the staff under 30, who presents more emotional exhaustion and more vulnerability to contact with suffering, also affecting psychologically. The differences are only significant in the dimension of social support in the personality scale, highlighting the peaks in the age group under the age of 30 and down over the years to average levels from the age of 51. The same happens with the variable number of children, although some publications increased vulnerability to emotional exhaustion observed in subjects without children [23], reaching maximum levels of burnout [12], which claims that the existence of children can contribute to the development of the syndrome resistance due to the increasing capacity to deal with problems and emotional conflicts [24]; however, in our case, although no significant effects in any of the dimensions of the scale of the syndrome are shown, we found that with more than one child the results are reversed, i.e, burnout especially increases emotional exhaustion, and main effects appear only in the background scale among people who have only one child or none.

As for the lack of bivariate significant main effects of the other variables studied like sex, relationships, professional category, shift, seniority, status and working hours, on the scale dimensions of burnout, we must consider limitations of this study, i.e., the sample size and skewed distribution among different subgroups of some variables that could be conditioning establishing statistically significant relationships

Moreover, taking into account the results of this research, one might wonder whether hardiness or fortress, considered as a protective factor against burnout, would also modulate the genesis and development of burnout in these psychiatric rehabilitation units. In light of the results found, especially in the dimensions of commitment and

challenge, it could be interpreted that hardiness would be the variable that most influence exerts, in this case blocking the development of burnout, as well as strong coping mechanisms that this sample of nursing staff shows, collected as high levels of perceived social support and direct coping, which are considered as positive factors in the prevention of burnout [25].

Also, like other studies of psychiatric nursing staff [11], high levels of perceived social support compared to low and moderate levels of burnout were found, which would corroborate the perception of cohesion and camaraderie exerts a protective action against burnout, because the more support and professional recognition received at work, either colleagues or superiors, the less emotional exhaustion, depersonalization and low professional satisfaction [26].

Finally, since this study also suggests that some personality variables could predict the burnout process, as the levels reached in the personality dimensions are inversely related with levels of burnout, which turned out to be low in general but high on emotional exhaustion (23.8%), especially staff with less experience in this area; we should consider taking appropriate measures to prevent the development of the syndrome and we should also consider any intervention focused on increasing stress coping, self-control and self-assertive communication skills, aimed at promoting the development of a strong personality, which allows to optimize the handling of stressful situations inherent in the nursing profession in the field of psychiatry and thus being able to perform stress and early prevention. In the same way, it would be interesting to have further work to identify the organizational and personal factors that may be impacting the nursing profession in other psychiatric services that are not engaged in rehabilitation, taking into account, as already mentioned, that the management of psychiatric patients is highly stressful if you lack certain skills.

CONCLUSIONS

This study shows that despite being nurses a working population liable to suffer burnout caused by depletion derived not only from both organizational and interpersonal factors but also from the specific features of interaction, directly and permanently from the area of psychiatric rehabilitation, there can be many other factors that influence this process in view of the low levels of burnout found in the studied population, which only highlights the high levels reached in touch with the pain and death of the background scale dimension syndrome and with little impact on the scale of consequences. Little relation to sociodemographic and occupational factors was also observed, and only significant differences were found to a bivariate level depending on the age and number of children. Finally, given the incidence of burnout and low levels in mid-high levels in all dimensions of strength and coping mechanisms like commitment, challenge, control, perceived social support, avoidance and direct coping and in this population, suggesting that these dimensions could contribute to block burnout, the personality variables must be taken into consideration when studying the burnout process.

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