Original Article

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Burnout-related effects of emotional labor and work-related stressors among psychiatric nurses in Japan

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Abstract

This study was performed to examine the effects of emotional labor and work-related stressors along with the relation between emotional labor and burnout in psychiatric nurses in Japan. A self-administered questionnaire survey was sent to the director of nursing at a mental hospital, who then sent the surveys to all 169 nurses at the hospital. From among existing measures, we chose the Japanese version of the Maslach Burnout Inventory-General Survey (MBI-GS) , to measure burnout; the emotional labor scale to measure emotional labor; and the Japanese version of the Areas of Worklife Survey (AWS) to measure work-related stressors.

Multiple regression analysis was applied to the data, with three subscales (*exhaustion*, *cynicism*, and *professional efficacy*) of the Japanese MBI-GS as dependent variables. The significant predictors of *exhaustion* were *reward* and *workload* (from the Japanese AWS) and *display of negative emotions to patients* (from the emotional labor scale) . Significant predictors for *cynicism* were *reward*, *workload*, and *values* (Japanese AWS) and *display of negative emotions to patients* (the emotional labor scale) . For *professional efficacy*, only marital status and *reward* (from the Japanese AWS) were found to have significant effects.

The present study revealed some effects of emotional labor, particularly negative emotional labor. However, work-related stressors, notably *reward*, *workload*, and *values*, had greater effects on worker burnout. Some forms of emotional labor, such as *empathy for patients and display of positive emotion*, *emotional dissonance*, and *emotional sensitivity requirements*, were found to have no effect on worker burnout.

In clinical practice, it is necessary to ensure that psychiatric nurses do not take on a disproportionate number of patients whose care would require negative emotional labor. It is also important that new nurses are trained by experienced nurses who demonstrate good awareness when engaging in negative emotional labor and know how to persuade patients. Furthermore, instead of simply assuming that emotional labor degrades mental health, we should actively pursue ways to allow professionals to exhibit empathy for patients and to handle emotional dissonance and sensitivity as needed. To prevent burnout among psychiatric nurses, organizations need to evaluate the nurses' performance, prevent individual nurses from becoming overworked, and reflect the nurses' sense of value in work. In this way, we can prevent burnout among psychiatric nurses and thereby provide better quality care to the patients.

KEY WORDS

psychiatric nurses, emotional labor, work-related stressors, burnout

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Introduction

1. On Emotional Labor

Hochschild[1], an American sociologist, introduced the concept of emotional labor in *The Managed Heart* (1983). She defines emotional labor as work that requires the control of one's emotions in order to provide service that would satisfy customers. Emotional labor has emotional rules that determine the emotions desirable for each occupation, and workers are required to display these emotions. Therefore, emotional labor can sometimes evoke emotions that workers do not feel and create emotional dissonance; this can degrade mental health[1]. Many studies of emotional labor have been conducted since Hochschild defined the term. A search of the PubMed database for studies on "emotional labor and stress," or "emotional labor and mental health" yields only 20 studies in1983; over 300 studies are listed for 2015.

2. Emotional Labor among Japanese Nurses

Hochschild's work was translated into Japanese in 2000[1], and the concept of emotional labor attracted increasing attention in Japan. The concept began to spread rapidly in the nursing discipline after Takei[2] published *Emotion and Nursing* (2001). Takei[2] argued that nursing is a type of emotional labor and that psychiatric nurses find it especially difficult to gain emotional rewards for emotional labor. Nurses' emotions are the foundation of psychiatric nursing, and their high emotional involvement (through empathy) is required. However, many patients have chronic issues, and recovery is not always smooth. Nurses are rarely rewarded for trying to understand these patients' feelings as if they were their own in order to alleviate the patients' suffering. Even worse, nurses often become the object of their patients' delusions, receive negative emotions from patients or their families, and receive unfounded physical or verbal abuse[3-5]. Therefore, psychiatric nurses are required to control their emotions and subdue negative emotions[6]. However, when emotional control is not possible, emotional dissonance occurs and the nurses experience burnout[7].

3. Review of Literature on Emotional Labor of Japanese Psychiatric Nurses

The Japan Medical Abstract Society Database was used to see how many studies on emotional labor of psychiatric nurses in Japan have been conducted since Takei[2] applied the concept to the nursing discipline. The search yielded 55 matches, with 35 of them from within the last five years. Among all matches, 10 studies were on psychiatric nurses, and 8 of those were published within the last five years. After excluding qualitative studies and case studies, 5 remained[3, 8-11].

The review of these studies revealed the following four issues: there are very few studies on emotional labor; different scholars define emotional labor differently, and there is no shared understanding of what it is; various measurements for emotional labor have been used; only one study[8] has examined the relation between emotional labor and burnout of nurses in Japan, even though Zapf[7] has suggested that nurses experience burnout as a result of emotional labor.

4. Study Objective

The main purpose of this study was to examine the effects of emotional labor by psychiatric nurses on their burnout in Japan. Work-related stressors were also measured and the effects of emotional labor and work-related stressors on burnout among psychiatric nurses were examined.

5.Measurements Used in the Study: Discussion of the Literature

1) Burnout Measurement

Burnout describes a state of emotional exhaustion or the process in which a person reaches such state. It is a phenomenon in which a person with full sense of responsibility first feels exhausted after being exposed to stress for an extended period time, just like a burning candle, and eventually develops cynicism and a diminished sense of professional efficacy[12, 13].

Maslach[14], a social psychologist, first published an article describing "burn-out" in 1976 and thereafter continued research on burnout. This led to the Maslach Burnout Inventory (MBI), an instrument to measure burnout[15]. The MBI uses the sub-concepts of *emotional exhaustion*, *dehumanization*, and *individual sense of achievement*. During the 1970s and the 1980s, burnout was regarded as a critical factor among service providers, who were susceptible l because of their relationships with service recipients. Consequently, the MBI Human Services Survey (MBI-HSS) for human care service professionals, and the MBI-Educators Survey (MBI-ES) for educators were developed[16]. The concept of burnout was further expanded in the 1990s to include ordinary workers, who were susceptible after being exposed to work-related stressors for an extended period of time. To respond

to this, Maslach et al.[17] published the MBI-General Survey (MBI-GS) in 1996. The MBI-GS uses *exhaustion*, *cynicism*, and a diminished sense of *professional efficacy* as subordinate concepts. The MBI-GS has been translated into various languages, and its reliability and validity have been examined in each country. Because of this, it is the most frequently used measure of burnout[13].

Other burnout measurement scales include the Staff Burnout Scale (SBS) developed by Jones[18] and the Tedium Scale developed by Pines et al.[19]. The SBS is aimed at medical professionals, and it was developed by adding 10 dichotomous question items to the MBI[20]. The Tedium Scale is used to measure *emotional exhaustion*, and is supposed to have a single-factor structure, although conflicting results have been reported. Hence, it does not seem to be a reliable scale[21], and some argue that the Tedium Scale is unsuitable as a standalone instrument for burnout research[20].

Turnover and leave of absence from work due to burnout have become problems in Japan, and scholars are actively pursuing understanding of burnout. However, many researchers have used a translated version of the Tedium Scale alone or an unvalidated translation of the MBI (without back-translation), that may lack reliability or validity. These cases make it difficult to compare the results of Japanese burnout studies with the results from other countries. In other countries, the MBI has been supported by many scholars, and Kitaoka and her colleagues have translated the MBI-HSS[20] and the MBI-GS[13] and developed the Japanese version of MBI with the aim of ensuring high reliability and validity.

Since our ultimate goal is to compare the Japanese results with those from other countries or from other occupations while being aware of changes in burnout concepts, this study employed the Japanese MBI-GS translated by Kitaoka et al.[13].

2) Work-related Stressor Measurement

A review of previous studies showed that the Job Content Questionnaire[22] and the scale from National Institute for Occupational Safety and Health[23] have been used as measurement scales for work-related stressors, and the Nursing Job Stressor Scale[24] has been used as a measurement scale for nurse-specific work-related stressors. For stressors, specific to the work of psychiatric nurses, the Psychiatric Nurse Job Stressor Scale[25] and 29 psychiatric stressor items[26] have been developed.

While stressors specific to the clinical experiences of nurses are important, the Areas of Worklife Survey (AWS) developed by Leiter and Maslach[27] was employed in this study because the purpose of this study was to examine the effects of emotional labor and work-related stressors on burnout. We think that the use of the AWS allows comparison with results from other occupations since the AWS can be used in more general work environments. The AWS reflects the occupational stress model and other theories. These theories include work demand and control, social support, effort and reward, conflicts at work, and interpersonal relations. It sets *workload*, *control*, *reward*, *community*, *fairness*, and *values* as critical work environment factors and, it is based on the premise that a mismatch between individuals and their work environment leads to burnout. The AWS[27] was translated into Japanese and was published as *The Japanese AWS: Diagnosis of six mismatches between individuals and their work environment*[28,29].

3) Emotional Labor Measurement

As discussed above, emotional labor as a concept was proposed by Hochschild1) and various studies on this concept have been conducted in other countries. Two main scales have emerged from these studies: the Emotional Labor Scale (ELS) developed by Brotheridge and Lee[30] and the Frankfurt Emotion Work Scale (FEWS) by Zapf et al.[31,32]. Different scales have been employed according to study objectives and the main concepts of the studies in emotional labor research in different countries[33]. For example, many studies using the ELS[30] focus on strategic aspects of emotional labor and treat surface acting (fake emotion: displayed emotions that are not felt; and concealed emotion: felt emotions that are not displayed) and deep acting (attempts to feel desired and appropriate emotions at work). In contrast, when the focus is on emotional dissonance (dissonance between felt and expressed emotions), the FEW[31,32], which includes the concept as one of the subscales, is often used. Beside these scales, Brotheridge and Taylor[34] developed the Extended Version of Emotional Labour Scale.

In Japan, the ELS-J[33] was developed by translating the ELS[30] (Brotheridge & Lee, 2003). Additionally, Ogino et al.[35] developed an emotional labor scale based on the FEWS[31,32]. The Emotional Labor Inventory for Nurses (ELIN) [36] was developed for targeting only nurses.

The current study employed the emotional labor

scale developed by Ogino et al.[35], which is based on the FEWS[31) 32)], because the FEWS has been most frequently used in studies in other countries and has emotional dissonance as a subordinate scale that is believed to be connected with burnout and depression.

Methods

1. Subjects and Method

A self-completed questionnaire survey was administered to 169 nurses working at a mental hospital with a single psychiatric department in the Hokuriku region of Japan. Questionnaires were given to the director of nursing, who distributed them to the nurses. Questionnaires were left with the respondents and collected later. Questionnaires were collected from 147 respondents (response rate = 87.0%). Five were removed as non-responsive, and so valid responses were obtained from 142 respondents (valid response rate=84.0%).

Table 1 shows demographic characteristics of the respondents. There were 92 women (64.8%) and 50 men (35.2%). In terms of age, more nurses in their forties, fifties, or above were included than those in their twenties or thirties, and their average age was 44.5 (SD=10.5) years old. More were married (117 individuals, 82.4%), and their average years of service as a nurse was 21.5 (SD=11.5) years generally, 17.2 (SD=11.4) years as a psychiatric nurse, and 2.8 (SD=1.6) years at the surveyed department. Some surveyed nurses additionally worked at the geriatric ward and dementia ward.

2. Study Period

June 18, 2015, to July 1, 2015

3. Research Design

The study is a quantitative exploratory study, using data obtained by cross-sectional self-completed questionnaires.

4. Question Items

The questionnaire form was composed of four parts with 77 items in total.

1) Demographic Attributes

Questions were asked to obtain information on the following 12 items: sex, age, marital status, having at least one child, years of service as a nurse, years of service as a psychiatric nurse, years of service at the current department, qualifications, job title, work arrangement, employment status, and work assignment.

2) The Japanese MBI-GS

Table 1. characteristics of the respondents

	N	(%)
Total	142	
Sex		
Male	50	(35.2)
Femel	92	(64.8)
Age		
20－29	11	(7.7)
30－39	41	(28.9)
40－49	36	(25.4)
≧50	53	(37.3)
No answer	1	(.7)
Marital Status		
Married	117	(82.4)
single	25	(17.6)
Have a child		
Yes	118	(83.1)
No	24	(16.9)
Years of service as a nurse		
9≦	27	(19.0)
10－19	34	(24.0)
20－29	32	(22.5)
≧30	47	(33.1)
No answer	2	(1.4)
Years of service as a psychiatric nurse		
9≦	45	(31.7)
10－19	33	(23.2)
20－29	34	(24.0)
≧30	28	(19.7)
No answer	2	(1.4)
Years of service at the current department		
1	24	(16.9)
2	46	(32.4)
3	38	(26.8)
≧4	32	(22.5)
No answer	2	(1.4)
Qualification		
Public health nurse	9	(6.3)
Clinical nurse	128	(90.2)
Assistant nurse	5	(3.5)
Job title		
Head nurse or higher	35	(24.6)
Staff	107	(75.4)
Work arrangement		
Day shift only	16	(11.3)
Three shift	116	(81.7)
On-call	10	(7.0)
Employment status		
Regular full-time	128	(90.1)
Other	14	(9.9)
Work assignment		
Co-ed psychiatric emergency ward	20	(14.1)
Co-ed severe chronic closed ward	15	(10.6)
Co-ed closed ward	15	(10.6)
Male open ward	16	(11.3)
Female open ward	8	(5.6)
Co-ed acute phase treatment ward (elderly)	18	(12.7)
Co-ed geriatric ward	19	(13.4)
Co-ed dementia treatment ward	11	(7.7)
Co-ed special ward	5	(3.5)
Outpatients/ Day care	8	(5.6)
Regional medical liaison office	7	(4.9)

The Japanese MBI-GS[13] has 16 items dividing among three subscales: *exhaustion* (5 items), *cynicism* (5 items), and *professional efficacy* (6 items). *Exhaustion* measures work-related exhaustion; *cynicism* measures the degree to which the respondent has lost passion for or interest in work and become emotionally distant and indifferent; *professional efficacy* measures confidence in ability and rewarding experiences at work. Respondents indicate the frequency of experiencing each item on a 7-point Likert-type scale ranging from 0 (never) to 6 (every day / always). Higher scores on *exhaustion* and *cynicism* indicate a higher degree of burnout, and lower scores on *professional efficacy* indicate a higher degree of burnout.

3) The Japanese AWS

The Japanese AWS[29] has 6 subscales comprising 28 items: *workload* (5 items), *control* (4 items), *reward* (4 items), *community* (5 items), *fairness* (6 items), and *values* (4 items). These subscales measure work-related psychosomatic burden, discretion at work, psychological reward obtained through work, sense of solidarity with co-workers, fairness regarding promotion and compensation, and values about work, respectively. Respondents indicate their degree of agreement with each item on a 5-point Likert-type scale. Scores on positively worded items are from 1 (strongly disagree) to 5 (strongly agree), and the reverse scale is used for negatively worded items. Higher scores indicate a higher degree of congruence between the worker and the workplace.

4) The Emotional Labor Scale

The emotional labor scale[35] has 4 subscales comprising 21 items: *empathy for patients and display of positive emotions to patients* (6 items), *display of negative emotions to patients* (6 items), *emotional dissonance* (5 items), and *emotional sensitivity requirements* (4 items). Question items used for each measurement include "I have to give warm attention to my patients" (*empathy for patients and display of positive emotions to patients*), "I have to show a feeling of anger to my patients" (*display of negative emotions to patients*), "I have to show insincere emotions" (*emotional dissonance*), and "I become especially sensitive to changes in my patients' feelings" (*emotional sensitivity requirements*). Respondents indicate the frequency of experiencing each item in their interactions with patients and patients' families on a 5-point Likert-type scale ranging from 1 (never) to 5 (quite often). The subscale scores were obtained by dividing the total of subscale-item scores by the number of items. Therefore, higher scores indicate a higher frequency of emotional labor.

5. Analysis Method

First, exploratory factor analyses based on promax rotation using maximum likelihood estimation were conducted for the Japanese MBI-GS, the Japanese AWS, and the emotional labor scale. Cronbach alpha coefficients were also calculated to examine factor validity and internal validity of each scale.

Second, one-way analysis of variance (ANOVA) was used to examine whether there were any statistically significant differences between the means of the scale scores of the Japanese MBI-GS, the Japanese AWS, and the emotional labor scale among groups having different demographic attributes.

The groupings of the respondents by demographic attributes were as follows.

1) Sex: Male or female (2 groups)

2) Age: 20-29, 30-39, 40-49, 50 or older (4 groups)

3) Marital Status: married or single (2 groups)

4) Have a child: yes or no (2 groups)

5) Years of service as a nurse: up to 9 years, 10-19 years, 20-29 years, 30 years or more (4 groups)

6) Years of service as a psychiatric nurse: up to 9 years, 10-19 years, 20-29 years, 30 years or more (4 groups)

7) Years of service at the current department: under 1 year, more than 1 year but less than 2 years, more than 2 years but less than 3 years, 3 years or more (4 groups)

8) Qualification: public health nurse, clinical nurse, assistant nurse (3 groups)

9) Job title: head nurse or higher, or staff (2 groups)

10) Work arrangement: day shift only, three shifts, or on-call (3 groups)

11) Employment status: regular full-time, or other (2 groups)

12) Work assignment: ward (8 possibilities), outpatients, regional medical liaison office, day care (11 groups)

Finally, stepwise multiple linear regression analysis was performed, with each burnout subscale as a dependent variable to examine the effects of both emotional labor and work-related stressors on burnout. Twelve variables measuring individual and occupational factors, the six Japanese AWS subscales, and the four emotional labor

subscales were entered as independent variables.

6. Ethics Considerations

The participants were informed of the following: that participation in the study was voluntary; that choosing not to participate would not affect them in any negative way; that data would be reported in an aggregate form so that individual answers would not be identifiable; personal information would not be connected to any person; data would be locked in a desk drawer to prevent leakage, theft, or loss of data; that any digital (resp., paper-based) data would be deleted (resp., shredded) once the analyses were completed; and that they could withdraw their participation whenever they wished. Participants were also informed of the objectives, method, expected results of the study, and ethics considerations in writing. Provision of responses was treated as an indication of consent.

The Japanese MBI-GS[13], the Japanese AWS[29], and the emotional labor scale[35] were used with permission. This study was approved by the Medical Ethics Committee of Kanazawa University (approval number: No.592-1).

Results

1. Factor validity and reliability of each scale of the study

1) The Japanese MBI-GS

An exploratory factor analysis extracted three factors that are believed to be also found in the original version. Cronbach alpha coefficients for *exhaustion*, *cynicism*, and *professional efficacy* were .882, .850, and .802, respectively.

2) The Japanese AWS

An exploratory factor analysis extracted six factors that are believed to be also found in the original version. However, as discussed by Kitaoka et al.[28) 29)], the factor loading on item 5 of *workload* ("I go home at closing time even when I have some work left.") was only .056. Hence, this item was omitted because it is believed to reflect some background differences. Moreover, two of the four items of *reward* were reversed; however, they were used as-is, matching past practice[29]. Cronbach alpha coefficients for *workload*, *reward*, *control*, *community*, *fairness*, and *values* were .725, .562, .788, .876, .723, and .750, respectively.

3) The Emotional Labor Scale

An exploratory factor analysis extracted four factors that are also found in the original version. Cronbach alpha coefficients for *empathy for patients and display of positive emotions to patients*, *display of negative emotions to patients*, *emotional dissonance*, and *emotional sensitivity requirements* were .775, .734, .764, and .753, respectively.

2. On Differences in Scales Scores of the Japanese MBI-GS, the Japanese AWS, and the Emotional Labor Scale, by Attribute

The results are shown in Tables 2-1, 2-2, and 2-3.

1) Sex: The scale scores of the Japanese AWS for *reward*, *fairness*, and *values* were significantly higher among women, and the scores of the emotional labor scale for *display of negative emotions to patients* were significantly higher among men.

2) Age: Those aged at least 50 scored significantly higher than those aged between 30 and 39 on *value* of the Japanese AWS. The scores on *display of negative emotions to patients* of the emotional labor scale were significantly higher among those aged between 30 and 39, and between 20 and 29, and they were significantly lower among those aged at least 50.

3) Marital Status: Married respondents scored significantly higher on *professional efficacy* of the Japanese MBI-GS, and single respondents scored significantly higher on *fairness* of the Japanese AWS.

4) Having a child: No significant differences were found for any factors.

5) Years of service as a nurse: Those with shorter years of service scored higher on *display of negative emotions to patients* of the emotional labor scale. The scores among those with up to nine years of experience, and those with 10 to 19 years of experience were significantly higher than the scores among those with at least 30 years of experience.

6) Years of Service as a Psychiatric Nurse: Those with up to nine years of service scored significantly higher on *display of negative emotions to patients* than those with at least 30 years of service.

7) Years of Service at the Current Department: No differences were found for any factors.

8) Qualification: Public health nurses and assistant nurses scored significantly higher than clinical nurses on *professional efficacy* on the Japanese MBI-GS. Scores on *empathy and display of positive emotions to patients* on the emotional labor scale were significantly lower among assistant nurses than among clinical nurses. Scores on *emotional dissonance* on the same scale were higher among public health nurses and significantly lower among assistant nurses.

Table 2-1. Differences in subscales scores of the Japanese MBI-GS by attribute

		Exhaustion		Cynicism		Professional efficacy	
	N	Mean±S.D.		Mean±S.D.		Mean±S.D.	
Total	142	3.29 ±1.38		2.21 ±1.46		1.96 ± .99	
Sex			n.s.		n.s.		n.s.
Male	50	3.42 ±1.38		2.49 ±1.48		2.09 ± .96	
Femel	92	3.22 ±1.38		2.07 ±1.44		1.89 ±1.01	
Age			n.s.		n.s.		n.s.
20－29	11	2.47 ±1.33		1.55 ±1.11		2.05 ± .88	
30－39	41	3.27 ±1.21		2.29 ±1.51		2.08 ±1.03	
40－49	36	3.55 ±1.53		2.53 ±1.61		1.60 ±1.00	
≧50	53	3.26 ±1.37		2.06 ±1.35		2.07 ± .95	
Marital Status			n.s.		n.s.		**
Married	117	3.36 ±1.37		2.24 ±1.50		2.07 ± .95	
single	25	2.98 ±1.43		2.08 ±1.29		1.44 ±1.05	
Have a child			n.s.		n.s.		n.s.
Yes	118	3.35 ±1.30		2.25 ±1.41		2.01 ±1.00	
No	24	3.00 ±1.71		2.03 ±1.70		1.72 ± .98	
Years of service as a nurse			n.s.		n.s.		n.s.
9≦	27	2.99 ±1.50		2.27 ±1.60		1.90 ± .79	
10－19	34	3.22 ±1.17		2.05 ±1.33		2.01 ±1.14	
20－29	32	3.66 ±1.48		2.58 ±1.69		1.76 ±1.07	
≧30	47	3.24 ±1.37		2.05 ±1.31		2.09 ± .93	
Years of service as a psychiatric nurse			n.s.		n.s.		n.s.
9≦	45	3.18 ±1.45		2.28 ±1.65		1.79 ± .89	
10－19	33	3.30 ±1.40		2.16 ±1.30		1.95 ±1.11	
20－29	34	3.43 ±1.41		2.51 ±1.57		1.89 ±1.10	
≧30	28	3.24 ±1.27		1.84 ±1.17		2.34 ± .81	
Years of service at the current department			n.s.		n.s.		n.s.
1	24	3.39 ±1.36		2.15 ±1.38		2.03 ±1.21	
2	46	3.11 ±1.52		1.90 ±1.36		1.99 ± .95	
3	38	3.44 ±1.25		2.69 ±1.52		1.77 ± .99	
≧4	32	3.26 ±1.38		2.15 ±1.53		2.09 ± .88	
Qualification			n.s.		n.s.		*
Public health nurse	9	2.80 ±1.60		1.40 ± .68		2.67 ±1.24	
Clinical nurse	128	3.31 ±1.35		2.28 ±1.50		1.88 ± .96	
Assistant nurse	5	3.72 ±1.76		2.08 ±1.29		2.67 ± .60	
Job title			n.s.		n.s.		n.s.
Head nurse or higher	35	3.42 ±1.35		2.05 ±1.37		2.03 ±1.01	
Staff	107	3.25 ±1.39		2.27 ±1.49		1.94 ± .99	
Work arrangement			n.s.		n.s.		n.s.
Day shift only	16	3.41 ±1.42		2.09 ±1.37		2.28 ± .90	
Three shift	116	3.28 ±1.39		2.30 ±1.50		1.94 ±1.01	
On-call	10	3.24 ±1.39		1.46 ± .94		1.67 ± .91	
Employment status			*		**		n.s.
Regular full-time	128	3.38 ±1.37		2.33 ±1.46		1.92 ±1.01	
Other	14	2.43 ±1.21		1.19 ±1.05		2.29 ± .82	
Work assignment			n.s.		n.s.		n.s.
Co-ed psychiatric emergency ward	20	2.86 ±1.14		2.15 ±1.67		2.17 ±1.08	
Co-ed severe chronic closed ward	15	3.37 ±1.62		2.00 ± .98		1.64 ± .79	
Co-ed closed ward	15	3.04 ±1.11		2.52 ±1.60		1.83 ± .85	
Male open ward	16	3.96 ±1.60		2.94 ±1.40		2.03 ±1.31	
Female open ward	8	3.45 ±1.26		2.20 ±1.71		1.63 ±1.47	
Co-ed acute phase treatment ward (elderly)	18	3.37 ±1.68		2.22 ±1.81		2.09 ± .76	
Co-ed geriatric ward	19	3.28 ±1.28		2.03 ± .98		1.56 ± .65	
Co-ed dementia treatment ward	11	3.07 ±1.26		1.64 ±1.33		2.24 ±1.27	
Co-ed special ward	5	3.32 ±1.49		3.00 ±1.88		1.87 ± .95	
Outpatients/ Day care	8	3.95 ±1.00		2.08 ± .87		2.23 ± .87	
Regional medical liaison office	7	2.54 ±1.36		1.54 ±1.69		2.57 ± .83	

1) One-way ANOVA *:p<. 05 **:p<. 01 ***:p<. 001

Table 2-2. Differences in subscales scores of the Japanese AWS by attribute

		Workload		Control		Reward		Community		Fairness		Values	
	N	Mean±S.D.		Mean±S.D.		Mean±S.D.		Mean±S.D.		Mean±S.D.		Mean±S.D.	
Total	142	2.69 ± .62		2.74 ± .71		3.11 ± .42		3.78 ± .60		2.89 ± .51		3.19 ± .61	
Sex			n.s.		n.s.		*		n.s.		***		***
Male	50	2.81 ± .54		2.70 ± .70		3.01 ± .43		3.66 ± .58		2.69 ± .52		2.91 ± .60	
Femel	92	2.62 ± .66		2.77 ± .72		3.17 ± .40		3.84 ± .60		3.01 ± .47		3.34 ± .55	
Age			n.s.		n.s.		n.s.		n.s.		n.s.		*
20－29	11	3.11 ± .53		2.70 ± .49		3.16 ± .38		3.76 ± .47		3.09 ± .46		3.02 ± .47	
30－39	41	2.74 ± .52		2.73 ± .64		3.13 ± .45		3.75 ± .66		2.76 ± .57		3.02 ± .63	
40－49	36	2.60 ± .63		2.65 ± .74		3.01 ± .41		3.81 ± .53		2.96 ± .43		3.16 ± .52	
≧50	53	2.62 ± .68		2.83 ± .80		3.15 ± .40		3.77 ± .64		2.91 ± .50		3.36 ± .63	
Marital Status			n.s.		n.s.		n.s.		n.s.		**		n.s.
Married	117	2.64 ± .64		2.73 ± .72		3.10 ± .45		3.77 ± .62		2.84 ± .52		3.18 ± .64	
single	25	2.89 ± .47		2.80 ± .68		3.15 ± .23		3.82 ± .48		3.15 ± .38		3.23 ± .37	
Have a child			n.s.		n.s.		n.s.		n.s.		n.s.		n.s.
Yes	118	2.67 ± .64		2.70 ± .72		3.11 ± .41		3.76 ± .62		2.86 ± .52		3.19 ± .63	
No	24	2.78 ± .56		2.95 ± .64		3.13 ± .44		3.86 ± .52		3.08 ± .42		3.20 ± .47	
Years of service as a nurse			n.s.		n.s.		n.s.		n.s.		n.s.		n.s.
9≦	27	2.79 ± .60		2.73 ± .60		3.06 ± .43		3.76 ± .50		2.88 ± .47		3.05 ± .49	
10－19	34	2.86 ± .46		2.70 ± .70		3.18 ± .38		3.79 ± .64		2.88 ± .60		3.04 ± .62	
20－29	32	2.48 ± .66		2.70 ± .66		3.05 ± .46		3.71 ± .58		2.91 ± .43		3.16 ± .58	
≧30	47	2.63 ± .69		2.84 ± .81		3.12 ± .41		3.79 ± .64		2.90 ± .53		3.37 ± .63	
Years of service as a psychiatric nurse			n.s.		n.s.		n.s.		n.s.		n.s.		n.s.
9≦	45	2.79 ± .54		2.74 ± .60		3.09 ± .45		3.78 ± .60		2.99 ± .44		3.07 ± .50	
10－19	33	2.69 ± .67		2.74 ± .68		3.14 ± .42		3.81 ± .52		2.81 ± .58		3.16 ± .71	
20－29	34	2.45 ± .71		2.65 ± .77		3.06 ± .39		3.68 ± .59		2.80 ± .56		3.22 ± .61	
≧30	28	2.79 ± .56		2.91 ± .85		3.15 ± .42		3.80 ± .70		2.95 ± .45		3.34 ± .60	
Years of service at the current department			n.s.		n.s.		n.s.		n.s.		n.s.		n.s.
1	24	2.68 ± .62		2.72 ± .87		3.10 ± .40		3.82 ± .62		2.99 ± .43		3.38 ± .47	
2	46	2.74 ± .63		2.72 ± .67		3.11 ± .39		3.85 ± .55		2.79 ± .60		3.17 ± .63	
3	38	2.72 ± .66		2.73 ± .72		3.06 ± .42		3.60 ± .64		2.87 ± .48		3.07 ± .59	
≧4	32	2.56 ± .60		2.85 ± .66		3.16 ± .48		3.80 ± .58		2.98 ± .44		3.18 ± .65	
Qualification			n.s.		n.s.		n.s.		n.s.		n.s.		n.s.
Public health nurse	9	2.91 ± .53		2.47 ± .40		3.31 ± .35		3.91 ± .62		2.96 ± .79		3.31 ± .50	
Clinical nurse	128	2.68 ± .63		2.79 ± .72		3.10 ± .42		3.77 ± .60		2.88 ± .49		3.19 ± .61	
Assistant nurse	5	2.48 ± .46		2.20 ± .60		3.10 ± .22		3.64 ± .57		3.07 ± .38		3.05 ± .62	
Job title			*		n.s.		n.s.		n.s.		n.s.		***
Head nurse or higher	35	2.50 ± .71		2.94 ± .69		3.12 ± .41		3.89 ± .57		2.98 ± .42		3.50 ± .49	
Staff	107	2.75 ± .58		2.68 ± .71		3.11 ± .42		3.74 ± .61		2.87 ± .53		3.09 ± .61	
Work arrangement			n.s.		***		n.s.		n.s.		n.s.		n.s.
Day shift only	16	2.96 ± .62		3.14 ± .89		3.27 ± .46		3.94 ± .48		3.02 ± .62		3.30 ± .70	
Three shift	116	2.63 ± .62		2.64 ± .65		3.08 ± .41		3.76 ± .62		2.87 ± .50		3.15 ± .59	
On-call	10	2.88 ± .57		3.30 ± .71		3.18 ± .33		3.70 ± .61		2.93 ± .35		3.53 ± .57	
Employment status			**		n.s.		**		n.s.		*		n.s.
Regular full-time	128	2.64 ± .61		2.71 ± .68		3.08 ± .40		3.75 ± .62		2.86 ± .49		3.17 ± .59	
Other	14	3.11 ± .65		3.09 ± .92		3.43 ± .44		3.99 ± .33		3.21 ± .58		3.39 ± .73	
Work assignment			n.s.		n.s.		n.s.		*		n.s.		n.s.
Co-ed psychiatric emergency ward	20	2.86 ± .49		2.69 ± .70		3.11 ± .37		3.92 ± .48		2.99 ± .36		3.06 ± .55	
Co-ed severe chronic closed ward	15	2.85 ± .33		2.85 ± .74		3.23 ± .32		3.80 ± .62		3.01 ± .24		3.22 ± .65	
Co-ed closed ward	15	2.80 ± .52		2.70 ± .57		3.02 ± .39		3.85 ± .60		2.70 ± .45		2.98 ± .54	
Male open ward	16	2.83 ± .65		2.83 ± .72		2.98 ± .53		3.49 ± .63		2.75 ± .49		3.17 ± .69	
Female open ward	8	2.83 ± .45		2.38 ± .83		3.00 ± .46		3.20 ± .97		2.75 ± .71		3.34 ± .73	
Co-ed acute phase treatment ward (elderly)	18	2.27 ± .59		2.64 ± .66		3.11 ± .50		3.87 ± .64		2.91 ± .65		3.32 ± .69	
Co-ed geriatric ward	19	2.59 ± .78		2.68 ± .74		3.09 ± .25		3.98 ± .24		2.89 ± .58		3.25 ± .52	
Co-ed dementia treatment ward	11	2.35 ± .81		2.77 ± .65		3.25 ± .45		3.78 ± .60		3.00 ± .35		3.25 ± .19	
Co-ed special ward	5	2.52 ± .30		2.60 ± .63		2.85 ± .29		3.28 ± .59		2.70 ± .52		2.85 ± .72	
Outpatients/ Day care	8	2.73 ± .44		2.91 ± .78		3.13 ± .38		3.85 ± .52		2.88 ± .51		2.97 ± .76	
Regional medical liaison office	7	3.09 ± .86		3.32 ± .99		3.46 ± .53		3.94 ± .51		3.21 ± .72		3.71 ± .42	

1) One-way ANOVA *：p<. 05 **：p<. 01 ***：p<. 001

Table 2-3. Differences in subscales scores of the Emotional Labor Scale by attribute

	N	Display of negative emotions Mean±S.D.		Empathy and display of positive emotions Mean±S.D.		Emotional dissonance Mean±S.D.		Emotional sensitivity requirements Mean±S.D.	
Total	142	2.66 ± .62		3.57 ± .58		3.10 ± .69		3.21 ± .75	
Sex			***		n.s.		n.s.		n.s.
Male	50	2.99 ± .56		3.53 ± .60		3.26 ± .60		3.34 ± .70	
Femel	92	2.48 ± .57		3.59 ± .56		3.02 ± .73		3.15 ± .77	
Age			***		n.s.		n.s.		n.s.
20－29	11	2.91 ± .38		3.56 ± .46		3.40 ± .41		3.11 ± .70	
30－39	41	2.93 ± .62		3.57 ± .55		3.22 ± .60		3.11 ± .75	
40－49	36	2.66 ± .60		3.60 ± .59		3.10 ± .70		3.31 ± .75	
≧50	53	2.39 ± .57		3.54 ± .62		2.96 ± .78		3.24 ± .76	
Marital Status			n.s.		n.s.		n.s.		n.s.
Married	117	2.65 ± .63		3.58 ± .59		3.11 ± .71		3.24 ± .74	
single	25	2.71 ± .53		3.49 ± .51		3.06 ± .59		3.08 ± .81	
Have a child			n.s.		n.s.		n.s.		n.s.
Yes	118	2.62 ± .63		3.57 ± .57		3.07 ± .71		3.24 ± .75	
No	24	2.85 ± .51		3.56 ± .63		3.26 ± .58		3.10 ± .75	
Years of service as a nurse			***		n.s.		n.s.		n.s.
9≦	27	2.91 ± .65		3.56 ± .58		3.25 ± .63		3.11 ± .77	
10－19	34	2.81 ± .56		3.52 ± .49		3.14 ± .63		3.18 ± .73	
20－29	32	2.69 ± .57		3.61 ± .63		3.15 ± .64		3.21 ± .79	
≧30	47	2.37 ± .59		3.59 ± .61		2.99 ± .80		3.29 ± .75	
Years of service as a psychiatric nurse			**		n.s.		n.s.		n.s.
9≦	45	2.84 ± .59		3.54 ± .53		3.20 ± .63		3.11 ± .76	
10－19	33	2.71 ± .60		3.60 ± .60		3.18 ± .77		3.27 ± .75	
20－29	34	2.61 ± .62		3.67 ± .60		3.13 ± .64		3.24 ± .78	
≧30	28	2.35 ± .60		3.45 ± .61		2.87 ± .74		3.28 ± .72	
Years of service at the current department			n.s.		n.s.		n.s.		n.s.
1	24	2.60 ± .58		3.49 ± .56		3.11 ± .88		3.23 ± .73	
2	46	2.71 ± .59		3.67 ± .55		3.14 ± .58		3.24 ± .87	
3	38	2.62 ± .65		3.46 ± .53		3.07 ± .77		3.08 ± .74	
≧4	32	2.66 ± .68		3.61 ± .67		3.13 ± .62		3.31 ± .59	
Qualification			n.s.		n.s.		*		n.s.
Public health nurse	9	2.93 ± .57		3.65 ± .46		3.31 ± .46		3.08 ± .88	
Clinical nurse	128	2.66 ± .60		3.59 ± .58		3.12 ± .69		3.22 ± .75	
Assistant nurse	5	2.17 ± .84		2.97 ± .49		2.36 ± .77		3.35 ± .58	
Job title			n.s.		*		*		n.s.
Head nurse or higher	35	2.54 ± .46		3.75 ± .47		3.34 ± .70		3.36 ± .69	
Staff	107	2.69 ± .66		3.51 ± .60		3.03 ± .67		3.17 ± .76	
Work arrangement			n.s.		*		n.s.		n.s.
Day shift only	16	2.42 ± .46		3.92 ± .48		3.15 ± .72		3.61 ± .55	
Three shift	116	2.70 ± .64		3.52 ± .58		3.08 ± .69		3.15 ± .76	
On-call	10	2.52 ± .54		3.58 ± .56		3.34 ± .74		3.35 ± .78	
Employment status			*		n.s.		n.s.		n.s.
Regular full-time	128	2.69 ± .62		3.54 ± .58		3.12 ± .70		3.18 ± .75	
Other	14	2.32 ± .50		3.83 ± .52		2.96 ± .66		3.50 ± .67	
Work assignment			**		n.s.		n.s.		n.s.
Co-ed psychiatric emergency ward	20	2.90 ± .54		3.54 ± .58		3.04 ± .48		3.19 ± .52	
Co-ed severe chronic closed ward	15	2.52 ± .47		3.46 ± .64		2.87 ± .71		3.12 ± .84	
Co-ed closed ward	15	2.98 ± .64		3.44 ± .70		3.21 ± .83		3.28 ± .83	
Male open ward	16	2.73 ± .66		3.52 ± .45		3.16 ± .90		3.20 ± .79	
Female open ward	8	2.77 ± .65		3.63 ± .31		3.45 ± .85		3.53 ± .66	
Co-ed acute phase treatment ward (elderly)	18	2.85 ± .69		3.59 ± .71		3.18 ± .73		3.31 ± .85	
Co-ed geriatric ward	19	2.32 ± .51		3.44 ± .64		2.92 ± .63		2.92 ± .92	
Co-ed dementia treatment ward	11	2.30 ± .55		3.73 ± .27		3.11 ± .43		2.95 ± .57	
Co-ed special ward	5	3.00 ± .67		3.50 ± .35		3.56 ± .22		3.05 ± .33	
Outpatients/ Day care	8	2.54 ± .44		3.77 ± .56		2.98 ± .52		3.69 ± .46	
Regional medical liaison office	7	2.14 ± .39		4.05 ± .50		3.17 ± .92		3.54 ± .70	

1) One-way ANOVA *:p<. 05 **:p<. 01 ***:p<. 001

9) Job Title: Scores on *workload* on the Japanese AWS were higher among staff and those on *values* of the same scale were higher among those who held a head nurse position or higher. Those who held a head nurse position or higher also scored significantly higher on *empathy and display of positive emotions to patients* and *emotional dissonance* on the emotional labor scale.

10) Work Arrangement: Those who worked three shifts scored significantly lower on *control* on the Japanese AWS. Those who worked only day shifts scored significantly higher on *empathy and display of positive emotions to patients* on the emotional labor scale.

11) Employment Status: Regular, full-time employees scored significantly higher on *exhaustion* and *cynicism* on the Japanese MBI-GS. Their scores on *workload*, *reward*, *fairness* on the Japanese AWS were significantly lower, while those on *display of negative emotions to patients* on the emotional labor scale were significantly higher.

12) Work Assignment: Scores on *community* of the Japanese AWS were higher among those at a co-ed geriatric ward and lower among those at a female open ward. Scores on *display of negative emotions to patients* on the emotional labor scale were higher among those at a co-ed special ward, co-ed closed ward, and a regional medical liaison office.

3. Effects of Emotional Labor and Work-related Stressors on Burnout

Table 3 shows the results from stepwise multiple

Table 3. Results of stepwise multiple linear regression analysis: Relationship between the Japanese MBI-GS, the Japanese AWS, and the Emotional Labor Scale

	Exhaustion		Cynicism		Professional efficacy	
	standardized coefficient β	t	standardized coefficient β	t	standardized coefficient β	t
Sex	.05	.54	.08	.98	-.10	-1.23
Age	.13	1.62	.12	1.52	-.09	-1.06
Marital Status	-.05	-.70	.01	.19	-.23	-2.86 **
Have a child	-.10	-1.30	-.06	-.89	.06	.55
Years of service as a nurse	.11	1.42	.06	.86	-.02	-.26
Years of service as a psychiatric nurse	.08	1.02	.02	.24	.10	1.11
Years of service at the current department	.00	-.03	.05	.73	-.04	-.46
Qualification	.09	1.11	.06	.89	-.10	-1.15
Job title	-.01	-.15	.03	.43	.01	.09
Work arrangement	-.09	-1.13	-.11	-1.53	-.10	-1.24
Employment status	-.04	-.44	-.05	-.62	.06	.66
Work assignment	.08	1.04	-.01	-.10	.05	.54
Workload	-.28	-3.75 ***	-.19	-2.66 **	-.05	-.60
Control	-.07	-.83	-.04	-.45	.11	1.30
Reward	-.30	-3.88 ***	-.38	-5.21 ***	.20	2.47 *
Community	-.12	-1.40	-.14	-1.74	.08	.98
Fairness	.01	.09	.04	.47	-.04	-.39
Values	-.07	-.81	-.22	-2.93 **	-.03	-.38
Display of negative emotions	.19	2.50 *	.16	2.23 *	-.05	-.55
Empathy and display of positive emotions	-.01	-.07	-.04	-.50	-.08	-.99
Emotional dissonance	.01	.14	.03	.41	-.06	-.70
Emotional sensitivity requirements	.06	.75	.03	.38	-.04	-.51
R-squared value (coefficient of determination)	.24		.35		.09	
Adjusted R-square (Adjusted coefficient of determination)	.22		.34		.08	

1) Stepwise multiple linear regression analysis *:p<.05 **:p<.01 ***:p<.001

linear regression analysis. The dependent variables were subscales of the Japanese MBI-GS.

1) Two of the six subscales of the Japanese AWS, and one of the four subscales of the emotional labor scale were found to have significant effects on *exhaustion*. These were *reward* (standardized coefficient: –.30), *workload* (–.28), and *display of negative emotions to patients* (.19). The variance explained was 24.0%.

2) Three work-related stressor variables (*reward*, *values*, and *workload*), and one variable of emotional labor (*display of negative emotions to patients*) were found to have significant effects on *cynicism*. The standardized coefficients of these variables were –.38 –.22, –.19, and .16, respectively. The variance explained was 35.0%.

3) Marital status, an individual level variable, and *reward*, a work-related stressor variable, had significant effects on *professional efficacy*. The standardized coefficients of these variables were –.23 and –.20, respectively. The variance explained was 9.0%.

Discussion

1. Effects of Emotional Labor and Work-related Stressors on Burnout

The emotional labor scale[35] employed in this study has four factors to measure emotional labor. These are *empathy for patients and display of positive emotions to patients*, *display of negative emotions to patients*, *emotional dissonance*, and *emotional sensitivity requirements*. Of these, our results show that only *display of negative emotions to patients* has an effect on *exhaustion*, which is the first sign of burnout. This is in line with the finding of a previous study[8] which used the emotional labor scale[35] and found that those who scored higher on *display of negative emotions to patients* also scored higher on *emotional exhaustion* on the Japanese burnout scale[37]. This suggests that when psychiatric nurses have to frequently display negative emotions; in other words, when it is often necessary to adopt a strict attitude toward patients with mental disabilities or display anger, they are more likely to feel exhausted. However, the findings of the current study show that two of the work-related stressors (*reward* and *workload*) have larger effects on *exhaustion* than emotional labor does. When nurses find their work psychologically unrewarding, believing that "their work is underappreciated" or "their effort is not noticed," or when they think that "they are doing many hours of hard labor" and "they do not have enough time to do their work," and feel the burden of their work, the level of their exhaustion becomes higher.

In line with a previous report[8], our study found effects from *values*, *reward*, and *workload* (work-related stressors) on *cynicism*. In addition, it revealed effects from *display of negative emotions to patients* on *cynicism* (emotional labor). However, the effects on *cynicism* appear to be smaller than those from work-related stressors. As for *values*, the results suggest that when nurses believe that "there is a mismatch between their values and those of the hospital" and are engaged in activities that are not compatible with their values, they are more likely to experience *cynicism*. In other words, psychiatric nurses are more likely to lose passion for nursing when there is a mismatch between their values and those of the hospital. As to the effects on *professional efficacy*, our study found that marital status, an individual-level factor, and *reward*, a work-related stressor, have significant effects, while emotional labor has no effects.

Hochschild[1] has argued that emotional labor degrades mental health. Therefore, we had expected that the effects of emotional labor on burnout would be larger than those of work-related stressors. The results showed some effects from *display of negative emotions to patients* on *cynicism*; however, the size of those effects was smaller than the impact of work-related stressors such as *reward*, *workload*, and *values*.

2. Emotional Labor and Burnout

In previous studies[9] [10], no relation was observed between emotional labor and depression, and the authors concluded that the negative effects of emotional labor on psychiatric nurses are minimal. Similarly, in this study, no relation was found between three types of emotional labor (*empathy and display of positive emotions to patients*, *emotional dissonance*, and *emotional sensitivity requirements*) and burnout were found in this study. However, the results indicated that *display of negative emotions to patients* has effects on both *exhaustion* and *cynicism*, which are the first and second precursors to burnout. Psychiatric nurses must display negative emotions to patients when they do not have time to listen attentively to the patient or when they have to adopt a strict attitude or display anger, and nurses are believed to feel exhausted in these situations. Moreover, psychiatric

nurses are compelled to wonder what effect their displays of negative emotions to their patients might have on their future relationship with them; as a result, they are forced to pay close attention, and this, in turn, is believed to deepen the level of their exhaustion. Furthermore, by being repeatedly in situations in which they must display negative emotions to patients, nurses come to lose their passion for their patients' recoveries, and lapse into cynicism.

In contrast with this line of reasoning, some have argued that *emotional sensitivity requirements* lead to *exhaustion*[35], and that *emotional dissonance* influences *cynicism*[8) 35)]. Furthermore, Schmidt and Diestel[38] have argued that *surface acting*, a type of emotional labor, negatively influences mental health. In the present study, however, no relation was observed between emotional labor and burnout. This could be because Ogino et al.[35] examined nurses and caregivers at a rehabilitation hospital, and we examined psychiatric nurses. As argued by others[10], the effects of emotional labor by nurses can vary depending on the type of hospital. Moreover, the average years of service of the psychiatric nurses included in the current study was 17.2 years, and so they might have learned to control dissonance arising from emotional labor.

Following the research findings of Hochschild[1], it has been often argued in Japan that emotional labor leads to burnout. The current study also revealed some effects of negative emotional labor on burnout, and it is important to devise measures to prevent burnout. However, the results from numerous empirical studies in Western countries do not show a clear relation between emotional labor and burnout, and scholars have started to pay attention to positive aspects of emotional labor. For example, Mitsuhashi[39] has argued that people experience burnout when they want to engage in emotional labor but are prevented from doing so, and Riley and Weiss[40] have contended that emotional labor conducted by medical professionals for healthcare service recipients is difficult to visualize and is, therefore, underappreciated as a skill. Empathetic and positive emotional labor ("try to empathize with patients," and "give warm attention to patients") should be considered a skill to be fostered among psychiatric nurses.

3. Suggestions for Clinical Practice

First, it is necessary to decrease negative emotional labor, such as adopting a strict attitude toward patients or displaying anger, in order to prevent burnout of psychiatric nurses. In daily clinical practice, psychiatric nurses sometimes must engage in negative emotional labor[41], but it is necessary to make sure that negative emotional labor does not fall disproportionally on some psychiatric nurses. Moreover, negative emotional labor is believed to generate negative emotions among patients, which could adversely influence future patient–nurse relationship; therefore, it is important that experienced nurses who have good awareness when engaging in negative emotional labor and can persuade patients, train new nurses.

We did not find effects on burnout from positive emotional labor, which suggests that we should encourage psychiatric nurses to actively engage in positive emotional labor, such as showing empathy for patients or giving warm attention, without fearing that emotional labor degrades mental health. Moreover, we should encourage nurses to appropriately handle emotional dissonance or emotional sensitivity requirements at work, with the aim of better supporting them.

We found that the effects of work-related stressors on burnout were larger than those of emotional labor. In order to prevent burnout of psychiatric nurses, organizational standards are needed to properly evaluate work performance and to allow nurses to actively reflect their values in their work. We believe that doing so will help to prevent burnout among psychiatric nurses and, as a result, allow providing better quality nursing to patients.

Limitations and Challenges of the Study

This study revealed the effects (or lack of effects) from emotional labor by psychiatric nurses in Japan on burnout. However, the data were obtained from nurses at only one hospital; therefore, we should be careful in generalizing the results of the study. Moreover, there are not many studies on emotional labor of psychiatric nurses in Japan, and we have not accumulated enough knowledge. Hence, to allow generalizing the results of this study, many studies of the subject should be conducted in the future.

Conclusion

1. Out of *empathy for patients* and *display of positive emotions to patietns*, *display of negative emotions to patients*, *emotional dissonance*, and *emotional sensitivity*

*requirement*s, only *display of negative emotions to patients* was found to have positive effects on *exhaustion* and *cynicism* (precursors to burnout).

2. Of work-related stressors, *reward*, *workload*, and mismatches of *values* were found to have positive effects on burnout, and their effects were larger than those from emotional labor. The effects from emotional labor on burnout were small compared with those from work-related stressors.

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日本の精神科看護師の感情労働および職場ストレッサーがバーンアウトに与える影響

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要　　旨

日本の精神科看護師を対象として、感情労働と職場ストレッサーの双方がバーンアウトにおよぼす影響を検討し、精神科看護師の感情労働とバーンアウトとの関係を明らかにすることを目的とした。1単科精神科病院に勤務する看護師169名を対象に自己記入式質問紙調査を実施した。バーンアウトは日本版MBI-GS（Maslach Burnout Inventory-General Survey）を、感情労働は感情労働尺度を、職場ストレッサーは日本版AWS（Areas of Worklife Survey）を採用し、測定した。

日本版MBI-GSの3下位尺度を被説明変数とした重回帰分析を行った結果、‘疲弊感’では日本版AWSの‘報酬’と‘仕事の負担’、感情労働尺度の‘患者へのネガティブな感情表出’が有意な説明変数となった。‘シニシズム’では日本版AWSの‘報酬’、‘仕事の負担’、‘価値観’、感情労働尺度の‘患者へのネガティブな感情表出’が有意な説明変数となった。‘職務効力感’では‘婚姻状況’と日本版AWSの‘報酬’のみが有意な説明変数となった。

感情労働の中でも、ネガティブな感情労働のバーンアウトへの影響を認めることができたが、職場ストレッサーがおよぼす影響の方がより大きいと考えられた。精神科看護師のバーンアウトを予防してより質の高い看護を提示していくためには、組織全体で看護師の仕事の成果等を正しく評価すること、看護師個々に仕事の負担がかかりすぎないように配慮すること、看護師の価値観を仕事に反映させることを重要視し、取組んでいく必要がある。