Introduction

Job stress is the harmful physical and emotional response to a poor match between job demands and the worker’s capabilities, resources, or needs. Stress-related disorders encompass a broad array of conditions, including psychological disorders such as depression and anxiety; other types of emotional strain, such as fatigue and tension, maladaptive behaviours, and cognitive impairment (1,2). In turn, these conditions may lead to poor work performance and can affect patient safety (3,4). Job stress is also associated with various biological reactions such as cardiovascular disease, migraines, hypertension or irritable bowel syndrome which may ultimately lead to a compromised health (5).

Numerous studies confirm that occupational pressures and fears are by far the leading source of stress for nurses, and that these factors have steadily increased over the past few decades as a result of health care’s rapid development, including high-care technology, shortened lengths of stay in hospitals, an emphasis on cost effectiveness and staff downsizing (6). Wheeler (7) identified a wide range of stressors for nurses, including work overload, role conflict and ambiguity, resource shortages and pressure from patients and management. A similar list was compiled at about the same time by Cheng and his colleagues (8).

Everyday, nurses confront stark suffering, grief, and death in a way that few other people do. A study comparing occupational stress among nurses and non-nurses reveals that nurses encounter significantly more stress factors than their non-nurse colleagues (9).

Stress may result in emotional withdrawal and burnout. Maslach & Jackson (10) characterized burnout as a syndrome of emotional exhaustion, depersonalisation, and reduced personal accomplishment in professionals. A large study of

Keywords: Burnout; nurse; patient-nurse relations; stress/distress, qualitative
43,000 participating nurses across five countries found that more than 40 per cent of the nurses were experiencing significant burnout (6).

A literature search revealed much quantitative research on stress in nursing focusing only on work stressors, and, moreover, qualitative studies focusing on nurses’ experience of stress and burnout are not always easily accessible. This review of the nursing literature aims to identify knowledge about how the experience of stress and burnout affect nurses.

Method

This article is based on a thesis prepared in connection with the Master of Science in Nursing programme (11). The research material was collected based on qualitative research reports published between 1998 and 2012 and referenced in the Cinahl, PubMed, EMBASE, psykINFO, EBSCO and Web of Science databases. In addition, a manual search of the Journal of Advanced Nursing and Qualitative Studies of Nursing (1998–2012) was performed. Manual searching guarantees a complete collection of relevant articles in the journals and helps with determining the search terms to use in the databases (12). The following search terms were used: occupational stress, stress, burnout, job satisfaction, patient-nurse relation, nurse/s, nurse experience. These terms were looked up in titles, keywords, or abstracts.

Inclusion criteria

The inclusion criteria were as follows: A peer-reviewed study published in a nursing journal, in which a qualitative approach was used, focused on the subject of nurses, stress and burnout, and written in English, Danish, Swedish, or Norwegian. Furthermore, eligible nurses had to have worked in hospital settings and cared for patients aged 18 years or older. The selection of articles was made in stages; based on the study titles, the summaries of selected research reports were read; suitable articles were then sought out and read. A reading guide developed by Sandelowski

<table>
<thead>
<tr>
<th>Authors/year</th>
<th>Aim</th>
<th>Sample Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Winters &amp; Neville 2012</td>
<td>To investigate the concept of “missed care”</td>
<td>5 nurses</td>
</tr>
<tr>
<td>Alderson 2008</td>
<td>To examine the processes by which nurses’ mental health is weakened</td>
<td>33 nurses</td>
</tr>
<tr>
<td>Moola et al. 2008</td>
<td>To describe nurses’ experiences of stressful incidents. Identify coping strategies and recommend ways in which these could be enhanced</td>
<td>10 nurses</td>
</tr>
<tr>
<td>Hallin &amp; Danielson 2007</td>
<td>To describe nurses’ experiences of their daily work</td>
<td>15 nurses</td>
</tr>
<tr>
<td>Rafii et al. 2007</td>
<td>To explore and describe nurses’ perceptions of their caring behaviour and related factors</td>
<td>38 nurses</td>
</tr>
<tr>
<td>Fagerström 2006</td>
<td>To gain understanding of nurses’ workloads and what characterizes a nurse’s experience in terms of the various levels of intensity of nursing care</td>
<td>29 nurses</td>
</tr>
<tr>
<td>Mcilfatrick et al. 2006</td>
<td>To explore the nurses’ experience of a day hospital chemotherapy service</td>
<td>10 nurses</td>
</tr>
<tr>
<td>Billeter-Koponen &amp; Fredén 2005</td>
<td>To obtain a deeper understanding of how nurses experience long-lasting stress and burnout</td>
<td>10 nurses</td>
</tr>
<tr>
<td>Särtilie et al. 2005</td>
<td>To describe nurses’ experiences in an acute care ward</td>
<td>5 nurses</td>
</tr>
<tr>
<td>Murphy 2004</td>
<td>To explore the perception of stress among nephrology nurses</td>
<td>10 nurses</td>
</tr>
<tr>
<td>Severinsson 2003</td>
<td>To describe and interpret the narrative of an Australian nurse’s experience of burnout</td>
<td>1 nurse</td>
</tr>
<tr>
<td>Williams 1998</td>
<td>To explore and describe the delivery of high quality nursing care from the nurses’ perspective</td>
<td>10 nurses</td>
</tr>
</tbody>
</table>
& Barroso (13) was used to assess the relevance of the study to the inclusion criteria. A total of 161 articles were selected, from which 56 abstracts were subjected to closer scrutiny. According to the abstracts, 31 articles dealt with nurses’ experience of stress and burnout, and twelve of these articles fulfilled the inclusion criteria. The articles were a sample of Irish, Norwegian, Swedish, Australian, Finnish, New Zealand, Canadian, South African, and Iranian studies. The studies included grounded theory, phenomenological hermeneutics and qualitative descriptive designs with semi-structured interviews. A total of 176 hospital nurses within different specialties (oncology, nephrology, dermatology, medical, geriatric, surgical, and acute unit) participated in the twelve studies.

Quality assessment
The issue of quality assessment in qualitative research has generated extensive debate and controversy (14). No consensus has been reached on quality criteria or whether it is even appropriate to try to establish such a consensus (12).

In this study, Sandelowski & Barroso’s (15) classification system for qualitative research was adopted. Sandelowski & Barroso suggest that findings from qualitative studies in health research can be classified according to how and how much the researcher has transformed the data in the analysis. They classify studies as “no finding”, “topical survey”, “thematic survey”, “conceptual/thematic description”, or “interpretive explanation”. The classification emphasizes the differences between the qualitative findings presented in research reports rather than differences in quality between qualitative studies. Articles selected for this study fell into the three last categories (Table 1).

Results
Collating the evidence from the literature led to the identification of six themes: The desire to provide ideal nursing; creating self-imposed demands; experiencing behavioural symptoms;
experiencing physical symptoms; experiencing psychiatric symptoms; having a mental breakdown. The themes should be seen as the different phases nurses undergo when they are affected by stress and burnout. The nurses can overcome stress at each stage if they receive help. If not, they progress to the subsequent phase. The nurses from the twelve studies included in the literature review were allocated throughout the different phases (Table 2).

Desire to provide ideal nursing

The nurses described a quest to provide ideal nursing. According to Severinsson (16), the nurses had “a desire to be an ideal nurse”. Ideal nursing was described as meeting all the patients’ needs, both physical and psychosocial. When ideal nursing was performed, positive effects were observed in the patients, and nursing was seen as a therapy that contributed to the healing process (17). The nurses stated that being a nurse was a social profession in which meeting people is elementary. It was important to create a good relationship with the patients. The relationship was the heart of the nurses’ psychic balance; it opened the door to sense and job satisfaction (18,19). According to research, there are many barriers to caring for patients, including staff shortage, work demands, and shortage of time (7,8). The nurses were frustrated by the stress of their work and the consequences for their patients. The nurses experienced feelings of inadequacy and guilt because they were not as close to the patients as they wanted to be and had been instructed to be during their studies (20). The nurses had problems addressing this frustration and balancing all the demands on them; they suffered from wanting to do more

### Table 2. Emerging themes and studies.

<table>
<thead>
<tr>
<th>Authors/year</th>
<th>Desire to provide ideal nursing</th>
<th>Creating self-imposed demands</th>
</tr>
</thead>
<tbody>
<tr>
<td>Winters &amp; Neville 2012</td>
<td>Wanted to provide good care</td>
<td>Felt responsible</td>
</tr>
<tr>
<td>Alderson 2008</td>
<td>Wanted to provide quality care</td>
<td>Felt responsible, heavy workload</td>
</tr>
<tr>
<td>Moola et al. 2008</td>
<td></td>
<td>Felt inadequate, decreased performance</td>
</tr>
<tr>
<td>Rafii et al. 2007</td>
<td>Wanted to provide good care</td>
<td>Felt inadequate and had a bad conscience</td>
</tr>
<tr>
<td>Hallin &amp; Danielson 2007</td>
<td>Wanted to provide good care</td>
<td>Felt inadequate and responsible towards patients</td>
</tr>
<tr>
<td>Mcilfatrick et al. 2006</td>
<td>Wanted to provide holistic, good quality care</td>
<td>Felt responsible</td>
</tr>
<tr>
<td>Fagerström 2006</td>
<td>Want to provide ideal care</td>
<td>Felt responsible</td>
</tr>
<tr>
<td>Sertie et al. 2005</td>
<td>Want to provide quality care</td>
<td>Felt inadequate and responsible towards patients</td>
</tr>
<tr>
<td>Billeter-Koponen &amp; Fredén 2005</td>
<td>Wanted to provide good quality care</td>
<td>Skipped breaks; worked longer; bad feelings towards patients and colleagues</td>
</tr>
<tr>
<td>Murphy 2004</td>
<td></td>
<td>Skipped breaks; bad feelings towards colleagues</td>
</tr>
<tr>
<td>Severinsson 2003</td>
<td>Wanted to provide ideal care</td>
<td>Felt inadequate and responsible towards patients</td>
</tr>
<tr>
<td>Williams 1998</td>
<td>Want to provide ideal care</td>
<td>Felt inadequate</td>
</tr>
</tbody>
</table>
than they were able to, and they wanted to realize and act on their inner ethical desires to provide good and ideal nursing (20). Sørlie et al. (21, p. 138) expressed these feelings well: “The nurses said they feel that they have to be satisfied with what they have achieved.” However, the nurses were not satisfied; instead, they focused on their inadequacy and their lack of involvement with the patients. They did not feel they could live up to their responsibility to provide ideal nursing. The included studies stated that the nurses were aware that they were feeling stressed and heading towards a burnout. However, even though the nurses had the opportunity to stop and reflect on their work situation and change it, this did not happen. Severinsson (16) suggests that the barrier to reducing stress in this case is the nurses’ own attitudes toward the ideal way to be a nurse. Nurses’ attitudes about being “only a nurse” emphasize their low self-esteem and lack of confidence instead of focusing on their clinical competence and decision-making skills. At the same time, the nurses’ expectations of themselves to be professionally efficient and effective can be one reason why feeling tired and being sick are considered unprofessional (18).

The nursing profession is currently undergoing several changes. Organisational and educational changes are happening rapidly and are affecting nurses’ work environments. The nurses in the included studies felt they had to be flexible and accept the new situation (22). Still, they found their technical role and their caring role “difficult partners” (18,19). Stress and burnout among nurses are signs of this conflict (18,23). The nurses feel responsible for making it work, thereby creating self-imposed demands.

<table>
<thead>
<tr>
<th>Experiencing behavioural symptoms</th>
<th>Experiencing physical symptoms</th>
<th>Experiencing psychiatric symptoms</th>
<th>Having a mental breakdown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of confidence</td>
<td></td>
<td>Frustration, dissatisfaction, worry, blame</td>
<td></td>
</tr>
<tr>
<td>Felt insignificant, low self-esteem, threatened mental health</td>
<td></td>
<td>Dissatisfaction, needed support, anxieties, worry</td>
<td></td>
</tr>
<tr>
<td>Low self-esteem, over-sensitive, temperamental</td>
<td></td>
<td>Felt exhausted, cognitive change, frustration, anger, emotionally fearful</td>
<td></td>
</tr>
<tr>
<td>Felt irritable, frustrated, change in personality and behaviour</td>
<td></td>
<td>Felt exhausted, no motivation, restless</td>
<td></td>
</tr>
<tr>
<td>Could not manage anything; memory problems</td>
<td>Pain in the neck and shoulders; General pain</td>
<td>Uneasiness, discomfort, worry</td>
<td></td>
</tr>
<tr>
<td>Sleeping problems</td>
<td></td>
<td>Frustration and isolation</td>
<td></td>
</tr>
<tr>
<td>Sleeping problems, loss of control</td>
<td></td>
<td>No energy, inferiority</td>
<td></td>
</tr>
<tr>
<td>Sleeping problems</td>
<td>Headache</td>
<td>Felt uneasiness</td>
<td>Developed long-term illness; felt trapped without any way out</td>
</tr>
<tr>
<td>Felt frustrated, no energy, exhausted, depressed</td>
<td>Heart palpitations; developed high blood pressure and high blood sugar values</td>
<td>No energy, depression, helplessness, loneliness</td>
<td></td>
</tr>
<tr>
<td>Sleeping problems</td>
<td>Headaches; became sick of the work environment</td>
<td>Tiredness, uneasiness, discomfort, worry</td>
<td></td>
</tr>
<tr>
<td>No strength reserve; memory problems</td>
<td>Developed fevers, infections, and physical illness</td>
<td>No energy, depression, helplessness, loneliness</td>
<td>Developed long-term illness; had to face not being able to handle anything anymore</td>
</tr>
<tr>
<td>Felt irritable, changed behaviour, thought negative</td>
<td></td>
<td>No energy, no strength reserve</td>
<td></td>
</tr>
</tbody>
</table>
Creating self-imposed demands

Self-imposed demands preceded stress and burnout for the nurses (18,19,21,22,24-26). It was assumed that the nurses felt they could not live up to demands or their responsibilities towards their patients, their own families, their colleagues or themselves, and this affected their entire situation in life. These self-imposed demands became accentuated by the increasingly all-absorbing focus on work, and the stress symptoms gradually progressed.

The efforts to perform ideal nursing forced the nurses to meet earlier in the morning, work longer, or skip breaks:

“The nurses accept that the work requires a lot of energy. They want to develop in their work. Nurses spoke about their own experiences with solving difficult situations without support. One simply had to keep going. They had tried to compensate for the challenging work situation by coming a bit earlier in the morning, skipping lunch and other breaks and working longer in the evenings” (18, p. 23).

The nurses expressed demands on themselves that appeared to be the result of their ideas about what patients demand from them. They believed that they should have time to sit, listen, communicate, and have eye contact with them. They assumed a need to respond immediately to these patients’ needs and requests. They thought they should appear calm at all times. When the nurses did not meet these perceived demands, they felt irresponsible toward their patients (21).

Time for professional work with patients, the importance of which was once taught the nurses, is now reduced. The imbalance of wishes and reality supports the feeling of being inadequate although nurses know that they are working hard. They felt responsibility toward their colleagues and became frustrated when colleagues were feeling bad, and they could not do anything.

“The expectation to go home on time when one is replacing two nurses causes as much stress as when nurses feel that they have to blame themselves for burnout” (18, p. 24). When colleagues were in the same stressful situation, it was hard for the nurses to support each other (19,22). At the same time, the nurses experienced a lack of support from managers, other professionals and society when they were experiencing stress and burnout.

“Pressure is coming from outside. It is shameful to be sick-listed” and “They are working in the care profession and are expected to master the situation” (18, p. 24). Such perceived pressures caused the nurses to conceal how they were really feeling.

“Some of the participants also voiced their reluctance to speak out against clinical practice issues as they believed this would be seen as complaining, particularly when they had tried to speak previously without being heard and without seeing any noticeable change in practice” (26, p. 23).

Consequently, the nurses were distanced from others and could not engage emotionally in the nurse-patient relationship. The nurses in three studies (16,19,27) described this dilemma. Without a trustworthy relationship, the nurses could not provide holistic care. Because of stress, they had lost control over the situation and felt guilty and anxious about what was going to happen. None of the nurses asked for help; they believed these feelings were their fault. The feelings of inadequacy and of losing control over their daily life caused fear. The nurses described how they were experiencing symptoms of stress and burnout which made them afraid of never returning to normality.

Experiencing behavioural symptoms

The feelings of not being a responsible and professional nurse led to frustration. In all of the included studies, time pressure made the nurses prioritize their time. Patients hygiene was the
first nursing care intervention to be let go (26) whereas administering medicine and attending to important vital functions were seen as first priorities. This emphasis on patients' physical rather than emotional needs resulted in increasing guilt and a feeling of chaos. Hiding their stress and burnout from patients, colleagues and others led the nurses to develop different mechanisms to make out that they still had strength reserves. This phenomenon was described in the studies by Williams (17) and Rafii et al. (25). When the nurses were no longer able to provide emotional care for their patients, they focused on the patients who had less need for psychological care so they did not have to get emotionally involved. They also picked out the patients they liked and gave them good care whereas the patients they did not care for simply received the care and treatment prescribed by their doctors. The nurses could not see why they should spend time with those patients. “We can thus conclude that burnout has made nurses modify their caring behaviours to fit the different types of patients they care for” (25, p. 302). The nurses’ dissatisfaction and stress resulted in selective focusing. Work was planned to most effectively utilize the time available within the parameters of safety. “Sometimes it is difficult to accomplish all that care and one thing you will notice I didn’t say was the observation. They are often the things I miss …” (26, p. 22). This strategy shows that a high stress level was associated with behaviour changes where the usual attributes and competences of the nurses were not practiced (17,22).

Many of the nurses had sleeping problems and described how they were unable to unwind. The nurses described a growing multitude of behavioural symptoms and emotional stress. They experienced personality changes, including an absence of positive feelings (18,22). Some of them described how they could feel sudden anger towards their patients (22) and lose their temper in a way they never had before: “They drain all my energy to the point where I don’t want to talk to them . . . They keep quiet when I shout at them, just like children” (25, p. 302). Other nurses described how they took “short-cuts”, resulting in them not paying proper attention to what the patients were trying to tell them, and how they avoided answering the patients’ questions (16,17,27). These factors showed that the nurses’ stress was turning into a burnout. The burnout manifested itself as isolation and social withdrawal. In Murphy’s (24) study, several coping mechanisms were identified, including smoking, drinking, reading a book, or watching television. Other nurses tried to isolate themselves from the outside world: “I withdraw totally, I lock myself in my room or in my home, see nothing, do nothing, almost a type of escape (22, p. 80).

During the stress and burnout processes, the nurses were no longer able to seek help. They felt inadequate and had low self-esteem. They tried to cope with their work as before, but experienced a lack of performance and control, which led to abandonment. Their intense focus on their work left the nurses blind and deaf to the influence on their bodies as well as the alarm signals.

**Experiencing physical symptoms**

Four studies (16,18,24,27) described physical symptoms of stress. The nurses experienced headaches, stomach-aches, and vomiting, often combined with pain in the muscles, neck, bones and joints, fever, and infections. The nurses tried to ignore this by neglecting early symptoms and the need for rest and recovery, but the physical symptoms grew stronger. In the end, some nurses experienced heart palpitations, breathing difficulties, high blood pressure, and high blood sugar levels.

**Experiencing symptoms of psychiatric illness**

The interpretation of the studies revealed several repeatedly occurring concepts explaining the nurses’ feelings of depression, helplessness, and loneliness. The nurses did not want to ask their colleagues for help because stress was a daily reality for them as well (16,18,19). In the studies,
some nurses described a sense of tiredness and uneasiness while others felt discomfort and worry (22,24). They tried to manage their work, but realized that their capacity was reduced. Some nurses described how they were affected by a sense of total loss of energy: “I had no energy to listen. No energy to arrange anything or to solve a problem” (18, p.24). The feelings of stress and energy loss left the nurses feeling passive with an inability to supply high quality nursing care, even when they had sufficient time to do so:

“... sometimes I notice the staff’s morale, and my morale along with it can sort of reach a point, a breaking point, and like, people get a bit blasé and a bit flippant when it reaches that point. It’s like a pressure cooker-type situation; you feel something’s got to give, so people just get really flippant and blasé and that’s when things left and quality care doesn’t get given. . . People just think “What the hell, I can’t stand this anymore”. And they put themselves first before the patients, because they feel themselves getting stressed, more and more stressed out” (17, p. 812).

In three studies, the nurses described deteriorated cognitive function in terms of memory difficulties, concentration, and decision-making (16,18,27). As the psychiatric symptoms worsened, the feelings of guilt, dissatisfaction, and frustration started to appear. This led to feelings of isolation and shame about being an inadequate nurse (16,18-20,22).

**Having a mental breakdown**

In two of the nine studies, the nurses had a mental as well as a physical breakdown. The nurses developed long-term illnesses because of stress and burnout. The nurses described the turning point in the burnout process, a process which they were unable to turn around. They felt trapped, alienated from others and from themselves, and they could not see any meaning to life (16,18). When the nurses stopped struggling, accepted the situation and took responsibility for themselves, it was the starting point for recovery and growth. “Possibilities gradually emerged once the nurse had made the decision to change the situation by taking responsibility for herself. However, developing a survival strategy and retaining control over one's life takes time” (16, p. 64).

After the breakdown, the nurses were able to work to identify the stressors that caused the situation. Because of their newfound self-understanding, the nurses realized that stressors prevented them from providing the ideal nursing. Some nurses found it difficult to return to work after a long-term illness. They had a desire to make changes for themselves and their colleagues to prevent stress and burnout in the nursing profession, but it was not possible. This led them to leave their jobs, seeking new careers.

**Discussion**

**Results discussion**

A prominent characteristic of the nurses was their willingness and desire to provide patients with good care. This desire turned into determination, compulsion and self-imposed demands which made them vulnerable and threatened them as skilled professionals. Richard Lazarus and Susan Folkman suggested in 1984 that stress can be regarded as a result of an “imbalance between demands and resources” and as an occurrence when “pressure exceeds one’s perceived ability to cope” (28). Therefore, nurses’ experiences of stress are highly individual. Experiencing behavioural symptoms made the nurses neglect their own essential needs, developing sleeping problems and personality changes. At the same time, they started taking shortcuts that were unsafe and potentially dangerous to the patients. It is uncertain what kind of support is available for nurses if something goes drastically wrong (29). Physical and psychiatric stress
symptoms lead to headache, breathing difficulties, high blood pressure, and a terrifying feeling of being lonely, passive, drained of energy, and hopeless. These findings are consistent with other studies (1). It is important to be aware of early signs of stress and stressors. Because of the substantial focus on stress, most nurses are aware of the symptoms; however, the findings derived from this study indicate that nurses choose to ignore them. This may be because general mental health problems and stress are met with silence and generate feelings of shame (30). There is a tendency; according to Hingley and Harris (31), to assume that feeling stressed is a sign of weakness.

According to the studies, present day nurses value the patient-nurse relationship, but they do not always have the power or opportunity to meet the patients’ needs for care. This result is similar to that of the study by Fagerberg (32) who found that nurses tried to organize their daily work situation according to patients’ needs and safety. These findings are interesting and in accordance with Sheward et al. (33) findings that patient contact appeared to be the greatest source of rewards and personal development for nurses. According to Antonovsky’s theory (34) “Sence of Coherence”, healthy people are characterized by possessing a sense of coherence, and they experience life as comprehensible, meaningful, and manageable. People with a strong sense of coherence are better able to handle stress without compromising their emotional lives. The nurses described an accidental and unpredictable working environment in which they tried to combine two roles; the caring role and the technical role. They sought to organize themselves out of conflicts, without succeeding. According to Antonovskiy (34), these nurses probably have a poorer ability to see coherence and meaning and thus are less willing to face confrontations. As a result, they are more likely to become stressed and burned out. Socialisation to nursing’s initial values, combined with a desire to provide ideal care, keep them in an inappropriate situation which eventually becomes a burden to both nurses and patients.

A key aspect of the burnout syndrome is an increased feeling of emotional exhaustion; as emotional resources are depleted, nurses feel that they are no longer able to devote themselves on a psychological level (11). According to nursing theorist Katie Eriksson (35), nurses thereby lose their ability to treat the patient as an individual, and it becomes impossible for them to relate to their patients. As a result, they inflict suffering on their patients. Riemen (36) also found that the absence of psychological care was viewed by patients as non-caring. Patients perceived the provision of physical care only, in a hurried way, as a devaluation of their individual concerns.

Having a breakdown made the nurses stop struggling, face a turning point and find a new self-understanding. One way to prevent burnout is through a combination of organizational change and education for the individual. Cooper et al. (37) assert that stress interventions focusing on the individual are concerned with extending employees’ physical and psychological resources. This enables them to deal more effectively with stress or modify their appraisal of the situation, thus reducing the threat it presents. The nurses in the studies described their managers as not being particularly helpful, saying that they listen to and are aware of what is happening, but do not themselves feel the anxiety or stress experienced by the nurses (22,24,26). This is unfortunate because manager involvement might provide a supportive and healthy environment with positive feedback and support in stress situations. Managers can use the opportunity as e.g. unit staff meetings to solve any problems and to present stress-reduction techniques (38). According to Karasek and Theorell (39), support from colleagues and management has a positive influence which may reduce unpleasant situations resulting from a stressful environment.

Methodological considerations

These findings can be generalized only to nurses
working in hospital settings with somatic patients. Nonetheless, the findings can be helpful for nurse practitioners in both hospital and nursing home settings, nurse educators, and nurse leaders in any settings who are interested in improving the nurses’ work environments. The literature review may have been restrictive in its inclusion criteria, but the sample included a large number of nurses from various settings and countries, making the findings potentially applicable to a wider population.

**Conclusion**

In the past year, the focus has been on work environments, including how stress and burnout affect nurses’ work, health, and life as such. Inspired by the ongoing debate, the purpose of this study was to examine the available knowledge about how the experience of stress and burnout affects nurses. While six themes are identified, one implication of the findings above all others has serious implications for the nursing profession. Nurses wish to provide ideal nursing. This desire is hindered by a socialization to other, more technical focuses, putting efficiency and productivity above personal interaction. In the analysis, it appeared that nurses had not changed their ideals. They felt a great sense of responsibility for their patients and experienced guilt and stress when they had no time for them. It cannot clearly be concluded whether the loss of a close patient-nurse relationship is conducive to stress and burnout or whether it is the increased amount of administrative work that prevents nurses from having the time and energy for their patients which leads to stress and burnout.

It can be concluded that nurses’ experiences with and the influence of stress and burnout are individual. The nurses created self-imposed demands, and in their attempt to maintain a facade to defend their threatened self-image, the nurses isolated themselves. The fact that stress remains the nurses’ personal secrets can speed up breakdowns because isolation reduces the nurses’ support. It must be concluded that a focus on preventive mental health care must involve the nurses’ own perspectives.

The analysis revealed that almost every nurse was experiencing behavioural, physical, and symptoms of psychiatric illness. Nurses overlook or ignore these signs of stress and burnout, hoping that they will pass by themselves. In conclusion, it is important to recognize these early signs of stress to avoid the risk of burnout, the feeling of personal failure, and breakdown.

There is a need to create interventions against stress and burnout to regain balance in life. The multitude of symptoms and various influencing conditions of stress and burnout found in this study imply that interventions must be individualized and should influence the person’s entire life, including behaviour, social life, and the workplace. Furthermore, management support and involvement are necessary to prevent stress and burnout.

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