



The Relationship between Burnout Levels and the Quality of Therapeutic Communication among Nurses

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Abstract

Background: Burnout is a state of severe physical, mental, and emotional exhaustion that can decrease individual performance. Therapeutic communication plays an important role in enhancing nurses' interpersonal skills, while unmanaged burnout may adversely affect the quality of nursing care. **Objectives:** This study aimed to examine the relationship between burnout levels and the quality of therapeutic communication among nurses. **Methods:** A quantitative study with a descriptive correlational design and cross-sectional approach was conducted. A total of 43 nurses were recruited using total sampling. Data were analysed using frequency distributions and the Spearman rank correlation test. **Results:** The findings indicated that most respondents were between 31 and 40 years old, with a mean age of 38.09 years and a standard deviation of 7.217. The majority of respondents were female (41 nurses; 95.3%), had a Diploma in Nursing (D3) as their highest educational qualification (23 nurses; 53.5%), were married (37 nurses; 86.0%), and had more than 10 years of work experience (25 nurses; 58.1%). Based on the dimensions of burnout, 46.5% of respondents experienced a low level of emotional exhaustion, 53.5% experienced a low level of depersonalization, and 83.7% demonstrated a high level of personal accomplishment. Statistical analysis revealed a significant negative relationship between burnout levels and the quality of therapeutic communication among nurses ($p=0.012$, $p<0.05$). The Spearman rank correlation coefficients were -0.379 for emotional exhaustion, -0.303 for depersonalization, and -0.333 for personal accomplishment. **Conclusion:** The findings indicate a significant relationship between burnout and therapeutic communication among nurses. Recreational programmes and other workplace activities promoting nurses' physical and psychological well-being may help manage burnout.

Keywords: Burnout Level; Nurses; Quality of Therapeutic Communication

Introduction

Nursing management is an important element in the health care system that ensures nurses are able to provide effective, efficient, and high-quality services to patients. It encompasses essential managerial functions such as planning, organizing, directing, and controlling, which aim to optimize both human resources and facilities so that the quality of care can be maximized (Demerouti, 2024). A well-managed nursing environment contributes to improved patient outcomes, increased nurse job satisfaction, and reduced risks of medical errors and patient complications (Coster *et al.*, 2017).

Burnout among nurses has become a significant concern in human resource (HR) management within healthcare organizations. In the context of nursing management, HR management involves coordinating, monitoring, and enhancing nurses' competencies to achieve optimal standards of care. Within the increasingly complex hospital environment, effective HR management is essential for ensuring the availability of competent healthcare professionals who can respond efficiently to patients' needs (Marquis & Huston, 2017). Nevertheless, excessive workloads, demanding job responsibilities, extended working hours, and unfavorable workplace conditions have been recognized as key contributors to burnout among nurses (Yudhianto, 2023).

Burnout is defined as a syndrome involving persistent physical and emotional fatigue, diminished job performance, and negative attitudes toward work-related responsibilities. This condition typically develops when occupational demands exceed an individual's available resources and coping capacities (Ungur *et al.*, 2024). According to Maslach and Leiter (2016), burnout results from an imbalance between job demands and job resources, which may be influenced by factors such as excessive workload, inadequate social support, and discrepancies between personal and organizational values. Furthermore, limited workplace support can intensify emotional exhaustion and depersonalization, thereby reducing employee performance and negatively affecting the quality of healthcare services (Demerouti, 2024).

The World Health Organization (WHO) has recognized burnout as a significant concern in the workplace, particularly within the healthcare sector. In 2019, burnout was included in the International Classification of Diseases, 11th Revision (ICD-11), as an occupational phenomenon rather than a medical condition. WHO defines burnout as a syndrome resulting from chronic workplace stress that has not been successfully managed, characterized by energy depletion or exhaustion, increased mental distance from one's job or feelings of cynicism, and reduced professional efficacy (WHO, 2019). In Indonesia, ensuring nurses' welfare and maintaining high-quality healthcare services remain critical priorities. In Indonesia, a national survey conducted by the Faculty of Medicine, Universitas Indonesia, found that 83% of health workers experienced moderate-to-severe burnout during the COVID-19 pandemic, with moderate-to-severe levels of emotional exhaustion, depersonalization, and reduced personal accomplishment reported by 41%, 22%, and 52% of respondents, respectively (FKUI, 2020). These findings indicate that burnout is a serious occupational and mental health challenge that requires immediate attention to safeguard both health workers' well-being and service quality.

Interpersonal communication is a fundamental competency for nurses and serves as an important approach to preventing and managing burnout. In primary prevention, effective communication can help reduce the likelihood of burnout occurring. In secondary prevention, it contributes to the early identification and management of burnout symptoms, thereby preventing their progression. Through effective interpersonal communication, nurses can clearly deliver medical information, better understand patients' concerns and expectations, and enhance patient satisfaction as well as the overall effectiveness of nursing care (Marquis & Huston, 2017).

Burnout has emerged as an important occupational issue in healthcare. It is associated with nurses' psychological well-being and may coexist with differences in work performance and professional interaction. In the present study, the relationship between burnout dimensions and therapeutic communication is examined as an association. Because the design is cross-sectional, the study does not establish whether burnout precedes changes in communication or whether other factors explain the observed relationships.

Methodology

This study employed a quantitative research approach that emphasizes the measurement and analysis of numerical data. A descriptive correlational research design was utilized to describe existing phenomena and examine the relationship between variables. Using a cross-sectional approach, data were collected at a single point in time to investigate the association between nurses' burnout levels and the quality of their therapeutic communication.

Research Design

This study employed a quantitative research approach focusing on numerical data measurement and analysis. A descriptive and correlational research design was used to provide a general understanding of the phenomenon and to examine the relationship between burnout levels and the quality of therapeutic communication among nurses. The research adopted a cross-sectional study design, which means data were collected at a single point in time to determine associations between the study variables.

Study Setting and Population

This study investigated burnout and therapeutic communication. Burnout was measured using the Maslach Burnout Inventory–Human Services Survey for Medical Personnel (MBI-HSS-MP), which contains 22 items assessing three dimensions: Emotional Exhaustion (9 items), Depersonalization (5 items), and Personal Accomplishment (8 items). Therapeutic communication was assessed using a 19-item questionnaire with five response categories (Maslach & Jackson, 1981). In the instrument testing reported in the source thesis, the therapeutic communication questionnaire demonstrated a Cronbach's alpha of 0.820, and the items were reported as valid. These details clarify that therapeutic communication was assessed using a multi-item instrument rather than a single self-rating item. Because communication quality was self-reported by nurses, the measure may still be affected by social desirability bias.

Variables and Measurement Instruments

This study investigated two primary variables: burnout as the independent variable and therapeutic communication as the dependent variable. Burnout was measured using the Maslach Burnout Inventory–Human Services Survey for Medical Personnel (MBI-HSS-MP), which contains 22 items designed to assess three dimensions of burnout: Emotional Exhaustion (9 items), Depersonalization (5 items), and Personal Accomplishment (8 items). The quality of therapeutic communication was evaluated using a five-point Likert scale. Respondents were asked to rate their communication practices based on the following categories: Very Good (5), Good (4), Fairly Good (3), Poor (2), and Very Poor (1). This scale was used to determine the level of therapeutic communication demonstrated by nurses in their interactions with patients (Maslach & Jackson, 1981).

Data Collection Process

Data were collected through structured questionnaires and interviews. The data collection procedure consisted of several stages. First, participants were screened to identify nurses who met the predetermined inclusion and exclusion criteria. Next, the researcher explained the purpose of the study and provided detailed information regarding the research procedures to all eligible participants. After receiving the necessary information, participants were asked to provide informed consent to confirm their voluntary involvement in the study. The collected data were then processed using SPSS software.

Data Processing and Analysis

Several data-processing procedures were carried out prior to statistical analysis. The first step was editing, which involved reviewing the collected data to ensure its accuracy, completeness, and consistency, as well as confirming that all responses had been properly recorded. Following the coding process, data entry was performed by inputting the questionnaire responses into the Statistical Package for the Social Sciences (SPSS) software using the designated numerical codes. Univariate analysis was used to describe respondents' demographic characteristics and the study variables. The results were presented in the form of frequency distributions, means, standard deviations, minimum values, and maximum values. Bivariate analysis was conducted using the Spearman rank correlation test to examine the relationship between the study variables, with statistical significance determined at a p -value of less than 0.05 ($p < 0.05$).

Ethical Consideration

The research obtained ethical clearance from the KEPK (Health Research Ethics Commission) of Hang Tuah University, Indonesia, with Reference Number 034 / KEPK / UHTP / XII / 2025 on 26th August 2025.

Results

Based on the results of statistical data processing, the ages of the implementing nurses are as shown in Table 1.

Table 1: Descriptive Statistics of Nurses' Ages in the Medical Inpatient Wards of Krisan Room, Kenanga 1, and Kenanga 2, Arifin Achmad Regional Hospital, Riau Province (n = 43)

	N	Range	Min-max	Mean	Standard deviation
Ages	43	32	24-56	38.09	7.217

The respondents' ages were normally distributed. The mean age of the staff nurses was 38.09 years, with a standard deviation of 7.217, a minimum age of 24 years, and a maximum age of 56 years.

Table 2: Respondent Characteristics Based on Gender, Last Education, Marital Status, Length of Service (n= 43)

Number	Respondent Characteristics	Frequency (N)	Percentage (%)
1	Gender		
	Male	2	4.7
	Female	41	95.3
2	Last Education		
	D3 Kep.	23	53.4
	S1	10	23.3
	Ners	10	23.3
3	Marital Status		
	Not Married Yet	6	14.0
	Married	37	86.0
4	Length of Service (year)		
	< 5	8	18.6
	5 – 10	10	23.3
	> 10	25	58.1
	Total	43	100

Table 2 presents the characteristics of the respondents. The majority were female (41 nurses; 95.3%) and married (37 nurses; 86.0%). In terms of educational background, more than half held a Diploma III (D3) in Nursing (23 nurses; 53.5%). With regard to length of service, most respondents had more than 10 years of work experience (25 nurses; 58.1%).

Table 3: Frequency Distribution of Burnout Variables

Number	Category	Frequency (N)	Percentage (%)
1	Emotional Exhaustion		
	Low	20	46.5
	Medium	18	41.9
	High	5	11.6
	Total	43	100
2	Depersonalization		
	Low	23	53.5
	Medium	15	34.9
	High	5	11.6
	Total	43	100
3	Personal Achievement		
	Low	1	2.3
	Medium	6	14.0
	High	36	83.7
	Total	43	100

As shown in Table 3, the largest proportion of respondents had a low level of emotional exhaustion (20 nurses; 46.5%). More than half had a low level of depersonalization (23 nurses; 53.5%), and the large majority had a high level of personal accomplishment (36 nurses; 83.7%).

Table 4: Frequency Distribution of Therapeutic Communication Variables

Number	Category	Frequency (N)	Percentage (%)
1	Enough	6	14.0
2	Good	34	79.0
3	Very Good	3	7.0
Total		43	100

Based on table 4, It can be seen from the 43 respondents at Arifin Achmad Regional General Hospital that, in the variable of therapeutic communication among inpatient nurses in the Krisan, Kenanga 1, and Kenanga 2 wards, the majority of respondents demonstrate good therapeutic communication, totalling 34 nurses (79.0%).

Table 5: Relationship between Burnout Levels (Emotional Exhaustion) and Therapeutic Communication in Inpatient Nurses in Krisan, Kenanga 1 and Kenanga 2 Wards

Burnout Levels	Therapeutic Communication			Total	P-value	Correlation Coefficient (r)
	Enough	Good	Very Good			
Emotional Low	1 (5.0%)	16 (80.0%)	3 (15.0%)	20 (100%)	0.012	-0.379
Exhaustion Medium	3 (16.7%)	15 (83.3%)	0 (0%)	18 (100%)		
High	2 (40.0%)	3 (60.0%)	0 (0%)	5 (100%)		
Total	6 (14.0%)	34 (79.1%)	3 (7.0%)	43 (100%)		

Table 5 shows the *p*-value obtained from the bivariate correlation analysis between the emotional exhaustion indicator and the quality of therapeutic communication. Among 20 respondents with low emotional exhaustion, 1 nurse (5.0%) had fair therapeutic communication, 16 nurses (80.0%) had good communication, and 3 nurses (15.0%) had very good communication. Furthermore, among 18 respondents with moderate emotional exhaustion, 3 nurses (16.7%) had fair therapeutic communication, 15 nurses (83.3%) had good communication, and none (0%) had very good communication. Among 5 respondents with high emotional exhaustion, 2 nurses (40.0%) had fair therapeutic communication, 3 nurses (60.0%) had good communication, and none (0%) had very good communication. The analysis resulted in a *p*-value of 0.012 (< 0.05) and a correlation coefficient of -0.379, indicating that there is a significant relationship between emotional exhaustion and the quality of therapeutic communication, with a negative (inverse) direction. This means that higher levels of emotional exhaustion are associated with lower levels of therapeutic communication. The correlation coefficient falls within the range of 0.2 to <0.4 , indicating a weak level of relationship.

Table 6: Relationship between Burnout Levels (Depersonalization) and Therapeutic Communication in Inpatient Nurses in Krisan, Kenanga 1 and Kenanga 2 Wards

Burnout Levels		Therapeutic Communication			Total	P-value	Correlation Coefficient (r)
		Enough	Good	Very Good			
Depersonalization	Low	2 (8.70%)	18 (78.30%)	3 (13%)	23 (100%)	0.048	-0.303
	Medium	2 (13.30%)	13 (86.70%)	0 (0%)	15 (100%)		
	High	2 (40.0%)	3 (60.0%)	0 (0%)	5 (100%)		
	Total	6 (14.0%)	34 (79.0%)	3 (7.0%)	43 (100%)		

On the depersonalization indicator related to the quality of therapeutic communication, among 23 respondents with low depersonalization, 2 nurses (8.7%) had fair therapeutic communication, 18 nurses (78.3%) had good communication, and 3 nurses (13.0%) had very good communication.

Furthermore, among 15 respondents with moderate depersonalization, 2 nurses (13.3%) had fair therapeutic communication, 13 nurses (86.7%) had good communication, and none (0%) had very good communication. Among 5 respondents with high depersonalization, 2 nurses (40%) had fair therapeutic communication, 3 nurses (60%) had good communication, and none (0%) had very good communication. The analysis showed a *p*-value of 0.048 (< 0.05) and a correlation coefficient of -0.303,

indicating that there is a significant relationship between depersonalization and the quality of therapeutic communication, with a negative (inverse) direction. This means that higher levels of depersonalization are associated with lower levels of therapeutic communication. The correlation coefficient falls within the range of 0.2 to <0.4, indicating a weak level of relationship.

Table 7: Relationship between Burnout Levels (Personal Achievement) and Therapeutic Communication in Inpatient Nurses in Krisan, Kenanga 1 and Kenanga 2 Wards

Burnout Levels		Therapeutic Communication			Total	P-value	Correlation Coefficient (r)
		Enough	Good	Very Good			
Personal Achievement	Low	0 (0%)	1 (100 %)	0 (0%)	1 (100 %)	0.029	-0.333
	Medium	0 (0%)	4 (66.7%)	2 (33.3%)	6 (100%)		
	High	6 (16.7%)	29 (80.6%)	1 (2.8%)	36 (100%)		
	Total	6 (14.0%)	34 (79.0%)	3 (7.0%)	43 (100%)		

On the personal accomplishment indicator related to the quality of therapeutic communication, among 1 respondent with low personal accomplishment, 1 nurse (100%) had good therapeutic communication.

Furthermore, among 6 respondents with moderate personal accomplishment, 4 nurses (66.7%) had good therapeutic communication, and 2 nurses (33.3%) had very good communication. Among 36 respondents with high levels of decreased personal accomplishment, 6 nurses (16.7%) had fair therapeutic communication, 29 nurses (80.6%) had good communication, and 1 nurse (2.8%) had very good communication. The analysis showed a *p*-value of 0.029 (< 0.05) and a correlation coefficient of -0.333, indicating that there is a significant relationship between personal accomplishment and the quality of therapeutic communication, with a negative (inverse) direction. This means that the greater the decline in personal accomplishment, the lower the quality of therapeutic communication. The correlation coefficient falls within the range of 0.2 to <0.4, indicating a weak level of relationship.

Discussion

Relationship between Burnout (Emotional Exhaustion) and the Quality of Therapeutic Communication Among Nurses

Based on the research findings, there is a significant relationship or correlation, with a correlation coefficient of -0.379, indicating a weak level of association and a negative (inverse) direction. This means that there is a relationship between burnout (emotional exhaustion) and the quality of therapeutic communication among nurses. This finding demonstrates that the level of burnout (emotional exhaustion) is related to the quality of therapeutic communication among nurses. These results are consistent with a study conducted by Ekawati (2019), which stated that the quality of nurses' therapeutic communication is associated with burnout levels, including emotional exhaustion, among nurses in inpatient wards. In that study, Ekawati found that nurses with excellent therapeutic communication skills tended to have lower levels of burnout compared to those with less optimal communication. This indicates that therapeutic communication plays a role in helping nurses manage emotional demands while providing nursing care to patients. Furthermore, a systematic review by Aryankhesal *et al.* (2019) reported that coping and communication skills training were among the most frequently used interventions for burnout among nurses and physicians and that most interventions had a positive effect in reducing burnout. Similarly, Widyakusumastuti and Fauziah (2016) found a strong negative relationship between interpersonal communication and burnout among inpatient nurses in Semarang (*r* = -0.705). Improving the quality of therapeutic communication is not only important for enhancing the quality of nursing services but also serves as an essential strategy for maintaining nurses' emotional well-being and preventing emotional exhaustion.

Relationship between Burnout (Depersonalization) and the Quality of Therapeutic Communication Among Nurses

In the depersonalization indicator and its relationship with the quality of therapeutic communication, the correlation coefficient obtained was -0.303, indicating a weak level of association with a negative (inverse) direction. This means that there is a relationship between burnout (depersonalization) and the

quality of therapeutic communication among nurses. This finding demonstrates that the level of burnout (depersonalization) is related to the quality of therapeutic communication among nurses in clinical care settings. A systematic review by Wilkinson *et al.* (2017) found that burnout, particularly depersonalization, is associated with lower empathy among healthcare professionals, which may hinder the development of effective therapeutic relationships with patients. Similarly, a meta-analysis of nurses by Li *et al.* (2024) reported that nurse burnout is associated with lower patient satisfaction and poorer quality of care. Román-Sánchez *et al.* (2022) likewise reported that burnout among nurses is related to their levels of empathy, a core component of effective therapeutic communication. According to the Burnout Theory by Maslach and Jackson (1981), depersonalization, characterized by cynical or apathetic attitudes toward patients, can hinder effective communication. Therefore, depersonalization is a component of burnout that requires serious attention, as improving nurses' emotional well-being plays an important role in maintaining the quality of therapeutic communication and the overall success of nursing care.

Relationship between Burnout (Personal Accomplishment) and the Quality of Therapeutic Communication Among Nurses

In the personal accomplishment indicator and its relationship with the quality of therapeutic communication, the correlation coefficient obtained was -0.333, indicating a weak level of association with a negative (inverse) direction. This means there is a relationship between burnout (personal accomplishment) and the quality of therapeutic communication among nurses. According to the burnout theory by Maslach and Jackson (1981), reduced personal accomplishment refers to a decline in performance due to burnout, which can impact the quality of communication with patients. This finding is consistent with Kwame and Petrucka (2021), who reported that effective nurse–patient communication is associated with greater patient satisfaction, while factors such as heavy workload and burnout act as barriers to therapeutic interaction. Similarly, Karimunovita (2023) reported a significant negative relationship between burnout and nurses' therapeutic communication in the inpatient wards of RSUD Dr. Soediran Mangun Sumarso Wonogiri, and comparable inverse relationships between burnout and interpersonal communication have been reported among inpatient and emergency nurses in Indonesia (Widyakusumastuti & Fauziah, 2016; Yudhianto, 2023).

According to Peplau (1952), therapeutic communication is an interpersonal process between nurses and patients aimed at achieving psychological growth and recovery through a relationship based on trust, empathy, and collaboration.

Limitations

This study has several limitations that should be considered when interpreting the findings. First, the cross-sectional design collected data on burnout and therapeutic communication at a single point in time, making it impossible to determine temporal relationships or establish causality. Therefore, the findings should be interpreted only as associations between the variables. Although the correlations were statistically significant, their strengths were weak, with approximate r^2 values ranging from 9.2% to 14.4%. This indicates that the burnout dimensions accounted for only a small proportion of the variation in therapeutic communication. In addition, therapeutic communication was measured through nurses' self-reports, which may be influenced by social desirability bias and could lead respondents to evaluate their communication practices more positively. The relatively small sample size ($n = 43$) and the inclusion of participants from only one hospital also limit the generalizability of the findings. Furthermore, the sample was predominantly female (95.3%) and married (86.0%), while differences based on gender and marital status were not specifically examined. Other individual and organizational factors that may be related to therapeutic communication were also not assessed. Therefore, these limitations should be taken into account when interpreting the results and applying the findings to broader nursing populations.

Future Scope

Future research should involve larger and more diverse samples of nurses from multiple hospitals to improve the generalisability of the findings. Longitudinal studies could help clarify the relationship between burnout dimensions and the quality of therapeutic communication over time. Future studies should also consider using independent observations or assessments of nurses' communication practices to complement self-reported data. In addition, factors such as workload, working hours, staffing levels, organisational support, and coping strategies should be examined to better understand their potential relationships with burnout and therapeutic communication. Intervention studies evaluating recreational programmes, stress-management activities, and workplace well-being initiatives are also recommended to determine whether these approaches can reduce burnout and support improvements in therapeutic communication among nurses.

Conclusion

This study examined the relationship between burnout and the quality of therapeutic communication among 43 inpatient nurses at RSUD Arifin Achmad, Riau Province. Overall burnout levels were favorable: the largest proportion of nurses reported low emotional exhaustion (46.5%), more than half reported low depersonalization (53.5%), and the large majority reported high personal accomplishment (83.7%). Most nurses (79.1%) rated their therapeutic communication as good. All three burnout dimensions were significantly and inversely associated with therapeutic communication (emotional exhaustion: $r = -0.379$, $p = 0.012$; depersonalization: $r = -0.303$, $p = 0.048$; personal accomplishment: $r = -0.333$, $p = 0.029$). Although these correlations were weak and, given the cross-sectional, single-hospital design, indicate associations rather than causation, they suggest that protecting nurses' psychological well-being may support better communication with patients. Hospital management is encouraged to provide recreational, stress-management, and other workplace well-being programs to help prevent and reduce burnout.

CRedit Authorship Contribution Statement

R.F.L.: Conceptualization, methodology, writing-original draft, writing-review and editing. **G.A.:** Investigation, data curation. **N.S.:** Formal analysis, visualization. **R.L.I.:** Writing-original draft. **H.C.H.:** Project administration. **S.E.:** Supervision, validation. **S.M.S.:** Writing-review and editing.

AI Assistance Declaration

During the preparation of this manuscript, the authors used generative AI models for language editing, clarity, organization, and formatting support. All AI-assisted content was critically reviewed, verified, and revised by the authors, who take full responsibility for the accuracy, originality, interpretation, and final content of the manuscript. Any AI model was not used for data collection or statistical analysis.

Conflict of Interest

The authors declare that they have no conflicts of interest.

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