

A Review of Burnout Experiences Among Nurses in Intensive Care Units

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Abstract

Burnout among nurses in intensive care units (ICUs) is a pervasive occupational health challenge with significant implications for healthcare delivery and patient safety. Defined by the Maslach Burnout Inventory (MBI) as emotional exhaustion, depersonalization, and reduced personal accomplishment, burnout is particularly prevalent in ICUs due to high patient acuity, prolonged shifts, and exposure to life-threatening conditions. Globally, studies highlight that ICU nurses experience overwhelming fatigue, moral distress, and psychological strain, often linked to inadequate institutional support and resource constraints. In sub-Saharan Africa, these challenges are compounded by systemic issues such as understaffing, limited protective equipment, and insufficient psychosocial support, leading to heightened emotional exhaustion and workforce instability. ICU nurses consistently report three dimensions of burnout: emotional exhaustion, depersonalization, and reduced personal accomplishment. Coping mechanisms include peer support, spirituality, and adaptive problem-solving, yet resilience alone cannot offset systemic shortcomings. The literature underscores the urgent need for mental health support, workforce policies, and resource provision to safeguard nurse well-being and ensure patient safety. Documenting ICU nurses' experiences provides critical insights into both the human and institutional dimensions of burnout, informing strategies to strengthen resilience and improve healthcare delivery in resource-constrained settings.

Keywords: Burnout, Nurses, Intensive Care Units, Occupational Stress, Emotional Exhaustion

1. Introduction

Burnout among nurses has become a critical occupational health issue, particularly in intensive care units (ICUs) where patient awareness, workload demands, and emotional strain are highest. Burnout, as defined by the Maslach Burnout Inventory (MBI), manifests through emotional exhaustion, depersonalization, and reduced personal accomplishment [1]. The Maslach Burnout Inventory (MBI) is the most widely used and validated tool for measuring occupational burnout, especially among nurses and other human service professionals.

1.1. Evidence from Global Studies

Studies consistently show that ICU nurses are at high risk of burnout identified uncertainty, fear of infection, and inadequate institutional support as major contributors to burnout among healthcare professionals [2]. Walton et al. (2020) emphasized the

importance of resilience programs and peer support in reducing burnout symptoms [3]. Burnout among ICU nurses has been linked to medical errors, reduced patient safety, and increased turnover, making it both a personal and systemic issue. Research shows that emotionally exhausted nurses are more prone to lapses in concentration, which can result in medication errors, delayed interventions, or compromised monitoring of critically ill patients [4]. A systematic review and meta-analysis of 85 studies across 32 countries found that burnout was associated with higher rates of nosocomial infections, patient falls, and adverse events, as well as lower patient safety climate and satisfaction scores [5].

In ICUs specifically, a review of 20,723 healthcare professionals reported burnout prevalence above 40%, with nurses showing particularly high levels of emotional exhaustion. This was directly correlated with increased risk of patient care errors and reduced

efficiency in ICU teams [6]. Similarly, studies in sub-Saharan Africa highlight that burnout contributes to attrition and workforce instability, as nurses experiencing depersonalization and reduced personal accomplishment are more likely to leave the profession [7]. The consequences extend beyond individual well-being. Burnout undermines hospital efficiency by increasing turnover, driving recruitment and training costs, and destabilizing staffing levels. Hospitals with high burnout rates face staff shortages, which further exacerbate workload intensity and perpetuate the cycle of exhaustion and error. As Demerouti et al. (2021) argue, burnout is not simply a personal struggle but a systemic phenomenon that erodes the foundations of safe and effective healthcare delivery [8]. These pressures are compounded by the emotional toll of caring for patients with life-threatening conditions and the constant exposure to suffering and death. Shanafelt et al. (2020) identified uncertainty in clinical outcomes, fear of infection, and inadequate institutional support as major contributors to burnout among healthcare professionals [2]. This highlights that burnout is shaped not only by the emotional burden of frontline care but also by systemic shortcomings within healthcare organizations, making it a complex challenge that requires both individual resilience and organizational reform.

Collectively, these results highlight the worldwide acknowledgment of burnout as an issue that undermines nurse welfare and hospital effectiveness, requiring measures that focus on mental health assistance, staffing policies, and institutional acknowledgment of nurses' roles. In sub-Saharan Africa, burnout is intensified by longstanding systemic challenges. Muliira & Ssendikaddiwa (2016) found high burnout levels among Ugandan nurses, which is linked to poor working conditions and lack of psychosocial support [7]. Similarly, Naidoo et al. (2021) documented emotional exhaustion among South African ICU nurses, worsened by limited protective equipment and overwhelming patient loads [9]. These findings highlight the fact that African nurses' experiences of burnout are shaped not only by clinical pressures but also by resource constraints and staffing shortages.

ICU nurses across different backgrounds consistently report three primary dimensions of burnout:

2. Emotional Exhaustion

2.1. Fatigue From Prolonged Shifts and Emotional Burden

→ *Nature of Fatigue in ICU Nursing*

- Physical fatigue — ICU nurses often work extended shifts (12–16 hours or more), with limited rest breaks, leading to exhaustion, sleep deprivation, and impaired recovery.
 - Cognitive fatigue — constant monitoring of critically ill patients requires sustained vigilance, decision-making under pressure, and multitasking, which drains mental energy.
 - Emotional fatigue — exposure to suffering, death, and family distress creates a heavy emotional burden, often compounded by moral dilemmas in care decisions.
- **Depersonalization** — feelings of detachment from patients as a coping mechanism.

- Depersonalization refers to a psychological defense mechanism where nurses emotionally distance themselves from patients to protect their own mental health. Instead of engaging empathetically, they may begin to treat patients as “cases” or “tasks” rather than individuals. This detachment is not intentional neglect but a way to manage overwhelming emotional demands in high-stress environments like ICUs (Maslach & Leiter, 2016) [1].

→ **Reduced personal accomplishment** — perceptions of inadequacy despite extraordinary effort.

- Nurses may feel that no matter how much effort they put into their work; their work does not lead to meaningful outcomes. This perception arises even when they are performing competently and with dedication. It reflects a loss of professional fulfillment, where achievements feel undervalued or overshadowed by systemic challenges.

High patient acuity despite extraordinary effort, critically ill patients may not improve, leading to feelings of futility [10,11]. High patient acuity refers to the situation in which patients present with complex, severe, and often life-threatening conditions that require intensive monitoring, advanced interventions, and continuous clinical decision-making. In the ICU, this means nurses are responsible for patients who are unstable, dependent on life-support technologies, and at risk of rapid deterioration. Resource constraints due to lack of equipment or staff support can make nurses feel powerless when caring for critically ill patients. Workload intensity can contribute to constant demands for leave, thus, there will be little time for reflection or recognition of success made by nurses. Institutional culture can result in limited acknowledgment or appreciation of nurses' contributions which can reinforce inadequacies perceived by nurses.

Reduced personal accomplishment is a critical dimension of burnout that deeply affects ICU nurses. When nurses perceive that their extraordinary efforts do not translate into meaningful outcomes, they begin to experience a decline in motivation and job satisfaction. This erosion of professional fulfillment often leads to disengagement, where nurses feel their contributions are undervalued or invisible within the healthcare system.

When nurses experience reduced personal accomplishment, the effects ripple beyond their own well-being and directly impact patients. Disengagement caused by feelings of inadequacy often translates into a decline in the quality of care. Nurses who feel ineffective or undervalued may struggle to maintain attentiveness, empathy, and precision in their clinical tasks. This can result in slower responses to patient needs, lapses in monitoring, or diminished overall standards of care.

Patients and families are highly perceptive of the emotional climate in healthcare settings. When nurses appear detached or indifferent, patients often interpret this as a lack of compassion, which erodes trust in the nurse-patient relationship. Consequently, patient satisfaction declines, as care is perceived as impersonal or

mechanical rather than supportive and empathetic. Evidence from multiple studies underscores this dynamic: burnout correlates with higher rates of adverse events such as medication errors and hospital-acquired infections; while simultaneously lowering patient satisfaction scores [2,5,6]. In intensive care units, where patients are critically ill and families are emotionally vulnerable, even subtle signs of disengagement can have profound consequences.

Thus, reduced personal accomplishment is not only a psychological burden for nurses but also a systemic risk factor for patient care. Addressing it requires interventions that combine institutional recognition, mental health support, and staffing reforms to ensure that nurses feel valued and empowered, while patients receive compassionate, high-quality care.

Coping mechanisms such as peer support, spirituality, and adaptive problem-solving provide ICU nurses with important psychological defenses against the strain of burnout. These strategies align with Resilience Theory, which emphasizes the ability to adapt positively in the face of adversity [3]. Peer support allows nurses to share experiences and validate each other's contributions, spirituality offers meaning and comfort in the midst of suffering, and adaptive problem-solving helps nurses reframe challenges into manageable tasks.

Yet, resilience alone cannot fully counteract the systemic shortcomings that perpetuate burnout. Without structural interventions, these coping strategies risk becoming temporary relief rather than sustainable solutions. Adequate staffing is essential to reduce workload intensity and prevent chronic fatigue. Mental health support, including counseling services and debriefing sessions, provides professional outlets for emotional distress. Resource provision, such as sufficient protective equipment and ICU capacity, reduces moral distress by ensuring nurses can deliver safe, effective care [12,13].

Evidence strongly supports this dual perspective. Moss et al. (2016) found that ICU nurses with high burnout scores were more likely to report medical errors and reduced efficiency, while West et al. (2018) highlighted that organizational culture plays a decisive role in either mitigating or exacerbating burnout. Demerouti et al. (2021) further argue that resilience interventions are most effective when paired with institutional reforms, underscoring that burnout is both a personal struggle and a systemic phenomenon. Shanafelt et al. (2020) also emphasize that without organizational commitment to well-being, individual coping strategies cannot prevent long-term attrition. Turunç et al. (2024) found that ICU nurses' burnout levels significantly influence turnover intention, with psychological resilience serving as a mediating factor [2,4].

Overall, while coping mechanisms rooted in resilience provide nurses with immediate psychological relief, they cannot substitute for organizational responsibility. Sustainable solutions require a dual approach: empowering nurses with resilience-building strategies while simultaneously reforming healthcare systems to

ensure safe staffing, adequate resources, and recognition of nurses' contributions.

2.2. Implications and Recommendations

Burnout among ICU nurses has significant consequences:

- **Nurse well-being** — increased risk of depression, anxiety, and attrition.
- **Patient outcomes** — higher risk of medical errors and compromised safety.
- **Hospital efficiency** — reduced productivity and staff shortages.

To mitigate burnout, literature recommends:

- **Mental health support** — counseling services, peer support groups, and resilience training.
- **Workforce policies** — adequate staffing, fair workload distribution, and protected rest periods.
- **Resource provision** — ensuring sufficient protective equipment and ICU capacity.

We recommend a multi-pronged approach to mitigate burnout among ICU nurses:

- **Mental health support** — counseling services, peer support groups, and resilience training programs.
- **Workforce policies** — adequate staffing levels, fair workload distribution, and protected rest periods.
- **Resource provision** — sufficient protective equipment and ICU capacity to reduce moral distress.
- **Institutional recognition** — valuing nurses' contributions and integrating their voices into policy-making processes.
- Documenting the experiences of ICU nurses provides critical insights into both the human and institutional dimensions of burnout. These findings contribute to global literature while offering locally relevant recommendations for strengthening resilience and safeguarding nurse well-being. Addressing burnout must remain a priority to ensure sustainable and equitable care delivery.

3. Conclusion

Burnout among ICU nurses is a global phenomenon, but in resource-constrained settings the challenges are magnified. Documenting these experiences provides critical insights into both the human and institutional dimensions of burnout. It should be emphasized that reduced personal accomplishment is not simply about self-perception; it is a systemic issue that undermines nurse retention, mental health, and patient care quality. Addressing it requires both individual resilience strategies and organizational reforms that ensure nurses feel valued, effective, and supported in their roles. This knowledge is essential for designing interventions that strengthen resilience, safeguard nurse well-being, and improve patient care across healthcare systems.

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