The effect of a psychological empowerment program based on psychodrama on empowerment perception and burnout levels in oncology nurses: Psychological empowerment in oncology nurses

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ABSTRACT

Objective: Oncology nursing is stressful by its nature, and nurses in the field experience a high amount of stress and burnout. In order to cope with occupational stress, nurses need to employ flexible adjustment mechanisms that allow them the power to process their experiences. Failure of efficient stress management causes burnout, and burnout is closely related to powerlessness. It is therefore believed that the occurrence of burnout can be reduced by means of psychological empowerment of nurses. Our study was conducted to determine the effect of a "psychodrama-based psychological empowerment program" on (1) the perception of empowerment and (2) the levels of burnout in oncology nurses.

Method: The sample was made up of 82 oncology nurses (38 nurses in the study group and 44 in the control/comparison group). Study data were collected using the Psychological Empowerment Scale, the Nurse Work Empowerment Scale, and Maslach's Burnout Inventory. The study group attended a "psychodrama-based psychological empowerment program" (2 hours, 1 day a week, for 10 weeks). For data assessment, we employed an independent *t* test and one-way analysis of variance.

Results: The psychological empowerment and workplace empowerment scores of nurses in the study group increased and their burnout scores decreased following attendance in the psychodrama-based psychological empowerment program.

Significance of results: We found that the psychodrama-based psychological empowerment program increased psychological empowerment and enhanced perception of workplace empowerment while decreasing levels of burnout in oncology nurses. The program is recommended and should allow oncology nurses to benefit from their personal experiences and thus increase self-empowerment, to enhance their perception of empowerment, and to prevent burnout.

KEYWORDS: Oncology nurse, Psychodrama, Psychological empowerment, Workplace empowerment, Burnout

INTRODUCTION

It is well known that healthcare personnel experience significant amounts of stress in an oncology care setting. Those who experience the most severe stress in an oncology environment are the oncology nurses. When unable to efficiently manage stress, they experience such physical and mental health symptoms as anxiety, depression, somatic disorders, and/or social dysfunction (Khamisa et al., 2013; Işıkhan, 2010). Those who suffer from powerlessness evaluate themselves as inefficient, obstructed, and

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failed, and these nurses frequently experience reduced job satisfaction, diminished work effectiveness, increased levels of burnout, and stronger feelings of self-resignation (Yong-Sook et al., 2014; Papathanasiou et al., 2014; Laschinger et al., 1997; Conger & Kanungo, 1988).

There is a growing body of research that identifies burnout as a significant issue in oncology nursing. Burnout has an impact on patient care, nurses' health, and healthcare costs (McHugh et al., 2011; Harwood et al., 2010). It is also a significant predictor of general health among nurses, which can compromise productivity and performance, as well as the quality of patient care (Khamisa et al., 2013; Poghosyan et al., 2010). Burnout and work-related stress also contribute to job retention among nurses (Heinen et al., 2013; Toh et al., 2012) and can lead to a further worsening of the current nursing shortage, a reduction in the quality and quantity of service delivery, and an increase in the costs associated with retraining (Toh et al., 2012; Harwood et al., 2010). Empowerment can play a key role in increasing nurses' intent to stay in their jobs and in decreasing nurse burnout (Meng et al., 2014).

Nurses need to have flexible adjustment mechanisms in order to cope with occupational stress. Most importantly, they need to feel powerful (Porter-O'Grady, 2003). Power is defined as the ability to cause an effect or to resist an effect on physical, mental, and moral terms (Turkish Language Association, 2013). It is an important concept for both nurse and patient. Nurses who feel empowered are reported to perceive less job stress, have more job satisfaction, experience less burnout, and provide higher-quality care (Donahue et al., 2008).

Nurses need empowerment activities to become powerful. The process of empowerment in nursing was first described by Chandler (1986). It is a process that can occur in two ways: (1) as structural (workplace) empowerment and (2) as psychological empowerment (Laschinger et al., 1997; Spreitzer 1995). The theory of structural empowerment, developed by Kanter in 1993, posits that opportunity and power in organizations are essential to empowerment and must be available to all employees for maximal organizational effectiveness and success (Manojlovich, 2007). Laschinger and her colleagues have done the bulk of the work on workplace empowerment in nursing (Laschinger et al., 2014; 2009; 2006; 2001).

Our study focuses on an alternative theoretical perspective on empowerment, one that defines empowerment as also a psychological experience. The theory of psychological empowerment was proposed by Conger and Kanungo (1988) and further developed by Spreitzer (1995). According to Spreitzer,

the process of psychological empowerment is a motivational construct that manifests as a set of four components (meaning, competence, autonomy, and impact) and is both independent of and dependent on the work environment (Spreitzer, 1995).

Much of the research on nursing empowerment focuses on activities that increase structural empowerment for nurses (Kennedy et al., 2015). Psychological empowerment (PE) is quite important because interventions aimed at environmental manipulations in the workplace can have a negative impact (e.g., increased work stress in adapting to changes) in broad areas of the nursing experience. PE can best be implemented and have positive effects if it is also considered as decreasing the risk of burnout (Boudrias et al., 2012). In addition, oncology nurses work in a stressful environment, often confronting issues of "moral distress," so that they need to be supported psychologically when workplace environmental changes are undertaken. In summary, workplace empowerment is not sufficient by itself for empowerment of oncology nurses, without inclusion of psychological empowerment (Browning, 2013).

There have been many studies that attempted to understand both concepts of workplace and psychological empowerment. Much of this research focused primarily on enhancing nursing workplace empowerment. There are only a few studies focused on enhancing psychological empowerment (Kennedy et al., 2015), and none of these interventions employed psychodrama techniques. Our study is based on the theory of psychological empowerment and the hypothesis that psychodrama can be a tool for improving psychological empowerment in oncology nurses.

The theoretical frameworks of psychological empowerment and psychodrama have many commonalities. Quinn and Spreitzer (1997) indicated that empowerment is a frame of mind that requires a process in order to develop, the first phase of which is personal evaluation and cognitive restructuring, which allow seeing things from another perspective. The second phase is reevaluating the problem from this new perspective and adopting a new approach. Redefining the self and one's role in a problem leads to the emergence of new patterns of behavior (Quinn et al., 2000; Quinn & Spreitzer, 1997). Theoretical information, which forms the basis of psychodrama, is highly parallel to empowerment theory as defined by Quinn and Spreitzer. In a psychodrama, the individual sees himself from without in the staged play. He can then progress to self-recognition and seize an opportunity to reevaluate the situation, now seen from different angles and from the viewpoints of others. The individual is then able to come up with unconventional solutions in the safe environment

provided by the psychodramatist (Kellermann, 2013).

Flexibility and creativity are also fundamental concepts of both psychodrama and empowerment (Kellermann, 2013; Blatner, 2000). According to Quinn and Spreitzer (1997), psychologically empowered individuals have acknowledged the importance of flexibility in adaptation to a complicated environment, are aware that empowerment is a frame of mind, and know that development of empowerment requires a process (Quinn & Spreitzer, 1997; Spreitzer, 1995).

The psychological empowerment of nurses increases job satisfaction, enhances quality of care, and helps to prevent burnout (Meng et al., 2014; Boudrias et al., 2012). Ours is an intervention study conducted to determine the effect of a psychodrama-based psychological empowerment program on the perception of empowerment and burnout levels in oncology nurses. Based on our current knowledge, the following hypotheses were formulated:

Hypothesis 1. Psychodramatic methods are effective in increasing psychological empowerment.

Hypothesis 2. Psychological empowerment will have a positive effect on increasing the workplace empowerment of oncology nurses.

Hypothesis 3. Psychological empowerment will have a positive effect on decreasing the burnout scores of oncology nurses.

METHOD

Sample

Our study was conducted with nurses working in the adult oncology inpatient services of Hacettepe University Oncology Hospital and the Gazi University Health Research and Application Center in Ankara, Turkey. We recruited nurses from these two hospitals for inclusion in our study in order to reach the appropriate sample size suggested by the power analysis from a previous pilot study. The two university medical centers participating in our study are quite similar in all major aspects of the work environment: available technology, number of nurses, quality, practice, and organization.

The available study sample included 132 nurses who work on adult inpatient oncology clinics. Based on the inclusion/exclusion criteria (scored less than 17 on the Beck Depression Inventory and did not have any diagnosed physical or mental disease), 113 nurses were evaluated, of whom 90 were deemed eligible and consented to participate in our study.

Using a computerized black-box randomization assignment program, these 90 nurses were assigned to receive either the 10-week psychodrama intervention ($n = 38$) or the control condition ($n = 44$; assessments only). Some 8 nurses dropped out of the intervention group and 1 dropped of the control group, leaving a study sample that comprised 82 nurses who completed the study.

Measures

The sociodemographic characteristics, workplace characteristics, and exclusion criteria for our study were assessed with the Demographic Information Form (DIF). The perception of empowerment perception among nurses was measured with the Psychological Empowerment Scale and the Nurse Work Empowerment Scale. Burnout scores were measured using Maslach's Burnout Inventory.

Psychological Empowerment Scale (PES)

This scale was developed by Spreitzer in 1995. A validity and reliability study of the scale was performed by Uner and Turan in 2010, and the scale was found to be applicable on psychometric terms. The scale defines psychological empowerment as having four components: meaning, competence, autonomy, and impact. Uner and Turan found the following values of Cronbach's α for nurses: meaning $= 0.86$, competence $= 0.89$, autonomy $= 0.81$, and impact $= 0.93$. Our study found the following values of Cronbach's α: total scale $= 0.90$, meaning $= 0.87$, competence $= 0.96$, autonomy $= 0.65$, and impact $= 0.92$.

The Nurse Work Empowerment Scale (NWES)

This scale was developed by Laschinger and colleagues based on Kanter's theory and finalized with a revision in 2001 (the Conditions for Work Effectiveness Questionnaire−II; CWEQ−II). The validity and reliability study for this scale in our country was performed by Mortaş in 2005. It measures nurses' perceptions of workplace structural empowerment in six dimensions: opportunity, access to information, support, resources, business activities, and organizational relations. Mortaş's validity and reliability study yielded the following values of Cronbach's α: opportunity $= 0.84$, access to information $= 0.84$, support $= 0.86$, access to resources $= 0.83$, job activities $= 0.90$, organizational relations $= 0.84$, and general empowerment $= 0.74$ (Mortaş, 2005). Our study found the following values of Cronbach's α: total scale $= 0.83$, opportunity $= 0.25$, access to information $= 0.97$, support $= 0.87$, access to

resources = 0.81, job activities = 0.78, organizational relations = 0.73, and general empowerment = 0.85.

Maslach's Burnout Inventory (MBI)

This scale was developed by Maslach and Jackson in 1981 to measure level of burnout. It is a 4-point Likert-type scale and is made up to 22 items. It has three subdimensions: emotional burnout, desensitization, and personal achievement. The validity and reliability study for this scale in our country was performed by Ergin and Akyapraklı in 1992, who found the following values of Cronbach's α: emotional burnout = 0.82, desensitization = 0.60, and personal achievement = 0.80. Our study found the following values of Cronbach's α: emotional burnout = 0.87, desensitization = 0.67, and personal achievement = 0.73.

Procedure

The ethics committees of Erciyes University and Hacettepe University both approved the study protocol. After obtaining the necessary permissions from the organizations where the study was to be conducted, the nurses who constituted the study population were informed about the program's content, time, duration, and participation details, with consideration for their weekly working schedules.

Some 113 nurses verbally consented and completed self-report measures, and 90 met the inclusion criteria for the randomized controlled trial based on burnout score rank (top 90). These 90 nurses were randomly assigned to either the psychodrama intervention or the control/comparison group.

The active intervention arm consisted of a psychodrama-based psychological empowerment program, which was delivered to the study group by the first author, who conducted all the psychodrama intervention sessions and is a certified psychodramatist. The control group received no active intervention but did receive the same full assessment battery at the same time intervals as the intervention group. The psychological empowerment program was conducted in 2-hour sessions, 1 day a week, for 10 weeks. There were 4 groups, with 11–12 nurses in each. Program sessions included a time for getting acquainted and for an introduction to the program. Discussions about the group contract, coping with stress, and cognitive distortion were held. Relaxation techniques were also taught, along with problem solving, self-recognition, empathy, and dispute resolution. Participants were given assertiveness training and were counseled about using the "I language." Delving into past empowerment experiences was also promoted and discussed. The group then studied the death theme.

Finally, the program was brought to completion, and farewells were made.

In every session, participants were given a module related to a particular scenario and asked to act it out extemporaneously. After every session, participant feedback was offered, and their awareness about the style of discussing the theme by themselves and with other group members, communication patterns and emotions, ideas and behaviors were registered. Nurses were again given the psychological empowerment, workplace empowerment, and burnout scales at one and three months after completion of the psychological empowerment program, and assessments were obtained at one and three months post-intervention. The one-month post-intervention assessment timeframe was employed because psychodrama intervention effects usually do not take until two to four weeks after an intervention due to the need of participants to process the information. In order to assess the sustainability of any derived beneficial effects, a three-month post-intervention assessment is relatively standard in psychosocial intervention trials (Breitbart et al., 2015).

The nurses in the control/comparison group were informed that they were included in the control/comparison group, and their written permission was obtained. These nurses were just administered the data collection tools at the same time as the study group, and no intervention was rendered.

After final assessments, information was provided about psychological empowerment and prevention of burnout, and nurses were informed that they were able to be included in the psychological empowerment program if they were willing.

Statistical Analyses

Statistical analysis of study data was made using the SPSS 21.0 software package (SPSS Inc., Chicago). Categorical variables were identified by figures and percentages in the data analysis. The final study sample was determined to be 34 nurses in the intervention group and 34 nurses in the control group, for a total of 68. The intra- and intergroup changes in empowerment and burnout score were compared using repeated-measures analysis of variance (ANOVA).

RESULTS

The demographic characteristics of the nurses are presented in Table 1. Of the nurses in the study group, 57.9% were between 28 and 37 years of age, 60.5% were married, 60.5% did not have children, 94.7% were university graduates, 68.4% had an income equal to expenditures, and 52.3% were commissioned at Gazi University Hospital and 44.7% at

Table 1. *Characteristics of nurses*

Characteristics of Nurses	Study Group		Comparison Group		Total	
	n	%	n	%	n	%
Age						
18−27	11	28.9	21	47.7	32	39.9
28−37	22	57.9	23	52.3	45	54.9
38 and above	5	13.2	0	0	5	6.1
Marital status						
Married	23	60.5	17	38.6	40	48.8
Single	15	39.5	27	61.4	42	51.2
Education						
University degree	36	94.7	41	93.2	38	46.3
Other (pre/post degree)	2	5.3	3	6.8	44	53.7
Income equal to expenditure						
Less	5	13.2	3	6.8	8	9.8
Equal	26	68.4	26	59.1	52	63.4
More	7	18.4	15	34.1	22	26.8
Working years						
0−5 years	12	31.6	28	63.6	40	48.8
6−10 years	14	36.8	11	25.0	25	30.5
11 years and more	12	31.6	5	11.4	17	20.7
Weekly work hours						
40 hours	34	89.5	31	70.5	65	79.3
40 and more	4	10.5	13	29.5	17	20.7
Nightshift						
Yes	23	60.5	41	93.2	64	78.0
No	15	39.5	3	6.8	18	22.0

Hacettepe University Oncology Hospital. Some 81.6% were permanent staff, 36.8% had been working for 5−10 years, 89.5% worked 40 hours a week, and 52.6% reported working the nightshift 5 to 8 times a month.

Of the nurses in the control/comparison group, 52.3% were between 28 and 37 years of age, 38.6% were married, 77.3% did not have children, 93.2% were university graduates, 59.1% had an income equal to expenditures, and 47.7% were commissioned at Gazi University Hospital and 57.3% at Hacettepe University Oncology Hospital. Some 68.2% were permanent staff and 63.6% had been working for 5 years; 70.5% worked 40 hours a week, 93.2% worked the nightshift, and 68.2% reported working the nightshift 5 to 8 times a month.

Nurses' psychological empowerment and workplace empowerment scores are given in Table 2. We

Table 2. *Nurses' psychological empowerment and structural empowerment scores by repeated-measures ANOVA*

Empowerment	Groups	Before Psychological Empowerment	One Month After Psychological Empowerment	Three Months After Psychological Empowerment	F, p*
		Min−max, mean $\pm$ SD	Min−max, mean $\pm$ SD	Min−max, mean $\pm$ SD	
Empowerment	Study	26−79, 63.76 $\pm$ 12.79	60−84, 76.60 $\pm$ 5.59	66−83, 76.03 $\pm$ 4.44	F = 24.00
	Control	25−79, 62.41 $\pm$ 12.88	21−83, 61.32 $\pm$ 14.36	28−83, 62.43 $\pm$ 12.53	p = 0.00
	F, p	F = 0.22, p = 0.63	F = 38.00, p = 0.00	F = 40.27, p = 0.00	
Structural empowerment	Study	40−106, 64.34 $\pm$ 2.26	54−98, 62.386 $\pm$ 2.11	59−95, 67.632 $\pm$ 1.57	F = 3.86
	Control	38−98, 67.86 $\pm$ 2.05	33−118, 62.614 $\pm$ 1.91	43−101, 61.136 $\pm$ 1.46	p = 0.049
	F, p	F = 0.39, p = 0.53	F = 3.50, p = 0.06	F = 9.11, p = 0.00	

* Repeated-measures analysis of variance.

found that there was a statistically significant difference between nurses' psychological empowerment and workplace empowerment scores ($p < 0.05$) and that nurses in the study group had higher psychological empowerment scores one and three months after the psychological empowerment program and higher workplace empowerment scores three months after ($p > 0.05$).

Table 3 presents nurses' burnout scores. We found that there was a statistically significant difference between nurses' scores in the subdimensions of emotional burnout, desensitization, and personal achievement ($p < 0.05$), and that nurses in the study group had lower levels of emotional burnout and desensitization and higher personal achievement scores at one and three months after the psychological empowerment program compared to nurses in the control/comparison group.

DISCUSSION

Our findings demonstrate that the psychological empowerment scores—and, in parallel, the workplace empowerment scores—of the nurses in the study group increased after the psychological empowerment program, but no observable change was observed in empowerment scores in control/comparison group nurses (Table 2). Consequently, our three hypotheses were supported by the study findings.

The psychodrama-based psychological empowerment program has been shown to have a positive effect on the psychological empowerment score of oncology nurses. Larrabee et al. (2003) emphasized that nurses who believe in their own skills and do not focus on their shortcomings feel empowered. Wahlin et al. (2010) reported that internal and external interventions affect psychological empowerment, Manojlovich and Laschinger (2002) suggested that empowerment can be fostered by ensuring stable psychological conditions and regulating workplace conditions. Further, Chang et al. (2008) stated that a training-based psychological empowerment program can increase the psychological empowerment of nurses. These findings support the ones reached in our study.

It is believed that there are several reasons why the psychological empowerment program based on psychodrama carried out in our study had a positive effect on psychological empowerment. The scenarios were designed to increase participant self-recognition, to allow them to develop creative solutions to problems, and to implement conflict-resolution skills. When staging a scenario, the facilitator showed the stage from different perspectives, so that nurses were allowed to experience different opinions. Feedback from other group members also contributed to participant self-recognition and the development of different points of view. Moreover, members were in a "safe" group environment and thus had the opportunity to exhibit behaviors they would normally refrain from in real life. Additionally, participants could break away from the limitations of their physical conditions and previous experiences with the help of psychodramatic techniques, and they had an opportunity to diverge from their routines, to use their imaginations, and to create novel conditions. Pines et al. (2012; 2014) found that the flexibility of nursing students with regard to stress is associated with psychological empowerment,

Table 3. *Nurses' burnout scores by repeated-measures ANOVA*

Burnout	Groups	Before Psychological Empowerment Min−max, mean ± SD	One Month After Psychological Empowerment Min−max, mean ± SD	Three Months After Psychological Empowerment Min−max, mean ± SD	F, p*
Emotional exhaustion	Study	14−40, 25.27 ± 6.81	11−26, 18.97 ± 3.96	11−29, 18.00 ± 3.70	F = 38.55
	Control	10−41, 23.61 ± 6.86	10−41, 26.11 ± 5.79	11−40, 24.64 ± 6.32	p = 0.00
	F, p	F = 1.18, p = 0.28	F = 40.33, p = 0.00	F = 31.61, p = 0.00	
Desensitization	Study	5−19, 10.78 ± 4.05	5−15, 7.89 ± 2.64	5−11, 7.46 ± 1.63	F = 12.80
	Control	5−16, 9.73 ± 3.01	5−19, 11.09 ± 3.06	6−16, 10.79 ± 2.43	p = 0.00
	F, p	F = 1.80, p = 0.18	F = 24.08, p = 0.00	F = 50.43, p = 0.00	
Personal achievement	Study	17−40, 29.08 ± 4.59	18−39, 30.62 ± 3.66	26−37, 31.08 ± 2.61	F = 10.34
	Control	18−36, 28.36 ± 4.11	14−35, 27.73 ± 4.55	16−38, 27.70 ± 4.73	p = 0.00
	F, p	F = 0.54, p = 0.46	F = −9.68, p = 0.00	F = −14.98, p = 0.00	

* Repeated-measures analysis of variance.

Knol and van Linge (2009) found that innovative behaviors are related to psychological empowerment and that psychological empowerment leads to innovative and creative behavior. There are other studies in the literature that indicate a relationship between innovative behavior and empowerment (Manojlovich & Laschinger, 2002).

In addition, participants gained insight into themselves and their communicative skills. It has been shown in the literature that psychodrama can be used to increase self-recognition, communicative skills, and empathy in healthcare providers (Sangappa & Tekian, 2013; Kesten, 2011). In the psychodrama study by Oflaz et al. (2011), participant nurses reported that psychodrama increased their level of self-recognition, helped them understand the viewpoint of others, enhanced their ability to express their own emotions and ideas, and helped to establish a connection with the feelings and ideas of their patients.

Another reason for the efficacy of the psychological empowerment program we employed is that we included discussions on the concept of death, an event frequently experienced by oncology nurses. O'Brien et al. (2011) found a weak relationship between stress and the structural empowerment scores of nurses who offer care to dying patients. This was explained by the hypothesis that moral problems cause a high level of stress in settings where death and terminal illness are concerned, and that environmental regulations, as in structural empowerment, are insufficient to cope with this stress. Browning (2013) also found decreased psychological empowerment to be related to increased moral distress in nurses caring for dying patients. The concept of "death" was studied during the ninth week of our psychological empowerment program, and participants were allowed to explore their perceptions of death.

Our psychodrama-based psychological empowerment program had a positive effect on the workplace empowerment of oncology nurses. Studies on empowerment have found a strong correlation between workplace empowerment and psychological empowerment (Laschinger et al., 2009; 2006; 2001; Wagner et al., 2010). The six subdimensions of psychological and workplace empowerment can be seen to be closely interrelated when reviewed together. The common points are "opportunity of the person to develop knowledge and skills" in the opportunity dimension of workplace empowerment and the effectiveness dimension of psychological empowerment, and "ability to decide independently" in the autonomy dimension of psychological empowerment and the formal power dimension of workplace empowerment. However, communication and solidarity developed with peers and colleagues in the informal power dimension of

workplace empowerment are associated with both psychological empowerment and burnout (Kennedy et al., 2015). Both psychological and workplace empowerment are closely associated with adaptation to a job, job satisfaction, and feeling respected at work (Chang et al., 2008). Spreitzer and Misha (2002) found that psychological empowerment enhances the ability to cope with stressful work and increases empowerment, while Knol and van Linge (2009) determined that psychological empowerment leads to workplace empowerment. These results support our findings, which indicate that our psychological empowerment program also has efficacy in enhancing workplace empowerment (Table 2).

From the measurements obtained at one month after the psychological empowerment program, we found that nurses' workplace empowerment scores dropped in the study group, but increased at three months. Workplace empowerment has been reported to be associated with workplace environmental factors (Laschinger et al., 2014). Prolonged nightshift and work hours are also thought to have an effect on this result. Studies have reported that total weekly work hours and job overload have an effect on empowerment and that empowerment is lower in nurses who work more than 40 hours a week (Boudrias et al., 2012; Josten et al., 2003). These findings are similar to those of our study (see Table 2).

Furthermore, psychological empowerment can have a positive effect on lowering the burnout scores of oncology nurses. In the first- and third-month post-program assessments of the nurses in the study group, emotional burnout and desensitization scores were found to be lower, and personal achievement scores were found to be higher compared to the control/comparison group. It can thus be concluded that the psychological empowerment program had a positive effect on reducing burnout in the oncology nurses we studied. Italia and colleagues (2008) found that a program including psychodrama, play therapy, relaxation techniques, and coping skills helped reduce burnout in oncology nurses and physicians. In a three-year observational study, Laschinger et al. (2006) found that empowerment is related to burnout and that empowerment practices have an effect on psychological empowerment and emotional burnout in nurses. From this point of view, it would be expected that our psychological empowerment program would have an effect on burnout scores (Table 3).

Such factors as conflict management, empathy, coping with stress, and flexibility are associated with both burnout and empowerment in the literature. In a study of the factors that affect burnout, Lee et al. (2003) found that role conflict and lack of empathy can lead to desensitization, and that role uncertainty can lead to a reduced feeling of personal

achievement. The same investigators reported that a lack of empathy and therapeutic communication problems can lead to insufficient empowerment. Sherwood and Tagar (2002) suggested that burnout can be prevented with a program they applied based on creating awareness about the experience of stress and aimed at developing stress-management skills. They also highlighted a relationship between flexibility in the face of stress and psychological empowerment. These studies support the conclusion that our psychodrama-based program, which deals with concepts closely associated with both burnout and empowerment—including coping with stress, empathy, and conflict resolution—can have a positive impact on burnout in oncology nurses.

LIMITATIONS

One limitation of our study is that our sample included only 38 participants who completed the study. In addition, despite the fact that participants were randomly assigned to the study group or the control/comparison group, the oncology nurses in our study group tended to be older than those of the control group. Also, the study group nurses worked fewer hours per week and pulled fewer nightshifts. This was primarily caused by the fact that eight oncology nurses who were younger and worked on the nightshift dropped out of the study group, while only one oncology nurse dropped out of the control group. The dropouts felt that joining the study would take up too much of their time, and that they would have had to carefully organize their shift work according to group hours. All of these factors could have had an impact on level of empowerment and burnout.

CONCLUSION AND SUMMARY

As a result of this study, we determined that attendance in our psychodrama-based psychological empowerment program was associated with lower burnout scores and increased psychological empowerment in our sample during the measurement period. The program also had an effect on perception of psychological empowerment, perception of workplace empowerment, and burnout levels in the nurses at our oncology clinics.

The results of our study are promising. However, there is a need to validate our findings in a larger population and over a longer period of time. Nevertheless, we can certainly recommend it and believe that oncology nurses will clearly benefit from psychodramatic techniques that boost personal awareness, which will enhance empowerment, improve perceptions, and prevent burnout.

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