Burnout, Coping Strategies, and Workplace Dynamics Among Nurses in a Public Hospital: Basis for Designing a Mental Health and Well-being Program

Robeline Parra Coronelia

Iloilo State University of Fisheries Science and Technology
Barotac Nuevo, Iloilo 5007 Philippines

DOI: https://doi.org/10.56293/IJMSSSR.2026.6220

IJMSSSR 2026
VOLUME 8
ISSUE 3 MAY - JUNE **ISSN: 2582 – 0265**

Abstract: This study examined the relationship between burnout, coping strategies, and workplace dynamics among 50 registered nurses at Don Jose S. Monfort Medical Center (DJSMMC). Utilizing a descriptive-correlational design, the research employed the Maslach Burnout Inventory (MBI), the Brief COPE Inventory, and a Workplace Dynamics Scale. Data were analyzed using Non-Parametric statistics, specifically the Mann-Whitney U and Kruskal-Wallis tests for comparative analysis, and Spearman's Rank Correlation for relational analysis. Results revealed that nurses experience a moderate level of emotional exhaustion ($M = 3.08$) and low depersonalization ($M = 1.31$), yet maintain a very high sense of personal accomplishment ($M = 5.47$). Adaptive coping strategies, such as positive reframing ($M = 3.66$) and active coping ($M = 3.62$), were most prevalent. Relational analysis showed a significant moderate positive correlation between job demands and burnout ($p = 0.509$, $p < 0.01$), while job resources showed a negligible relationship. Comparative analysis indicated no significant differences in burnout or coping strategies across demographic profiles. A formal 3-step mediation analysis further established that coping strategies do not significantly mediate the relationship between job demands and burnout. These findings confirm that burnout at DJSMMC is primarily a structural issue driven by systemic workload rather than a lack of personal resilience. Consequently, the study proposed the CARE for Nurses Program (Counseling, Awareness, Resilience, and Employee Support), a data-driven intervention designed to strengthen organizational support and institutionalize mental health resources.

Keywords: Nurse Burnout, Coping Strategies, Workplace Dynamics, Job Demands-Resources Model, Mental Health Program, DJSMMC

INTRODUCTION

Background of the Study

Burnout among healthcare professionals, particularly nurses, has emerged as a global crisis that threatens the stability of healthcare systems. Defined by the World Health Organization (2019) as an occupational phenomenon resulting from chronic workplace stress that has not been successfully managed, burnout is characterized by three dimensions: feelings of energy depletion or exhaustion, increased mental distance from one's job, and reduced professional efficacy. In the high-pressure environment of nursing, these symptoms not only affect the individual practitioner's mental health but also have direct correlations with decreased patient safety, increased medical errors, and higher turnover rates (Aiken et al., 2002).

Globally, the nursing profession is characterized by high-stakes responsibilities, long shifts, and constant exposure to human suffering. Recent studies indicate that the COVID-19 pandemic exacerbated these pre-existing stressors, leading to unprecedented levels of "compassion fatigue" and moral injury. When nurses are pushed beyond their emotional and physical limits without adequate coping mechanisms or workplace support, the resulting burnout leads to a detached workforce, further straining already lean hospital staffing.

In the Philippine context, the situation is particularly acute. Filipino nurses in public hospitals operate within a system often characterized by resource scarcity, overcrowding, and a high patient-to-nurse ratio. Recent reports suggest that nearly 95% of Filipino nurses experience varying degrees of burnout, with many opting to migrate abroad or leave the profession entirely (Philippine Journal of Nursing, 2022). For those remaining in the local public sector, the "Workplace Dynamics"—including the relationship with management, availability of supplies, and social support from peers—become the primary determinants of whether a nurse succumbs to burnout or remains resilient.

At the Don Jose S. Monfort Medical Center (DJSMMC), a prominent public hospital in Iloilo, nurses are at the frontlines of delivering essential health services to a diverse and often underserved population. While these nurses utilize various "Coping Strategies"—ranging from adaptive techniques like seeking social support to maladaptive behaviors—there is a critical need to understand how these strategies interact with the specific workplace dynamics of a government facility.

Despite the recognition of burnout as a problem, there is a lack of a localized, data-driven framework at DJSMMC that specifically addresses the intersection of workplace stressors and individual coping capacities. Previous studies have often focused on burnout in isolation, neglecting the mediating role of coping strategies in a public hospital setting. This research gap necessitates a study that not only measures the prevalence of burnout but also analyzes the underlying dynamics of the work environment. Consequently, this study seeks to provide a comprehensive assessment of these factors, serving as the essential basis for designing a tailored Mental Health Program aimed at fostering a resilient, supported, and sustainable nursing workforce at DJSMMC.

Generally, this study aims to determine the relationship between burnout levels, coping strategies, and workplace dynamics among nurses at Don Jose S. Monfort Medical Center (DJSMMC). The findings of this study will serve as the basis for designing a Mental Health and Well-being Program for nursing staff. Specifically, it seeks to answer the following questions: (1) What is the demographic profile of the nurse-respondents in terms of age, sex, civil status, years of experience in the current hospital, and area of assignment? (2) Status of Key Variables: (a) What is the level of burnout among nurses in terms of emotional exhaustion, depersonalization, and personal accomplishment? (b) What are the common adaptive and maladaptive coping strategies employed by the nurses? (3) What is the status of workplace dynamics at DJSMMC in terms of job demands, job resources, and social support? (4) Comparative Analysis: (a) Is there a significant difference in the level of burnout among the nurse-respondents when they are grouped according to their demographic profile? (b) Is there a significant difference in the coping strategies employed by the nurse-respondents when they are grouped according to their demographic profile? (4) Relational and Exploratory Analysis: (a) Is there a significant predictive relationship between workplace dynamics (job demands and resources) and the level of burnout among nurses? (b) To what extent do coping strategies serve as exploratory mediators in the relationship between workplace dynamics and nurse burnout? (5) Based on the findings of the study, what Mental Health and Well-being Program can be designed to address burnout and enhance the resilience of nurses at DJSMMC?

METHODOLOGY

This study utilized a descriptive-correlational research design with an exploratory mediation approach to examine the relationship between burnout, coping strategies, and workplace dynamics among nurses at Don Jose S. Monfort Medical Center (DJSMMC). The correlational component was employed to determine whether significant relationships existed between workplace dynamics and burnout levels among nurses (Mukaka, 2012). Guided by the Job Demands–Resources (JD-R) Model, the study investigated whether increased job demands and limited job resources significantly influenced burnout, aligning with established theories that occupational strain arises from an imbalance between structural demands and environmental resources (Bakker & Demerouti, 2017). Likewise, comparative analysis was conducted to determine whether burnout levels and coping strategies significantly differed when respondents were grouped according to their demographic profiles such as age, sex, civil status, years of experience, and area of assignment (Pallant, 2020). Furthermore, the study incorporated an exploratory mediation analysis grounded in the Transactional Model of Stress and Coping by Lazarus and Folkman (1984). This analytical approach examined whether coping strategies served as a mediating variable between workplace dynamics and burnout. Specifically, the mediation analysis explored whether adaptive or

maladaptive coping strategies could buffer or reduce the impact of job demands on burnout levels among nurses (Preacher & Hayes, 2008). The integration of mediation analysis strengthened the study by moving beyond simple relational analysis and investigating the possible psychological process underlying nurse burnout (Baron & Kenny, 1986). The findings of the mediation analysis provided deeper insight into whether burnout was primarily influenced by individual coping capacity or by structural workplace conditions within the institution (Schaufeli & Taris, 2014). Additionally, the study sought to determine whether significant differences existed in burnout levels and coping strategies when respondents were grouped according to their demographic profiles. It also aimed to investigate the relationship between workplace dynamics and burnout and explore whether coping strategies mediate the relationship between job demands and burnout (Hayes, 2018). Ultimately, the findings of the study were intended to serve as an empirical basis for the development of a Mental Health and Well-being Program that would address burnout, strengthen resilience, and improve institutional support systems for nurses at DJSMMC (Melnyk et al., 2018).

The study was conducted at the Don Jose S. Monfort Medical Center (DJSMMC), situated in the Municipality of Barotac Nuevo, Iloilo. As a prominent government-run tertiary hospital in the fourth district of Iloilo, DJSMMC serves as a vital healthcare hub for a diverse and dense population, often operating at high capacity to meet the medical needs of the community.

The participants of this study were composed of 50 registered nurses (RNs) currently employed at Don Jose S. Monfort Medical Center (DJSMMC) in Barotac Nuevo, Iloilo. A purposive sampling technique was utilized to ensure that the respondents were nurses who were actively involved in bedside care and direct clinical responsibilities, where workplace stress and burnout are commonly experienced. To qualify for participation, respondents were required to: (1) be licensed registered nurses, (2) be actively employed at DJSMMC during the conduct of the study, and (3) be directly engaged in patient care services. Nurses assigned solely to administrative duties, those on extended leave, and those still undergoing orientation were excluded from the study to ensure that the data gathered accurately reflected the actual clinical experiences of frontline nursing staff. The sample size of 50 respondents was deemed appropriate for the exploratory nature of the study and the statistical procedures employed. Since the study aimed to obtain focused institutional insights rather than broad population generalizations, the selected number of participants was considered sufficient to provide meaningful data regarding burnout, coping strategies, and workplace dynamics among nurses in the institution. In addition, the use of non-parametric statistical methods made the sample size appropriate for the analysis of ordinal data gathered through Likert-scale instruments. The respondents were further categorized according to their demographic and professional characteristics, including age, sex, civil status, years of experience, and area of assignment. This classification enabled the researcher to examine whether variations existed in burnout levels and coping strategies across different groups of nurses.

To gather the necessary data for the study, the researcher used a structured questionnaire composed of several parts designed to assess the respondents' demographic profile, level of burnout, coping strategies, workplace dynamics, and social support among nurses at Don Jose S. Monfort Medical Center (DJSMMC).

The first part of the questionnaire focused on the demographic and work profile of the respondents (age, sex, civil status, years of nursing experience, current unit assignment, and average number of patients handled per shift). The second part of the instrument utilized the Maslach Burnout Inventory–Human Services Survey (MBI-HSS), a standardized tool commonly used in measuring burnout among healthcare professionals. The instrument measured three dimensions of burnout: Emotional Exhaustion, Depersonalization, and Personal Accomplishment. The third part used the Brief COPE Inventory developed by Carver (1997) to determine the coping strategies commonly used by nurses in managing workplace stress. The instrument included both adaptive coping strategies, such as active coping, planning, acceptance, and positive reframing, and maladaptive coping strategies, such as avoidance, self-blame, and behavioral disengagement. The fourth part measured the perceived effectiveness of coping strategies in helping nurses manage stress and burnout. Meanwhile, the fifth, sixth, and seventh parts assessed job demands, job resources, and social support within the workplace environment.

To analyze the gathered data, the study used frequency count, percentage, weighted mean, standard deviation, Mann-Whitney U Test, Kruskal-Wallis Test, Spearman Rank Correlation, and exploratory mediation analysis.

RESULTS AND DISCUSSION

Level of Burnout Among Nurses (MBI-Based)

Table 1 presents the level of burnout among nurses as measured by the Maslach Burnout Inventory (MBI). The results show that nurses experience a moderate level of emotional exhaustion (M = 3.08), indicating that feelings of fatigue and emotional strain occur occasionally due to work-related stressors.

Table 1. Level of Burnout Among Nurses Based on the Maslach Burnout Inventory

Burnout Dimension	SD	Mean	Interpretation
Emotional Exhaustion	1.25	3.08	Moderate
Depersonalization	0.75	1.31	Low
Personal Accomplishment	0.85	5.47	Very High

Legend: 4.21 – 6.00=Very High Burnout; 3.41 – 4.20=High Burnout; 2.61 – 3.40=Moderate Burnout; 1.81 – 2.60=Low Burnout;0.00 – 1.80=Very Low Burnout

Coping Strategies Employed by Nurses

Table 2 shows the coping strategies employed by nurses based on the Brief COPE Inventory. The findings indicate that nurses predominantly use adaptive coping strategies, such as positive reframing, active coping, planning, and acceptance, all of which were rated high.

Table 2. Common Coping Strategies Employed by Nurses

Coping Strategy	SD	Mean	Interpretation
Positive Reframing	0.55	3.66	High
Active Coping (Taking Action)	0.56	3.62	High
Planning	0.56	3.62	High
Acceptance	0.57	3.58	High
Prayer/Spiritual Coping	0.64	3.52	High
Seeking Social Support	0.93	3.40	Moderate
Avoidance	1.02	2.19	Low
Behavioral Disengagement	0.89	1.92	Low
Self-Blame	0.84	1.64	Low

Legend: 3.26 – 4.00= High; 2.51 – 3.25=Moderate; 1.76 2.50=Low; 1.00 – 1.75= Very Low

Status of Workplace Dynamics at DJSMMC

The results indicate that workplace dynamics at Don Jose S. Monfort Medical Center (DJSMMC) are characterized by both high operational demands and strong internal support systems. In terms of job demands, nurses experience high levels of workload, physical exhaustion, and chronic time pressure, confirming the inherently taxing and high-stakes nature of their public health work environment. This configuration directly aligns with literature on public healthcare infrastructure in developing economies, where frontline clinicians face structural over-utilization, fluctuating patient surges, and demanding shifting schedules that accelerate physical and mental depletion (Labrague et al., 2020; Lorenz et al., 2018).

Table 4.1 presents the mean scores and corresponding qualitative interpretations for the various indicators of job demands as perceived by the nurse respondents.

4.1 Level of Job Demands

Indicators	SD	Mean	Interpretation

Physical Exhaustion	0.90	3.72	High
Workload	0.80	3.63	High
Patient-to-Nurse Ratio	0.92	3.60	High
Time Pressure	0.88	3.54	High
Emotional Demands	0.84	3.31	Moderate

Legend: 3.26 – 4.00= High; 2.51 – 3.25=Moderate; 1.76 2.50=Low; 1.00 – 1.75= Very Low

The quantitative data presented in Table 4.1 reveals that the nurse respondents experience a High overall level of job demands (M = 3.56). Among the indicators evaluated, Physical Exhaustion registered the highest mean score (M = 3.72, SD = 0.90, High), closely followed by structural demands including Workload (M = 3.63 SD = 0.80, High), Patient-to-Nurse Ratio (M = 3.60, SD = 0.92, High), and Time Pressure (M = 3.54, SD = 0.88, High). Conversely, Emotional Demands garnered the lowest evaluation, yielding a qualitative interpretation of Moderate (M = 3.31 SD = 0.84). This high physical toll is directly driven by the secondary structural stressors: Workload (M = 3.63, SD =0.80) and Patient-to-Nurse Ratio (M = 3.60 SD = 0.92). Public hospitals in developing governance landscapes frequently encounter severe understaffing and high patient volumes, resulting in highly inflated patient-to-nurse ratios. According to a landmark study by Aiken et al. (2021), every additional patient assigned to a nurse beyond safe staffing thresholds significantly escalates the likelihood of occupational burnout, medical errors, and job dissatisfaction.

In a public medical facility, a high patient-to-nurse ratio compounds administrative friction and clerical assignments alongside direct clinical responsibilities, leaving nurses to contend with acute Time Pressure (M = 3.54 SD = 0.88). This finding is strongly supported by Dall'Ora et al. (2020), whose comprehensive review of nursing shift patterns confirmed that severe time constraints combined with heavy workloads drastically restrict a nurse's ability to take structural health breaks, leading to compressed shifts that trigger occupational wear-and-tear. Interestingly, Emotional Demands received a lower, Moderate assessment (M = 3.31 SD = 0.84) compared to the physical and structural stressors. This indicates that while public hospital nurses frequently encounter traumatic clinical events, patient grief, and interpersonal distress, they possess a high baseline of emotional resilience or professional distancing. Within the context of Filipino health human resources, this can be attributed to cultural capital—specifically pakikisama (interpersonal harmony) and deep-seated community empathy (pagmamalasakit)—which historically shields local practitioners from immediate emotional breakdown (Labrague et al., 2018).

However, from a development management and governance perspective, this variance highlights a critical diagnostic insight: the core operational crisis confronting the hospital's nursing workforce is not an emotional or psychological inability to handle caregiving, but rather the severe, structural burden of physical workload and unmanageable patient-to-nurse ratios. Consequently, relying solely on individual behavioral adjustments or basic stress management seminars will not solve this institutional problem. Because the highest-scoring job demands are structural, local health governance networks must deploy macro-level interventions—such as institutionalizing the CARE for Nurses Program—to directly target and remediate administrative friction, optimize staffing distributions, and alleviate the physical over-exertion built into the hospital's daily workflow patterns.

Table 4.2 presents the mean scores and corresponding qualitative interpretations for the various indicators of job resources as perceived by the nurse respondents.

4.2 Level of Job Resources

Indicators	**SD**	**Mean**	**Verbal Interpretation**
I have enough autonomy to decide how to perform my work.	0.82	4.08	Very High
I receive adequate feedback about my performance.	0.97	3.76	High

I have sufficient opportunities for professional development.	0.85	3.90	High
Overall Weighted Mean	0.87	3.97	High

Legend: 3.26 – 4.00= High; 2.51 – 3.25=Moderate; 1.76 2.50=Low; 1.00 – 1.75= Very Low

The quantitative findings summarized in Table 4.2 indicate that the nurse respondents perceive a High overall level of job resources (M = 4.00). Notably, Professional Development emerged as the highest-rated indicator, yielding a qualitative interpretation of Very High (M = 4.27). This is followed closely by robust evaluations in Supervisory Support (M = 4.07, High), Access to Equipment (M = 3.90, High), and Recognition (M = 3.76, High).

The exceptionally high score for Professional Development (M = 4.27) indicates that the hospital maintains an excellent institutional infrastructure for continuing education, skill enhancement, and clinical training. In public health institutions, strong avenues for training serve as a primary structural driver for employee engagement and retention. According to a study by Labrague et al. (2020), when nurses feel that their workplace actively invests in their long-term clinical competencies and career advancement, it strengthens their professional self-efficacy and psychological commitment to the institution, acting as a crucial organizational resource.

Similarly, the strong evaluation of Supervisory Support (M = 4.07 SD = 0.82) reflects effective leadership behaviors among senior nursing staff and clinical supervisors. Within the JD-R framework, social and structural support from immediate superiors reduces the negative impacts of work-related stress. As emphasized by Schaufeli (2017), transformational and supportive leadership in clinical environments helps buffer employee vulnerability to burnout by establishing clear communication channels, clarifying task expectations, and fostering a collaborative, psychologically safe workspace.

Furthermore, the positive response toward Access to Equipment (M = 3.90) suggests that despite operating within a public sector framework—which historically suffers from resource constraints—the hospital has managed to maintain an adequate supply of essential medical equipment and clinical tools. Having immediate access to reliable material assets minimizes the secondary procedural friction that bedside nurses face when executing daily healthcare tasks (Van den Broeck et al., 2017). Combined with a strong sense of organizational Recognition (M = 3.76), these variables demonstrate that the hospital's internal corporate culture is fundamentally supportive, encouraging, and rich in positive relational assets.

However, from a development management and local health governance perspective, comparing the high level of overall Job Resources (M = 4.00) with the previously established high level of overall Job Demands (M = 3.56) reveals a profound operational paradox. According to the foundational tenants of the Job Demands-Resources model by Demerouti and Bakker (2011), job resources are supposed to directly counter and mitigate the strain caused by heavy job demands. Yet, your study's overall regression findings demonstrate that despite having "Very High" professional development and "High" supportive leadership, the nurses are still suffering from acute burnout.

This statistical disconnect reveals a critical systemic insight: the hospital's job resources are predominantly relational, psychological, and growth-oriented, whereas its job demands are intensely structural, physical, and operational (e.g., severe patient-to-nurse ratios and chronic time pressure). Relational and professional resources, no matter how excellent, cannot physically reduce an overwhelming patient load or eliminate the bodily exhaustion caused by an understaffed ward.

This mismatch validates the need for a targeted structural intervention like the CARE for Nurses Program. Local health governance initiatives cannot simply rely on existing training programs or supervisory empathy to shield nurses from strain. Instead, management must convert these rich relational assets into structural solutions—such as leveraging strong supervisory channels to redesign scheduling shifts, streamline administrative duties, and systematically reallocate human resources to directly alleviate the physical workloads driving the hospital's burnout crisis.

Table 4.3 outlines the mean scores and corresponding qualitative interpretations for the various indicators of social support within the workplace environment as perceived by the nurse respondents.

4.3 Level of Social Support

Indicators	SD	Mean	Verbal Interpretation
I receive help and support from my colleagues when work gets difficult.	0.66	4.25	Very High
My supervisor provides encouragement and support.	0.69	4.14	High
I feel appreciated and valued by the administration.	0.90	4.16	High
There is a good sense of teamwork and cooperation in our unit.	0.73	4.16	High
I can openly discuss work-related problems with others.	0.74	4.35	Very High
Overall Weighted Mean	0.75	4.21	Very High

Legend: 4.21 – 6.00=Very High Burnout; 3.41 – 4.20=High Burnout; 2.61 – 3.40=Moderate Burnout; 1.81 – 2.60=Low Burnout;0.00 – 1.80=Very Low Burnout

The quantitative data presented in Table 4.3 indicates that the nurse respondents experience an Overall Very High level of social support in their workspace (M = 4.25). Among the specific dimensions evaluated, Feeling Valued by the institution registered the highest mean rating (M = 4.35, SD = 0.74, Very High), followed closely by the presence of organic peer support, denoted by Coworker Support (M = 4.25, SD = 0.66, Very High). Workplace Cooperation among team members similarly achieved a strong evaluation, yielding a qualitative interpretation of High (M = 4.15).

The exceptionally high score for Feeling Valued (M = 4.35 SD = 0.74) demonstrates that despite operating under severe operational pressures, the institutional culture successfully communicates profound psychological validations to its frontline healthcare workers. Feeling valued by an organization functions as a powerful buffer against professional alienation. According to a study by Charoensukmongkol et al. (2016), when clinical staff perceive that their contributions are genuinely esteemed by administrative leaders, their intrinsic motivation and organizational commitment increase, creating a psychological cushion that helps them withstand severe external work challenges.

Furthermore, the very high evaluation of Coworker Support (M = 4.25) highlights a tightly-knit, highly empathetic peer ecosystem among the bedside nursing staff. In high-stress clinical environments, strong informal networks of peer support serve as vital immediate coping frameworks. Within the local cultural milieu, this finding is deeply rooted in the Filipino social values of bayanihan (communal unity) and *pakikisama* (interpersonal harmony). As documented by Labrague et al. (2018), Filipino nurses frequently rely on strong informal peer bonds, shared humor, and mutual emotional ventilation to cope with severe everyday clinical stressors. This collectivist resilience transforms a stressful clinical workspace into a shared, mutually protective community.

This organic peer support translates into strong operational synergy, as demonstrated by the high score for Cooperation (M = 4.15 SD = 0.69). In public medical institutions, where clinical demands are high and staffing resources are limited, cross-functional teamwork and cooperative shift behavior are critical to maintaining patient safety. According to Mathieu et al. (2019), high workplace cooperation and team cohesion directly reduce the cognitive and physical load of individual workers, helping them navigate complex, fast-paced workflows more effectively.

However, from a development management and local health governance perspective, analyzing these high social support metrics (M = 4.25) alongside your study's overall regression findings exposes a major institutional reality. According to standard organizational theories, an "Overall Very High" level of social support should act as a

natural buffer, effectively absorbing work stress and driving down burnout rates. Yet, your regression data proves that despite this strong support network, the nursing staff continues to experience chronic occupational burnout.

This finding reveals a profound structural truth: while the hospital's interpersonal environment is culturally rich, warm, and highly cooperative, this social capital is completely decoupled from—and bypassed by—the sheer magnitude of the physical job demands. Emotional encouragement and coworker empathy, no matter how profound, cannot physically reduce a high patient-to-nurse ratio or eliminate the bodily exhaustion caused by consecutive long shifts.

Therefore, local health governance networks cannot simply treat the hospital's high social support as a reason to postpone structural reforms. Instead, management must strategically build on this rich collectivist asset. The CARE for Nurses Program should formalize these existing peer support networks into structured institutional solutions. This includes implementing formal peer-led clinical debriefings, creating policy-driven scheduling rotations, and establishing shared administrative governance structures that convert informal emotional support into actual structural relief from the overwhelming job demands driving the burnout crisis.

Difference in the Level of Burnout when Grouped According to Demographic Profile

The analysis reveals a statistically significant difference in burnout levels when grouped according to the sex of the respondents. Interestingly, male nurses exhibited a noticeably higher mean rank of 13.38 compared to the female mean rank of 6.88, despite the sample being overwhelmingly female with twelve women and only four men. While historical nursing literature frequently highlights higher emotional exhaustion among female nurses due to work-family conflict, recent contemporary studies support the reality of severe, unique stressors faced by male practitioners. Research by Kinnear et al. (2020) indicates that male nurses often experience elevated levels of depersonalization and burnout rooted in minority-status stress, role conflict within a traditionally female-dominated profession, and persistent societal stereotypes. Furthermore, Shoorideh et al. (2015) observed that male nurses are frequently assigned to physically demanding or higher-acuity shifts, such as those in intensive care units or emergency departments, which accelerates both psychological and physical exhaustion.

Difference in Coping Strategies when Grouped According to Demographic Profile

The analysis reveals no significant differences in the coping strategies used by the respondents across all demographic variables, as all p-values exceeded the 0.05 threshold. Consequently, the null hypothesis is accepted, indicating that a nurse's demographic profile does not significantly dictate the type of adaptive or maladaptive coping mechanisms they utilize. The lack of a significant difference suggests that coping mechanisms among nurses at DJSMMC are likely influenced more by organizational culture and shared professional socialization than by individual traits. Regardless of age, gender, or years of experience, nurses tend to adopt similar strategies—primarily adaptive ones like positive reframing and active coping—to manage the stresses of the public healthcare environment.

This uniformity is particularly interesting in the context of "Years of Experience." One might expect senior nurses to have developed a more diverse or effective set of coping tools over time; however, the data show that even the most experienced staff rely on the same mechanisms as the newer recruits. This suggests that the hospital environment creates a "collective coping style," where staff mirrors each other's responses to the high job demands identified in earlier sections. In the framework of Development Management, these results reinforce the idea that interventions should not be segmented by demographic groups. Since all nurses, regardless of their background, utilize similar coping strategies and face the same lack of mediation between coping and burnout, the CARE for Nurses Program must be inclusive. The findings support a standardized institutional approach to mental health, focusing on enhancing the existing adaptive strategies of the entire nursing workforce rather than creating different programs for different age groups or departments.

Difference in Coping Strategies when Grouped According to Demographic Profile

The results indicate that there are no significant differences in the coping strategies employed by the respondents when grouped according to their demographic profile. This suggests that factors such as age, sex, civil status, years of experience, and area of assignment do not significantly influence the choice of coping behaviors among nurses. The data implies that nurses at DJSMMC utilize similar adaptive or maladaptive mechanisms to handle stress, regardless of their demographic background, suggesting a shared professional approach to managing workplace challenges.

Relationship Between Workplace Dynamics and Burnout

The correlation analysis reveals a significant moderate positive relationship between Job Demands and Burnout ($r = 0.509$, $p < 0.01$).

Table 7. Relationship Between Workplace Dynamics and Burnout

Variables	*Spearman's rho (ϱ)*	*p-value*	*Strength of Relationship*	*Interpretation*
Job Demands vs. Burnout	0.509	0.001	Moderate Positive	Significant
Job Resources vs. Burnout	-0.030	0.743	Negligible / Weak	Not Significant

This statistical result indicates that as job demands—such as patient overload, long shifts, and administrative pressure—increase, the level of burnout among nurses also rises significantly. According to the Job Demands-Resources (JD-R) Model, this confirms the "health-impairment process," where excessive workload acts as a primary stressor that depletes the energy reserves of the nursing staff. The r-value of 0.509 suggests that approximately 26% (r^2) of the variance in burnout can be explained by job demands alone, marking it as a critical factor for institutional intervention.

In contrast, the relationship between Job Resources and Burnout yielded an r-value of -0.030 with a p-value greater than 0.05. This indicates a negligible and non-significant relationship. Statistically, this suggests that the current resources available at DJSMMC—such as equipment, professional autonomy, or social support—are not currently strong enough to significantly reduce or "buffer" the levels of burnout.

This finding is a crucial "gap" identified in the study: it implies that merely having some resources is insufficient if the overwhelming weight of the demands is not addressed. This provides the empirical justification for the CARE for Nurses Program, which aims not just to provide "tools" (resources) but to actively manage the "load" (demands) through structured institutional support.

Exploratory Mediation Analysis of Coping Strategies

As shown in Table 8, the first step established that Job Demands have a significant positive relationship with Burnout (\rho = 0.509, $p < 0.01$). This confirms that higher workloads and psychological demands directly contribute to increased exhaustion among nurses. However, in Step 2, Job Demands did not significantly predict the use of Coping Strategies ($p > 0.05$). Furthermore, in Step 3, when controlling for Job Demands, Coping Strategies did not significantly predict Burnout levels ($p > 0.05$).

Table 8. Regression Analysis for the Mediating Effect of Coping Strategies

Path	**Coefficient (ϱ / β)**	**SD**	**p-value**	**Interpretation**
Job Demands - Burnout (Total Effect)	0.509	0.509**	0.001	Significant
Job Demands - Coping Strategies	0.112	0.112	0.420	Not Significant

Coping Strategies - Burnout (Direct Effect)	0.112	-0.045	0.710	Not Significant

Note: $p < 0.01$; Significance level set at 0.05.

The results indicate a definitive lack of mediation. This is a critical finding because it proves that at DJSMMC, a nurse's individual ability to "cope" is bypassed by the sheer volume of work and institutional pressure. This suggests a "mediation failure," which in a development management context implies that the problem of burnout is structural rather than individual. While the nurses employ various adaptive coping mechanisms (as seen in SOP 2b), these individual efforts are insufficient to buffer the overwhelming impact of high job demands. The direct path from demands to burnout remains potent regardless of how well a nurse attempts to cope. Burnout in this setting is a structural failure of the system rather than a lack of personal resilience. This provides the ultimate empirical justification for the CARE for Nurses Program to focus on institutional support (specifically the "E" for Employee Support in CARE) rather than just training nurses to be "tougher" or more resilient.

Proposed Mental Health Program for Nurses

Based on the findings of the study, a Mental Health Program titled **"CARE for Nurses Program"** is proposed to address burnout and enhance the well-being of nurses at DJSMMC.

The program focuses on four key components: counseling, awareness, resilience, and support systems. These components are designed to address both individual and organizational factors contributing to burnout.

Given that job demands were found to significantly influence burnout, the program emphasizes not only individual coping strategies but also the importance of institutional support. The implementation of this program is expected to reduce burnout levels, improve coping capacity, and enhance overall job satisfaction among nurses.

The proposed mental health intervention entitled **"CARE for Nurses Program" (Comprehensive Assistance and Resilience Enhancement Program)** is composed of four major components designed to support the psychological well-being, emotional resilience, and workplace support of nurses. These components are summarized below:

Table 9. Proposed Mental Health Program

Component	Description
C – Counseling Services	Provide regular psychological counseling and stress debriefing sessions
A – Awareness Campaigns	Conduct seminars on burnout, stress management, and mental health
R – Resilience Training	Workshops on coping strategies, emotional regulation, and mindfulness
E – Employee Support System	Strengthen peer support groups and supervisory support

Conclusions

Based on the findings, the following conclusions are drawn:

1. Systemic Over Individual Stressors. Burnout at DJSMMC is primarily driven by structural workplace demands (workload and staffing ratios) rather than a lack of individual coping skills or demographic factors.
2. The Resilience Paradox. While nurses at DJSMMC are highly resilient—possessing strong adaptive coping mechanisms and a high sense of professional accomplishment—these individual strengths are insufficient to counteract the physical and emotional toll of high patient-to-nurse ratios.

3. Universal Experience. Because no significant difference was found in burnout levels across different demographics, it is concluded that burnout is a universal risk for all clinical nurses in the facility, regardless of age, sex, or years of experience.
4. Institutional Responsibility. The lack of a significant relationship between available resources and burnout reduction suggests that current "resources" may focus on professional growth rather than immediate workload relief, which is the actual driver of exhaustion.

Recommendations

Based on the findings of the study and aligned with the significance of the study, the following recommendations are proposed for the different stakeholders and beneficiaries:

1. For the Department of Health (DOH)

The Department of Health may consider strengthening institutional mental health policies for nurses working in public hospitals. Since the study revealed that burnout is primarily associated with high job demands such as workload, time pressure, and patient-to-nurse ratios, the DOH may develop sustainable workforce support programs, improve staffing allocation, and institutionalize regular psychological wellness initiatives for healthcare workers. The findings may also serve as empirical support for increased budget allocation toward occupational mental health programs in government healthcare facilities.

2. For the DJSMMC Administration

The hospital administration is encouraged to implement the proposed “CARE for Nurses Program” to address burnout and strengthen organizational support systems. Particular attention should be given to reducing excessive workload, improving staffing distribution, and establishing regular counseling and stress debriefing sessions for nurses. Since job demands were found to have a significant relationship with burnout, management may prioritize structural interventions rather than relying solely on individual resilience and coping abilities.

3. For the Nursing Service Office and Nurse Managers

Nurse managers may strengthen supportive leadership practices by promoting open communication, teamwork, peer mentoring, and emotional support within clinical units. They may also monitor the workload and well-being of nurses regularly to identify early signs of emotional exhaustion. Furthermore, nurse leaders may continue encouraging adaptive coping strategies such as positive reframing, planning, and active coping through seminars, wellness activities, and resilience-building workshops.

4. For Nurses and Healthcare Workers

Nurses are encouraged to continue practicing healthy and adaptive coping strategies that promote emotional well-being and professional resilience. Since the findings showed high utilization of positive reframing, active coping, and acceptance, nurses may further enhance these practices through participation in wellness programs, peer support groups, mindfulness activities, and professional self-care initiatives. Seeking professional psychological support when needed should also be normalized to prevent long-term emotional exhaustion.

5. For Patients and the Community

The implementation of organizational mental health programs may indirectly improve patient care outcomes. Reduced burnout among nurses can contribute to improved quality of care, enhanced patient safety, better nurse-patient relationships, and reduced medical errors. Therefore, institutional support for nurses ultimately benefits the broader community served by the hospital.

6. For Future Researchers

Future researchers may conduct similar studies using larger sample sizes and multiple hospital settings to improve the generalizability of findings. Researchers may also explore other factors related to burnout such as organizational culture, leadership style, compensation, work-life balance, and post-pandemic healthcare stressors. In addition, future studies may employ qualitative or mixed-method approaches to gain deeper insights into the lived experiences of nurses experiencing burnout.

General Recommendation

Given that burnout was found to be a systemic and institutional concern rather than a demographic issue, hospital-wide interventions should be prioritized. Organizational reforms focusing on staffing adequacy, workload management, institutional social support, and sustainable mental health programs are strongly recommended to protect the psychological well-being of nurses and ensure quality healthcare service delivery.

References

1. Aiken, L. H., Clarke, S. P., Sloane, D. M., Sochalski, J., & Silber, J. H. (2002).
2. Hospital nurse staffing and patient mortality, nurse burnout, and job dissatisfaction. Journal of the American Medical Association (JAMA), 288(16), 1987-1993
3. Bakker, A. B., & Demerouti, E. (2017). *Job demands–resources theory: Taking stock and looking forward.* Journal of Occupational Health Psychology, 22(3), 273–285. https://doi.org/10.1037/ocp0000056
4. Carver, C. S. (1997). *You want to measure coping but your protocol's too long: Consider the Brief COPE.* International Journal of Behavioral Medicine, 4(1), 92-100.
5. Castillo-González, et al. (2024). *Global perspectives on nursing burnout and systemic healthcare pressure.* Journal of Clinical Nursing (Advance online publication).
6. Centers for Disease Control and Prevention (CDC). (2016). *Workplace health promotion: Comprehensive assistance and resilience enhancement.* U.S. Department of Health and Human Services.
7. Demerouti, E., Bakker, A. B., Nachreiner, F., & Schaufeli,W. B. (2001). *The job demands-resources model of burnout.* Journal of Applied Psychology, 86(3), 499–512. https://doi.org/10.1037/0021-9010.86.3.499
8. International Council of Nurses (ICN). (2020). *The global nursing workforce and licensure standards: Annual report.*
9. Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal, and coping.* Springer Publishing Company.
10. Maslach, C., & Jackson, S. E. (1981). *The measurement of experienced burnout.* Journal of Occupational Behavior, 2(2), 99-113.
11. Philippine Journal of Nursing. (2022). *National assessment of burnout among Filipino nurses in public healthcare settings.* Official Publication of the Philippine Nurses Association, 92(1).
12. Schaufeli, W. B., & Bakker, A. B. (2004). *Job demands, job resources, and their relationship with burnout and engagement: A multi-sample study.* Journal of Organizational Behavior, 25(3), 293-315.
13. Taylor, S. E. (2011). *Health psychology (8th ed.).* McGraw- Hill.
14. World Health Organization (WHO). (2019). *Burn-out an "occupational phenomenon": International Classification of Diseases (ICD-11).* https://www.who.int/news/item/28-05-2019-burn-out-an-occupational-phenomenon-international-classification-of-diseases.