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Work Stress, Occupational Burnout, and Psychological Capital among Hospital Staff

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Abstract

Hospital employees are frequently exposed to high work demands that increase their risk for occupational stress and burnout. This study examined work stress, occupational burnout, and psychological capital among hospital employees, as well as the relationships among these variables and differences across demographic and job-related factors. Using a quantitative cross-sectional design, data were collected from 480 hospital staff in China through standardized self-report questionnaires. Descriptive statistics, group comparisons, and correlation analyses were conducted. Results indicated that respondents experienced above-median work stress, particularly related to career development, workload, social identity, and patient relations. Despite elevated stress levels, overall burnout was low, characterized by very low emotional exhaustion and cynicism and low professional efficacy. Psychological capital was moderate to above median, with higher levels of hope, resilience, and optimism, although self-efficacy was slightly below median. Significant differences in stress, burnout, and psychological capital were found across occupation, working years, age, sex, and income, with occupation and work experience exerting the strongest influence. Work stress was positively associated with burnout, while psychological capital was negatively associated with both stress and burnout. The findings highlight the protective role of psychological capital in mitigating occupational stress and support the implementation of an integrated stress reduction program to enhance employee well-being in hospital settings.

Keywords: *work stress, occupational burnout, psychological capital, hospital employees, healthcare workers, psychological well-being*

1. Introduction

Hospital staff in China constitute the foundational workforce responsible for sustaining healthcare delivery within one of the world's largest and most complex medical systems. This population encompasses physicians, nurses, medical technicians, and administrators working primarily in public tertiary hospitals, which serve extremely large patient populations and function as the backbone of China's healthcare delivery system. These professionals operate in environments marked by high clinical responsibility, rapid decision-making, and continuous exposure to human suffering, alongside organizational pressures such as performance evaluations, policy reforms, and technological transformations (Yang et al., 2021; Jia et al., 2021). Over time, these cumulative demands place significant strain on hospital personnel, making them an appropriate group for examining psychological outcomes related to work stress, burnout, and internal coping resources.

Work stress is widely acknowledged as an inherent feature of hospital employment, referring to the psychological and physiological strain that occurs when job demands exceed an individual's capacity to cope effectively. For hospital staff in China, stressors commonly include excessive workloads, long working hours, staff shortages, and pressure to meet institutional performance metrics (Yang et al., 2021; Jia et al., 2021). The rapid implementation of digital health systems, administrative reporting requirements, and public health emergencies—particularly the COVID-19 pandemic—have exacerbated these stressors by increasing patient volume and emotional labor (Zhou et al., 2024). Recent empirical studies demonstrate that a substantial proportion of Chinese healthcare workers report high to severe levels of work stress in tertiary hospitals (Yang et al., 2021; Jia et al., 2021).

Prolonged exposure to work stress frequently leads to the development of occupational burnout, a chronic psychological response to sustained job-

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related strain (Schonfeld & Bianchi, 2021). Burnout is conceptualized as a multidimensional syndrome consisting of emotional exhaustion, cynicism (depersonalization), and reduced professional efficacy (Canu et al., 2020). Among hospital staff, burnout has been associated with decreased job satisfaction, increased absenteeism, higher turnover intention, compromised patient safety, and lower quality of care (Alkhraishi et al., 2023; Li et al., 2023). Nationwide studies in China have reported elevated burnout rates among clinicians, particularly in emergency departments and intensive care units (Hu et al., 2021), underscoring burnout as a critical psychological and organizational concern.

In response to the prevalence of stress and burnout, psychological capital has gained increasing attention within occupational health research. Psychological capital refers to an individual's positive psychological state characterized by self-efficacy, hope, optimism, and resilience, enabling individuals to persevere in the face of adversity and recover from setbacks (Nasreen et al., 2024). For hospital staff, psychological capital supports confidence in managing complex clinical tasks and sustaining motivation under pressure (Tian et al., 2023). Meta-analytic evidence confirms that higher psychological capital is associated with lower levels of burnout and psychological distress among healthcare professionals (Xue et al., 2023). Importantly, psychological capital is considered a developable capacity rather than a fixed trait, with interventions showing promise in enhancing employees' coping abilities (Nasreen et al., 2024; Mahmoud et al., 2025).

Despite growing scholarly attention, several gaps persist in the literature. Many studies focus primarily on documenting prevalence rates without examining the mechanisms linking stress to burnout. Others investigate psychological capital independently, without integrating it into comprehensive stress–burnout models. Research often concentrates on single occupational groups, such as nurses, limiting broader organizational insights. In the Chinese context, relatively few studies adopt integrative frameworks that simultaneously examine work stress, burnout, and psychological capital within public tertiary hospitals, particularly in the post-pandemic period when healthcare reforms and systemic changes have intensified work demands (Ding et al., 2025).

This study aimed to address these gaps by examining the relationships and interactions among work stress, occupational burnout, and psychological capital among hospital employees. Specifically, it sought to describe the demographic and professional profile of respondents; determine the levels of work stress, occupational burnout, and psychological capital; examine whether significant differences existed in these variables when grouped according to respondent profile; establish the relationships among the three variables; and propose an evidence-based psychological intervention program designed to reduce occupational burnout among hospital employees.

2. Review of Related Literature

2.1 Work Stress in Healthcare Settings

Work stress among hospital staff is conceptualized as the psychological and physiological strain resulting from an imbalance between job demands and an individual's capacity to cope effectively (Yang et al., 2021; Jia et al., 2021). Multiple theoretical frameworks elucidate the emergence and consequences of occupational stress in healthcare environments (Atento, Quinto & Espelita, 2025). The Job Demands-Resources (JD-R) Model posits that work stress arises when job demands—such as workload intensity, emotional labor, and role conflict—exceed available resources, including autonomy, social support, and psychological capital (Wójcik et al., 2022). The Conservation of Resources (COR) Theory conceptualizes work stress as a response to actual or threatened depletion of valued personal and organizational resources (Nahum, 2024). Complementing these perspectives, Role Stress Theory identifies role overload, ambiguity, and conflict as central stressors inherent in hospital environments (Mwakyusa & Mcharo, 2024). Collectively, these theoretical underpinnings illuminate the complex interplay between contextual factors and individual perceptions that contribute to the elevated prevalence of work stress among healthcare professionals (Nazir et al., 2022; Zhou et al., 2022).

Empirical research has identified multiple dimensions of work stress specific to healthcare settings. Workload stress—characterized by excessive quantitative and qualitative demands—consistently emerges as a predominant stressor, with studies documenting that heavy patient loads, staffing shortages, and extended duty hours significantly elevate stress levels among healthcare workers (Dall'Ora et al., 2020; National Academies Press, 2019; Rink et al., 2023). In China, post-pandemic research has revealed that electronic health record tasks and documentation requirements

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contribute substantially to workload stress (Zhou et al., 2024). Patient relations stress arises from emotionally demanding interactions, unrealistic expectations, and verbal aggression from patients and families (Simões et al., 2023; Zhou et al., 2024). Career development stress encompasses anxiety regarding promotion opportunities, professional growth trajectories, and income uncertainty, particularly under evolving healthcare payment reforms (Li et al., 2024; Hameli et al., 2024). Social identity stress, stemming from perceived societal devaluation or insufficient recognition of healthcare professionals' critical roles, further exacerbates occupational strain (Siegrist et al., 2010). Additionally, the perception of instrumental utility—wherein managers view institutional frameworks as effective tools for resolving departmental challenges rather than abstract reporting mandates—significantly influences proactive engagement and may either mitigate or amplify occupational strain (Garcia & Atento, 2026).

Further stress dimensions include administrative stress arising from bureaucratic procedures (Gamasan & Atento, 2026; Zhou et al., 2024), insufficient resources stress resulting from staffing and equipment shortages (Iheduru-Anderson, 2020; Yuan et al., 2023), and work-family conflict stress stemming from incompatible demands between professional and family roles (Gu et al., 2023; Ren et al., 2022). Healthcare adaptation stress relates to adjusting to organizational, technological, and policy changes (Larsson & Thesing, 2024; Bondarchuk et al., 2024), while social identity crisis involves uncertainty about professional value and recognition (Bamforth et al., 2023; Rhead et al., 2022). Emergency response stress, though acute in nature, may enable staff to develop adaptive coping strategies over time (Bondarchuk et al., 2024). These multifaceted stressors collectively contribute to an elevated risk of burnout, characterized by emotional exhaustion, depersonalization, and reduced professional efficacy (Bermido, Atento & Quinto, 2025).

Demographic factors consistently influence stress patterns. Female healthcare workers frequently report heightened emotional and relational stress attributable to caregiving expectations and emotional labor (Fida et al., 2023). Nurses and frontline clinicians experience greater workload and patient-related stress, whereas administrative staff report more bureaucratic and resource-related stress (Rink et al., 2023). Length of service also shapes stress exposure, with newer employees encountering challenges related to adaptation and role clarity, while senior staff experience cumulative stress from leadership responsibilities (Lan et al., 2025).

Collectively, evidence indicates that work stress in healthcare is multidimensional and shaped by individual, occupational, and organizational factors. The complexity of these interactions underscores the necessity of comprehensive, multimodal interventions that address not only individual coping mechanisms but also systemic organizational deficiencies contributing to elevated stress levels (Bermido et al., 2025). This multifactorial nature of stress highlights the importance of organizational strategies encompassing psychosocial support, ethical considerations, and the development of healthy, communicative educational cultures, particularly within culturally diverse contexts (Bermido et al., 2025). Such systemic pressures—including clinical placement scarcity, program viability tensions, and resource constraints—collectively impact both learner preparedness and faculty well-being (Aquino-Malabanan, 2026).

2.2 Occupational Burnout Among Hospital Staff

Occupational burnout is defined as a psychological syndrome arising from chronic workplace stress that has not been successfully managed (Amiri et al., 2024). Among hospital staff, burnout is conceptualized as a multidimensional phenomenon comprising emotional exhaustion, cynicism (depersonalization), and reduced professional efficacy (Canu et al., 2020; Chen et al., 2023). Emotional exhaustion refers to feelings of being emotionally overextended and depleted by work demands; cynicism reflects detachment and negative attitudes toward patients and colleagues; and reduced professional efficacy denotes diminished perceptions of competence and achievement in one's professional role (Ahmed et al., 2024; Bargsted et al., 2021). This tripartite model provides a robust framework for understanding the profound impact of sustained work-related stressors on the psychological well-being and professional functioning of healthcare professionals, highlighting the critical need for effective mitigation strategies (Bermido et al., 2025). Excessive workload, often exacerbated by staffing shortages and an increasingly demanding "publish-or-perish" culture within academic medicine, is a frequently cited contributor to

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burnout, particularly among healthcare professionals balancing clinical and academic roles (Bermido et al., 2025).

Research consistently demonstrates that burnout negatively affects employee well-being, motivation, and quality of patient care (Boudreau & Rhéaume, 2024). In China, studies have documented elevated burnout rates among clinicians, particularly in intensive care units and emergency departments (Hu et al., 2021; Chen et al., 2023). Emotional exhaustion has emerged as the most prevalent component, with key predictors including mandatory overtime, insufficient rest, and chronic workload pressures (Dall'Ora et al., 2020). Cynicism often develops as a coping response to prolonged emotional exhaustion and is associated with workload imbalance, patient conflicts, and inadequate institutional support (López-Núñez et al., 2020). Professional efficacy may fluctuate depending on workload demands and perceptions of recognition, with supportive work environments and strong leadership linked to higher efficacy and lower burnout (Belizario et al., 2024; Gilmartin et al., 2023; Zhang et al., 2022).

Burnout levels are significantly influenced by demographic and occupational characteristics. Longer tenure increases the risk of emotional exhaustion due to cumulative stress exposure (Rink et al., 2023). Frontline staff, including nurses and allied health workers, generally exhibit higher burnout than administrative or senior personnel because of direct patient care responsibilities, workload intensity, and emotional labor demands (Boudreau & Rhéaume, 2024). Personal factors such as marital status and family responsibilities are also associated with burnout, as married healthcare workers often report lower job satisfaction when balancing competing professional and family demands (Wen et al., 2024). Income and hierarchical position further influence burnout, with higher-paid or higher-ranked staff demonstrating greater job control and resource access, thereby reducing vulnerability to burnout (Bakker & De Vries, 2020). Conversely, academic faculty—particularly younger and early-career academics—face heightened vulnerability to burnout due to the confluence of doctoral studies, family responsibilities, institutional pressures for scholarly productivity, and a pervasive "publish-or-perish" culture (Bermido et al., 2025).

2.3 Psychological Capital as a Protective Resource

Psychological capital (PsyCap) is defined as a positive psychological state characterized by self-efficacy, hope, resilience, and optimism, which enables individuals to cope with workplace challenges, sustain performance, and maintain psychological well-being (Nasreen et al., 2024; Chen et al., 2024). Self-efficacy refers to confidence in one's capacity to execute tasks successfully; hope represents goal-directed energy and planning to achieve objectives; resilience is the capacity to recover quickly from adversity; and optimism reflects positive expectations about future outcomes (Dursun, 2021). PsyCap is conceptualized as a "state-like" resource that can be cultivated and strengthened through targeted interventions, rather than a fixed trait (Luthans et al., 2024). This malleability distinguishes PsyCap from more stable personality traits and underscores its utility in organizational development (Adame, 2026).

Research indicates that higher levels of psychological capital are associated with improved job performance, reduced stress, and lower rates of burnout across various professions. For instance, heightened resilience among healthcare professionals has been linked to reduced emotional exhaustion and depersonalization, underscoring its indispensable role in navigating crisis situations and mitigating psychological distress (Adame, 2026). This protective function extends to academic settings, where a growth mindset—a component of psychological capital—enables faculty to proactively engage with challenges and sustain effort, ultimately fostering well-being and work engagement (Aguilar, 2026).

In healthcare settings, PsyCap has been shown to reduce the likelihood of emotional exhaustion and depersonalization while enhancing engagement and professional efficacy (Zhou & Li, 2023; Søvold et al., 2021). Meta-analytic evidence from Asian studies confirms a substantial negative association between PsyCap and burnout, with resilience demonstrating the strongest protective effect (Zhou & Li, 2023). Self-efficacy is associated with enhanced problem-solving ability and adaptive coping (Chen et al., 2024), though some studies indicate that self-efficacy among hospital staff may be relatively lower than other PsyCap dimensions, highlighting the need for targeted interventions such as structured training and mentorship programs (Da et al., 2020; Broetje et al., 2025). Hope has been shown to enhance resilience to stress and sustain engagement, with brief interventions demonstrating improvements in hope scores among healthcare workers (Laranjeira & Querido, 2022; Zhou & Li, 2023). Resilience emerges as the strongest protective factor against burnout, particularly in

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high-stress units, enabling staff to manage emotional labor demands and adapt to policy and technological changes (Liu et al., 2023; Søvold et al., 2021). Optimism significantly mitigates the impact of chronic work stress and buffers against emotional exhaustion and cynicism (Jing et al., 2022; Liu et al., 2023). Collectively, these components of Psychological Capital function as critical psychological assets that enable sustained performance in emotionally demanding work environments (Chen et al., 2024; San Juan, 2026; Wojtczuk‐Turek, 2020).

Research demonstrates that PsyCap varies according to demographic and occupational factors. Older and more experienced staff tend to exhibit higher levels of self-efficacy, resilience, hope, and optimism, likely attributable to cumulative mastery experiences and exposure to supportive work contexts (Kibler et al., 2024; Carter & Youssef-Morgan, 2022). Occupational differences also emerge: nurses and allied health staff often develop stronger resilience and hope through direct patient care exposure, whereas physicians' optimism and self-efficacy are shaped by professional autonomy and resource access (Broetje et al., 2025). PsyCap theory, integrated with the JD-R model, provides a framework for understanding the stress-burnout-PsyCap relationship, with PsyCap serving as a personal resource that buffers the impact of job demands on burnout outcomes (Chen et al., 2024; Wang et al., 2024). This model posits that elevated job demands deplete energy and lead to burnout, whereas job resources—including PsyCap—foster growth and mitigate job demands, thereby enhancing well-being and reducing burnout. Specifically, PsyCap's components can be leveraged to foster adaptive coping mechanisms, enabling hospital staff to reframe challenging situations and maintain positive outlooks despite occupational stressors (Caponnetto et al., 2022; Fan et al., 2024).

2.4 Synthesis and Research Gaps

The literature consistently demonstrates that work stress, occupational burnout, and psychological capital are closely interconnected among hospital staff. Chronic organizational stressors—including high workload, patient relations challenges, career development pressures, and work-family conflict—serve as primary drivers of burnout, manifested as emotional exhaustion, cynicism, and reduced professional efficacy (Zhou et al., 2024; Chen et al., 2023; Rink et al., 2023). Psychological capital, comprising self-efficacy, hope, resilience, and optimism, functions as a key buffering resource, reducing burnout by enhancing coping capacities, sustaining engagement, and fostering professional efficacy (Zhou & Li, 2023; López-Núñez et al., 2020). Demographic and occupational factors such as age, tenure, occupation, and income further shape stress exposure, burnout susceptibility, and PsyCap levels (Kibler et al., 2024; Fida et al., 2023; Broetje et al., 2025).

Despite significant insights, several gaps persist in the extant literature. Many studies focus on single occupational groups or document prevalence rates without examining integrative stress-burnout-PsyCap models. The literature largely lacks comprehensive, multi-level models that examine how these variables interact within specific, high-stress healthcare environments (Bermido et al., 2025). In the Chinese context, relatively few studies have simultaneously examined these three constructs among diverse hospital staff in public tertiary hospitals, particularly following recent healthcare reforms and post-pandemic changes that have intensified work demands. Additionally, limited research has explored how demographic and occupational differences—beyond simple comparisons—may inform the development of targeted, evidence-based interventions.

Addressing these gaps requires a comprehensive investigation that examines work stress, occupational burnout, and psychological capital within an integrated theoretical framework, providing evidence to support tailored intervention strategies for promoting healthcare worker well-being. Further research is warranted to develop such comprehensive models, particularly within diverse healthcare systems where unique structural and cultural dynamics may modulate these relationships (Bermido et al., 2025). This study therefore aimed to investigate the interrelationships among work stress, occupational burnout, and psychological capital among a heterogeneous sample of hospital staff in China, considering various demographic and job-related factors, with a view to informing evidence-based interventions (Hu et al., 2025).

3. Methodology

3.1 Research Design

This study employed a quantitative descriptive correlational design, which systematically describes variables as they naturally occur and examines relationships through numerical data and statistical analysis without manipulation (Duckett, 2021;

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Bhandari, 2023). This design was appropriate for examining how varying levels of work stress relate to occupational burnout and how psychological capital may be associated with these variables in a naturalistic hospital setting.

3.2 Setting and Participants

The study was conducted in eight comprehensive public tertiary hospitals located in China's Yangtze River Delta and Central-Western regions. These hospitals were selected for their high daily outpatient volume (exceeding 5,000), handling of multidisciplinary complex cases, and involvement in medical reform policies, ensuring relevance to intense clinical and organizational contexts.

Participants were 480 full-time hospital employees with at least one year of work experience, including doctors, nurses, medical technicians, and administrative staff. Inclusion criteria focused on full-time employment with ≥1 year experience to ensure adequate exposure to workplace stressors. Stratified convenience sampling was used: within each hospital, participants were stratified by professional category to mirror national workforce data (China Health Statistics Yearbook, 2022), yielding a sample of 57.5% nurses, 23.1% doctors, 12.5% medical technicians, and 6.9% administrative staff. The sample size exceeded the G*Power-calculated minimum of 300 ($\alpha = 0.05$, effect size = 0.15).

3.3 Measures

Healthcare Workers Stress Assessment Scale – Revised (HWSAS-R).

This scale, based on Li Chaoping's (2019) framework, was designed to capture occupational stressors unique to healthcare environments. The HWSAS-R consists of 34 items assessing nine dimensions: workload stress, patient relations stress, career development stress, administrative stress, insufficient resources, work-family conflict, healthcare adaptation stress, social identity crisis, and emergency response stress. Items are rated on a 5-point Likert scale (1 = never stressful to 5 = constantly stressful), with higher scores indicating greater perceived stress. The scale has demonstrated strong internal consistency, with Cronbach's alpha reported at 0.88 (Li Chaoping, 2019), and has been validated in Chinese healthcare populations (Zhou et al., 2024; Li et al., 2022).

*Maslach Burnout Inventory – General Survey (MBI-GS), Chinese Version***.**

The MBI-GS, originally developed by Maslach and Jackson (1981) and adapted for Chinese medical populations by Li Xiaomei (2008), measures three core dimensions of burnout: emotional exhaustion (5 items), cynicism (5 items), and professional efficacy (6 items). Items are rated on a 7-point Likert scale ranging from 0 (never) to 6 (every day). Higher scores on emotional exhaustion and cynicism indicate greater burnout, while higher scores on professional efficacy indicate lower burnout. The Chinese version has demonstrated high internal consistency, with Cronbach's alpha values ranging from 0.80 to 0.90 across subscales (Chen et al., 2023; Zhang et al., 2022).

*Psychological Capital Questionnaire (PCQ-24), Chinese Version***.**

The PCQ-24, originally developed by Luthans, Youssef, and Avolio (2007) and adapted for Chinese populations by Zhong (2007), measures four dimensions of psychological capital: self-efficacy (6 items), hope (6 items), resilience (6 items), and optimism (6 items). Items are rated on a 6-point Likert scale (1 = strongly disagree to 6 = strongly agree), with higher scores indicating stronger psychological capital. The Chinese version shows strong psychometric properties, with Cronbach's alpha ≥ 0.85 for all subscales and confirmed construct validity (Zhou & Li, 2023).

3.4 Data Collection Procedure

Following ethical approval, structured surveys were administered electronically via a secure online platform. Participants were recruited using stratified convenience sampling to ensure coverage of multiple job categories and hospital departments. The survey platform included an information sheet explaining the study purpose, confidentiality assurances, and informed consent. Participants provided electronic consent before proceeding. The platform ensured all responses were complete before submission, maintaining data quality.

3.5 Data Analysis

Descriptive statistics (frequencies, percentages, means, standard deviations) summarized respondent characteristics and study variables. Group comparisons used Mann–Whitney U tests for two-group comparisons and Kruskal–Wallis H tests for comparisons across three or more groups, consistent with ordinal-scale measurement and distributional considerations. Associations among work stress, occupational burnout, and psychological capital were examined using

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Spearman's rank correlation coefficient (rho). Statistical significance was set at $p < 0.05$.

3.6 Ethical Considerations

Ethical approval for this study was obtained from the Ethics Committee of the institution. Participants were fully informed about the study purpose and assured that participation was voluntary. Informed consent was obtained electronically, and participants were informed of their right to withdraw at any time without consequences. All responses were collected anonymously, with no personally identifying information linked to the data. Data were securely stored in a password-protected database accessible only to the research team and will be destroyed after a predetermined period in accordance with institutional data management policies.

4. Results and Discussion

4.1 Demographic Profile of Respondents

A total of 480 hospital staff participated in the study. The majority were female (76.7%), while males comprised 23.3% of the sample. In terms of age distribution, the largest proportion of respondents were aged 31–40 years (42.3%), followed by those aged 26–30 years (20.8%) and 20–25 years (17.3%). Smaller percentages were observed in the 41–50 years (17.1%) and 51–60 years (2.5%) categories.

Regarding occupation, nurses constituted the largest group (57.5%), followed by doctors (23.1%), medical technologists (12.5%), and administrative staff (6.9%). Most respondents were married (66.9%), with 30.8% unmarried and 2.3% divorced. In terms of work experience, the largest proportion had 11–20 years of service (36.3%), followed by those with 6–10 years (19.8%), 1–3 years (17.7%), over 20 years (13.5%), 4–5 years (7.7%), and less than one year (5.0%). Monthly income distribution showed that most respondents earned 3,000–5,000 RMB (37.7%), followed by 5,000–7,000 RMB (25.2%), below 3,000 RMB (13.8%), 7,000–10,000 RMB (15.0%), 10,000–20,000 RMB (7.3%), and over 20,000 RMB (1.0%). The majority of respondents (87.5%) held no formal administrative position.

Respondents were drawn from a wide range of hospital departments, with the largest groups from the Laboratory Department (10.2%), Blood Dialysis Room (7.3%), Emergency Department (6.5%), Department of Neurology (6.3%), Cardiology Department (5.8%), Department of Nephrology (5.2%), and Department of Respiratory Medicine (5.0%).

4.2 Levels of Work Stress

Respondents reported an overall work stress level slightly above the scale midpoint (mean = 2.51 on a 5-point scale) Among the nine stress dimensions, career development stress ranked highest (mean = 2.83), followed closely by workload stress (mean = 2.82). Social identity crisis ranked third (mean = 2.62), while work-family conflict (mean = 2.59) and patient relations stress (mean = 2.58) also exceeded the median. Administrative stress was rated at the median level (mean = 2.50). Lower stress levels were observed for insufficient resources (mean = 2.38), emergency response stress (mean = 2.17), and healthcare adaptation stress (mean = 2.12). These findings indicate that hospital staff experience the greatest stress from career development concerns, workload pressures, and professional identity issues, while adaptation to healthcare systems and emergency responses are relatively less stressful.

4.3 Levels of Occupational Burnout

Overall burnout among respondents was low (mean = 36.21). Emotional exhaustion (mean = 11.27) and cynicism (mean = 9.03) were both classified as very low. Professional efficacy (mean = 15.91) fell within the low range, though it was the highest-ranked burnout dimension. These results suggest that while respondents experience low levels of emotional depletion and detachment, their perceptions of professional competence and accomplishment, though not severely diminished, represent the area of greatest concern within the burnout construct.

4.4 Levels of Psychological Capital

Overall psychological capital was above median/medium (mean = 4.01 on a 6-point scale). Among the four dimensions, self-efficacy was below median (mean = 25.44), while hope (mean = 24.24), resilience (mean = 23.24), and optimism (mean = 23.39) were all above median. This pattern indicates that respondents possess moderate-to-strong psychological resources in terms of future orientation, adaptability, and positive outlook,

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though confidence in specific task-related abilities (self-efficacy) represents a relative weakness.

4.5 Differences in Work Stress, Burnout, and Psychological Capital by Demographic Profile

. Significant differences in work stress were observed across multiple demographic variables. By sex, significant differences were found for workload stress ($p = 0.012$), patient relations stress ($p = 0.004$), career development stress ($p = 0.03$), administrative stress ($p = 0.019$), insufficient resources ($p = 0.002$), healthcare adaptation stress ($p = 0.012$), social identity crisis ($p = 0.001$), emergency response stress ($p = 0.024$), and overall stress ($p = 0.004$). By age, significant differences emerged for workload stress ($p = 0.017$), patient relations stress ($p = 0.038$), career development stress ($p < 0.001$), and social identity crisis ($p = 0.034$). Occupation showed the strongest and most consistent differences, with all nine stress dimensions and overall stress demonstrating significant variation (all $p < 0.01$). Working years significantly differentiated patient relations stress ($p = 0.011$), career development stress ($p < 0.001$), administrative stress ($p = 0.042$), insufficient resources ($p = 0.023$), healthcare adaptation stress ($p = 0.038$), social identity crisis ($p = 0.026$), and overall stress ($p = 0.02$). Monthly income showed significant differences for career development stress ($p < 0.001$), administrative stress ($p = 0.001$), insufficient resources ($p < 0.001$), social identity crisis ($p = 0.012$), emergency response stress ($p = 0.016$), and overall stress ($p = 0.008$). No significant differences in work stress were found by position ($p = 0.67$).

For burnout, significant differences were found across several demographic variables. Age significantly differentiated professional efficacy ($p < 0.001$) and overall burnout ($p = 0.004$). Occupation showed significant differences across all three burnout dimensions—emotional exhaustion ($p = 0.02$), cynicism ($p = 0.03$), professional efficacy ($p < 0.001$)—and overall burnout ($p = 0.003$). Marital status significantly differentiated professional efficacy ($p < 0.001$) and overall burnout ($p = 0.01$). Working years showed significant differences for emotional exhaustion ($p = 0.09$, borderline), cynicism ($p < 0.001$), professional efficacy ($p < 0.001$), and overall burnout ($p < 0.001$). Monthly income significantly differentiated professional efficacy ($p < 0.001$). Position significantly differentiated professional efficacy ($p = 0.004$) and overall burnout ($p = 0.031$). Sex showed no significant differences on any burnout dimension.

For psychological capital, significant differences were observed across multiple demographic variables. Age significantly differentiated all dimensions: self-efficacy ($p < 0.001$), hope ($p < 0.001$), resilience ($p = 0.009$), optimism ($p = 0.011$), and overall PsyCap ($p < 0.001$). Occupation significantly differentiated self-efficacy ($p = 0.002$), hope ($p = 0.025$), optimism ($p = 0.008$), and overall PsyCap ($p = 0.007$). Marital status significantly differentiated resilience ($p = 0.041$). Working years significantly differentiated all dimensions: self-efficacy ($p < 0.001$), hope ($p < 0.001$), resilience ($p < 0.001$), optimism ($p < 0.001$), and overall PsyCap ($p < 0.001$). Monthly income significantly differentiated self-efficacy ($p = 0.009$), hope ($p = 0.012$), and overall PsyCap ($p = 0.03$). Position significantly differentiated self-efficacy ($p = 0.025$), resilience ($p = 0.042$), optimism ($p = 0.029$), and overall PsyCap ($p = 0.023$). Sex showed no significant differences on any PsyCap dimension.

4.6 Relationships Among Work Stress, Burnout, and Psychological Capital.

Work stress demonstrated significant positive correlations with burnout. Emotional exhaustion was positively associated with all nine stress dimensions, with correlation coefficients ranging from $\rho = 0.584$ to 0.754 (all $p < 0.001$). Cynicism showed similar positive associations with all stress dimensions ($\rho = 0.543$ to 0.645, all $p < 0.001$). Professional efficacy was significantly associated only with healthcare adaptation stress ($\rho = 0.18$, $p < 0.001$) and emergency response stress ($\rho = 0.149$, $p = 0.001$). Overall burnout was positively correlated with all stress dimensions ($\rho = 0.442$ to 0.565, all $p < 0.001$) and with overall work stress ($\rho = 0.607$, $p < 0.001$).

Psychological capital demonstrated significant negative correlations with burnout. Self-efficacy, hope, resilience, optimism, and overall PsyCap were all negatively associated with emotional exhaustion ($\rho = -0.442$ to -0.53, all $p < 0.001$), cynicism ($\rho = -0.548$ to -0.631, all $p < 0.001$), professional efficacy ($\rho = -0.428$ to -0.513, all $p < 0.001$), and overall burnout ($\rho = -0.617$ to -0.723, all $p < 0.001$).

Work stress was significantly negatively correlated with psychological capital. All nine stress dimensions showed significant negative associations with self-efficacy ($\rho = -0.306$ to -0.403, all $p < 0.001$), hope ($\rho = -0.377$ to -0.461, all $p < 0.001$), resilience ($\rho = -0.365$ to -0.437, all $p < 0.001$), optimism ($\rho = -0.329$ to -0.423, all $p < 0.001$), and overall PsyCap ($\rho = -0.376$ to -0.487, all $p < 0.001$). Overall work stress was negatively

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correlated with overall PsyCap (ρ = -0.487, $p < 0.001$).

4.7 Proposed Intervention Program

Based on the findings that work stress was above median and negatively associated with psychological capital, while psychological capital was negatively associated with burnout, an Integrated Occupational Stress Reduction Program was developed. The program aims to reduce overall occupational stress through psychoeducation on stress and coping, skills-based stress management training, work organization and efficiency enhancement, communication and interpersonal effectiveness training, resilience building, work-life balance promotion, and peer support and group reflection activities. The program is designed to be implemented collaboratively by hospital administrators, human resources personnel, clinical psychologists, and occupational health units, with effectiveness evaluated through pre- and post-intervention stress assessments and participant feedback.

4.8 Discussion

This study examined work stress, occupational burnout, and psychological capital among hospital staff in China, revealing several important patterns. Respondents reported above-median work stress, particularly in career development, workload, and social identity domains. Despite elevated stress levels, overall burnout was low, with very low emotional exhaustion and cynicism and low professional efficacy. Psychological capital was moderate to above median, characterized by higher hope, resilience, and optimism, though self-efficacy was slightly below median. These findings align with and extend previous research on occupational health in healthcare settings.

Work Stress Patterns

The finding that career development stress ranked highest among all stress dimensions is consistent with research indicating that unclear promotion criteria, limited training opportunities, and income uncertainty under healthcare payment reforms generate significant anxiety among hospital employees (Li et al., 2024; Hameli et al., 2024). In the Chinese context, where DRG/DIP payment reforms have been implemented, performance pressure and income uncertainty may be particularly salient (Li et al., 2022). The high ranking of workload stress corroborates extensive literature documenting heavy patient loads, staffing shortages, and extended duty hours as major contributors to healthcare worker stress (Dall'Ora et al., 2020; National Academies Press, 2019; Zhou et al., 2024). The prominence of social identity crisis suggests that some hospital staff experience uncertainty about professional value and recognition, consistent with research on professional identity in large hierarchical hospital systems (Bamforth et al., 2023; Rhead et al., 2022).

Lower stress levels in healthcare adaptation and emergency response domains suggest that most respondents have become accustomed to hospital systems and protocols, and that repeated exposure to high-pressure situations may facilitate coping mechanisms and procedural confidence over time (Bondarchuk et al., 2024). However, the elevated stress in patient relations and work-family conflict indicates that emotional labor and the intersection of professional and personal roles remain significant challenges (Simões et al., 2023; Gu et al., 2023). Overall, these patterns suggest that work stress among hospital staff is predominantly chronic and organizational in nature, rooted in career structure, workload intensity, and professional identity, rather than episodic crises (Karanika-Murray et al., 2023).

Burnout Levels and Protective Factors

The finding of low overall burnout, with very low emotional exhaustion and cynicism, diverges from some previous studies reporting elevated burnout rates among Chinese healthcare workers (Chen et al., 2023; Hu et al., 2021). Several explanations may account for this discrepancy. First, the sample included staff from diverse departments, not only high-intensity units such as ICU and emergency departments where burnout is typically highest (Bruyneel et al., 2021). Second, the moderate-to-high levels of psychological capital observed—particularly hope, resilience, and optimism—may serve as protective factors buffering against burnout development (López-Núñez et al., 2020; Zhang et al., 2022). Third, organizational or contextual factors not measured in this study, such as leadership support or team cohesion, may contribute to lower burnout levels (Gilmartin et al., 2023).

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The finding that professional efficacy, though low, ranked highest among burnout dimensions warrants attention. Research suggests that professional efficacy can fluctuate depending on workload demands and perceptions of recognition, and may be more sensitive to workplace support than emotional exhaustion or cynicism (Belizario et al., 2024; Hermansson et al., 2024). Even when emotional exhaustion is low, healthcare workers may sometimes doubt their effectiveness, particularly in fast-paced hospital settings where performance expectations are high (Long et al., 2021). This pattern underscores the importance of reinforcing professional efficacy through recognition programs, continuous training, and supportive supervision.

Psychological Capital as a Psychological Resource

The moderate-to-above median levels of hope, resilience, and optimism, coupled with below-median self-efficacy, present an interesting profile. High hope, resilience, and optimism suggest that respondents possess positive future orientation, adaptability, and optimistic perspectives that help them manage stress and maintain motivation (Laranjeira & Querido, 2022; Jing et al., 2022). These attributes likely contribute to the low burnout levels observed, consistent with evidence that psychological capital buffers against emotional exhaustion and cynicism (Zhou & Li, 2023; Søvold et al., 2021).

The relatively lower self-efficacy indicates that some respondents may lack confidence in their ability to perform specific tasks or handle complex responsibilities. This finding aligns with research suggesting that self-efficacy among healthcare workers can be influenced by task-specific experiences, autonomy, and supportive supervision (Chen et al., 2024; Da et al., 2020). Self-efficacy is considered a developable capacity, suggesting that targeted interventions such as structured training, mentorship, and positive feedback systems could strengthen this dimension (Kibler et al., 2024; Broetje et al., 2025). Enhancing self-efficacy may further bolster overall psychological capital and improve job performance, particularly for staff in high-stakes clinical departments.

Demographic and Occupational Differences

The significant differences observed across occupation, working years, age, sex, and income reinforce that work stress, burnout, and psychological capital are shaped by individual and organizational factors. Occupation emerged as one of the strongest determinants, with nurses, doctors, medical technologists, and administrative staff experiencing different stressor profiles and burnout risks. This pattern aligns with research demonstrating that frontline clinical staff face higher workload and emotional labor demands, while administrative personnel encounter more bureaucratic and resource-related stressors (Rink et al., 2023; Boudreau & Rhéaume, 2024). The strong influence of working years suggests that stress exposure and psychological resource development accumulate over time, with newer employees struggling with adaptation and role clarity, and experienced staff developing coping strategies but also facing cumulative stress (Lan et al., 2025; Kibler et al., 2024).

The significant differences by sex across multiple stress dimensions, though not for burnout or PsyCap, suggest that male and female healthcare workers may experience workplace stressors differently. This finding is consistent with research indicating that female workers often report higher emotional and relational stress due to greater expectations for caregiving and emotional labor (Fida et al., 2023). The influence of income and position on professional efficacy and burnout supports the Job Demands-Resources model, suggesting that access to resources and job control may protect against burnout (Bakker & De Vries, 2020).

Relationships Among Constructs

The strong positive associations between work stress and burnout dimensions, particularly emotional exhaustion and cynicism, confirm that occupational stress is a major contributor to burnout among healthcare workers (Abdel-Azeem et al., 2024). The weak or non-significant correlations between most stressors and professional efficacy suggest that employees' sense of competence may be less directly affected by stress levels alone, potentially buffered by other factors such as training, experience, or social support.

The significant negative associations between psychological capital and all burnout dimensions provide strong evidence for the protective role of PsyCap. Staff with higher self-efficacy, hope, resilience, and optimism consistently reported lower emotional exhaustion, cynicism, and overall burnout, consistent with meta-analytic findings (Zhou & Li, 2023; López-Núñez et al., 2020). The negative associations between work

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stress and psychological capital indicate that higher occupational stress is associated with diminished psychological resources, supporting the resource depletion perspective of COR theory (Nahum, 2024). These patterns suggest that psychological capital may function both as a buffer against stress-induced burnout and as a resource that can be eroded by prolonged stress exposure.

Implications

The findings carry several implications for hospital management and occupational health policy. First, interventions should address both organizational stressors (workload, career development pathways, administrative burden) and individual psychological resources. Second, tailored approaches are needed for different occupational groups and career stages, recognizing that nurses, physicians, and administrative staff face distinct challenges. Third, enhancing psychological capital—particularly self-efficacy—through structured training, mentorship, and supportive supervision may reduce burnout risk and improve staff well-being. Fourth, regular assessment of stress and burnout can help identify high-risk groups for targeted support.

Limitations

Several limitations should be considered. First, the cross-sectional design precludes causal inferences about relationships among variables. Second, data were collected through self-report measures, which may be subject to social desirability and common method bias. Third, the sample, though diverse, was drawn from eight hospitals in specific regions of China, limiting generalizability to other healthcare settings or countries. Fourth, the study did not examine organizational-level factors such as leadership, team climate, or specific policy contexts that may influence stress and burnout. Fifth, the proposed intervention program has not been implemented or evaluated; its effectiveness remains to be tested.

5. Conclusion and Recommendations

5.1 Conclusion

Based on the findings of this study, the following conclusions are drawn:

1. Hospital employees in Chinese public tertiary hospitals represent a diverse workforce across departments, sex, age, occupation, work experience, and income. The sample was predominantly female, mid-career, nurse-dominated, and composed of rank-and-file staff without formal administrative positions, reflecting the broader composition of hospital workforces.

2. Respondents reported above-median work stress, with career development concerns, workload pressures, and social identity issues constituting the most prominent stressors. Despite elevated stress levels, overall occupational burnout was low, characterized by very low emotional exhaustion and cynicism and low professional efficacy. Psychological capital was moderate to above median, with hope, resilience, and optimism exceeding the median while self-efficacy fell slightly below. This pattern suggests that hospital staff possess meaningful psychological resources that may buffer against stress and burnout, though confidence in task-specific abilities represents an area for development.

3. Significant differences in work stress, occupational burnout, and psychological capital were observed across occupation, working years, age, sex, and income, while formal position showed limited effects. Occupation and work experience exerted the strongest influence on all three constructs, indicating that job role and career stage are critical determinants of occupational health outcomes.

4. Work stress was positively associated with burnout, particularly with emotional exhaustion and cynicism. Psychological capital was negatively associated with both work stress and burnout across all dimensions. These relationships suggest that higher occupational stress is linked to greater burnout, while stronger psychological resources are associated with reduced stress and burnout vulnerability.

5. The protective role of psychological capital in mitigating work stress and burnout supports the development of targeted

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interventions. Strengthening self-efficacy, hope, resilience, and optimism may enhance hospital staff capacity to manage occupational demands and sustain psychological well-being.

6. An Integrated Occupational Stress Reduction Program, combining psychoeducation, skills-based training, work organization strategies, communication effectiveness training, resilience building, work-life balance promotion, and peer support, is proposed as an evidence-informed approach to reducing occupational stress and enhancing psychological resources among hospital employees.

5.2 Recommendations

Practical Recommendations

1. Hospital administrators and human resource departments may implement the Integrated Occupational Stress Reduction Program to enhance psychological capital and reduce occupational stress among staff. Program components should be tailored to address the specific stressor profiles of different occupational groups and career stages.

2. Targeted interventions should be developed for high-stress groups identified in this study, including staff in high-intensity departments (emergency, ICU, dialysis), early-career employees struggling with adaptation, and mid-career professionals facing career development concerns.

3. Career development pathways should be strengthened through transparent promotion criteria, continuing education opportunities, mentorship programs, and clear performance feedback to address the high levels of career development stress observed.

4. Workload management strategies, including staffing optimization, flexible scheduling, task redistribution, and adequate recovery time, should be prioritized to reduce workload stress, particularly for nurses and frontline clinical staff.

5. Recognition programs, team-building activities, and supportive leadership practices should be implemented to strengthen professional identity and reduce social identity crisis among hospital employees.

6. Work-life balance policies, such as childcare support, mental health leave, and flexible work arrangements, should be considered to address work-family conflict, particularly for staff with family responsibilities.

7. Regular assessment of work stress, burnout, and psychological capital should be conducted to identify emerging concerns and evaluate the effectiveness of interventions. Anonymous surveys and feedback mechanisms can support early identification of high-risk groups.

Future Researchers

1. Future studies should employ longitudinal designs to examine causal relationships among work stress, burnout, and psychological capital, and to assess how these constructs evolve over time and in response to interventions.

2. The proposed Integrated Occupational Stress Reduction Program should be implemented and rigorously evaluated using randomized controlled trials or quasi-experimental designs to establish its effectiveness in reducing stress and burnout and enhancing psychological capital.

3. Research should examine organizational-level factors not included in this study, such as leadership styles, team climate, organizational culture, and specific policy contexts, to better understand their influence on staff well-being.

4. Comparative studies across different healthcare settings (public versus private hospitals, urban versus rural, tertiary versus secondary facilities) and across countries would enhance understanding of contextual influences on stress, burnout, and psychological capital.

5. Qualitative research methods, including interviews and focus groups, could provide deeper insight into the lived

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experiences of hospital staff and the mechanisms through which psychological capital buffers against stress and burnout.

6. Intervention studies should explore the effectiveness of specific PsyCap dimensions (e.g., self-efficacy training, resilience workshops, hope-based goal setting) to identify the most potent components for different occupational groups.

7. The psychometric properties of the measures used in this study should be further validated across diverse healthcare populations, and culturally adapted instruments should continue to be refined for the Chinese context.

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7. Tables

Table 1. Respondent's Demographic Profile (n=480)

Profile		
	f	**%**
Sex		
Female	368	76.70%
Male	112	23.30%
Age		
20 – 25 years old	83	17.30%
26 – 30 years old	100	20.80%
31 – 40 years old	203	42.30%
41 – 50 years old	82	17.10%
51-60years	12	2.50%
Occupation		
Administration	33	6.90%
Doctor	111	23.10%
Medical technology	60	12.50%
Nurse	276	57.50%
Marital Status		
Married	321	66.90%
Unmarried	148	30.80%
divorced	11	2.30%
Working Years		
Less than 1 year;	24	5.00%
1-3 years	85	17.70%
4-5 years	37	7.70%
6-10 years	95	19.80%
11-20 years	174	36.30%
Over 20 years	65	13.50%
Monthly Income		
Below 3000 RMB	66	13.80%
3000-5000 RMB	181	37.70%
5000-7000 RMB	121	25.20%
7000-10000 RMB	72	15.00%
10000-20000 RMB	35	7.30%
Over 20000 RMB	5	1.00%
Position		
Chief Physician	2	0.40%
Associate Chief Physician	4	0.80%
Attending Physician	10	2.10%
Charge Nurse	11	2.30%
Deputy Director	14	2.90%
Deputy head nurse	5	1.00%
Director	14	2.90%
None	420	87.50%

Table 2. Respondent's Demographic Profile by Hospital Department **(**n=480)

Department		
	f	%
Obstetrics and Gynecology	8	1.70%
General Practice	10	2.10%
Dermatoscopy Department	1	0.20%
Reproductive Medicine Department	1	0.20%
Internal medicine	5	1.00%
Radiology department	12	2.50%

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Pediatrics	4	0.80%
Psychiatry	2	0.40%
Ophthalmology	9	1.90%
Department of Tculosis	1	0.20%
General surgery	4	0.80%
Blood Dialysis Room	35	7.30%
Rehabilitation Department	2	0.40%
ICU	4	0.80%
Geriatric medicine	3	0.60%
Department of Respiratory Medicine	24	5.00%
Department of Electrophysiology	1	0.20%
Cardiology department	28	5.80%
Cardiothoracic surgery	4	0.80%
Orthopedics	15	3.10%
Pathology	11	2.30%
Anesthesiology	5	1.00%
Surgery	10	2.10%
Gynecology	1	0.20%
Oncology Department	7	1.50%
Dermatology	9	1.90%
Ultrasound Department	1	0.20%
Department of Nuclear Medicine	1	0.20%
Emergency department	31	6.50%
Emergency Department	1	0.20%
Department of Neurology	30	6.30%
Proctology	5	1.00%
Department of Nursing	3	0.60%
The Principal's Office	2	0.40%
Quality control department	3	0.60%
Information Department	6	1.30%
Public Health Department	5	1.00%
Department of Medical Affairs	11	2.30%
Hepatobiliary Surgery	6	1.30%
Department of Nephrology	25	5.20%
Trauma center	1	0.20%
Student Affairs Department	2	0.40%
Administration	2	0.40%
Spinal surgery	4	0.80%
Discipline Inspection Office	1	0.20%
Laboratory Department	49	10.20%
Endocrinology	2	0.40%
Urology	7	1.50%
Department of Thyroid and Breast	1	0.20%
Critical Care Medicine	7	1.50%
Sleep medicine	2	0.40%
Interventional Radiology	3	0.60%
Department of Plastic Surgery	1	0.20%
Personnel Department	1	0.20%
Neurosurgery	10	2.10%
RICU	10	2.10%
Operating room	4	0.80%
Burn unit	2	0.40%

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Department of Gastroenterology	1	0.20%
Pain Clinic	8	1.70%
Hematology Department	4	0.80%
Department of Traditional Chinese Medicine	7	1.50%
Icu	1	0.20%
Rheumatology and Immunology Department	3	0.60%
NUCU	1	0.20%

Table 3. Respondent's Work Stress (n=480)

Subscale	Mean	Md	Stdev	Rank	Interpretation
Workload Stress	2.82	2.75	0.923	2	Above Median
Patient Relations Stress	2.58	2.50	0.939	5	Above Median
Career Development Stress	2.83	2.75	1.05	1	Above Median
Administrative Stress	2.5	2.5	0.958	6	Average
Insufficient Resources	2.38	2.25	0.921	7	Above Median
Work-Family Conflict	2.59	2.33	1.034	4	Above Median
Healthcare Adaptation Stress	2.12	2.00	0.905	9	Above Median
Social Identity Crisis	2.62	2.67	1.071	3	Below Median
Emergency Response Stress	2.17	2.	0.938	8	Above Median
OVERALL	**2.51**	**2.45**	**0.848**		**Above Median**

Table 4. Respondents Level of Occupational Burnout **(**n=480)

Subscale	Mean	Rank	Interpretation
Emotional Exhaustion	11.27	2	Very Low
Cynicism	9.03	3	Very Low
Professional Efficacy	15.91	1	Low
BURNOUT	36.21		Low

Subscale: 6 -11 (Very Low), 12 – 17 (low), 18 – 23 (Moderate), 24 – 29 (High), 30-36 (Very High)

Table 5. Respondents Psychological Capital **(**n=480)

Subscale	Mean	Md	Stdev	Rank	Interpretation
Self-Efficacy	25.44	26	6.677	1	Below Median
Hope	24.24	24	5.977	2	Above Median
Resilience	23.24	23	5.053	4	Above Median
Optimism	23.39	23	5.259	3	Above Median
PSYCAP	4.01	3.98	0.861		Above Median / Medium

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Table 6. Differences in Respondents Work Stress when compared according to Profile (n=480)

	U|H	p-value	Interpretation
Sex			
Workload Stress	17384	0.012	Significant
Patient Relations Stress	16962	0.004	Significant
Career Development Stress	17821	0.03	Significant
Administrative Stress	17601	0.019	Significant
Insufficient Resources	16694	0.002	Significant
Healthcare Adaptation Stress	17413	0.012	Significant
Social Identity Crisis	16532	0.001	Significant
Emergency Response Stress	17732	0.024	Significant
OVERALL	16940	0.004	Significant
Age			
Workload Stress	12.05	0.017	Significant
Patient Relations Stress	10.15	0.038	Significant
Career Development Stress	28.85	<.001	Significant
Social Identity Crisis	10.4	0.034	Significant
Occupation			
Workload Stress	21.38	<.001	Significant
Patient Relations Stress	16.13	0.001	Significant
Career Development Stress	29.06	<.001	Significant
Administrative Stress	30.75	<.001	Significant
Insufficient Resources	26.88	<.001	Significant
Work-Family Conflict	15.97	0.001	Significant
Healthcare Adaptation Stress	16.68	<.001	Significant
Social Identity Crisis	23.87	<.001	Significant
Emergency Response Stress	13.7	0.003	Significant
OVERALL	25.85	<.001	Significant
Marital Status			
Career Development Stress	17.96	<.001	Significant
Administrative Stress	7.02	0.03	Significant
Work-Family Conflict	7.43	0.024	Significant
OVERALL	6.2	0.045	Significant
Working Years			
Patient Relations Stress	14.92	0.011	Significant
Career Development Stress	27.13	<.001	Significant
Administrative Stress	11.49	0.042	Significant
Insufficient Resources	13.09	0.023	Significant
Healthcare Adaptation Stress	11.78	0.038	Significant
Social Identity Crisis	12.74	0.026	Significant
OVERALL	13.41	0.02	Significant
Monthly Income			
Career Development Stress	25.92	<.001	Significant
Administrative Stress	20.38	0.001	Significant
Insufficient Resources	23.9	<.001	Significant
Social Identity Crisis	14.67	0.012	Significant
Emergency Response Stress	13.87	0.016	Significant
OVERALL	15.71	0.008	Significant
Position			
OVERALL	4.92	0.67	Not Significant

Legend: Significant at p-value < 0.05.

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Table 7. Differences on the Respondents Burnout when grouped according to Profile (n=480)

	Emotional Exhaustion			**Cynicism**			**Professional Efficacy**			**BURNOUT**		
	t|F	p-value	Int.	t|F	p-value	Int.	t|F	p-value	Int.	t|F	p-value	Int.
Sex	19025	0.22	NS	19882	0.57	NS	19968	0.618	NS	19828	0.544	NS
Age	2.56	0.64	NS	3.06	0.55	NS	42.5	<.001	S	15.58	0.004	S
Occupation	10.1	0.02	S	9.24	0.03	S	19.04	<.001	S	13.71	0.003	S
Marital Status	4.04	0.13	NS	2.4	0.3	NS	18.23	<.001	S	9.26	0.01	S
Working Years	9.64	0.09	NS	20.1	0	S	41.76	<.001	S	32.04	<.001	S
Monthly Income	4.23	0.52	NS	2	0.85	NS	25.2	<.001	S	6.64	0.249	NS
Position	4.48	0.72	NS	5.1	0.65	NS	20.67	0.004	S	15.39	0.031	S

Legend: Significant at <0.05 alpha level. S – significant, NS – Not Significant

Table 8. Differences on the Respondents Psychological Capital when grouped according to Profile (n=480)

	Self efficacy		Hope		Resilience		Optimism		PSYCAP	
	t|F	p-value	t|F	p-value	t|F	p-value	t|F	p-value	t|F	p-value
Sex	20533	0.954	19871	0.566	18671	0.13	20077	0.678	19657	0.459
Age	24	<.001	22.22	<.001	13.61	0.009	13.06	0.011	21.05	<.001
Occupation	15.33	0.002	9.31	0.025	4.45	0.217	11.96	0.008	11.99	0.007
Marital Status	5.84	0.054	3.15	0.207	6.39	0.041	1.64	0.44	4.45	0.108
Working Years	27.57	<.001	29.79	<.001	31.66	<.001	21.85	<.001	32.72	<.001
Monthly Income	15.29	0.009	14.74	0.012	8.42	0.134	9.66	0.085	12.35	0.03
Position	16.06	0.025	12.78	0.078	14.55	0.042	15.62	0.029	16.27	0.023

Legend: Those with underline is considered significant.

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Table 9. Relationship of the Respondent's Burnout to Work Stress and Psychological Capital (n=480)

	Emotional Exhaustion			Cynicism			Professional Efficacy			BURNOUT		
	rho	p-value	Int.	rho	p-value	Int.	rho	p-value	Int.	rho	p-value	Int.
Workload Stress	0.735	<.001	HS	0.582	<.001	HS	-0.06	0.193	NS	0.499	<.001	HS
Patient Relations Stress	0.651	<.001	HS	0.561	<.001	HS	0.024	0.594	NS	0.488	<.001	HS
Career Development Stress	0.635	<.001	HS	0.543	<.001	HS	-0.064	0.161	NS	0.442	<.001	HS
Administrative Stress	0.733	<.001	HS	0.638	<.001	HS	0.017	0.708	NS	0.557	<.001	HS
Insufficient Resources	0.703	<.001	HS	0.618	<.001	HS	0.025	0.581	NS	0.54	<.001	HS
Work-Family Conflict	0.754	<.001	HS	0.643	<.001	HS	0.007	0.874	NS	0.565	<.001	HS
Healthcare Adaptation Stress	0.584	<.001	HS	0.567	<.001	HS	0.18	<.001	HS	0.548	<.001	HS
Social Identity Crisis	0.717	<.001	HS	0.645	<.001	HS	0.007	0.874	NS	0.543	<.001	HS
Emergency Response Stress	0.614	<.001	HS	0.599	<.001	HS	0.149	0.001	HS	0.553	<.001	HS
OVERALL	0.787	<.001	HS	0.691	<.001	HS	0.029	0.526	NS	0.607	<.001	HS
Self-efficacy	-0.465	<.001	HS	-0.548	<.001	HS	-0.428	<.001	HS	-0.617	<.001	HS
Hope	-0.53	<.001	HS	-0.599	<.001	HS	-0.429	<.001	HS	-0.671	<.001	HS
Resilience	-0.482	<.001	HS	-0.59	<.001	HS	-0.46	<.001	HS	-0.672	<.001	HS
Optimism	-0.442	<.001	HS	-0.555	<.001	HS	-0.513	<.001	HS	-0.668	<.001	HS
Psychological Capital	-0.526	<.001	HS	-0.631	<.001	HS	-0.506	<.001	HS	-0.723	<.001	HS

Legend: Significant at <0.05 alpha level. S – significant, NS – Not Significant

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Table 10. Relationship with the Respondent's Work Stress to Psychological Capital (n=480)

	Self-efficacy		Hope		Resilience		Optimism		PSYCAP	
	rho	p-value	rho	p-value	rho	p-value	rho	p-value	rho	p-value
Workload Stress	**-0.33**	**<.001**	**-0.391**	**<.001**	**-0.365**	**<.001**	**-0.329**	**<.001**	**-0.389**	**<.001**
Patient Relations Stress	**-0.36**	**<.001**	**-0.404**	**<.001**	**-0.406**	**<.001**	**-0.391**	**<.001**	**-0.43**	**<.001**
Career Development Stress	**-0.306**	**<.001**	**-0.377**	**<.001**	**-0.368**	**<.001**	**-0.331**	**<.001**	**-0.376**	**<.001**
Administrative Stress	**-0.358**	**<.001**	**-0.408**	**<.001**	**-0.417**	**<.001**	**-0.356**	**<.001**	**-0.422**	**<.001**
Insufficient Resources	**-0.34**	**<.001**	**-0.4**	**<.001**	**-0.394**	**<.001**	**-0.357**	**<.001**	**-0.408**	**<.001**
Work-Family Conflict	**-0.373**	**<.001**	**-0.434**	**<.001**	**-0.43**	**<.001**	**-0.385**	**<.001**	**-0.447**	**<.001**
Healthcare Adaptation Stress	**-0.4**	**<.001**	**-0.436**	**<.001**	**-0.384**	**<.001**	**-0.408**	**<.001**	**-0.448**	**<.001**
Social Identity Crisis	**-0.389**	**<.001**	**-0.461**	**<.001**	**-0.427**	**<.001**	**-0.386**	**<.001**	**-0.461**	**<.001**
Emergency Response Stress	**-0.403**	**<.001**	**-0.448**	**<.001**	**-0.437**	**<.001**	**-0.423**	**<.001**	**-0.465**	**<.001**
OVERALL	**-0.411**	**<.001**	**-0.475**	**<.001**	**-0.461**	**<.001**	**-0.427**	**<.001**	**-0.487**	**<.001**

Legend: those with underline is considered significant

Table 11.

Proposed Intervention Program for Reducing Overall Occupational Stress

Key Results Area	Objectives	Strategies / Activities	Persons Responsible	Evaluation
Above Median Overall Occupational Stress	To reduce overall occupational stress among hospital employees by addressing key sources of work pressure	Integrated Occupational Stress Reduction Program which will include psychoeducation on stress, coping skills training, work organization and efficiency, communication and interpersonal effectiveness, resilience building, work–life balance promotion, peer support and group reflection	Hospital employees, HR, hospital administrators, clinical psychologists, occupational health unit	Reduced overall stress scores (pre/post assessments), improved coping and well-being, positive participant feedback, sustained engagement