CHAPTER 3

BURNOUT

With reference to chapter 1, section 1.7.1, the aim of this chapter is to conceptualise and integrate the existing literature on burnout, with special emphasis on burnout in the medical occupation.

In this chapter, a history of the burnout concept will first be presented, followed by discussion of the definitions and models of burnout. Hereafter, the dynamics of burnout, namely discussions surrounding the aetiology, symptoms, outcomes and management interventions of burnout in general and in the medical profession will be included. The chapter will conclude with an integration of the literature findings.

3.1 HISTORY OF THE CONCEPT "BURNOUT"

Burnout is a concept of enduring value that improves our understanding of the working world of many professionals. Farber (1983a, p. 1) states that burnout is more than a "hot topic"; it is a serious issue that affects the welfare of millions of human service workers and their tens of millions of clients and patients.

Almost four decades have passed since the inception of the burnout concept (Maslach & Jackson, 1981). In this period, there has been an extensive accumulation of empirical and clinical literature on the burnout concept.

A pioneer in the field, Freudenberger, first brought the concept of burnout to professional and public awareness in 1973 (Freudenberger, 1974). He coined the term "burnout" to describe a particular state of emotional and physical exhaustion. Working as a psychiatrist in an alternative health care agency, Freudenberger observed, "that over time, we began to note significant changes in mood, attitude, motivation and personality among the volunteers" Freudenberger (1989, p. 1).

At about the same time, Maslach (1978), a social psychology researcher, was studying the ways people cope with emotional arousal in a work context and was especially concerned with cognitive strategies such as “detached concern”(the medical profession’s ideal of blending compassion with emotional distance) and “dehumanisation is self-defence” (the process of protecting oneself from over-whelming emotional feelings by responding to other people more as objects than persons in the medical profession) (Schaufeli, Enzmann, & Girault, 1993). From this interest, Maslach (1982a) soon discovered that both the emotional arousal and the cognitive strategies had important implications for people’s professional identity, job and coping behaviour.

Central to Maslach’s 1978 view and Freudenberger’s 1974 view, which are still accepted as the most popular perspectives, is the emotional and demanding nature of the professional–recipient relationship as a root cause of burnout (Van Dierendonck, Schaufeli & Sixma, 1994, p. 95).

Farber (1983a, p. 8) expresses that the clinical approach of Freudenberger (1974) and the empirical approach of Maslach (1982) and Pines (1988) complement each other well. The findings, based on each perspective, are mutually corroborative and have generated a wealth of data and insights into the phenomenon of burnout. This led to the second stage of the development of the burnout concept, which was characterised by empirical research and theoretical development.

3.2 DEFINITION OF BURNOUT

To date, there are various definitions of burnout. Whilst each has contributed to the understanding of the burnout phenomenon, this lack of clarity and consensus has been the greatest limitation in the advancement of sound empirical testing at the theoretical and methodological levels. According to Beemsterboer and Baum (1984, p. 97), the understanding of burnout is hindered by the lack of a single operational definition and a clear set of criteria; it has become a catch–all expression which includes a variety of conditions and symptoms ranging from influenza to depression. Starrin, Larsson and Styrborne, (1990, p. 84) confirm, “it

is possibly easier to agree on a common description of burnout than a common definition of it."

The popular definitions which have contributed to the understanding of burnout assert the following:

- Burnout is a process that begins with excessive and prolonged levels of job tension, whereby the stress produces strain in the worker (feelings of tension, irritability and fatigue). The process is completed when the workers defensively cope with the job stress by psychologically detaching themselves from the job and becoming apathetic, cynical and rigid (Cherniss, 1994 in Ray, Nichols & Perritt, 1987).

- The burnout process is a "state of physical and emotional depletion resulting from conditions of work and the striving to reach some unrealistic expectation imposed by oneself or by the values of society" (Freeudenberger & Richelson, 1980 in Farber 1983a, p. 2).

- Burnout is " a progressive loss of idealism, energy and purpose experienced by people in the helping professions as a result of their work conditions" (Edelwich & Brodsky, 1980, p. 166 in Beemsterboer & Baum, 1984).

- Burnout is " a state of physical, emotional and mental exhaustion caused by a long-term involvement in situations that are emotionally demanding" (Pines & Aronson, 1988, pp 11-13).

The above definitions vary from each other in terms of scope and precision, yet each has uniquely contributed to the understanding of burnout. Maslach (1982a, p. 31) reiterates this by stating the following: "Some definitions are limited while others are more wide-ranging. Some are precise while others are global. Some refer to a purely psychological condition while others include actual behaviours. Some describe a state or a syndrome while others talk of a process. Some make

references to causes, others to effects, some emphasise the person variables and others environment variables."

Despite this chaos on a definition level, the different definitions do share certain similarities regarding key features of the phenomenon. There is general agreement that burnout (Carroll & White, 1982; Jackson, 1982 in Freudenberger, 1989, p. 3; Maslach, 1982a, 1982b; Ratliff, 1988, p. 147; Schaufeli et al, 1993; Starrin et al 1990, p. 86)

- occurs at an individual or agency level
- is an internal psychological experience involving feelings, attitudes, motives and expectations
- concerns problems, distress, discomfort and dysfunction
- is perceived by the individual as a negative experience
- symptoms manifest themselves in "normal" people who did not suffer from psychopathology before
- results in negative consequences
- leads to decreased effectiveness and work performance

Maslach and Jackson's (1981a, 1981b, 1984a, 1986 cited in Schaufeli et al, 1993, p. 20) tripartite definition of burnout is accepted across the literature as most comprehensive and will be used for the purpose of this study. They define burnout as "a psychological syndrome of emotional exhaustion, depersonalisation, and reduced personal accomplishment that can occur among individuals who work with other people in some capacity. Emotional exhaustion refers to feelings of being emotionally overextended and depleted of one's emotional resources. Depersonalisation refers to a negative, callous, or excessively detached response to other people, who are usually the recipients of one's service or care. Reduced personal accomplishment refers to a decline in one's feelings of competence and successful achievement in one's work" (Schaufeli et al, 1993, pp. 20-21).

3.3 MODELS OF BURNOUT

Perlman and Hartman (1981, p. 11) state that models of burnout serve the important functions of structuring burnout research, providing a basis for variables to study and attempting to predict who will burn out.

Over the years, different theorist have advocated models, emphasising different aspects of the burnout phenomenon. Harrison (1983), for instance, proposes a social competence model of burnout, focusing on the fundamental need of workers to perceive themselves as competent in their roles. Fischer (1983) employs a psychodynamic perspective to explain the burnout syndrome, pointing out specific characterological structures, tendencies and resistances of burned out workers. Heifetz and Bersani (1983) suggest that burnout among human service workers is best conceptualised within a cybernetic model, emphasising the critical role of feedback in professionals' pursuit of client growth and their own professional development. Other theorists have advanced the deficit model of burnout, which suggests that burnout is caused not by the presence of job stressors, but rather by the absence of job motivators. Thus, models of burnout have progressed from focus on intrapsychic features and discrete environmental stressors, to complex conceptual formulations that emphasise the role of mediation processes and the interactive nature of individual, organisational and social variables (Farber, 1983a, p. 245).

According to Paine (1982b, p. 15), for a model to be comprehensive, it must incorporate the following seven levels of analysis: individual, work groups or teams, organisational subunits, entire organisations, industries, professions and countries, and cultures. Three comprehensive models formulated by Perlman and Hartman (1981), Carroll and White (1982) and Maslach and Jackson (1981) attempt to incorporate these levels of analysis, and have gained wide recognition and acceptance in assuming a transactional perspective of burnout. Whilst not identical, these models converge various views into a more dynamic and systemic perspective as they consider the interaction of multiple factors resulting in the burnout effect.

3.3.1 Interactional models of burnout

The interactional perspective of burnout has its roots in the transactional conceptualisation of stress (see chap. 2, sec. 2.3.3.5). This model imaging the transactional stress model emphasises the interaction of individual, organisational and societal factors in understanding burnout (see fig 3.1).

According to Perlman and Hartman (1981), burnout is the result of a complex transaction between individual needs and resources and differing demands in the individual's immediate environment. Their model has a cognitive/perceptual focus which identifies personal and organisational variables and which may be related to burnout. Perlman and Hartman (1981, p. 12), claim their model is broad and includes almost all variables which have been studied in burnout research. Based on content analysis and a synthesis of all the definitions of burnout, Perlman and Hartman (1981, p. 6), propose a definition of burnout comprising its underlying prime dimensions. This leads to a definition of burnout as a response to chronic emotional stress with three main components:

- emotional and/or physical exhaustion
- lowered job productivity
- over-depersonalisation

In this model, the three dimensions of burnout reflect the three major symptom categories of stress: physiological (focusing on physical symptoms [physical exhaustion], affective-cognitive (focusing on attitudes and feelings [emotional exhaustion, over-depersonalisation]), and behavioural (focusing on symptomatic behaviours [overdepersonalisation, lowered job productivity]).

According to this model, individual characteristics, and work and social environments are important for the perception and impact of stress (burnout) with effective or ineffective coping influencing this.

The model contains four stages (see fig. 3.1):

- Stage one involves the degree to which a situation is conducive to stress. Stress results and depends, on the person's skills and abilities to meet the perceived or real demands. Perlman and Hartman (1981, p. 12) add that stress is likely when inadequate fit exists between the personal and work environment.

- Stage two involves the perceived stress and is dependent on a person's background and personality, as well as role and organisation variables. This stage has salutogenic implications because many situations conducive to stress do not necessarily result in people perceiving themselves as stressful.

- Stage three represents the three major categories of response to stress which could be physiological, affective/cognitive or behavioural.

- Stage four depicts the outcomes of stress. Burnout, as a multifaceted experience of chronic, emotional stress is placed in this stage.

The above four stages, represent the interaction of multiple factors in the explanation of the burnout phenomenon.

3.3.2 An ecological model for the analysis of burnout

Ecology concerns the interrelationships of organisms and their environments or ecosystems (Carroll & White, 1982, p. 41). This perspective advocates that in order to understand the multiple and complex roots of burnout, we have to focus on the person, his or her ecosystems and the reciprocal impact each have on the other. According to these authors, burnout occurs whenever a person with inadequate stress management and need-gratifying skills must work in a stressful and need-frustrating work environment. The dynamic interaction of personal variables (eg poor physical and emotional health) and environmental variables (eg poor supervision, excessive case load) which also includes the influence of other

ecosystems (eg family) generates burnout. According to Carroll and White (1982), this interaction can be expressed by the following formula:

BO = f (P X E)

Carroll and White (1982, p. 47) depict the individual's work environment and larger life space as containing the following two key components:

- P = the person. It is important to note that anything and everything can influence a person's work performance and must, therefore, be considered and evaluated. Carroll and White (1982, p. 48) mention physical and mental health status; the amount of education and training completed; and the person's coping skills, frustration tolerance, goals, needs, interests and values as some of the variables affecting individuals.

- E = Environmental components. A person's total environment is made up of the following four environments:

- *Microsystems,* which refer to the smallest organised ecosystem within which the person performs most of his or her work (eg the office, the home, or the assemblyline station).

- *Mesosystems,* which refer to the next highest level of organisation of the work environment. It includes all the microsystems that together form a larger whole (eg all the offices and departments of an organisation).

- *Exosystems,* which involve those nonwork elements of the larger environment that directly and frequently impact on the worker and his or her company's or institution's operations (eg surrounding community, legislators, regulatory agencies, his or her family).

- *Macrosystems,* which encompass all the other elements affecting the individual's life beyond the exosystem. These elements are more distant and

global in nature. Carroll and White (1982, p. 48) informs, that the influence of the macrosystem is often experienced more indirectly, although not necessarily less powerfully than the other three components of the life space, and include factors such as high interest rates, high unemployment, racial and sexual prejudice, and natural disasters.

This model, according to Carroll and White (1982, p. 47), reflects the complex, dynamic interactive, reciprocal impact of personal and environmental variables that result in burnout. The emphasis on this model is on the uniqueness of the burnout phenomena, as this model reveals that no two individuals can possibly experience burnout in quite the same way. This model also has implications for a multi-disciplinary approach to the study of burnout. In this regard, the ecological approach to burnout requires that interventions be multi-faceted and be aimed at individual and environmental issues.

3.3.3 The multidimensional nature of burnout

Theorists have moved away from viewing burnout in a unidimensional context, as updated research findings lend support for conceptualising burnout as a multidimensional construct, which, when measured, cannot be summed into an overall burnout "score" (Maslach & Jackson, 1981; Perlman & Hartman, 1981, p. 6). This multidimensional view of burnout reiterates that burnout should not be viewed as a static state, but rather as a dynamic process.

Based on years of exploratory research in a variety of "people-oriented" professions, Maslach and Jackson (1981) have developed a three component model of burnout which is presently accepted as the most comprehensive model in research testing.

Further to their operational tri-component definition of burnout (mentioned in section 3.2), these authors have developed a diagnostic instrument - the Maslach Burnout Inventory (MBI). This is a standardised questionnaire, used in individual assessment of burnout and has good psychometric properties (Maslach & Jackson, 1986). The properties of this inventory will be discussed in chapter 5.

The first dimension in this model is emotional exhaustion and can also be described as a wearing out, loss of energy, depletion, debilitation and fatigue (Maslach, 1982a, p. 32). This exhaustion in burnout refers to feelings of being emotionally overextended and is more emotional and psychological in nature than physical.

The second dimension is depersonalisation, which when broadly defined, refers to a negative shift in response to others and involves negative or inappropriate attitudes towards the recipients of one's service or care, loss of idealism and irritability (Maslach, 1982a).

Reduced personal accomplishment, the third dimension, refers to a decline in one's feelings of competence and successful achievement of one's work (Maslach, 1982a).

Just as there is a lack of consensus as to the definition of burnout, so too there is a lack of consensus as to the number and type of components/dimensions that comprise the burnout concept. Validation studies have supported Maslach's (1982) three factor model over the one and two factor models of burnout (Evans & Fischer; Gold et al; in Lee and Ashforth, 1990, p. 743).

In Leiter and Maslach's (1988) process model of burnout, emotional exhaustion occurs in the first stage of the burnout process and in response to excessive chronic work demands. This, in turn, brings about negative attitudes towards recipients (depersonalisation) as an attempt to gain emotional distance from them as a way coping with their exhaustion (Maslach, 1982). This, in turn, diminishes the worker's sense of personal accomplishment as the work loses its meaning (reduced personal accomplishment) (Van Dierendonck, Schaufeli & Sixma, 1994, p. 89).

Recent studies (Cordes & Dougherty, 1993; De Rijk, Le Blance, & Schaweli, 1988; Lee & Ashforth, 1996, p. 124) challenge the sequential developmental model and propose a mixed sequential and parallel development model. Research now indicates that both emotional exhaustion and personal accomplishment develop

either independently or in parallel with each other, rather than following from each other; these dimensions are reactions to different aspects of the work environment in human service work. These theorists also argue that personal accomplishment reflects a personality characteristic akin to self-efficacy, rather than a genuine component of burnout reaction.

The presentation of the above three models indicates that burnout is a complex multifaceted phenomenon and should be understood accordingly.

3.4 THE DYNAMICS OF BURNOUT

Professional burnout is a multidimensional phenomenon involving several individual and environmental variables in a complex interactive process (Rawnsley, 1989, p. 52). The following is a look at some conceptual complexities of the burnout process.

3.4.1 A clarification of the burnout and stress concepts

Burnout has come to be understood as a response set to stress and is often confused with and used interchangeably with the concept of stress. The following explanations attempts to clarify this.

3.4.1.1 Viewing burnout in terms of the general adapatation syndrome

According to Schaufeli et al (1993, p. 9), a relative distinction between burnout and stress can be made with respect to time.

If burnout represents a perceived substantial imbalance between demands and response capability under conditions where failure to meet demands is experienced as having important consequences (McGrath, 1976; Starrin et al, 1990, p. 87), then burnout can be considered as prolonged job stress, that is, demands at the workplace that tax or exceed an individual's resources. This is in keeping with the work of Seyle (1976), a pioneer in stress research. Seyle advocates that exposure to a stresssor leads to the general adaptation syndrome

consisting of three phases: alarm, resistance, and exhaustion. For Selye (1976), stress occurs when there is a substantial imbalance (perceived or real) between environmental demands and the response capability of the individual. In the final stage, the prolonged exposure to stress causes the physiological resources of the organism to become depleted, resulting in irreversible damage or burnout in this case. Similarly, building on Seyle's conceptualisation (1976), the transactional model of occupational stress (see chap. 2) defines work stress as the psychological state that is, or represents, an imbalance or mismatch between peoples' perceptions of the demands on them (relevant to work) and their ability to cope with those demands (Lazarus & Folkman, 1984b). When applying this principle, therefore, for burnout to occur, there has to be a break down in the adaptation to job stress.

Furthermore Schaufeli et al (1993, p. 10) add that "stress and burnout cannot be distinguished on the basis of their symptoms, but on the basis of the process". Other theorists also support the notion that burnout is a stress reaction (Perlman & Hartman, 1981, p. 10; Rogers, 1987, p. 105).

The transactional view of stress also highlights the crucial role of appraisal in coping. The process of appraisal takes into account the resources and supports available to the person for coping, the constraints placed on coping and on the person's control of the situation. Thus, appraisals of their situation may drive their coping behaviour and other more general responses, the success of which feed back into those appraisal processes. Cox and Leiter (1992) state that in addition to any consideration of its situational antecedents or cognitive and perceptual elements, the state of stress is often defined by the person's experience of negative emotion, unpleasantness and general discomfort, and in the slightly longer term by changes in general wellbeing. Feeling worn out, and possibly uptight and tense, may result not only from the experience of stress, but also from the effects of attempts at coping. At the same time, such feeling feeds back and partly determines the experience of, and response to, stress; burnout is thus a response set to stress.

Applying this interactive view of stress, the burnout concept can be seen to be a particular slice across the stress process. According to Cox, Kuk and Leiter (in Schaufeli,1993, p. 188), burnout is in the sense of this argument, a mixed bag of an appraisal outcome, an aspect of wellbeing and a coping strategy, but one that "hangs together" strongly for the helping professional.

3.4.1.2 Viewing burnout in terms of the stress-strain-coping model

The dimensional model of burnout can be understood in terms of the stress–strain–coping framework (Payne & Firth-Cozens, 1987). To illustrate this similarity, causes of burnout, such as role conflict and caseload, constitute sources of stress. Emotional exhaustion corresponds with the notion of strain as it has been linked to tension, anxiety, fatigue, insomnia and so on. Depersonalisation corresponds to the notion of coping, since through depersonalisation, the individual attempts to protect or defend himself or herself from further depleting his or her resources and hence, treats others as objects rather that people. Reduced personal accomplishment can be regarded as an outcome of the stress–strain–coping process. Personal accomplishment represents an aspect of self-efficacy and is thus linked to adjustment to demanding situations (Bandura, 1986 in Lee & Ashforth, 1990, p. 744).

3.4.1.3 Viewing burnout in terms of a conservation of resource model

The conservation of resource theory of stress provides another framework for understanding how such correlates are related to burnout (Hobfoll, 1989; Hobfoll & Freedy, 1983 in Lee & Ashforth, 1996, p. 123). This perspective suggests that burnout occurs when certain valued resources are lost, are inadequate to meet demands, or do not yield the anticipated returns. For example, the major demands of work refer to factors such as role stress, workload and lack of autonomy. The major resources include factors like social support, recognition, opportunities for career development (Cordes & Dougherty, 1993; Burke & Richardsen, 1993 in Lee & Ashforth, 1996, p. 123).

In encounters, the key decision for individuals is the number of resources they need to invest to meet demands and to protect themselves from further resource depletion. Strain occurs when the individual feels that he or she no longer has sufficient emotional resources to handle the interpersonal stressors and may adopt the defensive strategy of withdrawal (rather than engagement) through depersonalisation. The theory also proposes that certain behavioural and attitudinal outcomes are likely to occur as a result of resource loss; the most common one in helping professions is known as burnout (Hobfoll, 1989).

From the above explanations, it can be accepted that burnout and stress are conceptually different and that burnout is a product of the outcome of the stress process.

3.4.2 Burnout as a process

Whilst burnout is part of the stress process (see 3.4.1), this discussion is an attempt to reveal that burnout, in itself, is a process rather than a discrete event. It is a final step in a progression of unsuccessful attempts to cope with a variety of negative stress conditions (Farber, 1983b; Lemkau, Rafferty & Gordon, 1994, p. 682). Simply put, burnout should be viewed as a process that is initiated by stress and that develops over time. Bailey (1985, cited in Ellis, 1996a, p. 295) proposes the following four stages of burnout:

3.4.2.1 Idealistic enthusiasm

This is characterised by high energy, high ideals and a keen motivation to achieve these goals. This starts to give away towards the end of the first year of employment.

3.4.2.2 Stagnation

Here the employee starts to slow down and the energy levels become depleted. He or she begins to experience disappointment and personal needs are no longer satisfied entirely by the job; the honeymoon is over.

3.4.2.3 Frustration

The individual continually finds that he or she is unable to achieve the goals to which he or she aspired and was taught to pursue. He or she becomes frustrated at not being able to satisfy the needs of the patients and himself or herself. Patients and clients turn into enemies and are seen as bothersome.

3.4.2.4 Apathy

This is a sign of impoverished coping. A protective shell develops and the individual starts to live defensively. This stage is also characterised by cynicism and disillusionment.

These stages are a guide, since there is still disagreement about the number and sequencing of the components of burnout in the burnout process.

3.4.3 The aetiology of burnout

Just like the general theory of burnout, there is a lack of consensus about what produces burnout (Schaufeli et al, 1993). Initially, the main focus of burnout study revolved around the job factors and personal factors. These factors were initially studied in isolation. Today, theorists have realised that burnout should rather be seen as a combination of the work demands and one's personal coping resources (Varga, Urdaniz & Canti, 1996). This interactive approach to burnout has shifted the focus of blaming individuals to understanding the individual in a situational context. The following is a compilation of some major themes that are known to cause burnout:

3.4.3.1 Individual causes

Certain characteristics of an individual are shown to contribute to an explanation of why some individuals are more prone to burning out (Pines & Aronson, 1988). The following is a discussion of demographic, intrapersonal and interpersonal factors in burnout.

a Age

There is also mixed evidence with regards to age and burnout. Younger individuals consistently report higher levels of burnout (Maslach & Jackson, 1981), but other studies have found that more experienced employees reported lower levels of emotional exhaustion and depersonalisation (Cordes & Dougherty, 1993; Anderson & Iwanicki, 1984 cited in De Wet, 1998, p. 68; Maslach, 1982b). It is assumed that older professionals are more experienced, stable and mature, and probably have a more balanced perspective on life; this should render them less prone to burnout (Maslach, 1982b). The highest incidence of burnout is reported in junior doctors in the first year of medical practice because in the first year, one's expectations are often challenged, especially if these expectations are unrealistic (Schweitzer, 1994).

b Gender

Whilst some reports have found no significant relationship between gender and burnout other findings illustrate that men and women often report differences in levels of burnout (Cordes & Dougherty, 1993; Greenglass, Burke & Konarski, 1998).

Maslach (1982a in Starrin et al, 1990, p. 88) believes that although men and women are generally similar in their experience of burnout, there are some important differences. Women are known to experience more frequent and more intensive emotional exhaustion, while men get a more depersonalised attitude to people they are working with. These differences may reflect the traditional male and female sex role differences, whereby women are socialised to be more

emotionally oriented, more sociable and more sensitive than men who are supposed to be more rational, tough and emotionally insensitive (Ratcliff & Baum, 1990). This is further complicated by labour-market segregation in terms of sex roles, which often leave women in care giving roles. Eventually, this "double caring" role leaves women more susceptible to becoming emotionally exhausted (Greenglass, Burke & Konarski, 1998). Stress and depression have been shown to be generally higher in female junior doctors than male counterparts (Ellis, 1996b, p. 330). Pradhan and Misra (1995, p. 20), reports that female medical practitioners experience more burnout than their male counterparts.

c Marital status

There is a consistent finding that married individuals report lower levels of burnout than single individuals (Maslach, 1982a; Pines, 1988). Furthermore, research indicates that workers with young children exhibit less "emotional exhaustion" and "depersonalisation" than workers without young children, suggesting that children may provide a buffer against losing one's personal touch with patients. Families are often a source of emotional support and those with families are often older, more mature adults with realistic goals (Brownell & Dooley, 1981 in Farber, 1983, p. 17; Lemkau et al, 1994, p. 220; Maslach & Jackson,1981).

d Genetic endowment

Genetic endowment and congenital factors are also known to affect an individual's experience of burnout (Carroll and White, 1982, p. 49; Rogers, 1987, p. 94; Starrin et al, 1990, p. 86).

e Occupation

According to Farber (1983a), this concept of burnout has been used broadly to describe dysphoric feelings that may occur in almost any setting. Traditionally burnout was restricted to the human service's professions. Today, however, the borders have been extended to other types of professions including nonjob domains like parent burnout and marriage burnout. Pines (1988, p. 208) states

that “burnout is not merely an occupational hazard but rather can spill in all spheres of life that give people a sense of meaning.”

Beemsterboer and Baum (1984) advance that there is nothing inherent about “burnout” which would limit its effects to the human services, or any occupation for that matter, because any involvement with people is vulnerable to doubt, disillusionment and eventual loss of energy.

This extension of the burnout concept to other occupations and nonoccupational domains is controversial, because the popularly accepted dimensions as outlined by Maslach’s 1981 definition of burnout would not be applicable to all contexts. Many theorists (eg Schaufeli et al, 1993; Golembiewski & Munzenrider, 1988) question the meaning of the personal accomplishment and depersonalisation components of burnout in occupations that do not involve interaction with clients. Also, Farber (1983a, p. 13) states that restricting the definition of burnout to human service workers acknowledges the unique pressures of utilising one’s self as the “tool” in face–to–face work with needy, demanding, and often troubled clients.

On the methodological level, researchers are attempting to design instruments to measure burnout in different occupational settings. Leiter and Scaufelli (1996, p. 229-231) propose the new MBI–GS that is designed to measure burnout in occupations other than the human service sector. In the human service burnout, the focus is of distancing from the emotional demands of service provision. In general burnout, this subscale represents a distancing from engagement in the work itself, which the MBI–GS attempts to measure. Whilst research has found support for the validity of the scale through its consistency, further work is needed to consider its range of applicability, and to establish norms for various occupational groups.

The literature reports that burnout is a significant problem facing the occupation of medicine. McCranie and Brandsma (1988, p. 30) report the following: “While providing many rewards and satisfactions, the *practice of medicine* is increasingly recognised as also having many stressful aspects with potentially negative

consequences for physicians' health and well-being." McCue (1986) emphasises that physicians encounter stresses that are an intrinsic part of daily medical practice, including continually having to confront intensely emotional aspects of human experience (eg suffering, fear, sexuality and death), deal with difficult "problem" patients, and make serious clinical decisions on the basis of often conflicting, ambiguous, or incomplete information.

f Personality

The literature findings indicate that the personality of individuals may influence both the manifestation of burnout as well as one's predisposition to burnout (Cherniss, 1980b; Garden, 1989, p. 224; Welch, Madeiros & Tate, 1982).

Maslach (1978, p. 115) states: "What is emotionally painful for one staff person may not pose any special problems for the next." This statement can be explained from a salutogenic perspective, whereby burnout is not a general phenomenon specific to any particular setting; the sufficient cause may be sought among personal psychological factors. This is, however, not to undermine the importance of creating positive work environments.

Also Lazarus (1966) in his work in the field of psychological stress, claims that personality plays a vital role in the experience of stress and burnout. Carroll and White (1982, p. 46) caution that whilst this is true, there is no personality trait or personality configuration that, in and of itself, will cause an individual to burnout. It is possible, however, that certain personality characteristics may predispose and/or make someone more vulnerable to burnout.

The following section looks further at the relationship between burnout and personality.

3.4.3.2 A closer look at personality as a cause

Garden (1989, p. 230) correlates burnout scores and personality profiles across human services and nonhuman services samples. This analysis reveals that the

pattern of results is different for the personality types within each occupation, but similar for the personality types across the occupations. This indicates the potential importance of personality as an explanatory variable in burnout research.

a Is there a burnout personality type?

There is general consensus that burnout-prone individuals are empathic, sensitive, humane, dedicated, idealistic, and "people oriented," but also anxious, introverted, obsessive, overenthusiastic and susceptible to over-identification with others (Cherniss, 1980b; Edelwich & Brodsky, 1980; Freudenberger & Richelson, 1980 in Farber, 1983, p. 4; Pines et al, 1981). These theorists agree that people who go into the human service fields want to help others, sometimes desperately so, and thus may base their self-esteem too exclusively on the attainment of unrealistic, albeit humane, goals.

In general, these individuals are particularly sensitive to the needs of others and have a great empathy for the suffering of others. In accordance with Jungian theory of psychological types, human service professionals are "feeling types" instead of "thinking types" (Pines & Aronson, 1988).

Pines (1988) reiterates by adding that this "dedicatory ethic", combined with the emotional intensity of caring, makes the process of burnout almost inevitable.

Maslach (1982a, pp. 62-63) presents the following profile, based on research findings, of the person who is most likely to burnout:

> The burnout prone individual is, first of all, someone who is weak and unassertive in dealing with people. Such a person is submissive, anxious, and fearful of involvement and has difficulty in setting limits within the helping relationship. This person is often unable to exert control over a situation and will passively yield to its demands rather than actively limiting them to his or her capacity to give. It is easy for this person to become overburdened emotionally, and so the risk of emotional exhaustion is high. The burnout-prone individual is also someone who is impatient and intolerant. Such a

person will get easily angered and frustrated by any obstacles in his or her path and may have difficulty controlling any hostile impulses. He or she is likely to project these feelings onto clients and to treat them in more depersonalised and derogatory ways. Finally, the burnout-prone individual is someone who lacks self-confidence, has little ambition, and is more reserved and conventional. Such a person has neither a clearly defined set of goals nor the determination and self-assurance needed to achieve them. He or she acquiesces and adapts to the constraints of the situation, rather than confronting the challenges and being more forceful and enterprising. Faced with self-doubts this person tries to establish a sense of self-worth by winning the approval and acceptance of other people. In so doing the person may be so accommodating that he or she is overextended too often. This individual is more easily discouraged by difficulties and does not feel a sense of personal accomplishment and effectiveness in dealing with people.

Maslach (1982a) states that the above profile serves only as a guide as to who may be at risk, and cautions that possessing any one of the characteristics will not necessarily predispose you to burning out.

b Personality variables and burnout

The following is a discussion of the relationship between specific personality variables and burnout:

i Type A personality and burnout

Type A personality research (Glass, 1977 in Farber, 1983b, p. 4) also indicates that this aggressive, competitive, intense and moody class of individuals are prone to burnout, since they are more likely to be angered and stressed when they perceive their efforts to be unsuccessful than their type B counterparts. However, recent reports (Robbins, 1996) indicate that only the hostility and anger components may make one more susceptible to falling ill.

ii Salutogenic personality variables and burnout

From everyday experiences, it seems reasonable to say that some differentiating individual traits exist that would explain why some employees react more strongly than others to environmental stressors. The reason for this lies very much in the salutogenic explanation of coping. There is evidence that salutogenic personality constructs, such as sense of coherence (Antonovsky, 1987a), hardiness (Kobasa, 1979a), locus of control (Rotter, 1966) and learned resourcefulness (Rosenbaum, 1989) have negative correlation to burnout. Thus, the higher one scores on salutogenic constructs, the lower should be the experience of burnout. This relationship between salutogenic personality variables and burnout will be discussed in chapter 4.

Linked to autonomy, is the concept of control. Research indicates that a lack of control or an excessive need for control can lead to burnout (Latack, 1986 in Leiter, 1991). Individuals who feel helpless, constrained and powerless in their work are at risk of becoming burned out, as this real or perceived lack of control exacerbates the emotional pressure of caring (Maslach, 1982). Conversely, a need to control and a refusal to share or delegate power is characteristic of the authoritarian personality type. Freudenberger (1989) advances that the authoritarian person is particularly prone to burnout, because of his or her tendency to do everything and take on too much, and because of his or her tendency to overextend himself or herself.

Emotional control is another personality variable related to burnout. Frustration, failure, anger and irritation are common difficulties experienced in the work of the helping professional. Those who cannot deal constructively with these emotions often mis-direct their hostility at others in search of someone to blame; this becomes part of the depersonalisation process which is a core component of burnout (Maslach, 1982a). The ability to cope with fear, particularly fear of death and personal loss, is important for maintaining emotional stability in the helping profession. According to Maslach (1982a, p. 64), “failure to come to terms with fears often results in avoidance, denial, and ‘psychic numbing’, which feed into feelings of depersonalisation and consequently, burnout”.

Empathy is reported to be a crucial personality characteristics in the helping profession. Maslach (1982) suggests that the distinction between emotional empathy (the vicarious experience of a person's emotional turmoil) and cognitive empathy (understanding someone's problems and seeing them from his or her point of view) may have important implications for burnout. Maslach (1982) believes that, emotional empathy is a weakness in that it leaves one susceptible to emotional exhaustion and subsequent depersonalisation; cognitive empathy is recognised as less excitable and more psychologically detached thus having less difficulty in dealing with emotionally demanding situations.

iii Affectivity and burnout

Positive affectivity and negative affectivity can be defined as the predisposition to perceive events and individuals in a generally positive and enthusiastic or negative manner, respectively (Iverson, Olekalns, & Erwin, 1998, p. 4). Furthermore, these authors have discovered considerable evidence to indicate that negative affectivity will increase one's susceptibility to events that result in negative experiences or emotion and the rate at which stressors are reported, because people who score high on negative affectivity have

- a predisposition to interpret situations negatively
- an increased tendency to process information selectively that emphasises the negative aspects of the situation
- a decreased tendency to actively control the environment, as reflected by the use of lower direct coping strategies in stressful situations

iv Self-concept and burnout

Self concept – one's sense and evaluation of who one is - is a fundamental aspect of personality and is recognised as playing a crucial role in understanding an individual's wellbeing and behaviour, especially in the burnout process. If an individual has little faith and confidence in his or her own ability to meet the

challenges in a helping relationship, the challenges may become overwhelming (Maslach, 1982).

Self-esteem as a mediational variable in the burnout process has also been recognised (Farber, 1983b, p. 245; Rosse, Boss & Johnson, 1991). Self-esteem plays a role in the cause and consequence level of the burnout process, and is reported to be an important factor in predicting who will be more likely to develop burnout. The importance of rebuilding self-esteem as part of the rehabilitation of burned-out employees in the helping professions is noted. In this regard, Carroll and White (1982, p. 50) mention that the most damaging of all the dynamics associated with a negative self-concept, is the inability or refusal of the insecure human service provider to seek assistance from others. Therefore, when the demand of the job increases, the worker overextends himself or herself to meet the demand, resulting in burnout.

The research also indicates a link between self-efficacy and burnout. Bandura (1977, p. 1) defines self-efficacy as “people’s beliefs about their capacity to exercise control over events that affect their lives”. According to Bandura (1986, p. 399) by using these capacities, one can come to achieve a high level of self-efficacy in four ways: performance attainments, vicarious experiences, verbal persuasion and social influence, and psycholgocial state. Findings suggest that people with stronger perceived self-efficacy, experience less stress; since burnout is regarded as a stress reaction, this suggests a relationship between self-efficacy and burnout (Schaufelii et al, 1993).

v Flexibility and burnout

Flexibility is another personality trait that affects stress reaction. Khan and Rosenthal (1961 cited in Ratcliff 1988, p. 150) indicate that flexible people experience more stress associated with role conflict than more rigid people, because the more flexible people find it difficult to set limits and to say “no” to extra demands. However, these theorists discovered that people who are very rigid, display withdrawal, compulsivity and denial when coping with stress Thus,

although flexibility may make a person more susceptible to stress; flexibility may also allow the person to better cope with stress when it occurs.

vi The medical personality and burnout

Recent research indicates that there is a correlation between personality type and choosing a career in medicine, and a relationship between personality types and speciality choice (Ellis, 1996). Keeping in mind that these variables do not function in isolation, most data in the medical profession indicate personality differences as more important than background or situational variables in understanding differences in burnout in junior doctors (Lemkau et al, 1994; Lemkau, Purdy, & Rafferty, 1988, p. 688).

The following personal characteristics according to Ellis (1996a, p. 299) and McCranie and Brandsma (1988), are thought to be predisposing factors to burnout in the medical profession:

- feeling indispensable
- high levels of energy and high expectations of themselves
- poor delegators
- perfectionists
- overconscientious
- type A personalities
- the need to be in control and difficulty in asking for help
- fast consultation rates
- difficulty in saying no
- repressed feelings
- the need to be loved
- a fear of failure
- masking of vulnerabilities
- denial of problems

In accordance with the above, Gabbard and Menninger (1989 in Ellis, 1996, p. 299) state the following: "Up to 80% of doctors in general have been found to have compulsive personality traits and apart from perfectionistic and obsessive features, this trait consists of doubt, guilt and an exaggerated sense of responsibility."

While personality plays a central aetiological role in burnout, the contribution of environmental conditions (the job, the organisation and societal factors) must not be undermined. According to French and Caplan (1972 cited in Farber, 1983a, p. 4), how a person reacts to job stress is a function of both the stress encountered and individual personality type. It is the "goodness of fit" between job demands and personal abilities that determines the amount of stress experienced. What complicates the measurement and definition of stress is that individual perception of, and reaction to stress, is a subjective matter and varies significantly from person to person. Keeping in mind that the main focus of this research is the relationship between burnout and personality variables, the author is of the opinion that social and organisational change are often complicated and slow processes, especially in the light of financial constraints. Individuals are therefore often forced to cope with difficult situations – thus the importance of personality development in coping.

vii Motivations and expectations

Freudenberger (1974) believes the cause of burnout to be the excessive striving to reach some idealistic expectation imposed by oneself or by the values of society. Maslach (1982) indicates that this inappropriate personal motivation may add to an individual's susceptibility to burning out. Inappropriate motives, such as a strong need for approval and affection, seeking to gain appreciation and positive feedback, and using the helping situation to satisfy personal need for intimacy are other variables affecting burnout (Maslach, 1982b, p. 190).

Keeping in line with realistic goal-setting, professional carers have to have a clear understanding of their capabilities, limits, strengths and weaknesses (Fischer, 1983 in Ratcliff, 1988). Feelings of failure, resulting from discrepancies between

aspirations and actual accomplishments, are well documented in the burnout literature.

Unrealistic expectations are a frequent source of burnout in the medical profession. In this regard, Stevenson (1989, p. 38) states: "Medical professionals have high goals (the saving of life), which reality often places out of reach." In the current public health sector, demands on resources are expanding, while staff and funds are shrinking. In addition, as technology expands, care givers are increasingly forced to make decisions which could mean life or death. This responsibility is exacerbated by the cost of error in an increasingly litigious society (McCue, 1986).

viii Social support

Social support is presently highlighted as one of the most important issues in the study of burnout. The development of strong social support as being beneficial to treating and preventing burnout is replicated in the literature on burnout (Greenglass, Fiksenbaum & Burke, 1996, p. 185; Kahill, 1988, p. 163; Van Dierendonck, Schauefeli & Sixma, 1994, p. 90). According to these theorists, social support appears to have a positive effect on individuals' wellbeing, through two different processes. Firstly, support has been identified as a buffer between job-related stress and pathogenic influences in stressful events. Processes here include redefining the situation or believing that one has the necessary resources to cope with the situation. Secondly, social support can have a major affect on experienced stress. In this regard, social support is positively related to psychological and physical health, irrespective of the presence or absence of life or work stressors.

ix Asymmetry of the helping relationship

In the helping professions, the focus is primarily on the people who receive the service, and the role of the helper is defined by the needs of the client in terms of helping, supporting and understanding. According to Pines and Aronson (1988), this one-sidedness gives rise to an asymmetrical relationship situation which is

contrary to most human relationships which are symmetrical. This, combined with the emotional intensity characterising most human service work and the type of people who choose human service work (discussed above), have implications for greater susceptibility to burning out.

x Sense of community

The need for a "psychological sense of community is central to the positive experience of work" (Sarason, 1977, p. 283). Reports indicate that burnout becomes more prevalent as patient-professional relationships become increasingly encumbered by institutional constraints or confounded by unrealistic expectations (Farber, 1983, p. 12). Thus, institutional constraints of working in and for large bureaucracies and the public's perception of the "grandeur" of such work, impinges on the interaction of individual helper's expectations and goals. Cherniss (1980a) refers to this as the "professional mystique" that surrounds the public service professional. Cherniss (1980a) explains that this mystique is initially accepted by the incoming professionals and serves to reinforce their unrealistically high expectations of themselves. Invariably, this mystique clashes with the reality of bureaucratic constraints and work-related stresses, ultimately culminating in disillusionment and burnout (De Wet, 1998, p. 76). McCue (1986) indicates that this is a common problem in the medical profession, owing to medical doctors reluctance to express the difficulties of their work experience, commonly labelled as the "conspiracy of silence" (McCue, 1986, p. 7) or the maintenance of the legacy of the "medical macho image" (Ellis, 1996, p. 296).

xi Other personal factors and burnout

The following is a list of other generally agreed on personal factors, which are known to contribute to burnout: temperament, growth and development, physical health status, education and skills training, behaviour patterns, personal values and commitment, mental health status, work history, general life experiences, current life stresses, life changes (Carroll & White, 1982, p. 49; Ratcliff, 1988; Rogers, 1987, p. 94; Starrin et al, 1990, p. 86).

3.4.3.3 Organisational causes

"The search of causes of burnout" states Maslach (1978, p. 114), is "better directed away from identifying the bad people and toward uncovering the characteristics of the bad situation where many good people function". This viewpoint emphasises the central role of work-related stresses, that is, the nature of the work role and the nature of the work setting in the aetiology of burnout (Farber, 1983a, p. 5).

a Emotional cost of caring and responsibility for people

According to Maslach (1978), burnout is common in helping professions, because of the high level of arousal as a result of direct, frequent and intense interactions with clients. Thus, the very essence of helping professions work which is constantly dealing with other people and their problems, is a major source of burnout.

b Role demands

According to Robbins (1996), role demands relate to pressures placed on a person as a function of the particular role he or she plays in the organisation. Lack of clear role definition is often a cause of burnout in organisations. Role ambiguity refers to the lack of clarity about one's job. The ongoing experience of role ambiguity results in greater job dissatisfaction, job-related tension, lower levels of confidence, depressed moods, lowered self-esteem, anxiety, depression and high blood pressure (French & Caplan, 1980; Ivancevich & Matteson, 1993; Khan et al, 1964). Role conflict refers to conflicting job demands (Grobler & Hiemstra, 1998, p. 21) while role overload is experienced when the employee is expected to do more than time permits. Overall, the majority of findings indicate a consistent relationship between role demands and burnout (Cordes & Dougherty, 1993).

c Autonomy

Autonomy is another important variable affecting burnout. It is established that autonomy, sense of control and discretion are inversely related to burnout. The hospital organisation is often characterised by factors, such as little participation in management organisation and in hospital decision making; lack of participation of the planning of workloads which are organised solely on demand; hierarchical organisation structures which do not facilitate communication and are unable to inform on hospital strategic plans (Lemkau et al, 1988, p. 683; Varga et al, 1996, p. 208).

d Work overload

Another variable related to the experience of work is excessive workloads. Job overload can be quantitative or qualitative. Quantitative job overload refers to having too much work to do, whilst qualitative job overload refers to doing tasks that are too difficult and beyond one's capacity (French & Caplan, 1980). According to Graham and Ramirez (1997, p. 228), the most commonly reported source of job stress among hospital consultants is overload and its effect on home life.

e Need for recognition and career development stress and burnout

The lack of professional career paths to motivate doctors and recognise their merits has been cited as contributing to discouragement, demoralisation and eventually to burnout (Pines & Aronson, 1981).

f Other organisational factors

The job related stresses common to human service work are endless. The following are other known variables that cause burnout: isolation, job training, resources and the work environment, insufficient social support (co-worker,

supervisory and peer support) (Carroll & White, 1982; Farber, 1983; French & Caplan, 1980; Iverson et al, 1998, p. 3; Ratcliff, 1988, p. 149; Rogers 1987, p. 96). For reasons such as 24-hour turns of duty with instant pressure in emergency; occasional lack of team atmosphere, lack of autonomy, lack of rewards, the need for continuous medical education; excessive bureaucracy in medicine, it is clear why physicians are so greatly, susceptible to burning-out (Fain & Schreier, 1989; Graham & Ramirez, 1997; McCranie & Brandsma, 1988; Richardsen & Burke, 1991, Varga et al, 1996, p. 208).

The above factors create in individuals a sense of failure and meaninglessness. According to Farber (1983a, p. 6), the common element to most work-related stresses is that it creates a feeling of inconsequentiality, that is, no matter how hard one works, the payoffs in terms of accomplishment, recognition, advancement, or appreciation are not there; resulting in the experience of burnout.

3.4.3.4 Sociopolitical; economic and historical causes

Cherniss (1980a, 1980b) points out that sources of burnout are not confined to the individual and organisational levels, but burnout can also be viewed as a symptom of the broader societal concerns. In recent years the focus on the socio-economic and political contexts within which burnout occurs, accentuates.

It has been proposed that urbanisation and the resulting decline of traditional support systems have resulted in increased physical and psychological disorders and in increased caseloads for health professionals (Cherniss in Ratcliff, 1988, p. 151). This is exacerbated by the financial cut-backs (understating, lack of resources, under-payment), thereby increasing the burden on health professionals. Furthermore, Dressel (1980 in Cherniss 1980b, p. 83) points out that inadequate funds result from legislation that is largely symbolic and meant only to serve the political needs of the legislators. A fragmented and uncoordinated service system (Ellis, 1996a, p. 296), as in the present case of community service in South Africa, is yet another example of politicians' needs to demonstrate visible results.

Freudenberger (cited in Farber, 1983b, p. 243) argues that we must attend to the individuals and systems within which they work, to the interaction between individuals and their environment, and to the nature and effects of significant transformation in society. Freudenberger (1989) adds that a comprehensive understanding of burnout requires a framework within which antecedent variables, of both a personal and social nature, be explored in terms of how they impact on the present circumstance of a person, and in turn change that individual's view of the future.

3.4.4 The symptoms of burnout

The practical significance of studying burnout can best be understood in terms of the negative organisational outcomes and personal dysfunction (see fig. 3.2).

According to Rogers (1987, p. 92), burnout is a syndrome, or a group of signs and symptoms that appear together. In addition, this syndrome is a label for feelings and is defined by its physiological, emotional and psychological effects on individuals. These effects include depletion of energy, both a physical and psychological wearing out, and an emotional exhaustion. (Rogers 1987, p. 93; Pines et al, 1981).

Farber (1983, p. 247) cautions that it is important for the reader to keep in mind that little is known about the sequence of symptoms of burnout, the average duration of each symptom or cluster of symptoms, whether burnout abates – even without intervention - with the passage of time, and whether the stages of burnout vary across individuals.

The recent models on stress and burnout highlight the individual cognitive appraisal process. This appraisal process accounts for the reason why people approach the inevitable stresses of life and work in different ways. This differential experience, results in differential outcomes.

The following section attempts to discuss some of the accepted signs of burnout (Rogers, 1987; Pines & Aronson, 1988; Ellis 1996a, p. 294).

PHYSICAL	PSYCHOLOGICAL	WORK BEHAVIOUR
Fatigue	Feelings:	Dehumanisation of patients
Sleep disturbances	Anger	Victimisation of patients
Difficulty sleeping	Frustration	Fault finding
Difficulty getting up	Depression	Blaming other
Stomach ailments	Boredom	Defensiveness
Tension headaches	Discouragement	
Migraine headaches	Disillusionment	Impersonal, stereotyped
Gastrointestinal problems	Despair	communication with patients
Frequent colds	Apathy	
Lingering colds	Guilt	Applying derogatory labels
Frequent bouts of flu	Anxiety	to patients
Backaches	Suspicion	
Nausea	Paranoia	Physical distancing from
Muscle tension	Helplessness	patients and others
Shortness of breath	Hopelessness	
Malaise	Pessimism	Withdrawal
Frequent injuries	Immobility	Isolation
Weight loss	Resentment	Stereotyping patients
Weight gain	Moodiness	Postponing patient contact
Stooped shoulders	Attitudes:	Going by the book
Weakness	Cynism	Clock watching
Change of eating habits	Indifference	Living for breaks
	Resignation	Absenteeism
	Self-doubt	Making little mistakes
	Other:	Unnecessary risk taking
	Loss of empathy	Use of drugs and alcohol
	Difficulty concentrating	Marital and family conflict
	Difficulty attending	Conflict with co-workers
	Low morale	Decreased job efficiency
	Decreased sense of	Over commitment
	self-worth	Or undercommitment

Figure 3.2 The signs and symptoms of burnout (Pines & Aronson, 1988)

3.4.4.1 Physical symptoms

Generally, physical symptoms of burnout have been neglected at the expense of psychological and behavioural symptoms (Pines & Aronson, 1988). However, some reports are now realising the numerous atypical physical complaints that accompany burnout (see fig. 3.2). Physical symptoms are characterised by low energy and chronic fatigue. There may also be reports of eating disorders (either eating too much or too little). Sleep disorder may manifest in the extreme form of insomnia or over-sleeping. There may also be an increased susceptibility to illness and psychosomatic complaints. Other physical symptoms include peptic ulcers, headaches, lingering colds, backache, high blood pressure, gastrointestinal disturbances, shortness of breath, skin complaint; general aches and pains (Kelly, 1993 in Ellis, 1996a).

3.4.4.2 Psychological and emotional symptoms

Symptoms of this nature are characterised by a general malaise or depression (see fig. 3.2) and can be divided into:

- *Emotional exhaustion* which involves feelings of apathy, helplessness, hopelessness and entrapment (Muldary, 1983). This is accompanied by free-floating anxiety, which manifests as worry, apprehension and nervousness (Muldary, 1983; Pines & Aronson, 1988). The pervasive sense of discouragement results in a depletion of emotional energy, whereby the burned out worker reports that he or she has nothing left to give anyone.

- *Mental exhaustion* is characterised by difficulty in concentrating and paying attention (Muldary, 1983). Mental exhaustion is sometimes associated with an impaired ability in problem solving and decision making. Pines and Aronson (1988) indicates that the development of negative attitudes towards self, patients, colleagues and the work environment is yet another sign of mental exhaustion. This symptom is similar to what Maslach (1982) describes as depersonalisation which involves a callous, or excessively detached response

to other people who are usually the recipients of one's service or care. In addition, the burned out individual may begin to develop a lower opinion of his or her own capabilities and self-worth (Pines & Aronson, 1988).

Other psychological and emotional symptoms of burnout include irritability, sadness, irrational anger, unwarranted suspicion and paranoia (Rogers, 1987; Ellis 1996a, p. 294).

3.4.4.3 Behavioural symptoms

According to Cordes & Dougherty (1993), findings indicate a high correlation between self-diagnosis and the burnout assessed by close colleagues, that is, if people are burning out, whether they know it or not, and whether others around them will be aware of it.

Organisation-related behavioural changes include decreased performance efficiency (quantitative and qualitative), late coming, absenteeism and job turn-over (Pines & Aronson, 1988).

Other behavioural symptoms of burnout include changes in interpersonal functioning in and out of work (Grobler & Hiemstra, 1998). Empirical evidence supports the change in the quality and frequency of interactions with clients and co-workers. The deterioration of family and social relationships have also been recorded (Rogers, 1987). The consumptive behaviours, such as smoking and the increased use of alcohol and drugs, have also been reported as signs of burnout (Cordes & Dougherty, 1993).

Attitudinal behavioural effects of developing negative attitudes to work, clients and the self often manifest in communication problems, such as avoiding colleagues and clients and a change in tone and manner of interaction. Reports also indicate an increase in anger and hostility towards clients and others (Maslach & Jackson, 1981; Rogers, 1987).

3.4.4.4 The progression of symptoms

Despite the general unanimity of opinion regarding the symptoms of burnout, it is often difficult to determine if someone is infact burned out. The reason for this is because burnout is a process, and not a discrete event; the process is not identical for each person. Mattingly (1977 in Farber, 1983a, p. 3) points out that "burnout is a subtle pattern of symptoms, behaviours, and attitudes that are unique for each person". Furthermore, whilst the symptoms of burnout are varied, this is further complicated by the fact that many individuals attempt to disguise their symptoms. Pines et al (1981) suggest that this cover up may in itself be recognised as a symptom of burnout and can be identified when the normally quiet person who becomes gregarious may actually be seeking the company of colleagues to avoid clients and their problems. On the other hand, individuals who become very quiet or withdraw totally from the situation may be burned out.

Two classifications of severity of symptoms have been developed which divide burnout onto three stages (Rogers, 1987). The first model is based on the frequency and duration of signs and symptoms. Spaniol and Cuperto (in Rogers, 1987, p. 97), propose the following stages of burnout symptoms:

Stage 1: This stage involves mild transient signs of stress.

Stage 2: This stage is identifiable by regular signs that last longer. These signs are increasingly difficult to eradicate.

Stage 3: The continuous physical and psychological problems reach a stage of significant proportion. At this level, these problems cannot be overcome.

Maslach (1978 in Rogers, 1987, p. 98) advocates a second classification based on the presence of exact signs and symptoms of burnout:

Phase 1: This phase is categorised by emotional and physical exhaustion.

Phase 2: Here there is an increase in negative and dehumanising attitudes toward colleagues, clients and self. This is characterised by avoidance behaviour and/or withdrawal with decrease in work accomplishments.

Phase3: This stage is labelled terminal burnout and recovery without intervention is unlikely.

The above-mentioned classification schemes play an important role in the prognosis of recovery from burnout.

3.4.4.5 Symptoms of burnout in hospital doctors

Numerous sources (Lemkau et al 1988, p. 683; 1994; McCranie & Brandsma, 1988, p. 30) highlight that symptoms of burnout in the medical work situation, are potential precursors of more severe manifestations of impairment, including marital and family conflicts, psychosomatic illnesses, substance abuse, depression and suicide.

Some startling consequences of burnout in medical doctors warrant attention. The following statistics are far lower than the reality, because these incidences remain under-reported; many remain anonymous and unknown (Near, Rice, & Hunt, 1980; Sonneck & Wagner, 1996, p. 255; Ellis, 1996a, p. 299):

- Doctors have twice as many road accidents as the general population.
- Doctors are three times more likely to have cirrhosis of the liver or commit suicide than the general population.
- Doctors are at least 30 times more likely to be addicted to drugs.
- Doctors are 2,5 times more likely to be admitted to psychiatric hospitals.
- General practitioners have a high incidence of unresolved marital conflict and emotional problems.

From the discussion above on the symptoms of burnout, the consequences of burnout are not only far-reaching for the helping professional, but can lead to

deterioration in the quality of care or service provided; this lack of proper treatment can filter itself back into society. Maslach, (1982a, p. 39) sums up the outcomes of burnout by stating that "burnout has a connection with turnover, it is tied to the impairment of family relationships, and it appears to be linked to various types of health problems….it has major ramifications and can be costly for both the individuals and for institutions".

3.4.5 Interventions aimed at managing burnout

"Though treatment is possible, prevention is always superior" Rogers (1987, p. 91). Prevention of burnout can take various forms and may be implemented at different levels. From the literature, prevention can broadly be aimed at enhancing personal coping strategies and introducing organisational re-structuring. At the outset, individuals and organisations need to determine what can and cannot be changed within the system. Since there are limits as to what organisations can do to change (mainly due to financial constraints), individuals need to then identify what they can do within the parameters and constraints of the employing organisations (De Wet, 1998, p. 83).

3.4.5.1 Intrapersonal coping strategies

The following question raised by Ellis (1996a, p. 293) is linked to the salutogenic question: "Is there an inner strength which we acquire genetically or by lifestyle or by social support systems or by faith, whose strength helps us combat the vicissitudes of life or whose absence leads us into burnout and depression?"

Despite the increased awareness of the inherently stressful nature of medical work, the fact remains that many doctors do not develop symptoms of burnout or impairment (McCawley, 1983 in McCranie & Brandsma, 1988). If you consider the nature of the work to be neutral, the assumption is that burnout is influenced by individual personality traits and personal coping styles. These issues are addressed in chapter 4.

Pines and Aronson (1981) propose the following four major strategies to deal with burnout on an individual level:

- Be aware of the problem.
- Take responsibility for doing something about it.
- Achieve some degree of cognitive clarity.
- Develop new tools for coping and improving the range and quality of old tools.

Cherniss (1980) and Freudenberger (1989) propose that preventative measures would include helping professionals become aware of their own personal signs of stress, and helping them develop appropriate coping mechanisms that match both the person and the work environment. They add that a certain degree of disillusionment and loss of enthusiasm is part of a therapist's development. However, the manner in which one deals with this growth process during the early stages of one's career most likely influences one's ability to survive and flourish in one's careers.

Pines and Aronson (1988, pp. 137-144) and Turnipseed and Turnipseed (1991, p. 475) highlight the importance of learning and understanding which types of coping strategy to employ when faced with difficult situations. Building on the conceptualisation of Lazarus and Folkman (1984), individuals must be aware of whether to employ problem-focused coping (in an attempt to change the environmental source of stress) or emotion-focused coping (in an attempt to alter one's behaviours and emotions in response to the source of stress).

Intra-individual coping strategies are noncontingent and are probably the most effective form of coping, because having confidence in one's ability to get control of burnout is often the most crucial factor in realising the desired outcome (Pines & Aronson, 1988). However (as discussed in symptoms of burnout), very often the experience of burnout negatively affects the self-concept and this interferes with the individual's ability to manage the burnout at the intra-individual level.

3.4.5.2 Interpersonal coping strategies

According to Pines and Aronson (1988, p. 160), “the practical definition of social support is the people who support an individual through crises and calm and with whom feelings can be shared without fear or condemnation”. Across the literature, it has been established that the use of social support systems provides an effective prevention mechanism against burnout.

Pines and Aronson (1988) categorise the functions of social support into six basic groupings: listening, technical support, technical challenge, emotional support, emotional challenge, and the providing of social reality. Several research studies, in Pines and Aronson (1988), indicate that when work relations are good, professionals experiencing stress often turn to others for advice, comfort, tension reduction, help in achieving distance from the situation or in intellectualising it, and a sense of shared responsibility.

Family and friends, supervisors and co-workers produce a support network that mitigates the impact of work–related stresses. The converse of this is also true. Farber (1983) and Freedy and Hobfoll (1993, p. 312) point out that the prolonged depletion of resources, due to nonreciprocal or negative relationships, may be a major cause of psychological distress. The satisfaction and stresses of one’s personal life and those of one’s professional life are, therefore, mutually influential.

Detached concern is an interpersonal coping strategy recommended in dealing with clients in the helping professions. Detached concern refers to the healthy balance between over identification and under involvement (Lief and Fox, 1963). In other words, the health worker must maintain empathy, concern and caring, while balancing them with professional objectivity, that is, the role of humanist must balance the role of scientist (De Wet, 1998). Depersonalisation can be mastered through intentional and regulated physical, emotional or mental distancing from the health care environment. However, this process must not be mistaken for under involvement - a balance must be maintained.

3.4.5.3 Organisational coping strategies

Maslach (1978) noted the field had “reached the point at which the number of rotten apples in a barrel warranted examination of the barrel itself”.

Freudenberger (1974) and Ratcliff (1988, p. 153), urges agencies to provide ongoing training, maintain variety in job assignments, limit the number of hours worked, insist on time off, foster social supports among staff, provide a support group, reduce caseloads, provide supervision, attend to individual needs and differences of workers, provide positive environmental conditions and set clear, achievable objectives. Cherniss (1995) adds that organisations must provide careful orientation of new workers and periodic “burnout check-ups”.

Political and bureaucratic structural changes, whilst taking longer to yield results, aim at the real problems that contribute to burnout. According to Ratcliff (1988, p. 153), institutions must change their focus from financial accountability to public accountability. Other suggestions include instituting provisions for upward mobility, hiring supervisors who are attuned to the needs of clients and workers rather than organisational demands alone, decreasing routing of paper work, encouraging workers to use creativity and initiative, allowing workers to have input on major questions that affect their work life and focusing on quality rather than quantity of client-contact hours.

Cherniss (1980a, p. 94), concludes that “cultural, economic, and political analysis of burnout need not lead to paralysis or even pessimism, if we are willing to assume a longer time perspective, if we are serious about reducing burnout in the workplace, we must come to terms with the social forces that create it”.

3.4.5.4 A multidisciplinary approach

In order to be most effective, attempts to alleviate the burnout problem must occur at multiple levels. Paine (1982, p. 19) proposes four important sites for intervention.

a The Individual

These interventions are designed to strengthen an individual's ability to deal with job-related stress.

b The Interpersonal

This attempts to strengthen interpersonal relations or work group dynamics, either to decrease stress or to support an individual's abilities to deal with stress.

c The Workplace

This involves modification in the immediate work environment and is intended to reduce stress or ameliorate it in some way.

d The Organisational

This includes changes in policies, procedures or structures intended to deal with organisational factors related to burnout.

A number of approaches to treating burnout have been employed, with the specific choice of treatment varying most often as a function of the training and orientation of the burnout consultant. In Ellis's (1996b, p. 324) words, "everyone appears to have their own opinion as to how to cope with stress and burnout depending on the guru you consult". Farber (1983, p. 15) reiterates this in highlighting clinical, psychotherapeutic models and proposes individual or group psychotherapy for burned out professionals. He (Farber, 1983) mentions Freudenbergers (1981b) success with a short-term, goal-limited approach and Edelwich and Brodsky's (1980) use of "Reality Therapy". Cognitive-behavioural psychology proposes stress-reduction techniques, such as systematic desensitisation, relaxation training, biofeedback, meditation and yoga. Organisational and social psychologists have suggested structural changes in the work setting: reducing client-staff ratios, reducing work hours, sensitising

administrators to the problems and stressors of staff, offering greater flexibility in work schedules, increased autonomy, and improving in-service training.

Carroll and White (1982), in their ecological approach, suggest the combination of the above methods to assessment and intervention at both the person and environment level. According to this, for example, it is useless to reduce one's workload temporarily, without addressing the structure and policies of the organisation. In the words of Farber (1983b, p. 241), "burnout is not a simple, unidimensional problem with easily grasped causes and solutions, but rather a complex issue with roots in intrapsychic, interpersonal, occupational, organisational, historical and social problems".

3.4.5.5 Prevention and treatment of burnout in medicine

Implementation can only be successful if it occurs in a context of commitment on the part of the individual and the organisation. In the medical profession, implementation of coping strategies (individual and organisational) is hampered by the reluctance of medical doctors to seek help (McCue, 1986).

The literature reveals that the majority of doctors endure symptoms of burnout rather than seeking help which could lead to further dysfunction. Reasons for this reluctance include the following: they see themselves as a personal failure in terms of role and position in society, they fear losing status and control, they fear the feeling that "this is happening to me", they are in denial and fear the stigma of treatment (Steinert, 1995 in Ellis, 1996b; Levenstein, 1987; Schweitzer, 1994, p. 354).

Lyall (1989) advises that it is time medical practitioners break free of the attitude of admiration for those who work excessively long days, neglect personal relationships and gamble with their health. He (Lyall, 1989, p. 31) states the following: "Physicians need to be reminded it is implicit in the Hippocratic oath that the physician be in good health and be able to provide the best level of care." Similarly, Sonneck and Wagner (1996, p. 255) write, "we must keep in mind, that

despite being ‘gods in white,’ a medical degree does not infer immunity to mental illness, drug addiction, alcoholism, or other self-destructive behaviours”.

Rhoads (1977, in Ellis 1996b, p. 325) identifies two characteristics observed in doctors who are less likely to burnout than others are the ability to postpone thinking about problems until the time for action on the matter arrives and the ability to recognise when they were under strain and take some appropriate action. On an individual level, highlighting the importance of personal awareness, Sonneck and Wagner (1996, p. 232) mention “it is important for doctors themselves to recognise the development of burnout and counteract its effects”.

On an organisational level, prevention and intervention can include constructing (being helped to construct) a set of professional priorities, which should be translated into specific daily goals; these goals can then focus on the present, rather than concentrating on abstract goals which may never be attained. Stevenson (1989) adds that there must also be an opportunity for medical professionals to step aside from their regular routine to tackle a different, short-term task which can provide closure and a sense of accomplishment. Together, these two programmes may help medical professionals to use the present to “taste the wild strawberries” in their lives. Broadly expressed, strategies to combat burnout, can be divided into two main groups: those that involve taking on even more demands (eg increased recreation or exercise) or those that involve off-loading demands at work.

Ten practical coping strategies for medical practitioners, proposed by numerous sources include: leaving the job, delegating responsibilities or altering the job description, going on conferences/refresher courses, joining a team/group/club, increasing recreational alternatives, exercise, meditation, consult psychologist /seek professional help, reducing alcohol and caffeine intake, medication (Kobasa et al, 1982; Levenstein, 1987; Ellis, 1996b, pp. 325-328).

In addition to these strategies, the individual doctor may try to cope by altering the source of the stress (problem–focused coping) and when the practitioner attempts

to alter his or her response to stress (emotion-focused coping) (Lazarus & Folkman, 1984).

Increased awareness and discussion might also provide the basis of more in-depth investigations of how personality traits and coping patterns influence stress and stress resistance among physicians, which, in turn, produce knowledge suggesting more specific intervention strategies for reducing the risk of burnout and other manifestations of impairment (McCranie & Bransdsma, 1988).

Findings in the medical arena also quote the role of social support in helping the worker cope better with stress and burnout. One of the most significant factors in resistance to stress is the strength of the support system the medical practitioner has (Leiter, 1991; Richardsen et al, 1991; 1992, p. 56). Since the literature reveals that low levels of social support are associated with a higher number of reported symptoms of psychological distress in family practice residents, the UK, US, Norway and Canada have introduced formal, confidential support schemes for doctors (Ellis, 1996b, p. 328).

In 1993, a national survey of junior doctors (doctors who had graduated two and a half years ago from university) indicated that 77,8% of junior doctors in South Africa had suffered symptoms consistent with burnout (Schweitzer, 1994). In this survey, the highest incidence of burnout was among doctors working in day hospitals and clinics in contrast to those in private practice. In keeping with above literature review on the importance of social support as a buffer to burnout, 63% of the sample felt that a support group would be helpful.

The three main causes of stress in the South African junior hospital doctor are long hours, lack of support and universally “stressed” hospital and health systems (Schweitzer, 1994 in Ellis, 1996a, p. 296). In South Africa, Ellis (1996a, p. 296) states “the use of junior staff as cannon fodder to prop up undefended and collapsing health services is well known.” He (Ellis, 1996a, p. 296) continues to say that “this is further compounded by the attitude of ‘I went through it in my day, why shouldn’t you’”. The literature suggests that it is the legacy of the medical macho image which insists that one must be seen as coping and not “letting the

side down", all of which contributes to the silence of the burned out professional. The literature recognises that although the long hours may be the same as in the past, junior doctors are now working in a different environment of "new world" demands and new economic and social pressures which are more stressful than the more settled and supportive environment of the past (Firth-Cozens, 1987; Ellis, 1996a).

3.5 INTEGRATION

From the evidence in the research, it can be accepted that burnout is a concept that is highly relevant, socially as well as academically.

Following the journey of the burnout concept, from its inception to present, it can be concluded that burnout is not a simple, unidimensional problem with easily grasped causes and solutions; rather it is a complex issue with roots in intrapsychic, interpersonal, occupational, organisational, historical, and social phenomena. (Farber, 1983, p. 241). The challenge is now, therefore, to develop analytical procedures that can address its complexity to yield successful theoretical and empirical knowledge.

The time has come to be more specific and conclusive in the explanation of burnout, with a view to improving the quality of life for millions of health care workers upon whom the quality of life of so many others depend. With the high public need for primary care physicians, more attention needs to be paid to increasing the career satisfaction and emotional wellbeing of these caregivers, as it is unlikely that optimal medical care can be delivered by unhappy or maladapted physicians. (Lemkau et al, 1994, p. 221; McCue, 1986; Schweitzer, 1994, p. 352).

So in the last three decades, despite a lack of conclusive evidence, more is known about the phenomenon of burnout, its antecedents and its consequences, but most importantly the direction for the path ahead has been established.

3.6 CHAPTER SUMMARY

The above section attempted to trace the burnout concept from its roots to the present day status. Conceptual issues surrounding the burnout concept were discussed, followed by a discussion of the causes, symptoms, outcomes and management of the phenomena. The chapter ended with a discussion of the burnout specifically in the medical profession.

- **REMARK**

With regards to chapter 1, section 1.7.1, phase 1, step 2, this research has completed its stated aim in conceptualising and integrating the existing literature on the burnout phenomenon.

The next chapter will look at salutogenic functioning.