

GUIDELINES FOR THE PRIMARY PREVENTION OF MENTAL, NEUROLOGICAL AND PSYCHOSOCIAL DISORDERS

5. STAFF BURNOUT



DIVISION OF MENTAL HEALTH

WORLD HEALTH ORGANIZATION

GENEVA

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This document is part of a series of fascicles on the primary prevention of mental, neurological and psychosocial disorders, prepared in response to the Resolution WHA39.25, adopted by the 39th World Health Assembly, and resolutions AFR/RC38/R1, EM/RC35/R.8, EUR/RC38/R6, SEA/RC41/R5 and WPRO/RC39.R13, adopted by WHO Regional Committees.

It contains principles useful for the primary prevention of staff burnout syndrome. Other fascicles in this series address specific disorders.

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Dr J. M. Bertolote
Editor

FOREWORD

In 1986 the 39th World Health Assembly adopted a Resolution on the Prevention of Mental, Neurological and Psychosocial Disorders. This Resolution referred to a document in which WHO's Director-General listed a number of problem areas which could be significantly reduced with the implementation of well-defined, acceptable and affordable interventions¹.

After the adoption of that Resolution, WHO Regional Committees considered it and Member States were requested to review the situation in this respect². WHO was asked to produce specific and detailed guidelines for the prevention of mental, neurological and psychosocial disorders.

Those Resolutions and requests resulted in a series of fascicles on this topic. The present fascicle includes principles and practical guidelines for the prevention of staff burnout syndrome. With the help of literature and experts' advice we identified the most efficient interventions to this end. We tried to identify problems and interventions more specific to either developed or developing countries, or to both. Future issues in this series address other disorders.

We hope that the model presented here will be useful not only for guiding action for the prevention of the problem hereafter discussed, but also - and perhaps more important - for stimulating others to produce similar guidelines on other problem areas. In this way, in a concerted and collaborative fashion, the vast area of primary prevention could be gradually and progressively covered.

It is important to note that despite the fact that the title of this fascicle refers to staff, most of what is discussed here - except perhaps items relating specifically to employment - applies to many caregivers who have relatives affected by mental disorders. These disorders, often chronic in nature, pose a considerable burden both on those affected by them and on those who care for them, usually their family members. They should find some alleviation of this burden by following some of the actions described and discussed here.

All comments and suggestions on this series are welcome and should be addressed to:

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¹ World Health Organization. **Prevention of Mental, Neurological and Psychosocial Disorders**. (Doc. WHO/MNH/EVA/88.1). Geneva, WHO.

² AFR/RC38/R1, EM/RC35/R.8, EUR/RC/38, SEA/RC41/R5 and WPRO/RC39.R13.

HOW TO USE THIS DOCUMENT

This document is intended for a wide audience; the main target groups are policy makers, health workers and the general public. Each has specific needs and the degree of complexity of the information as well as the language used in each section of the document are therefore different; for this reason, the same information, adapted for these groups, has been printed on different coloured pages:

- White pages contain extensive, detailed technical information providing the scientific evidence about the facts and the measures proposed; they are intended for health professionals, the technical and scientific communities.
- Yellow pages contain less detailed information at a technical level; they are intended for primary health care workers or workers in other technical sectors, e.g. education.
- Green pages contain brief and to-the-point information; they are intended for those readers with little time available or little interest in scientific literature, e.g. the general public, policy makers, journalists, etc.

This document discusses the prevention of staff burnout syndrome. Previous documents in this series have described specific disorders or behaviours in detail (mental retardation, epilepsy and suicide) in addition to a document on general principles for primary prevention. In all of them prevention is proposed both in terms of specific interventions (e.g. salt iodization) and of the settings where those interventions can be developed (e.g. what can be done by the Ministry of Industry and Commerce).

1. INTRODUCTION

Freudenberger (1974) chose the expression "Staff Burn-out" to describe a syndrome of exhaustion, disillusionment and withdrawal in voluntary mental health workers. This concept has since aroused considerable interest in all the helping professions, with the publication of a large number of papers and books. This suggests that burnout is a major problem in health services today.

BURNOUT IS A
MAJOR PROBLEM IN
HEALTH SERVICES
TODAY

1.1 Definition

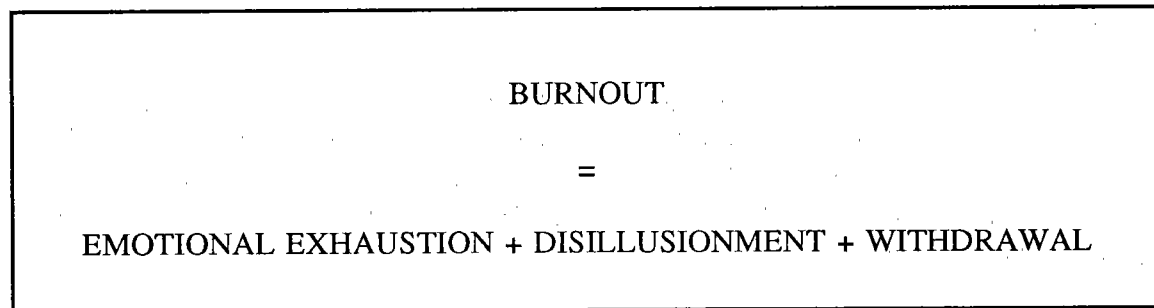
There is no single accepted definition of burnout; however, there is agreement among the authors in this field that this syndrome includes three main dimensions, to be found among various caregivers, particularly health workers and family members:

- (1) emotional exhaustion;
- (2) depersonalization; and
- (3) a reduced feeling of personal accomplishment.

There are other dimensions which are commonly described:

- (i) the phenomenon may occur at an individual or institutional level;
- (ii) it is an internal psychological experience that involves feelings, attitudes, motives and expectations; and
- (iii) it is a negative experience which highlights problems, distress, discomfort, dysfunction, negative consequences, or all of these.

It involves physical, emotional and mental signs and symptoms. Physical exhaustion is evidenced by low energy, chronic fatigue, weakness, weariness, increased susceptibility to illness, frequent headaches, nausea, muscle tension, back pains, various somatic complaints, and sleep disturbances. Emotional exhaustion may involve feelings of depression, helplessness, hopelessness, increases in tension and conflicts at home, increases in negative affective states (e.g., anger, impatience and irritability) and decreases in positive states (e.g., friendliness, considerateness, courteousness). Mental exhaustion may involve dissatisfaction and negative attitudes towards one's self, towards work, and towards life in general. Finally, an increase in work-withdrawing behaviours has also been noted (e.g., absenteeism and turnover).



Burnout is a developmental process, which "begins with excessive and prolonged levels of job stress. This 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, or rigid" (Cherniss, 1980).

1.2 Long-term effects of burnout

An important but poorly explored area is the possible long-term implications of burnout. Only one study up to now has explored the relationship between degree of burnout experienced during the first year of a career and the career adaptation during the next decade (Cherniss, 1992). Subjects were 25 human service professionals who were studied during the first year of their career and again 12 years later. Subjects who were more burnt out during the early part of their career were less likely to change careers and were more flexible in their approach to work as rated by confidants at the time of follow-up. On the whole, the results suggest that early career burnout does not seem to lead to any significant, negative, long-term consequences. However, burnout occurring later in the career might have more serious long-term effects.

One of the most important implications to be derived from this study is that health service workers can recover from early career burnout (Cherniss, 1992). Interestingly, some of the factors which helped these subjects to recover from burnout are the same ones which help prevent burnout, namely: new work situations which provide more autonomy, organizational support, and interesting work.

1.3 Research

The extensive research on psychological burnout has produced a much greater understanding of the problem, and many suggestions for addressing it. However, it has produced little concrete evidence of effective intervention strategies. This problem arises to a large extent from the need to differentiate burnout from other forms of occupational stress. Stress is an individual problem which ultimately requires individual attention. The primary rationale for burnout as a distinct syndrome is:

- (i) its specificity as a three-part syndrome encountered by human service workers, and

- (ii) the definition of burnout as primarily an organizational problem (Cox, Kuk & Leiter, 1993).

The literature on occupational stress has identified intervention strategies which are primarily built around relaxation and health programmes. Individual-oriented programmes are easier to implement and to assess, but they remain entirely consistent with established studies on occupational stress.

The task of implementing and assessing interventions directed toward work groups or organizational policies present formidable challenges in conceptualizing the intervention, enlisting the support of management, identifying specific, measurable goals for intervention, and measuring these constructs. Researchers encounter additional difficulties in designing standardized interventions which are adapted to the local conditions of a specific organization and which reflect the interests of its primary stakeholders. They must conduct a variety of interventions across many settings before they can identify general principles of burnout interventions. While researchers are attempting to pursue these research strategies, designing an effective burnout intervention requires a high degree of creative problem solving, and a willingness to extrapolate from general research findings to an intervention strategy.

2. MAGNITUDE OF THE PROBLEM

It is difficult to make a precise estimate of the magnitude of the burnout phenomenon, because, as it has been seen above, it depends on the interplay of a variety of organizational, environmental and individual factors. However, it has been stated that it may affect up to 30-40% of doctors, at a level sufficient to affect their personal or professional performance (Henderson, 1984). Health workers with other qualifications and from different settings may also suffer from high rates of burnout.

In a survey carried out among 1,176 employees of all occupational groups within one large UK health authority, health workers reported significantly greater pressure at work than a comparison group of workers from non-health care sectors (Rees & Cooper, 1992). However, there were no differences on measures of job satisfaction or physical ill-health, although contrary to expectations, the health workers reported lower levels of mental ill-health symptoms. Approximately one in 12 of the health workers showed levels of either mental or physical ill-health measured through the Occupational Stress Indicator that matched the average level of patients with neurotic disorders attending outpatient departments. In general, among the various professional groups, those at the bottom of the hierarchy tended to have the highest levels of symptoms; nursing staff especially had high rates of symptoms.

In one of the largest studies, stress symptoms, burnout and suicidal thoughts in 2,671 Finnish physicians were studied using a questionnaire (Olkinuora et al., 1990). In male specialists, highest burnout indices were found in general practice and occupational health; psychiatry and child psychiatry; internal medicine, oncology, pulmonary diseases, and dermatology and venereology. In female specialists they occurred in general practice and occupational health; radiology; internal medicine, neurology, pulmonary diseases, and dermatology and venereology. Non-specialists had higher burnout scores than specialists for

both sexes. Highest burnout scores in both men and women occurred in those working in municipal health centres. Lowest scores occurred in those working in private practice, universities, research institutes, and public offices and organizations. The results indicate a polarization between "higher burnout specialities", often dealing with chronically ill, incurable or dying patients (e.g. specialities such as oncology, pulmonary diseases and psychiatry), on the one hand and "lower burnout specialities", often dealing with curable diseases and favourable prognoses (e.g. specialities such as obstetrics and gynaecology, otorhinolaryngology and ophthalmology), on the other.

**ALL TYPES OF HEALTH WORKERS
EXPERIENCE HIGH LEVELS OF
BURNOUT**

Burnout was studied among a representative sample of 1,840 infectious diseases physicians, in the United States (Deckard et al., 1992). Forty-three percent of the physician sample reported high scores on emotional exhaustion, and 40.3% scored high on depersonalization. Personal accomplishment scores remained high, despite burnout levels, with 91.8% reporting high personal accomplishment. Contrary to the outcome of other studies, the highest percentage of burnout occurred among physicians in private practice settings (55%), followed by government settings (39%), and academia (37%).

The phenomenon seems widespread also among general practitioners (GPs). For instance, South Australian general practitioners (n = 966) provided information in a questionnaire study about four indicators of job stress: the burnout components of emotional exhaustion, depersonalization, and personal accomplishment, and a three-item measure of job dissatisfaction (Winefield & Anstey, 1991). Up to one third of respondents reported significant levels of job stress, which varied according to age and sex as well as attitudes to general practice.

One study has compared the levels of work-related stress and depression reported by physicians-in-training in emergency medicine in three survey sites in the United States, the United Kingdom, and Australasia, and has tried to determine the effects of gender and marital status on stress and depression among these physicians (Whitley et al., 1991). Significant differences in stress by survey site and gender and in depression for all three independent variables were found. Respondents from the United Kingdom reported significantly higher levels of stress than did respondents from the United States and women reported significantly higher levels than men. Respondents from the United States reported significantly higher levels of depression than did respondents from the other countries, women reported higher levels than men, and unmarried respondents reported higher levels than married respondents. In another study carried out among 488 doctors-in-training in emergency medicine, the mean levels of stress and depression were higher for women and the unmarried (Whitley et al., 1989).

In a survey comparing 291 GPs, 379 nurses and 387 pharmacists, nurses reported the highest level of stress, especially in terms of work overload, meeting patient needs, and on-the-job conflicts (Wolfgang, 1988).

A survey on 1,248 Swiss nurses confirmed the major stressors known: ethical conflicts about appropriate patient care, team conflicts, role ambiguity, workload and organizational deficits (Heim, 1991). In doctors, workload and shortage of time, combined with specific responsibility in decision making, are most prominent. Nevertheless, job satisfaction is still high in both professions. The specific role strain of female doctors is responsible for health risks with an alarming 10 years lower life expectancy than in the general population.

Job satisfaction, occupational burnout and general health was studied in a sample of 123 mental health care professionals (psychiatric nurses and nursing assistants, and smaller professional groups such as social workers, occupational and recreational therapists and psychologists) employed at a large Canadian psychiatric hospital (Huscott & Connop, 1990). Psychiatric nursing assistants exhibit more of the consequences of job-related stress (less job satisfaction, greater occupational burnout, greater incidence of negative physical and psychological symptoms of stress) relative to the other professional groups in the sample. This may be linked to their position within the hospital organization (having less authority and professional autonomy relative to the other groups), affecting their ability to cope with job-related problems and stresses experienced by all direct care workers.

Relations between working conditions and mental health status of female hospital workers were studied in a sample of 1505 women: 43% were nurses, 32% auxiliaries, and 7% ancillary staff; 13% were other qualified health care staff, mainly head nurses; 5% had occupations other than direct health care; 63% worked in the morning, 20% in the afternoon, and 17% on the night shift (Estryn-Behar et al., 1990). Five health indicators were considered: a high score to the general health questionnaire (GHQ); fatigue; sleep impairment; use of antidepressants, sleeping pills, or sedatives; and diagnosis of psychiatric morbidity at clinical assessment. Four indices of stress at work were defined: job stress, mental load, insufficiency in internal training and discussion, and strain caused by the work schedule. For all indicators of mental health impairment and especially high GHQ scores, the adjusted odds ratios increased significantly with the levels of job stress, mental load, and strain due to the work schedule.

Among social workers, a survey carried out among a representative sample in the U.S. in 1989 found that one-fourth of the respondents reported feelings of emotional exhaustion, although they reported little depersonalization (Siefert et al., 1991).

Burnout has also been described among psychotherapists: it has been stated that between 2 and 6% of psychotherapists can be considered burned out (Farber & Heifetz, 1990); the problem seems more frequent among institutional therapists.

3. ETIOLOGY AND RISK FACTORS

Most authors see stress, in one way or another, as the key factor in the development of burnout (Jenkins, 1993). It is, however, useful to analyze causes of staff burnout according to the locus at which preventive action can take place, i.e., job features, the organizational environment and the individual.

3.1 Features of the health services jobs

As seen above, burnout is a phenomenon very common to the helping professions, although it is not restricted to them. There are specific factors related to these professions which may be responsible for the occurrence of the phenomenon. Most importantly, achieving a sense of efficacy is perhaps the strongest job-related goal shared by health workers. To demonstrate this, we may quote a survey of 215 psychiatrists, psychologists and social workers, in which 74% of the therapists cited "the lack of therapeutic success" as the single most stressful aspect of their work (Farber & Heifetz, 1982). Other important factors were "inability to help an acutely distressed client" and "lack of observable progress with clients".

RISK FACTORS FOR BURNOUT INCLUDE:

***CHARACTERISTICS OF HEALTH SERVICES
ORGANIZATIONAL ENVIRONMENT
INDIVIDUAL TRAITS***

The very characteristics of the work with chronic, incurable and dying patients is particularly conducive to burnout. This is the case in working with the chronic mentally ill (Oberlander, 1990) and with AIDS patients (Ross & Seeger, 1988).

3.2 The organizational environment

A wide range of factors associated with occupation may lead to stress within an individual. Although none of them, taken in isolation, can be considered as a source of burnout, their interplay and the simultaneous presence of several of them (which is very often the case) can significantly contribute to causing burnout among health professionals. The following environmental and organizational factors in health services may cause stress:

- (1) role or case overload with few structured time-outs;
- (2) institutional disregard for the needs of clients in favour of administrative, financial, and bureaucratic needs;
- (3) inadequate leadership, supervision, or both;
- (4) lack of training and orientation specific to the job;

- (5) lack of a sense of impact on and control over one's work situation;
- (6) lack of social interaction and support among staff;
- (7) caseloads consisting predominantly of extremely difficult clients; and
- (8) majority of time spent on administration and paperwork tasks.

Perceived lack of control seems a particularly important risk factor for burnout (McDermott, 1984). In fact, some research has shown that therapists in institutional settings more frequently admitted to feelings of disillusionment than did therapists in non-institutional settings, including private practice (Farber & Heifetz, 1982). In a study carried out among two samples of social workers, one in full-time private practice, the other in full-time agency practice, in all measures of personal well-being, it was found that workers in private practice fared significantly better than their colleagues in agency settings (Jayaratne et al., 1991). However, as suggested by the authors, these differences may be related to differences in characteristics of practitioners who choose to enter private practice, differences in psychosocial aspects of private practice and public agencies as settings, and differences in the kinds of clients served, with the clients of private practitioners less likely to be poor, unemployed, old and uneducated.

Lack of social support is also a contributing factor to the development of burnout. Cherniss and Dantzig (1986) described six obstacles to the establishment and development of social support networks in the workplace:

- (1) differing theoretical perspectives,
- (2) differing degrees of resources, status and power,
- (3) organizational structure (*e. g.* front-line workers organizationally alienated from management),
- (4) personal commitments outside of the job which limit social support,
- (5) organizational protocol that limits social contact, and
- (6) high staff turnover rates.

A study has evaluated the effects of social support in reducing and/or mitigating the relationship between negative aspects of the work environment and burnout in nurses (Constable & Russell, 1986). The data were collected from a sample of nurses employed at a U.S. military medical centre. The major determinants of burnout were found to be low job enhancement (autonomy, task orientation, clarity, innovation, and physical comfort); work pressure; and lack of supervisory support, along with the interaction involving the combined effects of job enhancement and supervisory support. These predictors, in conjunction with demographic and job-related variables, explained 53% of the variance in emotional exhaustion, a central component of the burnout syndrome. It therefore seems that many health personnel may be more susceptible to burnout when working in areas where there is a lack of encouragement to be self-sufficient, tasks are not clearly defined, rules and policies are not explicitly communicated, there is a lack of variety and new approaches, and the work environment is less than attractive and comfortable.

Organizational climate, supervisor behaviour, and work group relations exert a direct influence on job satisfaction (Revicki & May, 1989). In particular, an environment which allows the expression of views is favourable and leads to more open and supportive relations

among nurses, which in turn reduces role ambiguity.

Role conflict was also recognized by 62% of 214 community mental health psychiatrists as the most important critical factor which potentially leads to the decision to leave the centre (Vaccaro & Gordon, 1987).

3.3 The individual

It has been suggested that some health workers possess personality characteristics that make them more prone to burnout. In particular, burnout has been associated with neurotic anxiety, unrealistic goals and expectations, and low self-esteem. Another important characteristic which affects stress reaction is flexibility. Flexible people tend to experience more stress associated with role conflict than do more rigid people, because the more flexible find it difficult to set limits and say "no" to extra demands.

Utilizing a prospective design, a study addressed the question of whether vulnerability to burnout among physicians is associated with certain long-standing, maladaptive personality tendencies that pre-date entrance into medical training and subsequent exposure to the intrinsic stresses of medical practice (McCranie & Brandsma, 1988). Subjects were 440 practising physicians whose personality traits and psychological adjustment had been assessed with the Minnesota Multiphasic Personality Inventory (MMPI) shortly before entering medical school. They were followed up by a mail questionnaire an average of 25 years later to evaluate current symptoms of burnout with the Tedium Scale. Results revealed that higher burnout scores were significantly correlated with a number of standard and special MMPI scales measuring low self-esteem, feelings of inadequacy, dysphoria and obsessive worry, passivity, social anxiety, and withdrawal from others. In contrast, burnout scores exhibited no significant associations with demographic or practice characteristics, including sex, age, medical speciality, practice arrangement, hours worked per week, or percentage of work time spent in direct contact with patients. Together, these findings suggest that subjective perceptions of work may be more important than objective work conditions in influencing burnout.

In another study, among 49 psychiatrists, burnout was found to be positively associated with anxiety and to a tendency to be sensitized by problems, and negatively related to learned resourcefulness (Naisberg-Fennig et al., 1991). Burnout was negatively correlated with tenure and years in place of employment (although not significantly).

4. PREVENTIVE MEASURES

As mentioned previously, scientific evidence on the efficacy of measures for the prevention of burnout is very scanty. With this in mind, it is nevertheless possible to identify a few interventions which carry a great potential for prevention (Cherniss, 1980). These are based on careful observation of the daily routine of caregivers, on the one hand, and on results of techniques employed for treating or attenuating already existing burnout, on the other hand. Overall, they are similar to the model for the prevention of mental illness in the workplace, proposed by Jenkins (1993).

For practical purposes these strategies can be grouped according to the level they specifically address, namely, the individual worker's level, the job and role structure level, and the organizational level. At the individual worker's level it is possible to envisage interventions directed at caregivers in general (e.g. staff development), or to those in supervisory or managerial positions (e.g. management development). Similarly, organizational interventions can be related to the organization's policies and goals, or to organizational decision-making processes.

A series of strategies, actions and interventions proposed for the prevention of burnout are set out below³. Most are straightforward in their formulation and immediate goals. Setting them depends greatly on a favourable organizational decision and their implementation is a task for whoever in the organization is in charge of personnel. Obviously the collaboration of other parties - such as staff counsellor, career development officer, staff's medical service, supervisors at different levels in the administration, staff association leaders, union leaders, as well as workers in general - is fundamental for an effective implementation of these interventions.

At individual workers' levels, interventions can be grouped according to their target as staff or management level, as follows:

Staff development

- Reduce demands workers impose on themselves by encouraging them to adopt more realistic and gratifying goals.
- Help workers develop and use monitoring and feedback mechanisms sensitive to short-term gains.
- Provide frequent opportunities for in-service training designed to increase role effectiveness.
- Teach staff coping strategies such as time study and time management techniques.
- Orient new staff by providing them with a booklet that realistically describes typical frustrations and difficulties that occur in the job.
- Provide periodic "burnout checkups" for all staff.

³ Adapted from Cherniss (1980).

Management development

- Create management training and development programmes for current and potential supervisory personnel, emphasizing those aspects of the role that administrators have most difficulty with.
- Create monitoring systems for supervisory personnel, such as staff surveys, and give supervisory personnel regular feedback on their performance.
- Monitor role strain in supervisory personnel and intervene when strain becomes excessive.

Actions can also be envisaged as relating either to policy and goals or to decision making processes, as indicated below:

Policy and goals

- Make goals as clear and consistent as possible.
- Develop a strong, distinctive guiding philosophy.
- Make education and research a major focus of the programme.
- Share responsibility for care and treatment with the client, the client's family and the community.

Decision-making processes

- Create formal mechanisms for group and organizational problem solving and conflict resolution.
- Provide training in conflict resolution and group problem-solving for all staff.
- Maximize staff autonomy and participation in decision-making.

In relation to jobs and role structure, the following actions are recommended:

Jobs and role structure

- Limit number of clients for whom staff are responsible at any one time.
- Spread the most difficult and unrewarding work among all staff and require staff to work in more than one role and programme
- Arrange each day so that the rewarding and unrewarding activities alternate.
- Structure roles in ways that allow workers to take "time-outs" whenever necessary.
- Use auxiliary personnel (e.g. volunteers) to provide other staff with opportunities for "time-outs".
- Encourage workers to take frequent vacations, on short notice if necessary.
- Limit the number of hours that a staff person works.
- Do not discourage part-time employment.
- Give every staff member the opportunity to create new programmes.
- Build in career ladders for all staff.

4.1 Focused interventions

Approaches to treating or ameliorating burnout have relied heavily on techniques derived within the stress management field. Experience indicates that they are probably effective for the prevention of burnout, as well. These techniques fit into essentially three categories which are suggestive of their focus: the individual employee, the work group, or the organization.

Drawing definitive lines between each of these categories is difficult at best since each may draw upon the methods of another. More and more researchers and practitioners of stress management suggest a combination of these or what Pines and Aronson (1988) referred to as a tripartite approach in which prevention capitalizes on the strengths of each of these methods.

FOCI FOR THE PREVENTION OF
BURNOUT ARE:

THE INDIVIDUAL EMPLOYEE
THE WORK GROUP
THE ORGANIZATION

Cherniss (1992) has suggested that a promising way to prevent burnout is to strengthen what he has called "organizational negotiation skills", that is, an ability to resolve stressful interpersonal conflicts, to overcome bureaucratic constraints, and to secure support for innovative and meaningful new projects and for one's initiatives. This also involves "a way of thinking about organizational barriers and conflicts that encourages a certain degree of analytical detachment and thoughtful reflection - a problem-solving attitude towards organizational difficulties". It is therefore important to assess to which extent these skills can in fact prevent professional burnout.

Individual-based techniques approach the individual as the most likely key to reducing stress and burnout, whereas organizational-based techniques view changes in management and work group functioning as the best avenue for reducing occupational stress. A number of stress interventions have been developed, most of which can be modified to accommodate individual, organizational, or a combination of approaches.

4.1.1 Individual and group interventions

The availability and viability of organizational methods of coping with burnout are often matters of personal control. Employees in settings which offer few opportunities to exercise personal control over their environments are restricted to individual coping methods in the first instance. If they cannot control the balance of demands and resources inherent in the job, coping can only be a matter of developing a greater capacity to endure. Thus, time management serves as a means of gaining some control when interacting with demands from clients or co-workers. *Relaxation* and *cognitive therapy* methods increase a person's capacity to tolerate the impact of demands (see below).

Employees within a supportive work group have a broader range of control, as they can work together to develop more effective procedures for addressing occupational demands and to develop resources to meet those demands. Indeed, supportive interactions among group members is a primary resource for enhancing the capacity to meet demands and to recover from the impact of overwhelming demands. This form of support is especially appropriate in addressing burnout, as it replenishes exhausted emotional energy. It also counters the impoverishment of personal relationships implicit in depersonalization which undermines a health service worker's capacity to maintain therapeutic relationships (Leiter, 1992).

**RELAXATION
COGNITIVE THERAPY
TEAM BUILDING**

ARE USEFUL WAYS TO
PREVENT BURNOUT

Pines and Aronson (1988) identified *team building* as a useful way to avert or ameliorate burnout. Social support networks at work comprise co-workers from within the organization and employees of similar occupational groups employed by other organizations. Social networks are a medium for exchanging innovative ideas on managing tasks, coping with stress, and developing in a career.

Cherniss and Dantzig (1986) summarize the literature outlining the key principles for conducting successful mutual aid groups which bring together people with similar jobs or interdependent jobs:

- * Ensuring that potential participants understand and agree to the reasons for forming such a group;
- * Ensuring that group members will participate actively in its development;
- * Ensuring that group members select a leader that they are willing to support in maintaining a productive focus;
- * Limiting the size of the group to between 8 and 12 members;
- * Promoting a structured group, rather than a process group, format.

Cherniss & Dantzig (1986) pointed out that even when all the above conditions are met, research suggests that "...the mutual aid or social support group may not be as effective in reducing stress as more focused and structured cognitive-behavioral interventions. Positive social support can be helpful, however, and mutual aid groups sometimes do succeed in fostering such support among their members".

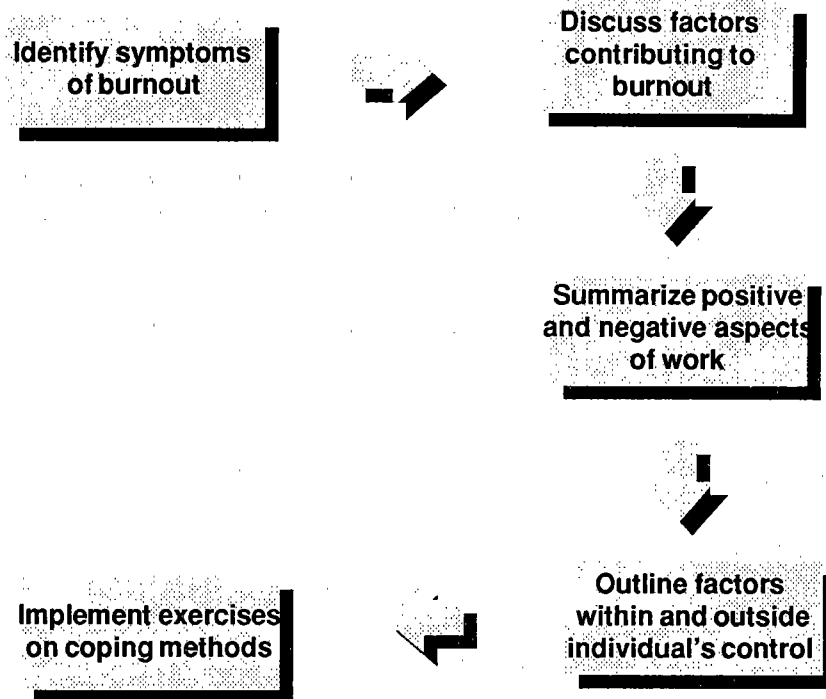
Educational Interventions

Educational interventions include a variety of techniques which are designed to increase the coping skills of individual employees. Training approaches for addressing stress and burnout often include progressive muscle relaxation (Bernstein & Given, 1984; Jacobson, 1938; Rice, 1987). Bernstein and Borkovec (1973) outline a ten session schedule which starts off with all sixteen muscle groups and eventually attends to only four. A detailed outline of a PMR schedule and instructions are presented in Rice (1987). The general purpose of these interventions is to increase the employees' capacity to tolerate the strains arising from the job. Not only will they then experience the job as more pleasant, they will cope more effectively in a relaxed state. Relaxation has particular relevance to burnout in that it ameliorates the experience of exhaustion and increases the capacity to interact effectively with service

recipients. Figure 1 indicates a typical format of educational interventions.

FIGURE 1

**Educational interventions for the prevention of
STAFF BURNOUT SYNDROME**



Advantages

- ☺ Relatively inexpensive as compared to one-on-one strategies; cover more people for less cost;
- ☺ Can serve as a good motivational tool for individual change and for fostering work group bonds;
- ☺ Encourages networking with employees belonging to similar occupations working for differing organizations (quasi-professional societies)

Disadvantages

- ☹ Focuses more on the victim rather than the organization (opponents see it as a form of victim blaming that relieves the organization of its responsibilities);
- ☹ May have only temporary effectiveness or what Cherniss (1980) calls the "temporary workshop high."

Educational interventions for increasing an individual's tolerance of occupational strains also include cognitive approaches, such as autogenics, a self-suggestion relaxation technique that utilizes cognitive imagery. The technique was coined by a German psychiatrist, Johannes Schultz, in the 1930s, as a way of probing the unconscious mind so as to bring about psychophysiological equilibrium (Luthe, 1969). Another approach to relaxation is biofeedback, an operant conditioning technique of monitoring (using an electromyograph, electroencephalograph or galvanic skin response detector) and controlling physiological responses (e.g., heart rate, blood pressure, brain electrical activity) often associated with stress. Systematic desensitization, the process of pairing increasing anxiety-producing stimuli with a relaxed state was developed by Joseph Wolpe and grew out of a learning theory. In stress inoculation (Meichenbaum & Jaremko, 1983), a technique closely related to desensitization, stressors are introduced on a gradual basis, but instead of relying on PMR, the trainee is presented with ideas and skills to cope with the stress at hand. The theory behind stress inoculation maintains that through coping with low levels of stress (stress anticipation), a trainee becomes more immune to higher levels of stress.

The main features of educational interventions are the following:

- They vary in duration (few hours to a few days) and content;
- They can be purely didactic or a combination of lecture plus experiential learning exercises (relaxation, assertiveness training, or small group discussions promoting awareness of causes and social netting);
- They can be implemented within a single organization or bring together the same occupational groups from different organizations.

4.1.2 Organizational techniques

Many proponents of organizational strategies view individual-based techniques as blaming the victim by concentrating on problems within individuals, overlooking stressors beyond individual control. Cherniss and Dantzig (1986) suggested three organizational strategies in overcoming job stress and burnout among human service professionals: modifying the job, reducing stress through supervision, and organizational problem-solving.

Organizational intervention strategies require the most extensive degree of control from the individual. Controlling the form and quantity of client demand often requires a definition of organizational policy regarding the institution's mandate in terms of client population or the quality of service to be provided. The allocation on an organizational level of resources to meet demands more adequately requires the capacity to influence organizational priorities. Adjustments of this kind require a careful balancing of the priority to maintain a workplace conducive to employee well-being with the priority to deploy organizational resources in a manner which will most effectively meet client needs.

Cox and Leiter (1992) discussed the personal impact of work environments from an organizational health perspective. They identified three domains of organizational environments which have an impact upon the psychological state of employees: task domains, problem solving environment and development domains. The *task domain* comprises issues of task design and meaningfulness, which Hackman (1986) identified as critical for the

development of job satisfaction and for peak performance. Cox and Leiter (1992) argue that poor task environments often aggravate the emotional exhaustion aspect of burnout through the wasting of employees' energy with meaningless tasks. The *problem-solving environment* comprises the systems through which people work together to address problems and make decisions. Healthy problem-solving environments require the means for inclusive decision making and for effective communication. Impoverished problem-solving environments weaken the social environment of the organization and contribute to the experience of depersonalization as well as further aggravating emotional exhaustion. The *development environment* comprises organizational systems for enhancing the skills and the career development of employees, including both learning intrinsic to the job and formal training opportunities. A strong development environment enhances feelings of professional efficacy and personal accomplishment; a weak environment engenders hopelessness and lethargy.

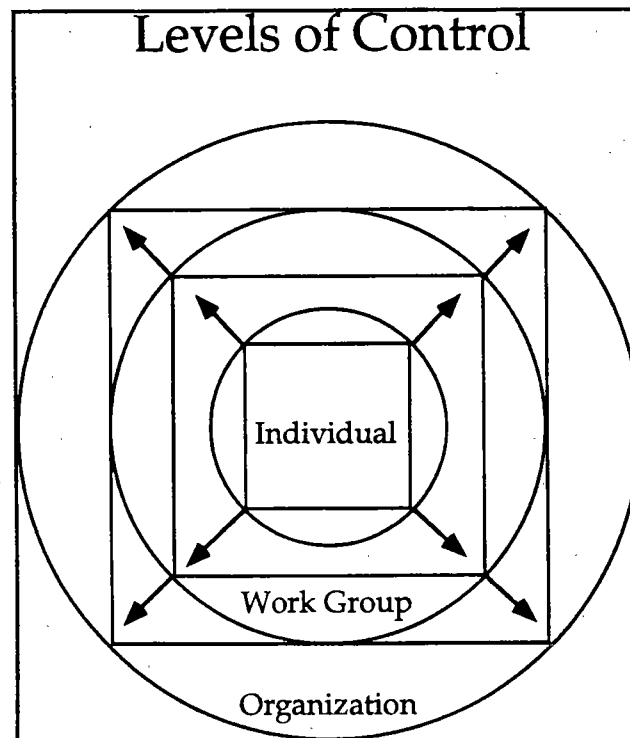
**MODIFYING THE JOB
SUPERVISOR DEVELOPMENT
SOLVING ORGANIZATIONAL PROBLEMS**

ALSO PREVENT BURNOUT

From the organizational health perspective, addressing burnout requires management involvement in enhancing the quality of these environmental domains. In general, goal setting and organizational planning exercises contribute to the enhancement of task environments. Improving the problem-solving environment requires team building interventions which enhance the capacity of group members to work together, and supervisor training to develop their capacity to delegate authority effectively. The quality of the development environment requires an examination of the organization's explicit and implicit values regarding skill development. Developing these organizational domains constitutes a major personal commitment and financial outlay. It requires that management addresses its fundamental values and practices. This commitment occurs only after a recognition that the problem of employee burnout is a reaction to aspects of the organizational environment which has a significant impact on organizational effectiveness.

Figure 2 depicts interactions among levels of an organization. To some extent individuals have control over their personal reactions to a work situation. This level of control permits them some discretion in alleviating the impact of stressful work group or organizational processes. In addition, individuals have the potential for making an impact on the functioning of their work groups; this potential is determined by the capacity for employees to communicate cooperatively, and by the degree of autonomy with which the work group may function within the larger organization. Work groups respond to pressures and demands from the larger organization by adapting their operations and by interacting with other groups in the larger organization to develop more workable conditions.

FIGURE 2



Individual Approaches

Modifying The Job

Modifying the job provides one of the simplest and most powerful ways of reducing stress by lessening role overload, underload, ambiguity or conflict. It also allows flexibility to permit compatibility between employees and their jobs (implies the value of effective human resource divisions in job placement) since a job considered as being stressful to one person might not be to another.

Cherniss and Dantzig (1986) recommended five ways to restructure jobs in order to reduce individual employee stress, as follows:

- (1) spread out the unpleasant work so that no one person or group of people have to shoulder all the burden;
- (2) arrange the day in order to alternate pleasant and unpleasant activities so as not to become overwhelmed by unpleasant tasks;
- (3) set aside time during the day for rejuvenative activities related to work *e.g.*, reading;
- (4) encourage part-time employment - this has the potential of increasing the number of available human resources while providing flexibility in individual schedules; and
- (5) give staff members the opportunity to develop new programmes (fosters job spontaneity and creativity and overcomes boredom of routine).

Supervisor Development

This strategy may help to modify supervisory behaviour whilst providing a sense of empowerment to rank-and-file workers. They help supervisors to become more open to suggestions and employees to feel that their opinions and suggestions are valuable. Feedback should be collected from subordinates through regular anonymous surveys at regular intervals (e.g. every six months). It combines meaningful structure and direction while providing support and confirming autonomy with a consultative supervisory style.

Organizational Problem Solving

Recognizing the need to institute "...permanent, formal mechanisms to monitor internal work climate and deal with problems when they first emerge" (Cherniss & Dantzig, 1986) would appear to be an important component of quality improvement programmes. Holding regular meetings with employees focusing on problem-solving contributes to reducing the sense of powerlessness, role ambiguity and conflict whilst encouraging improved communication patterns within the organization.

Evidence to support this is provided by Jackson's (1983) study of nursing and clerical staff, where subjects in the increased-participation group experienced lower levels of job dissatisfaction, absenteeism, turnover intention, role conflict and ambiguity. These positive outcomes were still evident during a six-month follow-up. However, the development of strategies for improving organizational problem-solving through employee participation is only effective with the support of top management.

The above organizational strategies are pretty much in line with Pines and Aronson (1988). The following factors have been suggested as contributors to the improvement of working conditions (healthy work environments that promote physical and mental wellness):

- reduction of staff-client ratios (or work-load);
- availability of time out periods;
- limitation of the number of hours of stressful work;
- increase in organizational flexibility from hiring (effectively matching the proper person with the job as a preventive measure) to job growth and change; and
- job related training (to improve work-related skills, including how to work effectively within an organizational/bureaucratic setting) and continuing education.

In addition, they also foster innovation and creativity, promote lines of communication where constructive critical feedback from supervisors and subordinates can be exchanged, and provide a sense of success through rewards, appreciation and recognition of task completion.

Golembiewski and Munzenrider (1988) reported one of the few assessments of an organizational intervention to address burnout. They differentiated between a high stimulus and low stimulus design for interventions on the basis of a distinction between passive and active modes of burnout. Simply put, they anticipated that a high stimulus intervention would overwhelm the coping capacity of extremely exhausted workers whilst being well suited to people languishing in situations which undermined their sense of personal accomplishment.

The high stimulus interventions involved confrontational group sessions or individual coaching, process oriented groups, and management policy development. The low stimulus design involved a milder, supportive form of negotiation between employees and management, as well as schemes for facilitating flexible job schedules. They found that this dual approach led to a lessening of burnout and of job turnover, as well as improved assessments of the work environment.

5. CONCLUSIONS

Burnout syndrome has become a major problem faced by caregivers of people affected by chronic disorders, both staff and family members. As such, it compounds and aggravates the several difficulties health services meet in their daily functions.

Whereas the hardships created by some disorders cannot be completely eliminated, the burden they place on those who have to deal with them can indeed be alleviated by using a few simple and affordable measures. This is true both in the workplace and at home, where more and more care is expected to take place, with the shift from hospitals to community-based health care. Therefore, the implications of what has been discussed here should not be overlooked by health managers, particularly, for example, those involved in programmes of deinstitutionalization for mental patients.

MID-LEVEL WORKERS' VERSION

1. INTRODUCTION

Freudenberger (1974) chose the expression "Staff Burn-out" (SBO) to describe a syndrome of exhaustion, disillusionment and withdrawal in voluntary mental health workers. This concept has since aroused considerable interest in all the helping professions, with the publication of a large number of papers and books. This suggests that burnout is a major problem in health services today.

BURNOUT IS A
MAJOR PROBLEM IN
HEALTH SERVICES
TODAY

1.1 Definition

There is no single accepted definition of burnout; however, there is agreement among the authors in this field that this syndrome includes three main dimensions, to be found among various caregivers, particularly health workers and family members:

- (1) emotional exhaustion:
- (2) depersonalization¹; and
- (3) a reduced feeling of personal accomplishment.

There are other dimensions which are commonly described:

- (i) the phenomenon may occur at an individual or institutional level;
- (ii) it is an internal psychological experience that involves feelings, attitudes, motives and expectations; and
- (iii) it is a negative experience which highlights problems, distress, discomfort, dysfunction, negative consequences, or all of these.

It involves physical, emotional and mental signs and symptoms. Physical exhaustion is evidenced by low energy, chronic fatigue, weakness, weariness, increased susceptibility to illness, frequent headaches, nausea, muscle tension, back pains, various somatic complaints, and sleep disturbances. Emotional exhaustion may involve feelings of depression, helplessness, hopelessness, increases in tension and conflicts at home, increases in negative

¹ A state of disorderd perception in which self-awareness becomes heightened but all or part of the self seems unreal, remote, or artificial; such changes occur in the presence of an intact capacity for emotional expression.

affective states (e.g., anger, impatience and irritability) and decreases in positive states (e.g., friendliness, considerateness, courteousness). Mental exhaustion may involve dissatisfaction and negative attitudes towards oneself, towards work, and towards life in general. Finally, an increase in work-withdrawing behaviours has also been noted (e.g., absenteeism and turnover).

$$\text{BURNOUT} = \text{EMOTIONAL EXHAUSTION} + \text{DISILLUSIONMENT} + \text{WITHDRAWAL}$$

1.2 Long-term effects of burnout

An important, poorly explored area is represented by the possible long-term implications of burnout. Only one study up to now has explored the relationship between the degree of burnout experienced during the first year of a career and the career adaptation during the next decade (Cherniss, 1992). On the whole, the results suggest that early career burnout does not seem to lead to any significant, negative, long-term consequences. However, burnout occurring later in the career might have more serious long-term effects.

One of the most important implications to be derived from this study is that health service workers can recover from early career burnout (Cherniss, 1992). Interestingly, some of the factors which helped these subjects to recover from burnout are the same ones which help prevent burnout; namely new work situations which provide more autonomy, organizational support and interesting work.

1.3 Research

The extensive research on psychological burnout has produced a much greater understanding of the problem, and many suggestions for addressing it. However, it has produced little concrete evidence of effective intervention strategies. This problem arises to a large extent from the need to differentiate burnout from other forms of occupational stress.

The literature on occupational stress has identified intervention strategies which are primarily built around relaxation and health programmes. Stress is an individual problem which ultimately requires individual attention.

Whilst researchers are attempting to pursue these research strategies, designing an effective burnout intervention requires a high degree of creative problem solving, and a willingness to extract from general research findings to an intervention strategy.

2. MAGNITUDE OF THE PROBLEM

It is difficult to make a precise estimate of the magnitude of the burnout phenomenon, because, as has been seen above, it depends on the interplay of a variety of organizational, environmental and individual factors. However, it has been stated that it may affect up to 30-40% of doctors, at a level sufficient to affect their personal or professional performance (Henderson, 1984). Health workers with other qualifications and from different settings may also suffer from high rates of burnout.

ALL TYPES OF HEALTH WORKERS EXPERIENCE HIGH LEVELS OF BURNOUT

3. ETIOLOGY AND RISK FACTORS

Most authors see stress, in one way or another, as the key factor in the development of burnout (Jenkins, 1993). It is, however, useful to analyze causes of staff burnout according to the areas where preventive action can take place, i.e., job features, the organization environment and the individual.

3.1 Features of the health services jobs

As seen above burnout is a phenomenon very common to the helping professions, although it is not restricted to them. There are specific factors related to these professions which may be responsible for the occurrence of the phenomenon. Most importantly, achieving a sense of efficacy is perhaps the strongest job-related goal shared by human service workers. To demonstrate this, we may quote from a survey of 215 psychiatrists, psychologists and social workers, in which 74% of the therapists cited "the lack of therapeutic success" as the single most stressful aspect of their work (Farber & Heifetz, 1982). Other important factors were "inability to help an acutely distressed client" and "lack of observable progress with clients".

The very characteristics of work with chronic, incurable and dying patients is particularly conducive to burnout. This is the case in working with the chronic mentally ill (Oberlander, 1990) and with AIDs patients (Ross & Seeger, 1988).

RISK FACTORS FOR BURNOUT INCLUDE:***CHARACTERISTICS OF HEALTH SERVICES
ORGANIZATIONAL ENVIRONMENT
INDIVIDUAL TRAITS*****3.2 The organizational environment**

A wide range of factors associated with occupation may lead to stress within an individual. Although none of them, taken in isolation, can be considered as a source of burnout, their interplay and the simultaneous presence of several of them (which is very often the case) can significantly contribute to causing burnout among health professionals. The following environmental and organizational factors in health services may cause stress:

- (1) role or case overload with few structured time-outs;
- (2) institutional disregard for the needs of clients in favour of administrative, financial, and bureaucratic needs;
- (3) inadequate leadership, supervision, or both;
- (4) lack of training and orientation specific to the job;
- (5) lack of a sense of impact on and control over one's work situation;
- (6) lack of social interaction and support among staff;
- (7) caseloads consisting predominantly of extremely difficult clients; and
- (8) majority of time spent on administration and paperwork tasks.

Perceived lack of control seems a particularly important risk factor for burnout (McDermott, 1984). In fact, some research has shown that therapists in institutional settings more frequently admitted feelings of disillusionment than did therapists in noninstitutional settings, including private practice (Farber & Heifetz, 1982). In a study carried out among two samples of social workers, one in full-time private practice, the other in full-time agency practice, in all measures of personal well-being, it was found that workers in private practice fared significantly better than their colleagues in agency settings (Jayaratne et al., 1991). However, as suggested by the authors, these differences may be related to differences in characteristics of practitioners who choose to enter private practice, differences in psychosocial aspects of private practice and public agencies as settings, and differences in the kinds of clients served, with the clients of private practitioners less likely to be poor, unemployed, old and uneducated.

Lack of social support has been indicated as a contributing factor to the development of burnout. Cherniss and Dantzig (1986) described six obstacles to the establishment and development of social support networks in the workplace:

- (1) differing theoretical perspectives,
- (2) differing degrees of resources, status and power,
- (3) organizational structure (*e.g.* front-line workers organizationally alienated from management),
- (4) personal commitments outside of the job which limit social support,
- (5) organizational protocol that limits social contact, and
- (6) high staff turnover rates.

Organizational climate, supervisor behaviour, and work group relations exert a direct influence on job satisfaction (Revicki & May, 1989). In particular, an environment which allows the expression of views is favourable and leads to more open and supportive relations among nurses, which in turn reduces role ambiguity.

Role conflict was also recognized by 62% of 214 community mental health psychiatrists as the most important critical factor which potentially leads to the decision to leave the centre (Vaccaro & Gordon, 1987).

3.3 The individual

It has been suggested that some health workers possess personality characteristics that make them more prone to burnout. In particular, burnout has been associated with neurotic anxiety, unrealistic goals and expectations, and low self-esteem. Another important characteristic which affects stress reaction is flexibility. Flexible people tend to experience more stress associated with role conflict than do more rigid people, because the more flexible find it difficult to set limits and say "no" to extra demands. Also, research findings suggest that subjective perceptions of work may be more important than objective work conditions in influencing burnout.

4. PREVENTIVE MEASURES

As mentioned previously, scientific evidence on the efficacy of measures for the prevention of burnout is very scanty. With this in mind, it is nevertheless possible to identify a few interventions which carry a great potential for prevention (Cherniss, 1980). These are based on careful observation of the daily routine of caregivers, on the one hand, and on results of techniques employed for the treating or attenuating burnout already installed, on the other hand. Overall, they are similar to the model for the prevention of mental illness in the workplace, proposed by Jenkins (1993).

For practical purposes these strategies can be grouped according to the level they specifically address, namely, the individual worker's level, the job and role structure level, and the organizational level. At the individual worker's level it is possible to envisage interventions directed at caregivers, in general (*e.g.* staff development), or to those in supervisory or managerial positions (*e.g.* management development). Similarly, organizational interventions can be related to the organization's policies and goals, or to organizational decision-making processes.

In pages 9 to 11 a series of boxes summarizes strategies, actions and interventions proposed for the prevention of burnout. Most are straightforward in their formulation and immediate goals. Setting them depends greatly on a favourable organizational decision and their implementation is a task for whomever in the organization is in charge of personnel. Obviously the collaboration of other parties - such as staff counsellor, career development officer, staff's medical service, supervisors at different levels in the administration, staff association leaders, union leaders, as well as workers in general - is fundamental for an effective implementation of these interventions.

4.1 Focused interventions

Approaches to treating or ameliorating burnout have relied heavily on techniques derived within the stress management field. Experience indicates that they are probably effective for the prevention of burnout, as well. These techniques fit into essentially three categories which are suggestive of their focus: the individual employee, the work group, or the organization.

Drawing definitive lines between each of these categories is difficult at best since each may draw upon the methods of another. More and more researchers and practitioners of stress management suggest a combination of these or what Pines and Aronson (1988) referred to as a tripartite approach in which prevention capitalizes on the strengths of each of these methods.

FOCI FOR THE PREVENTION OF
BURNOUT ARE:

THE INDIVIDUAL EMPLOYEE
THE WORK GROUP
THE ORGANIZATION

Cherniss (1992) has suggested that a promising way to prevent burnout is to strengthen what he has called "organizational negotiation skills", that is, an ability to resolve stressful interpersonal conflicts, to overcome bureaucratic constraints, and to secure support for innovative and meaningful new projects and for one's initiatives. This also involves "a way of thinking about organizational barriers and conflicts that encourages a certain degree of analytical detachment and thoughtful reflection - a problem-solving attitude towards organizational difficulties". It is therefore important to assess to which extent these skills can in fact prevent professional burnout.

Individual-based techniques approach the individual as the most likely key to reducing stress and burnout, whereas organizational-based techniques view changes in management and work group functioning as the best avenue for reducing occupational stress. A number of stress interventions have been developed, most of which can be modified to accommodate individual, organizational, or a combination of approaches.

4.1.1 Individual and group interventions

The availability and viability of organizational methods of coping with burnout are often matters of personal control. Employees in settings which offer few opportunities to exercise personal control over their environments are restricted to individual coping methods in the first instance. If they cannot control the balance of demands and resources inherent in the job, coping can only be a matter of developing a greater capacity to endure. Thus, time management serves as a means of gaining some control when interacting with demands from clients or co-workers. *Relaxation* and *cognitive therapy* methods increase a person's capacity to tolerate the impact of demands (see below).

Employees within a supportive work group have a broader range of control, as they can work together to develop more effective procedures for addressing occupational demands and to develop resources to meet those demands. Indeed, supportive interactions among group members is a primary resource for enhancing the capacity to meet demands and to recover from the impact of overwhelming demands. This form of support is especially appropriate in addressing burnout, as it replenishes exhausted emotional energy. It also counters the impoverishment of personal relationships implicit in depersonalization which undermines a human service worker's capacity to maintain therapeutic relationships (Leiter, 1992).

***RELAXATION
COGNITIVE THERAPY
TEAM BUILDING***
**ARE USEFUL WAYS TO
PREVENT BURNOUT**

Pines and Aronson (1988) identified *team building* as a useful way to avert or ameliorate burnout. Social support networks at work comprise co-workers from within the organization and employees of similar occupational groups employed by other organizations. Social networks are a medium for exchanging innovative ideas on managing tasks, coping with stress, and developing in a career.

Cherniss and Dantzig (1986) summarize the literature outlining the key principles for conducting successful mutual aid groups which bring together people with similar jobs or interdependent jobs:

- * Ensuring that potential participants understand and agree to the reasons for forming such a group;
- * Ensuring that group members will participate actively in its development;
- * Ensuring that group members select a leader whom they are willing to support in maintaining a productive focus;
- * Limiting the size of the group to between 8 and 12 members;
- * Promoting a structured group, rather than a process group format.

Cherniss & Dantzig (1986) pointed out that even when all the above conditions are met, research suggests that "...the mutual aid or social support group may not be as effective in reducing stress as more focused and structured cognitive-behavioral interventions. Positive social support can be helpful, however, and mutual aid groups sometimes do succeed in fostering such support among their members".

Educational Interventions

Educational interventions include a variety of techniques which are designed to increase the coping skills of individual employees. Training approaches for addressing stress and burnout often include progressive muscle relaxation (Bernstein & Given, 1984; Jacobson, 1938; Rice, 1987). The general purpose of these interventions is to increase the employees' capacity to tolerate the strains arising from the job. Not only will they then experience the job as more pleasant, they will cope more effectively in a relaxed state. Relaxation has particular relevance to burnout in that it ameliorates the experience of exhaustion and increases the capacity to interact effectively with service recipients.

Educational interventions for increasing an individual's tolerance of occupational strains also include cognitive approaches, such as autogenics, a self-suggestion relaxation technique that uses cognitive imagery.

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- They can be implemented within a single organization or bring together the same occupational groups from different organizations.

Figure 1 (on page 14) indicates a typical format of educational interventions.

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GENERAL PUBLIC VERSION

The problem

The expression Staff Burn-out Syndrome was coined to describe a condition characterized by exhaustion, disillusionment and withdrawal in voluntary mental health workers. This concept has aroused considerable interest in all the helping professions, with the publication of a large number of papers and books. This suggests that burnout is a major problem in health services today.

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HEALTH SERVICES
TODAY

There is no single accepted definition of burnout; however, there is agreement among experts that this syndrome includes three main dimensions, to be found among various caregivers, particularly health workers and family members:

- (1) emotional exhaustion;
- (2) depersonalization¹; and
- (3) a reduced feeling of personal accomplishment.

There are other dimensions which are commonly described:

- (i) the phenomenon may occur at an individual or institutional level;

¹ A state of disorderd perception in which self-awareness becomes heightened but all or part of the self seems unreal, remote, or artificial; such changes occur in the presence of an intact capacity for emotional expression.

- (ii) it is an internal psychological experience that involves feelings, attitudes, motives and expectations; and
- (iii) it is a negative experience which highlights problems, distress, discomfort, dysfunction, negative consequences, or all of these.

BURNOUT

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EMOTIONAL EXHAUSTION + DISILLUSIONMENT + WITHDRAWAL

Burnout involves physical, emotional and mental signs and symptoms. Physical exhaustion is evidenced by low energy, chronic fatigue, weakness, weariness, increased susceptibility to illness, frequent headaches, nausea, muscle tension, back pains, various somatic complaints, and sleep disturbances. Emotional exhaustion may involve feelings of depression, helplessness, hopelessness, increases in tension and conflicts at home, increases in negative affective states (e.g., anger, impatience and irritability) and decreases in positive states (e.g., friendliness, considerateness, courteousness). Mental exhaustion may involve dissatisfaction and negative attitudes towards oneself, towards work and towards life in general. Finally, an increase in work-withdrawing behaviours has also been noted (e.g., absenteeism and turnover).

Long-term effects of burnout

There are suggestions that early career burnout does not seem to lead to any significant, negative, long-term consequences. However, burnout occurring later in the career might have more serious long-term effects. In other words, health service workers can recover from early career burnout. Interestingly, some of the factors which help individuals to recover from burnout are the same ones which help prevent burnout: new work situations which provide more autonomy, organizational support, and interesting work.

Its frequency

It is difficult to make a precise estimate of the magnitude of the burnout phenomenon, because, as has been seen above, it depends on the interplay of a variety of organizational, environmental and individual factors. However, it has been stated that it may affect up to 30-40% of doctors, at a level sufficient to affect their personal or professional performance. Health workers with other qualifications and from different settings may also suffer from high rates of burnout.

ALL TYPES OF HEALTH WORKERS
EXPERIENCE HIGH LEVELS OF
BURNOUT

Its causes

Most authors see stress, in one way or another, as the key factor in the development of burnout. It is, however, useful to analyze causes of staff burnout according to the areas where preventive action can take place, i.e., job features, the organization environment and the individual.

Features of jobs in the health services

As seen above burnout is a phenomenon very common amongst the helping professions, although it is not restricted to them. There are specific factors related to these professions which may be responsible for the occurrence of the phenomenon. Other important factors are (i) inability to help an acutely distressed client and (ii) lack of observable progress with patients.

The very characteristics of the work with chronic, incurable and dying patients is particularly conducive to burnout. This is the case in working with people with chronic mental disorders and with AIDS patients.

RISK FACTORS FOR BURNOUT INCLUDE:

***CHARACTERISTICS OF HEALTH SERVICES
ORGANIZATIONAL ENVIRONMENT
INDIVIDUAL TRAITS***

The organizational environment

Although no factor taken in isolation can be considered as a source of burnout, their interplay and the simultaneous presence of several of them (which is very often the case) can significantly contribute to causing burnout among health professionals. The following environmental and organizational factors in health services may cause stress:

- (1) role or case overload with few structured time-outs;
- (2) institutional disregard for the needs of patients in favour of administrative, financial, and bureaucratic needs;
- (3) inadequate leadership, supervision, or both;
- (4) lack of training and orientation specific to the job;
- (5) lack of a sense of impact on and control over one's work situation;
- (6) lack of social interaction and support among staff;
- (7) caseloads consisting predominantly of extremely difficult patients; and
- (8) majority of time spent on administration and paperwork tasks.

Perceived lack of control seems a particularly important risk factor for burnout. In fact, research has shown that therapists in institutional settings more frequently admitted feelings of disillusionment than did therapists in noninstitutional settings, including private practice.

Lack of social support has also been indicated as a contributing factor to the development of burnout. In addition, organizational climate, supervisor behaviour, and work group relations exert a direct influence on job satisfaction. In particular, an environment which allows the expression of views is favourable and leads to more open and supportive relations among nurses, which in turn reduces role ambiguity.

The individual

It has been suggested that some health workers possess personality characteristics that make them more prone to burnout. In particular, burnout has been associated with neurotic anxiety, unrealistic goals and expectations, and low self-esteem. Another important characteristic which affects stress reaction is flexibility. Flexible people tend to experience more stress associated with role conflict than do more rigid people, because the more flexible find it difficult to set limits and say "no" to extra demands. Also, research findings suggest that subjective perceptions of work may be more important than objective work conditions in influencing burnout.

One solution: prevention

It is possible to identify a few interventions which carry a great potential for prevention. These are based on careful observation of the daily routine of caregivers, on the one hand, and on results of techniques employed for treating or attenuating already existing burnout, on the other hand, which have relied heavily on techniques derived within the stress management field. Experience indicates that they are probably effective for the prevention of burnout, as well.

FOCI FOR THE PREVENTION OF
BURNOUT ARE:

THE INDIVIDUAL EMPLOYEE
THE WORK GROUP
THE ORGANIZATION

In pages 9 to 11 a series of boxes summarizes strategies, actions and interventions proposed for the prevention of burnout. Most are straightforward in their formulation and immediate goals. Setting them depends greatly on a favourable organizational decision and their implementation is a task for whomever in the organization is in charge of personnel. Obviously the collaboration of other parties - such as staff counsellor, career development officer, staff's medical service, supervisors at different levels in the administration, staff association leaders, union leaders, as well as workers in general - is fundamental for an effective implementation of these interventions.

Individual and group interventions

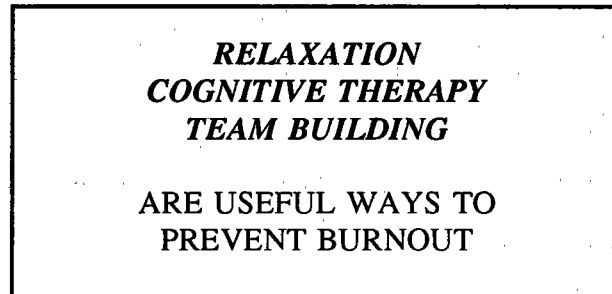
The availability and viability of organizational methods of coping with burnout are often matters of personal control. Employees in settings which offer few opportunities to exercise personal control over their environments are restricted to individual coping methods in the first instance. If they cannot control the balance of demands and resources inherent in the job, coping can only be a matter of developing a greater capacity to endure. Thus, time management serves as a means of gaining some control when interacting with demands from patients or co-workers. *Relaxation* and *cognitive therapy* methods increase a person's capacity to tolerate the impact of demands.

Team building also represents a useful way to avert or ameliorate burnout. Social support networks at work comprise co-workers from within the organization and employees of similar occupational groups employed by other organizations. Social networks are a medium for exchanging innovative ideas on managing tasks, coping with stress, and developing in a career. The key principles for conducting successful mutual aid groups are:

- * Ensuring that potential participants understand the reasons for forming such a group and agree with them;
- * Ensuring that group members will participate actively in its development;
- * Ensuring that group members select a leader whom they are willing to support in maintaining a productive focus;
- * Limiting the size of the group to between 8 and 12 members;
- * Promoting a structured group, rather than a process group, format.

Educational interventions include a variety of techniques which are designed to increase the coping skills of individual employees. Training approaches for addressing stress and burnout often include progressive muscle relaxation. The general purpose of these interventions is to increase the employees' capacity to tolerate the strains arising from the job. Not only will they then experience the job as more pleasant, they will cope more effectively in a relaxed state. Relaxation has particular relevance to burnout in that it ameliorates the

experience of exhaustion and increases the capacity to interact effectively with service recipients. Figure 1 (on page 14) indicates a typical format of educational interventions.



Organizational techniques

Many proponents of organizational strategies view individual-based techniques as blaming the victim by concentrating on problems within individuals, overlooking stress factors beyond individual control. Alternatively, three organizational strategies can help in overcoming job stress and burnout among human service professionals: modifying the job, reducing stress through supervision, and organizational problem-solving.

The development environment comprises organizational systems for enhancing the skills and the career development of employees, including both learning intrinsic to the job and formal training opportunities. A strong development environment enhances feelings of professional efficacy and personal accomplishment; a weak environment engenders hopelessness and lethargy.

a) *Modifying the job:* Modifying the job provides one of the simplest and most powerful ways of reducing stress by lessening role overload, underload, ambiguity or conflict. It also allows flexibility to permit compatibility between employees and their jobs (implies the value of effective human resource divisions in job placement) since a job considered as being stressful to one person might not be to another. These are ways to restructure jobs in order to reduce individual employee stress:

- (1) spread out the unpleasant work so that no one person or group of people have to shoulder all the burden;
- (2) arrange the day in order to alternate pleasant and unpleasant activities so as not to become overwhelmed by unpleasant tasks;
- (3) set aside time during the day for rejuvenative activities related to work *e.g.*, reading;
- (4) encourage part-time employment - this has the potential of increasing the number of available human resources while providing flexibility in individual schedules; and
- (5) give staff members the opportunity to develop new programmes (fosters job spontaneity and creativity and overcomes boredom of routine).

***MODIFYING THE JOB
SUPERVISOR DEVELOPMENT
SOLVING ORGANIZATIONAL PROBLEMS

ALSO PREVENT BURNOUT***

b) *Supervisor development:* This strategy may help to modify supervisory behaviour while providing a sense of empowerment to rank-and-file workers. They help supervisors to become more open to suggestions and employees to feel that their opinions and suggestions are valuable. Feedback should be collected from subordinates through regular anonymous surveys at regular intervals (*e.g.* every six months). It combines meaningful structure and direction whilst providing support and confirming autonomy with a consultative supervisory style.

c) *Organizational problem solving:* One of the objectives of a quality improvement program is the recognition of the need to institute permanent, formal mechanisms to monitor internal work climate and deal with problems when they first arise. Holding regular meetings with employees focusing on problem-solving contributes to reducing the sense of powerlessness, role ambiguity and conflict while encouraging improved communication patterns within the organization.

5. CONCLUSIONS

Burnout syndrome has become a major problem faced by caregivers of people affected by chronic disorders, both staff and family members. As such, it compounds and aggravates the several difficulties health services meet in their daily functions.

Whereas the hardships created by some disorders cannot be completely eliminated, the burden they place on those who have to deal with them can indeed be alleviated by using a few simple and affordable measures. This is true both in the workplace and at home, where more and more care is expected to take place, with the shift from hospitals to community-based health care. Therefore, the implications of what has been discussed here should not be overlooked by health managers, particularly, for example, those involved in programmes of deinstitutionalization of mental patients.

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