

Burnout and psychiatrists: what do we know and where to from here?

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Medicine in most parts of the world is becoming a stressful profession. Psychiatrists represent a high-risk group among doctors for experiencing burnout, alcohol and drug use, posing suicide risk and other forms of work-related stress. There are reports that entrants in the profession of psychiatrists are decreasing globally. Conceptual issues related to burnout are explored and factors contributing to burnout in psychiatrists are reviewed. Methodologically sound studies are needed to help us understand positive aspects of psychiatry as a profession and the environment psychiatrists work in. Effective treatment programmes for burnout are also needed not only to reduce suffering but also to retain psychiatrists in the profession.

Key words: burnout, psychiatrists, occupational stress, emotional exhaustion.

Introduction

Increasing rates of mental disorders, substance abuse, suicide and consequent impairment in functioning among doctors are well recognised. This has resulted in professional bodies like Canadian Psychiatric Association to issue position papers on treating impaired physician (Myers, 1997, 2008). In keeping with the Hippocratic tradition many doctors place their patients before themselves. Their work exposes them to a plethora of emotions, including a need to rescue the patient, a sense of failure and frustration when the patient's illness progresses, feelings of powerlessness against illness and its associated losses, grief, fear of becoming ill oneself or a desire to separate from and avoid patients to escape these feelings (Meier *et al.*, 2001). These emotions, powerful in nature and capable of causing distress, arise from the doctor–patient relationship.

Doctors are also exposed to stressors from outside the doctor–patient relationship. They have to work in an increasingly litigious and unforgiving environment (Myers, 2008). Bureaucratic requirements imposed upon them are increasing and medical knowledge is advancing rapidly with which doctors have to constantly keep in touch (Hughes *et al.*, 2002). A recent publication by the World Medical Association has observed '*physicians in many countries are experiencing*

great frustration in practising their profession, whether because of limited resources, government and/or corporate micro-management of healthcare delivery, sensationalist media reports of medical errors and unethical physician conduct, or challenges to their authority and skills by patients and other healthcare providers' (WMA, 2009, p. 114).

Furthermore, doctors are finding themselves working in an environment or in roles for which they were not trained. Service delivery is changing from an office-based model to a population-based health model. Doctors have to fulfil administrative duties, such as dealing effectively with workforce issues, often in addition to their significant clinical commitments (Hughes *et al.*, 2002). Fulfilling unaccustomed tasks creates stressors and it would appear that constantly changing work environment predisposes doctors to experiencing high levels of stress.

Such chronic exposure to stressors arising from work causes burnout. Burnout now a term in common usage, was first coined by Freudenberger (1974) to describe the emotional exhaustion experienced by workers in the public services. Over the last 30 years, research literature on this topic has accumulated and, according to one estimate, over 2500 publications on burnout had appeared by 1999 (Carson *et al.*, 1999). It is noteworthy that most of these publications have restricted the definition of burnout to human-service workers, a trend that acknowledges the unique pressures of utilising one's self as the 'tool' in face-to-face work with needy, demanding and often troubled clients (Carson *et al.*, 1999). Doctors fall in this category of professionals at high risk of experiencing burnout.

Psychiatrists represent a special group among doctors who may be particularly vulnerable to burnout – more

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so than their counterparts in other disciplines (Snibbe *et al.*, 1989; Deary *et al.*, 1996; Myers, 2008). Findings from these studies have not yet ascertained whether it is the nature of the work or the environment psychiatrists practice in or it is their personality structure that makes them susceptible to experiencing stress.

We do know that psychiatry has undergone significant and rapid change in a relatively short period of time, which may mean constant adaptation to new ways of working for many psychiatrists (Hafner, 2002). Psychiatry has also changed from being a custodial to a therapeutic discipline. Simultaneously, the expectations of a society have also increased dramatically: people seek psychiatric help not only for relief from disorder but also for manifold problems of everyday life whereas many psychiatrists may not feel equipped or comfortable in taking on such roles (Hafner, 2002). Some of these changes in philosophy and expectations may have occurred three or four decades ago, but their full impact on service delivery may still be current. Professional requirements to be met by psychiatrists have increased quantitatively and qualitatively with the change from a caring, paternalistic attitude towards the mentally ill to a therapeutic partnership (Hafner, 2002). Relatives of mental-health patients on the other hand widely harbour unrealistic expectations of therapy outcomes (Lozinskaia, 2002). Psychiatrists in many developed countries report excessive workload which they try to deliver in grossly inadequate and underfunded mental health services (Bressi *et al.*, 2009). There is an increasing expectation from the society that psychiatrists ought to be precise in predicting risk of violence and suicide among their patients even though the task of predicting is well recognised to be fraught with difficulty (Mellsop & Kumar, 2008).

Almost in parallel with such trend psychiatrists report being distressed by a higher frequency of face-to-face and often aggressive interactions with patients (Lasalvia *et al.*, 2009). Perceived unfairness at workplace, higher frequency of face-to-face interactions with patients and weak workgroup cohesion are reported to affect burnout in psychiatrists (Lasalvia *et al.*, 2009). The profession of psychiatry may be becoming stressful for many practitioners. Not paying urgent attention to the growing problem of burnout in psychiatrists may have dire consequences for the profession that is already facing diminishing entrants and stigma (Kendell & Pearce, 1997; Storer, 2002; Roberts, 2010).

What is burnout?

It is worth examining some of the concepts around burnout at this stage. Various definitions of burnout

have emerged in the last three decades. Kuremyr *et al.* (1994, p. 676) proposed a uni-dimensional model of burnout, which was based on exhaustion. They defined burnout as 'an experience of physical, emotional and mental exhaustion caused by long-term involvement in situations that are emotionally demanding'. This definition was based on the work by Pines & Aronson (1988). Lee & Ashforth (1990) defined burnout as a syndrome of emotional exhaustion, depersonalisation and feelings of low personal accomplishment. This definition was based on Maslach & Jackson's (1986) work, which used a three-dimensional model of burnout by adding two dimensions of depersonalisation and reduced personal accomplishment to the dimension of exhaustion. Emotional exhaustion (tiredness, somatic symptoms, decreased emotional resources and a feeling that one has nothing left to give to others) is used to mean people feeling emotionally overextended and exhausted by their work, 'Depersonalisation' describes when people develop negative, cynical attitudes and impersonal feelings towards their clients, treating them as objects, and 'reduced Personal Accomplishments' denote feelings of incompetence, inefficiency and inadequacy. The higher the Emotional Exhaustion and Depersonalisation scores and the lower the Personal Accomplishment scores, the more a physician would be suffering from burnout. This definition of burnout has been the most widely used in psychiatric literature and will be used here.

Why do we experience burnout?

We also need to understand why, when faced with chronic work stress, does one develop burnout? The symptoms of burnout have been hypothesised to appear in order to protect human psyche against further damage in the face of 'having no way out'. Freudenberger (1983) describes depersonalisation as a means of protection against further emotional drowning or a homeostatic mechanism in an emotionally exhausted worker. Along similar lines, one may argue that emotional exhaustion acts as a 'brake' to stop burnout individuals who may not know how or when to slow down. Negative changes in attitude (reduced work goals, loss of idealism, heightened self-interest and increasing emotional detachment from clients) have been described by Benbow (1998) as forms of coping. Huggard (2003) has suggested that even though disengagement and distancing are often employed as coping mechanisms by people facing burnout, they lead to reduction in empathy. Many doctors believe that detachment from emotional engagement with

patients is beneficial. Halpern (2001) has identified the main benefits of such detachment: protection against burnout, better concentration, sustained impartiality and objectivity, and better time management. Despite the benefits identified, maintaining empathy in a therapeutic relationship is beneficial and indeed may be preventative against burnout (Halpern, 2001; Huggard, 2003).

But is burnout the only type of reaction one can expect to have when exposed to chronic work stress? Exposure to specific types of stressor is reported to be associated with certain types of responses which may be different to burnout (McCann & Pearlman, 1990; Figley, 1995; Pearlman & Saakvitne, 1995; Cunningham, 2003; Huggard, 2003). Mental health professionals, such as psychiatrists, invariably work with people who have been traumatised and are at high risk of vicarious traumatisation. Vicarious traumatisation describes the impact of repeated empathic engagement with trauma survivors and associated cognitive, schematic and other psychological effects (McCann & Pearlman, 1990). Symptoms associated with vicarious traumatisation include anxiety, disconnection and avoidance of social contact, becoming judgemental, depression, somatisation and disrupted belief about self (Pearlman & Saakvitne, 1995; Cunningham, 2003). While some symptoms of vicarious traumatisation may appear to overlap with burnout, causation differs. Burnout may be caused by stresses associated with factors such as caseload and institutional stress, whereas vicarious traumatisation occurs due to counter-transference issues by virtue of working with or even repeated exposure to traumatic client material (Stamm, 1997).

Compassion fatigue is another term often described in the literature on occupational stress among professionals working with traumatised patients. It encompasses more advanced psychological disruption and is used interchangeably with secondary-traumatic stress disorder. Symptoms of secondary traumatic stress disorder are said to be identical to post-traumatic stress disorder, including those of intrusion, avoidance and arousal that may occur even after exposure to one incident (Figley, 1995). Two coping skills, sense of achievement and emotional disengagement, are said to protect against compassion fatigue, whereas prolonged exposure to traumatic materials, traumatic recollections and life disturbances leads to its development. New evidence has also emerged to suggest that rather than exposure to patients' traumatic experiences it is work-related stress that best predicts burnout among psychiatrists (Devilley *et al.*, 2009). Management process (workgroup cohesion) and two working life areas (fairness and control) were the strongest predictors of burnout in another study

(Lasalvia *et al.*, 2009). Systemic as well as socio-demographic factors perpetuate burnout among psychiatrists.

What are the consequences of burnout in psychiatrists?

We still fully do not understand the consequences of burnout in psychiatrists. Majority of the research on this topic has focused on causative or protective factors for burnout in psychiatrists (Guthrie *et al.*, 1999; Holloway *et al.*, 2000; Fothergill *et al.*, 2004; Kumar *et al.*, 2005). Lately some studies have focused on intervention strategies, but no methodologically sound studies have examined the immediate consequences of burnout on psychiatrists or their patients. In the absence of longitudinal data, the literature on consequences of burnout has largely evolved from cross-sectional or anecdotal reports. Caution needs to be exercised in interpreting causality from these studies because most of them describe factors that are associated with burnout in a cross-sectional survey of participants. Alternatively, they describe opinions of researchers or study participants about the consequences of burnout without providing any objective evidence of their occurrence or prevalence.

Studies on burnout in other professions suggest that high levels of emotional exhaustion is associated with a range of somatic symptoms such as headaches and sleep disturbances (Dell'Ebra *et al.*, 1994; Burke & Greenglass, 1988) or the intention to leave work (Lee & Ashforth, 1990). Psychiatrists as a group are reported to be at a significantly higher risk of substance abuse, depression, suicide and dysfunctional behaviour including risk of developing sexual relationship with patients than other disciplines (Firth-Cozens, 2007; Myers, 2008) and stress or burnout may be a contributing factor for such problems. Burnout in psychiatrists, therefore, has significant implication for the future of delivery of mental health (Wykes *et al.*, 1997).

Psychiatrists may suffer a direct consequence of burnout reported in other professions, namely decline in professional idealism and coping mechanisms. Gollither (1995) in a study of burnout in psychiatrists and psychologists hypothesised that as clinical experience increases, idealism and stress decrease, and the use of coping mechanisms increases. This study surveyed first-year psychiatric residents and first-year clinical psychology doctoral students (low-experience level), third-year residents and clinical psychology interns (medium-experience level) and clinical psychologists and psychiatrists (high-experience level) to determine their attitudes towards the mental-health profession. Their answers were analysed through

analysis of variance by the level of experience and discipline (clinical psychology or psychiatry) to determine significant differences in idealism, burnout levels and coping mechanisms. As predicted, clinicians with low-experience level were more stressed, more idealistic and used fewer coping techniques than those with high-experience level. The results for the medium-experience group were equivocal. Significant differences between clinical psychology and psychiatry included higher stress for psychiatrists and differences in the areas in which clinical psychologists and psychiatrists were idealistic. Significant interactions between the level of experience and discipline suggested a different progression through the three levels of experience for clinical psychology than for psychiatry (Gollhofer, 1995). A similar inverse relationship between burnout and clinical experience has been reported in two recent studies. Martini *et al.* (2004) compared burnout levels among residents in different medical specialities and found that 77.3% of first-year residents as opposed to 41.8% of second-year residents met criteria for burnout using Maslach Burnout Inventory. The authors, however, did not define what they meant by 'criteria for burnout'. Woodside *et al.* (2008), on the other hand, reported an inverse correlation between age and scores on depersonalisation subscale of Maslach Burnout Inventory in an American study of burnout in family medicine and psychiatry residents.

Absenteeism, productivity problems, job dissatisfaction, lower quality of care, adverse work environment, lowered retention of skilled staff as well as poor patient care and patient dissatisfaction have been identified as consequences of burnout in health professionals in general. More than half of the respondents in a Canadian study were considering relocating due to burnout (Thommasen *et al.*, 2001). In another study of Community Mental Health Nurses, one-quarter of respondents were found to possess negative attitudes towards their clients, and approximately one in seven experienced little or no sense of satisfaction with their work (Hannigan *et al.*, 2000). Whether or not these factors apply to psychiatrists remain to be seen.

Another effect of burnout could be on job satisfaction; as burnout increases job satisfaction decreases and vice-versa. A survey of 96 community mental health centre (CMHC) psychiatrists found that many suffered from burnout: 46 expressed dissatisfaction with their work in CMHCs, 14 expressed satisfaction, seven had mixed feelings, whereas the remaining respondents gave 'diverse responses' that did not fit into any clear category (Vaccaro & Clark, 1987). Factors contributing to dissatisfaction included lack of administrative support and validation, low pay,

responsibility without authority and pressure to sign documents related to patients unknown to them. Factors contributing to satisfaction were having a variety of tasks, being valued for having uniquely comprehensive experience, being supported in the clinical oversight role, being in charge of CMHC operations and working in a CMHC affiliated with an academic centre or the medical community (Vaccaro & Clark, 1987). From the studies reviewed above, a relationship between burnout and job satisfaction appears tentative (Vaccaro & Clark, 1987; Gollhofer, 1995). A more definitive relationship has recently emerged from an Italian study of burnout among 81 psychiatrists working in the Italian public mental health system (Bressi *et al.*, 2009). These authors reported a low score on the job satisfaction section of Job Diagnostic Survey predicted high scores on the Emotional Exhaustion subscale of Maslach Burnout Inventory, implying that job satisfaction may have a protective effect against burnout in psychiatrists. In other words, the relationship between burnout and job satisfaction in psychiatrists is poorly understood and often contradictory.

Where to from here?

A number of studies have investigated the factors that are associated with, or cause, stress in psychiatrists (Bressi *et al.*, 2009; Lasalvia *et al.*, 2009; Kumar *et al.*, 2011). While such studies have enriched our understanding of the subject, we need to move on to understanding the factors that create a positive work environment and protect psychiatrists against work stress. Applying Job Demands Resource Model, an emerging concept in recent scientific literature, to psychiatrists' work environment may give us some answers. This model brings the well being and ill health of employees along with antecedents and consequences of well being and ill health together (Hakanen *et al.*, 2008) and can be applied to any type of work and categorises the aspects of the job which affect stress into two groups: Job Resources and Job Demands (Hakanen *et al.*, 2008). Job Resource refers to the physical, psychological, social and organisational factors that reduce job demands, assist in achieving work goals and stimulate personal growth. They do this by enhancing external motivation (necessary for dealing with job demands and achieving goals) and internal motivation (by fulfilling the basic psychological needs of autonomy, belongingness and competence). Job Demands are those aspects of a job that require sustained physical and or psychological effort. The greater the job demand, the greater the strain on workers. Richness in Job Resources is said to increase work engagement. It can be postulated that this

study largely looked at 'Job Demands' though some protective factors against burnout were also investigated. By applying the Job Demands Resources model, we may be able to learn more about job resources and protective factors against burnout.

Similarly, we also need to understand what factors help psychiatrists find enjoyment or a sense of purpose from their work. This phenomenon has been described as work engagement (Bakker *et al.*, 2008). Such investigation may help us learn about the factors that prevent burnout in psychiatrists. Work engagement is a concept that is increasingly used in the occupational health psychology literature (Bakker *et al.*, 2008). It is a positive attribute and in many ways just the opposite of burnout characterised by vigour, dedication and absorption, each of which have been operationally defined (Hakanen *et al.*, 2008). High levels of mental energy, persistence and resilience are considered to characterise vigour, whereas a sense of significance, enthusiasm, inspiration, pride and challenge characterise dedication. Absorption is characterised by being engrossed in work, which gives rise to the feeling that time at work passes quickly. Learning about factors that enhance vigour, dedication and absorption among psychiatrists will help us learn about work engagement in psychiatrists. It has generally been recognised that engaged workers have high levels of energy and identify strongly with their work (Bakker *et al.*, 2008). Whether psychiatrists who are better engaged with their work would be protected against burnout will need to be seen through future research. The dimension of personal accomplishment in the construct of burnout has been outlined above. A recent literature has described a construct 'Positive Orientation' that captures evaluations about oneself, one's life and one's future (Caprara *et al.*, 2010). It sounds plausible that possession of such attitudes may protect psychiatrists against burnout. Future studies may wish to examine the level of protection offered against burnout by such personality attributes or attitudes.

We also need well-designed studies on intervention strategies against burnout. Two excellent systematic reviews have reviewed the evidence for the effectiveness of various intervention strategies against burnout (Marine *et al.*, 2006; van Wyk & Pillay-van Wyk, 2010). Stress management programmes are often suggested for managing staff burnout. However, the systematic review by van Wyk & Pillay-van Wyk (2010) found no evidence of effectiveness of brief stress-management training interventions in reducing job stress for health workers. The authors did find low-quality evidence to support the effectiveness of stress-management training of moderate intensity (defined as more than 6 h contact over 1 month) in short-term reduction of job stress levels, but the beneficial effects

diminished without booster sessions. The review found strong levels of evidence to support the effectiveness of intensive, long-term stress-management training programmes in reducing the job stress and risk of burnout among a wide range of health workers working in a variety of settings. This review looked at all health care workers and was not limited to psychiatrists alone. The systematic review by Marine *et al.* (2006) grouped intervention strategies against burnout into person-directed (cognitive behavioural therapy, relaxation, music making, massage and multi-component programmes) and work-directed (attitude change and communication, support from colleagues, participatory problem solving and decision making, and changes in work organisation). The authors found that there was only limited evidence to support the efficacy of either person- or work-directed intervention strategies in reducing burnout in healthcare workers, but concluded that the benefits of such interventions may be evident for as long as 2 years. This review highlighted the need for good quality intervention studies for burnout.

Combining the two systematic reviews, one could speculate that perhaps an intense stress-management programme with booster sessions delivered over a longer period may yield longer-lasting results in psychiatrists experiencing burnout. Future studies of intervention in burnout and job satisfaction in psychiatrists may wish to compare efficacy of long- and short-term programmes of varying intensities.

Conclusions

Doctors in general and psychiatrists in particular are prone to experience work-related stress and burnout. Factors related to the work environment appear to play a stronger role in causing burnout in psychiatrists than personal factors. Future studies will need to explore positive aspects of psychiatry as a profession, develop preventative strategies and effective treatment programmes against burnout in psychiatrists if the profession has to survive.

Conflict of interest

This work is based on an MD thesis submitted to the University of Auckland

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