

PREVENTION OF BURNOUT SYNDROME OF HEALTHCARE WORKERS

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ABSTRACT

Burnout syndrome is a frequent consequence of chronic stress among workers in various industries, especially in the healthcare sector. Slovak healthcare is chronically understaffed, exposed to public pressure, and the staff is underpaid. The mentioned facts adversely affect workers and expose them to a high risk of burnout. The aforementioned impacts were further exacerbated by the Covid19 pandemic. The aim of the work was to characterize the burnout syndrome, to outline the possibilities of prevention and to find out the real extent of their application in practice.

Keywords:

Burnout syndrome, Covid, Prevention, Health workers

INTRODUCTION

WHO understands burnout syndrome as a consequence of chronic stress caused by employment. Symptoms of burnout include a feeling of lack of energy, exhaustion, the development of mental and emotional distance from the job, a feeling of negativism or cynicism in relation to the job, and a decrease in professional effectiveness (manifested by the feeling that I have to exert more effort to achieve the same performance). Although burnout syndrome can affect the health status and can be a reason for seeking health services in itself, it is not included in the list of nosological units as a somatic or mental illness by the World Health Organization. The World Health Organization specifically characterizes burn-out as a phenomenon in the context of employment, and the term burnout should not be used to describe experiences and feelings in other areas of life.

HISTORY OF THE BURNOUT SYNDROME

The term burn-out was probably used as early as the 1960s and early 1970s, appearing for example in the title of Graham Greene's novel "A Burnt-Out Case", which told the story of a

doctor who worked in the Belgian Congo with patients suffering from leprosy. The term burn-out was first used by the American psychologist Herbert Freudenberger in his scientific article "staff burnout" from 1974. The article was based on his observation of volunteer employees (among whom he was a member) working in a rehabilitation facility for drug addicts. He characterized burnout as a set of symptoms that include exhaustion as a result of excessive workload, physical manifestations - headaches and sleep disorders, but also psychological changes - closed thinking, irritability, irritability. He also stated that a burnt-out worker looks, behaves and at first glance seems depressed. After the article was published, "burnout" became the subject of intensive study in professional psychological circles (Herbert, Freudenberger, 1974).

The key work for the modern understanding of burnout syndrome is the work of the authors Christina Maslach and Susan Jackson from 1981, in their work they also published a tool for assessing the burnout syndrome in a worker called "Maslach Burnout Inventory" (MBI). In her work, Christina Maslach describes burnout syndrome as escalating emotional exhaustion, depersonalization (dealing with clients, students, customers and colleagues in a distant or cynical manner) and a decrease in feelings of personal success in relation to work. The Maslach Burnout Inventory became the first and still the most widely used tool for assessing burnout. It was originally intended for employees working in certain service industries - especially teachers and social workers. However, it has also become an excellent tool for assessing health workers. Variants of this tool are used today to assess employee burnout in many industries. The WHO adopted the concept of burnout syndrome from Maslach, but does not view it as a mental disorder. Maslach does not classify burnout as a depressive condition, but recent studies suggest that it could be a depressive disorder (Maslach, C.; Jackson, SE 1981).

DIAGNOSIS AND CLASSIFICATION OF THE BURNOUT SYNDROME

In the latest revision of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), which was published in 2013, burnout syndrome is not listed as a mental illness. The nosological units "adjustment disorders" and "disorder associated with unspecified trauma and stressor" meet the definition of many types of burnout syndrome. Professional societies in some countries therefore include burnout syndrome under the mentioned nosological units, for example in the Netherlands they classify it as a subtype of adjustment disorder, it is included in Dutch textbooks and medical personnel are trained in its diagnosis and treatment ("QD85 Burn-out" .icd.who.int. Archived from the original on August 8, 2014. retrieved 2022-07-03).

The International Classification of Diseases (ICD) in the current edition classifies burnout syndrome with code QD85 and describes the condition as follows: Burnout syndrome is understood as the result of chronic workplace stress that has not been properly managed. It is characterized in three dimensions:

- 1) feeling drained of energy or tired
 - 2) growing mental distance from work or feelings of negativism or cynicism in relation to work,
 - 3) reduced work efficiency (the same work performance requires more and more effort).
- Burnout syndrome relates specifically to phenomena in the work context and should not be applied to describe experiences in other areas of life.

The syndrome is classified under the category "problems related to employment or unemployment" in the section "factors affecting health status or contact with health services". This section does not deal directly with nosological units. In a May 2019 statement, the WHO said that "burnout syndrome is included in the eleventh revision of the International Classification of Diseases (ICD-11) as an occupational phenomenon. It is not classified as a disease." It is worth noting that the WHO uses the term "caregiver burnout" within the classification also in connection with the QF27 code, which is associated with caregiving in the home environment and thus indicates that burnout syndrome can also occur when caring for a loved one at home ("QD85 Burn-out". icd.who.int. Archived from the original on August 8, 2014. retrieved 2022-07-03).

DIAGNOSTIC TOOLS

In 1981, the authors Maslach and Jackson developed the first widely used burnout assessment tool - the MBI. In accordance with Maslach's understanding of the burnout syndrome, this tool reveals the burnout syndrome in its three dimensions - emotional exhaustion, depersonalization and a reduced sense of personal success. However, some scientists are of the opinion that the burnout syndrome should be understood only in terms of fatigue and exhaustion, since the core of the syndrome is the feeling of exhaustion (Maslach, C.; Jackson, SE 1981).

In addition to this instrument, there are others that reflect a different understanding of the burnout syndrome, for example the Shirom-Melamed Burnout Measure, which understands the burnout syndrome as physical exhaustion, reduced mental performance, and emotional exhaustion. There are several other tools based on different understandings of burnout. In 2010, researchers at the Mayo Clinic used parts of the MBI along with other comprehensive assessments to develop an instrument called the Well-Being Index, a nine-part self-report

instrument for burnout and other dimensions of distress specifically designed for healthcare workers.

SUBTYPES OF BURNOUT SYNDROME

In 1991, Barry A. Farber, in his research conducted on teachers, proposed to divide burnout syndrome into three types:

1. "wearout" and "brown-out", characterized by long-term excess stress and/or insufficient feeling of reward.
2. "classic/frenetic burnout" characterized by trying to work harder and harder to overcome a stressful situation and/or to achieve a sufficient reward.
3. "underchallenged burnout" where the worker is not exposed to a high degree of stress, but the work does not fulfill him (Farber, Barry A. 1991).

In his research, Faber gathered evidence that the most idealistic among the teachers participating in the study were the most at risk of burnout (Farber, Barry A. 1991). There is increasing evidence that burnout syndrome is etiologically, clinically and nosologically very similar to depression. Studies comparing depressive symptoms in patients with burnout and patients with clinically diagnosed depression have repeatedly failed to find significant differences. Other studies have shown that 90% of workers who scored high on the MBI meet diagnostic criteria for depression. Especially the "dimension of exhaustion" of the burnout syndrome is highly correlated with the image of depression, as demonstrated by modern, sophisticated statistical methods. Many studies consider these findings to be sufficient support and burnout can be considered a form of depression. Some authors recommend revising the entire nosological concept of burnout syndrome or abandoning it completely, since it is not a separate disease and there is no consensus on diagnostic criteria. Likewise, most authors do not recommend using antidepressants in the treatment of burnout syndrome, as they can worsen the imbalance in the hypothalamus-pituitary-adrenal system. The subject of the study is also the relationship between burnout syndrome and chronic fatigue syndrome (Schaufeli, WB 2009).

RISK FACTORS OF BURNOUT SYNDROME

Research suggests that the etiology of burnout is multifactorial. Today, it is generally accepted that an important factor in the etiology of burnout syndrome is also the personality traits of the worker. Cognitive dispositional factors that are considered risky for depression also increase the risk of burnout. The most important risk factor is the presence of a stressor with

which the worker cannot fully cope. Authors Maslach, Schaufeli, and Leiter identified six risk factors for burnout:

1. workload imbalance
2. imbalance in the management of the work process
3. insufficient remuneration
4. loss of a sense of positive relationship with other employees at the workplace
5. the feeling of a lack of "fair access" in the workplace
6. conflict between values (Maslach, C., Schaufeli, WB; Leiter, MP 2001).

Burnout syndrome is considered an independent risk factor increasing morbidity and mortality in an employee.

EFFECTS OF BURNOUT SYNDROME ON THE EMPLOYEE

Mental health disorders, increased risk of cardiovascular diseases and reduced work performance can be considered the most serious effects of burnout syndrome on an employee. Decreased work performance is associated with emotional changes in relation to the workplace and the work performed - a decrease in attention at the workplace, reduced interest in the work performed, a reduced level of performance in the work process, a feeling of helplessness. Serious symptoms include sleep disorders. Signs of a depressive syndrome appear from mental disorders.

Reduced work performance is manifested by a variety of changes in the employee's behavior - the employee is without energy for a long time, reduced productivity is manifested, late arrivals to work are regular and frequent, often associated with a feeling of dread after arriving at the workplace, concentration disorders, forgetfulness, growing frustration and feeling overwhelmed by work, the employee has a tendency to be negative, may complain excessively or, on the contrary, show apathy, the employee often believes that he has no influence on colleagues or the work environment. The burnout syndrome is also often manifested by the employee's accumulation of absences, attempts to avoid the workplace and thoughts of terminating the employment relationship. Chronic burnout is manifested by severe changes in thinking and attention. Research shows that symptoms of burnout manifest differently in men and differently in women, in men symptoms of depersonalization prevail, in women symptoms of emotional exhaustion prevail. If it is a volunteer's burnout syndrome, it usually leads to a significant limitation of activities or a complete termination of volunteering.

COURSE OF BURNOUT SYNDROME

The burnout syndrome is not a static phenomenon, it is a dynamic process that develops over time. The worker goes through stages from the beginning to the developed burnout syndrome. The number of stages varies by author and model. The simplest Maslach model recognizes four stages:

1. Enthusiasm - the worker approaches work with enthusiasm and accepts overload
2. Overload - emotional and physical exhaustion is manifested
3. Attacking other people - dehumanizing other people as a defense against burnout
4. "Against everything" - the final stage, standing against everything and everyone, the appearance of the burnout syndrome in all its variety (falling away).) (Maslach, C.1981.

After the usual phase of "enthusiasm" with which workers (especially health workers) enter the practice, after a while the phase of "stagnation" begins. The phase of stagnation is primarily caused by a clash of ideals - positive expectations of the worker and the concrete reality of individual workplaces, which is dominated by negative and demotivating factors and overloading. If the solution to the situation is neglected for a long time and the worker does not actively apply preventive measures, the phase of "frustration" occurs. At the forefront of this phase is the experience of emotional and physical exhaustion. Workers in this phase are more concerned with thoughts about the meaning of their work. More often, they compare the results of their efforts with the evaluation they receive. At the same time, they do not understand only financial compensation as evaluation, but also social and moral appreciation, or the social status of their profession. If at this stage the worker cannot cope with the situation, he goes into the "apathy" phase. At this stage, the worker's attitude changes, he becomes convinced that it is not worth trying very hard. The worker develops the "necessary minimum" of activity, does not get involved, withdraws into himself. In the approach to colleagues and the environment in general, dehumanization is manifested as a defense against burnout. If the worker does not manage to cope with the situation even in this phase, find suitable preventive measures or seek professional help, he moves to the phase of self-burnout. In the burnout phase, all the symptoms and consequences of the burnout syndrome are fully manifested - psychological, physical and social.

The burnout syndrome itself subsequently takes place in three stages, which can be defined based on ongoing behavioral changes. The first stage is characterized by a long-term feeling of time pressure, the causes of which can be different. It can be, for example, insufficient staffing and thus substitution of work for colleagues, insufficient material and technical equipment of the workplace, administrative work. Performance of work tasks under time stress can also be caused by personal prerequisites for the performance of the profession, such as insufficient

professional ability in the implementation of diagnostic and therapeutic procedures, insufficient organizational skills, reduced resistance to handle stressful situations. If this condition persists, the worker loses his system at work, deficiencies in the work process appear with increased frequency during the performance of the profession. The worker perceives this condition very sensitively, he transfers problems from the workplace to his private life and is unable to rest effectively. In the second stage, signs of neurotic behavior begin to appear as a result of persistent mental and physical stress. Conspicuous are the compulsive manifestations of constantly engaging in some activity in order to improve the situation at the workplace and to make the work more bearable and manageable. The worker feels "that he has to do something so that the situation at the workplace can be managed." This constant effort, which lacks consideration of the meaning, importance, adequacy and appropriateness of specific activities, leads to chaotic and uncoordinated performance of activities, distraction, reduced concentration, or failure to complete the work started. In the third stage, the worker loses the feeling that he "must" manage the situation, on the contrary, defiance and the feeling that "I don't have to do anything" sets in. The interest in work gradually decreases, the joy of a job well done also disappears, the ability to enjoy positive things at work and in private life is absent. Only fatigue, exhaustion and disappointment remained from the initial work enthusiasm.

Based on the length and intensity of the factors causing burnout syndrome (short, sudden and intense or long-term, systematic), we distinguish the consequence in the form of acute or chronic burnout syndrome. In the healthcare industry, situations often arise that require excessive, sudden short-term loads, e.g. multiple services in a short period of time, a higher number of patients who require increased care (for example, after a mass car accident), temporary deterioration of working conditions. As a result of such influences, the development of acute burnout syndrome may occur. The improvement of the situation at the workplace, the disappearance of the provoking factor and the possibility of relaxation and rest lead to the stabilization of the situation and the withdrawal of symptoms. Chronic burnout syndrome, on the other hand, usually comes after years of practice, when the work has become mundane. Healthcare workers are exposed to negative influences every day at work, but often also in private life. Their elimination or the solution is usually not easy and is rarely effective. One type of emotional burden to which healthcare workers are exposed is the confrontation with patient suffering, with pain, with death, with treatment complications, with treatment failure, with a high risk of legal liability, with decision-making in a time crunch, with a low aesthetic level of the workplace, with increasing administrative duties (Maslach, C.1981 .

PREVENTION AND TREATMENT OF BURNOUT SYNDROME

The methods of treatment and prevention of a disorder or disease can be classified as primary prevention (preventing the occurrence of a disorder or disease), secondary prevention (removing the disorder or disease that has arisen) and tertiary prevention (aimed at mitigating the impact of the disorder or disease on the life of the affected person).

Primary prevention

Maslachová believes that the only way to prevent burnout is a combination of rational workplace organization and proper employee education. According to the author, burnout occurs when the worker and the employer get into a mismatch in six areas of the work process - workload, work process management, reward, work community, fair access, value ranking. Resolving these discrepancies requires an integrated approach with the participation of both the worker and the employer. As for the workload, it is the employer's (organization's) responsibility to provide the employee with sufficient resources - both material and time - to achieve the required performance. Both parties should participate in establishing a better work-life balance, which usually leads to improved work performance and reduced risk of burnout symptoms. In the area of values, it is beneficial if the employee feels the application of ethical principles clearly defined by the employer. Good leadership and good relationships with colleagues are important to prevent burnout. Regarding the fair approach in one study, employees met on a weekly basis and discussed perceived grievances, while also trying to address them. This approach led to an improvement in work performance, employees felt less exhausted and in better working well-being. Burnout prevention programs have traditionally dealt with cognitive behavioral therapy, thinking restructuring, stress management and relaxation training. CBT, training in relaxation techniques (both physical and mental) and changes in the schedule of activities are currently considered the most effective ways to prevent burnout in healthcare workers. The effectiveness of the measures is enhanced by changes at the level of the individual (employee) and at the level of the entire organization. However, a meta-analysis by Cochrane showed that the evidence for the effectiveness of CBT in preventing burnout in health care workers is of low quality, suggesting that it is not a superior approach compared to alternative methods (Maslach, C.1981).

In the prevention of burnout syndrome, several intervention systems are used, which help to improve the health of employees, including their psychological state, and reduce their stress load. (Okech- Neszméry- Mačkinová, 2020) In addition to intervention systems, stress management training is proven to be a successful method. Studies show that social-cognitive

processes such as promoting commitment to work, training effectiveness at work, training "ingenuity", promoting a sense of trust and hope in the workplace protect the employee from the onset of burnout. A more significant degree of employee control over their employment and work process is also one of the effective ways to combat burnout and cynicism in the workplace. Other methods of prevention include: starting the day with a relaxing ritual, yoga, following the principles of a healthy diet, regular exercise, proper sleeping habits, setting workload limits, limiting the use of modern technologies (including "rest from computer technology" and the like), applying the creative side of the personality and stress load regulation training. Barry A. Farber recommends strategies to prevent burnout: setting more attainable goals, focusing on the value of the work being done, and finding better ways to do the work, these help prevent the consequences of the stress an employee is exposed to. Such an approach can also help employees who are not bothered by the stress load but do not feel sufficiently "rewarded", these employees may benefit from re-evaluating the balance between workload and private life. Employees with low levels of stress may feel underappreciated, bored with their work, and may benefit from seeking a greater challenge, according to Farber. In one study, employees receiving high doses of B complex vitamins reported significantly lower levels of fatigue and lower rates of confusion and depression after twelve weeks. (Farber, Barry A. 1991) .

Secondary and tertiary prevention

Hätinen and colleagues compiled a list of treatment options that includes treatment of other health problems (which may contribute to burnout), stress management, work time management, treatment of depression, psychotherapy, improved ergonomics and other forms of physical and occupational therapy, physical training and relaxation exercises. According to their findings, the emphasis on group conversations on topics related to the work process and discussions about the relationship between private life, personal needs and the work process with a psychologist and representatives from the workplace is shown to be the most beneficial. (IN: Farber, Barry A. 1991) .

Authors Jac JL van der Klink and Frank JH van Dijk propose training in the form of "stress inoculation", cognitive restructuring, "graded activity" and "time contingency".

In the paper, Kakiashvili and colleagues state that the treatment of burnout syndrome is mostly symptomatic - it includes measures and procedures that prevent the onset and treat the symptoms. The authors report that the use of anxiolytics and sedatives to treat the stress caused by burnout is effective, but does not address the cause of the stress. They also claim that the sleep disturbances that burnout often causes (and the subsequent feeling of fatigue) are best treated with hypnotics and CBT (here, the authors also include "sleep hygiene, education,

training in relaxation techniques, stimulus control, and cognitive therapy). The authors do not recommend using antidepressants, as they worsen the dysfunction of the hypothalamic-pituitary-adrenal axis, which is the core of the pathogenesis of burnout syndrome. The authors consider a sufficient supply of vitamins and minerals to be crucial in the treatment of hypothalamic-pituitary-adrenal axis dysfunction. They consider omega-3 to be particularly beneficial in this regard unsaturated fatty acids. Docosahexaenoic acid supplementation may be a suitable way to moderate norepinephrine. 11 beta-hydroxysteroid dehydrogenase (and possibly other metabolites from licorice root extract (*glycyrrhiza glabra*) may help with the reduced cortisol response.) 1991) .

Salomonsson and colleagues found that for workers with fatigue disorder, cognitive-behavioral therapy had a better stress-reducing effect than a return-to-work intervention. Conversely, workers whose primary symptoms were depression, anxiety, or insomnia benefited more from a return-to-work intervention than from CBT.

Mačkinová, Monika - Planka, T. , Mačkinová, Michaela (2023) after a meta-analysis of the available literature found that an adequate amount of literature that would prove effectiveness exists only for cognitive-behavioral therapy, they further stated that successes were observed when using several procedures - CBT , acceptance and commitment therapy, a multimodal rehabilitation program, physical training, mental training, consumption of *rhodiola rosea* extract, and participation in an African dance program, however, noted that although several interventions have been studied for the treatment of fatigue disorder, the evidence for each type of intervention is limited.

One of the reasons why it is difficult to treat all three standard symptoms (fatigue, cynicism and ineffectiveness) is the fact that these symptoms respond differently to individual preventive and therapeutic activities. Fatigue is easier to treat than cynicism and professional ineffectiveness, which tend to be more resistant. Research shows that treatment can further reduce the professional effectiveness of a worker who already had low professional effectiveness at the start of treatment. Rehabilitation of the worker is a tertiary preventive intervention, which means that the strategies used in the rehabilitation help to alleviate the symptoms of burnout in the workers who are affected by this syndrome, but they cannot cure the burnout syndrome. Such rehabilitation procedures aim to maintain and improve the working abilities of workers and ensure a sufficient "stock" of capable and competent professionals in society.

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