Burnout in psychiatrists

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Psychiatrists as a group are vulnerable to experiencing burnout, more so than other physicians and surgeons. In this paper, various definitions of burnout are reviewed and the tools available for quantifying burnout are compared. The factors that make psychiatry a stressful profession are also examined. These include factors such as patient violence and suicide, limited resources, crowded inpatient wards, changing culture in mental health services, high work demands, poorly defined roles of consultants, responsibility without authority, inability to effect systemic change, conflict between responsibility toward employers vs. toward the patient, and isolation. In order to investigate how exposure to such stressors results in burnout, two theoretical models are examined. Recommendations are also made, on the basis of anecdotal reports, for addressing burnout in psychiatrists.

Key words: Burnout, psychiatrists, stress management, workforce

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Psychiatrists have a stressful life. They use themselves as "tools" in their profession and experience a range of powerful emotions in their clinical work. The doctor-patient relationship in itself evokes emotions such as the need to rescue the patient, a sense of failure and frustration when the patient's illness progresses or does not respond to treatment, 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 (1). Given the personal nature of the relationship psychiatrists have to develop with their patients, these emotions are likely to be intensified in their context. Psychiatrists are also exposed to external stressors, due to the rapidly changing ways of service delivery, the widening gap between the way they are trained and the way they practice, and the increasingly complex administrative and legal frameworks.

While stressors may originate from a variety of sources and may vary with settings and disciplines, the outcome of chronic exposure to emotional and interpersonal stressors on the job is invariably burnout (2,3). This paper examines the concept and causes of burnout and the relevant interventions as they apply to psychiatrists.

BURNOUT: DEFINITIONS AND MEASURES

The concept of burnout was first introduced by Freudenberger (4). Since then, various definitions have emerged. Kuremyr et al (5) defined burnout as "an experience of physical, emotional and mental exhaustion caused by long-term involvement in situations that are emotionally demanding". Lee and Ashforth (6), referring to Maslach and Jackson's (7) work, defined burnout as a syndrome of emotional exhaustion (tiredness, somatic symptoms, decreased emotional resources, and a feeling that one has nothing left to give to others), depersonalization (developing negative, cynical attitudes and impersonal feelings towards their clients, treating them as objects) and lack of feelings of personal accomplishment (feelings of incompetence, inefficiency and inadequacy). This definition of burnout has been the most widely used in literature.

While burnout may have a negative impact on workforce, patient care and the individual's health, it may also play a protective role. The symptoms of burnout have been hypothesized to appear in order to protect human psyche against further damage in the face of "having no way out". Freudenberger (8) describes depersonalization as a means of protection against further emotional draining or a homeostatic mechanism in an emotionally exhausted worker. Along similar lines, one may argue that emotional exhaustion acts as a "brake" for individuals who may not know how or when to slow down. Negative changes in attitude (reduced work goals, loss of idealism, heightened self interest, increasing emotional detachment from clients) have been described by Benbow (3) as a form of coping.

Standardized and valid instruments have been developed for the measure of burnout. Two are currently popular: the Maslach Burnout Inventory (MBI, 9) and the Burnout Measure (BM, 10). The MBI gives scores on the three subscales or dimensions of depersonalization, emotional exhaustion and lack of personal accomplishment, by determining how people respond to each of 22 statements on a scale of 0-6. The higher the respondents score on depersonalization and emotional exhaustion, the higher their levels of burnout, while the lack of personal accomplishment scale measures in the opposite direction. The inventory has been found to be reliable, valid and easy to administer. The BM contains 21 items (rated on a 7-point frequency scale) grouped into three subscales (assessing physical exhaustion, mental exhaustion, and emotional exhaustion). Unlike the MBI, the items have no explicit association with work and are presented in random order. The subscales have shown good (.80 to .90 range) internal consistency (11), and the total scale has shown a 1-month test-retest reliability of .89 (12). As with the MBI, factor analytical studies suggest that the BM is a unidimensional measure (11). Others have shown a high correlation between the total BM scores and the scores on the MBI emotional exhaustion scale (12).

WHAT CAUSES BURNOUT IN PSYCHIATRISTS

In order to understand psychiatrists' susceptibility to burnout, one needs to examine the factors that make psychiatry a stressful profession. Deahl and Turner (13) identified violence and the fear of violence, limited resources, crowded inpatient wards and an increasing culture of blame creeping into the mental health services as the main sources of stress for psychiatrists. High work demands without adequate resources, poorly defined roles of consultants, responsibility without authority, inability to effect systemic change, conflict between responsibility toward employers vs. toward the patient, isolation of consultants in community mental health teams and lack of feedback were identified as sources of stress by Thompson (14). A qualitative study of mental health professionals in a well-resourced community mental health team including psychiatrists (15) identified administrative demands, lack of resources, work overload, responsibility for patients and relapsing patients as the top five sources of stress. Overt bureaucracy, high workload and the lack of free time were reported as the factors which may either be responsible for premature retirement by specialist psychiatrists or be reasons why juniors would not pursue psychiatry as a career option (16,17). A large survey of psychiatrists identified out of hours or long hours of duty, dealing with difficult and hostile relatives of patients, arranging admissions, paper work, balancing personal and professional lives and managing suicidal or homicidal patients as particularly stressful experiences (18).

It is important to note that not every psychiatrist who is exposed to such stressors for extended periods develops burnout. Holloway et al (19) describe an interactive model that examines the relationship of the external stressors outlined above with mediating factors and stress outcome. To cite their example, "the poorly functioning doctor who lacks appropriate coping mechanisms and ends up working in an impoverished service may well experience more occupational stresses than his or her more successful peer working within a well resourced and professionally rewarding service. Overwhelming personal or professional life events (e.g., a patient homicide) may lead to decompensation of even most resilient and best supplied professional". Positive motivating factors or sources of job satisfaction, such as appreciation for job done well, responsibility for others, personal advancement and salary enhancement, may play an important role in the final outcome of stress exposure.

An inverse relationship between stress and job satisfaction has been reported in lawyers (20), rehabilitation workers (21) and public service employees (22). Surprisingly, such relationship does not appear to exist for psychiatrists: despite experiencing depression and burnout, they can continue to enjoy their work and consistently score high in job satisfaction surveys – a finding reported from the UK (23), Australia (24) and the USA (25,26). One could speculate that psychiatrists as a group are so committed and passionate towards their work that the exhaustion associated with burnout does not dilute their pleasure derived from work. Alternatively, while psychiatrists may be good at picking up changes in their mood state, they may believe that practising psychiatry in an exhausted state is part of their job (27). This peculiarity of psychiatrists as a group renders any model that relies on job satisfaction as a protective factor weak.

A study of psychiatrists and psychiatric residents investigated the relationship between demographic factors, work and leisure activities. Personality was assessed by the Munich Personality Test (MPT) and burnout with the Tedium Measure (TM) (28). Psychiatric residents reported significantly higher scores on TM and neuroticism, but lower scores on frustration tolerance on MPT. The study found that neuroticism alone explained a substantial proportion of the total TM variance. Work-related variables turned out to be of a small importance only, whereas no influence could be demonstrated for different leisure activities. Another study (29) reported that, as a group, psychiatrists differed significantly on various personality measures from physicians in other disciplines. They scored higher than physicians and surgeons on items of neuroticism, openness and agreeableness, but lower on conscientiousness. Even though psychiatrists reported less clinical work demands, they reported higher work-related emotional exhaustion and severe depression than physicians and surgeons. These findings imply that the very personality characteristics that attract people towards pursuing psychiatry as a career may also render them sensitive to stressors.

Another recent paper (30) examined the interaction between four sets of factors proposed to be responsible for burnout: predisposing, precipitating, perpetuating and protective. Many of the factors that were recognized as external, internal and mediating in Holloway et al's model (19) were encompassed in the above four "P" model, which also identified some systemic factors responsible for burnout, raising the possibility that reducing stress through these systemic issues could reduce burnout in psychiatrists.

The above study (30) pointed out that psychiatrists may be predisposed to burnout due to their personality traits, which make them prone to internalize their stressful experiences. Their training experience may also play a significant role in the causation of stress and burnout: psychiatric trainees are more closely involved with people's personal difficulties than trainees in other disciplines, and often labour feelings of self-doubt, fear, and fatigue (31). Psychiatrists are trained in long-term verbal interventions, but they are invariably employed to deliver short-term and mainly biological treatment modalities (32). Furthermore, it appears that workload on psychiatrists is set to increase globally due to increasing population, a progressive move to community-based treatment, increasing involvement in administrative roles, increasing standards of practice, greater expectations by doctors to have time for study and relaxation, as well as diminishing numbers of those choosing to go into psychiatry (33-36). In other words, psychiatrists as a group are predisposed to experience stress due to internal and external factors.

Against the background of these predisposing factors, psychiatrists are invariably exposed to triggers that precipitate burnout. Violence perpetrated by patients is widely prevalent in mental health services (37-41) and is widely recognized as stressful for all psychiatrists, irrespective of their level of experience (42). Most psychiatrists experience patient suicide and are invariably adversely affected by it (43,44). On-call duties and dealing with difficult and hostile relatives have also been described as distressing events in psychiatrists' profession (18).

The final appearance of burnout may depend on how one perceives and responds to stressful situations. Factors that affect such appraisal styles (so-called perpetuating factors) are instrumental in determining whether the stress originated at work may or not translate into burnout. Gender plays a significant role in the perception and origin of stress and consequently in the way one responds to stress: women respond to stresses through career dilution and diminution (working part time) and/or by using strategies to limit demands on intimacy (45). Personality traits may also play a significant role in predisposing psychiatrists to experience burnout and in perpetuating the phenomenon once it sets in (46). Certain systemic factors have been identified that contribute to psychiatrists' stress and therefore possibly burnout: they include changes in health service delivery model, clinician management conflicts, and time management and resource issues (47,48).

PROTECTIVE FACTORS AND INTERVENTIONS FOR BURNOUT

There are factors protecting psychiatrists against burnout. Some evidence suggests that lifestyle factors and paying attention to one's non-professional life may have a protective effect (49). Academic work has been reported (50) to be negatively correlated with depersonalization, emotional exhaustion and overall stress, implying that personality traits of people with academic interests may have a protective effect against burnout (51). While adding teaching to clinical commitments may increase workload, work-related stress may in fact decrease as a result and indeed the sense of professional accomplishment may increase (52).

While the above-mentioned factors may have preventive effects against burnout, their utility once burnout sets in remains untested through well-designed studies. It is worth noting that not only intervention studies are lacking for psychiatrists' burnout, but there is a significant dearth of studies across all disciplines. A recent systematic review (53) of resident burnout found that insufficient data prevented drawing conclusions about causal relationships between stressors and burnout or indeed any attempts to identify at risk residents based on socio-demographic or personality factors. A systematic review of stress, burnout and coping found no studies had evaluated the use of stress-management interventions in psychiatrists (47). The review found three intervention studies that had used samples of "mental health professionals" including psychiatrists. However, for reasons identified above, it might not be appropriate to lump psychiatrists with other mental health professionals when it comes to either stressors or responses to stressors including burnout. In the absence of any well-designed interventional studies, one may have to look at anecdotal reports. Holloway et al (19) listed interventions focusing on the individual (such as social skills training, stress management interventions, social support and time management) and on the organization (defining role and job characteristics, improving interpersonal relationships, encouraging decentralization in the organizational structure and improving the physical environment of work place). The authors emphasized the importance of formal support through regular feedback and appraisal of psychiatrists' performance, which need to occur even in the absence of any identified problem.

CONCLUSIONS

Burnout is a serious consequence of chronic exposure to work-related stressors. As a group, psychiatrists are at a high risk of experiencing burnout, due to external factors such as work environment, internal factors such as personality and appraisal styles, and mediating factors such as support and resilience. The onset of burnout can be seen as a consequence of the interaction between predisposing, precipitating, perpetuating and protective factors. While factors that are protective against burnout and therefore may have a preventive role have been identified, there is a lack of studies evaluating the efficacy of interventions once burnout has set in. Anecdotal evidence suggests that support through peers, organization or family/friends may be effective against established burnout.

References

1. Meier DE, Back AL, Morrison RS. The inner life of physicians and care of the seriously ill. JAMA 2001;286:3007-14.
2. Farber BA. Introduction: a critical perspective on burnout. In: Farber BA (ed). Stress and burnout in the human service professions. New York: Pergamon, 1983:1-20.
3. Benbow S. Burnout: current knowledge and relevance to old age psychiatry. Int J Geriatr Psychiatry 1998;13:520-6.
4. Freudenberger HJ. Staff burnout. J Soc Issues 1974;30:159-65.
5. Kuremyr D, Kihlgren M, Norberg A et al. Emotional experiences, empathy and burnout among staff caring for demented patients at a collective living unit and a nursing home. J Adv Nurs 1994;19: 670-9.
6. Lee RT, Ashforth BE. On the meaning of Maslach's three dimensions of burnout. J Appl Psychol 1990;75:743-7.
7. Maslach C, Jackson SE. The measurement of experienced burnout. J Occup Behav 1981;2:99-113.
8. Freudenberger HJ. Burnout: contemporary issues, trends and concerns. In: Farber BA (ed). Stress and burnout in the human service professions. New York: Pergamon, 1983:23-8.
9. Maslach C, Jackson SE, Leiter MP. Maslach Burnout Inventory Manual, 3rd ed. Palo Alto: Consulting Psychologist Press, 1996.

10. Pines A, Aronson E. Career burnout: causes and cures. New York: Free Press, 1988.
11. Corcoran K. Measuring burnout: an updated reliability and convergent validity study. In: Crandall R, Perrewe PL (eds). Occupational stress: a handbook. Washington: Taylor and Francis, 1995:263-8.
12. Pines AP. On burnout and buffering effects of social support. In: Farber BA (ed). Stress and burnout in the human service professions. New York: Pergamon, 1988:155-74.
13. Deahl M, Turner T. General psychiatry in no-man's land. Br J Psychiatry 1997;171:6-8.
14. Thompson C. The mental state we are in: morale and psychiatry. Psychiatr Bull 1998;22:405-9.
15. Reid Y, Johnson S, Morant N et al. Explanations for stress and satisfaction in mental health professionals: a qualitative study. Soc Psychiatry Psychiatr Epidemiol 1999;34:301-8.
16. Kendell RE, Pearce A. Consultant psychiatrists who retired prematurely in 1995 and 1996. Psychiatr Bull 1997;21:741-5.
17. Mears A, Kendall T, Katona C et al. Career intentions in psychiatric trainees and consultants. London: Royal College of Psychiatrists, 2002.
18. Rathod S, Roy L, Ramsay M et al. A survey of stress in psychiatrists working in the Wessex Region. Psychiatr Bull 2000;24:133-6.
19. Holloway F, Szmukler G, Carson J. Support systems. 1. Introduction. Advances in Psychiatric Treatment 2000;6:226-35.
20. Jackson SE, Turner J, Brief AP. Burnout among public service lawyers. Unpublished manuscript, University of Michigan, Ann Arbor, 1985.
21. Riggar TF, Godley SH, Hafer M. Burnout and job satisfaction in rehabilitation administrators and direct service providers. Rehabil Counsel Bull 1984;27:151-60.
22. Zedeck S, Maslach C, Mosier K et al. Affective response to work and quality of family life: employee and spouse perspectives. J Soc Behav Personal 1988;3:135-57.
23. Prosser D, Johnson S, Kuipers E et al. Mental health,'burnout' and job satisfaction among hospital and community-based mental health staff. Br J Psychiatry 1996;69:334-7.
24. Rey JM, Walter G, Giuffrida M. Australian psychiatrists today: proud of their profession but stressed and apprehensive about the future. Aust N Zeal J Psychiatry 2004;38:105-10.
25. Snibbe JR, Radcliffe T, Weisberger C et al. Burnout among primary care physicians and mental health professionals in a managed health care setting. Psychol Rep 1989;65:775-80.
26. Vaccaro JV, Clark GH Jr. A profile of community mental health centre psychiatrists: results of a national survey. Commun Ment Health J 1987;23:282-9.
27. Firth-Cozens J, Greenhalgh J. Doctors' perceptions of the links between stress and lowered clinical care. Soc Sci Med 1997;44:1017-22.
28. Amstutz MC, Neuenschwander M, Modestin J. Burnout in psychiatric physicians. Results of an empirical study. Psychiatr Prax 2001;28:163-7.
29. Deary IJ, Agius RM, Sadler A. Personality and stress in consultant psychiatrists. Int J Soc Psychiatry 1996;42:112-23.
30. Kumar S, Hatcher S, Huggard P. Burnout in psychiatrists: an aetiological model. Int J Psychiatry Med 2005;35:405-16.
31. Hoop JG. Hidden ethical dilemmas in psychiatric residency training: the psychiatry resident as dual agent. Acad Psychiatry 2004; 28:183-9.
32. Hafner H. Psychiatry as a profession. Nervenarzt 2002;73:33-40.
33. Brockington I, Mumford D. Recruitment into psychiatry. Br J Psychiatry 2002;180:307-12.
34. Goldman W. Is there a shortage of psychiatrists? Psychiatr Serv 2001;52:1587-9.
35. Scully JH, Wilk JE. Selected characteristics and data of psychiatrists in the United States, 2001-2002. Acad Psychiatry 2003;27:247-51.
36. Kennedy P, Griffiths H. General psychiatrists discovering new roles for a new era and removing work stress. Br J Psychiatry 2001;179: 283-5.
37. Haller RM, Deluty RH. Assaults on staff by psychiatric inpatients. A critical review. Br J Psychiatry 1988;152:174-9.
38. Hubschmidt T. The prosecution of violent psychiatric inpatients; one respectable intervention. Psychiatr Prax 1996;23:26-8.
39. Drinkwater J. Violence in psychiatric hospitals. In: Feldman P (ed). Developments in the study of criminal behaviour, Vol. 2. Chichester: Wiley, 1982:111-30.
40. Hodgkinson PE, McIvor L, Phillips M. Patient assaults on staff in a psychiatric hospital: a two year retrospective study. Med Sci Law 1985;25:288-94.
41. Rice ME, Harris GT, Varney GW et al. Violence in institutions. Toronto: Hogrefe and Huber, 1989.
42. Poster EC. A multinational study of psychiatric nursing staffs' beliefs and concerns about work safety and patient assault. Arch Psychiatr Nurs 1996;10:365-73.
43. Guthrie E, Tattan T, Williams E et al. Sources of stress, psychological distress and burnout in psychiatrists: comparison of junior doctors, senior registrars and consultants. Psychiatr Bull 1999;23:207-12.
44. Alexander DA, Klein ST, Gray NM et al. Suicide by patients: questionnaire study of its effect on consultant psychiatrists. Br Med J 2000;320:1571-4.
45. Cartwright LK. Role montage: life patterns of professional women. J Am Med Women Assoc 1987;42:142-3.
46. Naisberg-Fennig S, Fennig S, Keinan G et al. Personality characteristics and proneness to burnout: a study among psychiatrists. Stress Med 1991;7:201-5.
47. Fothergill A, Edwards D, Burnard P. Stress, burnout, coping and stress management in psychiatrists: findings from a systematic review. Int J Soc Psychiatry 2004;50:54-65.
48. Snyder TG, Kumar S. Who do I serve? An experiential perspective of problems in retaining psychiatrists in New Zealand. Australasian Psychiatry 2004;12:401-3.
49. Garfinkel PE, Bagby RM, Schuller DR et al. Predictors of success and satisfaction in the practice of psychiatry: a preliminary follow-up study. Can J Psychiatry 2001;46:835-40.
50. Clark GH, Vaccaro JV. Burnout among CMHC psychiatrists and the struggle to survive. Hosp Commun Psychiatry 1987;38:843-7.
51. Agius RM, Blenkin H, Deary IJ et al. Survey of perceived stress and work demands of consultant doctors. Occup Environ Med 1996; 53:217-24.
52. Rutter H, Herzberg J, Paice E. Stress in doctors and dentists who teach. Med Educ 2002;36:543-9.
53. Thomas NK. Resident burnout. JAMA 2004;292:2880-9.