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Occupational Burnout in Healthcare Workers

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Depression, burnout, and psychosomatic disease evolve owing to chronic stress due to the profession of healthcare workers. The diagnosis and management of burnout is a challenge. Although burnout is similar to depression, it fails to meet any of the latter's diagnostic criteria. The affected individual might commit suicide if not appropriately managed. Interventions to the individual might have, besides institutional improvements by the inclusion of the institutional management to process, beneficial effects on the prevention of burnout.

Keywords: Burnout, depression, profession, stress

INTRODUCTION

Healthcare workers develop chronic stress, depression, burnout, or psychosomatic illnesses owing to the stress they are subjected to due to their work or occupation (1, 2). Among the abovementioned problems, the concept of burnout has become quite a popular one. This term has been specially suggested by Schaufeli et al. (3) for individuals having different sub-dimensions (exhaustion, depersonalization, and personal success). Burnout was first introduced by Freudenberger in the 1970s. Freudenberger, who is basically a psychotherapist, observed that doctors who struggled with drugs were deprived of time and depressed. After thoroughly studying the situation, he stated that other occupational groups were affected by this situation too (4).

Among individuals with burnout, Schaufeli et al. (3) identified conditions such as exhaustion, fatigue, excitement and loss of enthusiasm, feelings of inadequacy, frustration, cynicism or inefficiency, and dysfunctional behaviors, which develop at the workplace (5).

In addition to this, the problem is also responsible for alienation, sickness-leave, resignation, or intensive workplace change. Among those who do not resign, a decrease in job productivity and efficiency, job satisfaction, and loyalty to work and organization in the exhausted employees is observed. Somatic and concrete disease-promoting effects of burnout are also observed to occur (e.g., depression, musculoskeletal pain, type 2 diabetes, cardiovascular disease, cognitive problems, and premature mortality) (6).

Although burnout is reported to cause concrete somatic problems, it is generally not considered a clinical entity. It is mostly expressed as psychological distress and a psychosocial problem (3, 5).

Schaufeli et al. (3) have proposed the term "engagement" to save the concept of burnout from the negative burden. "Affinity" is defined by sub-dimensions such as energy, participation, and effectiveness. It is preferable to use more positive expressions than terms such as burnout, cynicism, or disability.

PATHOGENESIS

The development of burnout is explained by a stress model. According to the model, stress is actually a protective reaction that protects the individual against a sudden and unexpected attack. However, in the case of a persistent state of stress, the individual remains unresponsive to the incoming influences, is blunted, and is exhausted. Exhaustion is not equal in every individual. For example, particularly, those who are easily accountable for and enthusiastic toward or integrated with their work more easily develop burnout. People who work in the service sector are more affected (i.e., teachers, lawyers, engineers, police, guards, etc.) (5, 7). It is possible to include healthcare workers, particularly family physicians, in this group (8, 9).

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RISK FACTORS

Maslach et al. (6) describe six risk factors that play a role in the development of burnout: incompatibility at work, incompatibility in job control, lack of awards, feeling of not being in a positive relationship with others in the workplace, perceptions of fair treatment, and conflicts between values. In addition, workload and time pressure, role conflict and confusion, lack of social support, lack of feedback, loss of autonomy, and lack of participation in decision making are considered as risk factors. On an institutional level, work autonomy, job security, personnel participation, work culture (participation, equity, and justice), and programs for mental health of employees influence burnout development (10).

Because of their work, during the development of burnout, individuals neglect the social environment, family experiences, and personal health. The level of the individual's job and self-control can be particularly decisive. As exhaustion deepens, the efficiency and efficacy of the individual's work gradually decreases. As mental concentration, creativity, and cognitive functions diminish, their memory also weakens. The number of mistakes in their work starts to increase, and they start to blame themselves and others unless they succeed. It is possible for them to experience day-to-day torture due to the intense stress they experience within them, dissatisfaction with themselves, anxiety, lack of courage, and mistakes they make. It is sometimes possible to find remedy in alcohol and substances (7).

DEVELOPMENTAL STAGES

When we examine this process in terms of the developmental stages of burnout described by Freudenberger and North, we could divide this process into 12 phases. Stages are not necessarily in pursuit of something. Sometimes it is possible for different phases to coexist (Table 1) (7).

DIAGNOSIS

Despite the emergence of somatic complaints as well as behavioral problems, burnout remains a problem in Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition V (11). In this moment it could be expressed as a somatoform disorder, whick could not be classified. In the International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10), it is expressed under the heading "Problems related to life management difficulty " (Z73) (7, 12). However, in some countries (Sweden and the Netherlands), burnout is treated as a medical diagnosis (3).

The Maslach Burnout Scale is the most commonly used measure of burnout, although there is no exact scale for burnout. This scale divides the phenomenon of burnout into three sub-dimensions: exhaustion, depersonalization, and personal accomplishment. Some researchers have stated that the main element of exhaustion is the exhaustion sub-dimension (3). On the other hand, increasing evidence suggests that exhaustion is similar to depression (13). However, it is also emphasized that this overlap should be confirmed by other studies. It covers the psychosocial dimension of depression. Rather than a psychiatric or clinical situation, it is a psychosocial condition (14).

MANAGEMENT

The treatment of exhaustion in individuals is difficult because all individuals react in different ways. If the employer does not have control over the stressors of the employees of the institution, it will be difficult to manage the exhaustion of employees. Studies have shown that situational and institutional factors play a greater role than individual factors. Exhaustion, cynicism, or professional activity can be treated more easily. Cynicism and professional activity were found to be more resistant to treatment (6).

When evidence-based reports were examined, it was found that interventions to reduce complaints, burnout, and work-related stress were more successful at both individual and small group levels. The level of achievement was moderate (10).

Smaller programs have also provided positive stress relief. Staff training and workshops have been shown to be successful in avoiding burnout complaints. It is possible to include awareness trainings on stress-related issues. Particularly, it has been argued that intervention may be more successful if staff develops perception that the environment is safe and not threatening (15).

TABLE I. Different phases of burnout

1. Trying to self-assert yourself: Compulsive self-initiative begins at work.	2. More work: To prove themselves to others or to the institution they work, they dedicate themselves totally to work. They try to do everything themselves.	3. Ignoring their needs: There is no time and energy for things other than work. Family, friends, nutrition, sleep, etc. These are neglected.
4. Avoiding conflicts: They realize that something is wrong, but they cannot produce a solution. They have a crisis within themselves. Solving the problem does not work. The first somatic complaint may arise.	5. Passing values in favor of the business: Focus only on work, emotional blunting starts. No time for anyone except work.	6. Disbelief is a new challenge: Dislike of things around and work together, increased cynicism and aggression, believe that the increasing problems were caused by lack of time, they do not see their change as a cause of this problem.
7. Move away: They isolate themselves. Hopelessness and irregularities begin. Take refuge in alcohol.	8. Possible behavioral change: A person who is alive and involved once becomes increasingly shy, fearful, and apathetic. The sense of worthlessness increases. People around them can not ignore the behavioral changes in the person.	9. Depersonalization: The irritation is cut off by themselves. They see neither themselves nor others as precious. They can not perceive their own needs. Life becomes mechanical.
10. Inner space: They grow desperately and act helplessly to fill the gap. Excessive sexuality, nutrition, drug or alcohol use. Free time is dead time.	11. Depression: An overly busy person becomes desperate and exhausted. No future expectations. There are concrete depressive symptoms. Ex. Agitation, apathy, the meaninglessness of life.	12. Burnout syndrome: Suicidal thoughts arise in order to avoid them. Some people commit suicide. They experience mental and physical depression. They need urgent medical support.

Cognitive behavioral therapies, particularly at the individual level, have shown modest positive effects on relaxation and meditation. In general, interventions aimed at individuals have been shown to be moderately successful (10). In addition to this, prevention of burnout could be provided by starting with relaxation exercises in the sun, eating healthy, being involved in sports, sleeping well, drawing limits, taking breaks in technology, improving creativity, and learning to cope with stress.

Studies including institutions have been rarely found (10). In one study, however, institutional interventions were claimed to have a longer effect (16). Prevention of burnout is possible only through institutional improvements and individual training. More importantly, effectiveness will be enhanced, especially in the presence of support by the institution (10). In the development of burnout, institutional problems related to imbalance of workload, control, reward, community, justice, and values are held responsible. Reducing workload by providing employees with enough rest and determining clear values in which employees of the institution may be involved, support of the working community by leaders and managers and the establishment of good relations with employees are recommended. Equitable management approach also relieves the employees. The rest of the workers' troubles caused a decrease in the level of burnout (6, 17).

CONCLUSION

Burnout is sneaky and management is a very difficult disease. Although it is expressed as being similar to depression, it still has no clinical diagnostic feature. If diagnosed and not timely intervened, it is a question that can lead to different clinical morbidity and mortality as well as depression and suicide. Although interventions have shown effect at the individual level, it might be possible to create positive effects by incorporating institutional improvements and, in particularly, by the involvement of the management into this process.

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