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Promoting Work Well-being: Professional Burnout & Occupational Stress

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Nevertheless, the authors and the editor acknowledge that every medical opinion is under the limitations of the time frame that this book was created, as well as possible mistakes that might have escaped their attention.
Readers of this textbook are encouraged to keep that in mind, while at the same time we hope that the information included will become a starting point for young colleagues or the more experienced ones, for new research projects, clinical trials or maybe an updated version of the book in the near future.

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Promoting Work Well-being:
Professional Burnout & Occupational Stress

Burnout: The Role of Personal Characteristics

Chapter 2

Alexander-Stamatios Antoniou

Introduction and definition

During the last decade, burnout has become a buzzword that has raised a long debate about its exact meaning. The term "professional burnout" was firstly introduced in 1974 by Freudenberger in order to describe a syndrome that he believed was specifically common among volunteers and professionals of mental health (Freudenderger, 1984). Primarily, this syndrome was thought the result of working intensely with other people for a long time distance and its use was restricted to the helping professions; for instance General Practitioners, dentists, paramedics, nurses, psychotherapists and social workers (Edelwich & Brodsky, 1980).

Yet, recent reports have extended the study of this phenomenon to other professions as well, like teachers (Russell et. al., 1987) and policemen (Burke & Deszca, 1986). Furthermore, the interest concerning burnout in business and management has increased (Golembiewski et. al., 1986; Lee & Ashforth, 1993; Levison, 1981). A recent national survey of 3,718 American employees indicated that 59 percent were burned out (Hammonds, 1993).

There are many researchers who claim that "burnout" is a loose term and there are overlaps with other terms as "occupational stress", "work dissatisfaction" and "depression". Although burnout as a psychological procedure presents some common aspects with occupational stress it would be wrong to be equated with that (Bailey, 1980). Generally, it could be said that burnout constitutes a certain aspect or

a consequence of occupational stress only with regard to the demands of work environment (Cordes & Dougherty, 1993; Shinn et al., 1984). Thus, the occurrence of burnout presupposes the existence of occupational stress.

But, burnout could also be the effect of chronic stress felt by people trying to fulfill more than one role such as spouse or parent. Specifically, there is a general agreement that the differentiation of burnout from occupational stress is focussed on its third basic characteristic (depersonalization). Even though burnout and dissatisfaction are both considered negative psychological experiences, "burnout' basically implies exhaustion or depletion of energy (Maher, 1983). Finally, Cherniss (1980) has maintained the existence of a strong overlap between "burnout" and "depression".

Despite the fact that burnout is a very popular research area and has become the object of a rapidly increasing interdisciplinary literature (Paine, 1982) there is not a general accepted definition at present. Perhaps the most widely cited definition of burnout is that of Christine Maslach whose name has been connected with burnout from very early. She defined it (Maslach & Jackson, 1977) as:

> *The loss of concern for the people with whom one is working including physical exhaustion and characterized by an emotional exhaustion in which the professional no longer has any positive feelings, sympathy, or respect for clients or patients. (p. 3)*

Evidently, burnout is difficult to define because it composes a complex psychophysiological phenomenon. For this reason, Maslach and Jackson (1981) claimed that it is possible to assess it by administering the Maslach Burnout Inventory (MBI) to employees. This is a widely used scale and measures the following three main elements: a) emotional exhaustion, b) depersonalization (attitudinal exhaustion) and c) low personal accomplishment.

For instance, the doctors under emotional exhaustion feel emotionally drained and frustrated by the day's events. Generally, they feel fatigued and unable to essentially help and communicate with their patients. As they view at their job every morning as an inescapable evil, it is sometimes impossible to develop humane warm relationships with the people who need their scientific but also their emotional support. Instead of that, they try to keep a "safety distance" from other people who are considered as the "source" of their exhaustion.

Since burnout comprises of these three distinguished elements, Maslach and Jackson (1984) stated that emotional exhaustion is the first stage of burnout which leads to depersonalization and low personal accomplishment, although there are dif-

ferent opinions on this matter (Golembiewski et al., 1986) which support the idea that depersonalization is a necessary defensive mechanism of the individual precedes the other two.

The depersonalization is presented as a cynical and negative attitude of doctors against their patients. Usually, they behave towards them as objects and belittle them. According to Cummings and Nall (1983), a characteristic example of this behaviour is the tendency to refer to the patients not by their names but by the room number or the type of illness. Lastly, the doctors who often report feelings of low personal accomplishment make very rigid criticisms about themselves and their attainments. In general, they question their own job effectiveness and often live in an environment of pessimism and unhappiness.

Burnout is not usually associated directly with certain traumatic life events which have traditionally been in the centre of stress research (Dohrenwend & Dohrenwend, 1980; Pines et al., 1981) but with the chronic daily stressors which have gained less attention (Lazarus, 1984). Rogers (1984) describes ten attitudinal characteristics of burnout like cynicism, fatalism, nastiness and escape. Therefore, burnout is the result of accumulative stress that the professional faces and resultant feelings that he/she is unable to cope.

In accordance with Edelwich and Brodsky (1980), burnout refers to the denial procedure of professional's great expectations of his/her job. The above researchers suggest that this procedure follows four stages:

I. **Stage of Idealism and Enthusiasm:** The individual channels his/her whole potential in the job on which he/she also invests a lot of time and effort.

II. **Stage of Stagnation:** He/she realises that the job does not fulfill his/her expectations and more essential needs. Progressively, usual matters start to become problems for him/her such as timetables, promotion and salary.

III. **Stage of Frustration:** The person asks himself/herself whether it is worth doing the specific job under a lot of chronic stress and without the acknowledgment of others. In essence, this stage is transactional because usually the employee decides either to continue the job modifying his/her behaviour and the job conditions which cause stress to him/her, or withdraws from the workplace adopting an attitude of indifference and alienation.

IV. **Stage of Apathy:** During this stage the employee invests very little energy and avoids responsibilities, changes or challenges in the workplace. Generally, he/she maintains the job because of living purposes (e.g. Edelwich and Brodsky, 1980).

The symptoms and consequences of professional burnout for health professionals

Some of the major burnout consequences to an individual's both personal and social life is the shrinkage of the supportive network, job dissatisfaction, the tensed relationships with significant people and the decrease of the sexual desire (Schaufeli, 1990; Schaufeli et al.,1993). The three components of Maslach Burnout Inventory (MBI) and their expected results (symptoms) have been presented graphically by Jackson (1984) in Table 2.1.

In general, the signs that burnout is occurring refer to changes in certain major levels, namely: physical condition, behavioral changes and work performance (Moss, 1981) or physical and mental health, interpersonal relationships and occupational behaviour (Cordes & Dougherty, 1993). Some researchers (e.g. Maslach & Jackson, 1984) apart from the physical, behavioural and occupational changes also add the emotional/cognitive changes in the symptoms of burnout.

- *The physical changes/symptoms* are divided in:
  - **a) minor ailments:** Exhaustion and chronic fatigue are the most common ones (Shirom, 1989). Typical physical symptoms are also headaches, aches in neck and waist, back pains, gastrointestinal disturbances and nausea. Moreover, Kahill (1988) reports sexual problems, sleep disturbances, change of eating habits and shortness of breath as signs of "burned out" individuals.
  - **b) serious health problems** such as hypertension, ulcer, cardiovascular disorders and/or chronic migraine headaches.

However, it is worth noticing that apart from the study of Melamed, Kushnir & Shirom (1992) regarding the risk factors for cardiovascular disease, there is no other

Table 2.1 *The three components of Maslach Burnout Inventory*

Emotional exhaustion →	*Depersonalization* →	*Low personal accomplishment*
Feel drained by work	Have become callused by job	Cannot deal with problems effectively
Feel fatigued in the Morning	Treat people like objects	Am not having a positive influence on others
Feel burned out	Don't care what happens to people	Cannot understand others' Don't problems or empathize with them
Frustrated	Feel others blame you for their problems	No longer feel exhilarated by job
want to work with people		

Source: Jackson (1984, p74)

evidence to prove the relationship of burnout with objectively measured physical manifestations.

- *The behavioural changes* include tendency for isolation, physical distancing from others, impersonal/stereotyped communication with others (e.g. patients) and applying derogatory labels to patients. Characteristic signs are also conflicts with co-workers and family, absenteeism and even suicide (Jackson & Maslach, 1982; Olkinuora et al., 1990; Pines & Maslach, 1978). In addition, some researchers have reported substance abuse (Nowack & Pentkowski, 1994), unhealthy habits concerning the poor diet and lack of exercise (Nowack, Hanson & Gibbons, 1985) as behavioural manifestations of burnout.
- *The organisational changes:* Similarly with the other changes/symptoms, there is inadequate evidence to support the hypothesis that burnout decreases the interest in working and consequently could lead an employee to quit. Furthermore, the link between burnout and work efficiency/productivity appears to be controversial as it has been found that there is both negative and positive relationship. For instance, a recent research study (Schaufeli, Keijsers & Miranda, 1995) found that the nursing staff with high levels of burnout displayed associated levels of efficiency. This unexpected result could raise a long debate as the low productivity levels of burned-out employees have been postulated in a great deal of research (e. g. Golembiewski and Munzenrider, 1988). Taking these factors into account, other symptoms of burnout concerning the work performance of health professionals could be the dehumanisation and victimisation of patients, the postponement of their contacts and frequent minor mistakes.
- *The psychological changes* regard a) feelings (anger, boredom, disillusionment, discouragement and resentment) and/or b) attitudes (cynicism, indifference and resignation) (Jayarathne & Chess, 1983; Richardsen et al., 1992).
- *The emotional/cognitive* changes refer to low self-esteem and self-confidence which are followed from depression, aggression, guilt and despair (Kahill, 1988).
- *The social changes:* According to some researchers (e.g. Maslach & Pines, 1977; Pines & Maslach, 1978) some of the above symptoms may be also characterised also as social changes such as withdrawal, isolation and generally problems with interpersonal relationships (colleagues, supervisors and subordinates).

Burnout and health professionals

The findings of a remarkable study by Olkinuora et al. (1990) showed that doctors who worked in hospitals experienced higher levels of burnout than those working in

private practice, research institutions, universities, public offices and organisations. The researchers also found that doctors working in clinics with patients with psychiatric, oncology and pulmonary disorders and with chronically and terminally ill patients, with poor prognoses and incurable diseases displayed much higher burnout than their counterparts in other departments (e.g. otorhinolaryngology, gynaecology and ophthalmology). Trying to interpret these results, the authors suggested that "hope and lack of it in medical work have important influence on feelings of burnout" (p. 83). Finally, they found that the non-specialists doctors and especially those up to thirty years of age (male and female) had higher burnout scores than the specialists.

Moreover, a more recent study (De Mercato et al., 1995) showed that burnout syndrome affects in the same way both medical (physicians) and non medical staff (nurses and ancillary workers). McCue (1982) points out that a lot of stressors which could lead to burnout are interwoven with the medical profession itself, as doctors face adverse working conditions and "difficult" people. At this point, the following question could be raised: "Which individual characteristics could be considered as more burnout-prone?".

Major causes of burnout

As regards the causes of burnout, the different theoretical models look for the solution in the dynamic interaction between individual and environment. Yet, some researchers (Pines, 1986) focus their interest in the stressful and diverse job conditions (e.g. work overload and lack of staff), whereas some others emphasise more the significance of the personal factors (McCranie et al., 1987). The latter support that the onset of burnout depends on the way in which the individual "interprets" and faces the stressful job conditions (Lazarus & Folkman, 1984) and the expectations from his/her job (Selder & Paustian, 1989).

Perhaps, the most important factor which leads to burnout could be the coping strategies that the persons uses. The studies by Leiter (1991) concerning the coping styles and the degree of burnout in employees of a mental hospital, are very interesting. He found that workers who used control strategies (taking charge of their lives) to deal with their job problems, showed low levels of exhaustion and high levels of personal accomplishments. On the other hand, the mental health workers who used escapist coping strategies (passively letting things happen) displayed high levels in both, exhaustion and depersonalization. Other important factors included general job conditions, leadership style and restricted opportunities for promotion (Leiter,1991).

Furthermore, as aforementioned, one of the primary factors that appears to contribute to burnout is the exposure to a great deal of stress for a long period of ti-

me. According to Vachon (1987) the degree of stress which the individual faces in the workplace depends on certain mediators that adjust his/her resistance to stress. These mediators include:

a) Personal characteristics (e.g. age, sex, marital status)
b) Interpersonal factors (e.g. support network)
c) Intrapersonal factors (e.g. personality, motivations, coping strategies)
d) Sociocultural factors (e.g. social expectations for job role, job philosophy)

However, the factors that cause burnout to the individual could be divided in two major categories: a) personal characteristics and b) job characteristics. In this section, the personal characteristics will be emphasised firstly because they are considered as key factors for the etiology of the health professionals' burnout and, secondly because in the last decade, particular attention has been given to this specific aspect of the problem. The relationship between high burnout levels and the personal characteristics of doctors and other health staff may be the answer as to why many doctors do not develop symptoms of burnout, or any kind of impairment irrespective of job characteristics and even under adverse work conditions. Furthermore, many researchers (McCawley, 1983; Mogul, 1985; Waring, 1974) believe that doctors' vulnerability to burnout is attributed to particular maladaptive personality traits and coping behaviours present before they join the medical profession. In conclusion, Naisberg-Fennig et al. (1991), declared that:

> *"little systematic research has been directed to personal characteristics which might exacerbate or predispose to the development of the burnout syndrome" (ibid., p201).*

Personal characteristics

Demographics traits

a) *GENDER:* Generally, no systematic relation has been found between gender and burnout because as Greenglass (1991) maintains, gender is usually correlated with occupational role and position rank. Moreover, Maslach (1982) claims that the existing differences between the two genders is the consequence of the gender-segregated nature of some occupations, rather than reflects real differences between masculine and feminine traits. It is widely known that the professions of police officers, bus/lorry drivers and physicians are considered more "masculine" than those of social workers, counsellors and nurses.

However, some evidence confirms the hypothesis that the women and especially

the female doctors display higher levels of burnout than their male counterparts (Kirkcaldy & Siefen, 1991; Richardsen et al., 1992). For example, Deckard et al. (1994) found that 64% of the female physicians experienced high Emotional Exhaustion compared to 53% of their male counterparts. In addition, Himle et al. (1987) studied 617 clinical social workers and found exclusively for females, an association between burnout and low levels of both role ambiguity and social support from supervisors and co-workers.

In a study by Etzion and Pines (1986), of 503 human service professionals in the United States and Israel, it was found that women reported higher levels of burnout than men and American individuals reported feeling more burned out than Israelis. Specifically, in this study four gender-related differences were detected in the use of coping strategies. The item "talking about the source of stress" was reported by a significantly greater number of women than men were. However, it was noted that this was not necessarily an unexpected result as men are usually less open and often manage their problems on their own (Etzion & Pines, 1986). In addition, women presented higher scores in the item "get sick and collapse" when they were under a lot of stress. This pattern was also true for Americans (of both gendess) in contrast with Israelis men and women respectively. As a result of these findings, the researchers concluded:

> *"As for coping, women reported using indirect and inactive coping strategies more than men, and Americans reported using them more than Israelis. The pattern of correlation between coping and burnout suggested that active-direct strategies were more effective in coping with stress than were the inactive and/or indirect behaviours." (Etzion and Pines, 1986, p. 191)*

b) *ETHNIC BACKGROUND:* Similarly with the above results there are a number of studies, which indicate the existence of some differences between certain ethnic minorities as regards burnout. For example, Maslach's research (1982) in the United States focussed on helping professions and found that there were only minor differences in burnout levels between Asian-American and whites helping professionals. On the contrary, burnout levels of black professionals were much lower (emotional exhaustion and depersonalization) than their white counterparts.

Maslach (1982) suggests that this phenomenon could be happening due to the close and warm relationships often present in the communities of blacks. Another possible factor she proposed that might protect black professionals is the considerable support from their family and friends. As well, perhaps, the long attempts of the

black population to improve their social status has made them more resilient to a great deal of pressures (Maslach, 1982). Nevertheless, one has to note that there have been few studies investigating burnout in other ethnic minorities.

c) *AGE:* The relationship between burnout levels and age appears to be more unambiguous. As would be expected, young employees (under thirty or forty) with fewer years of work experience display higher levels of burnout than their older and more experienced counterparts who hold managerial positions (Byrne, 1991). However, the so-called "healthy worker effect" creates some difficulties in the interpretation of the above conclusions because the individuals who are burned out have already left their jobs. This means that the older employees are the "survivors" who managed to deal with burnout at the early stages of their career.

Surprisingly, in European countries in contrast with the United States where the work system promote intensively the labour market mobility, burnout is quite common in the older employees (Schaufeli & Van Dierendonck, 1994). Nevertheless, what is interesting and contradictory to many previous research studies, is that concerning health professionals, many researchers (e.g. Maslach & Pines, 1977; Cherniss, 1980) have showed that burnout is more prevalent in young individuals who are in the first years of their job career. In the above-mentioned study by Deckard et al. (1994) it was more likely for the younger physicians with an age range between 30 and 44 years to experience high Emotional Exhaustion than their older counterparts (age range: 45-64 years). Similarly, Corcoran (1987) found that doctors' levels of emotional exhaustion and depersonalisation decreased as they got older and acquired more experience. In conclusion, although the findings are rather mixed, there is a tendency towards higher levels of burnout being reported by females and younger individuals.

d) *MARITAL STATUS:* An important element, which is associated closely with age, is the existence of social support. It is more likely for older employees to have a family whose supporting role helps them to cope with the job stressors (Maslach & Jackson, 1985). The support of spouse and children is an important emotional resource and help the individual to face the problems in a more optimistic way. Studies indicate that the worker with a family has a different personal view towards his/her job demands than a single or even a divorced colleague as the individual does not invest his/her total energies to the job. Generally, it has been found that either the direct or indirect effect of social support from whatever source, has beneficial outcomes for the individuals (Poulin & Walter, 1993). In conclusion, Maslach (1982) reports that married workers experience the least burnout, while the single ones experience the most. The divorced individuals fall in between the other two groups.

e) *EDUCATION LEVEL:* Although, there are not significant differences in burnout among different education levels it appears to be a tendency to relate burnout with higher levels of education. Maslach (1982) points out that the helping professionals who have graduated college but have not had postgraduate studies, displayed more emotional exhaustion and depersonalization and the least personal accomplishments compared to those who had had postgraduate training. The latter showed emotional exhaustion, which could only be explained due to an interrelation between education and occupation. According to Maslach (1982):

> *"The nature of their jobs may cause greater emotional stress, but their training has equipped them to cope more successfully with it" (p. 61)*

f) *LEVEL OF EMPLOYMENT:* It has been proved that it is more likely for front line workers to experience burnout than supervisors and administrators (Daley, 1979; Maslach, 1976). The above-mentioned study by Kermish and Kushin (1969) showed that 26% of the social workers (SW) who quitted their job were trainees, 32% were SW at level I, 36% were SW at level II and only 13% were supervisors. Furthermore, several studies (e.g. Edelwich & Brodsky, 1980; McLean, 1979) have revealed an association between reduced burnout scores and certain characteristics of top positions such as more power and autonomy, greater variety in work responsibilities, and higher salaries.

Personality traits

Although a large part of the relevant literature regarding the personality characteristics of health professionals in general is not confirmed by empirical studies, a considerable number of researchers (e.g. Edelwick & Brodsky, 1980; Farber, 1983; Pines et al., 1981) have suggested the existence of a burnout-prone personality with specific characteristics such as anxiety, empathy, sensitivity, high scores of introversion, low self-esteem, humanistic spirit and person-orientation. In particular, individuals with neurotic anxiety tend to be emotionally unstable, excessively concerned with others' opinion and usually set unrealistic goals. The latter characteristic has significantly correlated with burnout among human service workers (Cherniss, 1980; Deutsch, 1984).

Apart from neurotic anxiety, Cherniss (1980) reports two more personality traits which have an important impact on the individual's response to work stressors, namely: Type A syndrome and Locus of Control. He maintains that people with Type A personality are more likely to experience burnout. Firstly, Meyer Friedman & Ray Ro-

senman (1974) defined Type A Behaviour and concluded that the individuals with a such behaviour are especially prone to heart problems like coronary heart disease (CHD). According to Davidson and Cooper (1980) physicians, dentists, psychologists and other helping professions seem to be more prone to Type A Behaviour than other workers. This behaviour includes rapid moving, talking and eating, and high achievement, ambitions, hostility, competitiveness and aggressiveness.

It is evident that a number of personality characteristics which are associated with burnout, are also related with stress. In the past few years, a particular personality dimension, which has been associated closely with stressors and burnout, is the dimension known as hardiness (McCranie et al., 1987). Hardiness (Maddi & Kobasa, 1984) has been defined as the ability of some individuals to cope with stress factors effectively and remain healthy. Kobasa pointed out that three other components are included in this specific characteristic of personality: commitment, control and challenge.

Commitment refers to the tendency of the individual to involve actively in life events and sometimes to be entirely devoted to them. Control reflects the person's belief that the course of events is depended directly on himself/herself and in general, that fortune and luck play an unimportant role in his/her life. It could be asserted that this dimension of hardiness presents many similarities with Rotter's (1966) internal Locus of Control. People with internal Locus of Control feel that they can control their lives themselves and believe in a downgrading role of fate. The third element of hardiness, challenge is defined as someone's tendency to consider the change in life as a stimulus to growth and generally more preferable than stability. It is asserted (Kobasa et al., 1982) that the above three elements of the hardy personality support the individual in a cognitive appraisal level by offering him/her a positive interpretation of the events.

Keane et al. (1985), in a study investigating burnout in nurses in both intensive and non-intensive care units, found that across units the nurses who scored high in three dimensions of hardiness experienced lower levels of burnout. This conclusion was generalised in subsequent research (McCranie et al., 1987) confirming the existence of particular personality variables (commitment, control, challenge) all of which acted as stress resistants among 107 registered staff nurses. According to Antonovsky (1979), the resistance resources may buffer or neutralise the adverse effects of stressful events.

The researchers inferred that even though hardiness had beneficial effects towards burnout, it did not show to inhibit high levels of job stress. This means that when the hospitals were interested in having more efficient nursing staff, they must not only identify the "hardy" personalities but also reduce the intensity of job stres-

sors experienced by nurses. Except for those stressors, which are closely associated with the nature of the nursing profession, there are also some other manageable factors such as heavy workload and inadequate staffing, for which usually there is not a specific intervention policy and are considered minor issues (Papadatou & Anagnostopoulos, 1995). Some changes that Antonovsky (1979) suggested could be done in the hospital setting in order to reduce the burnout of the staff included a flexible schedule, the promotion of social support, a well-organised information network among all health professionals and a stable conflict policy.

The results of one more recent study (Papadatou et al., 1994) with female nurses in oncological hospitals, produced similar findings. More specifically, it was shown that burnout was associated with a sense of lack of control over external events. The vast majority of Papadatou et al.'s (1994) sample believed that "no matter how hard you work, you never really seem to reach your goals". Furthermore, a positive correlation was found between work overload and the dimension of emotional exhaustion.

Moreover, a study by Astrom et al. (1991) supported previous research (e.g. Pines et al., 1981) and found that less positive attitudes and lower levels of empathy were related to burnout among nursing staff independently of sex, category of staff and place of work. For instance, Astrom et al. (1991) suggested that empathy in a patient-staff relationship could mean the ability of the nurse to put himself/herself in the patients' difficult place and to perceive their thoughts and feelings. Therefore, the nurse who experienced empathy could prove more helpful to his/her patients. An interesting point stemming from the individual interviews was that nurses with the lowest level of empathy considered "patient's improvement" as the most significant factor, which in turn indicated that a negative event in the course of work (e.g. patient's worsening) may be a cause for burnout (Astrom et al., 1991).

With reference to social service workers, Kadushin (1974) claims that they are responsive to a "dedicatory ethic" which considers "devotion" as an inherent element of the profession. Furthermore, in a large-scale longitudinal study with 879 social workers burnout was associated with self-esteem (Poulin & Walter, 1993). It was observed that when burnout levels of individuals were low, their self-esteem was increased and reversely, when burnout was high, the self-esteem had decreased.

In addition, Garden (1989) points out that burnout is correlated positively with the Jungian "helping type" who is over-represented in human services (health-related professions, counselling and education) and is characterised by certain emotional demands such as need for affiliation, capacity for warmth and desire for harmony. On the other hand, the measure of burnout was associated with mental de-

mands and lower ambitiousness for the "thinking types" who are over-represented in managerial roles (Myers & McCaulley, 1985).

Moreover, as regards the personality characteristics of doctors, related to burnout, a study by Naisberg-Fenning et al. (1991) with forty-nine psychiatrists (age range: 27-65 years/M=40.5) working in public mental hospitals presents particularly interesting results. The investigators found significant correlations between doctors' levels of burnout and four other variables, namely: learned resourcefulness, anxiety, repression and sensitisation. Learned resourcefulness could be defined as the acquired cognitive ability which can assist individuals to enhance their self-control (Rosenbaum, 1980, 1983). The fact that psychiatrists are emotionally involved with chronically ill patients whose future is quite uncertain, constitutes a serious cause of their high burnout scores.

In addition, McCranie et al. (1988), examining the personality antecedents of burnout among 440 US physicians who were followed up during an average of twenty-five years, found a significant correlation between higher burnout scores and certain scales of Minnesota Multiphasic Personality Inventory (MMPI). This correlation means that doctors' levels of burnout are related to personality traits of low self-esteem, low self-confidence, proneness to dysphoria and obsessive worry, social anxiety, passivity and withdrawal from others. Even though these specific scales of MMPI are in accordance with the results of previous similar studies (Vaillant et al., 1972; Thomas, 1971) these correlations of burnout with personality antecedents are rather weak ($r<.15$). Nevertheless, it could be suggested that doctors' vulnerability to burnout may be related to maladaptive personality traits and coping strategies which were already present even from the first years in the Medical School (Murphy et al., 1984).

Finally, Bennett et al. (1994) studied 84 health professionals (doctors, nurses and social workers) working in the area of HIV/AIDS; this sample which came only from those hospital units with a high proportion of patients suffering from HIV/AIDS. They found that the health staff with increased burnout scores experienced higher levels of anxiety, stress and stigma, and used more often external coping strategies.

Coping strategies

A number of studies have proved the relationship between individual coping behaviour and personal characteristics (Ehrenfeld and Yoram, 1995), as well as the link between gender and level of education and coping strategies (Billings & Moos, 1981). As aforementioned in the studies of Etzion and Pines (1986), Maslach and Pines (1977) and Rohman (1988); the withdrawal coping strategies such as avoidance

medication and drinking, in general appear to be related with higher levels of burnout. On the other hand, active behaviour like problem-focused coping is associated with reduced burnout.

In particular, Thornton (1992), using Richard Lazarus's cognitive-phenomenological theory of stress and coping in 234 professional mental health workers (both doctors and the other helping staff) found a positive correlation between escape-avoidance coping and the degree of burnout. The escape-avoidance coping could be defined as an emotion-focused coping strategy and is represented by the phrase: "wished that the situation would go away or somehow be over with". Specifically, escape-avoidance coping strategy increased as the level of burnout approached the high degree. However, Thornton (1992) accepted that it would be difficult to conclude through her study "whether the increased use of escape-avoidance leads to burnout or burnout led the workers to an increased use of escape-avoidance in coping with work stress" (p.269).

It is also worth noting here, that Thornton (1992) adopting the theory of Freudenberger (1974) who has considered depression as a trait of burnout, attempted to present the above correlation between escape-avoidance coping and increased burnout as a relation between psychological symptoms and burnout. The above conclusion becomes clear when the items of the escape-avoidance scale are examined. These individual items, apart from coping strategies, are also considered as psychological symptoms leading to depression. For example, two of these items are: " I avoid being with people in general" and " I try to make myself feel better by eating, drinking, smoking, using drugs or medication".

Similarly, the findings of Koeske et al. (1993) supported the above conclusions and also suggested that there is little evidence to infer that avoidance strategies benefit individuals. However, Holmes and McCaul (1989) have stated that an avoidance-oriented strategy is better than no strategy at all. Moreover, Koeske et al. proved that the avoidant coping efforts have positive outcomes only when they are combined with control-based strategies (e.g. "Try to find out more about the situation", "Make a plan of action and follow it"). In general, they claim that control-oriented coping strategies could be a deterrent to job stress.

Attitudes associated to profession

The phenomenon of psychological withdrawal is quite common in situations of large caseloads in health professions (Koeske & Koeske, 1989; Skorupka & Agresti, 1993). A doctor may claim that certain tasks are not included in his/her job descri-

ption or he/she may use bureaucracy as an excuse to avoid them (Chiriboga & Bailey, 1986; Lee and Ashforth, 1993). Another type of withdrawal could be poor performance as a method to avoid additional cases because the typical system in helping professions is the "compensation" of individuals with high ambitions taking on more and more complicated cases (Stevens and O'Neil, 1983).

In particular, doctors and nurses, who empathise with patients' problems and are very close to the patients' pain, often use specific techniques such as emotional detachment, as a barrier to patients' excessive demands. Usually, a lot of pressure is caused, owing to the different assessments of the situation. The patient may feel angry and frustrated because he/she expected more concern on behalf of the helper for his/her "quite serious", based on his/her own assessment, problem. On the other side, the helper must face a patient who considers his/her problem unique and quite often even exaggerate a common cold. Thus, a negative interaction is created between helper and patient who blames the former for apathy and incompetence.

Finally, the human service workers who do not cope with extreme work pressures may decide to leave their job (Arth & Britton, 1989; Himle et al., 1987). In general, turnover is a very complicated matter, which is affected by many involved variables. For instance, among hospital workers a correlation has been found between the intention to leave the job and the expectancy of finding another job, (Mobley et al., 1978). However, Shinn (1982) suggests that one needs to examine whether a doctor quits his/her profession completely, rather than leaving a position and continue in a similar one. Many employees who do not want to leave the job entirely but refuse to remain in their present positions while underperforming, follow similar transfers in different posts with even more responsibilities than the previous.

Staff turnover

However, many researchers have pointed out that burnout may be a factor or at least one of the factors which lead to staff turnover (Pines et al., 1981). Moreover, it has been showed that burnout is associated with someone's intention to leave their job (Kafry, 1981). The intention to leave is considered a strong indicator because although the actual turnover is very difficult to predict due to different external factors, the intention to leave is a secure predictor of a future resignation (Mobley, 1977). The study of Jackson et al. (1986) is worth noting; they showed the correlation between school teachers' emotional exhaustion and turnover in the following twelve months. Likewise, Lazaro et al. (1985) presented a relationship between burnout and turnover or intention to leave.

It is generally accepted that turnover is a greater problem for the helping professions than for any other occupation. The statistics are very revealing and confirm the above conclusion. According to Katzell et al. (1971), the rate of turnover in social workers and rehabilitation services per year is almost twice (25-30 percent) that of other employees (8-15 percent). Muldary (1983) cites two more studies which maintain that the seventy percent of nursing staff in the United States gave up their jobs during only one year (Lysaught, 1970) and that the turnover rate in child protection services was between fifty and a hundred percent (Kempe, 1978).

The relationship between high turnover rates and age should also be noted. Kermish and Kushin (1969) found that 53.3% of 321 social workers who quit their job were under 25 years of age and 24.7% were between 26-30 years. A study by Firth and Britton (1989) presented emotional exhaustion and lack of perceived support from immediate superiors as significant predictors of absence through sickness and job turnover for 200 nursing staff.

At this point, it is worth mentioning the study by Lemkau et al. (1994) concerning the association between burnout and career-choice regret among 63 family practice physicians in the US. From this sample, only 52% stated that they would definitely choose to become doctors again. As regards burnout levels, the physicians displayed moderate levels on measures of Emotional Exhaustion and Depersonalisation (according to Maslach Burnout Inventory/MBI) and a high correlation between each other ($p<0.001$). Furthermore, another significant correlation was between these two dimensions of burnout and regret about the choice of a medical career ($p<0.01$ and $p<0.05$ respectively). On the contrary, the third measure of MBI, Personal Accomplishment was independent of both the other two dimensions and the career-choice regret variable.

The substantial impact of turnover in organisations could be easily understood due to the event that usually the demand for new personnel depends on staff turnover. Maslach and Jackson (1981) found that the high burnout levels of mental health staff were related to increased absences and breaks from work. Finally, in a study by Deckard et al. (1992) it was found that the 58.9% of physicians who expressed the intention to change jobs, reported high scores on Emotional Exhaustion.

Job-satisfaction

Several researchers have proved the existence of a relation between turnover and job satisfaction (Meeusen & Pool, 1996). In the above-mentioned study of Papadatou and al. (1994), it was also found that the job satisfaction of the "burned out" nurses was at low levels. Besides, according to Penn et al. (1988), burnout of human

service professionals is negatively related with the satisfaction of work, co-workers, supervision, pay and opportunities for promotion.

Although numerous researchers are not convinced as to whether job satisfaction is always associated with better performance, some studies have revealed a significant negative impact on absenteeism and turnover of employees in relation to job satisfaction. In particular, health workers who experienced high levels of burnout, had lost their ability to attain their personal expectations through work and felt dissatisfied about their job and life (Frilsen & Sarros, 1989). While the relationship of job and life satisfaction has been defined as reciprocal, some researchers suggest that job satisfaction may be the cause, which leads to life satisfaction (Near et al., 1983).

In a study by Lee and Ashforth (1993), the burnout of human service supervisors and managers was examined and a correlation was found between job, life satisfaction and exhaustion. The authors maintained that even though life satisfaction was a partial mediator between job satisfaction and exhaustion, it constituted a weaker correlation with exhaustion than job satisfaction (–0.17 versus –0.39).

As regards physicians, it has been found that an appropriate work environment plays a critical role in increasing their personal satisfaction and their ability to contribute to the hospital (Tabinkin et al., 1989). In conclusion, the consequences of helping professionals' job dissatisfaction influenced directly not only organisations (hospitals' costs) but also individuals (patients' care).

Job characteristics

A growing body of evidence suggests that burnout is caused by the dynamic interaction between the objective factors of work environment and employees' personal characteristics (Vachon, 1987).There are a great number of researchers who suggest that burnout is mainly attributed to stressful and adverse job conditions such as heavy schedule, lack of autonomy and power, inadequate psychological support and the autocratic management of organization (Pines, 1986).

Therefore, the degree of individual frustration, satisfaction, performance or burnout depends on both the expectations of the individual from the one side and the job demands from the other. Numerous studies (Schwab et al., 1986) have found that no balanced relationship exists between the above two variables because the work itself could not fulfill the personal needs and expectations of employees.

An important factor in individual's burnout involves the frequent and long contact with clients (e.g. patients) who face chronic problems and are generally in difficulty. According to Muldary (1983) the nature of the job of health professionals

(physicians, dentists, nursing staff) and educators requires close interactions with recipients who quite often display negative attitudes through aggressiveness, passiveness and apathy. Besides, as it has already been mentioned, other non-helping professionals such as managers may feel burnout due to increased responsibilities and because their role demands helping employees resolve not only job-related problems, but also overcome personal difficulties (Schuler,1983).

The contributing role of patient caseload in relation to burnout has been found to be significant. The patient caseload can be divided in two dimensions: quantitative and qualitative. When the patient caseload is large (quantitative dimension) the number and the duration of interactions with the recipient are minimized and the breaks become more rare (Pines & Maslach, 1978). The qualitative dimension refers to the impersonal relations when dealing with recipients' problems. The contact usually is indirect (e. g. through phone) and implies an emotional distance. For instance, doctors adopt a selective policy towards the patients' problems ignoring their minor difficulties, considering them a waste of time.

In addition, a negative relation has been found between role problems (role conflict and role ambiguity) and burnout not only in human service professionals such as nurses (Chiriboga & Bailey, 1986) and social workers (Himle et al., 1987) but also in other professionals (teachers, personnel workers and correctional officers). Kahn et al. (1978) suggested that role conflict refers mainly to jobs where the employee must fulfill the demands which stem both from people inside and outside of organization. Role ambiguity occurs when a individual has not got adequate information about his/her job objectives and responsibilities. As information could be restricted or not clearly defined and articulated (Jackson & Schuler, 1985), the employee's essential needs for certainty and predictability are not satisfied.

Both ambiguous and conflicting roles have received a great deal of attention in literature concerning burnout. They have been considered by several researchers (Ellis & Mathews, 1982; Duke, 1984) as precursors for high levels of stress and burnout, poor performance, job dissatisfaction and attrition of teachers. In a study of Fimian and Blanton (1987), it was showed that the total burnout of teacher trainees and first-year teachers was significantly correlated to role conflict and role ambiguity ($rs=0.32$ and 0.43 respectively) and the latter were correlated with one another ($r=0.64$) as well.

Similarly, Brookings et al. (1985), found a significant relationship between perceived role conflict and ambiguity and the three dimensions of burnout, in a sample of female human service professionals. Furthermore, there are some other studies (e.g. Jackson et al., 1987; Leiter & Maslach, 1988) which have proved the

correlation between role conflict and ambiguity and one of the three components of burnout.

The lack of autonomy and control is another job characteristic that may precede and eventually lead to burnout. In particular, health professionals who do not manage to meet their need for autonomy which is an indication of personal growth and maturity, usually adopt a behaviour known as "learned helplessness" (Landsbergis, 1988). The individual in such a situation could not actually receive feedback from the good outcomes of his/her work because he/she usually believes that they are attributed to factors beyond their control. Finally, the individual feels frustrated, powerless and "trapped" by others' demands and job restrictions (Muldary, 1983).

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