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Promoting Work Well-being: Professional Burnout & Occupational Stress

Edited by: Alexander-Stamatios Antoniou

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The content of this textbook reflects all the most recent knowledge and internationally accepted techniques as they are analyzed by experienced authors in the field, in each chapter.
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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16 PRINCESS DE TYRA STR, KARANTOKIS BUILDING
1642 NICOSIA, CYPRUS
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Promoting Work Well-being:
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The Relationship between Work Setting Characteristics and Professional Burnout of Health Professionals

Chapter 3

Alexander-Stamatios Antoniou

A considerable body of evidence suggests that professional burnout is caused by the dynamic interaction between the objective factors of work environment and individuals' personal traits (Vachon, 1987). There is 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 organisation (Pines, 1986).

Therefore, the degree of individual frustration, dissatisfaction, poor performance or burnout depends on both the expectations of the person from the one side and the work demands from the other. Numerous studies have found that no balanced relationship exists between the above two variables because the workplace itself could not fulfill the personal needs and expectations of people. Thus, many theorists consider burnout as a mismatch between person and job. More specifically, six areas have been detected in which this mismatch can occur, namely: work overload, lack of control, insufficient reward, breakdown of community, absence of fairness and value conflict (Cooper, 1998).

For instance, the bureaucratic character of some organisations constitutes a specific job characteristic which is significantly correlated to the experience of burnout by the employees (Schaufeli & Buunk, 1996). Radquepaw and Miller (1989) demonstrated that psychotherapists from outpatient clinics displayed higher levels of burnout than their colleagues working in an independent basis. Similarly, in a study with Finnish physicians conducted by Olkinuora and colleagues (1990), it was found that those who worked in hospitals experienced higher levels of professional

burnout in comparison with their colleagues working in other settings (e.g. private ptactice, research institutions and public offices).

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 such as physicians, dentists and nursing staff requires close interactions with recipients who quite often display negative attitudes through aggressiveness, passiveness and apathy. Recent research carried out by Van Dierendonck et al (1994) revealed that harassment from the side of patients experienced by a sample of general practitioners was linked to the development of burnout.

In an early study, Cherniss (1980) interviewed human services professionals including mental health professionals and public health nurses who had just entered their jobs. The results revealed that the young professionals experienced a "reality shock" and showed a firm tendency to withdraw psychologically from their recipients and from their duties. Especially for human services work settings, Cherniss (1980) specified the following eight potential sources of burnout: poor orientation, high work load, routine, narrow scope of client contact, lack of autonomy, incongruent institutional goals, poor leadership and supervision practices and social isolation.

The contributing role of patient caseload in relation to burnout has been found to be significant (Skorupka & Agresti, 1993). 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. Leiter (1991) found that quantitative caseload is significantly correlated only to the one dimension of burnout, the emotional exhaustion. 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 example, doctors adopt a selective policy towards the patients' problems ignoring their minor difficulties, considering them a waste of time. A relevant factor with that of caseload is the long working hours which also associated with high levels of burnout of health professionals (Landsbergis, 1988).

In addition, a negative relationship has been found between role problems (role conflict and role ambiguity) and professional burnout especially in human service professionals such as social workers (Himle et al., 1987) and nurses (Chiriboga & Bailey, 1986). Kahn et al. (1978) suggested that role conflict refers mainly to those jobs where the employee must fulfill the demands which stem both from people inside and outside of organisation. Role ambiguity occurs when a individual has not got

adequate information about his/her job objectives and responsibilities. In cases when the information is restricted or not clearly defined and articulated (Jackson & Schuler, 1985), the employee's essential needs for certainty and predictability are not satisfied.

In a study of Brookings et al (1985), it was found a significant relationship between perceived role conflict and role ambiguity and the three dimensions of burnout (i.e. emotional exhaustion, depersonalisation and reduced personal accomplishment), in a sample of female human service professionals. Likewise, a more recent study (Lee & Ashforth, 1993) showed the negative effects of both these role problems in a relevant sample. Furthermore, some other researchers have proved a consistent association between the lack of role clarity and at least one of the three components of burnout according to the Maslach's definition. Specifically, it has been observed that role conflict is positively related to emotional exhaustion, fatigue and negative attitudes towards recipients but not to a decrease in the personal accomplishment (Cordes & Dougherty, 1993; Jackson et al., 1987).

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". The individual in such a situation could not actually receive feedback from the good outcomes of their work because they usually believe that these outcomes are attributed to factors beyond their control. Finally, the individual feels frustrated, powerless and "trapped" by others' demands and job restrictions. The combination of high workload demands and the low decision authority can be the cause for high level of professional burnout and occupational stress (Burke & Richardsen, 1996).

According to a considerable number of studies (Leiter & Maslach, 1988; Ross et al., 1989), the lack of both work and home social support constitutes a causal factor for the development of burnout. Social support can be offered by various sources such as colleagues, superiors and family in order to provide mainly emotional comfort by encouraging individuals' growth, enhancing their self-esteem and sharing their anxieties and problems. Additionally, social support can provide more practical assistance and give useful information (Winnubst & Schabracq, 1996).

Even though, sometimes the social interactions with co-workers are not "ideal", it has been found that completely lack of support from colleagues is consistently linked to burnout (Digman & West, 1988). Interestingly, as regards the social support received by the members of family, several studies (e.g. Leiter, 1990; Zedeck et al., 1988) revealed that is directly related to lower levels of burnout in caring professionals.

A number of workplace interventions have been proposed in order to help in the prevention or the reduction of burnout. For example, work redesign in the form of job enrichment and job rotation could be an appropriate measure to cope with both quantitative and qualitative caseload which is considered one of the basic organisational variables leading to burnout. These methods could also help overcome problems arising from the difficulty, especially for female employees, to manipulate conflicts between work and home responsibilities.

Moreover, the attendance of training courses dealing with the effective communication with demanding and aggressive clients (e.g. patients) would be shown an additional way to decrease qualitative workload. Quite frequently, health professionals are the target of patients' criticisms, complaints and generally negative feedback regarding the inadequate services provided by other helping staff and the poor facilities offered by the hospitals.

Finally, social support which is regarded one of the most significant coping mechanisms against professional burnout and work stress must be encouraged in the work setting between colleagues and superiors by establishing regular times for consultations and meetings during a working week.

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