MentalPRAC

Training for practitioners who work with people with severe mental disorder

STUDY REPORT ON BURNOUT AMONG PROFESSIONALS TRAINED THROUGH THE 'MENTALPRAC' PROJECT

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1. INTRODUCTION

Burnout syndrome is an important psychosocial problem, given that the deterioration of physical and mental health of workers has negative consequences for the organization (for example, absenteeism, loss of productivity, etc.). Furthermore, the incidence of burnout is heightened among professionals in care and social professions and the deterioration of working life has in turn, repercussions on the people that use these services (Gil-Monte & Peiró, 2000).

An important issue is the **psychosocial risks**, as they represent the second biggest problem to occupational health in Europe, affecting more than 40 million workers in the European Union. These psychosocial risk factors can be defined as those referring to the conception, organization and management of work as well as the social and environmental context which may cause physical, social or psychological damage in working people (Martín, Vera, Cano & Molina, 2004).

Specifically, we have chosen to focus the present study on the psychosocial risk of **burnout syndrome** as part of the '*MentalPrac*' Project. The term is one which has been conceptualised in diverse ways, starting from the first definition of Freudenberger (1974). The American psychiatrist defined it as ″a feeling of failure and a state of fatigue and frustration as the result of excessive demands on the energy, resources and strength of the worker″. Freudenberger (1974) observed exhaustion, cynicism towards patients, a tendency to avoid patients and irritability among the group of young people that undertook volunteering work in his 'Free clinic' in New York. These symptoms developed between one and three years into their work (Buendía & Ramos, 2001).

Subsequently, Maslach and Jackson (1982) defined it as ″a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur among individuals who work with people″. From this three dimensional conceptualisation of the syndrome, these authors designed the "Maslach Burnout Inventory" (MBI), with the objective of investigating burnout in human service professions.

In 2001, Maslach, Schaufeli and Leiter defined it as ″a prolonged response to chronic stress that affects personal and working life". Following the same line, Gil-Monte (2005) defined it as ″a response to chronic work related stress, that surfaces when traditional coping strategies used to manage stressful working situations fail″. Marrero and Grau (2005) also found that burnout arises when workers lack the basic coping strategies to be able to manage their workload. There is a certain consensus in affirming that burnout is one of the most specific forms of work related stress, although both phenomenon have varying and on occasions, contradictory definitions (Buendía & Ramos, 2001; Olabarría & Mansilla, 2007).

Other authors such as Pines and Aronson (1988) consider that work related burnout may be present in people who do not work in social care services. That is to say that the syndrome can be observed in any profession, although there are specific groups of professionals that are more likely to show signs of burnout. Currently, burnout syndrome has been linked to different groups of professionals (Martínez, 2010).

The **symptoms** associated with burnout are varied and affect different areas (emotional, cognitive, behavioural and social). According to Buendía and Ramos (2001), the symptoms that may be present are the following:

- Emotional symptoms: depression, helplessness, despair, irritability, apathy, disillusionment, pessimism, hostility, a lack of tolerance, accusations towards patients/users of the service, suppression of emotions.
- Cognitive symptoms: loss of values, loss of expectations, changing self-image, loss of creativity, distractibility, cynicism or depersonalisation, general criticality.
- Behavioural symptoms: evasion of responsibility, work absenteeism, disorganisation, overworking, avoidance of decision making, rise in the use of alcohol and other drugs.
- Social symptoms: avoidance of social contact, interpersonal conflict, moodiness, isolation, avoidance of professional situations.

According to Edelwich and Brodsky (1980), the **development of burnout syndrome** has four phases or stages. The first stage is the initial phase of enthusiasm; a new job will often be accompanied by positive expectations; the second phase is characterised by an imbalance between work demands and personal resources (the stalemate phase); the frustration stage will be accompanied by emotional, physical and behavioural problems; and the final phase of apathy, is characterised by defensive coping mechanisms and a lack if involvement in work. This demoralisation has negative

repercussions on the quality of life of workers and consequently, the level of care they provide (Caballero, Bermejo, Nieto & Caballero, 2001).

It is important to highlight that burnout mainly effects professionals that work with people (school staff, social work professionals, health professionals, policemen etc.) that is to say **care professionals**. There is a high presence in professionals whose roles are characterised by dealings and contact with others (Hernández-Martín, Fernández-Calvo, Ramos & Contador, 2006).

The incidence of burnout syndrome differs according to the population group and the country in which the study is carried out. Accordingly, in the US the incidence of burnout was 10.6 % of the sample, 24.4% in Spain, 37.4% in Argentina and 3.2% in Holland. These figures also vary according to the clinical criteria used in different countries to diagnose the syndrome (Gil-Monte & Marucco, 2008).

Regarding **risk factors**, there are numerous contradictory results on demographic risk factors such as age, sex or civil status (Betancur et al., 2012; Maslach, Shaufeli & Leiter, 2001). Different authors also note that neither can the period of time spent in a job be considered as a variable for predicting when people feel burnt out by their work (Boada, De Diego & Agulló, 2004).

The concept of burnout has given rise to confusion with other constructs that share some of the same symptoms, such as work-related stress, therefore it is important to distinguish between the concepts. According to the European Agency for Health and Security in Work (2000), **work related or occupational stress** arises when work demands exceed the capacities of workers to meet and control these demands.

Burnout is often linked to **organisational crises**, as each person participates in the organisation which they are part of. Crises are inevitable in the development of any system, and they are crucial elements for the growth and organizational change. It is important to note that crises resolved in a dysfunctional manner can have repercussions on the quality of care offered to people who use the service of burnt-out workers (Olabarría & Mansilla, 2007).

There are many potential **causes** of burnout, such as the perception of earning a low wage, an irregular working timetable, excessive working hours (Schaufeli & Buunk, 2003), frequent staff changes, role conflict and ambiguity (Gibbs, 2001; Landsman, 2001), professions with little social recognition and a shortage of resources (Söderfeldt, Söderfeldt & Warg, 1995).

As well as the multiple causes already pointed out which can play a part in the development of burnout, there are a series of **stressors** which are present in mental health professionals, including the following (Quick & Tetrick, 2003; Vachon, 2000):

- Continued contact with people with mental illness requires a high level of engagement in order to be able to establish a supportive relationship.
- Frustration with the results of the intervention.
- A high number of patients to attend to.
- Lack of training in emotional control.
- Irregular working timetable.
- Lack of cohesion in the multidisciplinary team.

The **consequences** that may be suffered by a person with burnout syndrome are negative, and could have repercussions on their physical, psychological, occupational health and family environment (García-Izquierdo, Sáez & Llor, 2000). More specifically, Maslach, Schaufeli & Leiter (2001) noted the different consequences that are associated with burnout according to their incidence on physical, psychological and occupational health:

- Physical problems: cardiovascular problems, chronic fatigue, headaches and migraines, gastrointestinal illnesses, respiratory problems, trouble sleeping, dermatological problems, menstrual problems, sexual dysfunction and muscle and joint pain.
- Emotional problems: anxiety, depression, irritability, dysphoria, lack of self esteem, lack of motivation, low occupational satisfaction, difficulty concentrating, emotional isolation, professional frustration and the desire to abandon work.
- Behavioural problems: work absenteeism, alcohol and other drug use, rises in violent behaviour, high risk behaviour (reckless driving, gambling), eating problems, loss of productivity and the deterioration of quality service within the organisation.

The health sector is often one of the most common to display this type of problem, for this reason, the main objective of this study is to prevent the development of burnout syndrome among professionals who work with people with severe mental disorders.

2. METHODOLOGY

2.1. PARTICIPANTS

The study sample was made up by a total of 66 workers from the mental health profession (N=66), of which 66.7% were women (n=44) and 33.3% were males (n=22). The workers were from Fundación Diagrama (Spain, 47%), Diagrama Gemeinnützige (Germany; 7.6%), Action with Communities in Rural Kent and Catching Lives (UK, 19.7%) and Groep Ubuntu (Belgium, 25.8%). The age of participants ranged from 21 to 59 years old, with the average age of the sample being 38.14 years (D.T.=9.53).

The sample consisted of people who had received training from the *'MentalPrac'* Project and who had adequately filled out the evaluation questionnaires.

2.2. INSTRUMENT

The instrument used to carry out the study was a socio-demographic questionnaire and a questionnaire on burnout according to Maslach & Jackson's (1996) Maslach Burnout Inventory-Human Services Survey (MBI-HSS).

The socio-demographic data was collected by means of an *ad hoc* questionnaire designed for the study, which included the personal information included in the MBI-HSS and other variables considered relevant to the study.
The variables studied were the following: sex, age, nationality, civil status, duration of marriage to current partner, number of children, in the case that they have children how many live in the family home, educational level, current profession, employment status, work contract, weekly work hours, on call services, time spent in their current job, and if they have been on occupational leave during the previous year for any health problems.

Furthermore, the level of occupational satisfaction was investigated using the Andrews and Withey Job Satisfaction Scale (1976) which is in English, and adapting it to German and Spanish. Questions were responded on a Likert-type scale, ranging from 1 being "Terrible" to 7 being "Delighted".

The MBI-HSS investigates the three dimensions of burnout syndrome: emotional exhaustion (9 items), depersonalisation (5 items), reduced personal accomplishment (8 items), and it was designed specifically for use in professionals working in the human

service sector, where the syndrome has been universally detected. According to experts, the criteria used to determine if a person is suffering from burnout is when they receive a high score (PC=57-99) in emotional exhaustion and depersonalization and a low score in personal accomplishment (PC=1-33). It consists of 22 items evaluated by the 7 point Likert-type scale with a frequency scale ranging from 0 "Never" to 6 "Everyday". Versions adapted to Spanish, English and German of the MBI-HSS were also used. This is the most commonly used instrument to evaluate burnout syndrome, both in Spain and abroad.

2.3. DATA ANALYSIS

A descriptive analysis was carried out, as well as Pearson's Chi-square test using the SPSS Statistics 21.0: average, standard deviation, frequency and percentage distribution.

They analysed the results of the MBI both pre-test and post-test. In order to check if there were significant statistical differences due to professional training Pearson's Chi-square test was used.

2.4. PROCESS

The data of study was collected by responsible persons appointed by each partner or entity that participated in the study, which were then send to the Fundación Diagrama (Spain) to be analysed.

The evaluation questionnaire was distributed before the start of the professional training programme (pre-test) and 3 weeks after its completion (post-test). Furthermore, every participant received a letter of introduction in which they were asked to participate in the '*MentalPrac'* Project and give their informed consent.

The questionnaires respected the confidentiality of answers and the anonymity of those who participated in the study, in accordance with Ley Orgánica 15/1999, 13th December, on the Protection of Data of a Personal Nature.

3. RESULTS

3.1. DEMOGRAPHIC DATA

The data was collected from the sample of 66 professionals who work with people who suffer from severe mental disorders, and who adequately completed the evaluation questionnaires (see Tables 1 and 2). Among the sample, 44 professionals (66.7%) were women and 22 (33.3%) were men. The age of participants ranged from 21 to 59 years old, with an average age of 38.14 years old (D.T.=9.53). The majority of participants were of Spanish nationality (n=30; 45.5%), followed by Belgian (n=17; 25.8%), British (n=13; 19.7%), German (n=4; 6.1%), and Senegalese and Hungarian, each representing 1.5% (n=1) of the total.

Of the whole sample, 42.4% (n=28) were single, 40.9% (n=27) were married, 13.6% (n=9) were separated or divorced, and 3% (n=2) did not provide information on their civil status.
In terms of the time married, 25.9% of the participants had been married for less than a year, 29.6% from 1 to 5 years, 7.4% from 6 to 10 years, 25.9% from 11 to 20 years, and 11.1% for more than 20 years. The average time married was 8.5 years (D.T.=9.94), within a range of 2 months up to a maximum of 35 years.

There was a greater percentage of professionals who have at least one child (57.6%), compared to (42.4%) who don't. In terms of those who have children who live in the family home, 51.5% (n=34) live with a child while 48.5% (n=32) do not.
Regarding the level of education, 54.5% (n=36) of the professionals have a Professional Certificate, followed by 18.2% (n=12) who have university level studies, the same percentage have secondary level education, 6.1% (n=4) have vocational training and only 3% (n=2) have primary level education.

Table 1. Demographic and labour data		
	Frequency (n)	**%**
Gender		
Male	22	33.3
Female	44	66.7
Marital status		
Single	28	42.4
Married	27	40.9
Separated or divorced	9	13.6
NA	2	3.0
Nationality		
Spanish	30	45.5
Senegalese	1	1.5
British	13	19.7
Belgian	17	25.8
Hungarian	1	1.5
German	4	6.1
Participation body		
Fundación Diagrama	31	47.0
Diagrama Gemeinnützige GmbH	5	7.6
Action with Communities in Rural Kent & Catching Lives	13	19.7
Groep Ubuntu	17	25.8
Children		
Yes	38	57.6
No	28	42.4
Children living with		
Yes	34	51.5
No	32	48.5
Level of education achieved		
Primary (GCSE)	2	3.0
Secondary (A Level)	12	18.2
Professional qualification	36	54.5
University	12	18.2
VT	4	6.1
Employment situation		
Permanent employment	35	53.0
Temporary employment	13	19.7
NA	18	27.3
Type of contract		
Part time	21	31.8
Full time	35	53.0
Other	10	15.2
On-call services		
yes	28	42.4
No	34	51.5
NA	4	6.1
Time off work		
Yes	20	30.3
No	46	69.7

Note: VT= Vocational Training; NA=No answer.

Table 2. Chronological data				
	Mean*	**S.D.**	**Min.**	**Max.**
Age	38.14	9.53	21	59
Time married	8.52	9.94	0.2	35
Weekly work hours	34.91	6.22	13	40
Time in current job	4.36	5.45	.08	30
Time in current profession	7.12	7.63	.025	36

*Years.

3.2. LABOR DATA

All of the professionals who participated in the '*MentalPrac*' Project work in contact with people who suffer from severe mental disorders. The majority of these professionals are in permanent employment (53%), 19.7% were in temporary employment and the remaining 27.3% did not provide information on their situation. Furthermore, in 53% of cases participants are on a full time contract, 31.8% are on a part time contract and 15.2% another type of contract. The average number of hours worked on a weekly basis was 34.9 (D.T.=6.22), with a minimum of 13 and a maximum of 40 hours.

Regarding whether or not they offered on call services, the majority of participants responded negatively (51.5%), 42.4% responded positively, and 6.1% did not respond to the question. In the past year, 30.3% had been on leave for health problems, while 69.7% had not been.
The participants spent on average 4.4 years (D.T.=5.45) in their current position, they had been working in their field for on average 7.1 years (D.T.=7.63).

Finally, in relation to the level of satisfaction in their current job, the average score was 5.47 points (D.T.=.79), this rose to 6.48 (D.T.=.71) once they had completed the training.

Table 3. Job satisfaction				
	Mean	**S.D.**	**Min.**	**Max.**
Pre-test	5.47	.79	3	7
Post-test	6.48	.71	5	7

3.3. BURNOUT SYNDROME

By analysing the results obtained between the initial evaluation and the evaluation carried out after the training, it can be stated that there are significant statistical differences regarding burnout syndrome among the participants of the '*MentalPrac*' project (x^2=6.85; p=.021).

In the evaluation before training (pre-test), 15.2% of the sample obtained scores which demonstrate burnout, this figure fell to 7.6% 3 weeks after receiving the professional training (Figure 1).

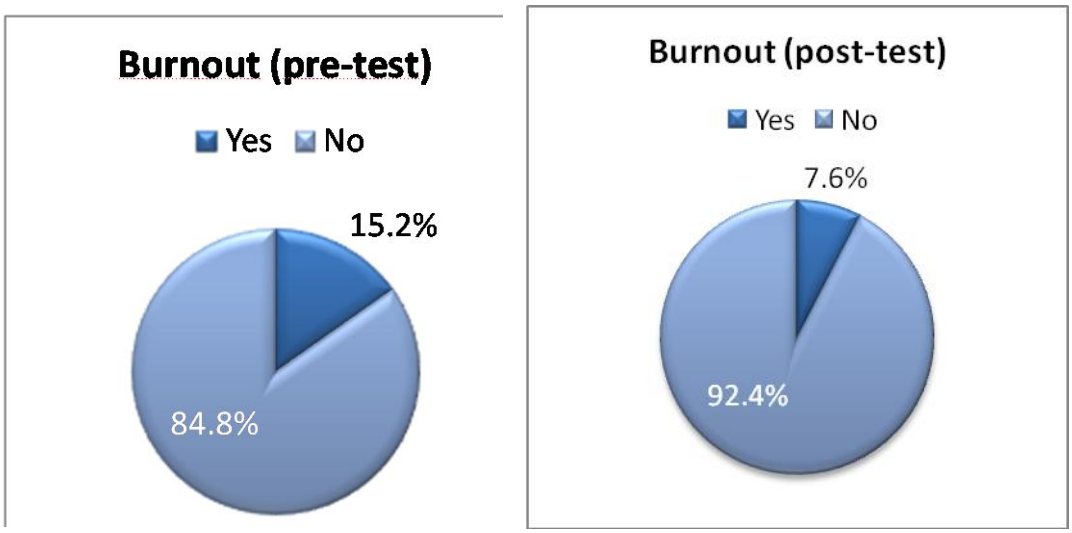

Figure 1. Pre-test and Post-test distribution of burnout syndrome.

If we consider the scores of the different dimensions of burnout (Figure 2), the pre-test scores were 16.8 in Emotional Exhaustion (EE), 5.2 in Depersonalisation (D) and 37.2 in Personal Accomplishment (PA), and with 15 points in EE, 4.5 in D and 38.3 in PA in the post-test evaluation.

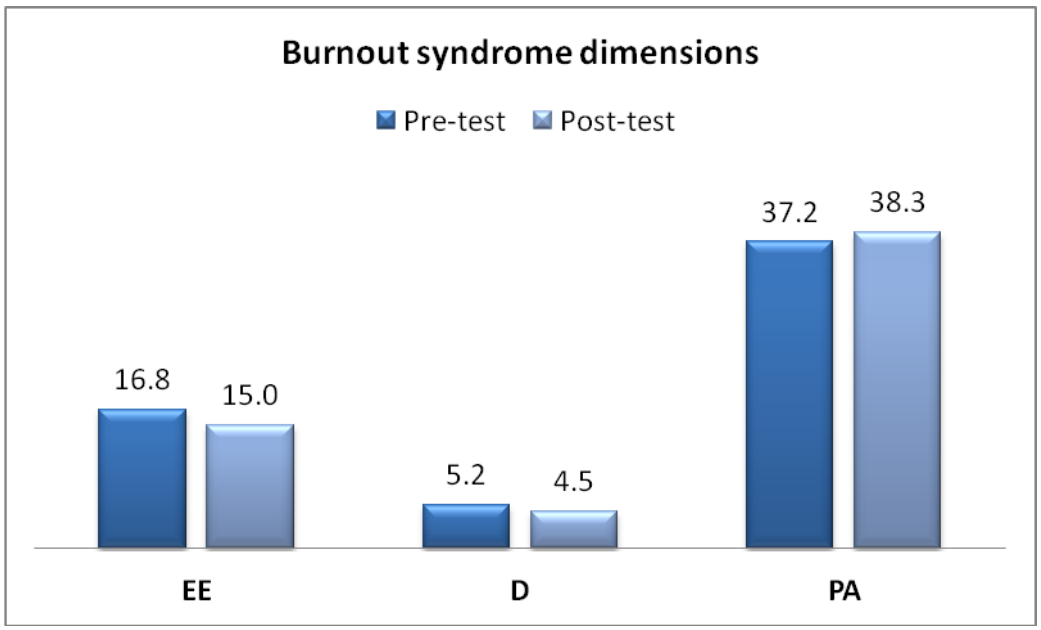

Figure 2. Burnout syndrome dimension scores.

In Table 4 the dimensions and sub-scales of burnout assessed before and after carrying out the professional training can clearly be observed. In the EE dimension, there are significant statistical differences in the low category (x^2=3.07; p=.042). In the medium category there were no statistically significant differences (x^2=.17; p=.682), there were however in the high category (x^2=26.25; p<.001).

In dimension D there were significant statistical differences in the low category (x^2=13.71; p<.001), medium (x^2=4.88; p=.027) and high (x^2=6.15; p=.022).

Finally, in the subscale of PA (inverse item) there were also significant statistical differences in the low category (x^2=9.95; p=.018), medium (x^2=5.76; p=.016) y and high (x^2=7.29; p=.024).

Table 4. Correlations of the MBI-HSS sub-scale scores

Dimension	Category	Chi-squared test	df	Value of p	Pre-test (%)	Post-test (%)
EE	Low-Low	3.07	1	.042*	50.0	59.1
	Medium-Medium	.17	1	.682	27.3	24.2
	High-High	26.25	1	<.001*	22.7	16.7
D	Low-Low	13.71	1	<.001*	51.5	48.5
	Medium-Medium	4.88	1	.027*	22.7	30.3
	High-High	6.15	1	.022*	25.8	21.2
PA	Low-Low	9.95	1	.018*	24.2	15.2
	Medium-Medium	5.76	1	.016*	19.7	27.3
	High-High	7.29	1	.024*	56.1	57.6

*p<.05

Finally, Table 5 shows the percentage of professionals who received scores from the lower, middle and upper categories of the three dimensions of the syndrome. The decrease in the percentage of professionals in the upper category of EE and D should be pointed out, while in the upper category of PA there is an increase, as this is an inverse item and professionals gave higher to scores to personal accomplishment once they had finished the training.

Table 5. Distribution of participants according to the MBI-HSS sub-scale scores

Dimension	Pre-test	Post-test	Pre-test	Post-test	Pre-test	Post-test
	Low (%)		Medium (%)		High (%)	
EE	50.0	59.1	27.3	24.2	22.7	16.7
D	51.5	48.5	22.7	30.3	25.8	21.2
PA	24.2	15.2	19.7	27.3	56.1	57.6

Note: EE=Emotional Exhaustion; D=Depersonalization; PA=Personal Accomplishment.

4. CONCLUSIONS

The results obtained show that 7.6% of the professionals who participated in the '*MentalPrac*' Project have burnout syndrome, the number of burnout cases fell by 7.6% after training. This figure is lower than that found in countries such as the USA and Spain and higher than that of Argentina and Holland, when using the MBI to carry out the assessment (Gil-Monte & Marucco, 2008).

Regarding the different dimensions of burnout, the scores in EE (1.8 points) and D (0.7 points) fell, while those of PA rose (1.1 points). Both in the pre-test and post-test evaluation the scores in the present study are lower in EE and D and higher in PA than the scores of the sample used (USA and Spain) to validate the MBI.

Job satisfaction increased once training had been completed, specifically it increased by 1.01 points, as a result it can be stated that receiving training in an organization can contribute positively to job satisfaction, as well as increasing professional competences. Therefore, continued training is a means of indirect care towards workers, which at the same time constitutes one of the strategies and intervention techniques to combat burnout (Martínez, 2010).

It is clear that there is a risk of burnout syndrome in professionals who look after people with mental problems or disorders (Olabarría & Mansilla, 2007), although the people who participated in this study experienced reductions in emotional exhaustion and depersonalization, at the same time as their sense of personal accomplishment increased.

Finally, it is necessary to provide information to professionals who work in contact with people with severe mental disorders, as it is this group of professionals who are exposed to high levels of stress which can develop into the symptoms of burnout or the syndrome itself.

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