

BURNOUT IN HEALTH CARE

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Burnout is the index of the dislocation between what people are and what they have to do. It represents an erosion in values, dignity, spirit, and will—an erosion of the human soul. With these words, Maslach and Leiter (1997, p. 17) describe a particular negative psychological state that is also observed among health care professionals. Burnout is a metaphor that is commonly used to describe a state or process of mental exhaustion, similar to the smothering of a fire, the extinguishing of a candle, or the draining of a battery that cannot be recharged anymore. In the dictionary “to burn out” is described as follows:

to fail, wear out, or become exhausted by making excessive demands on energy, strength, or resources.

Burnout was first described in greater detail by Herbert Freudenberger in the mid-1970s (Freudenberger, 1974). As an unpaid psychiatrist in a treatment center for drug addicts, he observed that young and idealistically motivated volunteers experienced a gradual energy depletion and loss of motivation and commitment, which was accompanied by a wide array of other mental and physical symptoms. Freudenberger labeled this particular state of exhaustion “*burnout*,” a colloquial term used to refer to the devastating effects of chronic drug abuse. Independently, and at about the same time, Christina Maslach—a social psychological researcher—stumbled across that very term in California. She studied the ways in which health care professionals cope with emotional arousal at work and observed that many of them were emotionally exhausted, had developed negative perceptions about their patients,

and experienced a crisis in their professional competence (Maslach & Schaufeli, 1993). In a way, the almost simultaneous discovery of burnout by the clinician Freudenberger and by the researcher Maslach marks the beginning of two different traditions that approach burnout from a practical and from a scientific point of view, respectively. So far, both traditions have developed relatively independent from each other. Initially the clinical approach prevailed, which was supplemented by a more scientific approach from the early 1980s, particularly after the introduction of a brief self-report questionnaire: the Maslach Burnout Inventory. By the turn of the century, approximately 6,000 scientific articles and books about burnout had appeared, and every year approximately 200 publications are added to this list. Most empirical studies were carried out in health care (34%) and in teaching (27%), with nurses (17%) as the most frequently studied health profession, followed by psychologists and psychotherapists (4%) and physicians (2%) (Schaufeli & Enzmann, 1998; p. 69–73).

Three conclusions can be drawn from the history of burnout: (a) burnout emerged as a social problem and *not* as a scholarly construct; (b) from the outset, burnout was strongly associated with “people work” in the human services, including health care; and (c) a clinical approach and a research approach to burnout have developed and coexist more or less independently.

The purpose of this chapter is to present a brief overview of burnout in health care. In the following sections, attention is paid to (a) symptoms and assessment; (b) related concepts such as job stress

and depression; (c) prevalence; (d) correlates, causes, and consequences; (e) psychological explanations; and (f) interventions.

SYMPTOMS AND ASSESSMENT

Initially when the clinical approach to burnout prevailed, more than 130 possible symptoms were identified (Schaufeli & Enzmann, 1998, pp. 20–31), ranging from *a* (anxiety) to *z* (lack of zeal). These symptoms can be grouped in five clusters: (a) *affective* (e.g., depressed mood, emotional exhaustion), (b) *cognitive* (e.g., poor concentration, forgetfulness), (c) *physical* (e.g., headaches, sleep disturbances), (d) *behavioral* (e.g., poor work performance, absenteeism), and (e) *motivational* (e.g., loss of idealism, disillusionment). Remarkably—except for motivational symptoms—these clusters appear to match perfectly with the usual categorization of stress symptoms. Typically, burnout is not restricted to symptoms at the individual level; in addition, interpersonal symptoms in relation to colleagues and recipients of one's care or services are observed (e.g., irritability, dehumanization, indifference) as well as symptoms that are related to organizational outcomes (e.g., job dissatisfaction, job turnover, low morale). Hence, burnout not only constitutes a problem for the individual health care worker but also for his or her colleagues and one's recipients and for the organization at large. The significance of burnout is particularly evident because of this multifaceted nature.

However, a laundry-list approach that merely sums up all possible symptoms is inappropriate to define the syndrome, because it denies that burnout is a process and confuses symptoms with precursors, correlates, and consequences. Instead, Schaufeli and Enzmann (1998, p. 36), after reviewing a dozen or so definitions of burnout, proposed the following description:

Burnout is a persistent, negative, work-related state of mind in "normal" individuals that is primarily characterized by exhaustion, which is accompanied by distress, a sense of reduced effectiveness, decreased motivation, and the development of dysfunctional attitudes and behaviors at work. This psychological condition develops gradually but may remain unnoticed for a long time for the individual involved. It results from a misfit between intentions and reality at the job. Often burnout is self-perpetuating because of inadequate coping strategies that are associated with the syndrome.

This definition of burnout specifies its symptoms, its preconditions, and its domain. More specifically, it narrows down more than 100 burnout symptoms to one core indicator (exhaustion) and four accompanying symptoms: (a) distress (affective, cognitive, physical, and behavioral), (b) a sense of reduced effectiveness, (c) decreased motivation, and (d) dysfunctional attitudes and work behaviors. Furthermore, frustrated intentions and inadequate coping strategies play a role as preconditions in the development of burnout, and the process is considered to be self-perpetuating, despite the fact that it may not be recognized initially. Finally, the domain is specified: The symptoms are work related and burnout occurs in "normal" people who do not suffer from psychopathology.

This description is somewhat more comprehensive than the probably most often cited definition of burnout by Maslach, Jackson, and Leiter (1986, p. 1):

"Burnout is a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur among individuals who do > people work' of some kind"

The Maslach Burnout Inventory (MBI) is the most widely used self-report questionnaire that consists of the three dimensions included in the definition. Emotional exhaustion refers to the depletion or draining of emotional resources. Depersonalization points to the development of negative, callous, indifferent, and cynical attitudes toward the recipients of one's care or services. The term depersonalization may cause some confusion, because in psychiatry it denotes a person's extreme alienation from self and the world. By contrast, in the definition of Maslach and colleagues, depersonalization refers to an impersonal and dehumanized perception of one's recipients. Finally, lack of personal accomplishment is the tendency to evaluate one's work with one's recipients negatively. It is believed that the objectives are not achieved, which is accompanied by feelings of insufficiency and poor professional self-esteem.

Because the MBI is *the* instrument to measure burnout, the definition of burnout of Maslach and Jackson (1986) has gradually become equivalent with the way it is measured—in other words, burnout is what the MBI measures. This tautology hampers burnout research, because the concept of burnout is broader and more comprehensive than the MBI assumes. At least with regard to one issue,

the original definition of burnout by Maslach and her colleagues was broadened. Initially, Maslach and her co-workers claimed that burnout occurs exclusively among professionals who do “people work”; that is, those who deal directly with patients, students, or clients, as is the case in health care, education, and social work, respectively. Hence, in their original view, burnout was restricted to these human services professions. However, meanwhile, the concept of burnout is broadened and defined as a crisis in one’s relationship with work in general and not necessarily as a crisis in one’s relationship with people at work (Maslach, Schaufeli, & Leiter, 2001). As a consequence, the three original burnout dimensions have been slightly redefined, and a new general version of the MBI (Schaufeli, Leiter, Maslach, & Jackson, 1996) has appeared that can be used among those who do not deal with patients or clients and the like, such as administrative hospital staff or maintenance and catering staff working in health care.

Generally speaking, the psychometric quality of the MBI is encouraging: The three scales are internally consistent, and the three-factor structure has been confirmed in various studies (Schaufeli and Enzmann, 1998, p. 51–53). The core symptom of burnout—emotional exhaustion—is the most robust scale of the MBI that is strongly related to other burnout measures (convergent validity). Paradoxically, as we will see, it is also the least specific scale that is related to measures of other concepts such as depression (discriminant validity). Although the MBI originates from the United States, similar positive psychometric results have been obtained with the French, German, Dutch, and Swedish versions of the MBI. Moreover, its cross-national validity has been demonstrated across German, French, and Dutch health care samples (Enzmann, Schaufeli, & Girault, 1994).

The MBI is designed as a research instrument to be used at the group level. Except for The Netherlands, there are no clinically validated cutoff points available for the MBI that allow to discriminate between burnout “cases” and “noncases” (Schaufeli, Bakker, Hoogduin, Schaap, & Kaldler, 2001). The MBI-test-manual presents only numerical cutoff points based on arbitrary statistical norms (Maslach, Jackson & Leiter, 1996). Although the test authors—correctly—warn that these should not be used for diagnostic purposes, there is a strong temptation to do so, especially for practitioners. Clearly, this is wrong, not only because the cutoff points are based on arbitrary statistical

norms but also because they are computed from a composite, nonrepresentative, convenience U.S. sample. Only nation-specific and clinically validated cutoff points should be employed for the purpose of individual assessment.

BURNOUT, JOB STRESS, AND DEPRESSION

Burnout has been equated with a myriad of terms; most of them are plagued by the same sort of definitional ambiguity. The most prominent examples are job stress and depression. Can burnout be distinguished from these concepts?

Job stress is a generic term that refers to the temporary adaptation process at work that is accompanied by mental and physical symptoms. By contrast, burnout can be considered as a final stage in a breakdown in adaptation that results from the long-term imbalance of demands and resources. In other words, burnout results from prolonged job stress. Moreover, burnout includes the development of dysfunctional attitudes and behaviors toward the recipients of one’s care or services (depersonalization), one’s job, and the organization one is working for. By contrast, job stress is not necessarily accompanied by such negative attitudes and behaviors. This assertion is empirically supported by Schaufeli and Van Dierendonck (1993), who showed in a sample of nurses that burnout can be distinguished from generic job-related mental and physical distress, albeit that emotional exhaustion shares approximately 30% of its variance with distress. Finally, it has been claimed that everyone can experience stress, whereas burnout can only be experienced by those who entered their careers enthusiastically with high goals and expectations. For example, Pines (1993) argued that people who expect to derive a sense of significance from their work are susceptible to burnout, whereas those without such expectations would experience job stress instead of burnout.

Clearly, burnout and depression are characterized by similar dysphoric symptoms. Nevertheless, clinical practice suggests that the syndromes differ (Liu & Van Liew, 2003): Depressive patients are generally overwhelmed by listlessness and lethargy and hold steadfastly to their ideas of guilt, whereas burnout victims present their complaints much more vigorously—they feel disappointed and aggrieved. Furthermore, burnout includes specific dysfunctional

attitudes and behaviors that are not typically found in depression. Finally, burnout tends to be job related and situation specific rather than pervasive, affecting other spheres of life as well. For instance, burnout is related to lack of reciprocity between investments and outcomes at work, whereas depression is related to lack of reciprocity between investments and outcomes in private life (Bakker, Schaufeli, Demerouti, Janssen, Van der Hulst, & Brouwer, 2000). So it is not surprising that after reviewing nearly 20 studies on burnout and depression, Glass and McKnight (1996, p. 33) wrote:

Burnout and depressive symptomatology are not simply two terms for the same dysphoric state. They do, indeed, share appreciable variance, especially when the emotional exhaustion component is involved, but the results do not indicate complete isomorphism. We conclude, therefore, that burnout and depressive symptomatology are not redundant concepts.

Thus, it appears that burnout can be distinguished conceptually as well as empirically from job stress and from depression. Nevertheless, emotional exhaustion shows some overlap with both concepts. The fact that depersonalization and reduced personal accomplishment are less substantively related to both other concepts implies that burnout is a unique, multidimensional, chronic stress reaction that goes beyond the experience of mere exhaustion.

THE PREVALENCE OF BURNOUT IN HEALTH CARE

How often does burnout occur in health care? Principally, the MBI can be used to answer this question because, at least in The Netherlands, this instrument can discriminate between cases and noncases. Based on the clinically validated MBI cutoff points, 4% of the Dutch working population was identified as burnout cases; that is, they exhibit burnout levels similar to those who receive specialized psychotherapeutic treatment (Bakker, Schaufeli & Van Dierendonck, 2000). More specifically, the prevalence of this so-called clinical burnout was particularly high among occupational physicians (11%), psychiatrists (9%), teachers (9%), general practitioners (8%), community nurses (8%), midwives (7%), and social workers (7%). With the exception of teachers and social workers, these are all health care professionals. Moreover, it appears

that particularly those who work in the community such as occupational physicians, general practitioners, community nurses, and midwives, suffer from severe burnout. This agrees with a British study that showed working in the community is more stressful than working in inpatient services (Prosser et al., 1999). Conversely, in The Netherlands, relatively low levels of burnout were found among police officers (1%), hospice workers (2%), intensive care unit (ICU) nurses (2%), oncology nurses (2%), staff working with the mentally retarded (2%), and correctional officers (3%). Probably the low level of burnout in law enforcement is caused by a selection effect, because police officers and correctional officers are screened psychologically (i.e., those who score high on neuroticism are excluded and drop out, and neuroticism is positively related to burnout). Finally and quite remarkably, highly specialized nurses working in ICUs or in oncology wards do not appear to suffer much from burnout.

Schaufeli and Enzmann (1998, p. 61) analyzed mean burnout scores of various professions, including nurses, physicians, and mental health professionals using more than 70 U.S. studies published between 1979 and 1988. They found that, compared with physicians, nurses experience slightly less emotional exhaustion but *much* less depersonalization and personal accomplishment. Although gender bias cannot be ruled out—nurses are predominantly women, and women tend to report less depersonalization than males—it is likely that differences in depersonalization reflect different professional roles and attitudes: the nurturing and caring role of the nurse versus the more distant curing role of the doctor. This observation agrees with a recently longitudinal study that showed that high levels of depersonalization protect doctors from future stress (McManus, Winder, & Gordon, 2002). In other words, developing a distant attitude toward their patients appears to be adaptive for doctors. According to Schaufeli and Enzmann (1998, p. 61), in mental health care, nursing staff members experience more emotional exhaustion and less accomplishment than psychologists and counselors. Probably this reflects the more stressful nature of the jobs of the former that are characterized by poor decision latitude (probably leading to emotional exhaustion), as well as less extensive training (probably leading to a sense of reduced personal accomplishment).

Finally, it appears that compared with those who are not involved in direct care, burnout levels are

TABLE 14-1. Correlates, Causes, and Consequences of Burnout in Health Care

Correlates	Causes	Consequences
<i>Demographic</i>	<i>Job demands</i>	<i>Individual health</i>
• Young age	• Work overload	• Psychosomatic complaints
• Male (depersonalization)	• Time pressure	• Depression
<i>Personality characteristics</i>	• Emotional demands	• Cardiovascular disease
• Nonhardy personality	• Role problems	<i>Work-related attitudes</i>
• Poor self-esteem	<i>Poor job resources</i>	• Job dissatisfaction
• Avoiding coping style	• Social support	• Low organizational commitment
• High level of neuroticism	• Job control	• Organizational behavior
• "Feeling type"	• Feedback	• Turnover
	• Participation in decision-making	• Absenteeism
		• Poor performance

higher in health care workers who deal intensively with patients on a daily basis. For instance, a large study among more than 200 Japanese health care facilities showed that burnout scores were significantly higher among direct care staff members compared with facility directors, middle managers, and other types of staff personnel (Ito, Kurita, & Shiya, 1999).

THE CORRELATES, CAUSES, AND CONSEQUENCES OF BURNOUT IN HEALTH CARE

Despite the impressive quantity of empirical publications on burnout, their quality is often questionable. For instance, the vast majority of studies are cross-sectional in nature so that only correlates of burnout can be identified, because to establish cause-effect relationships, longitudinal designs are necessary. In the next several paragraphs, the major variables associated with burnout in health care are discussed (see also Table 14-1), whereby special attention is paid to longitudinal studies. For a more detailed overview, see Cordes and Dougherty (1993), Lee and Ashforth (1996), Schaufeli and Enzmann (1998, pp. 69-99), and Schaufeli and Buunk (2002).

Demographic Characteristics.

Burnout is observed more often among younger health care professionals than among those aged older than 30 or 40 years. This is in line with the observation that burnout is negatively related to work experience. The greater incidence of burnout among the younger and less experienced health care workers may be caused by "reality shock" or by

an identity crisis caused by unsuccessful occupational socialization. However, a cautionary note should be made because survival bias cannot be ruled out: Those who burn out early in their careers are likely to quit their jobs leaving behind the survivors, who exhibit lower levels of burnout. Finally, it is consistently found that men report higher depersonalization scores than women, a finding that is in line with other gender differences such as higher prevalence of aggression among men and higher interest in the nurturing role among women.

Personality.

Burnout is *less* common among those with a "hardy" personality who are characterized by involvement in daily activities, a sense of control over events, and openness to change (Maddi, 1999). By contrast, burnout is more common among those with an external locus of control who attribute events and achievements to powerful others or to chance compared with those with an internal locus, who ascribe events and achievements to their own ability, effort, or willingness to risk. Moreover, burnout is related to poor self-esteem and an avoidant, nonconfronting coping style.

Burnout appears to be particularly related to neuroticism, which is characterized by low levels of emotional stability, as well as anxiety, sadness, and irritability. Typically, emotional exhaustion shares approximately 30% of its variance with neuroticism, and 10%-15% with the two remaining burnout dimensions. Depersonalization and reduced personal accomplishment share approximately 5%-10% of their variance with personality factors, with the latter being somewhat stronger related to an avoiding coping style (15%) (Schaufeli & Enzmann, 1998, pp. 77-80). Because neurotic

people are emotionally unstable and prone to psychological distress, neuroticism may act as a vulnerability factor that predisposes professionals to experience burnout.

Compared with “thinking types,” “feeling types” are more prone to burnout, especially to depersonalization (Garden, 1991). The former are more hard-boiled and achievement oriented and tend to neglect others, whereas the latter are more tender minded and are characterized by concern and awareness for people. According to Garden (1991), feeling types are overrepresented in health care and thinking types are more often found in business, which might explain the relatively high prevalence of burnout in this sector.

The question remains how important personality characteristics are relative to actual work experiences in explaining burnout. To answer this question, Burisch (2002) followed a sample of German female nurses on seven occasions during the first 3 years of their careers. He found that emotional exhaustion was particularly predicted by the nurses’ concurrent work experiences, whereas depersonalization and reduced personal accomplishment were particularly predicted by dispositional variables.

Personality variables not only have a direct main effect on burnout levels, they might also play a more complex moderating role. For instance, nurses who experienced high job demands and high job control, *and* who have an active coping style experienced lower levels of burnout compared with those who behaved rather passively (De Rijk, Le Blanc, Schaufeli, & De Jonge, 1998). Hence, it appears that the interaction hypothesis of the job demands control model, stating that job control buffers the negative effects of high job demands, is only supported for active coping nurses; for those who have a passive coping style, job control in fact increases burnout.

General Job Stressors.

Workload and time pressure explain approximately 25% to 50% of variance of burnout, especially of emotional exhaustion (Lee & Ashforth, 1996). Relationships are much weaker with the other two MBI dimensions. The high correlation with workload must be qualified, however, because this stressor is often operationalized in terms of experienced strain so that considerable overlap in item content exists with emotional exhaustion. This

agrees with the results of a longitudinal study (Hillhouse, Adler, & Walters, 2000) among U.S. residents that showed that future burnout was *not* predicted by quantitative workload (i.e., the number of working hours and hours on call) but rather by qualitative workload (i.e., experienced job stress). In addition, Krausz, Sagie, and Bidermann (2000) found that instead of work schedules per se, the extent to which work schedules were *preferred* (i.e., matched with personal preferences) predicted nurses’ burnout levels. Conversely, use of technology—*objectively* assessed by the number of ICU patients who were mechanically ventilated—was substantively related to nurses’ burnout levels (Schaufeli, Keijsers, & Reis-Miranda, 1995). In a somewhat similar vein, unfavorable patient-to-nurse ratios were shown to be positively related to burnout in more than 200 Pennsylvania hospitals (Aiken, Clarke, Sloane, Sochalski, & Silber, 2002). This study showed that an increase of one patient per nurse to a hospital’s staffing level increased nurse burnout by 23% and patient mortality by 7% (after controlling for patient and hospital characteristics).

Role conflict (i.e., conflicting demands at the job have to be met) and role ambiguity (i.e., no adequate information is available to do the job well) are moderately to highly correlated with burnout. Role conflict shares approximately 24% of variance with emotional exhaustion, 13% with depersonalization, and only 2% with personal accomplishment; the percentages for role ambiguity are 14%, 8%, and 10%, respectively (Schaufeli & Enzmann, 1998, pp. 82–83). A recent longitudinal study among Spanish primary health care professionals showed that role conflict and role ambiguity predicted future exhaustion as well as depersonalization, whereas personal accomplishment was predicted only by role ambiguity (Pieró, Gozalez-Romá, Tordera, & Mañas, 2001).

Clear evidence exists for a positive relationship between lack of social support and burnout. In particular, lack of social support from supervisors is related to burnout. On the average, support from supervisors explains 14% of the variance of emotional exhaustion, 6% of depersonalization, and 2% of personal accomplishment; for co-workers the amounts of variance are 5%, 5%, and 2%, respectively (see Lee & Ashforth, 1996). The longitudinal study of Leiter and Durup (1996) among health care professionals showed that emotional exhaustion predicted work overload and supervisor support, instead of the other way round, suggesting a cyclical process rather than straight

causation. Finally, three factors that determine self-regulation of work activities are related to burnout: lack of feedback, poor participation in decision making, and lack of autonomy (e.g., Landsbergis, 1988).

Recently, two studies among health care professionals have successfully tested the so-called job-demands resources model that states that job demands are particularly related to exhaustion, whereas lacking job resources are particularly related to depersonalization (Bakker, Demerouti, Taris, Schaufeli, & Schreurs, 2003; Demerouti, Bakker, Nachreiner, & Schaufeli, 2000). More specifically, the model assumes two underlying processes: (a) energy depletion is driven by high job demands (e.g., time pressure, emotional demands, shift work, cognitive demands) and is associated with exhaustion, and (b) erosion of motivation is driven by lack of job resources (e.g., supervisor support, feedback, control, task variety, financial rewards) and is associated with disengagement (depersonalization).

Specific Job Stressors.

A review of 16 studies revealed that, overall, and contrary to expectations, common job-related stressors such as workload, time pressure, or role conflicts correlate higher with burnout than patient-related stressors or emotional demands such as interaction with difficult patients, problems in interacting with patients, frequency of contact with chronically or terminally ill patients, or confrontation with death and dying (Schaufeli & Enzmann, 1998, pp. 84–85).

For instance, Mallett, Price, Jurs, and Slenker (1991) found only weak correlations between death of patients and emotional exhaustion and depersonalization in a sample of nurses. Instead, lack of staffing and insufficiently qualified staff were considered the most stressful aspects of their work. Obviously, confrontation with death and dying of patients is not the most disturbing part of the nurses' job. It is likely that nurses have developed adaptive mechanisms that prevent negative long-term effects such as burnout.

Individual Health.

Significant correlations with self-report measures of depression and psychosomatic distress are often reported (Schaufeli & Enzmann, 1998, pp. 86–89). As noted earlier, burnout cannot be reduced to mere depressed mood or distress; it is related to

both conditions. As far as self-reported frequency of various illnesses is concerned, Corrigan, Holmes, and Luchins (1995) reported a shared variance with emotional exhaustion plus depersonalization of 18% among psychiatric hospital staff. In a similar vein, Landsbergis (1988) found a significant positive relationship between nurses' self-reported symptoms of coronary heart disease and emotional exhaustion (3% shared variance) and depersonalization (4%); the relationship with reduced personal accomplishment was not significant (2 %).

Work-Related Attitudes.

Although high and unrealistic expectations are related to burnout, this association is not as strong and unequivocal as might be expected. This is probably because different concepts are used, such as omnipotence, irrational beliefs, idealism, unmet expectations, disillusionment, and outcome expectations. Furthermore, it is not always clear whether expectations refer to the organization, to patient's progress, or to personal effectiveness. Job dissatisfaction, poor organizational commitment, and intention to quit—all indicators of psychological withdrawal—share considerable amounts of variance with burnout: 5%–25%, depending on the dimension involved (Schaufeli & Enzmann, 1988, p. 80). The strongest associations are found with emotional exhaustion and depersonalization.

A longitudinal study among Israeli nurses showed that those most prone to leaving the hospital perceived their work as offering little challenge, autonomy or opportunity to express abilities or skills; in addition they also experienced high burnout levels (Krausz, Koslowski, Shalom, & Elkyakim, 1995).

Organizational Behavior.

Despite the popular assumption that burnout causes absenteeism, the effect of burnout on absenteeism is rather small and is best confirmed with respect to emotional exhaustion and next depersonalization. On the average, only approximately 2% of variance is shared with absenteeism as registered in the organization's records; relations with reduced personal accomplishment are marginal but significant (less than 1% of shared variance) (Schaufeli & Enzmann, 1998, pp. 91–92).

Generally speaking, intention to quit is positively associated with burnout, whereas the

evidence for a relation with actual turnover is mixed. For instance, an older study revealed that levels of depersonalization predict nurses' actual job turnover within 2 years (Firth & Britton, 1989), but a more recent study among HIV health care professionals showed that burnout scores at baseline are unrelated to job retention over 4 years (Brown et al., 2002). The fact that the relationship of turnover intention to burnout is much stronger than with actual turnover suggests that a large percentage of burned out professionals stay in their jobs involuntarily.

It is important to distinguish between self-ratings of performance and objective measures or ratings by others such as co-workers or supervisors. Self-rated performance correlates weakly with burnout; approximately 5% of variance is shared with all three MBI dimensions against less than 1% for supervisor-rated or objectively assessed performance (e.g., Parker & Kulik, 1995). Most health care professionals perform their jobs in teams. So the question becomes this: Is team performance negatively affected by burnout levels of its members? Empirical results are mixed. On the one hand, as expected, team-level emotional exhaustion and reduced accomplishment of psychiatric rehabilitation teams appeared to be negatively related with patient satisfaction ratings (Garman, Corrigan, & Morris, 2002). On the other hand, positive correlations with burnout are found as well. For instance, Keijsers, Schaufeli, Le Blanc, Zwerts, and Reis-Miranda (1995) obtained an objective measure of ICU performance by calculating for each unit a standard mortality ratio—the ratio of actual versus predicted death rates adjusted for several patient characteristics such as diagnosis and severity of illness. Contrary to expectations, they found a small but significant *positive* correlation of objective ICU performance with emotional exhaustion (explained variance 2%) and no relationship with depersonalization or personal accomplishment. It appeared that the nurses who felt especially exhausted were those who were employed in objectively (and subjectively) well-performing ICUs but who scored low on self-reported personal accomplishment. A possible explanation is that nurses in well-performing ICUs exert themselves more and, as a consequence, they feel more exhausted. An alternative explanation is that nurses in well-performing units have a higher standard of comparison and thus feel that they accomplish less. At any rate, it appears that—in contrast to the prevailing view—burnout is not necessarily linked to low levels of *actual* performance.

In summary, various correlates of burnout in health care have been identified. The most consistent and strong relationships—particularly with emotional exhaustion—are found with general job stressors, such as workload, role problems, and lack of social support. Relation with specific job stressors pertaining to interactions with patients, as well as with personality factors, and with negative outcomes such as individual health, withdrawal from the organization, and poor work performance are somewhat less strong. Strictly speaking, to date, few causes or consequences of burnout can be identified, probably because the considerable stability of burnout across time—approximately 40%–45% of the variance of burnout is explained by the level of burnout 1 year before (Schaufeli & Enzmann, 1998, pp. 96–97)—which leaves little room for other causal factors. Also, mean levels of burnout among health care professionals do not change significantly over time (e.g. Prosser et al., 1999).

PSYCHOLOGICAL EXPLANATIONS FOR BURNOUT

Many different psychological explanations exist for burnout. These explanations emphasize the importance of individual, interpersonal, organizational, and societal factors, respectively (for an overview, see Schaufeli & Enzmann, 1998, pp. 100–142). This section describes three interpersonal approaches that are assumed to be of special importance, for explaining burnout in health care, because they emphasize the role of emotionally demanding relationships with patients and the role of work teams in transmitting burnout symptoms.

Burnout as Emotional Overload.

According to Maslach (1993), interpersonal demands resulting from the helping relationship are considered to be the root cause of burnout. She argues that patient contacts are emotionally charged by their very nature, because health care professionals deal with troubled people who are in need. To deal with emotional demands and perform efficient and well, professionals may adopt techniques of detachment. When patients are treated in a more remote, objective way, it becomes easier to do one's job without suffering strong psychological discomfort. A functional way to do this is to develop an attitude of detached concern—the medical profession's ideal blending of

compassion with emotional distance. A dysfunctional way to do this is depersonalization (i.e., to develop a persistent callous, indifferent, and cynical perception of patients). Ironically, the structure of the helping relationships in health care is such that it promotes this dysfunctional strategy. For instance, the focus is on the patients' problems rather than on their positive aspects, and there is a lack of positive feedback from patients because they only return when things go wrong. As a result of depersonalization, quality of care is likely to deteriorate because the major vehicle for the success—compassion with and concern for others—has been destroyed in an attempt to protect psychological integrity. Because success is more and more lacking, the professional's sense of personal accomplishment erodes and feelings of insufficiency and self-doubt develop.

Based on the theoretical approach of Maslach, Leiter (1993) conducted a series of studies among health care workers in which he distinguished quantitative job demands (e.g., work overload, hassles), qualitative job demands (e.g., interpersonal conflict), and lack of resources (e.g., lack of social support, poor patient co-operation, lack of autonomy, and poor participation in decision making). Both types of demands were expected to be related to emotional exhaustion, whereas resources were expected to be related to depersonalization and lack of personal accomplishment. Indeed, these hypothesized relationships were observed (Leiter, 1993). Furthermore, as expected, emotional exhaustion leads to depersonalization, but contrary to expectations, personal accomplishment appears to develop rather independently from both of the other burnout dimensions. This agrees with Lee and Ashforth (1996), who concluded that the results of their meta-analysis are largely consistent with Leiter's (1993) mixed sequential and parallel development model of burnout.

Thus, burnout appears to be a multidimensional construct whose dimensions are differentially related to job demands and job resources. Emotional exhaustion develops in reaction to job demands, including interpersonal demands, and appears to lead to depersonalization. Personal accomplishment is positively influenced by the presence of resources, but it largely develops in parallel to the other two burnout dimensions.

Burnout as Lack of Reciprocity.

By definition, the professionals' relationship with patients is complementary, which is semantically

well-illustrated by the terms "caregiver" and "recipient of care"; the former is supposed to give care, assistance, advise, support, and so on, whereas the latter is supposed to receive care. Nevertheless, health care professionals look for some rewards in return for their efforts; for example, they expect their patients to show gratitude, to improve, or to at least make a real effort to get well. Because in practice these expectations are seldom fulfilled, it is likely that, over time, lack of reciprocity develops: Professionals feel that they continuously put much more in relationships with their patients than they receive back in return. As Buunk and Schaufeli (1993) have pointed out, lack of reciprocity—an unbalanced helping relationship—drains professionals' emotional resources and eventually leads to emotional exhaustion. This is typically dealt with by decreasing one's investments in the relationships with patients; that is, responding to patients in a depersonalized way instead of expressing genuine empathic concern. Accordingly, depersonalization can be regarded as a way of restoring reciprocity by withdrawing psychologically from patients. However, this way of coping with an unbalanced interpersonal relationship is dysfunctional because it deteriorates the helping relationship, increases failures, and thus fosters a sense of diminished personal accomplishment.

Indeed, positive relationships were found between lack of reciprocity at the interpersonal level and all three dimensions of burnout among various health professionals such as student nurses (Schaufeli, Van Dierendonck, & Van Gorp, 1996), general hospital nurses (Schaufeli & Janczur, 1994), medical specialists (Smets, Visser, Oort, Schaufeli, & De Haes, *in press*), and general practitioners (Van Dierendonck, Schaufeli, & Sixma, 1994). Although these studies are cross-sectional, there is some longitudinal evidence for a curvilinear relationship between lack of reciprocity and emotional exhaustion: feeling more deprived as well as feeling more advantaged results in higher exhaustion levels (Van Dierendonck, Schaufeli, & Buunk, 2001). Another longitudinal study showed that depersonalizing patients at Time 1 increases the likelihood of feeling harassed by them 5 years later, which in its turn fostered a lack of reciprocity, eventually leading to burnout (Bakker, Schaufeli, Sixma, Bosveld, & Van Dierendonck, 2000). Thus, a lack of reciprocity in the caregiver–recipient relationship appears to play an important role in the development of burnout in conjunction with the impairment of the quality of the doctor–patient relationship.

Furthermore, the relationship between lack of reciprocity and burnout appears to be moderated by personality factors. For instance, VanYperen, Buunk, and Schaufeli (1992) found that nurses who felt they invested highly in the relationships with patients showed elevated levels of burnout only when they were low in communal orientation, a personality characteristic that refers to a general responsiveness to the needs of others.

Similar social exchange processes that are observed in interpersonal relationships govern the relationship of the professional with the organization and with the team they work on. Each health care worker has a so-called psychological contract (Roussau, 1995) with the organization, which entails expectations about the nature of the exchange with that organization. Expectations concern concrete issues such as workload and career perspectives, as well as less tangible matters such as esteem and dignity at work and support from supervisors and colleagues. In other words, the psychological contract reflects the employees' subjective notion of reciprocity: (S)he expects gains or outcomes from the organization that are proportional to his or her investments or inputs. When the psychological contract is violated because experience does not match expectancies, reciprocity is corroded. Schaufeli, Van Dierendonck & Van Gorp (1996) showed in two samples of student nurses that in addition to withdrawal from the organization (i.e., reduced organizational commitment), violation of the psychological contract may also lead to burnout. Moreover, studies among therapists from a forensic psychiatric clinic and staff working with the mentally disabled confirmed that burnout is related to perceptions of inequity at the organizational level (Van Dierendonck, Schaufeli, & Buunk, 1996).

In addition to the individual level and the organizational level, social exchange processes play a role among colleagues in work teams. For instance, Buunk and Hoorens (1992) found some evidence that nurses keep a "support bookkeeping" that is based on the balance between giving and receiving support from others in their team. Given the centrality of the relationships with colleagues for work related outcomes, it appears plausible to expect that lack of reciprocity in the exchange relationship with one's colleagues is an important determinant of burnout as well. Indeed, Smets et al. (in press) found among medical specialists that in addition to lack of reciprocity at the interpersonal level, which was associated with emotional exhaustion and

depersonalization, and to lack of reciprocity at the organizational level, which was related to emotional exhaustion, lack of reciprocity at the team was related to emotional exhaustion as well. Hence, it appears that team members who experience an imbalance between their investments in and their outcomes from the work are likely to feel emotionally exhausted.

Burnout as an Emotional Contagion.

It has been suggested that colleagues may act as models whose symptoms are imitated through a process of emotional contagion (Buunk & Schaufeli, 1993). That is, people under stress may perceive symptoms of burnout in their colleagues and automatically take on these symptoms. In addition to this nonconscious emotional contagion, there is an alternative way in which people may catch emotions of others. Contagion may also occur through a conscious cognitive process by "tuning in" to the emotions of others. This will be the case when an individual tries to imagine how (s)he would feel in the position of another, and, as a consequence, experiences the same feelings. The professional attitude of health care workers that is often characterized by empathic concern is likely to foster such a process of consciously tuning in to emotions of others.

The contagious nature of burnout is exemplified by the observation that burnout tends to concentrate in particular teams, whereas it is virtually not observed in comparable other groups as was shown by Bakker, Le Blanc, and Schaufeli (2004) in a sample of almost 80 European ICUs. Of course, this concentration of burnout in particular ICUs also may be explained by higher workloads, which would contradict a symptom contagion explanation. However, this alternative hypothesis was rejected, it appeared that—after controlling for job autonomy, subjective workload and objectively assessed workload (i.e., complexity of nursing tasks)—nurses' levels of experienced burnout remained higher in some units compared with other units. Moreover, nurses from these units observed more burnout complaints among their colleagues than their fellows did in the other units. These intriguing results support the contagion hypothesis of burnout. In a similar vein, Miller, Birkholt, Scott, and Stage (1995) found among professionals who work with the homeless that emotional contagion was directly as well as indirectly—through communicative

responsiveness—related to burnout. Recently, a study with general practitioners (Bakker, Schaufeli, Sixma, & Bosveld, 2001) showed that those who perceived burnout complaints among their colleagues reported higher levels of emotional exhaustion and subsequent negative attitudes (depersonalization and reduced personal accomplishment) than those who did not perceive such complaints. In addition, individual susceptibility to emotional contagion was positively related to burnout, particularly in combination with the perception of burnout symptoms in their colleagues. That is, doctors who perceived burnout complaints among colleagues *and* who were susceptible to emotional contagion reported the highest exhaustion scores.

In summary, in a way, the three psychological explanations that are outlined here are complementary. The first approach assumes that burnout results from emotionally charged relationships between caregivers and recipients. It stipulates a dynamic process in which depersonalization is considered to be a dysfunctional attempt to deal with feelings of emotional exhaustion. However, it remains unclear *why* the relationship between caregiver and recipient is so demanding. This is where the second approach links in by emphasizing that this helping relationship is often characterized by a lack of reciprocity from the part of the caregiver. In addition, it is this lack of reciprocity, not only in interpersonal relationships but also in the relationship with the team and with organization that lies at the core of the burnout syndrome. Instead of working too long, too hard with too difficult recipients, it appears that the *balance* between give and take is crucial for the development of burnout. Finally, once burnout has occurred among individual team members, a group-based process of emotional contagion appears to play a role in spreading it among other team members.

INTERVENTIONS

Because individual characteristics as well as workplace characteristics are involved in the etiology of burnout, interventions may focus on the person or on the job. Although it is generally acknowledged that a *combination* of both approaches would be most effective, burnout interventions have been conducted predominantly on the individual level. This final section briefly reviews individual and workplace interventions to reduce burnout in health care. For a more

extensive, general review of burnout interventions see Schaufeli and Enzmann (1998; pp. 144–183).

Individual Interventions.

Individual approaches to prevent or reduce burnout include cognitive–behavioral techniques such as stress inoculation training, rational emotive therapy, cognitive restructuring and behavioral rehearsal. A cognitively oriented approach is relevant because burnout often involves “wrong” cognitions such as unrealistic expectations. In addition, relaxation techniques are often used to reduce burnout. A recent meta-analysis of nearly 50 (quasi) experimental studies revealed the effectiveness of these individual interventions in terms of symptom reduction, including burnout (Van der Klink, Blonk, Schene, & Van Dijk, 2001). It appeared that individual stress management interventions are effective, and, more specifically, that cognitive–behavioral interventions alone or in combination with relaxation are more effective than relaxation training. In addition, other measures have been recommended to combat burnout, including time management, balancing work and private life, physical training, dieting, and increasing one’s social skills—particularly assertiveness. To counteract the reality shock experienced by many beginning health care professionals, preparatory training programs may provide them with more realistic images of their profession, instead of fostering wrong expectations. Unfortunately, the effects of such measures on reducing burnout are largely unknown.

By contrast, the effectiveness of so-called burnout workshops has been studied in greater detail. Basically, these workshops rest on two pillars: (a) increasing the participants awareness of work-related problems and (b) augmenting their coping resources by cognitive and behavioral skills training and by establishing support networks. More specifically, workshops may include self-assessment, didactic stress management, relaxation, cognitive and behavioral techniques, time management, peer support, and the promotion of a healthy life style and a more realistic image of the job (Schaufeli & Enzmann, 1998, pp. 179–182). In other words, burnout workshops combine many rather general strategies for one specific purpose: preventing and combating burnout.

But what is known about their effectiveness? Pines and Aronson (1983) evaluated a 1-day burnout workshop for employees of two social

services that combined several individual approaches (e.g., relaxation techniques, cognitive stress management, time management, social skills training, didactical stress management, and attitude change). The participants' level of exhaustion decreased slightly but not significantly. However, compared with the control group that did not participate in the workshop, satisfaction with co-workers went up significantly in the experimental group. Schaufeli (1995) evaluated a somewhat similar burnout workshop for community nurses but found that only the symptom levels (i.e., emotional exhaustion, psychological strain, and somatic complaints) of the participating nurses decreased significantly. However, no significant changes were observed in levels of depersonalization and reduced personal accomplishment. Van Dierendonck, Schaufeli, and Buunk (1998) evaluated a 3-day burnout workshop for staff working in direct care with mentally disabled. The workshop was cognitive-behaviorally oriented and included aspects such as cognitive restructuring, didactic stress management, and relaxation, as well as career counseling. Results showed that emotional exhaustion dropped significantly for the experimental group compared with the control group at each follow-up after 6 and 12 months, but again no effects were observed for depersonalization and personal accomplishment. Registered absenteeism significantly decreased in the experimental group, but it increased in the control group. Freedy and Hobfoll (1994) used stress inoculation training among nurses to enhance their social support and individual mastery resources. Participants experienced significant enhancements in social support and mastery compared to the no-intervention control group. Particularly, nurses with low initial levels on both resources showed significant reductions in emotional exhaustion and depression. Similar positive results were obtained by West, Horan, and Games (1984), who used didactic stress management, training coping skills (i.e., relaxation, assertiveness, cognitive restructuring, and time management), and exposure via role playing. A 4-month follow-up showed that burnout (i.e., emotional exhaustion and reduced personal accomplishment) decreased significantly, as did anxiety and systolic blood pressure. More detailed analysis revealed that coping skills were the main ingredient of the program.

Workplace Interventions.

Only occasionally, workplace interventions are explicitly carried out to reduce stress or burnout.

Generally, other purposes are targeted such as increased productivity and efficiency, cost-effectiveness, smooth communication, or organizational flexibility. Nevertheless, there is an increasing awareness that preventing burnout is important because of the high direct and indirect costs associated with it. Workplace interventions to reduce burnout are more rare than individual approaches, and their effectiveness is seldom evaluated.

Recently, Spickard, Gabbe, and Christensen (2002) listed several suggestions for health care organizations to prevent physician burnout: establishing a mentor program, providing confidential support groups, establishing a physician health committee, providing an annual well-being retreat, institutionalizing a sabbatical program, providing membership in a fitness center, offering periodic continuing medical education programs, providing flexible time-scheduling, and reducing paperwork. In addition, from the outset work redesign (i.e., job enlargement, job rotation, and job enrichment) has been considered as a major tool to decrease quantitative and qualitative workload and thus to prevent burnout (Pines & Maslach, 1980). Because many burnout candidates feel "locked in" their careers, career development programs and career counseling are other organizational approaches that can prevent burnout. Two-way communication between management and employees, adequate procedures for conflict management, and participative decision making also have been proposed as antidotes to burnout. Moreover, it is suggested that social support from colleagues and superiors should be institutionalized in the form of regular consultations and team meetings.

What about the effectiveness of such workplace interventions? As noted earlier, few studies exist. The introduction of a system of planned nursing care in a Swedish psychogeriatric clinic in which each patient was assigned a particular nurse who was responsible for all nursing tasks, led to a reduction of burnout at the 1-year follow-up compared with the traditional ward system in which one patient was nursed by many different nurses (Berg, Welander-Hansson, & Hallberg, 1994). Unfortunately, a similar job redesign project among psychiatric nurses in The Netherlands failed to confirm this positive result (Melchior, Philipsen, Abu-Saad, Halfens, Van den Berg, & Gassman, 1996). The effectiveness of a training program in emotion-oriented care for cognitively impaired elderly persons was demonstrated (Schrijnemaekers et al., 2003): Compared with the control nursing homes,

caregivers' levels of burnout in the experimental homes had decreased significantly at follow-up after 6 and 12 months.

All three of these workplace interventions had been designed beforehand and were then implemented. However, a few case examples exist of participatory action research projects in which specific workplace interventions were introduced *during* the project in which employees, researchers, and consultants closely collaborated. For instance, Van Gorp and Schaufeli (1996) carried out an organizational development program to reduce burnout and sickness absenteeism in four large Dutch community mental health centers. Specific measures were introduced in each center to tackle the three common problems: work overload, poor team leadership, and poor collaboration between professional staff and support staff. At the 1-year follow-up, levels of burnout had not markedly decreased, but workers were more satisfied in all centers and registered absenteeism had decreased significantly in one of them. Le Blanc and Peeters (2003) described a participatory training program for functional teams of oncology care providers (nurses, physicians, and radiotherapy assistants). Based on a thorough assessment, specific team problems were identified for each team, and the teams were subsequently coached by a team counselor to solve these issues during the next 6 months. At the 1-year follow-up, levels of emotional exhaustion and depersonalization of the control teams had increased, whereas *no* change was observed for the experimental teams. Therefore, it appears that the team-based training was effective to prevent burnout from increasing. Finally, the effectiveness was evaluated of a large-scale participatory job stress reduction program that was implemented in 81 Dutch domiciliary care institutions including over 26,000 workers (Taris et al., 2003). Each of these institutions had implemented a specific set of measures that might include any combination of person-directed interventions (e.g., job mobility programs, opportunity to visit conferences) and work-directed interventions (e.g., introducing rules for lifting patients, employee participation in planning tasks and shifts). It was concluded at the 2½-year follow-up that (a) institutions with employees who reported high levels of exhaustion implemented many interventions of various kinds, and (b) employees working in institutions that had implemented many (more than four) interventions reported lower levels of exhaustion than did employees of other institutions. Thus, the more measures that were taken by the home-care

institution, the more levels of burnout of its members had decreased.

In summary, it appears that individual burnout interventions work. At the least, the core symptom of burnout—emotional exhaustion—can be reduced by training health care professionals to use particular coping skills, most notably cognitive restructuring and relaxation techniques. Conversely, levels of personal accomplishment and depersonalization appear rather resistant to change. This is not surprising because most techniques focus on reducing arousal rather than on changing attitudes (depersonalization) or on enhancing specific professional resources (personal accomplishment). Compared with individual interventions, the effects of workplace intervention programs to reduce burnout are somewhat disappointing. This is at least partly caused by methodological reasons because workplace programs are often participatory in nature so that a pretest posttest (quasi) experimental design is not feasible, and effectiveness cannot be demonstrated. Nevertheless, some examples in health care exist of participatory intervention programs to reduce burnout.

CONCLUSION

Based on estimates of its prevalence, severe burnout appears to be a problem in health care, particularly for those working in the community. In the past decades, burnout received quite a lot of attention, both from researchers and practitioners, because it is not only detrimental to the individual involved but also for the organization. Burnout appears to be related to job stress and depression but can nevertheless be distinguished from these alternative conditions on conceptual and empirical grounds. On the empirical level, burnout—particularly emotional exhaustion—is related to personality factors, job stressors, and individual and organizational outcomes. Theoretical approaches that emphasize the social nature of burnout by taking into account the emotional overload resulting from patient contacts, the disturbed balance between give and take, and emotional contagion on work teams appear to offer a promising route for explaining burnout in health care settings. Particularly individual-based interventions appear to be effective in reducing burnout (emotional exhaustion), whereas the effectiveness of organization-based interventions still stands out.

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