

Chapter 15

BURNOUT INTERVENTIONS: AN OVERVIEW AND ILLUSTRATION

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INTRODUCTION

Over the past decades, the level of job stress and burnout has risen alarmingly worldwide. In the 2000 European Working Conditions Survey (EWCS), job stress was found to be the second most common job-related problem (28%) across the EU Member States (Houtman, 2005). Burnout, a form of chronic job stress, is significantly related to negative outcomes for the individual worker, e.g., depression and psychosomatic distress (Schaufeli and Enzmann, 1998), and for the organization, including absenteeism, turnover, and lowered productivity (Cordes and Dougherty, 1993; Lee and Ashforth, 1996; Schaufeli and Buunk, 2003). The associated costs are high. For example, stress and burnout account for 300 million lost working days and cost American businesses an estimated \$300 billion per year (American Institute of Stress, 2002, in Halbesleben, Osburn and Mumford, 2006). So, from the individual, the organizational and the social point of view, efforts to combat (chronic) job stress are urgently needed.

A sector in which workers are most at risk of experiencing job stress and burnout are the so-called human services - such as health care, social services, and education - in which contact with other people plays a central role (Houtman, 2005). Next to stressors that are common to workers in other sectors (e.g., high workload, lack of autonomy), human service providers are confronted with (emotional) stressors that are inherent to the direct interaction with individual patients, clients or pupils. Examples of this type of stressor are patients' pain and suffering, or pupils' aggressive behaviours (Dollard et al., 2003). As the number of workers that are employed in the human services is rapidly growing, studies that yield more insight into ways to prevent or alleviate chronic forms of job stress such as burnout seem especially relevant to this sector. In this chapter, the current research on burnout interventions

is summarized, followed by an illustration of a burnout intervention program that was implemented in Dutch hospitals among oncology care providers.

BURNOUT INTERVENTIONS

Despite the relevance of the subject, relatively few well-designed scientific studies have been conducted on the effectiveness of burnout intervention programs. Generally speaking, burnout interventions focus on changing either individual workers or the workplace (Schaufeli and Buunk, 2003). In the following sections, we will first review some research findings on the effectiveness of different types of burnout intervention strategies, followed by a more detailed discussion of a methodology that, in our view, holds promise for burnout intervention, i.e. action research.

Individual Approaches

Even though almost every author on the subject acknowledges that a combination of individual and workplace approaches is likely to be most effective, the vast majority of burnout interventions have been conducted on the individual level (Schaufeli and Buunk, 2003). A recent study in a nationally representative Finnish sample of 3276 employees (Ahola et al, 2007) indeed showed that employees with burnout were less often targets of occupational interventions but participated more in individual-focused interventions when compared with other employees.

Most individual level strategies that are aimed at reducing burnout are well established and have a long and successful history in clinical or health psychology. However, they are often rather general in nature, focusing on managing stress per se rather than combating burnout in particular. Principally, these strategies seek either to increase workers' awareness, or to reduce the high level of (negative) arousal that characterizes stress in general. Examples of awareness-enhancing strategies are: self-monitoring of signs and symptoms of distress, self-assessment of one's personal level of stress or burnout, and didactic stress management providing practical information on (ways of coping with) stress and burnout. Frequently used strategies to reduce negative arousal are: relaxation techniques, promotion of a healthy lifestyle (e.g., physical training), and cognitive-behavioral techniques (e.g., stress inoculation training, rational emotive therapy, cognitive restructuring, and behavioral rehearsal). The latter strategies are particularly relevant, because burnout often includes 'wrong' cognitions such as unrealistic expectations and false hopes (Schaufeli and Enzmann, 1998; Schaufeli and Buunk, 2003).

For some of these individual level strategies, empirical evidence for their effectiveness in reducing burnout has indeed been found. Several studies demonstrated that *skills training*, for example in the form of stress inoculation training (Meichenbaum, 1985), may lead to a reduction in burnout levels by altering the way the individual processes information about stressful situations and identifying cognitive and behavioral coping skills to change unproductive ways of reacting. For example, Freedy and Hobfoll (1994) enhanced nurses' coping skills by teaching them how to use their social support and individual mastery

resources, and compared to a control group. A study by Van der Klink and colleagues (2001) simultaneously addressed both individual and organizational factors, which resulted in a significant improvement in coping skills and cognitive appraisal of the work situation. Rational emotive therapy (RET) was used in a working workshop for nurses (Schaufeli et al., 2001). After 10 sessions, the intervention program was evaluated. The program was found to be effective, resulting in a significant follow up. A training for reflective listening and emotional expression questioning, and (2000) found that skills (i.e., coping strategies for dealing with feelings of stress). However, significant decreases in burnout levels were found at 11, and 17 months.

In so-called 'workshops', participants' awareness is enhanced, e.g. by cognitive restructuring. Aronson (1983) that included management, attitude change, and significant, sat compared to the workshop was a workshop for participants' level (i.e., depersonalization). These results are a workshop for 8 weekly intervals and behavioral

resources, and found a significant reduction in emotional exhaustion in the training group as compared to the non-treated control group after the 5-weeks intervention period. In another study by West, Horan and Games (1984), several coping skills were taught to nurses simultaneously (i.e., relaxation, assertiveness, cognitive restructuring, and time management) which resulted in a significant reduction of emotional exhaustion and an increase in personal accomplishment at the 4-month follow-up. Higgins (1986) showed that learning palliative coping skills (i.e., progressive relaxation and systematic desensitization) was as effective as cognitive and behavioral skills training (i.e., time management, assertiveness training, and rational emotive therapy) in reducing levels of emotional exhaustion among a sample of working women from various helping professions. The same result was found by Van Rhenen et al. (2001), who compared the short- and long-term effectiveness of two brief (i.e., 4 sessions) intervention programs among a sample of Dutch telecommunication workers. One program was cognition-focused, aiming at restructuring irrational beliefs, whereas the other program was physically oriented, aiming at introducing physical and relaxation exercises in daily work activities. Their results showed that both types of interventions were equally effective, revealing a positive impact on burnout scores at short term as well as at 6-month follow up. A study by Corcoran and Bryce (1983) on the effectiveness of interpersonal skills training for social workers, demonstrated that focusing on affective components (i.e., reflective listening, personalization, and empathy) led to a significant decrease in feelings of emotional exhaustion, whereas focusing on cognitive components (i.e., open ended questioning, reflection of feelings, paraphrasing, and summarizing) did not. Finally, Rowe (2000) found that a program in which health care providers were taught proactive coping skills (i.e., using problem-focused strategies for solvable problems and emotion-focused strategies for problems where solutions are not readily available) was effective in reducing feelings of emotional exhaustion and increasing feelings of personal accomplishment. However, subjects who participated in the 6-weeks program reported only temporary decreases in burnout, while those subjects who also received 1-hour refresher sessions at 5, 11, and 17 months showed consistent decreases in burnout across a 2 ½ year period.

In so-called *burnout workshops*, several of the above-mentioned strategies are combined into a comprehensive program. Usually, these workshops rest on two pillars, i.e. increasing participants' awareness of their work-related problems and enhancing their coping resources, e.g. by cognitive and behavioral skills training (Schaufeli and Enzmann, 1998). Pines and Aronson (1983) evaluated a 1-day burnout workshop for employees of two social services that included several individual level strategies: relaxation techniques, cognitive stress management, time management, social skills training, didactic stress management and attitude change. Even though the decrease in participants' level of exhaustion was not significant, satisfaction with co-workers went up significantly in the training group as compared to the control group that did not participate in the workshop. This impact of the workshop was even observable after 6 months. However, when evaluating a similar 3-day workshop for community nurses, Schaufeli (1995) did find a significant decrease in participants' levels of exhaustion, but not in the other two, attitudinal components of burnout (i.e., depersonalization and reduced personal accomplishment) at the 1-month follow-up. These results are in line with those of Enzmann et al. (1992) who evaluated a 3-day burnout workshop for human services professionals (mostly hospice staff) that was spread across 3 weekly intervals. Participants kept a stress diary, had to use their newly developed cognitive and behavioral skills during the weekly intervals, and had to report on their last week's

experiences in the next session. The workshop included didactic stress management, relaxation training, coping skills training and interpersonal skills training. At the 2-month follow-up, only levels of emotional exhaustion were significantly lower in the training group as compared to the non-treated control group. Finally, Van Dierendonck, Schaufeli and Buunk (1996) evaluated a cognitive-behaviorally oriented burnout workshop for staff working in direct care for mentally disabled persons that included strategies such as cognitive restructuring, didactic stress management, and relaxation. In addition, a strong emphasis was put on career management, by letting participants analyze their strengths and weaknesses and draw up action plans for the future. After 6 months and 1 year, respectively, follow-up meetings were organized to evaluate these plans. Results showed that participants' level of emotional exhaustion dropped significantly compared to two non-treated control groups, i.e. an internal control group consisting of staff members from the same organization and an external control group consisting of staff members from another, similar organization. However, again, no effects were observed for depersonalization and reduced personal accomplishment.

It can be concluded that the empirical support for the effectiveness of individual level, cognitive-behavioral based burnout interventions – both in isolation and combined in multifaceted workshops – is generally quite strong. However, in most cases, only the core affective symptom of burnout (i.e., exhaustion) is reduced, whereas the other two burnout dimensions are rarely affected. This is not surprising since most techniques that are employed are aimed at reducing negative arousal and not – or to a much lesser extent – at changing attitudes or enhancing professional skills or resources (Schaufeli, 2003). An additional concern is that these programs “do little to change environmental stressors” (Cartwright and Cooper 2005, p.618, in Halbesleben et al., 2006), and as such do not address the underlying cause of the burnout and subsequently do little to actually reduce burnout itself. According to several scholars in the field of burnout (e.g., Golembiewski and Boss, 1992; Maslach, Leiter and Schaufeli, 2001; Halbesleben and Buckley, 2004), a more promising approach to the reduction of burnout is to attempt to make changes in the work environment, as this has a better chance of relieving stress and burnout for employees on a more widespread basis.

Organizational (Workplace) Approaches

There are both philosophical and pragmatic reasons underlying the predominant focus on the individual in burnout intervention, including notions of individual causality and responsibility, and the assumption that it is easier and cheaper to change people than organizations (Maslach and Goldberg, 1998). Nevertheless, this focus on individual-centered solutions is particularly paradoxical, given that the majority of the scientific research has found that social and organizational factors play a much larger role in (the development of) burnout than do individual factors (Maslach, et al., 2001; Schaufeli and Buunk, 2003). Up till now, very little attention has been paid to situational or organizational strategies for burnout prevention; in particular, situational strategies that are geared toward eliminating or modifying work stressors are seldom implemented. This might be due partly to the fact that this kind of organizational interventions are complex because many different people at different levels of the organization are involved and considerable time, effort and money are needed (Maslach et al., 2001). As a result, workplace burnout interventions are even less

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Job redesign (i.e., job enlargement, job rotation, and job enrichment) is generally considered as a major tool to decrease workload, and thus counteract burnout. Berg, Welander-Hansson and Hallberg (1994) studied the effects of introducing individually planned nursing care – a form of job enrichment – in a Swedish psychogeriatric clinic and found that at 1-year follow up burnout levels of nurses in the experimental wards had dropped significantly compared to the traditional control wards. However, two Dutch studies on job redesign in nursing found less positive effects on burnout. In the first study by Melchior et al. (1996), burnout levels of a group of psychiatric nurses working according to primary nursing (i.e., similar nursing principles as in the Swedish study) were compared with those of a control group that kept on working in the traditional way. During the 2 ½ -years period of this study, no differences in burnout levels between the two groups could be demonstrated. In the other study by Jansen (1996) among community nurses and nurses aides, the introduction of either differentiated practice (i.e., assignment of patients based on complexity of nursing care) or specialization (i.e., assignment of patients based on area of expertise) actually lead to an increase in burnout levels over a 1-year period. The author speculated that the introduction of these two systems might have lead to an increase in workload, because management had put more emphasis on productivity and efficiency.

Some other programs have focused on co-worker *support* as a key to burnout intervention. Already in 1978, Maslach found that burnout rates were lower in health care workers who actively expressed, analyzed, and shared their personal feelings with their colleagues, e.g. during so-called staff support group-meetings. This interaction between co-workers may also contribute to problem solving by yielding new perspectives on and solutions to job-related problems. However, the empirical evidence on the effectiveness of these peer-support groups is mixed. Studies by Brown (1984) and by Larson (1986) showed that nurses and oncology and hospice workers respectively, who participated in support groups were more satisfied with their supervisors and co-workers. However, their burnout levels were not reduced. On the other hand, in a study among special educators, Cooley and Yovanoff (1996) found that the combination of a 1-month peer-support collaboration program and a stress management workshop lead to significant reductions in levels of emotional exhaustion and depersonalization. These effects were still observable at 6-months and 1-year follow-ups. Finally, Rabinowitz, Kushnir and Ribak (1996) studied the effects of fortnightly Balint groups for nurses, in which they discussed patients about whom they felt concerned and aspects of their work that they found personally troubling. Results showed that nurses who participated in these groups for 10 months displayed less emotional exhaustion at the end of the course.

Another organizational approach to burnout intervention is *career counseling*, since feelings of being 'locked in' to your career can be conducive to burnout (Schaufeli and Buunk, 2003). Gorter et al. (2001) indeed demonstrated that a cognitive-behavioral career counseling program for dentists resulted in statistically significant improvements on both emotional exhaustion and personal accomplishment one month after the program ended. However, dentists in the control group who had self-initiated preventative measures - based on information about their burnout-scores - showed similar improvements. Moreover, at the 1-year follow-up, the program participants showed a relapse, whereas the controls who took action on their own initiative reported a beneficial effect in the long run as well (Te Brake et

al., 2001). The authors speculated that perhaps the latter group might have had a more intrinsic motivation for change and/or a heightened perception of being able to control (i.e., adapt) the working environment. Van Dierendonk, Garssen and Visser (2005) showed that a 10-day transpersonal, psychosynthesis-based intervention program was effective in reducing feelings of exhaustion and increasing professional efficacy among mid-career employees who were at risk for burnout. This program focused on personal growth, by exploring the structure of one's own psyche followed by an integration of its components into a harmonious, integrated whole. Participants were trained in self-acceptance, taking responsibility for their (working) lives, and trusting their 'inner wisdom'. In this way, meaning and purpose in life were (re)discovered, and participants' ability to choose behavior that is in line with their work-related goals and expectations was strengthened.

Finally, in the burnout literature, some empirical evidence on the effectiveness of *Organizational Development* (OD), i.e. a program of planned interventions that should improve the internal operation of an organization, can be found. For example, Golembiewski and Rountree (1991) described an OD program that was carried out in a chain of nursing homes to – amongst others – reduce burnout by releasing human potential for collaboration. In the five experimental homes, pairs of directors of nursing and chief executive officers received a 2 ½-day intensive training in team-building. After 1 year, the levels of burnout in the experimental pairs had dropped significantly compared to five matched pairs from other homes who didn't participate in the training.

So, although organizational interventions do seem to have great potential value for burnout intervention, more high-quality research to firmly establish their effectiveness is clearly needed. In addition, it is rather difficult to draw general conclusions about the effectiveness of specific burnout interventions based on the studies that were discussed in this and in the previous section. As these studies use different samples, procedures, time frames, measurement instruments and intervention methods, results are difficult to compare. In addition, some of these studies suffer from methodological inadequacies such as the lack of control groups and small numbers of participants (Schaufeli and Buunk, 2003). Perhaps the only conclusion that is (re)confirmed is that neither changing the workplace, nor changing the individual workers is enough; effective change occurs when both develop in an integrated fashion (cf. Maslach et al., 2001). A methodology to achieve this goal is offered by action research, which we will discuss in more detail in the following section.

Action Research

According to Halbesleben et al. (2006), perhaps the most significant limitation of organizational burnout intervention programs is that they tend to seek out universal solutions for organizational issues without taking into account the significant variety of stressors that may lead to burnout and the uniqueness of stressors that appear in any one organization. Moreover, some experts in the field of worksite stress management (e.g. Griffiths, 1999; Semmer, 2003) argue that organizational interventions designed to promote health and well-being can only be effective if they are based on workers' own experience and active participation. What is needed is a framework that does not include universal solutions for burnout, but one that helps determine the *specific* causes of burnout in a *specific* organization and allows organizational stakeholders to develop tailor-made interventions based on those

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organization-specific causes of burnout (Halbesleben et al., 2006). (*Participatory*) *action research*, i.e. an empirical and reflective process by which traditional research participants are engaged in a participative fashion to work towards a positive, practical outcome (Stringer, 1999), is based on this principle. It takes workers' (view of their) specific situation as a starting point and grants control over the design and the implementation of interventions that are part of the research to them as well. So, instead of treating participants as objects of intervention, in action research participants are the subjects of the change process thereby integrating theory and practice. Workers collaborate with expert researchers in identifying problems (e.g., job stressors) that are typical for their working situation and in developing, implementing, and evaluating plans to tackle them. In this way, the capability of teams or work groups to solve self-identified problems (Hughes, 2003) is increased as workers (re)gain job control.

Results of scientific studies evaluating the effects of action research approaches showed that these have been effective in e.g. decreasing depressive symptoms (Heany et al., 1993), registered absenteeism (Munz, Kohler and Greenberg, 2001; Van Gorp and Schaufeli, 1996), psychosomatic complaints (Van Gorp and Schaufeli, 1996), and work-related stress (Mikkelsen, Saksvik and Landsbergis, 2000), as well as in increasing work-unit performance (Munz et al., 2001). Moreover, already in 1986, this kind of approach was specifically recommended for burnout intervention by Golembiewski, Munzenrider and Stevenson, because it allows employees with a common history to solve problems specific to their own stressful environment. In a study by Halbesleben et al. (2006) among employees of the U.S. Federal Fire Service, the efficacy of this approach for reducing burnout was empirically demonstrated. In addition to giving a detailed description of the research process, this study evaluated the effectiveness of the action research intervention on burnout. Survey results indicated that employees were experiencing significantly less exhaustion and disengagement one year following the conclusion of the project compared to the situation prior to its implementation. The results of a Finnish study among female white-collar rehabilitation clients, showed that a new, participatory strategy was effective in reducing burnout, i.e. feelings of exhaustion and cynicism, during the 1-year rehabilitation period whereas the traditional strategy was not (Hätinen, Kinnunen, Pekkonen and Kalimo, 2007). Increased job control was identified as the mediator of change. Finally, another recent Finnish study provides some empirical evidence for the usefulness of this kind of approach to burnout intervention at the micro-level (i.e., the individual worker) as well. Salmela-Aro, Nataanen and Nurmi (2004) showed that two types of psychotherapeutic interventions were able to cause major changes in participants' so-called work-related personal projects (i.e., changes in project-related emotions and action tendencies and in project-related progress). In turn, over time, a reduction in negative emotions related to these personal projects was found to be related to a decrease in burnout levels.

In the final part of this chapter, we would like to present our own recent research on a participatory action research program, entitled *Take Care!*, that was implemented among oncology care providers working in general hospitals in the Netherlands (De Geus, Van Son, Le Blanc and Schaufeli, 2000; Le Blanc, Hox, Schaufeli, Taris and Peeters, 2007). Next to a description of the contents of the program, its effectiveness - in terms of changes in staff burnout levels - is evaluated. The chapter is concluded with some recommendations for future action (research).

Take Care!: A team-based burnout intervention program for oncology care providers.

Our burnout intervention program was especially geared to oncology care providers - i.e. nurses, physicians and radiotherapy assistants working in direct care of cancer patients - whose jobs can be considered quite stressful (Le Blanc et al., 2001; Le Blanc and Schaufeli, 2003). Because of the emotionally demanding nature of their jobs, oncology care providers can be expected to run a relatively high risk to deplete their (emotional) energy, and consequently to 'burn out'. The results of a preceding, nationwide questionnaire survey among members of five professional associations of Dutch oncology care providers ($n = 816$) indeed showed that they scored significantly higher on each of the two core burnout dimensions (emotional exhaustion and depersonalization) compared with norm-scores for Dutch health care providers. In addition, the quality of the working relationships with colleagues turned out to be of great importance for the well being of care providers in oncology (Le Blanc and Schaufeli, 2003). Therefore, we decided to focus our intervention on the *work-group*, i.e. *team*, level.

Participants

In total, 260 care providers working in 9 different oncology wards (teams) from 9 different general hospitals in the Netherlands were approached for participation in the intervention program. Participation in the program was voluntary, however, as the focus of the program was at the team level, as many staff members as possible were recruited. Participation rates across the staff of each of the 9 wards varied from 80 to 100 per cent (the number of participants per ward varied from 14 to 43 workers). Participants' mean age was 36 year, 72 per cent of them were females and on average they were working for almost 10 years in oncology. The control group consisted of a comparable sample of 404 care providers (working in 20 different oncology wards) who did not receive any training.

A Stepwise Approach

The intervention program Take Care! (De Geus et al., 2000; Le Blanc et al., 2007), was developed by researchers from Utrecht University in close collaboration with two experienced team counselors. In developing the program, the 'best practice' recommendations of Kompier and Cooper (1999) were used as a guideline. Before the program started, a detailed questionnaire survey on participants' (perceptions of their) working situation and well-being (Time 1 measurement) was performed, as one is poorly equipped to design a comprehensive intervention that targets occupation-specific stressors without an accurate assessment. To ensure lasting effects of the program, management support was acquired by means of extensive intake interviews, and a systematic and stepwise approach that was based on the principles of action research methodology (worker participation and control) was adopted.

The Take Care! program was designed following the six steps of a systematic intervention trajectory described by Janssen, Nijhuis, Lourijzen and Schaufeli (1996). As already mentioned, before an intervention program is started, attention should be paid to creating support within the organization. Even if an organization (i.e., the management) decided to participate in an intervention program, this does not automatically imply that

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employees have been consulted and that they are eager to participate. Actually, it is not unusual that employees have an aversion towards – yet another – intervention program! Therefore, the team counselors held extensive intake interviews with the management – e.g., head nurses, coordinators, and team leaders – of all wards (i.e., teams) where the Take Care! program was to be implemented. During these meetings, the protocol of the intervention was clarified, and potential effects of the intervention ('benefits') were discussed. The counselors also inquired after the ward management's reasons to participate in the intervention program, their main objectives, and their criteria for the successfulness of the intervention. Moreover, they gathered information on the structure and policies of the larger (i.e., hospital) organization. Finally, the ward management's perception of the working situation, including the main sources of job stress, was discussed. By means of this extensive intake procedure, the team counselors tried to increase the ward management's motivation for the implementation of organizational change processes. In addition, the team counselors performed a detailed review of documents (e.g., annual reports, policy memos, info-leaflets and newsletters) to get a clear picture of the 'status quo' in the participating hospitals.

Next, so-called kick-off meetings were organized for the entire teams of each of the 9 wards in which the program was to be implemented. During these meetings, the team counselors presented the protocol of the intervention program. In addition, a university researcher explained the design of the study that would be conducted in order to evaluate the short- and long-term effects of the Take Care! program on staff burnout levels. Staff was encouraged to ask questions. The main aim of these meetings was to increase staff's commitment to participate and to promote positive attitudes towards the program. In addition, these meetings should provide staff with a realistic picture of potential outcomes (effects) of the program.

For each ward, the information that was gathered during the intakes and the kick-off meetings was written down in a so-called take off-document, which was the first in a series of reports about the planning, progress and results of the program. Together, these reports formed a log-book on the intervention process, which was also used to keep all participants informed during the periods in between the training sessions. After the last training session, the team counselors wrote a final report with guidelines for the continuation of the change processes by the participating wards themselves.

The training program itself consisted of 6 monthly sessions of 3 hours each, and will be described in more detail in the following paragraph. The sessions were run for each of the 9 wards separately, so in total, the program consisted of 36 (9x6) sessions. The sessions were facilitated in several ways by the wards' management. Meeting rooms (outside the wards themselves) were booked and catering arrangements for the participants were made. Moreover, in between the training sessions, the topics that were discussed during the latest session and the plans and agreements that were made were put as items on the agenda of the work-meetings of the respective wards.

The Training Program

The framework for the training program was a classification scheme for the analysis of organizational problems that has been developed by one of the team counselors (De Geus and Brakel, 1996). This framework includes four categories of 'causal factors' that can be related

to (the level of) staff well-being, i.e. external factors (i.e. factors outside the organization), organizational factors, job-related factors, and personal factors. In the Take Care! program, this framework was used to classify potential determinants of burnout and related occupational health problems, to map team functioning and relate it to the broader organizational context, and to structure and stimulate the exchange of information between team counselors and program participants.

The 6 training sessions were supervised by both team counselors. The first session formed a general introduction to the training program. It started with some education about (the working mechanisms of) job stress. Next, the results of the questionnaire survey dealing with participants' (perception of their) working situation were fed back by means of the survey feedback method that is known to be useful in driving action research projects (Nadler, 1977). The classification scheme was used to assist participants in structuring their ideas and feelings, by providing them with relevant topics for discussion and for their plans to reduce work stress. At the end of the first session, the major job stressors that were to be dealt with during the training period, were selected by the participants. The remaining sessions each consisted of an educational part and an action part.

During the *educational* part of the second session, attention was paid to ways in which groups/teams preserve 'health-impairing' ways of working together and how to break out of these ways. Participants had to write 'team recipes' to create unwanted, stressful situations. The idea behind this is that, by writing down, participants will gain insight into the way they themselves contribute to these 'health-impairing' practices. This, in turn, is likely keep them from continuing this type of counterproductive behavior in the future. The third session addressed the (usual) ways of communicating and giving feedback between team-members, and how to improve these. Next, team members were educated about different types of work-related social support, followed by a discussion on the availability of and the need for specific types of support within their own team. In the final part of this session, participants made a start with building a social support network within their team. In the fourth session, ways to create a 'healthy' balance between job-related 'investments' and 'outcomes' was central. During the fifth session, participants were educated about (the distinction between) change processes and transition processes. Whereas the first type of processes are 'objective' and directly observable, the second ones concern the psychological acceptance of changes. A potential problem in intervention trajectories is that these processes do not always run in parallel. In order to prevent stagnation or early termination of change processes, the team counselors offered some guidelines to recognize and deal with this problem. In the sixth and final session, attention was paid to the consolidation of the change processes that had been started during the past months, to the ways in which team members could continue to contribute to these as well as future processes, and to the role played by external factors (outside the organization).

During the *action* part of the sessions 2 to 6, participants formed so-called problem-solving teams that collectively designed, implemented, evaluated, and re-formulated plans of action to cope with the most important stressors in their work situation that were identified in session 1. In the sixth session, participants' own experiences of the past months and the current 'state of affairs' with respect to the tackling of job stressors were presented by each of the different problem-solving teams and discussed plenary. Based on (the outcomes of) these discussions, teams decided upon some measures for continuation and consolidation of changes upon leaving of the team counsellors. So, even though the general intervention

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method was similar across all wards, i.e. PAR, the specific contents of the action part could differ between wards.

Results

Directly after the training program ended (Time 2 measurement), as well as 6 months later (Time 3 measurement), all program participants were again asked to fill out the questionnaire on their working situation and well-being. Then, the participants' scores on all three measurements were compared with those of the control group members who also filled out the questionnaire at the same three times. There are no significant differences in either emotional exhaustion or depersonalization between the two groups at the Time 1 measurement (before the start of the training). However, both at the Time 2 and the Time 3 measurements, the level of emotional exhaustion is significantly lower in the training group than in the control group. At the Time 2 measurement, the level of depersonalization is also significantly lower in the training group than in the control group, but at the Time 3 measurement the difference between both groups has ceased to be significant. Closer inspection of the data reveals that burnout levels in the training group remain stable between Time 1 and Time 3, however, this is not the case in the control group. In the latter group, we see a rather sharp increase in burnout levels between the Time 1 and the Time 2 measurements, followed by a slight decrease between the Time 2 and the Time 3 measurements.

Next, some statistical analyses⁹ were performed to see if changes in staff burnout levels are related to the key features of the intervention program (i.e., social support, control, and participation in decision making). Increases in social support and control between the Time 1 and the Time 3 measurements were significantly related to decreases in both burnout components, whereas an increase in participation in decision making between the Time 1 and the Time 3 measurements was related to a decrease in emotional exhaustion only. So, based on these findings, we conclude that the key features of our program are indeed significantly and meaningfully related to changes in oncology care providers' burnout levels.

In addition to the above, all members of the intervention wards who participated in the Time 2 measurement ($n = 231$) filled out some evaluative questions on the Take Care! program. Results showed that the participants were of opinion that the Take Care! training is of high quality, addresses topical issues in their working situation and makes (the tackling of) these issues a team's shared responsibility.

RECOMMENDATIONS FOR FUTURE ACTION (RESEARCH)

Our findings convincingly show that (even) a relatively brief, team-based intervention program can be effective in reducing burnout. Not only the stress-component of burnout (emotional exhaustion) decreased - as was the case in some previous studies - but also its motivational component (depersonalization). Given that Take Care! already had a stabilizing effect on burnout levels in the current sample - consisting of people who are (still) at work

⁹ These analyses and the corresponding results are reported in more detail in Le Blanc et al. (2007)

despite of their stress complaints - one might expect much stronger effects, i.e. decreases in burnout levels, in samples that suffer severely from burnout. The results of this study do not only corroborate the importance of social support at work, but also underline the effectiveness of an action research approach to burnout intervention by tailoring the contents of the intervention program to the specific working situation of its participants.

Based on the high, voluntary participation rate in the training group as well as participants' positive evaluation of the program, we conclude that the action research methodology is appealing and relevant to health care providers. Of course, the usefulness of action research as a tool for burnout intervention is not restricted to workers in hospitals or health care institutions in general, but can be extended to all different kinds of organizations where people perform (some kind of) team-work and are willing to take 'collective responsibility' to optimize their working situation. Its significance might even be enhanced by e.g. adding so-called 'booster sessions' as a follow-up to the main part of an intervention program, or by expanding interventions to the organization (hospital) level instead of the unit (team) level.

Our study, and the ones by Halbesleben et al (2006) and Hättinen et al. (2007), have provided the first empirical evidence for the usefulness of an action research approach to burnout intervention. More, well-designed scientific studies in different samples are needed to further strengthen its empirical basis. In addition, like Hättinen et al. (2007), these studies could take a closer look at the psychological processes through which this kind of burnout interventions work.

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