

# BURNOUT

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## INTRODUCTION

Burnout is a metaphor that describes a state of exhaustion, similar to the smothering of a fire or the extinguishing of a candle. The dictionary defines "to burn out" as: "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 although occasional accounts of burnout *avant-la-lettre* had appeared before, not only in works of fiction but also in journals for professionals. As a psychiatrist, he observed that volunteers who worked with drug addicts 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 labelled 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 (*cf.* Maslach and Schaufeli, 1993). She studied the ways in which health care professionals cope with emotional arousal at work and observed that many professionals were emotionally exhausted, had developed negative perceptions about their patients, and experienced a crisis in their professional competence.

Almost immediately after its discovery, burnout became a very popular topic, first in the popular press and then in academia. To date, more than 5,500 publications on the subject have appeared and over 1,000 empirical

studies were carried out, predominantly in health care (34%) and teaching (27%) (Schaufeli and Enzmann, 1998, pp. 69–73).

Three conclusions can be drawn from the history of burnout. First, burnout emerged as a social problem and *not* as a scholarly construct—it was “in the air”, so to speak. Second, from the outset burnout was strongly associated with “people work” in the human services. Third, two different approaches to burnout developed and coexist more or less independently: a clinical approach initiated by Freudenberger and a research approach initiated by Maslach.

The purpose of this chapter is to present a comprehensive overview of burnout in health care. In the following sections attention is paid to (1) symptoms and assessment; (2) burnout, stress and depression; (3) the prevalence of burnout in health care; (4) correlates, causes and consequences; and (5) psychological explanations.

## SYMPTOMS AND ASSESSMENT

Particularly in the initial pioneering phase when the clinical approach to burnout prevailed, many symptoms of burnout were identified. Recently, Schaufeli and Enzmann (1998, pp. 20–31) listed over 130 possible symptoms that have been associated with burnout, ranging from *a* (anxiety) to *z* (lack of zeal). Five symptom-clusters may be distinguished: (1) affective (e.g. depressed mood, emotional exhaustion); (2) cognitive (e.g. poor concentration); (3) physical (e.g. headaches, sleep disturbances); (4) behavioural (e.g. poor work performance); (5) motivational (e.g. loss of idealism). It is quite remarkable that—except for motivational symptoms—these clusters seem to match perfectly with the usual categorisation of stress symptoms. Typically, burnout is not restricted to symptoms at the individual level, in addition interpersonal symptoms in relation to recipients are also observed (e.g. irritability, dehumanisation, indifference) as well as symptoms at the organisational level (e.g. job dissatisfaction, job turnover, low morale).

However, such a laundry-list approach is inappropriate to define the syndrome since it denies that burnout is a process and it confuses symptoms with precursors, correlates and consequences. Instead, Schaufeli and Enzmann (1998, p. 36) reviewed various definitions of burnout and propose the following synthetic definition:

*Burnout is a persistent, negative, work-related state of mind in “normal” individuals that is primarily characterised by exhaustion, which is accompanied by distress, a sense of reduced effectiveness, decreased motivation, and the development of dysfunctional attitudes and*

*behaviours 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.*

More specifically, this definition narrows down over one hundred burnout symptoms to one core indicator (exhaustion) and four accompanying, general symptoms: (1) distress (affective, cognitive, physical, and behavioural); (2) a sense of reduced effectiveness; (3) decreased motivation; (4) dysfunctional attitudes and behaviours at work. 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 recognised initially. Finally, the domain is specified: the symptoms are work-related and burnout occurs in “normal” individuals who do not suffer from psychopathology.

This description is somewhat more comprehensive than the probably most often cited definition:

*Burnout is a syndrome of emotional exhaustion, depersonalisation, and reduced personal accomplishment that can occur among individuals who work with people in some capacity. (Maslach et al., 1996, p. 4)*

Its popularity is due to the fact that the most widely used self-report questionnaire—the Maslach Burnout Inventory (MBI)—comprises the three dimensions that are included in this definition. Emotional exhaustion refers to the depletion or draining of emotional resources. Depersonalisation points to the development of negative, callous, indifferent, and cynical attitudes toward the recipients of one’s services. The term depersonalisation may cause some confusion since in psychiatry it denotes a person’s extreme alienation from the self and from the world. In contrast, in Maslach *et al.*’s definition, depersonalisation refers to an impersonal and dehumanised perception of *recipients*. Finally, lack of personal accomplishment is the tendency to evaluate one’s work with 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 has become equivalent with the way it is measured—burnout is what the MBI measures. This tautology seriously hampers burnout research since the concept of burnout—as previously defined—is broader and more comprehensive than the MBI assumes. On the other hand,

because of this common standard, findings from different studies can be compared straightforwardly.

Generally speaking, the psychometric quality of the MBI is satisfactory (Schaufeli *et al.*, 1993). More specifically, the factorial validity and the convergent validity as well as the reliability of the MBI are quite encouraging. However, emotional exhaustion in particular overlaps with related concepts such as depression and job dissatisfaction, as well as with distress symptoms (see later). It seems that the most robust and reliable subscale—emotional exhaustion—that also displays the strongest convergent validity with other burnout measures, is at the same time the least specific dimension of burnout.

## BURNOUT, 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 stress and depression. In what ways can burnout be distinguished from these two related concepts?

Stress is a generic term that refers to the temporary adaptation process that is accompanied by mental and physical symptoms. In 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 behaviours towards recipients (depersonalisation), the job, and the organisation, whereas job stress is not necessarily accompanied by such attitudes and behaviours. This assertion is empirically supported by Schaufeli and Van Dierendonck (1993), who showed in a sample of nurses that MBI-burnout can be distinguished from generic job-related mental and physical distress, albeit emotional exhaustion shared about 30% of its variance with distress. Finally, it has been claimed that everybody can experience stress, while burnout can only be experienced by those who entered their careers enthusiastically with high goals and expectations. For example, Pines (1993) has argued that individuals 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 characterised by similar dysphoric symptoms. Nevertheless, clinical practice suggests that both syndromes differ: 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, contrary to depression, burnout

tends to be job-related and situation-specific rather than pervasive, at least initially, affecting all other spheres of life. Finally, burnout includes specific dysfunctional attitudes and behaviours that are not typically found in depression. Recently, Glass and McKnight (1996) concluded after reviewing nearly twenty studies on burnout and depression: "Burnout and depressive symptomatology are not simply two terms for the same dysphoric state. They do, indeed, share appreciable variance (about 25%, *W.S.*), 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" (p. 33).

Thus it seems 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, which illustrates that this dimension resembles most closely a rather general and orthodox stress variable. The fact that depersonalisation and reduced personal accomplishment are less substantively related to the other concepts implies that burnout is a unique, multidimensional, chronic stress reaction that goes beyond the experience of mere exhaustion.

## THE PREVALANCE OF BURNOUT IN HEALTH CARE

How often does burnout occur in health care? In principle, the MBI can be used to answer this question, but the distinction it makes between "cases" and "non-cases" is based on arbitrary statistical norms instead of norms that are clinically validated. Hence, the absolute prevalence of burnout in health care cannot be assessed; but what about relative levels of burnout? Table 2.1 presents an overview of mean MBI-scores across four occupational fields.

Levels of emotional exhaustion in health care (medicine and mental health) are relatively low, particularly when compared with teaching. Although levels of depersonalisation in health care are also relatively low, particularly when compared with the social services, physicians exhibit the highest scores. Finally, reduced personal accomplishment is least experienced in mental health care, particularly by psychologists and counsellors. Physicians also exhibit relatively low scores on this burnout dimension. Obviously, academically trained health professionals such as psychologists and physicians experience the highest levels of accomplishment in their jobs. Table 2.1 shows remarkable differences between professionals in both health care fields. Compared to physicians, nurses experience slightly less emotional exhaustion, but much less depersonalisation and personal accomplishment. Although gender bias cannot

**Table 2.1:** Burnout levels across occupational fields: mean MBI-scores of 43 USA studies published between 1979 and 1998

Occupational field Profession	Samples		Emotional exhaustion		Depersonalisation		Reduced personal accomplishment	
	No.	N	Mean	SD	Mean	SD	Mean	SD
<b>Teaching</b>	<b>6</b>	<b>5,481</b>	<b>28.15</b>	<b>11.99</b>	<b>8.68</b>	<b>6.46</b>	<b>11.65</b>	<b>7.41</b>
<b>Social services</b>	<b>7</b>	<b>1,631</b>	<b>24.29</b>	<b>12.79</b>	<b>9.47</b>	<b>7.16</b>	<b>13.45</b>	<b>8.55</b>
<b>Medicine</b>	<b>14</b>	<b>2,021</b>	<b>23.86</b>	<b>11.57</b>	<b>7.95</b>	<b>6.47</b>	<b>12.38</b>	<b>7.96</b>
Nurses	11	1,542	23.80	11.80	7.13	6.25	13.53	8.15
Physicians	3	479	24.03	10.77	10.59	6.46	8.64	5.93
<b>Mental health</b>	<b>12</b>	<b>2,137</b>	<b>20.27</b>	<b>9.81</b>	<b>6.22</b>	<b>4.54</b>	<b>8.81</b>	<b>6.46</b>
psychologists/ counsellors	6	1,804	19.93	9.59	6.26	4.41	8.36	6.23
Staff	6	333	22.09	10.96	6.03	5.22	11.24	7.58
<b>Total</b>	<b>39</b>	<b>11,270</b>	<b>25.33</b>	<b>11.65</b>	<b>8.19</b>	<b>6.26</b>	<b>11.50</b>	<b>7.52</b>

Note: Adapted from Schaufeli and Enzmann (1998, p. 62).

be ruled out—nurses are predominantly female and females tend to report less depersonalisation than males (Schaufeli and Enzmann, 1998, p. 76)—it is likely that differences in depersonalisation reflect different professional roles and attitudes: the nurturing and caring role of the nurse versus the more distant curing role of the doctor. In mental health care non-academic staff experience more emotional exhaustion and less accomplishment than psychologists and counsellors. Probably this reflects the more stressful nature of the jobs of the former that are characterised by less decision latitude (perhaps leading to emotional exhaustion), as well as their less extensive training (perhaps leading to a sense of reduced personal accomplishment).

## CORRELATES, CAUSES AND CONSEQUENCES

Despite the impressive quantity of empirical publications on burnout, their quality is often questionable. Accordingly, results have to be interpreted with caution. Table 2.2 summarises the most important correlates of burnout that are found in health care (cf. Cordes and Dougherty, 1993; Lee and Ashforth, 1996; Schaufeli and Enzmann, 1998, pp. 69–99).

*Biographical characteristics* Among younger employees burnout is observed more often than among those aged over 30 or 40 years. This is in line with the observation that burnout is negatively related to work

**Table 2.2:** Correlates of burnout in health care

<i>Biographic characteristics</i>	Young age Little work experience
<i>Personality</i>	Less "hardy" personality External locus of control Poor self-esteem Non-confronting coping style Neuroticism "Feeling type"
<i>Work-related attitudes</i>	High (unrealistic) expectations Job dissatisfaction Poor organisational commitment Intention to quit
<i>General job stressors</i>	High workload Time pressure Role conflict and ambiguity Lack of social support Lack of feedback Lack of participation in decision making Lack of autonomy
<i>Specific job stressors</i>	Much direct patient contact Severe patient problems
<i>Individual health</i>	Depression Psychosomatic complaints Frequency of illness
<i>Organisational behaviour</i>	Absenteeism Job turnover Impaired performance

experience. The greater incidence of burnout among the younger and less experienced may be caused by "reality shock" or by an identity crisis due to unsuccessful occupational socialisation. 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 low levels of burnout (see later).

*Personality* Burnout is less common among those with a "hardy personality" who are characterised by involvement in daily activities, a sense of control over events, and openness to change. In 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 to 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, non-confronting coping style.

Burnout seems to be particularly related to neuroticism. Typically, emotional exhaustion shares about 30% of its variance with neuroticism, and 10–15% with the remaining factors. Depersonalisation and reduced personal accomplishment share about 5–10% of their variance with personality factors, with the latter being somewhat more strongly related to an avoiding coping style (15%) (Schaufeli and Enzmann, 1998, pp. 77–80). Since neurotic individuals are emotionally unstable and prone to psychological distress, neuroticism may act as a vulnerability factor that predisposes professionals to experience burnout.

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

*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 caused by the fact that 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 organisation, to patients’ progress, or to personal effectiveness. Job dissatisfaction, poor organisational 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 and Enzmann, 1998, p. 80). The strongest associations are found with emotional exhaustion and depersonalisation.

*General job stressors* Workload and time pressure explain about 25 to 50% of variance of burnout, especially of emotional exhaustion (see Lee and Ashforth, 1996). Relationships are much weaker with both other MBI-dimensions. The high correlation with workload must be qualified; however, because this stressor is often operationalised in terms of experienced strain so that considerable overlap in item content exists with emotional exhaustion. On the other hand, Intensive Care Units’ use of technology—objectively assessed by the number of patients who were mechanically ventilated—was substantively related to nurses’ burnout levels (Schaufeli, *et al.*, 1995).

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 about 24% of variance with emotional exhaustion, 13% with depersonalisation, and only 2% with personal accomplishment; the percentages for role ambiguity are 14, 8, and 10% respectively (Schaufeli and Enzmann, 1998, pp. 82–83).

Clear evidence exists for a positive relationship between lack of social support and burnout, especially lack of social support from supervisors. On the average, support from supervisors explains 14% of the variance of emotional exhaustion, 6% of depersonalisation, and 2% of personal accomplishment; for co-workers the amounts of variance are 5, 5 and 2% respectively (see Lee and 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 (Landsbergis, 1988).

*Specific job stressors* Recently Schaufeli and Enzmann (1998, pp. 84–85) compared the results of 16 studies and found that, overall and contrary to expectations, common job-related stressors such as workload, time pressure, or role conflicts correlate more highly with burnout than do patient-related stressors 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. For instance, Mallett *et al.* (1991) found among nurses only weak correlations between the death of patients and emotional exhaustion and depersonalisation. 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 to these which 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 and Enzmann, 1998, pp. 86–89). As noted above, burnout cannot be reduced to mere depressed mood or distress, yet it is related to both conditions.

As far as self-reported frequency of various illnesses is concerned, Corrigan *et al.* (1995) reported among psychiatric hospital staff a shared variance with emotional exhaustion plus depersonalisation of 18%. 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 depersonalisation (4%); the relationship with reduced personal accomplishment was not significant (2%).

*Organisational behaviour* Despite the popular assumption that burnout causes absenteeism, its effect is rather small and is best confirmed with respect to emotional exhaustion and next by depersonalisation. On average, about 2% of variance is shared with registered absenteeism; relations with reduced personal accomplishment are marginal but significant (Schaufeli and Enzmann, 1998, pp. 91–92).

Levels of depersonalisation predict nurses' actual job turnover within two years (Firth and Britton, 1989), whereas levels of emotional exhaustion predict turnover among general practitioners within five years (Sixma *et al.*, 1998). In terms of shared variance, the significant effects are rather low, ranging between 1 and 5%. The fact that the relationship of burnout with turnover intentions is much stronger than with actual turnover, suggests that a large percentage of burned out professionals stay in their jobs reluctantly.

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; roughly 5% of variance is shared with all three MBI-dimensions against less than 1% for other-rated or objectively assessed performance (e.g. Parker and Kulik, 1995). However, as far as objective performance measures are concerned, positive correlations are found as well. For instance, Keijsers *et al.* (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 depersonalisation or personal accomplishment. It appeared that nurses felt exhausted 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 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, time pressure, role problems, and lack of social support. Relationships 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 organisation, and poor work performance are somewhat less strong. Strictly speaking, to date few causes or consequences of burnout have been identified, probably because the considerable stability of burnout across time—about 40–45% of the variance of burnout is explained by the level of burnout one year before (Schaufeli and Enzmann, 1998, pp. 96–97)—leaves little room for other causal factors.

## PSYCHOLOGICAL EXPLANATIONS

Many different psychological explanations exist for burnout that emphasise the importance of individual, interpersonal, organisational, and societal factors respectively (for an overview see Schaufeli and Enzmann, 1998, pp. 100–142). This final section concentrates on two particular interpersonal approaches that are assumed to be of special importance for explaining burnout in health care because they emphasise the role of emotionally demanding relationships with patients.

### *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. In order 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 is depersonalisation: a persistently 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 since they only return when things go wrong. As a result of

depersonalisation, 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 increasingly lacking, the professional's sense of personal accomplishment erodes and feelings of inadequacy 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). As Figure 2.1 shows, demands were expected to be related with emotional exhaustion, whereas resources were expected to be related with depersonalisation and lack of personal accomplishment. Indeed, Leiter's results largely confirmed the hypothesised model. High job demands led to emotional exhaustion which then led to depersonalisation.

Contrary to the model, however, personal accomplishment seemed to develop rather independently from both emotional exhaustion and depersonalisation. Indeed, Leiter described it as developing in parallel with these two burnout dimensions, provided that resources were lacking of course. Recently, Lee and Ashforth (1996) concluded that the results of

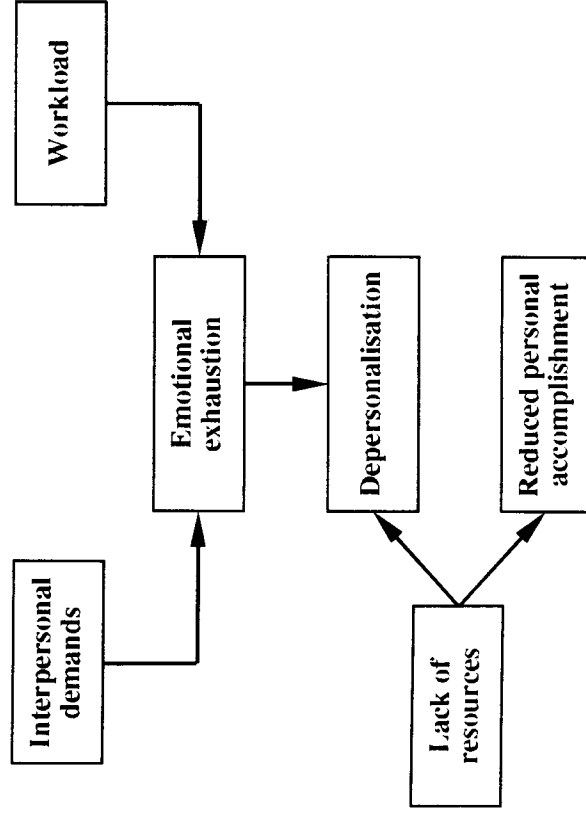


Figure 2.1: Leiter's process model of burnout (after Leiter, 1993, p. 245)

their meta-analysis are largely consistent with Leiter's (1993) mixed sequential and parallel development model of burnout.

### **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"; the former is supposed to give care, assistance, advice, support and so on, whereas the latter is supposed to receive them. Nevertheless, professionals look for some rewards in return for their efforts; for example, they expect their patients to show gratitude, to improve, or at least make a real effort to get well. Because, in practice, these expectations are seldom fulfilled it is likely that a lack of reciprocity develops over time: professionals feel that they continuously put much more into relationships with their patients than they receive in return. As Buunk and Schaufeli (1993) have pointed out, lack of reciprocity—an unbalanced helping relationship—drains the 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 depersonalised way instead of expressing genuine empathic concern. Accordingly, depersonalisation 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 since 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 *et al.*, 1996), general hospital nurses (Schaufeli and Janzour, 1994) and general practitioners (Van Dierendonck *et al.*, 1994).

Similar social exchange processes that are observed in interpersonal relationships govern the relationship of the professional with his or her organisation. Therefore, Schaufeli *et al.* (1996) have proposed a dual-level social exchange model (see Figure 2.2).

They argue that in addition to an unbalanced relationship at the interpersonal level, burnout is also caused by lack of reciprocity at the organisational level—that is, by a violation of the psychological contract. A psychological contract refers to the expectations held by employees about the nature of their exchange with the organisation. Expectations concern concrete issues such as workload, as well as less tangible matters such as esteem and dignity at work, and support from supervisors and colleagues. Thus, the psychological contract reflects the employees' subjective notion of reciprocity: they expect gains or outcomes from the

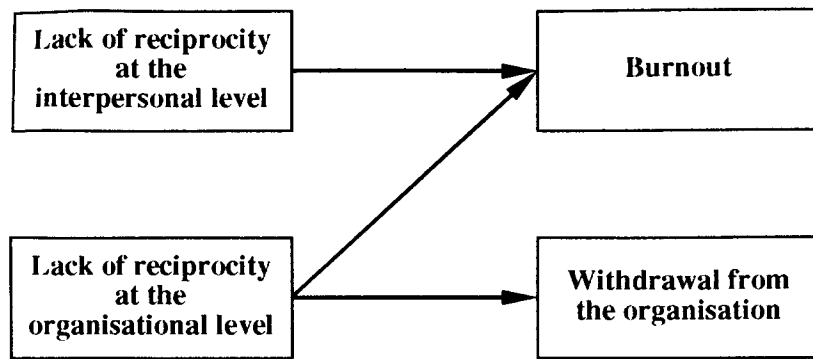


Figure 2.2: The dual-level social exchange model of burnout (source: Schaufeli *et al.*, 1996, p. 228)

organisation that are proportional to their investments or inputs. When the psychological contract is violated because experience does not match expectancies, reciprocity is corroded. Schaufeli *et al.* (1996) argued that in addition to cognitive and behavioural withdrawal from the organisation (reduced organisational commitment, turnover and absenteeism), violation of the contract may also lead to burnout. The dual-level model was tested successfully in two samples of student-nurses (Schaufeli *et al.*, 1996). Moreover, recent studies among therapists from a forensic psychiatric clinic, and staff working with clients with learning difficulties, confirmed that burnout is related to perceptions of inequity at the organisational level (Van Dierendonck *et al.*, 1996) and that those perceptions can be altered, leading to less emotional exhaustion and less absenteeism (Van Dierendonck *et al.*, 1998).

It seems that a lack of reciprocity is a key concept for understanding burnout in health care. Instead of simply working too long and too hard with difficult recipients—as is assumed in most traditional approaches to burnout—it appears that the balance between investments and outcomes is crucial for its development. It looks like this mechanism is working in similar ways at the interpersonal level of care giver and patient, and at the organisational level of professional and organisation.

## SUMMARY

To date, reliable estimates of the prevalence of burnout in health care do not exist, but it seems to be a serious problem given the huge attention it has drawn in past decades from researchers and practitioners. Burnout is

related to job stress and depression but can nevertheless be distinguished from these conditions on conceptual as well as empirical grounds. Comparisons with other occupational fields revealed that typical burnout profiles exist in health care with physicians, for instance experiencing high levels of depersonalisation and nurses suffering from reduced personal accomplishment. On the empirical level, burnout—particularly emotional exhaustion—was found to be related with many other variables, including personality factors, job stressors, and individual and organisational outcomes. Theoretical approaches that emphasise the social nature of burnout by either taking into account the emotional overload resulting from patient contacts, or the disturbed balance between give and take, seem to offer a promising route for explaining burnout in health care settings and addressing it.

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