Beliefs and perceptions about burnout amongst mental health professionals

Marieke Ledingham

Edith Cowan University
You may print or download ONE copy of this document for the purpose of your own research or study.

The University does not authorise you to copy, communicate or otherwise make available electronically to any other person any copyright material contained on this site.

You are reminded of the following:

- Copyright owners are entitled to take legal action against persons who infringe their copyright.
- A reproduction of material that is protected by copyright may be a copyright infringement.
- A court may impose penalties and award damages in relation to offences and infringements relating to copyright material. Higher penalties may apply, and higher damages may be awarded, for offences and infringements involving the conversion of material into digital or electronic form.
Use of Thesis

This copy is the property of Edith Cowan University. However the literary rights of the author must also be respected. If any passage from this thesis is quoted or closely paraphrased in a paper or written work prepared by the user, the source of the passage must be acknowledged in the work. If the user desires to publish a paper or written work containing passages copied or closely paraphrased from this thesis, which passages would in total constitute an infringing copy for the purpose of the Copyright Act, he or she must first obtain the written permission of the author to do so.
BELIEFS AND PERCEPTIONS ABOUT BURNOUT AMONGST MENTAL HEALTH PROFESSIONALS

By
Marieke Ledingham
School of Business
Faculty of Business and Law
Edith Cowan University
Western Australia

A thesis submitted in fulfillment of the award of Doctor of Philosophy

2015
Abstract

Protecting the wellbeing of the Australian mental health workforce has become important as demands on health services increase and resources are stretched. A number of studies show burnout to be a significant issue in this sector despite decades of research on its causes and widespread professional awareness of it. This thesis proposes an explanation for this paradox in human perceptual processes encouraging mental health professionals and managers to minimise recognition of, and response to, burnout.

So far there has been little systematic study of employees’ beliefs and perceptions concerning burnout. A review of social perception research, particularly studies of attribution theory, identified a number of human perceptual biases that can influence a person’s perception of his or her health and the need to take remedial action. These are predicted to cause mental health professionals to underestimate the risks and consequences of burnout and prevent them from acknowledging it or seeking help. Despite good objective knowledge of work stress, professionals may misperceive their own vulnerability and continue working to the point of emotional or physical exhaustion.

This study takes a phenomenological perspective, seeking to understand professionals’ perceptions and beliefs about burnout and how professional and organisational cultures influence these. Fifty-five mental health professionals responded to a survey asking open-ended questions about their beliefs, attitudes and knowledge of burnout and wellbeing at work. Twelve participants were also interviewed. Respondents were mental health nurses, psychologists, mental health occupational therapists, social workers, psychiatrists or counsellors. Responses were analysed and organised into themes using an inductive approach, linking conclusions as closely as possible to participants’ perspectives.

The findings show that professionals’ propensity to address symptoms of burnout is affected by their perceptions of whether managers would provide assistance, the stigma attached to burnout by colleagues or managers, and a tendency to self-blame. Their responses appear to be influenced by the perceptual biases predicted in attribution theory, along with a sense of personal self-esteem strongly tied to professional identity,
stress-induced cognitive deficits and certain values common in professional or organisational cultures. Together, these factors can reduce professionals’ ability to recognise burnout in both themselves and others.

This study contributes to the field by highlighting the role of mental health professionals’ perceptions in explaining the prevalence of burnout in organisations that have the professional resources to avoid it. Common biases in the perception of self or others can cause professionals to downplay their symptoms or use self-blame as an excuse to avoid seeking help while continuing to practice to the detriment of their health, clients and organisation. Organisational cultures and management practices may consciously or unconsciously reinforce these tendencies, along with stigma from colleagues and professional cultures.

The findings suggest that the mental health sector should move beyond the pervasive view of burnout as primarily a problem that frontline professionals themselves should detect and respond to. Supervisors and colleagues should work together as a professional community or team, supporting members when they can no longer support themselves. This requires managers, professionals, training institutions and professional bodies to better understand how burnout is created or exacerbated by common human perceptual processes.
ACKNOWLEDGEMENTS

First and foremost, thank you to my supervisors Assoc. Prof. Peter Standen and Assoc. Prof. Chris Skinner. Peter, your support given to me throughout this study will always be remembered. Your expertise was thoughtfully shared whilst allowing me the space to develop my own ideas. I have learned so very much from you. Chris, thank you for dedicating your time to continue to support me throughout my PhD, your enthusiasm, advice, ‘big picture’ view and warmth gave me so much encouragement.

Thank you to Prof. Christina Maslach, your encouragement to pursue my early ideas was incredibly generous. To the late Dr. Carol Holmes, thank you for encouraging me to undertake the PhD. To Dr. Sarron Goldman, for helping refine my research questions. Thanks to Assoc. Prof. Caroline Bulsara for her invaluable assistance in developing the questionnaire tool.

Thanks to the many people who helped with data collection. The staff at Amherst Psychology and Counselling, especially Peta, thank you. To Rebekah Adams, Katie Ireland, Nikola Horley, Kylie Dunjay, Mary Eastwood thanks so much for your assistance. Thank you to the North Metropolitan Area Mental Health Service, in particular Deb Mellican amd Prof. Flavie Waters.

Thank you to all the staff at ECU including Bev Lurie, Liz Lachowitz, Dr. John Hall for the editing and Dr. Sally Knowles for those wonderful writing retreats. Thanks to the ECU Scholarships office for making it possible for me to undertake this award.

Heartfelt thanks to Helena Gayler, Fran Hamilton, Janet Renner, Felicity Giltay and Ros King. To Gayle Ledingham – I truly could not have done this without you. Thanks for the babysitting and encouragement to get my ‘words’ done. Thank you to Justin, Ben, Inna and Sinead. Thanks to Francesca and Lee Neylon, who gave me the belief that this was possible and to my mother Francesca for enduring two long-haul flights, with my one-year-old, to enable me to attend my first international conference. Finally, thank you to my husband Paul who’s belief and support of me never wavered.
This thesis is dedicated to my son Harry, who arrived midway through my PhD journey, making it altogether more significant.
The declaration page
is not included in this version of the thesis
# TABLE OF CONTENTS

Acknowledgements .......................................................................................................... iv

Table of Contents ............................................................................................................ vii

List of Figures ................................................................................................................ xiii

List of Tables.................................................................................................................. xiv

Chapter 1: .......................................................................................................................... 1

Introduction to the study .................................................................................................. 1

1.1 Introduction ............................................................................................................. 1

1.2 Definition of terms ................................................................................................. 1

1.3 The growing need for mental health services in Australia ...................................... 1

1.4 The mental health sector in Australia ...................................................................... 2

1.5 The stressful nature of mental health work ............................................................ 3

1.6 The personal and organisational consequences of burnout ..................................... 5

1.7 Consequences of burnout for clients and professional ethics .................................. 6

1.8 Professionals’ perceptions and beliefs about burnout .............................................. 6

1.9 Significance of the study ......................................................................................... 7

1.10 Research questions ............................................................................................... 8

1.11 Method .................................................................................................................. 8

1.12 Implications for practice ...................................................................................... 9

1.13 Overview of thesis ............................................................................................... 9

Chapter 2: Literature Review ......................................................................................... 11

2.1 The origins of the concept of burnout ................................................................. 11

2.2 Burnout and stress ............................................................................................... 13

2.3 Individual factors contributing to burnout ......................................................... 15

2.4 Organisational factors ......................................................................................... 16

2.4.1 Person-job mismatch ....................................................................................... 16
3.3.2 Recruitment of participants ................................................................. 46
3.3.3 Questionnaire distribution ................................................................. 47
3.4 Questionnaire survey ............................................................................... 48
  3.4.1 Development of the questionnaire .................................................. 48
  3.4.2 Scales and coded responses ............................................................... 49
  3.4.3 Questionnaire structure ................................................................. 51
  3.4.4 Analysis of questionnaire data ......................................................... 51
3.5 Interviews ............................................................................................... 53
  3.5.1 Purpose of interviews ................................................................. 53
  3.5.2 Interview structure and development ................................................ 55
  3.5.3 Interview process ................................................................. 55
  3.5.4 Analysis of interview data ......................................................... 56
3.6 Validity .................................................................................................. 56
  3.6.1 Credibility ........................................................................ 56
  3.6.2 Transferability ........................................................................ 57
  3.6.3 Dependability ........................................................................ 57
  3.6.4 Confirmability ........................................................................ 57
3.7 Ethical considerations ........................................................................... 58
  3.7.1 Informed consent ................................................................. 58
  3.7.2 Privacy and confidentiality .............................................................. 58
  3.7.3 Harm and risk ........................................................................ 58
Chapter 4: Results ....................................................................................... 59
4.1 Introduction .......................................................................................... 59
  4.1.1 Demographics of respondents .................................................. 60
4.2 What do respondents know or believe about burnout and its causes? ........ 62
  4.2.1 Burnout is a common experience ............................................. 62
  4.2.2 Good objective knowledge of burnout ........................................ 63
4.2.3 Internal causes of burnout: Psychological vulnerabilities or risky behaviours ................................................................................................................................. 64
4.2.4 External causes of burnout: Excessive workload ........................................... 66
4.2.5 External causes of burnout: Poor supervisor support or organisational management ............................................................................................................. 67
4.2.6 Summary: Knowledge of burnout and beliefs about its causes ...................... 68
4.3 Perceptions of organisational managers’ attitudes to burnout............................... 70
  4.3.1 Managers lack interest or awareness .............................................................. 71
  4.3.2 Burnout is seen as the individual’s problem.................................................... 72
  4.3.3 Organisational cultures normalise stress ....................................................... 74
  4.3.4 Unwillingness to disclose symptoms of burnout ............................................ 75
  4.3.5 Perceptions of organisations that take burnout seriously ............................... 76
  4.3.6 Summary: Perceptions of managers’ attitudes to burnout.............................. 77
4.4 Perceptions of colleagues’ attitudes to burnout..................................................... 79
  4.4.1 Do burning out colleagues disclose their state?.............................................. 80
  4.4.2 Colleagues’ reactions to other colleagues with burnout ............................... 81
  4.4.3 Colleagues’ reactions to respondents with burnout ....................................... 84
  4.4.4 Summary: Perceptions of colleagues’ attitudes to burnout............................ 87
4.5 How does burnout affect professionals psychologically? ..................................... 88
  4.5.1 Self-blame and loss of self-esteem ................................................................. 89
  4.5.2 Loss of professional identity ........................................................................... 89
  4.5.3 Signaling a need to take more self-care .......................................................... 91
  4.5.4 Thoughts of leaving the profession............................................................... 93
  4.5.5 Summary: The psychological effects of burnout............................................ 94
4.6 Barriers to preventing burnout and strategies to overcome them......................... 95
  4.6.1 Time pressure and lack of time for self-care .................................................. 95
  4.6.2 Losing perspective as burnout sets in ............................................................. 98
  4.6.3 Perceiving burnout as inevitable ................................................................... 100
LIST OF FIGURES

Figure 1: Workers' compensation claims for mental disorders by industry
2007/8. .......................................................... 3

Figure 2: Steps in data collection............................................................... 41

Figure 3: A scale followed by open question, as part of a two-staged strategy for
eliciting more in-depth responses.......................................................... 50

Figure 4: Graphic rating scale with labelled midpoint.............................. 50

Figure 5: The phases of thematic analysis according to Braun and Clarke (2006) 52

Figure 6: Respondents’ profession.......................................................... 60

Figure 7: Years of practice as a mental health professional....................... 61

Figure 8: Distribution of participants’ age.................................................. 61

Figure 9: Proposed model of perceptual factors in burnout prevention and help-
seeking.......................................................... 131

Figure 10: Perceptual barriers to awareness of burnout and effective responding in
oneself.......................................................... 133

Figure 11: Perceptual barriers to responding to others' burnout.................. 143

Figure 12: Barriers to organisations responding to problem of burnout........ 150
LIST OF TABLES

Table 1: Common elements of all qualitative research…………………………………37

Table 2: Questionnaire item numbers relating to specific research questions……….51

Table 3: Defining and operationalising richness…………………………………….54

Table 4: Organisational strategies for avoiding burnout…………………………..102

Table 5: Personal strategies for reducing burnout ...........................................104
CHAPTER 1: INTRODUCTION TO THE STUDY

1.1 Introduction

This study investigates how burnout is seen and experienced by mental health professionals. A person’s perceptions and beliefs about the nature and causes of burnout determine his or her responses to it, and are an outcome of personality and experience as well as the influences of colleagues, managers and other members of the professional community. Where previous studies have treated burnout objectively, this study aims to describe and explain professionals’ subjective beliefs and how these are influenced by colleagues and managers’ views of it. These subjective factors are so far little addressed in the burnout literature. Previous studies of mental health professionals show high rates of burnout among this group, despite having knowledge of its causes and treatment. This thesis investigates a possible explanation for this paradox in perceptions and beliefs about burnout that discourage mental health professionals from giving it the attention it deserves, and considers the influence of corporate cultures and management practices as well as professional cultures on professionals’ beliefs and perceptions.

1.2 Definition of terms

Burnout

Burnout in the mental health professions can be described as the end point of a process of depletion and exhaustion in a worker. It is distinguished from ordinary stress symptoms by being the result of chronic stresses and job demands. A collection of long-term changes is seen in the worker, including emotional depletion, increased cynicism, detachment from clients and a reduced sense of personal accomplishment (Maslach, Schaufeli, & Leiter, 2001; Schaufeli, Leiter, & Maslach, 2009).

Mental Health Professional

In Australia ‘Mental Health Professional’ is an umbrella term covering several professional disciplines. Such professionals have completed tertiary education in a discipline specialised in the psychological, psychosocial, psychiatric or emotional care
and treatment of people suffering from emotional distress. This study uses the membership criteria of the Mental Health Professionals Network of Australia (MHPNA), which includes psychologists, social workers, mental health nurses, occupational therapists, psychiatrists, community mental health workers and counsellors providing primary mental health care (MHPNA, 2012). The context of the mental health sector is now discussed in order to illustrate the significance of burnout for mental health professionals and the community.

### 1.3 The growing need for mental health services in Australia

The health and community services sector in Australia is under increasing pressure and this is expected to increase with future population growth, increasing illness and changing demographics such as ageing of the Australian population (ABS, 2012). In particular, the demand for mental health services has increased significantly in recent years. The number of patients requiring admission to mental health facilities has risen by 23.7% since 2006 (Stokes, 2012), and the number of people requiring community and in-patient mental health services is expected to continue to increase in the future (ABS, 2012). It is estimated that 45% of adult Australians will at some point in their lives experience a ‘mental disorder’ (ABS, 2012), a term used by policy makers to describe a wide variety of emotional, behavioural and cognitive disorders. Slade, Johnston, Teesson, Whiteford, Burgess, Pirkis and Saw (2009) estimate that during any 12 month period over three million people will suffer from a mental disorder.

Mental disorders, particularly mood disorders such as depression and anxiety, accounted for 28% of all reported suicides (ABS, 2010) and 13% of the economic burden of all diseases in 2003 (Begg, Vos, Barker & Mann, 2007). In 2010 anxiety and depression were the second leading causes of illness and injury, after cancer (NMHC, 2012). Poor mental health has been linked to decreased physical health, increased crime and reduced economic and accommodation security (DoHA, 2010). The strong need to improve mental health service provision has seen significant policy reform in recent years (DoHA, 2009), and improving mental health has become a priority in planning and service delivery (MHCWA, 2012; NMHC, 2012). Therefore, the health, wellbeing and retention of mental health professionals who service the 45% of Australians suffering from mental health difficulties must also be a national priority. However, as
the next section describes, there are currently many challenges facing staff working in this sector.

1.4 The mental health sector in Australia

Workplace stress in all industries has increased in recent years (Safework, 2012) and stress compensation claims have in turn increased, costing the Australian economy $200 million in 2006 (Safework, 2006). The National OHS Strategy 2012-2022 lists the health and community services sector, including mental health professionals, among the most ‘at risk’ for occupational injury and disease (Safework, 2012, p.17; Safework, 2013). As Figure 1 illustrates, in 2007 and 2008 the health and community services industry had a significantly higher claim rate for work-related mental disorders, including stress disorders, than any other industry (Safework, 2010). It is evident that stress and burnout are problems in all industries, but particularly affect the employees who work with society’s least psychologically well and most vulnerable people.

Stress and burnout come at a great cost to the individual, workplace and community. A recent study of the economic costs found stress-related ‘presentee-ism’ (where a worker attends work incapacitated by stress and unable to function efficiently) and stress-related absenteeism together cost the Australian economy $14.81 billion per year (Econtech, 2008). The direct cost of mental stress to employers was estimated to be $10.11 billion per year (Econtech, 2008; Safework, 2013). This estimate does not include the additional expenses of recruiting and retraining when staff leave due to stress. Additionally, mental stress compensation claims have the highest median cost of any category to the economy, and the second highest average cost, due to the length of time sufferers are unable to work (Safework, 2013).
In recent years the mental health sector in Australia has faced many changes that have increased the pressure and stress faced by workers. Service delivery has changed significantly as mental health services move towards community-based care (Cleary, Walter, & Hunt, 2005). Mental health professionals working in in-patient care, such as hospitals workers, are faced with substantially increased workloads as their patient population becomes concentrated with the most severe and unwell. Patients are admitted to inpatient facilities much later than previously, and discharged earlier, increasing the caseload of community mental health nurses and making readmission more likely (Henderson, Walter, Willis, & Toffoli, 2008). Additionally, aggressive patients and the accompanying risk of violence are increasingly common in mental
health service centres (Happell, 2008). Beyond these difficulties in service delivery, mental health services also face serious staffing shortages. One reason for this is the ageing of the workforce. For example, twenty-five percent of mental health nurses and two-thirds of psychiatrists in Australia are over 55 (KPMG, 2009).

Recently an independent review of the West Australian mental health system in response to multiple suicides of recently discharged patients noted the difficulty of attracting adequate new staff into mental health work (Stokes, 2012). Attracting and retaining new graduates is difficult as young graduates take note of the stresses in caring for seriously unwell and possibly risky patients. Stokes suggested that students on clinical placements in mental health tend to see patients “at their worst” (p.65), which decreases the likelihood of them pursuing a career in mental health. Mental health has become less attractive and students today are able to choose from a myriad of other specialisation options.

The difficulty in attracting new staff, the turnover of current staff and changes to service delivery all contribute to increased stress-related disorders in the mental health sector (AIHW, 2011; Gilbody, Cahill, Barkham, Richards, Bee, Glanville, 2006; Happell, 2008; Morse, Salyers, Rollins, Monroe-DeVita, & Pfahler, 2012; Stokes, 2012). Existing staff find it very difficult to achieve work-life balance due to longer working hours, higher pressure workplaces, greater safety concerns at work and difficulty in accessing leave when needed. Issues such as stress and burnout in the mental health sector can influence its attractiveness to newly graduated professionals and retention of existing staff who may leave the profession (Paris & Hoge, 2010; Stokes, 2012). Addressing stress and burnout in the mental health sector is therefore crucial to providing services to the rising percentage of the population with mental health difficulties.

Mental health professionals are commonly assumed to have a particularly high risk of burnout and stress due to the unique, non-reciprocal emotional giving involved in working with distressed clients or patients (Acker, 2012; Freudenberger, 1975; Gilbody et al., 2006; Kim, 2011; Oddie & Ousley, 2007; Morse, Salyers, Rollins, Monroe-DeVita, Pfahler, 2012; Pines & Maslach, 1978; Schaufeli, Leiter & Maslach, 2009). Burnout in mental health professions differs from other kinds of burnout because it stems from the nature of the work involved in helping people with distressing and
unsolvable problems (Cox & Leiter, 1992), often within an environment lacking in resources (Stovholt, Grier, & Hanson, 2001). Figley (2002) similarly relates the high cost of working with people in distress to factors such as the constant exposure to others' trauma and suffering, the relentless demand to relieve this suffering and the emotional leftovers of professionals’ empathic response to the clients.

1.6 The personal and organisational consequences of burnout

Studies of burnout in the general population show it results in decreased work-commitment, absenteeism and job turnover, and a deterioration in the quality of service provided (Cimiotti, Aiken, Sloane, & Wu, 2012; Figley, 2002; Shanafelt, Bradley, Wipf, & Back, 2002). Burnout has been linked with health impairments such as obesity (Nevanperä, Hopsu, Kuosma, Ukkola, Uitti, Laitinen & Het, 2012), impaired immunity, cardiovascular disorders and sleep disturbances (Melamed, Shirom, Toker, Berliner, & Shapira, 2006). Furthermore, burnout requires a long recovery period, not just short term rest and recuperation. A moderate to severe burnout episode lasts on average 2.5 years (Kant, Jansen, Van Amelsvoort, Mohren, & Swaen, 2004).

Additionally, the burnout syndrome can spread amongst colleagues. It therefore reduces the wellbeing of a workplace (Ericson-Lidman, Norberg, & Strandberg, 2007) and the quality of the organisation’s client or patient services (Bakker, Le Blanc, & Schaufeli, 2005). It can also impact on the professional’s home life and personal relationships, including marital relationships (Story & Repetti, 2006). However, despite the risks and prevalence of burnout (Grawitch, Gottschalk, & Munz, 2006), legislation on health and safety rarely addresses its prevention, largely because stress and burnout are often not recognised by managers and colleagues (Johnstone, Quinlan, & McNamara, 2011).

Burnout may even cause professionals to leave their field and retrain for a new career (Figley, 2002; Paris & Hoge, 2010). This brings a considerable cost to the individual, and to the mental health community that invested heavily in their training and career development.
1.7 Consequences of burnout for clients and professional ethics

Besides the health costs to the individual and the economic costs to the employer, a stress-impaired practitioner also poses risks to vulnerable clients (Cimiotti, Aiken, Sloane & Wu, 2012; Pope, Tabachnick, & Keith-Spiegel, 1987; Shanafelt, Bradley, Wipf & Back, 2002). All mental health professionals are governed by professional codes of ethics that prescribe high standards of competence including monitoring of one’s level of functioning and engaging in strategies to prevent health impairment (AASW, 2010; ANMC, 2008; APS, 2007). For example, the Australian Psychological Society Code of Ethics stipulates that

"Psychologists continuously monitor their professional functioning. If they become aware of problems that may impair their ability to provide competent psychological services, they take appropriate measures to address the problem by: (a) obtaining professional advice about whether they should limit, suspend or terminate the provision of psychological services; (b) taking action in accordance with the psychologists' registration legislation of the jurisdiction in which they practise, and the Constitution of the Society; and (c) refraining, if necessary, from undertaking that psychological service" (APS, 2007, p.18).

A psychologist who continues to practice while impaired by burnout is therefore violating this Code of Ethics and is subject to disciplinary procedures by the registration board. Social workers, occupational therapists and nurses are all governed by codes of ethics with similar emphasis on impairment and self-care. For example: "Nurses value and accept responsibility for self-care. This involves maintaining their own health, acknowledging their physical and psychological strengths and limitations" (ANMC, 2008, p.7). Self care and prevention of burnout is now an "ethical imperative" (Barnett, Baker, Elman, & Schoener, 2007, p.604) and its neglect places professionals, clients and the organisation at risk of harm.

1.8 Professionals’ perceptions and beliefs about burnout

Despite increasing awareness of the nature, causes and consequences of workplace burnout in the literature (Maslach & Leiter, 2008) it is increasingly common amongst mental health professionals (Kumar, Hatcher, Dutu, Fischer, & Ma’u, 2011; Morse et
The review of the literature in Chapter 2 shows that empirical research has so far produced a general understanding of the causes and consequences of burnout for individuals and organisations, and advice on how to avoid it through self-care. However, there are many reasons why people may not act on information promoting healthy, self-protective behaviours. One is that a person’s information-processing limitations can lead to distorted perceptions of competence (Dunning, Johnson, Ehrlinger & Kruger, 2003; Oosterholt, Van der Linden, Maes, Verbraak, & Kompier, 2012) that could prevent a person from recognising, acknowledging and seeking help for impairment. Various cognitive biases can also lead individuals to underestimate health risks (McKenna, Warburton, & Winwood, 1993; Weinsten, 1984) and therefore to neglect self-care and other preventive behaviours.

Corporate cultures and values can also discourage self-care. Economic problems, a lack of human and other resources, a strong work ethic, or even a client-service ethic can shift staff focus away from self-care.

The effects of both individual perceptions and corporate values or beliefs can be understood through Attribution Theory (Heider, 1944, 1958; Jones & Davis, 1965; Kelley, 1972), a theoretical framework that helps explain how burnout prevention can become a low priority to individuals and organisations. Attribution Theory describes a tendency to attribute an individual’s circumstances to either internal causes such as disposition or personality, or to external forces such as work pressures. It describes how individuals make sense of the world around them, particularly in the face of ambiguous or unsettling events such as burnout.

1.9 Significance of the study

Little is known about how mental health professionals perceive and understand burnout, and the influence of corporate values on their beliefs and perceptions. Attribution Theory and related theories from social psychology suggest beliefs and perceptions have a strong influence on behaviour, including self-care and preventative behaviours.

Therefore, understanding how professionals conceptualise the risks and prevention of burnout, and how organisations encourage certain beliefs and perceptions, should improve understanding of when mental health professionals engage in preventive
behaviours such as help-seeking, self-care or intervening when a colleague becomes impaired, and when they avoid such positive behaviours.

This study is the first to systematically explore mental health professionals’ perceptions and beliefs about burnout in themselves and colleagues, along with their perceptions of the organisation’s values relating to burnout and how these values affect their willingness to undertake preventative self-care, seek help or help a colleague. An understanding of these factors would help researchers advise individuals and organisations how to identify and overcome the barriers currently inhibiting healthy self-protective behaviours in mental health professionals.

1.10 Research questions

The research questions are concerned with the beliefs and perceptions of mental health professionals regarding the following:

Q1 What burnout is and what causes it
Q2 Managers’ attitudes to burnout
Q3 Colleagues’ attitudes to burnout
Q4 The psychological effects of burnout
Q5 What strategies could professionals and managers use to reduce burnout and what barriers prevent the use of these?

1.11 Method

This study employs a qualitative methodology because its purpose is to describe and understand the beliefs and perceptions of mental health professionals. It takes a phenomenological and inductive approach, where the researcher aims to understand individuals’ own personal viewpoints as much as possible rather than imposing criteria or categories derived from theory or previous research. This approach is relevant because previous studies have not examined perceptions and beliefs of burnout, generally or in mental health professionals, and because a phenomenological perspective can help identify perceptual barriers and advise managers and others how to frame communications to overcome them.
An open-ended questionnaire is used to elicit professionals’ beliefs, perceptions and knowledge about burnout and how these might affect their ability to maintain wellbeing at work. The sample consists of employees from private and public mental health services including mental health nurses, psychologists, mental health occupational therapists, social workers, psychiatrists and counsellors.

### 1.12 Implications for practice

The current study is designed to inform management practice and organisational policy within mental health organisations. A better understanding of how mental health professionals think about and perceive burnout can help managers more adequately address unhelpful beliefs and attitudes in the workplace, and encourage helpful behaviours. Additionally, providing managers insight into their own beliefs and perceptions about burnout may improve their ability to respond effectively to burning-out employees.

### 1.13 Overview of thesis

Chapter 2 reviews the literature on the history of burnout research and the causes and nature of burnout. Gaps in knowledge of beliefs and perceptions of burnout are identified. The theoretical framework of Attribution Theory is introduced and related to previous studies.

Chapter 3 provides a description and justification of the methods used to collect data. The role of phenomenology as a philosophical framework is described. Participant recruitment, demographics, sampling and instrument development are discussed in detail, along with the limitations and ethical considerations of the data collection methods. Finally, the analysis of the data is described and its validity discussed.

Chapter 4 presents the findings, analysed according to categories and themes. These are supported by tables, figures and quotes from responses to questionnaires and interviews.

Chapter 5 presents two case studies that illustrate in depth the themes presented in Chapter 4.
In Chapter 6 the findings are discussed and related to current research on burnout, stress, Attribution Theory, organisational culture and climate. A new theoretical model is presented.

Chapter 7 presents a summary of the study’s findings and relates them to the research questions. The contribution to the literature is identified. Implications for practice and suggestions for further research are outlined. Finally, some limitations of the study are discussed.
CHAPTER 2: LITERATURE REVIEW

The field of burnout studies is relatively new, and this review begins by summarising its evolution over the last 30 years and its relationship to the broader literature on stress. As this study examines perceptions and beliefs about burnout, studies of the individual and organisational factors that predict it form an important background and are summarised next. Individual factors include personality and some demographic variables, while organisational factors include person-job mis-match, job demands and resources, social contagion and organisational culture and climate along with professional cultures. Studies of how organisations can prevent burnout are then examined, highlighting individual self-care, social support and reframing burnout as a social problem rather than an individual condition that reflects badly on the sufferer.

Although studies of burnout in organisations provide many useful empirical insights and theoretical perspectives, its basic nature as a form of stress and the important aspects of its avoidance are widely known amongst mental health practitioners as a result of their training in treating stress disorders. The prevalence of burnout amongst this group therefore invites the question of how practitioners face symptoms in themselves or colleagues. The final section of this review examines social psychological studies of how people perceive health problems and other human conditions that can be stigmatised as ‘weaknesses’. In particular, Attribution Theory explains how individuals distort perceptions of themselves and others to avoid apparent threats to their self-esteem. Studies showing how such biases cause individuals to downplay or misattribute many health problems or disabilities suggest these processes may also lie behind the neglect of burnout in mental health professionals. This is the primary thesis of this study.

2.1 The origins of the concept of burnout

The term “burnout” was first used by Herbert Freudenberger when working in a community clinic where drug addicted patients were called ‘burnouts’. Freudenberger noted that previously dedicated, passionate staff became despondent, cynical and detached over time, and he labelled this ‘burnout’ (Freudenberger, 1975).
At the same time the social psychologist Christina Maslach was investigating a syndrome she had noticed amongst community care workers. From her pioneering empirical studies she developed a model of burnout based on three components: emotional exhaustion, depersonalisation and reduced personal accomplishment (Maslach & Jackson, 1981). Emotional exhaustion embodies the individual response to stressors in the job, when workers feel their emotional resources are over-stretched and depleted. Depersonalisation describes the interpersonal response to chronic stress when a worker becomes overly detached from clients or patients, showing negative attitudes, cynicism and delight in no-shows. A sense of reduced personal accomplishment describes the self-evaluation component: judging oneself as incompetent or inefficient in work that was previously enjoyed (Maslach, Schaufeli & Leiter, 2001).

Subsequent researchers have reconsidered the role of reduced personal accomplishment as a core component following evidence that it tends to develop independently of emotional exhaustion and cynicism, is less frequent than these (Lee & Ashforth, 1996), and appears to be more related to the Big Five personality factors (see 2.3) than burnout itself (Schaufeli & Enzmann, 1998). Consequently emotional exhaustion and cynicism are now considered the two core components of burnout (Büssing & Glaser, 2000). Emotional exhaustion points to a considerable overlap between burnout and more traditional categories of stress response (Schaufeli & Enzmann, 1998).

Burnout was originally thought to be a problem only in human service professions such as psychology, medicine and nursing where intensive interaction with people in a helping role can be highly stressful. In more recent years the phenomenon has been recognised as a problem in many other professions including the military, office administration and law (Demerouti, Bakker, Nachreiner, & Schaufeli, 2001; Schaufeli & Enzmann, 1998). However, burnout in human service professions has some unique qualities due to their service ethic and focus on people who are often emotionally or physically vulnerable. When the emotional demands of serving such clients become exhausting professionals may react by detaching from and depersonalising their clients (Demerouti et al., 2001). While burnout in all professions includes both emotional exhaustion and depersonalisation, in jobs where there is no direct service recipient depersonalisation manifests in a less injurious manner. Human service professionals
need to be engaged with their clients to be effective (Martin, Garske, & Davis, 2000), and treating them in a detached or callous manner can lead to psychological harm.

### 2.2 Burnout and stress

Early studies established that burnout is distinct from the typical response to occupational stress, although related to it. These researchers found the stress experienced during a critical work incident such as interpersonal conflict or an untenable caseload involved a physiological response (Glendon, 2006, p.229). Selye’s pioneering studies of what he called the General Adaptation Syndrome (Selye, 1950; 1982, p.10) showed both short and long-term physiological responses to stress. He emphasised that these do not stem from an objectively real threat to safety so much as the *perception* of being unable to cope with the situation.

The process of cognitively ‘categorising an encounter’ is therefore important, a process intensively studied by Richard Lazarus and his colleagues. In a ‘primary appraisal’ an individual evaluates a situation and decides whether it is positive, irrelevant or stressful (Lazarus & Folkman 1984, p.31). This involves an often unconscious appraisal of what is being experienced and its meaning for the perceiver or people he or she cares about. This then produces an emotional reaction that might underpin, for example, aggressive or detaching responses. Primary appraisal and emotional reactions are highly subjective processes. One person may view the increasing demands of a busy mental health clinic as a challenge where another may see a threat beyond their emotional and physical resources.

Selye (1982) described three stages of physiological response to stress: alarm, resistance and exhaustion. In the *alarm phase*, adrenaline, cortisol and noradrenaline are released to activate the 'fight or flight' response. These hormones provide quick responses and increased energy, but are harmful over time. In the *resistance phase*, the body attempts to return to homeostasis. However its reserves of ‘adaptation energy’ are finite, and if the alarm stage is continually activated the body gradually wears down. In the *exhaustion phase* resources for resisting stress are depleted. This can lead to chronic illnesses such as heart disease or burnout. Selye compares adaptation energy to a bank account where withdrawal is possible but making deposits is prevented by the long-lasting effects of excessive stress.
Burnout is therefore the end point of chronic stress, where demands exceed resources (Lee & Ashforth, 1996; Schaufeli, Leiter & Maslach, 2009). It generally results from sustained occupational stress rather than a single stressor and, unlike less severe stress conditions, recovery requires a change in the environment or intervention by another person such as a psychologist (Brill, 1984). While burnout is considered a distinct construct, it shares the emotional, behavioural and physical responses to less severe occupational stress, such as irritability, anxiety, depression, emotional withdrawal, inability to concentrate, forgetfulness, poor judgement, decrease in work performance, increased absenteeism, impulsive behaviour, heart disease, hypertension, headaches, skin conditions and insomnia (Glendon, 2006, p.232). Burnout is increasingly recognised by medical and psychological professionals as a distinct syndrome. For example, in Sweden and the Netherlands work burnout is now a recognised medical disorder (Schaufeli et al., 2009), allowing sufferers to claim social security benefits and treatment guidelines to be established.

Despite the considerable overlap, there are important differences between stress and burnout, some particularly relevant to mental health professionals. In particular burnout can greatly reduce a person’s spiritual or existential experience of meaning and purpose in life, a serious problem for professionals who enter the human service field with a passion and drive to help people. Stovholt and colleagues refer to burnout as “the haemorrhaging of the self” (Stovholt, Grier, & Hanson, 2001, p.146), a profound weariness that overturns a conception of self previously based on strength and competence. Similarly Maslach and Leiter (1997, p.17) define burnout as an “erosion of the soul”, a loss of values, dignity, spirit and will. These descriptions illustrate the potential for burnout to seriously disrupt or derail a professional’s career and life, and why recovery requires more than simply “rest and recuperation”. Burnout prompts an ”existential crisis” (Skovholt, 2001, p.152), which can ultimately lead a worker to leave the profession altogether (Figley, 2002; Paris & Hoge, 2010).

The causes or precipitating factors behind this crisis are complex and researchers have identified a wide variety of individual, organisational and interactional factors. The next section provides an overview of these.
2.3 Individual factors contributing to burnout

From the beginning of the field researchers have typically assumed that certain people are more vulnerable to burnout. Studies have identified ‘at risk’ persons as more sensitive, idealistic, introverted or anxious (Farber, 1983; Pines & Aronson, 1988; Sussman, 1992). Other personality variables found to predict or mitigate against burnout include hardiness (Boyle, Grap, Younger, & Thornby, 1991), extraversion (Hochwälder, 2009) and neuroticism (Bakker et al., 2005).

An example of this approach is Bakker, Zee, Lewig, and Dollard’s (2006) examination of five basic personality factors - extraversion, agreeableness, conscientiousness, emotional stability and autonomy – as predictors of burnout. They found employees who are more neurotic, introverted and less stable were more prone to developing burnout as measured by Maslach’s three components of emotional exhaustion, reduced accomplishment and cynicism. However, the small sample size of this study suggests caution in accepting this conclusion.

Similarly Langelaan and colleagues (Langelaan, Bakker, van Doornen, & Schaufeli, 2006) examined the ‘Big Five’ personality factors in burnout and its polar-opposite construct engagement, defined as a “positive, fulfilling affective-motivational state of work-related wellbeing” (Leiter & Bakker, 2010). They found neuroticism predicted burnout, while extraversion was related to engagement.

Other individual factors found to contribute to burnout include demographic variables signifying limited coping resources, such as younger age, less work experience or lack of a partner, and psychological limitations such as a passive coping style (Lim, Kim, Kim, Yang, & Lee, 2010; Melchior, Bours, Schmitz, & Wittich, 1997; Schaufeli, Leiter & Maslach, 2009).

Overall this research supports the view that some people are more at risk of developing burnout than others, and provides knowledge important to the prevention of burnout in the workplace. However, this is only part of the picture as other studies show that a stressful work environment, particularly one requiring continual contact with people in distress, better predicts burnout. These studies are discussed below.
2.4 Organisational factors

Research on organisational influences on burnout has examined many aspects of job design, management practices and organisational culture or climate. Three well-established job-related causes of work stress are role ambiguity, where workers lack information on job requirements, work overload, and role conflict, where employees face competing demands. These factors also increase the likelihood of physical injury or accident in workplaces (Harrell, 1990; Iverson & Erwin, 1997), and have been consistently related to burnout (Leiter & Maslach, 2003; Maslach, Schaufeli & Leiter, 2001).

Amongst the management practices linked to burnout are tolerance of workplace conflict (Savicki, 1993), lack of opportunity for social support (Ross, Altmaier, & Russell, 1989), low involvement in decision-making (O'Driscoll & Schubert, 1988) and low autonomy (Kim & Stoner, 2008).

Besides these general aspects of management four features of the workplace have been implicated as particularly significant in burnout: mismatch between the job and the worker, how job demands balance with the worker’s resources, the contagion of exhaustion, and organisational culture and climate. These are discussed in the sections below.

2.4.1 Person-job mismatch

One view of burnout emphasises a mismatch between the job and the worker. Leiter and Maslach (2003) identified six such person-job mismatch factors, with work overload the most prominent in most human service fields. When the demands of clients or managers exceed a professional’s personal resources, chronic stress and ultimately burnout are likely outcomes. A second factor is the lack of control experienced where workers cannot make decisions or choices but feel forced to function within rigid rules, leaving little room for the satisfaction of personal accomplishment.

Third, insufficient reward for work tends to diminish its perceived value and lower the worker’s self-image. Reward includes not only monetary benefits, but also the time or resources to do a job well enough to feel proud of one’s work. Breakdown of community results when management isolates colleagues from each other or ongoing disputes
perpetuate antagonism between colleagues or between workers and management. A lack of fairness exists when complaints are not heard by management or when disparity in salary or workload leads workers to feel undervalued.

The final form of mismatch between an employee and the organisation is a values mismatch. A worker may be required to act in ways perceived to be ethically wrong, or may find the organisation’s espoused values contradict its actual practices (Argyris & Schon, 1974, p.7). For example, human service values may be espoused but decisions are based exclusively on economic value. These six forms of mismatch create stress and therefore contribute to burnout.

2.4.2 Job demands – resource model

A second prominent theory of burnout development is the Job Demands – Resource Model (JD-R) (Bakker, Demerouti & Sanz-Vergel, 2014; Demerouti, Bakker, Nachreiner, Schaufeli, 2001). This divides risk factors for burnout into two categories, demands and resources. High job demands, such as tasks involving extreme mental or physical effort, noise, workload or time pressure, increase the emotional exhaustion component of burnout. The greater the effort demanded of the worker, the greater the physiological and psychological cost.

Health-protecting resources in the JD-R help the individual in three ways: reducing the psychological and physiological costs of job demands, helping to achieve work goals, and enabling personal development or growth. Resources can be organisational, social or internal. Organisational resources include greater job control, involvement in decision-making or opportunity for advancement. Social resources are provided by colleagues, supervisors and personal networks, while internal resources include cognitive style and coping patterns. Although the validity of the internal component is currently uncertain, the JD-R has received much empirical support and is considered to be a reliable predictor of burnout across a broad spectrum of professions (Bakker & Demerouti, 2007).
2.4.3 Burnout contagion theory

This perspective highlights workers’ social context. Recent studies suggest burnout in one person can be transmitted to another (Bakker, Westman, & Schaufeli, 2007, p.221), following earlier research showing that work burnout can ‘spillover’ to adversely affect a marital partner (Jackson & Maslach, 1982). Bakker, Schaufeli, Sixma, & Bosveld (2001) suggest professionals who work with clients in an empathic framework are trained to ‘tune in’ to another’s emotions and may be overly susceptible to those of colleagues, particularly when the colleague frequently expresses negative feelings about work.

2.5 Culture and climate

Much research identifies organisational culture and climate as important influences on burnout. Schein (1990, pp.111–112) defined organisational culture as a set of assumptions about the right way to think and feel about work that are passed on to new members. These assumptions are expressed on three levels: artefacts, such as statements of philosophy, the manner in which people address each other, and annual reports; values, including norms or ideologies; and assumptions, the unconscious perceptions, thought processes, feelings and behaviours taken for granted by organisational members. Schein suggests that underlying assumptions give culture its ambiguous and contradictory nature.

The assumptions and values of an organisational culture are often not explicitly stated and tend to have unconscious or covert influence (Schein, 2010). Marshak (2006, p.12) describes these as collective ‘mindsets’ that guide individuals’ behaviour. Assumptions and values concerning employee health and safety are an important example: a culture of ‘health and safety first’ at every level from frontline staff to senior managers will lead to fewer accidents and preventable health problems (Attree & Newbold, 2009). An employee will feel more comfortable in raising concerns about overwork and stress, and more confident of managing the boundary between work and home life.

In health service organisations, cultures emphasising employee health and wellbeing are associated with greater satisfaction and commitment as well as better health care delivery and patient satisfaction (Burke, 2013; Fearon & Nichol, 2011; Siourouni,
An organisational culture with a strong commitment to staff wellbeing can also influence ethical care delivery to patients (Carney, 2006).

### 2.5.1 Quinn’s model of competing values

Organisational cultures contain values that often compete or clash. For example, a *safety* culture typically recognises the need to balance economic or external organisational goals with employee safety and wellbeing, where a *blaming* culture values the former above the latter. Quinn’s Competing Values Framework is an influential model of culture because it recognises that managers often face competing demands that are difficult to balance. Quinn and Rohrbaugh (1981) describe identified three “basic dilemmas of organisational life”. First, do managers seek *order and control* through authority, structure and coordination or *innovation and change* through diversity, individual initiative and organisational adaptability? Second, do managers focus on *internal needs* such as employee feeling or wellbeing, or *external needs* such as market share, competitiveness or returns to shareholders? Finally, should managers prioritise *end-goals* such as productivity or growth over values about the *means* to such goals, such as staff morale or planning? Quinn and Rohrbaugh suggest that organisations are likely to emphasise one set of values in each category over the other. They identify four archetypal cultures focused on *human relations*, *internal processes*, *external expansion* (‘open systems’) or *rational goal-seeking*, and propose that an organisation will be more effective when managers consider *all* these value-sets.

Carney’s (2004) study of nursing directors provides an example in which ‘value-for-money’ conflicted with the value placed on delivering quality care, a conflict resolved by compromising clinical effectiveness. This conflict reflected differences between the values of managers focussed on cost effectiveness and those of clinical staff focussed on client outcomes (Carney, 2006).

### 2.5.2 Safety cultures and blaming cultures

While some organisational cultures value safety and wellbeing, a more ‘traditional’ managerial mindset is a culture of blame in which safety and health problems are seen as failures of employees who do not follow correct procedure or act competently. A
culture based on a “bad apple” (Attree & Newbold, 2009) or ‘unsafe worker’ attitude (Bluff, 2011, p.13) emphasises “naming, blaming, shaming, retraining, and possibly dismissing individuals” (Bluff, 2011, p.146).

A blaming culture has been documented in numerous occupational health and safety studies in different industries. For example, Bluff’s (2010) study of Australian firms producing workplace machinery plants found 55% of managers believed workers were primarily to blame for accidents and safety incidents. This attitude is also convincingly documented in Safework Australia’s (2010) survey of workers from the five highest occupational risk industries - agriculture, forestry and fishing, construction, health and community services, manufacturing, and transport and storage. The most commonly cited cause of workplace injury or illness was ‘being careless’ (41%), a consistent finding over the 15 years the survey has run.

As Bluff (2010) notes, the unsafe worker attitude justifies ignoring health and safety strategies by implying that workers will continue to place themselves in danger despite such strategies, and discourages managers and operational employees from accurately assessing risks or reporting incidents (Attree & Newbold, 2009).

2.5.3 Sector, professional and individual values in organisational culture

Organisational values are not consciously and uniformly set by managers but evolve from a mix of different stakeholders’ values. Thompson, Stradling, Murphy and O’Neill (1996) describe several such sources: sector values such as those of the mental health sector; professional values, such as those instilled by training in counselling, social work or psychology, or formalised in a profession’s ethical code; and the individual values of each employee, particularly more influential organisational members.

Sector or professional values may include valuing or tolerating overwork as an essential, admirable or productive practice. A number of authors suggest human service organisations often assume work should be stressful (MacBride, 1983; Maslach & Goldberg, 1998; Maslach, 1982), despite strong evidence that chronic stress leads to burnout (e.g., Schaufeli & Janzur, 1994) and reduces productivity (Schaufeli, Maslach, & Marek, 1993). However, this assumption has not yet been empirically verified, and is addressed in the present study.
Employees’ *individual values* are also strongly related to burnout. Siebert and Siebert (2007) draw on Role Identity Theory to suggest that people in the helping professions tend to hold a distinct set of values and beliefs based on an idealised conception of a 'helper' who is needed, appreciated and otherwise selfless. This role-identity is reinforced when clients look up to the practitioner as an epitome of wisdom, knowledge and altruism (Siebert & Siebert, 2007). Lyall (1989) goes further in suggesting that people who enter the helping professions to do good may take such pride in their emotional and physical exhaustion that they forget or dismiss the need for strategies to prevent burnout: “When the tasks that need to be done, or could be done, are without limit, the temptation to keep increasing the workload and pace is virtually irresistible” (p.31).

Maslach and Goldberg (1998) relate such attitudes not only to individuals but also to a culture perpetuated within the helping professions. Professional groups inadvertently reward placing oneself at high risk of burnout by reinforcing a very tempting image of the professional worker:

> “The norms for these types of caregiving, teaching, and service occupations are clear, if not always stated explicitly: to be selfless and put others’ needs first; to work long hours and do whatever it takes to help a client, or patient, or student; to go the extra mile and to give one’s all.” (Maslach & Goldberg, 1998, p.63)

These values can be seen in virtually any health-related organisation where colleagues are praised for being exceptionally dedicated. Valuing overwork as virtuous discourages self-care practices and encourages working to the point of burnout (MacBride 1983; see also Section 2.8.1).

In summary, while the organisational culture literature suggests many organisations have cultures that overlook safety and wellbeing and blame individuals for transgressions, studies of human service professions suggest both individuals and professional groups tend to hold values that idealise professional workers and therefore also encourage overwork, stress and burnout. The influence of these multiple sources of values is investigated empirically in the present study.
2.5.4 Organisational climate

While organisational culture reflects enduring values, an organisation also has a changing climate reflecting employees’ shared perception of its current functioning, a ‘snap-shot’ of its mood (Bluff, 2011; Schneider, Ehrhart, & Macey, 2013; Schneider & Reichers, 1983). Climates in public service organisations in the mental health sector are presently particularly subject to substantial financial and resource pressures. For example, a recent United Kingdom Public Sector report on quality of work-life (Worrall & Cooper, 2012), estimated 46% of managers believed their department to be in decline, and 82% reported cost reduction as the leading reason for change. This climate coincided with a reduction in wellbeing and reduced tolerance to colleagues taking sick leave. There was also a marked increase in “presenteeism”, with 43% of managers reporting a culture of not taking sick-leave when unwell, up from 32% in 2007.

More than culture, organisational climate is based directly on collective emotions or mood that change quickly over time compared to values. Emotions are also ‘contagious’, with employees taking on colleagues’ feelings since empathic responses underpin social relationships (Barsade, 2002). One of the first studies to link climate to burnout is González-Morales, Peiró, Rodriguez, and Bliese’s (2011) survey showing Spanish teachers were more likely to report burnout symptoms when they also saw such symptoms in colleagues. This suggests organisational climate has a strong emotional component, corroborating other studies showing workplace emotions as highly contagious (Bakker, Schaufeli, Sixma & Bosveld, 2001; Bakker, Westman, & Schaufeli, 2007; Barsade, 2002).

2.6 Professionals’ beliefs and perceptions about self-care and social support

The review above suggests burnout is the outcome of a complex mix of both personal factors such as personality and demographic factors (2.3) and organisational factors including overwork and excessive job demands, poor job design or worker-job mismatch, and cultures or climates that encourage ‘blaming the victim’ and discourage self-care (2.4 & 2.5). The latter studies highlight managers’ responsibility for providing healthy work conditions and organisational cultures (Lee & Ashforth, 1996; Grosch & Olsen, 1994; Hu, Fix, Hevelone, Lipsitz, Greenberg, Weissman & Shapiro, 2012; Lee & Ashforth, 1996; Lyall, 1989; MacBride, 1983; Maslach & Goldberg, 1998; Maslach,
1982; Patrick, 1984; Putnik, de Jong, & Verdonk, 2011; Schulze & Roessler, 2007; Siebert & Siebert, 2007). However, professionals’ attitudes toward self-care and social support also need to be addressed.

2.6.1 Self-care

Practitioner self-care is the most commonly recommended burnout prevention strategy. Although it is widely accepted that self-care helps prevent burnout (e.g., Barnett, Baker, Elman & Schoener, 2007; Pines & Maslach, 1978; Schwebel & Coster, 1998) it appears only one study has directly examined its influence. Miner (2010) found a significant negative correlation between self-care practices and burnout in her study of mental health professionals. Strategies for dealing with stress such as mindfulness-based stress reduction (MBSR) techniques have received empirical support in other contexts (Irving & Dobkin, 2009; Kabat-Zinn, 2003) and appear relevant to burnout. However, more research into the efficacy of self-care is required.

Self-care has been described as comprising self-awareness, self-regulation and balance (Baker, 2003). Self-awareness involves taking time to observe how one is behaving and responding to clients and their problems. This helps a professional avoid acting out unconscious and unresolved conflicts, which may harm clients and reduce self-efficacy. Self-regulation refers to managing one’s impulses, anxieties and energy through such practices as exercise and relaxation, and helps the professional regulate his or her mood to avoid becoming overwhelmed. Balance is achieved by ensuring an equal emphasis on self and others, mind and body, and work and play (Baker, 2003).

Self-care practices include maintaining clear boundaries between work and home, restorative leisure activities, building strong relationships outside work (Maslach, 1982), developing and using stress management skills (Higgins, 1986), and becoming aware of one’s capacity and limits of responsibility as a professional (Friedman, 1985). Figley (2002) suggests two coping actions for reducing the stress of responding to a client in distress. First, establishing a sense of achievement for one’s services while recognising the limits of one's responsibilities lets the practitioner experience the rewards of the work without becoming over-involved. Second, disengagement can help lower stress as it "demands a conscious, rational effort to recognise that she or he must ‘let go’ of the thoughts, feelings, and sensations associated with the sessions with the
client in order to live their own life" (Figley, 2002, p.1438). Making a conscious decision to disengage is vital to protecting oneself from the costs of emotional work.

Self-care is widely discussed in the burnout literature (Norcross, 2000). In the collective wisdom of experienced mental health practitioners, self-care is integral to wellbeing (e.g., Orlinsky & Rønnestad, 2005). Despite this, self-care strategies are often not used by professionals or supported by managers (Barnett & Hillard, 2001; Leiter, Jackson, & Shaunessy, 2009). Broader workplace interventions, such as employee assistance programmes offering individual counselling, are also poorly used. Paradoxically, mental health professionals avoid seeking the same services they offer (Barnett & Hillard, 2001; Laliotis & Grayson, 1985).

Again, the need to change practitioners’ beliefs and perceptions is highlighted. Self-care training (e.g., Christopher, Christopher, Dunnagan, & Schure’s 2006) is one possibility, but overall the literature suggests educators, managers and mental health practitioners themselves often assume practitioners have self-care skills they do not actually possess. While they may be skilled at fostering self-care in others, their professional role identity, along with organisational cultures, management practices and colleagues attitudes present barriers. This paradox underlies the main research question of this study.

2.6.2 Social support

Support from colleagues and supervisors is known to significantly ‘buffer’ individuals from burnout (Afshin, Reza, Reza, & Iraj, 2012; Snyder, 2009). Snyder (2009) found empathic support – the expression of care and concern from colleagues - improved caregivers’ responsiveness to clients, and when combined with informational support such as advice on dealing with job demands, buffered professional staff from the effects of burnout. Other studies show supervisor support reduces depersonalisation and encourages professionals to form better client relationships (Ray & Miller, 1991; Snyder, 2009).

Many other studies confirm the importance of social support in managing occupational stress (Beehr, Farmer, Glazer, Gudanowski, & Nair, 2003; Halbesleben, 2006; Kahn, Schneider, Jenkins-Henkelman, & Moyle, 2006; Keller & Cacioppe, 2001; Vermeulen
& Mustard, 2000). For example, Afshin, Reza, Reza & Iraj, (2012) found perceived social support from supervisors or colleagues reduced the likelihood of stress leading to burnout in a manufacturing company. Staff with higher perceived support from supervisors were less emotionally exhausted.

Despite such benefits, in reality colleagues and supervisors do not always provide support to a burning out worker. Many possible explanations are investigated in this study. Some studies suggest workers often detect early warning signs in a colleague but may be unaware of their seriousness until the person takes sick leave (Ekstedt & Fagerberg, 2005; Shinko, 2011). For example, Ericson-Lidman and Strandberg (2007) interviewed medical and nursing staff who had worked with a burnt-out colleague. While in hindsight interviewees could recall signs of stress, such as attitudes of excessive self-sacrifice, struggling to achieve unattainable goals, social isolation or a sense of ‘falling apart’, these were not connected to burnout. Many of the reported symptoms came from behaviours encouraged in health sector culture, and were therefore likely to be ignored.

Even when professionals do perceive burnout in a colleague other obstacles may prevent an offer of support. For example, in a survey of licensed psychologists very few were willing to intervene when a colleague was not adequately performing his or her professional role (Wood, Klein, Cross, Lammers, & Elliott, 1985). There are many reasons for this: practitioners may doubt their judgement of the colleague’s state, may be reluctant to question another’s professional judgement or may fear repercussions or resentment (VandenBos & Duthie 1986).

The present study provides empirical evidence on the issues professionals face in offering support to burning-out colleagues. Further explanations for their failure to offer support are found in the common perceptual biases discussed in Section 2.10.

2.7 The social stigma of burnout

A key factor affecting professionals’ response to burnout in themselves or colleagues is likely to be its social stigma (Grosch & Olsen, 1994; Hu et al., 2012; Lyall, 1989; MacBride, 1983; Maslach & Goldberg, 1998; Maslach, 1982; Patrick, 1984; Putnik, de Jong & Verdonk, 2011; Schulze & Roessler, 2007; Siebert & Siebert, 2007). People who
burn out may be seen as “weak wimps who aren’t tough enough to handle something so trivial” (Maslach & Goldberg, 1998, p.69), or faking symptoms to avoid responsibility for their incompetence (Patrick, 1984). Some may see the sufferer as a “workaholic”, to blame for their burnout and needing to change their behaviour (Grosch & Olsen, 1994; Roeski, 1986; Sussman, 1992).

The assumption that the person is at fault is judgmental and does not help to solve the problem of individual or organisational burnout. Social stigma encourages professionals to hide symptoms of burnout rather than seek practical assistance or social support (Putnik et al., 2011; Schulze & Roessler, 2007). The possibility of stigmatising attitudes in mental health professionals is examined in this study.

2.8 The perception of burnout in self and others: Attribution theory

It may be puzzling to an observer that mental health professionals can treat clients with knowledge and empathy but respond to burnout in themselves by minimising the risks and avoiding empathy or self-care, and equally puzzling that burning-out colleagues are met with blame and avoidance. While research has so far identified these attitudes, it has not yet explained the paradox of their prevalence in the mental health field.

This study examines a potential explanation involving distortions in professionals’ perceptions and beliefs. Much research in social psychology describes the perception of self and others as a process of attribution, in which an explanation for a person’s behaviour is constructed from an implicit ‘theory’ of his or her personality more than the observed facts. Attribution Theory research suggests people are often self-deceptive in assessing their own competence, and correspondingly concerned to manage the impressions they give others. Many cognitive biases result from these attributional processes. The thesis of this study is that attributional distortions and biases cause otherwise highly trained and empathic professionals to misperceive their own symptoms and those of colleagues.

The sections below relate Attribution Theory to the perception of burnout in self and others, and consider the effects of stress and burnout on such perceptions. Attribution Theory stems from Fritz Heider’s seminal study of “naïve psychology”, the subconscious ‘theories’ of social behaviour people use to understand other people or to
compare themselves with others (Heider, 1944, 1958). Its modern form is much influenced by Jones and Davis’ (1965) and Kelley’s (1972) focus on the tendency to attribute others’ behaviour to either internal causes, such as disposition or personality, or external causes, such as work conditions.

Attribution theory attempts to explain how individuals make sense of interpersonal interactions when the complex and ambiguous sensory data is consistent with a variety of possible causes for a person’s behaviour. It developed from a more general perspective on human perception of the physical world, in which we unconsciously construct perceptual images from fragmentary cues. Unlike the photograph created by a camera lens, when humans perceive the physical world the sensory data is often incomplete or uncertain and must be processed using inferences drawn from past experience. At times this produces distortions, such as the many well-known optical illusions.

Attribution theory takes a similar approach to perception of the social world, in which perceivers construct explanations of behaviour based on assumptions about a person’s attitudes, beliefs, motives or traits, or about external forces such as pressure to conform to social or organisational norms (Malle, 2011). While we observe what people do, our interests depend more on why they behave this way and especially whether their intentions are positive or negative towards us. Since others’ motives are often hidden rather than present in the immediate sensory data we attribute motives to them. However, these attributions can be biased by the perceiver’s personality and other personal factors.

Attribution Theory is under-utilised in organisational research (Martinko, Harvey, & Dasborough, 2011). It has particular relevance to burnout as it proposes a fundamental human tendency towards attributing a person’s misfortunes to the kind of person they are rather than external factors. In individualistic Western cultures people tend to assume others’ behaviour is not random but has causes in their personality (Myers, Abell, Kolstad, & Sani, 2010), particularly when the behaviour is unusual. A new employee who is irritable towards a colleague may be judged as hostile, when in reality the behaviour may reflect stress from the demands of a new job, for example. This perceptual error is known as the fundamental attribution error (Heider, 1958; Weary, 2000) or ‘correspondence bias’ (Gilbert & Malone, 1995). It reflects a tendency to
ignore possible external causes of a person’s behaviour and construct internal attributions because these make people seem more predictable (Jones & Harris, 1967). Even when the evidence for external causes is obvious, behaviour is still often attributed to a person’s traits or disposition (Heider, 1944; Kelley, 1972).

Attribution Theory suggests a professional seeing a colleague become increasingly erratic and incompetent under a very demanding caseload is likely to attribute this to a trait such as ‘inability to cope with stress’ or ‘incompetence’. This is a perceptual ‘error’ because the causal inference is based not on a realistic interpretation of relevant data but a stereotypical image in which “true professionals” do not succumb to work pressure. Such errors are made by people of all levels of social and emotional intelligence. Indeed, more socially engaged and competent persons may be more likely to make attribution errors (Block & Funder, 1986).

2.8.1 The attribution of self-blame

Attribution theory also explains how individuals make sense of events in their own lives (Shaver & Drown, 1986). For example studies of responses to adverse events suggest people tend to make attribution errors in asking “why did this happen to me?”. Victims of illness or crime often blame themselves when the cause is actually beyond their control. This can involve a torturous process of self-questioning culminating in detachment or depression:

“Did I produce this instance of personal suffering or victimization? Could I have done something to avoid it? Regardless of my specific actions, should I be held morally accountable for the occurrence? I would like to think that I didn't intend to become a victim, but is that really true? Questions about self-causality and self-responsibility can be answered with a certain degree of detachment; judgments of self-blame may carry the affective connotations that can lead to depression.” (Shaver & Drown 1986 p.701)

Much evidence suggests self-blame leads to poorer adjustment after traumatic events or illness (Anderson, Miller, Riger, Dill, & Sedikides, 1994; Frazier, 1990; Miller, Handley, Markman, & Miller, 2010). In burnout, a tendency to continuously question
oneself can lead a person to work even harder to compensate for doubts, producing a ‘vicious circle’ based on mistaken perceptions and beliefs.

Self-blame can be characterological, where one’s character is seen as ‘weak’, or behavioural, where one’s past behaviour (e.g. taking on overtime) is seen as ‘wrong’ (Janoff-Bulman, 1979). Both are forms of self-stigma that reduce self-esteem and discourage disclosing the problem, like the stigma derived from others.

Maslach and Pines (1977) found self-stigmatising in burning out child-care workers lead them to keep their symptoms to themselves. Sufferers were therefore unaware that colleagues also experienced emotional depletion, and interpreted their own feelings as a sign of something wrong with them or that they were “bad people” (p.112). This “pluralist ignorance” (Breed & Ktsanes, 1961, p.383) further reinforces the avoidance of support or remedy. Maslach and Pines found those who did share their personal feelings with others had lower levels of burnout, suggesting organisations should develop peer-support mechanisms to counter self-blame.

### 2.8.2 Attributions that stigmatise others

Negative responses to people with mental health difficulties such as burnout may involve attributions similar to those found in studies of stigmatised groups in the population. Social cognition theory views stigma as an image or stereotype derived from biased perceptions of encounters with the stigmatised group (Corrigan et al., 2000).

A number of studies show that emotional and psychological illnesses are more likely to be met with stigma and discrimination than physical illnesses (Corrigan & Penn, 1999; Corrigan et al., 2000; Dijker & Koomen, 2003; Monteith & Pettit, 2011). For example, Weiner, Perry & Magnusson (1988) asked university students to rate groups of people with disabilities on two constructs: controllability, the degree to which a person is responsible for his or her disability, and stability, the extent to which the disability might improve over time. Persons with physical disabilities were considered less responsible for their condition and more deserving of pity or help than those with mental disabilities, which were seen as more controllable. Participants assumed mental
conditions were less likely to improve over time, and consequently felt less pity and more anger towards such persons.

Such studies suggest burnout sufferers may also face perceptions of their condition as a less serious health problem for which they can be held responsible. However, the evidence that burnout is stigmatised is so far anecdotal and has not yet been empirically investigated. This study looks for evidence of stigmatising perceptions and beliefs about why a person burns out and how it can be prevented in mental health professionals.

2.9 Self assessment and self deception

Sometimes mental health professionals who suffer burnout can, despite their training, fail to recognise it within themselves (Putnik et al., 2011). Studies of self-assessment suggest that individuals are often poor judges of their own competence (Ames & Kammrath, 2004; Davis, Mazmanian, Fordis, Van Harrison, Thorpe & Perrier, 2006; Mathieson, Barnfield, & Beaumont, 2010). For example, Dunning and colleagues (Dunning, Johnson, Ehrlinger, & Kruger, 2003) find people tend to assess their competence on the basis of preconceived beliefs rather than the evidence in front of them. A practitioner who believes “I am good at listening and empathising” (Ames & Kammrath, 2004) may use this as a reason to ignore information suggesting otherwise when under stress. A person’s self-beliefs therefore become an obstacle to accurately assessing their functioning in the present moment. Indeed Dunning et al. (2003) suggest individuals are often “blissfully unaware” (p. 83) of their incompetence or deficiencies.

To demonstrate this point, Ehrlinger, Johnson, Banner, Dunning and Kruger (2008) investigated the self-assessment of competence by asking undergraduate psychology students who had just completed an exam to rate their level of mastery over the course content and how they believed they scored. They found those with the worst performance tended to have the most inaccurate and over-confident self-assessments, while the most competent students tended to underestimate their competence. The former lacked the perceptual skills needed to recognise their incompetence. A similar perceptual deficit might explain the misperception of burnout symptoms and the avoidance of self-care in professional workers with good professional skills.
2.9.1 Impression management

Another way of understanding bias in self-assessment is found in impression management theory, which describes the tendency to ‘strategically’ manage how others perceive us by actively attempting to create the desired impression (Leary, Tchividijian, & Kraxberger, 1994; Swann, 2007). For example, people may behave differently in the presence of work colleagues or family members to meet their different expectations of desirable behaviour. Impression management is relevant to burnout prevention because it suggests sufferer will hide their symptoms when burnout does not fit the expectations of colleagues, managers or the wider community that mental health professionals will be healthy and well-functioning.

Impression management is closely related to self-deception (von Hippel & Trivers, 2011), since both involve misleading others and ourselves to appear more strong, competent or calm, for example, than we really are. We attend to information confirming our desired self-image and discount conflicting information, usually without conscious thought (Paulhus, 2007). We may ‘know’ much of the evidence available to an external observer but avoid conscious attention to it. A professional clearly suffering from burnout may deceive him or herself about this to preserve the self-image of a competent helper, and may react angrily if a colleague seeks to discuss the impairment. As Paulhus (2007, p.802) puts it, “people want accurate information about their world and its complexity; at the same time, they need to defend against information that would destroy the ideas that their lives are built on”. Paulhus considers self-deception has an evolutionary purpose in increasing self-confidence and social advancement by defending against unwelcome evidence of one’s failings.

2.9.2 Self-serving bias

Besides the general processes identified in theories of attribution, self-assessment and impression management describe above, many specific cognitive biases have been shown to affect perceptions of self and others (Reason, 1990, p.86). Two that are relevant to perceptions of burnout are self-serving bias and optimism bias. The self-serving bias (Miller & Ross, 1975) leads people to attribute negative events to external causes while taking personal (internal) responsibility for successes, in order to increase self-esteem. For example, if a psychologist’s clients start to quit treatment prematurely
he or she may attribute this to the client’s lack of commitment rather than examining his or her own functioning. Yagil and Ben-Zur (2009) investigated the self-serving attributions of service professionals such as customer service officers, librarians and hospitality staff. They found respondents were more likely to attribute customers’ negative behaviours to external causes in the organisation or the customer than to identify personal causes in their service provision. This protective response creates negative attitudes towards the organisation and its customers. During burnout, self-serving bias can cause a professional to dismiss the warning signs and focus on external causes, ultimately leading to cynicism or negative behaviours towards others.

2.9.3 Optimism bias

Optimism bias (McKennna, Warburton, & Winwood, 1993, p.39; Weinstein, 1984, p.431) can prevent professionals from taking small initial signs of burnout seriously due to a belief that “it won't happen to me”. Seeing oneself as less at risk than ‘normal people’ improves self-esteem in the short-term. Optimism bias has been used to explain many risky health-related behaviours. For example, McKenna, Warburton and Winwood (1993) found smokers consistently underestimated their risk of developing smoking related illnesses by adopting an “it won’t happen to me” attitude. Clarke, Lovegrove, Williams and Macpherson (2000) found women aged 50 to 70 were unrealistically optimistic about the risk of breast cancer, even though they knew they were in the ‘at-risk’ age group. “It won’t happen to me” is widely used to justify avoid preventative behaviours such as quitting smoking or having a mammogram.

This tendency is reinforced by each experience of successfully avoiding a hazard (Weinstein, 1989). For example, speeding without being caught by police or having an accident helps deny the belief that speeding is risky. Similarly, when overworking professionals do not see any health consequences the belief that they are immune to burnout is reinforced.

2.9.4 Cognitive functioning under stress

Stress is known to decrease cognitive functioning (Janis, 1982) and therefore leads to errors in evaluating evidence about one’s wellbeing. It also reduces self-esteem, providing further motivation for the biases and defensive cognitions discussed above.
Burnout is known to reduce a mental health professional’s competence (Cropanzano, Rupp, & Byrne, 2003; Glendon, 2006; Oosterholt, Van der Linden, Maes, Verbraak, & Kompier, 2012), and it appears reasonable to assume that this includes the metacognitive skills of self-assessment. Stress itself therefore creates a significant barrier to the early detection and prevention of burnout.

The physiological response to stress includes physical and mental preparations for ‘fight or flight’ responses that reduce cognitive functioning when continually triggered (Deligkaris, Panagopoulou, Montgomery, & Masoura, 2014). A burning-out person may experience loss of concentration, making more mistakes, difficulty in making simple decisions, increased forgetfulness, loss of perspective and poor judgement (Glendon, 2006; Oosterholt et al., 2012; Osterberg, Karlson, Malmberg, & Hansen, 2012). While this cognitive decline is reversed in recovery (Osterberg et al., 2012) it can have significant effects on decision-making (Janis, & Mann, 1977). Stress reduces a person’s ability to see and assess alternative solutions to a problem, causing “premature closure” where judgement is narrowed and long-term or broader consequences are overlooked (Janis, 1982, p.70).

2.10 Summary

The perception of burnout in self or others can be influenced by a desire to increase self-esteem though refining one’s self-image to exaggerate socially desirable qualities or deny undesirable ones. Self-blame, stigmatising of others or self, inflated assessment of one’s professional competence, self-serving attributions and denial of risk all involve misattributing the causes of stress and help justify avoiding healthy responses to it. Attribution Theory and social cognition studies more generally suggest these biases and perceptual distortions are widespread, and a growing number of studies identify their effects in professional employees including mental health workers. Stress by itself also reduces a worker’s ability to accurately judge his or her wellbeing, and is likely to threaten a professional’s self-esteem.

These studies may explain the paradox of mental health professionals’ difficulty in recognising and responding to personal symptoms of burnout while being able to recognise and treat it in others.
2.11 Chapter summary

This review has examined the origins of burnout research and current theories of its causes in both individual factors such as personality and organisational factors such as poor job design, high job demands, socio-emotional contagion or organisational culture or climate. While these issues are well recognised in the literature, evidence of persistently high rates of burnout amongst mental health professionals (Chapter 1) presents a puzzle: why do professionals trained in care and empathy for clients downplay their own symptoms to the point where they become seriously unwell, and why do they ignore symptoms in colleagues unable to see their own condition?

One answer is suggested in the widespread view of burnout as a ‘dispositional’ condition: perhaps some mental health professionals’ individual characteristics make them prone to burnout. This view appears to be common amongst professionals and their managers in many fields, including health generally. It can also explain professionals’ reluctance to help colleagues, by implying they are inherently weak persons or failing to uphold professional standards of self-care.

A second answer attributes burnout to working conditions in mental health organisations. Much evidence shows high levels of stress from work overload and high job demands, inadequate resources, poor job design, mismatch between the person and the job, the additional stresses of working with stressed or burnt out colleagues, organisational cultures that normalise high stress levels and ‘blaming the victim’ in health and safety problems, and organisational climates that spread negative emotions in response to pressures such as cost ‘blow-outs’ or organisational change. There is also the social stigma attached to mental health conditions in and out of the workplace. These external factors are also used by professional workers to explain burnout in themselves or colleagues, and by managers to explain burnout in subordinates. Burnout can appear an almost inevitable side-effect of the management and social environment of modern mental health work.

There is evidence to support both the internal and external explanations, although more studies focus on environmental causes and few attempt to incorporate both beyond suggesting the causes of burnout are complex. Of primary interest here is whether professionals or managers attribute burnout to the worker – to personal factors in
themselves or a colleague - or to the environment, and how these attributions influence their willingness to address the problem sympathetically or avoid it.

Attribution Theory offers a useful way of understanding this. It predicts perceptions and beliefs about burnout are frequently part of a defensive strategy to increase self-esteem and project (or introject) a self-image of professionalism. This can involve attributing personal symptoms to environmental causes, or symptoms in a colleague or subordinate to their personal problems.

Studies of burnout point to a professional’s role-identity as an important influence on this. It appears professionals in many fields may have unrealistic expectations of their ability to work long hours, to avoid stress and health problems experienced by other professionals, and their ability to self-monitor or self-correct. This study aims to provide a more systematic and empirically grounded explanation of the effects of such perceptions and beliefs on responses to burnout in mental health professionals.

2.11.1 Research framework

The questions raised by this review fall into three categories concerning people who burn out, the risks of burnout and how to prevent it. Seven specific research questions were identified:

1. What do mental health professionals believe about why people burn out?
   • What do mental health professionals understand about burnout and its causes?
   • Do mental health professionals discuss burnout with their colleagues?

2. How do mental health professionals see the risks of burnout?
   • Is burnout seen as a real occupational hazard in their workplace?
   • Do mental health professionals see burnout as avoidable or inevitable?

3. How do individuals and organisations encourage or discourage preventative strategies?
   • How does burnout affect professionals psychologically?
   • What barriers to avoiding burnout do mental health professionals perceive?
   • What personal and organisational strategies could reduce burnout?
Answers to these questions can contribute to the burnout literature by showing how mental health professional’s beliefs and perceptions influence responses to symptoms of extreme stress in themselves and colleagues. This study explores these issues through open-ended interview and questionnaire items about internal and external causes of burnout and their effect on participants’ or colleagues’ responses to it.

Mental health work provides an interesting case where high rates of burnout are found amongst workers with considerable professional knowledge of stress and its treatment, a paradox that invites consideration of how perceptual factors and belief systems can discourage workers from acting on knowledge they clearly have. This perspective suggests burnout cannot be addressed effectively by improving professionals’ (or managers’) knowledge or skills alone, but requires an internal reframing of their professional identity or role, and how it relates to self-esteem and ultimately health. Interventions that overlook the ‘intervening variables’ may have much less impact than those that address them.
CHAPTER 3: METHOD

This study takes a qualitative, phenomenological approach in investigating mental health practitioners’ perceptions and beliefs by trying to understand participants’ worlds through their own words rather than categories determined by the researcher. The questionnaire and interviews described below address the research questions raised in Chapter 2 primarily by asking participants to describe their views and experiences in a relatively unstructured way. This chapter details the rationale for this approach and the procedures used to recruit participants, collect data and draw conclusions.

3.1 Design: Strategy and framework

A qualitative methodology is more appropriate to understanding participants’ subjective worlds than quantitative methods, which tend to confine responses to the experimenter’s framework (Flick, 2006). Qualitative methods allow deeper study of the individual meanings people give to phenomena as they experience them, helping to better understand their different perspectives and influences of their life context (Yin, 2011). They provide a more personal and nuanced insight into participants’ experience.

Moustakas (1994) identifies the elements common to qualitative frameworks shown in Table 1.

Table 1: Common elements of qualitative research (Moustakas, 1994, p. 26)

<table>
<thead>
<tr>
<th>Common elements of all qualitative frameworks</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Searching for meanings and essences of experience rather than measurements and explanations</td>
</tr>
<tr>
<td>• Obtaining descriptions of experience through first-person accounts in informal and formal conversations and interviews</td>
</tr>
<tr>
<td>• Regarding the data of experience as imperative in understanding human behavior and as evidence for scientific investigations</td>
</tr>
<tr>
<td>• Formulating questions and problems that reflect the interest, involvement, and personal commitment of the researcher</td>
</tr>
<tr>
<td>• Viewing experience and behaviour as an integrated and inseparable relationship of subject and object and of parts and whole</td>
</tr>
</tbody>
</table>
Qualitative research generally begins with open-ended questions rather than a predetermined hypothesis or theory (Carter & Little, 2007), to avoid distorting or misrepresenting participants’ actual perceptions or behaviour as much as possible (Van Kaam, 1966, cited in Moustakas, 1994). However, qualitative methods do not simply describe a phenomenon as the data are usually analysed and reported in relation to existing theories.

A common criticism of qualitative methods is that data analysis and reporting is vulnerable to the researcher’s preconceived ideas, values and assumptions, since the researcher ultimately decides what is attended to, what it might mean and how to present the findings. Yin (2011, p. 11) contrasts emic and etic perspectives on this issue. The emic perspective focuses on participants’ personal meanings or interpretations of events, while the etic research focuses on the researcher’s interpretations and meanings. Good qualitative research is usually emic, but also addresses the etic by seeking to understand how the researcher’s values and prior experience influence the choice and use of research methods or data. It is not possible to remove all subjective influences, but steps can be taken to reduce them and make interpretations of participants’ experience more valid.

Therefore in eliciting participants’ ways of thinking about burnout from their own words it is important to take into account their organisational, professional and life contexts as well as those of the researcher.

3.2 Phenomenological approaches to qualitative research

The phenomenological approach to this study reflects the aim of representing participants’ perceptions and beliefs as they themselves describe them, to the extent possible. Phenomenology is the study of “consciousness from the first person perspective” (Woodruff-Smith, 2007, p. 233). It seeks to “richly describe the lived examples and experiences of the phenomena within the context of the participants’ lives” (Giorgi & Giorgi, 2003, p. 27) and interprets these to achieve an understanding of human beings in specific contexts such as the workplace.

Phenomenology has grown through two major traditions, descriptive and hermeneutic. The modern movement began in the early 1900s when the philosopher Husserl moved
away from the traditional scientific positivist focus on ‘objects’ towards describing how objects appear in a perceiver’s consciousness (Woodruff-Smith, 2007). In Husserl’s descriptive phenomenology, the methodology of natural science is unsuitable for problems concerning human nature. Rather he sought to reach the essence of human problems through a careful description of conscious experience (Walters, 1995), using subjective data exactly as presented and attempting to “bracket” out or disengage from the researcher’s prior knowledge of the phenomenon (Giorgi & Giorgi, 2003, p. 32) when collecting or interpreting data. Husserl saw his version of phenomenology as pre-theoretical, taking things “as they are” (Laverty, 2003, p. 6).

Husserl’s colleague Heidegger developed hermeneutic phenomenology as an alternative approach in which it is impossible to approach the essence of lived experience without taking into account the researcher’s context and presuppositions (Sembera, 2008). Therefore, phenomenology cannot be truly pre-theoretical, as Husserl suggests, since the researcher’s theoretical assumptions are always present when interpreting data. Heidegger’s criticism derived from his view that consciousness itself is a ‘theoretical’ concept.

I tend to agree with Heidegger’s view of the impossibility of setting aside one’s knowledge and experiences. While I attempted to bracket my knowledge of psychology and the burnout literature in seeking participants’ accounts with an openness to new knowledge and ways of thinking, this goal cannot be fully realised. Participants were viewed as experts in the field of burnout, each with unique views and experiences, but my own experiences and knowledge were necessarily used in making meaning from the data.

Beyond this, the phenomenological approach here is based less on a particular philosophy than on the need to learn about mental health professionals’ subjective beliefs and perceptions concerning burnout, to ‘understand’ (Sembera, 2008, p. 36), as far as possible, the phenomenon through participants’ words. As argued in Chapter 2, this perspective forms a useful base for addressing prevention of burnout in mental health and other professionals.

Another advantage of qualitative research generally is its openness to ambiguity. Parker (2004) discusses the value of “discontinuity” (p.148) in qualitative data, where
ambiguous and sometimes contradictory findings can restrict attempts to overly simplify the phenomenon studied. Parker suggests resisting the temptation to tie all the pieces together in a generalised explanation. While qualitative research seeks the essence of experience (Moustakas, 1994), this cannot be neatly packaged into one explanation covering the diversity of participants’ viewpoints. Discontinuity is seen as a strength since ambiguity and nuance provide the impetus for new investigations and understandings. The “reductionist” goal of a generalised explanation for complex findings defeats the emic purpose of qualitative research (Parker, 2004, p.148), and participants’ experiences may be more insightfully represented when conclusions adequately represent the “complex, rich, messy and ambiguous” nature of the data (Finlay, 2011, p. 9). For example, the findings below suggest individuals often have contradictory or ambiguous attitudes towards burnout in themselves or others.

3.3 Research methods

A phenomenological methodology attempts to capture informants’ viewpoints and experiences using their own words as much as possible. Accordingly, a primarily open-ended (qualitative) questionnaire was used to obtain participants’ beliefs and perceptions about burnout in themselves and colleagues. Fifty-five professionals in a variety of mental health fields completed the questionnaire, a large sample in qualitative research (e.g., Creswell, 1998, p.68; Mason, 2010; Ritchie, Lewis & Elam, 2003, p.84).

While interviews are often used in qualitative and phenomenological research, questionnaires have significant advantages in providing confidentiality and ease of administration (discussed below). To overcome the limitations of predetermined questions, semi-structured interviews were conducted with twelve questionnaire respondents to provide deeper exploration and elaboration of the questionnaire findings.

The data collection and analysis process is summarised in Figure 2.
**Questionnaires in Qualitative Research**

Questionnaires are a recognised tool in qualitative research (e.g., Fink 2003; Jansen 2010; Biggerstaff & Thompson 2008). Qualitative surveys differ from quantitative (statistical) surveys in using open-ended questions to identify “feelings, opinions and values of individuals” (Fink 2003) with a focus on depth of information and uniqueness (Fink 2003) or diversity (Jansen 2010) of responses. They use small samples since statistical generalisability is not the goal. This study used open-ended questions to reveal details of respondents’ thought processes. Asking them to respond to generalised statements in attitudinal rating scales or forced-choice items would not give sufficiently personal or subjective responses.

Phenomenological methodologies have previously been found suited to assessing the cognitions underlying participants’ health behaviours (Biggerstaff & Thompson 2008 p215; Kellett, Greenhalgh, Beail & Ridgway, 2010). They are particularly useful in inductive research, as participants’ perceptions or beliefs may differ from those ascribed to them by experts such as medical practitioners or academic researchers. Documenting the subjective perspective is now seen as an important development in health psychology research (eg Brocki & Wearden 2014 p88).

Interviews are often used in such studies, but questionnaires have important advantages in some contexts. A questionnaire is used here to provide anonymity, which an

---

**Figure 2: Steps in data collection and analysis**

- **Pilot Questionnaire**
  - 11 Participants
  - Questions informed by theory and research questions

- **Questionnaire**
  - 55 Participants
  - Questions refined from responses to pilot questionnaire

- **Semi-Structured Interviews**
  - 12 Participants
  - Questions derived from responses to questionnaire

- **Data Analysis**
  - Data from questionnaire and interviews analysed using thematic analysis
interview does not. Burnout is a sensitive topic as it affects a practitioner’s professional reputation, job performance, career prospects and self-esteem. Anonymity reduces concerns about disclosing information about one’s clinical practice (Siebert & Siebert, 2007), including the perception that the professional is suffering mental impairment or delivering substandard treatment. Qualitative questionnaires have also been found to provide more honest responses than interviews (Erickson & Kaplan, 2000). Anonymity also reduces the motivation to provide socially desirable answers, a common form of bias in surveys (Van de Mortel 2008), particularly with socially sensitive topics such as burnout.

Open-ended questionnaires are recommended by other researchers for eliciting more personal perspectives in terms of beliefs, experiences, ideas and attitudes (Arhar, Holly, & Kasten, 2001; Libarkin, Anderson, Beilfuss & Boone, 2005; Patten, 1998), producing a richer, more phenomenologically diversified data set (Reja, Lozar, Hlebec & Vehovar, 2003).

Questionnaires also have the practical advantage of accessing a broader sample with less time and cost than interviews, and are generally straightforward and unobtrusive to users (McLeod, 2003, p. 60).

Studies using qualitative questionnaires in health research include Erickson and Kaplan’s (2000) study of smoking behaviours, in which open-ended questionnaire responses were found to be more honest and insightful than interview responses, and Walker, Earl, Costa, & Cuddihy’s (2013) study of nursing graduates, the anonymity of the questionnaire eliciting some sensitive information about the experiences of bullying and workplace stress in the first year of nursing. Open-ended questions have been used in organisational research to elicit employee’s experiences and perceptions in their own words (e.g., Jackson & Trochim, 2002).

Open-ended questions suit the present study’s inductive goals since, as noted in Chapter 2, existing studies have given little attention to the subjective experience of burnout in work environments, particularly the thought patterns that might cause mental health practitioners to avoid recognising it. There is presently little empirical or theoretical basis for developing a quantitative questionnaire for deductive research on this topic.
A limitation of open-ended questions is in the depth of the data collected, since writing long answers by hand may bore or frustrate participants. The responses in this study showed considerable depth and writing did not appear to present a limitation. The interviews with a small sample of questionnaire respondents also confirmed the relevance and accuracy of the themes identified from the questionnaires.

A second limitation is that questionnaires provide no opportunity for participants to ask questions or clarify the requirements. To address this the questionnaire was pilot tested on ten individuals not used in the main study and subsequently refined (see 3.4.1).

*Interviews as a Complement to Questionnaires*

In quantitative research interviews are often used for inductive purposes, to gather information prior to the design of a survey instrument. In this study, *interviews* were used to follow-up on important or ambiguous findings of the questionnaire study, providing greater depth and clarity following Patton’s (2002) suggestion that research designs provide both breadth of sampling and sufficient depth to give a genuine understanding of the phenomenon.

The semi-structured interview format began with open-ended questions to stimulate a two-way conversation between interviewer and interviewee, and allowed sufficient flexibility to explain, probe more deeply or ask further questions. The semi-structured format allows a researcher to build rapport, leading to greater self-disclosure and fewer socially-desirable responses than more structured methods. Success in this relies largely on the interviewer’s skill in building rapport and eliciting detailed responses, which was facilitated here by the researcher’s training and experience as a psychologist and counsellor.

The interviews were not designed to identify new themes and in practice tended to confirm those identified from the questionnaire. Their primary use was in corroborating the survey findings and providing depth through additional background or contextual information. They provided some of the more detailed quotes used in Chapter 4 and the case examples presented in Chapter 5.
3.3.1 Population and sample

Purposive sampling is used to target a particular population using the researcher’s expert judgement (Given, 2008). A limitation of this is that another researcher may sample an entirely different section of the population. However, purposive sampling is considered appropriate if the population is small and confined to a limited geographical area or specific group where generalisation to a broader population is not the primary objective (Battaglia, 2008).

The sample in this study comprises Western Australian mental health professionals, a group who cannot be contacted randomly and were therefore sought through personal contacts and by approaching relevant organisations, followed by ‘snowballing’ in which participants were asked to pass questionnaires to other professionals who may be willing to participate (Morgan, 2008). This is therefore also a convenience sample.

The target population of this study is mental health professionals, an umbrella term here covering employees with tertiary qualifications in a discipline specialising in the psychological, psychosocial, psychiatric or emotional treatment of people suffering from psychological distress. The latter is an important characteristic of this sample as professionals working with clients in distress face demands that significantly increase the risk of burnout (Leiter & Harvie, 1996; Morse et al., 2012) due to the continual requirement for one-way emotional ‘giving’ (Cox & Leiter, 1992; Stovholt, Grier & Hanson, 2001).

Participants came from all fields represented in the Australian Mental Health Professionals’ Network, including psychologists, social workers, mental health nurses, occupational therapists, psychiatrists, General Practitioners, community mental health workers providing primary mental health care and counsellors (MHPN, 2012). The sample comprised professionals practicing in Western Australian organisations who met the occupational criteria below.

Mental Health Nurses

Mental health nurses have completed an undergraduate nursing degree and in some cases post-graduate studies in mental health. They must register with the relevant state nursing board apply to the Australian College of Mental Health Nurses (ACMHN) to
become a credentialed mental health nurse. In their day-to-day activities, mental health nurses work alongside psychiatrists in hospitals or community clinics, administering medication, providing emotional support and making behavioural observations of patients (ACMHN, 2012).

**Mental Health Occupational Therapists**

Occupational Therapists enable people to participate more fully in their daily activities. They work with individuals and groups in hospitals or the community, planning interventions to increase clients’ independence and teaching strategies for coping with mental health problems and improving self-confidence in social situations and other areas of difficulty (Occupational Therapy Association, 2012). Mental health occupational therapists have an undergraduate degree in occupational therapy and must register with the Occupational Therapy Board of Australia.

**Psychologists**

Psychologists are experts in human behaviour with undergraduate or postgraduate degrees covering neuroscience, memory, learning, human development and behaviour. They work with people experiencing emotional, behavioural or cognitive difficulties such as anxiety and depression. Psychologists tend to use scientifically-tested approaches to assess, diagnose, treat and prevent problems in individuals, families or other groups (Australian Psychological Society, 2012). Practicing psychologists must complete six years of training and register with the Psychology Board of Australia.

**Counsellors and Psychotherapists**

Counsellors and psychotherapists both work with individuals, couples and families on emotional problems. Counsellors use techniques that help clients to develop a clearer understanding of the problem and better deal with specific feelings, reactions and experiences. Psychotherapists perform the same functions but tend to have long-term goals such as reformation of personality or self (Psychotherapy and Counselling Federation of Australia, 2012). Most counsellors and psychotherapists hold an undergraduate degree in a related discipline, although there are no legal restrictions on identifying as a ‘counsellor’ or ‘psychotherapist’. Registration with PACFA requires 2 years of training and extensive clinical supervision.
**Social Workers**

Social workers work help individuals, families and other groups maximise wellbeing and social functioning by providing counselling, intervention, information and practical assistance. Their clients are typically distressed due to crises such as homelessness, parenting problems, poverty, grief, illness, relationship difficulties and domestic violence. Social workers must have a degree in social work and many jobs require membership of the Australian Association of Social Workers (AASW, 2012).

**Psychiatrists**

Psychiatrists have the undergraduate or postgraduate training of a medical doctor and additional training in emotional disorders and mental illness. They work in hospitals and in private clinics, diagnosing and treating people with difficulties such as schizophrenia, depression and panic disorder. Whilst some provide counselling or psychotherapy, they tend to treat mental illness with medications (Royal Australian and New Zealand College of Psychiatrists, 2012).

### 3.3.2 Recruitment of participants

Participants were recruited from six areas of mental health practice:

*Government Funded Community Agencies* include Women’s Health Centres, Men’s Health Centres, Sexual Assault Counselling Services, Child Protection Services, War Veterans Associations, Relationships and Family Services, Government Rehabilitation Services and Corrective Services.

*Psychiatric Hospital Wards* are publicly funded adult in-patient psychiatric wards, both locked and open.

*Private Practitioners and Private Agencies* include private organisations providing Employee Assistance Programmes, trauma debriefing, Personal Support Programme services and Job Capacity Account counselling services, as well as registered individual private practitioners offering a broad range of services.

*Older Adult Psychiatric Hospitals* provide services specifically for adults over 65 with psychiatric disorders.
Community Mental Health Clinics offer government-funded triage and inpatient services to patients with psychiatric disorders.

Educational Institutions including school psychologists, counsellors and student support staff as well as higher education counsellors working in universities or TAFE colleges.

Permission to contact public mental health services and ethics clearance was obtained from the WA Department of Health’s North Metropolitan Area Mental Health Services Unit.

As it was not possible to sample the six categories above proportionately, the final sample may reflect the perceptions and beliefs of some occupational groups more than others. However, it appears feasible to treat mental health professionals as a single category since strong variations in beliefs according to occupation are not expected. Results from different occupational groups could not be analysed separately due to the small sample size.

3.3.3 Questionnaire distribution

Recruiting a sample broadly representative of the target occupational groups was made difficult when, during the study design stage, the relevant Boards all handed registration authority to the National Registration Board of the Australian Health Practitioner Regulation Agency (AHPRA), which does not provide public contact information. Recruitment therefore involved three alternative methods:

1. Contact with management of appropriate organisations for permission to distribute questionnaires to staff. Three managers declined to participate and 25 agreed to distribute the questionnaires in staff meetings, with a brief explanation, or to email staff explaining the study and inviting them to collect the questionnaire from the reception desk. One hundred and fifty-five questionnaires were delivered to 28 supervisors. Many organisations received five to eight questionnaires, as they had only a small number of mental health professionals.

2. Posting questionnaires to private practitioners located from internet searches, directories or the researcher’s knowledge of mental health providers. Fifty questionnaires were distributed in this manner.
3. Five questionnaires were distributed to mental health professionals in the researcher’s personal network.

Interview participants were recruited via a form included with the questionnaire seeking contact details of those willing to be interviewed.

The response rate for the survey was 26%. Response rates in survey research are typically low (Cook, Dickinson, & Eccles, 2009; Glaser, 2008), and surveying health professionals involves particular difficulties including lack of time, office policies that prevent participation and concerns about confidentiality (VanGeest, Johnson, & Welch, 2007; Wiebe, Kaczorowski, & MacKay, 2012), which appears to be the case here. This is discussed as a limitation in Chapter 7.

3.4 Questionnaire survey

3.4.1 Development of the questionnaire

A questionnaire was drafted to address the research questions identified in the research framework developed from the literature review (2.11). The final version contained 21 questions covering demographics and perceptions or beliefs about the nature, risks and prevention of burnout (see Appendix A). The latter were all open-ended questions.

A draft was piloted with eight participants chosen for their professional experience, who provided written feedback regarding length, relevance, clarity and layout. Five also gave verbal feedback.

Following receiving feedback from the pilot participants, three experts on questionnaire design - the researcher’s two supervisors and an expert in qualitative research - then assessed each question for clarity, relevance and language. Responses from the experts and pilot study participants lead to modifications, including minor wording changes and the addition of tick boxes and scales as preliminaries to about half the open-ended questions. The latter were intended to stimulate more reflective and detailed responses to the open-ended questions (see 3.4.2), rather than to provide numerical data of interest in its own right, although a few summary statistics are reported in Chapter 4.
The redrafted questionnaire was then tested on three new participants, resulting in further minor changes.

The final questionnaire comprised four sections: (A) “Some information about you”, (B) “Questions regarding what you think about burnout”, (C) “Your experiences regarding burnout”, and (D) “Questions regarding the prevention of burnout”. Section A sought basic non-identifying demographic information including profession, years worked in the field, age and gender. Sections B, C and D contained primarily open-ended questions addressing the research questions in 2.11.

The questionnaire was distributed with a letter (Appendix B) explaining the background and rationale for the study, a reply-paid envelope, and a form requesting consent for the interview. As an incentive, participants returning the interview consent form were entered into a lottery for a relaxation massage voucher. These forms were removed from the return envelopes and stored separately to preserve respondents’ anonymity.

3.4.2 Scales and coded responses

The questionnaire was designed to gather subjective perceptions and beliefs using open questions such as “What is your understanding of professional burnout?”. The phenomenological approach of this study meant that where possible participants were given the freedom to express perceptions and beliefs about burnout or their own experiences in their own words rather than responding to prepared statements or closed questions. Responses were written in a box with room for several lines. Considerable attention was given to avoiding bias and ambiguity in question wording, for example by getting feedback from the three research experts and pilot sample.

While open-ended questions invite participants to explain their viewpoint in depth (Osgood, Suci, & Tannenbaum, 1957, p. 76), a drawback is the possibility of superficial responses. A qualitative methodology expert was consulted and as a result a two-stage procedure was adopted for eleven items to encourage deeper reflection in the open questions. Albaum et.al. (2007) found two-staged questions elicited more considered and truthful beliefs, perceptions and attitudes than single items. As Brace (2004) points out, spontaneous responses tend to elicit only what is “front-of-mind” (p.60), and can miss the truer essence of thoughts and beliefs. In the two-staged format a closed
question with a rating scale or forced-choice response is followed by an open-ended question with a text-box allowing respondents to elaborate (Figure 4). The closed questions had simple “yes” or “no” responses or rating scales as shown in Figure 3.

Question 14: How serious would the consequences be, for example on your health and employment, if you were to burn out?

   Extremely serious □  Serious □  Not very serious □  Not at all serious □
   Unlikely to happen □

Please comment on your answer.

Figure 3: A scale followed by open question, as part of a two-staged strategy for eliciting more in-depth responses.

A variation of the two-staged format used a graphic rating scale (Brace, 2004; Freyd, 1923; Paterson, 1922) for participants’ feelings of burnt-out and a text-box for written responses (Figure 4). Graphic rating scales are particularly suited when simplicity of responding is important, such as in subjective or reflective questions where verbal information can be distracting. They also give the questionnaire a more varied and interesting appearance.

Question 13: On a scale of 1 to 10 how would you rate your feelings of burnout over the past 2 weeks?

   No feeling of burnout  ❯  5  ❯  Strong feeling of burnout

Please comment on your answer.

Figure 4: Graphic rating scale with labelled midpoint
Around half the open-ended questions used these orienting devices: six had yes/no checkboxes, four had attitudinal checkboxes and one had a graphic rating scale. Responses to four attitudinal checkbox ‘scales’ were analysed and reported as frequencies in Chapter 4, but the others were not of interest in their own right.

### 3.4.3 Questionnaire structure

The questionnaire was divided into sections addressing the seven research questions as shown in Table 2.

Table 2: Questionnaire item numbers relating to specific research questions

<table>
<thead>
<tr>
<th>Research Questions</th>
<th>Questionnaire Item Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>What do mental health professionals understand about burnout and its causes?</td>
<td>5, 6, 7, 11, 13</td>
</tr>
<tr>
<td>Is burnout seen as a real occupational hazard in the workplace?</td>
<td>8, 9, 14, 16, 17</td>
</tr>
<tr>
<td>Do mental health professionals discuss burnout with their colleagues?</td>
<td>10, 11, 12</td>
</tr>
<tr>
<td>How does burnout affect professionals psychologically?</td>
<td>15</td>
</tr>
<tr>
<td>What strategies could professionals and managers use to reduce burnout and what barriers prevent the use of these?</td>
<td>17, 18, 19, 20</td>
</tr>
</tbody>
</table>

### 3.4.4 Analysis of questionnaire data

The questionnaire data were analysed with thematic analysis, a flexible process used by qualitative researchers to find patterns in large amounts of data (Braun & Clarke, 2006). Boyatzis (1998) describes thematic analysis as a “way of seeing” (p.4) that helps the researcher make sense of qualitative data by organising it in a meaningful way. Thematic analysis can take either an inductive or deductive approach. The
phenomenological framework of this study suggested the inductive approach of creating codes from the participants’ own words (Weisberg & Bowen, 1977).

Braun and Clarke’s (2006) phased approach to thematic analysis was used (Figure 5). First, responses were read through thoroughly and codes were developed from a sample of 20 questionnaires. The codes used participants’ words in order to lessen the possibility of the researcher ‘reading into’ responses. An example is “good relationship with manager”, “no one knew”, “loss of self-worth/self esteem” or “work is enjoyable”.

<table>
<thead>
<tr>
<th>The Phases of Thematic Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Familiarising yourself with your data</td>
</tr>
<tr>
<td>2. Generating initial codes</td>
</tr>
<tr>
<td>3. Searching for themes</td>
</tr>
<tr>
<td>4. Reviewing themes</td>
</tr>
<tr>
<td>5. Defining and naming themes</td>
</tr>
<tr>
<td>6. Producing the report</td>
</tr>
</tbody>
</table>

Figure 5: The phases of thematic analysis according to Braun and Clarke (2006)

Next, the reliability of the coding process was tested by the researcher’s two supervisors. Three randomly chosen questionnaires and the list of codes were given to each for coding, and these codes then compared to the researcher’s. There was high agreement between the two sets of codes, with only a few instances where the codes needed adjusting.

The large amount of qualitative data was managed with the qualitative data management tool NVivo 9. The open-ended responses were typed into NVivo 9 and each quote was coded into ‘nodes’ or themes. Next, the codes were grouped into themes in NVivo using terms such “organisational”, “prevention”, “stigma” “discussion about burnout”. Some themes also reflected theories relating to perceptions of risk, self-identity and attributions identified in the literature review.

A qualitative summary of the responses was made by integrating quotes for each code into ‘nodes’ in NVivo 9. The same was later done with the interview data (which was analysed separately), categorised under the same nodes, to create an overview.
The most significant themes, according to their relevance to the research questions, or commonly occurring themes were reported in the results. Where themes and codes occurred frequently the number of respondents is reported in Chapter 4. These frequencies refer to the proportion of the sample of 55. The frequencies refer only to questionnaire responses (not interviews) and represent the proportion of respondents (not responses), quantifying the relative emphasis of each theme within the sample.

Frequencies are widely recommended for both inductive and deductive purposes in qualitative research (e.g., Erickson, 2007; Fink 2003; Hammersley, 1992; Heath & Street, 2008; Sandelowski, Voils & Knafl, 2009; Schwandt, 2007; Becker, 1970). They give greater precision than words like “some”, “usually” or “most” (Becker, 1970), and a sense of what is common or atypical amongst respondents (Sandelowski, Voils & Knafl, 2009). In inductive qualitative research atypical responses are valued as insights into ‘exceptions that prove the rule’ or ‘outliers’ who may require special attention from practitioners (doctors, managers etc).

This study aimed to inductively identify attributional processes used by persons experiencing burnout and therefore generalising the findings to a larger population was not attempted. Attributional theorists often imply that biases such as fundamental attribution error are common if not endemic, although their actual prevalence has not been a topic of study. However, the frequencies presented below describe only this sample and their generalisation to any population of mental health professionals is an issue for future research.

3.5 Interviews

3.5.1 Purpose of interviews

The interviews aimed to deepen understanding of professionals’ beliefs, perceptions and attitudes about burnout, as the questionnaire data had limited detail and clarification or probing was not possible. The interviews added detail and ‘richness’ to the themes derived from the questionnaire data, particularly in sensitive areas such as respondents’ reluctance to disclose burnout symptoms or the stigma attached to it. The notion of ‘rich data’ is widely discussed in the qualitative literature but rarely defined. Ogden and
Cornwell (2010) provide a framework for the components of rich data shown in Table 3.

Table 3: Defining and operationalising richness (Ogden and Cornwell, 2010, p.1064)

<table>
<thead>
<tr>
<th>What is “Richness”?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Length: The word count of the response</td>
</tr>
<tr>
<td>Descriptive: The extent of emotions such as anxiety, anger, sadness or joy, and the extent of sensory perceptions</td>
</tr>
<tr>
<td>Personal: How personal the response is, e.g., first person singular or third person plural</td>
</tr>
<tr>
<td>Analytical: The level of analysis in the response, including level of self-insight</td>
</tr>
<tr>
<td>Action: Descriptions of behaviour, i.e. recounting specific actions taken</td>
</tr>
</tbody>
</table>

The interview schedule was designed to elicit rich responses from participants while limiting the involvement of the interviewer’s biases or preconceptions. The questions encouraged participants to discuss their perceptions and beliefs about burnout with little prompting and maximum personal authenticity. This was done by using open rather than closed questions, ordering questions from least to most sensitive to develop rapport, and by providing “gentle nudges” (Smith, 1995, p. 14) in the form of prompts or encouragers such as “can you tell me more about that?” (Gillham, 2005).

‘Funnelling’ was also used to transition naturally from general views to more specific aspects (Smith, 1995, p. 15), since beginning with the general reduces the possibility of the interviewer influencing later responses.

Following the phenomenological approach, the researcher aimed to experience the world of the participant as much as possible by exploring new directions and themes as much as possible. Participants were treated as experts in their own world and allowed to steer the interview (Smith, 1995). The interviewer used gentle probes or prompts to encourage rich responses and create a conversational tone.

This approach allowed the researcher to build rapport, increasing self-disclosure and reducing socially-desirability responding. This relies to a great extent on the
interviewer’s skill in building rapport (DiCicco-Bloom & Crabtree, 2006), which was assisted here by the researcher’s skills in counselling and interviewing.

The interview sample involved 12 survey respondents who returned the interview participation form. They worked in all the organisational categories and professional groups of the larger sample apart from psychiatrists. All were experienced professionals with at least five years in the field, and seven had more than 20 years’ experience. Nine were female and three male.

3.5.2 Interview structure and development

Experienced interviewers can be identified by the clarity, focus and economy of their questions (Gillham, 2005). Indeed, the interviewer rather than the interview schedule forms the research instrument in qualitative research, although a carefully designed schedule increases the trustworthiness of the results.

The seven research questions offered a framework for drafting interview questions. These were then trialled on two mental health professionals with experience in qualitative research. These interviews were used to practice skills and develop the interview process, and were not further analysed. They were not recorded but notes were taken on both the responses and the process. Some questions emerged as particularly useful for eliciting rich responses.

After each pilot interview, participants were shown the interview schedule and asked to comment on its wording, meaning, flow and relevance to the research questions. This process resulted in shortening the interview, clarifying some ambiguous words or phrases and adding an introductory question about participants’ workplaces.

Finally, the schedule was approved by the Human Research Ethics Committee and interviews were arranged in a location convenient to the participants.

3.5.3 Interview process

The interviews began with a brief explanation of the study and ethical issues such as confidentiality and anonymity. Participants were asked if they were comfortable with recording of the interview, and signed a letter indicating informed consent.
The interview schedule was adapted as described above. For example if a response happened to also address a later question, that question was not asked. The schedule was memorised but also kept in front of the researcher to ensure consistency of questions and themes across interviews.

3.5.4 Analysis of interview data

The interview data were analysed thematically using Braun and Clarke's (2006) method as described above. Each recording was played repeatedly to gain a sense of the respondent’s views and then transcribed for importing into NVivo 9. The transcription was then reviewed and significant statements highlighted. Those directly related to a research question were coded using NVivo’s ‘node’ function. Codes that overlapped were combined into a single code, and similar codes in multiple transcripts were joined into themes, as in the analysis of the questionnaires.

The frequencies reported in Chapter 4 refer only to questionnaire responses to avoid double counting a theme detected in both sources for a given respondent.

3.6 Validity

The validity of the findings is an important consideration in any qualitative study. Thomas and Magilvy (2011) list four areas in which confidence in validity must be addressed: credibility, confirmability, transferability and dependability.

3.6.1 Credibility

Credibility is established by searching the data for parallels between data sources and between participants. Here, the questionnaire and interview data were assessed for similarities across methods and across participants. Many common themes and similarities were found, suggesting that mental health professionals outside the sample might recognise the perceptions and beliefs of these participants. Data saturation was observed after approximately 20 responses were analysed, as themes occurred repeatedly in the data and new ones failed to emerge. The quantitative analyses of questionnaire data also showed parallels between participants in terms of common responses that reflected those in the qualitative analyses.
The credibility of the coding scheme is addressed by the high degree of consistency between the two experienced researchers who independently coded a sample of interviews.

Finally, as codes were expressed in interviewees’ words and named with direct quotes, the analysis tended to reflect respondents’ perceptual frames as least as much as the researcher’s.

3.6.2 Transferability

Transferability refers to generalising a study’s methods and results to another population. Thomas and Magilvy (2011) suggest thoroughly describing the population so the reader can establish how the findings might relate to other groups. Details of participants’ professions and organisational environments, and the selection process, are provided in Chapter 3.

3.6.3 Dependability

Dependability is similar to the notion of reliability in quantitative research. It is established when a reader can follow the researcher’s decision trail concerning selection of participants, data collection, coding and analysis, all of which are described above. Dependability is also increased by using independent researchers to verify the coding process, as discussed above. Finally, the simple statistical summaries in Chapter 4 help relate the findings to the coding process.

3.6.4 Confirmability

The researcher is an important element in qualitative data collection and analysis, although the possibilities of bias and subjectivity are also acknowledged. Confirmability refers to the researcher’s self-reflexivity and awareness of how the findings represent participants’ experience of rather than his or her biases (Jensen, 2008). Throughout this study I reflected on how my biases and experiences might influence the findings. My experience working in mental health, my observations of past colleagues, and my training in psychology all contribute to the subjective ‘lens’ (Yin, 2011, p. 270) through which I view the data. I endeavoured to maintain an open curiosity and to search for new or unexpected insights about burnout. To check for bias, I continually revisited
each transcript and returned questionnaire to check how they related to the research questions.

3.7 Ethical considerations

3.7.1 Informed consent

Participants were informed of the study purpose and methods and the voluntary nature of participation in a statement attached to the questionnaire.

3.7.2 Privacy and confidentiality

Confidentiality is an important issue here because participants were mental health professionals with ethical concerns about sensitive information and professional reputations or relationships. Privacy and confidentiality were ensured by using anonymous questionnaires, and by separating the interview consent form from the questionnaire so that names were not connected to questionnaires. Interviewees’ names were replaced by a code on transcripts and summaries. Identifying information such as place of work or colleagues’ names was removed from transcripts and other documents. All data was kept securely in a locked cabinet.

3.7.3 Harm and risk

Given the sensitive topic, a risk inherent in this study was the potential to raise painful memories or create distress. Although mental health professionals receive training in managing emotional distress, they are as susceptible to it as other professionals. It was therefore important interviewees knew they could withdraw at any time and that independent professional support was available if needed. The researcher is a trained psychologist and counsellor and used professional skills to ascertain whether debriefing or referral to a support person was needed. No such situations arose in the interviews, possibly due in part to the semi-structured format allowing participants to choose the depth of their responses.
CHAPTER 4: RESULTS

4.1 Introduction

This study aimed to investigate mental health professionals’ beliefs and perceptions about burnout. The data come from open-ended questionnaires returned by a sample of fifty-five professionals from different occupational groups, and semi-structured interviews with twelve questionnaire respondents.

The research questions identified from the literature review concern respondents' beliefs and perceptions about:

Q1 What burnout is and what causes it
Q2 Managers’ attitudes to burnout
Q3 Colleagues’ attitudes to burnout
Q4 The psychological effects of burnout
Q5 The strategies professionals and managers could use to reduce burnout, and what barriers prevent their use.

Before addressing these questions, the sample demographics are reported.

Presentation of Results

The themes presented below, along with the quotes, come primarily from questionnaire responses, augmented where indicated with interview quotes that further illustrate the theme. Chapter 5 uses responses from two interviewees as illustrative case examples of professionals’ responses to burnout.

As described in Chapter 3, the questions were primarily open-ended and responses were analysed thematically to reveal patterns (Braun & Clarke 2006). Major and minor themes were distinguished by how frequently they occurred, and described by numbers of respondents. Distinguishing common and atypical themes by their frequencies is a common strategy in qualitative analysis (e.g., Jansen, 2010; see also Chapter 3, p.53).
Where individuals provided multiple themes in a response to an open-ended question, the results reflect total *responses* rather than respondents.

### 4.1.1 Demographics of respondents

Data was obtained from 55 mental health professionals from the public and private sectors, comprising mental health nurses (*n* = 17); psychologists (16); counsellors or psychotherapists (11); social workers (7); psychiatrists (3) and mental health occupational therapists (1) (Figure 6).

![Figure 6: Respondents’ Profession](image)

Participants had been practising as a mental health professional for an average of 14.5 years, although the sample included some at the beginning of their career and others practising for up to 39 years (Figure 7).
Figure 7: Years of Practice as a Mental Health Professional

The sample comprises predominantly older workers (Figure 8), reflecting the aging of the Australian mental health workforce. This is particularly evident in mental health nurses, with a mean age of 46 years in Australia and two-thirds over 45 years (AIHW, 2011).

Figure 8: Distribution of Participants’ Age

Finally, respondents were predominantly female, with only 10 males in the sample of 55. This is representative of the largely female mental health workforce in Australia.
4.2 What do respondents know or believe about burnout and its causes?

The theoretical goal of this study was to explain the paradox of mental health professionals being trained to treat stress in others but unable to recognise its most serious form in themselves. Chapter Two highlighted a number of potential explanations involving practitioners’ thought processes, particularly perceptions and beliefs that attribute stress to internal or external causes in ways that allow the practitioner to avoid dealing with symptoms.

Research Question 1 sought some background information addressing respondents’ knowledge or beliefs about burnout and its causes. Respondents in the questionnaire and interviews were asked to write or talk openly about burnout, including their experiences of it, their knowledge of its symptoms and causes in the person or organisation, and what they did not know about it. The themes discussed below come from responses to Questions 5-7, 13, 18 and 21 of the questionnaire (see Appendix A).

4.2.1 Burnout is a common experience

Burnout appears to be widespread amongst this group of respondents, with 38 respondents reporting experiencing burnout at some stage in their professional careers (Q11a). The consequences were often serious: of the 38, 17 indicated that they had either resigned or took extended leave to recover. Further, the symptoms could be subtle: four reported not recognising burnout until it was so severe they had to stop working.

As almost two thirds had experienced burnout, this sample group is likely to have good awareness of it from either their own experience or that of colleagues. This also suggests burnout may be a serious problem for mental health organisations generally. Although generalisability was not the objective, this result is consistent with evidence of high rates in Australia (e.g., Di Benedetto & Swadling, 2014; Lloyd & King, 2004; Scanlan & Still, 2013) and elsewhere (Morse et al., 2012; Ray, Wong, White & Heaslip, 2013; Siebert, 2005).
4.2.2 Good objective knowledge of burnout

Participants reported good objective knowledge of the symptoms, process and consequences of burnout, derived from their training, personal experiences or observations of colleagues. When asked to describe their understanding of professional burnout (Q5), the most common themes identified were fatigue (23 respondents mentioned this), detachment or depersonalisation (22 respondents), perceived or actual incompetence (20 respondents), and stress (20 respondents). The responses suggest a good understanding of the nature of burnout as described in the literature (e.g., Maslach et al., 2001; Schaufeli & Enzmann, 1998). For example they reflect Maslach et al.’s often-cited criteria of cynicism or detachment (e.g., seeing clients as “just a number”), feelings of incompetence (“weakness”), and exhaustion (“nothing more to give”).

“Feeling emotionally exhausted, feeling irritable, impatient, and indifferent at times. Feeling disempowerment, despondent and episodes of anxiety and low mood. Feeling everyone is ‘at you’, no enthusiasm for work, feelings of being trapped and loss of confidence. Feeling fatigued a lot.”

“Secondary stress/trauma from clients (absorbing life stories) on top of own life stresses and normal challenges which can interfere with sleep patterns and ability to empathise without taking on or feeling responsible for other peoples’ lives.”


“Apathetic – not interested in my work. Do not find any fulfilment in work.”

“When clients’ issues begin to cause us as professionals to feel emotional distress. When we are unable to listen to any more awful mental health related stories.”

When asked about the consequences for a person’s life (Q14), most (44 of the 55 respondents) wrote about their belief that burnout would bring serious consequences
involving loss of income, health or self-esteem. Some recognised that it was sufficiently serious as to force a person out of the workforce:

“I’m needed as a mother and an income earner - I can’t afford to burn out.”

“Depression.”

“Time taken off work, poor health, impact on colleagues and family.”

“Clients would not get good care. Physical health would suffer. Employers may judge me negatively.”

### 4.2.3 Internal causes of burnout: Psychological vulnerabilities or risky behaviours

A central question in this study is whether people attribute the causes of burnout to internal, personal factors or to external, environmental factors. Attribution Theory, particularly the concept of the Fundamental Attribution Error, suggests burnout in others will tend to be attributed to internal causes more often than burnout in oneself. As predicted, when asked whether certain kinds of people are more likely to burn out (Q7) a common theme was people with psychological vulnerabilities (39 respondents) or those who took risks with their wellbeing (32). A few (5) saw lack of experience as the cause, possibly also reflecting psychological vulnerability or risk-taking. Only seven saw burnout as a universal risk, equally applicable to all professionals:

“No, because everyone I have worked with feels the same way and we are all very different.”

Overall, this sample had a strong tendency to see causes of burnout in the person.

The psychological vulnerabilities cited include a history of anxiety or depression, a lack of emotional resilience, intolerance to stress, and unassertiveness. Some illustrative responses:

“Subjugators, people pleasers, perfectionists, anxious or depressive personalities, individuals with poor coping skills or emotional regulation.”

“Those who are sensitive and unassertive”

“Personality styles – anxious, angry, avoidant, ambivalent.”
“If they are not skilled in how to be organised, routine or appropriately assertive. If they are prone to anxiety, depression because of past experiences and or upbringing.”

“Clinicians who have not gained sufficient self-insight to recognise, manage and appropriate self-regulate their self-subjugation and caretaking tendencies.”

The risky behaviours identified included perfectionism, workaholism and focusing too much on clients’ needs:

“High expectations of self, harsh self-judgment, perfectionism, need to please others, idealism (pursuit of social justice principles), anti-establishment views (always challenges the system).”

“Individuals who have a pattern of putting others’ needs before their own (e.g. self-sacrifice schema) and who subsequently don't set appropriate boundaries or take adequate time for self-care behaviours.”

“Yes people who do not take care of themselves (spiritually, emotionally and physically) and have other personal issues affecting their 'stress' levels.”

“Expectations of self to do more and more - does not create balance. Not being able to say no.”

A common theme in the latter responses is a lack of self-care and failure to set personal boundaries, a perception also prominent in responses to questions about colleagues who burned out (4.4) and respondents’ personal experience of burnout (4.5). ‘Lack of self-care’ is a more sympathetic attribution than a ‘vulnerable personality’, which can imply a sense of blame. The vulnerable personality belief was also evident when respondents reported on managers’ or colleagues’ attitudes to burnout (4.3), consistent with the FAE. The quotes above often suggest a sympathetic rather than blaming version of this belief, suggesting some respondents are less susceptible to the FAE and more aware of the mental state accompanying burnout (as described in 4.5 and Chapter 5).

The small number of responses describing burnout as a universal occupational risk among mental health professionals could have two interpretations. One is realistic, in that burnout can be expected in anyone unable to control serious continuing stress.
However, this belief could also represent a fatalistic attitude in which external factors inevitably prevent practitioners from taking control of their health. While the brief written responses did not discriminate between these interpretations, answers to other questions (below) suggest both are likely to be present.

In summary, respondents generally held the notion that some types of people are more prone to burnout. In some cases this was a sympathetic view, but others conveyed a sense of blaming the victim.

4.2.4 External causes of burnout: Excessive workload

A different picture of attributional perceptions or beliefs emerged when participants were asked to list the three leading causes of burnout (Q6). The great majority of respondents referred to external causes, notably excessive workloads and poor support from supervisors or organisational managers.

Workload issues such as too much work, too little time or inadequate staffing were often described in some detail and were clearly felt to be oppressive by 37 respondents. A tension between the demands on staff and the resources available to address them was often evident. There was a sense that the mental health system was fundamentally flawed and employees were simply trying to survive the workload:

“In the Public Sector - due to a complete lack of control of workload and the resources to adequately provide a service. Also the service runs on people providing a service on bare minimum resources.”

“Pushing staff to always do more work without the resources, trying to save money, economising re small things, poor staffing esp. not backfilling staff.”

“It's impossible, we recognise the workload is too much but we can't do anything about it.”

Workload was not just an issue of working hours: the intensity of mental health work was identified as a cause of burnout in seven responses. These respondents saw an increasing incidence of suicidal or extremely unwell patients in wards, and conveyed a distinct sense of frustration that their responsibilities were becoming too heavy to carry:
“Some of the issues we deal with are not easy to manage or cope with - events such as suicide - if repeated - can have serious effects on staff resilience.”

“The stress of providing care to people who are in distress, professional requirements such as confidentiality and isolation.”

“Unmanageable workload with frequent high risk situations.”

Overall, there was a strong perception that workloads were beyond what respondents could reasonably accommodate without cost to their health, and frustration at individual professionals’ lack of control over this.

4.2.5 External causes of burnout: Poor supervisor support or organisational management

Lack of support from supervisors or managers was the second most frequent cause of burnout in answers to Q6 (25 respondents mentioned this). Given the high level of perceived pressure and the emotionally draining nature of mental health work (e.g., Morse et al., 2012; Schaufeli et al., 2009), it is not surprising that respondents considered organisational support critical and found its absence created a distancing and demotivating gap between them and their managers:

“I would feel nervous approaching anybody. They almost exist as a kind of cohort, a gaggle of them. …… It kind of locks anybody out.”

“Poor management leads to sense of being devalued and unsupported (resulting in 'defensive practice')”

“Perception that management is inflexible, self-interested and immovable in relation to own and client needs - feeling unheard.”

Theories of response to stress suggest social support provides a critical buffer against its psychological effects (e.g., Afshin et al., 2012; Beehr et al., 2003; Halbesleben, 2006). Feeling “locked out”, “devalued” or “unheard” suggests serious problems may exist in these work environments, a perception further documented in the case studies of Chapter 5.
A related theme involving poor management practices was another leading cause of burnout, cited by 27 participants. These included inflexible leave policies, poor change management practices, a lack of training, low morale and impersonal or even employee-adverse workplace cultures:

“The politics of the workplace i.e. being presented with change and not being part of the consultative process. Our site is very parochial. Staff are presented with a dictate and not consulted.”

“Lack of management support.”

“Organisationally you're not always supported to be able to do what you can to make it any better for the staff that you might be responsible for.”

“The lack of hope that anything could or would change. I had flagged up the difficulty managing the workload frequently and regularly, it was identified in every IPR. Nothing changed. People sympathetic to problems but not able to enable any changes.”

“Bureaucratic inflexibility: targets, KPI's, bean-counting, without consideration of the wellbeing of staff - personnel aren't 'human resources' they're people!”

These quotes echo earlier responses in conveying a sense of isolation, management indifference, hopelessness and impersonality in respondents’ workplaces. A perceived lack of support appears to be a critical element behind these feelings.

4.2.6 Summary: Knowledge of burnout and beliefs about its causes

Overall, respondents reported good objective knowledge of burnout, particularly its symptoms and consequences, consistent with their training and general knowledge of stress. Two-thirds had experienced burnout, suggesting most of the others would have observed it in colleagues. Their beliefs about the causes of burnout showed theoretically interesting contradictions. On one hand most agreed that certain sorts of people were more likely to burn out (Q7), but when asked about the ‘causes’ of burnout, work environment factors – excessive workloads and poor support or indifferent management (Q6) – predominated.
Respondents clearly perceived their work environment as stressful – pressurised and antagonistic to their mental health needs – leading to feelings of frustration, isolation and even hopelessness. They attributed this stress to organisational causes, particularly poor management and lack of support, rather than the challenging nature of mental health work or factors internal to practitioners such as lack of professional knowledge or self-management skills. Since stress derives from perceptions of the work environment, it appears respondents do work under considerable stress. Although the sample is small, this finding is consistent with other studies of mental health work in Australia (Morse et al., 2012; Stokes, 2012). Further, stress is frequently related to organisational causes in the academic literature (e.g., Bakker, Demerouti & Sanz-Vergel, 2014; Leiter & Maslach, 2003).

However, professionals’ perceptions or beliefs about the causes of stress and burnout may not be objectively accurate. Attribution Theory shows how both internal and external attributions of cause can represent defensively biased beliefs. For example, attributing burnout in others to personality deficiencies helps distance the perceiver from vulnerability to such problems, a strategy reported in studies of other mental health problems (e.g., Corrigan et al., 2000; Dijker & Koomen, 2003; Monteith & Pettit, 2011). This ‘Fundamental Attribution Error’ helps the perceiver increase self-esteem through attributing socially-undesirable qualities to others. As Section 4.5 shows, self-blame can also reinforce negative self-views in persons under stress.

Conversely, attributing one’s own health problems to external causes helps justify ignoring the problem, since external causes can be considered uncontrollable. Externalisation is a form of the self-serving bias (Miller & Ross, 1975), in which self-esteem is maintained by exaggerating one’s own capabilities and attributing personal problems to external causes. Burning out persons attributing the causes of their stress solely to high workloads, lack of support or poor management practices have little incentive to address the issue. They may even exaggerate their symptoms to justify avoiding difficult issues such as challenging organisational authority or letting colleagues or clients down by taking leave in busy times (see 4.5 below).

The contradiction between the ‘vulnerable person’ view of burnout in others and the external factors listed when respondents (who generally appear to be under considerable pressure) are asked about its causes suggests both views often represent attributional
biases. Objectively, burnout is likely to be associated with both internal and external factors. Some respondents used sympathetic language in describing personal factors behind burnout in others, and a similar view of the external pressures is noted below in some perceptions of stress in colleagues (4.4) or respondents themselves (4.5). However, responses more often suggested a harsh, judgemental or intolerant attitude towards burnout in others, or a similarly negative – cynical, blaming or distancing – attitude towards the organisation or managerial staff, both suggestive of defensive perceptions or beliefs. Further evidence for this is presented in sections below.

4.3 Perceptions of organisational managers’ attitudes to burnout

Research Question 2 asks how respondents perceive their senior managers’ attitudes to burnout. Attribution theory and more recent theories of social cognition emphasise the strong influence of the social world on individuals’ perceptions and beliefs (Heider 1958; Fiske 2004). To understand how perceptions and beliefs about managerial attitudes affected participants, the questionnaire asked whether stress and burnout were seen as serious occupational hazards (Q8), and more generally how the organisation viewed stress and burnout (Q9). Questions about personal experiences of burnout (Q11), and whether participants would reveal it to managers (Q12), also provided insights. Relevant responses from these four questions are discussed together in this section.

Five themes are discussed below. First, respondents often perceived a lack of corporate interest in or awareness of burnout. Second, a tendency to blame the individual for personal weaknesses or professional incompetence was reported. Third, organisational cultures were seen to be impersonal or antagonistic to employee health by encouraging overwork and normalising stress. Fourth, these negative managerial and cultural values created a social stigma that could lead respondents to avoid raising symptoms of burnout with managers and supervisors. Finally, in contrast to the previous findings a smaller group of respondents perceived their organisational managers took a proactive approach to burnout and staff welfare generally.

The negative attitudes attributed to managers here are consistent with both the ‘vulnerable personality’ attribution and the externalising attributions identified in the previous section. Managers form a special case of social influence in the workplace,
since they hold organisational and sometimes personal power (French & Raven, 1959) over other employees. As ‘authority figures’ they are particularly likely to be the target of causal attributions, and power and status have a strong influence on social perception in general (Heider 1958; Keller & Cacioppe, 2001; Leung, Su & Morris, 2001).

4.3.1 Managers lack interest or awareness

The previous section described a common belief that burnout is caused by organisational problems such as high workloads, poor support for stressed staff and other adverse management practices. Questions 8 & 9a asked respondents more directly about their organisation’s attitudes. Many (29) perceived a lack of corporate understanding and a majority (38 respondents) believed that burnout and work stress were viewed less seriously than other occupational hazards. Their comments further illustrate the belief that managers often did not want to recognise burnout, or else misunderstood it:

“Denial of the problem by management.”

“It's swept under the carpet and hardly ever mentioned by management.”

“Burnout seems to be seen in loosely defined, ambiguous terms. Something that is feared but not completely understood.”

“Rarely acknowledged - will deal with individual incidents that contribute, but rarely acknowledge the long-term effects.”

Some explained this lack of awareness as an outcome of health and safety efforts focussed on discrete events to the exclusion of systemic issues such as stress:

“Certainly not by hospital management. Specific hazards are immediately identified and work instructions written, but stressful work environments are not "measured", no matter how often or eloquently they are reported, or how much quantitative data is potentially there to support points.”

“I think they are viewed less seriously because they are largely hidden - not as obvious as a broken leg from a fall in the workplace.”

“Because it’s less visible – staff usually expected to absorb the extra work.”
This explanation could be used to excuse senior managerial indifference through the difficulty of detecting stress-related issues. However, since managers in these organisations tend to have mental health training, and rely on middle managers and supervisors capable of identifying burnout, this can be questioned. Perhaps managers defensively adopt such ‘tunnel vision’. Another explanation, consistent with the attributional hypothesis developed above, is that excusing managerial indifference helps professionals defensively avoid accepting the reality of excessive work pressures while maintaining a positive view of managerial authority.

The more common perception was that managers actively avoided dealing with burnout and stress. This could indicate a serious organisational problem: if the high rate of burnout reported in this sample is generalisable, considerable cost to the organisation in sick leave and reduced productivity would be expected. More importantly, managerial denial could also exert a powerful social influence, reinforcing professionals’ own tendency to deny symptoms, withdraw from the organisation and avoid seeking help as described in 4.5.

The possibility that managerial ignorance or negativity are defensively exaggerated should also be considered. As this applies also to the three ‘negative’ themes below, it is discussed at the end of this section.

4.3.2 Burnout is seen as the individual’s problem

Consistent with the theme of managerial avoidance is the common perception (38 respondents) that managers see burnout as the problem of the individual rather than the organisation. Respondents often described a managerial view of burnt-out workers as too weak to cope with workplace demands and therefore not ‘cut out’ to work in the mental health field. The resulting turnover was justified as an unfortunate but inevitable result of the stress inherent in mental health workplaces:

“It is stigmatised as a personal failure, not a failure (in part) of the system. There is a culture of "chew them up and spit them out" with stress. The individual is replaced and the next person does the same job that in fact caused burnout, with no changes to the process, again and again.”

“Attitudes are often "toughen up or move on".”
They can be viewed as [having a] personal weakness, with a common attitude of “just get over it”, “it's just work - who cares?” and "why work so hard? No one would do it for you”.

“Can be seen as an individual issue although there are some statements which support staff. Difference between policies and practice.”

“Some individuals (eg supervisors or colleagues) may see it as "weak" and best left unexpressed.”

Some saw the tendency to blame workers expressed as a failure of workers’ professional responsibility to self-manage - not merely a personal limitation but a sign of serious professional incompetence:

“It can be a sign of failure (both professionally and personally). It is assumed that you "should know how to look after yourself". A sign of incompetence and "stupidity".”

“Individuals feel that an inability to 'cope' reflects badly on them professionally and personally.”

If these perceptions are objectively correct and generalisable, they suggest a need to educate mental health service managers about the problems created by blaming persons with mental health problems. Even highly trained professionals are susceptible to internalising powerful others’ views, which in this case may lower their self-esteem. Section 4.5 suggests many respondents are highly sensitive to negative judgements of their professional image, which is strongly tied to their self-esteem. Despite the widespread perception of excessive workloads and lack of organisational resources as causes of stress (4.2), many respondents were very concerned about being blamed for their inability to cope.

Alternatively, respondents may be exaggerating managerial negativity or projecting their own self-blame onto managers, as discussed below.
4.3.3 Organisational cultures normalise stress

The perception that managers minimised burnout often (29 respondents) appeared to be part of a broader problem whereby corporate cultures viewed staff as resources rather than persons with normal human limitations. Staff were expected to cope with funding cuts and increased workloads by absorbing extra work, regardless of the health consequences:

“No because it [burnout] is less visible and staff tend to be expected to absorb work pressures.”

“There is a sort of "blame" the sufferer not the system.”

“An unfortunate and unavoidable part of the service. Necessary evil - people have to provide max (sic) possible service from minimum resources.”

“Corporate model (over past 20-30 years) promotes constant increase of labour input to gain necessary 'sales'/ productivity/goods. This seen as a given and natural order to work longer hours, more clients/ patients/products, less time-out (tea breaks, lunch breaks etc).”

For a number of participants, rather than merely ignoring stress and overwork the organisational culture actively encouraged it:

“I think in the corporate sector it is usually encouraged and that being highly stressed is seen as the acceptable way to be.”

“Often feel that those who work in the mental health sector are expected to be hardened or detached. We are mental health professionals and therefore should be aware / more aware of burnout / stress. Some would say stress is part of working in a people occupation.”

The latter respondent appears to agree with the managerial view of stress as normal, perhaps having internalised it. Organisational culture is not influenced by all employees equally, but serves more as a means for managers to ‘internalise’ certain values amongst others through artefacts, espoused or actual values, and behaviours that communicate often unstated assumptions (Schein, 2010, p.25).
4.3.4 Unwillingness to disclose symptoms of burnout

The combined effect of the negative managerial attitudes and corporate cultures identified above is to *stigmatise* burnout, creating a sense of social disapproval that encourages hiding symptoms of health problems to avoid embarrassment or shame:

“Stigma attached to being ‘stressed out’”.

“It tended to be an embarrassment to those struggling emotionally. General avoidance of discussing burnout, a lot of externalisation.”

“A lot of people wouldn't share their experience and tend to suffer in silence.”

Q12 asked respondents directly whether they would feel comfortable telling their current manager about burnout. A significant group (24 respondents) indicated being uncomfortable since it would mean admitting failure, weakness or inadequacy, consistent with the managerial attitudes reported above:

“Would be a little nervous about creating a negative public perception, something about wanting to maintain my professional reputation.”

“If I was to feel overwhelmed or kind of stressed out at work, if I needed to take stress leave for example, I would be very aware of possible stigma that would be attached to me for that and that would negatively influence how I was seen by management.”

“I feel comfortable with the concept of burnout but would still be concerned about the way this disclosure may affect the perception of me in the workplace.”

The likely effect of hiding symptoms of ill health would be to increase the sense of isolation from the organisation and any supports it could offer, perhaps encouraging a professional to psychologically disengage from their job and perform only at a superficial level. This would compound any sense of isolation from colleagues (see next section). Withdrawal is likely to be associated with the internalising, externalising or avoidant thought processes identified elsewhere in this chapter.

Some participants would not raise burnout even with a *supportive* supervisor, because they did not expect a helpful response. This was explained in terms of the supervisor’s
limited control over pressures or constraints in the organisation or health system, or as a more general belief that nothing would be done:

“Comfortable, but no point to tell him/her as they are not in a strong position to make much difference (though genuinely supportive).”

“Kind of pointless because there’s not a lot they can do.”

“Comfortable telling managers about stress, however due to constraints of organisation often difficult for them to do anything to help.”

“I feel supported by my boss although [...] I have felt I should just deal with it because there is no alternative.”

These quotes suggest a fatalistic belief system that stops employees raising a potentially serious health problem. Fatalism involves the attribution of responsibility for one’s fate to an uncontrollable external source (e.g., Keeley, Wright & Condit, 2009; Straughan & Seow, 1998). If the supervisor lacks the personal skills or organisational power to change work conditions, this attitude may be in one sense a valid response. However, it could also be an excuse for not taking matters further, for example by lodging a complaint concerning the organisation’s duty of care, or seeking help externally from public help services. If problems are attributed to the sector generally, fatalistic thinking can even justify withdrawing from the profession.

Although 24 respondents felt uncomfortable raising burnout with their manager, a greater number (30) were comfortable with this. How much this reflects a positive organisational attitude to burnout is discussed in the next section.

4.3.5 Perceptions of organisations that take burnout seriously

In contrast to the responses above, a significant minority of respondents (17) perceived their organisations took burnout seriously and responded proactively (Q8 and 9a), for example by encouraging self-care:

“At [the] moment we have a few ppl (sic) with burnout so it is actually a hot topic that [management] realises it needs to be addressed and dealt with.”
“Self-care is placed as a very high priority so there is a really good awareness for identifying and dealing with burnout.”

“I have chosen to work for organisations that look after their clinical staff and are proactive in preventing/ minimising risk factors for burnout.”

Some respondents had left previous jobs in search of more supportive organisations, and were pleased their wellbeing was now taken seriously:

“In fact, the organisation I have been working within for the past 5 years does value staff and adjust workloads and supervision and management to minimise it, but this is an amazing exception.”

“In my job a few years ago it was ignored. There was not much discussion in the profession either. In my current new job it is discussed much more openly.”

Positive attitudes are also suggested by the 30 respondents who reported feeling comfortable raising burnout symptoms with their manager (Q12). For example:

“In this organisation it would be respected and celebrated that I had made a decision to look after my wellbeing.”

“The coordinator is open, warm, available and has great respect for my skill and knowledge – she would respect my concerns and we would address them together.”

“Current manager is very empathetic and kind. Feel that she genuinely has concern for her staff. Feel she would prefer to be informed of stress before getting to the point of burnout.”

The significance of these positive findings is further discussed below.

4.3.6 Summary: Perceptions of managers’ attitudes to burnout

Respondents held a fairly negative view of managers’ attitudes towards burnout: 53% perceived a lack of corporate understanding, 69% believed it wasn’t taken seriously, a similar number thought managers would blame the individual, and 44% were reluctant
to report symptoms of burnout. Less than 30% saw their organisation’s attitude as positive.

These negative managerial attitudes are consistent with the perception that burnout is caused by organisational issues (4.2): active avoidance or lack of interest in stress and burnout, and a tendency to attribute it to personal weaknesses or professional incompetence in employees. Organisational cultures were perceived to reinforce these attitudes by making stress appear acceptable or ‘normal’ and mental toughness or detachment a necessary attribute for professional staff. Respondents often believed supervisors or managers would stigmatised them for reporting stress symptoms.

Some observed that this managerial negativity can cause stressed professionals to feel isolated, frustrated and helpless (‘suffering in silence’), reinforcing doubts about their professional competence and encouraging fatalistic acceptance rather than proactive self-care. Such persons effectively internalise their managers’ negative attitudes.

It is also possible some respondents exaggerated managerial negativity or projected their own negative feelings onto managers, in order to justify avoiding facing up to difficulties that challenge their professional identity and self-esteem, as described below in 4.5. Blaming stress symptoms on uncontrollable organisational pressures justifies a fatalistic, externalising attitude, and internalising managers’ view of stress as a personal failure is also fatalistic.

Although these are respondents’ perceptions of managers it seems likely they have at least some objective basis, for several reasons. First, managerial avoidance, blame and stigmatising were widely reported in response to both the survey and interview questions. Second, studies in sectors outside mental health have identified similar managerial attitudes (e.g., APS, 2013; Vaughan-Jones & Barham, 2010). Third, from the perspective of managerialism, a philosophy often attributed to public health organisations (Chapter 2), it is in managers’ perceived economic and political self-interest to downplay the human costs of under-resourcing. Managers' attitudes were not directly studied here, and future research on their perceptions and beliefs is recommended.

However, it is respondents’ perceptions of managers that influence their responses to burnout, regardless of their objective basis. Managers’ power and status are likely to
give them a strong influence on professional staff. The perception that managers hold negative attitudes towards burnout may encourage professionals to also avoid it, further exacerbating the problem.

The role of supervisors

Respondents had a somewhat more positive view of their supervisors, with nearly half reporting a positive relationship and a willingness to reveal burnout symptoms to supervisors where only a quarter reported positive organisational responses. If generalisable this would be noteworthy, since supervisors are critical to detecting and managing burnout. However, Section 4.3.4 identified respondents with supportive supervisors who would not disclose burnout, believing the supervisor did not have power over relevant resources and higher level managers would not intervene. The case example of Fiona in Chapter 5 describes one manager’s difficulties in balancing team members’ workloads with the threat of burnout on one hand and avoidant organisational attitudes on the other. The role of supervisors in encouraging or discouraging disclosure of stress symptoms is therefore an important topic for future study.

Positive organisational responses

The positive attitudes towards burnout and stress reported by a smaller group of respondents are also worthy of future study. The background and outlook of managers of such organisations, particularly their perceptions and beliefs about stress and professionals’ mental wellbeing, may suggest interventions relevant to remedying negative attitudes in other organisations.

Overall, however, respondents had a more negative view of their organisation and its managers’ attitudes to burnout. These are expected to have a strong influence on professionals own attitudes, exacerbating existing tendencies towards self-blame or, conversely, giving them reason to externalise responsibility for stress problems.

4.4 Perceptions of colleagues’ attitudes to burnout

Research Question 3 addresses perceptions and beliefs of colleagues’ attitudes to burnout. These were expected to have an important influence on respondents’ responses to continuing high stress, since professionals tend to have closer relations with peers
than other organisational members and these peers are trained in mental health care. The survey findings suggest professionals in general have considerable experience with burnout: 45 respondents reported having colleagues they believed had burned out (Q10), even higher than the number reporting personal experiences of it (38 respondents, Q11).

Respondents were asked whether colleagues thought to have burnout disclosed their condition (Q10a), and whether other colleagues discussed such persons amongst themselves (Q10b). A more personal perspective was gained by asking respondents who had burned out themselves how colleagues reacted to this (Q11c).

The responses discussed below suggest many professionals are reluctant to raise symptoms of burnout with colleagues. Explanations involving attributional processes are suggested, including perceptual defences similar to those discussed above and a social stigma attached to burnout amongst professional groups. Respondents’ perceptions of their colleagues often mirror their perceptions of organisational managers, and may contribute similarly to explaining the paradox of burnout in mental health professionals.

4.4.1 Do burning out colleagues disclose their state?

When respondents who had known a colleague thought to be burning out were asked if this person had discussed “how they were feeling with you” (Q10a), about half replied negatively:

“No - it tended to be an embarrassment to those struggling emotionally. For others, detachment was at the level where they laughed it off, and dismissed any stress they felt as the problem of the client or management. General avoidance of discussing burnout, a lot of externalisation.”

“[No] they simply stayed and deteriorated until health or sanity finally gave way.”

“A lot of people wouldn't share their experience and they tend to suffer in silence.”

“Minimal discussion. Perceived to be ‘not professional’.”
Several reasons for this are implied in these responses. Embarrassment suggests internalising the cause of burnout as a *personal failure*, and detachment and externalization may also reflect this. Detachment could also indicate *physiological or cognitive impairment* associated with depression and depersonalisation as a burnt out person withdraws from social contact (Maslach et al., 2001), further discussed in 4.5.

Other respondents believed their colleagues *could not recognise* burnout in themselves:

“*They may not have thought so but my perception of them was ‘yes’*”

“No, they did not feel they were on the road to burnout”

“They didn't perceive it in the same way. I encouraged them to try to prioritise work / delay the less important tasks / take leave.”

Failure to perceive their state could reflect ignorance about the effects of extreme stress but is also consistent with defensive perceptual processes such as denial, self-blame or fatalistic externalising attributions.

It appears mental health professionals often perceive that colleagues ignore their symptoms of burnout, suggesting a culture of denial amongst some groups, as suggested by other findings. Perceived ‘peer pressure’ can lead a person to ignore his or her own stress symptoms.

### 4.4.2 Colleagues’ reactions to other colleagues with burnout

Twenty-two respondents reported having colleagues who *had* revealed having symptoms of burnout (Q10a). When asked how *other* colleagues responded to this (Q10b), the replies were equally positive and negative (22 respondents in each category). The *negatives* focused on stigmatising attitudes:

“Sadly, often the discussion centres around their coping skills or not being able to ‘fit in’. The blame often shifted to the victim and at the same time denying that they themselves may be vulnerable.”

“A couple in a disparaging way, like they were 'less able to cope'.”

“… they also felt this person should find another career.”
“Just not being able to handle things and not being tough enough.”

Such negative ‘gossip’ suggests the ‘vulnerable personality’ model of burnout is common amongst professionals as well as managers. This would be an important and unexpected finding if it generalises to mental health professionals beyond this sample. From an attributional perspective, ‘blaming the sufferer’ allows the perceiver to raise his or her self-esteem by creating a sense of superiority over those who ‘succumb’, which justifies discounting one’s own vulnerability to stress. This could be a comforting belief in a high-pressure environment.

The positive responses pointed to professional circles where burnout is seen as a signal to help rather than avoid or reject the affected person. These respondents described colleagues who provided both empathic understanding and practical supports such as advice, informal counseling or team-level interventions:

“Colleague discussed her stress and we discussed involving her line manager to assist her in dealing with the problem.”

“I needed to prompt the conversation. We identified some of the stressors and I was able to orchestrate a change of hours.”

“Yes they did and I provided supportive counselling. They continue to feel burnt out due to their employer’s expectations and caseload.”

“Support and empathy. Shared experiences mostly discussed. Offered stress management ideas. Discussed decreasing workload/ duties/ hours worked etc.”

“Discussed as a team, spoke individually to colleague who took more time off and a wellness room was created at a later date [as a result of colleagues’ request].”

However, some of these attempts to help were resisted:

“I discussed my concerns with a colleague who also expressed a concern and attempted [but failed] to discuss with the individual.”

“We encouraged that person to take a break but they did not.”

“We knew it was going on but she resisted assistance!”
“Not initially, only when I raised it. Even then responding by reorganising her life proved very hard. Another colleague had a heart attack before she was willing to address her schedule.”

Rejecting assistance from colleagues is consistent with the internalising or externalising cognitive defences mentioned above, perhaps in the context of depression or detachment. Even where colleagues are helpful, a person experiencing burnout faces significant internal difficulties in perceiving and responding to his or her state: a positive interpersonal climate does not help prevent burnout unless the affected person is willing to be helped. Why mental health professionals might resist help is discussed in 4.5.

Beyond stigmatising or helping, a third perception was that colleagues felt it was ‘not their place’ or ‘unprofessional’ to raise their concerns with burning out peers (9 respondents). This might indicate a very individualistic view of professional ethics or organisational responsibility. The latter could reflect a culture of competition rather than cooperation amongst professionals, or an organisational environment adverse to collegiality in ways noted above (4.3). However, a “not my problem” perception could also serve a defensive response - mental health professionals are likely to have both an ethic of care and skills relevant to discussing mental health issues with peers.

Overall, respondents were about evenly divided on whether colleagues would disclose burnout, and on whether this would produce a positive or negative response from other colleagues. Those who keep quiet about their burnout appear to be at least partly influenced by the perceived likelihood of a negative response.

It is also possible colleagues’ negativity was exaggerated to justify avoiding respondents’ own stress symptoms, as suggested in relation to managers. Heider’s (1958) Balance Theory predicts that a person with low self-esteem will adopt accordingly negative perceptions of others’ views of him or her self. However, a number of studies have identified stigmatising attitudes about burnout and barriers to helping peers in professional groups (Hu et al., 2012; Putnik et al., 2011; Schluze & Roessler, 2007), suggesting respondents’ colleagues may indeed often hold stigmatising attitudes.
Again, though, whether exaggerated or not the important finding for this study is that colleagues are often perceived to have negative attitudes, which is likely to influence respondents self-perceptions.

### 4.4.3 Colleagues’ reactions to respondents with burnout

A more direct perspective on colleagues’ reactions comes from the 38 respondents who had themselves experienced burnout. All but four reported disclosing it to peers (Q11b), a contrast to the perception (above) that burning out colleagues often failed to disclose it. Perhaps respondents gave more socially desirable responses when describing themselves. Social desirability bias is a widespread cognitive strategy that maintains self-esteem by gaining the imagined approval of others (Krumpal, 2013; Paulhus, 1991). This would be consistent with the hypothesis outlined in the next section, that burnout comes from overworking in order to gain the perceived approval of colleagues or managers.

Consistent with this, 20 of the 34 respondents who *had* disclosed their burnout to colleagues expressed a reluctance to do so, fearing being seen as weak, incompetent or lacking in professionalism (Q11b):

> “Nobody wants to appear inefficient and not competent. Particularly people who take pride in their work and are perfectionists in most of their life.”

> “Reluctant, don't want to be seen as weak or not capable.”

> “I felt embarrassed to discuss it with anyone. My work was affected. It was a colleague who advised me to get help and I realised that other workmates were concerned.”

The first response illustrates the ‘all or nothing’ thinking that can accompany burnout in professionals: people either have pride in their work and are perfectionists or are ‘weak’, inefficient or incompetent.

This perception of colleagues as judgemental mirrors a similar view of organisational managers (4.3 and 4.4.2), suggesting some workplaces provide a significant incentive to hide symptoms. Such professional and organisational cultures would influence new professionals to internalise similar attitudes, later discouraging them from dealing with
serious health issues and overriding any professional training concerning stress and self-care.

Q11c asked how colleagues reacted to the respondent’s burnout. Nineteen of the 34 respondents disclosing their burnout had encountered sympathy, support or practical help:

“Support and empathy. Shared experiences mostly discussed. Offered stress management ideas. Discussed decreasing workload/ duties/ hours worked etc.”

“Very good. My colleagues were supportive of my decision to change roles in order to better manage this stress.”

“Complete understanding as they had experienced similar. Willingness to discuss at length during peer-support session. Relief to share!”

“I had fantastic colleagues (…) I could talk to about how I was feeling. It was recognised that working with chronically ill clients in mental health (psychiatric hospitals) is challenging, difficult and exhausting.”

However, 15 of these 34 respondents found their colleagues lacked understanding, empathy or practical help:

“I have been close to burnout, to a large extent the cause was lack of support (with increased workload) from colleagues. Colleagues’ attitudes not helpful or empathic.”

“No one to talk to about it. Everyone else was also struggling with the workload.”

“Gossiping further.”

“Keep it vague and positive.”

“Inadequate and hurtful, self-esteem already low so I was devastated.”

The first respondent largely blames her burnout on colleagues’ lack of support, while the second sees colleagues as too busy to help. The third conveys a sense of rejection, and the last finds the lack of response “devastating”. Feeling socially isolated in the
workplace can have profound psychological effects (Rodríguez-Carballeira, 2009) and may trigger powerful defensive processes. Although there may be some objective basis to the attitudes above, blaming colleagues or believing nothing can be done because everyone else is ‘struggling’ with the problem externalises it. Similarly, feeling rejected or hurt could indicate internalising colleagues’ (or managers’) judgemental attitudes.

A few respondents reported both positive and negative responses in colleagues. The positives echo perceptions reported earlier:

“Mixed. Many were lovely - warm, understanding. Others were closed off fearful it might touch them.”

“Certain were supportive, others feeling overworked themselves were not interested.”

“Varied responses. Some acknowledged this, others did not know how to.”

The proportion of negative responses to respondents’ burnout (Q11c) is similar to that reported among third-party (non-respondent) persons with burnout (Q10b, 4.4.2), adding to the impression that negative attitudes are reasonably common in these workplaces.

Of the four who did not disclose their burnout two had changed jobs to reduce the stress:

“I didn’t really discuss it. I changed areas of work and took time out.”

“As I maintained a high standard of care they didn’t intrude. I got out before I went critical.”

Leaving the workplace may be encouraged by emotions such as embarrassment, hurt and feeling blamed or ignored, especially when associated with the loss of one’s professional image. How much the cultural values of professional groups are responsible for turnover due to burnout – in addition to the effect of organisational values - is a worthy topic for future research.
4.4.4 Summary: Perceptions of colleagues’ attitudes to burnout

Respondents perceived colleagues’ attitudes to burnout had both positive and negative aspects. They were equally divided on whether colleagues would disclose symptoms of burnout to others, and while almost all with personal experience of burnout reported disclosing it to colleagues, around half expressed reservations about this. When asked how peers would respond to burnout in themselves or colleagues, around half the sample expected negative responses.

This stigmatising response involves a ‘vulnerable personality’ attribution that those who can’t cope with stress are incompetent or unsuited to mental health work. Feeling rejected by peers is likely to have a strongly negative psychological effect since humans have strong need to belong to social groups, especially peer groups (Baumeister & Leary, 1995). This would compound any sense of isolation from organisational managers or supervisors (4.3), or any personal sense of inability to cope with the job (4.5). From an attributional perspective, the belief that ‘staff around here don’t discuss burnout’ implies those who do are weak, and provides yet another defensive justification for avoiding the problem.

While the possibility that respondents exaggerated colleagues’ negativity can be raised, other studies have found stigma towards burnout widespread amongst professional occupations. More importantly for this study, the perception of judgemental attitudes among peers appears to inhibit up to half the respondents with symptoms (depending on the extent of social desirability bias) from disclosing a serious health problem.

This reluctance to seek acknowledgement or support from one’s peers should be of concern to educators, managers and professional bodies since colleagues are a valuable part of the response process, often better able to see a highly stressed professional’s true state than either the affected person or their supervisor, and able to play a significant role in encouraging or discouraging that person’s attempts to regain health. The many positive responses reported above show the value of this help.

Respondents suggested colleagues exhibited many of the attributional processes suggested previously, including the vulnerable personality attribution and related stigmatising perceptions, externalising the causes of their stress to organisational factors, detachment and denial - even denying help when offered. This further supports
the hypothesis that mental health professionals’ susceptibility to burnout results from defensive cognitive processing of information about their wellbeing.

Such attributional processes can also explain professionals’ stigmatising of and reluctance to intervene with stressed colleagues. For example, perceiving colleagues’ health problems as beyond one’s professional role requirements could help maintain distance from the reality of stressful work, as does stigmatising the person or the ‘black and white’ belief that one is either a fully competent professional invulnerable to stress or weak, incompetent and unfit for the job.

In summary, while the two sections above show positive examples of managers and colleagues with a sympathetic approach to burnout, respondents perceived negative attitudes, social stigmatisation or adverse cultural values in half to two thirds of cases when thinking about their managers, and around half when thinking of colleagues. Such perceptions are likely to make affected persons feel socially isolated, rejected or even hurtfully disparaged, discouraging them from admitting their problem (to themselves or others) and seeking help for it.

The next section focuses on the psychological processes by which such perceptions come to exacerbate burnout.

4.5 How does burnout affect professionals psychologically?

The previous sections examined respondents’ beliefs about the causes of burnout and perceptions of managers’ and colleagues’ attitudes towards it, looking for evidence of defensive attributions that might contribute to burnout. Research Question 4 examines these in more detail and relates them to self-esteem and identity, fundamental aspects of human psychology that can help explain why mental health professionals persist with unhealthy cognitions to the point of emotional and physical exhaustion.

Q15 on the questionnaire asked “When you think about your role as a professional, how would burning out affect the way you see yourself?” The hypothetical phrasing aimed to gauge general attitudes rather than perceptions tied to specific experiences of burnout. In addition, Q11 about “your experience of burnout” revealed feelings about disclosing burnout and perceptions of colleagues that are used here as illustrative quotes.
These questions were asked toward the middle of the survey, when respondents were expected to be more open. A common design strategy is to make initial questions less personal and easier to answer in order to put the respondent at ease (e.g., Smith, 1995, p.14).

Answers to Q15 revealed high levels of self-blame or loss of self-esteem, and relatively little recognition of burnout as a sign of the need to increase self-care, a healthy response. In extreme cases this lead to thoughts of leaving the profession. This dysfunctional response can be related to respondents’ professional identity.

4.5.1 Self-blame and loss of self-esteem

Many respondents (44) believed burning out would cause them to blame themselves or feel like a failure:

“Self criticism of not handling the job well - low self esteem.”

“I would see myself as weaker and more vulnerable and less capable”.

“I would definitely feel I had failed in some way, like I am not tough enough to deal with typical work stress. Personally and professionally I feel I am resilient, so having that tested would be hard.”

“It has affected my idea of myself as a competent and capable person.”

Self-blame and loss of self-esteem or professional confidence echo the reasons respondents who had experienced burnout gave for not disclosing their condition to managers (4.3) or colleagues (4.4). The perception of burnout as a sign of “not handling the job”, “not being tough enough”, “weakness” or “vulnerability” appears to be common in this sample. Paradoxically, this attitude may actually promote burnout, for reasons illustrated below.

4.5.2 Loss of professional identity

Burnout was seen not only as a loss of self-esteem but also a challenge to one’s identity as a competent, efficient and resilient professional. Indeed, person-based and work-role based sources of esteem were strongly interconnected: respondents often appeared to
base their personal identity in the work-role identity. This theoretically-important theme was reflected in many responses to Q15:

“When feeling burnt out I am aware of a noticeable decline in my communication, assessment and de-escalation skills, which is difficult to cope with as I usually take pride in my professional role and my ability to do what I do well.”

“Hard to not think that others may judge you as being unable to cope. May question my own resiliency.”

“It has affected my idea of myself as a competent and capable person. Also much less positive and optimistic.”

“Although my job isn't everything to me, I'd lose a significant part of my identity if I burned out. I'd lose some self respect, because I'd not taken the necessary steps to prevent burning out.”

“It had a huge impact on me. From that point I decided that I was only cut out to do clinical work part time.”

“In my mind allowing myself to burn out would be unprofessional.”

Having a professional image in the eyes of others is clearly important in many of these statements, and is more directly stated here than in answering questions about managers or colleagues. Blurring of one’s self-evaluation as a person and others’ evaluation of one’s work as ‘professional’ therefore appears to underlie many respondents’ perceptions (or misperceptions) and beliefs about their symptoms of prolonged stress.

The mental process likely to be involved in maintaining self-esteem under such conditions is illustrated in the next chapter by a case example of an interviewee who could not – or would not - see how overwork was affecting her health, despite her training in mental health and the concerns of her colleagues and husband. She describes succinctly how her professional identity drove her to work harder. Her high standards lead to more work being given to her, but when she experienced physiological impairment and could not keep up she worked even harder, creating a ‘vicious circle’ of decline:
The things that I would [normally] do myself, like the exercise, self-care … just got less and less .. it ended up I wasn't doing anything. I used to go for a walk at lunchtime, in the end I was just sitting at my desk at lunchtime, eating my lunch and answering the phone. It must have been the way I responded to that, I just thought it was me, and I needed to work harder, so it became a vicious circle.

Key elements of this belief system have been noted above: a strong sense of professional dedication to clients and the organisation, a perfectionistic attitude towards work, a belief in one’s ability to manage high stress, and a desire to avoid any conflicting evidence in one’s physiological state or feedback from others. Chapters 5 and 6 examine this process in more detail, showing how the perceptual distortions identified by Attribution Theory might colour professionals’ responses in ways that shore up a false sense of self-esteem (Kernis, 2003) by emphasising professional achievement at the expense of healthy self-esteem. Healthy self-esteem has a more holistic basis than false self-esteem and is derived from satisfying basic psychological needs that cannot be met through work alone.

Ironically, these respondents appear to base their self-esteem too much on their competence as a mental health practitioner. Symptoms of high stress lead them to feel personally “judged” and to “lose a significant part of my identity [and] self-respect”. Working harder to meet their high standards - typically based on perceptions of managers’ or colleagues’ standards - leads them into a downward spiral towards emotional and physical exhaustion. Through this mental process even highly competent workers eventually become incapacitated.

4.5.3 Signaling a need to take more self-care

Perhaps the most important single finding of this study is that only 11 respondents saw burning out as a signal to implement coping strategies and self-care in answering Q15. Those who did showed a self-reflective mind-set:

“\[I'm not listening to myself and what's important.\]”

“That I have not been maintaining my exercise and other pleasurable activities and allowing work to dominate. See self then as ignoring danger signals and striving too hard.”
“I think as professionals we have a responsibility to ourselves, our organisation, and our clients to look after our own mental health. Moderate how much work we take on, take regular holidays, access support and counselling, demand supervision etc. Therefore I think it is mostly avoidable.”

These responses show that the mental outlook of burnout-resistant professionals is about “listening to myself”, enjoying “pleasurable activities” outside work and “accessing support” or help to reduce the effects of continuing high stress.

Not surprisingly, burnout was not always a simple signal to change behaviour but often part of a confused set of mixed feelings. Some respondents showed insight into the risks they faced and awareness of the need to take corrective action, but also struggled with self-blame, self-anger, fallibility, vulnerability or guilt:

“I would look at burnout as a sign that I need to change what I am doing – as it is, I make small adjustments so that I can do my work without feeling the job is my whole life. Initially, I would be angry at myself for allowing a burnout to happen but I have confidence in my ability to repair.”

“Recognise that I am human I suppose, that I am fallible. That I missed the signs, but have [since] created the resources and supports to reorganise myself”

“Guilt – should have prevented it.”

The negative feelings in these quotes - anger and guilt - are likely to be associated with defensive perceptions and beliefs that discourage changing behaviour or seeking help.

For some, the resolution of this struggle between personal wellbeing and professional identity became apparent only after suffering serious health consequences. These respondents learned the hard way that self-needs are ultimately more important than occupational demands, developing a more realistic perception of the stressful nature of mental health work and their own vulnerability:

“I have a child to care for now, so I would not allow that to happen again, i.e. my priorities have changed.”

“Once I would have felt I had failed as a professional. With time and experience, I have come to believe burnout is to some degree inevitable, almost an
occupational hazard. When I feel burnout though, I suffer ‘compassion fatigue’ and in my less rational moments, I condemn myself for this. As with most helping professionals, it can be quite difficult to accept one's limitations and to self-nurture.”

The latter respondent continues to experience the struggle between self-needs and professional identity. Despite having experienced burnout, she still feels driven by clients needs, and in “less rational moments” feels self-contempt and does not accept her limitations. Only the lessons of “time and experience” will prevent her facing burnout again.

4.5.4 Thoughts of leaving the profession

Respondents who could not mentally resolve the conflict between self-needs and perceived organisational or professional demands ended up questioning their suitability to the profession. Even those with many years’ experience in their profession began to feel ‘inauthentic’ as a professional, unable to look after themselves yet strongly motivated to look after others. They questioned whether they could continue to help others:

“I would feel as though I wasn't practicing what I preached. Hypocritical somehow.”

“Not feeling very authentic in my role.”

“Very low self-esteem, a doormat with nothing to offer the profession.”

“Feelings of incompetence. I would have to resign and assess my professional future”

This feeling of inauthenticity may signify an extreme form of internalisation where the practitioner takes personal responsibility for the organisation’s lack of resources to the point of changing careers. This may be a healthy response if all positions in the profession require greater time commitment than the practitioner can deliver, but could also indicate overinvestment of one’s self-image in the professional role and a need to ‘step back’ and examine whether the job can made healthier or a better one found before giving up the profession. Burnout appears to be associated with overly high personal
standards, but this is an unfortunate reason to leave a profession. Black and white thinking about this does not help: balancing self-needs with work-role needs appears to be a difficult issue for many respondents in this sample.

4.5.5 Summary: The psychological effects of burnout

Answers to Q15 provide a clearer picture of the feelings and thought processes of a person heading toward burnout, supporting many points noted in previous sections and suggesting a theoretical explanation. It appears the majority of respondents perceive burnout as a personal fault, a failure to work hard enough to meet organisational or professional standards. This self-blame may be associated with anger or contempt towards oneself and loss of self-esteem. In effect, the person’s perceived ‘incompetence’ contradicts his or her professional identity but is interpreted as a loss of self-identity. The person compensates by working harder, but when this does not solve the problem self-esteem declines further. Eventually physiological impairment leads to depression, detachment and cognitive impairment but the person continues to seek the solution in working harder, creating a spiral of emotional and physical decline leading ultimately to exhaustion.

This conflict between professional identity and self-esteem is hypothesised as a fundamental explanation for the paradox of high levels of burnout in mental health professionals. Such persons respond to continuing high stress by maintaining unhealthy levels of work, justified by self-stigmatising beliefs that internalise others’ negative attitudes to burnout as professional failure. They may also blame others - colleagues, clients, managers or “the workload” - externalising the problem as beyond personal control. Fatalism, dichotomous thinking, projection and denial are related cognitive strategies that help maintain a false sense of self-esteem as a ‘competent professional’, invulnerable to work pressures despite evidence to the contrary.

The long-term ‘survivors’ of burnout or severe stress reported a renewed understanding of their self-care needs and a more realistic appreciation of the stressful nature of mental health work. They highlighted “listening to myself”, enjoying “pleasurable activities” outside work and “accessing support” as key strategies to breaking the cycle of negative thought processes. Even after learning this the hard way, some still struggled to reconcile their professional identity with health and self-esteem.
Only a small number of respondents perceived burnout symptoms as a signal to increase self-care, suggesting this fundamental struggle remains common amongst this group, even though two thirds reported having experienced burnout. If this finding applies more widely, it should be a significant cause for concern in professional education, training and development activities (see Chapter 7).

The model of burnout developed here is illustrated by the case examples presented in Chapter 5, and further developed in Chapter 6.

4.6 Barriers to preventing burnout and strategies to overcome them

The later sections of the questionnaire (Q16-19) asked about the barriers to avoiding burnout in respondents’ organisations and how they could be overcome (Research Question 5). These questions aimed to provide recommendations for managers and other stakeholders, and were placed last on the questionnaire to give respondents a chance to reflect on the issues when answering previous questions. The responses often raised concerns identified previously, such as workload, and this section highlights three psychological barriers emerging from the questionnaire and interviews that are less well acknowledged above: the lack of time for self-care, the loss of perspective as stress leads to physiological deterioration, and the belief that burnout is inevitable. The final section covers respondents’ views of how the organisation and the professional can reduce burnout.

4.6.1 Time pressure and lack of time for self-care

Q18 asked about the three main barriers to preventing burnout in respondents’ organisations. Answers tended to echo those from Q6 about causes of burnout (see 4.2), particularly in focussing on external barriers such as excessive workload (39 respondents), poor management practices (20 respondents), inability to access leave (15 respondents), and social stigma among managers and colleagues (15 respondents).

As noted earlier, attributing the causes of burnout to organisational factors can indicate a self-serving bias that allows perceivers to avoid recognising their own part in a problem. However, other studies point to similar characteristics in mental health work: prevention must address both the work context and the perceptual issues.
Organisational barriers included the workload and managers’ and colleagues’ attitudes and values, as documented in 4.2, 4.3 and 4.4. One aspect of workload was, however, better represented in Q18 and the interviews: the lack of time for self-care necessary to avoid burnout:

“The main barrier to engaging in self care is if your employer has unreasonable expectations of your time and energy and if they don't value your self care.”

“Getting too busy to take time to step back and think [due to] ongoing caseload and new referrals.”

This was clearly a source of great frustration and conflict for respondents who felt they had to sacrifice either their professional image or their health. Time pressure was often more pervasive than the formal workload indicated: respondents cited a wide range of subtle pressures arising from bureaucratic management systems, paperwork or electronic reporting requirements, the need to multi-skill, and implicit expectations of working overtime:

“Expectations of organisations that workers will continue to take on extra and/or 'multi skill'.”

Interviewees described this in more depth:

“There are a lot of agencies taking on new graduates and basically flogging them until they drop. They're given an enormous amount of responsibility, they're not well supported, they are not particularly well-informed … people that I've studied with have withdrawn from social work within a couple of years because they can't maintain that.” (Interview quote)

“Staff have so much more to do [now], and with everything being electronic, you know like management plans, care plans - all this extra paperwork that they’ve introduced electronically - nurses haven’t got time to … sit and reflect. It does build up, and every time they have a bad shift it just gets worse and worse and worse, and … they don’t really have a chance to talk about it.” (Interview quote)
Time pressure could also be created by attitudes in respondents’ professional identity, consistent with the model in 4.5:

“A pressure I guess. I mean we just always seem so short staffed, officially at the right FTE but then people are off pregnant and sick and so they’re always calling, you know every day. I don’t directly feel any pressure from them [colleagues], more just from the organisation. I feel I recognise that’s totally my right to go home but at the same time there’s that little bit of guilt about not helping your colleagues that you’re working with day in, day out.” (Interview quote)

“… too many of us want to give the best possible care to our clients but we don’t want to let our colleagues down so we work the extra time, which management uses to not employ [more staff].”

One interviewee, a supervisor, recalled a subordinate’s strong feeling of being trapped:

“… she realised that she needed to get out of there but she was having trouble getting out of the roster and being moved to another area [and] it took too long, and she started to feel that she should look for another job. … And we got her into another ward and she started to get her skills and confidence back because she only had about two years out of Uni, and now that nurse is working as a community nurse and she's doing really, really well. Now, she nearly left it because she was in an environment that she felt trapped in. Trapped in.” (Interview quote)

As the model above predicts, a common response was to work harder to maintain one’s professional image, something supervisors did not always recognise:

“People are reluctant to be seen as vulnerable, it's like a threat to their image and [they] probably will struggle on against the odds, to their disadvantage, before they'll actually seek some help, and I think there is a skill in the supervisor to pick up on that, and say here are your options, these are some things you can access.” (Interview quote)

Another supervisor described a healthier attitude:
“Some people, they have a sense of obligation and they feel like they can't say no or they just want to help out because we're short, and I'll say, ‘Forget it. You know at the end of the day we'll work it out somehow.’” (Interview quote)

These quotes suggest managers aiming to reduce burnout should seek to better understand work pressure as it is experienced, not as a formally planned ‘workload’. This includes the subjective consequences of task fragmentation and bureaucratic distractions, inadequate training, and perceived pressures from managers or colleagues. A subjective perspective would highlight professionals’ need for time to reflect, reenergise, maintain social support and otherwise cultivate wellbeing, activities that are rarely counted in workload models yet underpin the quality and sustainability of professional performance.

4.6.2 Losing perspective as burnout sets in

While briefly mentioned in questionnaire responses, the cognitive decline associated with extreme stress was clearly described by interviewees who had experienced burnout – but was only recognised on looking back on the episode:

“I did not know I was burning out until I was approached by a supervisor”

“I think it’s about how long before I had been burnt out and how long ‘til I recognised it…I knew that I was stretched, but probably didn’t realise that emotionally that was starting to have an impact.” (Interview quote)

The physiological changes induced by extreme, prolonged stress reduce mental awareness, ability to concentrate, decision-making capacity and memory (Deligkaris et al., 2014; Oosterholt et al., 2012; Osterberg et al., 2012). This ‘mental fog’ then further reduces a person’s ability to perceive his or her state and make the decisions necessary to remedying the problem. Many interviewees described losing the ability to see how and why their stress was increasing, and several commented on the irony of being a mental health professional unable to recognise stress, anxiety or depression in themselves. The unfolding pattern of self-deceptive thought behind this is well illustrated in the case example of Sharon presented in Chapter 5. In a contrasting case, Fiona describes how her sense of self-esteem stopped her from continuing a self-destructive level of overwork.
Several interviewees were also health service managers who described this loss of perspective from ‘the outside’, having had staff keep their symptoms hidden until they reached the point of exhaustion:

“I don’t think it’s because they’re deliberately doing it, but I think they, you know to them at that point maybe it’s a little thing … And so they don’t say anything until they get to that point where it’s critical, and I think that’s what the problem is because, you know you don’t hear anything and the next thing the staff are being sick, it’s like, why are they sick? They’re sick because they’re just so stressed and burned out. And they end up taking sick leave.” (Interview quote)

“Often there's not an acknowledgement of burnout though, it'll be - they'll fall really sick with the flu, and there will be some sort of physical illness that will result in them stopping, and often they will get their body physically better just to get back over that line and they're back on that hamster wheel again, so they might be that person that has the high absenteeism but they're not even aware other than 'oh I get sick a lot'.” (Interview quote)

The latter respondent illustrates the model proposed in 4.5: when physiological or psychological evidence conflicts with one’s self-image as a professional, the evidence is ignored and the image upheld by investing more in work. Managers and colleagues reinforce this response when they value professionalism above wellbeing.

This loss of perspective suggests intervention strategies such as Employee Assistance Programmes are unlikely to be effective, as this interviewee observes:

“People will come back from the EAP and go, ‘oh, it just wasn't the right person’, or ‘you know it wasn't exactly what I was looking for’, I think sometimes people have let it go for so long they're in such a state of distress that nobody [no counsellor] is going to be the right person, nothing is going to be able to, in six sessions, turn that around for them, I think sometimes we suggest EAP too late, so we've really let the horse bolt before we try and capture what we need to.”
In this state of mental fog such persons are likely to continue externalising the problem (‘it wasn't the right person’) or otherwise avoid recognising it. Supervisors, peers, counsellors or persons outside the organisation may be able to help in this state, but it is important managers understand that the professional is physiologically incapable of managing a recovery.

4.6.3 Perceiving burnout as inevitable

A third psychological barrier to eliminating burnout is the belief that it is unavoidable. When asked about this (Q16), 12 respondents thought it was unavoidable. Previous research suggests people often avoid health problems because they see them as inevitable or untreatable in situations where other people or doctors would not (e.g., Hall et al., 2008; Keeley, Wright & Condit, 2009; Niederdeppe & Levy, 2007).

Many of these appeared to believe their organisation would never adopt appropriate self-care policies:

“Well, avoidable but the management have to make the decision to implement policies that encourage self-care. It is an ever present risk in this field.”

This was often explained by the management style and underfunding in public health agencies:

“In Public Sector - due to a complete lack of control of workload and the resources to adequately provide a service. Also the service runs on people providing a service on bare minimum resources.”

“Bureaucracy get ever more complicated every year, with ever more requirements of a one size fits all nature. These additional regulatory policy requirements will eventually get to you. This is not just one department.”

Others saw its inevitability in the psychological and emotional demands of working with suicidal, violent or distressed patients:

“Sometimes, even if you take care of yourself, the nature of our clients and workplaces means that we will feel burnt out at times.”
“Dealing constantly with patients who are distressed, aggressive, manipulative, traumatised will inevitably lead to some amount of stress or exhaustion for the clinician.”

“It’s hard – there’s no taking the easy option in mental health. My work starts before I get in the door!”

An insightful variation on this is that while good work requires an emotional investment, professionals rarely see good returns from their work:

“I believe that to do a "top" job with my skills, I need to invest some emotional energy into my work. The alternative seems to be not becoming emotionally involved at all, which I have often observed in other mental health professionals and I think that reduces the quality of service they provide. Therefore, if some striving and emotional investment is required, and outcomes (by nature of the work) are limited, often frustrating, I believe a degree of burnout is inevitable in order to do a "top" job.”

As noted earlier, fatalism can be used as an excuse to avoid taking action. Managers, educators and professional associations need to explicitly counter this attitude by showing how burnout can be avoided, especially in jobs that are intrinsically highly stressful.

4.6.4 Organisational and personal strategies for preventing burnout

Organisational strategies

When asked how their organisation could help them avoid burnout (Q19), respondents pointed to supportive supervision and open acknowledgement of the problem (Table 4).
Table 4: Organisational strategies for avoiding burnout

<table>
<thead>
<tr>
<th>Theme</th>
<th>Respondents (N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managers supporting staff need for self-care</td>
<td>29</td>
</tr>
<tr>
<td>Discussions about burnout</td>
<td>21</td>
</tr>
<tr>
<td>Wellness education programmes</td>
<td>13</td>
</tr>
<tr>
<td>Increase staffing</td>
<td>13</td>
</tr>
<tr>
<td>Regular quality clinical supervision</td>
<td>9</td>
</tr>
<tr>
<td>A written policy on burnout</td>
<td>4</td>
</tr>
<tr>
<td>Peer mentoring</td>
<td>4</td>
</tr>
<tr>
<td>Nothing can be done</td>
<td>1</td>
</tr>
</tbody>
</table>

Interestingly, respondents did not highlight workloads - the main perceived cause of burnout - so much as a more humane approach to management. Support appears to be as much a psychological as a practical necessity, reflecting the desire to be treated as a person rather than a resource:

“An astute supervisor who is tuned in to my emotional welfare regarding work, and makes appropriate suggestions / allowances as part of performance management ie supportive, effective supervision. NB: Discussion of burnout symptoms before they occur.”

“… what would have been helpful for me is someone saying look, we appreciate this job is difficult and stressful……and that could have an effect on you, you could end up being burnt out with this, how are we going to manage that.”

(Interview quote)

More practical suggestions involved wellness programmes, peer mentoring and a written policy on burnout.

Some interviewees with management roles perceived the value of respectful openness and support from the ‘other side’:
“I think it's about people like myself talking to our staff, in an ongoing way, about … how they're going, without fear of repercussion. There is that fear for people of ‘how do I still look like a credible professional if I'm admitting to the fact that I'm not really coping’.” (Interview quote)

“Just knowing that they [supervisors] are there to support them is what, that’s what they wanted to know … just having her there shows, you know - that we do care.” (Interview quote)

“At the moment I think everyone understands, you know ‘this is how it is, it is a busy ward’ - and I’m sure everywhere is the same, but I think the main thing is … that they just needed to know that management is listening to them.” (Interview quote)

The case of Fiona in Chapter 5 shows how supervisors seeking to be more supportive can run into conflict when senior managers do not share this concern.

**Personal strategies**

Answers to the question “how can a mental health professional prevent burning out?” (Q17) strongly pointed to *self-care* (Table 5), in contrast to the externalised perceptions of its ‘causes’ in workloads, managerial or supervisor indifference and peer stigma (4.2 - 4.4). This may reflect the shift from questions about ‘causes’ of burnout and others’ attitudes to personal and practical solutions, but is also consistent with the biased thinking suggested above.
Table 4: Personal strategies for reducing burnout

<table>
<thead>
<tr>
<th>Theme</th>
<th>Respondents (N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-care</td>
<td>45</td>
</tr>
<tr>
<td>Accessing clinical supervision</td>
<td>24</td>
</tr>
<tr>
<td>Self-awareness and honesty</td>
<td>15</td>
</tr>
<tr>
<td>Seeking peer support</td>
<td>13</td>
</tr>
<tr>
<td>Strong personal relationships</td>
<td>7</td>
</tr>
</tbody>
</table>

Self-care covered activities from diet, sleep, exercise and recreation to reflection, setting personal boundaries with patients and finding good external clinical supervision in order to debrief difficult cases and undergo personal therapy, as recommended for health professionals (Bober & Regehr, 2006; Smith & Lenz, 2010):

“Stopping to reflect on how we are coping, feeling and managing.”

“Moderate how much work we take on, take regular holidays, access support and counselling, demand supervision.”

“If the professional is willing to put their mental, emotional and physical health first. If they get lots of support, if they are willing to acknowledge how they feel, that they are not perfect, don't have all the answers.”

“If a person is willing to accept support, engage in supervision and be honest about the impacts of work on their wellbeing, it [burnout] is avoidable.”

Consistent with the model developed in 4.5, these responses suggest that reducing burnout will require confronting deeply-held habits in order to “stop” or “moderate” professional busyness and adopt health-restoring behaviours – and that change is only possible “if the professional is willing.” The model predicts that for burning out professionals, balancing their professional self-image with a more holistic self-respect is quite a difficult challenge.
4.6.5 Summary: Barriers to preventing burnout and strategies for overcoming them

The perceived barriers to preventing burnout tend to reflect the causes acknowledged earlier: workloads, managerial and supervisor attitudes, and peer stigma. This can be seen as an externalising viewpoint, although other aspects of the survey and other studies of mental health organisations in Australia suggest these issues are real.

The three psychological barriers identified here concern the subjective consequences of these issues. First, respondents clearly felt considerable frustration and conflict about balancing self-care with organisational time pressures. The latter were often very subtle, not well measured in workloads, and could reflect implied rather than formally stated expectations. These include expectations about not letting colleagues or clients down, which drove many to continue working despite untenable loads, consistent with the model above. Managers and others aiming to reduce burnout should recognise the subjective consequences of time pressure and the value of time for reflection and self-care in mental health work.

Another often unrecognised barrier is the professional’s loss of perspective as physiological depletion sets in. This appears to be a key part of why highly trained professional staff cannot recognise their own state (Putnik et al., 2011), and highlights the importance of supervisors, peers and external persons (family or clinically-trained professionals) in identifying symptoms before full burnout is reached. It also explains why EAPs and other conventional interventions often fail: professionals not only have cognitive biases against seeing their actual state but also a reduced capacity to perceive accurately and reason clearly.

A third psychological barrier is that many managers and professionals are accustomed to seeing burnout as inevitable. Both may justify this with a ‘managerialist’ view of organisations that normalises high stress and prioritises financial over human costs, or by the emotionally-draining nature of mental health work. Changing such fatalistic attitudes is important to reducing burnout.

Interestingly, respondents suggested organisational strategies for reducing burnout that emphasised supervisory support more than reducing the workload. Managers would do well to recognise that professionals want to be treated humanely in the first instance,
and will in return more readily accept many of the difficulties of mental health work. Increased staffing, education, mentoring and policy creation were other suggested initiatives.

It is also noteworthy that despite the externalising viewpoint encountered elsewhere, when asked what professionals can do respondents referred primarily to self-care. Overall, the findings of this chapter suggest an understanding of the cognitive processes that prevent professionals from doing this is essential to reducing burnout, an element so far missing from both academic and practitioner publications on burnout. The model identified in 4.5 and expanded in the Chapter 6 aims to help future researchers fill this gap.
CHAPTER 5: CASE STUDIES

5.1 Introduction

This chapter describes the experiences of two interviewees, Sharon and Fiona, who gave particularly clear insights into the thought processes of mental health professionals facing severe stress. Sharon’s sense of professionalism lead her to respond by working harder and not seeking help, eventually becoming incapacitated to a degree that required several months’ sick leave in order to recover. Fiona also overworked, to maintain her professional image as a ‘helper’, but recognised she was facing burnout and negotiated a lower load. Now a manager, her attempts to change the workload and culture in her team had met resistance from managers and other staff. Fiona’s interview provided good insights into managerial attitudes to burnout.

5.2 Sharon

*Professional identity and work context*

Sharon was a senior mental health nurse who tried to manage a heavy and emotionally demanding workload by running on adrenaline:

S: I mean it is really challenging [working in mental health], because you never know each day what is going to happen, you really need to be fairly experienced to be able to do it, to recognise what is a serious illness and what isn't, and know how to get people into hospital if they need it… I have kind of done some counselling since all of this happened, and all this stuff came out, that I needed the adrenaline to function, to work and in the rest of my life, that's what happened.

Sharon’s professional identity included being able to accurately perceive and cope with stressors, to be able to self-manage the workload at any cost. Failure to meet these perfectionist goals would involve self-blame:

I: When you think about yourself burning out in that job, how did you make sense of it at the time?
S: Well just all the stuff that...you know, you should be able to do this, you should be able to cope, what I have read, people who are a bit perfectionist, people who are a bit anal … because that's what I kept thinking, that if I got my processes sorted, you know if I have good processes, it will work. I had all sorts of processes for managing the workload, but eventually I don't think it matters [laughs], there was just too much work, and I mean anybody could see that, but you know, because nobody kind of says, ‘I know you're not managing it’, that's the job and somehow you've just got to manage, I guess that's what was in my head, you know, yeah, you're capable and you should be able to manage to do it.

**Losing perspective**

Sharon described her loss of perspective as she worked harder, and her subsequent disbelief that training in mental health had not prepared her to diagnose her condition until she reached the point of being unable to work:

S: I was working longer, and I never had lunch, you know all the kinds of things you think, why are you doing that? You know when you think of it, you're a mental health professional why wouldn't you see that? My husband used to say that to me, if you were listening to someone on the phone, telling you about this job, what would you advise them [laughs]. I mean I actually said to my boss at one point, ‘you need to performance manage me’, but she said, ‘no that is ridiculous, that's like I think you're not doing your job properly’, and I said ‘well.’.

Here Sharon shows a high degree of self-deception about her ability to work long hours and cope with stress. Self-deception is considered by social psychologists to be common in professionals’ self-evaluations (e.g., Dunning 2003), and is further discussed in Chapter 6. As a mental health professional, Sharon expects to be more resilient and self-aware than the average person. In reality, she did not recognise her high levels of anxiety and depression. By this time she was so unwell that recovery took a long time:

S: Well the difficulty was I actually got depressed, and I didn't recognise it, and I was always quite anxious, which was a lot to do with that whole adrenaline thing, kind of running on adrenaline. So after I eventually went to see my doctor and he actually, [laughs] he persuaded me that I should actually take sick leave
and it took about 6 weeks before I started to feel a bit better, but it really took about mid-March to be able to look back and think ‘what was I doing, why did I stick at that for so long and why didn't I recognise that something was wrong?’ Because eventually, my whole life, the way I coped with anything, it was like everything was kind of - I mean I was depressed and I wasn't enjoying the things that I've always enjoyed. So yeah, it did have quite a bad effect on me eventually. And I think that was part of the whole 'I should be coping'.

This realisation caused Sharon to question her capacity to work as a mental health professional:

S: I mean to start with I couldn't see myself ever working, I said that a couple of times to my husband, I don't know if I could ever go back to work, you know, and he said well you're not back at work yet so you don't have to think about it.

**Colleagues’ and supervisors’ attitudes, organisatinal culture and self-blame**

Sharon found her colleagues seemed to accept the “impossible” workload. Despite her supervisor encouraging staff to speak out in meetings, she did not disclose her condition as this would clash with a culture of professional behaviour, that tacitly stigmatised reporting stress. This pluralist ignorance (Breed & Ktsanes, 1961) led her to blame herself for being unable to cope:

S: Some colleagues said ‘you know, it's impossible, we recognise the workload is too much but we can't do anything about it.’ Um...

I: So, how was it talked about, you know, people being stressed out, burning out, that kind of thing?

S: It wasn't really. I mean, partly I think if it was introduced I would feel that I should come forward with it, but I've never felt able to introduce it myself in that forum [staff meetings]. I know that the nurse director is trying to get people to use the forum more, but it's just not [working], and I think that's part of the culture: you just cope. If you're in this position it is stressful, and you just cope.

I: Do people say that, or is that the .. undercurrent?
S: I think it's the undercurrent … I never didn't raise the subject that there were too many referrals, and emailed the team, and spoke to the supervisor, and put it out there, ‘26 referrals have come in today, it’s Wednesday today, each referral takes an hour so if you do the maths, there's no way I can do all these referrals’. And if people don't respond, and people don't make changes, you think, well, they don't care, they're not recognising it, and they're like, ‘well we're all like that, we've all got too much work’. So I still felt like it was my fault that I wasn't coping.

Although Sharon’s organisation provided an Employee Assistance Program, in general staff did not access it unless they were referred for visible behavioural problems such as interpersonal conflict:

S: Which is sad I think in many respects, I've always thought that in health [services] generally people treat each other quite badly really, and you'd think it would be better in mental health, and I think there's lip service to it, and obviously you can access counselling and stuff, because there is the workplace service and you're encouraged to but usually it's [only] if you're having conflicts with people.

_A vicious circle of hard work and low self-esteem_

Sharon well described how working harder lead not to improved self-esteem but to depression, creating a ‘vicious circle’ and leading her to shut out those who tried to help:

I: So you have some workplace wellbeing programmes?

S: Not really, I mean, the things that I would [normally] do myself, like the exercise, self-care, that … just got less and less as well. It ended up I wasn't doing anything, I used to go for a walk at lunchtime, in the end I was just sitting at my desk at lunchtime, eating my lunch and answering the phone. It must have been the way I responded to that, I just thought it was me, and I needed to work harder, so it became a vicious circle … What I think happened is once I started to get depressed, I don't know if anyone else [faces this], to be honest my husband was kind of frustrated, he was like, ‘what is going on?’, but … I didn't
really listen to him, and he was part of my support network but I didn't really listen.

**Saying “no”: Sharon discovers the downside of her personality style**

Sharon recognised in hindsight that she had difficulty saying “no” to work demands and was highly motivated to please others:

“I'm not someone who can kind of be short and rude … if someone comes and asks for something I would usually … try and help or explain it, but she [another nurse] would be like ‘oh I don't have time to speak to you about that, go and ask somebody else’. Because as the duty nurse you're always there, so if someone wants to know something, they come to you.

This desire to please gave Sharon a ‘nice girl’ or ‘helper’ image that contributed to her career success. She recognised it as an important part of her personality:

I: So the qualities that make you good at your job, made it harder for you in some respects?

S: Yeah, and I mean that's what a few people have said, ‘you know, you're too nice, you're too accommodating’. But if you're not like that.. I mean, that is just my personality, I would rather be like, ‘well, what can we do to help?’

In hindsight Sharon could see clearly how this style, coupled with a strong desire for professional success, had lead her to burn out:

S: I think that's part of the problem with it, I think up until now, I've never really *not* coped with something. You know, I've always - it's the story of my life, from school - I've always just been able to do stuff, I've been able to pass exams and do what I wanted to do, I went to university, did a science degree and worked in a lab and then got fed up with that, and then met someone who was a psych nurse and thought that sounds quite interesting, and went and did the course, and enjoyed it, and I've always enjoyed my work and now I've come to this job and I can't do it, and on a personal level that kind of.. ‘I can't do this!’ And then I was like, I'll just keep honing and then I'll be able to do it, so some of it is the job and
some of it the clash between my personality and my life experience and then the 'I can't do it, I can't do this’.

I: So, how do you make sense of it all now? What have you taken from the experience?

S: Well I think, you know in terms of expecting less of myself, you know, expecting a reasonable amount…

Coping with stress: The contributing effects of age and menopause

Sharon also saw contributing causes of her burnout in a loss of awareness and flexibility due to middle age or menopause, making her less “robust” than younger workers:

S: And I think my time in life as well, I mean I'm in my 50s and I'm probably menopausal, and I don't think that helped either, in terms of my awareness of what my expectations were, what my capabilities should be.

I: So this has kind of forced you into re-evaluating..

S: Yeah, and I think that's pretty much the average age, you know, for Mental Health nurses, it is a kind of older workforce, so from a service point of view it is probably quite important too. Because there is definitely something about that, you know the whole hormonal thing, the person who's doing the job now is younger and probably a bit more robust, I think the worry [is] … you get kind of cynical and you burnout when you're older, I just think you're less flexible to kind of come 'round again, you know.

The critical role of supervisors in detecting burnout

Her experience of being unable to recognise her own symptoms lead Sharon to give supervisors and organisational cultures a critical role in preventing burnout:

S: I think if someone has worked in mental health for 20 years and is suffering from burnout [but] can't recognise it, then, maybe.. it should be part of your manager’s role or just a matter of course that you're encouraged to think ‘well ok you've identified things that aren't working, and if that's the case, are you getting help?’ And I think it needs to be more acceptable, and I think at the moment
there certainly are lots of negative connotations, and I certainly saw it as, if I wasn't doing my job, then I was responsible, so I suppose what would have been helpful for me is someone saying ‘look, we appreciate this job is difficult and stressful’, and that was said, but the next thing that needs to be said was ‘and that could have an effect on you, you could end up being burnt out with this, how are we going to manage that?’

I suppose all jobs are stressful but it needs to be, ‘how do we cope with it, how do we get you to the point where you're not burning out?’ [not leaving it] up to people like me to say ‘well no, I'm not coping.’

Summary

Sharon’s story illustrates how the perceptions and beliefs identified in Chapter 4 can be used to shore up a professional’s work role identity when overloaded, causing them to work harder to avoid a loss of self-esteem. When stress leads to physiological decline, perhaps assisted by age or other physiological conditions, professional role identity ‘demands’ working harder to compensate. To maintain her professional self-image, Sharon ignored the inner signals and avoided disclosing her problems or seeking help from others, eventually becoming unable to function. Only in hindsight could she see this process in action. She was surprised how little her training had prepared her for seeing and responding to her own mental health symptoms.

5.3 Fiona

Professional identity and work context

Fiona was a Mental Health Occupational Therapy manager and practitioner who was able to see the issue of burnout from both the professional’s side and the managerial side. Her viewpoint is influenced by having burned out herself, and she well describes the internalising and externalising thought-patterns of both groups.

Professional’s expectations and disillusionment with the reality of mental health work

Fiona saw mental health occupational therapists’ professional self-image as strongly based on a desire to help patients. She identified a strong sense of disillusionment when new graduates’ expectations did not fit the time-pressured realities of the job:
If I look at the new grads generally they’re pretty high achievers. You know we’re still taught that you can do all of this for this patient. Here’s this prime mental health patient. What are you going to do with him? And we come up with all of these wonderful things. It’s great and it’s fantastic. Then the reality when they actually get into the workforce is that they only get time to do this tiny little piece of the pie. And so I think what often happens is that they have this desire to do all of it, and to perform really well, and to do best practice all the time for everybody, and the reality is ‘sorry but health care is not about best practice all the time anymore. It’s about the best practice in that little bit that you do’. It’s not about a holistic service in most cases, certainly [not] in acute care.

She had experienced burnout several times, and saw it as almost inevitable as mental health work. Professionals tended to lack awareness of burnout and their own vulnerability:

I’ve been [in the sector] for 20 years and I think I’ve probably come through that cycle a number of times, and I think that most people who work in health for that length of time will have touched upon that. [Through] people’s lack of insight and awareness they don’t think they’re actually approaching burnout.

**Losing perspective**

Fiona described a time when she realised she was burning out through having an aggressive emotional reaction to a client. She had believed she was self-aware and was surprised at how long she took to recognise the need to reduce the work pressure:

I: Can you tell me a little bit about a time when you did burn out?

F: I think [what strikes me is] about how long [it took] before I recognised it. I think I came to a point of recognition when I was working in mental health in the public sector, there was a gorgeous woman [who] had borderline personality disorder and I’d been seeing her for a length of time, and who knocked on the door and I just remember the first thing that came to my mind was, ‘what the hell do you want. There’s nothing I can offer, I’ve been through this before and there’s nothing more I can offer’. Beyond professional frustration, [this was] much more of an emotive reaction for me. It was just a big wake up call, I knew that I was busy, I knew that I was stretched, but probably didn’t realise that
emotionally that was starting to have an impact. And I think luckily I tend to be fairly self-aware and picked it up then, and negotiated a change from then on, because I just thought if I don’t I will really be at a point of looking at being burnt out in the full sense of the word.

At this point Fiona questioned her professional identity and career choice:

F: I think really, I had probably been burning out earlier, so it was a snapshot moment that made me recognise it, and I think at that point I did a lot of soul-searching about whether I wanted to be doing what I was doing. I had been a therapist about 13 years, certainly had always loved what I was doing, so it was unusual not to necessarily feel as satisfied with it, as challenged with it in a positive sense - the challenges felt more overwhelming. So I think there is that sense of yourself, of where am I? Am I failing at this? Not performing to my usual standard.

The role of self-awareness and self-esteem

Unlike Sharon, Fiona was eventually able to relate her feelings of stress to an unrealistic workload, an insight she attributes to her self-esteem and a perceptive awareness developed through considerable experience in the field:

I think for me, because I was able to look at the workload, I considered it to be a level which was unreasonable, for everybody not just for me, and I think I am fairly comfortable in my own skin … nobody could cope with that, it wasn’t just a failing on my part I think. … I had enough experience under my belt and enough confidence in my own abilities to go, ‘no, that's ok, it's not actually about my skill set, it's about the workload and the work situation’. Had I been 3 years out of uni [sic], a little bit greener, I think it would have been very much about ‘I’m failing, it's me as an individual’. I think I was lucky, at a time in my life where I had all that other experience, that professional maturity kicked in.

Fiona considered her level of self-awareness uncommon amongst health professionals, who often only considered physical illness as a cause of symptoms that were actually due to the stress of overwork:
I think that a lot of people in health care are so busy, they don't stop to think about it, they're just like hamsters on a wheel, they just keep going until all of a sudden they might not be able to do it any more. And often there's not an acknowledgement of burnout, they'll fall really sick with the flu, there will be some sort of physical illness that will result in them stopping, and often they will get their body physically better just to get back over that line and they're back on that hamster wheel again, so they might be that person that has the high absenteeism but they're not even aware other than 'oh I get sick a lot'.

**The role of supervisor support**

Fiona was grateful for a supportive supervisor who did not blame her or doubt her competence when revealing to her symptoms of burnout:

F: Thankfully I had a boss who was very open to me going to her and saying this is what I need, and she ran with it. I don’t think everybody would have that same experience.

I: So how did you feel going to your boss and talking about it?

F: I think because we had a good relationship, it was ok. Had we been in a situation where you didn’t have that relationship with those supervising you.. And to be honest I consider that quite unusual these days, I don’t think people always do have a good relationship with the person who is supervising them. I think [my supervisor had] an underlying respect, a good knowledge of my skill set, and knowing I was doing everything that I could to manage it, that it wasn’t in any way indicative of me performing to a certain level - I think if those things hadn’t been there I would have found it much more difficult to look at. I think in my situation the ducks kind of lined up [with my supervisor], and there's a lot of people that that doesn't happen for.

**Saying ‘no’ to managers’ expectations both essential and difficult**

Fiona also observed how organisational managers tended to see burnout as a sign that the individual needs to be fixed or to be trained in time-management. As a trainer in health industry time-management workshops, she focused on helping stressed professionals learn to say ‘no’ to managers’ expectations:
I: So these other people, have you come across or seen any colleagues burning out?

F: Yes. Well part of the work I do is I am involved in training in workplaces - management and leadership training in health. Often you'll end up with people [in training] who have been sent by management to help them "cope" better with what's going on. And often that's an environment where you see people who are very close [to] if not burnt out already, who are not being supported by the system. And they are being seen as not coping with their job and so they have to send them off for training. I think it is probably done with the right intent, it's just not necessarily the right intervention. And I think, you know often I'll be running time management sessions and people will come and say, oh, I'm here because I want to learn how to do more in my day and the first thing I will teach them is how to say no to things.

In contrast, Sharon had adopted the management perspective in seeing lack of time as her problem. Although a manager herself, Fiona recognised the workplace contributors to burnout perhaps because of her own experiences:

F: People are having more and more asked of them with less resources available to … deliver it, and the thing that is problematic … is that it's the individual that bears the consequence of the increased demand. So I think when I look at that with my training hat on, I see a lot of people who are really close to that line, or over that line.

She also saw how professionals’ belief in the organisation’s ability to set realistic workloads was mistaken, and lead them to overlook personal symptoms of stress:

F: They're not necessarily looking for solutions in the right places, they feel that [organisational] systems are going to make it possible for them to do things [better], when actually [they should] look at it from a more personal perspective - ‘how am I going with all of this?’ Until that's dealt with, I don't think there's any likelihood that they'll be able to cope any differently at all.
**Negative managerial attitudes**

Fiona also attributed professionals’ reluctance to speak up to stigmatising attitudes and black and white thinking among managers:

I: What do you think is preventing them from doing that, from stepping back and seeing it as an issue and what kind of support they might need?

F: I think it's the blame thing, I think they need to see it as something the workplace has contributed to, and often that's seen as very separate things, it's either this person couldn't cope with the workplace, or, it's the workplace is all to blame. And often it's the meshing of these two areas that results in someone burning out.

So I don't think there is a lot of [managerial] insight into burnout, I don't think that it is something that is valued and seen as real or tangible … it is seen as a sign of weakness in an individual .. [as a result] a person might consider it to be their own weakness … they won't even go there, it's not a conversation they'll have.

I: Have you heard people saying this kind of thing?

F: Yes, I think there is (sic) certainly comments passed about a person's capacity to cope with the workload, or cope with the demands.

**Changing managerial attitudes**

Perhaps because of her own experience of burnout, Fiona felt comfortable about raising the issue of workload as a health and safety issue with senior managers:

F: I guess I have run the gauntlet of administrators because I'm not prepared to say well yeah we'll keep doing what we're doing, because we can't. I think we do talk about it but we talk about it in terms of it isn't necessarily about burnout and isn't about the organisation taking responsibility, it still comes back to the individual, and in the long term I just don't see that as being all that helpful.

However, she recognised that most managers would not listen, despite the high cost to the organisation:
F: If we're really honest I think it still comes with the obligatory eye roll as you talk through those [burnout and work stress] things, I think it's not given the credibility of other elements of OSH might be. And yet it's probably one of the things that's having the greatest impact on [professionals’] fitness to perform and the outcomes … if we don't look after them and look after their mental health in the same way as we look after their sharps injury.. really the likelihood of [each] of those things [is] probably not dissimilar, and [yet] we take one of those extremely seriously, and have good systems and processes in place, and the other … we look at [as an] individual not really coping with the demands on them rather than seriously addressing it.

I think it needs to be embedded at a management level, I think until managers truly with hand on heart say, ‘we know that we contribute to this, we are trying on lots of levels within the organisation to try and look at it, we know it's probably also some personal stuff too, so we not only have the EAP there because we have to but because we value what it is that it can offer, and we'll be supportive of people in terms of the way they access that, and encourage them to access that.

This involves changing the organisational culture, not just manager’s attitudes or communications, through regular open dialog:

F: Until it becomes that cultural thing, I think it's about people like myself talking to our staff, in an ongoing way, about how are they giving [staff] an opportunity to talk about how they're going without fear of repercussion. There is that fear for people of how do I still look like a credible professional if I'm admitting to the fact that I'm not really coping.

In attempting to change the culture in her team by reducing overtime, Fiona and some of her team members had come into conflict with other managers or staff:

F: One of the things I’m big on is people not doing overtime. I have a great belief that overtime does nothing except mask an unmet need in our system, because it just really is us working additional hours.
I guess one of the things that I’ve experienced in a shared leadership role where I managed certain people in the team, and other people managed others, was that there was an almost an unspoken perception that my team weren’t working hard enough because they went home on time, and that as a professional you’re expected to do overtime.

And it was very interesting because one of the things that the staff would say is that they felt guilty for going home on time. I would say to them, ‘Look I’m telling you that’s what I want you to do,’ and they’d say, ‘Yeah it’s not about you. It’s about how I feel that other people might feel about what I’m doing.’ So how their peers who might not have a manager who is telling them to go home on time might then reflect on that individual and what they’re doing.

So I think that culture is alive and well, when somebody looks after themselves, I don’t know that that’s seen as a positive thing. I think it’s still a very mixed message out there. [It’s seen as] not working hard enough.

Fiona’s own response to the difficulties of changing the organisation was to lead by example as a middle manager:

F: I think sometimes when it comes from a manager its better, so if the manager is the one doing the role modelling around good practice, and then the next person down the line feels a bit more justified about doing that, that probably helps.

5.2.4 Summary

Like Sharon, Fiona described idealistic aspects of professional identity that encourage overwork, in this case beliefs about a professional’s ability or role in delivering a high quality service at odds with the organisational constraints. She reported the loss of perspective Sharon encountered, but was able to draw on her inner resources and a supportive supervisor to overcome it. She recognised self-blame, acceptance of stigmatising managerial attitudes, externalisation (eg., blaming symptoms on flu) and other internalising strategies as influences on her own and colleagues’ reactions to burnout. She also recognised avoidance, black and white thinking, stigmatising and externalisation among managers’ responses to it.
As a manager Fiona had the chance to reduce burnout in her staff, and had done so by reducing overtime and creating a supportive environment. However, this brought her into conflict with other staff and the organisational culture, and she recognised the difficulty of changing the organisation as a whole.

Both interviewees were surprised at the difficulty they had had in recognising their symptoms, despite their training, and both clearly saw burnout as a consequence of professionals’ faulty self-perceptions in conjunction with manager’s perception of mental wellbeing as a low priority for the organisation. Together, Sharon and Fiona’s interviews well illustrate the cognitive processes identified in Chapter 4.
CHAPTER 6: DISCUSSION

6.1 Introduction

This study examines the effect of mental health professionals’ beliefs and perceptions on their response to stress and symptoms of burnout, using a phenomenological perspective in which participants’ subjective views of the world form the basis for understanding behaviour. Mental health professionals are an occupational group highly susceptible to burnout (e.g., Gilbody, 2006; Morse et al., 2012; Schaufeli et al., 2009), despite their good objective knowledge of its symptoms, causes and serious impacts on mental and physical health. The findings show how professionals’ perceptions and beliefs about stress explain this paradox.

Although attitudes towards burnout have not previously been studied systematically, the literature on behavioural responses to other health problems shows how perceptual limitations and biases can lead individuals to minimise the seriousness of their symptoms and avoid seeking help (e.g., Putnik, de Jong, & Verdonk, 2011; Schulze & Roessler, 2007). Other studies have identified aspects of the work environment that encourage minimisation of stress symptoms, including an overly-strong sense of professional identity, self-stigmatising attitudes, social stigma and adverse workplace cultures and climates (Hu et al., 2012; Lee & Ashforth, 1996; Maslach & Goldberg, 1998; Putnik, de Jong, & Verdonk, 2011; Schulze & Roessler, 2007; Siebert & Siebert, 2007).

Five Research Questions were identified from these previous studies. This chapter begins by summarising the answers and relating them to the literature. It then presents an expanded version of the model outlined in 4.5, identifying factors in professionals’ perception of themselves, colleagues and managers that influence responses to symptoms of high stress.

The findings are largely based on a questionnaire given to 55 mental health nurses, psychologists, counsellors, psychotherapists, social workers, psychiatrists and mental health occupational therapists from public and private sectors. Predominantly older, female workers with a mean of 14.5 years’ professional experience, they are considered
reasonably typical of mental health professionals. Twelve of these respondents also participated in semi-structured interviews to further explore issues arising from the questionnaire.

6.2 Study findings and relation to previous research

Beliefs about burnout and its causes

As expected of mental health professionals, respondents generally had a good objective understanding of burnout: most reported good knowledge of its symptoms and the seriousness of its consequences. As a group, they also appeared to have significant subjective awareness since two-thirds reported having experienced it. The role of beliefs and perceptions in explaining the paradox behind this is shown in many contradictory aspects of their responses, including beliefs about the causes of burnout and their personal susceptibility to it.

Respondents’ beliefs about the causes of burnout showed two opposing explanations involving internal and external causes. When asked whether burnout was more likely to happen to some kinds of people most agreed, pointing to people with psychological vulnerabilities such as anxiety, depression, low emotional resilience, lack of stress tolerance or assertiveness, perfectionism and ‘workaholism’. The idea that burnout is caused by personal ‘weaknesses’ is now generally considered a misconception in the literature (e.g., Siebert & Siebert, 2007; Maslach & Goldberg, 1998; Hu et al., 2012), and researchers tend to describe its causes in situational variables (e.g., Lee & Ashforth, 1996; Schaufeli & Enzmann, 1998).

Respondents were also clearly aware of the environmental influences on burnout. When asked about its causes, two-thirds nominated excessive workloads, one third identified lack of supervisor or peer support, and the stress of working with difficult clients was often mentioned. High levels of job stress were apparent in many responses, often associated with feelings of pressure, frustration and even hopelessness. These reactions were exacerbated by perceptions of negative attitudes towards burnout among managers and colleagues: both groups but especially managers were seen to stigmatise burnout. These problems were seen as symptoms of systemic management failure in respondents’ organisations and the mental health sector generally, rather than localised
in the respondents work unit, consistent with other studies of mental health organisations (e.g., AIHW, 2011; Gilbody et al., 2006; Happell, 2008; Kim et al., 2011; Morse et al., 2012; Oddie & Ousley, 2007; Schaufeli et al., 2009). Environmental rather than personality causes also predominated when respondents described their own experiences of burnout.

This pattern is consistent with two well-known cognitive biases. In the fundamental attribution error (Heider, 1958; Weary, 2000), the behaviour of other people is explained by personality factors rather than situational or environmental factors. In the self-serving bias (Miller & Ross, 1975; Yagil & Ben-Zur, 2009), negative events happening to the perceiver are explained in terms external events, where positive events are attributed to personal factors.

A second contradictory aspect of respondents’ knowledge is that although two-thirds reported having experienced burnout, and a similar number had colleagues they thought had burned out, few respondents cited self-care as a strategy for avoiding it, and many appeared to believe they personally were able to avoid it, despite its prevalence. This appears to indicate ‘optimism bias’ whereby people are overly optimistic in their assessments of risk, preferring to believe “it won’t happen to me” (Weinstein, 1984, p.431; Clarke et al., 2000). Many of the responses and biases discussed below are consistent with an exaggerated belief in respondents’ ability to control their responses to stress.

These contradictory beliefs about the causes of burnout suggest increasing professional’s objective knowledge of burnout will not reduce the problem since many use such biased beliefs to justify avoiding self-care, minimising symptoms and failing to seek help until it is too late to avoid serious consequences.

**Perceptions of managers’ attitudes to burnout**

Previous studies suggest organisations tend to overlook burnout as a serious occupational hazard (MacBride, 1983; Maslach, 1982; Maslach & Goldberg, 1998), although there has been little empirical study of managers’ attitudes. Only a third of the respondents here considered their workplaces took burnout seriously by managing workloads appropriately and supporting staff in self-care. The rest perceived burnout was not taken as seriously as an occupational hazard: managers lacked interest or
awareness, blamed the individual, and tolerated or encouraged cultures that normalised stress and stigmatised those who could not manage it. The contrast with respondents’ own experience and awareness of burnout suggests a cultural divide between managerial and professional staff exists in these organisations.

Supervisors bridge this divide, and over half the respondents reported having a good relationship with their supervisor and feeling comfortable raising burnout or seeking help for it. However, answers to another question showed many would not actually raise it because negative attitudes - often justified by resource limitations - in the wider organisation meant their concerns would not be addressed. Many were also concerned they would be stigmatised by senior managers as weak individuals, lacking in self-management skills or failing to uphold a professional responsibility to manage stress.

These attitudes were seen as part of a broader culture of treating staff as resources rather than persons and minimising the organisation’s role in maintaining employees’ health. Staff were expected to simply absorb stresses, and burnout was seen as personal incompetence. This ‘stress culture’ is well documented in the literature. As long ago as 1983, MacBride described a failure to acknowledge burnout or take it seriously in US mental health organisations. More recently, Acker (2012), Attree and Newbold (2009) and Happell observed high rates of stress amongst mental health nursing and social work staff and Thompson et al. (1996) have described cultures that tolerate high stress, minimise recognition of burnout and seek to pathologise sufferers when they cannot ignore them. Mental health organisations may be particularly prone to this because managers can blame burnout on failure to maintain professional standards of self-care.

Managers may have self-serving economic, managerial and practical reasons for minimising the role of burnout in their organisation, as studies of ‘managerialism’ in public health agencies highlight. They may also have psychological motivations: like professionals, managers may consider absorbing high personal workloads important to their professional self-image, believing themselves immune to stress even under great pressure, and may therefore prefer to avoid admitting its existence in others. Future studies of burnout and workplace health should give greater attention to the motivations and mechanisms of managers’ influence on professional staff.
Managers’ attitudes are expected to strongly influence professionals since power and status are fundamental forces in person perception (Heider, 1958; French & Raven, 1985; Fiske, 2004). Clinical research further suggests managers are often subconsciously seen as parental figures (e.g., Hirschhorn 1988; Keller & Cacciope, 2001). Managers’ attitudes can therefore have a powerful influence on professionals.

However, Attribution Theory and person perception research generally suggest such perceptions are not always accurate and may be influenced by the perceiver’s desire to avoid facing difficult issues such as the need to set boundaries about workload. The discussion above and the theoretical model below identify a number of biases that may be used in such defensive thinking. Although negative managerial attitudes and a stress culture appear to exist in many organisations sampled here, perceptions of this may be exaggerated, and even if not they may be used as an excuse to ignore symptoms of burnout by believing ‘it’s beyond my control’, ‘the organisation has resource constraints’, ‘burnout is my problem not a management issue’, ‘managers will see me as incompetent or unprofessional’, ‘my supervisor says nothing can be done’ and so on.

Reducing burnout requires replacing these with realistic perceptions and beliefs about managers who understand, acknowledge and actively seek to reduce burnout. This may involve changing managerial values and practices, but given professionals’ considerable discretion to work long hours and desire to achieve high standards, they also may need to change their expectations.

**Perceptions of colleagues’ responses to burnout**

Colleagues are also likely to exert a strong social influence on professional workers. Beyond the individual attitudes of peers, professional groups have cultures that, like organisational cultures, inhibit recognition of burnout by stigmatising sufferers as persons transgressing professional or organisational norms (Grosch & Olsen, 1994; Maslach & Goldberg, 1998; Schulze & Roessler, 2007). Such beliefs reduce help-seeking in professionals with burnout (Hu et al. 2012; Siebert & Siebert, 2007; Putnik et al., 2011).

Respondents’ colleagues appeared to be well acquainted with burnout as nearly two-thirds reported having colleagues who had experienced burnout, similar to the number
that self-reported burnout. However, responses the relevant questions often suggested colleagues held negative attitudes towards affected persons.

In about half the cases, burning out colleagues had not raised it with the respondent, similar to the proportion of respondents who would keep silent. Such colleagues were seen as too embarrassed, afraid of being considered ‘unprofessional’, or unaware they had burnout. Around half the respondents perceived the other colleagues’ responses would blame the affected person. Whether accurate or not, such beliefs can justify the perceiver keeping quiet about stress. Another response was that professionals’ roles or ethics did not extend to helping colleagues, a belief that may have some objective basis but may also serve defensive purposes.

When asked about their own experience of burnout, many respondents expressed a similar reluctance to reveal it to colleagues for fear of being seen as weak or incompetent, or becoming a target of stigmatising gossip. Two had left the workplace without revealing they had burnout. Of those who had, half reported supportive responses, suggesting the negative reactions expected by many may be exaggerated. Equally, being rejected by one’s peers can have serious psychology effects and may stimulate defensive cognitions such as denial or self-blame.

As with managers, respondents’ perceptions of colleagues could be accurate or defensively biased. Since professional cultures are known to stigmatise burnout (Hu et al., 2012; Maslach & Goldberg, 1998; Putnik et al., 2011; Schulze & Roessler, 2007; Siebert & Siebert, 2007), there may be some basis to these perceptions. However the responses were often consistent with perceptual distortions such as self-serving or pluralistic ignorance biases (see below), suggesting beliefs about peers may defensively minimise the perceiver’s need to set boundaries to work hours and stress: ‘as professionals we can always manage stress’, ‘taking leave would my team members (or clients) down’, ‘I don’t want to give my colleagues extra work’, ‘others with higher workloads don’t complain’, or ‘I will be seen as weak or unprofessional - if they can manage the load so can I’.

Reducing burnout requires recognising the powerful role of professional group values and peer attitudes. However, as the next section shows, it is professional’s perceptions and beliefs about themselves that most need to be addressed.
Perceptions of self: Psychological processes in burnout

Why professionals hold biased perceptions of the causes of burnout and managers’ or peers’ attitudes became apparent in examining their self-beliefs. Previous authors suggest helping professionals tend to feel they should be immune to work stresses (Siebert & Siebert, 2007; Putnik et al., 2011) and even beyond normal human fallibility (Figley, 2002). Many of this study’s findings point to a belief system in which professional identity dominates a person’s self-concept and self-esteem.

Most respondents believed burnout would result in loss of self-esteem or self-confidence and lead to self-blame, and many linked this directly to loss of their professional identity. When self-esteem is strongly tied to professional identity working harder becomes a ‘logical’ response to stress, creating a vicious circle of self-blame, overinvestment in work and more stress. In the model of professional burnout proposed in 4.5, this underlies the perceptual defences suggested in many survey and interview responses. Ultimately, burnout is a product of self-deception (Paulhus, 2007; von Hippel & Trivers, 2011), in which the individual attends only to information confirming his or her desired self-image as a competent professional. Defending against evidence of one’s failings enhances self-esteem (Paulhus 2007), but this ‘false’ form of self-esteem (Kernis, 2003) does not serve a person’s long-term mental health needs.

This self-deception involves an exaggerated internal locus of control (Rotter, 1966) producing both the illusion of control (Langer, 1975) and the optimism bias behind the belief that ‘it won’t happen to me’, justified by thoughts such as ‘I’ll take time off when I’ve done this’, ‘I can look after myself’, ‘I’m doing ok, this is just temporary’ and ‘I know how far I can go’. Such beliefs lead individuals to underestimate their vulnerability (Clarke et al., 2000; Weinstein, 1984, p.431) and hence reduce health-enhancing behaviours including self-care (Bränström & Brandberg, 2010).

The findings suggest many aspects of mental health professionals’ self-image can encourage unhealthy behaviour: a belief in one’s ‘professionalism’ and competence, for example in meeting deadlines, client quotas or workload requirements; being a loyal and responsible employee or colleague; and being a professional ‘helper’ who puts clients’ needs first. These socially-desirable values motivate working harder to increase self-esteem. Putnik et al. (2011) similarly found helping professionals place more
importance on helping others than their own health, stretching their resources to the point of breakdown.

Such beliefs underpin professional’s unrealistic expectations of their ability to avoid burnout. Only 11 of the 37 respondents reporting symptoms of burnout had seen them as a signal to increase self-care, pointing to a need to change how mental health professionals balance their professional responsibilities with the ‘genuine’ self-esteem derived from a broader set of life goals (Kernis, 2003). This would require clinically-informed education or training to recognise self-deceptive perceptual processes, set appropriate boundaries and effectively counter the unhealthy expectations of colleagues or managers.

An important corollary is that information by itself will not reduce burnout, since strong perceptual defences act against challenges to deeply held beliefs. Prevention is further discussed below.

**Strategies for reducing burnout and barriers to their use**

Interestingly, when asked at the end of the questionnaire how organisations could reduce burnout respondents focused more on creating the conditions for healthy work – supporting staff to self-care, openly discussing burnout and providing wellness programs - than on workloads. Similar themes emerged when asked how professionals could personally reduce burnout: greater self-care, external clinical supervision and developing supportive peer and external relationships. This subjective perspective emphasises self-care and support from others more than the objective conditions of work.

This emphasis is consistent with researchers’ recommendations for self-care as a preventative to burnout (e.g., Miner, 2010; Irving & Dobkin, 2009). Suggestions for better supervisor support confirm evidence that this buffers professionals from the effects of burnout (Biron, 2013; Ray & Miller, 1991; Snyder, 2009), and the organisational strategies are also consistent with previous studies (Burke, 2013; Fearon & Nichol, 2011).

However, it is unlikely professionals or managers will adopt these strategies if their belief systems defensively minimise its significance or attribute its causes to solely
internal or external factors. Three important psychological issues were identified in responses to questions about barriers to preventing burnout: the debilitating effect of time pressure in reducing self-care amongst professionals; the loss of perspective, cognitive functioning and decision-making competence when burnout sets in; and the belief amongst managers and professionals that burnout is inevitable.

These self-identified psychological barriers remind managers of the importance of understanding professionals’ subjective view of their job. The emotionally or physiologically felt consequences of time pressure, coupled with a ‘mental fog’ and a fatalistic attitude of acceptance can lead even highly trained mental health professionals to work until exhausted, becoming aware of their state only when it is too late.

**Summary**

The findings show how defensive beliefs and perceptions can account for the paradox of high rates of burnout amongst mental health professionals. Although it was not always possible to tell whether a given response is accurate or biased, the pattern of responses (including contradictory aspects), their consistency with many known perceptual distortions, the direct identification of internalising and externalising strategies by clearly self-aware or perceptive respondents, and the link to the psychological model of professional burnout in 4.5 all suggest defensive thought-processes are commonly involved when professionals burnout.

The findings also suggest some respondents, colleagues, managers and organisations have positive, aware attitudes and attempt to reduce stress and maintain good self-care. In this sample these were in the minority.

Overall, the findings suggest burnout is common in mental health organisations not so much because professionals lack knowledge of its nature or remedies, but because perceptual biases encourage them to ignore warning signs and continue to overwork. This model is elaborated in the next section.

**6.3 A model of perceptual factors affecting responses to burnout**

Figure 9 shows a model of the perceptual factors that influence professionals’ recognition of burnout symptoms and willingness to reduce the stress of overwork. It
encompasses the perceptual defences identified in Chapter 4 and others from social cognition and person perception studies that complement those discussed above. The model is intended to guide future research on cognitive processes behind burnout, and is expected to apply to professionals in general, not just those in mental health.

Figure 9: Model of perceptual factors in burnout prevention and help-seeking.

The model assumes professionals’ behaviour is based on their perceptions and beliefs, and takes a phenomenological perspective in which each person’s unique outlook on burnout affects how they respond to it. The discussion below covers biases expected to reduce acceptance of burnout, recognising that all professionals have some biases but
each has a different set and responds differently to symptoms of high stress. These biases are not quantified in this study: whether they are the most common in any given population is a question for future research.

In Figure 9 a professional is impacted by chronic stressors in the work environment but perceives the effects of these through the lens of his or her perceptual processes, influenced also by the attitudes of colleagues and managers. Ultimately information about the person’s state and the environmental variables impacting it is filtered through his or her professional identity and self-concept, and often modified to conform to these, justifying a decision to ignore symptoms of ill health and the possibility of reducing the stressors. The sections below discuss these factors in more detail.

6.4 Perceptions of self and responses to symptoms of burnout

A key finding of this study is that many respondents found symptoms of extreme stress difficult to recognise in themselves until close to, or after, a state of physical and emotional breakdown had been reached. Even when they did recognise their condition, they tended to blame themselves and often avoided disclosing it to others for fear of negative judgement. It appears respondents often had strong perceptual and emotional barriers to dealing with personal burnout.

Figure 10 summarises the barriers to realistic self-perception, including a wide variety of cognitive biases identified by social psychologists. Underlying these is a tendency to self-blame or self-stigmatise, a sign of impaired self-esteem. In an attempt to increase self-esteem, individuals link their professional identity closely to their self-concept and self-esteem, causing them to work harder while ignoring the impact on their health. This is the basic model of psychological processes behind burnout developed in 4.5. As the stress increases, cognitive deficits further reduce the person’s ability to recognise symptoms. Together these factors mitigate against healthy responses such as setting boundaries to work hours, self-care behaviours and seeking help from colleagues, supervisors or external sources.
6.4.1 Self-blame and self-stigmatising: An Attribution Theory perspective

Attribution Theory is an influential psychological theory of self-perception and social perception that describes a fundamental human tendency to interpret the social environment by attributing causes of events to the behaviour of individuals. Attribution is necessary because the clues to human motivation can be fragmentary, conflicting or hidden. While attributions may be objectively correct at times, a large body of evidence from Heider (1958) shows they are often oversimplifications, distortions or imagined interpretations rather than objective perceptions of reality. This attribution process underlies the biases discussed below.

An important concept in AT is Fundamental Attribution Error (Heider, 1958; Weary, 2000), the tendency to attribute a person’s misfortunes to personal factors such as personality or behavioural styles rather than external factors that may have caused or influenced their attitudes or behaviour. FAE reflects a desire to overlook possible external causes of a person’s behaviour in preference for internal attributions because the latter depict people as more predictable (Jones & Harris, 1967). Even when there is obvious evidence of situational causes, behaviour is typically attributed to the person’s traits or disposition (Heider, 1944; Kelley, 1972).
While the fundamental attribution error applies to perceptions of others, analogous processes operate in self-perception. For example, negative situations can be attributed to the perceiver’s personality rather than external causes. This is most likely in individuals whose low self-esteem and an external ‘locus of control’ (Rotter, 1966) lead to a fatalistic belief that one’s own fortunes are determined by external factors. Shaver and Drown (1986) found victims of illness or crime erroneously assigned blame to themselves, and underestimated the impact of the environment or external forces. Blaming oneself can stymie recovery from an illness or traumatic event, since accepting causality makes a person feel unworthy and eliminates the need to seek help from others. Several studies have established a link between self-blame and poor adjustment outcomes after trauma or illness (Anderson, Miller, Riger, Dill, & Sedikides, 1994; Frazier, 1990).

Professionals burning out may blame themselves rather than consider causes in work pressures and other external factors. A strong sense of professional identity causes them to compensate by working harder in order to maintain self-esteem.

Self-blame has two forms: characterological blame involving one’s personality, for example seeing oneself as ‘weak’, and behavioural blame where misfortunes are attributed to one’s past behaviour, implying the problem can be solved by changing future behaviour (Janoff-Bulman, 1979). Here respondents tended to describe characterological self-blame, which implies the problem is beyond one’s control. Characterological self-blame helps explain why respondents were unwilling to speak up about their feelings: disclosing ‘weakness’ is shameful and would reinforce their low self-esteem, while the personality attribution implies there is nothing anyone can do to change their innate ‘weakness’.

A similar view was reported by Maslach and Pines (1977) in a study of child care workers who were experiencing burnout and assumed that their feelings were a sign of something wrong with them or that they were “bad people” (p.112). These workers kept their feelings to themselves despite knowing others had similar experiences.

_Self-stigmatising beliefs_
Self-blame is similar to self-stigma, a term used in the mental health literature to describe a prejudice towards oneself based on the assumption that people suffering mental health disorders are weak and unable to care for themselves (Corrigan, 2002). This belief produces emotional and behavioural responses such as failing to look for a job or neglecting self-care. Self-stigma can be seen as a long-term attitudinal disposition towards blaming one’s character for specific events such as burnout.

Many respondents who reported experiencing burnout found they came to believe they were weaker or less capable employees, often questioning whether they were ‘cut out’ for the job. This attribution of an underlying personality problem further contributes to the vicious circle of self-beliefs that feed burnout.

6.4.2 Cognitive biases

Self-blame and self-stigmatising are two fundamental ways of accommodating low self-esteem, but many more exist. The biases discussed below describe some of the many perceptual defences that professionals can use to increase self-esteem by ignoring information that threatens their professional identity.

The illusion of control

The illusion of control (Langer, 1975; Thompson, 1999) is an exaggerated sense of self-efficacy based on the belief that one has more control over one’s fate than environmental factors actually allow. Environmental factors include external influences of the physical world, other people or the organisation, along with internal influences such as one’s physiological and psychological limitations. Where characterological self-blame and self-stigmatising accommodate low self-esteem by attributing problems to unchangeable aspects of the self, the illusion of control attempts to raise self-esteem by the belief that one can control the internal and external environment.

In burnout, this illusion may result in a belief that helping professionals are immune to work stresses, or even infallible (Siebert & Siebert, 2007; Putnik et al., 2011; Figley 2002). The stories of Sharon and Fiona (Chapter 5) graphically illustrate how unrealistic expectations of their ability to control stress allowed them to continue overworking to the point of breakdown.
Paradoxically, professional and organisational cultures that give mental health professionals too much individual responsibility may exacerbate this illusion. Thompson, Armstrong and Thomas (1998) argue that illusory control is particularly likely when people act for themselves, since they can more often interpret their actions as causing outcomes that are really due to external causes. For example, professionals committed to clients’ welfare may exaggerate their ability to achieve it without exceeding personal or organisational resources, and each act of choosing this path reinforces the illusion of control over real-world limits. Such attitudes may reflect an overly strong sense of professional identity, and organisations that over-emphasise professionals’ responsibility for their own wellbeing can further encourage an exaggerated belief in one’s self-efficacy. Organisational and professional cultures may therefore contain values encouraging mental health practitioners to ignore personal limitations.

**Overestimation of self-competence**

Analogous to the illusion of control is a surprisingly common human tendency to overestimate one’s competence (Ames & Kammrath, 2004; Davis et al., 2006; Dunning, Johnson, Ehrlinger, & Kruger, 2003; Ehrlinger et al., 2008; Mathieson et al., 2010). For example, people tend to base judgements of their performance or ability on past ‘peaks’ rather than more realistic ‘averages’. Less competent persons are even more likely to overestimate their competence (Ehrlinger et al., 2008). Like many others, this illusion can be seen as an attempt to compensate for low self-esteem.

Overestimating self-competence would encourage professionals to avoid monitoring their wellbeing and performance under conditions of stress, ultimately allowing them to exceed their limits.

**Optimism bias**

A third attributional process allowing a person with low self-esteem to justify overwork to the point of burnout is optimism bias (McKennna, Warburton, & Winwood, 1993, p.39), the belief that "it won't happen to me” (Weinstein, 1984, p.431).

Respondents in this study often reported a generalised attitude of optimism toward the risk of burnout, leading them to ignore their symptoms and minimise the hazards of
their behaviour. Past experience of avoiding burnout in a high-stress situation may contribute to this: Weinstein (1989) found people who take risks without experiencing harm are less likely to believe they are at risk in the future. A high-pressure environment that continually stretches employees may therefore unwittingly encourage the belief that burnout is not a risk. Overestimation of self-competence and the illusion of control would further encourage individuals with optimism bias to ignore their physiological and psychological limitations.

*Self-serving bias*

Self-serving bias is the tendency to attribute negative personal outcomes to external causes rather than one’s own behaviour (Miller & Ross, 1975). Self-serving bias can be considered the “illusion of no control”.

Respondents in this study generally appeared to hold highly ambiguous attitudes towards burnout, seeing its general causes in poor self-care but attributing their own burnout to organisational causes such as high workloads and lack of management support. This is suggestive of self-serving bias, which would lead a worker to ignore the need for self-care by attributing the causes of stress to the organisation. This attitude may be accompanied by cynicism and negativity towards others, particularly managers but also colleagues who appear less affected by work pressures.

*Dichotomous thinking and the medical model of stress*

A tendency towards ‘black and white’ thinking was noted in several aspects of the findings. For example, respondents typically saw burnout as an occupational hazard with serious consequences for health, self-esteem, career, financial stability and relationships while on the other hand not perceiving it as a real threat to them personally. In this dichotomous thinking (Oshio, 2009), risky behaviours such as overwork are attributed as low risk behaviours when that helps the perceiver ignore the dangers, but are seen as serious when empathy with sufferers or concern over perceived lack of management interest can improve the perceiver’s self-esteem. The ‘minimising’ version can lead a mental health professional to ignore symptoms of burnout, while the ‘maximising’ attribution can justify the belief that ‘burnout cannot happen to me’.

Dichotomous thinking may be encouraged by professional training in medical
environments, where a person is either ill or well. Schaufeli, Leiter, & Maslach (2009) suggest that:

“Professionals with a psychological background tend to see burnout as a continuous phenomenon, whereas those with a medical background tend to see burnout dichotomously. To the former, burnout is a form of chronic distress that results from a highly stressful and frustrating work environment, whereas for the latter it is a medical condition” (p.214).

In this study, the psychologists commonly perceived burnout as a medical issue, perhaps because they worked in Health Department clinics, often with or reporting to psychiatrists. More generally, mental health professionals’ identity often centres on caring for or ‘curing’ ill persons. Attributing the carer as a ‘well’ rather than a ‘sick’ person is consistent with this dichotomous belief system.

Dichotomous thinking has a parallel in studies showing that many ill persons seek help only when their symptoms become so painful or uncomfortable they start to interfere with daily functioning (Mechanic, 1995). Indeed, the tendency to consider oneself mentally healthy as long as possible, despite evidence to the contrary, appears to be endemic. Medical practitioners’ definition of ‘health’ as the absence of pathology may also encourage a simplistic assessment of their psychological wellbeing by ignoring symptoms to maintain a self-image as a healthy person.

6.4.3 Stress-induced cognitive deficit

Stress and burnout involve a general decline in cognitive capability that reduces sense-making and decision-making capabilities (e.g., Oosterholt et al., 2012; Osterberg et al., 2012). For example, Janis and Mann (1977, p.82) found stress reduced decision-making capacity by impeding the ability to see and assess all the alternatives to a problem. In a work environment, cognitive decline may lead a person to ignore long-term consequences of over-work, and may underpin the feeling of being ‘trapped’ and unable to see how to improve one’s position.

Over time this loss of cognitive function can lead to learned helplessness and depression (Seligman, 1972). If attributed to a personal ‘failing’, it further increases the self-stigmatisation described above. It is also likely to exacerbate the defensive biases
discussed above, and may lead a professional to further increase work output to make up for lost productivity or poor work quality, thereby boosting false self-esteem (Kernis, 2003) while ultimately feeding the spiral of health decline.

6.4.4 The critical role of professional role-identity

In the psychological model proposed in 4.5, burnout through overwork is a sign of a person’s self-esteem being too closely related to their professional identity. Professionals in many disciplines tend to connect their self-esteem closely to an image of professionalism and self-competence, and human service fields also value an image of selflessly serving others. These images may be central to their self-identity as a person, not just a worker (Siebert & Siebert, 2007), a fusing of personal and professional identity in which the personal boundaries conducive to health are lost.

This narrowing of the self encourages the professional to see a ‘failure’ to maintain excessive workloads as reflection on self rather than an untenable workload. A high proportion of respondents (80%) indicated they would blame themselves if they burned out, describing it as a sign of weakness, failure and incompetence. Those who had burned out often recalled feeling that they were not ‘cut out’ for their job because they should be able to withstand its stresses.

This attitude may reflect several beliefs specific to mental health workers. First, since mental health professionals are trained in managing others’ psychological problems they should not suffer those themselves. As Figley (2002) suggests, helping professionals are often revered by the community, and may “gradually view themselves as others view them: someone who is an expert at helping others cope with life’s challenges. They seem to forget that they are human beings as well”. This encourages a belief that they are beyond human fallibility (Siebert & Siebert, 2007), an idealised view of mental health professionals reinforced by professional cultures as well as community perceptions. Participants in this study often described a need to feel competent and resilient, an image challenged by burnout symptoms and helped by defensive attributions.

Second, human service worker is often a vocation more than a job. Many participants described enjoying their work and the meaning or fulfilment it offered. However, when
work becomes a dominating life focus it can be a heavy burden. The assumption that mental health professionals should be fully functioning at all times is difficult to uphold, but on the other hand admitting limitations to others calls into question one’s professional competence (Barnett & Hillard, 2001; Johnson et. al., 2012). Over half the participants in this study were reluctant to disclose burnout.

Mental health professionals’ identity as a helper is related to this, since helping is an other-focussed activity. Siebert & Siebert (2007) found doctors and nurses had a strong identity as a helper but, paradoxically, were less likely to seek help themselves during stress-related impairment. Similarly, Putnik, De Jong, & Verdonk (2011) found human service professionals suffering from burnout did not seek help for a long time after symptoms began.

When professionals’ role-identity is built on such values, often reinforced by those of peers, professional bodies or managers, the distorting perceptions can have a powerful effect on employees awareness of burnout and willingness to remedy it.

6.4.5 The vicious circle of self-deceptive beliefs behind burnout

The perceptions and beliefs discussed above ultimately lead highly stressed professionals to work even harder to resolve the problems cause by high workloads, creating a cycle of self-destructive mental processes and behaviours. This is clearly shown in the case example of Sharon, a mental health nurse who saw in retrospect that being unable to accurately assess her situation lead her to blame herself rather than the excessive work overload and lack of managerial or collegial support. Her misperceptions lead her to work harder, and the self-care strategies previously second nature to her began to fall away: “I just thought it was me, and I needed to work harder, so it became a vicious circle”.

This points to the fallacy of expecting professionals to be responsible for avoiding burnout. Only after many months of leave and psychological and medical treatment was Sharon able to reflect on her experience clearly enough to see that her problem was an unreasonable workload, not her competence, coupled with her way of dealing with stress.

Ekstedt and Fagerberg’s (2005) qualitative study of burnt-out nurses found they
experienced being ‘cut off’ not only from their work but also from other people and life around them, and felt trapped in this state. This withdrawal is symptomatic of depression, which precludes both recovery activities and basic self-maintenance needs such as nutrition, exercise and social contact. The present respondents also reported feeling emotionally disengaged from their profession, career and organisation, ‘cut off’ and lacking the energy or cognitive capacity for self-care or seeking help. Ignoring physical and psychological symptoms that would alarm them if perceived in clients, they eventually ‘broke down’ or were saved by having the seriousness of their state made clear by someone else.

6.4.6 Consequences for the organisation

The notion that burnout involves escalating self-deception highlights the need for organisations to monitor mental health professionals’ wellbeing. Despite their training, professional staff may be incapable of recognising and responding to extreme stress. While studies of burnout prevention propose self-awareness as an essential prerequisite to effective self-care (Kelley, 1972; Schwebel & Coster, 1998), this will not usually happen by itself. Organisations can reduce burnout by checking for the health consequences of normal human responses to stress, rather than blaming the person or their lack of professional ethics. As Johnson, Barnett, Elman, Forrest, and Kaslow (2012) observe of psychologists:

“When personal distress, illness, or cognitive decline place psychologists’ competence at risk…. it may be both unreasonable and illogical to expect psychologists to accurately predict adverse effects of these events, or to fully recognize decrements in functioning, let alone to formulate a cogent and ethical response.” (p.554)

Almost half the respondents did not feel comfortable raising burnout with their supervisor or thought it would not help. Supervisors of mental health professionals should therefore encourage them to disclose stress-related problems in an open and non-judgemental way. Discussions with colleagues can also help professionals gain the confidence to do this (Munir, Leka, & Griffiths, 2005), an important step towards recovery (Regedanz, 2008). Colleagues and supervisors therefore have an important
‘buffering’ role (Afshin et al., 2012; Beehr et al., 2003; Snyder, 2009; Vermeulen & Mustard, 2000).

Colleagues and professional groups are well placed to help professionals who cannot help themselves, but this may require reorienting workgroup or professional cultures to incorporate concern for colleagues’ and subordinates’ health. Johnson et al. (2012) suggest that “individual notions of accountability must be augmented with interdependent, collectivistic, or communitarian perspectives on ethics, which balance individual responsibilities with community obligations” (p.557). A responsible and compassionate community of mental health professionals would support each others’ efforts to maintain wellbeing in stressful work environments.

Overcoming the vicious circle of self-deception would also be aided by educating mental health professionals to see their reactions to stress as normal human responses, to accept their own vulnerability and to set appropriate boundaries between their personal life and professional identity.

6.5 Perceptions of colleagues’ attitudes towards burnout

As social beings, professionals’ responses to burnout symptoms are closely affected by others (Fiske, 2004). Respondents with burnout symptoms appeared quite sensitive to colleagues’ attitudes, which could be supportive but were often seen as negative. Support from colleagues can have a significant role in ‘buffering’ employees against burnout (Afshin et al., 2012; Snyder, 2009), but colleagues were often perceived to blame or stigmatise others, mirroring the attitudes towards themselves discussed above. A model of the factors influencing perceptions of colleagues is shown in Figure 11.
6.5.1 Blaming cognitive biases

Respondents’ often saw colleagues as blaming persons with burnout for their problem, an attitude mirroring the self-blame discussed above. Respondents were reluctant to disclose their burnout to colleagues for fear of being blamed, and those who had burned out reported directly meeting such attitudes. Some reported discussions about a colleague’s burnout in which the affected person was seen as professionally negligent or culpable. Some described colleagues who burn out in terms such as “too dedicated, lacking boundaries, Type A, workaholics, people pleasers, incompetent clinicians, [and] perfectionists”, as one put it.

This blaming attitude is consistent with many cognitive biases (Steins & Weiner, 1999; Weiner et al., 1972). Several examples are presented below.

**Fundamental Attribution Error**

As described earlier, in the Fundamental Attribution Error people attribute others’ misfortunes to the ‘kind of person’ they are and underestimating environmental influences. This can simplify the complexities of burnout (Gilbert & Malone, 1995) and help maintain the perceiver’s self-esteem as someone immune to it by believing others succumb to stress due to “incompetence”, “perfectionism” or being “unwell”, rather
than external factors (“she has too much work”). This blaming attitude featured in many comments about colleagues’ attitudes to burnout.

**Hindsight bias**

A less direct version of blame is hindsight bias, also known as "creeping determinism". When evaluating an outcome in hindsight, people tend to overestimate its likelihood (Fischhoff, 1975, p. 288; Nestler, Blank, & von Collani, 2008): that is, they perceive the endpoint was more likely than they or others saw it before the event. Accordingly, when an employee burns out, his or her colleagues emphasise what he or she *could have* done to avoid it, for example working less overtime or more assertively saying “no” to work. The suggestion of neglect effectively blames the sufferer for the burnout.

**Belief in a just world**

A third form of blaming attributes others’ problems to a ‘fair and just world’ (Lerner, 1980, p. 11) in which negative events are a person’s fault, evidence of an internal personality problem (Weiner et al., 1972). Thus, “bad things happen only to bad people” or “people get what they deserve” (Furnham, 2003; Lerner, 1980). Such beliefs provide the perceiver with an exaggerated sense of personal confidence and control over situations in which they are actually vulnerable (Johnson, Mullick, & Mulford, 2002), such as high-stress work environments (Lerner, 1997).

**Pluralistic ignorance**

Although respondents were often reluctant to disclose burnout to managers or colleagues due to its perceived stigma, others had found colleagues supportive when revealing stress symptoms. It is possible expectations of negative responses sometimes represent a defensive belief to justify keeping silent. In ‘pluralistic ignorance’, members of a group erroneously assume others hold a more conservative or intolerant view than theirs (Breed and Ktsanes 1961; Krech, Crutchfield, & Ballachey, 1962, p.269). Group members could, for example, exaggerate the stigma of burnout to avoid revealing problems that challenge their professional identity.

Studies of conformity show this belief about the group’s attitude weakens members’ will to seek evidence to the contrary (Deutsch & Gerard, 1955; Krech, Crutchfield, &
Ballachey, 1962, p.512). Group members tend to assume that majority beliefs must be true (Festinger, 1950), particularly common in groups composed of peers, such as professional groups, and where the situation is not otherwise readily explained. Mental health professionals’ high regard for peers’ opinions may further encourage conformity.

**Blaming and perception of others’ control over their circumstances**

Professionals who blame others are also less likely to help them if they believe the person could have prevented a problem but did not. Research shows that empathy and helping behaviours are strongly influenced by perceptions of the sufferer’s control over his or her outcomes (Pullium, 1993). People perceived to have no control are seen as true ‘victims’ of fate and are more likely to be helped than those whose own actions or inaction lead to their problem (Berkowitz, 1973; Higgins & Shaw, 1999; Weiner, 1980). This has been demonstrated in areas such as medical professionals’ reactions towards obese or HIV patients (Jeong, 2007; Speakes-Lewis, 2009). Believing a person caused his or her problem by not trying to avoid it can trigger strong emotions such as anger, disgust or aggressive behaviour towards the victim (Amirkhan, 1990, p. 80; Rudolph, Roesch, Greitemeyer, & Weiner, 2004; Weiner, Russell, & Lerman, 1979).

The psychological nature of burnout may further exacerbate this tendency. Research on mental health stigma shows that people make different attributions of causality for physical illnesses such as heart disease, and emotional-behavioural illnesses such as post-traumatic stress disorder, depression or dementia. Emotional-behavioural illnesses are seen as more under the control of sufferers, who are consequently less deserving of sympathy.

The power of such beliefs is shown by the finding that the perception of blame can cause psychologically ill persons to have a worse prognosis than physically ill persons when other factors are taken into account (Corrigan et al., 2000; Weiner et al., 1988). Mental health professionals’ views of their colleagues may delay an affected person’s recovery from stress by encouraging self-blame and fatalistic beliefs, further lowering their self-esteem and perceived control over their health’.

Although blame may seem callous or lacking in empathy, the attributional perspective suggests this belief reflects cognitive processes similar to those stopping sufferers from seeing and responding to *their own* symptoms. Indeed such beliefs about others may be
part of the perceiver’s attempts to defend against recognition of personal symptoms or vulnerability.

6.5.2 The stigma of burnout

Blaming attributional processes may underpin the stigma widely attached to mental illness and other socially undesirable characteristics. ‘Stigma’ is a Greek word originally describing a mark made on persons to identify them as less morally worthy and therefore deserving of social ostracism (Oxford Dictionary, 2014). Stigmatised persons are not perceived as whole persons but judged in terms of specific attributes.

It is ironic that burnout has acquired this negative image. As noted in Chapter 2, the term “burnout” comes from Freudenberger’s (1975) drug clinic clients, who used it to describe their loss of energy and vitality for life. “Burnout” grew into a widely accepted term for work-related exhaustion precisely because it removed the stigma of mental illness previously associated with terms like “nervous breakdown” (Schaufeli et al., 2009). Today, it appears a significant stigma is once again attached to burnout.

The perception that colleagues or people generally would blame someone who burned out clearly influenced respondents’ willingness to help others with symptoms or to address their own. However, the role of stigma in inhibiting helping others or disclosing one’s symptoms has been acknowledged by only a handful of burnout studies (e.g., Putnik et al., 2011; Schulze & Roessler, 2007).

Stigma is more regularly associated with stress-related illness in contemporary studies outside the burnout field. For example, Collie, Britt and Henderson (2011) see stigma as a reason why Australian employees are three times more likely to claim workers’ compensation for physical injury than stress, burnout or another mental health issue. Denniss & Baker (2012) found significant stigma attached to mental health issues in their survey of 849 Australian workers’ work-life balance and workplace culture. Almost half were less comfortable discussing mental health issues with their manager than bullying or job security. Similarly, in survey of US doctors Hu et al. (2012) found only a small percentage were willing to seek support for burnout and 62% cited stigma as a major barrier.
6.5.3 The role of professional cultures

Professional role-identity is central to this model of burnout. The findings suggest professional cultures have a key role in creating an image of ‘professionalism’ that encourages overwork, self-reliance, silence about burnout and seeing oneself beyond human fallibility (Siebert & Siebert, 2007). Health professions have evolved specialised cultures conveying values, beliefs, attitudes, customs, language and behavioural standards that reflect historic factors such as the social class and gender of formative members (Hall, 2005). Cultural values and practices are continually passed on through both formal education and informal socialisation processes.

At present mental health professions appear to be redefining professional competence to include the explicit requirement to monitor one’s level of functioning and engage in strategies to prevent impairment (AASW, 2010; ANMC, 2008; APS, 2007). Self-management has moved beyond cautionary advice to inexperienced practitioners to become an ethical imperative (Barnett et al., 2007). However, this can become another way to blame affected colleagues: the present findings show such persons can be perceived to have failed in their professional or ethical requirement to maintain self-competence.

Blame or self-blame can also arise from a belief that professionals can prevent burnout by self-care alone. Professionals believed that they (and others) should be capable of coping with the demands of a stressful work environment, can and should be highly competent at all times, should not suffer from the problems faced by clients and were highly responsible persons. When overcome by stress they considered themselves (or others) not ‘cut out’ for the profession. To this idealistic image of professional competence they often added a strong identification with the ‘helping’ role. All these beliefs cause them to underestimate their vulnerability to burnout, and good objective knowledge of its causes, symptoms and effects did not appear to translate into personal awareness.

These beliefs highlight the importance of changing professional education and socialisation processes to instil a more human view of practitioners and their role in helping colleagues who cannot help themselves (see Chapter 7).
6.5.4 Lack of knowledge on when and how to help

Lack of knowledge about how to help or uncertainty about intervening with colleagues were sometimes cited as a reason for not helping affected persons, suggesting an important topic for professional education and training. The possibility that this response reflects defensive attributions – for example, the belief that burnout is ‘not my problem’ - was also raised.

6.5.5 Summary: The effect of colleagues’ attitudes on responses to burnout

Perceptions of colleagues’ attitudes were about equally positive and negative. Negative attitudes tended to blame or stigmatise persons who cannot cope with stress. Some colleagues were seen to lack empathy or the knowledge or skills to help, but whether these accurately reflect mental health professionals with undesirable attributes or are rationalisations is unclear. In general, while negative perceptions may have been exaggerated by respondents’ own perceptual biases, many aspects of the findings, along with other studies (Ericson-Lidman, 2007), suggest such attitudes are indeed common among professionals, including those with mental health training.

The tendency to blame the person may reflect the fundamental attribution error or related cognitive distortions, such as hindsight bias and belief in a just world, that encourage the belief that ‘burnout cannot happen to me’. In a high-pressure environment this belief can sustain the perceiver’s professional self-image and ultimately their self-esteem. Blaming appears to be encouraged by stigmatising beliefs about health problems, as found in other health professionals, and by values in professional cultures.

All these perceptions of colleagues can affect an individual’s professional self-image, feeding any existing reluctance to reduce the workload and restore health. The perception that colleagues would blame them and lacked empathy or understanding discouraged a third of the respondents from seeking potentially valuable assistance from peers - about half those with experience of burnout found colleagues responded with empathy or practical help, and a quarter saw colleagues as their primary source of support.
Researchers, educators, managers and others aiming to reduce burnout can benefit from greater understanding of the importance of colleagues perceptions in encouraging or discouraging healthy responses to stress, particularly the effects of blaming attitudes and stigmatising belief systems or professional cultures.

6.6 Perceptions of managers’ attitudes and organisational culture

Professionals’ perceptions of managers and the organisational culture are a third area of influence on their reactions to burnout symptoms. Many respondents perceived their organisations minimised the problem of burnout and failed to address it as a real workplace hazard. Only a third thought managers took burnout seriously, and four in five thought it was not taken as seriously as other health and safety issues. Interestingly, workers’ compensation claim data show burnout and work stress as the primary occupational health hazard in the Australian health and community care sector (Safework, 2013).

Respondents attributed the minimisation of burnout to organisational cultures that tolerate high stress and unhealthy work practices in general, a lack of supportive supervision, and managers with a narrow process-based view of the organisation in which external economic or political pressures justified resource constraints that prevent dealing with burnout (Figure 12). These cultural values and management practices treated professionals as human resources rather than persons who might face health issues from work pressures.
6.6.1 Process-driven management

Respondents often described managers as primarily interested in keeping staff working at maximum level in order to meet clients’ needs and consequently minimising health consequences including burnout. This approach to management appears to reflect health sector norms as well as managers’ individual beliefs and professional values. The latter may have some similarity to professionals’ perceptions and beliefs since managers tend to ‘come up through the ranks’, but corporate cultures are also strongly influenced by external funding agencies, corporate networks and management education programs. The prevailing culture in Australian health sector organisations has been called ‘managerialist’ (Klikauer, 2013, p.2) as it emphasises generic management values such as efficiency (e.g., cost minimisation) and accountability (e.g., hierarchical reporting) over values specific to the health care.

Quinn and colleagues’ Competing Values model of organisational culture (Quinn & Rohrbaugh, 1981) was introduced in Chapter 2 as a widely used model of corporate cultures based on four archetypal cultures: a human relations model emphasising employee collaboration and commitment, an internal process model based on stability and control, an open systems model focused on competition, growth and adaptation, and a rational goal model aimed at maximising output. Participants in the present study
often perceived their workplaces over-emphasised operational rationality, for example productivity and cost-efficiency, and under-emphasised human relations values including wellbeing. Quinn’s research suggests cultures focused only on internal processes or ‘rational’ goals lead to unhealthy workplaces and lower productivity.

Respondents reported three particular manifestations of this approach to management: a tolerance of high stress, a lack of concern for employee wellbeing and an absence of supportive supervision.

6.6.2 Tolerance of high stress

A focus on operations at the expense of staff health can lead to a culture where high stress is tolerated. Many participants perceived that supervisors and colleagues considered it ‘normal’ to be overworked and highly stressed, and any negative consequences were seen as the employee’s responsibility. Such a culture would contribute to the feelings of failure, incompetence or self-blame reported to accompany burnout by the great majority of participants.

This stress culture also tended to blame the individual for being unable to cope with stress (see also below), a common organisational response (Thompson et al., 1996). Avoidance simplifies management by removing the need to deal with complex human problems and keeps the focus on the bottom line. The possibility that managers have attributional processes devoted to ignoring personal symptoms of stress, similar to those identified in professionals, is raised as a valuable topic for future research.

6.6.3 Tolerance of unhealthy or unsafe work practices

Reason (1990) examined a wide variety of serious workplace health and safety failures, finding their causes in systemic failures of upper management. He observed that senior departmental or organisational decision-makers who create work systems are usually removed from the realities of everyday workloads, and therefore "create the local conditions that promote the commission of errors and violations (e.g., high workload, deficient tools and equipment, time pressure, fatigue, low morale, and conflicts between organisational and workgroup norms)" (p.1710). When staffing levels do not reflect the true workload ‘on the floor’, a culture accepting of unhealthy work practices follows,
where ‘it is unhealthy for us, but we just have to keep going’. It is difficult to imagine more visible physical injury hazards being so readily ignored (Bluff, 2011).

Almost all respondents complained of understaffing, suggesting their organisations accept unhealthy or unsafe work systems. Paradoxically, the attempt to save on salary costs can cost the organisation substantially in loss of productivity. Baicker, Cutler, and Song (2010) found each dollar spent on employee wellness programs saved $3.27 in medical costs and $2.73 in absenteeism costs. Staff wellbeing is therefore an economic investment (Naydeck, Pearson, Ozminkowski, Day, & Goetzel, 2008). However, realising the return requires managers to adopt the systemic perspective advocated by Reason, in which workers’ health is a key contributor to the economic and business goals.

The professionals surveyed here were acutely aware that burnout would have serious consequences for their physical or emotional health, yet almost a third saw it as inevitable in their job, and most believed it could be avoided with better working conditions. A similar perception is reported in an Australian Safety and Compensation Council survey showing 60% of nurses saw themselves at ‘high risk’ from work stress, greater than the risk of needle-stick or physical injuries (Driscoll, 2008). According to Safework (2010), ‘mental illness’ is the most common occupational health problem faced by mental health workers.

In summary, while burnout is perceived as a serious and common if not unavoidable problem by staff and researchers, managers sought to minimise its significance. This ‘cultural gap’ presents a serious challenge to stressed staff, who must choose between what their senses, and perhaps colleagues or external persons, tell them and the perceptions or beliefs of persons whose power and status may subconsciously resemble that of parent figures. Persons in a stress-impaired state may find it hard not to be influenced by such attitudes.

**Corporate stigma and blame**

As with colleagues, a central issue in perceptions of managers is their tendency to blame stress and burnout on the person, the attributional process behind the “unsafe worker” attitude (Bluff, 2011; Attree & Newbold, 2009). Attributing health and safety problems to workers’ personality implies they will continue to place themselves in danger, and
hence training or managing them to avoid hazards is unlikely to help (Safework Australia, 2010; Bluff, 2010). Blame also discourages employees from disclosing burnout, further helping managers avoid the problem.

6.6.4 Absence of supervisor support

Supervisor support provides an important psychological ‘buffer’ from the effects of high stress and reduces health-related absenteeism (Biron, 2013; Ray & Miller, 1991; Snyder, 2009). However many participants did not feel comfortable talking to their supervisor about burnout, and almost half of those who did would not out, believing the organisation would not or could not help. This is in line with an Australian Psychological Society (2013) survey showing 50% of employees across all industry sectors believed they would not receive organisational support for mental health issues such as stress. As in the present study, these respondents often reported that organisational cultures viewed persons with burnout as failures.

Respondents in this study who had burned out often saw in hindsight that they had not accurately assessed their mental health and blamed themselves rather than seek help. Supervisors and line managers are therefore important resources. Maslach (1982, p.218) sees managers as an early warning system for burnout detection, constructively drawing attention to changes in mood or attitudes that employees may not notice. Supervisors have formal ‘duty of care’ responsibilities such as referring employees to help services, arranging leave, reducing workload or providing resources, but also have an important social role as leaders. Even if supervisors are sympathetic, however, if they are not seen as interested and willing to support their staff burning out individuals will not disclose their problems. As Sharon’s example (Chapter 5) shows, supervisors may themselves face conflict in helping affected persons. To be an effective ‘frontline’ in reducing burnout, supervisors need to be seen as both encouraging and encouraged by those above them. Participants uniformly wanted supervisors to show genuine concern for them by paying attention to their wellbeing, raising the possibility of stress and burnout when signs appeared, normalising discussion of it, and keeping track of how staff were coping.

Denniss and Baker (2012, p.22) found employees with managers with a positive commitment to mental health were less likely to suffer work-related stress and anxiety.
compared to those with managers lacking commitment to mental health.

Such findings suggest supervisors and line managers may benefit from training in skills for intervening and providing emotional supports. However, powerful cultural barriers among managers also need to be addressed. A recent UK study found employers avoided proactively addressing employee health since it was considered ‘nannying’ staff or ‘invading their privacy’ (Vaughan-Jones & Barham, 2010). Supervisors may also resist discussing sensitive issues with subordinates, as the findings suggest for colleagues. Training through leadership development, coaching or mentoring programs can facilitate relevant social skills, but the perceptual barriers to accepting burnout in professionals and managers need to be addressed for such interventions to succeed.

6.6.5 External pressures and a reactive climate

A final aspect of respondents’ perceptions of managers was that external pressures - competitive pressures, budget constraints, government policy changes etc - dictated a reactive focus on short-term goals rather than a long-term, systemic perspective. Respondents were aware of increasing demand for community-based services in the WA mental health system and felt required to ‘make do’ or ‘fill the gap’ between resources and demand despite the personal cost. There appeared to be a sense of a perpetual ‘crisis’ requiring a reactive focus that justified treating staff as resources rather than people.

The objective problems caused by such reactive management are well documented. Worrall and Cooper’s (2012) found that when organisations in decline focussed on cost-cutting at the expense of employee wellbeing, sick leave was often replaced with ‘presenteeism’, leading to poor quality and inefficient work. Further, the pressures appear to be increasing: Worrall and Cooper found 46% of UK public sector managers considered their organisation in decline and 43% identified a significant cost to wellbeing. This had created a culture of not taking time off work when unwell, with presenteeism increasing from 32% in 2007 to 43% in 2012. Aumann and Galinksy’s (2009) representative sample of the US workforce also reported increased work stress, with two in five respondents feeling stressed and over half believing they lacked the resources to cope with stress. Australian health workers also face increased workloads
and stressors such as increased patient acuity, a shrinking workforce, ageing staff, declining recruitment and greater complexity of cases (AIHW, 2011; Graham & Duffield, 2010; Happell, 2008; Henderson, Toffoli, Walter, & Willis, 2012; KPMG, 2009).

Respondents also found growing job insecurity a source of stress. Jobs are increasingly ‘casualised’ (Broschak & Davis-Blake, 2006, p. 371) and almost a quarter of the Australian workforce is casual (ACTU, 2011). Concern about losing their job can reduce employees’ willingness to disclose stress (Davis-Blake, Broschak, & George, 2003).

Perceiving that the organisation is under pressure would add to professionals’ stress. It might also be exaggerated by managers, to justify avoiding paying attention to staff under a managerialist mindset, and exaggerated by both managers and respondents in a fatalistic belief that justifies avoiding their own work stresses. However, whether biased or not this perception is likely to feed into the self-destructive cycle at the heart of burnout in the model presented above.

6.6.6 Summary: Perceptions of managers and corporate culture

Two thirds of the respondents perceived their organisation minimising the problem of burnout by tolerating high stress, downplaying workers’ health and safety (particularly mental health) and failing to provide supportive supervision. This was often attributed to an overly process-focussed and inhuman approach to management, which itself could be justified (accurately or otherwise) by strong external pressures on the organisation. Respondents perceived ‘managerialist’ values conflicting with their own values regarding client service and their desire to be treated as persons facing health risks in a pressured environment. This suggests a cultural divide that could make professionals feel further isolated from the causes of their stress and the possibility of remediation.

Respondents often believed managers would blame staff for not coping with stress, which lead many to avoid disclosing burnout. Managers’ power and status are likely to give their views particular influence over professionals, further encouraging any existing tendency to self-blame, minimise the significance of symptoms or use perceptual defences to justify working beyond their physiological and psychological
capacity. A cultural divide between these groups would further heighten professionals’ sense of fatalism and being ‘trapped’ in a situation beyond their control.

6.7 Chapter summary

This chapter outlined a model of the perceptual processes believed to lead mental health professionals to downplay personal symptoms of burnout, avoid seeking help, and ignore burnout in colleagues. The paradox of high rates of burnout amongst such professionals is explained by a wide range of cognitive processes aimed at reinforcing their self-image as a competent professional devoted to clients’ needs and able to manage stress, and justifying ignoring evidence to the contrary. They may blame themselves for their difficulties in coping with excessive workloads.

Colleagues and managers are often seen to have similar attitudes of ‘blaming the victim’ and minimising the importance of stress and self-care. Corporate and professional cultures were seen to transmit these values, underpinned by a process-focused approach to management and external pressures that create resource limitations.

Although there may at times be some objective basis to these perceptions, they can all represent defensive mental processes. Persons with a professional identity strongly linked to their self-concept and self-esteem will then attempt to restore their self-esteem by working even harder, entering a spiral of physiological and psychological decline.

This model extends the literature on burnout by combining both internal and external explanations of its causes. The missing element in most previous studies is an understanding of how workers themselves see and understand the effects of prolonged high stress, and how this combines with their self-concept to create irrational self-destructive responses. Future research should have a much better chance of making realistic recommendations for the reduction of burnout with an appreciation of the underlying perceptual factors.
7.1 Research aim and major findings

Burnout has long been a problem in mental health workplaces (Gilbody, 2006; Kim et al., 2011; Kumar et al., 2011; Morse et al., 2012; Schaufeli et al., 2009), and remains so despite much research and considerable knowledge of it amongst professional employees (e.g., AASW, 2010; ANMC, 2008; APS, 2007). This study attempted to explain this paradox by investigating mental health professionals’ perceptions and beliefs about burnout.

Social psychologists have presented many studies showing people perceive themselves and others inaccurately to a surprising extent (e.g., Miller & Ross, 1975; Von-Hippel & Trivers, 2011; Yagil & Ben-Zur, 2009). Individuals bias or distort their perceptions and beliefs to simplify conflicting or ambiguous information about others’ motives, and to align sensory information with their self-image and beliefs. The perceiver often values his or her own beliefs over the perceptual evidence in order to maintain self-esteem, or at least a false or fragile sense of self-esteem (Kernis, 2003). All persons are susceptible to these defensive perceptual biases.

A few authors have suggested these defences can stop burning-out individuals from accurately perceiving their wellbeing or taking steps to improve it (Maslach & Goldberg, 1998; Siebert & Siebert, 2007). Similar cognitive processes are thought to underlie failure to seek help for medical conditions outside the work environment (e.g., Clarke et al., 2000; Leary, Tchividijian, & Kraxberger, 1994; Mechanic, 1995; Weinstein, 1989). However, the role of beliefs and perceptual processes in mental health professionals’ response to burnout has so far not been studied empirically.

The findings presented in Chapter 4 and 5 and the discussion and theoretical models in 4.5 and Chapter 6 suggest mental health professionals respond to burnout in themselves or others with many of the biases found in the social psychology literature. Despite good professional knowledge of stress-related disorders and their treatment, respondents often failed to recognise the seriousness of their own symptoms: two thirds had
experienced burnout and many recognised in hindsight how easily they were able to ignore symptoms until they reached the point of exhaustion.

A key element in explaining this is the perception that others will judge an affected person. Some respondents appeared to judge colleagues with burnout negatively, and many perceived colleagues, supervisors or senior managers would blame them for burning out. It appears a stigma is widely attached to burnout in organisational and professional cultures, whereby affected persons are considered to be ‘weak’, ‘unsuited to the job’ or ‘unprofessional’ in self-managing stress. As a result, many respondents would not reveal illness or seek help from colleagues or supervisors. Of those who had sought help, only about half reported supportive responses.

Respondents also applied blame to themselves, either seeing their inability to cope as a personal weakness or externalising its causes to uncontrollable external circumstances, both beliefs that justify ignoring symptoms. This self-deception defends a self-identity tied closely to an image of a competent professional committed to clients’ welfare and able to work long hours without succumbing to stress. Ultimately, burnout results from the lack of an adequate boundary between a person’s work-role identity and the broader self with health and other needs that cannot be met through work.

Some respondents appeared able to set such boundaries, but many struggled to do so. About a third expressed a need for more information on how to avoid burnout through self-care.

Respondents typically saw the causes of burnout in the work environment: organisational pressures to overwork, poor management practices and lack of supervisor support. Many also perceived colleagues would not have supportive attitudes to burnout. Only 30% thought their workplaces took burnout and employees’ wellbeing seriously, and even those with supportive supervisors often believed workload or other organisational barriers would prevent effective assistance.

7.2 A model of the perceptual factors in burnout

The study findings suggest the prevalence of burnout among mental health professionals with the professional competence to prevent it can be explained by (i) defensively biased perceptions and beliefs concerning their own susceptibility to stress and its
causes, (ii) the effects of physiological impairment on decision-making, and (iii) perceptions that colleagues, supervisors and organisational managers have negative attitudes towards burnout. The latter may be defensively exaggerated in some cases, but much evidence here and in other studies suggests organisational and professional cultures do often stigmatise burnout and minimise attention to staff welfare.

A model summarising these factors was presented (Sections 4.5 and 5.2-5; Figures 9-12) to guide future research aimed at reducing burnout in professionals generally and mental health professionals specifically. This model links cognitive distortions to a professional role identity that is too closely allied with the self-concept and self-esteem, leading professionals to ignore symptoms, self-blame and avoid seeking help in order to maintain the role identity. Colleagues’, supervisors’ and managers’ attitudes may reinforce this process.

Around a third of the respondents perceived their organisations dealt effectively with burnout, half were comfortable discussing it with their supervisor and a similar number with colleagues, and most of the latter reported positive responses. These positive examples suggest some staff are not strongly affected by defensive perceptions and belief. The examples of Sharon and Fiona in Chapter 5 describe two who recognized their cognitive errors with the benefit of hindsight - and for Sharon, substantial recovery time. Whether others avoid burnout without experiencing it, perhaps because they are more stress-resistant or better able to set boundaries, is an interesting question for future research.

However, this study supports previous research showing such positive examples to be in a minority of mental health workplaces, perhaps reflecting the critical role of professional identity in overwork. The perceptual barriers identified in this model may be widely used by professionals. These are now briefly summarised.

**Perceptual barriers to responding to burnout in professionals**

The *fundamental attribution error* leads professionals to attribute stress in others to internal causes, while the *self-serving* bias attributes one’s own stress to external causes. The findings also suggest the presence of: (i) the *illusion of control*, which leads professionals to overwork while unrealistically believing they can control stress symptoms; (ii) *over-estimation of competence* when professionals assess their
functioning; (iii) optimism bias, where professionals unrealistically believe burnout cannot happen to them; self-deception in ignoring evidence of burnout to preserve one’s self-image and (iv) dichotomous thinking about burnout as an all or none event, which allows professionals to ignore warning signs.

It appears these biases often represent an attempt to maintain respondents’ self-image as a competent reliable professional, educated to self-manage and therefore not susceptible to stress or burnout. Many saw stress symptoms as a threat to this identity and responded by working even harder. Others responded with self-blame or self-stigmatising, which can lead to working harder to compensate or to feeling incompetent and eventually depressed. Such thought processes can justify ignoring symptoms and avoiding self-care or seeking help, which further exacerbates the problem.

These cognitive processes are accompanied by a stress-induced cognitive deficit that further reduces the ability to assess one’s level of functioning.

**Perceptions of colleagues’ attitudes to burnout**

Similar biases appear to underlie perceptions of colleagues’ attitudes to burnout. Consistent with the fundamental attribution error, many respondents reported a widespread tendency to attribute burnout in others to personal weakness or failure to practice self-care, in contrast to the common view of personal burnout as caused by organisational factors such as workload. Blaming the person helps the perceiver to feel less vulnerable.

Blaming the person is also aided by hindsight bias, in which the perceiver overrates the predictability of burnout and believes others should have “seen it coming” and taken corrective action. A belief in a just world, in which “bad things happen only to bad people” has a similar effect. In pluralist ignorance, group members wrongly assume other members do not experience burnout, or have negative attitudes towards it, and therefore avoid revealing it.

A cultural manifestation of blame is social stigma, for example where professional group members’ ‘gossip’ implies people who succumb to stress as ‘weak’. Colleagues also saw burnout as a failure to maintain professional standards of self-competence or ethics. Many answers implicated professional cultures in stigmatising burnout.
Some respondents believed colleagues would not respond to others’ burnout through lack of knowledge of how to intervene, which may be true in some cases but given their mental health training appears to also be a defensive belief at times.

These perceptions of negative or stigmatising views among colleagues are expected to reinforce highly stressed persons’ tendency to self-blame and avoid dealing with the problem because it conflicts with their professional identity and self-image, particularly how they would like to be seen by others.

**Perceptions of managers’ attitudes to burnout**

Many respondents believed their managers did not see burnout as a serious occupational hazard, making comments suggestive of ‘managerialist’ or internal process-driven cultures focused on generic management processes aimed at productivity or cost-efficiency while downplaying staff wellbeing and values important in health care. Senior managers were often seen to be out of touch with the high workloads, time pressure, fatigue and low morale professionals experienced.

Such organisations were seen to have a ‘stress culture’ where overwork is normal, and a related tolerance of unhealthy work practices. Burnout was seen as the worker’s failure to self-manage or take their share as a team member. Taking sick leave or declining overtime were seen as disloyal and pressuring colleagues. These managerial attitudes blame or stigmatise burnout in similar ways to colleagues’ attitudes.

Respondents also perceived a lack of supervisor support. Many were uncomfortable raising burnout with their supervisor or believed nothing would be done, a serious problem since supervisors form a valuable ‘early warning system’ when staff cannot recognise their level of stress.

Finally, stress was perceived to result from external pressures on the organisation. While there may be some objective basis to this perception, it could also represent a defensive bias in respondents or managers that externalises an undesirable side effect of their client service or management practices.

As with colleagues attitudes, these negative perceptions of the organisational environment are expected to have a significant influence on professionals’ willingness
to admit to and remedy high levels of stress. Both sets of influences can reinforce the vicious cycle of hard work and self-blame underpinning burnout.

7.3 Contribution to burnout research

This study is the first to systematically examine the role of perceptions and beliefs in burnout using empirical research, although previous authors have raised the possibility of defensive attributions (Maslach & Goldberg, 1998; Siebert & Siebert, 2007). The ‘causes’ of burnout in pressured working conditions are now well-documented, in mental health workplaces and elsewhere (e.g., Demerouti et al., 2001; Kim & Stoner, 2008; Leiter & Maslach, 2003), and the view that it is ‘caused’ by personal factors is now largely rejected (e.g., Schaufeli, Leiter & Maslach, 2009). However, arguments over objective causes tend to miss two points: workers are not passive reactors to external forces but make choices about whether to attend and respond to information, and they do this on the basis of their perceptions rather than objective knowledge. For these reasons, reducing burnout requires understanding how individuals perceive it – a phenomenological perspective.

From this perspective, improving the work environment is only part of the solution to burnout. Professionals must also have realistic perceptions of what they can deliver and the importance of non-work activities to mental health and general wellbeing. If their their self-concept and self-esteem are focused too much on professional outcomes, their intrinsic motivation to work hard and their capacity as professionals to determine aspects of the work and work hours can lead them to self-induce overwork and ignore objective information about the consequences. Thus burnout must be seen to result from both external and internal factors, a balance not well represented in existing studies.

The present findings suggest reducing burnout will require addressing professionals’ perceptual ‘blocks’. It appears many have unhealthy and unrealistic attitudes towards themselves and other employees, and managers may often have similar attitudes. The model in Figure 9 can guide development of interventions to change these perceptions and beliefs. However, this will not be a simple or quick exercise as it involves changing fundamental aspects of human identify and motivation and common approaches to management.
Researchers can play an important role in this in several ways. First, there is a need to move beyond simplistic thinking about the causes of burnout in either pressured work conditions or susceptible workers and examine how these combine, as the model above suggests. The role of colleagues, supervisors and organisational managers, and their collective influences through organisational and professional cultures, should be included in this broader perspective. Crucially, researchers need to consider professionals’ perceptions of these influences as much as their objective reality.

The model above appears relevant to occupational contexts beyond mental health. High levels of stress, a strong sense of professional identity - perhaps involving helping others or similar socially desirable values - and a need to appear professionally competent to others may be common in occupations such as medicine, law, education and religious ministry. The perceptual biases described above, and other internalising or externalising defences, may be even less visible to such professionals if not trained in psychology.

This study contributes to understanding of the phenomenology of stress and burnout. Current research tends to use quantitative tests of hypotheses about the incidence, causes or effects of burnout and gives relatively little attention to how workers perceive and understand it. The biases and distorted beliefs identified here are likely to influence responses to questionnaires using predetermined definitions and response categories. Workers may have difficulty recognising burnout in themselves, and ‘third person’ reports may reflect the fundamental attribution error of focusing on internal causes. Social desirability bias is also highly likely in self-reports.

While these problems can be overcome with sophisticated quantitative techniques, exploring the phenomenology of burnout through unstructured questions and interviews is important since susceptibility to it appears to be strongly affected by perceptual styles and self-perceptions. Phenomenological methods can produce a richer understanding of how a highly trained, competent and motivated professional’s perceptions can contradict objective reality in ways that seem implausible to the worker and often those around him or her. This person goes to great lengths to avoid being seen as susceptible to stress, and deceives him or herself about this. Further, he or she holds contradictory beliefs. The steps leading up to burnout therefore appear to be more subtle and less easily detected by conventional surveys than the literature frequently implies.
7.4 Implications for managers and supervisors

The study findings suggest managers would benefit from greater understanding of the common human perceptual limitations that lead professionals and other staff to avoid taking responsibility for the effects of stress by blaming themselves or externalising the problem and shouldering the burden rather than trying to reduce it. Such staff may be highly competent and committed employees: indeed they may be too committed to professional goals. They may seek to hide their symptoms to avoid appearing less than competent or compromising in their service to clients. This by itself should concern managers as an operational risk, and if they reach the final stage of the process they will need leave for months or longer. By continuing to practice, such persons unintentionally incur a long-term cost to their health, the organisation and its clients or patients.

Managers should also consider how common values in organisational and professional cultures reinforce this process, assisted by attitudes that effectively blame the worker, minimise responsibility for workplace health and normalise unhealthy workloads. Changing the culture to become more humane through recognising employees as people with health needs rather than merely ‘human resources’ is not easy but will reduce the financial and human costs of stress-related conditions. Improving well-being and human relations in this way should also increase employee morale, engagement and retention, and the quantity and quality of work and reduce sick leave and turnover.

Although there is now good evidence that investing in staff well-being creates savings (e.g. Baicker, Cutler, & Song, 2010; Naydeck, Pearson, Ozminkowski, Day, & Goetzel, 2008), managers are often unaware of the significant costs of stress-related disorders, particularly burnout (Miller, Kyaw-Myint, Hmeidan, & Burbidge, 2006). A recent estimate valued the direct cost of stress to Australian employers at $10 billion annually (SafeWork, 2013), excluding indirect costs such as lower productivity, absenteeism and presenteeism, turnover, low morale, stress-induced accidents and poor patient care in the health sector.

Managers can use Reason’s (1990, 2000) model of systemic management, widely influential in the health and safety field, as an alternative to process-driven approaches focused solely on economic or business goals to the exclusion of staff welfare. This approach takes a more holistic view of the organisation as a system in which human
factors - including health and safety, communication and morale – are business concerns as much as ‘hard’ systems and financial resources.

A key step toward burnout prevention is to see it as the joint responsibility of the organisation and the individual. Stigma and blame can be reduced through regular open dialogue between staff in formal or informal settings. Professional development activities can be developed jointly: Maslach (1982, p.197) observes that self-care workshops are often seen as patronising attempts to avoid corporate responsibility. Professionals who understand the operational environment can be involved in decisions that affect the stress levels of jobs, and supervisors can be seen as ‘change agents’ highly familiar with both professionals’ stress levels and the organisational stressors.

Supervisors also play a critical role as the group best able to detect burnout, and should be aware of its nature and how to respond. However, the present respondents were very clear that senior managers must actively support burnout remediation and employee health initiatives. Broad support from managers, supervisors and colleagues (see below) is needed if the barriers in professionals’ own attitudes are to change. Managers and supervisors can lead by example, openly discussing burnout and self-care in meetings, development programs and performance reviews.

Respondents’ suggestions focused on increasing staffing, greater support from supervisors, better access to leave and clinical supervision for professional staff. These are a substantial improvement over traditional bureaucratic recommendations such as health and safety policies, manuals describing the dangers of stress, and training that identifies stress as a safety issue. However, while changing the culture and management style may reduce the stressors, the present findings suggest changes in professionals’ attitudes to themselves, their work and their colleagues are equally important. This would require targeted programmes designed to reduce the stigma of burnout, similar to the Coming Out Proud initiative aimed at mental health stigma (Corrigan et al., 2013). Intervention would require facilitation by suitably trained professionals, and a longer term approach appears to be an essential ingredient for effective, long-lasting change.
7.5 Implications for educators and professional associations

Professional educators have a special responsibility to help future mental health workers become aware of how their perceptual processes and beliefs can exacerbate stress and create burnout. Teaching them to recognise their limits and their vulnerability to stress would result in a more realistic and less idealistic professional role-identity. Graduates should appreciate the importance of work-life balance and self-restorative activities, and the dangers of overly attaching their self-esteem to professional competence. They should understand the high risk of burnout in professional occupations, know the warning signs and be prepared to access advice or support.

To achieve this, graduates requires an understanding of the perceptual barriers they face in recognising and responding to their own burnout. This should involve a basic introduction to physiology of stress, the social psychology of person and self-perception, and relevant clinical perspectives on the self-concept and self-esteem. If not already taught, basic components of interpersonal relations such as active listening, empathy, trust and the coaching approach to helping others would be highly desirable in encouraging communication with colleagues and between future supervisors and their staff.

It is also important graduates understand the value of colleagues’ support when severely stressed, and how to give support to others. The destructive effect of stigma and blame, should be identified, and their tacit presence in attitudes common amongst professionals and managers emphasised. Discussions of when and how to help burning out colleagues and the social and professional considerations behind intervention, including respect for others’ and their own personal boundaries, would be valuable. Intervening with a colleague can be a simple matter of listening, but can also be complicated by real or perceived interpersonal, organisational and ethical issues.

In all of these topics, students’ perceptual defences should be given a prominent role. Focusing solely on self-management or self-care can unintentionally encourage many of the biases above and an idealised image of one’s self-competence. Graduates should understand the value of colleagues and supervisors as sources of feedback on what they can’t see about themselves.
Since perceptual defences are not easily changed, continuing professional development programs may be needed to reinforce this perspective. Training for new supervisors and middle managers should also address these issues and relevant personal and social skills.

Professional associations can assist educators through development programs, conference presentations, newsletters and other opportunities to portray a more realistic picture of professional performance, including the risks of stress, its internal and external causes and particularly how professional identity and perceptual distortions lead to denial or avoidance of self-care. The value of peer support and the influence of professional cultures and peer attitudes in stigmatising burnout are other key themes. Challenging the entrenched image of professionals as people who unquestioningly work long hours as part of a vocational or human service ethic is vital.

7.6 Limitations of this study

This study has a number of limitations potentially affecting its reliability, validity and generalisability. The small sample size, whilst large for qualitative research, suggests caution in generalising the results to the wider population of mental health professionals. It is also possible respondents were motivated to respond by having burned out (or perceiving themselves to have burned out), thereby over-representing this group. However, confidence in generalisability is increased by consistency between the rate of burnout here and in other studies of mental health workers (Kim et al., 2011; Kumar et al., 2011; Morse et al., 2012; Oddie & Ousley, 2007; Siebert, 2005).

A related limitation is the response rate of 26%. The strategies used to counter low response rates (see Chapter 3) appear to have been partly successful. More importantly, this study had an inductive approach based on open-ended exploration rather than a deductive model of hypothesis testing and statistical generalisation. Data saturation was observed after approximately 20 responses were analysed, and overall the 55 participants appeared to be a rich data source with good insight into mental health professionals’ perceptions and beliefs about burnout.

The relatively small sample also made it difficult to analyse profession-specific themes, which may affect application of the results to specific occupations. Relatively few
burnout studies have investigated mental health professionals as a single group (Lasalvia & Tansella, 2011), but since the work of occupational therapists, social workers, counsellors, psychologists, mental health nurses and psychiatrists shares many common characteristics, the present study should make a useful contribution to research on stress in the mental health sector. It may also have implications for other health professionals and, as noted above, to other professional or human service occupations that face high-stress work environments. Such generalisation of the findings would require empirical confirmation.

A final limitation of the sample is that while respondents reported on their managers’ attitudes it was not possible to directly survey or interview managers. Findings reflecting managers’ views or organisational policy and practice are therefore subject to confirmation in future research.

A different sort of limitation comes from the use of self-report data, which are subject to biases such as the tendency to agree with statements or to give expected, conservative or socially acceptable answers (Paulhus & Reid, 1991). The potential for bias was reduced by carefully wording items and instructions (Chapter 3), and open-ended questions less readily suggest ‘the right answer’ than closed questions or scales. Negative affectivity bias, whereby a subjective state of distress distorts self-reported symptoms (Powell, Johnston, & Johnston, 2008), could also influence responses by encouraging participants with severe stress or burnout to give negative responses. The extent of this bias here is unknown.

Respondent anonymity should reduce social desirability bias and the perceptual defences hypothesised above, but may also lead to more impersonal responses than, for example, an interview with a known and trusted person. The questionnaire and the interview format may therefore limit the depth or authenticity of responses. However, the data does appear to present a rich picture of professionals’ actual perceptions and beliefs, fitting the study’s exploratory approach. Future investigations can examine the cognitive processes identified here with different populations, questions, interviewers and research approaches. It is especially important future researchers use more direct approaches such as lab experiments or questionnaires to study specific biases since they are inferred here from responses to more general open-ended questions.
A final limitation of this study is that the Western Australian sample may not generalise to other states or countries. However, stressful working conditions appear to be common in mental health jurisdictions and the perceptual factors identified here are expected to affect professionals’ decisions about self-care and prevention in many geographical contexts. Future research can confirm this.

7.7 Suggestions for future research

Suggestions for future research have been made in a number of places above. An important concern is to confirm and extend the predictions of Attribution Theory and related cognitive biases. Attribution Theory is a well-developed and widely supported approach to understanding social perception but is underutilised in organisational research (Martinko, Harvey, & Dasborough, 2011) and has much to offer research on burnout prevention.

A related question is how to design effective interventions to change misattributions such as those underlying self-blame, internalisation or the defensive attribution of control to external agents. As these relate to a person’s self-esteem, broader ‘ego-strengthening’ interventions may be necessary. This area of research and staff development would benefit from greater understanding of both social psychological theory and clinical approaches to personal development.

Future research should also further examine the influence of organisational and professional cultures on professionals’ perceptions and beliefs. The biases described above appear to be influenced by, and contribute to, the collective attitudes reflected in such cultures, but some professionals may be more resistant than others. Studies of cultural influence would also extend the Attribution Theory literature, which tends to take a more individualistic perspective.

Managers’ own beliefs and perceptions are another important piece of the puzzle of burnout in mental health professionals, and should be investigated directly to confirm the perceptions of professionals reported here. Managers with professional backgrounds could be compared to those with generalist backgrounds to determine the role of values specific to health professions on attitudes to burnout. Another salient question is why managers omit the costs of poor staff health in management decisions: do biased
perception and beliefs affect their decision-making and how can they be remedied?

Future researchers may also consider whether the cognitive processes identified above are unique to mental health services or more widespread. Attribution Theory views these as fundamental aspects of human perception, suggesting professionals and managers in other fields may use them to avoid facing burnout. Burnout is widely experienced in professional-service industries generally (Felton, 1998), but perhaps different reasons for its continuing presence, including different biases, exist outside mental health services. A related question is whether the perceptual factors are equally common in the different mental health professions.

Finally, while the present sample often had negative views of their own response to burnout, or colleagues and managers’ responses, between a quarter and a half had positive perceptions. Some professionals recognised the signs and increased self-care in time to avoid severe cognitive deficits. Some colleagues and supervisors were supportive, and some organisations had effective strategies against burnout. Research on the positive cases can show how individuals overcome common cognitive limitations, and how management systems and organisational cultures can avoid reinforcing negative images of stress and burnout. Case examples would be particularly informative in educating managers and future professionals, and can help researchers refine theory and design effective interventions.

7.8 Conclusion

This study suggests mental health professionals continue to experience high levels of burnout in large part due to common perceptual processes that cause even highly trained staff to misconstrue signs of extreme stress. Perceptions of colleagues’ and managers’ attitudes to burnout as largely negative further reinforce these biases and distortions. It appears colleagues and supervisors’ attitudes often reflect similar perceptual processes that encourage avoidance of burnout. Organisational and professional cultures and common management practices may further reinforce professionals’ avoidant behaviours.

An understanding of how burnout is exacerbated by fundamental aspects of the perception of self and others is important if professionals, managers, professional
bodies, educators and researchers are to devise better ways of reducing burnout. Without appreciation of the psychological difficulties stressed professionals face in perceiving and responding to their state, and the value of colleagues and supervisors in this situation, it is likely burnout will continue to be a major cost to mental health and other human service organisations.
REFERENCES


Erickson, P. I. & Kaplan, C.P. (2000). Maximizing qualitative responses about smoking in structured interviews. *Qualitative Health Research, 10*(6), 829-840


Stokes, B. (2012). *Review of the admission or referral to and the discharge and transfer practices of public mental health facilities/services in Western Australia*. Perth: Mental Health Commission.


APPENDIX A: FINAL QUESTIONNAIRE
Beliefs and Perceptions about Burnout amongst Mental Health Professionals

This is an anonymous questionnaire - please ensure that you do not write your name or any other identifying comments on it. Please read the Information Letter carefully as it fully explains the intention of the research project. By completing the questionnaire, you are consenting to take part in this research.

This research investigates mental health professionals' views of burnout. Please remember there are no right or wrong answers, it is your opinion that is of primary interest.

If you require more space for any answer please write on the back of the questionnaire and indicate which question you are answering. Thank you for your participation.

Section A: Some information about you.

1. What is your profession? Social Worker □ Nurse □ Psychologist □ Counsellor □ Psychotherapist □ Occupational Therapist □ Other _____________________

2. How many years have you worked in the field? ______

3. Age 20-25 □ 26 - 29 □ 30 - 39 □ 40 - 49 □ 50 + □

4. Sex Male □ Female □

Section B: Firstly, a few questions regarding what you think about burnout.

5. What is your understanding of professional burnout?
6. What do you think are the three leading causes of burnout? Please make a brief comment on why you think these contribute to burnout.

1) 

2) 

3) 

7. Do you believe there are certain kinds of people who are more likely to burnout?
   No □   Yes □

Please explain your answer.

8. Do you think that burnout and work stress are viewed as seriously as other occupational hazards? Please comment.
   No □   Yes □
9. How do you think burnout is seen within your (a) organisation? (b) profession?

a) Organisation

b) Profession

Section C. Now, some questions about your experiences regarding burnout.

10. A) Have you known colleagues whom you perceived to be experiencing burnout?
   No ☐ Yes ☐

   Did they discuss how they were feeling with you? What happened?

   Please comment.

B) Did other colleagues discuss how this colleague was feeling or functioning?
   No ☐ Yes ☐

   Please comment.
11. A) Have you personally experienced burnout?
   Yes ☐   No ☐ → Please go to question 12.
   Please describe your experience.
   ____________________________________________________________

   B) Professionals can sometimes be reluctant to disclose when they are not coping well at work. Did this affect you seeking help in dealing with burnout?
   No ☐    Yes ☐
   Why or why not?
   __________________________________________________________

   C) What was your impression of your colleagues' response to you?
   __________________________________________________________
12. In your current position how comfortable would it be to tell your manager that you felt 'burnt out'?

Very comfortable □  Comfortable □  Fairly uncomfortable □

Please explain your answer.

13. On a scale of 1 to 10 how would you rate your feelings of burnout over the past 2 weeks?

No feeling of burnout 1 5 10 Strong feeling of burnout

Please comment on your answer.
14. How serious would the consequences be, for example on your health and employment, if you were to burn out?

Extremely serious □ Serious □ Not very serious □ Not at all serious □

Unlikely to happen □

Please comment on your answer.

15. When you think about your role as a professional, how would burning out affect the way you see yourself?

Section D: Finally, some questions regarding the prevention of burnout.

16. Do you see burnout as avoidable when working in the mental health field?

Totally avoidable □ Mostly avoidable □ Mostly unavoidable □

Unavoidable □ Unsure □

Please comment on your answer.
17. If you see burnout as avoidable, how can a mental health professional prevent burning out?

18. What are the 3 main barriers to avoiding burnout within your current or past organisation?

19. What could your organisation do that might assist you in undertaking measures to avoid burnout?
20. Do you think you have sufficient knowledge and information in regards to maintaining your wellbeing at work and avoiding burnout?

- [ ] I have all the knowledge I need
- [ ] I have most of the knowledge I need
- [ ] I could use a little more knowledge
- [ ] I have very little or no knowledge

What type of information would be useful to you?

21. Do you have any other comments?

Please include your details on the provided slip if you are willing to be interviewed or would like to enter the prize draw.

Many thanks for your time and participation.
Dear Mental Health Professional,

Perceptions about Burnout amongst Mental Health Professionals
A Qualitative Study

The topic of burnout amongst mental health professionals has received increased attention in recent years as demand on health services in WA increase and resources continue to be stretched. Burnout can be seen as a collection of changes in a professional such as a sense of being emotionally depleted, increasingly cynical, detached from clients and feeling less effective in one's work. Researchers have come some way to understanding what may contribute to professional burnout in the “helping” fields, however we are yet to understand how professionals themselves think about burnout.

As you are a mental health professional practising within Western Australia we are seeking your opinions on the matter of professional burnout. Taking part involves filling in the questionnaire in which you will give your thoughts on various aspects of burnout. The questionnaire can be returned in the provided envelope without any identifying information to protect your privacy.

Your answers will remain completely confidential. All identifying information will be removed from the data to ensure anonymity. Please do not place your name on the questionnaire for this reason.

A number of in-depth interviews will be conducted as part of this study. If you are interested in being interviewed please write your contact details on the provided slip. Interviews will be conducted at your choice of location.

Returned questionnaires will go into the draw to win a relaxation massage voucher to the value of $80.

All identifying information will be removed from the interview transcription and final report.

Please be aware that your participation is entirely voluntary and you have the right to withdraw participation at any time. If you experience any distress as a result of this study, please contact the researcher who will assist you in accessing appropriate support.
This research project is being undertaken as part of the requirements of a PhD at Edith Cowan University.

If you have any questions about this study, please contact:

Marieke Ledingham (Chief Investigator)
Faculty of Business and Law
Edith Cowan University
270 Joondalup Drive
JOONDALUP WA 6027
mledingh@our.ecu.edu.au
Phone: 0416752477

Associate Professor Peter Standen
Faculty of Business and Law
Edith Cowan University
270 Joondalup Drive
JOONDALUP WA 6027
p.standen@ecu.edu.au
Phone: 08 6304 5283

Associate Professor Chris Skinner
School of Medicine
University of Notre Dame
47 Henry St
Fremantle WA 6959
cskinner@nd.edu.au
Phone: 08 9433 0230

This project has been approved by the ECU Human Research Ethics Committee. If you have any concerns or complaints about this project and wish to talk to an independent person, please contact:

Kim Gifkins
Research Ethics Officer
Edith Cowan University
270 Joondalup Drive
JOONDALUP WA 6027
research.ethics@ecu.edu.au
Phone: (08) 6304 2170

Thank you for your participation

Yours sincerely,

Marieke Ledingham
PhD Candidate