PROFESSIONAL BURNOUT: A CONCEPTUAL MODEL

by

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ABSTRACT

Professional burnout is a circumstance that can result from accumulated occupational stress among those who do caregiving work. The effects of burnout tend to be physiological, behavioral, psychological, spiritual and clinical in nature; thus impacting individuals and human service systems. The term burnout was first coined by Dr. Herbert Freudenberger in the early 1970's and since that time burnout has been discussed extensively.

The goal of this project was to develop my understanding of professional burnout, using my own experience as a social worker as the foundation for my inquiry. This project presents a conceptual model of burnout, resulting from the integration of the available literature on this topic, with my own professional experience. This model conceptualized the individual factors, including personal and professional variables, as well as the systemic factors including organizational and client variables, that can contribute to the risk for burnout among social workers, or other helping professionals. This project highlighted the interplay between individual and systemic variables pertinent to burnout and it suggested that there are both risk factors and protective factors that can be explored when assessing burnout.

The conceptual model and the assessment tool illustrated in this project, provides social workers with a framework for discussing, preventing, assessing, and/or treating professional burnout.
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It is important that I preface this work by discussing my personal beliefs, biases, and motivations regarding caring because they shape the context for my understanding of professional burnout.

My interest in professional burnout is a direct result of my personal and professional experiences. I have been amazed at the diversity and complexity of the people who do caregiving work, which includes commitment, vulnerability, and hopefulness. At the same time, in my ongoing commitment to self-awareness, I have paid attention to my own vulnerabilities and biases. As a result, my personal philosophy regarding helping has evolved and changed in the ten years that I have been doing caregiving work.

I believe, that as individuals, we are encouraged to compartmentalize our world and our relationships in it, resulting in much of the sorrow that can be part of living. Connections with ourselves and others, as well as with a higher power if one is so inclined, are often fragile, time limited or legislated. Caring is at the heart of what it means to be human; we are mortal beings who function in our relationship with one another and our environments. Living within this postmodern era, has left the world, at times, without a caring component. This has resulted in populations of disempowered, disenfranchised and disillusioned people. Professional helpers or caregivers are not separate, but part of, this often unforgiving culture of modern society.

Stress was recently featured in a CTV news special report; stress is being called the "epidemic of the 90's" (March 1998). Despite the growing place stress has in the western world, I feel hopeful about the potential of human beings. I believe we intuitively have the capacity to know the nature of our basic needs and that we are able
to re-learn our innate desires for simplicity, kindness and meaning; thus bringing about a transformation that will challenge the tragedies of child abuse, domestic violence, poverty, addictions and so on. Interestingly, popular culture leads me to have hope for our collective futures. I watch Oprah Winfrey abandon the pop culture agenda of tragedy as she embraces a new purposeful motive to her show, to act as a catalyst for human caring by way of introducing people to themselves. The fact that people have not changed the channel and that her ratings are steady, tells me human kind is not shy to possibility and still nurtures hope and possibility for a more holistic and congruent way of life.

I would like to dedicate this project to Peter Calabretta. Peter was my friend and colleague for five years. We worked together at the Children's Aid Society (CAS) in Ontario; he was a social worker there for fifteen years. In the spring of 1995, I received a telephone call from Jane Timleck (I was living in Prince George at this time), another friend and colleague at the CAS. She called to inform me that Peter committed suicide. He died in the garage of his family home; his wife, then six months pregnant, found him. He was surrounded by approximately one hundred and fifty social workers, five days a week. His pain prior to his death went unnoticed, or at least unaddressed. If Peter were a client, an "intervention" would have taken place the moment he was deemed to be "at risk". Yet, caregivers are treated differently, as if somehow they are different than the "average person"; they are supposed to be able to cope with more, problem solve better, never need help because after all they are in the helper role.

At the moment of the news of Peter's suicide, those of us who worked with him and knew him, were reminded that we, the professional helpers, are average human beings. We experience life with joy, sorrow, and limitations. After Peter's death, there
was tremendous grief, sadness and guilt among his colleagues. This was noticed and only partially addressed. Jane told me that a debriefing was offered, otherwise it was work as usual and very little was mentioned; she said it was "as if it never happened". I asked myself, why is this? We would offer our clients time to heal, someone with whom to talk. We would normalize their reactions to a sudden death and validate their experiences. We, as social workers, would do these things because we know that they are important in the healing process, so why for the most part, do we not afford ourselves and each other the same kindness? Again, we manifest the belief that we are somehow separate and untouched by our own painful life experiences.

I think this belief is fostered internally, within the professional's frame of reference; as well as externally, where other people assume that professionals are somehow superior and never need help. It also appears to be implicit in our education; little time is spent in university classrooms teaching us to care for the carers. Instead, we are urged to practice "professional distance" from clients and colleagues alike. In the end, I have to wonder if perhaps as professional helpers we really do not believe our own rhetoric. It appears that we believe it is weakness to need help or to acknowledge limitations, yet we obviously have a double standard where it is fine for others to ask for help or to have needs.

This project will discuss professional burnout. I have specifically opted to explore professional burnout, because for me, my friend's suicide represents the tragedy that can result when we don't take care of caregivers. I believe burnout is the thermometer we have to monitor the incongruencies between what we say and what we do as caregivers, as well as the warning sign to systems and organizations that
something is amiss in overall service delivery efforts. This project will, in part, illustrate this personal conviction and advocate for a different voice.
INTRODUCTION

The purpose of this project is to assimilate the available information and research regarding professional burnout into a conceptual model for understanding this phenomenon. This model will offer social workers a comprehensive tool towards understanding, preventing and treating burnout.

This project will become a catalyst in applying, in a comprehensive way, the information available to date regarding professional burnout for both individuals and organizations. A case study, derived from my own social work practice, will be described to illustrate the complexities of the burnout phenomenon. This case study is not inclusive of all variables pertinent to burnout, but rather, this example provides a window into exploring burnout, allowing me to operationalize the conceptual model proposed within this work.

Chapter one discusses an overview regarding professional burnout. Chapters two through five will provide a comprehensive literature review; as well, these chapters will illustrate my conceptual model of burnout. Chapter six highlights a case example taken from my own social work practice. This case example is assessed and my conceptual model is operationalized. Chapter seven explores some of the implications regarding social work practice that can be ascertained from this work. In addition, skepticism regarding burnout is noted. Chapter eight concludes with recommendations for future research and final comments.

This project aims to say it is okay for helpers to be human, hence to have human reactions to suffering. In part, this involves recognizing the impact that both our caring work and the human service systems in which this work prevails, have on social workers. In the end, I will propose a fundamental shift in our understanding of caregiving work, whereby social work will be defined by its inherent nature of relationship; where it can remain something that we are, not just something that we do. It is with this existential identity of social work practice, that I believe burnout can be extinguished.
CHAPTER ONE

An Overview of Burnout

Burnout can be described as “a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur among individuals who do “people work” of some kind” (Maslach, 1982a, p.3). There is a complex interaction of individual and environmental factors that need to be taken into account when exploring the issue of professional burnout. As personality factors and systemic variables that contribute to occupational stress interact, the likelihood of the crisis of burnout is prevalent.

The onset of professional burnout is slow. Burnout is often identified by others, yet remains invisible to the professional who has been overcome by its pervasiveness. The early characteristics of burnout include the feelings of emotional and physical exhaustion. Individuals can experience depression and grand malaise, as well as feelings of helplessness and hopelessness (Hagan, 1989, p.718). Other signs of burnout include a sense of alienation, cynicism, impatience, negativism, and feelings of detachment to the point that the individual begins to resent work and the people that are part of that work (Maslach, 1982a). Burnout has physiological, behavioral, psychological, and spiritual features (Grosch & Olsen, 1994, p.5); because it is often defined by these characteristics it is often not recognized until it reaches an advanced state (p.7). According to Gilliland and James (1993) burnout moves through stages of enthusiasm, stagnation, frustration and apathy. In its end stage, burnout is a crisis situation (p. 572).

Burnout has been a recognized phenomenon among professional caregivers since the 1970’s. In the years 1980 through 1985, it was the subject of over 300 refereed articles and 12 books (Schmidt, 1997). Burnout is a serious crisis that can have both personal and professional implications for the individuals who experience this depletion of the human spirit of care. Burnout is not just some “pop” psychology term designed to elicit sympathetic responses from one’s coworkers or family. It is a
complex individual-societal phenomenon that affects the welfare of not only millions of human services workers but also tens of millions of those workers' clients (Farber, 1983, p.vii).

Burnout is discussed as a work related phenomenon for those doing caregiving or helping work, especially when this work involves regular exposure to crisis and trauma (Stamm, 1995). Social workers, in my opinion, are increasingly exposed to crisis and trauma in their roles due to current social and political changes. In addition to burnout, social workers are also vulnerable to experiencing secondary traumatic stress (STS) and compassion fatigue. Secondary traumatic stress, is also commonly referred to as vicarious traumatization (Pearlman & Saakvitne, 1995) or compassion fatigue (Figley, 1995a). “Vicarious traumatization is the transformation in the inner experience of the therapist that comes about as a result of empathetic engagement with clients' trauma material” (Pearlman & Saakvitne, 1995, p.31). Where burnout is a result of accumulated occupational stress, secondary traumatic stress is a reaction to graphic descriptions of violent events, exposure to the realities of people's cruelty to one another, and involvement in trauma related reenactments, either as a participant or as a bystander (p.31). Critical incident stress debriefing (CISD) is considered to be valuable in minimizing the long term impact of traumatic events; therefore, CISD can be beneficial in preventing both burnout and secondary traumatic stress (Snelgrove, 1995).

The context of social work practice sets the stage for possible experiences with burnout. Social workers face increases in workload, while service delivery systems reorganize at accelerated rates. With the neo-liberal agenda of our times, there is a decrease in resources allotted to social programs, while at the same time an increase in the demand for these services (Ternowetsky, 1997). While social workers practice amidst this continuum of competing imperatives, increased attention is demanded in regard to their well-
being; in particular, in the area of burnout prevention.
CHAPTER TWO

Definitions of Burnout

There are a number of definitions for professional burnout. I noted Maslach’s (1982a) definition in the introduction; she followed the earlier work of Herbert Freudenberger (1980). Freudenberger was a practicing psychoanalyst who identified that a number of people who came to see him described circumstances and feelings that suggested that their lives had lost meaning. “These men and women were exhibiting signs of something amiss between themselves and their environment” (Freudenberger, 1980, p. xvii).

Freudenberger was the first person to coin the term “burnout”, in an attempt to describe what he was noticing in the people with whom he spoke. Eventually, he identified the 4 D’s of burn-out. These include the following: disengagement, distancing, dulling, and deadness.

Dass & Gorman (1985) conceptualize burnout in the following manner: i) a growing burden of personal responsibility leads to exhaustion and frustration; ii) tired of being with needy people; and iii) joy and inspiration give way to apathy and resignation. Later burnout was considered as a “syndrome which occurs in the care provider as a response to chronic emotional stress and which arises from the social interaction between a care provider and the recipient of care” (Courage & Williams, 1987, p.8).

William Powell (1994) suggests that burnout is closely linked to alienation. According to Powell (1994), alienation is characterized by the following: powerlessness (one can’t control the work conditions or the purpose of one’s labour), meaningfulness (one’s work and life narrative are devoid of meaning), normlessness (there are no superordinate rules to which all subscribe), isolation (each individual struggles alone and there is no sense of community), and self-estrangement (one’s labours have no relationship to one’s sense of self).

Overall, burnout is more than occupational stress, it is an erosion of the
human spirit; it evolves as a result of the many interactions inherent to caring work. The nature of burnout is very generalized and therefore it is difficult to identify. "Because of the difficulty in identifying burnout, it becomes much easier to chalk it up as a character deficit" (Gililand & James, 1993, p.539). Since there are so many definitions of burnout, this has resulted in the tendency of researchers to focus on the individual personality traits of the professional as the primary predictors of the occurrence of professional burnout. Likewise, there is a tendency to discuss burnout using the medical model, hence, using language like “symptoms of burnout”. As a result, burnout becomes pathologized, rather than describing it as a normal occupational hazard of doing caring work with people.

In addition to defining burnout, the literature reveals one conceptual model of burnout. Courage and Williams (1987) provide a multidimensional model that developed as a result of a literature review and they suggested that this model can be used for future studies that explore the issue of professional burnout. Specifically, their model would be useful for studying the relationship between the occurrence of burnout in care providers, the human service organization, and the recipient of care (p.7). The conceptual model suggested in this project differs from Courage and William’s multimatrix model.

Social Historical Context of Caregiving Work

Cherniss (1995) highlights the bureaucratic system inherent to human service organizations, noting the impact this structure has on professionals working within these settings. For example, he illustrates the pressures to provide quality care in a context of efficiency (Cherniss, 1995, p.29). Furthermore, he notes the ideologies present in the human services, things such as the prevalent societal beliefs about helping the "needy", in particular the current “ambivalence about supporting human service programs” (p.30). This ambivalence eventually can be interpreted as an overall devaluing of the work done by professionals within human service organizations.
Ultimately, human service workers are often criticized for what they do, yet they are expected to do more of it. It seems that the more programs are eliminated as a result of the neo-liberal agenda, the greater the demand for these programs. These competing imperatives result in tremendous strain on the overall system; in particular, on the workers within this system.

Helping always takes place within the larger social context. Recent decades have revealed the gradual erosion of community; consequently, individualism sets our personal and political agendas. “Everywhere around us we are encouraged to think of our own needs” (Grosch and Olsen, 1994, p. 62). Many believe we are living in an age of expectation and entitlement, where ongoing mantras regarding rights are voiced. “I deserve love. I deserve to be trusted. I deserve sexual freedom. I deserve friendship. I deserve respect. I deserve sexual pleasure. I deserve happiness” (Zilbergeld in Sykes, 1992, p. 41). A short time ago, relatively speaking, these notions would have been considered ludicrous. Sykes (1992) argues that this individualized structure has resulted in what he calls “a nation of victims”. He states:

...that is a formula for social gridlock: the irresistible search for someone or something to blame colliding with the unwillingness to accept responsibility. Now enshrined in law and jurisprudence, victimism is reshaping the fabric of society, including employment policies, criminal justice, education, urban politics, and, in an increasingly Orwellian emphasis on “sensitivity” in language. A community of interdependent citizens has been displaced by a society of resentful, competing, and self-interested individuals who have dressed their private annoyances in the garb of victimism (Sykes, 1992, p. 15).

There are many individuals, including policy makers, decision makers and so on who subscribe to the notion that society is “a nation of victims”. This labeling dismisses legitimate claims of oppression and therefore removes society’s responsibility towards alleviating oppressive structures. Furthermore, this opinion risks devaluing the suffering that many people experience. In saying that victimhood is an illegitimate plea, one risks giving permission to oppression.
Reciprocally, the efforts towards social justice and individual well-being that are initiated by social workers and other professional and non-professional groups, can be minimized, unsupported, and ignored.

I believe that the social context of helping, the ideologies distinguished within social policies, and the bureaucratic nature of human service settings, are critical components in understanding burnout among human service professionals. Unfortunately, I think that many professionals fail to consider the impact of the context of helping on their own feelings of disillusionment and perhaps burnout.

**Feminist Critique**

It is also imperative to understand the context of social work practice from a feminist perspective. “Service delivery systems mirror gender-defined roles in the larger society: The direct service providers, caretakers, gatekeepers, and primary care workers are mostly women; the decision makers, executives, and power brokers are mostly men” (Walter, 1995, p.11). Furthermore, human service work is obscured by devaluation (low prestige and low status make it an inferior segment of the job market); invisibility (stereotypical images mask the real nature of human service work); and fragmentation (bureaucratization and professionalization separate human service workers from each other) (Fisher, 1990, p.109).

Caring is central to the experience of women. It is also a form of oppression for women, since this culture demands that women care for, as well as care about, others. Yet society generally does not acknowledge the value of women’s caregiving tasks. Girls/women are labeled as ‘naturally’ more caring than boys/men. “This reasoning slips quickly from description to prescription and women become, as suggested by Jean Baker Miller (1976), constrained to traditional forms of caring or service” (Brabec, 1989, 165). Do women choose to do most of society’s caring work, because of deeply rooted moral or
psychological predispositions? Or do women 'care' because they are less powerful than men, and must exchange caring for material support? (DeVault, 1991, p.10) These questions as well as the possible responses, need to frame our understanding of burnout. These ponderings reflect the social, political and economic parameters of this discussion. It would be remiss to exclude the role of gender in discussions about burnout.

Women have been socialized to be caregivers and women's self-esteem is largely related to their relationships. "Since the esteem of many women is directly embedded in the success of their relationships, they must often sacrifice their own needs for the sake of a partner or children" (Kaschuk, 1992, p.161). Women have "been taught that it is selfish even to think of their own needs and certainly to put them before anyone else's (p.162). This speaks to the identity and psychology of women. It is relevant to this discussion on professional burnout, because it provides a social context to caregiving work. It also highlights the difficulties that so many female caregivers have in prioritizing their own self-care needs. Self-care is often exchanged with words like selfish, and contradicts a women’s socialization of self-sacrifice for the well-being of others. Hence, self-care is more than a decision, it is often a relearning of inherent personal needs and wishes. This feminist perspective regarding caring work must be acknowledged as an integral component to the remainder of the conceptualization of professional burnout within this work.
CHAPTER THREE

Individual and Systemic Variables

Burnout originates from three different areas including individual and systemic variables, and the interplay between the two (Grosch & Olsen, 1994). The next section of this paper uses the available literature relevant to burnout, to suggest a comprehensive understanding of some of the contributing factors which can lead to professional burnout.

Individual Variables

i) Professional

In 1985, MacFadden initiated research with child welfare social workers. This research concluded the following: i) women tend to experience higher levels of emotional exhaustion, while males experience higher depersonalization scores; ii) there are no significant differences in burnout between males and females; iii) as age increases, burnout decreases; iv) workers with B.S.W. degrees experienced stronger levels of burnout than M.S.W. workers; v) workers within smaller agencies experience more feelings of emotional exhaustion, compared to workers in larger agencies; vi) burnout did not increase uniformly with caseload size; vii) workers who meet formally and more regularly with supervisors, experience less burnout; and viii) child protection workers experience somewhat higher levels of burnout than a heterogeneous group of human service professionals. Poulin and Walter (1993) suggested that personal variables, such as self-esteem, health status, age, and hours worked, predict burnout. Those with low burnout had higher levels of self-esteem and were older than the workers with higher burnout (1993, p.8). Maslach’s (1982a) original research available on burnout, found that men experience more depersonalization, while women fall to emotional exhaustion; none the less, both men and women experience burnout. She also found that young workers are more at risk than older workers, single people are more at risk than married people, and those with children are less at risk of burnout (Maslach, 1982a).
ii) Personal

Herbert Freudenberger stated: "A burnout is someone in a state of fatigue or frustration brought about by devotion to a cause, way of life, or relationship that failed to produce the expected reward" (Freudenberger, 1980, p.13). He suggests that certain 'types of people' are prone to burnout: "Burnout is pretty much limited to dynamic, charismatic, goal oriented men and women or to determined idealists" (p.20). Overall, professionals with Type A personalities are seen as being at high risk for burnout. These Type A professionals tend to invest a great deal of time in the job as a means of finding a sense of fulfillment and identity. Competition and achievement serve as guiding values that correlate highly with the need to be seen as worthy and capable (Maslach, 1982a, p.66; Pines & Aronson, 1988, p.6-9).

Perhaps motivations regarding work need to be considered further; for example, it is important to understand an individual's orientation towards work. Some people live to work, while others work to live (LePage, T. & Sutherland, P., 1998). This is a significant distinction because it identifies the value system attached to the meaning of work. I worked with a colleague who very much appeared to live to work; hence, he derives a lot of satisfaction from work related activities, even when they appear to be excessive. Ultimately, individuals need to have their value system satisfied through the activity of their daily living. It is important that there is a congruence between a person's values and how they spend their time, both during work and non-work times. Value is not only ascribed to beliefs about work, but also to the meaning of helping. LePage (1998) stated that some people derive meaning from the change that can result from a therapeutic relationship, others derive meaning from the act of helping in itself versus the outcome these efforts produce. I suspect those who make great investments towards change outcomes are more susceptible to burnout versus those people who help for the sake of helping.

In addition to values, other variables appear to contribute to the onset of burnout. Overall, it seems that young, inexperienced social workers tend to be at a higher risk for
burnout. Perhaps this is related to levels of idealism upon first entering a helping profession. Pines (1993) differentiates burnout from stress, in that, while many people experience stress, only those who entered their professions with high ideals and motivation can experience burnout. In terms of age, there is a normal maturation process as one moves towards their adult identity. If this identity is one that demands that work sustain one's self-worth, burnout is probably more imminent. When self-worth is judged by external sources versus internal processes, one is more vulnerable to the critical nature of this feedback. This can create a rather fragile foundation for a person to develop their sense of personal worth, competence and self-esteem. In summary, I believe that the individual risk factors specific to burnout are perhaps more about one's sense of self than demographics or personality.

Systemic Variables
i) Organizational Variables

In 1980, Cherniss (1995) completed a qualitative study with individuals in the helping professions. This study revealed systemic variables that contribute to burnout. He explored the presence of burnout amongst novice teachers, nurses, therapists and lawyers; finding that various themes emerged regarding the onset of professional burnout. In particular, the following factors appeared to contribute to the development of burnout: i) the "crisis of competence" whereby the professionals felt ill-equipped to perform their various roles, as well they were conscious of their inexperience; ii) the realization that professional autonomy was not pervasive and that practice was largely influenced by institutional settings; iii) it was difficult to maintain their original idealism as they worked with "difficult clients"; iv) they experienced boredom and routine, hence, the myth that their professional work would remain meaningful and interesting was shattered; and v) professionals felt isolated and alone, noting the lack of peer support amongst their colleagues (Cherniss, 1995).

The research of Soderfeldt et al. (1995) also points to a number of organizational factors relevant to burnout. These factors are related to the work
organization and they include such things as relations with supervisors, team support, and/or existing work pressure. Poulin and Walter (1993) identify job stress, supervisor support, job autonomy, and organizational resources as organizational variables associated with burnout. Of these, the strongest predictor of burnout is the level of perceived job stress (p.7). Lastly, Farber (1983) discusses the following as cornerstones of burnout: role ambiguity, role conflict, role overload, and inconsequentiality, where workers have a feeling that no matter how hard they work, the outcome means little in terms of recognition, accomplishment, appreciation, or success.

ii) Client Variables

Organizations and systems contribute to the context of social work practice. The greatest part of front-line social work practice involves a helping or therapeutic relationship. The helping relationship itself is often initiated because the client has a problem. Within the context of the relationship, positive feedback and change can be minimal, while emotional stress can be high. The work environment, or the context of the helping relationship, are often characterized by high caseloads, and workers who have minimal control over the caring work that they provide (Maslach, 1982a).

Poulin and Walter (1993) identified the following client variables significant to the development of burnout: the severity of client problems, the percentage of time spent with clients, and workers' satisfaction with clients. According to the findings of Poulin & Walters, the respondents' satisfaction with their clients has a significant inverse association with burnout (1993, p.8). Ultimately, social workers aim to have positive relationships with their clients. This goal is the reason for much of the effort put forth by workers; unfortunately, these motivations become laden with other realities dictated by the organization. For example, paperwork, meetings, and other bureaucratic functions often demand much attention from the worker, leaving less energy available for the tasks within the therapeutic relationship. In the end, this can lead to decreased job satisfaction and possibly burnout.
Summary

There is obviously a complex interaction of individual and systemic variables that need to be considered to understand professional burnout. I have depicted a conceptual model (see Appendix 1) to use as a framework to aid towards the comprehension of burnout. This understanding should always be considered within the overall context of social work practice. Social work practice encompasses both process and planned-change actions. "Social workers often enter the profession with an idealized sense of mission or calling to help others and work within frequently demanding bureaucratic constraints" (Hagan, 1989, p.718). Being part of a bureaucracy is unavoidable for most social workers because most social work jobs exist within larger organizations. Hence, social workers must understand the context of their practice and develop the skills needed to cope with the bureaucratic system.
CHAPTER FOUR

The Cost of Burnout

Burnout is connected to loss of job productivity, impairment of interpersonal and intrapersonal relationships, and a variety of health problems (Maslach, 1982b, p.39). Organizations sustain both direct and indirect costs as a result of worker burnout.

Lost motivation, increased staff turnover, poor delivery of services, increased employee theft, increased tardiness, and greater absenteeism all result in significant indirect cost to organizations. Direct costs include employee health care costs for diagnosis and treatment of burnout (Caputo, 1991, p.132).

Billions of dollars are lost each year because of workers in all fields who can no longer function adequately in their jobs due to stress and burnout (Gilliland & James, 1993, p.537). “It sounds like a statement of the obvious to say that healthy employees work better, are absent less, cost a group drug plan less and cost the disability plan less...many employers have shied away from becoming involved in their employees’ health...that perception has now changed” (Kelly, 1997, p.3).

Maslach (1982a) describes the impact of burnout on the people receiving care; for example the helper may dislike the client, treat the person as a “thing” versus an individual and so on. Overall, “the negative, cynical feelings about people that develop with burnout are not limited to those individuals one encounters on the job. They become more pervasive and are the basis of a more permanently soured view of humanity” (Maslach, 1982a, p.84).

The tragedy of burnout, in my opinion, is the human cost involved with caregiving work. The human costs of lost meaning, disillusionment, and frustration erode something fundamental within the helper, the specifics of this loss are unique to individuals; nonetheless, the impact of these losses impact on the entire human service system.
Paine (1982, p.11) and Maslach (1982b, 29) report critics who propose that burnout is "part of the job", so if a human services professional "can’t stand the heat then he or she ought to get out of the kitchen", because there "always has been stress on this job and always will be". This dismissal of burnout does not consider the major personal, organizational or social costs that accrue when job stress turns into crisis (Paine, 1982, p.11); nor does it consider ways that the organization and worker can reduce burnout. Burnout is not just part of the territory; it has major ramifications for both individuals and institutions (Maslach, 1982b, p.39). It is a very real problem, with chronic occupational stress as a primary causal factor (Paine, 1982, p.16).

**Secondary Trauma/Compassion Fatigue**

Burnout is sometimes called a cost of caring (Maslach, 1982a). There are other "costs of caring", these include secondary traumatic stress (or vicarious traumatization) and compassion fatigue. Secondary traumatic stress (STS) differs from burnout. Burnout is the result of accumulated occupational stress, whereas secondary traumatic stress can occur following one traumatic incident. "In contrast to burnout, which emerges gradually and is a result of emotional exhaustion, STS can emerge suddenly and without much warning" (Figley, 1995b, p.17). Figley (1995a) developed a Compassion Fatigue Self-Test for Psychotherapists which produces two different scores. One score indicates the individuals risk for experiencing compassion fatigue, the other score highlights the risk of burnout (see Appendix 2).

Compassion fatigue, or compassion stress, can be used interchangeably with secondary traumatic stress. This term was first coined in print by Joinson in 1992. Joinson was looking at burnout amongst nurses and discovered the fatigue that can result from offering compassion to others (Joinson, 1992). Charles Figley (1995) stated
that there is a cost to caring. "Professionals who listen to clients’ stories of fear, pain, and suffering may feel similar fear, pain and suffering because they care" (Figley, 1995a, p.1). According to Figley (1995a), compassion fatigue is the natural consequent behaviors and emotions resulting from knowing about a traumatizing event experienced by a significant other; as well, it is the stress resulting from helping or wanting to help a traumatized or suffering person. It is important to consider both secondary traumatic stress and compassion fatigue as normal possible realities of caring work.

The following personal example illustrates an experience with secondary trauma. I remember a night, while working for the Children's Aid Society in Ontario, where I facilitated a sexual abuse investigation. This investigation was very difficult because of the graphic images it involved. I was with the young girl during her medical examination. I completed the interview investigation with the police, maintaining my professional composure throughout. Later, driving home, I pulled over to the side of the road, got out of the car, and vomited in the ditch. I got back in the car and finished my drive home. I did not disclose my reaction to this investigation to my supervisor, or anyone else. I was twenty-two years old, a recent graduate, and an enthusiastic new social worker. I was unaware of secondary traumatic stress or vicarious traumatization. In retrospect, I accept that incident of vomiting as a normal reaction to an abnormal and painful situation; a definite experience with secondary traumatic stress.
Burnout Prevention

Hagan states that, once burnout has developed, it is extremely difficult to reverse; therefore, she advocates that prevention is a successful strategy in eliminating burnout (Hagan, 1989, p.726).

Pines and Aronson (1988) report that research has found that equitable and supportive agency policies and practices are the main determinants of whether there will be significant burnout of staff. For example, agencies that allowed input into the mission of the organization, were flexible in providing instrumental and emotional support to workers, and had support groups to help workers solve problems associated with the high stress of their jobs, had workers with lower indexes of burnout (1988, pp. 107-111). MacFadden (1985) also concludes that organizational efforts aimed at reducing stressors and increasing coping strategies directed at removing or reducing the source of stress will reduce burnout. His research also emphasizes that workers need regular, formal supervision; opportunities for learning and variety in the work should be offered; as well, competency based practice should be emphasized (MacFadden, 1985, pp.13-15).

In terms of work with clients, Hagan (1989) suggests that the following efforts will lend well to preventing burnout: set realistic goals (clarity of goals and expectations that are established by both the practitioner and the client); focus on clients' strengths, abilities and resources; and receive feedback on performance (from clients, colleagues and supervisors).

Poulin and Walter (1993) also found that the level of burnout can be reduced if appropriate changes are made within human service organizations. Two main
variables towards this end would include an increase in both supervisor support and organizational resources (1993, p.10).

In addition to aspects of the work setting that prevent burnout, personal qualities of the worker also mitigate against burnout. These personal qualities include the following:

- resilience
- individuals who actively attempt to overcome their difficulties
- experience: those who had "pre-career" challenges, such as work or raising children, seemed to have the ability to explore options and these situations contributed to increased confidence and self-efficacy
- realistic about their strengths, weaknesses and preferences
- organizational negotiation skill: able to view systems problems and conflicts in an analytical way
- pursue professional development opportunities that are extensive
- have a fulfilling and enriching personal life
- set aside personal time that is used for meaningful and personally rewarding activities
- committed to achieving a balance between work and non-work aspects of their lives (Cherniss, 1995, pp.107-158; Hagan, 1989; MacFadden, 1985).

Freudenberger (1980) notes that burnout has a hard time staking out a claim where closeness exists (p.123). He identifies the need for workers to spend personal time with themselves, to get to know themselves, and have a closeness with themselves. According to Freudenberger (1980), the greatest deflector of burnout is self-awareness because we are the best judges of our own personal resources and limitations. Hagan (1989) also advocates for self-awareness; in particular, she encourages social workers to identify their personal limitations, personal needs and personal emotional responses. Unfortunately, in our society it is undesirable to admit our own limitations. In the case of a professional, this is an added issue because a professional is expected to be in control (Pines & Aronson, 1988, p.5). Dass & Gorman (1985) state that "as we reach a deeper sense of who we are, we discover how much more we have to give" (p.187); and "burnout is simply our motives coming home to roost" (p.191). These authors conclude that self-awareness is imperative in efforts towards preventing burnout.
Finally, it is always right to care for ourselves when we are caring for others (Dass & Gorman, 1985, p.201). I believe that it is in the process of caring for ourselves, that a self-awareness emerges and with this "we can do more than simply struggle to stay afloat; we can discover a more reliable source of continuous buoyancy" (p.210). Within human service work, "burnout is a constant sword hanging over the helper's head. One characteristic of the strong helper is making time for renewal experiences and other burnout prevention strategies" (Brammer, 1988, p.42). NiCarthy, Merriam, and Coffman (1984) suggest that it may take some experimentation, but they encourage a balance in life between work and play, between giving and receiving, between activities that demand much of you and those that replenish your personal and political resources (p.147). Self-care practices can happen on and off the job; the options for such practices are plentiful. Although some require financial resources, there are many self-care practices that only require a commitment to yourself. Pearlman (1995) highlights examples of self-care practices by noting the research findings which show the personal and professional self-care activities of 117 psychologists (see Appendix 3).

As professional helpers, we also are embedded in networks that define and sustain us (Grosch and Olsen, 1994, p.60). These networks must be explored on a continual basis so that helpers can maintain awareness of the context of their helping work. I have highlighted both systemic variables and individual characteristics, in that order, because recent work on caregiver burnout suggests that the major source of burnout is usually in the situation or context, not in the caregiver.

Although personality variables are certainly an important factor in burnout, research has led us to the conclusion that the problem is best understood (and modified) in terms of the social and situational sources of job-related stress. The prevalence of the phenomenon and the range of seemingly disparate professionals who are affected by it suggest that the search for causes is better directed away from the unending cycle of identifying 'bad people' and toward uncovering the operational and structural characteristics of the 'bad situations' (Larson, 1993, p.55).

Why is it that one person will burnout in the same context where someone else
will thrive? This is not to suggest abandoning the impact of environment, but rather to note that burnout is experienced as a result of the environment and that this context must be considered from a broad perspective. Part of this perspective includes an understanding of the complexity of worker’s lives. While one works, they also lead lives outside of work that contribute to overall stress levels and coping abilities. Therefore, the multisystem pressures on the professional (see Appendix 4) must be understood (Grosch & Olsen, 1994, p.66).

A Crisis of Meaning

It is important to understand the reasons that people gravitate towards careers within the helping professions. Cherniss (1995) establishes that those people who choose to enter fields such as nursing and teaching do so because they want to help others. He identifies that these “callings” are less lucrative and that “meaning is at least as important as money” (Cherniss, 1995, p.4). People in these positions enter a public service profession because they wished to serve. But they not only wished to serve; they also wanted to repair the world and make it a better place. It is this mission that gives their lives meaning (p.181).

We may feel called to do this type of work for a number of reasons; some of these might include: religious or spiritual motivations; a commitment to humanitarian ideals and a deep concern for the human condition; and/or a need to right past wrongs, for example, a person may have been abused as a child and now they want to ensure that this does not happen to other children (Schmidt, 1997).

Our initial motivation for selecting a career towards helping others, sets the stage for our possible experiences of burnout. Consider the person who selects social work as a career path as a result of his/her own personal desire to be liked. According to Grosch and Olsen (1995), this is a common theme among many professional helpers. In this circumstance, the person might have difficulty saying no, setting limits, delegating tasks and perhaps become depleted as a result of their people pleasing efforts. Furthermore, helping people may become difficult, as the helping agenda
becomes secondary to his/her wish to be liked (Grosch & Olsen, 1995, p.94).

The literature about burnout attempts to determine the tangible contributors of this phenomenon. More discreet, is the frequent mention of the role that meaning plays in the development of burnout. Pines and Aronson (1988) suggest that burnout is related to the human need to ascribe meaning to life, in this case at work. When meaninglessness appears in the workplace, burnout becomes more likely (p.230). "If social work practice no longer affirms an individual’s desired self-concept or supplies the meaning desired from one’s work, motivation for continuing practice may well be diminished" (Powell, 1994, p.234). Attitudinally, burnout represents a significant loss of commitment and moral purpose to one’s work (Cherniss & Krantz, 1983; Pines & Aronson, 1988, p.10).

Burnout becomes a crisis when individuals are so defeated and exhausted by the environment that they take extraordinary means to find relief such as quitting a job or occupational field, developing a serious psychosomatic disease, becoming a substance abuser or attempting suicide (Gilliland & James, 1993, p. 539). It is possible that, "the precipitating crisis of job burnout may move toward a more global, existential crisis, wherein individuals are in a state of crisis over living" (p.539). In some ways, the two decades of research in the area of burnout, ultimately lead to similar findings; even Herbert Freudenberger (1980) stated that the men and women who came to see him described circumstances and feelings that suggested that their lives had lost meaning.

Therefore, it is not enough to identify the individual and systemic variables that contribute to burnout, but rather the relationship these variables have with one’s sense of meaning or purpose.

Summary of Literature Review

Burnout, as mentioned, is about something fundamental to the human experience of caring. Caring, although innate, once put in the constructs of
professional helping, becomes something that can erode the human spirit and leave helpers searching for the meaning of not only their work, but their existence in general. “Having started out to help others, we’re somehow getting wounded ourselves” (Dass & Gorman, 1995, p.186). The tragedy of burnout is that it happens to individuals who at one time embraced the ideals and passions relevant to caregiving work. Pines and Aronson (1988) found that the most idealistic, altruistic, and committed helpers are among the first to burnout.

Often professionals doing people work of some kind will say things like, “being a social worker is not just something that I do, but rather it is something that I am”. This illustrates the profound sense of self that informs work of this kind. Whether participating in front-line clinical work, providing supervision, developing social policy, or performing research, a professional can be vulnerable to the costs of their caring, concern and noble intentions. Caring for others, as highlighted within the literature review, is often about something deeply rooted in what it means to be human. We call it work, we train, we practise skills, we obtain knowledge relevant to our disciplines and so on; nonetheless, at the end of the day the job of professional caring, helping, empowering, and understanding can leave workers wounded and depleted.

Burnout affects professionals in many different ways, including the following: physiological, behavioural, psychological, spiritual, and clinical (see Appendix 5). Burnout is not just compartmentalized to our work, but rather it impacts on both our professional and personal lives.

At the root of the experience of burnout, is something quite existential, causing victims to question the meaning of their work, their relationships and their overall circumstances. It is this spiritual nature of burnout, in my opinion, that erodes our buffer zones, or coping strategies, that usually allow us to manage life’s stressors. Burnout is more than stress, and greater than simple fatigue, it is an erosion of a part of our humanness; therefore, in my opinion, it
requires investigation from an existential perspective.

In summary, on an individual level, burnout requires that professional helpers are gentle with themselves, enabling their self-assessment process and eventual self-care practices. Burnout is about a connection to ourselves and others; therefore, the support of family, friends, and colleagues enables healing from this crisis of meaning. From a systems perspective, organizational issues require tremendous tenacity, allowing for structural evaluation and ultimate change.

Lastly, the responsibilities inherent to doing people work, and the vulnerabilities manifested in caring for another human being, are often devalued and therefore invisible. We need to make the invisible visible, thus offering a message of meaning to the lives of workers and clients alike.
CHAPTER SIX

Case Study

In my efforts to make the invisible visible, the following section describes a scenario from my own professional experience. I will describe a work day that I recently experienced as a social worker employed at the Prince George Regional Hospital. Following this, I will explore the impact of this day; using my conceptual model to operationalize my understanding of professional burnout from an individual and systems perspective.

The day started at 8:00 AM when I turned my pager on. It ended at 2:00 AM, 18 hours later. This day was one of the most emotionally taxing days of my social work career. I know this because I continue to return to my memories of this day.

I responded to a number of pages during the day, taking me from trauma to trauma. It began with an hour interview with a RCMP Corporal, who was inquiring about information I had in relation to a concern I reported to them the night before regarding a suspected case of elder abuse. This situation had consumed approximately five hours of phone calls during my previous shift. An elderly woman was fighting for her life, while unconscious and covered with bruises, evidence that she had recently been battered. I received phone calls regarding this patient; in particular, her friends were concerned that her daughter was presently using her mother’s (patient) credit cards to purchase new household appliances. There were also allegations that this daughter and her husband may be responsible for the physical assault of this woman, and therefore responsible for this medical crisis (which later may result in a homicide investigation).

Around 4:00 PM, I received a call from my supervisor letting me know that I needed to do a morgue viewing (my first one since I started my employment at the hospital). She accompanied me to prepare the deceased
person for the viewing. We called security to unlock the morgue and proceeded to locate the body. We lifted him from the morgue cold storage to the preparation room. There, we covered him with a blanket and spent a half an hour cleaning the dried blood from his face. After cleaning him as best we could, we wheeled him on the metal stretcher into the viewing room. We walked upstairs to get his wife and two friends. We emotionally supported these three individuals through the viewing of their loved one (this took a couple of hours), provided them with literature on grief and loss, hugged them in the main lobby of the hospital and wished them courage in the difficult days ahead. We returned to the viewing room to return this man to the morgue. This man had died earlier this day in a logging truck accident. He was 49 years old, a husband, a father, and a grandfather.

Again, my pager went off and it was the daughter of the woman I described earlier; she and her husband had just learned of the critical medical condition of her mother. She was very upset and wanted to talk with the social worker (note this patient did die the following morning).

My pager went off, emergency staff needed me to set up home nursing for an elderly patient, so that a hospital admission could be avoided. I finished this assessment (about the fifth assessment of the day), when switchboard called to say that an outpatient (previously known to me) needed to see me immediately. I met with him to learn he needed cab fare to get back home following a visit to emergency. This patient has been seen in emergency 188 times. There is a drug dependency problem which I am presently responsible for attempting to address within the context of the health care system. I ran upstairs to get him some money from our petty cash and while on my way back to him a CODE was called over the hospital intercom. I quickly gave him the cab fare and went to the emergency department, as per hospital protocol. A CODE indicates that someone in life threatening condition is en route to the hospital via ambulance.
It was 7:45PM. I was working for almost 12 hours and my shift was scheduled to end in fifteen minutes.

I learned the ETA (expected time of arrival) for the ambulance and realized that this was the second fatal MVA (motor vehicle accident) of the day. The ambulances began to arrive. I was handed an 18 month old boy who appeared to have minimal injuries (although he still required a complete examination). This boy's mother, a 19 year old female was in critical condition and medical staff began working on her immediately; her 23 year old common-law partner was in serious condition. His family were somehow already informed of the accident, and they were in the waiting room of the emergency department. I introduced myself to them and escorted them to the quiet room. I ascertained the name of family members of the young woman and I called her father to inform him of the accident. He arrived at the hospital emergency within fifteen minutes. I was with the six respective family members of the two victims. Interestingly, this was the first time that the two sets of parents met. My role was to provide emotional support and answers to their many questions regarding their loved ones (I am unable to speak to medical conditions).

Eventually, they were able to see the victims. Initially, I took Greg's family to his side before he went for emergency surgery. He was suffering from internal bleeding and as we stood at his bedside he was vomiting blood profusely. Family members were very upset and I returned with them to the quiet room, where I continued to offer emotional support. I then took Brianne's father to her side where she lay hooked up to a multitude of machines, IV lines and monitors. Her face was shattered on the left side and it was difficult to see her skin under the blood. Many of her teeth were broken or missing. I stood with her father as he held his daughter's shaking hand, and I rested my hand on his back. The room was silent except for the beeps of the life support equipment that sustained his daughter's breath. I taught him to talk to her as I introduced myself to her,
letting him know that she would sense his presence.

At 1:00 AM, I was finished in emergency. I had taken the 18 month old to the pediatrics floor. I had made arrangements for his discharge the following day. I held him for a while because he was very scared, I was familiar to him compared to the staff on the fifth floor (by this time I had spent five hours with him). Brianne had been air ambulanced to Vancouver and her father went with her. Greg was in recovery, in serious condition and his family left for home.

I went upstairs to complete my documentation for my colleague who would be following up with these situations the following day. I could smell blood, as well as the latex from the gloves I wore in the morgue earlier in the day. I felt sweaty and cold. The morning seemed a long time ago.

This vignette describes an exceptionally difficult day, offering a framework for operationalizing professional burnout. Cherniss (1995) states that burnout is a process, rather than a fixed condition; it begins gradually and becomes progressively worse. This day, in isolation, would not cause me to burnout; however, this experience did result in secondary stress where I needed to be aware of countertransference issues.

Assessing Burnout

This vignette describes one working day; imagine an accumulation of days that present issues related to grief and loss, trauma and oppression. This describes the context of practice for many social workers.

Job related stress can happen on varying levels, for example: organizational stress which includes one’s working environment; occupational stress related to the type of work one does; and single incident stress such as the death of a colleague, personal injury and so on. Toby Snelgrove (1995), a Critical Incident Stress Debriefing trainer, illustrated that we have varying responses to job related stress, these include: an acute response which is specific to the incident; a delayed response which results during a secondary event, after the initial incident; and a cumulative response which is known as burnout. Critical incident stress debriefing is a process that addresses some
of the acute responses to a stressful incident; hence, overall it can assist with burnout prevention.

In closely examining my work day (case vignette), various types of stress can be identified. Although in isolation, they do not produce burnout; the presence of these variables on an ongoing basis can contribute to the development of professional burnout. I believe one way of examining burnout, and subsequently developing both prevention, intervention and postvention strategies, is to identify both the risk factors and protective factors relevant to burnout.

I have already demonstrated that burnout involves an interaction of individual and organizational or systemic variables. Again, this conceptual model of burnout appears in Appendix 1. In order to operationalize this model, I must identify how it helps to assess burnout. I believe that if we can identify both the risk and protective factors at both the individual and organizational level, we can begin to prevent burnout. Risk factors can be defined as those variables that leave one vulnerable to experiencing burnout. Protective factors, on the other hand, are the variables that intervene and evolve to prevent burnout.

The case example, provides a foundation for illustrating this integrated assessment process for exploring burnout; whereby a shift from simply blaming individuals for burnout can take place, and the larger system context of helping can be equally evaluated. I have developed a tool for this assessment process (see Appendix 6). The following assessment, relevant to the case study defined, could be inserted into this table.

**Individual Risk Factors**
- I was experiencing secondary traumatic stress symptoms following the morgue viewing; whereby I could smell blood. This impacted me when I had to see further blood after the MVA. I also felt physically sick as the young man was vomiting blood.
- I am still a relatively new employee at the hospital, therefore my experience in
dealing with these acute medical traumas is minimal.

- I did not set limits around my involvement during the last crisis of the day. I might have been able to leave once the family knew what was going on; however I saw it through to the end, where all details were taken care of. It is difficult to remove myself from these situations once the family members see you as their only link to the ongoing intricacies of the situation (updates, where to sit, using the phone, wait times, someone to talk to, etc.).

- My husband and I had a conflict following this shift, normally he is part of my support system, however there was a learning curve for us both in this regard as a result of my new role at the hospital; this added stress to the situation.

**Systemic Risk Factors**

- I was working alone at the end part of the day, hence there were no other social workers on staff (after 5:00 PM I was the only social worker covering the entire hospital).
- I have minimal control over my work environment because I am at the mercy of the calls presented over my pager.
- I had to complete a task, the morgue viewing, in which I had no previous experience.
- The morgue viewings are something we continue to facilitate, although this issue is being discussed as problematic at the administrative level.
- There is no direction or supervision during a CODE, one is expected to respond quickly and without consultation.
- There was role conflict (support the family of the elder abuse victim regarding the woman’s condition, yet I also had to report the suspicions of abuse to the police).

**Individual Protective Factors**

- I accessed debriefing with a staff member at the end of it all.
- I recognized my limits by being prepared to refuse the second possible morgue viewing (there was a fatality in the MVA).
• I identified my needs by refusing to drive home after this day. I had our only car, yet called Paul (my husband) to take a taxi to the hospital to pick up our car. He later picked me up to drive me home. Recognizing my limits, my fatigue, and my fears about driving on the icy road conditions, was valuable self-awareness.

• I identified my support network. This was somewhat of a challenge, because not everyone can hear the details of such events, and telling the details is what is needed for effective debriefing.

• I wrote in my journal (a daily commitment that I maintain).

• I was self-aware and recognized countertransference issues (I have experienced personal losses due to MVA's so it was difficult doing the morgue viewing, etc.).

• I also recognized the presence of secondary traumatic stress.

• I practice ongoing self-care; I have hobbies and so on that provide me with a balance between work and play.

• I was able to sense a purpose to what I was doing. It is valuable to facilitate a meaningful beginning to a grief process. In taking the woman to the morgue to see her husband, I was part of her grief process. I was able to offer tenderness, compassion, silence and reassurance.

Systemic Protective Factors

• My supervisor was very supportive, accompanying me to the morgue viewing, talking after, and so on. She also called later in the evening to offer emotional support.

• There is tremendous team support, a colleague checked in with me and there were other supportive conversations following the situation within the department.

• There was appreciation voiced for the work that I did from members of the medical team, this reminded me that I was not working alone (although in the midst of it all it feels that way).

• There is consensus within the social work department towards advocating for changes in the social worker role relevant to the morgue viewings.
• I knew that I could call on additional staffing from the social work department if I needed to.
CHAPTER SEVEN

Intervention

I have highlighted the risk factors and protective factors relevant to burnout within this case example, themes of confidence, insight, support and resources are paramount to these variables. Awareness of both risk factors and protective factors are important in preventing burnout, likewise, this awareness is helpful when treating burnout. Considering burnout from this perspective provides a multitude of variables to be addressed. A treatment plan can be developed with this information, and the individual can feel empowered towards both some individual changes, as well as various systems changes.

Sometimes burnout is not prevented, or it presents at a later time following the accumulation of job related stress, and an intervention is required. Job related stress can have three sources: 1) stress that is part of a particular job or work environment; 2) stress caused by a lack of coping skills, where a particular job may not be highly stressful for most people but will be for the individual who is poorly prepared for the job; and 3) some individuals create their own stress, for example, a person might have unrealistic self-expectations or take on inordinate responsibilities (Sheafor et al., 1988, p.146).

"Rarely do professionals present for treatment of burnout as the primary issue" (Grosch & Olsen, 1994, p. 7). hence it is important to recognize the warning signs of burnout, so that it can be identified and addressed. Therefore, an initial assessment is needed to determine the presence of burnout. In addition to identifying the risk factors and protective factors, it is important to determine if the individual is experiencing burnout. There are a number of tools to assess burnout; including the Maslach Burnout Inventory (MBI) and the self diagnosis instrument for burnout (see Appendix 7) developed by Pines & Aronson (Larson, 1993, p.243). With this inventory the cut-off score is 4.0. In other words, a score of 4.0 or higher is in the burnout range (p.36).

As noted in the case example, I was able to identify many risk and protective
factors, yet I am not experiencing burnout. I completed the self-diagnosis instrument for burnout and scored 2.8. This model can be used at any time to explore burnout variables that may exist, this type of inventory, facilitated by individuals and agencies can go a long way towards preventing burnout.

Implications for Social Work Practice

Embedded in physical and social environments and their political and economic structures, individuals and primary groups continually experience environmental challenges, opportunities, and obstacles to adaptive functioning. Some of these upset the goodness-of-fit and lead to undesirable or even unmanageable stress (Germain & Gitterman, 1980, p.137).

This describes the interactions between people and their social and physical environments. Social work practice hinges on this understanding; specifically helping people deal with problems and needs arising from environmentally induced stress, or from the lack of environmental resources and supports (1980, p.140).

Burnout, as conceptualized in the model within this project (see Appendix 1), is a circumstance that results from social workers' interactions with their work environment. There is environmentally induced stress, which can result from a lack of resources and supports. Therefore, responding to burnout involves social workers doing caring work on their own behalf. After all, if social workers can not advocate on their own behalf, how can they advocate on behalf of others?

Burnout is best understood by considering it along a continuum, where social workers are considered as individuals working in bureaucracies. Along this continuum, time and circumstances are important considerations. At one time, someone may be resilient and another time, given extraordinary stress, the same person could experience burnout. Work does not take place separate from living, but rather it is part of daily life. Therefore, the personal lives of social workers are relevant to their professional work. Individuals are, for the most part, responsible for their own well-being. "The modern bureaucracy is incapable of meeting the emotional and spiritual needs of its employees. So do not expect your agency to give meaning and purpose to
life. Look elsewhere for ways of meeting those needs" (Sheafor et al., 1988, p.145).

Nonetheless, knowing the organizational characteristics that contribute to burnout can be valuable information to consider when searching for employment. One could structure their interview questions to prospective employers with this information in mind; for example, a person could ask about supervision, team support and so on. "Skilled workers know their value in the marketplace and look for work environments that cater to the overall concerns of their professional and personal lives" (Kelly, 1997, p.32). Unfortunately, many new graduates are in debt after financing their education. For the most part, they are at the mercy of the market for their employment options and may not be able to be highly selective regarding work setting.

Despite frequent reference to professional boundaries, we must acknowledge that we bring who we are to our social work practice. "The mental health field often subscribes to the tenet - drawn in part from the medical model - that a professional doesn’t “get involved” and that his or her feelings are signs of weakness, inadequacy, or poor boundaries" (Saakvitne & Pearlman, 1996, p.18). Although I strongly support the need for boundaries, I do not think the purpose of having them is to take the "human part" out of human service work. Feelings are part of life experience and it is this experience, combined with academic training, that informs a person’s social work practice. I believe, the more acknowledgment that can be given to this inevitable recipe for care, the less role conflict will exist for social workers. Role conflict contributes to the onset of burnout (Farber, 1988), therefore I recommend efforts at minimizing role conflict through increasing awareness regarding both the personal and professional self as forever integrated. This awareness should be explored increasingly within social work curriculum. Specifically, the experience of the social worker should be discussed, not just the logistics of what social work is; there is a difference between learning how to listen to human tragedy, and listening to human tragedy. This difference would be a valuable place to begin some important discussions. "Few graduate programs focus on the experience of the therapist or the helper" (Saakvitne & Pearlman, 1996, p.17).
Structurally, Larson (1993) suggests changes that will lead to a more caring, other-oriented society; for example, we need greater emphasis on cooperation and prosocial behavior in our media, in our families and in our schools. Secondly, instead of devaluing caring, we need to realign our cultural values and reward structures so that caregiving is reinforced and strengthened. This could be reflected in higher salaries for caregivers and increased economic support and recognition for all volunteer and nonprofit human service organizations by our national, state, and local governments (Larson, 1993, p.232).

A micro-perspective, might lead to closer examination of human service agencies in general. Often agencies reflect the same dysfunction as the families and/or groups they attempt to help. "Bowen [family of origin] theory helps explain why the workplace brings out in professionals roles similar to those they played in their families" (Grosch & Olsen, 1994, p.65). These dynamics could be assessed in agencies that have high numbers of staff presenting chronic problems with stress leaves, sick time, and burnout. The overall dysfunction of the agency may be a predominant cause of the distress experienced by employees. This sort of inquiry would seem appropriate at the agency level, and can be a tool for ongoing evaluation of the overall agency culture or climate. Eventually, this climate determines the effectiveness of service delivery.

Skepticism about Burnout

On the one hand burnout is fashionable, while on the other hand it is stigmatizing. "It has been suggested that all the attention given to the danger of burnout may rise to a self-fulfilling prophecy" (Sheafor et al., 1988, p.147). It is important to acknowledge these sorts of fears because they are commonplace in most prevention efforts, especially when the highlighted topic is undesirable. For example, it is difficult introducing suicide prevention programs to some teen groups, because many parents and teachers believe that if you talk to young people about suicide that you are promoting suicidal behavior as acceptable or as one parent said to me, "you are putting the idea in his [her son’s] head". This same linear thinking is true of burnout; some
people believe that it only exists when it is discussed. "Unfortunately, the term burnout has become so familiar as to take on the status of a cliché and is sometimes spoken of dismissively, perhaps as a way of distancing ourselves from the intense pain and disillusionment experienced" (Grosch & Olsen, 1994, p.3), by people who suffer with burnout.

Burnout is a term used frequently. In some ways I compare it to an average headache that commonly gets called a migraine; general stress and pressure is often called burnout by professionals who feel tired and worn out. Verbal references to stress and burnout need to be noted as they act as warning signals of possible need for concern regarding the overall well-being of workers. Certainly they are experiencing stress; however, burnout has clearly been identified as more than stress, therefore a continuum exists. Psychologists Louis Heifetz and Henry Bersani describe the prerequisites of a claim of burnout:

One common theme in discussions of burnout is some sort of motivational erosion: dedication becomes apathy; altruism becomes contempt; insomnia replaces the impossible dream; and crusaders become kvetches. The implicit assumption is that burnout must be preceded by commitment. For human service workers the focus of this commitment is fostering positive change - growth - in their clients. Any satisfactory theory of burnout must be limited to those workers whose clinical endeavors are substantially motivated by the desire to promote growth in their clients. Burnout may produce and perpetuate low levels of this motivation, but the process of burnout cannot begin unless the level of this motivation is high. Metaphorically, one must be "fired up" before one can burn out (Larson, 1993, p.29).

I believe most new social workers, regardless of their age upon entering the field, are "fired up" at the onset of their career. New, especially young, social workers are often criticized for their idealism. This criticism, or at best dismissal, is wrong. Our hope and optimism about individuals and the world we live in, are in part, rooted in our idealism. Perhaps senior clinicians could learn from this enthusiasm, such energy is a shield from burnout, while at the same time, like Larson (1993) suggests, a precursor to it. Knowing how to use idealism, hope and optimism in a meaningful and transformative way is of course the ambition of caring. This ambition does not inevitably pave the way
to burnout, but rather can set the stage for engaging therapeutic endeavors, individually and systemically.

The ambivalence to acknowledge burnout combined with the inappropriate references to it, demonstrate some of the opposition regarding embracing this cost of caring. Kane (1981) stated that “we seem to be socializing neophyte social workers to expect burnout simply because they care...It seems that nowadays people are burned out before they are lit” (p.2). I agree, to a certain extent, with Kane’s assertions; and would not want to discuss burnout to convince people that they are, or should be, experiencing burnout as an inevitable occupational hazard when working as a social worker, or within any other helping profession.

There is opposition towards validating burnout. Ideologies regarding work, which are shaped by values and beliefs, form the theoretical underpinnings of the arguments against burnout. It is important to understand these, and other, arguments because these will prove to be the obstacles when attempting to promote discussion and attention to the reality of caregiver burnout. Nonetheless, billions of dollars are lost each year because of workers in all fields who can no longer function adequately in their jobs due to burnout (Gilliland & James, 1993, p.537).
CHAPTER EIGHT

Future Research

In a 1993 literature search of the *Psychological Abstracts*, burnout appeared in over 1,100 articles and over 100 books since the term was coined by Freudenberger (1975) and carefully explicated by Maslach (1976) (Figley, 1995b, p.15). I think it is fair to say that there is consensus in the existing research regarding the validity of burnout.

Burnout has been recognized for well over twenty years. At this time, I believe the research in this area should focus on the context of social work practice. Political agendas foreshadow ongoing changes in the human service delivery system. Presently, social workers are impacted by ongoing reorganization within the system. Recently, in B.C., regionalization, the Closer to Home program in the Ministry of Health, and the formation of the Ministry for Children and Families have contributed to overall instability and uncertainty within the human service system. These changes have long lasting impact on both the service delivery system, as well as on the social workers practicing within this context. The impact of these systemic changes on the well-being of social workers should be researched. Issues related to job satisfaction, staff turnover and burnout should be discussed. So far it seems that social workers are allowed to be the casualties of downsizing, reorganization, cutbacks and systemic failings, with minimal support from their employers or their professional association. In my opinion, this is exemplified in the recent crisis in the Quesnel area.

In the fall of 1997, an audit was completed at the Quesnel office of the Ministry for Children and Families (MCF). This audit was requested by the Children's Commissioner, Cynthia Morton. There were systemic problems found and following the audit six social workers took stress leave. Seventy-one children have been removed from their homes since that time (Moore, 1998, p.5), and this situation has received considerable media attention.

Despite being unaware of specific details, I believe that the social workers are the scapegoats for a larger systemic crisis. In my opinion this crisis involves insufficient
resources. I base this on the fact that these six workers had been noting workload pressures and subsequent to their stress leaves, "fourteen new workers are rotating through the office to deal with a backlog of cases and more are on their way" (Moore, 1998, p.5). These staffing resources seem to be available after the fact, yet they were not provided prior to the crisis.

The Quesnel situation could serve as a case study for a qualitative investigation into the intricacies relevant to the individual and organizational variables that contribute to social worker burnout (presuming these workers are experiencing burnout as the media has suggested, this would have to be determined as part of this research study). This study, if nothing else, could give a voice to these six workers. Perhaps the information revealed via this qualitative study could be useful in preventing future MCF crises of this nature.

Despite the conceptual model of burnout proposed within this project, many people will argue that burnout prevention is an individual’s responsibility. There is always reluctance to evaluate organizational variables that may be contributing to employee burnout, because I believe there is a resistance to change in this larger context. It is easier to blame individuals for their difficulties, in this case social workers, than to mobilize systemic change. “Some organizations demand strict adherence to policies and procedures...exceptions represent feared precedents as individual needs are held hostage to bureaucratic needs” (Germain and Gitterman, 1980, p.142).

Although the individuals being discussed by Germain and Gitterman (1980) are service recipients, the service providers are ironically in the same situation and can be “held hostage to bureaucratic needs”.

I believe social workers need to be empowered towards their own well-being and resiliency. Burnout is not taken seriously because we have normalized suffering and as a society we are overwhelmed and fatigued by reports of personal pain. Society is no longer intrigued by tragedy as it is inundated with crisis. Future research should explore what individuals and organizations are doing with the information that is known
about burnout. Individually, what are social workers’ experiences with self-care and stress management? What barriers exist to helpers going for their own therapy? Structurally, are human service organizations putting burnout prevention on their administrative agenda? What are some of the unique considerations required for social workers in the north?

Burnout is in some ways an existential crisis. A qualitative study that seeks to understand this claim in further detail would be a valuable contribution to the existing body of knowledge regarding burnout. The research question might explore the areas where social workers ascribe meaning in the work that they do. Helping work itself is often considered to be intrinsically meaningful. The “great moments in helping” can often reveal one’s purpose in helping. In these moments, your caring expresses a core part of yourself and fulfills your personal mission as a helper (Larson, 1993, p.5). A study that explores the experiences of caring and helping, correlated with the sense of purpose that they seem to ignite in the helper, and consequently the burnout that results from this intimate relationship between caring and purpose, would provide valuable insights.

Stepping past the margins for a moment, I ponder a more existential question myself, please follow me for a moment. Sykes (1992) claims that:

The triumph of the therapeutic can perhaps best be understood as the ascendancy of a substitute faith. Filling the vacuum created by the decline of institutional faith and the collapse of the moral order it has provoked, psychoanalysis has assumed many of the functions traditionally performed by religion, and has done so by translating many of the theological and existential issues of human life into therapeutic terms (p.49).

I wonder if professional helpers do “fill this vacuum”? If so, do they realize it? The findings of this research question (if it hasn’t already been completed) could be correlated with experiences of burnout. In particular, if this “vacuum is being filled” and if the “theological and existential issues of human life are being translated into therapeutic terms”, is this the ultimate cause of burnout?

Again, I ponder beyond the margins; Krippner and Welch (1992) note that:
Modern medicine, nursing, social work, counseling, and psychotherapy address themselves to a person's physical, mental, emotional, and social problems but rarely to one's spiritual concerns. Nor are most practitioners aware of the cultural and ethnic differences in spiritual perspectives. Many health care professionals are embarrassed and speechless when a patient or client asks them, "But doctor, what does it all mean?" The closer people in need of professional help move toward a consideration of such spiritual issues as the fear of death, the feeling of loneliness, and the lack of meaning in their lives, the less likely it is that they can find professional workers who can be of assistance (p.6/7).

Ironically, clinical training increasingly introduces tools to get to the heart of the matter, one gets there and leaves. Is burnout a result of being taken "there", to the existential questions, over and over again? As helpers we are encouraged to go there, to the meaning. We even say that is where we are heading; perhaps that is where we are running from? Maybe this marathon is what burnout is all about? Future research should sit with some of these issues; asking questions about caregiver fears, limitations, vulnerabilities and humanness. Perhaps when this happens, helpers and clients really can be in the same race. Until then, maybe burnout fills this gap?

I bring my ideas regarding future research recommendations, in the area of professional burnout, to a close. Suffice to say, that I end this chapter with more questions than answers. I suppose, since asking questions is where learning comes from, that I conclude in a most inspiring place.

Conclusion

Stamm (1995) quotes Karger and Barr who note that service providers within the human services are caught in a struggle between promoting the well-being of their clients while, at the same time, struggling with policies and structures in the human service delivery system that tend to stifle empowerment and well-being (p.16). Therefore, social work practice is largely about competing imperatives, working with them, advocating against them and so on. As a result, it is obvious that the context of practice can be very stressful.

Each social worker responds differently to the demands of the profession: some
thrive, while others burnout. Burnout can be prevented and it is not inevitable in the helping professions (Sheafor et al., 1988, p.147). Through understanding burnout from the ecological perspective suggested in this work, I believe social workers and human service organizations can prevent burnout. Therefore, social workers and agencies can contribute to an effective context for caring and change on all levels; the individual, the community and society. “As a helper, you need to find a way to be emotionally involved in your work, to take your empathy, helping motivations, commitment and idealism and use them without burning out” (Larson, 1993, p.30). Most importantly, all parties involved in the overall systemic structure of social work practice must strive to create an environment that is conducive to worker well-being and health.

In closing, the goal of preventing burnout, in my opinion, is to foster the well-being of professional caregivers, in this case social workers; in turn this promotes quality service delivery and ethical social work practice. All efforts towards this end, that are embraced by individuals and the larger system, will lend kindly to the spirit of care.

Bernie Siegel (1993) said the following:

When you are burning up you are living your life, and taking a nap or vacation will provide you with energy and strength to go on. But burning out a simple rest won't cure. Burning out means misusing yourself, dying with much left over in the candle holder. It means never really having lived fully (p.4)

I hope my future work in the area of professional burnout can be a catalyst towards inspiring others to live fully, whatever that looks like for them.
REFERENCES


Appendix 1

Burnout: A Conceptual Model

Social Context

Professional

Organization

Personal

Client

The interaction between the individual & the human service system.
Appendix 2

Compassion Fatigue Self Test for Psychotherapists

Name _______________________________ Date _______________________________

Please describe yourself: _____ Male _____ Female _____ years as practitioner.
Consider each of the following characteristic about you and your current situation.
Write in the number for the best response. Answer all items, even if not applicable.
Use one of the following answers:

1 = Rarely/Never  2 = At Times  3 = Not Sure  4 = Often  5 = Very Often

Items About You:

1. __ I find myself avoiding certain activities or situations because they remind me of
   a frightening experience.
2. __ I have gaps in my memory about frightening events.
3. __ I feel estranged from others.
4. __ I have difficulty falling or staying asleep.
5. __ I have outbursts of anger or irritability with little provocation.
6. __ I startle easily.
7. __ While working with a victim I though about violence against the perpetrator.
8. __ I am a sensitive person.
9. __ I have had flashbacks connected to my clients.
10. __ I have had first-hand experience with traumatic events in my adult life.
11. __ I have had first-hand experience with traumatic events in my childhood.
12. __ I have thought that I need to “work through” a traumatic experience in my life.
13. __ I have thought that I need more close friends.
14. __ I have thought that there is no one to talk with about highly stressful
    experiences.
15. __ I have concluded that I work too hard for my own good.
16. __ I am frightened of things a client has said or done to me.
17. __ I experience troubling dreams similar to those of a client of mine.
18. __ I have experienced intrusive thoughts of sessions with especially difficult
    clients.
19. __ I have suddenly and involuntarily recalled a frightening experience while
    working with a client.
20. __ I am preoccupied with more than one client.
21. __ I am losing sleep over a client’s traumatic experiences.
22. __ I have thought that I might have been “infected” by the traumatic stress of my
    clients.
23. __ I remind myself to be less concerned about the well-being of my clients.
24. __ I have felt trapped by my work as a therapist.
25. __ I have felt a sense of hopelessness associated with working with clients.
26. __ I have felt “on edge” about various things and I attribute this to working with
    certain clients.
27. __ I have wished that I could avoid working with some therapy clients.
28. __ I have been in danger working with therapy clients.
29. __ I have felt that my clients dislike me personally.
Items About Being a Psychotherapist and Your Work Environments:

31. ___ I have felt weak, tired, rundown as a result of my work as a therapist.
32. ___ I have felt depressed as a result of my work as a therapist.
33. ___ I am unsuccessful at separating work from personal life.
34. ___ I feel little compassion toward most of my co-workers.
35. ___ I feel I am working more for the money than for personal fulfillment.
36. ___ I find it difficult separating my personal life from my work life.
37. ___ I have a sense of worthlessness/disillusionment/resentment associated with my work.
38. ___ I have thoughts that I am a "failure" as a psychotherapist.
39. ___ I have thought that I am not succeeding at achieving my life goals.
40. ___ I have to deal with bureaucratic, unimportant tasks in my work life.

Scoring Instructions:

The following scoring instructions apply to the above test. When administering the test it is important to indicate these instructions after the completion of the test.

(A) Be certain you responded to all items.
(B) Circle the following 23 items: 1-8, 10-13, 17-26, and 29.
(C) Add the numbers you wrote next to the items.
(D) Note your risk of Compassion Fatigue:

26 or less = Extremely low risk  
27 to 30 = Low risk  
31 to 35 = Moderate risk  
36 to 40 = High risk  
41 or more = Extremely high risk

(E) Add the numbers you write next to the items not circled.
(F) Note your risk of burnout:

17-36 less = Extremely low risk  
37-50 = Moderate risk  
51-75 = High risk  
76-85 = Extremely high risk

Source:

Appendix 3

Professional and Personal Self-Care for 117 Psychologists.

Mean ratings of how helpful 117 psychologists found those activities in which they engaged over the past six months (1 = not helpful, 6 = extremely helpful)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Took vacation</td>
<td>4.60</td>
</tr>
<tr>
<td>Social activities</td>
<td>4.34</td>
</tr>
<tr>
<td>Emotional support from colleagues</td>
<td>4.21</td>
</tr>
<tr>
<td>Pleasure reading</td>
<td>4.10</td>
</tr>
<tr>
<td>Sought consultation on difficult cases</td>
<td>4.06</td>
</tr>
<tr>
<td>Read relevant professional literature</td>
<td>3.91</td>
</tr>
<tr>
<td>Took breaks during workday</td>
<td>3.88</td>
</tr>
<tr>
<td>Emotional support from friends or family</td>
<td>3.83</td>
</tr>
<tr>
<td>Spent time with children</td>
<td>3.78</td>
</tr>
<tr>
<td>Listened to music</td>
<td>3.70</td>
</tr>
<tr>
<td>Spent time in nature</td>
<td>3.67</td>
</tr>
<tr>
<td>Attended workshop or conference</td>
<td>3.59</td>
</tr>
<tr>
<td>Aerobic exercise</td>
<td>3.00</td>
</tr>
<tr>
<td>Attempted to monitor or diversify case load</td>
<td>2.87</td>
</tr>
<tr>
<td>Community involvement</td>
<td>2.14</td>
</tr>
<tr>
<td>Relaxation exercises</td>
<td>2.04</td>
</tr>
<tr>
<td>Gardening</td>
<td>1.86</td>
</tr>
<tr>
<td>Artistic expression</td>
<td>1.51</td>
</tr>
<tr>
<td>Spiritual practice</td>
<td>1.29</td>
</tr>
<tr>
<td>Personal psychotherapy</td>
<td>1.17</td>
</tr>
<tr>
<td>Massage or bodywork</td>
<td>.95</td>
</tr>
<tr>
<td>Meditation</td>
<td>.88</td>
</tr>
<tr>
<td>Journal writing</td>
<td>.56</td>
</tr>
<tr>
<td>Yoga</td>
<td>.52</td>
</tr>
</tbody>
</table>

From Gamble, Pearlman, Lucca, & Allen (work in progress).

Source:

Appendix 4

The Multisystem Pressures on the Professional

Source:
## Appendix 5

### Symptoms of Burnout

<table>
<thead>
<tr>
<th>Physiological</th>
<th>Behavioral</th>
<th>Psychological</th>
<th>Spiritual</th>
<th>Clinical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fatigue</td>
<td>Loss of enthusiasm</td>
<td>Depression</td>
<td>Loss of faith</td>
<td>Cynicism towards clients</td>
</tr>
<tr>
<td>Physical depletion</td>
<td>Coming late to work</td>
<td>Emptiness</td>
<td>Loss of meaning</td>
<td>Day dreaming during sessions</td>
</tr>
<tr>
<td>Irritability</td>
<td>Accomplishing little despite long hours</td>
<td>Negative self-concept</td>
<td>Loss of purpose</td>
<td>Hostility towards clients</td>
</tr>
<tr>
<td>Headaches</td>
<td>Quickness to frustration and anger</td>
<td>Pessimism</td>
<td>Feelings of alienation</td>
<td>Boredom towards clients</td>
</tr>
<tr>
<td>Gastrointestinal disturbances</td>
<td>Becoming increasingly rigid</td>
<td>Guilt</td>
<td>Feelings of estrangement</td>
<td>Quickness to diagnose</td>
</tr>
<tr>
<td>Back pain</td>
<td>Difficulty making decisions</td>
<td>Self-blame for not accomplishing more</td>
<td>Despair</td>
<td>Quickness to medicate</td>
</tr>
<tr>
<td>Weight changes</td>
<td>Closing out new input</td>
<td>Feelings of omnipotence</td>
<td>Changes in values</td>
<td>Blaming clients</td>
</tr>
<tr>
<td>Change in sleep pattern</td>
<td>Increased dependence on drugs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Increased withdrawal from colleagues</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Irritation with co-workers</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Source:**

## A Tool for Assessing Burnout

<table>
<thead>
<tr>
<th></th>
<th>Risk Factors</th>
<th>Protective Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Individual Variables</strong></td>
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<td></td>
</tr>
<tr>
<td>professional</td>
<td></td>
<td></td>
</tr>
<tr>
<td>personal</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Systemic Variables</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>organization</td>
<td></td>
<td></td>
</tr>
<tr>
<td>client</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 7

A Self-Diagnosis Instrument For Burnout

You can compute your burnout score by completing the following questionnaire. How often do you have any of the following experiences?
Please use the scale:

1. Never
2. Once in a great while
3. Rarely
4. Sometimes
5. Often
6. Usually
7. Always

1. Being tired
2. Feeling depressed
3. Having a good day
4. Being physically exhausted
5. Being emotionally exhausted
6. Being happy
7. Being "wiped out."
8. "Can't take anymore."
9. Being unhappy
10. Feeling run-down
11. Feeling trapped
12. Feeling worthless
13. Being weary
14. Being troubled
15. Feeling disillusioned and resentful
16. Being weak and susceptible to illness
17. Feeling hopeless
18. Feeling rejected
19. Feeling optimistic
20. Feeling energetic
21. Feeling anxious

Computation of score:

Add the values you wrote next to the following items:
1, 2, 4, 5, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 21 (A) __

Add the values you wrote next to the following items:
3, 6, 19, 20 (B) __ , subtract B from 32 (C) __

Add A and C (D) __

Divide D by 21 __. This is your burnout score.

Source: