Beyond the organization.
Burnout and psychogeriatric work in the globalisation era

Ennio Cocco
MD, MHEM

Psychiatre NEPsySMAB (Granges/Marnand - Lausanne) SUISSE

Fondation OVE (Décines-Charpieu) FRANCE

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Correspondance: Ennio Cocco, MD, MEGS.
A.D.A.P.E.I. de l'Ain, CENORD, 10 rue Marc Seguin, 01100 Bourg-en-Bresse Cedex, France.

Phone: 0033 / 4 /74421050
Email: ennio.cocco**@**adapei01.asso.fr

ABSTRACT

Initially confined to care and school settings, the burnout phenomenon has now spread to all work settings within the labour market.

Moreover, in the near future, the demographic shift will take its toll, even on health professions. Globalisation-induced migration flows will cause major problems since professionals from different cultures will have different education and training backgrounds.

Burnout research therefore needs to become broader in scope. The problem of burnout must no longer be approached merely from a psychological or psychosocial angle. Instead, research should take labour market changes into account as well.

In psychiatric and gerontological fields, labour market variables will play a major role. They may even become every bit as relevant as specific variables linked to work processes (e.g. challenging behaviour).

A multidisciplinary approach to the study of burnout is needed, one in which not only physicians, psychologists and social caregivers but also economists, social policy experts, sociologists exchange information and work together.

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Introduction

Initial research on the burnout phenomenon began in the 1970s with studies being published by Freudenberger (1) (1974) and later by Christine Maslach (2, 3, 4). At the time, it was thought that the problem was limited to specific so-called “helping professions”, particularly caregiving professions, social caring professions and teaching.

In these early studies, emphasis was placed less on work-related factors as such but rather on gaining a greater understanding of the extent of suffering felt by caregivers who were working within an institutional context that could be best described as welfare-minded.

In Freudenberger’s “free clinic” (5), where the first study was conducted, caregivers were expected to handle an increasing workload that was directly caused by a “right to recovery” philosophy. In retrospect, this imbalance was almost certainly one of the main causes of the burnout syndrome observed.

Things have changed considerably since then: today the problem of burnout has spread far beyond the scope of helping professions as such.

Nowadays, researchers are focusing on the concept of work. The very meaning of this concept is changing under the influence of such factors as universal fungibility, which calls on workers to become versatile and flexible, to embrace the ideal of global marketiz ation and race towards it (6). This demand for greater versatility and flexibility is more than

likely the reason why the concept of work is changing so dramatically. This labour market trend seems to be accompanied by an increase and a rather generalised spread of the burnout phenomenon (7).

Various approaches to study burnout in psychiatric and gerontological settings: a retrospective view

Historically speaking, in the beginning of this type of studies researchers looked above all for patient-related factors as well as caregiver-related factors.

This approach proved insufficient over time and failed to shed any real light on the phenomenon. Gradually, attention shifted increasingly towards a more general approach that included contributions from other disciplines.

The approach to the problem of exhaustion among caregivers – first in the field of psychiatry and later in other medical fields such as oncology, palliative care and gerontology – was initially characterised by a virtually quantitative interpretation of the phenomenon. Researchers based their work on the hypothesis that there was a direct link between exposure to work and the risk of developing burnout syndrome. The approach gradually became more "sophisticated" and led to two different avenues of research, one focussing on patient-related factors and the other on caregiver-related factors.

In the first avenue of research, it was assumed that difficult, or even outrageous, patient behaviour had a draining effect on caregivers (8, 9).

These studies therefore set out to identify, or rather to isolate, problem patient behaviour.

In the second avenue of research, it was assumed that psychological factors, particularly caregiver personality, were the main culprits. Various factors were mentioned such as a tendency to feel guilty about and/or responsible for failures rather than blame external factors, – this internal/external dichotomy stemmed, of course, from Rotter's *locus of control* theory (10) – the person's subjective tendency/ability to trust others enough to delegate, his/her sensitivity to comment, and so on (11).

This approach, which is based on the psychological profile of the caregiver, has known a revival these last years with the studies referring to the concept of employee resilience (12).

As a corollary to the assumption that, through their subjective perceptions, the caregivers themselves were responsible for their own demise, researchers also began considering the general problem of their sense of well-being outside the work-related context as well as the balance between their personal and professional life, including the view of their own work, the value given to it and so on (13).

A third avenue of research, which began a few years ago and is considerably less developed within the biomedical research community, considers the impact of organisational factors as potential causes of burnout. Organisational factors include such things as ambiguity, superposition of roles, conflicts with superiors, leadership styles that involve different degrees of supervision of subordinates, gaps between

demand and available resources, uncertainty as far as tasks and objectives are concerned, uncertainty as far as performance evaluation systems are concerned (including the lack of positive feedback), excessive fragmentation of tasks, etc. This approach draws inspiration from both psychosocial and management theory. With the exception of the job latitude model developed by Karasek (14), it is more difficult to empirically test these assumptions in the field.

Burnout as a medical diagnosis

Since then, and particularly since the early 1990s, burnout has become a pathology in its own right. It is even listed among the various nosographic classification systems such as ICD-10 (15). Moreover, an increasing number of studies have been published on the subject, particularly in the biomedical field. Indeed, we now have a full range of studies designed to measure the level of burnout among professionals in various healthcare fields. These studies use classical, validated scales such as the Maslach Burnout Inventory (MBI) (16).

However, this approach, which seeks to measure the "temperature" of burnout for specific categories of professionals whose work is thought to be mentally and physically draining (e.g. typically, in the healthcare field, doctors and nurses who deal with patients suffering from chronic degenerative illnesses) reveals certain shortcomings. In fact, the organisational changes to the health and social health fields, which

began in the 1990s under the influence of new governance, have probably modified the role of caregiving.

In gerontology, for example, it's of interest to consider the context of retirement homes. Already plagued by a weak identity and a poorly defined mission, retirement homes are even faced with stigmatisation, despite the public health efforts and plans. Moreover, the workload tends to be higher since institutionalized people are more and more disabled and cognitively affected. Despite these negative factors, caregivers working in nursing home seems no more exposed to burnout than caregivers working in geriatric wards of hospitals (17).

On the basis of these data, apparently it is no longer purely and simply a matter of patient pathology (e.g. dementia or cancer) and associated burden on caregivers that lead to burnout. Probably, the organisational factors have better to be analyzed. And, beyond the organisation, one could find that changes taking place on the labour market play a major role, whether in the social health field in particular, or work in general (18).

Future outlook

Actually, a broader view is needed in order to take into account current labour market realities, starting in the 1990s (19). Indeed, new mechanisms are redefining the concept of work as such. In an era of globalisation and unbridled competition, the symbolic value of work

and its ability to reinforce a person's identity take a back seat to the laws of the market.

Within this context, the social role played by helping professions and other professions such as teaching, which previously had symbolic added value, has changed (20). In this context, the word "symbolic" considers the general value that work has in defining individual identity, a notion that people used to call by the name "vocation".

The need to take into account social changes in the analysis of burnout is even more important in light of the social and constitutive impact of employment at both micro and macro levels. Indeed, it has long been known (21, 22) that work, particularly work staff attitudes, can strengthen the identity of a person or weaken it (23).

In other words, worker identity is affected by his/her interaction with the group, whether in a positive or negative sense.

For the reasons stated above, greater attention needs to be paid to the studies that examine caregiver burnout from a broader perspective. These studies consider such things as the impact that the economic cycle has had on exhaustion levels among professionals as well as problems linked to migration, job insecurity, recruitment mechanisms and pay levels. These studies also examine the lack of training caused by cutbacks in resources as well as changing criteria used to select and recruit personnel, etc.

To illustrate this point, when people think of the concept of work, they generally associate this concept with stability. At least, this is generally the case in western societies. People also tend to link their identity to

the work that they do. If we agree that stability and work are strictly linked, then it follows that job insecurity could be a possible cause of burnout (24, 25).

An additional problem: the combination of welfare reform and globalisation.

The latest trend, which is expected to intensify in the years to come, is to reshape the helping professions so that they fit the mould of work "in general" and industrial labour in particular. In this scenario, industrial production becomes the paradigm and the market sets the gold standard. Probably, with some risk of oversimplification, there is a name for this imperative to bring the social health field in line with the needs of the market, this determination to inject market and industrial logic into the system: it is called new public management.

At the same time, the transformation process taking place in the health and social health field – a process that is occasionally referred to as "development of public utilities" – is taking place at a time when major social phenomena are affecting health and social systems. This is with reference to the interaction between migration, particularly migration of caregivers, and the ageing of general population. It's well-known that this latter topic (i.e. population ageing) will have tremendous implications in terms of chronic illnesses and disability.

The outlook for OECD countries over the next decade (26) shows that there will be a decreasing density of doctors and nurses in the

population. This development is caused by an ageing labour force and the increasing tendency of caregivers to leave the profession (27) due to the lack of counter measures to keep them.

There are also studies (28) that show that Europe is still the main host continent for immigration. These two phenomena will very probably interact, with many consequences.

Between these consequences: there will be a major problem at the operational level caused by the fact that caregivers come from different cultures and sometimes have very different education and training backgrounds.

With this “phylogenetic” paradox, i.e. those with the highest levels of education and training will have the greatest difficulty to integrate. This paradox raises the problem of how to ensure the quality of caregiving.

Here one could see, maybe, how ambiguous the concept of integration really is and even more so within the context of globalisation. Globalisation invariably creates an education and training mishmash where greater emphasis is placed on providing professionals with the skills needed to adapt and change.

Following this line of reasoning, the less educated and trained one is, the better. This is the known ideal of universal fungibility.

However, the material and immaterial costs of this are remarkably high as workers are invariably forced to retrain themselves on a just-in-time basis.

Indeed, it would seem that those who are the most cultivated, those who have the greatest cultural background, are better equipped to deal with

stress and burnout at the start of their activity. However, these same individuals run a greater risk of becoming exhausted and dropping out in the long run.

Maslach and Leiter (29) insisted repeatedly that burnout was caused by organisational factors rather than factors ascribable to individuals.

In these sense, the decision to create a specific nosological entity called burnout is ambiguous. It offers the disadvantage of placing the problem squarely on the shoulders of the individual. However, to claim that the problem is linked solely to organisational factors is not enough: beyond each organisation, the labour market exists.

The future burnout scenario in psychogeriatrics

In this age of total marketization, it is maybe useful to carry the analysis of burnout back to where the problem originated, i.e. in the field of psychiatry (and psychotherapics). From there, researchers could ask themselves what to expect in the future as burnout becomes more generalised.

As far as psychiatry and other fields are concerned, there is at least one conclusion that has come out of burnout research and analysis: social and organisational factors, as opposed to strictly clinical factors, lead to burnout syndrome. This is even truer when one considers the fact that clinics are often fragmented and atomised, where the categorical rather than dimensional approach takes precedence. Increasingly, and unfortunately, caregivers are reverting to very general and ambiguous

definitions, making ample use of overinclusive terms in their diagnosis such as “behavioural problem” or “aggressive behaviour” (the latter term taken to mean violent behaviour to be “overwhelmed” at all costs) and so on.

In these sense, the future scenario for psychiatry (especially for psychogeriatrics and liaison-psychiatry) would be an unequal confrontation between the clinical practice of psychiatry, deprived of its means, and organisation theory (or theories). Within this context, it will be management that sets the evaluation criteria. And considering that the clinical practice of psychiatry is often unsuccessful, economic criteria will prevail.

In this postmodern scenario (30) where *homo oeconomicus* gains to prominence, a question could arise concerning what will happen to psychiatry as a biological and an anthropological science (31).

In other words, it is interesting to note just how pervasive economic logic has become: as time goes by, this logic will spread throughout the caregiving context. In fact, more and more people, healthcare professionals included, state that it is better to have mediocre professionals in an effective organisation than *vice versa*.

That said, clinicians began migrating towards the organisation back in the 1990s …

It should be noted, almost as a working hypothesis, that blind faith in the organisation culture can actually lead in the opposite direction towards de-institutionalisation (32).

If alternative psychiatry has been able to undermine the institution with its self-referential approach, then "organisational" psychiatry could become the most efficient means of validating the self-referentiality of institutions (and practitioners).

Conclusion

Burnout has changed.

"Freudenberger burnout" was probably due, at least partially, to the burden of a major utopian effort. Nowadays, the burnout problem is probably caused by demands for greater flexibility, which originate from the new public management philosophy.

The new public management logic is quickly going in the direction of immaterial care. If one could ask an organisation theory *guru*, he might answer that the best strategy for preventing burnout is to make our work immaterial.

There will be losers in the dash to organise. At least some of these losers will be caregivers working in psychiatric or gerontological fields. Equally affected will be nursing assistants who deal with the more material aspects of care.

Based on the foregoing, the possible best strategies for dealing with burnout can be found above all by re-examining social policies, without neglecting psychological and sociopsychological approaches, of course.

Therefore, it is clear that in order to correctly perceive the problem of burnout, interdisciplinary and transdisciplinary approaches are required.

Actually, the tools used in a single discipline, whether psychology or sociology or occupational medicine will not suffice. Economic, managerial and social policy tools are also needed in order to analyse the context in which each organisation operates and to propose solutions from there (33).

This is a very complex approach, one that requires the joint efforts of professionals from different fields. This approach may also encounter resistance from various sides, as it is often the case with bottom-up initiatives (there is no doubt that the issue of burnout is a bottom-up way of looking at the quality of an organisation and the work done).

Moreover, the value given to caregiving is at risk. The stakes in this regard are high, and not only for healthcare systems.

As burnout spreading to all areas of the labour market, the old question posed by Friedmann (34) “Where is human work going on ?” becomes more relevant than ever.

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