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Burnout Syndrome in Mental Health Workers at Psychosocial Care Centers

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Abstract

Mental health workers are exposed to mental suffering due to the inherent psychosocial and work structure risks, due to the high work demands, to cope with the care and assistance demands of health service users. Studies focused on the mental health and Burnout syndrome of these workers are scarce. Thus, this study aimed to assess the prevalence of Burnout Syndrome among health workers at Psychosocial Care Centers and its associations with the biosocial and work-related characteristics of these professionals. This was an exploratory study, with a cross-sectional design and a quantitative approach, carried out in eleven Psychosocial Care Centers (PSCC) of the mental health network in a city in the interior of the state of São Paulo with a sample of 193 workers. PSCC workers with low or regular job satisfaction were 4.8 times more likely to develop Burnout Syndrome in the final predictive model when compared to those with good or excellent job satisfaction. The team's social support and job satisfaction can be identified as protective factors against the suffering of these professionals. For the realization of psychiatric improvements, it is also necessary to have a broader look at the mental health worker.

Keywords: Professional Burnout. Mental Health Care. Mental Health Services. Health Personnel. Occupational Health.

INTRODUCTION

Work can be a source of satisfaction and fulfillment or cause suffering and illness. Health workers whose work process "live work" during care is carried out with high intersubjective loads[1] between users and professionals and can be beneficial to both, but can also trigger suffering and the possibility of illness manifested as of Burnout Syndrome (BS).

The term Burnout was first described in the 70s, as a clinical phenomenon observed in workers of a rehabilitation service for drug users[2] and later recognized as a syndrome[3]. It is characterized by a state of complete exhaustion of the individual's energy associated with intense frustration with work[4].

The Syndrome can become manifested as psychosomatic, psychological, and behavioral symptoms and generally produces negative consequences at the individual, professional, and social levels[5], and is recognized in Brazil as a work-related mental and behavioral disorder[6].

Due to its high prevalence among health

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workers, BS was recently included in the 11th Review of the International Classification of Diseases (ICD-11), in the chapter entitled "Factors influencing health status or contact with health services"[6-7]. In the last 10 years there have been more than 10,000 publications on this topic, of which about 50% refer to health workers[8].

Health workers during their work activities are exposed to biological, ergonomic and, above all, psychosocial and work organization risks, due to the high work demands, multifunctionality of tasks, difficulties in teamwork, and deficiencies in material and human resources to meet the demands for care and assistance of health service users[9-10].

On the other hand, mental health workers, in addition to occupational risks common to care activities, deal with people who have psychological disorders and unpredictable behaviors due to acute crises, which expose them to high emotional tension[11]. These professionals need to establish a network of intersubjective relationships as a work tool to deal with the clientele who are there precisely because of bankruptcy or breakdown of their relationships[12]. Moreover, they also live with the real and subjective "emergencies" of users in an environment permeated by the fragility of the mental health service network[13].

The network of assistance and care in mental health after the Brazilian psychiatric reform was included in the Unified Health System (UHS), consists of a wide network of mental health-based assistance and care in Psychosocial Care Centers (PSCC) as one of its main pillars[14]. The work in PSCCs is complex and depends on the coordination of multidisciplinary teams, involving different knowledge, practices, and experiences.

In this context, workers experience intense and antagonistic and often conflicting feelings, which, added to work overload and precarious working conditions, can compromise their health[15]. The illness of workers who take care of mental health is a contradiction, because by affecting the health of these professionals, it compromises the quality of care provided to users of these services.

There are currently 2,661 PSCCs in the country[16], and few studies on the health-disease process of workers who work in these mental health services. Moreover, there is no study on the assessment of BS among these professionals. Thus, this study aimed to assess the prevalence of Burnout Syndrome among health workers at the PSCC in a city in the interior of the state of São Paulo, and its associations with the biosocial and work-related characteristics of these professionals.

METHODS

Study design and location

This was an exploratory study, with a cross-sectional design and a quantitative approach, carried out in eleven Psychosocial Care Centers (PSCC) of the mental health network of a city in the interior of the state of São Paulo, this is a portion of a larger study[17].

All types of PSCCs in the city were part of the research, including six adult PSCCs; three alcohol and drugs (AD) PSCCs, and two children and youth PSCCs.

Population or sample; inclusion and exclusion criteria

The sample was non-probabilistic for convenience. Subjects were selected according to their presence during the period of data collection. The study population included all PSCC workers from different professional categories: physicians, nurses,

nurse technicians and assistants, psychologists, coordinators, occupational therapists, social workers, monitors, pharmacists, pharmacy technicians, physical educators, and speech therapists[17].

Inclusion criteria were: working at the institution for at least six months, working at the PSCC at the time of data collection, signing the informed consent form, and returning the complete questionnaire. The workers who met the inclusion criteria were approached individually at the workplace by the responsible researcher and informed about the objectives and invited to participate in the study. The survey questionnaires were made available to the participant in a sealed and coded envelope, with guidelines on how to answer them. Respondents were able to choose whether or not to respond to the instruments in the workplace.

From a total of 395 PSCC workers, 70 professionals who had less than six months of experience, five who delivered incomplete questionnaires and 15 professionals who were on vacation or maternity leave were excluded from the study. From the eligible sample of 305 workers, there were 112 losses due to refusal to participate in the study or forgetting to hand in the questionnaires after at least five attempts. The final study sample consisted of 193 participants.

Collections were carried out in the morning, afternoon, and evening, until all professionals were approached. The delivery and return of the filled envelopes took place personally and individually to the responsible researcher.

Study protocol

Two self-reported data collection instruments were used: a biosocial questionnaire, based on other studies on the subject[5,18-19], and the Human Services Survey (HSS) version of the Maslach Burnout Inventory (MBI)[2], translated and adapted into Portuguese[19].

The biosocial questionnaire aimed to know different aspects of the study population. It is a self-applicable instrument in which the following characteristics were considered: gender; age; marital status; children; profession; time of education; time of profession; educational level; time working at the institution; occurrence of work accidents; absence due to health problems in the last two years; satisfaction with work and interpersonal relationships.

The Maslach Burnout Inventory (MBI-HSS) has 22 items distributed in three domains (Emotional Wear, Depersonalization, and Low Professional Fulfillment) with a Likert-type scale with a score from zero to four. Burnout indicators are those who present, concomitantly, high scores in emotional exhaustion and depersonalization and low professional fulfillment[2,19].

The Emotional Wear dimension has nine items that assess how often the subject feels emotionally exhausted (worn out) by work. The Depersonalization dimension has five items that assess how often the subject expresses a cold and impersonal response to the demands of health service users. The Low Professional Fulfillment dimension is composed of eight items to assess the health professionals' feelings of personal and professional competence to carry out their work[19].

Analysis of results and statistics

The results were analyzed using the resources of the Statistical Package for Social Science version 2.0 software. Categorical variables were described using ratios and proportions. The level of significance (α) adopted was 5%, and $p<0.05$ and 95% confidence intervals (CI) were considered significant. Differences in proportions were tested by Pearson's test (chi-squared) or Fischer's test, when necessary,

while differences in means were tested by the Kruskall-Wallis test.

Multivariate analysis was calculated using binary logistic regression. Logistic regression models were run with all variables, which were removed from the models as the p-value was greater than 20% (stepwise model). The measure of association used was the Odds Ratio (OR) and their respective confidence intervals (95% CI).

Ethical aspects

The research was approved by the Ethics and Research Committees (ERC) of the Faculty of Medical Sciences of the State University of Campinas – UNICAMP under protocol n° 848136, and meets the ethical and legal precepts of Resolution no. 466/2012 of the National Health Council, which deals with the guidelines and regulatory standards for research involving human beings.

RESULTS

There was a predominance of female workers (74.0%), without children (58.3%), who were single (50.5%). The average age of the professionals was 35.2 years old. The average length of experience in the health field was 10 years. The average working time at the PSCC was 4.9 years and the average workload was 42.9 hours per week.

The research participants were nurse technicians (27.6%), psychologists (21.2%), nurses (19.3%), pharmacists, pharmacy assistants and monitors (11.4%), coordinators (4.1%), psychiatrists (4.7%), and social workers or speech therapists (1.6%). Most participants worked full-time (59.9%).

Most participants (60.1%) considered interpersonal relationships with co-workers to be good, while the others classified these relationships as regular (21.7%) or bad (5.7%). The level of job satisfaction was considered great or good for most participants (78%). For some professionals, there was an intention to leave the PSCC (17.2%).

Among the professionals, sick leave was reported in the previous year (20.7%); however, most had to work sick (57.5%), and the main reason described for going to work was responsibility and ethical commitment they have with users, in addition to not overloading colleagues (43.0%).

The distribution of Burnout syndrome domains among the participants is described in Table 1. About a third of the professionals presented high emotional exhaustion and depersonalization, while a quarter of the participants had low professional fulfillment. The prevalence of Burnout Syndrome was 7.3%.

Table 2 describes the significant associations ($p<0.05$) between the participants' biosocial variables and the domains of the instrument used by the MBI-HSS ($p\leq0.05$) to assess BS. It was found that bad/very bad job satisfaction was associated with the three domains of the Syndrome. While "not feeling valued", "coming to work sick", and having the "intention of leaving the PSCC" was associated with the emotional exhaustion dimension.

The final predictive model of job satisfaction or dissatisfaction was considered a risk factor for Burnout, as described in table 3.

Table 1– Distribution of Burnout syndrome domains in mental health professionals at the PSCCs, Campinas, SP, 2017.

Domains	Cut-off Points	Frequency	%
Wear			
Low	≥ 10	43	22.3
Medium	11-20	88	45.6
High	≤ 21	62	32.1
Depersonalization			
Low	≥2	36	18.7
Medium	3-7	91	47.2
High	≥8	66	34.2
Professional Fulfillment			
High	≥26	68	35.2
Medium	19-25	78	40.4
Low	≥20	47	24.4
One domain		42	21.7
Two domains		37	19.1
Three domains (Burnout)		14	7.3

Table 2– Association between biosocial data and Burnout domains in professional mental health workers at the PSCC, Campinas, SP, 2017.

Variables	Emotional Wear	Deperson-alization	Low Professional Fulfillment	Burnout
Full-time Schedule	0.0076(*)			
Job satisfaction Bad/very bad perception	<.0001(*)		<.0001(*)	<.0001(*)
Not feeling valued	0.0001(*)			0.0144(*)
Worked sick Yes	<.0001(*)	0.0337(*)		
Intent to leave PSCC	<.0001(*)	0.0064(*)	0.0022(*)	0.0001(*)
Interpersonal relationship Bad/very bad perception	0.0292(*)	0.0331(*)		
Self-Reported Current Illness Yes		0.0459(*)		
Age Younger	0.0006(*)	0.0060 (*)		
Years of experience Fewer years	0.0037(*)			

(*) Chi-squared test

Table 3– Final predictive model for risk factors for Burnout yes x no in professional mental health workers at the PSCCs, Campinas, SP, Brazil, 2017. (n=193).

Variables	Category	p	OR (95% CI)
Job satisfaction	reg./bad vs. good/great	<0.0001	4.827 (2.508- 9.289)

§Bivariate logistic regression

DISCUSSION

Regarding the biosocial data of the sample, there was a predominance of females without children, single; and most participants who are part of the multidisciplinary team are nurses, followed by psychologists. Other studies on PSCC workers also pointed to the predominance of middle-aged workers and most professionals belonged to the nursing category and reported the need for training in mental health[20-21].

The daily activity of mental health professionals demands great subjective involvement and has proven to be exhausting, causing suffering and illness[22]. Unsatisfactory working conditions affected workers' health and reported anxiety, insomnia, headaches, depressive symptoms, high blood pressure, skin diseases, and urinary tract infections. Most of the complaints are in the psychosomatic field and can be influenced by the difficulties of these professionals in not being able to do the work in the way they imagines, and this can become a

sickening experience[23].

The professionals' impotence of action generates exhaustion, a feeling of uselessness, illness, and exhaustion[24]. PSCC workers find themselves in the eye of the hurricane as they produce "relief in others, but they have no relief to look to and reconsider their own work"[25]. The manifestations of psychosomatic illnesses can also occur when the demand for work is high and the worker's degree of control over work is low[26].

The high emotional demand for work and low control triggers stress in mental health professionals, leaving them more vulnerable. This was exemplified in herein when finding that 60% of professionals had symptoms compatible with emotional exhaustion, especially among younger workers. Studies show that emotional exhaustion is the main dimension of Burnout Syndrome and mainly affects younger workers with less experience[27].

Workers sick by BS in health institutions may have high levels of absenteeism, with repercussions on the quality of services provided to users[28]. On the other hand, the high level of commitment of the participants with the service and with the team makes most of them come to work even if they are ill. The causes of presenteeism are diverse and the most common is the fear of losing a job[29]. However, the workers of the PSCC studied revealed that the responsibility and ethical commitment to users and not to overload colleagues and co-workers were the main reasons for coming to work ill.

For PSCC workers, the collective dimension of interdisciplinary work enhances management and strengthens the group space and the sense of belonging[30]. In this research, the social support of the team, manifested by most participants as good interpersonal relationships with co-workers, and job satisfaction in its psychosocial dimension, can be designated as protective factors against the suffering of these professionals. Feeling fulfilled with one's work contributes to the construction of day-to-day psychosocial care provided and makes it possible to rearrange an effective way of working and developing activities and attitudes that are capable of providing them with pleasure[31].

On the other hand, the lack of investment in mental health services, especially municipal administrations that do not fully assume the Ministry of Health's proposals contribute to the precariousness of infrastructure resources and training and preparation of teams, generating insecurity. Moreover, defense mechanisms may not be enough to prevent these professionals from falling ill[32]. These adverse conditions were observed in the eleven PSCCs studied in the city and the signs of illness of these professionals were manifested in the dimensions of the Burnout Syndrome.

About a third of the participants showed emotional exhaustion and depersonalization, with negative repercussions for the health of these professionals and for the service itself, in terms of the lower quality of teamwork and service provided to users. Exhausted professionals are unmotivated and lack energy for professional performance. In addition, they demonstrate progressive emotional distancing from co-workers and patients which reduces the potential needed for receiving and caring for a client that is experiencing mental suffering as well.

In addition to compromising their work, it is highlighted that a quarter of the participants had low professional fulfillment, which damaged to their lives beyond work, as well as the prevalence of BS in fourteen participants (7.3%); these professionals should take a temporary leave from work and undergoing treatment. From an institutional point of view, it is necessary to train managers to understand what is happening with their teams and ensure that these professionals are heard and atten-

ded to in their needs in a paradoxical context of a daily life marked by the care of people who are suffering mentally, as also pointed out in other studies[24,32-33].

When comparing the results of this study with other health services that used the same instrument (MBI-HSS) to assess BS in health professionals from three hospital institutions, it was found that the prevalence of emotional exhaustion in workers from those institutions varied between 21.1% and 26.3%, lower than the data obtained in this study (32.1%). Depersonalization ranged from 20% to 28.8% was also lower than that found in our study (34.2). The dimension of low job satisfaction, with a variation between 24.6% and 28.9%, was similar to the present study (24.4%)[5,34,35]. 4.8% and 5.9% of BS (workers who presented concomitantly high exhaustion, high depersonalization, and low professional fulfillment) was found in those services, respectively. 6.3% were inferior to the present study (7.3%)[5,34-35].

The fact that "low personal fulfillment" was the least compromised dimension among studied professionals could be justified, due to the high sense of belonging and the possibility of changing the paradigms of the old asylum model by the daily construction of the psychosocial rehabilitation precepts in the daily life of users by PSCC professionals. Relationships in care are constituted in the collective social contract so that a new social place can be guaranteed for people in psychological distress. Furthermore, in this sense of belonging and recognition by the work team and its users, they may emerge with feelings of pleasure towards their work and contribute to their remaining in their professional activity[36].

One of the pillars of commitment and achievement at work is the involvement of these professionals with something they believe in – transformed here into an ideology – which is of psychosocial construction and intervention, and the satisfaction of working in the professional field of choice that, despite all the adversities, remains as a factor of personal fulfillment at work[30,34].

A study carried out with workers from a PSCC in Rio de Janeiro, RJ found that the ideology underlying the Psychiatric Reform acquires a special standing for the recognition of its social function. Therefore, working at the PSCC is reported as a choice because it gives much more meaning as at type of activism or a utopia to be pursued at work, as opposed to a mere means of financial return[24].

On the other hand, compassion for the mental suffering of PSCC users goes beyond mental illness and often requires the team to work within the community, ranging from the acquisition of social rights to the fulfillment of basic needs, such as housing and food, as many live on the streets. Experiencing this suffering on a daily basis, along with the limitation and impotence of the health professional in not being able to solve all the patients' problems can cause suffering and frustration for professionals[37].

In this context, despite the defense strategies against illness in the form of engagement with the team and complicity with a cause, the following individual aspects of the participants had a positive association with “emotional exhaustion”: considering job satisfaction as bad or terrible; not feeling valued; having worked sick in the last year; intending to leave the PSCC; considering interpersonal relationships as bad or terrible; working full-time, being younger, and having fewer years of experience in the health field.

Several studies indicate that being younger and having fewer years of experience in the health area are predictors of BS[4,27]. The lack of experience of these workers contributes to a feeling of insecurity and a reality shock of which they were not trained for and realize that the work will not guarantee the fulfillment of their expectations and desires[37].

Regarding the other variables mentioned, feeling undervalued and not having a good interpersonal relationship with the work team contributes to dissatisfaction at work and the intention to leave the PSCC. The lack of purpose at work for these professionals enhances suffering and predisposes them to illness.

On the other hand, "depersonalization", in addition to the aspects mentioned in the exhaustion domain, presented a positive association for the aspects "going to work sick in the last year" and "having a current illness". It is possible that the disease reported by these professionals are clinical manifestations of the two dimensions of Burnout (exhaustion and depersonalization)[5,38].

An individual's encounter with work at the institution generates expectations that may or may not be satisfied, and conflicts may emerge when personal needs are not met by the organization which may generate dissatisfaction, suffering, or chronic anxiety which are rarely translated into words or explained by the worker themselves[39]. In this sense, the negotiation is with the user, with an individual, and not with the disease, which makes the prescribed work difficult considering the characteristics of PSCC users. Therefore, the clinical practice must be invented and reinvented daily.

According to the final predictive model between having or not having BS, described in Table 3, the adjusted analyses between Burnout and biosocial variables showed that PSCC workers with low or regular job satisfaction were 4.8 times more likely to develop Burnout when compared to those with good or great job satisfaction. It can be considered that the perception related to job satisfaction exerts a great influence on a positive or negative outcome in the illness and burnout process among the professionals of the studied PSCCs[40].

A recent study confirmed that the increasing expansion of the Psychosocial Care Network managed to reduce the rates of psychiatric hospitalization in the period and regions of the study[40], thus, it is essential to look at the workers who are involved in this unique work process.

The results of this study showed chronic and recurrent problems in PSCCs distributed throughout the country. However, a limitation of this research is the regional character and the specificities of municipal management and administration, and the possibility that the sample profile does not represent the complete universe of workers.

CONCLUSION

PSCCs are the main pillars of mental health care in the SUS; however, the lack of resources and administrative aspects of municipalities in the transfer of resources affects the infrastructure of these services and weakens the work processes of multidisciplinary teams, thus, compromising the quality of care provided to users experiencing mental suffering in the country.

Despite the numerous difficulties reported and demonstrated, the power of these services lies in the commitment of teams and professionals who remain consistent in the struggle for the consolidation of psychiatric reform and humanized care for patients with mental disorders. However, the deficient permanent education, the lack of staff, the high workload, the precariousness of work contracts, and the high work demands weaken the health of these workers.

Signs of suffering and illness are manifested as psychosomatic symptoms and illnesses and Burnout syndrome. About a third of the participants displayed emotional exhaustion or depersonalization, and a quarter of them

have low professional fulfillment. Furthermore, in addition to compromising the work of the teams and the quality of care, this indicates that these professionals need support and help. It is observed that the feeling of satisfaction with work and with interpersonal relationships act in a protective way against suffering at work; therefore, collaborative relationships built on a working life and on the multidisciplinary team should be encouraged and cultivated.

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