

Clinician Perceptions of How Burnout Impacts Their Work

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Abstract

Objective: This mixed-methods study identified ways that professional burnout may affect clinical work and consumer outcomes. **Methods:** Clinicians (N=120) participating in a burnout intervention trial completed a survey prior to intervention, including ratings of burnout and open-ended questions of how burnout may affect their work. Responses were analyzed using team-based content analysis. **Results:** Clinicians reported specific ways that burnout impacts work, including reduced empathy, communication, working alliance, and consumer engagement. Clinicians acknowledged negative impacts on outcomes, though few actual consumer outcomes were specified. Clinicians with higher levels of depersonalization were more likely to report that burnout impacts how staff work with consumers ($r=.21$; $p<.05$); however, emotionally exhausted clinicians were less likely to report an impact on consumer outcomes ($r=-.24$, $p=.01$). **Conclusions:** Reducing professional burnout may have secondary gains in improving quality of services and consumer outcomes; findings point to specific aspects of care and outcome domains that could be targeted.

Professional burnout, characterized by emotional exhaustion, depersonalization (negative/cynical attitudes towards care recipients), and reduced personal achievement (1), has been widely studied among mental health workers. Reviews demonstrate associations between burnout and problems for mental health service providers (e.g., depression) and their employer organizations (e.g., absenteeism), and growing evidence that burnout impacts consumers of those services (e.g., poor satisfaction) (2, 3).

Although burnout has long been considered a problem for quality of care, few studies have directly assessed these links in mental health (4). Consumers being served by mental health teams with high levels of burnout report lower levels of client satisfaction (5) and have had higher rates of hospitalization (6). Community mental health workers with higher burnout report lower levels of quality of care (4), while psychiatric nurses reporting high levels of work engagement tend to report higher levels of quality of care (7). Aside from hospitalizations (6), extant research provides little direction on which outcomes may be affected by burnout and how quality of care may suffer.

As part of a burnout intervention trial, we asked clinicians how burnout affects their clinical work. We were interested in how burnout might affect the ways in which clinicians work with consumers as well as the potential ramifications for consumer outcomes. We were also interested in how burnout may affect working with colleagues, as research in other fields has shown that burnout may act as a contagion, negatively affecting co-workers (8). Through content analysis of open-ended questions, we explored how burnout is perceived to impact

mental health services. In addition, we explored the relationship between staff perception of burnout impact and scores on a burnout inventory.

Methods

Clinicians in this mixed-methods study were participating in an RCT of a burnout intervention. For the parent study, clinicians were recruited from a VA Medical Center, a veteran-focused social services provider, or a community mental health center. Recruitment was open to anyone providing mental health services, regardless of current burnout level. Data for this study were collected from the baseline assessment, prior to any intervention, between January and June, 2013; 123 participants were recruited and completed an online survey. Of these, 120 completed the open-ended questions and are included in this study. All procedures were approved by [University] Institutional Review Board and [VA] Research and Development Committee.

Most participants were white (92, 77%) and female (83, 69%), and the mean age was 46.3 ± 11.7 years. The educational background included 12 (10%) with less than a Bachelors degree; 22 (18%) with a Bachelors degree, 63 (53%) with a Masters degree, and 22 (18%) with a doctorate. The mean length of time in the current job was 4.6 ± 5.7 years and length in the mental health field was 14.5 ± 10.7 years. Participants reported spending a mean of 75.9 ± 26.3 percent of their time in direct care.

Burnout was assessed with the Maslach Burnout Inventory for Human Services (9), a widely-used measure of three components of burnout: emotional exhaustion, depersonalization, and personal accomplishment. The subscales have shown good internal consistency, stability over time, and convergent validity with related constructs (9).

Perceptions of the impact of burnout were assessed through the following open-ended questions: How, if at all, do you think burnout affects the way you work with clients? How, if at all, do you think burnout affects the outcomes of the clients you work with and which outcomes? How, if at all, do you think burnout affects the way you work with colleagues? If you felt more energized and engaged in your work, how would your clinical work be different? If you felt more energized and engaged in your work, how would it impact the outcomes of the clients with whom you work? If you felt more energized and engaged in your work, how would it impact the way you work with colleagues?

Responses to open-ended questions were collated into Excel for content analysis. Using emergent, consensus based coding for conventional content analysis (10), the research team independently examined responses from approximately 10 participants to create an initial list of categories. We met as a group to discuss, merge and refine categories. We repeated this process until we agreed on a list of codes (three iterations). Pairs of raters independently coded all responses, determining if each category was present in a particular participant's answers and if so, whether the target of the impact was consumer, colleague, both, or other/unspecified. Raters met to review codes and reach consensus.

We examined the types and frequency of impacts that clinicians described using consensus codes. We then explored whether the level of burnout was related to perceptions that burnout impacted their work with consumers or colleagues, or impacted consumer outcomes, using point biserial correlations.

Results

More than half of clinicians (58%) described burnout as having a negative impact on the quality or amount of their work (Table 1). Additional negative impacts included withdrawing from others, having less patience and less energy, poor communication and/or listening skills, worse consumer outcomes and attitudes toward treatment, and colleagues displaying frustration or negative attitudes. Although our survey questions were focused on clinical work, a few participants spontaneously described burnout affecting their home life, for example, “I try not to allow the way I feel impact the Veterans. I take it out on my family.” Surprisingly, a few clinicians mentioned positive aspects of burnout, for example, bringing staff closer together, or serving a tempering function (e.g., in response to the impact of being more engaged, one participant responded “They would probably find my [sic] even more annoying as I would be intrusive in their time/space.”).

Overall, 101 (87%) answered open-ended questions indicating burnout has some type of impact on how they work with consumers, and 104 (93%) described an impact on how they work with colleagues. In addition, 75 (68%) reported burnout having an impact on consumer outcomes. However, this overall category included responses that we later categorized as processes, rather than outcomes. For example, a clinician responded to the question of whether burnout affects consumer outcomes with the following: “I hope my burnout is not affecting them but we are having tremendous turnover right now and I know that affects them. They get accustomed to working with someone, developing trust, then that person leaves.” This response reflects an impact on *poor alliance/relationships* in our coding system, rather than a consumer outcome. Clinicians who did not think burnout impacted their work, often responded

with “I don’t think it does,” but some did elaborate, for example “Ultimately my clients determine their own outcomes,” or “I try very hard not to let it affect my interactions with clients.”

Overall impact responses were examined in relationship to level of burnout reported in the same survey. Burnout was not related to perceived impact on colleagues (r 's ranged from .11 to -.09). Higher depersonalization was associated with reporting an impact on how they work with consumers ($r = .21, p = .024$). Clinicians with higher levels of emotional exhaustion were less likely to report an impact on consumer outcomes ($r = -.24, p = .010$).

Discussion

Most clinicians described negative impacts of burnout on mental health services, particularly in interactions with colleagues (93%) and consumers (87%). Fewer, but still a sizable number, reported impacts on consumer outcomes (68%). These findings are consistent with empirical studies linking burnout to reduced consumer satisfaction (5), lower perceived quality of care (4), and worse consumer outcomes (6).

This study extends prior work, however, by pointing to a variety of different aspects of care that could be studied in relation to burnout. Clinicians’ ability to provide care with enthusiasm, patience, empathy, effective communication skills, attention, and creativity were all identified as areas influenced by burnout. Process indicators, such as therapeutic alliance and consumer engagement, appear to be important elements of care negatively impacted by burnout. All of these factors could conceivably lead to reduced consumer outcomes and are worthy of future study.

While most clinicians (68%) reported that burnout affects consumer outcomes, the coding system revealed fewer clinicians (45%) reporting specific consumer outcomes. That is, when asked about “outcomes,” clinicians sometimes responded with items that coders included as process variables instead. It may be that clinicians have a different view of outcomes, have a harder time conceptualizing outcomes as distinct from clinical processes, or perhaps intended to describe a process that might eventually lead to an outcome without specifying which outcome. This lack of differentiation may also reflect reality in that some constructs can be conceptualized as both processes and outcomes (c.f. recovery; (11)). When asking about outcomes in the future, it may be helpful to provide greater specification.

The exploration of level of burnout with answers to open-ended questions led to some interesting findings. Clinicians with higher levels of depersonalization appeared to recognize the impact of burnout on how they work with consumers. This may reflect validity of the coding system rather than a unique finding. For example, the depersonalization subscale includes items such as “I feel I treat some recipients as if they were impersonal objects.” Interestingly, the most emotionally exhausted clinicians, however, were *less likely* to report that burnout affected consumer outcomes. Although these correlations represent small effect sizes (12), they are notable in the context of mixed-methods, with less risk of common method variance inflating correlations. It could be that exhausted clinicians are not able to see the impacts, perhaps because of reduced energy or attention, or perhaps through self-protective denial. Alternatively, clinicians who are working the hardest to affect consumer outcomes or to keep burnout from affecting outcomes may become more emotionally exhausted. With few

exceptions (6), burnout has not been studied in relation to actual consumer outcomes, but appears to be a ripe area for future study.

While this study provides greater depth of understanding the ways in which professional burnout may impact clinical care and outcomes, we also recognize limitations. This study relies solely on self-reported impact, and while clinicians can provide useful insights, the field also needs studies linking burnout to actual consumer outcomes. It is possible that participants seeking an opportunity to address burnout may be more likely to endorse ways in which burnout could impact care. This could result in higher levels of perceived impact than might be found in a more general population of clinicians. Yet even in this sample of clinicians who were interested in reducing burnout, it is notable that almost a third of them reported that burnout would not affect client outcomes and those were the clinicians with higher emotional exhaustion.

Conclusions

Clinicians perceive a variety of ways burnout may impact how they work with people, and ultimately consumer outcomes. The level of burnout may also impact how clinicians view care being affected. Future research is warranted in linking clinician burnout with processes of care (e.g., working alliance and consumer engagement), and consumer outcomes.

Table 1. Impact of Professional Burnout (N=120)

	Code Used		Target of Impact				Sample Quotes		
	n	%	Client		Coworker		General		
			n	%	n	%	n	%	
Poor quality or amount of work (not mistakes)	69	58	40	34	8	7	25	21	It dulls my clinical skills; Less thorough evaluation and intervention; It affects my paperwork and efficiency.
Withdraw/avoid helping others	48	40	11	9	56	47	2	2	I am less interactive with colleagues which causes a disconnect that can directly affect care for our veterans and cohesiveness of our team.
Less patience	57	48	31	26	39	33	2	2	I am more intolerant and impatient; Sometimes I feel stressed and at those times I am more apt to ""get my buttons pushed"
Worse client outcomes	54	45	54	45	n/a		n/a		Perhaps it will take longer, more services for them to accomplish their desired treatment goals
Less energy/motivation	47	39	34	29	9	8	9	8	It exhausts my creativity and energy for clients; Mental, emotional, physical and spiritual fatigue all take a toll at times.
Others get poor attitudes	44	37	34	29	23	19	0	0	They will feel hopeless; The negativity may rub off on them.
Poor communication and listening skills	44	37	14	12	35	29	0	0	I'm sure I get short/edgy at times with them; Sometimes I might be snippy or negative, but usually, I am friendly and upbeat.
Less empathy	42	35	35	29	10	8	0	0	You care less about them; Less empathically connected.
Less focused/attentive	40	34	35	29	5	4	2	2	I get distracted and cannot fully give my clients the attention they deserve; It affects my not paying attention and sometimes can miss what is being said.
Others withdraw or are less engaged	34	29	33	28	4	3	0	0	Clients may leave treatment prematurely or be less skilled when they leave the service if I am not at my best;
Less creative	34	29	30	25	4	3	4	3	I don't have time to research new group ideas so the same old things get rotated around; I am less likely to think creatively.
Poor alliance/relationships	32	27	16	13	22	18	0	0	Difficulty establishing strong working alliance; Damaging to relationships with them.
More mistakes	12	10	9	8	2	2	1	1	If I forget to send a medication, they can't start taking it; Missing important information or missing opportunities to use information, which might be helpful.
Other impact outside work	7	6	n/a		n/a		7	6	I take it out on my family; I think the problem is that I use up all of my energy at work and my family life and stress level are negatively affected by this.
Positive impact	6	5	0	0	5	4	1	1	I think it brings us closer together. We work as a team and if someone is feeling down there's always someone to help out.

Note: Row percentages do not add to 100 because target of impact was not mutually exclusive in responses.

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