



Review / meta-analyses

Burnout in mental health professionals: A systematic review and meta-analysis of prevalence and determinants

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ABSTRACT

This study aimed to estimate the level of burnout in mental health professionals and to identify specific determinants of burnout in this population. A systematic search of MEDLINE/PubMed, PsychINFO/Ovid, Embase, CINAHL/EBSCO and Web of Science was conducted for original research published between 1997 and 2017. Sixty-two studies were identified as meeting the study criteria for the systematic review. Data on the means, standard deviations, and prevalence of the dimensions of burnout were extracted from 33 studies and included in the meta-analysis ($n=9409$). The overall estimated pooled prevalence for emotional exhaustion was 40% (CI 31%–48%) for depersonalisation was 22% (CI 15%–29%) and for low levels of personal accomplishment was 19% (CI 13%–25%). The random effects estimate of the mean scores on the Maslach Burnout Inventory indicate that the average mental health professional has high levels of emotional exhaustion [mean 21.11 (95% CI 19.98, 22.24)], moderate levels of depersonalisation [mean 6.76 (95% CI 6.11, 7.42)] but retains reasonable levels of personal accomplishment [mean 34.60 (95% CI 32.99, 36.21)]. Increasing age was found to be associated with an increased risk of depersonalisation but also a heightened sense of personal accomplishment. Work-related factors such as workload and relationships at work, are key determinants for burnout, while role clarity, a sense of professional autonomy, a sense of being fairly treated, and access to regular clinical supervision appear to be protective. Staff working in community mental health teams may be more vulnerable to burnout than those working in some specialist community teams, e.g., assertive outreach, crisis teams.

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1. Introduction

The novelist Graham Greene first introduced the term 'burnout' when he wrote about a fictional architect who could no longer find meaning in art or pleasure in life [1]. The term 'burnout' was introduced to the scientific literature in 1974 by an American psychologist Herbert J Freudenberger where he described burnout as a 'state of mental and physical exhaustion caused by one's professional life' [2]. Freudenberger defined it as something that related exclusively to frontline human service workers. Subsequently, Maslach and Jackson defined burnout as a psychological syndrome that occurs in professionals who work with other people in challenging situations that is characterised by (a) emotional exhaustion; feeling overburdened and depleted of emotional and physical resources, (b) depersonalisation; a negative and cynical

attitude towards people, and (c) a diminished sense of personal accomplishment [3,4]. Although, this definition of burnout remains most prominent in the literature other definitions of burnout have also been proposed [5]. Kirstensen et al. 2005 proposed that fatigue and exhaustion are the core feature of burnout but that depersonalisation is a coping strategy, while reduced personal accomplishment a consequence rather than a defining feature of burnout [5]. Demerouti and Bakker (2007), proposed that burnout was defined by two core dimensions (a) affective, physical and cognitive exhaustion and (b) disengagement from work [6]. An important development in this field has been an attempt by researchers to expand their understanding of burnout by looking at what could be considered its positive antithesis which has been defined as 'work engagement' [7,8]. However, while some researchers consider engagement to be the opposite of burnout [7]. Others define engagement as a persistent, positive affective-motivational state of contentment that is characterised by the three components of vigour, dedication and absorption. In this view, work engagement is an independent and distinct concept, which is not the opposite of burnout [9].

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Burnout has been found to be associated with job dissatisfaction, low organisational commitment, absenteeism, intention to leave the job, and turnover [7,10]. Furthermore, there is considerable evidence that burnout has negative impacts on the physical and mental well-being of the individual worker [11], the welfare and functioning of the team and organisation in which they work [12,13], and is associated with lower productivity and impaired quality of care provided to patients [14]. Factors particular to the mental health field have been proposed to make workers in this field more vulnerable to burnout [7]. These factors include stigma of the profession [15], demanding therapeutic relationships [15] and threats of violence from patients and patient suicide [15,16]. However, a systematic review and meta-analysis of the prevalence and determinants of burnout in MHPs has not been conducted.

1.1. Aims of this study

The aim of this review is [1] to quantify the level of burnout in MHPs and [2] to identify specific determinants of burnout in MHPs.

2. Methods

2.1. Literature search

We used the PRISMA guidelines. A systematic search of MEDLINE/PubMed, PsychINFO/Ovid, Embase, CINAHL/EBSCO and Web of Science was conducted in May 2017 for original research published from 1st January 1997 until 31st December 2016. Relevant controlled vocabulary terms and free text terms related to burnout and MHPs were used to search each database. In all databases, the search was restricted to studies published in English. All studies had to be published in a peer-reviewed journal. The reference lists from articles and reviews were examined for any additional studies. The full search strategies for the individual databases can be found in Appendix 1.

2.1.1. Inclusion and exclusion criteria

The inclusion criteria were [1]: the study examined the prevalence/ determinants of burnout [2], the sample population was comprised of MHPs (including doctors, nurses, social workers, psychologists, occupational therapists, counsellors) working in mental health services [3], the study had to be empirical and quantitative [4] the response rate was greater than 25% [5], the study sample was comprised of at least 50% MHPs [6], the study included at least 50 participants. The exclusion criteria was [1] the study did not use a validated measure of burnout.

2.1.2. Study selection, data extraction and assessment of study quality

After removing the duplicates, two investigators (KOC and DMN) reviewed study titles and abstracts for eligibility. If at least one of them considered an article as potentially eligible, the full texts were assessed by the same reviewers. Any disagreements were resolved by discussion. Detailed information on the country, data source, study population, and results were extracted from each included study into a standardized spreadsheet by one author and checked by a second author (KOC and DMN). EndNote X7.3.1 (Thomas Reuters, New York, USA) was used to organize the identified articles.

Two investigators (KOC and DMN) independently assessed the risk of bias of each of the included studies. A score for quality, modified from the Newcastle-Ottawa Scale (NOS), was used to assess the appropriateness of research design, recruitment strategy, response rate, representativeness of the sample, objectivity/reliability of outcome determination, power calculation provided, and appropriate statistical analyses (See Appendix 2). Score disagreements were resolved by consensus. An NOS score of

8 or more was considered 'good,' a score of 5 or less was considered 'poor.'

2.2. Data synthesis

The meta-analyses were conducted using Comprehensive Meta-Analysis software, version 3 (Biostat Inc., NJ, USA). In light of expected differences in study sample and design, random-effects models were used to calculate the pooled means and prevalence. Heterogeneity across studies was tested using Q statistics [17], and the I^2 [18]. Results from studies grouped according to pre-specified study-level characteristics were compared using subgroup analyses (for MBI-HSS High EE/DP/PA 'cut off' score, geographical location and NOS) and random effects meta-regression (for age, sex, study size and professional background of participants). To address the issue of publication bias, we examined funnel plots [19], and used the Eggers Test [20].

3. Results

3.1. Search outcome

The electronic literature search identified 1348 unique citations. Based on a review of article titles and abstracts 1262 citations were excluded. After full-text review 62 articles remained (See Fig. 1 for PRISMA flow diagram). The features of the identified studies are summarised in Table 1.

3.2. Study population and study design

Studies conducted across 33 different countries were identified. The vast majority of studies were cross-sectional (N = 57) and multi-site (N = 47). However, five studies had a longitudinal design with follow-up times varying between six months [67,68] and five years [50]. Self-reported questionnaires were utilised in every study. The number of respondents ranged from 60 [36] to 2258 [45]. The mean study size was 370.61 (SD 457.77), the median was 195. In most studies, female respondents were over-represented. Mean age of respondents ranged from 30.9 years [39] to 51.6 years old [71] and the response rate varied between 26% [16] and 100% [28]. The minority of studies (N = 11) examined burnout in the inpatient setting exclusively. The rest examined burnout in community settings or a mix of community and inpatient settings.

Most studies examined the prevalence and correlates of burnout in several different MHP groups (N = 31). Data on burnout in nursing staff was gathered in 30 studies, in doctors in 17 studies, in psychologists in ten studies, in occupational therapists in eight studies, in social workers in 12 studies. Although the data on individual professional groups was not reported in each of these studies.

3.3. Quality of studies

On the modified Newcastle-Ottawa Scale (NOS) 15 of the studies rated as being of good quality (score ≥ 8) 41 studies rated as being of moderate quality (score 6–7) and six studies rated as being of poor quality (score ≤ 5) [36] (See Table 1)

3.4. Measurement of burnout

Eight validated measures of burnout are cited in the literature between 1997 and 2017. These are the Maslach Burnout Inventory (MBI) [83] (n = 54), the Oldenburg Burnout Inventory (OLBI) [6] (n = 2), the Copenhagen Burnout Inventory (CBI) [5](n = 3), Pines Burnout Measure (n = 3), the Psychologists Burnout Inventory (n = 2), the Organisational Social Context Scale (OSCS) [84](n = 1),

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