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Standard Paper

Perceptions and misperceptions about burnout: Implications for burnout prevention in mental health workers

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Strand **Well-being and Work**

Background

Burnout has long been a problem in mental health workplaces and remains so despite much research and considerable knowledge of it amongst professional employees. This paper will address this paradox by outlining the findings of a study on mental health workers' perceptions and beliefs about burnout.

The paper will discuss how human perceptual processes appear to encourage mental health workers to minimise recognition of, and response to, burnout. Attribution Theory and related theories from social psychology suggest beliefs and perceptions have a strong influence on behaviour, including self-care and preventative behaviours. Despite good *objective* knowledge of work stress, workers may misperceive their own vulnerability and continue working to the point of emotional or physical exhaustion.

As the first study to systematically and empirically investigate the influence of perceptions and beliefs on workers' responses to burnout, the findings presented in this paper suggest a new perspective on burnout prevention. **Learning** how perceptions about stress and burnout in the workplace can impede prevention can assist organisations and professionals in **sharing** responsibility for addressing the problem, **impacting** burnout prevention efforts, and in turn, work productivity and engagement.

The findings are likely to be applicable to many sectors and organisations affected by burnout and work stress. Therefore this presentation may be of interest to researchers and managers interested in the nature of burnout, its manifestation in specific occupational groups, changing public and workplace perceptions of burnout, or the phenomenology of stress and burnout. Additionally, the general public may find this paper applicable to their own experiences of burnout or work stress regardless of occupational category.

Method

This study was qualitatively, phenomenologically driven as it sought to understand how individuals make sense of burnout. Fifty-five mental health workers returned an open-ended questionnaire on their beliefs, attitudes and perceptions about burnout and how these might impact upon their ability to maintain their wellbeing at work. Additionally, 12 participants were interviewed in-depth. Occupational groups investigated included mental health nurses, psychologists, mental health occupational therapists, social workers, psychiatrists and counsellors.

The questionnaires were analysed using thematic analysis. An inductive approach to data analysis was taken where the assigned codes were derived from the participants' own language and responses. As the first step in this contextual approach a sample of 20 questionnaires were used to develop a series of codes for each item number. Data analysis was complemented by NVivo 9.

Participants were predominantly older workers with 60% of the sample aged 40 and over, including 33% of these aged over 50, reflecting the aging of the mental health workforce in Australia. The participant group was predominantly female, again reflecting the mental health sector, with males representing only 19% of the sample.

Findings and Discussion

A key finding of this study was that respondents found it difficult to recognise burnout in themselves until signs of physical and emotional breakdown had started to impact their functioning. Even when they recognised their burnout, they tended to blame themselves and had a difficult time disclosing it to others for

fear of negative judgement. These observations suggest respondents had strong perceptual and emotional barriers to dealing with burnout. This paper will present a model of the perceptual barriers to recognising and responding to burnout.

Self-Blame

A very high proportion of respondents indicated they would blame themselves if they burned out, describing it as a sign of weakness, failure and incompetence. This helps explain why they are unwilling to speak up about their experiences.

For example one participant recalled: "I just thought it was me, and I needed to work harder, so it became a vicious circle". Several studies have established a link between self-blame and poorer adjustment outcomes after trauma or illness (e.g., Frazier, 1990).

Self-stigmatising beliefs

Many respondents who reported suffering burnout found they came to believe they were weaker or less capable employees. This attribution of an underlying personality problem is another contributor to the vicious cycle of self-beliefs that both feed and are fed by burnout.

The illusion of control

Participants reflecting on past burnout were aware that unrealistic expectations of their ability to avoid burnout had allowed them to continue overwork to the point of breakdown. This suggests the presence of an illusion of control (Thompson, 1999), an exaggerated sense of self-efficacy based on the belief one has more control over one's fate than environmental factors allow. In burnout, this illusion may result in a belief that helping professionals are immune to work stresses or even infallible.

Optimism bias

A third attributional process allowing a person to justify overwork to the point of burnout is the belief that "it won't happen to me" (Weinstein, 1984, p. 431), or optimism bias. The findings show workers often had a generalised attitude of optimism concerning the risk of burnout which led them to minimise the hazards of their behaviour and ignore symptoms of burnout. Past experience of having avoided burnout in high-stress situations may have contributed to this.

Thinking of burnout in dichotomous terms

Another form of attribution identified was a tendency to view burnout in black and white terms. On one hand, most respondents saw burnout as a very serious occupational hazard, with more than half believing it can have serious consequences for a person's health, self-esteem, career, financial stability or relationships. Many saw that it could force them out of the workforce. On the other hand, it was often not seen as a real threat to them individually.

Stress-induced cognitive deficit

An interesting point made repeatedly in the interviews was that as burnout reduced a professional's mental or physical health and work competence, it also reduced their ability to recognise that they were suffering from burnout. Therefore, once the process of depletion had begun, professionals were less likely to seek support and more likely to ignore the warning signs. Several commented on the irony of being a mental health worker yet being unable to recognise symptoms of stress, anxiety and depression in themselves. Many previous studies show a decline in capabilities such as decision-making or sense-making under stress (e.g., Oosterholt, Van der Linden, Maes, Verbraak, & Kompier, 2012).

Effects of professional role-identity

Those who had burned out often recalled feeling then that they were not 'cut out' for their job because they should be able to withstand its stresses. This 'should' seems to reflect a belief that since mental health workers are trained in managing others' emotional and psychological problems they should not suffer from these themselves. This role identity can have a powerful distorting effect on an employee's awareness of burnout and willingness to increase self-care or seek help.

Conclusions

The perceptual biases discussed above all lead a person to a distorted view of his or her health. Self-blame and self-stigmatising allow the possibility of taking action to be ignored, while the illusion of control, optimism bias, and dichotomous thinking lead to minimising or ignoring symptoms. Stress itself can add to these effects by narrowing sense-making and decision-making capabilities. Values of competence and

selfless helping of others in professional identity of many mental health workers may further exacerbate the basic attributional tendencies.

The present perspective suggests that the mental health sector should move beyond the pervasive view of burnout as primarily a problem that frontline workers themselves should detect and respond to.

Organisations should not view failure to seek help for self-impairment as a 'violation' of professional ethics but a normal human response to the stress process. As a consequence, mental health workers need others to help them recognise their symptoms and seek treatment. This does not reduce their responsibility for self-care, but highlights the organisation's duty of care for staff who are unable to see their own situation, whether due to unrealistic or unhealthy workload expectations or factors outside the employer's control.

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