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BURNED-OUT

by CHRISTINA MASLACH

After hours, days and months of listening to other people's problems, something inside you can go dead, and you don't give a damn anymore. At this point, professional researchers find, a lot of other stresses begin to complicate matters. Happily, there are new ways to cope.

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Just before Christmas, a woman went to a poverty lawyer to get help. While discussing her problems, she complained about the fact that she was so poor that she was not going to be able to get any Christmas presents for her children. The lawyer, who was a young mother herself, might have been expected to be sympathetic to the woman's plight. Instead, she found herself yelling at the woman, telling her, "So go rob Macy's if you want presents for your kids! And don't come back to see me unless you get caught and need to be defended in court!" Afterward, in thinking about the incident, the lawyer realized that she had "burned out."

Hour after hour, day after day, health and social service professionals are intimately involved with troubled human beings. What happens to people who work intensely with others, learning about their psychological, social or physical problems? Ideally, the helpers retain objectivity and distance from the situation without losing their concern for the person they are working with. Instead, our research indicates, they are often unable to cope with this continual emotional stress and burnout occurs. They lose all concern, all emotional feeling, for the persons they work with and come to treat them in detached or even dehumanized ways.

For the past few years, I have been studying the dynamics of burnout in collaboration with coworkers at the University of California in Berkeley. We have observed 200 professionals at work, conducted personal interviews and collected extensive questionnaire data. Our sample includes poverty lawyers, physicians, prison personnel, social welfare workers, clinical psychologists and psychiatrists in a mental hospital, child-care workers and psychiatric nurses. Our findings to date show that all of these professional groups (and perhaps others that you can think of in your own experience) tend to cope with stress by a form of distancing that not only hurts themselves but is damaging to all of us as their human clients.

For one thing, the worker's feelings about people often show a shift toward the cynical or negative. According to one social worker, "I began to despise everyone and could not conceal my contempt," while another reports, "I find myself caring less and possessing an extremely negative attitude." In many cases, professionals who have burned out from stress and can no longer cope begin to defend themselves not only by thinking of clients in more derogatory terms but even by believing that the clients somehow deserve any problems they have. As one psychiatric nurse reported to us, "Sometimes you can't help but feel, 'Damn it, they want to be there, and they're fuckers, so let them stay there.' You really put them down. . . ."

There is little doubt that burnout plays a major role in the poor delivery of health and welfare services to people in need of them. They wait longer to receive less attention and less care. It is also a key factor in low worker morale, absenteeism and high job turnover (for a common response to burnout is to quit and get out).

Further, we found that burnout correlates with other damaging indexes of human stress, such as alcoholism, mental illness, marital conflict and suicide. The suicide rate of police officers, for example, is 6½ times higher than that of people in non-law enforcement occupations, and psychiatrists contribute more than their share of numbers to the suicide toll.

If stress cannot be resolved while on the job, then it is often resurrected at home. Sometimes the professional is unaware of the causes and wrongly attributes the increased fighting to something that has gone wrong in the family relationship. As one correctional officer put it, when talking about the pressures of working in prison, "None of my three wives understood."

Burnout varies in severity among different professions and is called by different names (some law enforcement groups refer to this suppression of emotion as the "John Wayne syndrome"), but the same basic phenomenon seems to be occurring across a wide variety of work settings.

In our project, we are uncovering the interpersonal stresses that plague these workers, learning what (if any) preparation they receive to cope and isolating the techniques that they use to "detach" themselves from clients or patients. Also, we seek to identify the human consequences for American society that result from use of such distancing techniques, and we are addressing ourselves to solutions. What can be done to prevent the destructive process of burnout?

The verbal and nonverbal techniques used to achieve detachment were remarkably similar among all the many professional groups we studied. By reducing the worker's emotional involvement, these techniques make a client seem less human, more like an object or a number.

We found that a change in the terms used to describe people was one way of making them appear more objectlike and less human. Some of these terms are derogatory labels ("They're all just animals" or "They come out from under the

Photograph by Don Jim. Illustrated by Keith Batchelder

"The emotional stress triggered by taking responsibility for unpopular or painful decisions can be eluded if a worker often tells clients, 'Those are the rules, and I have to follow them.' "

rocks"). Others are more abstract terms referring to large, undifferentiated units, such as "the poor," "my caseload" or "my docket."

Another way of divorcing one's feelings from some stressful event is to describe things as precisely and scientifically as possible. In several professions, the use of jargon (e.g., "a positive GI series," "reaction formation") typically serves the purpose of distancing the person from a client who is emotionally upsetting in some way.

Patients are often labeled by their immediate medical problem, such as "He's a coronary." While this aspect of the patient is the most important one that a physician should be attending to, the fact that it is often the *only* one means that the patient's complex humanness—his or her accomplishments, hopes and feelings and beliefs—is disregarded or ignored.

A related technique that we discovered involves recasting a volatile situation in more intellectual and less personal terms. For example, in dealing with a mental patient who is being verbally or physically abusive, a psychiatric nurse may try to stand back and look at the patient analytically so as not to get personally upset. "I think that if someone on the outside were to hit me, I would get really angry and hit them back," a nurse told us. "But I don't get angry if a patient hits me, because it's a different situation. The patients who strike out are not really angry at you—they're striking out in fear, or they're so out of it that they don't even know what they're doing. Sometimes a patient is striking out at the devil. So, at the moment, you happen to look like the devil, but it's not you personally that he's striking out at—so I don't get angry at that."

Another way of distancing is to make a sharp distinction between job and personal life. Many professionals whom we studied do not discuss their family or personal affairs with their coworkers, and they often refrain from discussing their experiences on the job with their spouses and friends. "My husband and I have an explicit agreement that neither of us will 'talk shop' at home. I'm in social work, and he's in clinical practice. Neither of us wants to burden the other with more emotion-arousing anecdotes from the day, as we each have had enough of our own to cope with," explained one of our subjects.

Some of the prison personnel even refused to tell people what their job was. In response to questions, they would only say, "I'm a civil servant" or "I work for the state." By leaving their work at the office and not reliving it once again at home, the emotional stress is confined to a smaller part of the professional's life.

One social worker in child welfare stated that if he did not leave his work at the office, he could hardly stand to face his own children. Likewise, when he was at work, he could not think of his family because he would then overempathize with his clients, leading to unbearable emotional stress. As one might expect, he doesn't have the usual family photos on the office desk. Rules forbidding staff to socialize with their patients or clients outside the job setting can help to bring about this clear distinction.

For many psychiatrists, a drawback of going into private practice is that job and private life can merge in disturbing ways. As one of our respondents put it, "Every time you hear your telephone ring at night, you think, 'Oh, no—I hope it's not a patient.' At times it seems as if you can't ever get away from your patients' problems for some peace and quiet for yourself. When I worked at the hospital, there wasn't the same problem because when I went home for the day, another shift came on—and so I could relax in the evenings because I knew that if any of the patients needed help, there was someone else there to provide it."

Another technique for cooling emotion is to minimize physical involvement in a tense encounter. How does it happen? We observed a number of ways. Some people physically distanced themselves from others (by standing farther away, avoiding eye contact or keeping their hand on the doorknob) even while continuing a minimal conversation. Withdrawal was also achieved by communicating with the patient or client in impersonal ways—superficial generalities, stereotyped responses and form letters.

In some cases, professionals simply spend less time with their patient or client, either by deliberately cutting down the length of the formal interview or therapy session, or by spending more of their time talking and socializing with other staff members. Many of the psychiatric staff were able to point to specific patients with whom they limited their interaction. "There was one woman who was very suicidal. She had injured herself in some bizarre ways and had set herself on fire several times on the ward. She was extremely depressed, and I did a lot of work with her. One day I had to spend my entire eight-hour shift with her, and I was so down by the time I left that I knew I had to limit my time with her. I wouldn't spend more than two hours with her because she really got to me after a while," a psychiatric nurse told us. Or, in another case: "There's a 13-year-old schizophrenic boy that I'm working with now who thinks he's a machine, or a 'mutant.' I like him, but he frustrates me tremendously. Sometimes all I can handle is a 30-minute conversation with him because he's very nongiving. Sometimes I deal with the frustration by separating myself from the patient. I won't spend as much time with him; instead, I'll spend more time with other patients whom we're achieving a little more with."

Related to withdrawal is the technique of "going by the book" rather than unique factors of a situation. It's another way of short-circuiting any personal involvement with a client or patient. By applying a formula, the professional can avoid having to think about the nature of the problems. Also, the emotional stress triggered by taking responsibility for unpopular or painful decisions can be eluded if a worker says, "I'm sorry, but it's not my fault—those are the rules around here, and I have to follow them."

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For many of the people whom we observed, social outlets

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proved to be a more gratifying, if ironic, route to detachment. They solicited advice and comfort from other staff members after withdrawing from a difficult situation. Such social support eased the stress and pain, fostered a sense of distance from the situation and tended to neutralize the emotions. Reported one of the professionals, "When we get together, we bitch a lot to each other. We hash things out. We laugh at it sometimes. We talk about it a lot and try new ways. It helps to talk about it, and if you can't see it another way, then somebody else might be able to."

Social support also led to a perception of diffused responsibility among staff members, which helped the individual worker to feel even more remote from troublesome clients. Another social technique was the use of humor. Joking and laughing about a stressful event reduced personal anxiety by making the situation seem less serious, less frightening and less overwhelming. The battlefield surgeons in *M*A*S*H*, who made "sick" jokes and flirted with the nurses while they performed grave operations, are a particularly apt example of this technique at work. As one of our respondents put it, "Sometimes things are so awful and so frustrating that in order to keep from crying, you laugh at a situation that may not even be funny. You laugh but you know in your heart what's really happening. Nevertheless, you do it because your own needs are important—we're all human beings, and we have to be ourselves."

Many of these detachment techniques can be used by professionals either to reduce the amount of personal stress or to cope with it successfully while still maintaining concern for the people they must work with. However, because some forms of these techniques preclude any continued caring, we found that they often degenerated into the total detachment and dehumanization of burnout. In these cases, the worker's attempts at emotional self-protection came at the expense of the client, patient, child, prisoner, etc. The professionals donned such thick armor that nobody could get through.

At the moment, we cannot present a total solution to the problem of burnout. However, our work thus far has pointed to a number of factors that could reduce the harm done by burnout or prevent its occurrence altogether.

Burnout often leads to a deterioration of physical well-being. The professional becomes exhausted, is frequently sick and may be beset by insomnia, ulcers and migraine headaches, as well as more serious illnesses. Some of the prison guards reported physical problems with their back and neck, although only a few seemed to realize the psychosomatic nature of these ailments. "On the way home from my first day on the job," says one guard, "I realized that my neck hurt. The muscles were tight, and that caused me to have a headache. Perspiration was heavier than normal. Later on, I realized that my neck and back would begin to get stiff and sore and painful just before I went to the prison—and it would last until I got home again."

In order to cope with these physical problems, the worker may turn to tranquilizers, drugs or alcohol—"solutions" that have the potential for being abused. Better measures include regular vacations (where one can rest completely and "recharge one's batteries") and physical exercise. In a booklet on burnout, put out by the Drug Abuse Council, Dr. Herbert Freudenberger suggests, "Encourage your staff and yourself to exercise physically. If you want to run, do it. Play tennis, dance, swim, bicycle, exhaust yourself on the drums. Engage in any activity that will make you physically tired. Many times the exhaustion of burnout is an emotional and mental one that will not let you sleep."

Burnout often becomes inevitable when the professional is forced to provide care for too many people. As the ratio increases, the result is higher and higher emotional overload until, like a wire that has too much electricity flowing through it, the worker just burns out and emotionally disconnects. The importance of this ratio for understanding burnout is vividly demonstrated in the research on child-care workers that I recently conducted with Ayala Pines. We studied the staff members of eight child-care centers where staff-to-children ratios ranged from 1 to 4 to as high as 1 to 12.

The staff from the high-ratio centers worked a greater number of hours on the floor in direct contact with the children and had fewer opportunities to take a break from work. They were more approving of supplementary techniques to make children quiet, such as compulsory naps and the use of tranquilizers for hyperactive children. They did not feel that they had much control over what they did on the job, and overall they liked their job much less than did the staff from low-ratio centers.

Social welfare workers said that a high ratio of clients to staff was one of the major factors forcing a dehumanized view of clients. "There are just so many, you cannot afford to sympathize with them all," explained a social worker. "If I only had 50 clients, I might be able to help them individually. But with 300 clients in my caseload, I'm lucky if I can see that they all get their checks."

When staff ratios are low, then the individual staff member has fewer people to worry about and can give more attention to each of them. Also, there is more time to focus on the positive, nonproblem aspects of the person's life, rather than concentrating just on his or her problems. For example, in psychiatric wards with low staff-patient ratios, the nurses were more likely to see their patients in both good times and bad. Even though there were upsetting days, there were also times when the nurses could laugh and joke with the patients, play Ping-Pong or cards with them, talk with their families and so on. In a sense, these nurses had a more complete, more *human*, view of each patient.

Opportunities for withdrawing from a stressful situation are critically important for these professionals. However, the type of withdrawal that is available may spell the difference between burnout and successful coping. The most positive form of withdrawal that we observed is what we have called a "time-out." Time-outs are not merely short breaks from work such as rest periods or coffee breaks. Rather, they are opportunities for the professional to voluntarily choose to do some other, less stressful, work

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while other staff take over client/patient responsibilities. For example, in one of the psychiatric wards we studied, the nurses knew that if they were having a rough day, they could arrange to do something else besides work directly with patients. "There are times on the ward when I know that I'm not as capable of giving that much of myself, so I'll sit in the office and do a lot of paperwork. The way our schedule is, it gives you the opportunity to do that. You can withdraw and choose to attend meetings for a while. Or you can ask to get assigned to medications, so that you spend the entire day in the medicine room. Then, the only time you see patients is when you're calling on them for medicines." In this system, when one nurse took a time-out, the other nurses would cover for her and continue to provide adequate patient care.

In contrast to sanctioned time-outs were the negative withdrawals of "escapes." Here, the professional's decision to take a break from work always came at the expense of clients or patients, since there were no other staff people to take over. If the professional was not there to provide treatment or service, then people in need simply had to wait, come back another day or give up. The professionals were more likely to feel trapped by their total responsibility for these people; so they couldn't temporarily withdraw without feeling some guilt. When guilt was heaped upon the already heavy emotional burden they tenuously carried, the load often became too much to bear.

The use of sanctioned time-outs versus guilt-arousing escapes seemed to be primarily determined by the structure of the work setting. Time-outs were possible in well-staffed agencies that had shared work responsibilities, flexible work policies and, most importantly, a variety of job tasks for each professional, rather than just a single one. When institutional policies prevented the use of voluntary time-outs, we found lower staff morale, greater emotional stress and the inevitable consequence of more dissatisfied citizens, frustrated at not getting the care they needed.

The number of hours that a person works at a job is very likely to be related to that person's sense of fatigue, boredom, stress, etc. So one might suspect that longer working hours would lead to a higher burnout rate. However, our data reveal a somewhat different pattern of behavior. Longer work hours are correlated with more stress and negative staff attitudes only when they involve continuous direct contact with patients or clients.

Our study of child-care centers provides a good illustration of this point. Longer working hours were related to signs of burnout when the longer hours involved more work on the floor with children. When the longer hours involved administrative, non-child-related work, burnout was less likely to occur. Basically, staff members who worked longer hours with children developed more negative attitudes toward these children. They were more approving of institutional restraints on the children's behavior, and when they were not at work, they wanted to get as far away as possible from children and child-related activities. Staffers who worked just as many hours but spent a smaller proportion of time in direct contact with children did not develop such negative attitudes toward young people. Instead, they felt positively about them and about the child-care center in general. Perhaps the quality of caring, if not mercy, may have to be time-shared.

In many of the institutions we studied, there was a clear split in job responsibilities—either the professionals worked directly with clients or patients, or they worked in administration. As an example, most of the child-care workers spent all their time on the floor with the children, while the directors only had a few (if any) hours with the children and spent the rest of their time in administrative work and meetings. Burnout was more likely to occur for the workers. Often, they would then escape into administrative work.

We were initially surprised to discover how many social workers were returning to school to get advanced training for this kind of higher level, "nonclient" work (and we found it bitterly ironic that clients should be such outcasts in a profession that would not exist without them). As one social worker said, "We can all point to people who have burned out—who are cold, unsympathetic, callous and detached. And each of us knows that we have the potential to fit that role as well, if we haven't already. And that's why we're going back to school to become administrators or teachers or whatever—so that our client contact will be limited, and we won't be forced to become callous in order to stay sane."

Our findings on the effect of prolonged direct contact suggest some job changes that would modify the amount of such direct contact. Possible work alternatives include shorter work shifts, greater opportunities for time-outs, or jobs that involve varied work responsibilities so that an individual staff person is not constantly required to be working directly with other people.

The availability of formal or informal programs in which professionals can get together to discuss problems and get advice and support is another way of helping them to cope with job stress more successfully. Contrary to the beliefs of some skeptics (one physician stated that such a system would only provide the nurses with another opportunity to chit-chat rather than work), such support groups serve a very valuable function for their professional members. Burnout rates seem to be lower for those professionals who have access to such a system, especially if they are well-developed and supported by the larger agency.

Some of the psychiatrists reported being part of a social-professional support group when they were doing their residency. They would meet regularly to discuss problems that they were having in treating their patients, to vent frustrations or to report their successes. After leaving the hospital and entering private practice, some of these psychiatrists found that the lack of such a group was a serious, unanticipated loss to them. "I felt cut off, isolated—I didn't feel I had people whom I could turn to when problems arose, and whose opinions I could trust," one therapist told us. Some psychiatrists even made efforts to rejoin the hospital meetings of the residents, although not always successfully.

Since health and social service workers often experience

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strong emotional reactions, efforts must be made to constructively deal with these feelings and prevent them from being extinguished, as in burnout. We were surprised to find that many of our subjects did not know that other people were experiencing the same feelings they were; each of them thought their personal reaction was unique. And it was easy to keep this illusion, because they rarely shared feelings with colleagues. In many cases, workers felt that something was wrong with them—they were "bad persons" to have such feelings—and several had sought psychiatric help to deal with what they thought was personal failing.

Even though many of these professionals keep their feelings to themselves, it is painfully clear that they have a strong need to talk to someone about them. Throughout our work, we have been struck by the outpouring of emotional responses to our research from health and social service professionals. They are extremely eager to talk with us about the problems of detached concern and burnout. In fact, we often receive calls from other professional people who have heard about our research. For example, while we were collecting information from the staff of the psychiatric ward at a county hospital, several of the nurses from the alcoholism treatment ward contacted us and asked to be interviewed as well. All too often, their reason for volunteering for the research was "I know that I have burned out—but I want to understand why."

Our findings show that burnout rates are lower for those professionals who actively express, analyze and share their personal feelings with their colleagues. Not only do they consciously get things off their chest, but they have an opportunity to receive constructive feedback from other people and to develop new perspectives and understanding of their relationship with their patients/clients. This process is greatly enhanced if the institution sets up some social outlets such as support groups, special staff meetings or workshops. In general, we found that those professionals who are trained to treat psychological problems were better able to recognize and deal with their own feeings.

In contrast, prison guards who experienced great fear were constrained from expressing, or even acknowledging, it by an institutional macho code, one consequence of which was the channeling of this emotion into psychosomatic illnesses. According to one former prison guard, "Male identity is a killing factor within the all-male prison society. Concern of any kind is all too often translated as weakness. All new correctional officers must learn to control their emotions, especially the incredible fear. Each of us reacted to the fear in his own way, but we had no way to release tensions."

It seems clear from the research findings to date that health and social service professionals need to have special training and preparation for working closely with other people. While they are well trained in certain healing and service skills, they are often not well equipped to handle repeated, intense, emotional interactions with people. As one poverty lawyer put it, "I was trained in law, but not in how to work with the people who would be my clients. And it was that difficulty in dealing with people and their personal problems, hour after hour, that became the problem for me, not the legal matters per se."

In recommending that these professionals receive training in interpersonal skills, I do *not* mean to suggest that somehow these people are antisocial types who are personally unable to relate to other people. Rather, I believe that their occupations require them to operate in situations of unique stress, for which their previous life experiences have not adequately prepared them. Any of us, facing such a stressful set of circumstances, would probably burn out fairly quickly, but we expect these professionals not to do so. Such an expectation, however, is unwarranted unless they have careful training.

Such training should focus on the personal stress involved in the work—what its sources are, what the constructive and ineffective techniques for dealing with it are, what the possible changes in attitudes and emotions are (and why they occur). In other words, professionals need to be made aware of the importance and relevance of their psychological state to their work with other people.

In addition, it is important that they understand their own motivations for entering their particular career and recognize the expectations they have for their work. As Freudenberger points out in his booklet, staff members can be on a variety of "trips": a self-fulfilling ego trip; a self-aggrandizement ego trip; a self-sacrificing, dedication-to-others ego trip; or a trip to deny their own personal problems.

Although many of our subjects stated that they wished they had had prior preparation in interpersonal skills, some reported that there was no time for it in their already packed curriculum. Others felt that such preparation was just "icing on the cake" and not an essential part of professional training. The view of several physicians was that the competent practice of medicine was all that they need to know to be successful in their career, and that any psychological training simply amounted to knowing how to make "small talk" with their patients. Such a skill was viewed as pleasant but unimportant. In my opinion, this viewpoint is sadly in error, for it trivializes an essential aspect of the doctor-patient relationship and fails to recognize that both the doctor and the patient are human beings whose personal attitudes and emotions can affect not only the delivery of health care, but also how and even whether it is accepted.

Is burnout inevitable? Some professionals seem to think so and assume that it is only a matter of time before they will burn out and have to change their job. The period of time most often cited in one psychiatric ward was 1½ years, in free clinics it was usually one year and some poverty lawyers spoke of a reduction of the former four-year stint down to two. I would like to think that burnout is *not* inevitable and that steps can be taken to reduce and modify its occurrence. My feeling is that many of the causes of burnout are located not in permanent traits of the people involved, but in certain specific social and situational factors that can be influenced in ways suggested by our research. **IB**