Social capital and burnout among mental healthcare providers

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Abstract:

Background: Provider burnout is a critical problem in mental health services. Contributing factors have been explicated across three domains: personal, job, and organizational characteristics. Of these, organizational characteristics, including workplace environment, appear to be particularly important given that most interventions addressing burnout via the other domains (e.g., bolstering personal coping skills) have been modestly effective at best.

Aims: This study builds on previous research by using social capital as a framework for the experience of work social milieu, and aims to provide a richer understanding of how workplace social environment might impact burnout and help create more effective ways to reduce burnout.

Method: Providers (n=40) taking part in a larger burnout intervention study were randomly selected to take part in interviews regarding their workplace environment and burnout. Participant responses were analyzed thematically.

Results: Workplace social milieu revolved around two primary themes: workplace social capital in provider burnout; and the protective qualities of social capital in cohesive work teams that appear to mitigate burnout.

Conclusions: These results imply that work environments where managers support collaboration and social interaction amongst work teams may reduce burnout.

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Introduction

Healthcare provider burnout remains a major public health issue with profound personal, patient care, and organizational implications. Burnout among employees is characterized by three components: emotional exhaustion (e.g., a sense of being overwhelmed by workplace demands), depersonalization (e.g., developing cynical attitudes towards the work they do or the clients they serve), and diminished personal accomplishment (e.g., feeling as though their work is not making a difference) (Maslach & Jackson, 1984). Burnout is highly prevalent among mental health providers. Up to 67% of mental health providers are estimated to experience high levels of burnout (Rohland, 2000; Morse et al., 2012). This rate ranks among the highest compared to other health specialties, such as palliative care clinicians that report a 62% rate of burnout (Shanafelt et al., 2015; Kavalieratos et al., 2017; Westwood, et al., 2017). Burnout has also been associated with physical and mental health problems in providers (Halbesleben, et al., 2008; Peterson et al., 2008; Acker, 2010; Pompili et al., 2010; Fridner et al., 2011; Welp, Meier, & Manser, 2014).

In community mental health settings, burnout is a key driver of organizational costs related to provider turnover, absenteeism, recruitment and training of new staff (Schaufeli, et al, 2009; Rollins, et al., 2010). Mental health organizations face severe staff and financial shortages

that pose additional strains to their employees, such as excessive workload and job instability (Waldman, et al., 2004; Honberg, et al., 2011). Moreover, research has linked health providers' burnout to poor quality of care, negative feelings about patients, and low expectations of patients' recovery (Garman, Corrigan, & Morris, 2002; Holmqvist & Jeanneau, 2006; Salyers, Brennan, & Kean, 2013; Salyers et al., 2016). Therefore, burnout is a critical issue in mental healthcare delivery because it threatens the sustainability of the mental health service workforce and negatively affects the mental healthcare of patients (Boyer & Bond, 1999; Priebe, et al., 2005; Lasalvia & Tansella, 2011).

Several risk factors have been identified for provider burnout, including job stress, personal characteristics, and organizational factors (Maslach, Schaufeli, & Leiter, 2001). Among organizational factors, work environment is increasingly recognized as a driver of burnout (Gershon et al., 2007; Bettinardi, et al., 2008; Glisson & Green, 2011). A cross-sectional study showed that high workload, perceived low levels of empowerment and efficacy, and poor communication among team members were related to high levels of burnout (Galletta et al., 2016). Another study investigating nurses' work environment reported that a poor practice environment was the leading cause of job burnout and a critical feature affecting job retention and intent to leave (Nantsupawat et al., 2016). While these studies have shown the importance of work environment in relation to burnout, they are restricted to quantitative analyses, limiting an in-depth understanding of how the dynamics of work environment may impact burnout.

Social capital is an aspect of work environment that is rooted in social relationships (Eliacin, 2013; Putnam, 2000; Kawachi & Berkman, 2000), and includes a number of social dimensions, such as social interactions among constituents, cohesion among members of a workgroup, and social resources that members rely on to shape their behaviors, values in the

workplace, and responses to stressful circumstances or work duties. Hofmeyer and Marck (2008) added a useful ecological framework for social capital in healthcare settings that depicts several dimensions of the construct: the formation of groups and networks who interact with one another, trust and solidarity among group members, a sense of cooperative action, information and communication, and social cohesion.

Emerging research suggests that social capital may be important for understanding burnout in clinical settings (Read & Laschinger, 2015; Stromgren, et al., 2016; Van Bogaert et al., 2017). The presence of social capital among employees has been linked with positive organizational outcomes (Ernstmann et al., 2009; Hammer et al., 2013). For instance, one study showed that nurses with low social capital experienced high burnout, especially high levels of emotional exhaustion (Farahbod et al., 2015). Another study showed employees working in units with low social capital, compared to those in units with high social capital, experienced higher health impairments (Oksanen et al., 2008). Moreover, clinicians who complained about low levels of social capital in their organizations were twice as likely to report feeling emotionally drained (Driller, et al., 2011). Aspects of social capital such as social cohesion and social interactions among clinicians foster greater job satisfaction and the adoption of evidence-based medicine (Ommen et al., 2009; Mascia, et al., 2011; Stromgren et al., 2016).

Our goal with this study was to identify ways in which the experience of social capital interacts with the experience of burnout and other aspects of the workplace context, ultimately informing organizational intervention strategies to reduce burnout. For example, areas of strength or vulnerability demonstrated by these interactions might provide targets for prevention or intervention of staff burnout. Moreover, considering the collaborative nature of mental health service delivery, social capital may be valuable in understanding the social contexts of mental

health providers work environment and how they affect employee burnout. Toward this end, we examined narratives of mental health providers about their experiences of burnout - - and how they relate to perceived work social capital.

Methods

Participants and Settings

Qualitative data were collected from May 2012 to April 2014, as part of a randomized controlled trial assessing a burnout intervention for mental health providers at three Department of Veteran Affairs (VA) medical centers and two nonprofit social service agencies in three Midwestern cities (Rollins et al., 2016).. A total of 145 providers, delivering a range of behavioral health, substance use, and psychiatric rehabilitation services took part in the intervention trial; of these, 40 participants (27 VA and 13 Social Services providers) were randomly selected via stratification across sites and intervention vs. control groups to participate in a one-time interview. One VA medical Center from the parent study was excluded from interviews due to timing of this element of the study protocol (i.e., they were still completing assessments for the parent study).

Study procedures

Participants provided written informed consent prior to being interviewed. The semi-structured interviews lasted approximately 30 minutes and consisted of open-ended questions formulated to facilitate participants' descriptions of their own experiences while exploring in-depth issues related to burnout at local, organizational, and system levels. While the interview guide (See Appendix A) focused broadly on burnout in the organizational context, this manuscript is based on themes that emerged from the data related to work environment and social contexts. All interviews were audio-recorded, transcribed, de-identified, and imported into Atlas.ti, (Altas,

2010), to facilitate analysis. Research procedures were approved by the University affiliate's institutional review board and our local medical center research and development committee.

Data Analysis

We conducted data analysis using an emergent thematic analysis approach over two distinct phases (Patton, 1990; Braun & Clarke, 2006). In the first phase, the research team independently read sets of transcripts to identify emergent themes and gain a general understanding of the data. We conducted open coding by dividing portions of the text into meaningful units of analysis or codes and common themes that emerged across the transcripts (Miles, Huberman, & Saldana, 2014). Themes emerged as dominant issues based on frequency, pervasiveness, and the intensity with which participants discussed them.

We then used an iterative, consensus-building process that involved systematic review, coding, and analysis of 12 transcripts (30% of the data) to finalize the coding scheme. Coding discrepancies were discussed to emphasize the content of disagreements, and were resolved through in-person consensus discussions. In the second phase of data analysis, we coded all transcripts using the final coding scheme. The team then generated sub-themes, made connections between themes, and linked them to broad content areas.

Results

Participants described a dynamic and complementary relationship between social capital and burnout in which burnout undermines employees' social capital and in turn, the absence of social capital, namely lack of social cohesion, resources, and social relationships at work contributes to burnout. In contrast, high levels of social capital buffers risks of burnout. In what follows, we depict participants' discussions of the relationship between job burnout and social capital, particularly how job burnout undermines opportunities for developing social capital. In

their discussions, participants emphasized how aspects of organizational contexts, such as demands for productivity, contributed to burnout, and ultimately reduced social capital. To further illustrate, participants described social isolation at work as a manifestation of extremely low social capital as well as a contributor to job burnout. Participants also discussed the interplay of work environment and social capital; specifically, how workplace social structures and policies contributed to burnout and low social capital. Lastly, we examined how social capital may buffer risks of job burnout.

Organizational contexts contribute to burnout, which undermines social capital

As demonstrated in the following quote, several participants' responses indicated that work productivity demands, which they link to risks of burnout, directly reduce social capital and promote isolation:

> Everybody was worried about productivity … you can't rely on your co-workers as much because everybody is for their own. I work for two teams. I can be sitting back in my office and not talk to another teammate in a whole week… When they come to talk, I want to do my work. I do not want to talk. That's the culture now.

Participants explained how increased productivity demands, particularly if they are exacerbated by fear of possible punitive actions upon failure of meeting standards, limited providers' opportunities to interact with coworkers. Participants noted that due to increasing productivity expectations, they spent less time problem solving and collaborating with co-workers, key behaviors that are often needed in mental health settings where providers often face challenging and emotionally taxing clinical situations. They also noted that the pressure to meet productivity expectations undermined organizational practices that could buffer risks of burnout, such as team consultation or huddles (i.e., brief brainstorming sessions to facilitate team

collaboration). Instead of being useful to providers, participants viewed professional interactions with co-workers as burdensome tasks that encroached on valuable time needed to meet productivity expectations.

While participants discussed the need to protect time to meet individual productivity goals, they also lamented how these actions negatively impact interactions with co-workers. When participants felt burned out, they became less generous with their time and limited professional and social interactions with peers. Participants added that burnout decreased empathy towards co-workers and clients. For example, one participant described her interactions with co-workers as follows: "*when you're burned out, sometimes your frontal lobe stops working and stuff comes out*." In her narrative, she further elaborated that she became irritable and impatient with co-workers. Another participant explained that burnout affects her relationships with clients: "*I just feel like I'm under so much pressure that I can't offer the empathy [to clients] that I feel like I'm supposed to*." The next excerpt further illustrates:

> [Burnout], I think it affects my relationship with my co-workers because I've had times where I've been snippy when I'm like that. If they come in and ask me a question, I'll answer probably short with them.

Moreover, participants noted, as shown in the next quote, that burnout reduced the quality of their social environment, and created an unfriendly and isolating atmosphere:

> People are just walking right by you, trying to hurry and get their stuff done because they know they're being scrutinized. It becomes an unfriendly place to be.

Discussions of social isolation at work were also salient for providers who spend time out of the office or who work alone. For most participants, being part of an active team buffered

stress. Working in isolation from other co-workers deprives employees of valuable social capital – opportunities to interact with co-workers and develop social resources. One participant emphasized this point dramatically, explaining how the restructuring of his organization to no longer being part of a team contributed to his isolation: "*you are the only man on the boat and you are going down really fast.*"

For some participants, social isolation was a key characteristic of their work environment despite being part of a multidisciplinary team. They noted how features of their jobs such as high productivity demands, their organizations' shared values about co-workers' socialization, and even their work's physical environment contribute to an isolating social milieu. One participant captured this theme in the following quote: "*We all have our doors closed. It is like a funeral parlor here, the morgue. You might see somebody in passing when they are taking a patient down.*" Other providers were also poignant in their narratives as they discussed their sense of social isolation and its impact. As illustrated in the following quote, the isolating effect of burnout extends beyond the workplace to affect personal lives.

> Outside [work], I am really isolated. I had a friend probably not even six weeks ago call me on that and said, what's going on? You have been in a shell for a long time. [I am] so very isolated. I just want to shut everything off when I get home.

Workplace structures and policies contribute to burnout and low social capital

Work procedures that curtail providers' time for recreation, self-care, and training also diminish social capital. Participants talked about the loss of the one-hour lunch and explained that with a half-hour lunch break, they are less likely to socialize with co-workers and engage in

self-care activities such as taking a walk outside. The impact of a shorter lunch is described in the following quote:

> When we had the hour lunch, a lot of us would sit in the break room. It would be nice to chat with each other or have a laugh. Now, if I go in there [lunch room] sometimes, there's nobody there. I'm not socializing as much as I used to.

They also noted that due to budgetary restrictions, they no longer host social events such as holiday parties, and annual retreats that offered employees opportunities to get to know each other, develop collaborations and trust.

Participants discussed that budget cuts and restrictive organizational travel policies further restrict the ability to network with others. Professional and training opportunities not only facilitate social interactions, but also provide employees valuable social resources and foster work engagement. For VA participants, trainings were unique opportunities to connect with colleagues at a national level and increase competency and professional efficacy, one component of burnout. To illustrate, one participant endorsed professional trainings, but also noted that administrative and financial barriers may limit participation in training opportunities:

> I've been very impressed with the formatting of the roll outs that the VA has done. Not only you get training, but you get consultation and resources as you're continuing to provide the protocols. I think that keeps people fresh … and it's fun. . . . administratively, they need to support that we are professionals in a field that isn't static. …at a national level, they understood the value of training …. I don't know that the bonuses and the financial incentives are always there at the local level to support that. But I think that's important.

Social capital buffers risk of job burnout

Participants talked at length about the benefits of having a positive work environment and high levels of workplace social capital. They identified supportive co-workers as their most critical resource at work, and emphasized the protective features of strong social ties with co-workers as well as the importance of organizational support for social activities. Supportive co-workers and supervisors help solve problems and manage negative emotions, sometimes by brainstorming on difficult cases or using humor to connect and cope with burnout. A sense of camaraderie with co-workers also makes it easier to collaborate and reach out for support when needed.

Moreover, for many participants, social capital, expressed even as brief social interactions with peers, alleviate stress and reduce their risks of burnout. Several described social interactions as energizing and a key factor in keeping employees engaged and productive. This belief is described in the following quote:

> Our team is pretty close so that really helps burnout when I can just vent about either a client issue or administrative or family issues. I can go to them and vent for ten, fifteen minutes, feel better, and then get back concentrating to what I was doing.

Participants also emphasized the importance for direct supervisors, team leaders, as well as higher level administrators to set the tone for a supportive social milieu and to create organizational policies and procedures that foster social capital. Several participants noted that their supervisors' open door policy and active engagement with employees facilitated social capital, even amidst organizational turmoil. As illustrated in the following quote, one participant

noted that despite high turnovers in their team, a situation that is often associated with burnout, team spirit remained high due to the social relationships and open door policy amongst co-workers and supervisors:

> The team I work with, there's a lot of turnover. But the people who are here, we're really good at talking with each other. I don't see a lot of my team members very often. But I feel like I can stop and chat with them if I need to. . . My boss has an open door policy. Our Associate Director's good at staying involved. . ..A lot of the people that I work with are also friends with each other outside of work, which is good.

Discussion

In this study, we examined how the social context of mental health providers' work environments influence the experience of burnout. Mental healthcare providers rely on a cohesive and collaborative work environment to effectively serve clients. Yet, our findings reveal that for many participants, social contexts at work undermine social capital and contribute to burnout. Moreover, these relationships appear reciprocal.

Study participants acknowledged social capital as a critical resource at work. They linked social capital – having strong social ties with coworkers and a work environment that values and fosters social connections – to reduced risks of burnout. However, organizational practices, such as productivity demands, and individual behaviors undermine social capital. For example, organizational activities that foster social interactions become ineffectual as unrealistic productivity demands negatively affect the quality of social interactions among co-workers as well as overall workplace social milieu. Our findings suggest that efforts to foster workplace social capital and reduce risks to burnout should involve providers' individual actions as well as

organization-sponsored activities. While it is up to staff to reach out and engage each other, organizations also need to support connections between staff, particularly ongoing management support in face of high productivity demands and stressful work.

As noted earlier, few studies have examined the role of social capital in job burnout. Although limited, existing research studies, albeit in non-mental healthcare settings, have reported similar conclusions. These studies show that low levels of social capital contribute to burnout among healthcare providers, and may also adversely impact quality of care for patient, whereas high levels of social capital contribute to positive work environment and increased employee satisfaction and engagement (Read & Laschinger, 2015; Stromgren, et al., 2016; Van Bogaert et al., 2017; Farahbod, et al., 2015; Driller, et al., 201; Mascia, et al., 2011; Stromgren et al., 2016). Furthermore, a recent study conducted in 15 healthcare settings demonstrates the mediating role of social capital between job performance and organizational citizenship behavior or employee engagement (Basu, Pradham, and Tewari, 2017). The authors conclude that organizations should leverage and facilitate social capital to increase employee performance. They also assert that social capital, including social network building, may serve as an asset to organizations and create a competitive advantage for attracting and retaining employees.

In addition to these studies, Hofmeyer and Marck's (2008) ecological framework for social capital in modern healthcare systems provides a useful roadmap on how healthcare leaders in mental health settings may help foster social capital. They identified five dimensions of social capital that leaders can use to assess and strengthen social capital: 1) develop groups and networks; 2) trust and solidarity; 3) collective action and cooperation; 4) information and communication; and 5) social cohesion and inclusion. Likewise, our findings coincide with these dimensions for building social capital among mental health care providers.

First, Hofmeyer and Marck (2008) noted that organizations can help develop *groups and networks* among employees, which could facilitate exchange of information. In so doing, organizations and managers establish a positive work social milieu and foster relationships. Our findings indicate that organization-sponsored activities such as social events, conferences, and training opportunities foster social capital. *Trust and solidarity* among providers allows staff to rely on their colleagues, which is a fundamental building block for developing confidence in relationships, calculated risk-taking, and organizational resilience. As our study participants indicate, when providers know their peers at a personal level and spend time socializing together, they are more likely to turn to their peers for advice and support when they are stressed, and to brainstorm strategies that could improve patient care. In addition to individual peer support, group clinical supervision models where teams are encouraged to problem-solve difficult clinical cases together might also improve the quality of care while decreasing social isolation amongst team members (Rapp, Goscha, & Fukui, 2015). Social and emotional support from clinical supervision has also been associated with lower levels of burnout and reduced intention to turnover (Barak, 2009).

Relatedly, *collective action and cooperation* addresses how providers work together and respond to crises. This dimension is salient for mental health providers who work in volatile situations, with constant policy changes, chronic understaffing, and frequent personal crises amongst clients. Our findings demonstrate how work environments that foster a cohesive team of coworkers and a supportive supervisor, can help mitigate work demands and facilitate problem-solving, even under duress. Organizations can foster greater social cohesion by facilitating periodic small events like team retreats or informal lunches. Coworkers might be encouraged to

get to know one another to foster a sense of closeness that can serve as social capital during times of work stress.

Building clear *information and communication* channels facilitates workplace social capital by encouraging access to communication necessary for staff to work effectively. This dimension builds on the others as team trust facilitates communication. Finally, *social cohesion and inclusion* are critical to build social bonds. Organizations could promote social capital through the implementation of policies or activities that allow workers to forge social relationships. They could also help develop strategies to foster social cohesion, inclusion, and collaboration in work settings. Our findings suggest that while substantive changes to productivity standards may be perceived as prohibitive without increases in external funding of mental health services, organizations do set the tone for how these policies are conveyed and rationalized to staff. Open and shared communication across an organization can relay the sense that the managers and employees are "in this together" to serve the population with both high value, person-centered care and remain a viable healthcare business entity. By focusing on these aspects of social capital at different levels or units, managers and leaders can help create activities such as regular unit celebrations, events, or professional development activities that encourage cohesion, inclusion, the adoption of shared values, and a sense of community.

One limitation of this study is that it was conducted with staff from a limited number of organizations. While the organizations were diverse and all themes discussed were identified across the different settings, the organizations do not represent all mental healthcare settings and organizational contexts, diminishing generalizability. Nevertheless, our study produces valuable insights into the experiences of mental healthcare providers and shows how work environment may affect social capital and burnout. Our findings suggest several implications for practice.

Although limited, most burnout interventions focus on the individual, such as provider's ability to cope with burnout (Rollins et al., 2016; Salyers et al., 2011). However, growing evidence is pointing to the important role of organizations in reducing burnout (West, Dyrbye, Erwin, and Shanafelt, 2016; Panagioti et al., 2017). Our study contributes to this effort by providing providers' perspectives on how organizational social contexts interact with burnout, thus identifying concrete steps for future interventions.

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