2019

"I should have known". The perceptual barriers faced by mental health practitioners in recognizing and responding to their own burnout symptoms

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This article was originally published as:
Ledingham, M., Standen, P., Skinner, C., & Busch, R. (2019). "I should have known". The perceptual barriers faced by mental health practitioners in recognizing and responding to their own burnout symptoms. *Asia Pacific Journal of Counselling and Psychotherapy, 10* (2), 125-145.

Original article available here:
https://www.tandfonline.com/doi/full/10.1080/21507686.2019.1634600

Ledingham, M.D., Standen, P., Skinner, C., and Busch, R. (2019). "I should have known". The perceptual barriers faced by mental health practitioners in recognizing and responding to their own burnout symptoms. *Asia Pacific Journal of Counselling and Psychotherapy, 10*(2), 125-145. doi: 10.1080/21507686.2019.1634600

‘I should have known’. The perceptual barriers faced by mental health practitioners in recognising and responding to their own burnout symptoms.

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Abstract

Many studies have shown burnout to be a significant problem in the mental health field, causing workers to experience serious health problems and reducing the quality of care provided to clients. Yet despite mental health practitioners’ training in supporting others’ emotional health, they may be reluctant to seek help for burnout symptoms. This paper addresses this paradox by showing how human cognitive processes could act as powerful blocks to the recognition of and response to burnout. Fifty-five mental health practitioners’ beliefs and perceptions about burnout were examined using qualitative interview and survey data interpreted through a phenomenological perspective on attribution theory. The study identified four specific perceptual biases: self-blame, optimism bias, dichotomous thinking and overestimation of competence. A practitioner’s professional identity and degree of stress-induced cognitive deficit also appeared to influence the recognition and response to burnout. Implications for practitioners, supervisors, managers and educators are discussed.

Keywords: Burnout, help-seeking, mental health, role identity, attribution theory

Introduction

Burnout has long been considered a significant hazard in the mental health workforce around the world (Kumar et al., 2011; Morse et al., 2012; Schaufeli et al., 2009), and is one of the key challenges facing counsellors and psychotherapists (Lee, Lim, Yang & Lee, 2011). Commonly described as a collection of long-term changes in a practitioner as a result of chronic job demands and stress, burnout symptoms include emotional depletion, increased cynicism and a reduced sense of competence (Maslach et al., 2001). Research now links a wide range of serious health issues to burnout, including

obesity, clinical depression, impaired immunity and cardiovascular disorders (Bianchi, 2013; Melamed et al., 2006; Nevanperä et al., 2012). Amongst mental health practitioners such as counsellors, psychotherapists and psychologists, burnout is also associated with reduced quality of care, negative attitudes towards mental health consumers (Holmqvist & Jeanneau, 2006; Salyers et al., 2015; White et al., 2015) and costs to the employer including absence, turnover and low morale (Bingley & Westergaard-Nielsen, 2004; Du Plooy & Roodt, 2010).

However, despite decades of research (see Morse et al., 2012) and considerable knowledge of it amongst counsellors, psychotherapists and psychologists, burnout remains widespread (Green et al., 2014; Morse et al., 2012; Volpe, et al., 2014). This paper examines this paradox through the lens of attribution theory, showing how mental health practitioners' perceptions and beliefs about burnout can cause them to ignore symptoms and continue working until the health consequences become too severe for them to continue. The study aimed to explore how mental health practitioners perceive their vulnerability to burnout, and the causes and personal consequences of developing the condition.

Much research has examined the causes of burnout in mental health workplaces (Lee et al., 2011; Lent & Schwartz, 2012; Steel et al., 2015), typically focusing on either stressors in the work environment or practitioners' responses. Environmental stressors include working hours, available resources, organisational cultures, autonomy and the need to deal with difficult clients (Ben-Porat & Itzhaky, 2015; Lee et al., 2011; Maslach & Leiter, 2008). Studies have examined the use of self-care practices and the role of self-awareness and self-regulation in creating work-life balance (Baker, 2003; Barnett et al., 2007; Irving & Dobkin, 2009; Lee et al., 2011; Orlinsky & Rønnestad, 2005; Wardley et al., 2016). Environmental influences have received the greater attention, but the perceptual processes practitioners use when perceiving external stressors, their own vulnerability or their options for responding are likely to be critical in determining their responses. According to Merleau-Ponty (2012), perceptions involve the sense-making of experiences or our engagement with the world. Perception cannot be easily separated from sense-making as our perceived world, no matter how 'complete' or 'truthful' we think it is, is always affected by our invested meanings and values.

Perceptions constantly develop and evolve through our contexts in order to make sense of our world (Toadvine, 2018).

The observation that some individuals respond better to stressors than others has led to research on psychological resilience in the face of workplace stress (Rees et al., 2015), but so far very little research has examined the role of perceptual processes in this. The consideration of practitioners' perceptual processes does not imply that burnout is 'caused' by personal factors, a view now largely rejected (e.g., Schaufeli et al., 2009). Rather we recognise that practitioners make choices about whether to attend or respond to information, often using perceptual processes for simplifying the complex information received from external or internal stimuli. In this paper we use the lens of Attribution Theory to identify cognitive biases or distorted beliefs that discourage acknowledging or responding to burnout symptoms.

Although recommendations for preventing burnout in counsellors and psychotherapists have often focused on self-care practices (e.g., Barnett et al., 2007; Pines & Maslach, 1978; Schwebel & Coster, 1998), it appears self-care is not often used (Barnett & Hillard, 2001; Leiter et al., 2009). Nor are broader interventions like employee assistance programs that offer individual counselling (Barnett & Hillard, 2001). Paradoxically, it seems practitioners avoid seeking the help they offer to others (Putnik et al., 2011). The common assumption that burnout can be prevented by making practitioners, managers, educators or professional associations aware of the need for self-care is therefore called into question (Johnson, Barnett, Elman, Forrest, & Kaslow, 2012): interventions must also take into account how practitioners' perceive stressors, their internal state and the consequences of different responses.

It is important to emphasise that understanding individual differences in the perception of burnout does not involve shifting the responsibility for healthy work conditions away from organisations and regulators, thus creating a 'blame the victim' mentality, as widely documented in organisations (Hu et al., 2012; Lyall, 1989; Maslach & Goldberg, 1998; Putnik, de Jong, & Verdonk, 2011; Schulze & Roessler, 2007; Siebert & Siebert, 2007). Instead, we suggest the paradox of burnout

amongst mental health practitioners requires a more sophisticated understanding of their perceptual processes. Although attribution theory has not been utilised in the area of burnout research, we draw upon this theory as a framework to help explain the conundrum of burnout in mental health practitioners.

Literature Review

Attribution Theory

Attribution Theory derives from Fritz Heider's seminal study of 'naïve psychology', exploring a fundamental human tendency to interpret the social environment by attributing causes of social events to characteristics of individuals in ways that go beyond the sensory clues provided (Heider, 1944, 1958; Jones & Davis 1965; Kelley, 1972). Attribution is necessary because the empirical clues to the motivations of others often form a fragmentary, conflicted or unfathomable picture. While attributions may be rationally logical or correct at times, a large body of evidence from Heider (1958) shows that they are often oversimplifications, distortions or imagined interpretations rather than objective perceptions of reality. Such perceptual errors are made by people of all levels of social and emotional intelligence (Block & Funder, 1986). Attribution Theory is underutilised in organisational research (Martinko et al., 2011), but has particular relevance to burnout as it predicts that individuals may emphasise internal or external influences. For example, perceiving symptoms of stress as a sign of personal 'weakness' rather than an outcome of environmental causes, coupled with a belief in one's own invincibility, can justify ignoring one's symptoms.

Attribution Theory thus explains how individuals make sense of events in their lives, often with faulty logic. This study focuses on how biases in *self*-perception underpin dysfunctional responses to work stressors. Four specific biases are identified from the literature: self-blame, optimism bias, dichotomous thinking and overestimation of competence. A worker's professional identity and degree of stress-induced cognitive deficit are also hypothesised as key influences on such defensive thinking.

Self-Blame

The tendency to use self-blame in explaining one's misfortunes has been reported in other fields. For example, persons affected by serious illness or crime may ask 'why did this happen to me?' and find an answer in personal faults when the causes are actually beyond their control (Bulman & Wortman, 1977; Shaver & Drown, 1986). Self-blame has been described as a coping strategy in the face of stress because it facilitates meaning-making after an unfortunate event (Park, 2010). However, much evidence suggests self-blame leads to poorer adjustment after traumatic events or illness, since it lowers a person's self-esteem and sense of agency. This leads them to avoid seeking help from others (Anderson et al. 1994; Collie et al., 2011; Corrigan & Watson, 2002).

Self-blame can take two forms. Behavioural blame involves attributing one's misfortune to past behaviour, falsely implying that the problem can be eliminated by changing future behaviour, whereas characterological blame involves one's personality, for example seeing oneself as a 'weak' person (Janoff-Bulman, 1979). Behavioural self-blame could involve a mental health professional blaming their own lack of professional self-care for their burnout symptoms, ignoring issues such as unsustainable workloads and thus reducing help-seeking.

Studies of mental health clients have identified a tendency towards seeing people suffering mental health disorders as weak and unable to care for themselves, a 'self-stigmatising' belief that produces behavioural consequences such as failing to look for a job or neglecting self-care (Corrigan et al., 2015; Corrigan & Watson, 2002; Oliveira et al., 2016). While mental health practitioners are generally thought not to share such attitudes, some authors have identified mental health stigma (Crowe & Averett, 2015; Reavley et al., 2013) and self-stigma (Adams et al., 2010; Putnik, 2011) in this group. If self-blame in mental health practitioners seems paradoxical, much of attribution theory and related research emphasises the ubiquity of defensive processes clouding human self-assessment (e.g. Ames & Kammrath, 2004; Dunning et al., 2003; Ehrlinger et al., 2008).

Overestimation of competence

Sometimes mental health practitioners who suffer burnout can, despite their training, fail to recognise it within themselves (Putnik et al., 2011). Overestimation of self-competence is the surprisingly common human tendency to overestimate one's level of functioning (Ames & Kammrath, 2004; Dunning et al., 2003; Dunning, Heath & Suls, 2004). For example, Dunning et al. (2003) found people tend to assess their competence on the basis of preconceived beliefs rather than the evidence in front of them. Therefore, a practitioner who believes 'I am often able to read people's true emotions correctly' (Ames & Kammrath, 2004, p. 193) may ignore signs of depersonalisation whilst under stress. A person's self-beliefs therefore become an obstacle to accurately assessing their functioning in the present moment. Indeed Dunning et al. (2003) suggest individuals are often "blissfully unaware" (p.83) of their incompetence or deficiencies. This perceptual deficit might explain the misperception of burnout symptoms and the avoidance of self-care in mental health workers with good professional skills.

Optimism Bias

Another attributional process allowing a person to justify ignoring burnout is the optimism bias (see McKenna et al., 1993; Sharot, Korn & Dolan, 2011; Sharot, 2011), a belief that 'it won't happen to me' (Caponecchia, 2010; Weinstein, 1984, p.431). Optimism bias has been used to explain many risky health-related behaviours. For example, McKenna, Warburton and Winwood (1993) found smokers consistently underestimated their risk of developing smoking related illnesses by adopting an "it won't happen to me" attitude. Clarke, Lovegrove, Williams and Macpherson (2000) found women aged 50 to 70 were unrealistically optimistic about the risk of breast cancer, even though they knew they were in the 'at-risk' age group. 'It won't happen to me' is widely used to justify avoiding preventative behaviours such as quitting smoking or having a mammogram.

A practitioner's belief that they are immune to burnout is reinforced when working in a high-pressure environment for a period of time without any health consequences. This could equally relate to the private practice setting, as to the agency or community setting. Past experience of avoiding

burnout may contribute to this belief that 'it won't happen to me'. Perhaps some individuals perceive the risk of burnout to be very low, and therefore do not view their actions, or lack of action, as placing them at risk. It is possible that people really do not think about burnout, or consider it seriously, until it happens to them (Stovholt, Grier, & Hanson, 2001).

Dichotomous Thinking

Viewing burnout as an 'all-or-nothing' condition also helps avoid paying attention to stress symptoms. Such dichotomous thinking (Evers, Tomic & Brouwers, 2005; Oshio, 2009) could be used to justify overwork by allowing a person to minimise risk to the point of triviality. Dichotomous thinking may be encouraged by training in medical environments where a person is either ill or well (Schaufeli et al., 2009). Defining 'health' as the absence of pathology could encourage a simplistic assessment of one's symptoms. Dichotomous thinking has a parallel in studies showing that many ill persons seek help only when their symptoms become so painful or uncomfortable they start to interfere with daily functioning (Mechanic, 1995). Thus, it is possible that mental health practitioners may only recognise burnout in themselves when it has become so severe that they are unable to function in their professional and personal lives.

Professional Identity

Professional identity refers to a subset of a person's self-concept describing the roles, values and attitudes members of a profession are expected to exhibit (Adams et al., 2006). Siebert & Siebert (2007), drawing on Role Identity Theory (Burke & Tully, 1977), relate the values and beliefs of helping practitioners to an idealised conception of a 'helper' who is needed, appreciated and selfless. This image is reinforced when clients also regard the professional as an exemplar of wellbeing, self-knowledge and altruism.

Such idealised standards can become internalised, incorporated as central to one's personal identity rather than merely the professional role. Individuals can emphasise the professional role-identity and minimise their broader subjective sense of self: they lack boundaries between personal

and professional identities, striving for role-based achievement rather than subjective wellbeing. From a clinical perspective, a 'false self' drives behaviour (Freudenberger, 1985) aimed at shoring up 'false self-esteem' (Kernis, 2003), and the experience of normal human emotions is restricted (Shostrom, 1978). As a result, it can be very hard to recognise symptoms and admit to burnout, or even to normal human emotional problems (Figley, 2002; Hu et al., 2012; Kilburg et al., 1988; Maslach & Goldberg, 1998).

As Figley (2002, p. 1439) observes, 'helping practitioners' are often revered by the community and 'may gradually view themselves as others view them: someone who is an expert at helping others cope with life's challenges. They seem to forget they are human beings as well.' This may lead practitioners to overestimate their ability to withstand external pressures, such as an overwhelming caseload, without suffering adverse effects such as burnout. Admitting limitations also calls into question their professional competence (Barnett & Hillard, 2001; Johnson et al., 2012).

Stress Induced Cognitive Deficits

The final factor in our model involves the physiological depletion caused by stress (Selye, 1950, p. 5) and the resulting decline in general cognitive capability, including sense-making and decision-making capabilities (e.g., Oosterholt et al., 2012). For example, Janis and Mann (1977, p. 82) found stress reduced a person's decision-making capacity by impeding the ability to see and assess all the alternatives to a problem. In the workplace, cognitive decline may lead a professional to misjudge the long-term consequences of stress or the traps evident in their defensive thought patterns and responses. The person becomes further 'trapped' in these, unable to see an escape. Further loss of cognitive functioning eventually leads to learned helplessness and depression (Seligman, 1972). Attribution theory is extremely relevant to the study of burnout prevention. However, as yet, it has not been utilised in the area.

Research Approach and Methods

To understand the perceptual processes of mental health workers' attributions of themselves and their work in relation to burnout, we draw from Merleau-Ponty's phenomenological philosophy.

This approach understands the experience of perception as a confluence of constructivist epistemology and realist ontology. For Merleau-Ponty, while the individual body is dependent on an external reality, experience is constructed through the subjectivity of being in the world (Merleau-Ponty, 2012). Constructivism is a stance in that what we experience and know about the world exists in/through individual meaning-making activities of the mind engaging with objects in the world (Crotty, 1998). Therefore, our meaningful interpretations of our social experiences can be determined through our unique perceptions of reality (Merleau-Ponty, 2012). A constructivist lens allows us to focus on how perceptual and cognitive qualities of social experience are interpreted. While we acknowledge the knowledge of the world is constructed through our perceptions as individual human entities, our epistemological approach is also guided by a realist ontology whereby we assume individuals interact with and therefore perceive an external reality that is independent to them. However, we specifically adopt a subtle realism, which posits that while individual consciousness and reality are treated as separate, we can only know of both of these phenomena through our perceptions (Angen, 2000; Dillon, 1988). Subject and object are fused in/through the perception of phenomena (Strong & Lock, 2010).

Although we use attribution theory as a specific theoretical focus for our methodology, we reappropriate it through a fused phenomenological lens to enable descriptive and experiential understandings of how mental health workers process their beliefs and perceptions in relation to their work. Attribution theory assumes a realist ontology to understand how individuals may attribute internal or external causes to their actions. However, this is predominantly from a scientific realist ontology. While we partially embody some of the realist language of attribution theory (e.g., 'errors' and 'biases'), our theoretical interest is not in objectivist causality. Rather than starting the analysis purely from an outer objective reality/ontology or an inner subjective knowing, our starting point of understanding attribution is through perception as a phenomenological understanding of how we attribute our experiences through/between internal subjectivity and external objective reality, neither of which can be teased apart easily. This phenomenological fusion of constructivist epistemology and

subtle realist ontology, (re)using attribution theory, provides a detailed and specific experiential understanding of situated individuals and their perceived burnout attributions.

Phenomenological methodologies have previously been found suited to assessing the cognitions underlying participants' health behaviours (Biggerstaff & Thompson, 2008; Kellett et al., 2010). They are particularly useful in inductive research, as participants' perceptions or beliefs may differ from those ascribed to them by experts such as medical practitioners or academic researchers. Documenting the subjective perspective is now seen as an important development in psychology research (e.g., Brocki & Wearden, 2014, p. 88).

Sample

Ethics approval was granted by the University Human Research Ethics Committee, and the North Metropolitan Health Service Mental Health, Research and Governance Office. The target population was mental health professionals, a group comprising employees with tertiary qualifications in a discipline specialising in the psychological, psychosocial, psychiatric or emotional treatment of people suffering from psychological distress. One hundred and fifty-five questionnaires were delivered to 28 supervisors from mental health workplaces agreeing to participate in the study, including government-funded community agencies, psychiatric hospital wards and community mental health clinics. Completed questionnaires were returned anonymously by mail, and respondents could volunteer for the interview using a separate form. Fifty-five professionals (26%) returned the questionnaire, providing a large sample in qualitative research (e.g., Creswell, 1998, p. 68; Mason, 2010). Twelve (22% of the 55 professionals) volunteered for the interview, for which informed consent was obtained prior to the interview.

The sample obtained comprised mental health nurses (n=17), psychologists (n=16), mental health occupational therapists (n=1), social workers (n=7), psychiatrists (n=3) and counselors (n=11). Participants were predominantly older workers: 33% were aged over 50, reflecting the aging mental health workforce in Australia (AIHW, 2011). Participants were also predominantly (81%) female, as is this sector generally. The interview sample included all the organisational categories and

professional groups of the larger sample, apart from psychiatrists. Nine were female and three male. The interviewees were an experienced group: all had at least five years' experience and seven had more than 20 years' experience.

Questionnaire

In line with our phenomenological approach, a primarily open-ended, qualitative questionnaire was used to gather participants' beliefs and perceptions about burnout in themselves and colleagues. Questionnaires are now a recognised tool in qualitative research (e.g., Fink, 2003; Jansen, 2010; Biggerstaff & Thompson, 2008). Qualitative questionnaires differ from quantitative ones in using open-ended questions to identify individuals' feelings, perceptions, opinions, experiences or beliefs, with a focus on depth of information and richness, uniqueness or diversity of responses (Fink, 2003; Jansen, 2010; Reja et al., 2003). Open-ended questionnaires thus provide a more personal perspective (Arhar et al., 2001; Libarkin et al., 2005; Patten, 1998).

While qualitative questionnaires typically use small samples, since statistical generalisability is not the goal, we saw two important benefits. A questionnaire provides anonymity, an important consideration for mental health professionals who may find burnout a sensitive topic affecting their professional reputation, job performance, career prospects or self-esteem. Finally, qualitative questionnaires can access a broader sample with less time and cost than interviews, and are generally straightforward and unobtrusive to users (McLeod, 2003, p. 60). However there are limitations to the use of qualitative questionnaires, such as low response rates and uncertainty as to who participated due the anonymity provided.

A questionnaire was drafted to address the research questions developed from a comprehensive literature review. Our primary research questions driving the study were: what do mental health professionals believe about why people burn out, and how do mental health professionals see the risks of burnout? These questions were based on identified gaps in the literature, and the central research question of how mental health workers attribute the causes of burnout in themselves and others. The questions were designed to understand whether individuals tended to

emphasise internal or external influences to the development of workplace burnout and how these attributions impacted their ability to recognise and respond to burnout in themselves. The final version contained 21 questions covering demographics and perceptions or beliefs about the nature, risks and prevention of burnout. The latter were all open-ended questions.

Our questionnaire was pilot tested on ten professionals not used for data analysis, and three experts on questionnaire design assessed the questions for clarity, relevance and language. This lead to minor wording refinements and the use of tick boxes or scales to eleven open-ended questions. The latter provided prompts, eliciting more reflective and detailed responses to the open-ended questions - the numerical data were not of strong interest in their own right. While open-ended questions invite participants to explain their viewpoint in depth (Osgood et al., 1957, p. 76), a drawback is the possibility of superficial responses. Albaum et al. (2007) found two-staged questions elicited more considered and truthful beliefs, perceptions and attitudes than single items.

The final questionnaire had 20 questions addressing perceptions or beliefs about the nature, risks and prevention of burnout, and four covering respondents' demographics. The final questionnaire comprised four sections: Section A, 'Some information about you', sought basic non-identifying demographic information including profession, years worked in the field, age and gender. Section B was labelled 'Questions regarding what you think about burnout' and contained primarily open-ended questions addressing the research questions. An example of a question in this section is 'What do you think are the three leading causes of burnout? Please make a brief comment on why you think these contribute to burnout.'

Section C was labelled 'Your experiences regarding burnout' and aimed at eliciting respondents' experience of their own burnout, for example, 'Have you personally experienced burnout? Please describe your experience'. Section D was labelled 'Questions regarding the prevention of burnout' and included questions such as:

'Do you see burnout as avoidable when working in the mental health field.'

Totally avoidable □ Mostly avoidable □ Mostly unavoidable □ Unavoidable □ Unsure □

Please comment on your answer:

For most questions, a large box was provided in which to write one or more sentences. Some questions were phrased hypothetically (e.g., 'How would burning out affect how you see yourself as a professional?') to gauge general attitudes rather than perceptions tied to specific experiences of burnout.

Interviews

Twelve respondents were also interviewed to address some disadvantages of the questionnaire-focused survey approach. Van Manen (1997) suggests writing is inherently reflexive, encouraging interpretation more than staying close to one's actual experience. The semi-structured interviews therefore encouraged deeper exploration of the complexities and nuances of respondents' experience. Some examples of questions were: 'Can you talk a bit about how you understand professional burnout?' and 'Do you think you are at risk of burnout and why?'

The interviews were not explicitly designed to identify new themes. Their primary use was to deepen understanding of the questionnaire findings and supplement them with additional background, depth or contextual information. They took approximately 50 minutes and were held at a private location of the participant's choosing.

Analysis

Responses were analysed using an experiential and theoretical thematic analysis (Braun & Clarke, 2006, 2013). This involved two phases. The first phase involved an inductive approach using semantic coding where codes reflected participants' own words of experience. Boyatzis (1998, p. 4) describes thematic analysis as a 'way of seeing' or making sense of qualitative data by organising it in a meaningful way. Experiential thematic analysis examined participants' perceptions in how they experience and understand their reality (Braun & Clarke, 2013) of working in mental health.

The second phase included a theoretical analysis of the experiential coding using the concepts from attribution theory to make sense of participants' perceptual processes. Questionnaires were read

repeatedly and codes developed using statements identifying different themes, such as ‘blamed myself’, ‘no one knew’, ‘loss of self-worth/self-esteem’ or ‘work is enjoyable’. For example, the codes ‘blamed self’ and ‘should have prevented it’ were grouped into the attributional theme of ‘self-blame’.

Cross-coding was then performed by two co-researchers to allow for multiple interpretations of the data. Some discrepancies were revealed and through discussion the codes were refined to eliminate these. The codes were then entered in NVivo 9 as a data management tool. Interview recordings were transcribed and analysed thematically, using the Braun and Clarke (2006, 2013) method described above for questionnaires.

Findings and Discussion

A key finding was that respondents often reported difficulty recognising they were burning out until signs of physical and emotional breakdown appeared. On recognising this, they tended to blame themselves and had a difficult time disclosing it to others for fear of negative judgment. These observations point towards strong perceptual and emotional barriers to facing burnout, despite respondents’ training in mental health. The factors identified in Figure 1 provide a framework for understanding this conundrum. We suggest the factors of professional identity, perceptual biases, self-stigma and stress induced cognitive deficits feed off each other, leading to a spiral or vicious circle of self-destructive thinking leading ultimately to physical and emotional exhaustion.

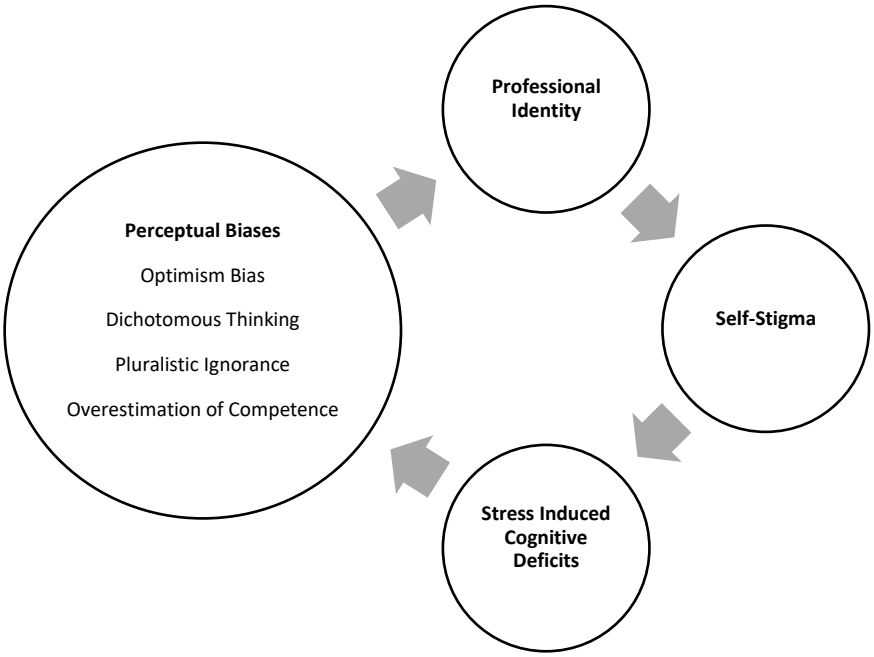

Figure 1. Model of perceptual and emotional factors influencing recognising and seeking help for burnout. Perceptual barriers to recognising and responding to burnout. While the questionnaire and interview responses were analysed separately, the model shown in Figure 1 was developed from both sources and quotes from both are used below.

In line with attribution theory, participants tended to assume that burnout symptoms were *internally* caused and therefore under the personal control of the individual.

Self-Blame

Many respondents believed burning out would cause them to blame themselves, describing it as a sign of weakness, failure and incompetence. This was true for those reporting having had experienced burnout, but also for those who hypothesised how they might respond should they experience burnout. As one respondent put it:

I would definitely feel like I had failed in some way, like I am not tough enough to deal with typical work stress. Personally and professionally I feel resilient, so having that tested would be hard.

Self-blame is also seen in a tendency to downplay the influence of high workloads and stressful workplaces. Participants observed:

I just thought it was me, and I needed to work harder, so it became a vicious circle.

You should be able to do this, you should be able to cope.

There was a strong perception that burnout was a sign of 'not being tough enough', 'weakness' or 'vulnerability' and incompetence:

It has affected my idea of myself as a competent and capable person.

Of those who reported suffering burnout, many had similarly come to believe they were weaker or less capable employees:

From that point I decided that I was only 'cut out' to do clinical work part time.

We suggest self-blame is a process that helps practitioners make sense of difficulties by making problems seem either beyond their control or easily remedied. Either way, seeking remediation is discouraged.

Cognitive Biases

The biases discussed below are a sample of those consistent with the findings of our study and resulting model. These biases tend to have a similar focus on avoidance of recognising signs of burnout and maintaining the professional's self-esteem.

Overestimation of Self-Competence

Overestimating self-competence encourages practitioners to avoid monitoring their wellbeing and performance under conditions of stress, ultimately allowing them to exceed their limits. This tendency was implied in responses describing the difficulty participants had recognising they were burning out until seriously impaired:

> *Did not know I was burning out until I was approached by a supervisor.*

> *I think it's about how long before I had been burnt out for and how long 'til I recognised it…I knew that I was stretched, but probably didn't realise that emotionally that was starting to have an impact.*

> *Despite spending my working life doing triage assessments and giving people mental health advice, I did not recognise symptoms increasing in me, due to the stress of trying to manage my workload. Eventually I simply could not function.*

Apart from its effects on practitioners' health**,** overestimation of one's self-competence can also effect work quality and contribute to a culture of overwork.

Optimism Bias

A third attributional process allowing a person to justify ignoring burnout is the optimism bias. Although two-thirds of participants reported having experienced burnout, and a similar number had colleagues they thought had burned out, many appeared to believe they personally were able to avoid it, despite its prevalence. This appears to indicate optimism bias whereby people are overly optimistic in their assessments of risk, preferring to believe "it won't happen to me" (Weinstein, 1984, p.431; Clarke et al., 2000). Many of the responses were consistent with an exaggerated belief in respondents' ability to control their responses to stress.

> *I know what I need to do to self-care, therefore unlikely to happen to me.*

> *I think as practitioners we have a responsibility to ourselves, our organisation, and our clients to look after our own mental health. I think it is mostly avoidable.*

> *With adequate self-care and support, most people should cope well most of the time.*

Pluralistic Ignorance

In pluralistic ignorance, the majority of group members harbour the illusion that they are the only person suffering from a problem, creating a culture of denial. It appears such cultures exist in the workplaces we surveyed. More than half the respondents were reluctant to disclose when they were not coping well with the work, or to seek help due to the negative perceptions of burnout discussed under self-blame. One described feeling like she was the only person feeling stressed:

And I was continuing to operate, trying to continue to operate, and I thought how the heck I was feeling this way and everybody else was taking it somewhat in their stride.

If this person's colleagues held similar attitudes, as appears likely in many cases, this would create a culture of denial amongst practitioners.

Dichotomous Thinking

Commonly burnout was viewed as an 'all-or-nothing' condition by respondents. This respondent, for example, only recognised she had become unable to function when her doctor instructed her to take extended sick leave:

I guess that's what was in my head, you know, you're capable and you should be able to manage to do it….. Yeah, and I was working longer, and I never had lunch, you know all the kinds of things you think, why are you doing that?

Managers in mental health workplaces had observed this tendency to ignore early symptoms:

They don't have time to stop and think about how they're going, they're just like hamsters on a wheel, they just keep going until all of a sudden they might not be able to do it anymore.

I don't think it's because they're deliberately doing it, but I think to them at that point maybe it's a little thing …And so they don't say anything until they get to that point where it's critical, and you don't hear anything and the next thing the staff are sick and

it's like, why are they sick? They're sick because they're just so stressed and burned out. And they end up taking sick leave.

A maximising version in which burnout is equated only with catastrophic symptoms can equally underpin avoidance in professional employees: –

I am a long way from burnout, a full mental breakdown.

Black and white thinking was evident in contradictory views widely held amongst respondents. On one hand, most saw burnout as a very serious occupational hazard: more than half believed it had serious consequences for a person's health, self-esteem, career, financial stability or relationships:

Time taken off work, poor health, impact on colleagues and family.

Feelings of incompetence. I would have to resign and assess my professional future.

It would be another high qualified and skilled Mental Health professional leaving an already vulnerable workforce.

On the other hand, it was often not seen as a personal threat to respondents. As described as an exaggerated sense of control, participants reported responding to signs of burnout by working harder and telling themselves that they should be able to cope. Black and white thinking can be used to minimise recognition of symptoms in multiple ways.

In summary, statements from the questionnaire and interviews are consistent with a variety of cognitive biases found in other areas of health research. Table 1 provides a summary of these, showing the wide variety of ways individuals justify ignoring symptoms. A key reason for using such strategies appears to lie in respondents' identity as a professional, as we discuss in the next section.

Table 1. Summary of Cognitive Biases

Cognitive bias	Example
Self-blame	"I would feel I had failed in some way - I am not tough enough to cope with typical work stress." "Allowing myself to burnout would be unprofessional."
Exaggerated self-competence	"I knew I was stretched but didn't listen to the emotional signs that it was starting to impact on me."
Optimism bias	"It won't happen to me."
Dichotomous thinking	"I'm fine, I'll have a rest when I get to the end of the year."
Pluralistic ignorance	"I'm stressed, but everyone else seems to be coping."

The Key Role of Professional Identity

A theme either directly stated or implied in many, if not all, the thought processes documented above concerns respondents' identity as a professional. The central role of professional identity was clear in several ways. Those who had burned out recalled feeling that they were 'not cut out' for their job because they 'should' be able to withstand its stresses. This 'should' suggests a belief that since mental health practitioners are trained in managing others' emotional and psychological problems, they have the resources to avoid these problems themselves. The belief that it was 'unprofessional' to burn out was equally evident in those who had not burned out. We suggest

that the thought-patterns identified above help defend such persons by denying their symptoms or justifying working harder to overcome the stress. When this fails to resolve the problem, further defences are employed. The person is caught in a vicious spiral in which dysfunctional thought-patterns, reduced awareness of feelings or emotions and increasing debilitation lead, if unchecked, to full burnout – a process seemingly invisible to the person.

A common belief was that respondents' professionalism and competence would protect them from burnout (e.g., 'In my mind, allowing myself to burnout would be unprofessional'). While this respondent may indeed avoid burning out, this belief minimises the contribution of *external* factors found to as predictive of burnout as individual behaviour. In contrast, participants having already experienced burnout were aware of having unrealistic expectations of their ability to avoid burnout and how this led them to overwork to the point of breakdown.

> *When I feel burnout... I suffer 'compassion fatigue' and in my less rational moments, I condemn myself for this. As with most helping practitioners, it can be quite difficult to accept one's limitations and to self-nurture.*

One described a new-found sense of responsibility:

> *I think as practitioners we have a responsibility to ourselves, our organisation, and our clients to look after our own mental health. Moderate how much work we take on, take regular holidays, access support and counselling, demand supervision etc.*

In these cases, the discrepancy between the expectations of oneself and the resources actually available is resolved by perceiving unrealistic expectations to be realistic. Whether driven by cultural norms, self-image or both, each act of evaluating oneself against unrealistic standards reinforces the illusion of control.

Although my job isn't everything to me, I'd lose a significant part of my identity if I burned out. I'd lose some self-respect, because I'd not taken the necessary steps to prevent burning out.

In my mind allowing myself to burn out would be unprofessional.
I think up until now, I've never really not coped with something… and I've always enjoyed my work and now I've come to this job and I can't do it…I can't do this!

Stress-Induced Cognitive Deficit. The final factor in our model reflects the depletion in cognitive abilities caused by stress. Respondents often observed that their colleagues failed to recognise their own burnout:

They may not have thought [they were burning out] but my perception was yes.

As described in relation to *overestimation of competence*, respondents who had had burnout had experienced first-hand losing the ability to see how and why their stress was increasing. One respondent described working harder and longer as her stress increased, and expressed disbelief that her training had not prepared her to recognise her condition until she reached exhaustion, even though her doctor and husband could see it:

I didn't recognise it… kind of running on adrenaline. So after I eventually went to see my doctor and he… persuaded me that I should … take sick leave, and it took about 6 weeks before I started to feel a bit better, but it really took [months] to look back and think 'what was wrong, why did I stick at that for so long and why didn't I recognise that something was wrong?

I think if someone who has worked in mental health for 20 years and is suffering from burnout [but] can't recognise it, then, maybe it should be part of your manager's role.

Many specific cognitive biases can similarly lead to avoidance by either exaggerating or minimising the importance of symptoms. Several respondents recognised the irony of being a mental health professional yet unable to recognise stress, anxiety or depression in themselves. We suggest this is due to both the desire to avoid recognising it and the physiological impairment of cognitive capacity.

Our data identifies a number of ways in which perceptions and beliefs can distort recognition of stress symptoms amongst counsellors and psychotherapists. We suggest burnout results from a self-identity too closely fused with a role-based professional identity as 'helper', leading stressed individuals to self-blame and employ cognitive distortions to avoid admitting to normal human feelings and limitations. The physiological and cognitive effects of stress further reduce practitioners' ability to make rational responses to the problem. Paradoxically, the 'helping' professions' core values of professional competence and selfless helping of others lie at the heart of this. Professional cultures may reinforce these tendencies.

Conclusion

This study aimed to investigate how burnout is seen and experienced by mental health practitioners. The causes of burnout have been well-documented (e.g., Schaufeli, Leiter & Maslach, 2009). However, discussion over objective causes tend to miss two points, mental health practitioners are not passive reactors to external forces but make choices about whether to attend and respond to information, and they do this on the basis of their perceptions rather than objective knowledge. For these reasons, reducing burnout requires an understanding of how individuals perceive it – a phenomenological perspective. This study found that the prevalence of burnout amongst mental health practitioners with the professional competence to prevent it can be explained by (i) defensively biased perceptions and beliefs concerning their own susceptibility to stress and its causes, (ii) the effects of

physiological impairment on decision-making, and (iii) a professional role identity that leads professionals to ignore symptoms, self-blame and avoid seeking help in order to maintain the role identity.

From this perspective, improving the work environment is only part of the solution to burnout. Mental health practitioners must also have realistic perceptions of what they can deliver, self-compassion for their limitations, and recognition of the importance of self-care activities to mental health and general wellbeing. If their self-concept and self-esteem are focused too much on client outcomes, their intrinsic motivation to work hard can lead them to self-induce overwork and ignore signs of burnout.

Supervisors also play a critical role as the group best able to detect burnout, and should be aware of its nature and how to respond. Supervisors and management can lead by example, openly discussing burnout and self-care in meetings, development programs and performance reviews. Supervisors would benefit from greater understanding of the common human perceptual limitations that lead practitioners to avoid taking the effects of stress seriously. Such staff may be highly competent and committed employees: indeed they may be *too* committed to professional goals. They may seek to hide their symptoms to avoid appearing less than competent or compromising in their service to clients. This by itself should concern managers and supervisors as an operational risk, and if they reach the final stage of the process they will need leave for months or longer. By continuing to practice, such persons unintentionally incur a long-term cost to their health, the organisation and its clients or patients.

Practitioners need help to recognise their symptoms and encouragement to seek treatment from their colleagues, supervisors and managers. This does not reduce their responsibility for self-care, but highlights the organisation's role in not only providing healthy working conditions but also proactively supporting staff to undertake self-care by providing time and resources. Managers also need to combat the stigma widely attached to burnout. They should consider how common values in organisational and professional cultures reinforce this stigma, assisted by attitudes that effectively

blame the worker, minimise responsibility for workplace health and normalise unhealthy workloads. Changing the culture to become more humane through recognising employees as people with health needs rather than merely 'human resources' is not easy but will reduce the financial and human costs of stress-related conditions.

Professional educators have a special responsibility to help future mental health practitioners become aware of how their perceptual processes and beliefs can exacerbate stress and create burnout. Teaching them to recognise their limits and their vulnerability to stress would result in a more realistic and less idealistic professional role-identity. Graduates should appreciate the importance of work-life balance and self-restorative activities, and the dangers of overly attaching their self-esteem to professional competence. They should understand the high risk of burnout in professional occupations, know the warning signs and be prepared to access advice or support. To achieve this, graduates requires an understanding of the perceptual barriers they face in recognising and responding to their own burnout. This should involve a basic introduction to physiology of stress, the social psychology of person and self-perception, and relevant clinical perspectives on the self-concept and self-esteem.

In all of these topics, students' perceptual defences should be given a prominent role. Focusing solely on self-management or self-care can unintentionally encourage many of the biases above and an idealised image of one's self-competence.

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Funding Acknowledgement: One of the researchers was the recipient of an Australian Postgraduate Award.