Izgorevanje
Burnout

Avtor / Author

Ustanova / Institute

Zlatka Rakovec-Felser[1], Cvetka Pernat Drobež[2]

[1]Univerza v Mariboru, Medicinska fakulteta, Maribor, Slovenija;

[2]Univerzitetni klinični center Maribor, Oddelek za gastroenterologijo, Maribor, Slovenija

[1]University of Maribor, Faculty of Medicine, Maribor, Slovenija;

[2]University Medical Centre, Department of Gastroenterology, Maribor, Slovenija

Ključne besede:
zahteve dela, pogoji dela, neravnovesje, izgorevanje

Key words:
work demands, work resources, imbalance, burnout

Članek prispel / Received
23.09.2016
Članek sprejet / Accepted
22.11.2016

Naslov za dopisovanje / Correspondence
Doc. dr. Zlatka Rakovec–Felser, spec. klin. psih.
Univerza v Mariboru,
Medicinska fakulteta,
Katedra za psihologijo,
Taborska ul. 8, 2000 Maribor,
Slovenija
Telefon +386 40899239
E–pošta: zlatka.rakovec–felser@triera.net

Izvleček

Članek je posvečen problematiki izgorevanja v zdravstvu. Poleg opredelitve pojava kot posledice porušenega ravnovesja med zahtevami in možnostmi, med skrbjo za druge in skrbjo zase se seznanimo s kompleksno prepletenostjo eksternih in internih razlogov zanj, z znaki, ki opozarjajo na sprožen proces, pa tudi s podatki o opravljenih raziskavah izgorevanja med zdravniki. Novejše ameriške in evropske raziskave odkrivajo – glede na ostali del prebivalstva – visoko stopnjo prevalence izgorevanja med zdravniki. Pojav, kot poudarjajo avtorji, zato ne more biti več zgolj problem zdravnikov samih, pač pa zaradi obsega in posledic odpira vprašanja učinkovite obravnave tako bolnikov kot tudi zdravstvenega sistema v celoti. Raziskovalci govorijo o epidemičnem značaju pojava, zaradi česar razmišljajo o potrebnih preventivnih ukrepih tako znotraj zdravstvenih ustanov – še zlasti, ker je stopnja zadovoljstva in izgorelosti zdravnikov

Abstract

This article is devoted to burnout in medical care. Except a definition of phenomenon as a result of imbalance between work demands and resources, physician's caring for others and caring for oneself, the complex interactions between the external and the internal causes of professional burnout are highlighted. It informs us also with manifestations, signs, and the phases of a triggered burnout process. As North American and European research data in the comparison with the general population reveal higher extent of burnout among physicians, authors emphasize that higher extent of burnout is not only a physicians' problem, but because of its epidemic character and consequences a vital element of quality and patient outcomes, well–functioning health care system as well as public health in general. They pointed out that the effective prevention programs and helping interventions needs to go in both directions – interventions of medical

pri delu, glede na novejše izsledke, pomembno odvisna od njihovega vodenja – kot tudi o potrebnih ukrepih na individualnem nivoju, t.j. o samozaščitnem življenjskem slogu zdravnikov samih. Predstavitev teh najdemo v zaključnem delu članka.

organization as well as the preventive interventions on an individual level. The latter are presented in the article upon completion.

DESCRIPTION AND CAUSATION ASPECTS OF BURNOUT

Burnout is probably a term more misused than properly used. For example, is it proper to say that someone who has never achieved anything has burned out? The word "achiever" is not referring to elitism, however, although it is commonly treated as such. Achievers do not have to be professionals; they can be labourers or assembly line workers who "have had it". And it is true that, in one way or another, we all have fashioned wings and wax and, like Icarus, flew too close to a symbolic sun and then plummeted emotionally. This is burnout (1).

Actually, there is no single definition of burnout that has been accepted as a standard. Freudenberger (1974) defined it as a "specific psychological condition in which people suffer emotional exhaustion, experience a lack of personal accomplishment and tend to demoralize others" (2). Edelwich and Brodsky (1980) described burnout in the helping professions as a process of increasing disillusionment, i.e. "the progressive loss of idealism, energy and purpose experienced by people in the helping professions due to conditions in their work". Maslach and Jackson (1986) pointed out that burnout is a process of "emotional exhaustion, depersonalisation, and reduced personal accomplishment that occurs among individuals who do "people work" of some kind" (3). Maslach and Leiter (1997) saw it as an index of the dislocation between what people are and what they have to do; it represents an erosion in values, dignity, spirit—an erosion of human soul (4).

While there is no standard definition, the general agreement is that burnout in professionals occurs because of interaction between intrinsic (e.g., pleasure of mastering something new, satisfaction of curiosity) and extrinsic (e.g., supportive colleagues, proper feedback from one's superior) characteristics. These factors are associated with the nature of the job (number of clients, severity of client problems), occupational characteristics (insecurity, pay level) and/or organizational work characteristics (relationships, information) (4, 5).

Several authors tried to clarify the emergence of job burnout with a number of theories and theoretical models. Commonly used models include Kahn's Demand-Control Model (DCM; Karasek, 1979, 1998), Schaufeli-Buunk's Integrative Comprehensive Social Exchange Model (1993), and the Effort-Reward Imbalance Model (ERI-Model, Siegrist, 1996). The latter model is based on the assumption that job strain is the result of an imbalance between effort (extrinsic job demands and intrinsic motivation to meet these demands) and reward (salary, self-esteem reward, security/career opportunities). In their Balance Job Demands-Resources Model (JD-R), Demerouti (2001) and Bakker (2003) classified specific work characteristics of each occupation into two general categories, job demands and job resources. The central assumption of the JD-R model is that job strain develops when job demands are high and job resources are limited. Job demands refer to physical, psychological, social or organizational aspects of the job that require sustained physical and/or psychological (cognitive and emotional) effort or skills (e.g., processing a large scope of information, emotionally demanding interactions

with patients), and are therefore associated with physiological and/or psychological costs. Job resources may increase motivation and either play an intrinsic (foster employees' growth, learning and development), or an extrinsic motivational role (instrumental in achieving work goals). They may be located at the level of the nature of job (e.g., job autonomy, holding a valued social position, thankfulness of patients), occupational characteristics (e.g., pay, career opportunities), and/or organizational work characteristics (e.g., role clarity, style of leadership, support from colleagues) (5).

Individual factors: Who experiences burnout?

The personal factors which can impact on burnout are demographic variables, personality characteristics, work-related emotions, motives, attitudes and expectations. Of all the demographic variables that have been studied, age is the one that has been most consistently related to burnout. Among younger employees, the level of burnout is reported to be higher than among those over 30 or 40 years old. Age is confounded with work experience, so burnout appears to be more of a risk earlier in one's career. While sex is not a strong predictor of burnout, unmarried people (especially men) are more prone to it than married people. Some studies have found that those with a higher level of education report higher levels of burnout than less educated employees. It is possible that people with higher education have jobs with greater responsibilities and more stress. Moreover, they may have higher expectations for their jobs, and are thus more distressed if these expectations are not met (6).
Regarding personality characteristics, people who display low levels of hardiness (a sense of control over events, openness to change) have higher burnout scores, particularly on the exhaustion dimension. Burnout is also higher among people with an external locus of control rather than an internal locus of control. Similar results have been reported regarding the relationship between coping styles and burnout. Burnout patients cope with stressful events in a rather passive, defensive way, whereas active and confronted coping strategies are associated with less burnout. In particular, confronted coping is associated with the dimension of efficacy. It has been argued that low levels of hardiness, poor self-esteem, an external locus of control and an avoidant coping style typically constitute the profile of a stress-prone individual (Semmer, 1996). Obviously, the results from the burnout researches confirm this personality profile (6).

Other research shows that burnout is linked to the Big Five Personality Test dimension neuroticism, which includes trait anxiety, hostility, depression, self-consciousness and vulnerability. Neurotic individuals are emotionally unstable and prone to psychological distress. Furthermore, the exhaustion dimension of burnout appears to be linked to Type A-behaviour (competition, time-pressured lifestyle, hostility and an excessive need for control). There are also indications that individuals who are "feeling types" rather than "thinking types" (in terms of Jungian analysis) are more prone to burnout, especially to cynicism (6). The hypothesis that high, idealistic or unrealistic expectations are risk factors for burnout has received mixed empirical support—about half of the studies confirm the hypothesized correlation, whereas the rest does not. It is possible that high expectations cause people to work too hard and do too much, thus leading to exhaustion and eventual cynicism when the high effort does not yield the expected results (6).

According to Fischer (1983), burnout reflects a narcissistic disorder. Individuals who have idealized their jobs and suffer subsequent disillusionment could either reduce their ideals or leave the situation. However, instead of giving up, reducing their ideals or looking for another job, they redouble their efforts in order to achieve their unrealistic objectives. They are motivated by the fear of having to give up their narcissistic "illusion of grandiosity", the erroneous notion of being special and superior. The burnout candidate's basic sense of self-esteem is grounded in this narcissistic illusion (7).

From the perspective of learning theory, burnout results from wrong expectations with respect to reinforcements, outcomes and efficacy (Meier, 1983). Group norms and personal beliefs influence people's expectations, and thus—indirectly—the burnout pro-

cess (8, 9). Burisch (1993) claimed that the action episodes which reflected latent motives (e.g., being an effective helper) may trigger burnout when coping fails: motives may inflate or extinguish, action planning may become inadequate, aspiration levels may shift downwards, feelings of self-efficacy may decrease and demoralization may set in (10).

Situational factors: When does burnout occur?

Maslach and Leiter (1997) formulated a model that focuses on the degree of mismatch between the person and six domains of his/her job environment. The greater the mismatch between the person and the job, the greater the likelihood of burnout; and conversely, the greater the match (or fit), the greater the likelihood of engagement with work. In other words, burnout arises from chronic mismatches between people and their work setting in terms of some or all of these six areas: workload, control, reward, community, fairness and values (6).

A mismatch in workload is generally defined as excessive overload, a situation when too many demands exhaust an individual's energy to the extent that recovery becomes impossible. Generally, it is most directly related to the exhaustion aspect of burnout (6).

Mismatches in control most often indicate that individuals have insufficient control over the resources needed to do their work or have insufficient authority to pursue the work in what they believe is the most effective manner (insufficient autonomy, lack of feedback, few opportunities for participation in decision making). A mismatch in control is generally related to the inefficacy or reduced personal accomplishment aspect of burnout (6).

A third type of mismatch involves a lack of appropriate rewards for the work people do. Sometimes these may be insufficient financial rewards, even more important is the lack of social rewards, as when one's hard work is ignored and not appreciated by others. In addition, the lack of intrinsic rewards (a sense of doing something of importance and doing it well) can also be a critical part of this mismatch. Lack of reward is closely associated with feelings of inefficacy (6).

The fourth mismatch occurs when people lose a sense of positive connection with others in the workplace. People thrive in community and function best when they share praise, comfort, happiness and humor with people they like and respect. Chronic and unresolved interpersonal conflicts (constant negative feelings of frustration and hostility, reduced social support) are destructive to this sense of community (6).

A serious mismatch between the person and the job occurs when there is no perceived fairness in the workplace. Unfairness can occur when there is inequity of workload or pay, when there is cheating, or when evaluations and promotions are handled inappropriately. A lack of fairness exacerbates burnout by emotional upset, exhaustion and a deep sense of cynicism about the workplace (6).

The sixth area of mismatch occurs when there is a conflict between values. In some cases, people might feel constrained by the job to do things that are unethical and not in accordance with their own values. There may be a mismatch between their personal aspirations for their career and the values of the organization (6, 7).

DIMENSIONS AND MANIFESTATIONS OF BURNOUT SYNDROM

Maslach and Jackson (1989) postulate that burnout signs can be manifested in three dimensions:

- Emotional exhaustion, feelings of being emotionally overextended and exhausted by one's work;
- Depersonalization, an unfeeling of impersonal response toward clients;
- A reduced sense of personal accomplishment, a loss of personal self-efficacy (2);

Manifestations of burnout signs can be grouped into six major categories: mental, physical, behavioural, social, attitudinal and organizational (8, 9, 11).

Mental manifestations: Typically, the burned-out person's emotional resources are exhausted and he/she feels empty, trapped and at the end of their rope. Affective symptoms that relate to depression are most prominent (depressed mood, helplessness, hopelessness and meaninglessness). A sense of failure, insufficiency and impotence is observed, which eventually leads to poor self-esteem. The second type of affective symptom relates to aggression and anxiety. The burned-out person's frustration tolerance is diminished. He/she is irritable, over-sensitive and behaves in a hostile or suspicious manner, not only towards recipients, but also towards colleagues and superiors. In addition, cognitive symptoms (inability to concentrate, forgetfulness, difficulties in decision making) and sensory-motor symptoms (nervous tics, restlessness, inability to relax) may be observed (Kahill, 1988) (9, 12, 13).

Physical manifestations: The most typical physical manifestation of burnout is chronic fatigue (Shirom, 1989). Other frequent symptoms include headaches, nausea, muscle pains, particularly lower back pain (Belcastro, 1982), sexual problems, sleep disturbances, loss of appetite and shortness of breath (Kahill, 1988) (10). It was found that burnout may be a strong predictor of coronary heart disease incidence. Individuals with high levels of burnout have a significantly higher risk of developing coronary heart disease compared with those with low levels of burnout (9, 14, 15).

Behavioral manifestations: These are mainly caused by the person's increased level of arousal (hyperactivity, violent outbursts). In such person it is observed an increased consumption of stimulants like coffee and alcohol (Quattrochi-Tubin, Jones, and Breedlove, 1982) as well as substance abuse (Nowack, Hanson, and Gibbon, 1985) (8, 9, 11).

Social manifestations: The burned-out individual withdraws from social contacts and is in danger of isolating himself/herself. At work, one of the most obvious characteristics of burnout is the decreased involvement with patients (not moved or touched by anything she/he gets involved in during his duty). Burned-out individuals might take their work problems home (Jackson and Maslach, 1982). These problems come to dominate family life and might also increase interpersonal conflicts with spouse and children (8, 9, 11).

Attitudinal manifestations: The most characteristic sign of burnout is a dehumanizing, callous, detached, indifferent and cynical attitude towards patients, e.g., "that ulcer from room 34" (Cummings and Nall, 1983). Such negative attitudes are particularly striking since the initial relationship with recipients was characterized by involvement, empathy, concerns and understanding (Pines and Kary, 1978). Negative attitudes might also develop towards the job or the organization (Richardson, Burke, and Leiter, 1992). The person's initial intrinsic motivation has vanished; his/her zeal, enthusiasm, interest and idealism are lost (8, 9, 11).

BURNOUT IS A PROCESS

Usually, burnout syndrome does not develop overnight. Furthermore, the signs are not visible or detected very early because people can mask them for a long period. That is why we say that burnout is a progressive and chronic state (1).

The basic tenet of Edelwich and Brodsky's approach (1980) is that the idealistic expectations of the "helpers" are frustrated. They described four stages of progressive disillusionment that characterize the burnout process: enthusiasm, stagnation, frustration and apathy (11).

Freudenberg (1980) suggested that burnout develops when individuals firmly believe in their idealized images of themselves as charismatic, dynamic, inexhaustible and super competent; trying to uphold their idealized self-image with false strategies: disengagement, distancing, dulling and deadness.

North (1992) created a list of 12 phases of the burnout process (12):
The compulsion to prove oneself; often found at an early career stage, characterized by excessive ambition ("I feel weird when I leave work early sometimes");

Working harder; in order to meet high personal expectations, he/she tends to focus solely on work. It may happen that they become obsessed with doing everything themselves to show that they are irreplaceable ("I often work long hours or do a lot of overtime");

Neglecting their needs; since they have to devote everything to work, they now have no time and energy for anything else ("Lately, I have to put in extra attention to make sure that I do not forget or overlook anything");

Displacement of conflicts; he/she becomes aware that what they are doing is not right, but they are unable to see the source of the problem. More conflicts with colleagues or the spouse arise, along with not sleeping well, showing first physical complaints, forgetting appointments, accumulating appointments, not showing up on time, etc. ("I have trouble falling asleep or I often lie awake at night");

Revision of values; he/she becomes insensitive, emotionally blunt, tough and calculative. The concept of time is disturbed and only the present is seen. The personal horizon becomes narrow ("I feel considerably more stressed at work than before");

Denial of emerging problems; the affected individuals start becoming increasingly cynical and bitter, and gradually start isolating themselves from the outside world. They show signs of impatience, intolerance and latent and/or overt aggressiveness ("I often feel that others do not understand me");

Withdrawal; spouse, family and friends are now seen as a burden or even as being hostile. Criticism is not tolerated anymore. The affected persons describe a feeling of loss of orientation and helplessness. In order to feel good, they turn to alcohol, drugs, etc. ("I do not really feel happy about anything anymore");

Obvious behavioral changes; they now start showing signs of paranoia—everything is seen as an attack. Any additional demand at work is seen as a burden, and they try to evade it ("I would like to be left alone by others when I am at home");

Depersonalization; individuals describe a loss of contact with the self; they see themselves as machines that have to function. They see their lives as being meaningless and inescapable ("I function more and more like a machine");

Inner emptiness; individuals feel completely dejected, blank, useless, exhausted, anxious or panic-stricken. Phobias and panic attacks can occur. They may exaggerate activities such as overeating or sex to overcome these feelings ("I have an unpleasant feeling about work already on the weekend");

Depression; in that case, the person is exhausted, hopeless, indifferent and believes that life has no meaning ("I often want to just lie in bed and sleep");
Burnout syndrome; in this phase, physical disease, mental and emotional collapse occur; the situation is an absolute emergency ("I just cannot do anything anymore") (12).

CARING FOR OTHERS VERSUS SELF-CARE: THE GREAT HUMAN DRAMA

Numerous studies indicate that communication between clinicians and patients is the single most effective predictor of patient adherence to a treatment plan. If the clinician utilizes effective communication skills, the patient will become an educated participant in the treatment. But effective communication occurs only if the receiver understands the exact information or idea that the sender intended to transmit. The ability of empathetic communication is a teachable skill that has tangible benefits for both clinicians and patients. Effective empathetic communication enhances the therapeutic effectiveness of the clinician-patient relationship. Appropriate use of empathy as a communication tool facilitates the clinical interview, increases the efficiency of gathering information and honours the patient. It may even happen that someone's life depends on the ability of a health professional to communicate effectively. However, when confronted with people's needs, problems, and suffering, it is not easy for the health professional to maintain his/her own emotional balance. The ability to empathize can be a double-edged

sword; it is simultaneously doctors' or nurses' great asset but also their point of real vulnerability (6).

Exhausted when saying "yes", guilty when saying "no"—it is struggle between giving and taking, between other care and self-care, between altruism and self-preservation. This is a universal dilemma in occupational fields involving helping, teaching, guiding, advising or healing. Here, giving is a constant requirement for success (4).

Patients seek medical help due to physical problems but often their emotional needs from the doctor become equally important (to be accepted and understood). Following the patient's needs, the practitioner must be able to feel for, be involved with and then separate from person after person in a highly effective, competent, useful way. Making empathic attachments, being engaged and making positive separations with others in need of healing is the core professional skill of clinical practice. In this context, a physician's work reflects the larger drama of connection and disconnection between people. With the endless cycle of caring (empathic attachment, active involvement, felt separation, recreation), various questions arise. How can one be both connected and separated from the ocean of distress emotion, especially when patients enter into contact with a plurality of unsolved personal problems? When they respond with intense negative emotions—transference reactions of stubbornness, resentments, anger and lack of cooperation? How to cope with special cases—when patients are frightened or confronted with bad news? How to prepare them to make changes in lifestyle, to adhere to the medical regimen when they are not ready—over and over again—this month, this year, throughout a career? And finally, why should one work so hard and do so much, but get so little in return (4)?

Learning how to regulate and modulate the level of emotional attachment takes time. And it is a paradoxical skill—learning how to be emotionally involved, yet emotionally distant, united but separated. The demand to be attuned, to be interested, to be energetic for another person—who is often sad, afraid and worried, desperate and angry, hopeless or in deep resistance—and to continue to do it well with patient after patient, can be difficult as well as deeply rewarding work (4, 16).

BALANCING CARING FOR OTHERS AND CARING FOR SELF

A. Sustaining the professional self

Sustained by meaningful work: To alleviate physical pain of post-surgery patients, enable them to get better mobility, vision, hearing, metabolism and sleep or/and to reduce their fears and anxiety, etc.—these are all ways in which health professionals can make people' lives a little better. They do their work because they evaluate it to be of great value. Work that benefits other people can provide enormous meaning and purpose. For the sustenance of the self, therefore, health professionals must find a way to feel that they are succeeding—even if it is in very small ways (4).

Maximizing the experience of professional success: The feeling of professional success depends on four fields of health professional functioning: patients, colleague's work support, relationships, expertness and competence. The first two domains cannot be influenced, because the lives of others are beyond our control, but control over own work and relationships provides some satisfaction and is possible (4).

Reduced expectations and focusing on small changes: Helping professionals often want to help so much that they get caught up in wanting to make a big difference for many people. It can strengthen patient's ambivalence about change and make improvement less possible. Reduced expectations and focusing on small changes can be more empowering for both patient's and practitioner's self-care (4).

Thinking in long-term: Such type of thinking and building professional and personal self-care can change one's perspective and approach (coping ability throughout the entire professional career) (4).

Individually-designed development method: To stay alive and grow professionally, one must be open to

new information and feedback about one's own performance. Experience is necessary for moving from one level of expertise to another, but experience alone does not produce expertise (4).

Professional self-understanding: Grosch and Olsen (1994) pointed out that many individuals attracted to the helping professions may come from families in which the helper, as a young person, took on the role of an adult, perhaps in a highly stressed family and received validation and admiration for their helping attempts. In adulthood, the need for admiration is sought in a helper role but cannot be satisfied because the patient role is not designed to meet the basic self-esteem needs of professional helpers. According to the attachment theory, practitioners who have a poor personal history of attachment may have problems to perform their work well—this is a great reason for understanding one's own professional role (4).

Creating a professional greenhouse at work: Five elements seem to create a greenhouse effect at work: leadership that promotes a healthy other-care vs. self-care balance, social support from colleagues, receiving other-care from a senior consultant, mentoring others and having fun. For example, if a leader speaks on a symbolic level "Here we care for patients and also for practitioners" it will achieve a powerful force for each individual within the group and his/her professional vitally (4).

Using professional venting and expressive writing to release distressing emotions: Because practitioners need to motivate individuals for change when their internal motivation is limited, and as they often work in an environment of loss, anxiety and pain, venting and expressive writing can be a positive professional method to stay and offer hope within the professional caring cycle (4).

The "good enough practitioner": Practitioners are often afraid of underperforming and want to perform perfectly. However, this is an illusion which can lead to occupational exhaustion as well as a loss of creativity and personal growth (4).

Understanding the reality of early professional anxiety: A study found high levels of pervasive anxiety among beginners and a substantial reduction of this anxiety among seasoned veterans (Rennestad and Skovhold, 2003). This is not surprising because the beginner must rely on the expertise of others, textbook theories, journal research studies or the advice of a supervising senior practitioner. The initial anxiety can thus only be reduced when external expertise is replaced with internal expertise (4).

Increasing intellectual excitement and decreasing boredom: Some veteran practitioners may get bored because of having a narrow set of clients and performing identical health procedures repeatedly. In such cases, it is important to consider ways to create more novelty, challenge and energy. Experienced practitioners must keep reinventing themselves through periodical changing of work tasks (e.g., doing supervision instead of direct service), methods (e.g., replacing individual process with group process), population (e.g., working with adolescents instead of adults), or/and time allocation (e.g., research rather than clinical practice all the time) (4).

Minimizing ambiguous professional loss: Ambiguous professional loss describes the constant series of connections that practitioner make with the patient that end without ending. Awareness of this stressor can help to acknowledge it. There are many small ways to blunt ambiguous professional loss making the ambiguous concrete, e.g., through a promotion, a new certification or professional writing (4).

Learning to set boundaries, limits, and to say "no": It is useful to admit to oneself that success and failure are relative, and that there are always limitations to what someone can offer. It is important to avoid being preoccupied with one's own inferior status or with heroic aspirations as Stone (1988) highlighted (4).

B. Sustaining the personal self

Professionals in the helping fields need to be assertive about their own well-being and balance active health care in the four dimensions of health: emotional/social health, physical health, intellectual health and

spiritual health. We present some methods to reach that. The aim is not to increase a person's capacity to be self-centered, but to enable the capacity to help others over decades of professional work (4).
First, for those assisting others with physical, emotional and educational needs, it is important to continuously search and find positive life experiences which could produce feelings of zest, peace, euphoria, excitement, happiness and pleasure (4).

Second, it is important to be aware of the danger of one-way caring relationships in the personal life. Those who are in the helping professions are experts at one-way caring. Others search for their help because of their expertise and caring attitude, but this unidirectional communication should not extend into their personal life. They have to make a distinction between personal relationships on the one hand and professional relationships on the other. If no boundaries are defined, a doctor may be asked to diagnose a mysterious ailment in the middle of a festive party (4).

Third, each part of the personal self—for example, emotional, physical, humorous, loving, financial, playful, priority-setting, recreational, etc.—need nurturing for ongoing sustenance (4).

Because helping professionals often use the self as the work instrument, it is important to be open-minded und understanding toward oneself in the cases of painful failure rather than being harshly self-critical. Other useful coping strategies include perceiving experiences as a part of life rather than as defeat, and holding painful thoughts and feelings in a mindful awareness rather than over-identifying with them. Developing a sense of self-compassion can help individuals to respond to the highs and lows of the work in a more productive way (4).

There is strong evidence that intense physical exercise is an antidote for emotional toxins in the helping profession. Because helping professionals often have lack-of-time problems and tend to put the needs of others before their own, physical activity is advisable (4).

The next essential component of overall health is sleep (7 to 9 hours per night), because a lack of sleep is linked to decreased cognitive performance and mood difficulties such as anger, anxiety and sadness (4).

Maintaining a sense of humor is the next career-sustaining behavior. Actively laughing, being playful, telling jokes and being humorous are very positive activities for individuals whose work environment is often filled with human problems. Learning how to be both serious and have fun can help sustain the self (4).

Affection in helpers' personal life can be a source of professional vitally, enabling them to sustain balance in the middle of professional stress. For many practitioners, a family is a very rich source of the best ingredients of self-care. For others, loving and being loved takes a different form. In general, however, it is confirmed that "being loved by another, or others" is an excellent way of self-care for those in the high-touch fields (4).

Another important contributor to overall health is nurturing of the financial self. Most jobs within high-touch occupations are paid modestly or, more accurately, paid well but not in cash. In such a case, the pay can come from making a significantly positive difference in the lives of many other people, or from the satisfaction and pleasure one gets from working at the deeper level of human existence. Nevertheless, low-paying jobs in human services, education or health can become demoralizing and hence a source of permanent financial stress, especially in the consumption culture and by financially unassertive individuals. Consequently, this could affect the helping professionals and lead to unflavored reactions. Dominguez and Robin (1992) argue that frantically living to pay for overspending is a very unwise use of time, which they call a person's most precious resource. In their book "Your Money or Your Life" they draw attention to the option "chasing money for spending or having time for a life." They suggest that the attitude "chasing money for spending" reduces the time and energy that individuals need to work to pay bills instead of using their time for richly meaningful life activities (4).

The world of play helps make the world of work possible. This is a child ego state. The emotional worlds of the practitioners is filled with adjectives like earnest, hard, stressful, challenging, serious and more intense words like sad, anxious, fearful and angry. The words of play are different and include fun, zest, relish, delight, enjoyment, gusto, enthusiasm, exuberance. How should one reveal this part of oneself? There are lots of ways, for example while cycling, we tend to commune with nature, feel life's elements and repeat a simple mantra of sensations: blue sky, white clouds, green trees, apple scent, bright sun, warm breeze. Looking through this kaleidoscope of color, shape, and form brings pleasure and peace, as does just doing nothing but transcending the reality of the work life and being renewed by one's own playfulness (4).

For individuals, especially those in helping professions, skills in prioritizing tasks and effective time management are imperative. The modern life is overloaded with information, boundaries are disappearing and everyone can be reached by cell phone, e-mail, text messing, video conferences, and social networking anytime and anywhere. Being in a state between two conflicting options, standing upright and following one's own compass—these skills are mastered by setting priorities and boundaries (4).

For practitioners and others in a helping profession, hobbies are of special value. The key is to be taken away from the attention only focusing on professional job demands. Usually hobbies are—in contrast to helping professional work—concrete; one can see, feel and enjoy the results (4, 16).

CONCLUSION

It is important for physicians to get familiar with the occurrence of burnout, to become aware of potential imbalance in their caring relationships with patients. They have to recognize threats and signs of emotional exhaustion, depersonalization and reduced effectiveness, in order to take all the necessary protective measures for themselves in timely manner. A focus on the job environment along with the person in it is essential for interventions in dealing with burnout. Therefore individually-oriented approaches (cognitive-behavioural techniques, time management, assertiveness training, rational emotive therapy, training in interpersonal and social skills, relaxations techniques, and a meditation) may help physicians and other health professionals, but they may not be sufficient enough in dealing with imbalance between work environment demands and resources effectively. Especially, since it is known that organizational leadership has a significantly influence on the physician's well-being at work (Shanafelt et al., 2015). So neither changing the setting nor changing the individuals is enough; effective change occurs when both develop in an integrated fashion.

REFERENCES

1. Lynn R. Burnout in Professional Care Giver: Does the Phoenix Have to Burn or Why Can't Icarus Stay Aloft? In: Wessells DT et al, editors. Professional Burnout in Medicine and the Helping Professions. New York: Routledge, 1989: 21-6.
2. Maslach C, Jackson SE. Maslach Burnout Inventory. Palo Alto: Consulting Psychology Press, 1986.
3. Hogan RL, McKnight MA. Exploring burnout among university online instructors: An initial investigation. Internet and Higher Education 2007; 10: 117-24.
4. Skovholt TM, Trotter-Mathison M. The Resilient Practitioner. Burnout Prevention and Self – Care Strategies for Counselors, Therapists, Teachers, and Health Professionals. 2 nd edit. New York: Routledge, 2011.
5. Bakker AB, Demerouti E. The Job Demands-Resources model: state of the art. JMP 2007; 22: 309-28.
6. Maslach C, Schaufeli WB, Leiter MP. Job Burnout. Ann Rev Psych 2001; 52: 397–422.
7. Fischer HJ. A psychoanalytic view on burnout. In: Farber BA, editor. Stress and burnout in the human service profession. New York: Pergamon Press, 1983.
8. Schaufeli WB, Buuk BP. Burnout: An Overview of 25 Years of Research and Theorizing. In: Schabracq MJ, Winnubst JAM and Cooper CL, editors. Handbook of Work and Health Psychology. 2 nd edit. New York: John Wiley and Sons, 2003.
9. Schaufeli WB, Enzmann D. The Burnout Companion To Study And Practice: A Critical Analysis. London: Taylor and Francis, 1998.
10. Burisch M. Das Burnout-Syndrom. 3. Ausgabe. Theorie der inneren Erschöpfung. Heidelberg: Springer Medizin Verlag, 2006.
11. Rakovec-Felser Z. Professional Burnout as the State and Process – What To Do? Coll Antropol 2011; 35: 577-85.
12. Ponocny-Seliger E, Winker R. 12-phase burnout screening – development, implementation and test theoretical analysis of a burnout screening based on the 12-phase model of Herbert Freudenberger and Gail North. ASUI 2014; 49: 927–35.
13. Westman M, Bakker AB. Crossover of Burnout among Health Care Professionals. In: Halbesleben JRB, edit. Handbook of Stress and Burnout in Health Care. New York: Nova Science Publisher, 2008: 111-25.
14. Toker S, Melamed S, Berliner S, Zeltser D, Shapira I. Burnout and Risk of Coronary Heart Disease: A Prospective Study of 8838 Employees. Psychosom Med 2012; 74(8): 840-7.
15. Melamed S, Shirom A, Toker S, Berliner S, Shapira I. Burnout and risk of cardiovascular disease: evidence, possible causal paths, and promising research directions. Psychol Bull 2006; 132: 327-53.
16. Rakovec-Felser Z. Psihologija telesnega bolnika. Razumeti in biti razumljen. Maribor: Založba Pivec, 2009.