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How Much is Geriatric Caregivers Burnout Caring-Specific? Questions from a Questionnaire Survey

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Summary:

Background and Aims: Research dealing with occupational strain and burnout in geriatric care is generally focused on the behavioral problems of the patient and/or the psychological traits or attitudes of the carers rather than on organizational functionality. This paper describes data from a survey of all geriatric professions, using the Stressful Events Questionnaire (SEQ), a tool that takes into account multiple dimensions that can affect the genesis of burnout, including the patient, the geriatric health care professional, and the health care organization. The aim of this study is to compare patterns of answers among different roles in geriatric care.

Method: Patterns of SEQ answers are described for the entire sample as well as for workers experiencing burnout and for each caring profession investigated: certified nursing assistants (CNAs), registered nurses and physicians/psychologists.

Results; In general, carers refer more often as stressful the facility-related events; the only exception is that CNAs working in general hospital geriatric wards refer most often as stressful the patient-related events. The self-related events area seems to have a great importance for all professions.

Discussion: The specificity of gerontological burnout has to be discussed, to better define the role played by caring problems, including psychological attitudes of carers versus the role played by the institution and by the social situation of each worker. For CNAs, the interaction between educational background and the length of time spent as a CNA seems to be a critical topic.

Keywords: Burnout, caregiver continuous training, geriatrics, healthcare marketization, nursing assistants.

INTRODUCTION

Despite the growing mass of scientific reports, attention to job strain and burnout in the health professions has remained high since the 1970s. Attention to caregiver burnout has persisted for many reasons, including the risk of worsening professional performance and caring malpractice, as well as problems with absenteeism and consequent work stoppages, the early retirement of professionals and the increasing loss of personnel from the caring professions [1]. The shortage of health care professionals is linked to major problems in public health.

It is well known that the impact of stress and burnout on the indirect costs of health systems is very high from an economical point of view [2].

Professional caregivers in the geriatric domain are at risk for burnout, because working with the elderly forces confrontation with serious illness and death.

From a synthetic point of view, as Cohen-Mansfield states [3] "because the long-term care industry is labor-intensive, staffing concerns are always significant".

In general, the bio-medical literature cites the role of wear due to caregivers' interaction with patients' disability and their challenging behavior in caregiver burnout [4, 5].

In a wider bio-psycho-social perspective, researchers give attention to the psychological profile and vulnerability of the professionals in geriatric health care, especially regarding the coping strategies, with an aim of improving their resilience [6].

Contributions based on management theory emphasize psychosocial and organizational factors that can provoke as well as prevent stress, such as leadership style, ambiguous tasks, role conflicts, and level of structured social support (buffering hypothesis) [7].

Additionally, growing attention has been recently paid to the personal situation of the geriatric health care professional, the so-called problem of *work-life balance*, or equilibrium between professional and personal spheres. That equilibrium may be variable and subjective for each worker [8].

From a general point of view, the specificity of the ward as an organizational factor also seems to be connected to the dynamics of burnout [9]. Nevertheless, it is difficult to approach the whole organizational functioning of a facility, with the multiple variables that can influence job distress among professional caregivers. For these reasons, studies seldom take into account some factors that could have an

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effect, such as of facilities of absenteeism, as well as their rates of employee turnover or loss.

Nevertheless, an examination of organizational and institutional factors in burnout is necessary, because these factors can play an important role in the genesis of stress and burnout, following the social model of stress [10].

A geriatric facility is always integrated into a specific health system. In this sense, a variable such as the trade power of professionals in the public or private health market should be taken into account in research on professionals' wellbeing. Nevertheless, studies concerning burnout seldom deal with indicators such as ownership of the facility [11].

Trade power (with job insecurity as a narrow consequence) is linked to legislation and contractual references, as well as to human resource policies of each organization, particularly the mechanism of management of carer's progression as well as the mechanism of remuneration of the professional. Research on the economic dimensions of the problem is likely to gain growing attention in the future, due to the financial limitations to which all health systems in developed countries will be subjected [12].

Facing to that complexity, the study on the opinion of geriatric workers about the importance of three different types of factors (i.e. caring factors, personal factors and social factors) in the genesis of their job strain and burnout seems to be interesting.

METHODS

In the geriatric care domain, the 45-item Stressful Events Questionnaire (SEQ) [13, 14] takes into account three sides of the stress: the geriatric and/or psychogeriatric patient (16 items), the worker's self dimension (10 items); and institutional problems, named in the questionnaire as "facility-related" events (19 items). This last sector of the questionnaire deals with organizational problems in terms of resources and "functioning".

The SEQ works with the statement of the carer about the stressful or nonstressful nature of each event/item.

To our knowledge, the only non-English utilization of the SEQ concerns the context of a large Italian survey about stress and burnout. This survey was conducted at the end of the 1990s among 540 professionals working in three public nursing homes (NHs) as well as in nine public general hospital geriatric wards in Northern Italy [15].

This survey used General Health Questionnaire-12 (GHQ-12) [16] and the Maslach Burnout Inventory (MBI) [17], where SEQ was also distributed but not included in analysis.

In the present study patterns of the SEQ replies among this sample of geriatric health care workers are described and discussed.

The mean percentage of "stressful statement" for each of the three areas of the SEQ (i.e. patient-related events, self-related events and facility-related events) are presented with respect to the whole population of workers, in general hospital geriatric wards and in NHs. The mean percentage of "stressful statements" among the sub-sample of workers experiencing burnout, defined as individuals who score positive for burnout on at least one MBI subscale, is also presented.

The profile of "stressing answers" for each health care profession is also presented: for certified nursing assistants CNAs), registered nurses (RNs) and physicians / psychologists.

Finally the CNAs were divided into two groups of workers with high and low seniority, (defined as greater or less than ten years of work as a specific health care professional), taking into account their educational level (high or low).

Each subgroup had a different position regarding burnout, following the MBI: people experiencing burnout (scoring positive on at least one MBI subscale) and people not experiencing burnout (scoring positive on neither MBI subscale).

RESULTS

Results concerning the SEQ replies of all workers in general hospital geriatric wards and in NHs are reported in the Table **1**.

The facility-related events are those the most often reported as stressful by all workers, especially by the general

Table 1. Events Described as Stressful by General Hospital Workers (n = 183) Expressed as a Mean Percentage for Each Class of Event

	All Workers	**Workers in Burnout**
Patient-related events (16 items)	36.6	43.3
Self-related events (10 items)	30.2	35.2
Facility-related events (19 items)	39.5	47.1
Events described as stressful by Nursing Home Workers (n = 172) expressed as a mean percentage for each class of event		
	All Workers	**Workers in Burnout**
Patient-related events (16 items)	28.4	37.9
Self-related events (10 items)	17.3	26.9
Facility-related events (19 items)	28.6	40.6

Table 2. Events Described as Stressful by General Hospital RNs (*n* = 115) Expressed as a Mean Percentage for Each Class of Event

	All RNs	RNs in Burnout
Patient-related events (16 items)	42.7	44.1
Self-related events (10 items)	32.3	34.9
Facility-related events (19 items)	46.3	49.8

Table 3. Events Described as Stressful by General Hospital CNAs (*n* = 26) Expressed as a Mean Percentage for Each Class of Event

	All Workers	Workers in Burnout
Patient-related events (16 items)	38.7	45.1
Self-related events (10 items)	22.8	36.5
Facility-related events (19 items)	34.7	42.2
Events described as stressful by Nursing Home CNAs (*n* = 107) expressed as a mean percentage for each class of event		
	All Workers	**Workers in Burnout**
Patient-related events (16 items)	29.9	42.3
Self-related events (10 items)	18.8	31.9
Facility-related events (19 items)	30.0	44.6

Table 4. Events Described as Stressful by General Hospital MDs and Psychologists (*n* = 41) Expressed as a Mean Percentage for Each Class of Event

	All Workers	Workers in Burnout
Patient-related events (16 items)	20.7	28.7
Self-related events (10 items)	25.9	37.6
Facility-related events (19 items)	30.9	48.1

hospital RNs (Table **2**), and those which increased more among workers experiencing burnout, in both general hospitals and NHs.

The greater difference between the general hospital and NH workers, concern the self-related events area (reported as stressful for 30.2 % of workers in the general hospitals, and 17.3 % of workers in NHs).

General hospital CNAs are the only group having mainly patient-related problems, independently of their burnout status (Table **3**).

Nevertheless, it is of interesting to observe that among general hospital CNAs the wider difference between workers in burnout or not in burnout was in the self-related events area, with a difference of 13.7 %. On the contrary, this same area shows only a slight increase among all geriatric health care workers in general hospital (5 %).

Physicians/psychologists are the only subgroup in which self-related events are even more stressful than patient-related events (Table **4**).

Finally, with respect to work seniority ("young CNAs" versus "old CNAs") (Table **5**), young CNAs with a higher level of education show a lower burnout level than those with a lower level of education. However, among "old CNAs" this situation is reversed: in fact, those with less education experience less burnout. In other words, CNAs with a higher educational level seems associated with less burnout at the beginning of their careers, but are more likely to experience burnout later in their careers.

DISCUSSION

Current approaches to burnout are often sector-based with respect to the type of worker examined as well as the discipline of reference of the researcher (psychiatry, nursing, occupational medicine, or economic management).

Generally speaking, biomedical literature devotes less attention to the organizational and economical sides of the problem.

Taking into account these factors, it seems of interest to describe the subjective perceptions of stress among all gerontological roles to better explore the link with patient problems as well as with self-related and organizational problems.

Table 5. Relationships Between Work Seniority, Formal Education and Burnout Levels Among CNAs (*n* = 122*)

	MBI (EE)	MBI (DP)	MBI (PA)
CNAs with basic education level and < 10 years' work seniority(n = 27)	17.2	4.8	37.0
CNAs with high education level and < 10 years' work seniority (n = 21)	12.6	2.3	40.5
CNAs with basic education level and > 10 years' work seniority (n = 64)	19.4	4.7	35.6
CNAs with high education level and > 10 years' with work seniority (n = 10)	20.0	4.9	36.8

* 11 CNAs did not provide information about seniority

The link between a subjective statement of the worker and the "true" cause of the stress is never well defined: for example, workers could describe a stressful situation in self-dimensional terms when the situation may actually arise from other mechanisms. Therefore, there are some bias even possible, linked to the specific sensitivity of worker as well as a "take a pencil" reaction.

Furthermore, the SEQ has not been investigated regarding its construct validity, so overlap is possible between events that could act on the self area and the facility area at the same time.

Despite these limitations, regarding stress and burnout the subjective dimension of carers remains important. In reality, people may organize their choices on the basis of a subjective statement (regarding work stoppage for example).

From a merely descriptive point of view, these data seem to confirm the first observations of Benjamin and Spector [13]: according to the SEQ, not only for RNs, but for all gerontological healthcare roles the facility-related events are those most frequently perceived as stressful.

In addition, the area of self-related stressful events seems to be quite critical, particularly the wider difference between geriatric health care professionals in NHs and hospital wards as well as the wider difference between hospital CNAs experiencing or not experiencing burnout.

Facility and self-related events are by definition independent factors from patients. Therefore, furthers studies are probably needed in gerontology to better investigate the true role played by clinical problems in the genesis of job strain.

Patient-related events (the clinical dimension) are not a major problem for every gerontological health role in general hospitals, but only for general hospital CNAs. Unfortunately, general hospital CNAs are unlikely to benefit from structured liaison-consultation psychiatry intervention, because of their low level of interaction with psychiatrists.

Nevertheless, among general hospital CNAs, as previously described, the greater variation between all CNAs and CNAs experiencing burnout is associated with self-related events. In this regard, one could speculate that patients become a problem for carers who are experiencing personal problems (in the context of a critical work-life balance) and institutional problems (for example, in the context of high job insecurity depending on the type of contract).

These data seem confirm the specificity of the role of CNAs in gerontological field [18]. Despite their fundamental tasks, CNAs often present a lack of education regarding the psychiatric management of behavioral problems; additionally, they exhibit a lower compliance to quality-oriented survey projet [19]. The annual rate of job turnover for CNAs in long term care (such as gerontology) is very high, nearing 100 % in some countries [20]. On the other hand, CNAs may be more affected than other geriatric health care professionals by the labor market situation, as well as by cyclic variations in the economy, (e.g., regarding job insecurity, which is linked to characteristics of each national labor market as well as to legislation and social policies) [21].

From this point of view, one might observe that self-related events concern social conditions and socio-political conditions (from family situation to home conditions, from public transportation to job insecurity) as well as strictly personal conditions [22].

Again regarding CNAs, a higher level of education seems less associated with burnout at the beginning of the career, but is more associated with burnout later on. These descriptive observations fit with some data indicating that among CNAs, those who remain tend to have less formal education than those who leave [23, 24]. Clearly, an adverse selection phenomenon is possible, such that among more-educated CNAs only those unable to leave for a better position are forced to remain.

One could imagine that better-educated professionals could more easily leave the CNA role and progress on the labor market, whereas those who remain at the same level despite their high education may have other problems. Alternatively, the following hypothesis could be evaluated: people who have a better education are more able to cope with stress and burnout at the beginning of their activity, but because of their higher level of expectations as well as their higher ability to criticize their work, later on these people either leave the organization or become subject to a higher risk of experiencing burnout.

Seniority is a critical topic in geriatric health care. Burnout scores among geriatric nurses increased with seniority, attaining levels much higher than those observed in oncology

nurses [25], among whom burnout decreases with length of employment experience.

The interaction between the level of formal education and the development of work seniority in geriatric care requires more investigation, taking into account the continuous training processes. Longitudinal, analytical studies are required to better evaluate this topic.

Of course, some caution is needed when facing this type of problem, and the different recruitment policies in each country must also be taken into account.

In this survey, the wider difference between geriatric health care workers in NH and general hospital settings concerns self-related events (Table **1**). People working in general hospitals perceive self-related events as stressful more frequently than people working in NHs, independent of their burnout situation. There is maybe a "basic" more stressing situation in the general hospital. People working in general hospital geriatric wards may experience a higher level of baseline stress compared with people working in the NH setting. Therefore, self-related events seem to play a major role, which may weaken the "true" caring specificity of carers' burnout. However, the importance of the organization factors must be emphasized, as shown in a Dutch study dealing with RNs and caregivers in a hospital and NH settings [26].

Although these data refer to a survey carried out some years ago, the situation is unlikely to have improved since, particularly when examining the phenomena linked to globalization, including the migration phenomena connected to the social inequalities, with the so-called marketization of the carers' role. This phenomenon has been rising progressively in Italy since the end of the 1990', in conjunction with the population becoming older overall, among the highest in the Organization for Economic Cooperation and Development (OECD) group [27].

This transition occurs at a time when the level of resources is becoming more and more critical in all developed countries (e.g., with regards to resources available for the support of professionals, and a continuous rise in the retirement age).

CONCLUSION

Professional geriatric carers, and in particular carers experiencing burnout, seem to show the following trend: above all other sources, they identify the facility/institution as a source of stress. Institutional functioning in geriatric facilities, as well as management and human resources policy area must be better explored. To achieve this aim, a multidisciplinary frame is needed that integrates different approaches, from the biomedical and psychosocial to the socioeconomic and managerial perspective.

To achieve continuous quality improvement, both analysis of the organization (with its links to the labor market) and attention to individuals (with their subjectivity) are required.

COMPETING INTERESTS

The author declare that they have no competing interest.

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