Prevention of *burnout* and its impact on *coping* strategies

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Summary

The subject of our research is the burnout of nurses confronted with the successive and repeated deaths of patients on their ward. We propose to discuss the theoretical links between burnout, stress response strategies and alexithymia. Our initial hypothesis is that the situation of working in a palliative care unit tends to reduce :
- the characteristics of burn-out, *particularly in terms of the three components developed by Maslach: emotional exhaustion, depersonalisation and loss of a sense of personal accomplishment;*

- negative, defensive and ineffective coping strategies (withdrawal, denial, guilt, alexithymia, aggression).

On the other hand, working in a palliative care unit with the support of a team trained and motivated to work with the dying tends to develop more effective, positive and adaptive strategies: focus, use of social support, conversion, control.

The verification of this hypothesis is based on the analysis of the results obtained with the Toulousian Coping *Scale and the*

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Maslach Burnout *Scale proposed to two groups of nurses, one working in a palliative care unit and the other working in a traditional cancer ward.*

Keywords: *burnout, coping strategies¸ alexithymia, palliative care, curative care.*

Introduction

The need to take into account the suffering of carers faced with the death of the patients they care for leads us to better define the concepts of stress and burnout in the context of palliative and curative care. Faced with this stress, which generates a real crisis, carers develop *coping* strategies in order to adapt, defend themselves against themselves and others, and thereby re-personalise themselves by reaffirming their identity (identity strategies) and relaunching a self-project (project strategy). If the health professional experiences the crisis in an intense way, if his or her internal resources and those linked to the environment are insufficient, then he or she may devalue him or herself by developing a negative self-image and a loss of interest in patients: characteristic signs of *burnout.*

Position of the problem

In wards where deaths are frequent, nurses' stress is expected to occur more frequently and with greater intensity. Caregivers are in a difficult situation when faced with the permanent crisis of the dying person and the families. As Vachon (1978)

has shown, they would feel stress comparable to that of a widow or widower through the mourning work that their activity involves.

When this confrontation with the dying creates an excessive level of external pressure, *"perceived to threaten psychological well-being"* (Folkman and Lazarus, 1980), the nurse responds with intense stress. Her *coping* strategies may become ineffective, perceived as socially negative, manifesting as the presence of disturbed behavioural and physiological responses. The state of extreme suffering of the carer is defined by the concept of professional exhaustion, a real emotional, mental and physical wear and tear, accompanied by the devaluation of his/her competence. It therefore becomes interesting to analyse the links between coping strategies and burnout and to verify the influence of the type of care on the nature and intensity of these links.

Palliative care's primary objective is to relieve the overall suffering of the person at the end of life and their family, rather than treating to cure (the objective of curative care). Focusing on the person at the end of life requires active care: treatment of pain and symptoms, listening to and providing psychological support to the dying person and the family, and support for the health care team. Working in a palliative care unit leads the nurse to be less of a failure in her reparative dynamics and to integrate palliative care into her daily practice, valuing it as much as curative care.

Furthermore, through the sharing of experiences in institutionalised discussion groups, the emotional expression of professional experience encourages the recognition of the existence of the carer's suffering. The need to reflect on the modalities of relationship and care around the patient at the

end of life and his family appears, therefore, in palliative care services, as one of the ways to prevent professional wear and tear.

Coping behaviours as a response to the stressful situation

The conceptualisation of *coping*, i.e. the definition and analysis of the modalities by which a subject reacts to a stressful situation, is a central aspect of contemporary theories of stress. Coping behaviours, maintaining a certain psychosocial adaptation through stress management, are defined as a dynamic process mediated by two other - processes: controllability (cognitive appraisal) and the search for effective control (strategies), which are themselves in interaction (Paulhan, 1992).

These processes are developed in relation to the individual's personal resources and environmental factors. Coping strategies include the appraisal by which a person attributes meaning to the situation (e.g. threatening) based on his or her own ability to respond. The various works on the concept have been based on different conceptions: binary (Lazarus and Folkman, 1984), three-dimensional (Billing and Moos, 1981; Pearlin and Schooler, 1978), or multi-dimensional (e.g. fourteen dimensions proposed by Carver, Scheier and Weintraub, 1989).

However, *coping is* defined by all as the set of modes, strategies and behaviours developed by the subject to cope with the stressful situation. The critical analysis of existing *coping* scales has enabled the team of the "Personalisation and Social Change" Laboratory to develop a new scale defined on the basis of three fields, six strategies and eighteen dimensions (Tap, Esparbès and Sordes-Ader, 1993),

The "fields" defined by these authors in terms of behaviours and activities concern: 1. the *behavioural* or conative *field*; action in preparation and execution; 2. the *informational* or cognitive field: the process of seeking information about the environment in order to make the behaviour appropriate to the situation; 3. the *emotional* or affective *field*, including not only emotions, but also values and feelings

The six proposed strategies each include three dimensions (associated with the active, cognitive and affective fields):

Focusing: focusing on the activity or information as a means of solving the problem. Emotional focus, on the other hand, is characterised by emotional invasion, for example in the form of aggression and/or guilt;

Social support, characterised by the offer of or demand for external help, intervenes at the level of action (cooperation) as well as the provision of information or emotional support;

Withdrawal (avoidance of the situation, mental withdrawal, addictiveness). Addictiveness refers to compensation in an oral mode: refuge in tobacco, alcohol, food, medication.

Conversion involves the change or transformation of actions, attitudes (acceptance of reality) or values (religious, moral conversion).

Control may be involved in mastering the situation, in analysing and planning behaviour, or in managing emotions.

Denial can be manifested by distraction, denial of the problem or alexithymia, the latter characterised by the inability to describe one's emotions and the tendency to repress them.

Furthermore, the study of coping strategies in terms of social desirability highlights the ***perceived positive or negative nature of reactions to stress*** (Sordes-Ader *et al*., 1995). The positive perceived behaviours include active and cognitive focus, the three dimensions of control and the three dimensions of social support. Some dimensions, more ambivalent, mediate between the positive and negative dimensions: behavioural conversion, value conversion, distraction and acceptance.

Perceived negative behaviours combine the dimension of emotional focus with withdrawal and denial strategies, in particular the dimensions of denial, mental withdrawal and alexithymia. Alexithymia is described (Pedinielli, 1992) on the basis of four dimensions: the inability to express emotions verbally, the limitation of the imaginary life, the tendency to resort to action to avoid conflicts and the detailed description of facts, events and physical symptoms. It is seen as an effect of stress involving the inability to identify stressful events and produce effective adaptive strategies, Krystal (1988) mentions the existence of alexithymic traits in concentration camp survivors, who have experienced severe stress related to - traumatic events. Nurses who are frequently confronted with the dying have been compared to concentration camp survivors. Millerd (1977) refers to the *survivor syndrome* found in nurses who are convinced that they are living their lives at the cost of others.

Alexithymia, defined as a negative ***coping*** strategy, can therefore be related to the caregiver burnout syndrome.

Burnout

Freudenberger (1974) first mentioned the term "***burnout".*** This syndrome of physical and emotional exhaustion

particularly concerns professionals involved in the helping relationship. It manifests itself through a real identity crisis that calls into question all the characteristics of the person, on the physical, psychological and relational levels.

Maslach (1978) describes attrition as involving the development of a negative self-image, a negative attitude towards work, and a loss of interest and feeling for the patient.

Authors who have studied this phenomenon identify several phases in the development of burnout. Four are mentioned by Edelwich and Brodsky (1980):

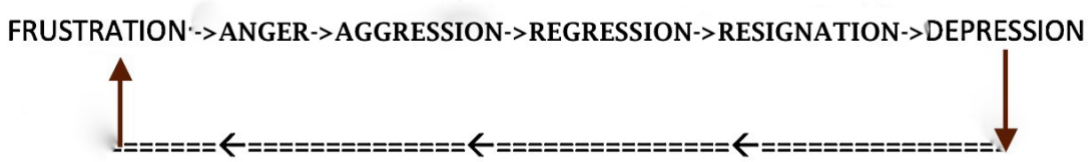
- the ***phase of enthusiasm*** accompanied by hyperactivity where a feeling of omnipotence dominates;

- the ***stagnation phase, which is characterized*** by intense fatigue, psychosomatic complaints and irritability;

- the ***frustration phase*** marked by guilt and a great sense of powerlessness;

- the ***demoralisation phase,*** manifested by a drop in morale affecting performance and by apathy.

Eliezer (1981) proposes five phases, with the following sequence:



He emphasises the onset of depression that comes from unexpressed frustration.

Eight phases are described by Burke, Schearer and Deszca (1984). They emphasise the starting point of burnout marked by high motivation, a particularly high sense of personal achievement in relation to idealistic and unattainable expectations. This is followed by feelings of failure, shame and guilt. A state of despair accompanied by avoidance mechanisms then emerges, leading to depersonalisation of the other and then to exhaustion marked by cynicism. The whole process can be revived if a renewed sense of personal accomplishment reappears.

Maslach and Jackson (1981) focus on three phases:

1. emotional exhaustion (from the helping relationship)
2. → depersonalised relationship (depersonalisation of others to protect oneself)
3. → feelings of worthlessness (guilt)

Faced with these difficulties in the relationship, the professional protects himself through a withdrawal of investment or a depersonalised relationship which leads him to develop a strong feeling of guilt with a loss of the sense of personal accomplishment. These authors therefore propose three dimensions of burnout: emotional exhaustion, depersonalisation of others, associated with relational and social difficulties, and a feeling of non-fulfilment. All the authors mention the external origins of burnout linked to the stressful situation and the intensity of relationships, but also the internal ones, linked to the person's history, idealism and vulnerability, emphasising the notion of personal crisis.

With regard to the nursing profession, Maslach (1978) describes the manifestations of professional exhaustion as addictive behaviour, distancing from the patient, absenteeism, psychosomatic complaints, and especially the expression of fatigue. The studies carried out by Corin and Bibeau (1985)

show that nurses with a high rate of professional exhaustion have coping strategies in terms of withdrawal. Other authors describe avoidance (Kimmel, 1989; Ceslowitz, 1989) or flight (Ceslowitz, 1989). Moreover, the latter author mentions the use of problem-solving, evaluation and social support strategies among nurses with low burnout rates.

Empirical research

General assumption

Our initial hypothesis is that the "palliative care" objective allows a better adjustment to the stress caused by death, and tends to decrease in the nurse:

- the characteristics of burnout, particularly in terms of the three components developed by Maslach: emotional exhaustion, depersonalisation and loss of a sense of personal accomplishment;

- negative, defensive and ineffective coping strategies - (withdrawal, denial, guilt, alexithymia, aggression).

Furthermore, working in a palliative care unit with the support of a team trained and motivated to work with the dying tends to develop more effective, positive and adaptive coping strategies: focus, use of social support, conversion, control.

Population

Our study was conducted in several health care institutions in France. The population consisted of nurses (N = 185) who were most frequently involved in the care of dying patients in cancer wards and palliative care units.

The two samples compared were nurses working in palliative care units (N1 ~ 53) and nurses working in curative care units (cancer, hematology) (N2 = 132).

Measuring instruments

The MBI *(Maslach Burnout Inventory)* scale

This scale, proposed by Maslach and Jackson (1981) for the helping and health professions, measures the burnout syndrome. It consists of twenty-two items allowing the three dimensions of *burnout* to be assessed: emotional exhaustion (nine items), depersonalisation-disocialisation (eight items) and personal fulfilment (five items).

For each item, nurses are asked to indicate the frequency and intensity of their reaction (seven-point scale). The MBI scale is an instrument considered to have good validity (Maslach, Jackson, 1986; Rolland, 1991, 1993). In many studies, Cronback's alpha coefficient is above 0.70, the threshold above which the value is satisfactory (Cortina, 1993; Cronback, 1951). In our population, the homogeneity of the scale is excellent with an alpha of 0.86.

The ETC scale (Toulousian *Coping* Scale*)*

This scale proposed by the "Personalisation and Social Change" Laboratory (1993) is made up of fifty-four items that the nurse attributes to herself to varying degrees (five-point scale). It includes six strategies: focus, social support, withdrawal, conversion, control, refusal), which, when crossed with the fields of action, information and affectivity, make it possible to analyse eighteen dimensions (three items per dimension). The coherence of the scale is mentioned by the

authors (Esparbes, Sordes-Ader and Tap, 1996) with a Cronback alpha of 0.79. For our sample, the alpha is 0.82.

Results

Coping strategies

In the analysis of the overall results, "general *coping*" and "positive *coping*" do not show any significant difference between the two nurse populations. On the other hand, nurses in curative care used negative *coping* strategies more than nurses in palliative care. For all three behavioural domains, the score for the affective domain was significantly higher for nurses in curative care,

With regard to strategies, the only difference found was for withdrawal, which was more often used by nurses in curative care. The dimensions of *coping* most often used by nurses in palliative care are cognitive focus and behavioural conversion. Thus, working in a palliative care unit mobilises the active and cognitive fields in the nurse, especially the positive dimensions of these fields. Nurses working in palliative care are more likely to change their behaviour by analysing the situation and seeking information, while nurses working in curative care are more likely to use negative strategies, particularly in the affective field. The defensive nature of their strategies therefore appears to be more important than their disengagement behaviours.

Overall, among nurses working in palliative care units, positive strategies are more strongly correlated with each other than among nurses working in curative care units. On the other hand, for this group, there are significant correlations between socially perceived positive and negative strategies, in

particular conversion and withdrawal (.36), conversion and refusal (.22), control and refusal (.25). Withdrawal and refusal are more strongly correlated (.66) with each other.

We can deduce from this that palliative care nurses are more differentiating (mixing positive and negative images for themselves). The only correlation between positive and negative found was between social support and withdrawal. This seems to imply that these nurses are able to seek help and support even when the situation pushes them to adopt withdrawal behaviours.

Curative care nurses, on the other hand, link all strategies more closely together, and in particular those based on denial and control. This "strategic amalgam" can be interpreted as defensive.

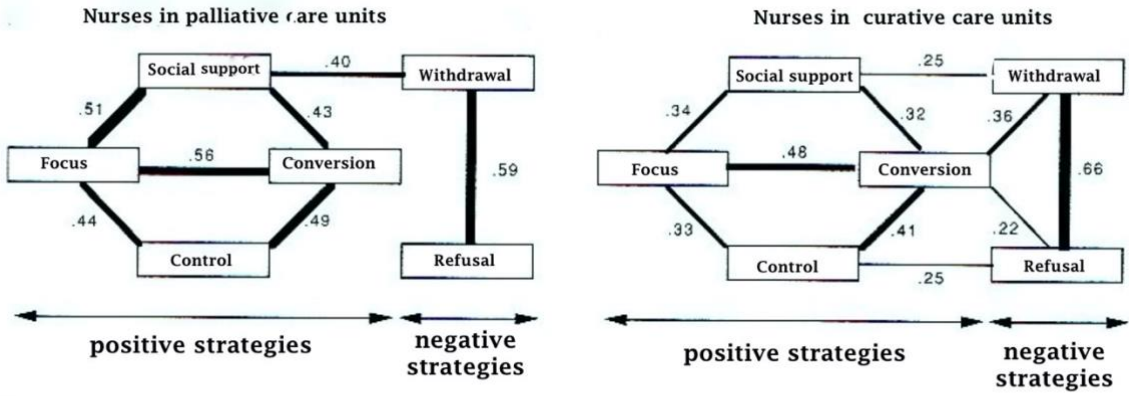


Figure 1 - Correlations between coping strategies

professional wear and tear (burnout)

According to the Maslach Burnout Inventory, the level of *burnout* is significantly higher for curative care nurses, both for emotional exhaustion and depersonalisation. There was no significant difference in personal accomplishment between the two populations.

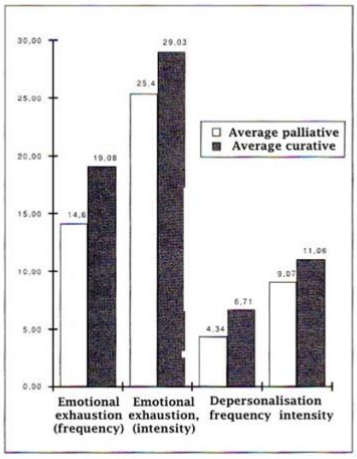


Figure 2 - **Dimensions of burnout : Comparison of averages**

The links between occupational wear and tear and the six coping strategies

For all nurses, burnout, in frequency and intensity, is strongly correlated with the withdrawal strategy. Palliative care nurses associate burnout (intensity) with conversion and social support: they may change their behaviour or seek help.

Even if they change their behaviour, they tend to be overwhelmed by emotions or to have defensive attitudes (withdrawal, refusal), more frequently than nurses in palliative care.

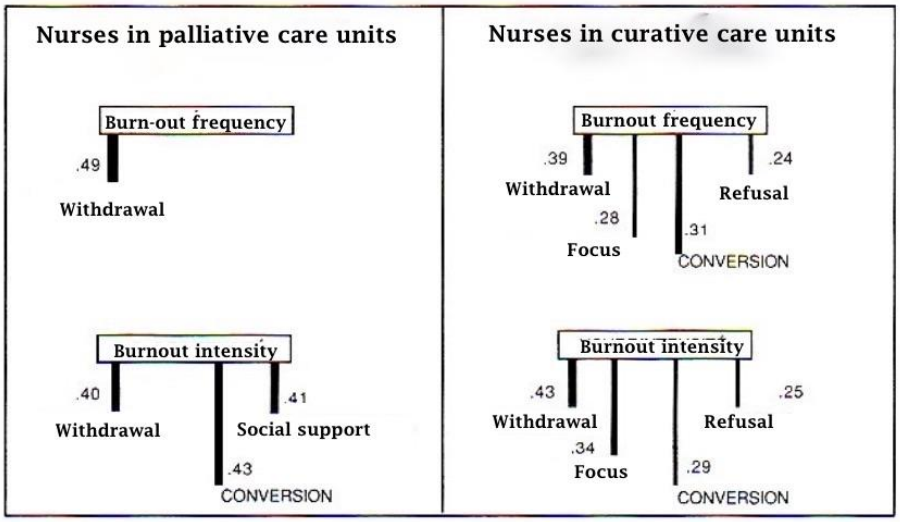


Figure 3 - **High correlations between burn-out and coping strategies**

The links between the dimensions of coping behaviours and those of occupational wear and tear.

A more detailed analysis of the relationships between these dimensions highlights the close link established by nurses in curative care between depersonalisation of others (frequency or intensity), withdrawal strategies and those concerning the emotional field, particularly alexithymia.

Conclusion

The frequent and close death of their patients constitutes, for the nurses, an excess of mental pressure (both affective and cognitive), associated with the increase of external constraints. This exaggerated pressure produces psychological and somatic suffering. To combat this pressure and suffering, nurses try to control the situation through piecemeal resolutions, emotional control and stress reduction.

In palliative care units, adaptation to the situation is more flexible, behaviour is less defensive, often resulting in a change in behaviour and requests for help from others.

In curative care units including palliative care, nurses adopt more emotionally mobilising strategies, which can lead them to experience the situation more critically and to feel exhaustion (emotional and relational). Depending on the case, this may be the result of strong personal aspirations that have not been fulfilled, frustrations regarding the recognition of their professional value or disappointments linked to the nature of the work.

The objective of palliative care allows nurses to give meaning to their personal or collective actions, insofar as it is clearly stated and favours the emergence or revival of an involved but realistic professional project. Project strategies allow nurses to manage their realising tension favourably (personalisation through finalised and operational behaviours), by mobilising hope and solidarity, beyond occasional difficulties.

Socially desirable 'coping' strategies, in particular the ability to control oneself and the situation, and the ability to seek or accept help from others, are more frequently present when opportunities for inter-individual expression of carer suffering arise.

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