

Burnout in staff working at the Mathari psychiatric hospital

DM Ndetei^{1,2}, M Pizzo¹, H Maru^{1,4,5}, FA Ongecha^{1,3}, LI Khasakhala^{1,2}, V Mutiso¹, DA Kokonya^{1,6}

¹Africa Mental Health Foundation, ²Department of Psychiatry, University of Nairobi, Kenya, ³Coast Provincial General Hospital, ⁴Mathari Hospital, ⁵Ministry of Health, Kenya, ⁶Kakamega Provincial General Hospital, Kenya

Abstract

Objective: As there are no data on burnout in staff in Kenyan psychiatric hospitals, this study sought to document the level of burnout among the staff at the Mathari Psychiatric Hospital. **Method:** This was a cross sectional descriptive study of staff working at Mathari Psychiatric Hospital. The hospital staff completed self-administered questionnaires on socio-demographic characteristics and work environment and the Maslach Burnout Inventory – Human Services and General Survey. Analysis of the data was undertaken using the Statistical Package for the Social Sciences (SPSS) version 11.5. **Results:** Ninety-five percent of the respondents reported low to high emotional exhaustion while 87.8% reported depersonalization. Low accomplishment was reported by only 38.6% while 61.4% reported average to high personal accomplishment. Several work- and non-work-related factors including young age, number of own children, number of years worked, heavy workload and low morale were positively associated with various syndromes of burnout. Relationships at work, with family and society were generally rated as average. The staff made recommendations on how to improve the social support system and work performance. **Conclusion:** High levels of burnout were reported. These should be addressed at individual, collective and institutional levels.

Keywords: Burnout; Psychiatric hospital staff; Kenya

Received: 26-11-2007

Accepted: 17-12-2007

Introduction

Burnout has been defined as a three-dimensional syndrome which includes: 1) Emotional exhaustion (feeling emotionally drained by one's contact with other people); 2) Depersonalization (negative feelings and cynical attitudes toward the recipient of one's services or care) and, 3) Reduced personal accomplishment (a tendency to negatively evaluate one's own work).¹ Unlike major depressive disorder which pervades all aspects of a patient's life, burnout is a distinct work-related syndrome, which occurs more among individuals who work with human recipients of services, specifically those with psychological, social and physical problems. Generally, burnout may have a negative impact on the emotional and physical health of the professionals themselves and this affects the recipients of the services since the professionals may be relatively impaired in providing quality service.² Burnout as a syndrome, is associated with job turnover, absenteeism and low morale and seems to be

correlated with physical exhaustion, sleep disorder, substance abuse and family problems.³

Earlier studies report that risk factors for burnout included younger age, lack of role clarity, perceived inadequacy of resources, lack of personal support and workload.^{4,5} On the other hand, hardiness, which is the individual's relative potential and capacity to remain healthy during stressful times, has been suggested among some protective factors.⁶ Of all the service providers, health workers, and especially mental health workers, are particularly vulnerable as provision of medical and other health care services is characterized by involvement of intense emotions, lack of communication, frequent and unpredictable aggressive behaviour from patients whose non-compliance to involuntary treatment exacerbates stress. In addition, relatively heavy workloads, understaffing, job insecurity and continuing rapid organizational change, all of which are major sources of stress and eventual burnout and its consequences, further aggravate the situation.^{7,8}

In Kenya, there is a dearth of both human and physical resources for mental health services in comparison to western countries. Thus staff providing mental health services are likely to be overworked in environments that are grossly underfunded and physically inadequate. Yet, there are no available data on burnout in mental health workers in Kenya. Besides using them as a basis for interventions, such data

Correspondence:

Prof. DM. Ndetei
University of Nairobi & Director, Africa Mental Health Foundation
PO Box 48423, 00100-GPO, Nairobi, Kenya
email: dmndetei@mentalhealthafrica.com or dmndetei@mail.uonbi.ac.ke

would be useful in providing cross-cultural comparisons with other countries in the West. This study therefore aimed to provide data for Kenya and also to fill a gap in the global pool of data.

Methods

Study setting

Mathari Psychiatric Hospital is Kenya's only national referral and teaching psychiatric hospital with a capacity of 600 beds. The staff who provide services to the hospital include a total of 243 nurses, 7 psychiatrists, two of whom are in full-time administration, 2 pharmacists and several support staff.

Subjects

All the staff working at the hospital were eligible to participate in this study.

Instruments

The instruments consisted of a self-administered questionnaire which elicited information on socio-demographic characteristics, job descriptions, work attitudes and relationships and the Maslach Burnout Inventory (MBI) – Human Services and General Survey.¹

A written explanation on the purpose of the study and consenting process was provided on the instrument. Participation in the study was entirely voluntary and participants had the right to decline or withdraw their participation at any time without any loss of any benefit. Participants were assured that all the information provided would be kept confidential. No identifying information was to be provided on any section of the instrument. Although the information required was sensitive, no invasive procedures were used. The questionnaires were distributed through sectional heads that ensured that all staff who were present during the one-week data collection period received a questionnaire. All questionnaires, fully, partially or not completed, were to be deposited by each respondent into a centrally located ballot box which was forwarded to the first author. The questionnaires were then coded and data entry, cleaning and analysis done using the Statistical Package for the Social Sciences (SPSS) version 11.5. Pearson's tests were done to establish correlations between syndromes of burnout and other factors. Results are presented in narratives and tables.

Results

Socio-demographic characteristics

The questionnaires were distributed to 75.1% (N = 398) of the total staff population of 530. The return rate was 71.6% (N = 285) and among those who returned fully completed questionnaires (n = 121; 42.5%), 80 (66.4%) were clinical staff (doctors, nurses and pharmacists), 14 (11.2%) were non-clinical staff and 27 (22.4%) were support staff. The mean age of the respondents was 40 years (range 22-57 years) and nearly half of them (44.4%) were aged 43 years and above. Sixteen percent of the respondents were aged between 18 and 32 years while 34% were aged between 33 and 42 years. A greater proportion of the staff (64.5%) was female and 77.7% were married. Nearly seven percent (6.6%) of the respondents did not have children of their own and among those who had children, 57% had between one and three. More than half of the staff (52.1%) had between six and ten dependants whom they supported economically. Forty-three percent of the respondents had worked at the institution for up to five years while 15.7% had between 20 and 26 years of work experience.

The MBI scores and burnout levels (Table I)

Overall, the mean MBI scores on the subscales of emotional exhaustion, depersonalization and personal accomplishment fell between average and high levels.

Up to 95% of the respondents suffered from various levels of emotional exhaustion with 38% reporting high levels. Low to high levels of depersonalization were reported in 87.8% of the respondents while 38.6% experienced low levels of personal accomplishment. Relationships at work, within the family and society were generally rated as average.

Attitudes toward work and relationships with others

Overall, 61.2% of the respondents reported that they were satisfied with their accomplishments at work. Seventy-one percent and 69% of the respondents reported generally satisfactory relationships with their juniors and seniors respectively. Satisfactory relationships between colleagues at the same job level were reported by 79.3% of the respondents. Up to 39.7% of the staff responded positively to all four questions pertaining to satisfaction on the job and with others, denoting all round satisfaction, while 47.2% responded positively to between two and three questions. Up to 58.7% of

Table I: MBI Scores and burnout levels

MBI scores					
Subscales	Range	Mean	Median	SD	% of mean over max
Emotional exhaustion (max= 54)	0-46	17.2	17.0	9.78	31.9
Depersonalization (max=30)	0-25	7.3	6.5	5.82	29.2
Personal accomplishment (max=48)	1-44	29.3	31.5	10.26	66.6
Burnout levels (%)					
	Low	Average	High	None	
Emotional exhaustion	32.0	25.0	38.0	5.0	
Depersonalization	18.9	21.1	47.8	12.2	
Personal accomplishment	38.6	24.1	37.3	0	

the respondents described their workload as normal, 32.2% reported that they felt overworked while 7.4% said they were underworked.

The staff were asked if they would accept a job offer on the same salary in another institution. Nearly two thirds (64.5%) of the respondents said they would not, quoting good working conditions at the hospital as their reason for staying. Poor working conditions at the hospital, heavy workloads and a poor relationship with the management staff were quoted as some of the reasons that would cause 35.5% of the respondents to leave for another job.

Other work dynamics

When asked about involvement in decision-making, 55% of the respondents reported that they had played an active role and 41% said that they had not. The remainder were not sure. Thirty-eight percent of the respondents reported that they felt more comfortable playing by the rules rather than participating in making rules affecting their work while 57% reported that they were not comfortable. Most of the respondents (64%) reported that they felt free to make decisions to improve their performance.

One-third of the respondents reported between one and four incidents of verbal aggression within the one-month period preceding the study. These incidents occurred between themselves and their seniors, juniors, work colleagues at the same level and students (Table II). The reasons for the aggression at work included lateness/absenteeism or work-related problems. Forty-seven percent of the respondents had experienced anger towards their seniors, juniors, work colleagues at the same level and students. This anger resulted from work-related problems, lateness/absenteeism and ill treatment.

Table II: Incidence of verbal aggression and anger at work within previous month

Have you experienced verbal aggression or felt angry in the past one month?	Aggression	Anger
Yes	33%	47%
Who was involved?		
Senior	21.4%	22.3%
Junior	20.4%	16.5%
Colleague at same level	13.5%	14.4%
Students	10.7%	3.3%
No	67%	53%

Issues affecting work and work performance (Table III)

Relationships at work, attitudes toward work and family relationships and attitudes were generally rated from average to good. Twenty-eight percent of the respondents reported that they had family issues which affected their work performance negatively. These issues were related to health, finances, security and transport and relationships within the family. Work-related issues included physical and emotional exhaustion. Illnesses also affected work performance and accounted for one of the reasons the hospital staff took time off

Table III: Issues affecting work and work performance

Issues related to the work place	Range	Mean
Verbal aggression (max score 4)	0-4	1.6
Anger (max score 4)	0-4	0.6
Work relationships (max score 7)	2-7	6.0
Work attitudes (max score 11)	8-11	9.6
Family relationships and attitudes (max score 4)	2-4	3.1
Issues related to the work itself	% age affected	
Physical exhaustion	57.6	
Emotional exhaustion	55.0	
Issues related to the family		
Health of family member	4.1	
Financial obligations	16.5	
Insecurity and transport	9.1	
Poor family relationship	7.5	
Issues related to health		
Sick leave (1-90 days, average 9 days)	23.0	
Time off to see a doctor	36.0	
None of the above	41.0	

from work. Twenty-three percent of the respondents reported that they had taken sick leave ranging between one and 60 days (average 9 days) within the past 12 months preceding the study.

Social support

One third of respondents were happy with the work situation while a similar proportion reported conflict of interests between work and family and its negative effect on their families. Their social life was affected by the work situation because of:

- Heavy workload, no allowances, stress at work transferred to family, stigmatization and difficulties in balancing time, work and family.
- Minimal support from the hospital e.g. lack of staff welfare services, lack of medical cover/allowances and poor working environment.
- Minimal social interaction outside the hospital due to limitations of time coupled with stigmatization from the larger society.

Improving performance

The following suggestions to improve work performance were given by the respondents:

- Better working conditions in terms of timely salary increases, staff promotions and improvement in physical and medical facilities (28%)
- Improved work relationships between management and other staff and involvement of staff in decision making (10%)
- Motivation of staff through incentives such as full medical care, allowances and more leave days (22%)
- Improvement in staff welfare services including counseling, increased staff recruitment, more professional staff and capacity building opportunities for the staff (15%).

Table IV: Correlations and associations between socio-demographics and psychopathology

	Age	Gender	Marital status	Number of children	Number of dependants	Department years worked	Job type	Number of	Workload	Morale
Depersonalization	.111	.810	.727	.418	.602	.039	.048	.886	.034	.945
Personal accomplishment	.030	.89	.653	.707	.470	.638	.880	.520	.078	.606
Emotional exhaustion	.000	.475	.984	.003	.052	.078	.807	.0495	.000	.001

Correlations/associations between socio-demographics and psychopathology (Table IV)

Significant positive correlations were found between younger age and emotional exhaustion ($p < 0.001$). Correlations between younger age and personal accomplishment ($p = 0.03$) were negative. Number of children was significantly associated with increased emotional exhaustion ($p = 0.003$) as were a greater number of years worked ($p = 0.049$), a heavy workload ($p < 0.001$) and low morale ($p = 0.001$). Depersonalization and heavy workload showed a positive significant relationship ($p = 0.034$).

Discussion

The socio-demographic characteristics reported in the Mathari hospital sample reflected the age structure of staff in other medical institutions where most of the professionals would have spent several years in professional training. It is the norm within the Kenyan socio-cultural context for a working person to financially support other people outside the nuclear family. Most government employees in Kenya are on permanent employment terms until they attain retirement age (assuming no gross violation of the employment terms) and it is therefore not unusual to find employees working at the same place for several years.

Emotional exhaustion and depersonalization as indicators of burnout were found to be highly prevalent. Despite this, a relatively high sense of personal accomplishment was reported among the staff. Furthermore, the majority of the staff reported satisfactory work relationships and would not change their jobs for the same amount of money. These findings suggested that the staff were happy with their current work stations. The fact that more than half (59%) of the staff had either taken sick leave or taken some time off work within the past year may have been an indication that they suffered some level of burnout.

The correlations found between the three subscales of the MBI and various socio-demographic variables may explain the determinants of burnout syndromes. In Mathari hospital, the staff to patient ratio is very low and this creates a situation where the staff feel overloaded with work. It was likely that the more the number of patients one had to attend to, the more the burnout experiences due to emotional drain and the higher the levels of depersonalization, that is, having more negative feelings toward the patients. This finding is similar to the findings of Gabbel et al⁵ who reported an association between burnout and self-reported workload.

Fagin⁷ argues that increased burnout was related to workload, understaffing, job insecurity and low morale due to poor working conditions. All the above attributes and in particular, poor working conditions, were recorded at Mathari hospital where the physical infrastructure is much worse

compared with that in general medical facilities. Thus it was significant that poor morale was associated with emotional exhaustion.

The association between younger age and high emotional exhaustion as well as low personal accomplishment corresponded with Mirvis et al's⁴ finding that younger age was one of the factors associated with burnout. Those who burnout early in their careers are likely to quit their jobs and this leads to 'survival bias' where older respondents with lower levels of burnout were selected. The other predisposing factor associated with burnout was the number of children, as having more children meant additional financial and emotional responsibility.

The findings at Mathari hospital that most of the staff got on fairly well with each other and with family members despite the high levels of burnout is in disagreement with the finding by Maslach⁹ in USA i.e. that physicians scoring high on emotional exhaustion wanted to get away from people. That same study found that 77.7% of the physicians reported that they would rather be left alone to do their work without interacting with anybody.⁹

A high percentage of the responses in the current study suggested high job satisfaction, job accomplishment and low interference of family issues despite the fact that the scores were indicative of the existence of burnout in the majority of respondents. One plausible explanation to explain this finding is hardiness.⁶ In Kenya, as in other underdeveloped countries with poorly performing economies, people are deployed to work in the prevailing poor conditions amidst high rates of unemployment and poverty. They thus portray satisfaction with their working conditions and have the ability to remain healthy in stressful times, as they have adapted mechanisms to cope with the hardships they come across in the course of their lives.

Limitations

A major limitation of this study is that out of the 530 members of staff on the hospital payroll, only 398 (75.1%) were available at the time of the study and the response rate was lower than desired. In the absence of similar data from any other institution in Kenya one cannot draw any comparisons between Mathari Hospital as a mental institution, other medical institutions or any other organizations.

Conclusion

The results show high burn out levels in all categories of staff at Mathari Hospital. Improvement in social support systems, working conditions and physical facilities, as well motivation of staff will go a long way towards raising staff morale and improving job performance.

Recommendations emerging from the study include the

initiation of peer support groups and supervision which should enhance the ability to cope with stress in the course of provision of health care services. Efforts should be made to adopt a community-based approach in provision of mental health services as this will take psychiatric care beyond the institutions into the family and the society at large. This would greatly ease the burden of taking care of the mentally ill in the hospital, as there will be a lighter workload on the professionals.

Acknowledgement

This study was supported by a grant provided by the Africa Mental Health Foundation (AMHF). The authors would like to thank Grace Mutevu of AMHF for the analysis and Patricia Wekulo for her editorial input.

References

1. Maslach C, Jackson SE. *Maslach Burnout Inventory Manual* (2nd ed.). Consulting Psychologists Press, Palo Alto, 1986.
2. Maslach C, Scahufeli WB, Leiter MP. Job Burn out. *Annual Rev Psychol* 2001; 52: 397-422.
3. Jackson SE, Maslach C. After-effects of job-related stress: families as victims. *J Occup Beh* 1982; 3: 63-77.
4. Mirvis DM, Graney MJ, Kilpatrick AO. Trends in burn out and related measures of organizational stress among leaders of department of Veterans affairs medical centers. *J Health Management* 1999; 44: 353-365.
5. Gabbe SG, Melville J, Mandel L, Walker E. Burn out in chairs of obstetrics and gynecology. *Am J Obst Gynec* 2002; 186: 601-612.
6. Kobasa SC. Stressful events life events, personality and health: an inquiry into hardiness. *J Personality Soc Psychol* 1996; 37: 1-11.
7. Carson J, Cooper C, Fagin L, West M. Coping skills in mental health nursing: do they make a difference? *Int J Social Psych* 1996; 42(2): 102-111.
8. Fagin L, Carson J, Leary J, De Villiers N. Stress, coping and burn out in mental health nurses: findings from three research studies. *Int J Social Psych* 1996; 42 (2): 102-111.
9. Maslach C, Burned-out. *Human Beh* 1976; 5 (9): 16-22.