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Occupational Burnout In A Sample Of Geriatric Social Care Professionals In Malaysia

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ABSTRACT

Penyelidikan ini mengkaji hubungan antara burnout pekerjaan dengan pelbagai pembolehubah sosiodemografi, beban pekerjaan, dan kejelasan pekerjaan di kalangan pekerja sosial geriatrik di Malaysia. Maslach's Bunout Inventory digunakan untuk mengelaskan burnout pekerjaan kepada tiga kategori: tahap kelesuan emosi, nyahpersonalisasi dan pengurangan pencapaian personal. Keputusan menunjukkan terdapat perbezaan signifikan bagi jantina dan status perkahwinan dalam nyahpersonalisasi. Tambahan lagi, responden dengan kejelasan pekerjaan yang rendah dan mereka yang mempersepsikan mempunyai beban tugasan yang berat didapati lebih banyak mengalami kelesuan emosi. Keputusan ini dibincangkan konteks tekanan kerja yang dihadapi oleh pekerja sosial di Malaysia.

INTRODUCTION

Work plays an important role in the daily lives of most people, but can also cause frustration, stress and other psychological outcomes if not well-managed. Indeed, the work environment may contain a variety of objective stressors, such as chemical or biological hazards, as well as more subjective stressors including uncertainty about the future, responsibility-related pressures and interpersonal clashes (e.g., Cooper, 1998; Furnham, 1997; Levi, 2000). These stressors may lead to a variety of psychological outcomes, including health complaints, depression, anxiety, dissatisfaction and so on (Warr, 1987). Occupational stress is among the most frequent reactions that employees report, and a specific category of stress identified in the literature is occupational burnout.

Occupational burnout is a condition of 'emotional, mental, and physical exhaustion, along with cynicism towards work in response to long-term job stressors' (Furnham, 1997:339). Traditionally, the concept of occupational burnout is defined in terms of emotional exhaustion (the depletion or draining of emotional resources), depersonalisation (a negative, callous and cynical attitude towards the recipients of one's care) and reduced personal accomplishment (a tendency to negatively self-evaluate one's accomplishments at work) (Maslach, 1978a, 1978b, 1993; Maslach & Jackson, 1981a, 1981b, 1986). Studies among human service professionals such as nurses, policemen and teachers have shown that emotional exhaustion is the core component of burnout, though it is usually accompanied by client-directed (depersonalisation) and self-directed (personal accomplishment) negative attitudes (e.g., Shirom, 1989).

Researchers have tried to identify the factors that affect occupational burnout in order to better understand the phenomenon and thereby reduce distress. For example, Courage and Williams (1987) found that various socio-demographic variables, such as age, sex, marital status, educational qualifications, familial status, socio-economic status and ethnicity, all had significant relationships with occupational burnout. Of these, sex is perhaps the most widely researched but also the most equivocal in terms of results. Thus, Maslach, Schaufeli and Leiter (2001) argue that sex is not a strong predictor of occupational burnout, whereas other studies have found that women experience greater occupational burnout than men (cf. Pines, 1997). It may be that with women now doing the jobs that were once the preserve of men, there is no longer a consistent pattern of sex differences in occupational burnout (Himle, Jayaratne & Chess, 1987).

Age has been reported to be a better predictor of occupational burnout (Poulin & Walter, 1993), with the highest level of burnout among young employees occuring between the ages of 30 and 40 (Maslach et al., 2001). However, some studies have argued that it is not age per se that matters, but job experience. In particular, burnout tends to occur during early career stages (Maslach et al., 2001) and decreases with greater experience (Corcoran, 1987; Koeske & Kirk, 1995; Schaufeli & Enzman, 1998). Other variables that have been examined in some detail include marital status, with Maslach and Jackson (1981b) reporting that single and divorced employees show higher levels of occupational burnout than their married peers. Educational qualifications also play a role in determining eventual occupational burnout, although the findings in this area remain equivocal as to whether higher qualifications leads to decreased likelihood of burnout (Maslach et al., 2001).

It is, therefore, clearly of importance to examine the different variables that may affect occupational burnout, especially among social care professionals. Previous studies have suggested that healthcare professionals experience a high rate of burnout (Simoni & Patterson, 1997; Visintini et al., 1996). In comparison with welfare services aimed at a range of age groups, however, there has been a dearth of research examining occupational burnout among geriatric service professionals (Cocco, Gatti, Lima & Camus, 2000; Poulin & Walter, 1993). The present study, therefore, sought to extend the previous literature by examining the relationship of various socio-demographic variables (sex, age, marital status and educational qualifications) with occupational burnout in a sample of geriatric social care professionals in Malaysia.

Caring for elderly people, who may be frail or ill, is a fundamental challenge facing not just developed societies but also developing nations whose populations show increasing signs of aging (Glazer, 1990). Although Malaysia's population is not particularly elderly, this is expected to change over the next two decades. With improved health, life expectancy, low mortality and declining fertility, the proportion of elderly in Malaysia is on the rise, and is expected to reach almost 10% of the population by the year 2020 (Ong, 2002). Moreover, older Malaysians make an average of 6 visits to healthcare professionals, almost 3 times the number of visits of Malaysians across age

groups (Chia, 1996). However, there is a dearth of professional geriatric expertise despite the establishment of geriatric care in Malaysia (Ong, 2002).

Thus, it may be expected that geriatric welfare workers will be at increased risk of occupational burnout compared with other health care professionals given the high levels of job overload. The nature of aging itself will be expected to increase work-related stress among geriatric welfare workers (cf. Chappell, 1993; Eustis & Fischer, 1991). For example, the health status of clients in a single home for the aged in Malaysia in 1991 (the last year of census) showed that almost a half suffered some form of illness, just under 40% were mentally infirm, and a fifth were handicapped (Ong, 2002).

METHOD

Participants

The extended family has long been the primary source of care for the elderly in Malaysia. However, the erosion of the extended family system and increasingly smaller-sized families have combined to motivate institutional care. Nevertheless, institutional care for the aged in Malaysia is often only accessible to those who can afford it (in the case of private nursing homes) and is mostly available only in urban areas. Admission to public old persons' homes under the Department of Social Welfare is usually a last resort, and provided only to elderly people who have no heirs or shelter, or to those who are destitute (Ong, 2002).

Service to old persons under the Department of Social Welfare typically involve external services (e.g., financial and material assistance). Institutional care is provided in old people's homes (*Rumah Seri Kenangan*) administered by the federal government. These homes are staffed by administrative professionals, nurses and attendants, and offer accomodation, counselling and guidance, occupational rehabilitation, devotional facilities, recreational activities and medical treatment as necessary (Ong, 2002).

The present study was conducted in three old persons' homes located in Kinarut, Sandakan and Tawau, in the state of Sabah (East Malaysia). A total of 59 participants (28 women, 31 men) took part in the study, comprising support staff (administration and nursing) and direct staff (attendants). The socio-demographic variables of participants are presented in Table 1.

Questionnaire

Participants were instructed to complete a self-reported questionnaire anonymously. The questionnaire consisted of questions on socio-demographic variables, a Bahasa Malaysia (Malay) version of the Maslach Burnout Inventory (MBI), and scales of job clarity and workload. All participants were debriefed following the experiment.

Table 1: Sociodemographic variables of 59 geriatric social care workers

	Average	(SD)
Age	42.64	7.54
Working hours per week (h)	40.5	11.9
	Number	(%)
Sex		
Female	28	47
Male	31	53
Marital status		
Single	6	10
married or cohabiting	51	86
Widowed	2	4
Highest educational qualification		
primary (SRK)	7	12
mid-secondary (SRP)	34	57
secondary (SPM)	11	19
post-secondary diploma	6	10
Undergraduate	1	2
Occupation		
Attendant	42	71
Nurse	7	12
administrative staff	3	5
Years of experience as geriatric staff		
1-2 years	5	8
3-5 years	2	4
6-9 years	5	8
>10 years	47	80
Monthly income		
RM500-750	10	17
RM751-1000	29	49
RM1001-1500	12	20
>RM1501	8	14
Daily number of patients cared for		
< 5	5	9
6-9	2	3
10-14	15	25
> 15	37	63

Maslach Burnout Inventory. The MBI consists of 22 items, assessing burnout on a Likert scale from 0 (not at all) to 7 (very strong) for intensity (Maslach & Jackson, 1986). The MBI was translated into Malay by two independent teaching staff fluent in English and Malay. A back-translation certified its validity.

Cronbach' _ coefficients was 0.88 for emotional exhaustion, 0.57 for depersonalisation and 0.62 for reduced personal accomplishment.

Job clarity. Scales measuring job clarity comprised three items which questioned participants (1) about their understanding of social care; (2) if they had been on a training course for social care, and; (3) if they understood the

approach of the Department of Social Welfare to social care. For each of these items, participants responded on a binary scale (1=Yes, 2=No).

Workload. Occupational workload was measured directly as the daily number of patients cared for (see Table 1) and participants' perceived workload measured on a 5-point scale (1=Light, 5=Heavy).

Socio-demographic variables. Socio-demographic variables included sex, age, marital status, highest educational qualification, occupational post, years of experience as geriatric staff and monthly income (see Table 1).

RESULTS

Descriptive statistics

For responses to items on job clarity, 48 participants (81%) said they understood what was meant by social care, 21 (36%) had been on a training course for social care, and 47 (80%) said they understood the approach of the Department of Social Welfare to social care. For responses to perceived workload, 1 (2%) participant felt that the workload was very light, 2 (3%) that it was light, 24 (41%) that it was moderate, 24 (41%) that it was heavy, and 8 (13%) that it was very heavy.

Correlations and further analysis

Table 2 shows the mean and standard deviation scores on the MBI and correlation coefficients among the variables measured. Most correlation coefficients of socio-demographic variables, workload or job clarity with the MBI were 0.40 or less. Depersonalisation was correlated with sex, marital status and understanding of the departmental approach to social care, and; emotional exhaustion was correlated with understanding of social care, having been on a training course, understanding of the departmental approach, and feelings about workload. Reduced personal accomplishment was not correlated with any of the variables.

Table 2: Correlations among MBI and socio-demographic factors, workload and job clarity

	Mean (SD)	2	3	4	5	6	7	8	9
MBI									
1.Emotional exhaustion	22.32 (9.87)	0.52**	-0.01	-0.14	-0.07	-0.12	-0.15	0.11	0.16
2.Depersonalisation	6.17 (4.36)		0.12	-0.26*	-0.07	-0.38**	-0.07	0.21	-0.04
3.Reduced personal accomplishment	30.80 (6.35)			0.11	0.11	0.02	0.25	-0.19	-0.23
Socio-demographic factors									
4. Sex					0.25	0.18	-0.20	0.24	0.20
5. Age						0.42**	-0.16	-0.15	0.34**
6. Marital status							0.07	-0.27*	0.28*
7. Highest educational qualification								-0.58**	-0.51**
8. Occupation									0.42**
9. Years of experience									
10. Monthly income									
Job clarity									
11. Understand social care									
12. Training course									
13. Understand departmental approach									
Workload									
14. Daily number of patients									
15. Feelings about workload									

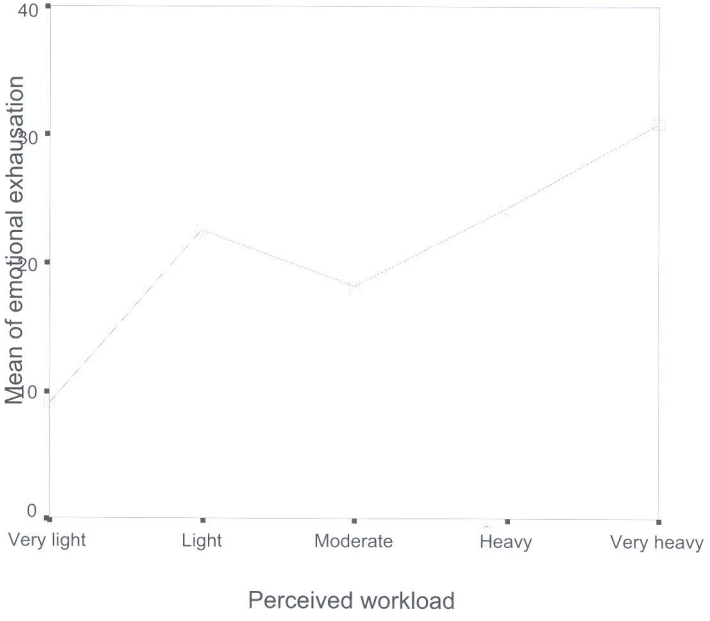
Table 2 (Continued): Correlations among MBI and socio-demographic factors, workload and job clarity

	10	11	12	13	14	15	16	17	18
MBI									
1. Emotional exhaustion	-0.11	0.30*	0.31*	0.32*	-0.02	0.44**			
2. Depersonalisation	-0.06	0.12	-0.03	0.29*	-0.07	0.18			
3. Reduced personal accomplishment	0.11	-0.08	-0.18	0.04	-0.08	0.01			
Socio-demographic factors									
4. Gender	0.06	0.24	0.28*	0.11	-0.12	-0.05			
5. Age	0.33*	0.21	-0.05	-0.02	0.04	-0.02			
6. Marital status	0.38*	-0.03	-0.14	-0.14	0.03	0.14			
7. Highest educational qualification	0.56**	-0.28*	-0.32*	-0.14	-0.05	-0.03			
8. Occupation	-0.59**	0.27*	0.29*	0.15	-0.22	0.53			
9. Years of experience	-0.06	0.17	0.10	-0.01	0.06	0.06			
10. Monthly income		-0.11	-0.30	-0.12	0.10	-0.09			
Job clarity									
11. Understand social care			0.36**	0.41**	-0.06	0.12			
12. Training course				0.38**	0.09	0.08			
13. Understand departmental approach					0.26*	0.24			
Workload									
14. Daily number of patients						-0.10			
15. Feelings about workload									

* $p < 0.001$,** $p < 0.05$

To examine the direction of these correlations, one-way analyses of variance (ANOVAs) were conducted on the appropriate variables. The results showed that, for depersonalisation, men scored significantly higher than women [*M* 7.23 vs 5.00, $F(1,58)= 4.04$, $p<.05$]. Single participants ($M=10.00$) had the highest mean scores for depersonalisation, followed by married or cohabiting participants ($M=5.94$) and widowed participants ($M=0.50$) [$F(2,58)= 4.59$, $p<.05$]. Finally, those who did not understand the Departmental of Social Welfare's approach to social care scored significantly higher on depersonalisation than those who did understand the approach [*M* 8.67 vs 5.53, $F(1,58)= 5.32$, $p<.05$]

Figure 1: Increasing emotional exhaustion with greater perceived workload



Emotional exhaustion was significantly correlated with all three measures of job clarity and with participants' perceived workload. A one-way ANOVA showed that participants who did not understand social care were more emotionally exhausted than those who did [M 28.45 vs 20.92, $F(1,58)=5.64$, $p<.05$. In addition, participants who had not been on a course for social care were more emotionally exhausted than those who had [M 26.60 vs 20.00, $F(1,58)=4.83$, $p<.05$], as were those who did not understand the departmental approach to social care compared with those who did [M 28.58 vs 20.72, $F(1,58)=6.66$, $p<.05$]. Finally, there was a general pattern of increasing emotional exhaustion with perceived heavier workload [$F(4,58)=3.92$, $p<.001$] (see Figure 1).

DISCUSSION

This study investigated occupational burnout in a sample of geriatric social care workers in Malaysia, and found them to suffer from relatively moderate levels of occupational burnout. More specifically, depersonalisation was found to differ amongst sexes, marital status and correlated with understanding of departmental approaches to social care, whereas emotional exhaustion was correlated with measures of job clarity and perceived workload. Reduced personal accomplishment was not associated with any of the variables, which may reflect the documented suggestion that reduction in personal accomplishment often occurs independently of emotional exhauston and depersonalisation (Lee & Ashforth, 1996).

In the present study, depersonalisation was significantly different between sexes, with male participants showing greater depersonalisation than female respondents. As discussed earlier, previous studies that have examined gender and occupational burnout have been equivocal in nature (e.g., Maslach et al., 2001; Pines, 1997). Nevertheless, the results of the present study appear to be in accordance with some studies which have found that men experience greater levels of depersonalisation than women (e.g., Maslach & Jackson, 1986; but see e.g., Evers, Tomic & Brouwers, 2001; Smith & Leng, 2003). For example, in a study of Dutch dentists, Brake, Bloemendal and Hoogstraten. (2003) found that men experience significantly higher levels of depersonalisation than women, which they attributed to the greater number of patients examined by male dentists in comparison with their female colleagues.

In the present study, however, participants' sex was not significantly different in workload, which would require an alternative explanation for the finding that men experienced greater depersonalisation than women. One possible explanation is that women more fully utilise the social support they receive. For example, Emmerik (2002) has argued that emotional support, a harmonious work environment and practical help in the workplace provide a greater benefit for women than men. This is because women are more likely to also be involved in childcare in family settings and therefore more likely to appreciate assistance in the workplace. In the present study, we did not explicitly measure social support and can only therefore hypothesise such an explanation. Future studies would do well to include measures of social support in their research.

In accordance with previous studies (e.g., Maslach & Jackson, 1981b, 1986; Ross, Altmaeir & Russell, 1989), the present findings showed that marital status was significantly different in depersonalisation. Single employees were more likely to experience greater levels of depersonalisation than married, cohabiting or widowed participants. Maslach (1986) proposed a number of reasons to explain this difference: (1) married employees tend to be older, and thus more psychologically stable and mature; (2) the relationships that married employees have with their partners and children give them greater experience in handling personal problems and emotional conflicts; (3) the family is a source of emotional strength, and helps individuals cope with emotional demands in the workplace, and; (4) married employees have different views about their jobs compared with single employees (that is, having a family ensures that married individuals view their jobs as a source of income for their families).

In the present study, emotional exhaustion was significantly correlated with measures of job clarity, including respondents' understanding about social care and the Department of Social Welfare's approach to social care, and significantly different whether respondents had been on training courses for social care. Those who responded negatively to these items showed greater levels of emotional exhaustion than their counterparts who responded affirmatively. Moreover, lack of understanding of the departmental approach to social welfare was associated with greater levels of depersonalisation.

These results are perhaps not surprising: employees who are clear about their job description and/or who have received specific job training will be more likely to perform their tasks successfully, which in turn would be expected to lead to lower levels of occupational burnout. It is interesting, however, that in the present study, job clarity was not significant correlated with reduced personal accomplishment, which would suggest that job clarity affects emotional exhaustion and depersonalisation independently of a reduction in personal accomplishment (cf. Lee & Ashforth, 1996). Nevertheless, the implications of this finding are clear: occupational burnout could be countered by providing adequate training and successfully embedding employees in the ethics of social care. A shared perspective between departmental guidelines and social care workers may aid employees in the provisioning of healthcare services.

The findings of this study also show that emotional exhaustion is significantly correlated with perceived workload. Interestingly, it is not actual workload per se that is important, but rather what employees feel their workload to be. Those who perceive their workload as being heavy are more likely to feel emotionally exhausted than employees who perceive their workload as being light. One way in which this could be countered is to help social care employees view their work in a less individualistic manner, and instead feel that they are performing their tasks as part of a team. Certainly, increased social support from supervisors and work colleagues would be expected to reduce levels of emotional exhaustion.

In terms of limitations, the correlational design of the present study precludes any comment on the effects of occupational burnout on the care received by patients or the efficacy of social support. In addition, the relatively small sample size of the present study may be influenced the outcome of this research. It is also possible that the sample does not accurately reflect the socio-demographics of those involved in geriatric social care in Malaysia (e.g., the mean age of the present sample is possibly skewed in favour of older respondents). Although every effort was made to recruit as large a number of participants as possible, this was not always feasable for logistical reasons. As a preliminary study of social care in Malaysia, however, these findings provide an important base from which future studies can be conducted. In short, further studies are required to confirm and extend the findings of this study.

These limitations notwithstanding, the present study has important implications for the delivery of healthcare services in developing nations. In countries where social welfare is relatively under-developed and under-funded, it is of importance that those involved in the provisioning of care are adequately trained. This will serve not only to improve the care received by patients, but also prevent occupational burnout among those providing care. While this may be expensive to begin with, the long-term benefits are manifold, including a better work ethic, increased productivity, and decreased costs to organisations and governments (Pines, 2002).

REFERENCES

Brake, H., Bloemendal, E., & Hoogstraten, J. (2003). Gender differences in burnout among Dutch dentists. *Community Dentisty and Oral Epidemiology*, *31*, 321-327.

Chappell, N. L. (1993). Implications of shifting health care policy for caregivers in Canada. *Journal of Aging and Social Policy*, *5*, 39-55.

Chia, Y. C. (1995). Primary care in the elderly. In First Symposium on Gerontology (Ed.), *Issues and challenges of ageing: Multidisciplinary perspectives*. Kuala Lumpur, Malaysia: Gerontology Association of Malaysia.

Cocco, E., Gatti M., Lima, C. A., & Camus, V. (2003). A comparative study of stress and burnout among staff caregivers in nursing home and acute geriatric wards. *International Journal of Geriatric Psychiatry*, *18*, 78-85.

Cooper, C. L. (1998). *Theories of organizational stress*. Cambridge: Oxford.

Corcoran, K. (1987). The association of burnout and social work practitioners' impressions of their clients: In D. F. Gillespie (Ed.), *Burnout among social work* (pp. 57-64). London: Haworth Press.

Courage, M. M., & Williams, D. D. (1987). An approach to the study of burnout in professional care providers in human service organizations. In D. F. Gillespie (Ed.), *Burnout among social workers* (pp. 7-19). London: Haworth Press.

Emmerik, I. H. V. (2002). Gender difference in effect of coping assistance on the reduction of burnout in academic staff. *Work and Stress*, *16*, 251-263.

Eustis, N. N., & Fischer, L. R. (1991). Relationships among home care clientsand their workers: Implications for quality of care. *Gerontologist*, *31*, 447-456.

Evers, W., Tomic, W., & Brouwers, A. (2003). Aggressive behaviour and burnout among staff of homes for the elderly. *International Journal of Mental Health Nursing*, *11*, 2-9.

Furnham, A. (1997). *The psychology of behaviour at work: The individual in the organization*. Hove: Psychology Press.

Glazer, N. (1990). The home as workshop: Women as amateur nurses and medical care providers. *Gender and Society*, *4*, 479-499.

Himlee, D. P., Jayaratne, S. D., & Chess, W. A. (1987). Gender differences in work stress among clinical social work. In Gillespie, D. F. (Ed.), *Burnout among social workers* (pp. 41-56). London: Haworth press.

Koeske, G., & Kirk, S. (1995). The effect of characteristics of human service workers on subsequent morale and turnover. *Administration in Social Work*, *19*, 15-31.

Lee, R. T., & Ashforth, B. E.(1996). A meta-analytic examination of the correlates of the three dimensions of job burnout. *Journal of Applied Psychology*, *81*, 123-133.

Levi, L. (2000). *Guidance on work-related stress: Spice of life or kiss of death?* Luxembourg: European Commission, Directorate-General for Employment and Social Affairs, Health and Safety at Work.

Maslach, C. (1978a). Job burnout: How people cope. *Public Welfare*, *36*, 56-58.

Maslach, C. (1978b). The client's role in staff burn-out. *Journal of Social Issues*, *34*, 111-124.

Maslach, C. (1993). Burnout: A multidimensional perspective. In W. B. Schaufeli, C. Maslach, & T. Marek (Eds.), *Professional burnout: Recent developments in theory and research* (pp. 19-32). Washington, DC: Taylor & Francis.

Maslach, C., & Jackson, S.E. (1981a). The measurement of experienced burnout. *Journal of Occupational Behavior*, *2*, 99-113.

Maslach, C., & Jackson, S.E. (1981b). Burnout in organizational setting. *Journal of Occupational Behavior*, *5*, 133-153.

Maslach, C., & Jackson, S.E. (1986). *The Maslach burnout inventory manual* (2nd Edition). Palo Alto, CA: Consulting Psychologists Press.

Maslach, C., Schaufeli, W., & Leiter, P. (2001). Job burnout. *Annual Review of Psychology*, *52*, 397-422.

Ong, F. S. (2002). Ageing in Malaysia: A review of national policies and programmes. In D. R. Phillips, & A. C. M. Chan (Eds.), *Ageing and long-term care: National policies in the Asia-Pacific* (pp. 63-79). Ottawa, Canada: IDRC.

Pines, A. M. (1997).Why are Israelis less burned out? *European Psychologist*, *9*, 69-77.

Pines, A. M. (2002). The changing psychological contract at work and employee burnout. *Journal of Health and Human Services Administration*, *25*, 11-32.

Poulin, J., & Walter, C. (1993). Burnout in gerontological social work. *Journal of Social Work*, *38*, 305-310.

Ross, R. R., Altmaie, E. M., & Russell, D. W. (1989). Job stress, social support, and burnout among counseling center staff. *Journal of Counseling Psychology*, *36*, 464-470.

Schaufeli, W., & Enzmann, D. (1998). *The burnout companion to study and practice: A critical analysis*. London: Taylor & Francis.

Shirom, A. (1989). Burnout in work organizations. In C. L. Cooper, & I. Robertson (Eds.), *International review of industrial and organizational psychology* (pp. 25-48). New York, NY: John Wiley & Sons.

Simoni, P. S., & Patterson, J. J. (1997). Hardiness, coping and burnout in the nursing workplace. *Journal of Professional Nursing*, *13*, 178-185.

Smith, D., & Leng, G. W. (2003). Preavalence and source of burnout in Singapore secondary school physical education teachers. *Journal of Teaching Physical Education*, *22*, 203-218.

Visintini, R., Campanini, E., Fossati, A., Bagnato, M., Novella, L., & Maffei, C. (1996). Psychological stress in nurses' relationships with HIV-infected patients: The risk of burnout syndrome. *AIDS Care*, *8*, 183-194.

Warr, P. B. (1987). *Work, unemployment and mental health*. Oxford: Clarendon Press.