Mediterranean Journal of Clinical Psychology MJCP

ISSN: 2282-1619

VOL IV N.1 (2016)

The burnout syndrome in palliative home care workers: the role of coping strategies and metacognitive beliefs

LENZO VITTORIO[1], INDELICATO FEDERICA[1], GRISOLIA ELISABETTA[1], TOFFLE M. ELLEN[2], QUATTROPANI MARIA C[1].

1 Department of Cognitive, Psychological, Pedagogical Science and Cultural Studies, University of Messina, Italy.
2 Department of Political and Giuridical Sciences, University of Messina, Italy.

Email Corresponding author: vlenzo@unime.it

Abstract: Healthcare professionals are daily confronted with events involving the suffering of others, which are likely to generate highly negative and stressful emotions. In palliative care the emotional commitment is exacerbated by the constant confrontation with the theme of suffering and death. The failure to successfully down-regulate negative emotions is a key risk factor for a severe form of discomfort, known as burnout syndrome. Burnout is a psychological state of exhaustion, related to stress at work. Maslach (1996) describes it as a psychological syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment. Recent studies have shown that healthcare worker coping strategies may function either as a risk or aprotective factor for the development of distress and emotional problems. Furthermore, other studies highlighted the role of the dimensions of metacognition as vulnerability factors in predicting the development of psychological symptoms. The aim of this study is to examine and assess the relationships between burnout, coping strategies and metacognitive beliefs in workers involved in home palliative care. A group of operators working in a team of Integrated Home Palliative Care participated in the research. The study was based on a protocol including the Italian version of MCQ-30, used to assess a range of metacognitive beliefs and processes relevant to vulnerability and maintenance of emotional disorders; the Brief Cope (BC) to survey coping strategies; Maslach Burnout Inventory (MBI) to measure burnout. The questionnaire includes a socio-demographical section. The results show the presence of a statistically significant correlation between the variables investigated.

Keywords: home palliative care; burnout; metacognitions; coping strategies; health workers.

INTRODUCTION

Palliative care consists of the assistance provided by health care systems in order to help people who suffer from a chronic, incurable, progressive disease which may lead to a terminal situation, usually experienced with many complex symptoms, psychological distress and existential suffering. According to the World Health Organization (2004), palliative care is “an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual”. Palliative care is “an approach that improves the quality of life of patients (adults and children) and their families who are facing problemsassociated with life-threatening illness. It prevents and relieves sufferingthrough the early identification, correct assessment and treatment of painand other problems, whether physical, psychosocial or spiritual” (WHO, 2015). Over the last years, the practice of palliative care has expanded, and has become associated with end-of-life care.

Professionals who work in palliative care need to have specialized knowledge and skills in order to deal with all the complex situations they face, developing the best global care plan possible for each particular person and family. The interdisciplinary aspect is considered to be one of the core elements of palliative care. In fact, the other nuclear elements which build palliative care – symptom control, psychological, emotional and spiritual support, family support during the disease process and grief – can only be achieved by a multi-professional team, which acts in an interdisciplinary way, sharing information, decisions and having “(…) a good degree of trust, respect and confidence in each other’s skills and ability (Speck, 2004)”.

The literature refers to some relevant attributes in order to work in palliative care. Flexibility, idealism, spontaneity, the capability to develop self-awareness and to cope with adversity and frustration have been identified as desirable qualities. Teams should have a shared purpose, be capable of empowerment, be able to build positive relationships, effective communication, optimal performance, recognition and motivation (Bernardo, 2006). The work teamis also a way for professionals to help and look after each other, sharing emotions, giving interpersonal support and building a "sense of belonging".

Every day, workers have to confront human vulnerability, suffering, dying and death. This constant confrontation may also cause suffering for the workers themselves to the point that they develop a burnout syndrome.

Burnout is a psychological state of exhaustion, related to stress at work. Maslach describes burnout as "a psychological syndrome of emotional exhaustion, depersonalization and reduced personal accomplishment that can occur among individuals who work with other people in some capacity" (Maslach, 1996). The next section discusses the various definitions associated with burnout.

Emotional Exhaustion (EE) can be described as a feeling of fatigue and weakness, exhaustion and stress.

Depersonalization (D) is demonstrated by numbness, lack of feelings and impersonal responses toward others.

Personal Accomplishment (PA) consists of low feelings of productivity, adequacy and coping successfully (Demir, 2003).

Burnout affects the personal well-being and quality oflife of the healthcare professional. It is associated with withdrawal from the job, increased risk of suicidal ideation, and absenteeism (Schaufeli, 2009; Dyrbye, 2008; Toh, 2012). In addition, burnout impairs the quality of patient care. It is also linked to a poorer quality of care which increases medical errors and lawsuits (Shanafelt, 2002; Fahrenkopf, 2008).

The literature discusses the characteristics of palliative care as part of the risk factors for burnout development. It states that palliative healthcare providers may experience physical, psychological and emotional exhaustion, with the occurrence of burnout. In addition to this, professionals are confronted with death and dying which, consequently, could contribute to their own suffering (Pereira, 2011).

Furthermore, another key risk factor for burnout (Maslach, 1993) is the failure to successfully down-regulate negative emotions. The ability to regulate emotional responses is thought to have an impact on the perceived quality of working life and on professionals' psychological wellbeing as well as their performance.

Recent studies have shown that healthcare workers' coping strategies may either be a risk or a protective factor for the development of distress and emotional problems (Dorz, 2004).

Coping has been defined as a multidimensional process that includes both cognitive and behavioral efforts to manage external and/or internal demands that are evaluated as taxing or exceeding the individual's resources (Lazurus, 1984).

Numerous scientific studies have examined the strategies individuals commonly use to cope with stressful events. Coping strategies are not simply reactions; rather they are actively employed strategies that create a resource that influences worker wellbeing (Tugade, 2004). Coping strategies are vital in assisting caregivers to manage burdens as they form a preventive measure against affective disorders commonly associated with caregiving (Parks, & Novielli, 2000).

Caregiving experiences are multifaceted, presenting a combination of positive and negative elements (Pierce, 2007). Emotional management among caregivers in palliative care institutions is often one of the most vital aspects necessary to maintain work requirements and satisfaction (Karabanow, 1999). Positive and negative emotions and the relationship between them play an important role within caregivers' emotional experiences and their coping ability.

Furthermore, many studies highlighted the role of dimensions of metacognition as vulnerability factors in predicting the development of psychological symptoms. Several lines of evidence indicate that there is a strong relationship between emotional processes, cognition, metacognitive beliefs and behaviors (Brune, 2006).

Metacognition is defined as "the aspect of information processing that monitors, interprets, evaluates and regulates the contents and processes of its organization" (Wells, 1999). According to Wells and Matthews (1994, 1996) dysfunctional metacognitive beliefs are the basis for the development and maintenance of psychological disorders.

The present study aims to examine and specify the connections between burnout, metacognitive functions and coping strategies. The hypothesis of the present work is that the appropriate use of positive and flexible coping strategies and functional metacognitive beliefs may relate to the management of distress and emotional problems.

Materials and methods

Subjects

The study examined a group of twenty-five caregivers (18 male and 7 female) of the A.D.I.P. (Assistenza Domiciliare Interdisciplinare Palliativa) belonging to the A.S.P. (Azienda Provinciale Sanitaria), provincial health service for interdisciplinary palliative home care in Messina, supervised by the Consorzio SISIFO, a union of Social Cooperation. Most respondents were between 18 and 58 years old (M =32,5; SD = 15,84), and with ≥ 1 years (M = 4.54; SD = 7.87) of experience in home palliative care.

Participants weretold by the researchers that all data would be treated confidentiallyand only for research purposes. Before the beginning of the study,all participants gave written consent.

The demographic s of the subjects are presented in Table 1.

Table 1. Demographic characteristics

Variable	**N**	**%**
Gender		
Female	18	72
Male	7	28
Position		
Physicians	5	20
Psychologist	4	16

Nurse	7	28
Social HealthWorkers	9	36
Experience		
≤ 5 years	13	52
> 6 years	12	48

Instruments

All the patients underwent the following test:

- Questionnaire to determine demographic features of the participants (gender, age, marital status, palliative care experience).

- The Italian Version of the Maslach Burnout Inventory (MBI), (Serigatti, 1988) was used. The MBI is a self-reporting scale. It consists of 20 questions, divided in three subscales: Emotional Exhaustion (EE), Depersonalization (DP) and Personal Accomplishment (PA). Each item is to be rated on 7-point scale, according to how often a feeling is experienced, ranging from “never” to “every day”.

-The Brief COPE (Carver, 1997) was used. It is intended to foster a wider examination of coping in naturally occurring settings. The Brief COPE includes only 28 items, which measure 14 conceptually differentiable coping reactions. Some of these reactions are known to be generally adaptive; others are known to be problematic. The Brief COPE thus provides researchers a way to assess potentially important coping responses quickly.

-The Metacognitions Questionnaire (MCQ-30) (Quattropani et al., 2014) was used. The MCQ-30 is a brief, reliable and valid self-reporting measureof metacognitions. It consists of 30 questions, which measure a range of metacognitive beliefs and processes relevant to vulnerability and maintenance of emotional disorders (Wells, & Cartwright-Hatton, 2004).

Statistical analysis

All data were entered on an Excel (Microsoft, Redmond WA) spreadsheet and analyzed by using SPSS for Windows (version 19, IBM Corp., NewYork, USA). Descriptive Statistics were used to characterize overall subjects.

Spearman correlation coefficients were used to examine the bivariateassociations among study variables. The significant levels for the correlation coefficients were $p < 0.05$and $p < 0.01$.

Results

Significant correlations were found in different scalesof the MBI, Brief COPE and MCQ-30 and significant statistical relationships were found between the same sociodemographic variables and single scales of the instruments.

Table 2 shows correlations between MBI and MCQ, and some demographic variables (years and palliative experience).

Table 2. Correlations between MBI, MCQ and demographic variables

	Variabile					**MetacognitionsQuestionnaire–30**			
		Years of workers	Palliative Experience	**CC**	**POS**	**CSC**	**NEG**	**NC**	**Total**
MaslachBurnout Inventory	**Emotional Exhaustion**	-.10	-.15	.25	.10	.31	.53**	.23	.35
	Personal Accomplishment	.44*	-.10	.16	.37	.43*	.23	.43*	.40
	Depersonalization	-.20	.14	.16	-.04	.15	-.01	.08	.15

p<0,05 ; **p<0,01

Table 3 and 4 show correlations between MBI and Brief COPE.

Table 3. Correlation between MBI and Brief COPE

Variabile		Brief-Cope						
		Self distraction	Active coping	Denial	Substance use	Use of emotional Support	Use of Instrumenalsupport	Behavioraldisengagement
MaslachBurnout Inventory	Emotional Exhaustion	.08	.52**	.30	.15	.47*	.39	-.08
	Personal Accomplishment	.03	.33	.09	-.23	-.02	.18	-.07
	Depersonalization	-.12	.03	-.40	-.25	.00	.01	.04

p<0,05 ; *<0,01

Table 4. Correlations between MBI and Brief COPE

Variable		Brief-Cope						
		Venting	Positive reframing	Planning	Humor	Acceptance	Religion	Self-blame
Maslach Burnout Inventory	Emotional Exhaustion	-.04	-.05	.23	-.04	.32	.24	.40
	Personal Accomplishment	.49*	.25	.36	.03	.64**	.19	.31
	Depersonalization	.14	.11	-.09	.32	.09	.15	.04

p<0,05 ; **p<0,01

As can be seen in tables2, 3 and 4, there were moderate correlations for the variables.

Results indicate that Emotional Exhaustion is positively associated with Negative Beliefs (.53**).

Low Personal Accomplishment is related to years of workers (.44*), Self-Consciousness (.43*), need to Control Thoughts (.43*)

Correlations between MBI and Brief COPE show Emotional Exhaustion related with Active Coping (.52**), use of Emotional Support (.47*). Moreover, low Personal Accomplishment related with Venting (.49*), Acceptance (.64**).

Moderate correlation coefficients highlighted that there were other variables that influence these associations.

Discussion

The current study aimed to explore and assess the relationships between burnout, coping strategies and metacognitive beliefs in professionals involved in home palliative care. Previous research has shown that many potential stressors are part of palliative care environment, such as organizational demands, lack of gratification, imbalance between work and family.The absence of studies on metacognitive beliefs led us to explore associations between metacognitions and deeper investigation of the literature on burnout and coping strategies.

The results of the current study highlight the role of metacognitions in a field where there has been limited research: the home palliative care area. We emphasize the importance of specific dysfunctional metacognitive beliefs in this population and the importance of considering the associations on the basis of the burnout disorders.

It is necessary to further elucidate the cause and explore the predictors of burnoutsymptoms in the future.

We believe that ineffective coping and dysfunctional metacognitive beliefs often lead to the accumulation of stressors, with a considerable impact on caregivers and their working abilities. However, more studies have shown that healthcare workers’ coping strategies may be a risk or protective factor for the development of distress and emotional problems (Dorz, 2004).

So this study has highlighted the importance of coping, the necessity of supporting formal caregivers and including measures to prevent burnout and stress.

In order to alleviate the factors predictive of stress, it is highly desirable to establish a worker management system in which workers' physical and mental fatigue and burdens do not increase, and support is provided for the professional team. In addition, personal growth in workers themselves, such as acquiring self-efficacy or resilience, learning flexible and varied coping methods, and enhancing nursing skills, is also desirable (Terakado, 2015).

These findings can be very useful for developing more efficacious and tailored preventions treatments for these subjects.

The study had some methodological limitations: this study design surveyed a small numbers of subjects. Moreover, some demographic information was not collected sufficiently, such as length of work shifts, number of hours worked per week, number of patient seen per months and day.

Other limitations of our study were: the data collection method, which created difficulties in ascertaining causality; using *self-reported* data and non parametric statistics.

Finally, we did not evaluate psychological status such as depression and also job satisfaction. A more detailed analysis of data is, however, necessary to find out the role of metacognitions and coping in the field of palliative care, especially in connection with burnout. Research of this kind is currently in progress by the authors.

REFERENCES

Bernardo, A., Rosado, J., Salazar, H., (2006).Trabalhoemequipa. In Manual de CuidadosPaliativos, A Barbosa, I.G. Neto (eds), FundaçãoCalousteGulbenkian e Faculdade de Medicina da Universidade de Lisboa, Lisboa, 463-473.

Carver, C. S. (1997). You want to measure coping but your protocol'too long: Consider the brief cope. International journal of behavioral medicine, 4(1), 92-100.

Demir, A., Ulusoy, M., &Ulusoy, M. F. (2003). Investigation of factors influencing burnout levels in the professional and private lives of nurses.*International journal of nursing studies*, *40*(8), 807-827.

Dorz, S., Novara, C., Sica, C., &Sanavio, E. (2003). Predicting burnout among HIV/AIDS and oncology health care workers. *Psychology and health*, *18*(5), 677-684.

Dyrbye, L. N., Thomas, M. R., Massie, F. S., Power, D. V., Eacker, A., Harper, W., ... &Shanafelt, T. D. (2008). Burnout and suicidal ideation among US medical students. *Annals of internal medicine*, *149*(5), 334-341.

Eelen, S., Bauwens, S., Baillon, C., Distelmans, W., Jacobs, E., &Verzelen, A. (2014). The prevalence of burnout among oncology professionals: oncologists are at risk of developing burnout. *Psycho-Oncology*, *23*(12), 1415-1422.

Fahrenkopf, A. M., Sectish, T. C., Barger, L. K., Sharek, P. J., Lewin, D., Chiang, V. W., ... &Landrigan, C. P. (2008). Rates of medication errors among depressed and burnt out residents: prospective cohort study. *Bmj*, *336*(7642), 488-491.

Folkman, S. (1984). *Stress, appraisal, and coping*. Springer Publishing Company LLC.

Iannello, P., &Balzarotti, S. (2014). Stress and coping strategies in the emergency room. *Emergency Care Journal*, *10*(2).

Karabanow, J. (1999). When caring is not enough: Emotional labour and youth shelter workers. *The Social Service Review*, *73* (3), 340-357.

Maslach, C., Jackson, S. E., & Leiter, M. P. (1996). Maslach burnout inventory (3rd edn). Consulting Psychologists. Press: Palo Alto (CA).

Parks, S., &Novielli, K. (2000). A practical guide to caring for caregivers. *American Family Physician, 62*(12).

Pereira, S. M., & Fonseca, A. M. (2011). Risk of burnout and protective factors in palliative care. *Exploring Issues of Care, Dying and the End of Life. Oxford: Inter--Disciplinary. Net*.

Pierce, L., Steiner V., Govoni, A., Thompson, T., &Friedeman M. (2007). Two sides to the caregiving story. *Top Stroke Rehabilitation*, *14* (2), 13-20.

Quattropani,M. C., Lenzo, V., Mucciardi, M., & Toffle, M. E. (2014). Psychometric properties of the Italian version of the Short Form of the

Metacognitions Questionnaire (MCQ-30). Bollettino di PsicologiaApplicata, (269).

Schaufeli, W. B., Bakker, A. B., & Van Rhenen, W. (2009). How changes in job demands and resources predict burnout, work engagement, and sickness absenteeism. *Journal of Organizational Behavior*, *30*(7), 893.

Shanafelt, T. D., Bradley, K. A., Wipf, J. E., & Back, A. L. (2002). Burnout and self-reported patient care in an internal medicine residency program. *Annals of internal medicine*, *136*(5), 358-367.

Sirigatti, S., Stefanile, C., &Menoni, E. (1988). Per un adattamento italiano del MaslachBurnout Inventory (MBI). Bollettino di PsicologiaApplicata, (187-188), 33-39.

Speck, P., (2009).Team or group – spot the difference. In Teamwork in Palliative Care: Fulfilling or frustrating?, Speck,P.(ed), Oxford University Press: Oxford, 7-23.

Terakado, A., & Matsushima, E. (2015). Work stress among nurses engaged in palliative care on general wards. *Psycho-Oncology*, *24*(1), 63-69.

Toh, S. G., Ang, E., & Devi, M. K. (2012). Systematic review on the relationship between the nursing shortage and job satisfaction, stress and burnout levels among nurses in oncology/haematology settings. *International Journal of Evidence-based Healthcare*, *10*(2), 126-141.

Tugade, M., Fredrickson, B., & Barrett L. (2004). Psychological resilience and positive emotional granularity: Examining the benefits of positive emotions on coping and health.*Journal of Personality*, *72* (6), 1161-1190.

Uren, S., & Graham, T. (2013). Subjective experiences of coping among caregivers in palliative care. *OJIN: The Online Journal of Issues in Nursing*,*18*(2).

Wells, A. & Cartwright-Hatton, S. (2004). A short form of the Metacognitions Questionnaire: Proprieties of the MCQ-30. *BehaviorResearch and Therapy, 42*, 385-39.

Mediterranean Journal of Clinical Psychology, Vol. IV, No. 1 (2016).
Doi: 10.6092/2282-1619/2016.4.1120