

Burnout in Indian Psychiatrists

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ABSTRACT


Background: Individuals associated with service providing and decision-taking are prone for stress leading to burnout. **Aim:** The aim of this study is to find out the details of burnout among Psychiatrists in India. **Materials and Methods:** Copenhagen Burnout Inventory (CBI) with structured biodata sheet was sent to the representative sample of psychiatrists by e-mail. Basic statistical analysis was done to find out prevalence, analyze response pattern, and differences between those with and without burnout. **Results:** The number of psychiatrists that responded to survey was 110–81 (74%) male and 29 (26%) female. The number of burnout cases in one or other spheres was 51 in 35 psychiatrists accounting for the prevalence of 46%. 32% of psychiatrists have burnout. Four psychiatrists have burnout in all three dimensions, nine in two dimensions, and 22 in one dimension. Personal burnout topped in the three dimensions (63%) followed by work burnout (24%). Patient burnout was least at 14%. **Conclusions:** Burnout, though not very high, is to be taken seriously by Indian psychiatrists and protective and preventive measures are in order.

Key words: Burnout profile, burnout, Copenhagen Burnout Inventory, psychiatrist

INTRODUCTION

There is no profession without stress and tension, which differs from profession to profession and person to person. Professions involving guidance, decision-making, etc., are more prone to it. Even in these professions, it will not be the same and depends on the individual, conditions of work, work environment, socioeconomic background, etc. Depending on numerous factors, occupation can lead to a condition known as Burnout Syndrome (BS) – exhaustion of physical or emotional strength or motivation usually because of prolonged stress or frustration.^[1] There is all round feeling of drained-out with the individual becoming mechanical.

BS is not depression or anxiety disorder. BS can occur in any profession but most frequently occurs in the caring professions.^[2] Among medical specialties, emergency medicine (>50%) tops the list immediately followed by critical care medicine (50%). Psychiatry, ophthalmology, pediatrics, and rheumatology are at the lower end – 33%.^[3] Because of universal concern, it was extensively studied. With higher stakes, ambitions, expectations the stress has increased all round in Indian medical profession that can lead to BS in the vulnerable. The toll of BS is heavy not only on the individual but society also. The consequences of BS varies – it effects personal, family, professional, and social life of the

Access this article online	
Website: www.ijpm.info	Quick Response Code 
DOI: 10.4103/IJPSYM.IJPSYM_265_17	

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How to cite this article: Sarma PG. Burnout in indian psychiatrists. Indian J Psychol Med 2018;40:156-60.

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individual. The earlier concern toward patient will not be there, interaction with colleagues will be superficial, and marital discord will be common. Relationship with colleagues and staff working under will be strained. Professional performance will not be the same as earlier.

Kristensen *et al.* presented a new tool for the measurement of burnout in 2005 – the Copenhagen Burnout Inventory (CBI).^[4] CBI is a public domain questionnaire measuring the degree of physical and psychological fatigue experienced in three subdimensions of burnout: personal, work-related, and client (patient in the present case)-related burnout. PUMA study^[4] (project on burnout, motivation, and job satisfaction) analyses indicate very satisfactory reliability and validity for the CBI instrument. The CBI had acceptable reliability (internal consistency and homogeneity) as well as factorial and criterion-related validity.^[5] Personal burnout is defined as the degree of physical and psychological fatigue and exhaustion experienced by the person; work burnout is degree of physical and psychological fatigue, and exhaustion that is perceived by the person as related to his/her own work and Patient burnout is a degree of physical and psychological fatigue and exhaustion that is perceived by the person as related to his/her work with patients.^[4]

MATERIALS AND METHODS

Data of psychiatrists – name, place, mail ID, and phone numbers were collected from various associations and sources. A questionnaire about details of the doctor was prepared. To avoid mechanical answering, CBI scale was jumbled and additional nonscoring questions were added. The questioner containing details of the psychiatrist and CBI scale was sent as attachment to the representative sample of psychiatrists. When there was no response, reminders by personal phone/mail/SMS/WhatsApp was done. If still there was no response, mails were sent to other persons in the selected list till the target size was achieved and colleagues from the area were approached to get the data from the concerned. A case was considered as BS, if the average score in any dimension is fifty and above. All the responses in CBI were clubbed. Simple statistics were applied to find out characteristics of burnout persons. Comparison was made between those with and without burnout in the variables – gender, age, marital and spouse status, qualification, experience, commitment and support

system, habits, exercise, work effect, appreciation, talent utilization, earning mismatch, and satisfaction. The data were entered in Excel Spreadsheet and analysis was done using statistical packages.^[6,7] The three dimensions of burnout were analyzed using basic statistics, ANOVA of burnout – between and within groups and *post hoc* test of multiple comparisons with personal burnout as dependent variable.

RESULTS

Response rate for the e-mail survey with personal follow-up was 68%. Data from 110 to 81 (74%) male and 29 (26%), psychiatrists were analyzed. The number of burnout cases in one or other spheres was 51 in 35 psychiatrists – 25 (71%) male and ten (29%) female, accounting for 46%. There were no nonresponders (not answering three or more questions in each dimension). Four psychiatrists have burnout in all three dimensions, nine in two dimensions, and 22 in one dimension. Analysis was done with both the sexes combined as there was no difference between sexes in burnout.

Personal burnout topped in three subdimensions of burnout followed by work burnout.

Table 1 gives burnout cases and score details for the three categories – personal, work, and patient Burnout.

Table 2 gives response pattern to questions in the three dimensions in personal, work, and patient Burnout.

Table 3 gives ANOVA of burnout – between and within groups.

Table 4 gives *post hoc* test of multiple comparisons with personal burnout as dependent variable.

Table 5 gives details of variables with no difference with and without Burnout.

Table 6 gives details of variables with difference with and without Burnout.

DISCUSSION

It was reported that response from psychiatry was lowest at 27.1% with an overall survey response rate

Table 1: Burnout cases and score details for the three-dimensions – personal, work, and patient burnout (n=110)

	Number of cases	Percentage of total burnout	Score			
			Maximum=100	Minimum=0	Mean	SD
Personal burnout	32	63	79	0	37.3	16
Work burnout	12	24	71	0	22.6	17.65
Patient burnout	07	14	63	0	18.2	15.78

SD – Standard deviation

of 35.0% where survey was through the Internet using a well-known and established survey company (www.surveymonkey.com), and multiple methods were used to encourage survey response such as individual personalized e-mail invitations, multiple reminders, and a draw for three gift certificate prizes were used to increase response rate.^[8] The present high response rate despite not using incentives may be due to the uncharted topic of BS in Indian Psychiatrists that roused their curiosity prompting them to respond.

It was reported that psychiatrists are at considerable risk for burnout – 25% to 57% of the profession at any given time.^[9] Comments gathered in a national survey of community mental health center psychiatrists indicate that many suffer from burnout.^[10,11] The present study agrees with the report that the least burned-out physicians are dermatologists (37%), psychiatrists (38%), and pathologists (39%),^[12] and other studies from Canton of Zurich, Switzerland (18%).^[13] Those who have not responded, in spite of assurances of doing so on contact reminders – telephonic, SMS, WhatsApp, or mail might have been cases of burnout not willing to come out.

The ANOVA shows difference in the three dimensions of burnout. In addition, the pair-wise burnout pattern for the three dimensions, tabulated in multiple comparisons, show clear-cut differences pair-wise that

Table 2: Response pattern to questions in the three-dimensions – personal, work, and patient burnout (n=110)

	Always	Often	Sometimes	Seldom	Never	Total
Personal burnout	9	55	298	180	118	660
Work burnout	20	25	159	218	348	770
Patient burnout	8	21	94	196	341	660

$\chi^2/df/P=276/0.00$

Table 3: ANOVA of burnout – between and within groups (n=110)

	Sum of squares	df	Mean square	F	Significant
Between groups	21,164.564	2	10,582.282	38.810	<0.001
Within groups	89,162.591	327	272.668		
Total	110,327.155	329			

Table 4: Post hoc test of multiple comparisons with personal burnout as dependent variable

Threshold (I)	Threshold (J)	Mean difference (I-J)	SE	Significant	95% CI	
					Lower bound	Upper bound
Personal	Work	14.4000*	2.22657	<0.001	10.0198	18.7802
	Patient	18.7636*	2.22657	<0.001	14.3562	23.1166
Work	Personal	-14.40008	2.22657	<0.001	-18.7802	-10.0198
	Patient	4.33636*	2.22657	<0.001	-0.0438	8.7166
Patient	Personal	-18.73636*	2.22657	<0.001	-23.1166	-14.3562
	Work	-4.33636	2.22657	<0.001	-8.7166	0.0438

*The mean difference is significant at the 0.05 level. CI – Confidence interval; SE – Standard error

are highly significant. This indicates that the three can be mutually inclusive or exclusive giving them individual status.

The present study agrees with the observation that supportive relationships, extracurricular activities by way of exercise, yoga, a positive attitude toward one’s work, and high job satisfaction.^[14,15]

Psychiatrists, as a group are vulnerable to experiencing burnout, and the factors that make psychiatry a stressful profession include factors such as patient violence and suicide, limited resources, crowded inpatient wards, changing culture in mental health services, high work demands, poorly defined roles of consultants, responsibility without authority, inability to effect systemic change, conflict between responsibility toward employers versus toward the patient, and isolation.^[16] As psychiatrist, one sees the lowest of human relationships, base behavior, breakdown of relations, etc., which can be thought of as additional contributory factors for BS. Emergency, critical care, terminal care, and oncology doctors (and nursing staff) stare at death almost in every case which can explain high burnout in those branches. Psychiatrists stare at almost living death of patient – figuratively in patients and caregivers, in addition to prolonged misery, stigma, and social ostracizing. These are sure recipes for burnout. Medical practice in India, more so psychiatric practice, is relatively free from patient and family litigation till now. This is fast changing and this could be an additional contributory factor in the future.

The International Classification of Diseases, Tenth Revision (ICD-10) codes burnout under Z73 – problems related to the life-management difficulty that excludes problems related to socioeconomic and psychosocial circumstances. It is coded as Z73.0 burnout include state of vital exhaustion.^[17] Nevertheless, it has not come under the net of psychiatry till now.

Psychiatrists working in Mental hospitals or having psychiatric hospitals with many inpatients have different stressors than psychiatrists who see only outpatients. This is a mixed sample as it consists of all

Table 5: Details of variables with no difference with and without burnout

Variable	BS (n=35)*	No BS (n=75)*
Marital status		
Married	29	65
Never married	5	7
Other (separated/widowhood)	1	3
Spouse working		
Does not arise	5	7
Working	23	51
Not working	7	15
Spouse doctor		
Does not arise	5	7
Yes	15	35
No	15	33
Age group		
21-30	10	9
31-40	6	16
41-50	8	13
51-60	3	17
61-70	5	15
>70	3	5
Qualification		
Diploma	10	12
Degree	19	51
Combination or other	6	12
Experience (years)		
<5	8	12
<10	8	12
11-19	8	13
20-30	5	21
>30	6	16
Religious		
Yes	25	56
No	10	18
Physical health		
Good	22	53
Maintaining well with treatment	12	18
Not good	1	1
Commitments		
Present	26	48
Nil	8	25

*Total may not tally in some variables as some information blanks were there in some areas. BS – Burnout syndrome

types of psychiatrists – consultation, inpatient caring, academic, etc., with different work environment, targets, pressure, etc., and hence the results may be deceptive. The psychiatrists in the former category may be more liable for burnout and no effort was made to analyze from that angle.

There were questions about the diagnosis of burnout as a separate entity.^[18-20] Irrespective of the arguments for and against the entity and notwithstanding the fact of it being an ICD-10 entity, one should take note of the fact that many psychiatrists have potential for BS as measured by an acknowledged instrument. Two

Table 6: Details of variables with difference with and without burnout

Variable	Burnout (n=35)*	No burnout (n=75)*	P
Support			
Present	27	73	0.001
Absent	8	1	
Vacation			
Present	14	57	<0.001
Absent	20	18	
Exercise			
Present	19	65	0.000
Absent	16	9	
Use of antianxiety			
Never	23	63	0.023
Rarely	7	11	
Occasional	3	0	
Frequent	2	1	
Use of sedatives			
Never	26	67	0.009
Rarely	5	8	
Occasional	2	0	
Frequent	2	0	
Work related			
Effect of work on personal/family life			
No effect	9	27	0.029
Mild	14	40	
Moderate	10	7	
Severe	2	1	
Recognition of work by colleagues			
Appreciation	23	66	0.002
Grudging admiration	6	1	
Ignored	6	6	
Feeling of talent underutilization			
Do not bother	15	35	0.038
Hurt	2	1	
On and off	15	38	
Always	3	0	
Mismatch between talent and earnings			
At times	15	19	0.031
Do not bother	2	0	
Never thought of it	12	31	
On and off	3	15	
Always	2	10	
Work satisfaction			
Satisfied	24	38	0.028
Well satisfied	6	34	
Dissatisfied	1	0	
Not satisfied	3	2	

*Total may not tally in some variables as some information blanks were there in some areas

Indian studies relating to medical profession used CBI – one in residents in a tertiary hospital^[21] and another in psychiatric nurses.^[22] The consequences of BS can be devastating – higher suicide rates than those of the general population and higher rates of divorce and substance abuse compared with other

physicians and nonphysicians.^[23] These should make the profession alert. Whatever may be the status of the entity, quantum of prevalence, Indian Psychiatrists should be on guard. It is immaterial what exactly is the prevalence of burnout in psychiatry vis-à-vis other branches of medicine as a burnout psychiatrist can cause more long-term damage to the patient than other branches. Looking at it another way nearly a third of patients – assuming that to be the proportion of patients seen by these psychiatrists is at risk. The profile of the BS psychiatrist in India seems to be that of a person with less exercise, vacation, support system, antianxiety, sedative resorting, with work effecting family/social life, unappreciated, unsatisfied, underutilized services, and mismatched earnings.

This is the first-time assessment of burnout in Indian Psychiatrists. The drawbacks of the survey include noninclusion of other variables such as work condition details. Even though representative, the study might have missed burnout cases as severely burnout might not be inclined to respond. Further, there was no way to detect false responses (lie-detect questions were not there).

CONCLUSIONS

Indian psychiatrists need protective measures against burnout.

Acknowledgment

The author acknowledge the advice and help in the statistical analysis by Dr V V HaraGopal M.Sc PhD, professor and chairman BOS, Department of Statistics, Osmania University, Hyderabad - 500 007, Telangana, India.

Financial support and sponsorship

Nil.

Conflicts of interest

There are no conflicts of interest.

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