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Emotional Burnout Syndrome in Elderly Women–Physicians

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Abstract—This paper presents the results of a comparative study of the clinical symptoms of emotional burnout syndrome among 84 elderly women working in the specialty of physicians and 48 women who have officially ceased working in this specialty. The findings suggest that emotional burnout syndrome can take place in the elderly and is most closely associated with continued professional activity. The cessation of this working activity leads to stress, often with the subsequent development of posttraumatic stress disorder and stress-induced diseases. However, in this case, the clinical symptoms of emotional burnout syndrome do not disappear but are only transformed with joining of various psychosomatic disorders. Thus, the elderly who suffer from emotional burnout syndrome are a risk group as regards the formation and development of stress-associated diseases and require close attendance within the compulsory program of medical examination.

Keywords: women–physician, work, stress, emotional burnout, clinical transformation

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INTRODUCTION

Clinical manifestations of the so-called emotional burnout or chronic fatigue syndrome are usually observed, according to the literature, in young and middle-aged people as a result of all sorts of emotional dissatisfaction and the daily routine of work [4, 5, 10, 13]. That is why the leading place in the list of ways to overcome this pathological disorder is taken by advice on changing professional activity, overcoming the boring stereotype of fulfilling certain duties, especially those that do not require any creative approach but are rather some automatic actions. Psychologists also advise making work breaks with a different duration if there is no possibility of radical changes in the content of the work performed. It is quite often recommended to "get distracted" from a routine, mundanity, "grayness" of life with the help of sports activities, various hobbies, by introducing diversity into personal life, including intimacy, etc. [3, 4, 10]. But researchers very rarely turn to the age aspect of emotional burnout syndrome, mainly confining themselves to referring to the long-term, many-year fulfillment of the same professional or household responsibilities, regardless of the patients' age.

Meanwhile, in recent years there has appeared a quite large cohort of people at retirement, elderly, and even senile age who make complaints that correspond to the typical clinical manifestations of emotional burnout syndrome. These people, as a rule, do not seek help from a psychologist but often turn out to be patients of therapists, neurologists, endocrinologists, gynecologists, and doctors of other specialties. With consideration for the age of patients and a number of chronic diseases they have, they are given a wide variety of diagnoses, varying from pathological menopause to hypertension, depression and thyrotoxicosis, and are prescribed an equally diverse treatment, which often has the nature of polypharmacy. However, there is often no significant result of such treatment, and patients are forced again and again to seek medical help but already with a forming or already formed phobia of many diagnosed and progressive diseases that cannot be treated.

The described situation forced us to turn to the problem concerning the possibility of development of emotional burnout syndrome in elderly and senile people. This also seems to be relevant for healthcare workers due to the fact that representatives of medical professions are often mentioned among the people that are susceptible to emotional burnout syndrome [1, 2, 4, 10, 11, 14]. Moreover, it is doctors who often continue their professional activities for many years after reaching the retirement age.

The goal of the study is to determine the comparative features of the clinical manifestations of emotional burnout syndrome in the elderly women who are representatives of the medical profession of two categories (working and nonworking women).

MATERIALS AND METHODS

Two groups of women aged 60–74 years who had the specialty of a physician and suffered from diagnosed emotional burnout syndrome were observed: the first group ($n = 84$) was formed by the women who continued their professional activity despite reaching

the retirement age; the second group (n = 48) consisted of women who had officially stopped working and had not worked for at least 1 year. The choice of only women for the study was explained by two factors: first, there are few men among physicians in general, and, second, women are more susceptible to emotional burnout syndrome [4, 10]. The inclusion of men in the study would require additional identification of gender differences, which would hardly reach the degree of statistical certainty due to the very low presence of men.

The choice of only physicians was explained by the fact that even when planning the research we aimed to maximize the homogeneity of the representatives of the compared groups by the professional principle. This was due to the fact that each profession, including the medical profession, has its own characteristics, which often determine the formation and development of emotional burnout syndrome [4, 5, 10, 11, 14]. Therefore, the study involved only representatives of the therapeutic specialty, which is the most common among doctors in general. In addition, as already indicated, it is doctors who continue to work in their specialty for a very long time after reaching the retirement age. The latter created certain difficulties just in attracting a group of persons at retirement age that had completely stopped working in medicine.

The study did not involve the people who suffered in the period of clinical manifestation of emotional burnout syndrome from chronic age-related diseases of moderate and hard severity, including cardiovascular, bronchopulmonary, oncologic, neurodegenerative, and musculoskeletal diseases, as well as pathological menopause. This made it possible to exclude the probable effect of a number of pathological processes on the formation and development of the studied emotional burnout syndrome as early as the initial stage of the study.

A certain problem that arose in connection with the planned study was its anonymity. However, the mentioned anonymity was associated not with an anonymous questionnaire, which is used by most researchers, but with the use of the "blind" research method, in which a studied subject did not even suspect that she was an object of study as regards the presence or absence of emotional burnout syndrome. This provided significant advantages for obtaining the most objective results that were completely unrelated to possible personalized distortions, which are almost always present if the subjects are notified about the orientation and purpose of a study and experiment.

The study used the main standard methods for diagnosing emotional burnout syndrome: the questionnaire of C. Maslach and S.E. Jackson [15, 16] and McLean's questionnaire measure of organizational stress in the Russian version [4]; V.V. Boiko's method of studying emotional burnout syndrome [3] for measuring the level of emotional burnout; Lusher's widely known color test for determining the dissociation of the true and desired with respect to one's own personality; the classical technique of E.P. Ilyin and P.A. Kovalev [4] for identifying a subject's propensity towards conflicts and aggressiveness as personal characteristics, etc. The presence and severity of occupational stress in working doctors was determined using a questionnaire with a point scale of occupational stress [12] that consisted of 22 questions. The score of 0–15 indicated the absence of occupational stress and emotional tension; in this case, the professional activity did not cause difficulties. The score of 16–30 indicated the moderate level of stress and the presence of mental stress in the absence of signs of adaptation breakdown. The score of 31–45 implied the presence of professional stress, difficulties at work, and neurotic and psychosomatic disorders. If the score of 46–60 was achieved, it could be affirmed that there were varying degrees of adaptation breakdown, which is accompanied by failures in professional practice with a risk of development of mental and psychosomatic disorders.

Nevertheless, when making a comparative analysis, we were more interested not in the results of the quantitative, scaled expression of emotional burnout syndrome but in the qualitative components, i.e., the presence of certain symptoms and clinical manifestations of the indicated syndrome in the representatives of the two groups. Therefore, to make a comparative study, we chose the following clinical symptoms, which are the most common within emotional burnout syndrome, namely: (a) physical symptoms (increased fatigue up to exhaustion, dizziness, weight change, headaches, back pain, chest and muscle pain, general poor feeling, excessive sweating, trembling, fluctuations in blood pressure, and increase in the frequency of catarrhal diseases); (b) emotional symptoms (self-doubt, indifference, exhaustion, loss of motivation, professional and life perspectives, feelings of helplessness and hopelessness, emotional exhaustion, loss of ideals and hopes, hysteria, cynicism and dehumanization, feelings of loneliness and guilt, depressive pessimism); (c) behavioral symptoms (avoiding responsibility, impulsive emotional behavior, using food, drugs, or alcohol to "suppress" problems, social self-isolation, accusing others of one's own misfortunes, increase in the time for doing the usual work, lack of physical exercise, and denying the need for such).

The symptoms of intellectual decline and social handicap were deliberately not included in the presented list. This is due to the fact that, first, they often appear quite late, secondarily to the first three distinguished variants of the symptoms, and, second, they are, in essence, clinical disorders that are described within the emotional, behavioral, and, in part, physical symptoms of emotional burnout syndrome.

RESULTS AND DISCUSSION

The above-mentioned physical symptoms of emotional burnout that were present in the quantity of no less than three in one patient were clearly prevalent among the persons who had stopped working (Fig. 1), $p < 0.05$. Meanwhile, it is just the presence of the indicated symptoms that was the main incentive for 42 (91.3%) of 46 women to consult a doctor in order to diagnose and treat some somatic disease but not to cease the professional activity "due to a serious disease," which "prevented working in full force."

Among the mentioned physical symptoms of emotional burnout, the leading symptoms in the representatives of both compared groups (n = 103; 78%) were sensations of pain in different body points (n = 103; 100%), episodes of very strong fatigue (n = 87; 84.5%), and fluctuations in blood pressure (n = 79; 76.7%) mainly towards its increase. Meanwhile, in 22 (45.8%) representatives of the second group that had left the professional work more than 1 year ago, the pains had become chronic independently of their localization. Based on the data we obtained earlier [7–9], this may indicate that the women who suffered from chronic pain syndromes had survived a fairly heavy stress impact or a number of impacts, which had left their trace in the form of posttraumatic stress disorder. Most probably, there were at least two stress factors: (1) the emerged clinical manifestations of emotional burnout syndrome; (2) the cessation of long-term working activity. The representatives of the first group who continued their professional activity were diagnosed to have chronic pain syndromes in only six (7.1%) cases. However, in all these persons, the score on the occupational stress scale [12] was 46–60 points, and this indicated different degrees of exhaustion of adaptive reserves with failures in professional activity. The results obtained confirm our hypothesis about the prevalent combined stress impact in the cases of the complete cessation of professional work. The frequency of other physical symptoms in the representatives of the two compared groups was entirely comparable ($p > 0.05$).

The emotional symptoms related to the general emotional burnout syndrome took place in all observed women, and they were the starting point for making the diagnosis. However, the frequency of individual variants of the symptoms of this range significantly varied in the distinguished groups.

When making a comparative analysis, we subdivided the observed emotional symptoms into four categories: the first—self-doubt, indifference, loss of motivation, professional and life perspectives; the second—very strong fatigue, feelings of helplessness and hopelessness, emotional exhaustion; the third—loss of ideals and hopes, cynicism, dehumanization; the fourth—hysterics, sense of loneliness and guilt, depressive pessimism. The results of the comparative analysis are shown in Fig. 2.

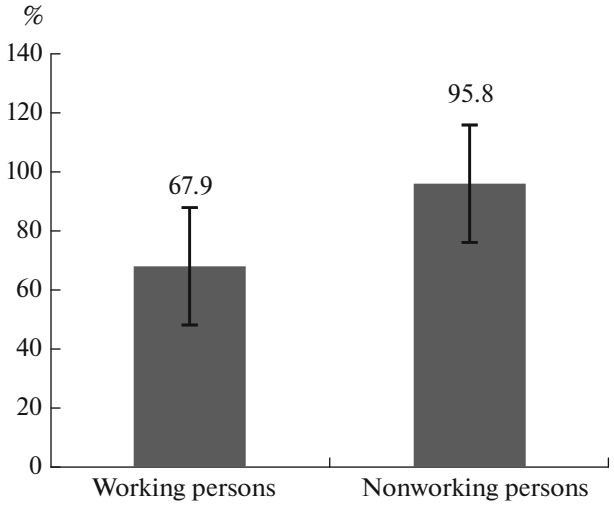

Fig. 1. Physical symptoms of emotional burnout syndrome.

The data in Fig. 2 make it evident that some or another frequency of individual distinguished categories of emotional symptoms is in a clearly opposite dependence on the fact of a women–physician staying in her profession or, on the contrary, not staying in it. All (n = 84) working women had a lack of self-confidence and self-reliance, loss of motivation for performed professional duties and for professional growth, reduction or complete disappearance of professional and life perspectives. Out of 48 nonworking women, only 16 had such symptoms (33.3%); the emotional symptoms in this first category were based on the worsening of life rather than professional perspectives.

An interesting fact is that 15 of these 16 women (93.7%) had a 1–2 year period of work stoppage, and they had not had time to adapt to a new stereotype of life and had not managed to find an adequate substitute for the former professional activity. Out of the remaining 32 nonworking women, only seven (21.9%) also had a 1–2 year period of work stoppage, but nevertheless they had partially adapted to the new conditions of their life and found new hobbies, new areas of activity. However, the episodes of depressive pessimism, which were accompanied by feelings of guilt, loneliness, and hysterical paroxysms (the fourth category of emotional symptoms), were observed in the overwhelming majority of the nonworking women (n = 44; 91.7%) in contrast to the working women (n = 6; 7.1%); $p < 0.001$. However, these were basically (n = 40; 90.9%) only episodes that repeated with different frequency but not constant sensations.

Differences in the frequency of emotional symptoms of the second and third categories that we distinguished were not so significant, but, nevertheless, were statistically significant ($p < 0.05$) towards their prevalence in the nonworking women. On the other

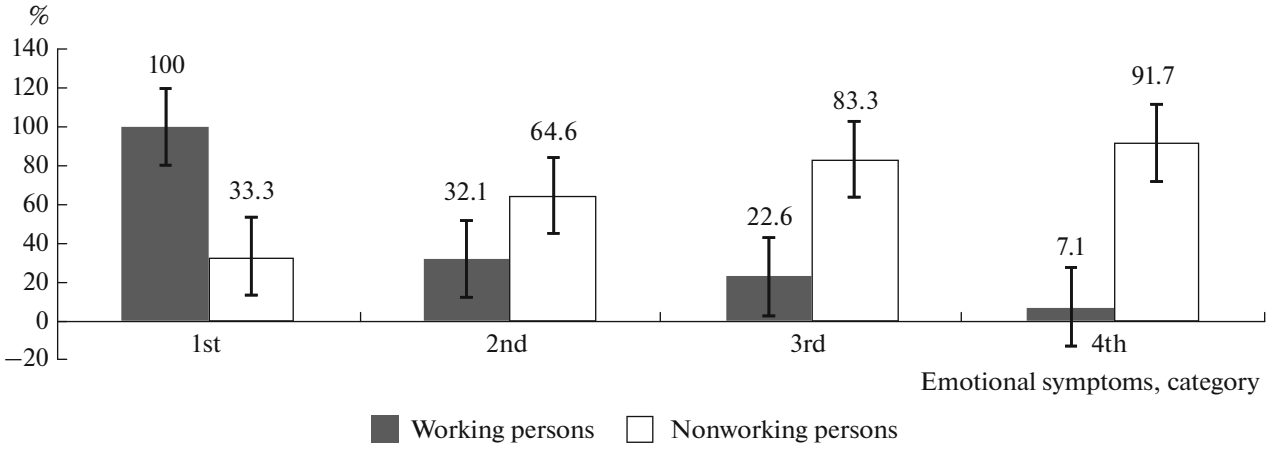

Fig. 2. Emotional symptoms of emotional burnout syndrome.

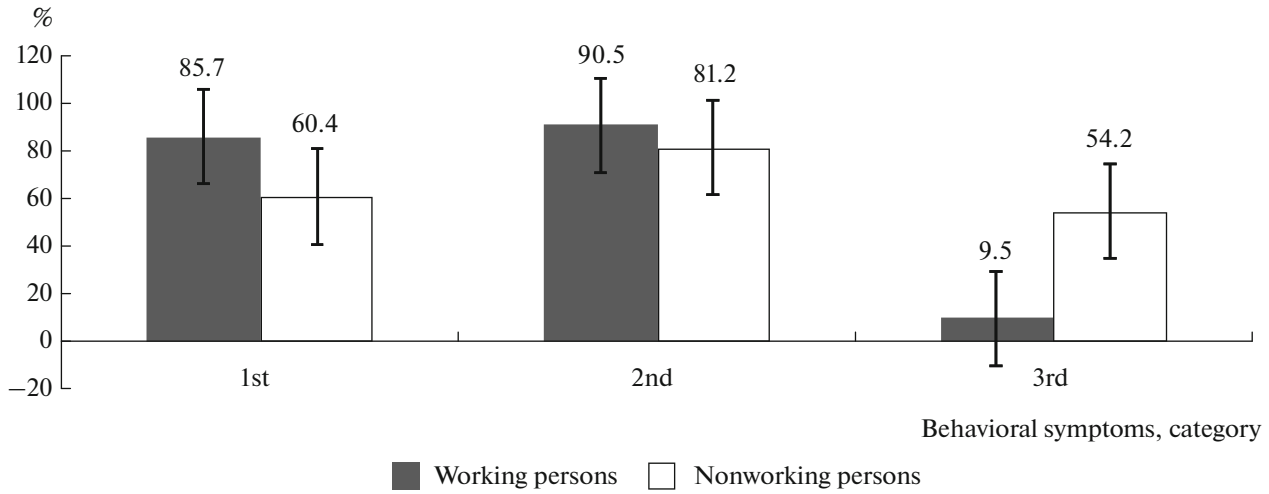

Fig. 3. Behavioral symptoms of emotional burnout syndrome.

hand, the most psychologically heavy sensations, such as exhaustion, hopelessness, complete loss of ideals, and dehumanization, were experienced by the persons (n = 8; 16.7%) that had left their work comparatively recently, 1–2 years ago, and, as they said themselves, "had not found a place for themselves in a new life." The women who continued to work, on the contrary, had symptoms that are not so serious to overcome, such as helplessness, emotional exhaustion, and partial loss of hopes for the future. Thus, the results from the comparative analysis of the emotional symptoms indicate that both their frequency and severity depends on three components: (a) staying or not staying in the profession; (b) the time that has passed since the cessation of professional work; (c) the presence or absence of a fairly adequate substitute for the former professional work.

The behavioral symptoms of emotional burnout syndrome that were met in our observations were subdivided into three categories: the first—impulsive emotional behavior, accusing others of one's own misfortunes, aspiring to avoid the responsibility; the second—increase in the time for doing the usual work, noticeable insufficiency of physical activity; the third—social self-isolation, overeating, using alcohol to "suppress" emerging problems. Drugs were not used by any of the observed women. The results of the comparative analysis are presented in Fig. 3.

The first two categories of behavioral symptoms were met somewhat more often ($p > 0.05$) in the representatives of the first group (the women working in the specialty) than in the nonworking women. However, the content of these symptoms was different. In the working women, the first category of symptoms (n = 64; 76.2%) was most often represented by the impulsive emotional behavior and aspiration to avoid responsibility; in the nonworking women, they were most often manifested in accusing others of their own

misfortunes (n = 23; 47.9%), which were primarily related to the fact of dismissal. Out of the presented symptoms of the second category, the representatives of the first group were noted to have only the desire for self-isolation, which, in the words of the subjects themselves, "greatly hampered work." It was only after dismissal when 26 (54.2%) representatives of the second group gradually acquired a predilection for excesses in food and/or alcohol, which further increased the desire to blame others, often members of their families, in their own misfortunes, worsening of health, downfall of ideals, and lack of aspirations and motivations.

In the course of the study, we sought to explain the development of emotional burnout syndrome and its individual clinical manifestations not only by purely professional aspects, which has been described in a number of publications [4, 5, 10, 11, 13, 14], but also by other possible causative factors. We considered marriages and divorces, widowhood, departure of children from the family, loneliness, probable former stresses, the degree of possible propensity towards conflicts in the subjects, their character traits, including perfectionism, etc. However, the careful research, including with the help of the above-indicated test methods, scales, and questionnaires, revealed no statistically significant quantitative predominance of any factors in one of the two compared groups. The exception was only the previously mentioned high level of occupational stress among six representatives of the first group, who continued to work in the specialty and suffered from chronic pain syndromes. But all of them left work within 1 year after our research, which was quite expected due to the decrease in the level of their adaptive abilities.

Thus, it seems that the paramount role in the development of emotional burnout syndrome in elderly women–physicians is, nevertheless, played by the professional factor. But this raises another question concerning the average timing of the manifestation of emotional burnout syndrome in the representatives of the two compared groups. To get an answer to this question, we simply asked the subjects to recall how many years or months ago at least one of the known symptoms of emotional burnout syndrome had appeared. In the representatives of the first group, the periods indicated by them varied from 8 months to 16 years (m = 10.1 ± 1.3), and they varied from 3 to 28 years in the second group (m = 21.4 ± 3.1), $p < 0.05$. Meanwhile, all representatives of the second group noted the appearance of the first symptoms of emotional burnout syndrome as early the period of their professional activity.

Thus, it can be argued that the manifestation of emotional burnout syndrome in the women who work or previously worked as physicians is in all cases most closely related to the professional activity. This is also confirmed by the fact that all subjects without exception that represented both compared groups pointed to the monotonous, even nature of their "boring" work, mainly in the conditions of a polyclinic. None of the observed doctors tried to diversify their professional activities, sought to obtain additional medical specialties, participated in scientific research, and aspired to a high career growth, even though some of the subjects had features of perfectionism. The existing propensity towards conflicts was mainly due to "injustice" as regards the professional burden and level of wages.

It was the presence of emotional burnout syndrome that was the main reason for stopping work as a doctor in the representatives of the second group. But this did not lead to the expected healing, the clinical manifestations of emotional burnout syndrome did not disappear but only transformed, changing their content, "coloring." In a number of cases, the clinical symptoms even intensified after the cessation of labor activity, and they were joined by psychosomatic and stress-induced disorders.

Within 1 year after the dismissal, the forms of pathology that are most typical for stress-induced disorders either activated or became manifested in all representatives of the second group [7–9]—disorders of the musculoskeletal system (n = 43; 89.6%), cardiovascular system (n = 26; 54.2%), and gastrointestinal tract (n = 19; 39.6%). Twenty-two (45.8%) of 48 women who had stopped working were detected to have definite, albeit not strongly pronounced (51–60 points on a traumatic stress questionnaire [6]) clinical signs of posttraumatic stress disorder with the presence of mainly the "avoidance" symptoms. Moreover, only the recollection of individual details of the former labor activity became painful, and a visit, for example, to the polyclinic, in which the subject previously worked, could lead to a psychological breakdown accompanied by hysterics, marked sleep disorders, and aggressive behavior.

CONCLUSIONS

Of course, the group of elderly women–physicians presented in this study is a kind of clinical model for the study of emotional burnout syndrome in persons of the elderly, retirement age. It seems that many of the revealed regularities can be extrapolated to representatives of other professions and to men.

The data obtained indicate that the distinct signs of emotional burnout syndrome can occur in the elderly and be most closely related to continuing professional activity. In the presence of emotional burnout syndrome, the cessation of this labor activity in the elderly age leads to stress, often with the subsequent development of posttraumatic stress disorder and a complex of stress-induced pathology. In this case, the clinical manifestations of emotional burnout syndrome itself do not disappear, as one might expect, but only trans-

form with the addition of a number of psychosomatic disorders.

The elderly suffering from emotional burnout syndrome are, in fact, a risk group for diseases, in the formation and development of which stress factors play an important role. It is these people who need close attendance, consultations of a psychologist and psychotherapist, and a broad checkup within the mandatory program of medical examination.

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