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Emotional Burnout in Health Care Workers

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Abstract: Consideration is given to the issue of emotional exhaustion related to medical professionals. An analysis of perspectives of potential sources of frustration in the profession is provided. The formation and models of emotional exhaustion syndrome are explained from the perspectives of H. Freidenberg, K. Maslach, V. V. Boyko, D. Direndonk, and V. Schaufeli. The characteristics of psychodiagnostic methods employed to examine emotional fatigue and psychosomatic patterns are delineated. An effort is made to compile a list of psychological characteristics and behavioural traits that prevent the development of emotional exhaustion syndrome and preserve professional longevity and psychological resources. In the future, it is intended to examine the specifics of the development of emotional burnout syndrome in medical personnel with varying lengths of service in the context of an increased workload and to develop recommendations for prevention.

Keywords: Emotional burnout syndrome, emotional tiredness, depersonalisation, diminished professional accomplishments, burnout models.

Introduction: In the healthcare industry, emotional exhaustion syndrome (EBS) is one of the primary causes of profound frustration. The COVID-19 epidemic has transformed the function of healthcare workers [1, 2]. Through remarkable endeavours, they preserve the lives and well-being of individuals. Established BMS phases can influence the quality of life of healthcare professionals, the emergence of psychosomatic disorders, as well as physiological, affective-cognitive, behavioural responses, and unstable psychoemotional conditions. All of this diminishes the professional dependability of medical professionals, thereby posing a danger to their patients.

This assesses the significance of the exhibited work.

Emergency Response Systems in healthcare is a thoroughly researched subject. At the same time, there is a lack of sufficient detail in the practical recommendations and measures for the psychological prevention of ERS among employees of medical institutions.

The objective of the research: Examine theoretical frameworks about the development of emotional burnout syndrome among medical practitioners. Following the specified objective, the following tasks are to be addressed: - theoretical analysis of the issue, ERS models, and the peculiarities and speed of ERS phase development; - search for studies on successful adaptation to psychotraumatic factors, inhibition of ERS development, and preservation of professional longevity in conditions of intense workloads; - development of proposals and measures for the psychological prevention of ERS among medical professionals. Principal component. American psychiatrist H. Freidenberg originally delineated ERS in 1974. In 1976, K. Maslach described it as a condition of bodily and emotional fatigue. Psychotraumatic events lead to emotional exhaustion syndrome, which is a psychological response of the body. Its distinctive feature is a total or partial cessation of feelings. The risk factors of ERS [3-8] in medical professionals include constant stress, which is specifically caused by the following circumstances: - high neuropsychic tension, - overtime work, - constant observation of other people's pain, - negative emotions, - threat of infection, including coronavirus infection. ERS symptoms include a persistent sense of fatigue that persists even after sleep, anxiety, irritability, apathy, lethargy, changes in appetite, sleep disorders, frequent migraines, and a reluctance to engage in social activities [3-11]. This condition comprises three fundamental components. 1. Affective fatigue. The sensation of desolation and powerlessness becomes more prominent as the sharpness of emotions diminishes. Engagement in work diminishes. Frustration with coworkers and patients manifests. Initially, these emotions can be managed, but it subsequently become increasingly challenging to conceal them. As a consequence, there may be an increase in emotional distress and resentment. The victim may transform into a someone seeking assistance and support. 2. An insensitive attitude towards oneself, patients, and others is a component of depersonalisation. Contacts assume a formal nature. A "victim" mentality develops, characterised by an obsession on personal demands and self-preservation. The individual strives to psychologically detach himself from his surroundings. 3) Diminution of professional accomplishments - a sense of inadequacy, discontent with oneself. Self-esteem diminishes, resulting in a desire to resign from employment. Numerous studies indicate that burnout manifests in various forms [6, 9-11]. Individuals may exhibit a variety of symptoms, while others exhibit all recognised symptoms. N. V. Govorin and E. A. Bodagova examined the ERS of medical professionals in the Transbaikal Territory's healthcare facilities [6]. A total of 383 individuals participated in the study. The BMS diagnostic questionnaire by V. V. Boyko was utilised. V. Boyko. Emotional exhaustion was identified in 67.6% (n = 259) of cases. Simultaneously, 10.5% (n = 40) of physicians exhibited the condition at its formative stage. 21.9% (n = 84) of responders exhibited no indications of emotional fatigue. This implies that the majority of physicians in the Transbaikal Territory are exposed to psychotraumatic factors in some capacity as a result of their professional practice [6]. Differential manifestations of the condition among various medical professional groups have been identified [3]. Dentists are more likely to experience emotional exhaustion and less likely to experience depersonalisation [9]. Nurses in acute care and intensive care units are more prone to exhibit elevated scores on the "depersonalisation" metric [10]. Research conducted by N. V. Chernyshova, E. O. Dvornikova, and E. V. Malinina indicates that personnel at public and private medical institutions exhibit varying levels of burnout intensity. Employees in the public sector exhibit heightened symptoms of depersonalisation and diminished professional accomplishments. Private company specialists exhibit a lower level of emotional depletion in contrast to the predominantly average level of depersonalisation and the reduction of professional accomplishments [11]. In 1994, D. Direndonk, V. Schaufeli, and H. Siksma published the findings of their research on burnout among Dutch nurses. Social insecurity, a sense of injustice, dependence on management, and the opinion of patients were identified as the specific determinants of exhaustion. An key factor contributing to the development of burnout in nurses is the prevalence of adverse events in the workplace [3]. Efforts have been undertaken to examine the correlation between personal personality traits and BMS. Age does not influence the progression of this condition. It is observed in both young and experienced specialists. Gender partially influences the expressions of the syndrome. Consequently, men have a greater propensity for depersonalisation, whilst women are more prone to emotional weariness. Socioeconomic status is also affected by the inclination towards empathy. Empathy for others can mitigate burnout and foster faith in the significance of work and personal efficacy. A correlation exists between burnout and work motivation. Increased burnout correlates with

diminished motivation, resulting in minimal job effort from an individual. The evolution of BMS is also influenced by character accentuation. Burnout models are delineated, considering the characteristics and analysis of one or more components. In 1988, the creators of the one-factor model, A.M. Pines and E. Aronson, observed that burnout is defined and examined by one or several components. Aronson observed that burnout is a condition characterised by physical, emotional, and cognitive weariness resulting from extended exposure to emotionally taxing circumstances [3]. In this instance, burnout signifies solely fatigue. Besides tiredness, the two-factor model considers depersonalisation (D. Dierendonk, V. Schaufeli, H. Siksma). The three-factor paradigm associates burnout with emotional weariness, depersonalisation, and diminished personal accomplishments (K. Maslach, S. Jackson). [3]. Within the four-factor model, one element of the three-dimensional system comprises two factors: depersonalisation pertains to both the work environment and the recipients (G. H. Firth, A. Mims, I. F. Ivanici, and R. L. Schwab) [3]. Burnout, like any process, is characterised by a temporal progression through multiple stages or phases [3, 5, 12]. Burnout symptoms develop progressively, affecting both professional and personal domains, and intensify with time. J. Greenberg identifies five stages. 1. The initial phase (“honeymoon”): as stressors emerge, enthusiasm and job satisfaction are supplanted by a sense of discontent. 2. The second ("fuel shortage"): a deficiency of resources and energy, accompanied by symptoms including exhaustion, apathy, and sleep disturbances. 3. Third (“chronic symptoms”): fatigue, persistent irritation, depressive feelings. 4. Fourth (crisis): persistent ailments emerge, resulting in diminished quality of life. 5. Fifth (“breaking through the wall”): a confluence of psychological and physiological issues. The dynamic model was introduced by B. Perlman and E. A. Hartman. The impact of three primary categories of stress responses on the progression of burnout is demonstrated. The concept encompasses four stages of stress: - an individual exerts extra effort to acclimatise to work, - intense stress experiences, - physiological, affective-cognitive, and behavioural responses; total exhaustion [3] Quantitative metrics delineate the extent of development of each phase of burnout. Dominant symptoms are identified in distinct periods and overall. The elements causing them are identified as either professional environment or subjective personal characteristics. The diagnostic of professional burnout, as proposed by K. Maslach and S. Jackson (modified by N. E. Vodopyanova), comprises three scales [13]. 1) "Emotional exhaustion" (scored from 0 to 45 points). A high score correlates with oppression, indifference, extreme tiredness, and emotional misery. 2) "Depersonalisation" (0 to 25 scores). Indicates the quality of interpersonal relationships with coworkers and the overall self-perception in regard to professional endeavours. A high score indicates a callous and formal attitude towards patients, reflecting a perception of their unjust treatment. 3) “Diminution of personal accomplishments” (ranging from 0 to 40 points). This measure assesses the degree of optimism, self-assurance, work ethic, and perceptions of employees [13]. The following resources can be employed to evaluate the mental state and stress level: the psychological stress scale PSM-25 [14], the assessment of neuropsychic tension (T. A. Nemchin) [14], the diagnosis of stress (A. O. Prokhorov) [14], a questionnaire that ascertains the propensity to develop stress (as per T. A. Nemchin and Taylor) [14], and the differentiated assessment of reduced work capacity states (DORS) technique, which was developed by A. B. Leonova and S. B. Velichkovskaya as a survey. B. Velichkovskaya's questionnaire titled "Fatigue - Monotony - Satiety - Stress" [14]. The correlation between occupational burnout and the likelihood of developing somatic illnesses can be examined with the Giessen questionnaire. Five scales are utilised: four fundamental scales and one aggregate scale. This strategy elucidates the influence of psychological variables in illness progression. This paper addresses the topic, "Who is safeguarded against burnout?" Burnout, as a result of maladaptation, correlates with a pessimistic perspective on life. Evidence indicates that social adaption and professional achievement are more prevalent among optimists and psychologically healthy individuals [3, 5, 7]. A correlation between burnout and self-actualization has been shown. Greater discontent with life correlates with higher unrealised inner potential and poorer creativity. Increased creativity correlates with enhanced life satisfaction and a diminished risk of burnout [5, 7].

CONCLUSIONS

The findings of the study enable us to formulate the conclusions outlined below. 1. Emotional exhaustion syndrome is a psychological reaction of the organism to psychotraumatic incidents. The emotional nuance or intensity of emotional expression varies in this instance. K. Maslach associates ERS with the syndrome of emotional and physical fatigue. V. V. Boyko posits that emotional regulation strategy (ERS) serves as a psychological defence mechanism that entails the total or partial suppression of emotions in reaction to psychotraumatic occurrences. The expression of ERS is defined by the degree of development of the phases "Tension," "Resistance," and "Exhaustion." When

evaluating this level, the indications of physiological, affective-cognitive, and behavioural responses to stress are crucial. 3. The approach of V. V. Boyko, along with that of K. Maslach and S. Jackson (modified by N. E. Vodopyanova). 4. The Giessen questionnaire, T. A. Nemchin's assessment of neuropsychic tension, the PSM-25 psychological stress scale, A. O. Prokhorov's stress diagnostics, T. A. Nemchin and J. Taylor's questionnaire for assessing susceptibility to stress, and A. B. Leonova and S. B. Velichkovskaya's technique for differentiated evaluation of diminished work capacity states are employed to identify the nuances of stress response and mental state. Optimists, creative folks, and those content with their quality of life and accomplishments have enhanced protection against ERS. 6. Personnel of medical establishments may be advised: - individual psychological consultations with a corrective focus (in instances of pronounced, established BMS phases); - medical and psychological prophylaxis appropriate for heightened workload (in cases of non-expressed BMS). Future research are intended to examine the characteristics of emotional burnout syndrome among medical professionals with varying levels of expertise under situations of heightened workload and to offer prevention strategies.

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