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EUROPEAN PERSPECTIVES ON RESEARCH, EDUCATION AND PRACTICE

Volume 3: 2008

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Appendix. Contd.

Competency	*Positive examples of Manager Behaviour*	*Negative examples of Manager Behaviour*
Communication	• Keeps team informed what is happening in the organisation • Communicates clear goals and objectives • Explains exactly what is required	• Keeps people in the dark • Holds meetings 'behind closed doors' • Doesn't provide timely communication on organisational change
Taking Responsibility	• 'Leading from the front' • Steps in to help out when needed • Communicating 'the buck stops with me' • Deals with difficult customers on behalf of employees	• Saying 'its not my problem' • Blaming the team if things go wrong • Walking away from problems
Knowledge of Job	• Able to put themselves in employees' shoes • Has enough expertise to give good advice • Knows what employees are doing	• Doesn't have the necessary knowledge to do the job • Doesn't take time to learn about the employee's job
Empathy	• Takes an interest in employee's personal lives • Aware of different personalities and styles of working within the team • Notices when a team member is behaving out of character	• Insensitive to people's personal issues • Refuses to believe someone is becoming stressed • Maintains a distance from employees 'us and them'
Seeking Advice	• Seeks help from occupational health when necessary • Seeks advice from other managers with more experience • Uses HR when dealing with a problem	• n/a

A CASE OF TEACHER BURNOUT

Pedro R. Gil-Monte

CHAPTER OVERVIEW

The purpose of this study is to present and discuss a case of burnout in a teacher. The subject is a 56-year-old woman dedicated to teaching for thirty-four years. At the time of the diagnosis she had been on sick leave for three years due to a set of symptoms characterised by intense anxiety, depressive disorders, cognitive and affective alterations, and negative attitudes and behaviours toward the job and her students. A description of the subject's symptoms is presented, as well as the evolution of the case over a ten-year period. Her symptoms are discussed in light of the literature, and the conclusion drawn that this case represents an example of burnout.

INTRODUCTION

Work-related stress is one of the greatest professional risks that employees face in the contemporary world of work. Studies carried out in the European Union (EU) have concluded that work-related stress is a major problem in Europe and one that costs business and society dearly. Stress is the fourth most common health symptom reported by Europe's workers (Parent-Thirion, Fernández, Hurley & Vermeylen, 2007). In the United States, work-related stress constitutes a problem similar to that in the EU. According to the National Institute for Occupational Safety and Health (NIOSH, 1999), the percentage of workers who report their job is stressful ranges from 28 % to 40 %, and 26 % of workers report they are "often or very often burned out or stressed by their work". Moreover, workers affected by anxiety, stress, and neurotic disorders experience much greater work loss than those with all other nonfatal injuries or illnesses: 25 days away from work compared to 6 in 2001 (NIOSH, 2004).

Workers in the education sector are a high-risk population with a high prevalence rate for work-related stress (Parent-Thirion et al., 2007). Working in contact with the users or clients of the organisation may frequently expose workers feel to stressors such as aggression and interpersonal conflicts, overload, role conflict and ambiguity, perception

of imbalance in the social interchanges, absence of control over results, etc. These work conditions favor the development of burnout (Maslach, Schaufeli & Leiter, 2001). According to a report by the European Agency for Safety and Health at Work (2007) on emerging psychosocial risks related to occupational safety and health, burnout, job-induced tension and depression are consequences of new forms of employment, new types of contracts and job insecurity.

Burnout is a psychological response to chronic work-related stress of an interpersonal and emotional nature that appears in professionals in service organisations who work in direct contact with the clients or users of the organisation. Edelwich and Brodsky (1980) have defined burnout as "a progressive loss of idealism, energy, and purpose experienced by people in the helping professions as a result of the conditions of their work". It is a process that progresses from enthusiasm to stagnation, frustration and, finally, apathy. Price & Murphy (1984) define burnout as a disordered or unsuccessful process of adaptation to a stressful work situation that progresses from shock and disorganisation to volatile emotions (e.g., irony), guilt and loneliness.

The currently most widely used definition of burnout is the one elaborated by Maslach & Jackson (1981), who define it as a syndrome characterised by the appearance of low personal accomplishment (feelings of incompetence and a lack of achievement in one's work with people), emotional exhaustion (feelings of being emotionally over-extended and depleted of one's emotional resources) and depersonalisation (impersonal, negative, callous, or excessively detached response toward the recipients of one's care or service). The Maslach Burnout Inventory-Human Services Survey (MBI-HSS) (Maslach & Jackson, 1981) assesses these three aspects of burnout. It is the most commonly used measure of burnout, and has dominated research in the field (Densten, 2001).

On the basis of this conceptualisation, the literature offers several models that describe the process of burnout as a temporal sequence. The model of Golembiewski, Munzenrider and Carter (1983) states that burnout progresses from depersonalisation through lack of personal accomplishment to emotional exhaustion. A second model was developed by Leiter and Maslach (1988). This model states that burnout progresses from emotional exhaustion through depersonalisation to lack of personal accomplishment. A third model, developed by Lee and Ashforth (1993a, 1993b), states that burnout progresses from emotional exhaustion to depersonalisation, and from emotional exhaustion to lack of personal accomplishment. They proposed that elevated levels of emotional exhaustion directly evoked decreases in personal accomplishment rather than indirectly through

depersonalisation. All three models have been tested extensively, but previous research has failed to provide convincing evidence for any of the three models (Taris, Le Blanc, Schaufeli, & Schreurs, 2005). Based on appraisal models of stress, Gil-Monte, Peiró and Valcárcel (1998) proposed a model to explain the relationships between the MBI-HSS dimensions. According to this model, burnout progresses in a parallel way from personal accomplishment to depersonalisation and from emotional exhaustion to depersonalisation. The model has been tested, and some cross-sectional studies have provided evidence for the development of burnout proposed by the model (Durán, Extremera & Rey, 2001; Manassero, García, Vázquez, Ferrer, Ramis & Gili, 2000; Manzano & Ramos, 2000).

Diverse studies have suggested that the core of the burnout phenomenon is feeling worn out, or the combination of emotional exhaustion and physical fatigue as an affective state (Moore, 2000; Shirom & Ezrachi, 2003).

Depersonalisation is a feeling and an impersonal response towards recipients of one's service, care, treatment, or instruction (Maslach & Jackson, 1981). In human service professions, recipients can be a source of frustration (e.g., students who do not collaborate), which creates aggression that is generally directed towards the source of frustration (Berkowitz, 1969). Those professionals who behave insidiously towards recipients use depersonalisation to escape from guilt feelings (Bandura, 1986).

Guilt is conceptualised as the unpleasant and remorseful feelings associated with the recognition that one has violated, or is capable of violating, a moral standard (Jones & Kugler, 1993). In contrast to shame, where the focus of attention involves a negative evaluation of the global self, guilt involves a negative evaluation of a specific behaviour (Tangney, Stuewing, & Mashek, 2007). It draws attention to the wrongfulness of the precipitating event and to injury suffered by the victim (Quiles & Bybee, 1997).

From an interpersonal perspective (Baumeister, Stillwell & Heatherton, 1994), guilt is described as a social emotion linked to the communal relationships (intimate or close relationships in which the individual responds to the needs of the other person) and not to an exchange in which reciprocity is expected. The origins, the functions and the process of guilt have important interpersonal aspects, as it is a variable that reinforces ties in relationships (Tangney et al., 2007). Guilt has the symbolic role of reaffirming commitment toward the other person and the responsibility of taking care of him or her. It is used as a strategy to gain influence over others, and it makes it possible to alleviate the stress produced by the lack of balance in the emotional states that results from social exchanges. Guilt has prosocial effects, as it motivates people to make amends to others,

correct their errors and apologise. These interpersonal actions reduce the feelings of guilt, so that the expression of guilt and remorse is a way of recovering a relationship after committing some type of transgression. For Hoffman (1982), the stress derived from empathy and a self-attribution of responsibility for the causes that have produced suffering in other individuals intervene in the appearance of guilt; Berndsen and Manstead (2007) have concluded that responsibility is best regarded as an elaborated appraisal generated by guilt, rather an antecedent of guilt.

However, excessive or inappropriate levels of guilt can produce a dysfunctional and disruptive experience, and in some cases clinical alterations (Lewis, 1971). Some studies have concluded that the association between guilt and psychopathology is accounted for by shame (Pineles, Street & Koenen, 2006). However, other studies have found positive and significant relationships between guilt and depression (Harder & Zalma, 1990; Ghatavi, Nicolson, MacDonald, Osher & Levitt, 2002; Mitchell, Goodwin, Johnson & Hirschfeld, 2008; O'Connor, Berry, Weiss & Gilbert, 2002), anxiety, somatisation and psychoticism (Harder, Cutler & Rockart, 1992). Quiles and Bybee (1997) obtained positive and significant correlations between guilt and depression, anxiety, somatisation and psychoticism, and they concluded that chronic feelings of guilt could be an indicator of the use of inappropriate coping strategies and the failure of the individual to regulate his emotions. Ghatavi et al. (2002) found that individuals with depression problems had a history of feelings of guilt, and in their conclusions they suggest the possibility that guilt represents a variable that predisposes individuals to illness.

Guilt appears to be involved in the burnout syndrome (Ekstedt & Fagerberg, 2005; Farber & Miller, 1981; Freudenberger, 1974; Gil-Monte, 2005; 2008; Maslach, 1982; Price & Murphy, 1984). One of the frequent causes of feelings of guilt in professionals is the existence of negative thoughts about others and the negative and cynical way they have treated them (Maslach, 1982). Some professionals feel they are becoming cold and dehumanised, and this experience leads them to reaffirm their commitment toward other people and the responsibility of taking care of them (Baumeister et al., 1994; Tangney et al., 2007). In such a situation, they feel higher levels of burnout. As a result, they develop a sense of failure and loss of self-esteem, which can lead to a state of depression (Maslach, 1982). The clinical alterations produced by feelings of guilt (e.g., depression) can cause an increase in the rate of absenteeism (Baba, Galperin, & Lituchy, 1999). In a cross-sectional study Gil-Monte (2008) obtained empirical evidence for the influence of guilt in the relationships between depersonalisation and absenteeism (i.e., number of work days missed in the past year). Those professionals who presented high levels of depersonalisation showed

more absenteeism, but only when they felt high levels of guilt about their attitude/behaviour at work.

CONSEQUENCES OF BURNOUT

Outcomes associated with burnout are numerous. Statistical evidence has been obtained to draw conclusions about the significant relationships between burnout -or some dimensions of the MBI- and physical symptoms (Honkonen et al., 2006; Leiter, 2005; Melamed, Shirom, Toker, Berliner & Shapira, 2006; Pines & Keinan, 2005; Tang, Au, Schwarzer & Schmitz, 2001; Toppinen-Tanner, Ojajärvi, Väänänen, Kalimo & Jäppinen, 2005), such as gastroenteritis (Mohren, Swaen, Kant, Amelsvoort, Borm, & Galama, 2003), musculoskeletal system diseases (Toppinen-Tanner et al., 2005), sleep quality (Grossi, Perski, Evengard, Blomkvist & Orth-Gomér, 2003; Vela-Bueno et al., 2008), etc.; and psychological symptoms, such as depressive mood (Grossi et al., 2003; Hätinen, Kinnunen, Pekkonen & Aro, 2004; Mohren et al., 2003), anxiety (Bruce, Conaglen & Conaglen, 2005; Grossi et al., 2003), and cognitive failures that lead to increased distraction, poor performance and inhibition errors (Van der Linden, Keijsers, Eling & Schaijk, 2005). Ahola et al. (2008) have concluded that severe burnout is associated with an increased probability of having a medically certified episode of sickness absence.

Empirical evidence is available to suggest that these psychosomatic alterations may be related to alterations in the immune and defensive system of the organism (Bargellini et al., 2000; Nakamura, Nagase, Yoshida & Ogino, 1999), to alterations of a physiological nature related to cortisol levels (Grossi et al., 2005; Melamed et al., 1999; Moch, Panz, Joffe, Havlik & Moch, 2003; Pruessner, Hellhammer & Kirschbaum, 1999), and inflammation biomarkers (Toker, Shirom, Shapira, Berliner & Melamed, 2005).

On the other hand, clinical observations indicate that chronic burnout is associated with impaired cognitive functioning. Sandström, Rhodin, Lundberg, Olsson and Nyberg (2005) found statistical evidence leading to the conclusion that significant decreases in performance were present in chronic burnout patients on nonverbal memory in association with the slowing of performance on attention measures. These cognitive impairments may have originated because chronic stress can have profound effects on neuronal functions, notably hippocampal cells. Moreover, stress can also affect the functions of the frontal cortex. On the other hand, the authors state that most of the patients in the study reported sleeping problems, with frequent awakenings during the night as well as early wakening

Alterations in sleep might thus influence cognition. Another explanation offered by the authors for these results is that some recent data also suggest that increased activity in the hypothalamic-pituitary-adrenal axis can be an important link to cognitive dysfunction after chronic stress.

Bibeau, Dussault and Larouche (1989) have proposed a series of subjective and objective criteria for making a clinical diagnosis of burnout. The main subjective indicator is a general state of severe fatigue that is accompanied by: (a) loss of self-esteem resulting from a feeling of professional incompetence and low job satisfaction, (b) diverse physical symptoms related to the stress without there being any organic cause, and (c) problems of concentration, irritability and negativism. The main objective indicator is a progressive and significant reduction in performance at work as the months go by. The symptoms must not be the result of the professional incompetence of the individual, who had previously done his work well for a reasonable period of time. It must not be the result of a previous psychopathology either, or caused by family problems.

In the EU, there is a climate of sensitivity toward psychosocial risks on the job that can produce the appearance of work-related stress and health disorders (European Agency for Safety and Health at Work, 2007). Due to this climate, some countries in the EU have paid legal attention to the burnout syndrome, considering it a psychological problem stemming from work. In Spain, from a legal point of view, an occupational illness is one stemming from an employee's work in the activities specified in the framework approved by Royal Decree 1995/78 of the 12th of May. Burnout is not included in this list of illnesses, so it cannot legally be considered a work-related illness, even though it meets the characteristics for being considered a work-related pathology (Masiá, 2001).

Due to these legal restrictions, burnout has been considered a work-related accident (Martínez de Viergol, 2005) by the Spanish Supreme Court (October 26th, 2000, Recourse Num: 4379/1999). Other judicial decisions in Spain have also recognised burnout as a work-related accident in trade union delegates (Social Court number 3 of Vitoria-Gasteiz, decision 14/02, from the 27th of March, 2002), teachers (Social Court number 16 of Barcelona, proceedings 751/2001), healthcare professionals (Social Court of Alicante, proceedings 188/2004; Superior Court of Justice of Cataluña, 5367/2003), and food services professionals (Superior Court of Justice of Galicia, 2537/2002), etc. There has also been a recognition of the right of professionals working with the mentally disabled to earn an extra risk bonus for being exposed to work conditions susceptible to causing burnout (Social Court number 1 of Vigo, proceedings 24/1999; Superior Court of Justice of Galicia, 5302/2001).

TEACHING AND BURNOUT

Burnout has been recognised as an important stress-related problem for people working in education (Guglielmi & Tatrow, 1998; Vandenberghe & Huberman, 1999). In this occupational sector the relationship between professionals and clients is central to the job, and the nature of the work is highly emotional (Näring, Briët & Brouwers, 2006). Providing affective, instructional and moral services to pupils makes emotional demands. These demands take place within a complex network of interactions with students and their parents, colleagues, principals, inspectors and the administration of the organisation or centre. A literature review makes it clear that teacher burnout is a function of the quality of life in the workplace. Kyriacou (2001), summarising a number of international studies, found ten main stressors for teachers. These include: teaching students who lack motivation, maintaining discipline, time pressures and workload, coping with change, being evaluated by others, dealings with colleagues, self esteem and status issues, problems dealing with administration/management, role conflict and ambiguity and poor working conditions.

In the last few decades, there has been a series of changes that have affected organisations, jobs and workers. Some of these changes have contributed to the development of burnout. In the case of education, the changes in social structures such as the family have caused educational responsibilities to be transferred to the school. Teachers complain that parents too often withdraw and delegate the education of their children to them, so that they have to fulfill the role of parents, sexual advisors, social workers, socio-cultural cheerleaders, pedagogues and psychologists. Globalisation has contributed to an increase in the population and the ethnic and cultural heterogeneity of the population in certain geographic areas (e.g., countries of the EU), without a proportional increase in the number of educational organisations or the number of workers in these centres. As a result, there has been an increase in the levels of work overload for these teachers, who carry out a fragmented activity in which they must fight simultaneously on different fronts: maintain enough discipline while remaining kind and affectionate, individually attend to high achieving students who would like to go faster but also to those who have to go slower, take care of the class environment, programme, evaluate, orient, receive parents and keep them up to date on the progress of their children, organise diverse activities for the centre, frequently take care of bureaucratic problems, etc. (Antoniou, Polychroni & Vlachakis, 2006; Forlin, 2001). The list of demands seems endless. Teachers have cited work overload as a major stressor in their job (Byrne, 1999). Empirical findings have shown work demands to be significantly related to emotional exhaustion (Dorman, 2003; Peeters & Routers, 2005). Moreover, only highly motivated individuals can burnout (Pines, 1993).

For some teachers, the government, with its changes in laws and norms, is one of the principal sources of burnout, as it has favored the development of a greater number of undisciplined and unmotivated students (Antoniou et al., 2006). Furthermore, the news media present inappropriate models, and the system has not been able to substitute authoritarianism for democratic authority, which means the students are aware of their rights but not their obligations. There are an increasing number of students who make unreasonable requests, citing their rights as citizens, but far from any minimum norms of education and courtesy. In some cases, students have been known to tell the teacher to be quiet, arguing that "my father is paying you". Empirical studies have found significant relationships between discipline problems with students and burnout (Ben-Ari, Krole & Har-Even, 2003; Friedman, 1995; Kokkinos, 2007). The teachers perceive that education has become a consumer product. A result of this culture is the loss of respect and prestige for teachers who feel excluded from making the decisions that affect educational reform and changes in their workplace. Schwab, Jackson & Schuler (1986) found that the lack of participation in decision-making explained 14% of the variance in the attitudes of depersonalisation in a sample of teachers.

According to some teachers, students and their parents see teachers as *slackers* who work in education because they don't have anywhere else to work and, furthermore, have many vacations and a good salary. Demands made by the parents constitute one of the main causes of burnout in education (Friedman, 2002). Many parents simplify what is wrong with the educational system and find teachers responsible for everything that doesn't work right. The lack of social recognition leads to many emotional and physical problems, deprives the individual of the possibility of finding meaning in his work, and favors the development of burnout.

Studies on the prevalence and incidence of burnout in teachers have yielded inconsistent findings. According to estimations by Shirom (1989), the prevalence of burnout in teachers can be situated between 10% and 30%. Unda, Sandova and Gil-Monte (2007/08) concluded that the prevalence of burnout in a sample of Mexican teachers was 17%, and Farber (1991) estimated that 5% to 20% of American teachers are truly burned out.

Regarding demographic characteristics, in previous studies on teacher burnout, a great deal of attention has been paid to the influence of personal characteristics, such as gender, age, and length of teaching experience. Gender is a strong predictor for depersonalisation, which appeared to be higher for male teachers than female teachers (Anderson & Iwanicki, 1984; Greenglass, Burke & Ondrack, 1990; Lau, Yuen & Chan, 2005).

With regard to emotional exhaustion, some studies have found that female teachers reported greater burnout than male teachers (Antoniou et al., 2006; Byrne, 1999; Lau et al., 2005), but other studies found the reverse to be true, and still others have reported no significant differences (Byrne, 1999). Regarding personal accomplishment, the studies have yielded inconsistent findings. Explanations for the differences have been attributed to the socialisation of the masculine and feminine roles (Anderson & Iwanicki, 1984; Greenglass et al., 1990; Maslach & Jackson, 1985; Schwab, 1986).

Some studies have found that younger teachers reported higher levels of burnout compared to older colleagues (Antoniou et al., 2006; Meadow, 1981; Mor & Laliberte, 1984). For emotional exhaustion (Antoniou et al., 2006; Meadow, 1981; Mor & Laliberte, 1984), and depersonalisation (Mor & Laliberte, 1984), the frequency in the perception of the symptoms is low between the ages of 20-25 years, higher between 25-40 years of age, (Mor & Laliberte, 1984), and minimal from 40 (Mor & Laliberte, 1984) or 50 years of age onwards, approximately (Antoniou et al., 2006). According to Huberman and Vandenberghe (1999), older teachers with more than ten years experience are more at risk of burnout. The relationship between the levels of burnout and age has been explained considering the chronic nature of the pathology, and the process, acquired with age, of learning the mechanisms to deal with stress. As professionals –e.g., school psychologists- become older, they may develop a variety of behavioural and attitudinal patterns that reduce the likelihood of burnout (Huberty & Huebner, 1988). However, Maslach et al. (2001) conclude that among younger employees the level of burnout is reported to be higher than it is among those over 30 or 40 years old.

The purpose of this study is to analyse the case of a burned out female teacher. Taking the clinical history of the patient as a reference point, the main symptoms that characterise burnout in teachers, their evolution, and their link to social interaction are examined, in order to contribute to a proper diagnosis of this psychological disorder.

CASE PRESENTATION

The subject in this case is a 56-year-old Caucasian woman. She worked as a primary school teacher for thirty-four years, and at the time of the diagnosis presented a three-year disability leave, attributed to a group of symptoms characterised by intense anxiety, depressive disorders, cognitive and affective alterations, negative attitudes toward the job and students and a deterioration in student behaviour.

The patient began her professional activity as a teacher at the age of 21. Due to her dedication to her work, she was appointed as Director of the Centre after two years of professional work. She carried out this job with very few resources, so that she developed states of exhaustion at the end of the teaching periods. However, after resting between these periods, she went back to work with more energy and enthusiasm.

According to her clinical record, at the age of 34, and after thirteen years of professional activity, there progressively began to appear symptoms of permanent exhaustion, muscle pain, sleep alterations and different types of somatisation, which caused a progressive reduction in her job performance. At the same time, her vocational commitment diminished. She also developed a behaviour pattern characterised by exclusive dedication to her job during the school week, complete rest on the weekends, and loss of interest in social activities and quality of life. Around this time, she saw that she could not get through the working week, and she sought a solution to the problem by consulting different medical specialists. She presented short periods of absence from work with increasing frequently.

Nine years later, at the age of 43, after twenty-two years of professional activity, the set of symptoms continued and worsened with the appearance of numbness, fears, phobias, irritability, dysthymias, migraines and crises of insomnia. Furthermore, cognitive blocks appeared while giving class, she made graphic inversions, had difficulty speaking, and committed errors while giving explanations in the classroom. These symptoms increased the anxiety crisis, the exhaustion, and the need to rest on the weekend. Upon doctor's orders, she began treatment with anxiolitic drugs and analgesics. Her state of mind worsened, and she developed a negative attitude toward her work and toward the students, who she perceived as being the direct cause of her psychological deterioration.

Two years later, at the age of 45, and ten years before the definitive diagnosis, she was diagnosed with "Depressive Syndrome" in the neurology service of the Public Health Service. Given the persistence of the symptoms, she consulted a private psychiatric clinic, where a psychometric evaluation was carried out, and she was diagnosed with "extreme anxiety, depression and a high degree of neuroticism". Treatment was recommended with anxiolitics and disability leave from work, which improved her symptomatology.

However, upon returning to teaching activity, the symptoms reappeared. During the next two years, and after various attempts to return to work, the patient developed feelings of guilt and low self-esteem, due to the perception of job incapacity. She went through psychotherapy treatment without obtaining positive results. Diagnostic tests were performed with

a scanner and electroencephalogram, which appeared normal, leading to organic causes for her disorder being ruled out, and she was diagnosed with "Generalized Anxiety Disorder" (DSM-IV, 300.02) (APA, 1994). This diagnosis is ratified by professionals (doctors, psychologists and psychiatrists) from different health centres and organisations that, in some cases, also incorporate the diagnosis of "Conversion Disorder" (DSM-IV, 300.11).

In spite of psychological treatment consisting of therapy and pharmacological treatment with anxiolitics and anti-depressives, symptoms persisted, so that the patient remained in a chronic state for about a decade. During this time, she continued with programmed visits to the psychiatrist and occasionally visited the emergency room owing to the appearance of anxiety crises. The diagnosis referred to above was maintained. The clinical record states that every time the patient tried to go back to work, there was a worsening in the process that would only improve if she stopped her professional activity.

After a decade, when the patient was 55 years old, the psychiatrist following her progress decided that the symptoms she has been showing all these years could constitute a *"Personal Exhaustion Syndrome"*, leading to a change in diagnosis. Eleven months later, this psychiatrist omitted the diagnosis of burnout, reporting that in the chronicity of the symptoms the only stressor that appeared was job activity, and that the patient presented a personality characterised by a high level of self-demand, which, together with her professionalism, led her to take on a large number of responsibilities. He added that although the patient initially had a high performance capacity, this was gradually reduced as the psychosomatic and cognitive symptomatology began.

DISCUSSION AND CONCLUSIONS

In the case described, there are enough indications to conclude that the set of symptoms developed fits a case of burnout. The patient worked in one of the main occupational groups where this disorder appears as a result of chronic work-related stress (Guglielmi & Tatrow, 1998; Vandenberghe & Huberman, 1999). She presented a chronic situation with a progressive onset, characterised by an emotional impairment resulting from interpersonal relationships on the job, a cognitive impairment that negatively affects her self-evaluation of her professional capacity, a deterioration in her attitude toward the clients of the organisation - the students-, and the appearance of guilt feelings. The symptoms are closely related to her professional activity, and no organic cause of the problem was identified. The characteristics of

the case fit the subjective and objective criteria formulated by Bibeau et al. (1989) for making a diagnosis of burnout.

A feeling of being emotionally over-extended and depleted of one's emotional resources, i.e., emotional exhaustion, is the core of burnout (Maslach et al., 2001; Moore, 2000; Shirom & Ezrachi, 2003). The patient initially presented states of exhaustion at the end of teaching periods that stopped during rest periods. However, at the age of 34, when she had been working in the profession for thirteen years, symptoms of permanent fatigue appeared progressively. At the age of 43, after twenty-two years of professional practice, the exhaustion and need for rest increased as exhaustion intensified due to job activity. These symptoms are characteristic of burnout, and they are included in the most widely used questionnaires for evaluating the syndrome (MBI, Maslach & Jackson, 1981; BM, Pines & Aronson, 1988).

At this age, 43, the increase in levels of exhaustion were accompanied by cognitive blocks while classes were going on, with the subject experiencing graphic inversions, difficulty in speaking, and errors in explanations in the classroom, which caused and increased the anxiety crises. As a consequence of these symptoms, and due to the perception of job incapacity they produced, the patient developed low self-esteem. Similar symptoms are described in cases of chronic burnout patients. Van der Linden et al. (2005) found that the level of burnout was significantly related to inhibition errors and poor performance; and Sandström et al. (2005) found statistical evidence to conclude that significant decreases in performance were present for chronic burnout patients on nonverbal memory in association with slowing of performance on attention measures. The cognitive impairment suffered by the patient is a characteristic of burnout, and the symptoms are linked to the practice of the work activity. The symptoms reappeared, and a worsening of the process occurred when she tried to go back to work after a period of disability leave.

The loss of self-esteem and the deterioration in the self-evaluation of the capacity to perform the job is one of the symptoms that characterize the appearance of burnout (Cherniss, 1993; 1995; Gil-Monte, 2005; Maslach et al., 2001). Perlman and Hartman (1982), in one of the first review studies of the symptoms that characterize the syndrome, concluded that it should include symptoms such as low morale and negative self-concept. In studies with teachers, the loss of self-esteem has been proposed as an antecedent of low personal accomplishment (Byrne, 1999), and as a symptom related to the development of burnout due to the perception of professional failure (Kelchtermans, 1999).

The patient also developed a negative attitude toward the job and toward the students, whom she saw as the direct cause of her psychological deterioration. This symptom is widely included in the literature as a characteristic symptom of burnout. According to Maslach et al. (2001), a key dimension of burnout involves feelings of cynicism and detachment from the job. The cynicism or depersonalisation "represents the interpersonal context dimension of burnout. It refers to a negative, callous, or excessively detached response to various aspects of the job" (p. 399).

In the appearance of depersonalisation, blaming clients for problems that are perceived as the cause of personal and professional failure plays an important role (Bandura, 1986; Cherniss, 1995; Maslach, 1982). When behaviour is reproachable, some moral justification is needed in order to carry it out. Individuals perform cognitive restructuring to achieve socially acceptable behaviours and to justify performing certain behaviours without feeling guilty. According to Bandura (1986), among these mechanisms are found attribution of blame and dehumanisation. A cognitive strategy for acting aggressively toward people without suffering self-condemnation is dehumanisation or depersonalisation.

Burnout is a prolonged response to chronic emotional and interpersonal stressors on the job (Maslach et al., 2001). In the case presented here, the process did not begin with the working life of the patient. According to the medical records, it was after thirteen years of professional activity, at the age of 34, when the symptoms of permanent fatigue, muscle pain, sleep alterations and various types of somatisations began to appear, which caused a progressive reduction in her job performance and a loss of professional commitment, although the first symptoms of exhaustion were detected after two years on the job. According to Maslach et al. (2001), younger employees feel higher levels of burnout than those over 30 or 40 years old. However, other studies have concluded that the highest levels of burnout appear between twenty-five and forty years of age (Antoniou et al., 2006; Mor & Laliberte, 1984), or between twenty-seven and thirty (Meadow, 1981). According to Huberman and Vandenberghe (1999), teachers with more than ten years of experience are more at risk of burnout.

The levels of emotional exhaustion and burnout in the patient in this case may also have increased and been maintained over time due to gender. Some studies have found that female teachers reported greater burnout than male teachers (Antoniou, 2006; Byrne, 1999; Lau et al., 2005).

Another variable that may intervene in the chronicity of the burnout process is guilt. The patient mentioned that after various attempts to return

to work she developed feelings of guilt. The theoretical model elaborated by Gil-Monte (2005; 2008) integrates guilt into the burnout development process. According to this model, it is possible to distinguish two patterns in the development of burnout. In both patterns, depersonalisation can be understood as a coping strategy that arises to handle emotional exhaustion (Lee & Ashforth, 1990) and the perception of low personal accomplishment (Edelwich & Brodsky, 1980; Price & Murphy, 1984). However, while for a series of professionals this coping strategy is sufficient and allows them to manage the levels of strain (Bandura, 1986), other professionals find this manner of proceeding to be inadequate, and they develop feelings of guilt (Gil-Monte, 2008; Jones & Kugler, 1993). Therefore, these professionals become more and more involved in order to reduce their feelings of guilt (Baumeister et al., 1994), so as to diminish the stress arising from the self-attribution of responsibility regarding the causes that have produced the suffering of other individuals (Hoffman, 1982).

One personality characteristic of the patient that is associated with high levels of burnout is perfectionism (Stoeber & Rennert, 2008), and the high level of self-demand that led her to take on a large number of responsibilities and become excessively involved in the practice of her profession (Edelwich & Brodsky, 1980; Heifetz & Bersani, 1983; Pines, 1993). Heifetz and Bersani (1983) have pointed out that the commitment to the job precedes the appearance of burnout, in such a way that the process of burnout will not begin unless there are high levels of motivation toward the work activity. This commitment is enhanced by the desire to induce a positive change in the students. According to Maslach (1978), burnout is a process that appears because helping professionals lack preparation for coping with the unique emotional stresses of their work. These professionals are unable to maintain the care and commitment they initially brought to the job. Pines (1993), concludes that a person with no initial motivation can experience other psychological disorders, i.e., stress, depression, fatigue, etc., but not burnout. On the other hand, Farber (1990; 2000) proposes the existence of three types of teacher burnout (worn-out, classic burnout, and under-challenged types of burnout). The case presented here would fit the classic burnout subtype, "an individual who works increasingly hard, to the point of exhaustion, in pursuit of sufficient gratification or accomplishment to match the extent of stress experienced" (Farber, 2000, p. 677).

The patient presents a range of somatisations and psychic alterations that at some moments caused the incapacitation of her professional practice. These symptoms appear significantly associated with the development of burnout (Bruce et al., 2005; Golembiewsky & Munzenrider, 1988; Hätinen et al., 2004). Some studies have concluded that these somatisations may be

associated with physiological alterations of an immunological (Bargellini et al., 2000; Nakamura et al., 1999) or metabolic (Melamed et al., 1999; Moch et al., 2003; Pruessner et al., 1999; Toker et al., 2005) nature produced by the burnout. In the case presented here, there have been no studies of this type carried out that could contribute to establishing a more precise diagnosis.

The process began with the emotional deterioration of the patient, which was accompanied by exhaustion and maintained with different levels of intensity. Later, after twenty-two years of professional practice, she referred to the appearance of cognitive deterioration, which increased the affective and attitudinal impairment. Using the results of these studies as a reference, it is possible to conclude that in the process of developing burnout, the attitudinal deterioration , i.e., depersonalisation, appeared as a result of the cognitive impairment, i.e., low personal accomplishment, and the emotional deterioration, i.e., exhaustion. Currently, one of the lines of research open in the study of burnout is establishing the sequential order of the appearance of its symptoms when evaluated with the MBI (Cordes, Dougherty & Blum, 1997; Gil-Monte et al., 1998; Taris et al., 2005). Due to the limitations of the empirical studies, it has been recommended that qualitative studies be carried out that can contribute to clarifying this relationship (Ashforth & Lee, 1997). In this sense, this study contributes to better understanding the process of the development of burnout.

In the case presented, the time that passed from the onset of the symptomatology to diagnosis is noteworthy. After eleven years of evolution, the patient received the diagnosis of "Depressive Syndrome"; two years later, thirteen since the beginning of the problem, the clinical picture was diagnosed as "Generalized Anxiety Disorder" (DSM-IV, 300.02), and "Conversion Disorder" (DSM-IV, 300.11), and eight years later, twenty-one since the onset, the symptoms were again diagnosed as *"Personal Exhaustion Syndrome"* and burnout. At least a couple of circumstances may have contributed to this situation. On the one hand, numerous professionals lack sufficient knowledge about this pathology. On the other hand, there is no specific category in the DSM-IV (APA, 1994) manual that makes it possible to identify and define burnout.

Using the DSM-IV manual as a reference, some authors prefer to include burnout in the category of "Adjustment Disorders" (Bibeau et al., 1989). According to these criteria, the category that most closely approaches the symptoms and development of burnout is "Adjustment Disorder Unspecified, Chronic (309.9)". Another diagnostic option would be to consider burnout as a work-related problem and include it in Axis I, which groups the "Clinical Disorders and other conditions that may be

a focus of Clinical attention", codifying it as an "Occupational Problem" (V62.2). This category can be used when the focus of clinical attention is an occupational problem that is not due to a mental disorder or, if it is due to a mental disorder, is sufficiently severe to warrant independent clinical attention. It includes problems like job dissatisfaction. However, burnout as a pathology presents some symptoms that are much more serious and incapacitating for the individual and for the practice of the job activity than the lack of job satisfaction.

In order to more fully understand the relationships between burnout symptoms, future studies should consider the single case and use qualitative research to examine the generalisability of the current results.

Implications for practitioners

The current study may advance knowledge about burnout. Regarding the practical contributions, it should be pointed out that this case contributes to clinical knowledge about the phenomenon. The study may be an important point of reference for facilitating diagnosis and treatment by professionals who treat subjects with burnout, and it may also contribute to its prevention.

The study provides a useful addition to the tools for the diagnosis of burnout, which currently rely mainly on questionnaires. Diagnosis in the initial stages of burnout could avoid the increase in intensity of the symptoms and make possible earlier recovery. The results of the present study point towards recommending the incorporation of the evaluation of guilt as a symptom of burnout in order to carry out a more complete diagnosis, discriminate among subjects affected by the syndrome, and recognise its influence on disorders of health, and job absenteeism. It could also be useful in detecting the need for intervention programmes that eliminate sources of stress and detecting the need to train teachers in techniques for dealing with stress.

Although the case discussed here concerned a teacher, burnout affects members of other helping professions. The health deterioration process described above may operate when professionals have to do their work in extreme situations, such as taking care of victims of natural disasters, e.g., hurricane Katrina, or terrorist attacks, e.g., the September 11, 2001, attacks to the towers of the World Trade Centre in New York City; the 11 March, 2004, Madrid train bombings; the 7 July, 2005, attack on London's public transport system.

Courtroom expertise is an emerging area of practice for occupational health

psychologists. Carrying out assessments, managing workplace violence and conducting independent medical evaluations are among the professional activities of these experts (DeAngelis, 2008). The case presented here is a source of information for occupational health psychologists whose work takes them into the judicial context. The development of work-related illnesses or accidents as a result of exposure to psychosocial risks grants workers the right to some type of economic compensation. In these cases, occupational health psychologists may have an important role to perform in terms of diagnosis and evaluation for the Justice Department (or equivalent), and in recommending measures to prevent burnout.

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THE RELATIONSHIP BETWEEN ORGANISATIONAL JUSTICE AND JOB STRESS: INSIGHTS, ISSUES AND IMPLICATIONS

Andrew J Noblet and John J Rodwell

CHAPTER OVERVIEW

Management scholars have long been interested in the impact of injustice on attitudes and behaviours that are critical to organisational functioning, including job satisfaction, organisational commitment, absence behaviour, in-role performance and citizenship behaviours (e.g., Adams, 1965; Colquitt, Greenberg, & Zapata-Phelan, 2005; Walster, Walster, & Berscheid, 1978). However this research has tended to overlook the relationship between justice perceptions and health — especially the more serious, chronic indices of strain such as psychological distress (Judge & Colquitt, 2004; Tepper, 2001). Although empirical assessments of the justice-health relationship are rapidly emerging (28 articles published between 2001 and 2007, compared to two prior to the year 2000), there are elements of this relationship that remain unclear (Fujishiro & Heaney, 2007). For example, the health impact of justice variables in comparison to more traditional work-based sources of employee health (e.g., social support and job control) is under-researched and there is some uncertainty regarding the unique contributions that justice perceptions can make to the work-health relationship. Similarly, studies examining interactions between perceptions of justice and traditional work-based sources of well-being are relatively recent and little is known about the extent to which working conditions moderate justice perceptions and vice versa. Despite these limitations, the considerable body of literature involving organisational justice concepts provides important insights into the pervasiveness of justice in modern worklife. This literature can not only help inform future justice-health research, but also has significant implications for strategies aimed at preventing and/or reducing the stress and dissatisfaction associated with injustice.

The purpose of this chapter is three-fold. First, we aim to review the literature documenting the effects of organisational justice, not just in terms of worker health but also in relation to broader measures of organisational