

Occupational burnout and medically certified sickness absence: A population-based study of Finnish employees

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Abstract

Objective: Occupational burnout is a common problem in working populations, but its association with sickness absence is poorly understood. The contribution of occupational burnout to medically certified sickness absence was examined in a population-based sample of employees. **Methods:** A representative sample of 3151 Finnish employees aged 30–60 years participated in a comprehensive health study in 2000–2001, including an assessment of physician-diagnosed physical illnesses and *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)* mental disorders based on the Composite International Diagnostic Interview. Burnout was measured with the Maslach Burnout Inventory—General Survey. Sickness absences longer than 9 days in 2000–2001 were extracted from a register of the Social Insurance Institution of Finland. **Results:** The occurrence of medically certified sickness absence was more prevalent among employees with burnout than among those without

burnout. After adjusting for sociodemographic factors and mental and physical disorders, the odds ratio of sickness absence for severe burnout was 6.9 [95% confidence interval (95% CI)=2.7–17.8] for men and 2.1 (95% CI=1.1–4.0) for women. Among employees with mental or physical disorders, severe burnout was associated with a 7.7-fold risk of sickness absence among men and with a 2.6-fold risk among women. The duration of absence was related to burnout among men with absences, for whom severe burnout accounted for 52 excess sickness absence days during the 2-year period after adjusting for sociodemographic factors, mental disorders, and physical illnesses. **Conclusions:** Severe burnout is associated with a substantial excess risk of medically certified sickness absence among both men and women. This association is independent of prevalent mental disorders and physical illnesses.

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Introduction

Burnout is a psychological outcome of chronic stress [1]. By definition, it refers to a state of exhaustion combined with cynicism towards the value of one's work and with

diminished experience of professional efficacy [2]. The estimated prevalence of severe burnout, which has been found to be persistent in nature [3], varies between 2% and 7% in working populations [4–6].

Burnout is explained by high work demands and low resources at work, in combination with insufficient means of coping [4,7]; these attributes are also the basic elements in theories of psychosocial stress [8]. Because psychosocial work characteristics are risk factors for sickness absence [9–13], the contribution of burnout to such absences could be substantial.

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Among 4810 representatives of the Swedish working-age population, self-reported stress-related absences lasting at least 1 month were more common among those with burnout [5]. In prospective studies on specific occupational branches, burnout has been shown to be related to an increased number of self-certified sickness absence days and periods [14], company-registered absence duration [15], and medically certified periods of absence [16]. However, no population-based evidence on burnout and medically certified sickness absence is available.

Because burnout is associated with mental disorders [6,17] and physical illnesses [18], these disorders and illnesses could explain associations between burnout and sickness absence. For example, depression and other mental disorders constitute a major economic burden to employers in terms of lost workdays and reduced productivity [19–23]. Absence from work due to mental disorders has increased in both the United States and European countries [24–28]. Because previous studies on burnout and sickness absence have not controlled for mental and physical disorders, the independent contribution of burnout to sickness absence remains unknown at the population level.

The aim of this study was to investigate the relationship between burnout and long (>9 days) register-based medically certified sickness absence in a representative population sample. In addition to sociodemographic factors, we controlled for co-occurring mental disorders and physical illnesses in the analyses to determine the independent burden of burnout in sickness absence.

Methods

Study population and procedure

A multidisciplinary epidemiological health survey, the Health 2000 Study, was carried out in 2000–2001 in Finland. The two-stage stratified cluster sample was representative of the Finnish population and included 8028 persons aged ≥ 30 years [29]. Five university hospital districts were used for stratification and sampling, each serving approximately 1 million inhabitants and differing in several features related to geography, economic structure, health services, and the sociodemographic characteristics of the population. First, the 15 largest cities in Finland were included, with a probability of 1. Next, 65 other areas were sampled by applying the probability-proportional-to-population-size method. Finally, from each of these 80 areas, a random sample was drawn from the National Population Register.

The data-collection phase started in August 2000 and was completed in June 2001, during which 93% of those alive on the day the first phase of the study began attended at least one phase of the study. The participants were first interviewed at home and then given a questionnaire (Questionnaire 1) to be returned approximately 4 weeks later upon clinical health examination, which included a structured interview on

mental health. During home interview, the respondents received an information leaflet explaining the procedure, and they gave their written consent. The Health 2000 Study was approved by the Ethics Committee of Epidemiology and Public Health in the hospital district of Helsinki and Uusimaa in Finland. Data on sickness absence were extracted from a register of the Social Insurance Institute of Finland and linked to our data by means of the participants' personal identification number, which is a code all Finnish citizens receive at birth and is used for all contacts in health care.

Of the original sample, 5380 persons were of working age (30–60 years). These working-age persons composed the base population of our study. Of this sample, 87% were interviewed, 84% returned Questionnaire 1, 83% participated in the clinical health examination, and 80% produced a valid mental health interview. Altogether, 3307 working-age persons reported that they were currently working and not taking a maternity or parenting leave. Of these, 93 were excluded due to more than one missing value per dimension of the burnout inventory, and 63 were excluded due to missing data on the clinical health examination or the mental health interview. Therefore, the study population was reduced to 3151 persons. Those with a maximum of one missing value per dimension on the burnout inventory were included, and, if present, the missing value was replaced by the mean of the existing values of the respondent in question on that dimension. Compared to participants with full information, those who were excluded more often had at least one long sickness absence (29% vs. 20%, $P=.022$).

Measures

Burnout

Burnout was measured with the Maslach Burnout Inventory—General Survey (MBI-GS) [2], which was included in Questionnaire 1. The MBI-GS consists of the following three subscales: exhaustion (five items), cynicism (five items), and (lack of) professional efficacy (six items) [30–33]. Subscale reliabilities (Cronbach's α) were between .79 and .91. The items were scored on a 7-point frequency rating scale ranging from 0 (*never*) to 6 (*daily*). High scores for exhaustion and cynicism, and low scores for professional efficacy are indicative of burnout. Items on professional efficacy were reversed (lack of professional efficacy).

In order to assess the level of burnout, we calculated a weighted sum score from dimensional scores so that exhaustion, cynicism, and lack of professional efficacy had different weights in the syndrome ($0.4 \times \text{exhaustion} + 0.3 \times \text{cynicism} + 0.3 \times \text{lack of professional efficacy}$) [34]. Burnout was categorized as follows: no burnout (sum score, 0–1.49), mild burnout (sum score, 1.50–3.49), and severe burnout (sum score, 3.50–6). According to this categorization, symptoms were experienced approximately daily or weekly with severe burnout; occurred monthly with mild burnout; and were experienced only a few times a year or never in cases of no burnout [6,34].

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