

**BURNOUT AMONG CAREGIVERS OF PATIENTS WITH CHRONIC  
PHYSICAL ILLNESS**

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## **APPROVAL SHEET**

This is to certify that I have read the dissertation entitled “*Burnout among Caregivers of Patients with Chronic Physical Illness*” submitted by Mst. Swampa in partial fulfillment for the degree of M.Phil in Clinical Psychology, Faculty of Biological Sciences, University of Dhaka. This is an original study carried out by her, under my supervision and guidance. The thesis may now be processed for examination.

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## **Burnout among Caregivers of Patients with Chronic Physical Illness**

### **ABSTRACT**

The purpose of the study was to investigate burnout among caregivers of patients with chronic physical illness. In this study both quantitative and qualitative research methods were used and data was collected from five different Govt. and non Govt. hospitals with purposive sampling. In the quantitative phase, participants were 365 and in qualitative phase, number of participants was 10. Socio-demographic questionnaire, Bangla form of Copenhagen Burnout Inventory and a topic guide were used in the present study. Quantitative data was analyzed by SPSS-20 and qualitative data was analyzed manually. Result shows that 28.2% caregivers of chronic physical illness have burnout problem and personal burnout rate is high than work burnout and client burnout. Significant differences of burnout have found between male and female, formal and informal caregivers where female and informal caregiver burnout rate is high than male and formal caregivers. The result also shows that there are significant differences of burnout among caregivers of six chronic diseases and also by care giving duration. Result also highlights some important contributory factors like lack of financial support, work overload, limited social life, irregular daily activity, worry about patient etc. On the other hand, some significant protective factors have found like love for patient, hope for patients recovery, sense of responsibility, religious belief, patients happiness, coping strategies etc. It can be concluded that caregivers are an important part of care giving and they need special attention to mitigate and prevent burnout problem.

**Key words:** Burnout, caregiver, chronic physical illness, contributory factor, protective factor.

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Date:

Sincerely,

***DEDICATED***  
***TO***  
***MY RESPECTED SUPERVISOR***  
***(Kamal Uddin Ahmed Chowdhury)***

# **CHAPTER I**

## **INTRODUCTION**

Burnout is a physical, mental and emotional response to constant levels of high stress. This condition is marked by tiredness, loss of interest or frustration, hopelessness, powerlessness that interferes with job performance. It is also a term for a physical or psychological emptiness which ensues a chronic job related stress. So it results after prolonged stress. Burnout is also defined by emotional and physical exhaustion that results from exposure to environmental and internal stressors and inadequate coping skills. It can also be said to come from unhealthy relationship between the job and the individual. Burnout has become an interesting and important topic for researchers and practitioners over the last couple of decades. In 1974 clinical psychologist Herbert Freudenberger identified the concept of ‘burnout’ and Social Psychologist Christina Maslach introduced burnout in 1976. Christina Maslach and Susan Jackson developed the Maslach Burnout Inventory which is the most widely used instrument for assessing burnout. In 2005, Kristensen et al presented a new tool for the assessment of burnout: the Copenhagen Burnout Inventory which is now used widely in different countries.

### **Section 1.1: Conceptualization of burnout**

#### **1.1.1: Definition of Burnout**

Freudenberger (1974) defined burnout as “use up of inner sources of individuals due to exhaustion, loss of energy or demands not met”. According to Schaufeli, Leiter & Maslach, (2009), burnout is a common psychological problem among work related health problems. They argue that burnout is a syndrome of emotional exhaustion, depersonalization and a reduced sense of personal accomplishment. Emotional exhaustion means the feeling of being emotionally over extended and exhausted at

work. It is characterized by lack of energy and a feeling that emotional resources are used up. Depersonalization means negative or disengagement response to other people at work. That means, workers may show a detached and an emotional coldness and they may be distrustful toward co-workers, clients and the organization. Reduced personal accomplishment means the feeling of loss of efficiency and productivity at work. It is characterized by a tendency to evaluate negatively. It becomes difficult for the individual to successfully achieve in their work or interactions with people. Frequently, there is the perception of a lack of progress. Sometimes emotional exhaustion is considered as a main feature of burnout, but reduced personal accomplishment and depersonalization are also important features of burnout syndrome (Maslach & Fernet, Stephanie Austin, Sarah-Genevieve Tre'panier, and Marc Dussault, 2013).

Farber (2001) criticizes the fact that most researchers have contemplated burnout as a single phenomenon. On the other hand, he proposed differentiation of the syndrome based on the description of three clinical profiles. According to the author, these three types are frenetic type, under challenged type and worn-out type that could be the result of different ways of responding to stress and frustration at work.

### **1.1.1a: The frenetic type**

The frenetic type profile can be characterized by the following properties: involvement, ambition, rejection of failure, overload and anxiety and irritability. Involvement is an increasingly greater effort to face the difficulties of work. It is an attempt to raise the probability of producing expected results. Ambition is the sense of considerable need for achievements and external approval resulting from brilliant operations. Rejection of failure is an absence of acknowledgement of failure. It is one's own limitations in the belief that results reflect personal worth. Overload is the

sense of risking one's health and personal life for work, investing intense and uninterrupted effort. Anxiety and irritability is the excessive worry with work demands, until one feels overwhelmed and has difficulties relaxing or sleeping. The frenetic type works harder until he or she is exhausted and seeks satisfaction or success. Here, individuals generally adopt negative tone, venting about their workload.

#### **1.1.1b: The under-challenged type**

The under-challenged type is characterized by the following properties: indifference, lack of development, contemplating another job, boredom and absence of overload-induced stress. Indifference is a way of performing work in a superficial and detached manner, although without neglecting all responsibilities. Lack of development is defined as dissatisfaction felt on not seeing one's talents acknowledged in the performance of task that pose no new challenges. Contemplating another job is sense of questioning the suitability of one's current job and weighing up other employment options. Boredom may be seen as one's experience of work as routine and monotonous, due to the thoughtless performance of task. Absence of overload induced stress corresponds to a way of performing tasks without too much stress as there is no need to cope with major demands. The under-challenged type present insufficient motivation to cope with monotonous and unstimulating work conditions that do not provide necessary satisfaction.

#### **1.1.1c: The worn-out type**

The worn-out type is characterized by the following properties: neglect, lack of control, lack of acknowledgement, difficulties and depression. Neglect is a personal involvement in work related tasks, leading one to give up as a response to any

difficulty. Lack of control is the presence of feelings of extreme anxiety caused by absence of control over results. Lack of acknowledgement refers to the feeling of lack of acknowledge effort and dedication of the organization he or she works for. Difficulties are a feeling of repression due to the lack of resources and obstacles preventing one from performing effective work. Depression is the presence of depressive symptomatology. The worn-out type struggles with stress daily and ultimately chooses to neglect their work because of those pressures.

Herbert Freudenberger & Gali North (1974), theorized that the burnout process can be divided into twelve phases which are neither necessarily followed sequentially, nor necessarily in any sense be relevant or exist other than as an abstract construct: a compulsion to prove oneself, working harder, neglecting one's own need, displacement of conflict (person does not realize the root cause of the distress), revision of values (friends and hobbies are completely diminished), denial of emerging problem, withdrawal, behavior changes become obvious to others, depersonalization, inner emptiness, depression, burnout syndrome.

According to Maslach & Jackson, (1996), burnout can also be defined as three dimensional syndrome of exhaustion, cynicism and diminished professional efficacy. Maslach, Schaufeli, & Leiter, (2001) postulated that burnout is a process in which the psychological resources of an employee are gradually exhausted as a consequence of prolonged stress at work. Schaufeli & Enzamann (1998), and Ahola et al., (2006) found that high work load, lack of participation and lack of social support increase the risk of burnout.

These definitions suggest that some researchers define burnout as a psychological syndrome (a group of symptoms), but most researchers defined burnout as a single

phenomena. On the other hand, some researchers like Farber proposed differentiation of the syndrome, based on the description of three clinical profiles. Other researchers say burnout is a process where an individual gradually experiences burnout. It is also remarkable that most researchers suggest burnout occurs from high levels of stress which is work related.

### **1.1.2: Prevalence of Burnout**

Burnout is very prevalent and plays a crucial role among health care services, especially for caregivers. Family caregivers of dementia patients suffer from high levels of burnout. Annibal Truzzi, & et al, 2012 studied about three dimensions of burnout (emotional exhaustion, depersonalization and reduced personal accomplishment) among family caregivers of dementia patients. It was found that high level of emotional exhaustion was present in 42.1%, depersonalization was present in 22.8% and reduced personal accomplishment was present in 38.6% in caregivers. Low level of depersonalization and reduced sense of personal accomplishment and moderate level of emotional exhaustion was found among day care providers (Kathleen H. Wilber & Clare V. Specht, 2010).

Ashkar K, Romani M, Musharrafieh U, Chaaya M, (2010); studied about the prevalence rate among medical residents. High level of burnout was found in 80% of medical residents and highest level was found in the domain of emotional exhaustion (67.7%). Burnout has been more prevalent in the helping professions, and high levels of burnout have been found in the healthcare professions, especially in nursing profession. Kelly Fernanda Assis Tavares, Norma Valéria Dantas de Oliveira Souza, Lolita Dopico da Silva, Celia Caldeira Fonseca Kestenberg, 2014; studied about the prevalence of burnout syndrome among resident nurses. In this study ten residents (20.83%) displayed alterations in all three dimensions (emotional exhaustion,



depersonalization and personal accomplishment), which are warning signs for the syndrome.

Kirsi Ahola, & et al, (2006), measured burnout among general population and found small difference among different population group. Henrik Gustafsson, Göran Kenttä, Peter Hassmén and Carolina Lundqvist, (2007) found that 9% of athletes displayed elevated burnout. Finally it can be said that burnout is found in all professions and population groups, however it is more prevalent among health care professionals.

### **1.1.3: Impact of Burnout**

Work is a significant source of stress in all occupation including health care professions. In the long run this stress may develop burnout. American Psychological Association (APA) showed that approximately 75% of Americans experienced substantial stress at work and nearly half noted that their work productivity decreased because of the stress. When a person feels burnout, they lose the capacity to provide the intense contribution needed to have a meaningful impact at work. If they continue working in this situation, the work appears to be unimportant. According to Freudenberger (1974), burnout is the gradual emotional depletion, loss of motivation and reduced commitment. He found these emotional conditions among volunteers of the St Mark's Free Clinic in New York's East Village.

According to Ferber (1983), the experience of burnout is not only occupational hazard, but also a destructive attack on profession. Neglecting other options, dedicated people give unusual effort to their work for a valued reason. Subsequently they experience exhaustion. Joan F. Milar, (2011) found from his study that burnout affects their professional work and they experience difficulty in taking care of patients. This means burnout is associated with negative patient outcome.

Burnout affects not only professional work but also one's personal life. Some studies were conducted on new graduates where burnout found as highly related to burnout. Cho, Laschinger, and Wong (2006) found that 66% of new graduates were experiencing severe burnout which impacted on professional practice and it was associated with negative workplace conditions. Among 545 U.S medical students burnout was present in 239 students (45%) and their negative personal life events were also correlated in the last twelve months (Liselotte N. Dyrbye, & et al, 2006). Personal life satisfaction was also hampered because of burnout. Life satisfaction represents satisfaction about own life (Telman and Ünsal 2004). Life satisfaction has been used as a global indicator of quality of life. From a study finding it has been found that occupational stress has a meaningful and negative effect on life satisfaction (Azzem Ozkan, Mahmut Ozdevecioğlu, 2012). Daniel Smith and Goh Wai Leng, (2003) found that physical education teachers in Singapore also experienced moderate levels of burnout. So it can be said that though burnout arises from work related issues, it impacts on person's professional work as well as their personal life.

Manifestation of burnout can be grouped into six major categories: mental, physical, behavioral, social, attitudinal and organizational.

### **1.1.3a: Mental manifestations**

Typically burned-out person's emotional resources are depleted and they feel 'empty', 'trapped' or 'at the end of the rope'. Affective symptoms are related with depression, aggression and anxiety. Affective symptoms related to depression are low mood, hopelessness, helplessness and worthlessness. A sense of failure, insufficiency and impotence is observed which leads to poor self-esteem. The person becomes irritable, over-sensitive and behaves in a hostile and suspicious manner towards recipients,

colleagues and superiors. There are some cognitive symptoms like inability to concentrate, memory loss, inability to make decision and some sensory motor symptoms like inability to relax, nervous tics and restlessness (Kahill, 1988).

#### **1.1.3b: Physical manifestations**

Individual with burnout complain of headache, nausea and muscle pain, particularly lower back pain (Belcastro, 1982). Sexual problems, sleep disturbance, loss of appetite and shortness of breath are also reported by individuals who suffer from burnout (Kahill, 1988). However, chronic fatigue is the most typical physical manifestation of burnout (Shirom, 1989). Various psychosomatic disorders have been found to develop such as ulcer, gastro-intestinal disorders and coronary heart disease (Belcastro, Gold and Grant, 1982).

#### **1.1.3c: Behavioral manifestations**

Individual's behavioral manifestations are mainly caused by their increased level of arousal like hyperactivity and violent outburst. An increased consumption of stimulant like coffee and alcohol as well as substance abuse are also observed (Quattrochi-Tubin, Jones and Breedlove, 1982; Nowack and Pentkowski, 1994). Beside these, physical activity and adequate diet are negatively associated with burnout (Nowack, Hanson and Gibbons, 1985).

#### **1.1.3d: Social manifestations**

Because of burnout, interpersonal problems occur with recipients, colleagues, supervisors and subordinates. Typically an individual with burnout withdraws oneself from social contacts and becomes isolated. Physical and mental withdrawal from others is observed in burned-out individual (Maslach and Pines, 1977). One of the important characteristics of burnout is decreased involvement with recipients. Burnt-

out individuals might take their problems home, which might increase their interpersonal conflict with family (Jackson and Maslach, 1982).

#### **1.1.3e: Attitudinal manifestations**

Dehumanizing, callous, detached, indifferent and cynical attitudes towards recipients are the most important signs of burnout. When involvement, care, empathy and concern are needed for the recipients, burned-out individual shows these negative attitudes. The person's initial intrinsic motivation, enthusiasm, interest and idealism are lost, and they don't feel appreciated by the organization. In this situation, boredom and dissatisfaction develop and they lose their concern for the organization (Pines and Kafry, 1978; Richardsen, Burke and Leiter, 1992; Jayarathne and Chess, 1983).

#### **1.1.3f: Organizational manifestations**

Golembiewski and Munzenrider, (1988) found lower individual productivity among burned-out individuals. On the other hand, nurses' efficiency in intensive care units was better when their burnout level was higher (Schaufeli, Keijsers and Reis Miranda, 1995). In a cross-sectional study, it has been found that burnout is associated with tardiness, personal injuries and accidents, employee theft, neglect and mistakes on the job (Kahill, 1988).

#### **1.1.4: Background of Burnout Concept**

Research on burnout began following work conducted on emotion, arousal and the way in which people cope with the arousal (Maslach & Jackson, 1984). In the research of Wilmar B. Schaufeli, Michael P. Leiter & Christina Maslach (2008), Cherniss and Kraanz (1983) observed that 1950 onwards the human service of USA and Europe was rapidly professionalized and bureaucratized because of greater government and state influence. That time burnout was virtually absent in

monasteries, Montessori schools and religious care centers. In these places, people considered their work as a calling rather than just a job. They argued that such “ideological communities” provide a collective identity that prevents burnout because of social commitment and shared values.

In the 1960s, “cultural revolution” weakened the professional authority among doctors, nurses, teachers’ social workers and police officers. Simultaneously recipients expected more than before. Recipients’ demand of care service, empathy and compassion intensified. As a result, a discrepancy grew between professionals’ efforts and the rewards. This “lack of reciprocity” is known as burnout (Schaufeli, 2006).

Since the Second World War, traditional social communities such as church, the neighborhood and family have eroded. Sennett (1998) stated that this is the result of the emerging “flexible capitalism”. It replaced traditional rigid homogeneous and predictable social institutions by a more flexible, heteronymous and continuously changing one. He called the development of social fragmentation “the corrosion of character” which is similar to burnout. In that time a “narcissistic culture” was developed. Lasch (1979) said that it is characterized by transient unrewarding and even combative social relationship that produced self-absorbed, manipulative individuals who demanded immediate gratification of their desires, but they remained perpetually unsatisfied. As Farber (1983) noted the combination of the trends toward individualization and narcissisms produces “a perfect recipe for burnout”: the former produces stress and frustration while the latter weakens peoples' coping resources.

In the next phase of development, researchers designed systematic studies to examine burnout. But most of their work was on their personal experiences or narrative based specific program or case studies and it was characterized by conceptual disagreement.

In 1969, the term “staff burnout” was first mentioned by Bradley in an article about probation officers running a community based treatment program for juvenile delinquency. Though Bradley first used the term “staff burnout”, Herbert Freudenberger (1974) is considered as a founder father of the burnout syndrome. His influential paper on staff burnout set the stage of burnout concept. Freudenberger worked in a New York Free Clinic for drug addicts as an unpaid psychiatrist. This clinic was staffed mainly by some young and motivated volunteers. Freudenberger observed that many of them experienced gradual energy depletion, loss of motivation and commitment and some mental and physical symptoms. Freudenberger labeled this state as burnout.

Around the same time, in 1976 Christina Maslach, a social psychologist became interested about how people in human services cope with their emotional arousal at job and then she and her co-workers decided to adopt the term burnout. The term burnout then became very popular to media professionals and researchers.

In the late 1970s and early 1980s, gradually more systematic empirical studies on burnout were conducted and published. During these years, the concept of burnout was more conceptualized and defined. Beside these an accepted, standardized and psychometrically sound instrument, the Maslach Burnout Inventory was developed to measure burnout (Maslach & Jackson, 1981, 1986).

### **1.1.5: Theories and models of Burnout**

#### **1.1.5a: Social comparison theory**

Social comparison theory is important for understanding stress at work and stress is relevant to burnout. Individual's perception and interpretation at work is relevant with the burnout progress. There are two major assumptions behind the perspective of social comparison theory. Firstly, people in the human service professionals involved in the relationship with client or patient. These relationships' social exchange process and expectations of fairness and reciprocity play an important role. As Maslach (1982b) noted, stress is a characteristic sign of burnout and it arises from the social interaction between helper and recipient. Secondly, individuals will be inclined to deal with problems at work and engage in social comparison with their colleagues and relate their own experiences with those in a similar problem. Such comparison plays an important role in the development and persistence of burnout. Classic experiments of Schachter (1959) were on the relationship between fear and affiliation where stress and social comparison was originated by classic experiments. Including emotion, Schachter expanded the domain of social comparison. In his research, it has been found that women experienced fear because of anticipating electric shocks and they wanted to be with someone who is in same condition. Schachter told that, people under stress search for others because of self-evaluation and evaluate the correctness of their own reaction. It can be said that when people feel uncertain about their feelings and reaction, social comparison is enhanced. Wills (1981) suggested that when individuals face any threat to self-esteem, they engage in downward comparisons with less competent person. It is an attempt to restore how they feel about themselves. He told the motivation as "self-enhancement". Some other studies have shown the same result. From the research of Blalock, Mc Evoy-De Vellis, &

Devellis (1989) it has found that patients with arthritis compare themselves with those who are in a similar condition. Affleck & Tennen, (1991) found that mothers of medically fragile infants and women with impaired fertility tend to compare themselves with others who are facing similar stressors. Buunk Yan Yperen, Taylor, & Collins, (1991) showed that people who are in problematic a marriage preferred less contact with people who had better marriage, but people with happy marriage tend to contact more with people who are in a better marriage. According to the social comparison theory of burnout, burnout develops primarily in a social context. Taylor and Lobel (1989) suggested that people under threat avoid contact with persons who are doing worse and prefer persons who are doing better. They argue that people under stress are faced with two major coping tasks: regulating their emotions and obtaining relevant problem solving information (Lazarus & Folkman, (1984). Regulating their emotion is addressed through the use of downward, self-enhancing comparisons and problem solving information requiring affiliation with people who are better off. So Taylor & Lobel (1989) assume that people under stress not only affiliate with those who are better off but also wanted to obtain information about others. In social comparison theory, uncertainty, imbalance and lack of control are three important stressors or elements that play an important role. Uncertainty has been found in some research among nurses. In the study of Mac Grath, Reid, & Boore, (1989), it has been found that nurses who wonder if they are too involved with patients or not involved enough, may feel uncertain about how to deal with various patients' problems and may experience insecurities about what they are doing. Imbalance is second prominent stressor between investments and outcomes in relationship with patients. (Walster et al., 1978) assumes that there is a human tendency to get reward from others to whom we provide care, empathy and attention.



But (Maslach, 1982b, Maslach & Jackson, 1982) found that such expectations are not fulfilled most of the time among health professionals. Patients may be anxious and worried and often may not follow the advice properly. As a result they may improve slowly and the care provider may feel that their relationships or interactions are not working and then such interactions are not rewarding. Lack of control plays a central role in stresses. Landsbergis (1988) found from his research that among Swedish nursing home employees, burnout was significantly higher with low perceived control.

#### **1.1.5b: An Alternative model from appraisal model**

In an alternative model, burnout progresses from lack of personal accomplishment to emotional exhaustion to depersonalization and from emotional exhaustion to depersonalization. In this model there are three aspects to explain burnout process. The Golembiewski and colleagues model (Golembiewski, Munzenrider & Carter, 1983; Golembiewski, Munzenrider & Stevenson, 1986; Golembiewski, Munzenrider, 1988) states that burnout progresses from depersonalization through lack of personal accomplishment to emotional exhaustion. This model was based on a phase approach and establishes eight phases in the progression of burnout. The second model was developed by Leiter and Maslach (1988). According to the model, burnout progresses from emotional exhaustion through depersonalization to personal accomplishment. The third model was developed by Lee and Ashforth (1993a, 1993b). This model states that burnout progresses from emotional exhaustion to depersonalization and from emotional exhaustion to lack of personal accomplishment (Pedro R. Gil-Monte, Jose M. Peiro, Pilar Valcarcel; 1998). In the alternative model, burnout progresses from lack of personal accomplishment to emotional exhaustion, from lack of personal

accomplishment to depersonalization and from emotional exhaustion to depersonalization. In this model personal accomplishment is regarded as a strain. In contrast, (Golembiewski et al., 1983, Leiter & Maslach, 1988: Lee & Ashforth, 1993b) consider depersonalization which is derived from stress. In the relationship between emotional exhaustion and depersonalization, it can be said that emotional exhaustion is work related strain and depersonalization is a way of coping from the exhaustion (Dignam, Barrera & West, 1986: Holgate & Clegg. 1991; Leiter, 1991; Gil-Monte, Peiro & Valcarcel, 1993). In this model, self confidence, social support, role stress, coping and intention to leave has significant relation with burnout. (Maslach, 1982, Leiter. 1990; Pierce & Molloy, 1990; Cherniss, 1993; Gill-Monte et al 1993a) told that self confidence is considered as an antecedent of burnout. Bandura (1986) also found from study that people with low self confidence perceived more role stress because they exaggerate environmental difficulties and who have higher self confidence try active coping strategies. Gil-Monte et al (1993a) found that personal accomplishment is strongly associated with self confidence. Several studies showed that social support is also associated with burnout. (Firth, McIntee, McKeown & Britton, 1986; Eastburg, Williamson, Gorsuch & Ridley, 1994), state that social support at work has a significant relation with emotional exhaustion and depersonalization in nurses. Sutherland & Cooper, 1992; Peiro & Salvador, 1993 also showed that perceived social support can reduce perceived role stress and improve job satisfaction, mental and physical health. Role stress is also an important aspect in the investigation field of burnout. Role stress means role ambiguity and role conflict are significantly related with the MBI (Maslach Burnout Inventory) dimensions. Coping is an important variable in burnout study. Here, Pratt & Andrews, 1988; Lee & Ashforth, 1990; Leiter, 1992 showed coping is positively correlated with personal

accomplishment and negatively with emotional exhaustion. Maslach & Jackson, 1982; Leiter, 1991 found that escaping coping has a significant positive relationship with emotional exhaustion., Golembiewski et al., 1986; Gil-Monte, Peiro, Valcarcel & Grau 1996; Schaufeli & Dierendonck, 1993 found a significant positive association with burnout, particularly with emotional exhaustion. At last intention to leave also has a positive significant relation with burnout, especially with emotional exhaustion (Jackson, Schwab & Schuler, 1986; Koeske & Koeske, 1989).

### **1.1.5c: The JD-R Model of Burnout**

In contrast to the above models, the JD-R model has given some different ideas. This model hypothesizes that job demand and job resource are the main characteristics of any working environment. Job demand comprises of the physical, psychological, social and organizational aspects of job that require sustained physical and/or psychological effort. It is associated with certain physiological and/or psychological costs (Demerouti et al., 2001). It is also associated with exhaustion. Job resources encompass the various physical, psychological, social and organizational aspect that support individuals in the accomplishment of their tasks. By facilitating task accomplishment these resources can reduce job demand and contribute to well-being of the employee (Demerouti et al., 2001). Richter & Hacker (1998) distinguish resources in two categories, external resources (organizational and social) and internal resources (cognitive features and action patterns). Organizational resources include job control, potential for job qualification, participation in decision making and task variety. Social resources include support from colleagues, family and peer groups. When external environmental resources are limited, individuals cannot cope with the negative influence of environmental demand and they can't achieve their goal. In this

situation, an individual's motivation is reduced and they may subsequently withdraw from their job. According to this model, burnout develops when job demands are high and job resources are limited. JD-R model assumes two psychological processes to explain burnout components; the energetic process and the motivational process. In the energetic process, job demand drains employees' mental and physical energy and then contributes to emotional exhaustion. In the motivational process, the absence of job resources impacts employees' motivation and then contributes to disengagement and withdrawal (Bakke & Demerouti, 2007). The interaction between job demand and job resources is important for the development of burnout.

#### **1.1.5d: The self-determination theory of Burnout**

The self-determination theory states that individuals have basic psychological need for autonomy, competence and relatedness. Autonomy refers to the experience of preference and self approval of one's action (de Charms, 1968). It is the ability to make decision without being controlled by anyone. It is defined as freedom of choice. The autonomy becomes high when there is no external or other person's pressure and people enjoy their work. Competence indicates sufficiency of knowledge and skill that enables someone to act in a wide variety of situations. According to White, (1959), competence refers to the judgment of one's ability to achieve. It is perceived as self belief. Relatedness is a sense of shared experience. It means the degree to which a person feels connected with others (Baumeister & Leary, 1995). The satisfaction of these psychological needs may be considered as psychological resources. When these psychological needs are fulfilled, psychological and physical well-being is ensured. In the study of Gagne', Sene'cal, Koestner, (1997); it has been found that needs satisfaction is associated with work motivation. In a study from Van

den Broeck, Vansteenkiste, de White, and Lens (2008), it has been found that need satisfaction is related with emotional exhaustion which is a component of burnout.

#### **1.1.5e: Conservation of resource theory of Burnout**

According to the resource theory, individuals gather resources so that they can apply to accommodate, resist or overcome threats. They might accumulate personal resources, such as self-esteem and optimize material resources, such as money or condition resources such as status and social support. Stressful or traumatic events use these resources, thereby augmenting their sensitivity to subsequent stressors. Some resources like reputation enable individuals to secure other resources. When individual's reputation is favorable, they feel more autonomy and enjoy tasks which can improve their performance (Hochwarter, Ferris, Zinco, Arnell, & James, 2007). According to this theory, individuals experience stress when resources are depleted or when they cannot fulfill their demands. For example, when an individual loses money or status, they experience actual stress (Hobfoll, 1989). Anticipatory stress can also be as acute as an actual stress (Hobfoll, 2001). According to this theory, burnout can occur from persistent levels of actual or anticipatory stress. This theory indicates burnout occurs after persistent loss of resources that are needed to fulfill demands or regular failure to generate expected resources (Hobfoll, 2001). Consequently Naidoo et al (2012) showed that if an individual primarily struggles to avoid losses rather than approaching gain, they feel their problem is a threat to the existing resources. In such situation, burnout occurs.

So it has been found that burnout process can be explained by several theories and models. Some theories explain that burnout arises from the interaction between care provider and care recipients. Some theories explain that burnout arise from lack of

resources that individuals need. Burnout also arises when job demands are high and job resources are low. On the other hand, some theory explains that burnout arises when a person's basic psychological need (autonomy, competence and relatedness) are not fulfilled.

#### **1.1.6: Symptoms of Burnout**

The symptoms of burnout present with the feeling of being emotionally drained. In this situation individuals feel that they have nothing left to give to the person or relationship that is most important to them. Burnout is associated with situations in which a person feels overworked, underappreciated, confused about expectations and priorities, concerned about job security, overcommitted with responsibilities and resentful about duties that are not appropriate. Burnout can occur when one feels unable to meet constant demands and becomes overwhelmed and depleted of energy. The reaction sadness and/or anger also happen in burnout. Finally the person begins to lose interest and motivation. Burnout is not an overnight occurrence. It is important to recognize early signs and symptoms before it becomes severe. In a chronic state of stress and the body begins to show the following signs: psychosomatic illnesses, digestive problem, headache, high blood pressure, heart attack, stroke, teeth grinding, and fatigue. When individuals are on the verge of burnout, he or she may feel the following symptoms: powerlessness, hopelessness, being drained out, like a candle burning on both sides, frustrated, detached from people, little satisfaction from work, bored, feeling of failure, unsure about choice of work, isolated from co-workers and friends, insecure about competence and abilities, cynical, irritable and anxious. Besides these, burnout symptoms include depersonalization (loss of identity and feeling of unreality about own behavior), emotional exhaustion (a clear sign of burnout is exhaustion when a person feels tired all the time. It can be emotional,

physical or mental. It is the sense of not having any energy, a sense of reduced personal accomplishment, lack of motivation ( does not feel any internal motivation for work), cognitive problems ('fight or flight', tunnel vision negative effect on problem solving and decision making skill), interpersonal problems at home and work (having conflicts with other people like getting into arguments or withdrawing from co-workers or family members), not taking care of oneself (ceasing to take care of oneself or engage with unhealthy coping strategy like drinking, smoking, eating too much junk food, not eating enough or not getting enough sleep), decreased satisfaction ( tendency to feel less happy and satisfied at work and at home). Person may become stuck about what is going on in own life, (in the community and social activity). Wright, Thomas A.; Cropanzano, Russell, 1998 found from their study that emotional exhaustion was associated with both performance and subsequent turnover. Among 101 person who had encountered life- threatening danger, sixty percent reported five or more features of depersonalization (Russell Noyes Jr., Roy Kletti, 1977). It is clear that burnout is related to the personal, family and organizational life of the individual. It is shown that individuals who feel burnout display tiredness, psychosomatic problems, failures in psychological health and a tendency to distance themselves from family members (Surgevil 2006; Ardic and Polatsci 2008).

### **1.1.7: Causes of Burnout**

Burnout often develops by an interaction of external and internal factors. External factors are work related and internal factors are individual related. External factors include overload of work, monotonous work (Something that is very boring because it has a regular, repeated pattern of work which never changes), lack of recognition at work, unclear job responsibility, lack of autonomy of decision making etc. So work environment, work organization and personal situation at work are important external

factors. Internal factors that can lead to burnout are poor problem solving ability, perfectionism (a perfectionist person continuously focuses on what needs to be improved rather than what has been completed), high personal ambition (strong desire for achievement) and deficiency to maintain psychological balance, strong professional philosophy ('helper' syndrome). In health care profession, empathy and compassion are essential qualities and these qualities can increase emotional stress that can lead to burnout.

Drs. Michael P. Leiter and Christina Maslach, 2013; points six specific sources of burnout at work: lack of control, values conflict, insufficient reward, work overload, unfairness and breakdown of community.

#### **1.1.7a: Lack of control**

An individual's sense of control is very important. When an individual loses this control, they feel nothing can be said or done about whatever is going on. One study has conducted about job demand and lack of control has found that the combination of high job demand and lack of control has the risk of health problem especially coronary diseases (Karasek, R., et. al, 1981).

#### **1.1.7b: Values of conflict**

In many situations, there is a disconnection between own core values of employee and core values of the organization. If the employee becomes unable to adjust with the values of the organization, the conflict may lead to stress and burnout.

#### **1.1.7c: Insufficient reward**

Absence of reward or insufficient reward produces some negative consequences which is difficult to deal for an employee. Insufficient reward or lack of reward negatively affects the productivity of work of an employee. Constant insufficient reward may lead to stress and burnout.



#### **1.1.7d: Work overload**

Work overload is a vital issue of any organization. Jex (1998) defined overload as ‘employee’s insight that they had to work extra than the work required to be completed within given time period, all the work overload faced by someone in their job will be treated as job overload’. Because of over workload, an employee becomes unable to relax and function properly. Overload of work produces stress, decreases the performance and reduces the employee’s involvement in their job.

#### **1.1.7e: Unfairness**

Unfairness is characterized by inequality or injustice. It is a common problem at workplace or organization. This means there is a culture of discrimination and illogical fashion in some organizations. If an employee continuously faces this type of unfairness, it can lead to frustration and burnout.

#### **1.1.7f: Breakdown of community**

Community break-down is a community breaking down and separating due to the lack of communication and trust. With the increase in nuclear families and increased employment rates, people hardly get to spend time and exchange views and daily experiences with friends and families. This lack of sharing leads to stress which may increase the risk of burnout. A result has found that care workers in Japan express dissatisfaction about interpersonal relationship with their clients and their families. According to this finding, conflict with clients and client’s families are related to burnout among home care workers (Kohreisya Huhushi To Hohmuherupah Syoku Tyosa, 1997).

Besides these causes, there are some other causes of burnout. When an individual stops deciding for him or herself and spend their time to fulfill others’ expectations, it

may become a cause of burnout. It is also important that, sometimes individuals perceive an issue bigger than the reality.

*A devoted husband*

*Rahman (not actual name) was a farmer. He had a happy family with his lovely wife and only son. His son was 9 years old studying in a local school. He had some land where he farmed and he had no extra earning source. But he was happy with his life and he had good relationship with his own family members (brothers, mother). He had also good relation with his in laws family because his wife was only daughter of her parents. But 3 years ago, suddenly everything has changed when her wife diagnosed as a cancer patient. He started to struggle not only with the disease but also with the society and his own self. He had to continue his wife's treatment regularly and he has been continuing his caregiving for last three years. Lots of situations have changed over the three years. He has to sell his land and nothing is left for further living. As he provided his caregiving twenty four hours to his wife, he couldn't do any work for living cost. Even he had to give his only loving son to an orphanage. His relatives started leaving him as were afraid of helping them financially. There was no person beside him to share his feelings too. He was to wet pillow crying silently at night. He was just doing his duty as he married her with commitment to care for her. He was experiencing various types of difficulties doing household works and while caregiving as he was not used to do that. He couldn't eat, sleep timely and even didn't get little break from caregiving. Sometimes he would feel that if he could kill his wife and go for a long distance. Then he talk with himself that the disease might happen to him and as modern treatments were available, so there were hope that patient will recover with his caregiving. His hope for patient's recovery and his commitment were stimulating him to continue his caregiving. Rahman's only wish was if there were only one more caregiver to look after his wife, he could earn some money and be free from some worries.*

## **Section 1.2: Conceptualization of stress and depression**

### **1.2.1: Stress and burnout**

Dr. Hans Selye used the term stress for the first time in 1936. She defined stress as the non specific response of the body to any demand for change. Stress is body's way of responding to any kind of demand. Stress may be defined as a state of psychological and/or physiological imbalance resulting from the disparity between situational demand and the individual's ability to meet the demand. Most researchers define stress as an outgrowth of person-environment interactions (e.g., French & Caplan, 1972; McGrath, 1976; Schuler, 1980). McGrath and Schuler defined stress as a dynamic condition in which an individual is confronted with an opportunity, constrain or demand on being or doing what one desires and for which resolution is perceived to have uncertainties, but which lead to important outcomes.

Stress can be positive or negative. Stress is positive when the situation offers an opportunity to gain something for a person. It increases motivation for highest performance. Stress is negative when a person faces social, physical, organizational or emotional problems. Stress can come from any situation or thought which is called a stressor. It makes an individual frustrated, angry, nervous or anxious. Burnout is not simply excessive stress. It is a complex reaction to ongoing stress. There are some differences between stress and burnout. Individuals can face stress in daily life. Every single person experiences some degree of stress in their lives each day. On the other hand, burnout may be the result of unrelenting stress. Stress is characterized by over-engagement and burnout is characterized by disengagement. In stressful situations, emotions are over reactive. On the other hand, in burnout situation emotions are blunted. Stress produces urgency and hyperactivity and burnout produces helplessness and hopelessness. In stressful situations, the primary damage is physical and leads to

anxiety disorder. On the other hand, in burnout situation, the primary damage is emotional and leads to detachment and depression. Finally, it can be said that excessive stress will result in physical problem, but burnout is primarily psychological condition which can manifest with physical problems.

### **1.2.2: Burnout and depression**

In a general sense, burnout and depression has some common features. The relationship between depression and burnout are mixed. According to (Beck, 1970), depression is a dysphoric experience like fatigue, social withdrawal and failure. Burnout comprises emotional exhaustion, depersonalization and personal accomplishment. The emotional exhaustion of burnout is similar with the sadness and fatigue of depression. Depersonalization has the feature of social withdrawal. The burnout feature, reduced personal accomplishment is similar with the element of learned helplessness of depression (Abramsen, Seligman, & Teasdale, 1978). It can easily be said that burnout and depression are similar and correlated to each other.

Some characteristics of burnout are different from depression. The distinction between burnout and depression derives from the difference of attributional pattern and their context. Burnout basically is a social construct. It is essentially enmeshed with a person's social and organizational context whereas depression has implications for social relationships and especially reflects on personal thought and emotion. Burnout can be defined as a three dimensional syndrome of exhaustion, cynicism and diminished professional efficacy (Maslach and Jackson, 1996). In turn, depression can be defined as a way of reacting to challenges that are perceived as impossible, as a mental disorder (Grenberg & Goldstein, 2003). Depression is non-specific in nature

and can develop in any domain of life. On the other hand burnout develops from work related area.

In the MBI (Maslach Burnout Inventory), there are items which measure positive and negative experiences to interaction with service recipients in the workplace (Maslach & Jackson, 1986). In contrast, depression items attribute negative experiences to own self and do not make direct reference to a specific context. The global nature of depression is also evident in the Profile of Mood States (POMS) depression subscale (Mc Nair, Lorr, & Droppleman, 1971 ) where the respondent indicates the intensity with which they experienced various feeling, such as “miserable” or “sad”. Burnout is an occupational issue specific to human service professionals. It assumes a desire to make a significant contribution to people experiencing distress and emotional demands of providing service to them. But such effort has been met with limited success. Depersonalization in particular, did not generalize outside of human service professions. (Lee & Ashforth, 1993). In contrast, depression is not limited to an occupational context, but may have an impact on occupation, performance and problems at work.

In a Dutch study it was found that lack of reciprocity in the work domain was associated with burnout, whereas lack of reciprocity in intimate relationship outside work was associated with depressive symptoms (Bakker et al., 2000). Several studies have found qualitative difference in the process and associates of burnout and depression. For example, in Dutch study among teachers a reduced sense of superiority, i.e., the ability to rate oneself favorably in comparison to others was related to depressive symptoms but not to burnout (Brenninkmeijer, Van Yaperen, & Buunk, 2001). Similarly, in a French study among health care professionals, burnout and depressive symptoms were differently related to socio-demographic and work

factors (Martin, et, al., 1997). Burnout was more common among female workers with unconventional work hours and those who had active work motivation, whereas depressive symptoms were more common among senior workers and those with a low level of social support at work. There are differences between burnout and depression also on the inflammatory biomarker level (Toker, Shirom, Shapira, Berliner, & Melamed, 2005).

In the cases of depression, individuals are unable to enjoy pleasurable activities which they enjoyed before, but in burnout cases, individual can enjoy non work activities. There also exists an unrealistic guilt feeling in depression, but in burnout no unrealistic guilt feeling are exist (if existing, there is realistic guilt feeling which may be work related). In depression, Individuals are more dependent on other persons and have a tendency to avoid conflicting situations. But in burnout, individuals are more independent and their interpersonal conflicts are increased. Finally it can be said that depression and burnout do not always co-exist, but burnout symptoms may increase the risk of someone getting depression.

### **Section1. 3: Conceptualization of Chronic Physical Illness**

A chronic illness is a disease that has a prolonged course and does not resolve spontaneously. Chronic disease lasts for a long time, at least three months or more or for lifetime (U. S. National Center for Health Statistics). Chronic illnesses are mostly characterized by complex causes, many risk factors, long latency period (time between exposure to the illness and feeling its effects), a long illness, functional impairment or disability. Chronic diseases cannot be completely cured and their progression is slow; some can be immediately life-threatening (such as heart attack or stroke). Chronic diseases cannot be prevented by vaccines or cured by medication.

Chronic diseases are more common with age and are leading causes of mortality in the world. According to a report by the World Health Organization (2011), about 63% of deaths worldwide are caused by chronic diseases. There are many types of chronic diseases, each with own symptoms, causes and course. Sometimes chronic diseases are inherited and sometimes they are caused by environmental factors such as exposure to pollutions. Some chronic diseases are arthritis, cancer, diabetes, heart disease, kidney disease, HIV and AIDS, stroke, disability, epilepsy etc. A chronic illness can be stressful and may change the way a person lives and their relationship with others.

Many patients with chronic illness cannot live independently without family caregivers because these patients' capacity to do their personal work decreases. In this situation, family caregivers function as advocates and provide physical, mental, emotional and financial support frequently. In maximum cases, family caregivers don't have any training. So there is a significant role of a family caregiver with the patient of chronic physical illness.

## **Section 1.4: Conceptualization of Caregiver**

### **1.4.1: Definition of Caregiver**

Typically a caregiver is a family member or friend who willingly sacrifices his time and energy for a loved one who are chronically ill or disabled. A general definition of caregiver is someone who is responsible for the care of someone who is mentally ill, mentally handicapped, physically disabled or whose health is impaired by sickness or old age (Metlife Mature Market Institute, August, 2006).it can be also said that caregiver is a part of the art of caregiving. Caregiver can be of two types, informal caregiver and formal caregiver.

#### **1.4.1a: Informal Caregiver**

Informal caregiver is an individual who provides ongoing care and assistance without pay for a family member or a friend due to physical, cognitive or mental conditions (Canadian Caregiver Coalition, 2001). Informal caregivers play a vital role in maintaining health, well being and functional independence of the ill person. They assist in their daily activities like transportation, meal preparation, shopping, housekeeping, medication management, toileting, eating, bathing and personal hygiene. Informal caregivers play their role as responsibility. Sometimes they do their responsibility ignoring their own needs.

#### **1.4.1b: Formal Caregiver**

Formal caregiver is a paid professional who provides care as a doctor, nurse, social worker or home care worker. Formal caregivers are well trained and they know about their duties. To some extent, they can deal with medical crisis of the care recipient. In some cases, formal caregivers may provide full time support for the care recipient. This type of help may reduce stress and increase mental health of the recipient and their family members as well.

On an average, caregivers spend 20.4 hours per week for providing care. Those who live with their care recipient spend 39.3 hours per week caring for that person. Older caregivers who are over 65 years provide 31 hours in an average week to caregiving; on the other hand, middle aged caregivers report spending 19 hours per week (National Institute for caregiving and AARP, 2009).



## **Section 1.5: Conceptualization of Caregiver Burnout**

Caregivers are an important part in the health care services. Caregiver burnout is a state of physical, emotional and mental exhaustion of caregivers. Caregiver burnout occurs when they don't get the help they need (physically, mentally or financially). Caregivers often are so busy caring for others that they tend to neglect their own emotional, physical and spiritual health. For neglecting these needs they suffer from symptoms like withdrawal from friends and family, loss of interest in activities (which they previously enjoyed), feeling blue, irritable, hopeless and helpless, changes in appetite and weight, changes in sleep pattern, getting sick more often, neglecting responsibilities, excessive use of alcohol, medications or sleeping pills etc. Primary caregivers experience three stages of burnout; frustration, isolation and despair.

In the frustration stage, caregivers express frustration and disappointment for the recipient's lack of progression. It becomes difficult for them to accept that they have nothing to do more than they are doing for the care recipient. Caregivers struggle to provide proper care.

Therefore in the isolation stage, they may express feelings of loneliness because of being unappreciated or criticized by other family members or care recipient. Then they become unable or unwilling to get help from others.

In the despair stage, caregiver feels helpless and aimless. They become unable to concentrate and lose effectiveness or quality of care. As a consequence, caregiver neglects personal cares, social contact, avoid pleasurable activities such as reading books, watching movies, etc.

Some factors leading to caregiver burnout include role confusion (sometimes, it may be difficult for a caregiver to separate their role as spouse, lover, child, friend etc), unrealistic expectations (many caregiver expect that their effort will have positive change of patient which may be unrealistic), lack of control (many caregivers become frustrated for lack of money, resources and skills to plan effectively), unreasonable demands ( some caregivers feel that taking care of their patient is their sole responsibility, hence place undue burden on themselves). Many caregivers cannot recognize their burnout condition and are not conscious about the causes of burnout.

Among working caregivers 69% report having difficulty to rearrange their work schedule, decrease their work hours or take unpaid leave in order to meet their caregiving responsibilities (The Economic Value of Family Caregiving. AARP Public Policy Institute, 2012). 70% working caregivers suffer work related difficulties due to their dual caregiving roles (The National Alliance for Caregiving and AARP, 2009). Working women caregivers may suffer a particularly high level of economic hardship due to their caregiving. Female caregivers are more likely than males to have made alternate work arrangements: taking a less demanding job (16% female vs. 6% males), giving up work entirely (12% vs. 3%), and losing job related benefits (7% females vs. males 3%). 11% of family caregivers report that caregiving has worsened their physical health (The National Alliance for Caregiving and AARP, 2009). 40% to 70% of family caregivers have clinically significant symptoms of depression (Zarit, S. 2006). Full time working caregivers who are younger than 45 years showed the greatest emotional health deficit as well as physical health (Gallup Healthways Wellbeing Survey, 2011). Forty one per cent of the caregivers reported that their health had worsened over the past year and attributed these changes to a lack of time,

lack of control and decreased psychological energy (N.A. Murphy, B. Christian, D.A. Caplin & P.C. Young, 2006).

### **Section 1.6: Early studies of Caregiver Burnout among Patient with Chronic Physical Illness**

It is well established that caregivers experience different types of mental health problems like stress, depression and burnout. Different studies have been conducted among caregivers of patients having chronic physical illness in different countries. These studies suggest that caregivers of chronic physical illness experience burnout on different levels which affect their quality of life. Burnout levels also depend on the relationship within the patient and the caregiver.

From the study of M. Takai, & et al, (2008); it has been found that caregivers of patient with dementia often experience chronic and emotional strains which may lead to emotional exhaustion and burnout. The higher level of burnout was found to correspond to higher level of depressive symptoms and lower quality of life.

Buhse, Marijean, (2008); assessed caregiver burden in families of persons with multiple sclerosis. Multiple sclerosis (MS) is a chronic, unpredictable, progressive and disabling disease. Study result showed that caregiver burden is a multidimensional response to physical, psychological, emotional, social, and financial stressors which was associated with the caregiving experience. Caregivers who experience burden are more likely to have a higher risk of depression and a lower quality of life.

Yuki Yajima, & et al, (2007); conducted a study on “The effects of caregiving resources on the incidence of depression over one year in family caregivers of disabled elderly”. It has been found from the study that significant predictors of

depression were caregiving satisfaction, physical health and emotional support network and intention to care affect the incidence of depression of caregivers.

Barnard & et al, (2006); conducted a pilot study which investigated the relationships between stressors, work supports, and burnout among nurses with cancer patients. One hundred and one registered nurses completed self-report questionnaires and responses to open-ended questions to measure these constructs. 50% of the sample experienced the 50 listed stressors. Most of the work support of the nurses came from their peers rather than supervisor and organizational supports. The overall level of burnout was found moderate to low among the nurses. Significant positive correlations were found between Stressors and Emotional Exhaustion and Depersonalization subscales of the Maslach Burnout Inventory and a significant weak positive correlation was found between Peer Support and Personal Accomplishment (intensity).

Jennifer C. Maytum, Mary Bielski Heiman, Ann W. Garwick, (2004); conducted a descriptive qualitative pilot project where 20 experienced nurses who worked with children with chronic conditions were interviewed about their experiences with compassion fatigue and burnout. Findings of the study indicated that compassion fatigue is commonly and episodically experienced by nurses working with children with chronic conditions and their families. Participants reported that insight and experience helped them develop short- term and long-term coping strategies to minimize and manage compassion fatigue episodes and prevent burnout.

Robert A. Schneider, (2004) conducted a study to assess fatigue severity among caregivers of end-stage renal disease patients. The Fatigue Severity Scale was used among caregivers. The study results suggested that physical fatigue may be more prominent than mental fatigue as a feature of caregiver quality of life.

Ennio Cocco, Monica Gatti, Carlos Augusto de Mendonça Lima and Vincent Camus, (2003); conducted a comparative study of stress and burnout among staff caregivers in nursing homes and acute geriatric wards. The aim of the study was to compare levels of stress and burnout among staff caregivers in nursing homes and acute geriatric wards of general hospitals. A cross-sectional survey was conducted in three nursing homes (270 caregivers) and nine geriatric sections of general hospitals (280 caregivers). Socio-demographic data, the General Health Questionnaire (GHQ-12), the Maslach Burnout Inventory (MBI) and the Stressful Events Questionnaire (SEQ) were used for the study. From bivariate analysis it has been found that, staff caregivers of general hospital show higher GHQ scores, higher depersonalization and emotional exhaustion and lower personal accomplishment sub-scores of MBI than the staffs of nursing homes. Stressful events are more frequently reported by staff caregivers of general hospital.

Kyoko Fujiwara, Eri Tsukishima, Akizumi Tsutsumi, Norito Kawakami and Reiko Kishi, (2003); conducted a study to examine interpersonal relationship in work setting and burnout among health care workers in Japan. It has been found from the study that home care workers' conflict with the client and their families were significantly related to emotional exhaustion and depersonalization. So it is suggested from the study that conflict with clients and their families are important indicators for emotional exhaustion and depersonalization of home care workers.

Jan F. Ybema, & et al, (2002) conducted a study on Caregiver burnout among intimate partners of patients with a severe illness. From the study, it has been found that higher perceptions of inequity are strongly associated with higher emotional exhaustion, depersonalization and lower feelings of personal accomplishment. This study also showed that intimate partners of both cancer patients and patients with

multiple sclerosis are likely to experience burnout when they feel that they do not invest or benefit enough with their ill partner. Beside this, burnout depends on general marital quality, gender, duration of illness and the physical and psychological condition of ill partner.

In 2002, Angelica G. Belasco, Ricardo Sesso conducted a study to assess perceived burden and health related quality of life and investigate factors influencing this burden of caregivers for hemodialysis patients. The main types of caregivers' relation with patients were wives (38%) and daughters (27%). The majority of caregivers was women (84%) and married (66%). The study showed that caregivers of hemodialysis patients experienced a significant burden and an unfavorable effect on their quality of life. It has been also found that emotional aspects of caregivers and patients are important predictors of burden.

Britt Almberg, Margareta Grafström and Bengt Winblad, (1997); conducted a study on caring for a demented elderly person — burden and burnout among caregiving relatives. Regression analysis of the study showed that limitation in social life, poor health and a lack of positive outlook on caring were the most important independent variables explaining variance in burnout among caregivers of demented elderly person living at home and in an institution.

### **Section 1.7: Rational of the present study**

Caregivers play an important role in health care services. In Bangladesh, there are some study on the caregivers of psychiatric illness, but no study done on caregiver burnout of patients with chronic physical illness. So the main focus of this study is to assess burnout among caregivers of patient with chronic physical illness and explore factors related to burnout. This study will confirm that caregivers of patient with

chronic physical illness are suffering from burnout or not as well as which factors lead to contribute for burnout and which factors protect them from burnout. So from the light of the present study we will be able to provide knowledge about caregiver burnout to the mass population and the researchers also. We will also be able to make some burnout management program or recommend further study on burnout management for caregivers.

### **Section 1.8: Objectives of the present study**

#### **Major objectives:**

The major objective of the present study is to assess burnout among caregivers of patients with chronic physical illness.

#### **Specific objectives:**

- Assess burnout among caregivers of patients with chronic physical illness.
- To compare burnout experience among caregivers of patient with asthma, diabetes, cancer, stroke, heart disease and dementia.
- To compare burnout experience between the informal and formal caregivers of patients with chronic physical illness
- To compare burnout experience between the male and female caregivers of patients with chronic physical illness
- To compare burnout experience among duration of care giving among caregivers of patients with chronic physical illness
- To compare burnout experience among daily caregiving time among caregivers of patients with chronic physical illness
- To explore the contributing factors of burnout among formal caregivers of patients with chronic physical illness

- To explore the contributing factors of burnout among informal caregivers of patients with chronic physical illness
- To explore the protective factors of burnout among formal caregivers of patients with chronic physical illness
- To explore the protective factors of burnout among informal caregivers of patients with chronic physical illness

**Section 1.9: Research questions:**

- Are the caregivers of chronic physical illness suffering from burnout?
- Is there any difference of burnout experience among caregivers of patients with different types of chronic physical illness (cancer, diabetes, stroke, heart disease, dementia, asthma)
- Is there any difference of burnout experience between formal and informal caregivers of patients with chronic physical illness
- Is there any difference of burnout experience between male and female caregivers of patients with chronic physical illness
- Are there any differences of burnout experience among caregivers by the duration of care giving?
- Are there any differences of burnout experience among caregivers by the daily caregiving time?
- Which contributory factors lead to burnout experience among formal caregivers of patients with chronic physical illness?



- Which contributory factors lead to burnout experience among informal caregivers of patients with chronic physical illness?
- Which protective factors lead to mitigate burnout experience among formal caregivers of patients with chronic physical illness?
- Which protective factors lead to mitigate burnout experience among informal caregivers of patients with chronic physical illness?

## **CHAPTER II**

### **METHODOLOGY**

This section describes the methodological process and procedures for conducting the current study starting with theoretical stance for conducting the study in hand. The major objective of the current study is to assess burnout experience of the caregivers of patient with chronic physical illness and explore the contributing factors and the protective factors that mitigate burnout experiences of caregivers of patient with chronic physical illness. So both qualitative case study and quantitative survey method will be employed. Quantitative research approach especially survey design will be employed to assess burnout among caregivers of patient with chronic physical illness. Exploratory qualitative case study will be employed to explore the contributing factors of burnout and protective factors that mitigate burnout experience among caregivers of patients with chronic physical illness. In this section, study design, sampling, data collection method and data analysis method will be discussed. Two phases of the study; survey and case study discussed below.

#### **Section 2.1: Understanding Survey in the present study**

##### **2.1.1: Theoretical stance**

The study follows a positivist approach, widely used by social scientists and referred by Auguste Comte, John Stuart Mill and Emile Durkheim. Positivist researchers prefer precise quantitative data and often use experiments, surveys and statistics. They usually seek rigorous, exact measures and objective research. Positivism says that, “there is only one logic of science, to which any intellectual activity aspiring to the little of “science” must confirm (Keat and Urry, 1975).

### 2.1.2: Study design

The study employed quantitative research approach specifically survey design as the major aim of this study was to assess burnout among caregivers of patients with chronic physical illness. Survey research produces quantitative findings about the social world and describes some features about people or the social world itself. Using this design researchers ask many people about their past or present behavior, attitude, beliefs, opinions, characteristics. Survey research seeks many responses from the same question.

### 2.1.3: Sample and Sampling technique

In this study sample size was comprised of 365 caregivers covering male and female, informal and formal caregivers as well as patients with different types of chronic diseases also. Those samples were collected using purposive convenient sampling from different govt. and non-govt. hospitals in Dhaka city. Sampling distribution are presenting in the table below:

**Table 2.1.3:** Sample distribution of survey

Diseases	Informal caregivers		Formal caregiver		Total
	Male	Female	Doctor	Nurse	
Cancer	25	25	11	10	71
Diabetes	24	27	10	10	71
Stroke	17	38	10	10	75
Heart disease	27	18	10	11	66
Asthma	20	29	10	12	71
Dementia	2	2	0	7	11

#### **2.1.4: Inclusion and exclusion criteria**

To ensure the accuracy of data collection and to maintain the ethical standard of data collection the following inclusion and exclusion criteria were used.

##### **Inclusion criteria**

Only caregivers of patient with cancer, diabetes, cardiovascular disease, asthma, stroke and dementia were included. Both outdoor and indoor patients' caregivers were included in the survey. Only caregivers of age above 18 were included. Doctors and nurses were selected as formal caregiver and spouse, sibling, parents and adult children were selected as informal caregiver. Participants were included who provide their care giving more than two hours daily and duration of care giving were more than two months.

##### **Exclusion criteria**

Caregivers who were not interested to participate were excluded. Also diagnosed psychiatric ill patients caregivers were excluded. Caregivers who were under 18 years old were also excluded. Beside this participants were excluded who expend their care giving less than two hours daily.

#### **2.1.5: Data collection method**

Socio-Demographic questionnaire and Bangla form of Copenhagen Burnout Inventory (CBI) was used in the present study. Copenhagen Burnout Inventory developed by Kristensen et. al (2005) which has been used in different country to assess burnout. The Copenhagen Burnout Inventory (CBI) is a public domain questionnaire measuring the degree of physical and psychological fatigue experienced in three sub-dimensions of burnout: personal, work- related and client – related

burnout. The CBI had acceptable reliability (internal consistency and homogeneity) as well as factorial and criterion- related validity. Validity and reliability of this tool was assessed/ examined by the study on New Zealand secondary school teachers (Taciano L. Milfon & et al, 2007). Bangla form of Copenhagen Burnout Inventory was translated by Gayen & Mozumder (2011). The Bangla form of CBI was used as a tool to assess “Burnout among the Clinical Psychological Service Providers of Bangladesh” (Gayen & Mozumder, 2011). CBI is self rating tool. CBI has 19 items with three sections (Personal burnout, Work burnout, Client burnout).

a. **Personal burnout**

Personal burnout had been defined as a prolonged physical and psychological exhaustion. This section consisted of six questions with five responses.

b. **Work burnout**

Work burnout had been defined as a prolonged physical and psychological exhaustion which was perceived as related to the person’s work. This section consisted of seven questions with five responses.

c. **Client burnout**

Client burnout had been defined as a prolonged physical and psychological exhaustion which was perceived as related to the person’s work with client. Client could be patient, student, children, intimates or other kind of recipients. This section consisted of six questions with five responses.

### **2.1.6: Data collection procedure**

The researcher has visited five different specialized hospitals (NIDCH, BIRDEMH, NICRH, NHFB, and SWBF) of Dhaka city. Approval for data collection was obtained from the authorities using the formal procedures. Informed consent was obtained from all participants and they were assured of confidentiality before data collection. Then researcher administered socio-demographic questionnaire and the Bangla form of Copenhagen Burnout Inventory with instruction to 365 caregivers of patient with chronic physical illness. Privacy was also maintained during data collection.

### **2.1.7: Data analysis**

SPSS-20 was used for data analysis. To measure significant difference, t-test was done. Descriptive analysis was done form measuring mean, percentage and frequencies. ANNOVA test was applied to test extent of differences among burnout experiences of patients with six types of chronic physical illness.

## **Section 2.2: Understanding case study of the present study**

### **2.2.1: Theoretical stance**

The case study method often involves simply observing what happens to the case of a single participant or group of individuals. It's an idiographic approach. Qualitative case study methodology provides tools for researchers to study complex phenomena within their context. It's a valuable method in health science research to develop theory, evaluate programs, and develop interventions. Both Stake (1995) and Yin (2003) base their approach to case study on a constructivist paradigm. Constructivists' claim that truth is relative and it is depends on one's perspective. This paradigm recognizes the importance of the subjective human creation of meaning, but it does

not reject idea of objectivity. One of the advantages of this approach is the close collaboration of researchers and the participants. Through this collaborative work, participants became able to describe their views of reality, by which researcher also became able to understand the participants' actions (Lather, 1992; Robottom & Hart, 1993). According to Yin (2003) a case study design should be considered when the focus of the study is to answer "how" and "why" questions.

### **2.2.2: Study design**

In this study exploratory case study design has been used to explore the contributing factors of burnout and explore the factors that mitigate the burnout experience among caregivers of chronic physical illness.

### **2.2.3: Sample and sampling technique**

The sample had been selected from the participants of survey. Purposive sampling was used for case study. Total 10 cases were interviewed for the case study phase. Five cases had been selected who were suffering from high burnout and five cases had been selected who were not experiencing burnout. During data collection maximum variation was ensured through age, sex, relationship, burnout level, socio-demographic factors, economical condition, education, marital status, duration of caring. The sampling distribution given below:

**Table: 2.2.3:** Sample distribution of case study

case	Age	Sex	Relation	Spend time daily	Duration of care giving	Type of patient	No. of co caregiver
1	70	F	Mother	12 hours	3 years	Asthma	1
2	31	F	Wife	24 hours	7 months	Asthma	0
3	55	F	Wife	24 hours	3 months	Cancer	0
4	25	M	Son	5 hours	6 months	Stroke	1
5	52	M	Son	12 hours	5 years	Dementia	2
6	50	M	Husband	24 hours	3 years	Cancer	0
7	53	M	Father	5 hours	26 years	Asthma	1
8	30	M	Doctor	8 hours	2 years	Heart disease	3
9	43	F	Nurse	8 hours	13 years	Cancer	3
10	23	F	Nurse	8 hours	4 years	Dementia	1

#### **2.2.4: Inclusion and exclusion criteria**

Sample of case study were selected from the participants of survey phase. Only Caregivers of patient with cancer, heart disease, asthma, stroke and dementia were included. Both outdoor and indoor patient's caregivers were included for case study. Only adult caregivers were included whose age range up to 18 years. In this study, doctors and nurses were selected as formal caregiver and spouse, sibling, parents and children were selected as informal caregiver.

#### **2.2.5: Data collection method:**

##### **2.2.5a: In depth interview:**

For the in depth interview, at first participants consent were taken for the interview and record keeping. Then rapport was build up by asking about participant's current condition and about the patient. They also informed about their score of the burnout scale. And then they asked about their type and duration of caring, relationship with patient and their feelings, emotion and behavior related to care giving. Beside these,



they were asked about the challenges related to care giving (personal, institutional, patient's and others) as well as about their coping skill. Total interview was recorded in a digital voice recorder.

### **2.2.5b: Topic guide:**

Topic guide was used as the tool of in depth interview. Topic guide was developed by identifying the areas which were the main focus of case study. Researcher and supervisor collaboratively develop the topic guide for interview. In the topic guide following areas were covered for data collection:

- Relation with patient
- Duration of care giving
- Type of patient
- Type of care giving
- Spend time of care giving
- Knowledge about disease of patient
- Role of care giving
- Challenges or problems related to care giving
- Feeling about care giving
- Contributing factors of caregiver burnout
- Protective factors of caregiver that mitigate burnout experience
- Coping skill

### **2.2.5c: Voice recorder:**

A digital voice recorder was used with permission while taking data for the case study.

### **2.2.6: Data collection procedure:**

At first, researcher selected five cases who were suffering from high burnout and five cases that were not experiencing of burnout. Those cases were selected after SPSS-20 analysis of data from survey. After selecting those cases, researcher called them over phone and fix up time and place for interview where privacy and confidentiality will be maintained. Then the researcher interviewed with the topic guide and voice recorder. After completing interview, collected data converted into transcript and then data was analyzed manually.

### **2.2.7: Data analysis:**

Case study data was analyzed manually.

## CHAPTER III

### RESULT

#### Section 3.1: Result of survey

The result from the data analyses are presented in the following tables where 49 and below scores indicate no burnout and 50 and above score indicates high burnout. Findings of burnout among caregivers of patient with chronic physical illness like percentage of burnout experience cancer, asthma, stroke, heart disease, diabetes and dementia; burnout experience of formal and informal caregivers; male and female caregivers' burnout experience and burnout experience by duration of care giving and spent time daily is presented below.

**Table 3.1.1:** Frequency and percentage of total Cases

Total	N	Personal Burnout		Work Burnout		Client Burnout	
		No Burnout	Burnout	No Burnout	Burnout	No Burnout	Burnout
caregivers	365	253(69.3%)	<b>103(28.2%)</b>	288(78.9%)	64(17.5%)	295(80.8%)	61(16.7%)

Total N=365, Mean Age=35.45, Total missing data=9 (2.46%)

Table 3.1.1 showed that among total caregivers 28.2% met criteria (50 and above in CBI) of personal burnout, 17.5% work burnout and 16.7% client burnout. Result also showed that among three section of CBI scale, personal burnout rate is high than work burnout and client burnout.



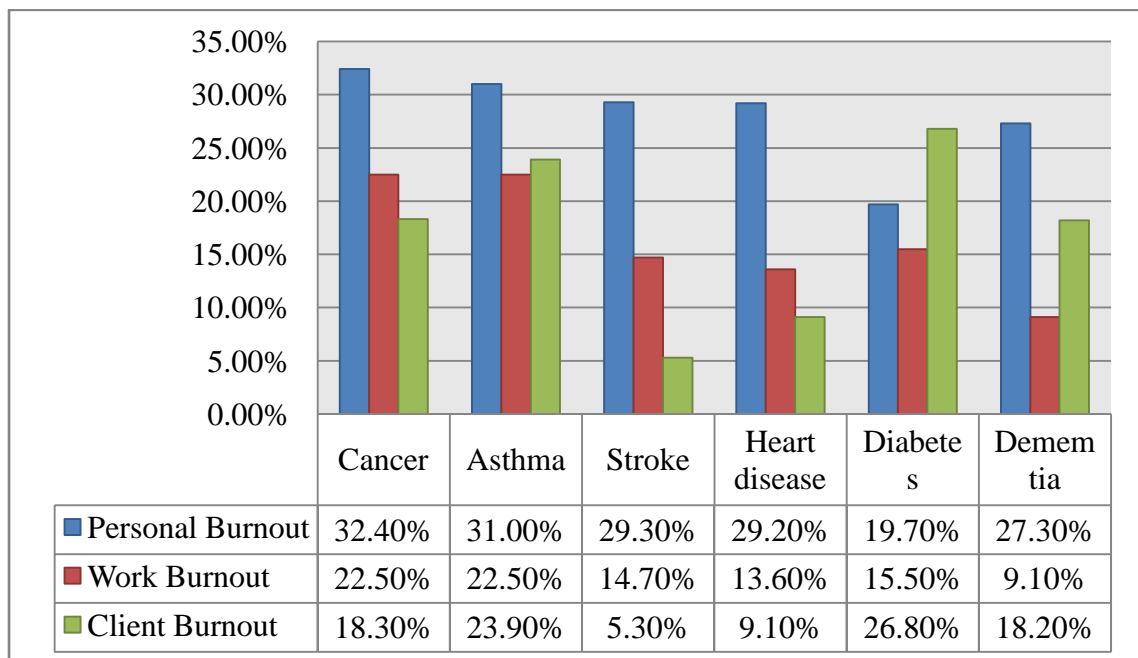
**Figure: 1:** Percentage of burnout cases

**Table 3.1.2:** Frequency and percentage of Burnout among caregivers of patient with six chronic diseases

Caregivers	N	Personal Burnout		Work Burnout		Client Burnout	
		No Burnout	Burnout	No Burnout	Burnout	No Burnout	Burnout
Cancer	71	46(64.8%)	<b>23(32.4%)</b>	54(76.1%)	<b>16(22.5%)</b>	57(80.5%)	13(18.3%)
Asthma	71	48(67.6%)	22(31.0%)	51(71.8%)	<b>16(22.5%)</b>	49(69.0%)	17(23.9%)
Stroke	75	51(68.8%)	22(29.3%)	62(82.7%)	11(14.7%)	70(93.3%)	7(5.3%)
Heart disease	66	46(70.8%)	19(29.2%)	56(84.8%)	9(13.6%)	60(90.0%)	6(9.1%)
Diabetes	71	55(77.5%)	14(19.7%)	55(77.5%)	11(15.5%)	50(70.4%)	<b>19(26.8%)</b>
Dementia	11	7(63.6%)	3(27.3%)	10(90.9%)	1(9.1%)	9(81.8%)	2(18.2%)

Table 3.1.2 showed that among the caregivers, cancer patient’s caregivers 32.4% met criteria (50 and above in CBI) of personal burnout, 22.5% work burnout and 18.3% client burnout; asthma patient’s caregivers 31.0% met criteria (50 and above in CBI scale) of personal burnout, 22.5% work burnout and 23.3% client burnout; stroke patient’s caregivers 29.3% met criteria (50 and above in CBI scale) of personal burnout, 14.6% of work burnout and 5.3% client burnout; caregivers of heart disease patients 29.2% met criteria (50 and above in CBI scale) of personal burnout, 13.6% work burnout and 6.9% client burnout; diabetes patient’s caregivers 19.7% met

criteria (50 and above in CBI scale) of personal burnout, 15.5% work burnout and 26.8% client burnout and dementia patient’s caregivers 27.3% met criteria (50 and above in CBI scale) of personal burnout, 9.1% work burnout and 18.2% client burnout. Result also indicated that in every disease, personal burnout was higher than work burnout and client burnout. In other hand, personal burnout was high in cancer caregivers than in others. Work burnout was high in both cancer and asthma patients caregivers. Client burnout was high in diabetes patient’s caregivers. Significant difference has been found within group and between group in personal burnout, work burnout and client burnout carried out by ANNOVA. The limit for significance was set by alpha <.05

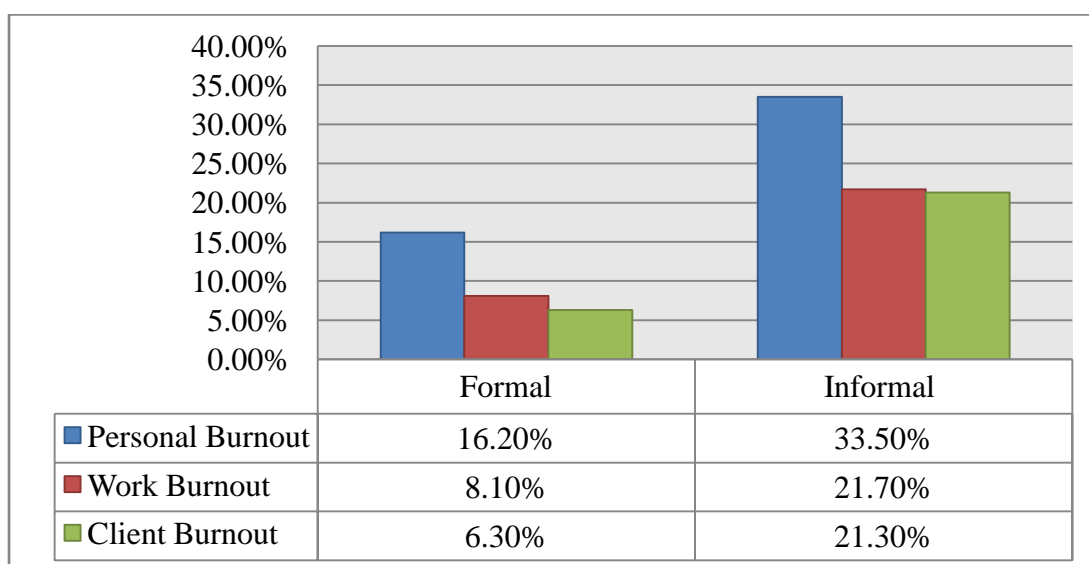


**Figure 2:** Percentage of Burnout among caregivers of patient with six chronic diseases

**Table 3.1.3:** Frequency and percentage of Burnout among formal and informal caregivers

Gender	N	Personal Burnout		Work Burnout		Client Burnout	
		No Burnout	Burnout	No Burnout	Burnout	No Burnout	Burnout
Formal	111	92(82.9%)	18(16.2%)	101(91.0%)	9(8.1%)	104(93.7%)	7(6.3%)
Informal	254	161(63.4%)	<b>85(33.5%)</b>	187(73.6%)	<b>55(21.7%)</b>	191(75.2%)	<b>54(21.3%)</b>

Table 3.1.3 showed that formal caregivers 14.2% % met criteria (50 and above in CBI) of personal burnout, 8.1% work burnout and 6.3% client burnout. On the other hand, informal caregivers 33.5% % met criteria (50 and above in CBI) of personal burnout, 21.7% work burnout and 21.3% client burnout. Result showed that burnout rate was higher among informal caregivers than formal caregivers in three section of CBI. Significant difference has been found in formal and informal caregivers among three types of burnout carried out by t-test. The limit for significance was set by alpha <.05

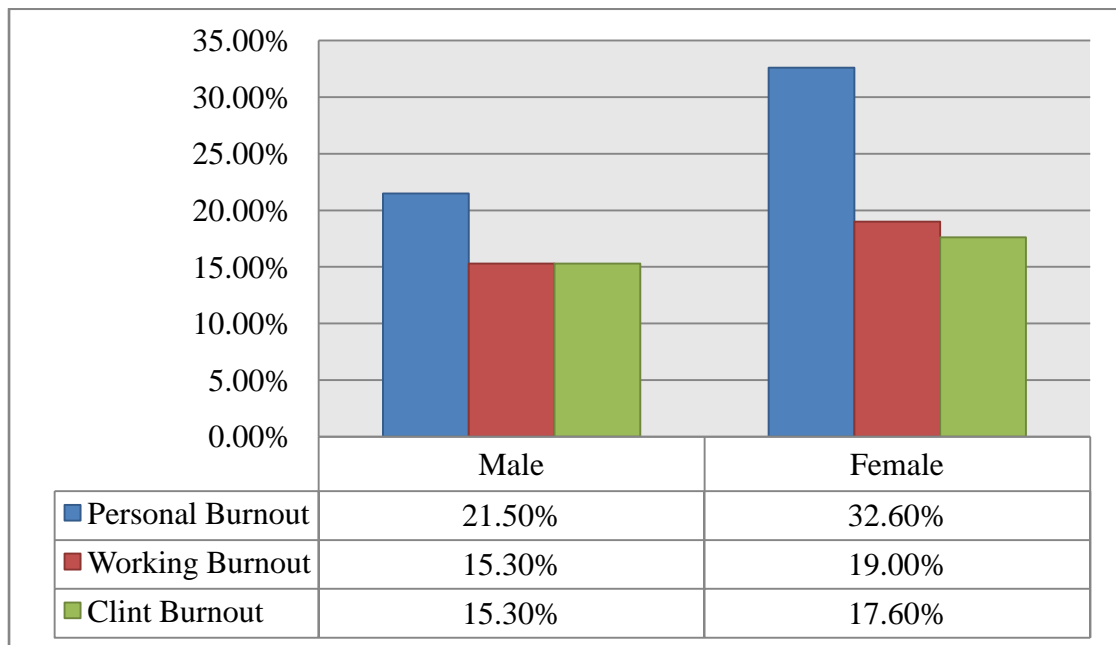


**Figure 3:** Percentage of Burnout among formal and informal caregivers

**Table 3.1.4:** Frequency and percentage of Burnout among male and female caregivers

Gender	N	Personal Burnout		Work Burnout		Client Burnout	
		No Burnout	Burnout	No Burnout	Burnout	No Burnout	Burnout
Male	144	112(77.8%)	31(21.5%)	118(81.9%)	22(15.3%)	119(82.8%)	22(15.3%)
Female	221	141(63.8%)	72( <b>32.6%</b> )	170(76.9%)	42( <b>19.0%</b> )	176(79.6%)	39( <b>17.6%</b> )

Table 3.1.4 showed that male caregivers 21.5% met criteria (50 and above in CBI) of personal burnout, 15.3% work burnout and 15.3% client burnout; female caregivers 32.6% met criteria (50 and above in CBI) of personal burnout, 19.0% work burnout and 17.6% client burnout. Result showed that burnout rate among female caregivers were higher than male caregivers in three section of CBI. Significant difference has been found in male and female caregivers among three types of burnout carried out by t-test. The limit for significance was set by alpha <.05



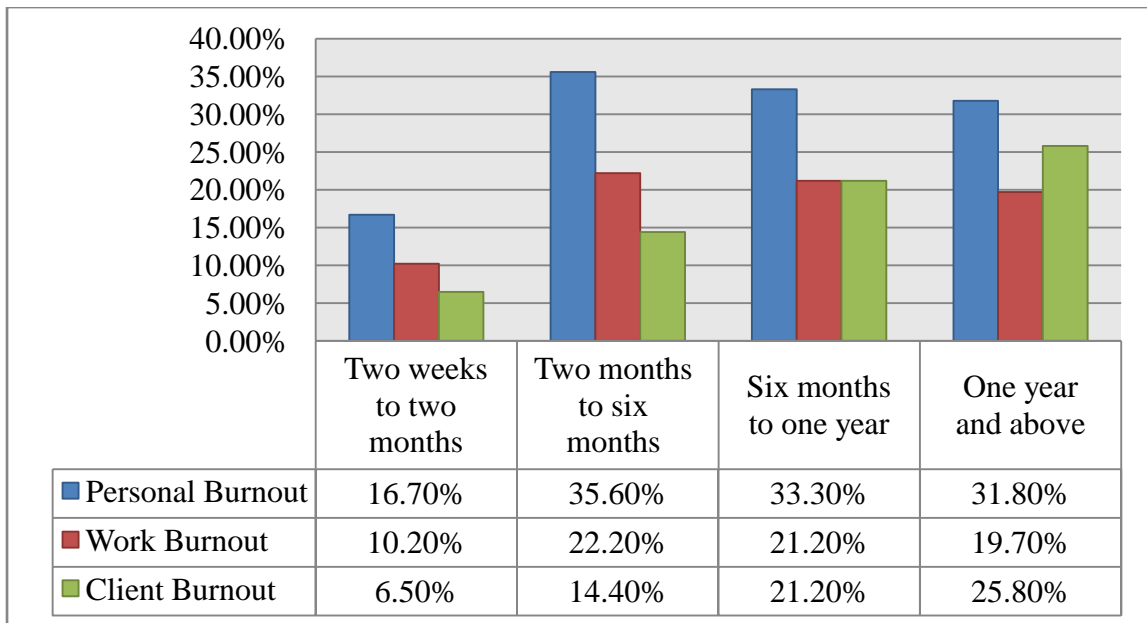
**Figure 4:** Percentage of Burnout among male and female caregivers

**Table 3.1.5:** Frequency and percentage table of Burnout among caregivers by care giving duration

Duration of care giving	N	Personal Burnout		Work Burnout		Client Burnout	
		No Burnout	Burnout	No Burnout	Burnout	No Burnout	Burnout
Two weeks to two months	108	89(82.4%)	18(16.7%)	96(88.9%)	11(10.2%)	101(93.5%)	7(6.5%)
Two months to Six months	90	56(62.2%)	<b>32(35.6%)</b>	69(76.7%)	<b>20(22.2%)</b>	73(81.1%)	13(14.4%)
Six months to One year	33	22(66.7%)	11(33.3%)	26(71.8%)	7(21.2%)	26(78.8%)	7(21.2%)
One year and above	132	84(63.6%)	42(31.8%)	96(72.7%)	26(19.7%)	93(70.6%)	<b>34(25.8%)</b>

Table 3.1.5 showed that caregivers who were providing their care to their patients for two months and below 16.7% met criteria (50 and above in CBI) of personal burnout, 10.2% work burnout and 6.5% client burnout; caregivers who were providing their care to their patients for six months and below 35.6% of personal burnout, 22.2% work burnout and 14.4% client burnout; caregivers who were providing their care to their patients for one year and below 33.3% of personal burnout, 21.2% work burnout and 21.2% client burnout; caregivers who were providing their care to their patients for two years and below, participants were two and they were not suffering from burnout; caregivers who were providing their care to their patients for two years and above 31.8% met criteria (50 and above in CBI) of personal burnout, 19.7% work burnout and 25.8% client burnout. Result showed that burnout rate was high among caregivers who were providing their care for six month and below of personal burnout and work burnout. On the other hand, client burnout rate was higher among caregivers who were providing their care for above two years. Significant difference have been found among caregivers with caregiving duration.





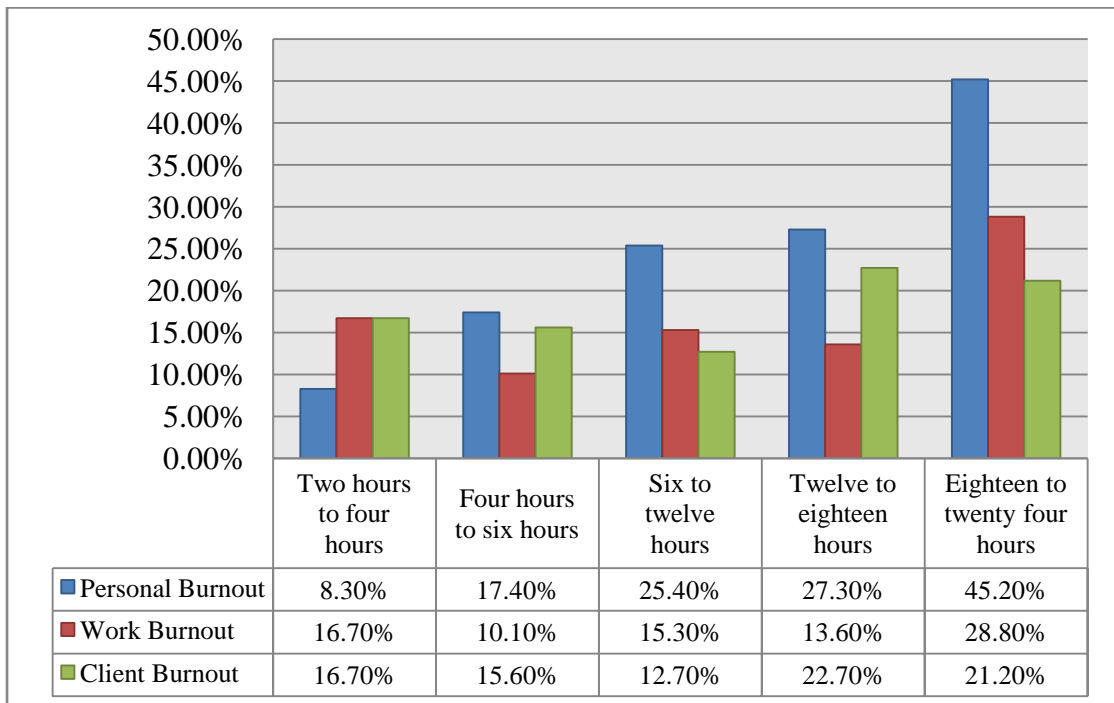
**Figure 5:** Percentage of Burnout among caregivers by care giving duration

**Table3.1.6:** Frequency and percentage of Burnout among caregivers by care giving time daily

Spend time (daily)	N	Personal Burnout		Work Burnout		Client Burnout	
		No Burnout	Burnout	No Burnout	Burnout	No Burnout	Burnout
Two-Four hours	12	8(66.7%)	1(8.3%)	8(66.7%)	2(16.7%)	10(83.3%)	2(16.7%)
Four-Six hours	109	89(81.7%)	19(17.4%)	96(81.1%)	11(10.1%)	91(83.5%)	17(15.6%)
Six-Twelve hours	118	86(72.9%)	30(25.4%)	98(83.1%)	18(15.3%)	101(85.5%)	15(12.7%)
Twelve-Eighteen	22	16(72.7%)	6(27.3%)	18(81.8%)	3(13.6%)	17(77.3%)	<b>5(22.7%)</b>
Eighteen-Twenty four hours	104	54(51.9%)	<b>47(45.2%)</b>	68(65.4%)	<b>30(28.8%)</b>	76(73.1%)	22(21.2%)

Table 3.1.6 showed that caregivers who were providing their care daily for four hours and below to their patients 8.3% met criteria (50 and above in CBI) of personal burnout, 16.7% work burnout and client burnout; caregivers who were providing their care daily for six hours and below to their patients 17.4% met criteria (50 and above in CBI) of personal burnout, 15.3% work burnout and 15.6% client burnout;

caregivers who were providing their care daily for twelve hours and below to their patients 25.4% met criteria (50 and above in CBI) of personal burnout, 15.3% work burnout and 12.7% client burnout; caregivers who were providing their care daily for eighteen hours and below to their patients 27.3% met criteria (50 and above in CBI) of personal burnout, 13.6% work burnout and 22.7% client burnout; caregivers who were providing their care daily twenty four hours and below to their patients 45.2% met criteria (50 and above in CBI) of personal burnout, 28.8% work burnout and 21.2% client burnout. Result indicated that burnout rate was higher among caregivers who were providing their care for twenty four hours and below daily of personal burnout and work burnout. On the other hand, client burnout was high among caregivers who provided their care for eighteen hours and below.



**Figure: 6:** Percentage of Burnout among caregivers by daily care giving time

### Section 3.2: Result of case study

**Table 3.1.7:** Contributing factors of burnout among formal caregivers of patient with chronic physical illness

<b>Contributing factors</b>	<b>Content</b>	<b>Total</b>
Lack of financial support	Case 8 (I have to do many honorary degrees besides my job. More ever I have to bear my own cost as well as my family. Actually there are lots of problem comes together. In my age, financial issue is an important factor)	1/3
Work overload	Case 8 (Sometimes I have to do 48 hours duty continuously and I feel overloaded. Actually then, I can't do lots of thing even I have intention).	1/3
Limited social life	Case 8 (Well you see that I can't attend in my friend's marriage ceremony, and it happens very often.	1/3
Irregular daily activity	Case 8 (As we have to do our duty according to roaster, it's a factor that I can't do my daily work timely like eating, sleeping even anything).	1/3
Over expectation from patients	Case 8(same person when comes to OT, tells that operate me and make me healthy. So their expectation level is so high but in our country there is absence of the system to fulfill their mental satisfaction with their treatment).	1/3
Non cooperation from patient's attendance	Case 8 (there are some patient who don't cooperate with us. It is seen that they show power. Actually this	1/3

	type of behavior does the person who comes with the patient. It becomes really difficult to handle them properly).	
Non-empathic management in hospital	Case 8 (patients come to us through so many painful steps of management of hospital. When they come to us, naturally behave aggressively with us).	1/3
Lack of cooperation from colleagues	Case 8 (It would better, if our colleagues were more cooperative).	1/3
Hazardous educational system in medical	Case 8 (there are so many pain in every step of our educational system in medical. It's a continuous process. Medical system could be smoother in our country).	1/3
Negative thoughts	Case 8 (sometimes I think that all of my friends are doing good job with better position in USA and Canada. In that case, I feel that I am in a wrong way).	1/3

Table 3.1.7 showed the contributing factor of burnout among formal caregivers of patient with chronic physical illness. Those factors have been selected according to the formal caregiver's perspective and their view point. Here some description on these factors. Among three formal caregivers, one was talking about lack of financial support as a contributory factor of burnout. That means this caregiver was mostly unable to fulfill family's and own need. Lack of financial support means lack of financial recourses that are needed to fulfill one's basic and other needs as well. One, out of three formal caregivers talked about work overload. Work overload represents the weight of hours, sacrifice of time and the sense of frustration with the inability to

complete tasks in the given time. Work overload may be seen as qualitative or quantitative. Quantitative work overload is defined as having too much work to do in the time available whereas qualitative work overload refers to skill level of the employee or care provider. Most of the time this participant's had to do long time duty in hospital; sometimes it may 24 hours to 48 hours which was described as work overload. Limited social life was an important contributory factor of burnout. One formal caregiver was experiencing limited social life. Limited social life means lack of opportunities to do enjoyable things in life. This participant was unable to meet friends regularly, attend friend's and family's occasions, giving time to own hobbies.

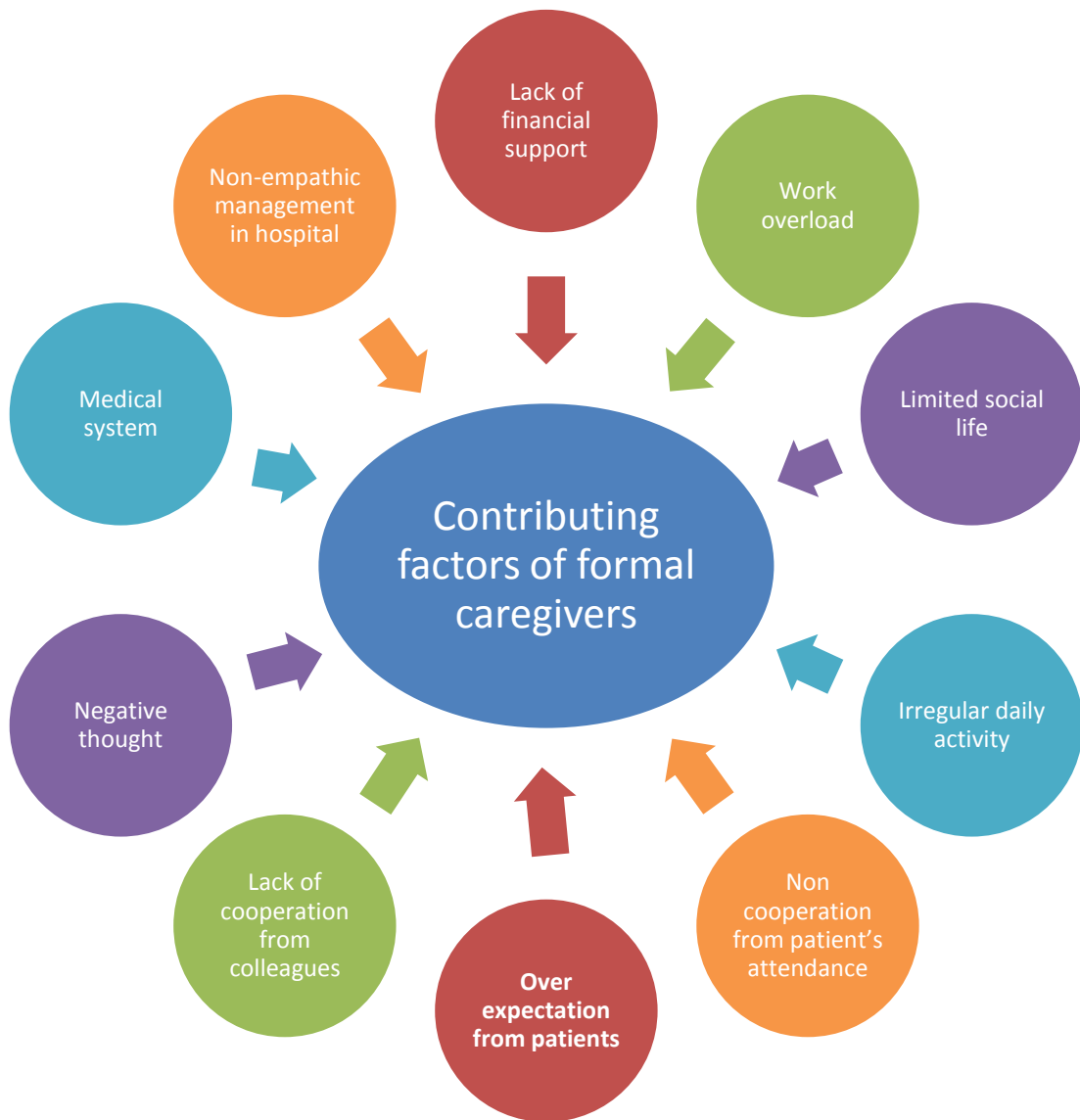
One formal caregiver was experiencing burnout as caused by irregular daily activity. Every person has some daily activity in their own life. While care giving, caregiver have given more attention to the patient and have to do some daily routine work for assisting the patient. To fulfill the need of the patient, caregivers was paying less attention to own life. From the study findings over expectation of patient have found as a factor which leads to burnout. Patients expectation refers to the meaning that patients think something good may happen in their life from treatment. So over expectations of patients might be described as they were not satisfied with their treatment. Non cooperation from patient's attendance have found as a contributory factor of burnout among formal caregivers. Sometimes patient's attendances' were showing their power and wanted extra attention from formal caregivers which was very difficult situation for them. Participant described that situation as non co-operation which needed additional efforts to deal with those difficulties.

Non empathic management in hospital refers that when a patient started to take treatment in hospital; they suffered or experienced hardship in every stage. Afterward

when they reached to the formal caregivers, they expressed their painful feeling to the formal caregivers as they were responsible for their sufferings.

One formal (doctor) caregiver was experiencing non co-operation from colleagues. Non cooperation refers to failure or refusal to co-operate. According to the participant as he helped his colleagues doing duties, he wouldn't get enough co-operation when he could not manage own duty. He was also addressed about hazardous educational system at medical in Bangladesh. Medical education and training varies across the world. Various teaching methodologies and systems have been utilized in medical. In Bangladesh doctors need to complete their MBBS as a minimal requirement of providing treatment and getting their license.

Negative thoughts have found as a contributory factor of burnout among formal caregivers. That factor have found in one among three formal caregivers. Negative thinking indicated a mental attitude of anticipating the worst possible outcomes on situations, events and circumstances or the ability of mind to produce thoughts that not deemed favorable to what the person wanted.



**Figure 7:** Contributing factors of burnout among formal caregivers of patient with chronic physical illness

**Table 3.1.8:** Contributing factors of burnout among informal caregivers of patient with chronic physical illness

<b>Contributing factors</b>	<b>Content</b>	<b>Total</b>
Lack of financial support	Case 1 (there are lots of problem in my body like pain, high blood pressure etc. It doesn't come true that I will take treatment for me because of money. Will I treat my son or mine? It demands money), case 2, case 4, case 6	5/7
Worry about patient and disease	Case 1, case 2, case 3 (All the time the imagination comes to my mind that "hey Allah! What will happen? When he will recover? Allah, you save my husband and I don't want anything from you." All time I pray to Allah for his recovery), case 4, case 6	5/7
Difficult situation during care giving	Case 1, case 2 (when he wants something, I have to give instantly), case 3, case 5, case 6 (when she do vomiting, I have clean that. As a result I can't eat properly. Again she cries for pain at night and I can't sleep also), case 7	5/7
Sense of over responsibility	Case 1, case 2, case 3 (Though I face difficulties, I must do these work. It's my foremost work. If husband become ill, wives responsibility to take care him even feel so worst), case 6	4/7
Work overload	Case 2(My whole responsibility is to do all household work like take care of husband, take care of children, shopping, cooking, everything. I feel puzzled while working), case 3, case 5, case 6	4/7



Irregular daily activity	Case 2 (very often it is seen that no work is done timely), case 5, case 6	3/7
Sexual dissatisfaction	Case 2 (As I have my husband it is usual that I have sexual demand from him but I don't get this support from him maximum time), case 5, case 6	3/7
Lack of co-caregiver	Case 2, case 3, case 6 (if there would be someone beside me to take care her, then I could work and earn some money. There is nobody to help me).	3/7
Fear of loss of loving person	Case 3, case 5 (parents will not live forever, one day they will go. This thinking makes me feel bad).	2/7
Belief in fate	Case 1, case 2 (May be Allah wrote this in my fate)	2/7
Lack of scope for recreation	Case 2 (I feel if I could be free for some time, if I could go outside!)	1/7
Relative's lack of involvement	Case 3, case 6 (Though my wife is only daughter of her parents, they don't come to look her because of fear that they have to pay money for treatment. They have cut up relation with us after diagnosis of cancer)	2/7
Relative's unwanted involvement	Case 4 (I like to follow the advice as doctor has said, but he thinks that doctors don't know everything)	1/7
Lack of cooperation in hospital setting	Case 3(while working cleaners do quarrel and never do well behave with us. If they want, they clean and our cookerries and the things throw wherever they wish)	1/7

Table 3.1.8 showed the contributory factors of burnout among informal caregivers of patients with chronic physical illness. Among seven informal caregivers five have

mentioned about lack of financial support as a contributory factor of burnout. Among the informal caregivers, some of them had no income and some of them had very little income. Most of the participants were from Dhaka city and their living cost was very high for them. Beside this, caregivers were providing their care to the chronic physical ill patients. Those illnesses were non curable and needed lifelong treatment. Caregiver participants shared that if they had no financial problem; they could feel better and could provide better service to the patients.

Five informal caregivers noticed that worry about patients and their diseases were underlying factors of their burnout. Worry means uneasy or concerned about something which was important for someone. As informal caregivers were very close to the patients, caregivers were tending to be worried about patients and their diseases. They were also worried about the patient's difficulties, mental condition and characteristics of diseases.

Five informal caregiver reported difficult situation during care giving as an important contributory factor of their burnout. Informal caregivers were very often facing difficulties during care giving. Caregivers had to do most of the personal work of the patient like bathing, cleaning dresses, changing dresses, cleaning vomiting as well as fulfill instant need of the patients.

Sense of over responsibility has the essence of control, force, fear and trust of own self, others and the universe. Caregivers who were dealing or taking care of someone ill, they were able to be trusted and involve important decisions. But caregivers felt that they were bound to do these duties or they must do these, they became stressed and they were continuing their stressful conditions.

Work overload was the situation where informal caregivers had to do too much work for the patients. Four informal caregivers confirmed that work overload was their contributory factor of burnout. From the caregivers' perspective, they expressed that very often they couldn't go fast with time.

Irregular daily activity have also found as a contributory factor among informal caregivers. Informal caregivers were very close to their patients and were fulfilling their need, caregivers couldn't fulfill their own need even their daily activity like eating, bathing, cooking, doing other household works etc. Three informal caregivers told about that factor.

Sexual dissatisfaction have found as a contributory factor among three informal caregivers. Sexual dissatisfaction defined as the inability to fully enjoy sexual life. Those informal caregivers reported that they couldn't enjoy their sexual life because of patient's illness. One informal caregiver expressed that sometimes their intercourses were happening forcefully which was unwanted for both patient and caregiver.

Informal caregivers experienced burnout as they didn't have any co caregiver. Three informal caregivers noticed about this factor. Fear of loss of loving person was also found s a factor that led to burnout among informal caregivers. Fear of loss referred a feeling of distress or apprehension caused impending danger or pain. Informal caregivers were often felt fear that they might be loss their loving person because of non curable chronic illness.

Two informal caregivers mentioned about fate as a reason of their sufferings and burnout. Fate regarded as determined by supernatural power. So they believed that everything was happening in their life because of their fate or supernatural power.

Lack of scope for recreation have found as a contributory factor of burnout among informal caregivers. Recreation meant an activity of leisure, leisure being discretionary time. They needed to do something for recreation as an essential element of human biology and psychology. Informal caregivers were not getting time for recreation and were doing their daily monotonous work.

Informal caregivers were experiencing relatives' unwanted involvement in the care giving process. Involvement means concern or association. They have reported that their relatives' were involving without their concern.

On the other hand, relative's lack of involvement have also found as a contributory factor for an informal caregiver. When his patient diagnosed as cancer, each and every relative started to keep distance from the family even the patient's own parent and sibling. That caregiver was feeling so lonely that he had nobody to share his feelings. He thought that if he could get support from only one person for caring his wife, he could earn some money by working.

One informal caregiver was informing about lack of co operation while receiving care in hospital setting. That caregiver was asking about non cooperation from servant who was responsible for cleaning in the wards. The servants were not caring for the patients and the attendances.



**Figure 8:** Contributing factors of burnout among informal caregivers of patient with chronic physical illness

**Table 3.1.9:** Protective factors of burnout among formal caregivers of patient with chronic physical illness

<b>Protective factors</b>	<b>Content</b>	<b>Total</b>
Hope for patients recovery	Case 8, case 9, case 10 (one ill person will recover with my caring, this hope give me energy).	3/3
Dream job	Case 8, case 9, case 10 (from childhood, my dream was to do such a job where people will be served by me).	3/3
Coping strategies	Case 8 (sometimes I make some sharing with my friends and family, do some writings, do photography), case 9, case 10	3/3
Support from family	Case 8 (my father is a great inspiration for me. He tells me that “you are a doctor and you have to go long way”. He also tells that “you have to do something good and we are with your journey”. They give me mental support), case 9, case 10	3/3
Sense of responsibility	Case 9, case 10 (it’s my responsibility to take care herself).	2/3
Patients happiness	Case 8, case 10 (patient comes to us with severe illness and recover from treatment. Then I become mentally too much satisfied to see their mental satisfaction).	2/3
Good feedback from practice	Case 8, case 10 (when my knowledge of study and result of practice becomes same, I feel very happy. This is my inspiration and energy).	2/3
Financial support	Case 9 (I can support my family financially and others by providing information doing my job), case 10	2/3

Importance to others	Case 8 (though we doctors are frustrated for the educational system of our country, we are too much important person to our family, society, friends and even to the patients. When I get this importance feel better and inspired), case 9, case 10	2/3
Love for patient	Case 10 (I have already told you that I ask her grandmother and she also asks me as grandchild. I feel better when I see that she is well).	1/3
Religious belief	Case 9 (there are purity in care giving. First of all we are Christian, and secondly we seem to care giving as our religion.	1/3
Wish fulfillment	Case 10 (As I can't look after my grandmother, I think I am taking care of my grandmother while care giving).	1/3

Table 3.1.9 showed the protective factors of formal caregivers of patient with chronic physical illness. Here in some description on protective factors of formal caregivers of patient with chronic physical illness.

Dream job has found as a protective factor. From childhood their dream was to do such a job where people would get care from them. So, it was a great pleasure for them to do the job of caring patients.

Formal caregivers were using coping strategies which kept them serviceable. Coping strategies referred to the specific efforts, both behavioral and psychological, that they employed to master, tolerate, reduce or minimize stressful events. Their coping strategies were like sharing, doing photography, taking rest and doing some

pleasurable activity. Three formal caregivers used coping strategies to reduce their stress.

Formal caregivers reported about the support from their families. Family support was a set of relationship that strengthened the developmental journey with their families. Caregivers were getting support from their father, mother and husband which kept them potential to their care giving.

From the findings, sense of responsibility have found as a protective factor among formal caregivers. Sense of responsibility described as motivation to do their responsibilities or work.

Good feedback from practice also found as a protective factors among formal caregivers. Feedback was considered as knowledge of the result of any treatment which was influencing on their further modification or performance.

Formal caregivers very often were getting importance from others because of their profession which kept them strong and dedicated to their care giving.

One formal caregiver expressed that her love for patient was giving her energy to care more. Love was an intense feeling or affection towards patients.

Religious belief have found as a protective factor in a formal caregiver. Religious belief referred to attitude towards spiritual aspects of religion. Though religious belief and religious practice was different, but according to the caregiver, she was caring her patients meant she was maintaining her religion. Care giving was her religion.

One formal caregiver mentioned about her wish fulfillment as her protective factor. Wish was a feeling of wanting to do or have something. It was an act of thinking about something that she wanted. In the findings, caregiver's wish was to care her



own grandmother which was currently impossible. So, she was providing care to the patients and felt that she has been caring her grandmother.



**Figure 9:** Protective factors of burnout among formal caregivers of patients with chronic physical illness

**Table 3.1.10:** Protective factors of burnout among informal caregivers of patient with chronic physical illness

<b>Protective factors</b>	<b>Content</b>	<b>Total</b>
Coping strategies	Case 1 (When I feel bad my blood pressure become increase, then I take medicine, watering my head and then again do my work), case 4, case 5, case 6, case 7	5/7
Love for patient	Case 3 (Crying comes with deep stream. I am in too much pain mother, too much (crying). I never go anywhere leaving her for a single moment. I always stay with him), case 1, case 4, case 5	4/7
Hope for patients recovery	Case 1, case 2, case 3 (Energy comes from mind. This is my energy that my husband will recover with my caring. I have this energy. Allah manage this energy), case 6	4/7
Religious belief	Case 3, case 6, case 7, and case 5 (Actually our religion encourages me. Islam has described the benefit of caring parents. One day Jibrail(A:) pray, “to be destroyed those persons who got their parents alive in old age but couldn’t achieve heaven, caring their parents”. Amen. So, this hadis give me so much energy and I want to achieve heaven).	3/7
Sense of responsibility	Case 6 (All human being has their responsibilities as human being. My father had told me that “never do harm if you can’t do benefit to anybody”. As I have married her, total responsibility in going on me. When I married her, I promised that I will afford her all liability. Now I can’t	2/7

	leave her. I am doing my duty.	
Support from friends	Case 5 (Friends call me Haskurni of this era), case 7	2/7
Scope for sharing	Case 5, case 7 (I spend time with my friends, mix with people. For this I keep some time)	2/7
Scope for recreation	Case 5, case 7 (Actually I keep some time for my recreation within my daily work though people are astonished to see me that my child is so sick and I am so relax!)	2/7

Table 3.1.10 showed the protective factors of informal caregivers of patient with chronic physical illness. Here in some description on protective factors of informal caregivers of patient with chronic physical illness. Protective factors referred the factors that were mitigating burnout experience and kept caregivers efficient to their work.

Most of the informal caregivers were using coping strategies in stressful situation during care giving. Coping strategies were reducing their stress during care giving situation. Coping strategies were such as taking a break, watering head, taking medicine, sharing with friends.

Love for patient was found as a protective factor among informal caregivers. Love was a feeling of warm personal attachment or deep affection for their patients. Four caregivers told about love for their patient.

Informal caregivers were gaining spirit from the hope that their patient will recover with their care. Four informal caregivers have indicated about this factor. Hope was a

feeling of expectation and desire for a certain things to happen. In one caregiver, hope has found in a broken way.

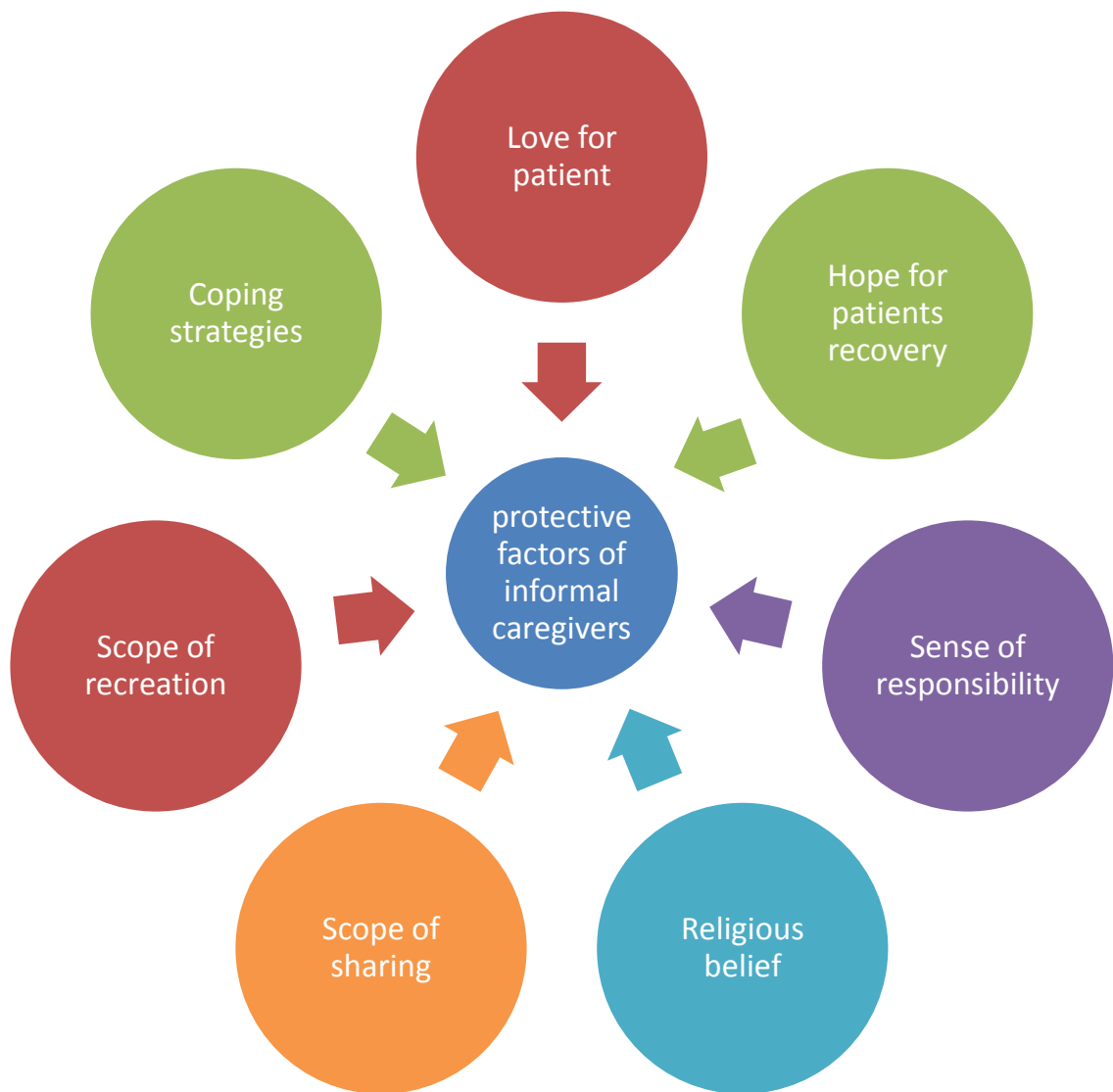
Religious belief has also found as a protective factor among three informal caregivers. Religious belief referred to attitude towards spiritual aspects of religion. They believed that it was a duty from religion to take care of ill patients.

Sense of responsibility has found as a protective factor among informal caregivers from the study findings. Sense of responsibility described as enthusiasm of them to do their farm duties or efforts.

Informal caregivers obtained supports from friends who made them competent to carry out their care giving and diminish burnout experience. Support meant helping someone emotionally or practical way.

Two informal caregivers told that their scope of sharing with friend and family were protecting them from burnout experience. Sharing referred to the term that they could express their feelings or experiences about caregiving difficulties with each other.

Two informal caregivers told that their scope of recreation was protecting them from burnout experience. Recreation referred to the activity done for enjoyment or doing something to relax or fun



**Figure 10:** Protective factors of burnout among informal caregivers of patient with chronic physical illness

## **CHAPTER IV**

### **DISCUSSION**

This study was conducted with the aim to assess the personal burnout, work burnout and client burnout among caregivers of patients with chronic physical illness and the factors related to burnout among caregivers. The study result indicated that a great number of caregivers of chronic physical illness were experiencing burnout in Bangladesh. As care giving was ongoing and routine work and chronic physical illnesses were non- curable, patients needed caregiving. So, caregivers have been paying more attention to the patients sacrificing their own need. As caregiving was a continuous process where stress was very common, so continuous stress of caregivers were turned in to burnout. This finding were similar with the study conducted by Gayen and Mozumder (2011) which found that considerable proportion of Bangladeshi Clinical Psychology service providers were burnt out in all three aspects (Gayen and Mozumder, 2011)). Another study by Deborah F Gelinas, Patricia O'Connor and Robert G Miller (1998) confirmed that Caregivers were heavily burdened and their outside activities were severely limited. (Table 3.1.1)

The second objective of the study was to assess burnout experience among caregivers of patients with asthma, diabetes, stroke, heart disease, cancer and dementia. Result showed that personal burnout and work burnout was higher among caregivers of patients with cancer. As cancer was a serious disease caused by cells that are not normal and that could spread to one or more parts of body. Cancer was considered as non curable disease in Bangladesh. Available treatments were also costly for most of them. Caregivers also were facing different types of difficulties during care giving while continuing treatment. Treatment procedure of cancer was long term which was

also painful for both patients and the caregivers. While constantly experiencing those situations, informal caregivers of cancer patients suffered from burnout. Ulrika and et al (2010) also found that considerable proportion of significant others related to patients with lung cancer affected by negative mental health (Ulrika & et al 2010). Study findings also showed that client burnout was higher among caregivers of diabetes. Diabetes was such a disease where patient needed to stay in regular follow up with doctor and regular checking of blood sugar at home. In most patients, insulin injection was essential with medicine regularly and they also needed to maintain a healthy life style. In Bangladesh, people are mostly aware about the treatment of diabetes but non compliant to maintain healthy life style specially while food intake. Caregivers of diabetes had to give their best effort for patients' compliance. That might play a vital role of higher number of client burnout. (Table 3.1.2)

The third objective was to assess comparison within male and female caregivers of patients with chronic physical illness and the present study showed that female caregiver's burnout rate was higher than male caregivers in three aspects of CBI. In Bangladesh, females are more responsible for caring their ill family members. Very often female person in a family is bounded to provide their care. Beside these, female persons have to play a multiple role in a family which become a burden for them. Sometimes they don't get any co caregiver to help them for their betterment as well as for the patient. In Bangladesh, male person also takes some responsibilities like providing money for treatment, emergency support while hospitalization, buying medicine etc. But female are more responsible for the daily routine work of patients, sacrificing their own need. These factors might be a vital cause of large number of female burnout. Gayen and Mozumder (2011) also found from their study that

females were higher among all three types of burnout as compared to male. (Table 3.1.3)

This study also indicated that informal caregivers have been experiencing from burnout more than formal caregivers. Informal caregivers spend most of the time with their patients for providing their care and helps in most of the daily work of the patients. On the other hand formal caregivers are responsible for providing their care in a certain period in hospital setting and they don't need to be too close with their patients like helping their daily work. Informal caregivers are more responsible to provide care to their patients. So, Informal caregivers are playing a critical role in health care service in Bangladesh. This study results are consistent with the study conducted by Hanaoka and Norton (2008) which reported that informal caregivers are the most common source of care provider, though formal caregiver is provided (Hanaoka & Norton,2008). Though, informal caregivers' burnout experience have been found as higher, formal caregivers' burnout rate also remarkable. This might caused by the poor hospital management system and lengthy educational system of medical in Bangladesh. Several studies showed the similar result that formal caregivers experience burnout less than the informal caregivers.

Formal caregiver's burnout rate has found as low than informal caregivers in the present study. But in Bangladesh, nursing profession is known as most stressful profession in health care service. Nurses experience burnout when they feel overwhelmed and unable to meet constant demands. In most cases, nurse burnout occurs from workplace stressors. When their stress continued, they began to lose their interest or motivation that led to take the role of burnout later. Some study indicated that working overtime was associated with nurse burnout (Sparks et al, 1997).



In the present study, most of the nurses and doctor participants as formal caregiver were from Govt. hospitals who were satisfied with their financial condition, benefits from organization and work environment. That might be a basis of a lesser amount of burnout among formal caregivers. Different findings have also been found from the study of Marie Dahlin and et al (2005). From their study, it has been found that medical students had higher depression rates than the general population. Another study suggests that burnout is more common among physicians than among other US workers (Tait D. Shanahfelt, 2012). The study of Kelly Fernanda Assis Tavares, Norma Valéria Dantas de Oliveira Souza, Lolita Dopico da Silva, Celia Caldeira Fonseca Kestenberg, (2014) also indicates that burnout syndrome is developing among nursing residents. Another study from Matthias C. Angermeyer and et. Al 2006, it has been found that Professional and nonprofessional caregivers face a similar degree of burden. (Table 3.1.4)

The study also indicated that caregivers who were providing their care for more than two months were experiencing high personal and work burnout. Caregivers who were providing their care for more than one year were experiencing high client burnout. It can be said that burnout experience is related with the duration of caregiving period. This result supports the definition of burnout that burnout comes from long term stress. (Table 3.1.5)

The present study revealed that caregivers who were spending time on caregiving more than twelve hours, burnout range was higher among them. It is easily understandable from the finding that caregiving drained emotionally to caregivers for spending more time with their patients. It may cause that caregivers don't get enough time to fulfill their own need even for their daily work. (Table 3.1.6)

From the light study findings it has shown that there were several factors to contribute burnout among caregivers of patients with chronic physical illness. That means multiple factors worked together for caregiver burnout rather than a single factor. It can be also said that for a single caregiver more than one factor were responsible for burnout. Some factors have found as common among formal and informal caregivers. Besides this, there are some factors which has found in one caregiver. Here in some discussion on these contributing factors.

*The committed son*

*Hassan (not actual name) was a 53 years old caregiver of demented mother. He was married, have two children and have been living with his parents from last 25 years for the purpose of caregiving. He was the only son of his parents who lived in Bangladesh. 25 years ago he had a good job and had better opportunities for the future. Once his mother became sick and gradually she needed care from others. As he was doing his job away from home, it became difficult for him to care for his mother. Hassan was very obedient, responsible, religious minded and lovely son of his mother. So he took the decision to leave his job to care for his mother properly staying with family. Then he came home and started a little business near his home and started to play his new role as a caregiver. Though his mother was suffering from dementia for five years, she was sick even before that and needed care for the last 25 years. So he was continuing his caregiving since then leaving his professional identity and bright career. He had no regret for losing his career. Very often he was facing some difficulties doing the responsible job as he had to be present whenever his mother wanted, he couldn't do his daily work regularly, he couldn't give his wife quality time and sometimes he felt irritated. He had some good friends who appreciated him for his noble work. Whenever he felt burdened, he remembered his Allah and hadith from Quran where it is clearly declared that "The person is unlucky who got their parents alive in old age but couldn't achieve heaven". To him it was a divine way to get heaven with providing care to his parents. His friends named him 'Haskurni' of this era. Supports from Hassan's friends and his religion provided him lots of liveliness to do that prime work and he was committed to achieve heaven.*

Lack of financial support, work overload, irregular daily activity and lack of support from management in hospital setting have found as common contributing factors among both formal and informal caregivers. Bangladesh is a developing country and people's average income isn't so high. In Bangladesh, financial discrepancy is also common among people. There are many people in this country who can't afford their daily needs but they have to pay a lot for their treatment which need special attention at health care services as well as to the Govt. Even the doctors who did not complete their post graduation and doing their job at private hospitals also face lack of financial support; moreover they have to support their family financially. Beside this, doctors have to continue their honorary degrees with their job which makes them conflicted and very often they become frustrated about their profession that affects the quality of service, as a doctor shared '*Will I fulfill my own financial need or my family's?*' Ana Bobinac, N. Job A. van Exel, Frans F.H. Rutten, Werner B.F. Brouwer (2010) found from their study that economical issue was related to the Dutch informal caregivers.

As caregiving is an assistance of an ill person who needs help with daily activities and it requires huge attention to the patients, caregivers become unable to manage time to their own daily activity in regular time basis. That means caregivers become exhausted because of their frequent irregular daily activity and mismanagement of their time; as a wife shared, '*I can't run with time and I'm tired*'. Hospital management is a system that establishes systematic method of managing hospital where both in patients and out patients are able to get support effectively and efficiently. But in here, caregivers highlighted about lack of support in hospital setting by which both patients and caregivers suffers a lot. A wife shared that '*We are patient here but stuffs don't behave well with us*'. Caregivers reported that patients get lots of hardship in every stage while receiving treatment at hospital. These lacks of support

increases their emotional vulnerability and make them feel worse about the system. The study of S. M. Bruce (2005) highlights the presence of significant workplace difficulties for physicians and need to develop a preventive support system for the protection of physicians and the patients in their care.

Doctor also reported about the educational system in medical which is related to the care giving system. The educational system of medical is too lengthy that they become frustrated for that which affects their care giving system and related to burnout. Negative thoughts are also related with the lengthy educational system of medical. According to the formal caregivers, patients want to fulfill their mental satisfaction with their main treatment. But in Bangladesh there is no system to fulfill their mental satisfaction with their main treatment. It was described as over expectation from patients. Formal caregivers have to be too busy and they have to provide caregiving among more patients within fixed time which is not enough for the patients. It can be expressed in other way that, patients rate is high than caregivers in a hospital. So, formal caregivers are bound to provide caring as much as possible within their time and then patients turned into dissatisfied with treatment and care. But it is most important to fulfill patients' mental satisfaction. If patients become satisfied with the treatment, caregivers will be also satisfied; this will keep them mentally healthy. Informal caregivers also reported about non empathic hospital management such as a doctor shared, '*Patients suffer hardship in every stage of management in hospital which they express with us*'. They reported that fourth class employees don't cooperate with them cleaning ward and misbehave with them. Informal caregivers are already overwhelmed with their emotion about the patient and disease, this type of behavior from hospital staffs make them more helpless. In hospital setting, attendances are used to come with the patient. Sometimes, attendances' show their

power and dignity to the formal caregivers. They think that showing their power, they will get best medical support than they could. This type of attitude from attendance makes formal caregivers embarrassed. Formal caregivers think that every patient is equal to them and the perception of equality will be helpful for patients. But it becomes very difficult to make them understand the fact. This type of situation takes more time to make them understand about the fact caregivers where they could serve more patients while this time, such as doctor shared '*It's too much difficult to deal with them and it's very time consuming also*'. So, these types of stressful situations like patients' over expectation, non cooperation from attendance, non empathic hospital management happen very often. As a result, constant stressful situation lead to burnout among formal and informal caregivers. Formal caregivers also experiences lack of co operation from their colleagues. Such as doctor shared, '*Colleagues might be more cooperative*'. This non cooperation is also associated with burnout among formal caregivers. Besides this, formal caregivers mentioned that very often they can't maintain their social life like attending family programs, friends' marriage ceremony, social gathering etc. Every person needs to maintain social bonding and connections but they couldn't do that for their responsible profession. As a result, their social life becomes limited and they feel disconnected from society which leads their burnout experience.

Informal caregivers' highlights that their worry about patient and disease is associated with their burnout experience such as a wife was crying and shared, '*What will happen with my dearest husband!*' Most of the families in Bangladesh are joint family. People like to live together so that they can exchange love and care within family and get support when needed. So, living together, people become more attached emotionally with their family members. In that case, when a person in a

family become ill chronically, other family members worried about the outcome of disease and gets feared about loss of their loving person. In Bangladesh, not only family members but also relatives and neighbors are attached with each other and relatives and neighbors become worried and used to stay connected with the ill person's family. Sometimes relatives also involved with providing care and assistance which is very important in the context of Bangladeshi health care service.

Different findings have found about relatives which is related to care giving process. One informal caregiver reported that his relatives especially his uncle interferes while taking any decision about treatment which was unwanted for the caregiver as he shared that, *'Uncle thinks Doctors don't know everything; and he takes all decisions where I had to control my anger towards him'*. That situation was stressed him because his uncle constantly interferes negatively and he couldn't express his feeling as his uncle was elder than him. It is also a cultural issue that a younger person can't be assertive to the elder family member or relatives. So, this caregiver suppressed his emotion constantly which led to anger and stress.

On the other hand, lack of relative's involvement has found as a contributory factor in one informal caregiver, as a husband shared, *'When my wife diagnosed as cancer, all our nearest disconnected from us, may be they think that they have to help us financially'*. This caregiver was only person to provide care his wife with cancer. He had to leave his work for the care giving and he was not getting any support from his own family or from in laws though his wife was only daughter of her parents and her brothers were too rich to help financially. But when the patient diagnosed as cancer, in laws family disconnected relation with them to avoid any type of help. Even the caregiver's own brothers and sisters were also started to avoid the family. Relatives'

involvement in health care service might be an issue of further study in the context of Bangladesh.

Informal caregivers were facing difficulties during care giving. Patients' who were suffering from chronic illness, most of the time they need help in variety of tasks such as cooking, cleaning, providing companionship, assist in taking medication, bathing, toileting, dressing, shopping and taking to the doctor even hospitalization if needed. All these work are not so easy to do for a caregiver. Caregivers couldn't take food after cleaning vomiting, can't sleep in night as patient cry for pain. A husband has told, '*usually wives are responsible for doing household works but now I am bound to do these types of work which is unexpected*'. He expected that his wife will cook food, ready food for him, wash his dress but the current situation is totally different. A son has reported that his mother keep him busy for less important work. A wife has report that she had to fulfill her husband's any type of demand whenever he need. These difficulties are very closely related to burnout among caregivers. Even, in most cases caregivers don't have any co caregiver. Lack of co caregiver has found as a contributing factor among caregivers. It's really difficult for a person to play so many roles in together.

Sense of over responsibility has found to be a contributory factor of burnout among caregivers which is similar with the study of Doumit, Myrna A. A., Huijer, Huda Abu-Saad, Kelley, Jane H. Nassar, & Nada (2008), where feeling of added responsibility has found as related with difficult experience among family caregivers. Sense of over responsibility means caregivers take responsibilities for the choice of others, compromise their own feelings and feel bound to provide care and assistance. A wife thinks that, '*as he is my husband, I am bound to provide care*'. Eleanor Palo Stoller and Karen L Pugliesi (1988) also found same result from their study that a

large time commitment contributes to burden. In Bangladeshi culture wives are responsible to care their husband. It is negatively perceived by the society if any wife ignore or care less her husband.

Sexual dissatisfaction found as an important factor that was related to burnout. Caregivers have to sacrifice their sexual life like hobbies or other recreational activities. Basically the patients, who are chronically ill, suffer from fatigue, low energy, irritable mood and their treatment such as radiation therapy, chemotherapy and a cocktail of medication may also lead to low energy. This incapability of patient suffers their spouses a lot. A wife mentioned that, *'See, as a human being I have sexual need but my husband never ask me for full intercourse, but he used to touch my body parts which makes me more unhappy'*. She also expressed that, *'I can never do sex with someone else to make me satisfied because of the society'*. A husband has reported that, *'I can't manage time for sex because I have to be busy with taking care of my mother'*. Sex life is important for good mental health and marital life. It become as a stress when caregivers can't fulfill their sexual need. Continuous unhealthy sexual might lead to burnout among caregivers. But research from the sociology department at Georgia State University suggests that about 15% of married couple have not had sex with their spouse in the past six months to one year. Besides these factors one informal caregiver reported about fate which was responsible for her sufferings and burnout. People are used to believe in fate after happening something unexpected and undesirable. Sometimes it may help as coping strategy. (Table 3.1.7 and table 3.1.8)

Some protective factors have found since the study findings. Caregiving is so crucial role that they have to continue their caring with their physical, psychological or any other problem. So, to maintain this caregiving role as efficient, they use coping



strategies very often. Caregivers' coping strategies differ from each other. Someone take rest and get back for caregiving, someone does photography, someone keep patience, someone get a little break and goes outside of home and then come back for the responsible duty. These coping strategies keep them steady for their caregiving though they are suffering from burnout. It's very difficult for the caregivers to provide caregiving with burnt out. Actually caregivers get support from their coping strategies.

Hope for patient's recovery has found as a protective factor. Caregivers keep hope and think that their patient will recover from their caregiving. Hope is a key element of caregiving in case of family caregiving. Hope can be expressed as behavior, feeling and as a way of thinking. Here in caregivers reported their feeling and thinking as hope for patient's recovery. Among the caregivers, a husband's hope has found as broken way. As he shared, *'I am doing my duty with a hope that she will be recovered one day'*. As hope is contributed to quality of life and involves relatedness with others, caregivers with cancer patient were going through very difficult situations. They were not getting enough support from others and they were experiencing lower quality of life. So, there is a significant chance to loss their hope. This result is similar with the study of Tami & et al (2002).

Doctor and nurses reported, *'it was my dream from childhood to such a job where people will be served by mine'*. Dream job can be defined with sum of different aspects related to work, life and personality. Here, dream is not about during sleep but it is an idea or emotion about their profession in future life. This care giving profession is also perceived as a respected job by them. In Bangladesh, when a child is growing up, parents decide what would be his or her profession in future. Most often, parents' want their child would be a doctor because of the societal perception

about this profession. Among the participants, two caregiver's dream was built by their parents and the society and one caregiver's dream was built by herself. So, the societal perception and their childhood dream give them energy and keep them healthy while care giving. Further research might be done on why people think so. Formal caregivers get importance from other which has also found as a protective factor from the present study. Usually while getting hospitalized treatment, patients feel helpless and need support from doctors and nurses. Then they become dependent on them. This dependency might make them important to the patients. Besides this, when people face any type of physical problem seek help from nearest familiar doctor or nurse for better information about treatment. People get better information and caregivers get importance. Wish fulfillment was also associated with these protective factors where formal caregivers fulfill their wish to serve helpless or ill patients.

While doing the responsible job, formal caregivers need supports from their surroundings and some caregivers were getting support from their friends and family. Study of [Mary P. Gallant](#) (2003) shows the same result with the present study that formal and informal caregivers get support from their family and friends which give them energy to play the vital role of care giving. As an example, father of a doctor told him that "*I am with you to support you. So, do your work carefully*". Support from family and friends can be said as social support which plays a crucial role in caregiver's ability to make healthier choices. These supports during a stressful situation have a positive emotional effect on caregivers. During stressful time caregivers tend to experience different types of physical and psychological difficulties. However, the support from friends and family during difficult period provide some comfort.

The most important thing is to have a sense of responsibility or concern for a patient during caregiving. Sense of responsibility have found as a protective factor among both formal and informal caregivers. As a nurse shared, *'It's my duty to care my patient'*. Different findings has found from the study of Eleanor Palo Stoller and Karen L Pugliesi (1988). Results indicated that when caregiving involves a large time commitment, do contribute to burden.

One of the important factors that energize the caregivers is love for patient. This factor has found among both formal and informal caregivers. One wife caregiver was describing about the relation with her husband. Their relationship was so full of love within whole life. She couldn't be able to giving her interview properly as her husband was alone in bed without her. She was tearful most of the interview time. That means caregivers feel closer and connected with their patients. This feelings gives them confidence and make them more competent. It also gives inspiration and strength for caregiving. Different findings has found from the study of Kyoko Fujiwara & et al (2003), where conflict with clients and their families significantly related to emotional exhaustion and depersonalization. Related to love for patients, there have been found another protective factor that was patients' happiness which makes the caregivers fulfill. There is a positive effect of patients' satisfaction in healthcare service. Caregivers of the present study reported that when patient smiles after recovering from disease, they forget every pain and energized more to do their work effectively. Good feedback from practice has also found as protective factor among formal caregivers. As a doctor has told *"I feel very happy when I do my study and get similar result from practice"*.

The protective factor religious belief is similar with the study of Doumit et al (2008), where reliance on God was related to the family caregivers. Both formal and informal

caregivers keep belief on God which has found in the present study. In the present study caregivers were from Islam and Christian religion and both religions ask for caring. Their religious belief was so strong that they were getting too much energy from their belief as a nurse shared, '*Caring is our religion*'.

Caregivers also reported that their scope for sharing and scope for recreation energize them and protect them from burnout. These are very important skills for caregivers. Getting some break from caregiving can improve the quality of caregiving which is important for both patients and caregivers. The study of Eleanor Palo Stoller and Karen L Pugliesi (1988) also established that roles outside the family are associated with improved caregiver well-being. (Table 3.1.9 and table 3.1.10).

Mother Teresa said, "It is not how much we do, but how much love we put into doing it. It is not how much we give, but how much love we put into the giving."

The present study has the implications on the mental health of caregivers of patients with chronic physical illness. The knowledge of the study can be used for all caregivers of any types of disease for awareness. Researchers will also be helpful to conduct their further research on burnout.

It can be concluded that the present study found as burnout is real and has risk in healthcare service. Caregivers think that they should pay attention on everyone's need before their needs. But this thinking is unhealthy for both caregivers and patients. Caregivers should be aware about their own needs and feelings and also keep in mind that burnout is common among them. So the caregivers deserve special attention for their health. Special attention towards caregivers will be helpful for both patients and caregivers. For this further research is recommended on burnout management among

caregivers of patient with chronic physical illness. It is also recommended to conduct further research minimizing limitations of the present study; there are so many chronic diseases but the study included only six chronic diseases and systematic sampling technique was not applied in the study.

Here some recommendations for caregivers to keep them healthy for their significant work:

- Focus on why you are suffering from burnout
- Take a good vacation or leave of absence
- Practice positive thinking
- Clear your role
- Letting go of guilt
- Spent time with friends or involve with social activity
- Employ personal strategies to avoid or cope with burnout.
- Balance your life style
- Build positive social support
- Control negativity in your environment
- Be assertive
- Identify people, place and activities that make you feel good. Stay away from relationships that drain you
- Talk with yourself

Caregivers can practice the following techniques to prevent them from burnout:

- Start your day with relaxation
- Adopt healthy eating, exercise and sleeping habit

- Take a daily break from technology
- Nourish your creativity
- Manage your every stress
- Manage your time better
- Do something you enjoy every day
- Indulge yourself (doing something pleasurable after a long pressure or difficult work. You can indulge yourself with ice cream, chocolate, sharing with friends, taking a body massage, taking a nice aroma bath, perfume room with freshener, decorate your room with flowers, play a song you love, spending time with partner or children or pet, grow a garden which may small

Being helpful to others delivers immense pleasure and can help to reduce stress as well as broaden your social circle. While it's important not to take on too much when you're facing burnout, helping others doesn't have to involve a lot of time or effort. Even small thing like a kind word or friendly smile can help lower stress for you and the other person.

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## Appendix I

### অংশগ্রহণকারীর তথ্য সংগ্রহের সম্মতিপত্র

আমি (মোছাঃ শম্পা) ঢাকা বিশ্ববিদ্যালয়ের চিকিৎসা মনোবিজ্ঞান বিভাগের এম. ফিল, ২য় বর্ষের একজন গবেষক। দীর্ঘমেয়াদী শারীরিক রোগে ভুগছেন এমন রোগীদের যারা দেখাশোনা করছেন তাদের উপর একটি গবেষণা করছি। আমার গবেষণার তত্ত্বাবধায়ক সহযোগী অধ্যাপক কামাল উদ্দিন আহমেদ চৌধুরী। আমার গবেষণায় আপনার সহযোগিতা খুবই প্রয়োজন। আপনি চাইলে গবেষণায় অংশগ্রহণ নাও করতে পারেন। তবে আপনার প্রদান করা তথ্যের মাধ্যমে যে গবেষণা করা হবে তা থেকে জানা যাবে যে রোগীর যত্নকারীরা বার্ন - আউট ( এক ধরনের মানসিক সমস্যা) এ ভুগছেন কি না বা কি কি কারণে এই সমস্যায় ভুগছেন। আপনার প্রদান করা সকল তথ্য গোপন থাকবে এবং গবেষণা ছাড়া অন্য কোনও কাজে ব্যবহার করা হবে না। এই গবেষণায় আপনার কোন প্রকার ক্ষতি হবে না সে বিষয়ে আমি প্রতিজ্ঞা করছি।

যদি তথ্য প্রদান করতে আপনার কোন আপত্তি না থাকে তবে নিচে সম্মতি সূচক স্বাক্ষর করুন।

আপনার সহযোগিতার জন্য ধন্যবাদ।

অংশগ্রহণকারীর সম্মতিসূচক স্বাক্ষর.....

## Appendix II

তথ্য সংগ্রহের অনুমতিপত্র

বরাবর

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.....

মাধ্যমঃ চেয়ারম্যান, চিকিৎসা মনোবিজ্ঞান বিভাগ, ঢাকা বিশ্ববিদ্যালয় ।

বিষয়ঃ এম.ফিল গবেষণার তথ্য সংগ্রহের অনুমতি প্রসঙ্গে ।

জনাব,

আপনার অবগতির জন্য জানাচ্ছি যে, আমি মোছাঃ শম্পা, ঢাকা বিশ্ববিদ্যালয়ের চিকিৎসা মনোবিজ্ঞান বিভাগের একজন এম.ফিল গবেষক । আমার গবেষণার শিরোনাম “ Burnout among Caregivers of Patients with Chronic Physical Illness”. আমার গবেষণার জন্য আপনার প্রতিষ্ঠানে কর্মরত চিকিৎসক, নার্স এবং রোগীর কেয়ারগিভারদের থেকে তথ্য সংগ্রহ করা প্রয়োজন ।

অতএব, আমাকে গবেষণার তথ্য সংগ্রহ করার সুযোগ দিয়ে বাধিত করবেন ।

নিবেদক

মোছাঃ শম্পা

এম.ফিল (২য় বর্ষ)

চিকিৎসা মনোবিজ্ঞান বিভাগ

ঢাকা বিশ্ববিদ্যালয়

তত্ত্বাবধায়ক

কামাল উদ্দিন আহমেদ চৌধুরী

সহযোগী অধ্যাপক

চিকিৎসা মনোবিজ্ঞান বিভাগ

ঢাকা বিশ্ববিদ্যালয়

## Appendix III

## **LIST OF HOSPITALS**

NIDCH: National Institute of Chest Disease and Hospital

BIRDEMH: BIRDEM Hospital

NICRH: National Institute of Cancer Research and Hospital

NHFB: National Heart Foundation of Bangladesh

SWBF: Sir William Beveridge Foundation

## Appendix IV

### Demographic information's of the caregiver

১. আপনার নামঃ
২. মোবাইল নাম্বারঃ
৩. বয়সঃ
৪. মহিলা/ পুরুষঃ
৫. বৈবাহিক অবস্থাঃ ক) বিবাহিত খ) অবিবাহিত গ) বিবাহ বিচ্ছেদ ঘ) বিধবা/ বিপত্তিক
৬. শিক্ষাগত যোগ্যতাঃ ক) এস এস সি এর নিচে খ) এস এস সি-এইচ এস সি গ) স্নাতক স্নাতকোত্তর ঘ) উচ্চতর ডিগ্রী
৭. পেশাঃ ক) শিক্ষার্থী খ) গৃহিণী গ) বেকার ঘ) চাকুরীজীবী উ) ব্যবসা ছ) শ্রমজীবী জ) অন্যান্য
৮. মাসিক আয়ঃ ক) ১০০০০ খ) ১০০০০-২০০০০ গ) ২০০০০০-৪০০০০০ ঘ) ৪০০০০০ এর উপরে
৯. পরিবারের সদস্য সংখ্যাঃ
১০. রোগীর সাথে সম্পর্কঃ
১১. প্রতিদিন রোগীর সাথে কত সময় ব্যয় করেনঃ
১২. রোগীর নামঃ
১৩. রোগীর বয়সঃ
১৪. রোগীর বৈবাহিক অবস্থাঃ ক) বিবাহিত খ) অবিবাহিত গ) বিবাহ বিচ্ছেদ ঘ) বিধবা/ বিপত্তিক
১৫. রোগীর শিক্ষাগত যোগ্যতাঃ ক) এস এস সি এর নিচে খ) এস এস সি-এইচ এস সি গ) স্নাতক স্নাতকোত্তর ঘ) উচ্চতর ডিগ্রী
১৬. রোগীর পেশাঃ ক) শিক্ষার্থী খ) গৃহিণী গ) বেকার ঘ) চাকুরীজীবী উ) ব্যবসা ছ) শ্রমজীবী জ) অন্যান্য
১৭. রোগীর মাসিক আয়ঃ ক) ১০০০০ খ) ১০০০০-২০০০০ গ) ২০০০০০-৪০০০০০ ঘ) ৪০০০০০ এর উপরে
১৮. আপনার রোগী কি রোগে ভুগছেনঃ
১৯. কতদিন ধরে এই রোগে ভুগছেনঃ
২০. রোগী কি কোন ধরনের মানসিক সমস্যায় ভুগছেন?
২১. বর্তমানে কোন হাসপাতালে চিকিৎসা করাচ্ছেন?/ হাসপাতালের নাম ও অবস্থানঃ
২২. ইনডোর / আউটডোর
২৩. আপনি কতদিন ধরে রোগীকে দেখাশোনা করছেনঃ
২৪. আর কে / কারা রোগীর দেখাশোনা করেনঃ
২৫. রোগীর কোন কোন কাজে আপনি সহযোগিতা করেনঃ

## Appendix V

### বার্ন-আউট বিষয়ক প্রশ্নমালা

নিচের বিবৃতিগুলো পড়ে গত এক সপ্তাহের মধ্যে এই বিবৃতিগুলো আপনার ক্ষেত্রে কতটা প্রযোজ্য তা বিবৃতির পাশের সম্ভাব্য পাঁচটি উত্তরের যেটি প্রযোজ্য সেটির ঘরে (✓) চিহ্ন দিয়ে নির্দেশ করুন। আপনাকে সম্ভাব্য এই পাঁচটি উত্তর থেকে যে কোন একটিকে বেছে নিতে হবে এবং সবগুলো প্রশ্নের উত্তর দিতে হবে। অনুগ্রহ করে লক্ষ্য করুন সবগুলো উত্তর দিয়েছেন কি না।

প্রথম অংশঃ ব্যক্তিগত বার্ন আউট						
সংজ্ঞাঃ ব্যক্তিগত বার্ন আউট হচ্ছে দীর্ঘকালীন শারীরিক ও মানসিক অবসাদস্ফূর্ত্ত অবস্থা।						
প্রশ্নমালাঃ						
১। কতো ঘন ঘন আপনি ক্লান্তি বোধ করেন?	সবসময়	প্রায়ই	মাঝে-মাঝে	কদাচিৎ	কখনো নয়/ প্রায় কখনো নয়	
২। কতো ঘন ঘন আপনি শারীরিকভাবে অবসাদস্ফূর্ত্ত হয়ে পরেন?	সবসময়	প্রায়ই	মাঝে-মাঝে	কদাচিৎ	কখনো নয়/ প্রায় কখনো নয়	
৩। কতো ঘন ঘন আপনি আবেগীয়ভাবে অবসাদস্ফূর্ত্ত হয়ে পরেন?	সবসময়	প্রায়ই	মাঝে-মাঝে	কদাচিৎ	কখনো নয়/ প্রায় কখনো নয়	
৪। কতো ঘন ঘন আপনি ভাবেনঃ “আমি আর পারছি না”?	সবসময়	প্রায়ই	মাঝে-মাঝে	কদাচিৎ	কখনো নয়/ প্রায় কখনো নয়	
৫। কতো ঘন ঘন আপনি নিঃশেষিত বোধ করেন?	সবসময়	প্রায়ই	মাঝে-মাঝে	কদাচিৎ	কখনো নয়/ প্রায় কখনো নয়	
৬। কতো ঘন ঘন আপনি দুর্বল বোধ করেন এবং অসুস্থ হয়ে পরবেন বলে মনে করেন?	সবসময়	প্রায়ই	মাঝে-মাঝে	কদাচিৎ	কখনো নয়/ প্রায় কখনো নয়	
দ্বিতীয় অংশঃ পেশাগত বার্ন-আউট						
সংজ্ঞাঃ দীর্ঘকালীন শারীরিক ও মানসিক অবসাদস্ফূর্ত্ততা যা পেশাগত কাজের সাথে সংশ্লিষ্ট বলে ব্যক্তি মনে করেন						
প্রশ্নমালাঃ						
১। আপনার কাজ কি আপনাকে আবেগীয়ভাবে অবসাদস্ফূর্ত্ত করে তোলে?	খুব বেশী মাত্রায়	বেশী মাত্রায়	কিছুটা	কম মাত্রায়	খুব কম মাত্রায়	
২। আপনার কাজের কারণে আপনি কি “বার্ন-আউট” বোধ করেন?	খুব বেশী মাত্রায়	বেশী মাত্রায়	কিছুটা	কম মাত্রায়	খুব কম মাত্রায়	
৩। আপনার কাজ কি আপনাকে হতাশ করে?	খুব বেশী মাত্রায়	বেশী মাত্রায়	কিছুটা	কম মাত্রায়	খুব কম মাত্রায়	
৪। কর্মদিবসের শেষে আপনি কি নিঃশেষিত বোধ করেন?	সবসময়	প্রায়ই	মাঝে-মাঝে	কদাচিৎ	কখনো নয়/প্রায় কখনো নয়	
৫। দিনের শুরুতে আরেকটি কর্মদিবসের কথা ভেবে আপনি কি অবসাদস্ফূর্ত্ত হন?	সবসময়	প্রায়ই	মাঝে-মাঝে	কদাচিৎ	কখনো নয়/প্রায় কখনো নয়	
৬। আপনি কি এমন অনুভব করেন যে প্রতিটি কর্মঘণ্টা আপনার জন্য ক্লান্তিকর?	সবসময়	প্রায়ই	মাঝে-মাঝে	কদাচিৎ	কখনো নয়/প্রায় কখনো নয়	
৭। অবসর সময়ে পরিবার ও বন্ধুদের সঙ্গ দেবার মতো যথেষ্ট প্রাণশক্তি কি আপনার থাকে?	সবসময়	প্রায়ই	মাঝে-মাঝে	কদাচিৎ	কখনো নয়/প্রায় কখনো নয়	
তৃতীয় অংশঃ ক্লায়েন্ট বার্ন-আউট						
সংজ্ঞাঃ দীর্ঘকালীন শারীরিক ও মানসিক অবসাদস্ফূর্ত্ততা যা ক্লায়েন্টদের * সাথে কাজ করার ফলে হয়						

বলে ব্যক্তি মনে করেন। (* ক্লায়েন্ট হতে পারেঃ রোগী, ছাত্র, শিশু, কারাবন্দী অথবা যেকোন সেবাপ্রার্থী)						
১। ক্লায়েন্টদের সাথে কাজ করতে কি আপনার কষ্ট হয়?	খুব বেশী মাত্রায়	বেশী মাত্রায়	কিছুটা	কম মাত্রায়	খুব মাত্রায়	কম
২। ক্লায়েন্টদের সাথে কাজ করতে কি আপনার হতাশ লাগে?	খুব বেশী মাত্রায়	বেশী মাত্রায়	কিছুটা	কম মাত্রায়	খুব মাত্রায়	কম
৩। ক্লায়েন্টদের সাথে কাজ করে কি আপনার শক্তির অপচয় হয়?	খুব বেশী মাত্রায়	বেশী মাত্রায়	কিছুটা	কম মাত্রায়	খুব মাত্রায়	কম
৪। আপনার কি এই অনুভূতি হয় যে ক্লায়েন্টদের সাথে কাজে আপনি যা পান তার চেয়ে বেশী দিয়ে দেন?	খুব বেশী মাত্রায়	বেশী মাত্রায়	কিছুটা	কম মাত্রায়	খুব মাত্রায়	কম
৫। ক্লায়েন্টদের সাথে কাজ করে কি আপনি ক্লান্ত?	সবসময়	প্রায়ই	মাঝে-মাঝে	কদাচিৎ	কখনো নয়/প্রায় কখনো নয়	নয়
৬। কতকাল আর ক্লায়েন্টদের সাথে কাজ চালিয়ে যেতে সক্ষম হবেন- এরকম ভাবনা কি মাঝে মাঝে আপনার হয়?	সবসময়	প্রায়ই	মাঝে-মাঝে	কদাচিৎ	কখনো নয়/প্রায় কখনো নয়	নয়

**Appendix VI**  
**Topic guide for case study**

**Title:** Burnout among caregivers of patient with chronic physical illness

**Objective:**

- To explore contributing factors and protective factors of Burnout experience of caregivers

Area	Questions
Relationship	রোগীর সাথে আপনার সম্পর্ক কি?
Duration of care giving	আপনি কতদিন ধরে রোগীর দেখাশোনা করছেন?
Spend time for care giving	প্রতিদিন রোগীর সাথে কত সময় ব্যয় করেন?
Knowledge about the disease	রোগী কি রোগে ভুগছেন? এই রোগ সম্পর্কে আপনার ধারণা কি ?
Role of caregiver	রোগীর কোন কোন কাজে আপনি সাহায্য করেন?
Challenges / problem for care giving	এই কাজগুলো করতে গিয়ে আপনি কি ধরনের সমস্যার সম্মুখীন হন ? ক) রোগীর দিক থেকে কি ধরনের সমস্যার সম্মুখীন হন? খ) ব্যক্তিগত দিক দিয়ে কি ধরনের সমস্যার সম্মুখীন হন? গ) প্রতিষ্ঠানের দিক থেকে কি ধরনের সমস্যার সম্মুখীন হন? ঘ) পারিপার্শ্বিক দিক থেকে কি ধরনের সমস্যার সম্মুখীন হন?
Feelings and cause	এই কাজগুলো করতে আপনার কেমন লাগে? ক) শারীরিক ভাবে কেমন লাগে? কেন এমন লাগে বলে আপনি মনে করেন? খ) আবেগিক ভাবে কেমন লাগে? কেন এমন লাগে বলে আপনি মনে করেন? গ) আপনার কই ধরনের চিন্তা হয়? কেন এমন হয় বলে আপনি মনে করেন? ঘ) আপনি কই ধরনের আচরণ করেন? কেন এমন করেন বলে আপনি মনে করেন?
Protective factors	এই কাজগুলি করতে কোন বিষয়গুলি আপনাকে সাহায্য করে/ কোন বিষয়গুলি আপনাকে শক্তি দেয় ?
Coping skills	এই কাজগুলি করতে গিয়ে কোনও সমস্যার সম্মুখীন হলে কি করেন?