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Stigma Surrounding Burnout and Mental Health Issues among Healthcare Workers in Pakistan

Madeeha Malik[1]*, Hamza Saeed[2], Azhar Hussain[3], Ayisha Hashmi[1]

[1]Cyntax Health Projects, Contract Research Organization (CRO) & Corporate Firm, Islamabad, Pakistan.
[2]Hamdard Institute of Pharmaceutical Sciences, Hamdard University Islamabad, Pakistan.
[3]Department of Pharmaceutical Sciences, Pak-Austria Fachhochschule: Institute of Applied Sciences and Technology, Haripur, Pakistan.

***E-mail** ✉ Madeehamalik19@gmail.com

Abstract

Burnout and mental health disorders are widely recognized as important factors in the global health crisis. This study aimed to investigate the stigma associated with burnout and mental health conditions among healthcare providers in Pakistan. A descriptive cross-sectional design was used for the study. To assess burnout, the Maslach Burnout Inventory (MBI) was used, while anxiety symptoms were assessed with the Generalized Anxiety Disorder Scale (GAD-7), and the severity of work-related depressive symptoms was evaluated using the Occupational Depression Inventory (ODI). The sample consisted of 382 healthcare professionals, and data analysis was performed using SPSS version 21. Spearman's correlation was used to examine the relationship between dimensions of burnout and occupational depression. The findings showed that there was no significant difference in MBI scores across different demographic groups. A weak positive correlation was observed between burnout and occupational depression. All dimensions of burnout were found to be intercorrelated. The study concluded that healthcare workers experience considerable burnout, along with mild anxiety and moderate occupational depression. Males showed higher levels of generalized anxiety compared to females. Higher rates of occupational depression were observed among male workers, those with over 20 years of experience, and professionals employed in nursing and community pharmacy roles.

Keywords: Pakistan, Burnout, Healthcare professionals, Mental illness

Introduction

Burnout is described by the International Classification of Diseases (ICD-11) as "a syndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed." It is characterized by (i) feelings of physical or mental exhaustion, (ii) increasing emotional detachment from one's job, (iii) negative or cynical attitudes toward the profession, and (iv) a decrease in professional efficacy. It is considered an occupational phenomenon rather than a medical condition [1]. Despite global efforts to address the issue, mental illness remains heavily stigmatized due to pervasive negative stereotypes in society [2]. Various initiatives have focused on altering healthcare providers' attitudes toward mental illness, as they often hold the same prejudices as the general public. This perpetuates the stigma, discourages individuals from seeking help, and creates a culture in the medical field where future professionals adopt similar views [3]. The stigma surrounding mental illness represents a significant barrier to effective treatment [4, 5]. The stigma is primarily composed of discrimination, misunderstanding, and harmful judgments [6].

The stigma associated with mental illness can obstruct access to opportunities and deny individuals equal rights

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within society [7]. It can also hinder campaigns advocating for mental health treatment, resulting in fewer people seeking care, with many remaining undiagnosed. This not only impacts the quality of life but also adds to the burden on both the individual and the community [8]. While healthcare providers are typically viewed as compassionate and supportive, this is not always the case, and sometimes the healthcare system itself contributes to the stigma in certain settings [9].

Mental health disorders are often linked to burnout among professionals. A study in Japan explored the relationship between burnout and the stigma associated with mental illness, revealing that mental illness stigma, burnout, and occupational stress are negatively correlated. Consequently, efforts must be made to reduce stigma to prevent burnout from developing [10]. Research in the United States and Lithuania found higher levels of burnout among American professionals compared to their Lithuanian counterparts, who were found to be more adaptable and resilient in challenging work environments [11]. A qualitative study in Ghana revealed that primary healthcare workers commonly experience job-related stress and burnout, factors that contribute to high staff turnover and dissatisfaction among both patients and providers [12]. A study in France investigated the link between borderline personality disorder, depression, and burnout, finding that burnout in women was related to the “affective insecurity” and “impulsivity” aspects of borderline personality disorder [13]. In Bahrain, a study examined the connection between mental illness stigma and evidence-based care, demonstrating that healthcare professionals who supported evidence-based practices were less likely to harbor stigma against patients with mental illness [14].

In recent years, the World Health Organization (WHO) has recognized burnout as an official syndrome resulting from long-term stress in the workplace, impacting nearly 25% of the global workforce [15]. Mental illness, particularly depression, affects approximately 264 million people worldwide, with 76% to 85% of individuals in low- and middle-income countries not receiving treatment. In the United States, burnout alone leads to annual losses between $125 billion and $190 billion [16]. In Pakistan, the prevalence of mental health disorders is on the rise, yet due to the social stigma surrounding mental illness, many cases remain undiagnosed. The growing workload on healthcare professionals negatively impacts their productivity and increases the risk of burnout, while the stigma surrounding mental health further hampers their effectiveness in such demanding environments. Research conducted in Pakistan found no significant link between burnout and the doctor-patient relationship [17]. A cross-sectional survey of gynecological residents in Pakistan showed higher levels of burnout in government institutions compared to private ones [18]. A study in Lahore revealed that burnout among physicians was more prevalent than international reports suggest [19]. In a tertiary care hospital, a study on nurses highlighted that burnout, primarily due to excessive workloads, was common and had a detrimental effect on their quality of life, which in turn impacted patient care [20].

Burnout arises from occupational stress and low wages in an underpaid labor market. Given Pakistan's inflation, healthcare workers often face an increased workload due to low salaries. A lack of a supportive work environment and extended hours contribute to mental exhaustion, reducing overall quality of life. Mental health issues are still stigmatized in society, leading to many cases being neither diagnosed nor reported. Healthcare professionals in Pakistan are expected to remain unaffected by mental illness, adding to their distress as they attempt to manage stress and burnout independently, which leads to lower productivity and diminished patient care. Few studies have examined the barriers to addressing burnout and mental health challenges among healthcare workers in Pakistan. Hence, this study aims to evaluate burnout and the stigma associated with mental illness among healthcare professionals in the country.

Materials and Methods

A descriptive cross-sectional study design was used to explore burnout and the stigma related to mental illness among healthcare professionals in Pakistan. The study sought to identify the relationship between burnout and the stigma surrounding mental illness. Ethical clearance was granted by Hamdard University's Ethical Committee (Ref. No. HU/DRA/2022/085). Data collection occurred across various settings, including district hospitals, tertiary care institutions, both public and private healthcare facilities, medical schools, pharmaceutical companies, regulatory agencies, and marketing departments in Pakistan. Participants included nurses, doctors, and pharmacists. Given the absence of an up-to-date and validated list of healthcare professionals in the

country, convenience sampling was employed, involving all willing respondents available during the data collection period. The sample size was determined using the Rao Soft calculator, set at a 95% confidence level and a 5% margin of error, resulting in a sample of 382.

The study employed three validated instruments for assessment. The Maslach Burnout Inventory (MBI) was utilized to measure burnout, comprising three sections: emotional exhaustion, depersonalization, and personal achievement, with 22 items scored on a Likert scale from 0 to 6 (0 = Never, 1 = A few times a year, 2 = Once a month, 3 = A few times a month, 4 = Once a week, 5 = A few times a week, and 6 = Daily). The sections were scored separately, and a total score was calculated for the entire inventory [10]. Anxiety symptoms were evaluated using the Generalized Anxiety Disorder Scale (GAD-7), which consists of seven items plus an additional question, each scored on a Likert scale from 0 to 3 (0 = Not at all, 1 = Several days, 2 = More than half the days, and 3 = Nearly every day), with the total score being the sum of individual responses, commonly used as an anxiety screening tool [21]. Job-related depression was measured with the Occupational Depression Inventory (ODI), which includes nine items plus a question on turnover intention. Responses are scored on a Likert scale from 0 to 3 (0 = Never or almost never, 1 = A few days, 2 = More than half the days, and 3 = Nearly every day), and the total score is derived by summing the individual scores [13].

Data collection took place between January and May 2022. Once collected, the data was checked, cleaned, coded, and entered into SPSS version 21 for analysis. Descriptive statistics such as frequencies and percentages were calculated. Non-parametric tests, along with correlation and regression analyses, were used to examine differences and relationships between the variables.

Results and Discussion

Among the 382 participants, 51.3% (n = 196) were male, and 49.7% (n = 186) were female. The predominant age group was 25-30 years, representing 38% (n = 145) of the total respondents. Regarding marital status, 34% (n = 130) were unmarried, while 63.1% (n = 241) were married. In terms of income, 40.8% (n = 156) of the respondents had an income ranging from Rs 51,000 to Rs 100,000. As for professional roles, 38% (n = 145) were doctors, 34.6% (n = 132) were pharmacists, and 27.5% (n = 105) were nurses. Additional details can be found in **Table 1**.

Table 1. Demographic characteristics of respondents

Indicator		N (%)
Age (years)	25-30	145 (38.0)
	31-40	160 (41.9)
	41-50	62 (16.2)
	51-60	10 (2.6)
	> 60	5 (1.3)
Gender	Male	196 (51.3)
	Female	186 (49.7)
City	Islamabad	105 (27.5)
	Rawalpindi	98 (25.7)
	Taxila	93 (24.3)
	KPK	64 (16.8)
	Others	22 (5.8)
Setting	Urban	328 (85.9)
	Rural	54 (14.1)
Marital status	Single	130 (34.0)
	Married	241 (63.1)
	Others (Divorced, widowed)	11 (2.9)
Years of experience	≤ 2 Years	65 (17.0)
	3-5 Years	115 (30.1)
	6-10 Years	167 (43.7)
	11-20 Years	25 (6.5)
	> 20Years	10 (2.6)
Income	≤ 30,000	24 (6.3)
	31,000-50,000	116 (30.4)
	51,000-99,000	156 (40.8)
	100,000-200,000	70 (18.3)
	> 200,000	16 (4.2)
Profession	Doctor	145 (38.0)
	Pharmacist	132 (34.6)
	Nurse	105 (27.5)
Working setting	Hospital	212 (55.5)
	Academia	78 (20.4)
	Community pharmacies	31 (8.1)
	Sales and marketing	21 (5.5)
	Regulatory affairs	14 (3.7)
	Industry	26 (6.8)

Others	0 (0)

The MBI mean score was 60.32 (± 15.58), showing a high degree of burnout. The GAD-7 score was 7.7 (± 4.53), pointing to mild anxiety levels in healthcare professionals. The ODI score was 9.91 (± 5.86), which reflects a moderate degree of occupational depression **(Table 2)**.

Table 2. Mean scores of MBI, GAD, and ODI for healthcare professionals

Indicator	Mean (± SD)
Exhaustion	15.4 (± 8.20)
Depersonalization	13.15 (± 8.61)
Personal achievement	31.74 (± 10.23)
Composite	**60.32 (± 15.58)**
Generalized anxiety disorder (GAD-7)	7.7 (± 4.53)
ODI	9.91 (± 5.86)

There were no significant differences (P > 0.05) in MBI scores among healthcare professionals based on factors such as gender, work environment, age, experience, income, profession, or setting. A significant difference (P ≤ 0.05) in Generalized Anxiety Disorder scores was found between genders, with male healthcare professionals experiencing higher levels of generalized anxiety compared to females. No substantial variations (P > 0.05) were noted about other demographic characteristics. For ODI scores, significant differences (P ≤ 0.05) were observed based on years of experience, gender, profession, and work environment. Males showed higher levels of occupational depression than females. Professionals with over 20 years of experience had more occupational depression, and nurses had greater levels of occupational depression than doctors and pharmacists. Additionally, community pharmacists reported higher occupational depression compared to their counterparts in other work settings. No significant differences (P > 0.05) were found for other variables. Spearman's correlation analysis revealed a mild positive link between burnout dimensions and occupational depression, with all burnout dimensions being interrelated **(Table 3)**.

Table 3. Comparison of MBI, generalized anxiety disorder, and ODI score among healthcare professionals

Indicator	N	MBI			GAD-7			ODI		
		Mean rank	Test stats	P-value	Mean rank	Test stats	P-value	Mean rank	Test stats	P-value
Gender	Male = 196 Female = 186	197.50 185.18	17052.50[a]	0.268	205.45 176.80	15493.50[a]	**0.010**	210.93 171.02	14419.500[a]	**0.001**
Setting	Urban = 328 Rural = 54	191.89 189.11	8727.0[a]	0.860	191.83 189.47	8746.50[a]	0.887	191.78 189.78	8763.0[a]	0.906
Age (years)	25-30 (n = 145) 31-40 (n = 160) 41-50 (n = 62) 51-60 (n = 10) > 60 (n = 5)	197.05 185.34 194.02 173.25 232.70	1.867b	0.767	185.79 194.45 190.23 211.55 238.50	1.758[b]	0.788	192.83 191.63 176.36 234.85 249.80	4.133[b]	0.391
Years of experience	≤ 2 (n = 65) 3-5 (n = 115) 6-10 (n = 167) 11-20 (n = 25) > 20 (n = 10)	197.70 198.47 184.46 191.34 189.00	1.349b	0.855	164.80	8.826[b]	0.068	188.30 203.72 187.72 143.22 255.50	9.825[b]	**0.046**
Income	≤ 30,000 = 24 31,000-50,000 = 116 51,000-99,000 = 156 100,000-200,000 = 70 > 200,000 = 16	206.06 198.56 188.59 182.95 184.28	1.489b	0.828	203.63 195.78 160.36 231.85			204.90 197.54 188.10 178.91 215.88	2.546[b]	0.643

Profession	Doctor = 145 Pharmacist = 132 Nurse = 105	182.87 203.44 188.40	2.514b	0.284	188.25 189.19 192.67 192.25 198.47	0.157b	0.997	186.93 176.06 217.22	8.549[b]	**0.015**
Working setting	Hospital = 212 Academia = 78 Community pharmacies = 31 Sales and marketing = 21 Regulatory affairs = 14 Industry = 26	188.70 183.40 231.92 196.29 227.18 167.38	7.456b	0.186	202.27 176.52 195.46 169.22 179.47 200.07 178.65	3.973b	5.929b	207.50 157.16 222.76 184.50 162.75 147.96	19.608[b]	**0.001**

A hierarchical multiple linear regression analysis was conducted to assess the association between ODI scores and various burnout dimensions. The initial stage of the emotional exhaustion (EE) analysis did not reveal any significant predictors. However, in the subsequent stage, the inclusion of ODI resulted in a substantial variance shift ($F = 30.13$, $P < 0.01$). In the analysis of depersonalization (DP), gender was identified as a key predictor in the first step. The second stage showed that ODI significantly contributed to additional variance ($F = 76.90$, $P < 0.01$), indicating that stigma was linked to heightened DP levels. Regarding personal achievement (PA), no significant predictors emerged in the first step, but the addition of ODI in the second stage led to a noteworthy variance change ($F = 23.03$, $P < 0.01$). Detailed findings are presented in **Table 4**.

Table 4. Hierarchical multiple linear regression analysis and the ODI scores on the MBI

	Emotional exhaustion		**Depersonalization**		**Personal achievement**	
	Step 1 β	Step 2 β	Step 1 β	Step 2 β	Step 1 β	Step 2 β
Age	-.019	-.018	-.005	-.003	- .018	-.020
Gender	-.063	.012	-.156	-.053	.085	.018
ODI		**.001		**.001		**.001
R	.063	.439	.155[a]	.616	.089	.393
R2	.004	.193	.024	.379	.008	.155
R^2 change score	-.001	.187	.019	.374	.003	.148
F	.761	30.13**	4.690*	76.90**	1.517	23.03**

*P ≤ 0.05; **P ≤ 0.01; step 1: adjusted for age and gender; step 2: adjusted for ODI

The stigma surrounding mental illness is a growing public health concern worldwide, with its prevalence being particularly high in developing nations due to inadequate coping strategies among healthcare professionals [22]. This issue significantly impacts their productivity. Occupational stress is a key factor contributing to the stigma associated with mental illness, and when burnout remains undiagnosed or untreated, it can escalate into severe mental health disorders [23]. This study aimed to examine the link between burnout and stigma related to mental illness among healthcare professionals in Pakistan.

Findings indicated that the exhaustion component of the MBI showed a low level of burnout, as most healthcare professionals reported experiencing emotional exhaustion only once a month. This could be attributed to their training, which equips them to handle stressful work environments. A study in the USA yielded similar results, where doctors reported lower levels of exhaustion [24]. However, the depersonalization component revealed a high level of burnout, as many professionals displayed cynicism or negative attitudes toward patients several times per month. The personal achievement component also indicated high burnout levels, with respondents expressing doubts about their abilities to achieve goals. This may stem from their inability to focus on personal and professional development due to excessive workload. Overall, the study identified a high prevalence of burnout among healthcare professionals.

Regarding occupational depression, no notable differences in MBI scores were found among professionals, but those with over 20 years of experience exhibited higher occupational depression, possibly due to heavier workloads associated with specialized roles. Nurses reported higher occupational depression levels than other healthcare professionals. A study in the USA found that among various healthcare settings, community

pharmacists had the highest occupational depression levels, possibly due to a loss of compassion toward patients, colleagues, and managers, leading to diminished interest in their profession [19]. Similar trends were observed in Japan, where a study on psychiatric nurses revealed widespread occupational depression in this group [25].

The current study also found a weak positive correlation between burnout and ODI, with all burnout dimensions being interrelated. Age and gender contributed to variations in emotional exhaustion, depersonalization, and personal achievement scores. A study in Sweden produced similar results, linking a low sense of personal achievement to avoidant behaviors and attitudes among psychiatric staff toward patients [26]. Another study in Japan found that stigma related to mental illness significantly influenced only the depersonalization component of burnout [10]. Additionally, the negative beta coefficient suggested that age was inversely related to all three burnout subscales. Research conducted in Spain also identified a connection between burnout dimensions and pessimistic attitudes among mental health professionals toward their patients [27].

Limitations

This study faced several constraints, including limitations in time, financial resources, and sample size, which may affect the extent to which the findings can be applied to the broader population. Additionally, some participants were reluctant to express their opinions on sensitive topics, which could have influenced the responses.

Conclusion

The findings highlight the widespread presence of burnout and stigma linked to mental illness among healthcare professionals. A notable degree of burnout was identified, alongside mild anxiety and moderate occupational depression among healthcare workers in Pakistan. To mitigate these concerns, routine health evaluations should be conducted within healthcare institutions. Organizations should implement coping mechanisms, including problem-focused, emotion-focused, and social support strategies, to alleviate burnout. Furthermore, specialized workplace health promotion initiatives for healthcare professionals should be introduced to address mental health stigma. Promoting interventions aimed at combating both stigma and burnout can support the psychological well-being of healthcare staff. Mental health training emphasizing social engagement may also help reduce workplace stigma.

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