Chapter 70
Burnout Among Formal Caregivers and Risk of Violence Against Institutionalized Elderly

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ABSTRACT

Sociodemographic changes occurring in past decades are reflected as increased population aging, resulting in a higher need to institutionalize elderly. Violence against elderly is a relevant public health problem. The aims of the present cross-sectional exploratory and descriptive study with a quantitative approach were to analyze burnout among formal caregivers at institutions for elderly and to assess the risk of violence against institutionalized elderly. As a part of project ESACA—Envelhecer com Segurança no Alentejo (Prevenir as Quedas e a Violência sobre Idosos)—Compreender para Agir (Aging Safely in Alentejo [Preventing Falls and Violence against Elderly]), the present study analyzed 34 formal caregivers from three institutions that provide care to elderly in the Evora district, Portugal. No situations involving violence against institutionalized elderly were detected. Most participants (96.3%) did not exhibit burnout, although they did report feeling physically and emotionally tired.

INTRODUCTION

Population pyramids have undergone considerable changes in recent years, pointing to demographic aging, with consequent challenges to unprepared governments, families, and communities.

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Demographic aging is a social phenomenon with significant multidimensional impacts that demands urgent reflection and decisions to help adjust social contexts and integrate this new reality with a minimum of negative consequences for citizens while strengthening consensual harmonization. It is not difficult to recognize that healthcare will be one of the sectors most likely to feel the impacts of demographic aging.

Social responses that address a significant number of elderlies are therefore a priority; such response essentially involves speaking about reform in the Portuguese state, and of a period of transition, with a view toward well-being, social protection and social rights. This new paradigm calls for qualified formal caregivers for elderly, with the expectation that better training of the former will result in better provision of care and, consequently, better quality of life and protection of the latter.

According to the Portuguese Association for Victim Support (Associação Portuguesa de Apoio à Vítima – APAV) (2010, p. 41), "recognizing that elderly are victims was slow, but at present it is an increasingly evident phenomenon within the current process of global population aging" (Portuguese Association for Victim Support – APAV, 2010, p. 41). According to The APAV (2013) estimates, 39.4% of elderly in Portugal are victims of aggression. The country is ranked by "the World Health Organization as the fifth among 53 European countries surveyed with significant rates of violence against elderly" (Coler, 2014, p. 19).

Institutionalization might promote the occurrence of violence against elderly, for which reason accurate knowledge of the associated conditions and risk factors is necessary to develop intervention/prevention strategies (Carrilho, Gameiro & Ribeiro, 2015).

Several authors (Jamieson, Teasdale, Richardson & Ramirez, 2010) observed that exposure to stress at work might harm the mental health of formal caregivers, particularly the more compassionate and altruistic ones, resulting in patient exhaustion and impacts on their own personal, family, and institutional lives. Studies on burnout are critical, as formal caregivers of institutionalized elderly are considered a high-risk group as a function of the demands inherent to their job (Meireles, 2016).

The aims of the present study were to analyze burnout among formal caregivers at institutions for elderly and to determine the risk of violence to institutionalized elderly within the context of project ESACA — Envelhecer com Segurança no Alentejo (Prevenir as Quedas e a Violência sobre Idosos) — Compreender para Agir (Aging Safely in Alentejo [Preventing Falls and Violence against Elderly] — Understanding to Act) Ref: ALT20-03-0145-FEDER-000007.

THEORETICAL FRAMEWORK

Aging

Even though defining elderly exclusively based on age is controversial and limited, here, this group is considered to include men and women aged 65 years or older. This notion is accepted by international organizations such as the World Health Organization (WHO) and the United Nations (Paschoal, 2000). Aging is a variable process, and according to "the times, culture, lifestyles, and scientific, medical and technological means, thus are the changes in the aging process" (Imaginário, 2008, p. 41).

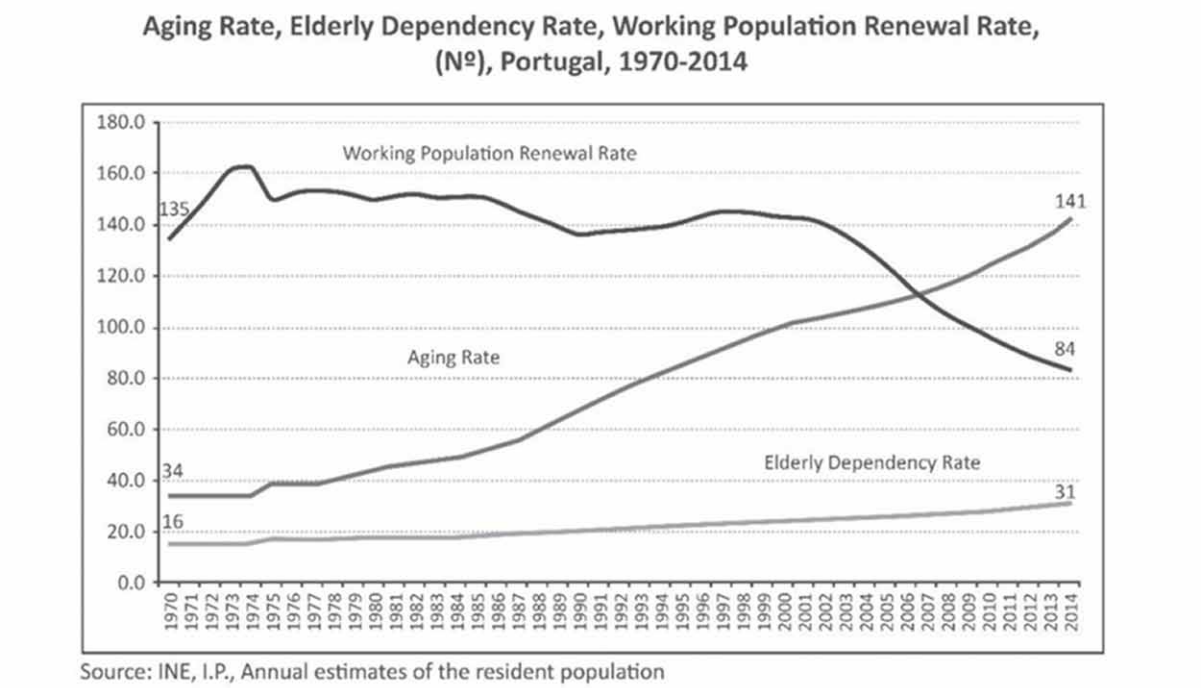
Lehr (1998) observed that aging occurs at the biological, physiological, mental, and social levels. According to the National Institute of Statistics (Instituto Nacional de Estatística–INE),

demographic aging expresses changes in the age distribution of a population, denoting a higher proportion of elderly in the population. This dynamic is a consequence of the processes of birth rate decline and increased longevity, and is internationally understood as one of the most significant demographic trends of the 21st century (INE, 2015, p. 1)

As a result of declining birth rates, increased longevity, and reduced mortality, youths and the population of economically active age have decreased in Portugal in the past decades, while the elderly adult population has increased (INE, 2015).

From 1970 to 2014, "the dependency ratio for elderly continuously increased, from 16 elderly/100 people of economically active age in 1970 to 31 in 2014" (INE, 2015, p. 3). In turn, the turnover rate of economically active persons has decreased, especially in the past 15 years: indeed, it has continuously decreased from 1999 onward to become less than 100 in 2010 and 84 in 2014 (INE, 2015) (Figure 1).

Figure 1. Aging index, dependency rate for elderly, and turnover rate of economically active people (n), Portugal, 1970–2014.
Source: INE, 2015, p. 3. Available at: https://www.ine.pt/xportal/xmain?xpid=INE&xpgid=ine_destaques&DESTAQUESdest_boui=224679354&DESTAQUESmodo=2



Graphic 1 – Aging index, dependency rate for elderly, and turnover rate of economically active people (n), Portugal, 1970–2014. Source: INE, 2015, p. 3. Available at: https://www.ine.pt/xportal/xmain?xpid=INE&xpgid=ine_destaques&DESTAQUESdest_boui=224679354&DESTAQUESmodo=2

According to INE projections for the Portuguese population, relative to the period until 2080, "the peak number of elderly will be reached by the end of the 40s to begin decreasing afterward" (INE, 2017, p. 4). This development is because "larger generations will reach this age range, [generations] already born within a context characterized by sub-replacement fertility" (INE, 2017, p. 4).

Institutionalization and Risk of Violence against Elderly

Increasing population aging, socioeconomic and cultural changes, and modifications in the structure of families in the past decades—reducing their ability to meet the needs of older members—have resulted in an increasing need for institutionalization (WHO, 2011).

Sousa, Figueiredo, and Cerqueira (2004) essentially describe institutionalization as the process of elderly leaving their homes (for a short or long period of time) that comprises the steps of decision-making, choice of institution, and adapting to the new environment. According to Fernandes (2000), institutionalization is a relevant resource for the elderly when considering their general state of health and autonomy.

Throughout the process of institutionalization, elderly must deal with several problems that interfere with their functional autonomy and abilities in various ways (Fernandes, 2000). The consequences of adaptation to institutionalized life might have a positive or negative influence on their quality of life. Institutionalization might be deleterious when elderly are deprived of their daily and family activities and are restricted by institutional regulations (Pestana & Espírito-Santo, 2008).

Institutions that provide care to elderly include different actors (older people, their family, formal caregivers, the community, etc.), and in this context, human dynamics and organizational aspects underlie the actual provision of care.

While institutional violence is a fact, it seldom reaches official sources of information, often remaining restricted to informal complaints. Therefore, the awareness of healthcare professionals and society at large about the risk of violence at medical and social institutions established to protect elderly is crucial (WHO, 2011). Healthcare professionals see some practices as "forms of abuse and neglect and that within the family context, it is worth noticing that some such practices are not considered by them as violent or abusive actions, but are even a part of professional standards and procedures" (Gil & Fernandes,2011, p. 9).

The risk factors for violence seem to be present in all levels of the ecological context of human development, including the interpersonal/psychological, interpersonal/familial, social networks, institutional, community/social, cultural, and historical (Schiamberg et al.,2011). Institutionalized elderly might be exposed to higher risk of violence as a function of their dependence, physical weakness, and ignorance of their legal rights, combined with fear of retaliation for eventual complaints (Dias, 2005).

Formal Caregivers

The rise in population aging and in the frequency of chronic and progressive degenerative diseases poses new challenges to families and institutions for older people and, consequently, also to formal and informal caregivers. Within this context, formal caregivers have "an outstanding role, inasmuch as changes in the family structure often result in the need to transfer the task of caring for elderly to institutions specific for this age group" (Meireles, 2016, p. 1).

Here, it is worth calling attention to differences between informal and formal caregivers. The former correspond to situations in which care is continuously provided to dependent older people by family members, friends, and/or neighbors, who are not paid and do not have specific training for this task (Silva, 2016). In contrast, formal caregivers have "specific training for the role entrusted to them, and are integrated into the occupational environment according to the particular competencies of each professional, and are paid and/or volunteer at hospitals, hospices, the community institutions, etc." (Meireles, 2016, pp. 8-9). Formal caregivers are therefore professionals with competencies that enable them to implement an intervention based on a holistic approach to aging (Kim, Bursac, DiLillo, White, & West, 2009). They have accurate knowledge of the needs of older people and provide them support in the performance of the activities of daily living (Hartke, King, Heinemann, & Semik, 2006).

The aim of professional provision of care to elderly is to improve their well-being and quality of life and to compensate for transient or permanent functional disabilities whenever possible (Silva, 2016). Therefore, formal caregiving demands different social responses and the involvement of multidisciplinary staff, requiring contributions from qualified health, psychology, and social science professionals, among others.

The inherent complexity of providing care to elderly places high professional, emotional, and personal demands on formal caregivers, which might interfere with their health and often serve as stressors (Ferreira, 2014; Meireles, 2016).

Moreover, inadequate working conditions might be a source of stress for caregivers that might become permanent and contribute to the development of burnout syndrome (Silva & Carlotto, 2008), which is characterized by clear manifestations of emotional exhaustion, depersonalization, and reduced personal accomplishment (Tamayo & Tróccoli, 2009).

While some caregivers who abuse elderly are opportunists or sociopaths, others might simply have an excessive workload (Sibbald & Holroyd-Leduc, 2012), an increasingly common situation in Portugal (Carrilho, Gameiro & Ribeiro, 2015).

Given the constant challenges posed to formal caregivers and the pressures to which they are subjected, there is a need to reflect on the problem of burnout and on policies and practices.

Burnout Among Formal Caregivers

Several studies on burnout "point to the occurrence of exhaustion and fatigue triggered by compassion in the relationship between formal care providers and recipients" (Saúde, 2013, pp. 3-4).

Maslach (2003) observed that occupations involving provision of care are the most susceptible to burnout, as caregivers are required to establish a strong and durable relationship with people often undergoing problematic situations who are full of feelings of frustration, fear, or despair. The tension and stress that result from such relationships might trigger the phenomenon of "emotional dryness," which makes professionals feel empty and emotionally predisposed to burnout.

The notion of burnout was first discussed in 1974 by Herbert Freudenberger within the context of a study with healthcare professionals in which he realized that many of the volunteers at healthcare services gradually developed emotional depletion, loss of motivation and reduced commitment, accompanied by physical and mental symptoms which pointed to a state of exhaustion. Freudenberg noticed that the professionals in such a state of mental and emotional exhaustion were idealistic, seemingly highly competent, dynamic, tireless, and active even when the outcomes they achieved were not those expected (Meireles, 2016).

Thus, Freudenberger detected the occurrence of continuous stress in the workplace and defined burnout as "wearing out, physical and emotional exhaustion, derived from excessive and highly demanding work in physical, emotional and/or psychological terms" (Ferreira, 2014, p. 10). Burnout syndrome is therefore a "state of fatigue or frustration brought about by devotion to some cause, way of life or relationship that failed to produce the expected reward" (Freudenberger, 1980, as cited in Queirós, 2005, p. 27).

The term burnout is morphologically composed of the words burn and out, "which suggests that the individual affected by this type of stress is physically and emotionally consumed, and evidences manifestations of aggressive behavior and constant irritation" (Meireles, 2016, p. 14). Vernacularly, burnout points to something that stopped working due to absolute lack of energy, and this term might be metaphorically applied to the individuals who have reached their limit due to lack of energy and exhibit a consequent state of physical and mental fatigue. This phenomenon affects countless professionals, and the idea is that of a "candle or bonfire dying out" or a "discharged battery" (Benevides-Pereira, 2002; Queirós, 2005).

In 1974, Freudenberger (as cited in Queirós, 2005) described the following as causes of burnout: low job commitment, lack of supervisor and manager support, high levels of work pressure, age, job characteristics, lack of social support, task uncertainty, low autonomy at work, physical discomfort, and technological changes.

Based on Freudenberger's studies, in their research, Maslach and Jackson (1982) concluded that burnout syndrome has three components:

a) Emotional exhaustion, which involves personal and situational factors. The affected individuals feel an emotional load heavier than that under normal conditions, a feeling of exhaustion which makes them feel unfit in regard to others, deprived of any type of emotional resources whatsoever, which reduces their performance at work.
b) Depersonalization, characterized by the adoption of a rather inflexible and impersonal stance toward others and while performing one's duties. This attitude might be seen as a defense mechanism, in the sense it mitigates the feelings of powerlessness, defenselessness and personal hopelessness.
c) *Reduced personal accomplishment, namely, the feeling that one's job is not deserving of any energy expenditure, that each and any eventual effort to change the profession or move to another institution is nothing but an utter waste of time* (Ferreira, 2014, pp. 9-10).

According to Ferreira (2014), burnout begins with stress and efforts to overcome it, evolving along three stages:

The first consists of an imbalance between the level of stress and the resources to cope with it; the second stage is signaled by the appearance of emotional tension, fatigue and exhaustion. The third step involves changes in attitudes and behaviors, a tendency to deal with clients in a mechanical manner and a concern with personal gratification (Ferreira, 2014, p. 10).

Silva (2016) observes that one should distinguish between stress and burnout, since prolonged occupational stress might lead to burnout. Stress is the result of an imbalance between a caregiver's resources and the demands placed on him or her, although the individual has full awareness of such imbalance and the feeling that he or she might control the situation, which would make discomfort go away (Neto, Areosa, & Arezes, 2014; Bakker, Demerouti & Sanz-Vergel, 2014). In contrast, under a state of burnout,

caregivers have few personal resources, and it is very difficult for them to confront the situation that causes stress; the negative tension that arises in the workplace compels them to change their attitudes and behaviors (Silva, 2016).

As a result of depersonalization, professionals lose their ability to identify and empathize with the people who seek their help, and do not deal with them as human beings, but as "things," "objects." They tend to see anything related to their job as a disturbance, as just one further problem to be solved (…) Thus contact with people is merely tolerated, and the overall attitude one of intolerance, irritability, anxiety (França & Rodrigues, 2005, p. 54).

Maslach (1976), as cited in Queiroz (2005), describes burnout as a state of exhaustion, expressed as physical and mental fatigue, characterized by a set of strategies adopted by individuals—such as detachment and depersonalization—which change their behavior in the workplace. The emotional demands to which formal caregivers are subjected are the main cause of burnout (Maslach, 2003).

Burnout is one of the most relevant consequences of occupational stress, especially among workers whose job is based on interpersonal relationships.

Indeed, within the context of provision of care to elderly, burnout is common when workers do not have sufficient resources to meet task demands (Silva, 2016).

Providing care to elderly might elicit psychological discomfort and physical illness, resulting in patient tiredness and the worker's feelings of deteriorating health, physical and psychological exhaustion, and consequent burnout (Ferreira, 2014).

Burnout is certainly a relevant issue to consider in the world of work at present, because its consequences are perceptible to the affected individuals, the institutions to which they are affiliated, and the recipients of care, which becomes of questionable quality Studying these aspects substantially elucidates the consequences of the impact of occupational activities on workers at organizations (Silva, 2016).

Several studies have shown that the high demands to which formal caregivers of elderly are subjected in the workplace and their concomitant impact on health translate as high levels of stress. It is worth observing that organizations lack mechanisms to deal with their employees' problems (Saúde, 2013).

According to Maslach (2003), one way to prevent burnout is to promote a compromise between professionals and the institutions where they work to increase caregivers' energy, thereby helping to enable them to perform their job with greater commitment and efficacy.

METHODS

A cross-sectional exploratory and descriptive design was selected for the present study to accomplish the intended aims.

Sample

Participants were 34 formal caregivers from three institutions that provide care to elderly in the Evora district and are participating in project ESACA, Ref. ALT20-03-0145-FEDER-000007 (ESACA, 2017). The participants met the inclusion criteria set in project ESACA: they were caregivers of frailer elderly

and agreed to participate in the study by signing an informed consent form and had no serious cognitive deficits.

Data Collection Instruments

Considering the research topics and aims of the present study, questionnaires were selected as data collection instruments. The following questionnaires were administered: Copenhagen Burnout Inventory (CBI) (Kristensen, et al. 2005) adapted and validated for the Portuguese population (Fonte, 2011) and the Shirom-Melamed Burnout Measure (SMBM) (Gomes, 2012).

The CBI investigates burnout through 19 questions distributed across three scales:

- **Personal Burnout:** Six Questions that investigate the frequency and degree of physical, psychological, and experienced personal exhaustion, answered on a five-point Likert scale (1=always; 5=never/almost never).
- **Work-Related Burnout:** Seven questions that investigate the degree of physical and psychological fatigue and perceived work-related exhaustion, answered on a five-point Likert scale (1=always; 5=never/almost never).
- **Client-Related Burnout:** Six questions that investigate the perceived degree of physical and psychological fatigue and exhaustion related to work with clients, answered on a five-point Likert scale (1=always; 5=never/almost never).

The total score is calculated by adding the average scores of items; scores equal to or below 3 indicate a high level of burnout.

The SMBM was adapted to the Portuguese context by Gomes (2012), based on the original studies by Armon, Shirom, and Melamed (2012) and Shirom and Melamed (2006). This instrument comprises 14 items answered on a seven-point Likert scale (1=never; 7=always) and distributed across three domains: physical fatigue—questions #1 to #6 (feelings of tiredness in regard to work resulting in reduced physical energy); emotional exhaustion—questions #7 to #11 (feelings of emotional exhaustion in interpersonal relationships, e.g., with coworkers, clients, etc., manifesting as reduced cordiality and sensitivity to other people's needs); and cognitive weariness—questions #12 to #14 (feelings of cognitive exhaustion in regard to work manifesting as reduced attention and thinking capacity). According to Gomes (2012, p. 3) "the score is obtained by adding [the scores] on each subscale items," such that "higher scores indicate higher levels of physical fatigue, emotional exhaustion and cognitive weariness." In other words, "higher levels of burnout are associated with higher physical fatigue, emotional exhaustion and cognitive weariness scores" (Gomes, 2012, p. 3). The SMBM helps to determine the level of exhaustion of the respondent's energy resources by calculating the global score that "results from adding the scores on the three subscales, then [dividing] by three" (Gomes, 2012, p. 4). As these are "merely indicative scores to establish the presence of feelings of burnout (without diagnostic application, as there are not references values available) one might suggest values equal to or over five on the Likert scale ('sometimes') as indicators of problems in this domain" (Gomes, 2012, p. 4).

Procedures

Data collection was performed in August and September 2017.

Treatment and statistical analysis of the data were performed using the SPSS–Statistical Package for the Social Sciences software (version IBM SPSS Statistics 21.0).

Given the relevance of assessing the sensitivity and reliability of the data, the items corresponding to personal burnout, work-related burnout, client-related burnout, and the SMBM were subjected to internal consistency analysis by means of Cronbach's alpha (α).

Once the questionnaires were administered, analysis of the internal consistency of the various domains of the CBI was performed. The obtained Cronbach's Alpha was 0.894 (Table 1), which indicates that the instrument and its domains are reliable.

Table 1. Internal consistency of the various burnout domains

Domains	Number of items	Cronbach's alpha	Categorization
Personal burnout	6	0.869	Very good
Work-related burnout	7	0.748	Good
Client-related burnout	6	0.863	Very good
Global score	19	0.894	Very good

The internal consistency of the SMBM was also assessed. The obtained Cronbach's alpha was 0.880 (corresponding to the "very good" category), so the global score of the scale and its various items was used for analysis.

The study complied with all the ethical requirements (informed consent, confidentiality, and anonymity) included in the Declaration of Helsinki on ethics in research involving human beings.

All the participants were informed as to the subject, aims, purpose, and possible usefulness of the present study. They received clear information about all the procedures and declared their awareness of the voluntary nature of participation. All the participants signed an informed consent form.

RESULTS

Most participants/formal caregivers at the three analyzed institutions were aged 45 to 50 years old (30%), followed by the age range 40 to 45 (20%), while only 3.3% were 55 to 60 years old. All of the participants were female.

Approximately 56.3% of the sample was married, 31.3% had a stable union, 9.4% were divorced, and 3.1% were single.

Approximately 87.1% of the participants had children, while 12.9% did not. Among the participants with children, 45.8% had two, 41.7% had one, and 12.5% had three. Approximately 78.9% of the respondents did not have other dependents, while 21.1% did (one single participant reported having three dependents).

In regard to their educational level, 45.5% of the sample had completed secondary school, 30.3% had finished elementary education (3rd cycle), 12.1% had completed higher education (BA), and 6.1% had completed the 1st cycle and 6.1% the 2nd cycle of elementary education.

Most participants had worked in the job for five to 10 years (51.5%), followed by one to five years (15.2%), and 15 to 20 years (15.2%). Approximately 43.8% of the participants had worked in the current institution for five to 10 years, 28.1% one to five years, and 15.6% 15 to 20 years; 2.9% of the participants worked at another institution for a total of 17 hours per week.

Approximately 37.5% of the participants worked in shifts, and 62.5% had a fixed work schedule. The working hours were quite variable: 55.6% of the participants worked 40 hours/week, 29.6% 35 hours/week, 7.4% 42 hours/week, and 7.4% 37 hours/week. Approximately 60% of the sample had permanent employment, and 40% had precarious, fixed-term contracts.

Approximately 33.3% of the participants provided care to elderly admitted to institutions, and 66.7% provided home and institutional care.

Approximately 68.8% of the sample reported having never missed work in the past year, 25% having missed seldom, 3.1% having missed sometimes, and 3.1% having missed work often. Approximately 87.1% of the participants reported having never missed work in the past month, 6.5% having missed seldom, 3.2% having missed sometimes, and 3.2% having missed work often.

Approximately 74.2% of the participants stated that they would not quit their job at the current institution, and 25.8% that they would, given the possibility to do so. Approximately 66.7% of the sample reported that they would remain in the profession, while 33.3% would change their occupation.

In regard to their state of health, 67% of the participants stated that they did not have any disease diagnosed by a physician, while 32.4% did. The most frequent diseases reported were hypertension, musculoskeletal disorders, depression, chronic venous insufficiency, heart problems, and diabetes. Approximately 54.5% of the sample did not regularly take medications, and 45.5% used medications often, 76.5% of them with a medical prescription.

Burnout

In regard to physical, psychological, and experienced personal exhaustion, 88.2% of the participants reported feeling tired "often" or "sometimes," and 8.2% reported feeling fatigue "often" or "sometimes." Feelings of being weak and susceptible to disease were reported less frequently: 44.1% of the sample responded "seldom" and 17.6% "almost never/never."

The participants' responses to feelings of personal burnout were as follows: 58.8% of the responses were "sometimes," 23.5% "seldom," and 14.7% "often" (Table 2). The average score for personal burnout was 3.03, standard deviation 0.71, which denotes a low level of personal burnout (Table 3).

On the assessment of work-related burnout, 47.1% of the participants responded that their job is "always" or "often" emotionally exhausting, and 64.7% said that they "sometimes" felt exhausted at the end of the working day. Nevertheless, 41.2% of the sample stated that they still have time for family and friends in their leisure time. Approximately 65.6% of the participants were classified as being at level 3, 18.8% at level 4, and 15.6% at level 2 (Table 2). The average score for work-related burnout was 3.03, standard deviation 0.59 (Table 3).

Regarding client-related burnout, for 58.85% of the participants, it was "sometimes" hard to work with clients, and 41.52% "sometimes" wondered how long they would be able to continue working with clients. Statistical analysis of the global score showed that 57.6% responded "seldom," 36.4% "sometimes," and 6.1% "almost never/never" to questions asking about frequency of client-related burnout (Table 2).

Table 2. Burnout global score

	n	Always 1	Often 2	Sometimes 3	Seldom 4	Almost never/Never 5
				%		
Personal burnout	34	2.9	14.7	58.8	23.5	0.0
Work-related burnout	32	0.0	15.6	65.6	18.8	0.0
Client-related burnout	33	0.0	0.0	36.4	57.6	6.1
n – number of valid cases						

The average score for client-related burnout was 3.69, which denotes a low level of this category of burnout. Standard deviation was 0.58. The participant with the lowest level of client-related burnout had an average score of 5, and the one with the highest level of burnout an average score of 3 (Table 3).

Table 3. Sample characterization according to average burnout levels

	n	Minimum	Maximum	Mean	Standard deviation
Personal burnout	34	1	4	3.03	0.61
Work-related burnout	32	2	4	3.03	0.59
Client-related burnout	33	3	5	3.69	0.58
n – number of valid cases					

Physical Fatigue, Emotional Exhaustion, and Cognitive Weariness (SMBM)

Statistical analysis of the global score on the physical fatigue scale showed that it was equal to or over 5 (sometimes) for 35.7% of the participants (Table 4). According to the results relative to the global score on the physical fatigue scale, 35.7% exhibited values establishing the presence of feelings of burnout (however, without diagnostic application, as there are no reference values available) as indicators of problems in this domain.

In regard to cognitive weariness, 16.6% exhibited scores equal to or over 5 (sometimes) (Table 4). Analysis of the global score on the cognitive weariness scale showed that only 16.6% exhibited values establishing the presence of feelings of burnout (however, without diagnostic application, as there are no reference values available) as indicators of problems in this domain.

Statistical analysis of the global score on the emotional exhaustion scale evidenced that no participant exhibited scores equal to or over five (sometimes) (Table 4). Therefore, according to the global score on the emotional exhaustion scale, no participant exhibited values indicating the presence of feelings of burnout.

Next, the global score on the SMBM was subjected to statistical analysis, which showed that 3.7% of the participants reported scores equal to or over 5 (sometimes) (Table 5). According to the analysis of the global SMBM score, only 3.7% of the participants exhibited values establishing the presence of feelings of burnout (however, without diagnostic application, as there are no reference values available) as indicators of problems in this domain.

Table 4. Global scores for physical fatigue, cognitive weariness, and emotional exhaustion

	n	1 Never or almost never	2 Very infrequently	3 Quite infrequently	4 Sometimes	5 Quite frequently	6 Very frequently	7 Always or almost always
		%						
Physical fatigue	28	0.0	14.3	14.3	35.7	17.9	10.7	7.1
Cognitive weariness	30	20.0	23.3	20.0	20.0	13.3	3.3	0.0
Emotional exhaustion	30	50.0	30.0	13.3	6.7	0.0	0.0	0.0
n – number of valid cases								

Table 5. Global score on the Shirom-Melamed Burnout Measure

	n	1 Never or almost never	2 Very infrequently	3 Quite infrequently	4 Sometimes	5 Quite frequently	6 Very frequently	7 Always or almost always
		%						
Global score on Shirom-Melamed Burnout Measure	27	7.4	22.2	37.0	29.6	3.7	0.0	0.0
n – number of valid cases								

RESULTS DISCUSSION

The results of the present study indicate that the analyzed formal caregivers (96.3%) did not exhibit burnout, although they reported feeling physically and emotionally tired. They feel that their job is emotionally exhausting, and most (64.7%) feel exhausted at the end of a working day. They often (15.6%) or sometimes (65.6%) feel burned out because of their work. It is worth noting that the analysis of the global score on the SMBM showed that one participant exhibited values suggestive of burnout. These results agree with those of the study by Melo, Gomes, and Cruz (1997), who reported high levels of stress related to work overload and suggested eventual consequences relative to job dissatisfaction and the possibility of stress generating pressure and discomfort among caregivers.

As in the previously mentioned study, in the present study, job dissatisfaction was identified, since 25.8% of the sample stated that, given the possibility, they would leave their job at the current institution. In addition, 33.3% would change their occupation. Over the course of the study, we came to understand that the participants' desire to leave their jobs was associated with personal burnout ($r=0.38$; $p=0.025$). This relationship is corroborated by Pereira (2002), according to whom individuals with burnout usually manifest a desire to leave their job. In addition to the employees, institutions might also feel the effects of burnout through reduced employee performance, low job satisfaction, and diminished interest in the profession, which could increase absenteeism and might result in actual exit from the job. Therefore, implementing preventive strategies against burnout that are likely to improve working conditions is essential, as improvements will be reflected in better provision of care.

The participants' dissatisfaction notwithstanding, they tended not to miss work. Approximately 68.8% of the sample reported not to have missed one single work day in the past year, and only 3.1% stated that they missed work often. This situation became more evident when, upon being asked about absences from work in the past month, 87.1% of the participants responded they had not missed one single day, while only 3.2% stated they missed work often.

Formal caregivers of elderly with considerable levels of burnout exhibit physical and mental health problems and low personal accomplishment, the rate of absenteeism is high, and the quality of the care provided is impaired, resulting in client dissatisfaction (Saúde, 2013). Approximately 32.4% of the participants in the present study reported having diseases diagnosed by physicians, the most frequent being hypertension, musculoskeletal disorders, depression, chronic venous insufficiency, heart disease, and diabetes. Approximately 45.5% of the participants reported taking medications often, 76.5% of whom had a medical prescription.

Approximately 55.6% of the sample worked 40 hours per week, and 7.4% worked 42 hours per week. According to the literature, the working hours are among the organizational factors that might contribute to the development of burnout syndrome, especially when workers are continuously forced to change their work schedule over a short period of time or to work shifts (Patrick & Levery, 2007).

CONCLUSION

Violence against elderly is an alarming public health problem that amounts to explicit violation of human rights. There is an urgent need to analyze the risk of violence against elderly and to formulate healthcare policies and community intervention strategies to minimize this problem. It is also necessary to dispel the negative stereotypes associated with aging and to change the current way of conceiving of and perceiving aging to increase the social value of elderly and the attention paid to problems related to their rights and needs.

Analysis of the results of the present study evidenced a low risk of violence against the elderly admitted to the three analyzed institutions in the Evora district in association with burnout among formal caregivers. Most of the caregivers (96.3%) did not objectively exhibit burnout, although they reported feeling physically and emotionally tired. It is worth emphasizing that tiredness is not a synonym of burnout, as the latter consists of a state of emotional exhaustion, depersonalization, and reduced personal accomplishment. However, a small proportion of the sample, 3.7%, exhibited levels compatible with burnout, which might represent a risk to the elderly under their care.

Organizations should be able to manage situations characterized by physical and emotional fatigue, prevent burnout, perform periodic evaluations of employees through appropriate instruments, and formulate and adopt measures to minimize and prevent these situations. In this way, they will help improve working conditions and, consequently, the care provided to elderly. Institutions are responsible for implementing policies and organizational management strategies to prevent burnout among formal caregivers and thus to help avoid the occurrence of violence against institutionalized elderly.

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