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Burnout in Female Dental Professionals

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ABSTRACT

Burnout is growing problem for health care workforce all over the world specifically in dentistry. Women dental professionals, numerous, which can lead them to experience emotional exhaustion, depersonalization, a lack of accomplishment and other issues. Emotional labor, physical dexterity, and patient centered care are often overlooked areas of their work which contribute to burnout. Burdened with societal expectations and family responsibilities on top of their professional roles, women encounter additional obstacles. The objective of the study was to explore burnout levels in female dental professionals and to determine the relationship of independent variables such as work related stress, work-life balance and years in the profession on the experienced rate of burnout. We obtained data from total of 150 female dental professionals using the Maslach Burnout Inventory (MBI) along with some demographic information.

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Introduction

American psychologist Herbert Freudenberger was the first to use the term “burnout” in a clinical context in the early 1970s. Social psychologist and academic researcher Christina Maslach built upon Freudenberger’s concept, working to define the construct further and creating what has become the most widely adopted burnout assessment tool. The field surrounding the study of burnout has often been marked by two largely parallel streams of work.

1. A practice-based approach focused on burnout cures, which has created the entire “burnout industry” including workshops, training programs, counseling, psychotherapy, organizational consulting and other costly services.
2. Academic research, which has produced thousands of scientific papers (75,000 according to Google Scholar and 10,000 according to Psych Info in March 2017).

It's fascinating to view these two fields side by side. In fact, only 25 studies of which 14 were randomized controlled trials were identified in a systematic review of burnout prevention programs, showing how few burnout intervention strategies have been scientifically tested. In a more new study, Laurentiu Maricuţoiu, Florin Sava, and Oana Butta's meta reviewed various types of burnout intervention programs rather than specifically prevention programs. Only 47 studies were made it their meta-analysis, and they found that only 6% of the 913 intervention studies they had originally identified conducted a controlled intervention. The results of this meta-analysis show that interventions may reduce burnout in a way that is both modest and sustainable.

A person who experiences persistent, accumulated emotional exhaustion from unmanageable, work related stress and pressure is said to have burnout syndrome, also known as job burnout. A person’s capacity to work efficiently and uphold relationship with others around them may be hindered as a result of feeling exhausted, weak, discouraged, lacking energy or dissatisfied at work. Long term burnout may cause physical and mental health consequences, such as depression, insomnia, or other medical conditions as well as antisocial behaviour and feelings of isolation.

In his novel “A Burnt-Out Case” Graham Greene was the first to use the term burnout to describe the journey of an architect who found no meaning in hi work or pleasure in life. Freudenberger later popularised the term and introduced it into the field of psychology, defining burnout as lack of energy, exhaustion and frustration brought on by a professional attempt that does not meet expectations. At first, the author restricted it to volunteer at a care facility that served individuals social issues and mental illness. Because of their line of work, these employees felt demotivated and exhausted and they also felt animosity towards the people they served

Maslach defined burnout as a gradual process of emotional exhaustion, negative idealism, and a decrease in dedication to social service professionals shortly after introducing the term into professional discourse. Following a number of empirical investigations, Maslach and Jackson reinterpreted the term

and developed a more exciting and practical definition of burnout as a psychological syndrome that can manifest in professionals who provide care for others. This definition includes emotional exhaustion, depersonalization and a diminished sense of professional efficacy.

The pivot between two definitions is the notion of burnout as a syndrome, with a syndrome described as in a syndrome variant or collection of symptoms and signs appearing in currently and clinically assuring a specific condition different from others.

Yet, other authors argue that all three of these factors are not entirely completely distinct from one another. This assertion can be supported by existing literature. First dimension that shows up when dealing with job stress is where they diverge (emotional exhaustion vs. depersonalization). The Longitudinal studies have indicated a cause effect sequence among the primary dimensions of burnout. Hence individual showing see an increase in cynicism or depersonalization. Similarly, evidence based studies suggest that exhaustion and depersonalization implies essential aspect of burnout at work, and lack of professional satisfaction categorised as a past cause of burnout wave or even as an aftermath of burnout.

Such methods are reformulated by Salanova et al who also suggest an expanded burnout model made up,

1. **Emotional exhaustion** (caused by crisis in the individuals' relationship with their job in general).
2. **Depersonalization** (distant views towards the individuals one works for and one with).
3. **Reduced personal accomplishment** (a decline in one's perception and success at work).

Emotional exhaustion

Emotional exhaustion describes a drop in one's inability to be productive and success at work. Professionals might think they're ineffective, unproductive, and unable to reach their work goals.

Effects

- Emotional exhaustion lower confidence in one's abilities results in less drive and involvement in work.
- Professionals might feel like they've failed and aren't good enough, which can bring down overall spirit.
- Over time, this can lead to job unhappiness and a stronger desire to quit. Bandura's Self-Efficacy

Theory applies here. When people face repeated setbacks or don't get positive feedback, they start to doubt their ability to do tasks well. This weakened belief in them adds to feelings of reduced personal accomplishment.

Depersonalization

Depersonalization is a phenomenon in which the practitioner adopts a detached attitude towards patients. A dental practitioner who is depersonalized operates under the impression that patients are not people but rather objects, creating an attitude that minimizes empathy and compassion.

Effects

- Depersonalization negatively impacts the quality of care for patients with compassion and empathy stripped from the professionally charged experience.
- It harms the patient-provider relationships, resulting in lower patient satisfaction and general trust.
- Coworkers might see the affected person as cold or distant. This can strain relationships in the workplace.

Fruedenberger's burnout theory points to depersonalization as a way to cope. When emotional demands become too much, professionals might distance themselves to protect themselves. But this detachment makes burnout worse and lowers job satisfaction.

Reduced personal accomplishment

Reduced personal accomplishment is a term used to describe a decline in one's perception of one's own competence and success at work. Professionals may feel ineffective, unproductive, and unable to meet their professional goals.

Effects

- Decreased self- efficacy leads to reduced motivation and engagement in work.
- Professionals may experience feelings of failure and inadequacy, which can lower overall morale.
- Long-term effects include career dissatisfaction and increased turnover intentions.

Bandura's self-efficacy theory is relevant here. When individuals experience repeated setbacks or lack positive feedback, their belief in their ability to perform tasks effectively diminishes. This reduced self-efficacy contributes to feelings of reduced personal accomplishment.

Why does burnout appear and how does it develop?

Many theories have been developed since the term first appeared in the scientific literature in an attempt to explain how and why burnout occurs. Emphasis should be on the most recent and empirically supported explanatory theories of burnout complement one another and offer a more comprehensive and thorough understanding of the syndrome.

Specifically, the theories listed below are summerised:

- Theory of social cognition
- Theory of social exchange
- Organizational theory
- Theory of demands for resources
- Theory of structure
- Theory of emotional contagion

Theory of social cognition

Based on this hypothesis, personal factors such as self-efficacy, self- confidence and self- concept considered the most essential part in the development and progression of burnout. Therefore, whenever a member of marginalized group has doubts about their capacity to reach career objective, this syndrome kicks in. A study involving 274 secondary school teachers in Spain provided support for these tactics by demonstrating that burnout transpired subsequent to the commencement of crises in professional efficacy.

The following circumstances allow for the emergence of efficacy crises or inefficacy expectation:

- History of failure that has been negative.
- An absence of role models who have faced and overcome comparable challenges.
- Insufficient external reinforcement of the work,
- Absence of feedback about completed work or excessive negative criticism.

- Issues at work, effectiveness crises would thus result in poor levels of job satisfaction, which, if sustained over time, would lead to emotional weariness and, as a copying mechanism, cynicism/depersonalization.

Theory of social exchange

According to this hypothesis, a professional experiences burnout when they observe a disparity between their contributions and efforts and the outcomes they achieve at work. Professionals' emotional energies are depleted by this lack of reciprocity, which may have happened with clients, coworkers, managers and organisations. This leads to a persistent emotional tiredness.

Burnout may be fueled by the high stakes nature of interpersonal interactions that clients/ users who subject you to emotional labor. So in order to not touch the wellspring of pain, depersonalization or cynicism becomes a stress management technique that results in a lack or personal satisfaction.

Organizational theory

This view sees burnout as the outcome of organizational and work stressors combined with the inability of individuals to cope effectively with such stress. Within the theory, however, to competing alternative models seek to explain the relationships between dimensions of burnout.

According to Golembiewski et al, due to the presence of risk factors or organizational stresses, including work overload, some people exhibit a decline in organizational commitment as a coping mechanism; this is quite comparable to cynicism and depersonalization. Emotional exhaustion and a lack of personal fulfillment at work are the subsequent causes of burnout syndrome. Therefore the signs of burnout would be depersonalization, a feeling of low self- fulfillment, and emotional exhaustion. The alternative proposal is this view is by Cox et al. According to these authors, the initial stage of the syndrome lies in the emotional exhaustion, followed by low personal accomplishment.

Theory of demands for resources

This approach states that burnout occurs when expectations available resources are not balanced. Job demands are those aspects of a job that necessitate prolonged mental or physical effort. They are linked to psychological costs, such as subjective exhaustion, diminished focus and redefining task requirements as well as psychological costs (e.g., subjective fatigue, reduced focus of attention, and redefinition of task requirements) brought on hypothalamic–pituitary–adrenal axis being activated. Work overload, emotional labor, time pressure, or inter- personal difficulties are examples of common work demands. When

reputation is insufficient or inadequate in the face of such demand, it leads to a state of physical and mental exhaustion.

At work resources can be both personal and organizational. Fatigue arises when demands outweigh available resources; if this disparity persists over time, fatigue turns into a chronic condition and, eventually, burnout appears. While job demands have a direct and positive correlation with burnout, especially exhaustion, the existence of job resources has the opposite effect on depersonalization by reducing or eliminating its use as a coping mechanism.

Theory of structure

According to this method, burnout happens when expectations and resources are not balanced. The elements of job that that requires sustained mental or physical effort are known as job demands. They are associated with psychological costs, including subjective exhaustion, decreased focus and reframing task expectations as well as psychological costs (e.g., subjective fatigue, decreased focus of attention, and reframing of task expectations) brought on hypothalamic–pituitary–adrenal axis being activated. Work overload, mental strain, hectic schedule, or inter- personal challenges are examples of common work demands. When reputation is insufficient or inadequate in the face of such demand, it leads to a state of physiological and psychological exhaustion.

At work, resources can be both personal and organizational. When demands exceed available resources, fatigue develops; if this disparity continues over time, fatigue becomes a chronic condition and, ultimately, burnout manifests. The presence of job resources has the opposite effect on the depersonalization by decreasing or eliminating its use as a coping mechanism, despite the fact that job demands have a direct and positive correlation with burnout, particularly exhaustion.

Theory of emotional contagion

The emotional contagion is the process by which people automatically imitate and synchronise their posture, movements, vocalization and facial expressions with those of others leading to emotional alignment. People who work together encounter shared experiences which generate collective emotions including both positive and negative feelings. The theory explains that work group experience burnout because they develop shared emotions and beliefs through social interaction. Burnout contagion primarily affects teaching and health professionals and spouses when they interact outside the work

environment. The development of burnout at work and in external settings is influenced by how emotional contagion operates.

Situations that cause burnout

Antecedents are the things that will motivate, trigger, and/or maintain a person with burnout syndrome.

In general, these aspects can generally be classified into two major categories:

- Organizational elements like the workload or the emotional load for instance.
- Individual traits like, the employee's personality or coping mechanisms. Although it can come from a variety of sources, changes in the external environment are the primary causes of change.

The development of burnout emerges primarily from exposure to specific work environments and not from inherent personality characteristics. The causes of burnout stem directly from various work elements including task content and environmental structure as well as professional relationship with users, clients, bosses and colleagues. The general opinion suggests that organizational elements can create burnout independently but specific individual factors function as additional controlling elements.

The element of burnout might intensify because personal traits like self – confidence deficits and stress avoidance coping methods work together with situational elements. When individual features of optimism and active coping exists, they have the power to weaken and even delay the harmful impact of organizational factors on burnout development and its outcomes.

Consequence of burnout

The effects of burnout create multiple negative outcomes that affect individuals and organizational operations. Psychological effects start the series of problems which when prolonged lead to physical health problems and altered behaviors in workers, thus, producing unwanted organizational outcomes.

1. **Psychological effects**

Psychological alterations brought on by the burnout syndrome at work happen on both an emotional and cognitive level. Numerous studies have linked this syndrome to issues with memory and focus, trouble making decisions, decreased coping skills, anxiety, depression, life dissatisfaction, low self-esteem, sleeplessness, irritability, and increased use of alcohol and tobacco. This syndrome has also been linked to a considerable risk of suicide, according to other researchers.

2. **Health consequences**

Several reviews of research come to the conclusion that workers who experience higher levels of burnout are more likely to experience a range of physical health issues, including headaches, cardiovascular disorders, musculoskeletal pain, stomach changes, insomnia, and chronic fatigue. Additionally, burnout has been shown to raise blood cortisol levels alarmingly and is a risk factor for type 2 diabetes on its own. Now, not everyone experiences these symptoms in the same way, and they are not all required to appear.

3. **Behavioral consequences**

Apart from physical and mental health issues, burnout is typically associated with job dissatisfaction low organisational commitment, increased absenteeism, intention to leave and performance decline. However, some workers with burnout syndrome may choose to stay on the job, while others may legitimately quit.
Work presenteeism—when people show up for work but fail to carry out their duties because of health concerns—may result from this. Burnout can also result in workers acting in ways that are irregular and counterproductive, acting aggressively towards users and their co-workers, abusing alcohol and psychotropic drugs, misusing company property, or even stealing. But these distinct effects—behavioural, psychological, and health—don't always take the same shape or develop in the same way.

All cases experiences different patterns of change in their psychological, health and behavioral outcomes which emerge from these factors.

- **Mild**: Individuals experience mild physical symptoms which include headaches, back pain, low back pain along with fatigue and operational decline.
- **Moderate**: People experience insomnia alongside attention and concentration deficits. Detachment combined with irritability leads to cynicism and fatigue which results in a progressive loss of motivation that makes people feel emotionally drained and experience frustration while developing incompetence and guilt as well as negative self- esteem.
- **Severe**: The condition leads to elevated absence rates and work avoidance while people develop depersonalization and begins to abuse alcohol and psychotropic drugs.
- **Extreme**: People reach a point of isolation along with aggressive behavior and existential crisis which leads to chronic depression and potential suicide.

4. **Organisational consequences**

Adapting to change remains the most challenging aspect for any person who faces a transition. Burnout employees disrupt team operations through work interference and conflict which reduces productivity and extends production durations for the organization.

Major transformation often remains hard to accept, yet people discover that their experience improves or worsen based on their responses and attitudes toward these events. People typically begin to accept new conditions before they adapt to their surroundings

Effects of burnout in female dental professionals:

1. **Physical health impacts**

- Constant emotional and physical demands can result in persistent tiredness.
- Burnout is associated with headaches, musculoskeletal pain (common in dental practice due to prolonged static postures), and gastrointestinal issues.
- Stress-related burnout can lead to insomnia or poor-quality sleep.

2. **Psychological impacts**

- Burnout increases the risk of anxiety disorders and clinical depression .
- Feelings of inadequacy and reduced personal accomplishment can damage self-confidence.
- Difficulty managing emotions can lead to mood swings and irritability.

3. **Professional impact**

- Emotional exhaustion and depersonalization impair the ability to provide high-quality patient care.
- Cognitive fatigue and reduced concentration can result in clinical errors, posing risks to patient safety.
- Burnout contributes to higher turnover rates and frequent absenteeism, which disrupts workplace dynamics and increases costs for dental clinics.

4. **Personal life impacts**

- Burnout disrupts personal relationships due to irritability, lack of time, and emotional unavailability.
- Affected professionals may withdraw from social interactions, further exacerbating feelings of isolation.

Situations that cause burnout

Occupational stressors that are specific to female dentists lead to high levels of burnout, which negatively impacts their well-being, ability to function professionally, and patient care. Although there

is a wealth of research on burnout among healthcare workers, few of these studies concentrate exclusively on female dentists. Developing focused solutions requires an understanding of the unique characteristics contributing to burnout in this population.

Significant and scope of the study

This study is significant in addressing an unexplored yet crucial issue in health care. It extends the existing research on burnout by focusing specifically on female dental professionals in India.

The scope includes;

- Evaluating burnout levels across different practice settings.
- Main stress factors that lead to emotional exhaustion and depersonalization along with decreased personal accomplishment.
- Recommendations for workplace modifications, policy development and psychological support strategies should focus on the specific needs of female dental professionals..

By examining these aspects, the study aims to contribute to the broader discourse on mental health and occupational stress in healthcare, paving the way for interventions that enhance the well-being of female dental professionals.

Materials used:

The numbers must represent all variables listed in the research study. Before going into the details of the tools used to measure, let us see the dispositional variables in this study and describe each one in brief:

1. Age: measured in years as a continuous variable.
2. Years of experience: duration of the dental field work experience.
3. Qualification: educational background categorized as BDS, MDS or postgraduate student.
4. Work setting: The type of workplace (private clinic, academic institution or hospital).
5. Style of practice: Refers to whether the respondent runs their own practice, works under another employer, or holds an academic or administrative position.

Measures

The research instrument depended on the Maslach Burnout inventory (MBI) as main measurement tool.

- The most popular instrument to measure burnout in different fields.
- The evaluation tool includes three parts which are, Emotional Exhaustion, Depersonalization, and

Personal Accomplishment.

Scoring key

Each tool used in the study employed a standard Likert scale scoring system.

Maslach Burnout Inventory (MBI): Contains items scored on a 5-point Likert scale ranging from 0 (Never) to 5 (Always).

- Emotional exhaustion: Sum of responses to relevant items (Q1- Q9)
- Depersonalization: Sum of responses to items reflecting detachment (Q10- Q14).
- Reduced personal accomplishment: Sum of items related to sense of achievement (Q15- Q22).

Statistical tool:

The descriptive statistical tool in this analysis involves calculating the Mean and Standard Deviation that demonstrate the distribution of sample. Inferential statistics were used to test the hypothesis and extend the results to the population. The data collected from the study was rated by the subject on a 5-point rating scale, and was further tested.

Procedure:

Data was collected from female dental professionals. Data was collected through a virtual means via a survey form. These individuals were explained about the reason and the purpose of the research before data was collected. After obtaining the permission from the individuals and ensuring about the confidentiality, the researcher was able to win the confidentiality. Participants were recruited through various channels, including dental associations, academic institutions, and professional networks, ensuring a diverse and representative sample of female dental professionals.

The purpose of the study was explained and these female dentists from various work groups were informed that the participation was voluntary. Those who were willing to participate were then provided with the informed consent form before filling the questionnaire. The informed consent form was also provided via the online platform. After building adequate rapport all required information was collected and it was assured that confidentiality would be maintained.

Appropriate instructions were given to fill the questionnaires and all the doubts and queries were clarified during this process.

In this chapter we described the process of transforming research variables into numerical data through psychological assessment methods while covering the specific analytical procedures alongside sample

specifications. The upcoming chapter will present the analysis findings which emerged from sample scores on the previously described tools.

Result and Discussion

The research studies statistics are covered in this chapter, along with the tables containing the results of analysis. Finding the relationship between the variables and extent to which they influence one another is the goal of the analysis.

There were 150 female dental professionals working in corporate and private organizations in India and GCC in the present study and the statistical tools used were Mean, Standard Deviation, Pearson's Product Moment Correlation and Mediating Analysis.

Descriptive analysis

To begin with descriptive statistics for Age and Burnout was conducted. The results are presented in Table 1. Participants had a mean age of 33.95 years (SD = 6.21), with a range of 24 to 52 years

Table-1: Overview of the ages and burnout scores of female dental professionals alongside Mean and standard deviation

Descriptive statistics

	Mean	SD	Min	Max	Range	IQR
Age	33.95	6.21	24.00	52.00	28.00	9.25
Burnout	2.75	0.35	2.05	3.52	1.48	0.52

Tests of Normality

The next step was to test if the data was normally distributed or not. Hence a Shapiro-wilk test for normality was done. The Shapiro-Wilk tests indicated that both Age and Burnout significantly deviated from normality ($p < .01$), suggesting the use of nonparametric statistical tests (Table 2).

Table 2: Provide results of Shapiro- wilk normality test for age and burnout scores.

Normality test for Age and Burnout

	Shapiro-Wilk	df	Sig.
Age	.945	150	< .001
Burnout	.969	150	.002

Correlation analysis

First to find if there existed a correlation between Age and Burnout, Spearman's rank-order correlation was conducted. This revealed a significant positive correlation between Age and Burnout (r = .213, p = .009), indicating that higher age was associated with slightly increased burnout levels (Table 3).

Table 3: Spearman's correlation results for age and burnout among female dental professionals.

Correlations

	1	2
1. Age	-	.213**
2. Burnout	.213**	-

Note: **p < .01** (2-tailed).

Group difference in burn out by experience

Since experience was categorical variable**,** A Kruskal-Wallis H test was conducted to examine differences in burnout across four levels of professional experience (0–1, 1–5, 5–10, and 10+ years). Since the data was normally distributed, ANOVA can't be used and hence the Kruskal-Wallis test was used**.** The test was statistically significant, $\chi 2(3) = 14.44$, p = .002, indicating that burnout levels differed by experience group (Table 4).

Table 4 –Kruskal-Wallis H test results to compare burnout scores across participants grouped by years of professional experience.

Experience Group	N	Mean Rank
0–1 years	9	82.00
1–5 years	50	61.46
5–10 years	30	65.95
10+ years	61	90.75

Kruskal-Wallis test

Test	χ2	df	p
Kruskal-Wallis	14.44	3	.002

DISCUSSION

As previously stated, the study's goal was to determine the prevalence of burnout among female dental professionals and investigate how it related to age and work experience. The descriptive results revealed a moderate average level of burnout across the sample, aligning with previous research suggesting that dentistry is a profession with significant emotional and occupational demands.

A key finding of the study was the positive correlation between age and burnout, indicating that older dental professionals may experience slightly greater burnout. This could be attributed to cumulative stress over years of practice, increased responsibilities, or reduced coping flexibility. This finding is consistent with existing literature which indicates that long-term exposure to clinical demands can gradually erode emotional resilience.

The analysis also demonstrated significant differences in burnout levels across different experience groups. Interestingly, professionals with over 10 years of experience exhibited the highest burnout, while those in the early career stage (1–5 years) reported lower levels. This suggests that prolonged

exposure to clinical and administrative challenges may gradually contribute to burnout, underscoring the importance of long-term support and coping interventions for senior professionals.

These results support the alternate hypotheses proposed in the study — specifically, that age and professional experience are significantly associated with burnout. The findings highlight the importance of early detection of burnout symptoms and the implementation of mental health strategies across all stages of a dental professional's career.

Conclusion:

The study sheds valuable insight on the causes and characteristics of burnout among female dental professionals in India. The results clearly indicate that **burnout is not confined to early-career stress or specific job roles**; rather, it tends to grow over time, particularly with increasing age and years of experience. These findings suggest that **burnout is a cumulative experience**, gradually building as professional responsibilities intensify and personal resources become strained.

By revealing that burnout is significantly related to age and years of experience — and **not** significantly influenced by job designation, qualification, or setting — the study partially supports the null hypothesis. In other words burnout appears to be more of a **universal, progressive challenge** than one tied to any particular demographic group or practice environment.

This conclusion carries important implications for dental institutions, professional associations, and policymakers. To protect the mental health and professional longevity of female dental practitioners, there is an urgent need for comprehensive wellness programs that go beyond surface-level interventions.

Strategies such as routine psychological assessments, access to counseling, work-life balance training, and peer mentorship programs should be integrated into both academic and clinical practice environments.

Lastly this study recognizes its limitations, especially its reliance on self- reported data and cross sectional design even though it significantly advances our understanding of burnout in female dental professionals.

In conclusion, addressing burnout is not just a personal issue — it is a professional and systemic one. By creating environments that foster resilience, psychological safety, and continuous support, the dental

profession can ensure the well-being of its female workforce and enhance the quality of care delivered to patients.

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